SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
12 June 2023

Day 5 & Day 6
Monday, 19 June 2023
Tuesday, 20 June 2023
Jamie Redfern

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19 June 2023

10:00

THE CHAIR: Good morning, ladies and gentlemen. I think we are able to resume our hearing with Mr Redfern. Am I correct, Mr Duncan?

MR DUNCAN: That is correct, my Lord.

THE CHAIR: Right. Good morning, Mr Redfern.

THE WITNESS: Hi.

THE CHAIR: As you are aware, you are about to be asked questions by Mr Duncan but, before then, I understand you are prepared to take the oath.

THE WITNESS: Yes.

Jamie Redfern

Sworn

THE CHAIR: Thank you very much, Mr Redfern. Now, I do not know how long your evidence will take, but understand that it may extend over the day and possibly even into tomorrow, but we will just see how things develop. I would usually take a coffee break at about half past eleven, so we will probably rise about then but, if at any stage in your evidence you want to take a break, just give me an indication and we will break. I mean, feel that-- It is entirely a matter for you.

THE WITNESS: Okay, thank you.

THE CHAIR: Right. Mr Duncan.

Questioned by Mr Duncan

Q Thank you, my Lord. Good morning, Mr Redfern.

A Hi.

Q I wonder if we could start maybe by just having you move your microphone just a wee bit closer.

A Is that better?

Q I think so, yes. Sometimes the acoustics in here are not terribly great. I wonder if we might just begin by having you give us your full name.

A James McDonald Redfern.

Q Could you tell us what your profession is?

A I'm director of Women and Children's within NHS Greater Glasgow and Clyde.

Q Were you previously the general manager for acute hospital paediatrics and neonatology?

A Yes, I was. Yes.

Q You describe your responsibilities in your witness

statement, I think, as being "the operational delivery of clinical services." Is that right?

A Yes.

Q Is that as general manager, or as director, or as both?

A It's more operational as general manager. The director role is a more strategic outlook to it, and a wider scope. It's women and children's as opposed to just hospital paediatrics and neonatology.

Q Okay. Last week, we had evidence from clinical and nursing staff, and the clinicians all said that they saw their duty as being about the provision of clinical care, and they saw management's job as being about the provision of a safe environment in which to conduct that care. Is that a distinction you would recognise?

A Yes, but I would qualify that by saying that I work very closely with them in achieving that. So it's a very close working relationship between myself, colleagues who you would call "managers" within the service, and the clinicians that you're referring to.

Q Yes. I wonder if you could maybe just describe to us, then, what-- How would you encapsulate your role, if we just take general manager to begin with?

A So, general manager primarily has a number of functions. The first is that we have a safe clinical environment for which to work in. We have very strong relationships with the clinical teams that are working there. We are looking to try and make sure that there's a robust patient engagement, and that the services function at the key priorities that the board and Scottish government expect from us. So that could be both scheduled care, unscheduled care, so from waiting times to emergency care.

Q Okay. Thank you. Now, what I want to do is move forward and start to look at some of the events that the Inquiry is interested in. Now, there are a number of issues I want to ask you about in relation to the period around the handover of the hospital, and events in 2015 and after that but, I want to actually focus, to begin with, on slightly later events because there is quite a lot to go through on those. I think we want to make progress on them as much as possible now. So I am going to start with the events in March 2018 in relation to the matter that, I think, came to be known as "the water incident." I think you have got two or three paragraphs in your statement about that. So I would like to ask you just a little bit more about

that matter. I do not think you will need to look at your statement, but have you got it beside you?

A I do. Sorry.

Q Yes. Thank you. Now, the two issues I particularly want to focus on are to do with communication. One is communication with patients and families, and one is communication within the organisation to do with the concerns that were being discussed at that time. Now, let us take the second of those issues, so communication within the organisation. Now, in your statement, at paragraph 71, what you say is that:

> "Normal escalation processes were in place through the Chair of the IMT and the service via myself were in place ultimately to the chief operating officer [and so on]."

Now, can you explain to me what that means?

A Okay. So the IMT has a responsibility to, obviously, chair-- Sorry, the chair of the IMT has a responsibility to making sure the IMT functions properly. One of those functions is that, at the end of it, there will be a formal minute of it, and that there will be a summary of events that have unfolded through the IMT up the organisation. So the chair has a responsibility to communicate that, ultimately, to the board's director of Infection Control. So they would make that report of what the outcome of the IMT was.

Q Okay. A couple of things that arise from that. Let us take them in stages. I think we can see in the IMT minutes that there is, I think, always a section in the minutes at least, that records a discussion around communication. Is that right?

A Yes.

Q Would that section set out the agreed communication strategy at the IMT?

A Yes. There would normally be somebody from the comms department at the IMT. What they would do at the end of the IMT as well is that-- Sorry, I thought, in the previous question, you were asking about the formal escalation up the organisation. They would take and draft a statement for purposes of either release within the organisation or indeed if we had to report to outside stakeholders, and that would go through that process corporately to director of comms and senior execs within the board.

Q Thank you. Now, I was asking also about the escalation

question. As I say, in your statement you talk about the normal escalation processes being in place, and that those included going via yourself. So what does that mean?

A So I would report the outcome of the IMT to-- My direct line manager at that time was Mr Kevin Hill.

Q Thank you. Now, the evidence that we have had so far is that, at the IMT of 6 March, at which you were not present, there was an expressed dissatisfaction about senior management response to previously expressed concerns about environmental risks from infection control. Is that something that you have a recollection of?

A Well, I wasn't at the said IMT. I know there were challenges in terms of the whole Infection Control situation, but I can't remember directly anybody raising any specific concerns with myself.

Q Okay. I wonder if we could, Mr Castell, please go to bundle 1, and go to page 56.

THE CHAIR: Thank you.

Q If you just take a moment to orientate yourself, Mr Redfern, this is the IMT in question. As I indicated, you were not present. If we go, please, over the page to page 57. If you go to the bottom bullet point, "BG and DM." Have you got that?

A Yes. Yes. Sorry.

Q

"BG and DM queried if the concerns of the clinical teams relating to the environmental risks in 2A had been communicated higher. TI explained that she shares these concerns and had indeed reported these to the highest level in GGC and HPS over two years ago. DM and BG felt dissatisfied that there had been any response from senior management or outwith GGC which offered reassurance to clinicians."

Do you see that?

A Yes.

Q Do you have a recollection of any discussion of that matter around that time?

A I do not.

Q You do not. Would you agree that it appears to indicate two things? First of all, that Teresa Inkster is saying that she had previously raised concerns at the highest level, and that secondly there had not been a response, and there was a dissatisfaction around that. Would you agree that that is what that suggests?

A Yes, I think that's what that wording says.

Q Yes. Are you saying that you do not recall whether you were made aware of this, or are you saying that you were not made aware of this?

A In the period of when we moved into the hospital to this IMT starting off, I wasn't aware that there were issues outstanding between senior management and clinicians around infection control issues.

Q Okay, that is the first point. So if we take that first point as to whether there were outstanding concerns. We have had some evidence that, at the end of 2017 and previously, there had been concerns raised by Infection Control about aspects of the environment. Can you say whether that is something that you were aware of at the time?

A No, I wasn't made aware of that that I'm aware of.

Q Is that something that you ought to have been aware of, do you think?

A Yes, because I think, as we went through from this IMT to thereafter, it was, you know, it was important from a good engagement with clinicians and a good engagement in terms of how we were going to deliver services that that relationship and that information was there, yeah.

Q Yes. So, just to be clear, are you saying that, as far as the previously raised issues, are you agreeing that that is something that you ought to have been aware of prior to then?

A Yeah. I'd have expected to know that.

Q Yes. As far as the expression of dissatisfaction, just so I am clear I am understanding your evidence-- As far as the expression of dissatisfaction, which appears to involve Dr Inkster, Dr Murphy and Professor Gibson, about an absence of response, are you saying you do not recall or you do recall that dissatisfaction?

A I did not-- I did not-- Well, first of all, I'm assuming that dissatisfaction was not with myself because I didn't have anything that I had been asked of to respond to, because I have just outlined, I was unaware of this. The second thing is clear that, as we went into the IMT, they had-- all these colleagues had articulated that position.

Q Yes. I mean, it goes on to say that:

> "TI encouraged clinicians to share their concerns with senior

management again and reported that this incident has been reported [and so on and so forth]."

Have you got a recollection of these concerns being shared with you at about this time?

A Yes, because that was us moving into the IMT, and I was actively involved through that process thereafter.

Q Right. So are you saying that you do have a recollection of a concern about an absence of response being raised with you at that time?

A Through the IMT process it became aware that there were issues and the clinicians were unhappy, yes.

Q Okay, thank you. Now, we can put that to one side. What I want to do now, then, is to focus on the other aspect, which is the communication with patients and families. Now, we have already seen almost all of the IMTs here, and I am going to try and avoid looking at documents that we have seen before. I think it is also clear that, as far as the early IMTs on the water incident are concerned, I think the first three do not record you as being present. If I just give you the dates, you can maybe tell me whether that would accord with your recollection. So we have just looked at the one on 6 March. I think the first one was on 2 March, and then it was 6 March, and then one on 9 March. It looks as if you were not present at those. Would that accord with your recollection?

A If that-- I can't remember back to those times, specific times but, yeah, if I'm not there then I'm not there, because accurate minutes would be taken of each.

Q Well, there have been observations made already in the evidence about the accuracy of minutes, and I do not think any criticism was intended of the minute taker, but did the IMT minutes always faithfully record everybody who was at IMTs?

A Well, they should, yes.

Q They should, but did they?

A My understanding was they did, and we would have a chance to go through subsequent IMTs to check the minute was accurate.

Q Yes. Thank you. Now, if we move then to the first one that I think you attended. Mr Castell, could we stay in bundle 1 and go to page 63, please? Again, Mr Redfern, if you just take a moment to orientate yourself, you will see it is an IMT at 12 March,

and I think we see you recorded as being among the attendees. We have looked at these before, so if you will forgive me, I just want to go to the parts about your communication, just to understand what was going on at this point. So if we go, please, to page 65, and it is the top half of the page. Hopefully that is sufficiently enlarged for people. Have you got that, Mr Redfern?

A Yes.

Q We see:

"Emma Somerville and Professor Brenda Gibson have updated all the families/patients on Friday night."

Then, below that, in relation to press, there is a discussion about Dr Inkster, you, Jen Rodgers and so on and so forth. Do you see all of that?

A Yes.

Q Can you say whether that indicates that, at this stage, it was the clinical staff who were doing the updating of the patients at this point?

A We would-- Yes, the clinical staff would always be updating the patients in terms of just a consultant to patient relationship.

Q Yes. I mean, does it indicate that your involvement would be more around the press statement side of things?

A Yeah, I would be trying-- At that stage there, we'd be trying to articulate what that position was in association with the views of the senior charge nurse and the consultant who were attending the IMT.

Q When you say, "I would," does that mean you do not have a clear recollection of what exactly happened at this time?

A Well, again, I can't remember going back to the actual IMT, but I would expect-- Yeah, I would say I would fulfil that-- I have confidence that I would have fulfilled that duty.

Q Yes. Really, the question I am asking is if-- This part of the IMT might be read as indicating a division of tasks with Emma Somerville and Professor Gibson dealing with the patients and the parents, and others dealing with the press. Would that be what was going on at the time?

A Not necessarily, because the way that we worked at that stage in the IMT process was that, although Emma and Brenda would have that direct contact with patients because of the roles they had, if there were any concerns that a parent or family had, that both myself and Dr Inkster would have been more than welcome, and actively would have spoken to them.

Q Yes. Thank you. Now, I think the evidence that we have had from two of the nurses who gave evidence last week is that-- I think their recollection is that it is rather later in the events that you and Jennifer Rodgers become more actively involved in the process of directly communicating with patients and families. Can you say whether that accords with your recollection?

A There were-- When we'd moved to Ward 6A, there was a much more proactive approach to releasing statements and going round every single patient rather than an opt-in. However, I did speak to specific parents prior to that in Ward 2A with Dr Inkster and Professor Gibson because of the request of individuals as part of that process I have described.

So the general sort of how this functioned was we would have the IMT. There were patients who were directly linked to the IMT because of the infection. If any of those parents had a query that they wished raised that neither the senior charge nurse or Professor Gibson felt that they could answer, then Dr Inkster and I would make ourselves available, and that option was picked up. It is fair to say that, as we went through the IMT processes, that that changed from an

opt-in to Jen Rodgers and I actively going around every single parent on the wards to update them on where we were with that relevant IMT at the time.

Q I think I understood you to say a moment ago that that approach of you, as it were, proactively doing that is something that you associate more with once you were on 6A. Is that right?

A Yes.

Q Yes. If I tell you that that also accords with the recollection, I think, of at least one of them----

A There was a definite shift in terms of how we communicated with parents.

Q Yes. As far as "opt-in" is concerned, that is a phrase that you use in your statement. "Opt-in communication" is what?

