Scottish Hospitals Inquiry
Witness Statement of
Sarah-Jane McMillan

WITNESS DETAILS

1. My name is Sarah-Jane McMillan.

2. I am a Clinical Nurse Educator, which is a specialised role, within the Haematology and Oncology Unit at the Royal Hospital for Children (RHC) in Glasgow. I began this role in June 2020.

3. I am currently studying for a post graduate qualification in Academic Practice. Prior to this, I obtained a Batchelor Degree in Adult Nursing then completed a degree in Children's Nursing.

PROFESSIONAL BACKGROUND

4. In my current role as a Clinical Nurse Educator, I facilitate all the education within the Haematology and Oncology unit within ward 2A and ward 2B. If any new nursing practices or procedures are brought in then my role is to inform and train the staff, making sure everyone's training is up to date.

5. I also support staff clinically. If there are new staff nurses, I will arrange and support their training. I also deal with the annual training updates and ensure all the training is current.

6. My previous role was a Band 6 Nurse (Senior Staff Nurse) within ward 2A at the Royal Hospital for Children (RHC).

7. My current line manager is Catriona Riddell who is the Lead Nurse. Before that, in my last role, my line manager was Emma Somerville, who was the Senior

Charge Nurse for Ward 2A. Emma came into her post in 2017. Before Emma, I think it was Jean Kirkwood that was the senior charge nurse. I think it was 2009 that I joined the RHC, so I have been here for thirteen or fourteen years. It was around about June 2015 when we moved from Yorkhill to the RHC. When I first began on ward 2A I was a Band 5 nurse. I became a Band 6 Nurse in December 2015, then in June 2020 I progressed to my current role.

8. The Band 6 Nurse is Senior Staff Nurse, so my role is to support the Senior Charge Nurse. We would have patients, but we also look after the staff. On a day-to-day basis, if someone else was in charge that day, I would nurse the patients. If I was in charge, I would oversee the unit and be there to support the staff and the families.

9. I could be involved in anything general that was happening on the ward, for example, I would be on ward rounds, meeting with medics (doctors), making sure the nurses were kept up to date with what was happening on the ward round and ensuring that everything that should have happened for the patients did happen.

10. Also, if the Senior Charge Nurse wasn't in, anything that had to be done that the Senior Charge Nurse would usually do, I would step into that role also, which was the management side. This would include organising staff rotas. I also dealt with the staff holidays.

EVIDENCE FROM PATIENTS ANDFAMILIES

11. In relation to the Public Inquiry, I did follow the evidence from the patients and families. There probably wasn't anything that was said that I wasn't aware of because I was working on the floor, and I was looking after these patients and families for a long time. If the families were unhappy about something or if they had any concerns and I was the nurse in charge on that day, I would be the person that they would be dealing with, so many of these things I had already heard before.

OVERVIEW

12. I worked in both the old Yorkhill hospital and transferred over to the new hospital with Yorkhill closed in 2015 and the Royal Hospital for Children (RHC) opened in 2015. I continue to work within the Haematology and Oncology Unit which is also known as the Schiehallion Unit. I was working in Ward 2A/2B when the ward closed and the patients and staff were decanted to Ward 6A of the Queen Elizabeht University Hospital (QEUH) in September 2018. I worked in Ward 6A of the QEUH and can speak to my experiences within the new hospital.

THE SCHIEHALLION UNIT (WARD 2A) RHC
DESCRIPTION OF WARD 2A

13. In 2015 we moved from Yorkhill to the RHC at the new Queen Elizabeth University Hospital (QEUH) Campus. Ward 2A is an in-patient facility for patients who have haematology and oncology conditions. We are also the transplant unit and would also look after patients with non-haematology or oncology conditions.

14. Originally in Ward 2A when we moved to the Queen Elizabeth we were a 26 bedded unit. When we returned to the ward after the decant, we only had 24 beds. I understand the reason for this is because a playroom was added for the patients aged between eight and twelve years and extra facilities for our pharmacist services were also created. We have a Teenage Cancer Trust (TCT) Unit within the area too.

15. For a family coming in with a new diagnosis, we would have a consultation with their consultant and a nurse, who would then explain that this is where we treat children with cancer. The consultation would be with the consultant but a nurse is always present, so that if the family have any queries later and the consultant

is not available, then the nurse may be able to answer their questions and offer further support.

16. We would tell them about the work we do in the Unit such as administering stem cell and bone marrow transplants. We would also tell them that we deal with children with non-cancer conditions such as a blood disorders.

17. In the ward, when we first moved over to the new hospital, we had 26 beds so that would generally be the number of patients we would be dealing with, we would be full. We may also have had children who were boarded out into other areas, depending on how that patient was and what they needed.

18. If we were going to board a patient out, the consultant would have to assess certain factors such as who would be an appropriate patient for this. For example, we would not board a patient out if they needed chemotherapy, as all that is carried out by trained staff on the ward.

19. If a patient was only going to be in for another 24 hours and had an intravenous antibiotic which other nursing staff are capable to dealing with then we may consider them, so we would be ensuring that wherever the patient went, the nursing staff were equipped with the skills required to care for them properly.

20. The same protocols which apply to the patients in the Schiehallion ward would also follow the patients if they went elsewhere. For example, if a patient was boarded to another ward, nursing staff from Schiehallion would have a handover with the nursing staff on the other ward where they would be given a full overview of the patient, including their diagnosis, why they were with us, how long they had been in for and what care they require.

21. This would include factors such as which antibiotics they were on, how much they should be given and when etc. Once the patient is in another ward they would be reviewed daily by a medic from our unit and also the nurses. If there were any queries or concerns about the patient then staff from the other ward

will call the Senior Charge Nurse in our Unit or they could call me for any advice

22. Generally, our patients would come in via the Day Unit (Ward 2B). We could have a pre-booked patient coming in for chemotherapy or for treatment, but we could also have patients coming in as emergency patients who had been unwell at home and had to come to the hospital. They would go to the Day Unit first and then we would be told about them.

23. I would then liaise with the Bed Manager and they would tell me where there was a bed available. Where the patient may go would depend on why the patient was coming in. If they were coming in for chemotherapy, they would have to come to our unit as we have the only staff trained to administer that. For example, if a patient was post chemotherapy and at high risk of neutropenia or infection, then they would need to go into a room called a Positive Pressure Ventilated Lobby (PPVL) room, then they would have to go into a ward where there was a room with that facility.

24. When I was a Band 6 Nurse, I would work twelve and a half hour shifts, 07:30am until 19:00pm. I would usually be in early, around 07:00am to allocate the board. This meant that I would have to look at our patients and their workflows, then I would allocate the nurses to patients by looking at the skill mix. You would have to look at each nurses' skill and the patient needs, and you would have to allocate appropriately to ensure that the patient received the care they needed that day.

25. If the Senior Charge Nurse was off, I would oversee the other nurses. Depending on whether the ward was full and what patient workload involved, I would generally have staff nurses working and also support workers. I would also have housekeepers too.

26. Also, depending how the patient was clinically, for example if it was a transplant patient who was unwell, they would have one to one nursing. If you were with a

patient who needed chemotherapy or someone who had a high temperature requiring antibiotics, then you would have, in general, two and a half patients to one nurse. Some nurses, depending clinically how well the patient was, would maybe have two patients each.

27. During my time as a Band 6 Nurse, I didn't work within ward 2B, which was out-patient facilities, Ward 2B have their own staff.

FACILITIES IN WARD 2A

28. When we moved over to the RHC, it was lovely. It was a nice, fresh building and everything was new. The only thing that I would say was that whenever we were moving, we were told we'd have like for like, and by this, I mean that everything we had in Yorkhill I thought we would be getting the same or better. This was not the case.

29. In Ward 2A I would say that the facilities that they had for teenagers was brilliant. We had four beds that were off from the ward, and we had a big teenage room that had a big couch, TV with Sky, a computer with games, state of the art juke box and a pool table. The parents had the facilities in there to make them toast, there was a microwave and a kettle there.

30. We also had a parents' kitchen which wasn't that big. It was quite a small family room we had, if you were looking at it from a parent's point of view. We had the teenagers' facility, which included their own kitchen, the kitchen and we also had a playroom. Moving to Ward 2A after having what we had in Yorkhill, those facilities were quite small in the RHC. The play area was quite small.

31. Any children from 12 years upwards, could use the Teenage Cancer Trust (TCT) facilities but any children under that age had the playroom that parents and children could go into. Generally, children about eight years old wouldn't use it because the smaller children would be in, and it just wasn't attractive for them from that point of view. In Yorkhill the playroom was a lot bigger.

PARENTS ROOM

32. In Yorkhill we had two bedrooms which could be used for parents staying over, so they could spell parents with their children overnight. The two extra rooms are where, if we had an emergency coming in overnight and both parents came, one of them could go round and get some sleep. Or maybe if a parent was having a difficult night, they could go round to the room.

33. It was still within the Ward's area, but we could try and get them to go and have a couple of hours sleep while you then sat with their child to give them a rest, because obviously, if your parents are not sleeping, they're tired, and you need to support them also so they can support their child. These rooms were very beneficial because they helped the parents take a break out of the ward to get some sleep as it's very busy.

34. Also there was an area for the parents which included a kitchen and a sitting room. Again, this was away from the hustle and bustle of the ward and gave families a place to go for a break. Often parents had been with their ill child constantly for prolonged periods of time, or they'd had bad news and just needed somewhere quiet to go for a rest and a cup of tea. The parent area in Yorkhill was really good.

35. When we moved over to RHC we ended up with just one sitting room that was quite small and right in the middle of the ward. it was noisy and you could still hear buzzers, and all the hustle and bustle that was going on. Parents were not able to go and get away from the busy areas like they could in Yorkhill.

36. I don't feel the facilities for the families were moved over as like for like, as we now only have one room and parents' kitchen. It's down another side of the ward which you have to walk past, so if someone is in the teenage end of the ward, they would have to walk right down through the transplant side, which would take them past bedpans and bowls and things like that.

AREAS FOR STAFF

37. Again, in Ward 2A, another thing that I think was a difficulty is that there were two beds that were directly behind the nurses' station. In my opinion this made things quite difficult for whoever was in those beds, as the nurse's station is the central place for meeting up with other nurses. We would be chatting and discussing things there and doctors would also come there to speak with us. It was a generally busy area. It was just constant and there was just constant hustle and bustle.

38. I just felt it wasn't practical for two beds behind the nurses' station as it was very loud, parents could constantly hear all the noise from that area. This has changed since we moved back in, one of the beds is now the Tween Room and the other is the Pharmacy Room. These are the beds that we lost which I mentioned earlier.

39. Other than that, it was a nice, big unit. It was bright, it was big but we thought, how do we nurse in here? In Yorkhill we had a straight ward where we could see everything that was going on. In the new hospital, the corridors were oval shaped, and if you were in one section, you couldn't see what was going on in the other two.

40. In Yorkhill, we used to be allocated so many patients to individual nurses, however we had to change our tactics towards team nursing, we had to split up into three teams to cover the top, middle and bottom sections of the ward and patients would then be allocated to the teams.

41. Nurses have to do their handovers and catch ups in the middle area of the ward, as this is the safest place to discuss our patients. In the new hospital our staff room is actually off the ward, and we can't take nurses off the floor in case a buzzer goes off, so it's the only place we have to do that.

42. I've previously mentioned the team nursing, so because we were in teams we would be discussing who was going to do what in respect of the patients and it wasn't ideal as families could possibly hear what was being said, although it was more the workload you'd be discussing rather than personal things about patients. All our phone calls were made from there too so it was just a really busy area.

43. When we were in Yorkhill, we had a staff room which was just off the ward and beside the parents' suite. In the new hospital we didn't have a staff room that was on, or near to the ward. In fact, we had to leave the RHC and go through the link corridor to the canteen in the QEUH. I know it's only through a linked corridor, but in the event of any emergencies, if we were in there then we wouldn't know what was happening. In Yorkhill, if there had been an emergency, even though you were having your break, all staff could just come straight through and help.

44. The staff room was also an area where we could go if the ward was having a difficult morning or where staff could go to chat if something upsetting had happened. However, the big canteen in the QEUH is massive, open and loud and it's cold during the winter as the big double doors are open. It's just not a nice atmosphere to have your break in.

45. When the area you work in is so busy, you just want somewhere you can go for your break that's quiet and you can just rest or, if you want to, you can chat to a colleague who may be having the same type of day as you. You can't get that at the QEUH canteen which is in a big open space and next to the out-patient facilities and the shops below.

46. Some things have been changed after we asked for them to be put in. We already had our TCT room and the same playroom, but as well those rooms, we now we have a preteen room, or the Tween room, which was kindly donated by a family so that children that are aged eight to 12 years old have somewhere to play. However, when we had Covid, it couldn't be used freely as

time slots had to be booked. That has now returned to normal. The unit is much the same as it was before, however we now have a staff room.

LAYOUT OF WARD 2A

47. In ward 2A we have 8 beds which are in double-doored rooms. They had the ante-rooms, and they were just for transplant patients with positive pressure. We have the negative pressure ones too. It would depend on what type of transplant the patient had then it would depend on what type of room from an infection control point of view where they would be placed in those transplant rooms.