A So, by that, when Brenda was-- So, two groups of patients that we're talking about here. The first group, those directly involved in the IMT. So there would be infected children who had triggered the IMT normally. If there was any concerns that either Professor Gibson or a senior charge nurse or anyone within the clinical team, because Professor Gibson wouldn't necessarily be the consultant that was looking after all of those types of patients-- If there was

anything that they wished a senior manager to become involved in, then I would put myself forward for that and speak to those parents. If I've used the wrong words in terms of "opt-in," my apologies, but it was that they were offered that opportunity, and should have been offered that opportunity at all times to speak to but, we didn't proactively go beyond what Professor Gibson and Emma did, or the senior charge nurse of the time.

Q Thank you, and just to be clear, I am absolutely not suggesting that you have used the "wrong words" as you put it. These are your words, and if you would just bear with me, what I think you are saying is that "opt-in" means that, if somebody wanted more information from management, that was available.

A Yes.

Q Thank you.

A If I couldn't answer the questions they were asking, we would give a guarantee that we would go and get those answers for them.

Q Yes. Just while we are on this, while we are discussing this at this sort of general level, I am assuming that what you are describing relates to inpatients. Is that right?

A Yes.

Q What was the process at this point in relation to outpatients?

A There wasn't really a process there for outpatients at that time.

Q Thank you. Now, if we move then a little further on in time, please, to another IMT at which you were present. It is at page 66 of bundle 1, please, Mr Castell, and it is 16 March-- Sorry, my Lord.

THE CHAIR: My fault entirely. Mr Redfern, in relation to outpatients, I have your answer as, "Not really a process at that time."

A Sorry, in describing what I've just described in terms of our inpatients, I did not do that for outpatients.

THE CHAIR: Right, and we are talking about March 2018, or are we talking about the later stage in Ward 6A?

A In the later stages of Ward-- When we were in Ward 6A, there was proactive approach to communicate to outpatients as well. Yeah.

THE CHAIR: Sorry, you said "inpatients."

A Sorry.

THE CHAIR: It is my fault. I am really just concerned to understand "at that time," so I am following your

evidence. The absence of process with outpatients applied in-- I assume it applied in March 2018.

A Yes.

THE CHAIR: Are you indicating it applied after the decant to 6A or not?

A It would have been round about the decant. I can't remember when the exact change in process occurred but, it was noted that there had been a focus on inpatient communications, and that there had to be a change, and that we had to make that change and include it to patients who were coming through for outpatient attendances, and indeed who were not attending the hospital, but could at some point in the future depending on their illness.

THE CHAIR: Sorry, Mr Duncan.

Q Not at all, thank you, my Lord. If we move then to 16 March, please, Mr Redfern, at page 66. Again, just take a moment to orientate yourself. It is an IMT, 16 March, and I think we see that you are one of the attendees. Again, maybe just to help us a wee bit with the timeline. If we scroll down a bit, Mr Castell, to underneath "patients," and hopefully that is large enough for everybody to see. Just stop there. We see that we have got three additional hospital-acquired bacteraemia cases at that point. You see that?

A Yes.

Q Again, I just want to move to the communications aspect. If we go to page 68, and if we enlarge the "communication" section. Thank you. I will just walk you through that again. We see that Professor Gibson and Dr Inkster have spoken to one of the patient cases that morning. Is that right?

A Yes.

Q Then Dr Murphy is going to deal with another one, but it is really the next two paragraphs I am interested in:

"All patient information has gone out to all current inpatients regarding the water issues. If any patient/parent enquires about receiving Ciprofloxacin they are to say it's just a precaution due to issues with the water incident."

I am interested in that second aspect. What would you say that that indicates in relation to communication around Ciprofloxacin?

A Sorry, could you repeat that question?

Q What would you say that the paragraph about Ciprofloxacin indicates about the approach to communication of that matter?

A This is a summary of a minute. It's giving an instruction to whoever is speaking to the parents about how they would refer to the use of the therapy and why it was being issued.

Q Can you say whether it indicates that the organisation-- Sorry, let me rephrase that. Does it say whether it indicates that the organisation's communication about the use of this drug would not be part of its communication with patients and families?

A Sorry, say that----

Q Can you say whether this indicates that there would not be a communication about the use of this drug unless somebody asked?

A I don't know the answer to that question, but I would have assumed that if Professor Gibson and Dr Inkster were speaking to parents, then that would be explained to them.

Q Okay.

A If I was present, then I would have assumed that to be the case as well. I'm not sure why I wasn't mentioned as being present at these discussions because my recollection was, normally there would be the three of us undertaking that. It was a clinician, manager and a colleague from Infection Control.

Q Who would proactively go to the ward to have this sort of communication?

A If the opt-in process was asked for, yeah.

Q Yes. So that qualifies what you have just said. If asked, you were available.

A Yes.

Q What I am asking you is whether this indicates that a discussion about the use of Ciprofloxacin would only occur if asked.

A No. Well, I would have assumed that the clinician to the patient, there would be an explanation for why a particular drug therapy was being offered.

Q Yes.

A I would not-- From my own personal perspective, I would not expect to hide from that that it was linked to water supply if that was the reason.

Q That it was linked to----

A Water supply, if that was the reason. If there(? 00:58.12) was like a transparent process, we would encourage that at all times.

Q If it assists, the evidence from two of the clinicians last week said that they certainly would not have been content with communication to

their patients where they simply said, "We are giving you this as a precaution."

A Yeah, I would fully endorse the position that both clinicians took, and would encourage them at all times to do that, and would expect that, and the excellent doctors that they are and the relationships they have with their patients that they would explain everything in full, and there would never be any instruction to them. None of them would ever have taken that instruction, that they are nothing but transparent in terms of why a drug is being offered, or a therapy.

Q Can you say whether it would be your expectation and wish that, as an organisation, any communications that the organisation was making would reflect that approach also?

A Yes, 100 per cent. I think through the IMT process-- Again, obviously a minute is a record of the IMT, but it won't catch everything verbatim. There would be a process when we were checking with the individual consultants of patients who were infected, or indeed a summary of the ward that everybody was informed of what the situation was, they were aware of it and that there was full transparency.

Q Okay, thank you, and just to complete looking at this particular minute, please, could you go to page 69? Just underneath, "Press," if we enlarge that. We can see that there is a reference to a press statement in which the fact that three patients are affected is mentioned, and in the next paragraph it says, "Dr Armstrong will speak to the chief executive, Jane Grant, to see if a proactive press release statement should be released." So, I have got two questions there. The first question is, what is a proactive press release?

A A release-- they release it before the press ask questions, I think. I don't work in comms, but I would assume that's what that is.

Q Thank you, and I am grateful for what you just said. You must indicate if you feel that these are not questions for you.

A So I caveat that, but I think that is what that is, that they will make a release before being asked by the press about a specific matter.

Q The second question I have around that is, as far as the process of agreeing communications, was it your understanding at the time, or rather-- let me rephrase that. Can you say whether it was your understanding at the time that the

most senior directors and executive officers were involved in this process?

A Yes. Well, that's what the minute clearly states, and my experience at the time was that while you'd referred to an earlier minute that we were looking at drafting briefs or media statements, whatever you want to call them, they would be forwarded up through the organisation hierarchy for final sign-off.

Q Okay, thank you.

A All press statements would be signed off through the corporate process.

Q Thank you. Now, I want to look at a couple of communication documents from this time, please, Mr Redfern. Mr Castell, could you take us to bundle 5, please, and could we go to page 112? I wonder if we can just enlarge that a bit. Thank you. I think we can see, if you take a moment just to have a look at it, it says that:

> "The NHS GGC are investigating the presence of bacteria in the water supply towards the Royal Hospital for Children. These bacteria pose very low risk to anyone with a healthy immune system but can pose harm to patients whose immunity is compromised. Three children are currently receiving treatment for infections that may be linked to these bacteria found in the water supply. Tests are going to confirm if they are indeed linked."

Then if I just ask you to pass over the quotations from Dr Inkster, and you will see a reference to Health Protection Scotland. Do you see that?

A Yes.

Q It then says:

> "In the meantime, alternatives to tap water supplies to paediatric patients in Wards 2A, 2B, 3C and the hospital's intensive care unit have been put in place, given the low immune system of patients in these wards. We have also given them oral antibiotics."

What I should have done at the very outset is just identify this: this appears to be a media statement of 16 March. Is that right?

A Yeah, from the date on the statement.

Q Yes. If we go over the page, then, and just noting before we do that, that there is a reference in this to patients being affected by infections linked to the hospital and to the use of antibiotics. So, if we go over the page, please, to page 113. Now, our understanding is that this is a

communication to parents and carers, as the note suggests, on the same date, and if you just take a moment to read that and tell me once you have done it.

A I've read it.

Q Thanks. It appears not to include the references to the infections and to the provision of antibiotics. Is that correct?

A It doesn't mention it in the final paragraph.

Q No, thank you. Now, I think it is only right to say that, as far as we understand it, there are two communications to patients and families over this period with the possibility of a third. It is not clear, but certainly from what we understand the position to be at the Inquiry this is what went out or it bears to be what went out on that on that date. I guess my question is this: are you able to say why is the communication from the organisation to the patients and families contains less information than the information that was given to the media?

A I couldn't answer that question. I don't know.

Q Well, as somebody who was a senior manager at the time and actively involved in managing all of this, can you say whether that difference is explicable to you?

A No. I would have assumed that the information to the media would be replicated with the patients and should be as informed as it possibly could be.

Q Thank you. Now, if we move back, please, to bundle 1, please, Mr Castell. Can we go to page 70, please? Again, just to orientate yourself, it is an IMT minute of 19 March, and I think we see your name mentioned as an attendee. You got that?

A Yes.

Q Okay, thank you, and if we go, please, to page 73.

A I beg your pardon.

Q Yes, 73, top of the page. Maybe we could enlarge the communication section. You discussed with us earlier the recording of the communication strategy in the IMT. We see here that what is recorded is that there is a request for some sort of discussion in relation to the PICU, and there is a reference to the staff receiving updates, but there does not seem to be any record of any communication strategy featuring the patients and families. Is that right?

A It follows the process I described before, which is when there was a patient who wished, or a parent

who wished for further information, then normal circumstance would be that the consultant – Dr Inkster is the main infection control link – and myself would speak to them. So yeah, at that time, that was the main process for how we would update individual families.

Q Yes. Thank you. If we move, then, please, to the next IMT, which is 21 March, and it is at page 75 of bundle 1. Again, just to identify it, we see that you are recorded as an attendee.

A Yes.

Q Just to pick up on one or two details from this one. If we go to page 79, underneath "Hypothesis."

A Yes.

Q Forgive me. I am drawing this to your attention simply because I do not recall that we have actually looked at this so far. I just wonder if you recall something along these lines:

> "Dr Inkster explained that Scottish water and main tanks are negative. Post-filtration tanks and risers are negative. The bacteria concerned, like oxygen and taps/showers, are heavily contaminated."

Do you remember that or----

A Yes, I remember. Again, I'm not a microbiologist and I'm not an infection control doctor, but my recollection of that is that the water into the system was clean so it was a problem with the internal system.

Q If we go over the page, please, to page 80, and we enlarge the top half of the page. Thank you. Again, we see the communication aspect. Would you agree that the records, in relation to patients and families, is concerned with really what is coming back from patients and families rather than what is going to them?

A Yes. At the time, as I've mentioned, the approach that was taken was to use the words "opt in."

Q Yes. I wonder if you take a moment to look at what is said under the heading "Press and Public," and if you look in particular at the second of the paragraphs that refers to Mr Dell, can you indicate whether that suggests a concern that was coming from somewhere around the approach to communication?

A That's what that paragraph says, yes.

Q That reference to a lack of transparency, is that something that you recall became a feature of concerns at that time?

A I can't specifically

remember that particular comment at that IMT. I certainly can't remember ever, in terms of feedback, where there was a lack of transparency in that what we were offering Dr Inkster, the clinicians or myself-- I don't know whether there was anything further up organisationally. I don't know. I can't remember. I certainly think the provision I described, there was nothing but transparency. There was obviously the limitations of what we knew, which might be that we were, you know-- and what we didn't know at the time because we were working through the hypothesis and what the problems were and what the solutions would be. So, you can only report what you know at that particular time, and that might have felt that there were some issues with transparency. I don't know.

Q Well, we have seen – just on that point – we have seen that around this time there was reporting going to the media which included an indication that there were infections that were thought possibly to be linked to an issue with the environment and that there was the prescription of prophylaxis being given. We have seen that that was not being said in the handout, at least the one that we looked at, at that time. We just

wonder, against that background, whether you have any thoughts as regards whether a concern about transparency might be understood.

A Right through the whole process of every IMT as part of this public inquiry into the Children's Hospital, I never, ever felt that there was a lack of transparency. I never, ever felt that and I would never ever have allowed that to happen personally for myself. I always felt that everyone spoke truthfully, honestly, articulately as much as they possibly could on the circumstances at that specific time, and that is my honest opinion. As I've said before, the IMT reported upwards on everything that was being discussed, and as far as I'm aware, the IMT minutes go through the board's infection control processes right up to board meetings and are published. So, I always worked on the basis that the organisation was being as transparent as it should be, but further up the organisation in terms of media statements and whatever, I can't answer. I don't think intentionally anybody would have excluded a particular bit of information, but that's just my general feeling of the culture within the organisation.

Q Well, that would be a question for somebody else----

A Yes.

Q -- not for you. Is that right?

A Yes.

Q Yes. Well, what I am asking you really are two questions. First of all, looking at what is recorded here, can you say whether you recall that there was a concern coming from patients and families about a lack of transparency?

A There was unhappiness, yes. There was unhappiness and because of the circumstances that patients were and parents were having to experience. Of course, it was a horrible set of circumstances that they were dealing with in terms of the precautions that had been put in place. Whether it transpired that we were showing a lack of transparency, I can't formally remember that, but I do remember there being general unhappiness about the whole thing, and quite rightly. It was not a good set of circumstances to be in.

Q The question I was really asking you was is this, Mr Redfern, and just try and confine yourself to the question----

A I'm sorry.

Q -- if you do not understand it just say. What I am asking you to do is cast your mind

back and to say whether you recall that there were concerns from patients and families about the transparency of communication.

A I think there probably was, from memory. Yes.

Q So that is the first question, and the second one is, when we go back to just think about those two communications that we looked at and the fact that there seemed to be less being said in the one to the patients and families, can you say whether or not you consider that the concern about transparency might be understandable?

A I think from the way you explain that, yes, but I would still go back to the point I made that a parent with the relationship with either the individual consultant or through the discussions with Dr Inkster and myself, that we would be fully upfront and transparent about any-- well, you're speaking about the prophylaxis, I think that we would be explicit about why that was there. I cannot believe that a parent would not know why their child was getting prophylaxis. I think you'd said that the consultants agreed that. So organisationally we were providing that information. Whether it should have been in the media statements is for the people who prepared those

media statements.

Q So let me take this in stages. I think what you are saying is that, at this point, the organisation was relying upon its clinicians and its nurses to provide the necessary information. Is that right?

A I think clinically that would always be the case, but I think also with the opportunities that I've described from a management perspective and also from an infection control perspective was there.

Q Yes, but the principal mode of communication in relation to clinical matters and also concerns about the environment at that time, I am taking you to say was through the clinicians and nurses. Is that right?

A That was the initial gate of entry in terms of day-to-day communication because obviously they are having day-to-day interactions with children and families on the ward.

Q Yes, and you have talked about one aspect of the communication that we were talking about, prophylaxis. The other one that we saw mentioned in the media communication was the existence of infections on the ward. Are you saying that it was being left to the clinical and nursing staff to make a judgment on whether they should tell patients and

families about infections that other patients had on the ward?

A Well, obviously there's patient confidentiality about anything, but I think that when we were in the situation we were in and why we had these precautions, of course, we would be explaining to all families why those precautions were being put in place. I certainly wouldn't just rely-- and I can't remember the specifics at the time. We would have a visible presence on the ward. We would be walking about, speaking to people at the time, both Jen and I. It wasn't just that the senior charge nurse or consultant would be left to explain that whole process. No, I don't think that would be fair.

Q Well, the question I was really asking is this, and we will move on in a moment: we have seen that there was an agreement at the IMT that the media briefing would include mention of the fact of there being infections, and we have seen that there was mention of that in the media briefing. So, a decision has been taken somewhere that that is appropriate. Is that right?

A Yes.

Q We do not see any recorded instruction to the clinical staff or the nurses to tell patients that there are other patients who have infections.

Is that correct?

A If there are no documentation of that, then that must be correct. Yeah.

Q Indeed, one of the clinicians last week did emphasise the anxiety that they would have about that sort of discussion. Would that accord with your understanding of how you would approach it?

A I could fully understand if a clinician felt uncomfortable with that, but that's the whole position that I articulated earlier, that when they were in that situation, then I was available to speak, as was Jen Rogers.

Q Yes, but that would mean, if we just follow my train of thought, that the organisation would be entirely relying upon the discretion of the clinician as to whether or not the clinician mentioned that there were other infections in the ward. Is that right?

A Yes, yes.

Q Thank you. Right. Now, moving on, please, if we might. If we move on to the next item in the bundle, please, the IMT minute of 23 March is at page 81. Again, take a moment to orientate yourself, please, Mr Redfern. You see that you are present. Again, just to pick up some references, please, if we go to page 84. Again, I just want to pick up on something that we may not have looked at, under "Hypothesis." "Dr Inkster," have you got that?

A Yes.

Q

"Dr Inkster has found numerous pathogens predominantly found in soil and plant material. It is very unusual to see this."

Do you have a recollection of a discussion around those terms?

A Yes.

Q What about the next paragraph? "Facilities have informed the group that this could have happened during the commissioning period." Do you have a recollection of that?

A I have a recollection of all of this conversation.

Q Yes. So that was the advice that was coming at the time. Is that right?

A Yes.

Q Yes. If we go to page 85, the top of the page, "Communications." Again, does it appear that the discussion of communication is around what was coming from the patients and families rather than what was going to them? Is that right?

A Sorry, say that again.

Q If you look at the section on communications, "Patients/parents. No concerns from patients/parents with the RHC." Is that right? You got that?

A Yes.

Q I wonder whether that indicates that the focus was on what was coming from the patients rather than what was going to them. Would that be fair?

A Yeah, you could make that assumption.

Q Yes. Finally, just to conclude this section, please, make sure we have seen all the references, could we go, please, to page 86. Again, if you just take a moment, Mr Redfern, you see you are mentioned as one of the attendees.

A Yes.

Q I do not know whether you remember this one, but our understanding is that this is point at which this IMT closed, I think. Would that be right?

A I would need to go through the IMT, but yeah, the timeline looks about right.

Q Right, thank you. That is something we can perhaps pick up on later if we need to. Now, we have had a bit of evidence already on this, and I will not take up your time on it, and the evidence is it is recorded in the IMT that there was a report of a widespread problem in the RHC with pathogens and fungal sites being found on both sites. Is that your recollection of what was said?

A Yes.

Q Now, if we go, please, to page 89. There is just a detail I would like to pick up on here underneath "Update on Contingency Plans." I just really want you to have a look at the first paragraph, the one concerning you, and just have a read at it and then let me know when you have done that.

A Read it.

Q Thank you. Can you tell me what this is about? What are the contingencies(? 01:24.20)?

A I'll summarise this as best I can.

Q Thank you.

A So, the IMT had worked its hypothesis of the problems that will have been documented in the minute. What follows once we've got hypothesis is solutions that need to be put in place. The solutions at this time, to my knowledge, were that we would allocate filters to the taps and that we would, at a later stage, look to treat the water. The question being posed here was what would happen if the filters

failed. There was strong emphasis from the supplier at the time that the filters would not fail and that this was backed up with all their academic and other reporting of the adequacy of the equipment that was being put in place and that, to my knowledge, there was no other contingency beyond that as we went through that process so there was a reliance on these filters working while we treated the water.

Q Okay, and--

A And the filters from there do their job.

Q I suppose my question might be this: what was it about this group of patients and what was it about the hospital that required there to be a contingency plan, from your perspective?

A Because patients were being infected, so we had to try and minimise the risk of infection. That was the whole purpose of the IMT. I suppose what I'm trying to say there is that we've worked out a hypothesis, we've put solutions in place, but if those solutions don't work, then what is it that we're going to do thereafter?

Q Okay. Thanks very much.

A Suppose it's a managerial question to clinical colleagues.

Q Thank you. If we just look at the section a little bit further down on communications-- "No concerned parents at the moment but the longer this goes on with the BMT patients the more worried about the inconvenience." There is a concern that you have raised but, again, I do not think we see any communication strategy as such for them. Is that right?

A Yes, it's not mentioned there.

Q Again, that would be in keeping with everything you have said.

A Yeah. I suppose what I was trying to get across in terms of where we were with this-- it was, again, incredibly difficult circumstances, how we were putting solutions in place, ultimately, until we got the filters and the treatment solutions identified. It was how you managed-- that whole time was very challenging, but yeah, there's no reference to media statements, as you say.

Q No reference to patient statements.

A Patient statements, sorry.

Q Thank you. Now, I want to look at another document that we have not looked at yet during the

Inquiry hearing, just again to try and bring it out if you do not mind and just to get your reflections on it. It is in bundle 8, please. That is at page 53. If you just look at the top of the page, it is "Full Incident Management Team Report", and the author appears to be Dr Inkster. It refers to the date of a first IMT meeting 2 March and a last one 13 April. Do you see all of that?

A Yes.

Q Is this a document you have seen before?

A I can't remember.

Q Is it a style of document that you are familiar with?

A No.

Q Does it appear to be-- and do say if you cannot help us with this. Do you know whether it appears to be a review of the-- well, as it describes it, a full incident management team report? Does it appear to be a review of what we want?

A Sorry, I'm looking at a document. It looks like it's a PAG report.

Q Okay.

A From that, yeah, that's what it looks like. So, I have seen that type of document, sorry.

Q Okay. Well, maybe what we should do, especially as you are not sure whether you have seen it before, I will just take you to passages in it, and you can tell me whether it jogs your memory, and you can also maybe tell us a bit about whether it helps you with the sort of document this is and the purpose it might serve. Does that seem fair?

A Yes, that's okay.

Q Okay, thank you. So if we go, please, to page 54, and if we just enlarge the top half of the page. Next to "Sources of exposure," it says, "Contaminated water supply." Do you see that?

A Yes.

Q **"**Duration of incident from 1 March," and then it says:

> "Complex incident. Contaminated water supply. Long-term preventative measures will take some time to implement. This report focuses on the acute incident and any learning from that."

Do you see that?

A Yes.

Q Again, if we go further down the page, please, just to the foot of the page where it says:

> "Areas of incident occurrence. Initially, Ward 2a then throughout RHC and QEUH."

Do you see all of that?

A Yes.

Q Now, again, just pausing. Seeing these references, does this jog your memory at all as to whether you----

A Yes. So there's two things. First of all is a-- if this was a representation of a PAG meeting, then the PAG is preliminary to the IMT and will normally either trigger an IMT or say there is no need for an IMT, so I am familiar with that process. I certainly would expect to be aware if there was a PAG happening, and get feedback, not necessarily always getting the documentation. I would hope that I would get that, but I can't recall this specific bit of information. I was aware of, certainly at the time-- we were all aware because we all became involved in the IMT that followed.

Q Thank you. Now, I think, in all fairness to you, Mr Redfern, I should say to you that we have a bundle of PAGs, and that was based upon what we were provided with by the Health Board, and this is not among them. So that is the first point I would mention to you. The second point is: this rather looks to me as if it is a review that comes after the IMT process, which would maybe suggest that it is not a PAG. Do you want to have a think about that?

A Yes, I think that's correct.

Q Okay, well, we will continue going on. If there are any particular bits that we look at that you think are of assistance on this question of what this is, do tell me. So if we go to page 55, we see-- If we go further down the page to "Main Conclusions," and enlarge that so that those-- Everyone else can see it, thank you:

> "Possible all cases are linked to water as links in time/place/person. We just haven't found the strain as yet. Typing continues."

Again, just thinking back to your experience through the IMTs, can you say whether what is set out there accords with what your understanding was at the time of the working hypothesis?

A Yes, I think that's correct.

Q Yes. If we go over the page, please:

> "Overall summary from investigation. Water testing revealed contamination of water supply within the RHC and QEUH."

Do you see that?

A Yes.

Q Again, can you confirm

whether it is your recollection that that was the advice that was being given at the time. Is that right?

A Yes.

Q Yes. The hypothesis was:

> "Contamination took place during installation and has built up in the system creating thick biofilm."

Again, can you recall whether that was what was being said during the IMTs?

A Yes.

Q Yes. I do not know whether it is my fault or your fault but, probably realistically both of us, but I have noticed that we are starting to, sort of, talk across each other.

A Sorry.

Q No, I tend to ask long questions. So if you would let me finish the question and then answer, and I will try and shorten my questions. Thank you. If we go to page 57. Now, this picks up on something you said a moment ago, "Main conclusions," if we enlarge the top of the page:

> "There are no further bacteraemias. Therefore, control measures were deemed successful."

Is that right?

A Yes.

Q Again, just so we are clear, does that accord with your recollection that the IMT finished after the point of use filters were on and there were no further infections being seen. Is that right?

A Yes.

Q Thank you. What about the reference before that, "Filters are a short-term measure"? Do you recall that being said?

A I can't remember it specifically being mentioned as a short-term measure, but the understanding was that further solutions thereafter would make(? 01:35.07) whether or not the filters were required. I don't know whether we would have said that is a short-term measure, but certainly if the water was treated successfully and that, through further testing, the water was clear, then filters would naturally not be required.

Q Thank you. If we move onto the next page and-- Sorry, just before I do that, just to be clear: what you have just said, was that your understanding of the advice at the time about filters?

A Well, that would be a natural position to take, yeah.

Q Yes, thank you.

A You wouldn't need filters

if the water was successfully treated, as repeat tests showed that it was clear.

Q In all fairness to you, if you just look at what is said below that, "long-term measures," is that essentially setting out what you have just said?

A Yeah, so we have been asked on-- probably be picked up later on, but we've been asked through the duration of further communications with families when we've said that the water is safe, you can drink from it, you can-- Parents have asked, "Why do you have filters?"

Q What is the answer to that question?