48. As far as I was aware, the other rooms on the ward were just the standard rooms we had when we moved from Yorkhill to ward 2A in the RHC.

49. As far as I was aware in Yorkhill, we had our double-doored rooms, these rooms had two doors on them to maintain an airlock. One set of doors has to be closed all the time so that air entering the room from outside is minimal, to protect the patient from anything from outside. We had other rooms for patients who were receiving their own cells back and different rooms for patients who were receiving their transplant from someone else. When we moved over, we did think we had like for like on that side of things.

50. From my understanding, the positive pressure rooms are where any air that comes in is blown out of the room so the room would stay clean basically. Patients who were receiving a transplant from somebody else, they would generally be the sicker of the transplant patients so they would go into these rooms.

51. My understanding of the negative pressure rooms is when nothing is blowing out. A lot of the time, patients maybe had flu for instance something that could be passed on to another patient for example, so it stops it coming out and infecting other children.

52. There are specialist facilities in our ward geared towards oncology and chemotherapy. Within RHC, we have lots of general wards, which have their own specialities. There is a Surgical Unit, a Renal Unit, an Orthopaedic Unit, and we also have a day surgery. All these wards have their own sort of specialities and facilities within their area.

COMPARISON WITH YORKHILL

53. I keep going back to Yorkhill but I worked there for a long time. The ward in Yorkhill was a straight ward. You walked in and down the ward. Bed one would start at the top and it went all the way down, right round and up. You could stand in the middle of the ward and see all of the rooms except for your four bedded bays, as they were to the side.

54. The families would maybe socialise in the areas where the children would play and they'd come out and there would be toys. You would maybe have a tractor going up and down the ward, they would see other kids, and the families would chat to each other because of the kids if they were out.

55. I feel that when we went to the RHC that changed, because the ward was so big and vast. It was a big horseshoe shaped ward so somebody could be up one end of the ward and another could be at the other end of the ward. Parents told me they felt a bit isolated because of the style of the ward compared to what it had been like over at Yorkhill.

56. For staff, if you were working in the transplant side and someone else was working in the teenage side, you maybe wouldn't see some of the staff all day because you would never have a reason to go up to the other side because it was so big.

57. My personal opinion is that I do not like the layout of the ward in the new hospital. Clinically, the patients we treat on the ward can become very ill very

quickly, so we have to be able to nurse one to one, we need to be able to see buzzers. For any kind of unit it's just not practical if you can't see the buzzers. If you were able to see them, you would know right away if patients needed you or staff needed assistance.

58. In Ward 2A, if patients are buzzing, you have to go to the control screen in the centre of the ward to check to see who was actually buzzing, unless you happen to walk past the activated buzzer on the way there. You could walk up and down the ward to see but it was a massive ward. In the grand scheme of things, it's not a massive issue, but it can create a slight delay in tending to the patients who need you.

SCHIEHALLION UNIT PROTOCOLS

59. Within ward 2A, we have our Standard Operating Procedures (SOPs), which we call SOPs. For our patients we have SOPs for pretty much everything we do with our patients. If we had a child who was in with a high temperature, we have a SOP that tells you what to do from when the patient comes in. It tells you when they should be reviewed, how long it should take for a medic to review the patient and how long it should take for them to get their antibiotics.

60. One of the things a SOP would cover, for instance, would be when you're taking blood cultures. All children who come in with a temperature get blood cultures taken which are then obviously sent for testing. For everything we do there is a SOP for us to follow.

61. Every ward will have their own SOPs for their patients. For example, intensive care will have SOPs for specific treatments that they do, and neonatal will have their own specific SOPs for their treatments. I think SOPs are standardised throughout the world. At the moment, I've been involved in a new service where I'm researching a unit in Canada where there's a SOP that's relevant, so I'm assuming everyone uses these.

62. We have our SOP which is standard for Infection Control. This includes hand hygiene, the putting on and off of aprons for going into the next room and for patient placements. There are infection control processes for everything. On everyone's desktop, there is an infection control folder that you can go to. If you have a child who comes in with a high temperature or D and V, you can go in and get the care plan for the management of that patient. There are infection control standards for everything.

63. For the administering of medication, there are NHSGGC guidelines in place for this. NHSGGC have their own, safe administering of medicine policy that we follow. This is GGC wide, not just specific to where I work. Medicine administration should be the same for everybody.

64. There are principles for administering medication, so when you're giving a child a medicine, you would check that patient's identification, you would check the prescription is correct and you need to check you have the right notes.

65. For paediatrics there are two nurses, we both check it is the correct patient, we check their identification band and we both ask for a verbal identification that the patient is the correct patient. The process should be the same throughout NHSGGC when checking medication.

66. No other areas give chemotherapy, so the administration of chemotherapy SOP will only be relevant for our area, but the principles are still the same for the safe administering of medicine. How you administer it and how you check you have the correct patient should be the same as the guide for the safe administering of medication.

67. If I am interacting with the patients and families on a non-clinical basis, for example, if I went into a room and the patient's family members starting talking to me, there is a nurses code of conduct that we need to follow. I remain professional at all times and I support my patients and their family. I would always go back to my code of conduct and ensure that I remained professional,

but also that I supported the families the best I could at that time and in that situation.

68. I had never heard of the term “Schiehallion Umbrella” that was used by the Patients and Families in their evidence, however I did hear families talk about the “Schiehallion family”. Parents would say that because they were in for such a long time.

69. When their child is diagnosed with cancer, it’s not a short journey, they’re not just in hospital for a couple of days. Some of these children are being treated for up to three years, some of them relapse and come back.

70. Some of them have been with us for a long, long time and you build up relationships with these families and they’re able to trust you and trust your judgement and trust your clinical abilities as a nurse. So, a lot of the families would say “we’re back to our Schiehallion family.”

71. I am aware that some of our SOPs won’t be relevant to other areas of the hospital unless there are looking after our children. For example, in Schiehallion, if we have a child who has nausea and vomiting, generally, as soon as the child said they feel sick, a haemo-oncology nurse would get them some anti-emetics.

72. However, as a standard, that might not be the same thing that would happen in other wards if children with other conditions were feeling sick there, depending on the medical procedures they follow. In Schiehallion, we would automatically get the child intravenous anti-emetics, but maybe some of the other wards would give them oral anti-emetic first. I don’t know this for certain though.

73. As a nurse in Schiehallion, there are more areas where we are trained as it’s a very specific area. It’s specialised, but if nurses in other areas aren’t sure about how to deal with any patients that were boarded from our ward, then the procedure is that they should phone us.

74. If anti-emetics are given to children, they would generally be on our ward, 2A when they're getting chemo. If patients are moved to other areas, if they are boarded out, they are generally patients who are well and getting ready for discharge. Our patients are assessed for this before they are boarded out, but if they go to another ward, then the same Shiehallion SOPS and procedures apply to them. This is part of the handover with the staff when the patient is moved.

75. Once a patient is moved then nurses in other areas will look after them and clarify anything they need to do with us. These patients are chemo patients so if there is something the nursing staff are unsure about or want to clarify, then they would check either in the relevant SOP or by phoning us in the Ward.

76. Even though our nurses don't following the patients when they are boarded out, the doctor will follow them to the Ward and see them on their ward round so the doctor will always be the point of contact. It would never be the doctor from that other area, it will always be our doctors.

77. The only other process I can think of that may be different is the accessing of central lines. We always used a sterile procedure but have now changed to Aseptic Non-Touch Technique (ANTT). We changed our practice to the reflect that non-touch-techniques in a sterile procedure. We have been using ANTT now for over five years now.

78. I can't tell you if it makes a difference to the number of infections the patients get. There will be other infections in patients, however from seeing the CLABSI figures. I know the practice is very good. Also, as the educator who looks at nurse's practices, what they do and how they implement practice into the clinical settings, then I know they are very effective in using the ANTT. I don't know the dates when we changed to ANTT but I think it was 2017, it was certainly after we moved to RHC.

79. The ANTT is a technique is not a sterile procedure, but it's an asepsis technique. The principles of asepsis are that when you are accessing a central line, you are not touching anything that is going to touch that central line. Basically, you can set up your tray that we set up for cleaning and you would set up your syringes so that you're ready. The key parts would be things like the end of the syringes, the end of the needles and the end of the line.

80. The ANTT would mean that you can be confident in touching your syringes, but you should never touch the ends of them. So anything that is meeting the end part of the central line should never touch hands or surfaces, and they should never be cross-contaminated. With a sterile technique, you're keeping everything contained, cleaned and in the one area where it will be sterile at all times, but with ANTT you can touch the syringe, although, you would have sterile gloves on.

81. There are two different techniques, but evidence has shown that ANTT is working and is not as long a process as the sterile procedure, where more things can go wrong too if things aren't cleaned properly. You would always make sure you are cleaning things properly. With ANTT you're not touching the key parts so it's a straightforward process.

82. ANTT was being developed down south and it's been in use for a long time down there. There's a website if you type in ANTT and it will give you all the information. For the majority of the roll out i was a Band 6 Nurse, and it was used when they were looking at the line infections and it was one of the different ways that was identified to help with infection.

83. I'm assuming that the decision to use ANTT would have been made by management. Like everything, they would have consulted infection control, they would have involved the ward, there would have been a full process involved prior to them identifying this was going to happen. I think it's management who make the decision but I wasn't in this role at the time and wasn't part of the decision making, so I don't know for sure.

84. If a Schiehallion patient was on another ward and needed a line accessed, it would be done the same way we would do it in the Schiehallion Unit. There is a general programme for central-line training or central device training, and it's the same programme throughout the hospital, so any nurse who is central device-trained has the exact same training as a Schiehallion nurse.

85. We all deliver the same training. I personally deliver it to the nurses within my area, but I work closely with the educator who delivers the general programme, so it's the same training that's delivered throughout.

THE NEW HOSPITAL – THE BUILT ENVIRONMENT

86. In my opinion the new hospital was not state of the art. I would have thought it should have at least what we had before in Yorkhill, or better. For me, for a hospital, we didn't have what we had before. If it's state of the art, then it should be better or at least the same.

87. I was aware that there were issues in the rooms on the wards where the TVs and the blinds wouldn't work.

88. The blinds in the bedrooms were in between two sheets of glass. At the outside of the window that faced into the patient's room there was a control, a wee knob at the side that you would twist to open and close the blinds, but sometimes it would stick. If that happened then the blinds wouldn't open or close, but it's my understanding that to fix it, the pane of glass would have to come out. This wasn't an easy job to do.

89. The TVs in general didn't work, but I don't know why this was.

90. If there was an issue in the bedroom, patients would tell you or, if you were the nurse in charge, some of the nurses would come to you. These are not issues

that we could fix ourselves. We would log any issues with Facilities and the appropriate person would be allocated the job of fixing the problem.

91. This could be frustrating, as we would often have engineers, joiners or electricians in rooms fixing blinds, TVs etc. and this could often involve them having to take things off the wall. This work could not be carried out whilst there were patients in the room. This was not an ideal situation if there was not an empty room to move the patient into whilst the work was being done and this meant that maybe sometimes the family wouldn't get it fixed while they were in but then it would be fixed for the next family.

92. If we couldn't get the TV fixed for the patient, then sometimes it was frustrating and I can see why parents would be annoyed. If you've got a small child and you're trying to keep them entertained, it could be really difficult. We would try and explain to the family why issues couldn't be fixed there and then. If you had a full unit, you couldn't just move someone out the room. If I was in charge and there was ever a problem on the ward and we had an empty room, I would offer to move the family into another room. If you have a full unit, you can't do this.

93. To get these issues fixed, you could phone the facilities manager and they would just direct you to the right person or area that would deal with it. You could also find out if someone was on their way up or if it was the next job or that someone was just coming up.

94. If it was something simple for example, if we had a patient coming into a room and the TV wasn't working, we would ask if we could get someone up. Generally, you would try and get somebody to fix things as soon as possible.

95. We sometimes had issues with the temperatures of the rooms. This is also something Facilities would deal with. We would get Facilities to try and put the temperature up or temperature down, whatever was needed.

96. They would then deal with that. Sometimes if it was too warm, they would put the temperature down then it would be too cold. It was sometimes a hard line to find the balance. When we put a request in, generally someone would have to come and check it.

97. I wasn't aware of any issue with a lack of plug points, or any issues with battery packs within the ward. When we have patients in the ward who are really sick, they require multiple infusions with a lot of different machines so sometimes the plug points were full, but it would be the equipment we would be using to ensure that the patient was getting all the treatment they needed so the plug points would be used appropriately. That's why plug points would probably be full, as they were being used for essential equipment.

98. If a parent said they needed to charge their phone and we had something plugged in, we would take it out for them for a few minutes. Generally, there were plugs available. There were four sockets at either side of the bed, so that gives eight sockets which would generally never always be full.