A It's an added precaution, but ultimately probably is not one that is need-- Well, not "probably." If the water is-- if the testing from the water is that it's clear, then you do not need filters.

Q I think----

A Filters are there to protect you from a dirty water supply, is my understanding.

Q Nevertheless, if we look at the long-term measures, do we see the fourth one is, "The use of filters in the long term in high-risk areas." Is that right?

A That's what it says, yes.

Q So was that your recollection, that even with those other measures one to three----

A Well-- Sorry.

Q -- measures one to three, the advice was, the filters would have to remain in high-risk areas?

A Yes. At that time, yes.

Q Thank you. If we go over the page, please, to page 58. If we enlarge the top half of the page, under "Summary," it says:

> "Evaluation of impact and achievement of objectives. Concerns expressed regarding the lack of comms from clinicians."

Now, I will ask you again: reading that, does this jog your memory as to whether or not you have seen this document before?

A I cannot specifically remember reading it, but I am sure that I will have.

Q Thank you. Is it your recollection that there were concerns being expressed about the lack of communication?

A I think that there was obviously concerns around communication because we made changes in terms of the process of how we, as an organisation, reported the further IMTs and problems that we

had.

Q Yes. I know that you did not draft this, and your recollection of reading it is not clear, and you may consider this an unfair question or at least not a question for you. Insofar as it refers to, "From clinicians," would it be your expectation that that refers to concerns from the clinicians about communications?

A Yes, that's what it's-- that would be my interpretation of that comment.

Q Thank you. As far as "Main conclusions: challenging incident with high anxiety," is that an assessment you would agree with?

A Yes, I think that's articulate of the situation that was faced at the time.

Q It goes on to say:

> "Difficult balance with releasing info and not causing undue alarm. To be discussed further in the debrief."

Again, can you say whether or not that reflects your assessment of----

A Yeah, I think there is always a balance between there, and that comes across in every IMT, and that's why you make a decision about whether you release information or not, and there's a formal process for how the IMT comes to the conclusions that it does around release of information.

Q Yes. Then I just noticed something that says, under the section, "Antecedents of outbreak," Mr Castell, if we could just scroll down a bit. If I have you look at, "What is the likelihood of a similar event occurring?", it says, "High, in a new build hospital." Have you got a recollection of seeing that or that being said at the time?

A No, I can't remember-- I can't remember that comment.

Q Thank you. Now we can put that to one side. Thank you. Now, you spent a few minutes looking at it and you had an opportunity to consider whether you saw it, and I think I took you to say that it is likely that you would have seen it. Is that right?

A It looks to me like it's a debrief of the IMT or IMTs.

Q Do you know what, if any, response there was to it from management?

A In terms of the actual paper, or----

Q Yes.

A I can't recall a formal response from the organisation.

Q What, you cannot remember whether there was one?

A Yeah. I don't know, I

wasn't part of a formal response.

Q Okay. So are you able to say whether or not there was any sort of review at senior managerial level on what we have just seen set out?

A In terms of that previous IMT? Yeah, because there was an ongoing process for how we resolve the situation.

Q Well, if we take a step back. Can you say whether you agree with me that that report that we have just been looking at sets out what might be described as a number of learnings from the incident?

A Yes.

Q Do you know whether there were any steps taken to address and review those learnings?

A I don't know.

Q Okay.

A That would be within Infection Control and other corporate departments, not operationally at my level.

Q Yes. I mean, in your statement, you described the organisation as a "learning organisation." What do you mean by that?

A I think that we learn from our experience. That's what I always look for in my own practice. I think that's demonstrated through this IMT

in terms of how I communicated with parents and families.

Q So, would it be your expectation, just picking up on what you have just said, that there will be something that followed upon this and indicates a review and an attempt to learn from what had happened?

A Yeah, I would assume that would happen with all IMTs, but my understanding would be, that would be through Infection Control and Prevention.

Q So that would be----

A Or led through that process.

Q So, what about on the managerial side? A review of these kind of reflections, where would that sit?

A When I say, "Infection Prevention Control," I mean at a corporate level with corporate instruction around how you would take forward-- you know, you've received this document and what you were going to do with it.

Q Thank you. Now, we are going to move forward in a minute to look at the summer of 2018. Before we do that, I just want to think about your reflections on communication with patients and families over the period that we have just been looking at. In

your statement, you indicate that you are aware that there were criticisms, and you say that the organisation has learned. What do you mean by that?

A I mean we changed our approach to how we communicated with people.

Q What was it you thought that you had not got right?

A I think the lack of media statements. Statements to families being issued formally as opposed to the opt-in approach, and we changed that.

Q What about the appearance, and we have only just looked at one, I quite accept-- the appearance of a difference between what was being said to the media and what was being said to patients and families. Do you know whether that was something that was looked at?

A To be honest, I cannot remember ever thinking we were telling a different narrative to the media to what we were telling parents and families at that time. That is not something that would be, coming into this Inquiry, answering these questions, that I would have thought was happening. It certainly was never instructed to me that that was what was happening, and I don't know. Others will have to answer the different

statements that were issued, but I cannot ever remember that we would say that, you know, there was any communication informally to me that we were saying something to the media and saying something different to families. That is not something, again, that I would be comfortable with.

Q Okay. Thank you. If we move on, then, please, to the summer of 2018. Now, again, we have had quite a bit of evidence on this already, Mr Redfern. I will maybe just lead you a little bit at the start. If you want to go to a document to clarify something, we can do that. Similarly, if you want to go to your statement, we can do that. Our understanding from the IMTs that we have seen and the evidence that we have had is, round about the start of June, and we know that there was an IMT on 4 June 2018, there was evidence that there were further gram-negative bacteria cases emerging. Does that accord with your recollection?

A Yes.

Q Yes. We have had evidence about clinician concerns about 2A, that they were not comfortable admitting patients, and that the prescription of prophylaxis had to be re-instigated. Does that again

accord with your recollection?

A Yes.

Q Thank you. The clinicians have explained to us that their understanding of what was being said, and I emphasise, Mr Redfern, we are only interested in what was being said, not whether things were or were not accurate. Their understanding of what was being said is that it was thought that there was a site-wide issue with the drainage system. Is that your recollection?

A No. My understanding of the situation, in terms of this particular group of infections was that, as we went through the IMTs, there was an unintended consequence of the implementation of filters, and a splashing effect coming from the drains, and that, as a response to that-- Sorry if I'm going a bit further along. As a response to that, through the IMT, it was identified that the sinks had to be replaced. Whether that was an overall problem with the drains, I can't remember all at that particular point in terms of solutions in operational, being able to deliver a safe service was that the sinks had to be removed and changed, and that was what, ultimately, we moved to.

Q Thank you. Now, just maybe helping you a bit with what you

have just said, and helping us in turn: why not have a look at your statement, please? It is at paragraph 86B. Mr Castell, I wonder if we could get this up on-screen. The statement bundle, it is page 389. It might just help people to see this. So, it is paragraph 86, and it is B. Do you see that?

A Yes.

Q Is that what you have just been describing?

A Yes. To my mind, that was the-- If I could summarise it in terms of where, as a non-microbiologist, non-clinician, where I was coming from was: we had a problem with the water supply. We put filters in place to treat that problem. They worked for a period of time. There was then a second round of infections, which we went through an IMT process, which identified that there was a-- to all intents and purposes, in my mind, what was described to me was a splashing effect because of the proximity between filter and sink, which was creating infection in the-- or risk of infection to the children, and the only solution was to remove the sinks and make that distance greater to nullify the risk of splash. To do that, we had to move.

Q Yes.

A So, that's my summary of

what was described to me and what led, ultimately, to us moving to Ward 6A.

Q That is helpful, thank you. You have given us one bit of the jigsaw, which is the role of the filters in this. What we had had evidence of thus far is the other bit of the jigsaw, which is as regards the sinks themselves. I think the evidence that we have had from the clinicians is that what they were being told is that there was site-wide concern around contamination within the sinks or within the drainage. Is that your recollection?

A So there was obviously some sort of problem underneath the sink because a splashing coming from a source was leading to infection, so yes.

Q So it is the combination of the two things was your understanding. Is that right?

A Yes, but in the context that I am not a microbiologist and I'm not an infection prevention control doctor, the primary focus I had at the time was in terms of how we minimised the risk, and how we provided a safe clinical environment.

Q If I reassure you that everybody last week provided similar caveats that they were not expert on these matters, and I say that simply, again, to emphasise, Mr Redfern, I am just interested in understanding what people were being told.

A So, there was a-- From my memory of what we were being told was there was a splashing effect. There was a problem underneath the sink which was creating-- The splashing was leading to risk of infection and the sinks had to be changed.

Q Thank you very much, that is very helpful. Now, if we start to just look at one or two of the IMTs in this period, and we will see if we can try and take things up to more or less the point of the decant before we have our mid-morning break. So, if we could go, please, to the IMT on 6 June, which is at bundle 1 again, Mr Castell, and it is page 99. Again, just orientate yourself and see that we are looking at an IMT at 6 June that looks like-- that you attended. It is our understanding from the evidence that we have had already that, as I have indicated, that around this time there were further cases emerging. Would that accord with your recollection?

A Yes.

Q Yes. I really just want to look again at the media and patient communication aspect. So, if we could go to page 102, please. The foot of

the page:

"The press office were approached by the Evening Times, so a press statement was released yesterday. Media have ran exactly what was put out with the addition of some quotes from patients/parents. So far there has been no media interest today. No media update will be sent out today but may get some follow-up questions from the media in the next days."

If we go over the page:

"Advice to public. Information was given to parents who have patients in Ward 2A and Ward 2B regarding the HPV clean."

Do you see that?

A Yes.

Q If I just reassure you that, in the redacted section, there is nothing that is germane to what we are discussing. It is to do with an individual case. So, there is a reference to advice being given, or rather to information that there is going to be HPV cleaning. I think we understand HPV to be hydrogen peroxide vapour. Is that right?

A Yes.

Q Sorry, and if we just go a little bit further down the page,

"Assurances moving forward." It says "Jamie." Have you got that?

A Yes.

Q So, there is a reference to an executive group chaired by Kevin Hill which will meet. What was that group?

A That group never ever took place, it was-- What we were trying to do was allow the IMT to function on IMT business and, where there were operational issues and trying to implement what the IMT were putting forward as solutions, we would spend more time on that. It was actually felt that it was a duplication and it was the same people in the same meeting talking about the same things.

Q Okay, so there were no meetings at all of this group?

A Not that I can remember.

Q Okay. Thank you. Now, if we look at, again, some communication documentation from this period. Can we go to bundle 5, please, Mr Castell. If we go to page 139. Just take a moment to read that, and then I will maybe ask you some questions about it. Okay?

A Yes.

Q Thank you. Now, again, I have on board the caveat that not only are you not a specialist in water,

you were not involved in drafting this. What I am interested in, though, is your reflections on it. It appears to indicate that the media are being briefed that there was bacteria being found during testing. Is that right?

A Yes, that's what it says.

Q And that bacteria can be harmful to those with compromised immunity. Is that right?

A Yes.

Q Is it indicating also a link to the earlier issue with taps. Is that right?

A Yes.

Q And that the families are going to be informed. Is that right?

A Yes.

Q Now, if we go, please, to a communication from three days later, which is at page 142. If you just take a moment to read that, and indicate to me once you have done that.

A All right, I have read it.

Q Thank you. Now, there is no mention of the bacteria. Is that right?

A Yes.

Q There is no mention therefore of their harmful nature. Is that right?

A Yes.

Q I wonder whether you think that this indicates that the issue might be something to do with people putting things down the sinks?

A I think that is an instruction to families not to do that, yes.

Q I wonder whether you think that somebody reading this might think that the cleaning of the drains was down to something to do with people putting things down the sinks?

A Yes, you could take that. It's not as explicit as in the previous media statement that you said.

Q Well, it is quite different, is it not?

A Yes.

Q Are you able to explain the difference?

A Sorry, sorry, sorry. No, no, but I would re-emphasise that I cannot remember, and cannot--certainly did not come into this Inquiry thinking that we were telling one narrative to the press and one narrative to parents. Although that, maybe, is what I think you're highlighting, that was not my experience at the time in terms of interaction, or with staff.

Q As you said earlier: in due course, we will need to speak to those who were actually running communications, but you were on the front line.

A Yes, I was.

Q You are able to give us an informed view of what was going on. So, what I am asking you is----

A So, when I-- I'm sorry.

Q Yes. I mean, it is really a repeat of what I said earlier: looking at that difference in communication, I wonder whether you think it would be understandable if a parent perhaps thought they were not being told the full story.

A I think that there is a difference between the two narratives that are on paper. I think what I would say is that, working with the clinical teams and myself or Jen or others on the ward, with staff, we would have been more explicit about the issues that were being faced, because we would provide debriefs from the IMTs, which would potentially have been verbal, but we would certainly have been articulating what was coming from it, and what-- we would be answering any questions that were posed of us, either informally or on a formal basis. That's where I mean that there was no lack of transparency from, as you say, me at the operational end that was delivering that message. I never ever-- I never felt corporately under instruction not to do that.

Q This at a point, as you

have already said, where you are still working on the opt-in approach. Is that right?

A For formal, but we would do walkabouts. We're a visible management team. We would do walkabouts to the ward.

Q Yes. Now, I think it is important when we are looking at these pieces of paper that they have dates on them and we have an understanding of what their purpose is, but I entirely accept that, at this point, we maybe do not know precisely what they are, when they were issued. On the face of it, this bears to be something that had been prepared by the organisation setting out what the organisation intended that patients and families be told on 7 June. Would that be your assessment?

A Yeah, if that's what-- if that's the document, that's the document. That's what would have been issued to them, yes.

Q Yes. So again, if you just go back to, really, my question. I mean, thinking-- forgetting about what you may or may not have been saying in your opt-ins and what clinical staff may have been saying and just thinking about the organisation's position. I wonder whether you think that a parent who saw this and then

saw a media report based on that briefing with that additional information, I wonder whether you think such a parent might well think, "I am not being told the full story."

A I can't-- well, if I put myself in the position, if I was a parent, then yeah, I may reach that conclusion.

Q Thank you. My Lord, I think----

A But again, I really would like to stress that I don't think that was a narrative that was being set organisationally, certainly not to myself or to Jen Rogers or anyone. There was never any instruction to limit what we were saying to them.

Q Who-- where did your instructions come from as regards communication?

A Just from the IMT and feedback from the IMT. I would always feed back to staff what the position of the IMT was, and what I've described to you, in very layman's terms, about splashing and sinks was clear to everyone. I certainly would never have said that we don't disclose this, or we don't disclose that.

Q Thank you.

A That's my general feeling from-- whether it was informal instruction or whether it was just how I

presented information to staff and to families with regards of what was going on.

Q Thank you, Mr Redfern. As Lord Brodie indicated we would normally take a break around now, but I think I might just try and squeeze in a couple of questions and at least move us on to July 2018 if I can.

A Yes.

Q So, before I do that, just a point of detail that I would quite like to pick up on, my Lord.

THE CHAIR: Mr Duncan, before you could do that, could I just maybe square off what Mr Redfern's evidence is on this matter? You have drawn attention to the terms of the update of 7 June. Mr Redfern, you accepted that, just on the basis of that update, a parent might come to the conclusion they were not being given as much information as was being generally disseminated through press statements. Now, but you wanted to emphasise that there was never any instruction and that is how I have noted it. Now, is that instruction to you or instruction by you? It is my----

A Instruction to me. Instruction to me or instruction by me. I would always be as transparent as I possibly could be, and I think what I'm rightly or wrongly maybe trying to take

from the line of questioning and the comparison of the two documents is that, yeah, when you look at both documents they are different in their narrative. Clearly, you can just do that by reading them, but in terms of actually as an organisation what we were saying to parents and families at the time or what I was certainly saying was not that there was any ever instruction for there to be that difference or for us to not tell parents and families specific bits of information.

THE CHAIR: Mr Duncan asked a question which I do not think I heard an answer to. Where were your instructions coming from? Did you ask that question?

A I did and I understood you to answer it. I do not know how you want to approach this, my Lord.

THE CHAIR: Perhaps just----

A The IMT.

THE CHAIR: Right. Yes.

A Where I come back to with all the-- because there's a fundamental issue here about transparency. I think what we're talking about is that the IMT is a formal process that the organisation has. It is properly minuted. It goes through the organisation and is up to board level and as far as I'm aware minutes and

everything else is published and available. I just would love-- I'd like to stress that at all times I always felt I was working in an organisation that was being transparent at the point that I was there, and I was never ever told not to be that. Whether the communication is effective between the two is for those who derive those media statements to answer.

THE CHAIR: Now, Mr Duncan, you were going to go on to another matter which I am quite content that you do if you want to do that.

Q Perhaps, we might as well just take the break at this point, my Lord, and we can move on to the next stage after the break if that suits your Lordship.

THE CHAIR: Very well. We will take 20 minutes for a coffee break, and we will sit again at five to twelve.

(Short break)

THE CHAIR: Before I ask the witness to join us again, can I remind legal representatives that conversation may be appropriate when the witness is not giving evidence, but conversation is not appropriate when a witness is in the course of their evidence. I am sure legal representatives appreciate that. Mr

Duncan.

Q Thank you, my Lord. Mr Redfern, I was going to move on and ask you about a couple of other IMTs from-- still in June 2018. The first one I would like to go to, please, is in bundle 1 at page 119. It is not really something that is, arguably, anything to do with this hearing. It is just to see if you can help me a bit with a detail that may be of importance in some of our other investigations. So again, we see it is an IMT you were at on 12 June on the face of it. If I could just ask you to go, please, to page 121, and if we enlarge the section under "Staff." If you just read to yourself that section about NHS Lothian. So, those five paragraphs and then tell me when you have done that.

A (Inaudible 02:28.12).

Q Thank you. Now, again, I emphasise, I am only really trying to find out where we go to investigate this, if it is indeed something that needs to be investigated. Do you have a recollection of what that was about?

A I do.

Q Can you maybe help us?

A So, there's two points to this. The first is, I think a question you alluded to earlier about learning points and about new builds, and I think that's the reference to whether or not there

would be communication between the respective boards at medical director or chief exec level or whatever level of the organisation around what Glasgow is experiencing to what might be relevant to Edinburgh. I think that's what that component is. The latter bit is around the fact that if we have got issues within operation or within Glasgow, there needs to be a discussion with my counterpart in NHS Lothian about their ability to take patients.

Q Thank you.

A So, one is an operational issue, and one is a more strategic build issue.

Q Thank you very much. Okay, if we move on, please, and if we could go, please, to the next IMT at page 128 in the bundle. It is an IMT of 15 June. Again, we see that you are present. Now, the evidence we have had at this stage is that, again, there are a number of cases of gram-negative bacteria. There is also a case of a gram-positive bacteria that we might speak about later, so I will not take your time up on that just now. If we go please to just page 130, and it is underneath the heading of "Communications." If we just enlarge the paragraph that has "Jamie informed." Thank you. Again, Mr

Redfern, if you could just take a moment to read that and indicate once you have done it.

A Yes.

Q Thank you. Now, well, two things. First thing is do you have a recollection of a discussion along those lines at this time?

A Yes, I think I do.

Q Are you able to explain to us what this indicates?

A So I think it's to do with the two IMTs that were built in around this, one about the water supply in particular, and then the second about the implications of the drains and about just how we were communicating that.

Q Yes. Are we to take from this that you are feeding back that there is some confusion on the part of parents?

A Yeah, that's what it says.

Q Would you indicate then whether that suggests that, at least from the perception of parents, communication was not all it could have been?

A I think that if there's confusion with parents then, yeah, I think you can take that.

Q We can put that to one side, Mr Castell. One of the things that has already been looked at with another witness is the written information that was being given to patients at this time regarding the use of hydrogen peroxide vapour, and the fact that all it said was that it was happening and that there would be a need to decant rooms, but with no explanation for why it was necessary. Now, does that accord with your recollection of what was being provided?

A It certainly wouldn't have been the information that I was given to-- that I would have been giving to our clinical teams and/or explanation I would expect to be handed to parents.

Q Okay. Well, I mean, maybe best just look at the document, then. Can we go to bundle 5, please? It is page 144. Now, again, could you just take a moment to read that, please, and tell me once you have done that?

A Yes.

Q Thank you. Now, it is the Inquiry's understanding – it is only an understanding from what we have been told by the Health Board – that this was a written communication that was provided to patients around about the time that we have just been speaking about. Does it look like that to you?

A Yeah, it's an explanation

of what HPV is and why we're doing it. Well, why we're doing it in terms of the outcome of what HPV will provide.

Q Yes. I think you have just touched on the issue. In fact, I do not think it does say why it is being done. Is that right?

A Yeah, it doesn't give a reason specifically of what has triggered the HPV.

Q Yes. Why would that be?

A I don't know. I think the statement is obviously being prepared to explain what is happening and the impact it will have on the child and family.

Q If we proceed on the basis of our understanding that this was a written communication that was to be used to update patients and families, how would that written communication have come about?

A My understanding was that if this was a solution that had been proposed through the IMT process, then it will have been an action set from that meeting.

Q Yes. So the understanding is that-- what I take from your answer and the document is that the settled position of the IMT was that patients and families were to be told that HPV cleaning was happening, yes?

A Yes.

Q But it does not indicate that they have to be told why it was happening. Is that right?

A From reading the document, it doesn't.

Q Yes. Why would you not want to tell patients and families what the concern was that the cleaning was intended to address?

A I don't know why this statement doesn't have that and I never prepared the statement. What I would say again is that in discussion with the clinical teams and with any parents when we were walking about the ward, we would have explained that it was all part of the IMT process and that it's an effective mechanism for ensuring a clean environment in the hospital.

Q Sorry, say that again.

A It's an effective mechanism----

Q No, all of what you just said.

A So my understanding would be that as part of what I've described earlier in the feedback from the IMT, both to clinicians and to parents, of speaking to them or asked, that it was a recommendation that came from the IMT, and it's a belt and

braces approach to ensuring a clean environment.

Q Yes.

A It's a well-recognised process that we chose to implement.

Q The patients and families who have been on the ward, whether as inpatients or outpatients, had been through this situation in March. Is that right?

A Yes.

Q We know that there has been a return of infection concern in June, yes?

A Yes.

Q And the settled position of the IMT is to tell them that there is going to be cleaning, but on the face of it not to tell them why that is so. Is that right?

A I don't know whether it would have been-- well, it wouldn't have been the instruction of the IMT not to tell them. That would not have been an instruction at the IMT.

Q So there was not an instruction not to tell them, but nor was there an instruction to tell them. Is that right?

A I think my recollection of any IMT would, as I've said before-- is that it would be as informed as it possibly could be, and that we had a return of infections and we were working through a whole range of solutions to how we would try and resolve the situation.

Q Yes. I am not sure that is an answer to the question, Mr Redfern.

A Sorry.

Q On the face of it, if this is setting out the settled position of the IMT, which I take you to be saying it is, on the face of it, there is no instruction to tell patients and families why cleaning is taking place. Is that right?

A It doesn't say there why.

Q Now, again, just putting yourself in the position of patients and families, can you say whether you would find it understandable that they might think they are not being told the whole story?

A Yes, I could see that position.

Q Thank you. Now, if we move on, please. We can put that to one side, please. We will go on to July and, again, we have had some evidence about the cases in July and I will not trouble you with that. One thing I do want to ask you about is this. Thinking about what we have just been looking at, the IMTs in March 2018 and in June 2018 and moving on into July, can you say whether you were aware, at that time, of the discovery of a risk

assessment of the water system that had been carried out by a company called DMA Canyon three years before?

A No.

Q Do you recall any mention of that at that time?

A I can't remember.

Q Have you subsequently heard about that?

A Yes.

Q Are you able to say when and how you found out----

A I've just seen it in a variety of media and----

Q A variety of----

A Different stories around the Public Inquiry and reference to it.

Q Okay, so are you saying----

A I haven't formally been-- said, "Here is a document. Please read this," if that's what you mean.

Q No, what I am asking you is when did you find out about its existence?

A I can't remember a specific time of it. I honestly----

Q Well, what you indicated a moment ago, Mr Redfern, was that you-- I took you to associate it with media attention around the Public Inquiry. Is that right?

A Yeah, I think so.

Q Are you saying, therefore, that you do not recall it ever being brought to your attention by any source within the Health Board?

A I wasn't-- I can't formally recall ever being told that about that document.

Q I mean, you held even at that time a pretty senior managerial position. If there were a document, a risk assessment, that had been discovered in 2018, a risk assessment that dated from three years before that, and if it were the position that the risk assessment raised concerns that had not been acted upon in the interim period, thinking about your role and your responsibilities, is that the sort of thing that you would have expected to be drawn to your attention?

A Yes.

Q Are you saying it was not?

A Not that I'm aware of.

Q So if we think about the events in the run-up to the decant, are you saying-- Let me take a step back. You have obviously indicated that you are aware of this issue as being something that is of interest to the Public Inquiry and the media. Is that right?

A Yes.

Q Have you given any

thought prior to today about when it was that you yourself learned about the existence of this report?

A I suppose more that my primary focus in all of this has been how I managed the situation operationally on the ground for the circumstances that we faced. That was where my primary focus was on. I do have obviously an understanding that anything I was communicating through the different stages of how we were doing that with patients and families, it was accurate and was transparent.

Q I have your position on that, but that is not the question I asked. I asked you whether you have given any thought, prior to this moment, as to when you became aware of the existence of this report.

A Yeah. I would have liked to have known it quicker than what I did.

Q But have you yourself cast your mind back or carried out any investigation----

A No.

Q -- or spoken to anyone about this?

A No.

Q Are you coming along here as the director of the Women and Children's directorate to say that you have no idea when the risk assessment carried out by DMA Canyon was brought to your attention?

A Yes.

Q Are you coming along here to say that you have had no discussion or carried out no investigation on that point?

A I've not carried out any formal investigation on that.

Q Okay, thank you. Now we can move on to another issue that arises around about that time. It is an issue to do with cladding and you deal with it in your statement. Now, I would quite like to take this reasonably quickly if we can. In your statement in relation to the issue of cladding, I think you explained it was to do with a concern that arose out of the Grenfell Inquiry. Is that right?