99. I was not aware of there being any issues with the park area outside the hospital. Our patients generally would be advised not to go outside where possible. If they were going out, it was usually because they were getting discharged. Generally, if our patients were in the hospital area, they were there for treatment. Sometimes they would get out on pass, but you wouldn't be wanting immunocompromised children going out to parks where there are other children.

100. One other thing that was apparent was the sewage smell at the hospital. It wasn't all the time, just at certain points, but this was a smell that anyone could pick up on if it was there, especially during the summer. It was quite strong, and we could smell it in Ward 2A. I don't know if it was obvious in other wards but it was a smell that, even if you were coming from the car park, it was strong.

101. We put it down to the nearby sewage facility because that was our understanding. You can still smell it now when you're getting out the car, especially in the summer. It's quite noticeable.

102. Patients going through chemotherapy can have quite severe nausea and vomiting because of the treatment and some of the children would say that the smell of sewage was making them feel sick. It was difficult to be certain if it was chemotherapy or the smell though. I'm not aware of any impact it had on staff, but it really wasn't nice.

CLADDING – 2017/2018

103. I was aware there were issues with the cladding on the building, but I was never involved in anything to do with it. I am aware that patients were asked to come in another door because they were doing work, but I wasn't involved in this and don't have any information.

104. Management didn't talk about it, it would maybe be the Senior Staff Nurse that would tell us anything. Usually if there was information, it would be put forward to staff by our lines manager at the time, that there was work going on. I'm sure they were doing work on the outside of the RHC and that's why patients had to use another door.

105. I can't remember exact dates or if it's correct, but there was a point where children were having to come through the adult doors, and this was an area where there was a lot of cigarette smoke due to the adult patients smoking outside there.

106. I can't remember if this was the same time as the cladding, I just remember they had to go through a different door and that the smell of smoke was bothering the patients and the families, especially if they had a post chemotherapy chid who was feeling nauseous and vomiting.

107. The families raised this with the senior charge nurse who raised this with management. I know there was work done to try and move people away from the building as it should be a smoke free zone. It was escalated from my line manager to management.

108. I remember seeing emails at the time about how they could try and stop this from happening and the patients being affected by it. I think signs were put up asking families to use a different door after that so the families could come in another door, and they also tried to prevent the smoking in that area.

COMMUNICATION - CLADDING

109. (**A38845769 - Cladding briefing for inpatients dated 7 September 2018, Bundle 5, page 101**) is a letter to parents and carers giving information about ongoing cladding works. I remember seeing briefings like this. That was actually one of the letters we were given to give out to the families. If we were given letters like this, after having been given instructions and what information, we would go round each patient – the inpatients –give them the letter and explain what it was and why we were giving them the information.

110. At this time, some of our patients had just been started on anti-fungals and it was a consultancy session. So, the consultant looked at the patients who were high risk and they spoke to the families about it and gave them the information that they needed.

111. The decision to prescribe prophylaxis would have come from the IMT, so that would come from management. I was never involved in any of these discussions. Then it would be the consultant who would decide which patients would get the antibiotics.

GLAZING

112. I was aware that a few glazing panels had fallen out of the windows. There was a lot of talk around about it so I did hear about it, however this was something I heard about because of what people were talking about rather than actually seeing any briefings or information about.

FLOODING IN EN SUITES

113. I am aware of one occasion when one of our patient's bathrooms flooded. I was on shift, and we moved that patient from that room and got facilities to come up to fix the bathroom. I cleaned up the room and sent the Facilities Management (FM) report to get someone up to fix it.

114. I did think it was strange that as our washrooms were wet rooms, it really shouldn't be flooding, but I thought maybe it was a blockage. I know myself, when I'm washing, my hair falls out, so I assumed it was a blockage like that. I wasn't aware of it happening all the time.

115. We had the patient moved, and the work must have been done when I was off, as it was fixed when I came back in for my next shift. Because we work shifts, I only worked 3 days a week. Because of this, if there were things happening, you might not be the person who's following them up, it would be whatever nurse was on that day. By the time I came back for my shifts, the room was in use again and I wasn't aware of any other problems. I was aware there were problems with other bathrooms, but it wasn't common, it didn't happen all the time.

116. It was only that one occasion where I was directly involved with a flooding bathroom and I wasn't expecting anything major to be wrong so I just thought it was blocked. The rooms are constantly in use, so I didn't think it was unusual that it had become blocked. You're in a hospital so you weren't concerned about things like that as you expect things to be safe.

CONCERNS RELATING TO KEY BUILDING SYSTEMS
WARD 2A – THE WATER SUPPLY

117. I never had any concerns about the water until we began using bottled water and portable sinks, which made me wonder why we couldn't use the water in the taps. This was around the time when the number of children getting line infections increased in ward 2A.

118. Whenever we have a child with a line infection, bloods would be taken that were then sent to lab. The lab would get the results and identify if there was any infection in the blood cultures. The labs would then tell Infection Control and Infection Control would then contact us to tell us there was an infection.

119. Although, as I heard at the Incident Management Meetings (IMTs) I attended, line infections were higher, it wasn't until there were different types of bacteria in the water that they wouldn't normally find that I was concerned. Normally we aren't told what the actual infections are, we're just told if it's a positive culture.

120. The principle is to ensure the patient gets the treatment they need, so if a doctor tells us there was a positive culture and we needed to administer certain antibiotics, then we would do that. I also heard a bit more at this time because I was going to IMTs, so I heard what was being discussed in those forums.

121. I was also given information by Jen Rodgers, who was the Senior Charge Nurse, and the senior team. Because all the line infections were happening then, everything else was being looked at as a potential possible cause. It was never actually confirmed that there was anything wrong with the water.

122. When we had our Ward Meetings, the Service Manager (Jamie Redfern) and our Chief Nurse (Jen Rodgers) would sometimes come and sit with the staff and ask if there were any questions about what was happening. When we asked if the ward was safe, they reassured us that it was.

123. We knew that Infection Control were looking into why the infections were so high and that they were looking at testing the water. There would be people turn up, test the water and take samples. In all honesty, I can't even recall exactly when we found out about the water, it was a very stressful time at that point as before this, everything else was being looked at.

124. For example, Infection Control were looking at the medics (the doctors) to see if they were doing their jobs properly. Then the nurses were going through weekly hand hygiene audits to see if they were doing their nursing practice properly and checks were being made to make that everybody washed their hands the way they should.

125. We also had enhanced supervision, where Infection Control would come in and monitor our Lead Nurse, the senior Charge Nurse of the Ward, check the facilities and look around to see if the ward was clean. We were very much under scrutiny from a nursing point of view. It felt as if we were scrutinised through audits for everything we were doing to make sure it wasn't us who were contaminating the patients' lines.

126. From being on the ward, I knew that they were looking at our ward, but I don't know if they were looking at other areas. We weren't thinking about other areas at that time, we were thinking of our own ward and our patients.

IMT MEETINGS IN 2018 – WATER INCIDENT

127. I was only at a handful of Incident Management Team (IMT) meetings. I know that within the meetings they would use the HIIATT scoring system to gauge whether the Public Perception scored high enough to put something out, for example if it was amber or red. Then they would get together and decide whether they needed to put something out or not. So they would look at

communication as part of the HIIATT process, but they did have a separate part of the meeting about communication also.

IMT – 29 MAY 2018

128. **(A36706508 29.05.2018 - IMT Minutes E cloacae 2A, Bundle 1, page 91)** I attended an IMT meeting on 29 May 2018. I remember hearing about the problems assessment group. It was called the PAG (Problem Assessment Group) and I remember Emma saying she was going to the PAG meeting, but I am not sure if they discussed anything in relation to Enterobacter. I can remember I think they would discuss the patients at them. My understanding was, they discussed the patients, and how they were doing, if any of them needed a line removed, everything like that. More from an infections point of view. There is a link between the PAG and the IMT meetings but I am unclear which comes first.

129. This was my first IMT. The Charge Nurse, Emma Somerville, was on leave at that time, so I went in place of her. As the band 6 nurse, part of my role would be to cover her when she was off. That was the first time I was involved in anything like that. My role was to provide any information from ward 2A from a nursing point of view in relation to in-patients. I was direct link to information from a nursing point of view.

130. The meeting was in relation to the enterobacter. I can't recall anything leading up to this meeting. I can remember sitting it the meeting when I'm reading the minutes, but I can't remember anything.

131. When looking through the minutes, there's nothing that I have picked up on. If had noticed at the time that something wasn't right, I would have picked up on it at the time.

132. I remember the meeting being very formal, having never been involved in anything like it before. The IMTs were all very matter of fact but from my

perspective, I remember being very emotionally involved, so at the time I didn't understand how they could just be so matter of fact.

133. I understand now, why they had to be that way. They were looking at things and looking how to make things better, but I remember at the time being emotional about what was happening.

134. At this IMT there is discussion of the 48-hour rule. This is the time period given regarding how long patients were without infection after admission into the hospital. When you are looking at any HAI's in the hospital then you would be looking at whether it is bacterial, viral or fungal.

135. My understanding would be that the patient had maybe come in with a temperature and had blood cultures done and it was picked up straight away rather than the patient having been an in-patient in the ward, and it being linked to the ward.

136. We would look to see if the patient has been an inpatient or if they have been in hospital for a period of time, like a 48 hour period, then we would decide if any infection was HAI or community acquired. Any results would be included in a chart showing types of infections, time limits and durations of any infections.

137. I can't remember the impact on the new patient regarding the enterobacter. There are so many patients I have nursed.

138. I don' think I have the infection control leaflets. I can't even recall if they were designed the same way as the ones that were sent out by management.

139. In general, anything that we do, as a principle, so if I was writing any information or any guidelines, I'd have to put it to our governance group to, like, ensure that all the information that was in it was correct, accurate, evidence based. It all had to be checked for. I'm assuming, I don't know; but that's the same. That committee that's mentioned is their governance group or similar.

140. The main point of concern was the increase in the gram-negative infections so that would have been the enterobacter so that's why this meeting would have been called, as they were concerned about the increase in this family of infection. I can't recall what the solution proposed at this meeting was.

141. So, staff morale was low, we were under intense scrutiny and like myself, we were trying to do the job to the best of our ability but at the time it felt like we were being blamed for the increase in the infections. Maybe not blamed directly, but that was the perception as our practises were under such scrutiny. I can't recall a resolution but support wise the senior team would come and speak to staff.

COMMUNICATION - WATER SUPPLY

142. I know there was always communication that came round after the IMTs. Staff would be told, then the families would receive communication, but I can't remember what that was or when. I don't know when the communications started but Emma was always very open about what she knew.

143. I don't know at what point management would come to the unit. I can't remember if it was Jamie Redfern, the Service Manager at the time who would come to the ward and have discussions with the staff but I can't remember when that was or how far into what was happening that it was. I know Emma had asked for the nurses to be informed about what was going on as she wanted us to be kept in the loop.

144. We would get a bit of A4 paper with the information on it. There would be one for the staff then one for the patients and families. It would be the same information we were given that the patients and families were given. I think this information came from the Health Board.

145. I think the only change to it would be the heading. I have them here. If you were on the floor, you would receive one and also give the patients and families ones out to the families. They would give information about what had happened at the time.

146. We weren't told what to tell patients and families that I recall. We were only given the information a short period before the families got it. When we were going round to see the patients and families, the Senior Nurse and the Chief Nurse would come up to explain what was happening to the families depending on the information going out.

147. The Chief Nurse at the time was Jennifer Rogers, Emma Somerville was the Senior Charge Nurse. There are two different Lead Nurses, we started with Melanie Hutton and then we had Kathleen Thomson in ward 2A. Claire Hall was the Lead Nurse in ward 6A.

148. We would try and visit the families: Emma would go with Chief Nurse and the Lead Nurse to see some, and a band 6 Nurse would go with the Lead Nurse to see some of the other families. We would explain the communication that came out, giving them a copy of it, depending what was going on at the time, and we would explain what was going on.

149. Usually after an IMT meeting or if there had been something in the newspapers, then we would receive some communication. It wasn't a regular occurrence; it just happened a handful of times. Obviously, we know that the newspapers exaggerate and it's easier now to look at the newspaper articles and see how it linked into what we knew at certain points.

150. However, we had never been exposed to media attention like that before or how it can all be embellished; it was a very difficult time. The families were worried about their children, which was completely understandable, and they were looking for answers. There was a lot of staff anxiety and very low staff morale.

151. I'm not aware of anything else that would have gone to families from management. From a ward point of view though, the Charge Nurse was always available to speak to, to alleviate anxieties or concerns. Emma would always be around to speak to the families about the information that we knew. If we needed to, we could have contacted our lead nurses, they would also speak to the families and give them reassurance.

152. I knew there were circumstances where the Lead Nurse came up and the Chief Nurse and whatever the title was of the person in Facilities, they all came to speak to families. I can't remember when, but I do remember they spoke to families or individuals when required.

153. I would only know about things once the communication came out unless I had been at an IMT. However, information I heard at the IMT was wasn't information I could share at ward level at that point, as often the discissions were speculation about what the problems could be – but certain actions often needed to be completed before any factual results were obtained. There would be things said but they would be actions to look at first before anyone came back with information.