A Yes.

Q Yes. I think what you say in your statement is that your role was to ensure that we understood how we would maintain as near as possible business as usual. Is that right?

A Yes.

Q Now can you explain what it is that you required to do to achieve that?

A So it was primarily about inconvenience to patients, as the work was completed-- patients and families,

in particular, noise.

Q Okay, but just trying to understand what you say, are you indicating that there having been an issue identified in relation to cladding that required action to be taken, your job was to ensure that that was addressed in a way that did not----

A Yes.

Q -- impact upon patients and families?

A Yes.

Q Yes?

A And obviously also that we had strong communication on what was happening and that we had robust protection in terms of any implications of the work that was going on, working with Infection Control.

Q If we think about what we have been discussing thus far about issues to do with the water system, is it also your role to ensure that that was responded to and addressed in a way that maintained as near as possible business as usual?

A That is my role. That is what I saw my role, as operationally trying to deliver a service with the circumstances that we faced.

Q Now, just on the issue of cladding, you have got some evidence in your statement about this, about communications to patients and

families in relation to this issue. Can you confirm whether or not, as far as you recall, there was or was not something of a delay in relation to that happening?

A I think there was. I think that was articulated in a minute that was shown to me when I was preparing my statement that I had said that. I can't specifically recall it now, but it's written there.

Q Okay, thank you. That is helpful. Now, we have quite a number of email communications on this, and I really do not want to take time up on this if we can avoid it. So if I put some propositions to you, can you say whether you agree with them? If you do not, we can always look at the documentation.

A Yes.

Q The understanding that the Inquiry team has is that a concern about an impact from the cladding works was raised sometime in about mid-August of 2018. Would that be about right?

A Yes.

Q And that there was a request at that time, mid-August, for a communication to go to patients and families to explain what was happening and the contingency around that. Would that be right?

A Yes.

Q The emails that we have seen indicate there was a delay waiting for sign-off at senior level. Can you recall that?

A Yeah, I've seen the email.

Q Yes. In fact, there was a chasing email from you, now into the beginning of September, to Mr Hill to get a position on what patients and families were to be told. Is that right?

A Yes.

Q And the briefing, I think, was eventually issued round about 7 September. Does that accord with your recollection?

A Yes, from what I've read from the email correspondence.

Q Can I ask you two questions and you deal with them in whatever order you wish? First of all, what was the process for getting sign-off on this communication? Secondly, why did it take so long?

A So the process was a standard that we would identify a need for communication with families from the intelligence we were picking up at the ground level, and that it would be prepared through the organisation's comms department. The delay, and I can't-- I don't know why there was a particular delay in that. It was just that it was an outstanding action that I wanted followed up on.

Q Yes, I mean, as you have already indicated, the process of communication seems to have involved senior level. Is that right?

A Any media statement comes through corporate comms. We would not do them ourselves.

Q I am talking about senior levels of management. I mean, do you have any understanding of the levels of management at which this communication was being handled?

A Certainly chief operating officer, if not above.

Q Yes. Thank you. Now, if we can move on then to a different topic. Just trying to move forward through the chronology to September 2018, I am going to ask you a bit about the decant from Wards 2A and 2B. I think probably the easiest way to do this-- it might help you a bit in terms of focusing your answers. I am going to take it in two bits. The first thing I want to really explore is the reasons for the decant and the communication around that, and the second thing I am going to look at is the analysis around where the patients should go. We know they ultimately went to 4B and 6A, and I will ask you about the work that you did on that a wee bit later. So if we start then

with the reasons for the decant and the communication around that. You say in your statement, I think, that it was to implement a change in the sinks. Is that right?

A Yes, as I've alluded to earlier.

Q I just wondered if there was any more to it than that, as you recall?

A The reason for the decant?

Q Yes.

A We were working on the basis of an IMT instruction that the solution to eradicate the risk, or to take away the risk of infection, following the proximity of tap to sink, was to remove those sinks. To be able to remove those sinks, we had to find an alternative location. If we had continued trying to do the removal of sinks, then we ran the risk of children being infected.

Q Yes, thank you. I think you have essentially answered the next question I was going to put to you, but I will tell you what the clinicians said about this last week. They said that looking at the IMTs, their recollection is that from March into September, there were around 23 gram-negative bacteraemias by that stage. A hypothesis of an environmental cause; a concern from Professor Gibson, at least, about a site wide problem; a reference to the staff not feeling the unit was safe; Dr Murphy saying that he was concerned that there would be further problems and indeed that the rest of the site would be a risk. One thing that was said was that there was unanimity among the clinicians that they wanted off the unit. Now, can you recall whether that accords with your recollection of things?

A In answer to your question, yes. However, I think the context within that is that there were two separate scenarios that we've described in terms of the IMT process and that number of infections. In terms of the first IMT, which is the filters being added to the taps, we thought that that was eradicating the problem and that the solution, followed up with the treating of the water, would have resolved the situation, and we would have had a safe clinical environment in 2A/2B. The unintended consequences of that prompted the second run of infections, which we had no similar solution to put in place without moving. Therefore, as part of the ongoing discussion with the clinical team, it was felt necessary to move.

Q Yes. I mean, at the risk of repetition, I think as you said yourself, or I took you to say earlier, there was a continuing concern about a risk of infection, as point one and point two, as the work required to address that required the children to be removed from the ward. Is that right?

A Yes. Without doing that, we had no solution similar to what we had at the time or thought we had at the time with the filters.

Q Okay. Now, what I would like to do now, Mr Redfern, then is to just look a bit at the IMT minutes that deal with the decant. As I indicated, one of the things I am interested in at this point is the communication on this with patients and families, and we will come to the choice of decant destination in a minute. So, Mr Castell, can we go to bundle 1, please, and look at page 160. Now, when you orientate yourself on this one, you will see your name is not there. I do not think it is, anyway. So I do not think this is one that you recorded as attending, but you were at the next one. I think you said earlier that the minutes of previous ones would be before the next one. So that being so, is it likely that you will have seen the minutes of this meeting?

A Yes.

Q Thank you. Now, if we stay, please, on page 160 and maybe just enlarge the section at the bottom under "Incident Update," and if I tell you that the redaction is to do with patient confidentiality and that we have taken a better safe than sorry approach as regards that. So I will just tell you that obscured by the redaction is an indication that there were a certain number of gram-negative bacteraemias being focused upon at that time. What I want you to look at, however, is if you go over the page, page 161, and if we enlarge the top paragraph. Now, accepting that you were not there when this said this, but I am just wondering if you can help us with it. It seems to record Dr Inkster saying something:

"Typing results. Some patients remain outstanding. Teresa said she is not able to classify the cases in more detail. Teresa explained that typing results in an environmental incident are unreliable."

Have you got a recollection of that sort of thing being said around that time? By Teresa Inkster, I mean.

A Through the IMT process, there would obviously always be investigation of-- through microbiology about typing of patients,

and sometimes there were delays in that typing. Sometimes there was contamination. Sometimes there were a whole variety of things that would influence how the IMT would react in the fullness of time and accurate information being available. I think that is just an example of where we were waiting for further information. She would need to explain the processes and everything that was involved in that.

Q Yes, I mean a recurrent theme in your evidence and others is making sure that people are not being asked to give evidence on things that they are not expert in. So I understand that you are not a microbiologist but, there is a record on the face of it, of Dr Inkster saying that typing results are unreliable. I am really asking you a question whether you remember that ever being said at that time.

A I can't remember that specific line because I wasn't at the meeting and I can't remember it being picked up at the future meetings. I'm clear in my mind about-- that we had a problem and that we had to seek an operational solution to resolve it. So I don't think we ever disputed that there was an issue in that.

Q If I was to suggest to you that what it might indicate is that Dr

Inkster is saying that she herself does not consider that typing results are reliable in environmental incidents, is that something that you can offer a view on?

A No.

Q No. Okay, fair enough. If we go over the page, please, to page 162. I want to focus on the section that is redacted. Now, again, our redaction has been very much better safe than sorry, and I will help you with a bit of what is underneath it, which is that Dr Inkster appears to be indicating that certain patients, parents affected by gram-negative bacteria, should be spoken to. I mention that, Mr Redfern, just so that we can understand the bit that is not redacted where she says, "Teresa explained under duty of candour that they should be spoken to as well." So there seems to be a discussion about a communication that has to take place in the context of duty of candour. We can see from the IMTs that – I think it is in 2018 – that we do start to see duty of candour as being something that is flagged. I am just wondering if you are able to help us understand what that is and why it starts to appear at this time.

A I would go back to my original comments that any child or family who were part of an IMT should

be fully informed of that. Whether there was a reason why we started to use the word "duty of candour", which to all intents and purposes was--

A -- what it is that we're being very articulate in terms of what circumstances a child and family are facing, that that was carried out and that it should be reported through the IMT process, that it was done and is documented.

Q Okay, and I will help you a bit with this. I am not trying to put you on the spot and tell us all about the legislation on organisational duty of candour, but I think the statutory provisions on organisational duty of candour came in in April 2018 and maybe that that is why we start to see it being mentioned.

A Yeah.

Q How would you understand the organisation's duty of candour? How would you describe it?

A I would say again that those directly involved with a child or family who have had an infection should be fully made aware of that circumstance and what the likelihood of cause was, what was happening with them and how we were hopefully reaching a successful outcome for the child and family. In terms of the wider organisational responsibility, it comes

to the whole commentary that we've been discussing, that those associated with similar children and families were aware of the risk and were aware of what was happening.

Q Yes, thank you, and that is very helpful. I mean, my understanding from my own research, as regards to the legislation, is that duty of candour-- organisational duty of candour, I mean, is about a duty to be candid about unintended or unexpected incidents which result in or could result in harm or additional treatment. Would that accord----

A That's what I meant.

Q Yes, and I understood you to say, in your answer there, that you would see that as being engaged at a point where there has been an infection and the parent would need to be told about the----

A For individual parents, yes, and I would have assumed that was happening and would expect that to happen as part of the legislation.

Q Yes, and I think you said one of the things that the parent would, or the patient would require to be told would be the likelihood of the cause. Is that right?

A Yes.

Q Yes, so are you saying that, at the point where there is a

hypothesis that is accepted by the IMT, that would, as you see it, engage the requirement to tell the patient and the family about that hypothesis?

A Yes.

Q What did you say there?

A One hundred per cent.

Q One hundred per cent, yes.

A That would be my view, yeah.

Q So a hypothesis would engage it.

A Yeah.

Q Okay. Now if we move on, please. I want to go back then to just try and understand the timeline on the decant communication if we can. So, if we go please to-- still in bundle 1, to page 164. We have got an IMT of 14 September 2018. You are attending it. One detail I would quite like to pick up on, which I think might tie in with what you were saying earlier about the hypothesis-- If we go, please, to page 165, under "Control measures continued," can you just have a look at the paragraph with the reference to aerosolization and tell me when you have done that?

A I've read it.

Q Yes. Is that what you were describing earlier about the interaction between the filters and the sink, or is that something different?

A No, I think that's something different.

Q Do you know what that is? Can you recall that?

A No, I can't recall that particular commentary from Ms Rankin.

Q Okay, thank you very much. Can we go over, please, to page 166? If we enlarge the "Phase 1 Contingency, continued":

> "Dr Kennedy questioned that, due to this problem potentially being throughout the whole hospital, then management must liaise with CDU with regards to having a room that has had their drains environment cleaned for patients being admitted into Ward 2A via CDU."

Do you have a recollection of that sort of thing being said?

A That's a patient pathway for oncology patients and it would stand to reason that, while they were in CDU, they were in a safer environment as they would be in 2A, 2B, or moving from CDU to wherever we decanted.

Q I am asking you whether you recall an indication or a discussion around the problem potentially being throughout the whole hospital.

A So, there would be the same sinks right across the hospital. We would have had the same issues with the water supply, hence why we were looking to the replacement of sinks and, as a result of that, we had nowhere to decant within the RHC, so yes.

Q Are you saying the whole hospital refers only to the Children's Hospital?

A Yes, because there were different types of sinks in the Queen Elizabeth, which is my understanding, hence why we were allowed to move there.

Q Okay, thank you. So, if we go on, please, to page 167. I want to look at the communication section again. If we could maybe just enlarge that and we see that there is a redacted section which does not particularly matter:

> "Communications have been sent out with regards to increased drain cleaning with more communications to patients once a decision has been made by the senior management team this afternoon."

Then under the heading "Public":

> "The media will be contacted once the senior management has met, after this meeting, to agree if they go with the proposals of this IMT."

You see all of that?

A Yes.

Q Does that indicate that, as far as the process of communicating with the patients and families are concerned about the decant, that that is a decision that is to be made by the senior management team? Is that right?

A Yes, that's what it says.

Q Yes, and the media will be contacted once the senior management team has made its decision. Is that right?

A Yes.

Q Is that the decision around the decant?

A Yes, I think that's what that refers to.

Q Yes, thank you. So, if we move a little forward in time to page 169, we see the IMT of 17 September, page 169. Again, you are present. You see that?

A Yes.