154. From a ward point of view, we tried to be as open and transparent as we could, but sometimes the patients and families thought we knew more before they did and we didn't. We would have to say we don't know. I felt this broke some of the trust that we had built up with the families. I would then speak to Emma trying to get better communication for the families. Sometimes it was a case of waiting on results, so they didn't have the answer at that time either.

155. I am aware that there were meetings held with patients and families, but I don't know if they were about the water. I only worked three days so wasn't always there. I would sometimes hear that there had been a meeting and I would be told what was said, but I can't remember what was said specifically or at what point in time they would have been.

156. (**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**) is an email from Angela Johnson to senior charge nurses dates 28th March 2018. I am not copied into the list but nurses from Wards 2A and 2B are. The subject of the email is, "Water Incident Update." I can remember this; we are looking at types of good practice which were brought in. These emails would have been sent to the charge nurses, and Emma would then have put anything we needed to know on to the safety brief.

157. I understand it now looking back and doing the role I'm in just now, but I don't think I had a full understanding back then. It feels as if it's all rolled into one and I can't remember what happened and when.

158. I know Emma Sommerville came to the staff with the information she had been given. She was my Senior Charge Nurse and was transparent with all the information she knew. Generally, we would get the same communication that the parents and families would get just before the parents were given it. It would be the same information.

159. I felt that that us getting the same information at the same time as or just before the parents did broke down some of the relationships with the families because we weren't able to answer their questions, because we were getting the information at the same time. That was the biggest concern I had, the relationships with the families, because they felt we knew more than we did, and in actual fact, we didn't.

160. When we started to use portable sinks and bottled water in Ward 2A, by that time I was concerned about what was wrong with the water. I did ask at one of the meetings, though I can't remember much more about when or where it was. I was told the IMT were looking at the water, they found certain bacteria in the water that was uncommon to this area. That's why we weren't using it at that point.

161. The filters were then put on. I was always told it was safe to use the water at all the meetings we had with Jamie Redfern and Jennifer Rodgers, so although I can't remember exactly when that meeting was, I know they are the people I would be having the meeting with.

162. As a Band 6, staff would come to you in general and raise concerns because we were being told to use bottled water and the portable sinks. I was never told when asking, that the water was unsafe. I was told by management when they came to the meeting to talk to us.

163. At both meetings, the Chief Nurse at the time and I think it was the Service Manager at the time attended and they were there for reassurance. We had staff meetings and if we needed more support or had concerns, the Senior Charge Nurse would then ask for someone to come up and give reassurance.

164. If she had information, she would share it with us but then she wasn't able to offer the reassurance that staff required at that point in time because they were using bottled water and portable sinks so there were concerns.

165. I think it was management who explained that the bacteria that was uncommon to this area, so they were looking at that and they were dousing the sinks and drainage system and that's why we were using those sinks.

166. I remember at one of those meetings, a clinical member of staff asked if the water was safe to use. This was when we were still using the water from the taps. The uncommon bacteria that was found was never mentioned at those meetings, it was only from a Band 6 Nurse position that I knew about that.

167. Those type of meetings were a chance for staff to ask questions, for example, 'are the patients safe in the unit?' and, 'are we safe to use the water?'

168. I think it was at one of those meetings near the end when we were told about the bacteria. It was before they turned off the water and started dousing and

people were asking it the water was safe. I can't say for sure when we were told about the bacteria because I wasn't at a lot of those meetings as I wasn't on every shift.

169. Just to be clear, we were never told there was anything wrong with the water. There were some meetings when we were told bacteria had been found, but we were told it was normal to have bacteria in water and we could find it anywhere.

170. Staff were going in and having conversations about their concerns as to how sick their patients were not knowing about the bacteria. They were asking why the water was switched off and why we were using portable sinks when there was supposed to be nothing wrong with the water, but we were told everything was fine. That was why staff were concerned though, why were they using bottled water and portable sinks if there was nothing wrong with the water?

171. I can't remember what was said about the bottled water as I wasn't at all the meetings, I only know that they were swabbing drains because I attended an IMT meeting.

172. I can't say for sure that it was the water that was the problem. I just know there was an increase in positive cultures to what there was before. That's where my concerns originally came from as there was an increase in line infections, and we were looking at other parts from a nursing point of view.

173. It was only when I started going to IMT that there was stuff, like the gram negatives, bacteria being discussed. There were different bacteria, one of the patients had serratia in their blood which was one that was really uncommon and that was found in the water.

174. I'm not a microbiologist but we were told it was uncommon to find this in water, but it was seen in our water. They were dousing the water to make sure it was clear I think, and it was done every week and the drains too. They are still doing this.

CONTROL MEASURES

175. From a nursing point of view, we did not have to change our approach as we were already doing everything we could, including the infection control type of work that we were aware of. I do not know exactly when but eventually they started putting filters on the taps. It's not normal to have filters on the taps, well it wasn't then but it is now. They were put on so that the water would be purified. This didn't impact on our ability to do our job; they were just a bit bulky but generally the basins were quite big anyway.

176. I am aware that there were cleaning measures introduced to try and help the situation. They introduced sink cleaning which involved the dousing of the sinks with chloride dioxide in ward 2A. I think they did this weekly. Initially the IMT thought they would have to move patients out of the rooms to do this chemical dousing, but in fact, they didn't have to do this.

HPV CLEANING

177. The IMT also introduced Hydrogen Peroxide Cleaning (HPV). This was a spray and patients did have to be moved out of their rooms for this to be done. This had an impact on patients as they were having to move all their stuff out of their room. This could be frustrating as some of the patients and families had been in their room a long time and had a lot of stuff, so it was a bit like moving house for them.

178. This process also had an impact on staff as it would increase our workload. This was particularly true for the healthcare support workers. They had to move all the furniture on top of all their other tasks so that the nurses could continue their clinical role with the patients, for example, administering medication and chemotherapy.

179. Everything had to be moved out of the rooms for the cleaning. I had to move patients and explain to the families that I was moving them to get the room

cleaned. I explained what was happening and that they would be moving and which room they would be moving to.

180. We would have to go in and help them pack up all their stuff, take the furniture out and help them move rooms. Rooms had to be empty for them to be cleaned then once it was cleaned you would have to move all the furniture back in. We had 26 rooms to do so this took a long time.

181. As nurses, we would be told when the HPV cleaning was being done and then we would have to organise which patients were being moved where to allow that to be done. The Band 6 Nurse or possibly a Charge Nurse, whoever was on shift, would then look at all the patients and how they were clinically. We would maybe have some patients that were too sick to be moved.

182. If the patient was able to be moved, we would have to look at what rooms were empty and what rooms were appropriate for the patient to go in to. We would have to look at the clinical demand for each patient as you wouldn't want to put all the sick patients into one area because that could spread the nursing teams out too thinly.

183. We had to spread the workload out so that the patients were getting the care that they required. We didn't have to liaise with Infection Control to do this as they wouldn't know what rooms were suitable for which patients however, if we were unsure if a patient could go into a certain room, we would ask them for advice. This would maybe apply if a patient needed to go into isolation.

184. If one of these patients needed boarded out, they would be boarded to a ward who were properly equipped to look after someone with their condition.

185. I was only involved in this process once, so I don't know how many times it happened. I'm sure there was communication put out to the families about the HPV cleaning, so that they knew what was happening and why it was happening. It was another reminder to staff, whose morale was already very

low, what our patients were having to endure. They're in this hospital and we're having to go in and tell families that they were moving. It was demoralising for staff.

186. Although it did impact on staff and patient morale, there was never any impact on patient safety and care. The patients would always be in a clinical room where they could be nursed appropriately so I'm not aware it would ever impact on how we cared for the patients.

187. Most parents were understanding, and most families knew we were just doing our job. Some weren't happy with the upheaval, I totally understood that. They have this sick child and on top of that they're having to move. It really was like moving house. Some were frustrated but most understood. People were frustrated but nobody ever said they weren't moving. They were understanding with staff. They understood it was difficult for staff to do and a lot of work for them too.

188. Then when we moved to ward 6A, they started cleaning the chill-beams every six weeks. I think this started after the incident with the Cryptococcus which was the pigeon droppings. So much has happened so I can't remember exactly when things did happen.

189. I'm not aware of any issues now and we've moved back to ward 2A. We've been told it's safe to be there. There was some anxiety about moving back but we've been told the water is safe to use. The taps still have the filters on, and we've started cleaning the chill beams again. We've carried on with this. There's no portable sinks and they weren't used on ward 6A either.

190. **(A39123885 - Update for parents on ward dated 6 June 2018, Bundle 5, page 142)** This is an update for parents in Wards 2A and 2B, dated 7th June 2018. I remember this, we would have just received the same information probably just before the parents. We would have received this around the time all these things were going on. This is similar to other updates we received for

parents and families around that time. If there was any information for parents and families, they would always get that information from the nurse in charge and the senior charge nurse.

191. I can't remember patients being on prophylaxis at that time. I can remember our patients getting cetaprocticin but I can't remember if it was at this point or if it was another point in time.

192. **(A38662234 - Update for parents on cleaning dated 13 June 2018, Bundle 5, page 144**). This is information for parents about the HPV cleaning in Ward 2A. I can remember seeing this the letter, or at least, I can remember a letter going out about the HPV cleaning but it's quite a while since I've seen anything like this. There was a letter like this which was given out to parents about it .Again, the Senior Charge Nurse would go around the parents and hand them the information while they were in the hospital. They were like handouts rather than letters which would be sent to people's homes. I'm not sure how it worked for the outpatients as obviously we would only be looking after the inpatient side of it. I'm not sure how it worked for the outpatient side, but I know when they were inpatients, that's what we would do, we would go round each patient.

IMPACT OF HPV CLEANING/MOVING ROOMS

193. The HPV cleaning had a substantial impact on everyone. Again we were having to explain about why we were doing everything, whilst the families were already worried about their children who were sick inpatients and had a lot of anxiety.

194. For staff, it did increase their workload when, on top of their duties for the day, then they're having then to move patients from room to room. They have to empty the rooms, the health care support workers or your nurses on the floor are having to move all the furniture as well which also increases their workload.

195. Then obviously it impacts on the nurses in the ward as well, or your nurse in charge who will then have to co-ordinate all the rooms. They have to make sure

that rooms are available, they have to make sure that they're moving patients to appropriate areas within the ward, appropriate rooms.

196. You have to look at whether patients can go off isolation, you have to look at how sick your patients are, if they require a transplant room. Maybe the night before if I knew I was coming in in the morning, I would try and have a plan in my head for that next day, but you could then come in the next morning and everything will have changed, for example, we could have a patient who had been really sick overnight.

IMPACT OF WATER ISSUES – WARD 2A

197. I can't remember when it happened, but sometime after we moved to ward 2A we started using bottled water to wash our hands and then there were portable sinks. I was also hearing that there was bacteria in the water. I can't remember what came first, the information about bacteria, or the bottled water and portable sinks. I don't know when all this happened as it all merges together, but I do know that I was concerned that the water was contaminated.

198. I have never been told there was anything wrong with the water. As far as I'm aware, it has never been confirmed that there is actually anything wrong with the water. We were moved out of our unit. They had taken out sinks and changed some of them and they changed other stuff, but we were told they were upgrading the unit.

199. When we were using bottled water to wash our hands, two people needed to be involved. One would wash and the other would pour the water. It wasn't a normal occurrence, that's what we had to use for hand hygiene, cold bottled water. I know myself and my colleagues were ensuring we washed our hands. We ensured we were doing hand hygiene the way it was supposed to be done and we knew were doing patient care the way it should be done.

200. I also recall that there was a very difficult period of time where we were dealing with portable wash hand basins in patients' rooms. They were foot operated to allow us to maintain hand wash standards. In practical terms they were quite easy to use, but they were a change from our normal processes, so we had all the families asking us why we were using them, and we didn't have the information available to reassure the families ourselves.

201. There was also a period of time when water was switched off over night. Staff had to use portable toilets outside. I can't remember when this was, but I know that water was switched off. I don't know if it was only one night or if it was over a period of time.

202. There was only one night that I was working and the water was switched off. I can't remember if we were told why the water was off I can't remember if it was because they were dousing the water, that is, putting chemicals in it. I don't know if that's 100% correct though

203. At that time, I think the bathrooms were still working in the Adult Hospital, so we had to go there to use the toilet. I didn't use the portable toilets. My understanding was that they were on hospital grounds, but I can't tell you where. We didn't use them as they were outside. They didn't let us go outside in uniform, the uniform policy is that you should not go outside in uniform due to infection control purposes.

204. I am not aware that there was any increase in patients being put in isolation during the water investigations, even with the patients who had positive blood cultures. There were two types of isolation, one is source isolation. This would be used if a child had something like diarrhoea and vomiting that could be spread around.

205. We would put them into source to protect other patients. Then we had strict isolation. This would be used for a transplant patient or a very immuno-

compromised patient because they are so at risk of infection. We would put them in strict isolation to protect them.

206. We would only every put patients into isolation if they fell under those two categories. We never put them in isolation unnecessarily unless they required it as these families are already isolated If a patient had a positive blood culture, they didn't have to go into isolation as the infection was contained within the blood and couldn't be passed on to another patient. They would only be put in source if there was a risk they had something they would pass on to other patients.

SIGNAGE ABOUT WATER SYSTEMS

207. There was the concern that families were putting things down the sinks, or handwashing basins and leaving things around the sinks. We put a sign up to say, "Please don't put anything down the sink," we would take it away, cups of tea for example, anything we saw that could be put down the sink, we would remove it.

208. As you can imagine, when you have sick small children, anything can get put down the sinks, toy cars for example. So, the signage was there to stop people putting things down the sinks and to let them know that we would remove anything.

209. Because they were classed as hand washing sinks, then nothing should ever be going down it, things like food or drinks, or anything like sugary drinks that could maybe grow bacteria if they were sitting there. I think this was done because of advice from Infection Control.

210. What was put in place was a communication from Emma, and I think she maybe worked with Infection Control to develop a leaflet and a sign that was put up at the hand washing sinks to explain why things should not be put down there.

211. (**A39123918 - CWH8 Poster, Bundle 5, page 143)** is a sign telling us that this basin is for Hand Wash Only. I recognise this. At the time, there was a concern that people were putting stuff down the sink that was causing bacteria, this could potentially be the cause of the bacteria growing, or bacteria growing in the sink or making it worse. I think these signs were put up to discourage people from putting things down the sink.

IMT – 5 SEPTEMBER 2018

212. **(A36629284 05.09.2018 IMT minutes FINAL, Bundle 1, page 149)** I attended an IMT on 5 September 2018. I think was from the gram-negative event. There were organisms that were identified from the drain samples that were also identified in the blood cultures, so I think that's why this meeting had been called.

213. I don't recall picking up on anything that was inaccurate, but I do remember being at this one because the Senior Charge Nurse was about to go off on annual leave. I went there with her so that when she was on leave, there was a senior nurse within that ward that knew what was going on. If anything was missing from the minutes, I would have picked up on this at the time.

214. I don't know why if they were HAI by the 48-hour rule. If they were healthcare associated, I'm assuming that it's because their lines have been accessed as they would have been in hospital. Healthcare associated would have been, I think, when the line has been accessed by a healthcare professional at some point. I don't know if it maybe means that the 48-hour rule wasn't applied?

215. The patients that had the same pathogen in their blood that was found in the drains, I would have had to have looked at the patients notes as there's been so many patients over a long period of time.

216. I would have to see how it affected each patient, to be able to tell you how they differed in support. Each patient is different so, although these patients one could have been well and maybe one wouldn't have been so well, I can't recall the exact impact on each patient.

217. HCSW staff are Healthcare Support Workers, so they're our band 2, 3 and 4 staff. If other areas in the hospital were short staffed and we have our quota of staff, they would maybe take staff from us to staff another area. There would maybe be a concern that there would be a drop in standards as you wouldn't have the healthcare support workers to help the nursing staff with the cleaning.

218. I don't know for sure if there was a general shortage of staff across the hospital at that time but if staff are pulled off another area, then there must have been a shortage in the other areas.

219. It could maybe have been because we had maybe 3 support workers on shift and another area had no help from a support worker so they would have to weigh up the risk if we had three and the other areas had none. It's not at our level that makes those decisions, it's made at management level.

220. I mentioned earlier about signage being put up telling people not to put things down the sinks. This was an action from a previous meeting, they found the drains to be harbouring the different bacteria that was unusual.

221. They then acted to ensure that was nothing was being put down, so we would put up signs. But we would also explain to the families why we ask them to do that, so that would be what we would do as a general rule, we would explain it was infection control.

222. I can't remember what we were told about elaborating on infection control standards, but if a parent asked me to elaborate, I would then tell them that putting anything down the sink might cause it to stick to the drain and ask them

not to. Generally, people were very obliging if we were asking them not to do it. Most people were fine with it.

223. We were educating the parents, and this was in the form of giving them information about the hand-wash basins only being there for hand washing and that no other substance should be going down it. Then there was the process that was put up at the hand-wash basins and the families were informed that they shouldn't be putting things down the sinks.

224. I'm not sure if there was any view at this point as to whether there was a connection between the increased rate of infections and the parents, families and visitors. I can't remember if that was looked at.

225. (**A39123933 - Parent poster dated 6 September 2018, Bundle 5, page 147**) is titled "Keeping your child safe from Infection". This looks like a kind of general information one, I remember seeing this. They were up in the patient areas. They would go up in all the patient rooms like a poster, and then, obviously, communication has also been given out for our staff which would be handed over at each shift.

IMT – 10 SEPTEMBER 2018

226. **(A36629302 10.09.2018 Minutes Ward 2A IMT, Bundle 1, page 154)** I attended an IMT on 10 September 2018. From looking back at the minute, I knew families that had gram negative infections and I think due to the number of cases in that period of time, that was why the IMT was called.

227. I had raised that the new method of cleaning would cause a lot of disruption clinically as the ward was currently full, so it was suggested there was a meeting to plan the logistics of that. I can't remember if it was myself or if it was some of the other band 6s, but the cleaning just went ahead.

228. I think what the issue was that they needed the cleaning to be done but because we were full, I can't move a patient to a room where there's no room. That was my point, I can't put a patient in a corridor. I think eventually what came back from that was that in actual fact the drain cleaning didn't mean the patients being removed from the ward.

229. They would do the drain cleaning without the patients being moved from the room, so it did manage to go ahead. There was no impact on the patients, or the care given as it was basically just a substance that was put down the drains. The Chill Beam cleaning, HPV and drains, we would organise the logistics of that ourselves.

230. There were four rooms to be validated. These rooms were closed but I can't remember why they were closed. They were getting work done on them and the validation process just means that they were fixing the rooms, and once they were validated, once they were ready, then they would be put back into circulation.

231. There were staff concerns and questions about the drain cleaning which was referenced as an incident in IMT. I'm sure at that point someone came down to speak to staff regarding it, I think it was the next day. I can't remember what the response was but they did come and speak to us, they were aware we had concerns.

232. I can't remember what communications that were handed out about the cladding. I can't remember the information that would give to families. As I said before, a lot of the information we would get, would be the same the families would get.

233. It was continually raised that there were staff concerns because there was just a continued emphasis on gram negative cultures. There were a lot of positive blood cultures.

IMT – 13 SEPTEMBER 2018

234. (**A36629307 13.09.2018 Minutes Ward 2A IMT, Bundle 1, page 160)** I attended an IMT Meeting on 13 September 2018, I think this is the last one I went to about events at that time. It was about the serratia which was very uncommon, and I personally had not heard of it before.

235. In the minutes it states, 'Sarah-Jane said staff in the area are very concerned about the ward ad if it's safe for patients.' This was near the time of moving, and I think staff were just a bit flat. There were whispers going around that we were going to be moving out of the unit and staff are just concerned why are they moving out of the unit; could it be the unit wasn't safe? So my remarks were made about the concerns of the staff for the safety of the patients. was round about the safety for their patients.

236. There was a meeting with Jamie Redfern, Teresa Inkster and Jen Rodgers in the Medi-cinema which I attended. Kevin Hill, who, at that point, was the Director of Nursing. I can't remember his title exactly. Kevin Hill, I think, talked about reassurance and about the ward move.

237. I can't recall everything that he said at the meeting, it was quite a long time ago. There was quite a lot of staff there but not ward level, they would have still been looking after their patients so you would have had had all your management side there, Angela the lead nurse, the consultants, all of those kinds of people.

238. I put this on a safety brief. The safety brief is what we use to communicate with staff as we have over 70 members of staff that work in the in-patient unit. For communication you would put it in a safety briefing which is read out at every hand over, anything that staff need to know about is put on the safety brief. This would be read to the morning and night shift and was how we relayed information to staff.

239. I don't think I had increased concerns regarding safety, I just remember being concerned about the moving from the unit and that they were picking up on things that were never picked up on before. I just remember wondering what was going on, that was my thought process. I was wondering if it was safe for us to be in the unit which is why I asked this question, as I knew a lot of the staff felt the same way.

240. That was my role; I'm not only an advocate for the patients, when you're a charge nurse, you're an advocate for your staff too. You're the senior person there to advocate for your staff, to support your staff and they were coming to me with these questions, and I had to put them forward.

CLOSURE OF WARD 2A/2B AND MOVE TO WARD 6A/4B – September 2018

241. I think the reason for ward 2A and ward 2B closing was to upgrade the ventilation system and the drains and drainage. We were only just told that it was drains that they were looking at, sinks and drainage. We had identified black marks on the sinks around the plug holes, so they were checking plug holes and the piping around the back too.

242. The sinks in the hospital are quite different to your home sinks where you have a plug that you can fit in, there's no plug that you can put in to stop things, they're kind of open. and I think that's where the liquid dowsing and things came in.

243. I think it may also have been to do with moulds that were found in the bathrooms. There was mould found around there, but all the bathrooms are shower rooms, so the showers are open, you know, they are like open bathrooms, wet rooms. Some mould had been found around about where the showers were coming down, because of where the lino had kind of connected to the flash wall, I think that's what it's called.

244. Then the Microbiology team would come and swab to see what that was, they were generally checking everything, asking sure there was nothing causing a build-up. If I was in charge of the unit and then I would be told when have to then obviously facilitate, to make sure they could get access to these areas.

245. I can't remember how we were told the ward was moving. I would imagine there was a meeting for staff that were on the ward that day then the Senior Charge Nurse would advise everybody that was happening – but I can't confirm that as I don't remember being at one. I don't know if there was a communication put out but again, I would imagine something would have gone out from senior management.

246. I can't say for sure as it was so long ago. Sometimes communications came out in the form of emails and if you weren't at work, you would see them when you came back. I did both dayshifts and nightshifts, so some things were sent out when I wasn't at work.

247. All I knew was that it was a senior management that would be responsible for making a decision about moving the ward, not from a nursing point of view but higher management who I have never met before, names that I didn't recognise. I can't remember when we were told. I think it was September 2018 that we moved. There wasn't a lot of time between moving and being told.

248. I was at an IMT where there was discussion about moving, but in my mind at the IMT, they would have to go away and action things before the communication came out. None of the staff in the unit had any say about the move and none of our opinions were sought from what I can remember.

249. I think risks would have been looked at for the move. I remember, from one of the IMTS I attended, there was a gentleman, I can't remember his name, who was working in the project side for the move, and he was looking for an appropriate place that would have been safe. There was some discussion at the IMT but my opinion wasn't sought regarding a move.

250. As far as I'm aware, everything appropriate would have been done in terms of risk assessing any move. You don't do anything without risk assessing first. I wasn't involved in carrying out any risk assessments myself. We don't do anything major without doing a risk assessment of what we're doing. What I was involved in was moving the patients; so I was involved in setting up the schedule of who we would move and how we did it.

251. I'm not aware of any concerns about moving. There was anxiety around the fact we were moving to an adult hospital, but we were told by Jamie Redfern and Jennifer Rodgers that it was the safest thing to do for our patients. As a nurse, I'm going to do what I'm asked if it's the safest thing for our patients.

252. Our anxieties were just around general things like the set-up of the unit. In a paediatric unit, you have got the facilities, play areas, all the appropriate facilities for children like the televisions. Ward 6A was an adult ward design and looked like an adult ward. This is different to a paediatric ward which is set up for children, it's more child friendly and colourful. I think at that point there had been so much happened in ward 2A that I think we all had anxieties about moving.

253. We went over to have a look at the unit as we had been informed we would be moving there. As well as being in Ward 6A, we were in 4B too, so overall we were split over the two areas with transplant patients in 4B, which is an adult transplant unit, and the other patients in 6A

254. As I've said, ward 6A was not child friendly but we still had single beds, everything was pretty much the same, single beds for safety, there was wall art, they made a parent's area, but it wasn't open for long because of covid.

255. They had a parent's kitchen that used to be the bathroom and eventually we got a room for staff. We did change some things in the ward, anything we asked for, they changed it for the children. Our main concern was to adapt the

rooms appropriately for the patients. We also had to encompass our day unit within the one area, whereas we were split over two areas at the time.

256. We are one unit, but in 2A/2B children stay across from us, but in 6A both the inpatients and outpatients were together, so we had to work out how the same unit was going to fit into the ward. In the process we also had to try and make it as child friendly as possible. As you can imagine, it's a very different in an adult setting, whereas we were used to being in much brighter, more child appropriate surroundings.

257. When we moved, there were concerns that, if there was an emergency, how long in terms of care would it take to get to the unit. If you have an emergency, you need a paediatric resuscitation team to attend.

258. Our paediatric resuscitation team is based within in the children's hospital, so the intensive care comes from the first floor or even the second floor, so if a patient became unwell, the response time would be longer, although I don't think it was a long, long time, but it would be longer than what we would generally expect.

259. So, rather than having to travel one floor, they would be coming from one hospital to another, and then they’re having to come up to the sixth floor as well. Ward 2A in the children's hospital would be where we were based for our Paediatric intensive care unit, on the first floor in this children's hospital, but then to get to the adult hospital they have to get to the lift and get up to the sixth floor.