Q Just to pick up on a couple of points in the IMT itself, as we have got it in front of us. If we go to page 171, please, and we enlarge the second paragraph. Have you got a recollection-- if you just take a moment to read that first sentence. Have you

done that?

A Yes.

Q Have you got a recollection of Dr Inkster relaying expert opinion that you should not be having to clean the drains continuously?

A I recall the name Peter Hoffman. I recall there would be discussion between Dr Inkster and a number of other UK or international experts on the issues that we faced. In the particular line about what came thereafter from Mr Hoffman, I can't specifically remember.

Q Thank you. If we go over the page to page 172 and underneath "Contingency/Decant," Mr Hill assuring the group that decant option was not off the table. It is really the last sentence I am interested in:

> "It was stressed that a decant should be as short as possible and may take up to four weeks."

See that?

A Yes.

Q Can you recall whether that is what was being said at the time?

A I can't recall the specifics of four weeks, but I do know that we would want a decant to be as short as possible because of the operational challenges that it would present, but it would have to be moving back into a safe environment so it would be as long as it had to be. If that was an estimation at the time of four weeks-- I can't remember that particular time being put forward but it's minuted so obviously that was what was thought of at the time. From my recollection, I was assuming more of an eight-to-ten-week period.

Q Okay, and a little further down the page, again, it is just to, maybe, help us with a detail if you can. You might not be able to. The paragraph that starts "Mary Ann Kane," where it says, "Mary Ann Kane wanted to emphasise..." Have you got that?

A Yes.

Q

> "… wanted to emphasise that the facility that the children would be moved to on the adult QEUH site was not better from a ventilation perspective."

Can you recall that being said or what that was about?

A So, we were moving to the Queen Elizabeth. We were not moving to a specific haemato-oncology unit so we would have the infrastructure that a general ward, an adult environment, would have. I think

that's what she ultimately means. Obviously, there is an exception to that in moving to 4B, which was for the bone marrow transplant patients, which did have the infrastructure for a transplant unit because that's where the adult transplant----

Q The ventilation infrastructure?

A Yeah, yeah.

Q Thank you.

A So we're in a general adult ward, not a purposeful built, paediatric, haemato-oncology ward.

Q Now, if we go over the page, please, to page 173, we get to really what it was I particularly wanting to ask you about. So, if we enlarge the top half of the page, thank you. It says, "It was agreed that the statement created on Friday, but not shared with parents, can be updated." Now, if I just stop there and help you, Friday was the 14th, so the IMT that we just looked at was the Friday. "It should mention that there was enhanced cleaning undertaken over the weekend and ongoing maintenance of drain cleaning." If we just pause there, are we to understand that, at this point, there had not been anything issued to patients and families yet?

A I think that's what that's saying.

Q If we go down the page, please, to under the heading of "Public." That's fine:

> "Claire Cook, from the press office, said that no proactive statement was released regarding the possibility of decanting, and there is a reference to a draft statement that, at the weekend, stated that enhanced cleaning was being undertaken in Ward 2A and 2B."

You see that?

A Yes.

Q Now, if we just go back up, just to pick up a detail, please. Back up to the section under "Staff," and if you could take a moment to look at that, and just tell me once you have done it.

A Yes.

Q Can you recall----

A I can recall that particular event.

Q It might be thought to indicate a really high level of anxiety among staff. Would that be fair?

A Yes.

Q Is that how you recall matters, at the time?

A Yes.

Q Now, if we go on a little further in time, and I will turn up the documents if we need to, it is our

understanding-- the Inquiry team's understanding from the documents, that-- just going back then to the communications bit of this that we have just looked at and the bit about not telling the patients and families just yet. It would appear that there was a media briefing on the decant that day, on 17 September 2018. Is that something that you have a recollection of?

A I can't have a specific recollection of having a media briefing and having a draft staff briefing. What I would expect, at the time, would have been that we would have had a formal communication to both groups – to the media and to parents and families and to staff – of (A) The decision being taken by the IMT reinforced by the corporate management team and how we would be undertaking that and what it meant for families.

Q Yes. I think we know from-- or, at least, the evidence indicates from Jennifer Rogers' statement that it was not, in fact, until the IMT the following day on 18 September that a communication to parents was approved. Does that accord with your recollection?

A Yeah.

Q So, if we accept – and I think you are accepting – that there had been a communication to the media on the 17th, but the one to the parents did not go until the 18th. It is obvious that there has been a disconnect there. Is that right?

A There's been a difference in the timelines.

Q Yes. I mean, we had quite a bit of evidence from patients and families about this, that some of them had learned of the decant from the media.

A I remember parents indicating that.

Q Yes. Can you remember how they felt about that?

A Not good. I'd much rather have had a proactive approach and been able to deal face to face with any parent or family around the circumstances being faced.

Q One of the things we heard quite a bit of evidence about last week was about the process for patients who are on a path towards a bone marrow transplant and how time critical that can be, both as regards getting the treatment and as regards ensuring that the donor is available. I am just wondering whether thinking about that sort of patient, whether it is easy to understand just how stressful it could be to learn from the media that you might be about to move from your

current ward.

A I think it would be stressful for all patients and the haemato-oncology family.

Q Yes. Now, just to complete this bit, and we will move on to decant options in a minute, I want to go to one last IMT from this stage, please, and it is the next one. It is page 175 of bundle 1. It is really, again, just to pick up on a couple of details. I think we see, again, Mr Redfern, that this is one that you were at. Is that right?

A Yes.

Q If we go over the page, it is again just to try and see if you recall something being said. Enlarge the top paragraph. Just take a moment to read it, please, and tell me when you have done that.

A I've read it.

Q Thanks. Have you got a recollection of a discussion about a concern about the temperature of the water within the water system?

A I don't have a specific recollection of that, but if it's minuted then it would have been discussed.

Q Thank you. If we go over the page, please. Page 177, and if we go to the-- sorry, the foot of the page, Mr Castell, the bottom paragraph, if we just enlarge that. "The group has

agreed that an area within the RHC site would not be suitable for a decant." Do you recall that?

A Yes, I've alluded to that already by the fact that the proximity issue which, to my recollection and understanding, was the issue which was prompt and splashing. It was the same type of sinks that were in there and we couldn't resolve the issue by moving to another ward in the paediatric hospital. That was not the case in the QEUH.

Q Thank you. Finally just if you can help me with one aspect in relation to communications, over the page at 178, under "Communications." If you want to read all three paragraphs do so, but I am really only interested in the third paragraph: "It was agreed a statement for staff, parents, patients and the press will be drawn up outwith this group. Each communication should have the same common narrative with strict disciplines." Why was the communication being drawn up outwith the group?

A I think, from recollection of that, that would be individuals within the group that were doing that, and it's maybe just been how it's been worded in the minute.

Q Okay, thank you. We

can put that to one side. Now, I want to hopefully get through this before lunch. I want to start moving on, then, to the decant options and maybe let us take it in these stages. First of all, what was your role as far as identifying a decant, an alternative place for the patients to go?

A So operationally, I had, through the IMT process, been told that we had as a solution, we had to move out with the ward. My role would be to facilitate that.

Q Yes. Is it back to the ensuring how you were going to maintain as near as possible the same service?

A So, I had two primary objectives in terms of maintaining service: the general haemato-oncology and patient day case service, and the bone marrow transplant national service for Scotland.

Q Okay. I would like to ask you just some questions about-- We can see from the IMTs that a number of possibilities were considered.

A Yes.

Q One I would like to ask you a wee bit about is the use of a new modular unit which ultimately was not selected as the preferred option. Why was that?

A The primary reason, from

memory, was the timeline that it would take for a modular build, the estimated timeline for a modular build to be procured and situated and fit for purpose, and also whether or not it was actually a practical solution that we could implement bearing location and pathway between said location where we put the modular build and how we would actually create a safe environment for patients moving backwards and forwards from it to the rest of the hospital.

Q Okay, so just so I have got that, the time scale is one?

A Yes.

Q And the pathways is the other?

A Yeah.

Q Okay. Could I have you look at your statement please, Mr Redfern? It is in the statement bundle at page 390. I think you set out at paragraph 88----

A Yes.

Q -- certain criteria. Were these the criteria that you had regard to when you prepared your decant options paper?

A Working with the clinical team, that was what we came up with. The key criteria that would decide what the final option we choose would be, yes.

Q If we look at paragraph 89 now, you explain why the Beatson was not used, and then you say, due to point 4 a new modular build was not possible. You see that?

A Yes.

Q Is that a reference to D, "an ability to scale up at the earliest opportunity"?

A Yes. Sorry, it says D instead of .4. I think that's a typo.

Q What is the ability to scale up at the earliest opportunity?

A Have it in place.

Q Have it in place.

A Yes.

Q Right. It does not indicate anything in relation to having to scale up in the event of some change in the patient cohort or anything like that?

A No, I don't think so.

Q No.

A Primarily, it was to do with the commissioning of the building, but it was also, as I say, about the pathway from an external environment, internal to the points made in 88.A.

Q Yes. That is helpful. We are to understand that the ability to scale up at the earliest opportunity refers to the time within which----

A That was certainly clear in my mind what it was.

Q Okay, that is helpful. Thank you. Now, one of the things that you say in your statement also about the decant-- One of the considerations around safety was the fact that the source of water in the adult hospital was the same as in the children's hospital. Is that right?

A Yes.

Q Just single supply. Is that right?

A Yes.

Q Now, a number of witnesses, patients, parents and clinicians appear to recall having been told that it was a different supply in the adult hospital. They do not, I think, say that you said that, to be clear, but they have a recollection of understanding that. Do you have any explanation for that?

A No. Certainly my position around all of this was it was the same water supply. The only different water supply was, from recollection, to the maternity hospital on the campus.

Q Yes, thank you. Now, just a couple of other points of detail about Ward 6A and Ward 4B, and if you do not know the answer to this, please say. Were there point-of-use filters, if that is the word, on the showers as well as the taps?

A I don't specifically know, but what I do know is what the instruction of Dr Inkster would have been, prior to the move, they would have been fitted.

Q Thank you. Please do not think that I am suggesting that they were not there. I genuinely do not know. It is just something that had occurred to me. Are you indicating that-- Well, actually, let me not lead you on this. What are you indicating?

A So, what I'm indicating is that, prior to the move, Ward 6A, as we've described, was not a paediatric haemato-oncology unit. There was a lot of preparation work which was carried out prior to decanting to that ward and instruction would have been from microbiology, infection prevention control and the clinical team around what they would expect and there was a process put in place to make sure that, prior to the move, operationally, every action against that was completed.

Q Okay. Thank you.

A I would assume that would include the use of filters to the satisfaction of Dr Inkster.

Q Yes. Can you recall whether there was a risk assessment made in relation to the move to 6A and 4B?

A There was a whole process put in place around risk assessment and around standard operating procedure for overseeing that move.

Q I am thinking in particular about risk assessment in relation to any repeat of the sort of risks that had been perceived in the children's hospital, in other words, risks from the water supply. Was there any risk assessment around that that you recall?

A I can't remember formal risks, but I'll give you the context of what my understanding was at that time: that Ward 6A would be equipped with the filters; that the treating of the water supply had been carried out and had been found effective; the deficiency in the children's hospital was the splashing from sink to filter and that was not an issue for Ward 6A or for Ward 4B.

Q Okay, maybe if I rephrase my question: which department or which area of management should the Inquiry look to find any risk assessments that were made in relation to the move? Whose responsibility would that have been?

A I think that would have been a shared responsibility between the director of Infection Prevention

Control/Microbiology and Estates.

Q Okay. Thank you. The final question on this is: can you recall what, if any, contingency planning was made at this stage around what would happen in the event that there were further problems on Wards 6A and 4B?

A I can't recall further contingency of a further move because I don't think there were other options open to us at that time. However, we had confidence in the situation that the filters were functioning the way they should function and that the risk of splashing was resolved and therefore we were of the assumption that we were moving into an environment that, while not ideal for the reasons I've just described, was functional.

Q Thank you, Mr Redfern. My Lord, I have come to the end of a chapter so this may be a suitable point.

THE CHAIR: I can only congratulate you on your timing, Mr Duncan. That seems pretty well dead on one o'clock. We will take an hour for lunch, Mr Redfern, and you will be taken to the witness room. We will sit again at two o'clock.

(Short break)

THE CHAIR: Good afternoon, Mr Redfern. I think we are ready to resume.

MR DUNCAN: Thank you, my Lord. Good afternoon, Mr Redfern.

A Good afternoon.

Q We have reached the point of the decant and I am going to ask you, in a minute, some questions around life in Ward 6A in 2019. Before we get there, I want to ask you some questions about issues that were identified in relation to Ward 2A in the later part of 2018. You have got some evidence in your statement about that, and it might be helpful for you just to cast your mind-- or rather refresh your memory as regards to what your statement says. I wonder if we could go to the statements bundle, sorry Mrs Soska(? 00:31.39), and if we go please to page 392 and I just have you look at paragraph 97. Under the heading "Work in Ward 2A, 2B RHC," you say, "At this time," – in other words, autumn 2018:

> "At this time, we were informed by the new director of facilities that, as the ward had been decanted, there was an opportunity for the replacement of a new ventilation system to be implemented in Ward 2A, 2B, and that this would be progressing

while we were on decant."