260. If they were bringing equipment, they can't carry the equipment up the stairs, so it's about co-ordinating how they were going to get the lift and get the lift quickly and looking at sign posting and the quickest way of them coming. I wasn’t involved in any of the processes that took place to look at that concern.

261. There were also concerns about the move itself, the transferring of the patients to the adult hospital from paediatrics if the patient was immunocompromised as we had concerns around going through areas the general public used. They did allocate an area that was only used by our patients, this was at the time of the move, around one of the lift areas and included one of the lifts which was the core lift at the time.

262. It was signposted at Ward 2A that we had moved to the adult hospital. There was nurse there that was just allocated to our area, and it was sign posted so that the team knew they had to come to Ward 6A.

263. There was a run carried out to see how long it would take to get to the emergency unit or to get equipment up to the patient. I was not involved in the test run. I don't know who carried out the test moves but they would have been from a senior point of view. We weren't involved in any of that.

264. In ward 6A, we ended up with the day unit and in-patient facilities in the same ward. We had one treatment room which was quite small. The prep room, where we would prep our drugs was small and we had two units, inpatients, and outpatients, within that area.

265. I think what happened was that we ended up with staff for both areas. If there were any emergencies, we were all together and there were more staff members there. There was capacity in the treatment room for both areas so you could go to both, whereas in the RHC, we were two separate areas.

COMMUNICATION AROUND THE MOVE TO WARD 6A – September 2018

266. (**A38662124 - Press statement from NHS GGC on decision to move patients dated 17 September 2018, Bundle 5, page 148)**. This is information about drains testing and the decision to move patients out of Wards 2A and 2B at that time. Generally, the way we would get information like this is we would get the paper copy and give it to the families. We would go round the families in

the Inpatient Unit and give them the information, if we've got a paper copy we would give them a copy. So, we would just leave it with them and let them ask any questions they might have.

267. **(A38662124 - Press statement from NHS GGC on decision to move patients dated 17 September 2018, Bundle 5, page 148**). This a Core Brief dated 18th September 2018 and is a statement from NHSGGC about the water supply and drains in Wards 2A and 2B of the RHC. I will have read it because I do read them all but I don't specifically remember this particular one, however I know the information that's in it because I was there when it was happening.

268. I personally feel that the communications about the move from ward 2A to ward 6A between management and staff, could have been a bit quicker in light of the situation.

269. The staff found out around the same time as the families, and we felt a bit blind-sided. The families would ask us questions and I just sometimes felt that maybe we weren't as prepared as we could have been if we had a bit more knowledge before that.

270. However, I also understand that at the time of the IMT, maybe there were other factors involved that were maybe still to come out or be clarified so that's maybe why they couldn't tell families any more at that point. It would take maybe a couple of days from the IMT happening for the information to come out.

271. It was often the scenario where, for example, they would be looking at three possibilities or factors for something, but how they were going to identify it or fix it, and then they would want to put the communication out once they had answers to what they were doing and why they were doing it.

272. My point is, staff were getting the same information as the families, but they were just getting it maybe just a few minutes before the families were.

273. Obviously, if I hadn't been involved in the IMT, I maybe wouldn't have understood that, but because I had information from the IMT I had an idea of what was going on. However, it could be frustrating for the staff who didn't understand the process of what was happening at the IMT. We knew management were looking into this and Infection Control were looking into this, and then once they have answers they would get back to us.

274. If staff had been given the information earlier, I think there may have been less stress for staff. As a nurse you want to do everything you can to look after the children who are your patients. You want to be able to do everything for them and look after them 100 percent of your ability and for me, not having that information to be able to give to them, I felt that I was somehow doing them an injustice because I couldn't give them what they were wanting.

275. I wanted to try and be as open and honest as possibly with the families. That's the only way we are going to be able to give support to the families and it's the only way we can help them get through their journey. When we were getting the information just before them, you weren't really prepared.

276. A lot of the time, what was in the media, was inaccurate, they would get basic information and they would elaborate on it. I can only tell you what the information was that I got and what was shared with the families at the time. I don't know what information could have been given out, so maybe it was the case that we were all told everything.

277. If, in their communications they had said that was all the available information, I think that would have helped. Sometimes we would get more in-depth information and some of it was just reassurance around the unit. If there was anything that had happened, they would give us reassurance and tell us they were looking into it, or trying to look at what can be done.

278. Regarding media statements again, I think for us, there could be an article that would come out and then staff would come in on their shift. It would be really quite upsetting for them to come into work having seen some of the things in the press, they were never positive, it was always very negative. So, as I've said, the worst part was that all the anxiety was very high and staff morale was already very low.

279. It just probably made them feel a bit more anxious about what was going on and worry more, as that's first and foremost with our patients, and making sure that they are safe here. The media coverage definitely had a negative impact on the staff and the families. If I was going in to be in charge and I saw an article in the media such as the ones that were being printed, I would then try to prepare myself for lots of questions, because you knew you would be asked about it.

280. I would have nurses telling me families had seen the article and were asking questions and asking me if I would speak to them, which I would, but a lot of the time I didn't have any more information That was frustrating for families, because I think sometimes they thought you were hiding information from them, however, in actual fact you didn't have any more information than they did. It was about trying to reassure them that I would then go and see somebody higher up than myself and try to find out. It was very frustrating.

281. I think because of the nature of our patient group, we look after these families for such a long time, we always find we've had really good relationships with our families because one of the biggest things for us is trust. I think that kind of broke down a bit then, because they felt that we weren't answering their questions, so they assumed we must be hiding something. But a lot at the time we didn't know any more than they did.

IMPACTS OF MOVE FROM WARDS 2A/2B to WARDS 6A/4B – September 2018

282. In relation to the move from ward 2A to ward 6A, there was general anxiety and concern about going to the adult unit amongst the families. I can't remember exactly what was said but they were anxious and understandably so; they had sick children in hospital, and they're concerned about everything that was happening.

283. The newspapers got hold of what was going on and it was sensationalised all over the media, in social media, in television and in the newspapers and I think people were scared. They were anxious, worried, and concerned for their children. I can't say anything about the impact on patients when they moved from ward 6A to CDU as I wasn't there.

284. There was also a clinical impact when we moved to ward 6A. We were still administering chemotherapy, but we weren't taking any new admissions. I think this was in relation to the move to CDU. Patients had to go to Edinburgh or other centres to a shared care centre to get their treatment for a few weeks.

285. I think this was after the Cryptococcus event in December 2018 that we were closed to new admissions. At that point we were transferring chemotherapy patients to other areas who could take them and administer their chemotherapy.

THE MOVE TO THE CLINICAL DECISION UNIT (CDU) – January 2019

286. There was a meeting I was at where we were being told that we would be moved from Ward 6A to the CDU. I can remember being anxious around what we were being told. The question was raised that, if it's safe, then why are we being moved? A lot of factors involved in us moving were discussed at the time. I think the meeting would have been taken by Jamie Redfern and the Chief Nurse, Jennifer Rodgers. The Lead Nurse Catherine Thomson was also there. I

also think a lot of our consultants were at the meeting too, as well as people from the IMT. I believe there was another meeting the next week, however I wasn't at that one, and I wasn't there when move happened, I was on leave, but when I came back, they had already moved.

287. We moved out of Ward 6A to the Clinical Decision Unit (CDU) in January 2019. I remember being at a meeting about that. Emma was on leave at the time, so I had gone to the meeting, and then I was going off on leave when Emma was coming back. I can remember telling Emma that looked as if we were going to be moving again.

288. There were no different medical protocols for the patients when they were moved wards but I think it was frustrating for them having to be moved. If you have patients who have been admitted, the first admission could be for six months, and it was quite a lot of movement forthem.

289. However, in a clinical sense, everything we would have done in 2A would have been done in 6A. How we would have treated the patients, how the care would have been delivered would have been the same.

ISSUES IN WARD 6A

290. I can't think of anything that I was aware of regarding the environment in ward 6A other than it being an adult ward with adult settings. There was a door at the back of the ward that people could just walk in and out of. Anybody could just walk into our unit so we asked for this to be closed due to the type of patients we had. I can't think of anything else.

291. When we first moved over, I wasn't aware of any issues with mould. I think there was mould identified in the bathrooms. Some of the patients had identified that they had seen mould in the shower or they had found it in the bathrooms. I think what happened was to do with the linoleum.

292. In your house you would just have the linoleum on the floor but I think on the ward it came up the walls so the mould was gathering at the skirting boards. I don't think anybody spoke to myself about it. If anyone ever raised it, I would have moved them out the room. I would not have put a patient in the room until facilities had been up and had sorted it. That's what I would have done, I can't actually remember ever being involved in this though.

293. **(A39123898 - Update Briefing for Parents dated 6 September 2019, Bundle 5, page 345**). This is a letter giving information to parents and carers about work being done in Ward and unusual infections. It doesn't mention what ward its in relation to but I see from the date its from September 2019 when we were in Ward 6A. It looks very familiar to what they all look like. I maybe wasn't on shift; it would have been one of the other girls that would have received the information and they would have taken it into the parents. I think there might have been a few like that where they were just giving them an update, that there had been an IMT and that they would get information through after that. This would have been the same way of passing information out to the staff as all the other sheets.

294. When you're a Band 6, there's just been a charge nurse and with or without your chief nurse or lead nurse on the ward, they would sometimes they would come up also and go round with you if you were handing stuff out to the patients.

295. (**A39123903/A41501454 - Letter to parents on ward 6A dated 12 November 2019, Bundle 5, page 382**) This is a letter from Kevin Hill, the Director of the Women and Children's Directorate. It is dated 12 November 2019. It's an update on investigations into unusual infections on Ward 6A. I remember seeing this letter. The process for handing these out to patients were the same as all the other pieces of information.

296. **(A39123935 – Letter Haemato-Oncology Unit 6A dated 14 November 2019, Bundle 5, page 383).** This is a letter from Jane Grant about a meeting which

was held on 2nd November 2018. The letter is dated 14 November 2019. I remember this, I think we had done a nurse day to set up our meetings at the time this was going. I can't remember where the meeting was and don't know what form it took because I wasn't at the meeting, I wasn't involved in it. I can only remember there was a meeting in the main hospital with that letter coming out afterwards.

297. When we went to ward 6A, there was a problem with Cryptococcus which was the pigeon poo. I think we had communication about that, but I'm afraid I can't remember who told me or how we were told. It may have been through one of the communications that went out or it might have been one of the set things that was focussed on when we had discussions with the Service manager at the time, or it may have happened when I was off duty or been on a day off as I worked shifts – but I was aware of it.

IMT 18 JANUARY 2019 - CRYPTOCOCCUS

298. **(A36690595 - IMT Cryptococcus 18 January 2019, Bundle 1, page 274)** There was a Cryptococcus incident management meeting on Friday 18 January 2019, this was the one after the Cryptococcus had been identified. I can't remember much about it. Staff morale at this meeting was really bad though.

299. Morale had started to pick up, but by then it had been so low for such a long time for the staff in the unit while all of this was going on. We did have a large group of new staff that weren't involved when all of this was going on, but for the staff who were involved, morale was quite low and they thought well, we are going back to things getting better and then this.

300. This is at the point where we were moved to Ward 6A, because it was safe to be there and in actual fact, they found out that there were Cryptococcus issues. They had concerns around that and any information that they had seen.

301. There were lots of concerns about the Cryptococcus and the families, it was another factor that was presented to us on top of everything else that had happened to us on ward 2A. It was another aspect of anxieties for parents, families and staff.

302. We have what's called a core brief and this is sent out to all the staff. We get core briefs all the time with information updates on them. I can't remember if it's sent out by Jane Grant but she would send out updates on anything. They're sent out by email, and you get them every time there's an information update. The Core Brief is generic information that would go to everybody across GGC whereas the Safety Brief was only for our area.

303. Staff on ward 6A had requested more information about the Cryptococcus as they were only given the same information as the families were. They wanted to get a better insight to what was happening, why it was happening and to get a better understanding of what was going on.

304. We had already had all the infections in ward 2A so now to get this in Ward 6A, it's not the same thing but it was similar as our patients had infections. I can't remember how much information was given.

305. I think there was talk about Cryptococcus in the ventilation and it was causing issues for people with respiratory conditions. It was definitely a concern when you're being told that there's something in the ventilation that could cause skin rashes and respiratory problems, and that it can be detrimental to pregnant women too, so of course staff were concerned.

306. We and we were told pigeons had gotten into one of the ventilation plants and contaminated it, it was everywhere basically. That's why the ward had problems with Cryptococcus in our patient group in ward 6A. In ward 2A, this was never a concern, but in 6A, I believe this was when it was an issue.

307. Regarding Gram Negative Infections, we had the CLABSI group who were always monitoring line infections, so I knew from my job as a Band 6 Nurse that there was always concern about line infections and that they were always being monitored.

308. I knew that the HEPA filters were installed because of the ventilation. I think this happened around December time because I remember it being around Christmas time 2019 and we were having to set the HEPA filters up.

309. [redacted] had the Cryptococcus infection so I was aware that a patient had been affected. I wasn't aware of any risk of infection relating to the ventilation in 6A in relation to the Cryptococcus before we had been told about it. My understanding of the ventilation work being done at this time was that it was being upgraded, this was in relation to Ward 2A.

310. When we moved to ward 6A, it was an adult ward and it wasn't built for haematology oncology. It wasn't an area that was specifically designed for our patients so there were HEPA filters placed in the patients' rooms and on the ward to filter the air appropriately as it should be within the unit. That was my understanding of the HEPA filters and also what we were told.

311. I'm not aware of any issues relating to the HEPA filters. I know sometimes the families would switch the HEPA filters off; they are very loud. If you can imagine being in an aeroplane, they sound like that. They were kept at certain levels in the rooms and at higher levels in the wards because of the noise.

312. I'm sure they were checked to see what levels they had to be at because the rooms are smaller but sometimes you would maybe go in the rooms, and they would be switched off or turned up or down but I can't think of any other issues with them.

313. In ward 6A, I wasn't aware of more isolation cases due to the ventilation. I'm not aware of any patient being into isolation that wasn't an appropriate isolation.

314. Then when we moved to ward 6A, they started cleaning the chill-beams every six weeks. I think this started after the incident with the Cryptococcus which was the pigeon droppings. So much has happened so I can't remember exactly when things did happen.

315. We did the chill-beam cleans for which I think were 6 weekly. We were cleaning them but by the end, we were just replacing them. They had stuff coming out of them and I remember being on shift and seeing they were quite dirty looking. There was condensation coming out of the plastics tube that comes out of the vent, so it was to prevent that.

316. The process for this was that Estates would come and replace them, but our role would be to move the patients out of the room. The room would have to be emptied and, as the nurse in charge, you would have to co-ordinate who could be moved and identify where it was safe for them.

317. This is because, you have to think about it in terms of, if you have a sick patient, you don't want them to be far away from the nurse's station. So, you had to think about patient placement, but then you also had to co-ordinate staff because our staff would have to move them.

318. So, it would be staff on the floor, on top of their job they would then have to also move the patient's room. Then our staff would have to come and clean the room. Similarly, after the cleaning crew came in and done the deep cleaning, we would have to clean all the equipment and put all the patients into the room, and we would have to move all the setup. So, all the bays, the cabinets, everything had to come out of the room, nothing could be in the room that wasn't cleaned.

319. There would have been some communication came around relating to that but I couldn't tell you how often or how much as it was that long ago.

320. We had been moved to 6A because of the increase in infections in 2A, then we had patients who had Cryptococcus infections, so again, the nurses were under a lot of scrutiny. We were worried for the patients and their families.

321. Whilst we were in Ward 6A, we were initially told that they weren't sure where the Cryptococcus was coming from. But then we were told it was in the plant rooms, that it could have been due to the pigeons that had been getting access to the plant room.

322. I researched Cryptococcus and pigeons myself, but I was never involved in any of the hospital investigations into it. We also had line infections at the time so there were different types of infections and different types of bacteria in our patient groups.

323. I've looked back at the information that we were given at that time as I can't remember it all. I know that Cryptococcus was identified and that it was due to the pigeons. We ended up being moved out of ward 6A to the CDU, but I can't remember for certain 100% if it was all due to that.

324. I'm sure we were moved to CDU because of the issues with the pigeons and the only reason I remember that is because when we went to CDU, I remember there being pictures of birds on the walls. I heard they had removed the bird pictures.

325. I was on annual leave when they were discussing moving so I wasn't involved in that. I think it was only for four to six weeks that we moved. We went to the clinical decision unit (CDU) and the patients that were there were moved to ward 2A as they hadn't started the building work on the ward yet.

326. We were then going back to RHC, and it upset our oncology unit having to move again. I think we were told it was only going to be for a couple of weeks that we were moving for. We moved to ward 6A in September 2018 and then we moved to CDU in February 2019 and that was for a couple of weeks.

327. I don't recall being told it was CDU that we were moving to initially, I just remember being told we were moving. I wasn't aware of any risk assessment being carried out for the move to CDU or why CDU was chosen. CDU is where RHC patients come through via the emergency department in the RHC. They might be stable but need observation then there's a decision made as to whether they can go home are kept in.

328. As far as I'm aware, since we have moved back, all the rooms now have positive pressure. We now have a lock system on the door too.

THE VENTILATION SYSTEM – WARD 2A

329. I can't recall being aware of any issues with the ventilation when we were on ward 2A. From a ventilation point of view, I understand it's to do with the air changes in the unit and they were upgrading the ventilation to ensure we were matching the recommended air changes. The ventilation system we had before had air changes lower than the standard.

330. My awareness of ventilation was that you are supposed to have so many air changes and it filters the air clean for our patients, so that would have been my understanding. I've never really had to think about the ventilation. As a nurse, I didn't have to consider it and never had any views on it, so my understanding was that the ventilation was how it should have been.

331. When we first moved over, I think now, looking back, I think my understanding was that all of the rooms should have had positive or negative ventilation. Now that we've moved back into 2A, we have positive ventilation in all the rooms, one room with negative ventilation, although there may be more, I'm not working in that area now so I'm not sure, as I'm no longer involved in the running of the Ward.

332. Looking back, I don't think they weren't ventilated rooms, it could just be my understanding, but it's now changed regarding the way the rooms look. They now have long letter boxes at the top of the doors that let the air out.

333. I can't remember having any concerns about ventilation when we moved in 2015. I went in early, and I would look after my patients to the best of my abilities. I rely on the people that are experts in ventilation to keep that part as it should be, and I do my job. I've never thought about the ventilation.

334. I can recall when we moved to Ward 6A we were told it was because of the ventilation as the number of air changes within the rooms done were lower than they should be. I can't remember if I had any concerns about ventilation before that.

335. From what we were being told by senior management, they were upgrading the ventilation system. They told us this at a meeting we had at the time, I can't remember when this was. I'm sure it was at one of the meetings when we were moving and why we were moving to Ward 6A.

336. That was when we were told they were upgrading the ventilation system, so we were out of the ward. It wasn't a meeting as such, it was where the Chief Nurse and I'm not sure what the other one's title was but they would come up and explain to staff what was happening. It was more a communication meeting. I cannot remember how frequent these meetings were.

337. Again, any communication that was given out regarding the ventilation system, we would get from the communications team. My understanding was that the communications team would put together all the information and it would be passed down through management to ourselves.

338. We would have the information then the parents would get it. There wasn't a great deal of time between us getting the information and the parents getting it, but again, the Chief Nurse and Lead Nurse would come up and we would go to

the families with the information and the piece of paper which the information was written on.

339. There was no communication about how we told the families anything, we were just given the information we needed to pass to them. The information we were given was all we knew too, so we couldn't tell them anything further, as that was all we had.

340. There is a Facebook page for parents but I was never involved in it so I don't have any access to it, it so I can't tell you what was on the Facebook page. I do know it was set up so that communication could be given more widely wider to families.

341. There were the families that could be in for a longer term, and there would be inpatients, also patients who were getting outpatient treatment, so they wouldn't technically be in hospital and would not be getting the same comms the inpatients would be getting. So, I think the Facebook page was created for management to share more information more openly with the families who maybe weren't inpatients at the time.

HOSPITAL ACQUIRED INFECTIONS (HAI)

342. A hospital-acquired infection is also known as a healthcare-associated infection. When you're looking at your infection system, you associate it with any care that's delivered within a hospital setting or care setting.

343. So if you're acquiring a healthcare hospital system infection, then it's within a hospital setting, but also it can mean that a patient could come in that has maybe been outside the hospital for 40 hours. So technically doesn't mean it's been hospital-acquired or healthcare-acquired, but it's been identified as in a hospital setting.

344. In the sense of our patients, they are immunocompromised so for instance, if they catch the common cold, they are more susceptible because they have no immune system it can also make them pretty poorly. They also have objects, central lines which are channels into the patients' chest, into their heart.

345. These are tubes going straight into the bloodstream, so they are more susceptible to infection. They're at higher risk of getting an infection and need to be handled appropriately. There's always a risk of infection in this patient group and the whole point of infection control and all the policies and principles that we have in place is to try and prevent them. But they are not always preventable.

346. There are things that I talked about earlier such as accessing the line and wearing PPE and decontamination that we do to try and limit the risk of infection.

347. I'm not an infection control expert so I don't know if infection numbers can rise even though we do everything can. For our patients we've always seen infections of the central line/devices. These are plastic lines leading into their chests, so we've always seen infections in these. What had happened when we moved to RHC was that there was an increase in infections. I wouldn't say there's always a risk, I'm not confident enough.

348. When we were in ward 2A, we did see an increase in our line infections, so if that's why I think at the start, all our staff group practices were being closely scrutinised to see why the numbers of infections were so high.

CENTRAL LINES

349. There are different types of central access devices that we use. You may have heard them being called other things. A central line, or Hickman Line as you may have heard of, is essentially the same thing. We would have port-a-caths

which is a central device as well. We would also have PICC lines, dialysis lines and then we have peripheral lines that we put in.

350. These are not inserted into the heart, they are not going in centrally, they are going in peripherally and you would also have cannulas. A peripheral line is a line that goes into a vein, a central or Hickman line would be inserted into the heart. These lines would all be used for our patient group.

351. The central line is a tube that goes into the chest and there's a bit that constantly hangs out so as you can imagine, there can be infection round the skin that can then contaminate the line. You can have an infection through the bloodstream. If you have got a port-a-cath, which is a chamber inserted under the skin that you access with a needle.

352. You would insert the needle into the skin then into the chamber, then the skin can get contaminated. There are different ways it can get contaminated. You would try to mitigate infection risk by making sure you are using appropriate decontamination procedure for the skin and the central line.

353. The end of the line is covered at all times with a port protector. Any device that our children have in situ, we would put a protector on the end of it. So, any device, anything that's a device, even a peripheral camera, they all have a protector on the end at all times.

354. There is alcohol in the port protectors and when you're working with the line it's decontaminated with a solution that is made up of 70 per cent alcohol and 2 per cent chlorhexidine. There is also a solution in a stick that we use to clean the skin. This is also made up of 70 per cent alcohol and 2 per cent chlorhexidine. There is also an SOP to follow on how you should clean the skin.

355. If we suspect a patient has a suspected line infection, there are protocols that we follow. If the patient has a temperature, we will take blood cultures. This is automatically what we do and when the results come back, we are able to

identify if the patient had an infection in the line. We would then decide what antibiotics the patient should be started on.

356. We would get in touch with microbiology to decide what antibiotics were required to treat the line infection. The antibiotics may change from the ones the patient had been started on once the infection was confirmed and identified.

357. The microbiologists would discuss with the doctors which antibiotics should be given to patients with a line infection. Infection control are more to do with the preventing of infection rather than the treating of them. If there is an infection, infection control will be involved to see how we stop it and moving forward, prevent it. That's my understanding of how they work.

358. When we take the blood cultures, we send them over to the lab and they analyse the blood. I don't know exactly what they do as I've never worked in microbiology, but I think they take the sample and put it under heat. I think they then leave this for 48 hours to see if anything grows. Sometimes something grows quicker, but they leave it for a certain period of time so that people are able to identify the infection or bacteria.

359. If a patient has an infection and they become really unwell, or would require antibiotics, sometimes we would give them through the line. Sometimes the patient, if they have an infection, may not be bothered by it at all, they might just have a temperature, but some can be really unwell and require more care.

360. The body can shut down meaning they may become dehydrated, and they may require more antibiotics and their line removed. If we have to remove the line, there may be an impact on the patient receiving their chemotherapy.

MONITORING OF AND INVESTIGATION OF INFECTIONS

361. When I joined the unit, I wasn't aware how the hospital monitors, investigates or acts upon infections being found but now I'm aware of a working group that

looks at all the data from infections. I know infections are monitored by microbiology from a medical point of view.

362. We have a working group, Central Line Associated Blood Stream Infections (CLABSI) that was up and running when I joined this role. I'm not sure when or why it was set up as it was established when I joined.

363. The group consists of surgeons, advanced practitioners, consultants, myself, and the senior charge nurse so it's quite a big group. Microbiology are involved in this as well. We look at the data every month at what infections we have. The CLASBI look at all the different infections within the lines on our ward.

364. The Chief Nurse gets given the information from the group and escalates it to Management. It's the Advanced Nurse Practitioner who collates it all. My side is from a communications point of view. Anything that comes out of the group, I take from an education point of view so I don't do any of the management of the process. The purpose is to understand line infections.

365. When we look at the data, we look at all the different types of cultures that have been identified and we put it on to a database that we are looking at. We look at how may lines that they have, how infections they have within a specific group may and what the different type of infections that have been identified on these cultures then all of that is reported.

366. Before being part of the CLASBI group, I knew there was a group that looked at the line infection data as they used to share the information in the wards. I'm not sure if they do the same thing hospital wide. The data they look at is obviously the type of line infection the patient has. They look at the different types of line infections, how many line infections the patient might get, and each patient is looked at and each infection is looked at, if that makes sense.

367. If they get positive cultures back for patients, they look at whether the line needs to be removed, and then whether the patient needs to get another line.

All the staff would get to see the information on the chart on the wall. It would show information about the different infections.

368. I'm not sure if our data is shared round the hospital or other wards. I think other areas may see our data, but I don't know what they do with it. We look at gold standard which is used throughout the world so we can see where we're sitting and how our infections are gold standard throughout the world. We only look at our own patient group.

369. When there was an increase of line infections on ward 2A, we started to look at our practices. Our children have always been sick naturally due to the type of patients they were, but more patients were getting sicker and it would be discovered that they had line infections.

370. It seemed that there were a lot of line infections and because of this, they started looking at our nursing practices as they wanted to ensure the nurses weren't doing anything that was causing an infection. It was demoralising for the nursing staff as our practices haven't changed for a long time and we still work that way. They were checking everything that we were doing.

371. As I've said before we did see patients that had positive cultures in Yorkhill. Unfortunately, it's the nature of putting a line in a child's chest that they do hold a risk of line infection, but it just felt there were more patients in ward 2A.

372. When you are on the floor, you are just told that the child has positive cultures and need antibiotics. As a Band 5 Nurse, you would be aware that maybe a child had an infection so the doctor would need to speak to microbiology because of what they found in the blood cultures.

373. As a Band 6 Nurse I would hear more information in the hand overs, about gram negative blood stream infections and they would go into all the different types of bacteria that would maybe be found in these.

374. I didn't have any specific concerns at this point, it was more around the fact that the patients were more sick than usual. They were coming in with line infections and we were seeing children that were sicker than they had previously been. That's maybe just how we were seeing it. It maybe wasn't the case, but it was how we felt.

IMPACT OF INFECTIONS ON PATIENTS

375. The impact of an infection on the patient would be that they maybe have longer in-patient stays, or need lines removed, those were the kind of things we were seeing. If a patient had an infection and needed a line to be removed, we would have to go in through the chest and remove the line surgically. The patient would require an anaesthetic, and then the surgeons would remove it.

376. Also if it maybe took a lot longer for the infection to come out, then the patient would maybe need different types of antibiotics.

INFECTION CONTROL

377. Before the increase in line infections, we would always be in contact with infection control if we had patients who had been identified as having something. Even it was someone we had sent a stool sample for who had been in isolation.

378. Infection control would call us and tell us what the patient had, and then ask if they were still in isolation or if they still had symptoms. We would keep them in isolation for 48 hours to see if the symptoms stopped. I think it's been since all of this started that infection control are more present on the ward, but I can't remember exactly when it started.

379. Now someone comes in and does a hand hygiene audit, I think these are done every month. They would stand in the middle of the ward and watch people wash their hands. I was never asked for my opinion about these, and I think the

results are reported back to the nurse in charge, but they may also speak to individuals.

380. Morale wasn't good, this was the time when we were still in Ward 2A I'm referring to. We still have these audits to this day although they aren't so frequent now. What happens during the audit is someone comes and watches everyone washing their hands, they note whether you're washing them appropriately and at appropriate times and ensuring you don't have any long sleeves on or watches, or if you're going into patient rooms, that they've been removed.

381. If you gel your hands, they check you are gelling them appropriately for the appropriate time. That still happens to this day. I didn't have a role in carrying out the audits.

382. There's also enhanced supervision I think, but I'm not completely certain, because in the role I'm doing just now, I'm not directly on the ward. I think the enhanced supervision is every six weeks, but it was every one to two weeks at one point. This is where the senior charge nurse, infection control, facilities and the chief nurse come up to do a walk around of the ward. They check all the areas.

383. Infection Control look at everything and check everything to make sure there is no dirt, and that the cleaning is being done correctly. The senior charge nurse walks round with them so they'll report back to that person on the ward and anything they find will be actioned straight away. For example, if there's dirt or dust that needs cleaned, it's done straight away.

384. There's also a report which comes out and the senior charge nurse will sign it when actions have been completed. It's stressful because we're under continuous scrutiny and we always do everything right. Those are the interactions we would have with Infection Control on top of the normal day to day stuff, for example, if your patient took ill or a positive sample was returned.

385. In Yorkhill, we didn't have the same involvement with infection control. We wouldn't interact with them unless there was a patient that came in with diarrhoea and vomiting but the cultures were negative, and we were trying to work out what to do with the patient. We would ask infection control for advice but that would be the only interaction we would have.

386. I have taken advice from infection control before at Yorkhill and have received the normal communications from them that all staff have had. I'm not aware of any other actions from infection control at that time. We would always work in conjunction with Infection Control.

387. If we had a patient that we maybe had concerns about, or we just wanted general advice, for example, if we see a patients come in with vomiting, but they are also on chemotherapy, we could just phone Infection Control and ask them for advice, we've always been able to do that. We've always been able to work closely with them and ask them for advice.

388. Although we have the enhanced supervision, I think our wards are always very clean and we had very high standards because of the patients' group that we have but they were looking at the high infection rates and it was the nurses that were being looked at.

389. We had very, very high standards for our patients just in general. All of our staff work very hard to process a patient's room. Even before everything happened, our ward has always been very clean.

390. We have schedules of what needs to be cleaned, if we finish using equipment, it should always be cleaned afterwards. So, we're always taking care to ensure that everything is as clean as possible, and we are working to the standards that we are supposed to keep our patients safe. So that's what I mean by that, it's always something that we particularly pay attention to for our patient group,

because it's important that the patients who are immunocompromised are in the safest environment possible.

391. I don't think any of our cleanliness or hygiene procedures have changed since I was at Yorkhill. As far as I'm aware, we followed the same processes. There are separate processes for cleaning different things, so there are some that have been added. For example, we now clean the chilled beams, that has been added since we moved to the RHC, but when we first moved, it was all the same processes. There were also different things put in place when Covid happened too.

392. I don't really have any observations of other areas I the hospital. I don't have any patients anywhere else in the hospital so I don't need to go anywhere else or work in another area. If patients are boarded out to other areas of the hospital, then the nursing staff in that area look after them under direction from us.

393. When we first moved to ward 6A, it was clean and empty. We followed our processes and kept the wards clean. It was the same in CDU. Our healthcare workers had very high standards and were doing most of the cleaning and they did a good job in keeping it clean.

394. They still audit our hand hygiene, and they audit our ANTT process. That's a peer review so they would come in and look at processes. Auditing is standard in the RHC for ANTT now and it's being rolled out to other areas, but I don't know how long it's been getting rolled out for. I'm not aware of anything else that's going on to look into other areas.

395. I wasn't involved in auditing as such. Infection control would do the hand hygiene and the enhanced supervision that would be fed back. Microbiology would be doing tests on the drains, but I wouldn't have received feedback from that.

396. There were measures brought in to try and assist with the rate of infections. They changed our practice for accessing the central lines as I mentioned earlier. Also, we have the port protectors that I also mentioned earlier which are capped on the end of the line. They introduced taurolock into the line. They used to block the line with a ketrine based substance that stopped the line from blocking, but they changed to stat lock which is microbial. It's an antimicrobial, and it has an anticoagulant effect to stop the lines from blocking the line, so they don't get infections. This was whilst I was on Ward 6A.

397. These are the same things as the green caps. The green caps are port protectors, but we've changed over to blue ones now. The children were able to move the green ones, so we moved to a different company.

398. I think the caps were introduced as part of the measures for decontaminating the line. The previous lines would have nothing on them. Children would touch them so port protectors were placed at the end of the line, so they were protected all the time.

399. There was no further advice that I can remember when this was going on to manage infection. Probably because the type of unit that we were in, as part of our training, we are trained to treat these children that are immunocompromised. You're trained to make sure they don't get an infection.

400. I was only at a couple of the IMT meetings and I can't recall there being any further information to give to families that raised concerns about the infections.

401. However, we wouldn't be managing these patients; we would be nursing them. Management of the patients would come from medical staff, microbiology and infection control for treating that infection. From a nursing point of view, we nursed on the advice we were given from the Infection Control team, the medical team and microbiology.

402. At the staff meetings that were held for our assurance, I was only at a couple of them so I can't remember who it was that would give us the information about the infections, whether it was microbiology or the medics.

403. I think there was information given out and articles given to us but I can't remember who gave us them. We were given an article when the Cryptococcus was found, for example.

UNCOMMON INFECTIONS IN PATIENTS

404. I can only remember the Cryptococcus. I was aware of a case where someone had suffered an infection that was linked to the hospital environment, and it was the Cryptococcus.

405. I discussed earlier that we were given the information at the time but I can't remember whether it was through a communication or if it was a subject discussed with the Service manager – or even if it was passed to us when I was either days off or on leave, but I do remember being aware. I only remember Cryptococcus as it was one patient.

406. We were given information round about what it was and what caused it and then we were given advice on the treatment that should be given to the patient and how to give the treatment. We wouldn't be managing these patients though; we would be nursing them. The management side would come from the medical staff and microbiologists that were treating the infection so from a nursing point of view, we would nurse that patient from the advice we were given from the medical team and microbiology.

407. I can't remember who gave us the information about the type of infection it was, but I do remember it was the Cryptococcus and that it was the pigeons that had caused it.

408. I wasn't aware of the Cryptococcus being related to the water or anything; as I've said earlier on, I was never told there was anything wrong with the water. I had a basic understanding that it was caused by pigeon droppings. There was information in relation to it and evidence round it being caused by pigeon droppings, but I can't recall how it was brought to my attention. I can't comment on the impact the infection had on the patient.

COMMUNICATION – CORE BRIEFS

409. Core Briefs are daily briefings from the go out to everyone from the GGC via their emails. It's a general briefing or newsletter type document, if you read through it, there might be something to do with the adult hospital and then it'll go to the paediatrics, or it'll be used to promote something like wellbeing. A lot of information comes out in the Core Briefings, so if any major work was being done in the hospital there would have been something about that, although it would most likely be general information, not a detailed breakdown.

410. As an example, at the moment they're doing some more work in the hospital, so there is information in the Core Briefs about guidelines the hospital has been given which has led to the work being done. However, there are often articles about promoting things such as wellbeing sessions. They will also have articles about financial difficulties and will guide you to places that can give help or support.

411. There probably wouldn't be anything in the Core Briefs about outbreaks of infection if they were limited to a specific area. However, if there is anything changing in respect of protocols or procedures, there may be something about that.

412. For example, just now we are changing one of our leukemic protocols, but it's only for paediatrics, so I wouldn't expect to see that sort of thing on the Core Briefs. Once the details have been finalised, I would find the details out from the Cancer Network rather than through the Core Briefs.

413. For something like that, I will work within our unit with the Pharmacy Consultant, and we will look at the protocol before it starts so that we can educate the practitioners, but that's not going to be hospital-wide. If it's going to impact the hospital, then it would on the hospital guidelines website.

414. So I think the Core Briefs, or the ones I have read, tend to be more for positive news items, saying 'well done,' or telling us what we've achieved, or telling us about work that's being done to make things better for the patients or ourselves, all with emphasis on the more positive stuff.

COMMUNICATION WITH STAFF – HUDDLES

415. We have Huddles twice a day in the RHC, in the morning and then in the afternoon. Basically, all the wards will attend these, they will be led by a co-ordinator, the Lead Nurse who's on for that day, the Hospital Co-Ordinator, and your Bed Manager. I've been away from doing Huddles for a long time, however what happens is they will ask staff to look at patient numbers, acuity of patients, whether the patients are 'Watchers' (i.e. requiring close monitoring), any high dependency patients and what their acuity is, etc.

416. This helps our Intensive Care Unit, who are represented there, as they can make notes of the higher acuity patients in case they end up having to look after them. They will also look at staffing on for each shift, what the numbers are like, whether numbers are short, and they will ask you to identify whether you are safe or not safe in terms of staffing levels.

IMPACT ON SELF

417. Everything that happened during this time had a massive impact on me. I was concerned about the patients, and I was also in charge of staff at the time, dealing with their concerns too. During this time there was a lot of change,

there were a lot of things happening, it was very unsettling, very stressful. Also, because the floor staff morale was very low, that concerned the patients too.

418. Being in hospital is always a very stressful time for these patients and families anyway, and I think we always try to have really good relationships with our families, and we always have done that very well, but there were some occasions where we felt that trust was at risk, such as when the families thought we knew more than they did. It was a difficult time for everyone.

419. I have struggled a lot with it all. I ended up having to put a lot of time in at work, and I ended up having to book some time off from work also. It was just quite a lot to take. I think us nurses were very well at just doing what we had to do at the time and making sure our patients were safe at the time, but this took its toll.

420. When all this was happening, we just kept going, and kept going, and kept going. I think we had all kept going as best we could for as long as we could. All we could do was to make sure we looked after our patients to the best of our ability, we just gave them the best care that we possibly could under the circumstances.

421. Now, looking back and actually having time to think about it, because I'm now out of it all, this is probably when it has hit me the most. When I do think about it all, I do still get quite emotional.

422. 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.