Do you see that?

A Yes.

Q What do you mean there was an opportunity?

A That's how it was described to me. There was an opportunity or-- maybe opportunity is a wrong word, but to all intents and purposes, we get told they were taking the vacation of the ward to put a new ventilation system in.

Q Yes. When you say you have maybe chosen the wrong word, did somebody say there is an opportunity?

A Tom Steele said to me that they were putting a new ventilation system in.

Q Did he say there is an opportunity has arisen to do this?

A I can't remember his exact words.

Q I am just curious about your choice of word, and I wonder if we might just look at that. I wonder if we might look at something that might help you a bit with that. I wonder if we could have bundle 5 in front of Mr Redfern, please. It is at page 157. Now, this appears to be a media statement of 6 December 2018. Can you recall whether this is something that you have seen before?

A I would assume I've seen it, yes.

Q At the time?

A Yes, but I can remember specifically Tom Steele telling me that they were doing this.

Q Okay, so if we just work our way through. It says:

> "Our engineering experts have now completed work to resolve the water and drainage issues in the two paediatric cancer wards at the Royal Hospital for Children."

Let us pass over the next two paragraphs, Mr Redfern, and it says, "Following this work, we have decided to upgrade the ventilation system in this area," and it goes on to say that this will cost £1.25 million and there is a reference to a 12-month program. You see all of that?

A Yes.

Q It then says:

> "Kevin Hill, RHC Hospital Director, said, 'As our patients and staff had already relocated to another ward, this provided a good opportunity to carry out this upgrading of the system. We have informed patients, their families and their staff about the plans for the ward and I am grateful for their understanding.

> [It says] While the BMT Unit has already had a ventilation upgrade, its proximity to Ward 2A means that the best option is for those patients also to remain in the adult hospital until all work is completed.'"

There is then a background note. If you look at the paragraph that refers to the drains, you see the reference to, "This allowed our technical staff to carry out remedial works and to make investigations into the whole environment." You see that?

A Yes.

Q It then says, "It was during this period that our teams identified the opportunity to upgrade the ventilation system and the work is now being progressed." Then, if you go over the page, there is a question:

> "Has the current ventilation system been causing risk to patients since the hospital opened? We regularly monitor infection rates and the trigger for the work that has taken place over recent months on the water supply and drainage was a rise in the presence of bacteria and a number of infections above the rate we would normally expect in this cohort of patients. The ventilation work is not linked to infections but is an opportunity to install the very highest standards currently achievable."

You see all of that? I just say that you have a recollection of seeing that at the time. Is that right?

A Yes.

Q I wonder whether it was the use of the word opportunity in that statement that perhaps led you to say what you said in your statement.

A I never drafted my statement on the basis of that document, so that wasn't how I came up with the word opportunity. Probably, though, is how it was presented at the time to me, and what my memory is, that the ward was vacant and there was a decision that I was told (A) we're going to replace the ventilation system, (B) you're going to have the most modern ventilation system in paediatric healthcare and (C) it's going to extend the time that you're in Ward 6A.

Q Can you remember whether, going back to (A) of that list, there was an explanation for why the ventilation system was going to have work done to it?

A Just that they were modernising it.

Q Okay. I wonder if the witness----

THE CHAIR: Sorry, my fault for not hearing. Why they were doing it: your answer is to----

A They were modernising it.

THE CHAIR: Okay. Thank you.

A What was sold to everybody was the fact that they were saying you could have the most state-of-the-art ventilation system, and I think everybody was very happy about that.

Q That is what you were going to end up with?

A Yes.

Q What I am interested in is what you had at the minute. What was being said?

A There was never-- The IMTs that I was involved in that triggered the move to Ward 6A never had anything around ventilation-- never specifically had anything around a ventilation system. It was a by-product-- not a by-product. It was mentioned to me in the course of an IMT where we were talking about the length of duration in Ward 6A that I was told to prepare for it being longer because we're going to replace the ventilation system and that was what was articulated to me at the time.

Q Who articulated that to you?

A Tom Steele.

Q Can you remember whether it was articulated on the basis that it was something that had to be done or whether it was just an option to do it?

A I'd say it was articulated to me that it was the latter.

Q It was just an option to do?

A Yeah.

Q It did not need to be done?

A That was my recollection of it.

Q I wonder if we could have a look, please, at something on bundle 4, please, and it is at page 132. Now, we have got an SBAR here. We have had an explanation of what an SBAR is, and that seems to be an SBAR that has gone from one person in Estates to another. Is that right?

A Yes, from the SBAR that is in power to Tom Steele, deputy general manager of Estates to the director of facilities which incorporates Estates.

Q Okay. If we look at the section next to "Situation" and maybe enlarge that slightly so everybody can see it properly. Thank you, Mrs Soska:

"Single-bed accommodation

has a nominal air change rate of 2.5 air changes per hour with the single rooms being neutral to negative pressure relative to the ward corridor. This combined with the potential risk of air recycling from en-suite WCs, with the supply airstream via air passing through bypassing the thermal wheel heat recovery unit, introduce a potential for cross-contamination between single-room suites."

You see all that?

A Yes.

Q Can you have a recollection of either seeing that document or being told anything of that nature at the time?

A No. Reading that doesn't-- I mean, it sounds like there was a potential risk, but I wouldn't understand the wording of that.

Q I am sorry, say that again. I did not hear you.

A I wouldn't understand the wording of that, even reading it just now. It's engineers' speak.

Q But you do understand the wording, "a potential risk"?

A Yeah, oh yeah, yeah.

Q Are you indicating to us that you are at least able to read that as indicating a potential risk? Is that right?

A Yeah, I can see that.

Q Yes. Well, yes, you agree with----

A Yes.

Q Yes. Now, maybe just to help a little further on this, I wonder if we could go to bundle 1, please? It is page 227, sorry. Thank you. There is an IMT of 13 November 2018, and you seem to have been at it. Is that right?

A Yes, I'm the last name.

Q Yes. Now, if we go over the page to page 228, and if we enlarge the paragraph that begins, "An external review." If you could just read that paragraph and then indicate to me once you have done that.

A Yes, I've read it.

Q Yes. Now, do you have a recollection of that discussion?

A I don't have a recollection of the discussion between Ian Powrie and Dr Inkster. I do have a-- To go back to the point, I do have a recollection that I was informed that the ventilation system was being replaced, and that this would have an extended decant in the time. I can't remember what has been relayed here which might be prompting for that decision to be made.

Q Well, if we just take this in stages: we looked at these

documents last week with Dr Murphy and Professor Gibson and, of the issue that is raised here in the IMT about pressure, Professor Gibson explained that her understanding would be the risk in not having positive pressure would be that material could get into a patient's room. Is that something that you would understand?

A Yes.

Q In relation to these documents, Dr Murphy said, looking at the SBAR, his understanding would be that the ventilation system was deemed not fit for purpose. Now, can you recall whether that is what you understood the position to be at the time?

A No. That was never articulated to me, that the ventilation system was not fit for purpose.

Q Okay. Can you recall whether what was being said was that the ventilation system required to be remediated or upgraded?

A Well, I assumed that, if we were upgrading the ventilation system, there would be reasons for why we were doing that----

Q What I am pressing you on, if I may, Mr Redfern, is: do you remember, in the discussion at the IMT and in your understanding of this matter at the time, that this was

something that required to be done?

A I don't recall that being mentioned at the IMT.

Q Doing the best you can today, was it or was it not a requirement, or was it just something that was nice to have?

A I worked on the premise that-- I don't think it was just that it was nice to have. I think that is a bit unfair to say, but I do not recall saying that-- it ever being mentioned that the ventilation system had to be taken out and replaced.

Q I did not say that. The question I am asking you is whether the advice at the time was that there was a requirement to do work to the vent----

A I don't recall that being said, that there was a requirement.

Q So, is your recollection then that this was only ever said in the manner of, "There is an opportunity that has arisen to upgrade"----

A That's my recollection, and the fact that, as I said, there would be an extension in our stay within Ward 6A and the decision had been taken to do it.

Q Okay. The reason I am asking you this is that-- The reason I am interested in the similarity between the choice of word in your witness

statement and in the media briefing is that there was evidence from the patient and family witness group that the media briefing was effectively an exercise in spin and did not reflect the situation with the ventilation system at the time. How would you respond to that?

A I couldn't comment for what the media statement was for the ventilation system in terms of spin, but I wouldn't think the organisation would be looking to do that.

Q Well, there is a quote from Mr Hill, who was your boss at the time?

A Yes.

Q Yes. So, I think what is being suggested, if I understand it, is that he put a more positive spin on things than was the true position. How do you respond to that?

A I would say that there was a positive aspect of what was happening, in that this was going to be a state-of-the-art ventilation system. What triggered it, as I've said, was-- as what was relayed to myself, was that we were out of the ward and they were taking the decision to replace the ventilation system. I was never in the understanding that, if we had been in the ward, we would have had to get out the ward to have the ventilation

system replaced, if that makes my position clearer.

Q Now, could you say that again, please, sorry?

A So, the circumstances being that we were experiencing-- We were out of the ward, yeah? So the ward's vacant, and they were replacing the ventilation system. If we were in the ward, and we hadn't had the water, and nothing had been going on, there was no inclination to me up until that time and thereafter that we would need to get out the ward for the ventilation system to be replaced.

Q Okay, thank you. We will move on shortly from this.

A So, I wasn't expecting to hear Tom Steele say at the time that we're going to replace the ventilation system.

Q Yes. No, I understand the point. What you did say, when we looked at the SBAR, is that you were able to read that as indicating identification of a risk. Is that right?

A I think that's what-- From a non-engineering perspective, I think that's what it's saying.

Q Okay. If there is an identification of risk, can you say whether that would indicate that it would therefore be a requirement to address the risk?

A I think, from an engineering perspective, they would have to take it through that and what the degree of risk was, weighed against the implications of----

Q If you just answer the question, please, Mr Redfern. Would you agree with me that, if there has been identification of a risk, you, as a senior manager with responsibility for this group of patients and the clinicians, would recognise that as something that required to be addressed. Is that right?

A I think yes.

Q Yes. Well, can I ask you again whether you think that the language that was used at the time about it being an "opportunity" to address the situation with the ventilation system was or was not a reasonable and fair assessment of things?

A I think that, from what you're saying and from the other information that you've presented, there could have maybe been something more specific around that, yeah.

Q Well, something more accurate. Is that what you mean?

A Yeah, yes.

Q Thank you. Now, if we move on, please, to Ward 6A and life in Ward 6A. Now, we have had quite a lot of evidence on this, Mr Redfern, and I do not want to go over that unnecessarily. I also want to say something to you which I hope gives you some reassurance about what we are about to cover, and has been indicated to the other witnesses. We are obviously aware of certain, very anxious patient cases that arose over that period of time, and I am very nervous about you or I discussing anything that might intrude in relation to any issues of patient confidentiality. So if I reassure you that that is certainly not my intention, and if you and I just both try and tread quite warily, are you happy to proceed in that way?

A Yes, I'm happy to do that.

Q Thank you. You have provided us with some evidence about life on Ward 6A, and I am really just focusing on the early part of 2019. I wonder if we might, please, just go to an IMT that you do deal with, but I just want to, sort of, tease out one or two aspects of it. It is in bundle 1, Mrs Soska, and it is at page 255. Once again, just in terms of identifying what this is: IMT of 7 January 2019. We see your name mentioned and, I think as you say in your witness statement,

this was one that you were at. Is that right?

A Yes.

Q Okay. Now, I just wanted to identify one or two aspects of the discussion that will help us in creating our understanding of the narrative, and then I am going to ask you a couple of questions about things that you are recorded as discussing. So, if we could go, please, to page 256. Are you able to read that as it currently stands, without it being enlarged?

A The full page?

Q Well, I will tell you why I ask: because I want you to have a look at the very top, first of all. Can you read that, "Air samples"?

A Yes, I can read that.

Q So, a "Heavy growth of fungus but no Cryptococcus." Then, if you drop down the page, underneath the, sort of, two paragraphs above "Hypothesis." Still on page 256, please, Mrs Soska, sorry. You see, just two paragraphs above "Hypothesis," "In 6A and 4C," do you see that?

A Yes.

Q

"We would expect to see fungus on plates as they are not HEPA filtered wards, however, 6A seems significantly heavier fungal growth than 4C, the reason for which is unclear."

We have already looked at at least some of this, and I just wanted to have you give us your recollection of whether you recall that sort of thing being said at the time.

A Yes, I recall it.

Q That is great. Thank you. Now, I wonder if we can go over, please, to page 257. If we look at the top paragraph and just enlarge that slightly. If you just go four lines up from the bottom of that paragraph, you see, "Parents continue to ask questions"?

A Yes.

Q Have you got that? Again, we have had some evidence on this already, so it is just to get your perspective:

"They continue to ask questions about why their children are receiving prophylaxis and BG concerned that there has been no formal statement from the board. She added that staff locally have provided a statement to the parents which was generated in conjunction with TI."

You see that?

A Yes.

Q I am just really asking you this question at this point: do you

have a recollection of a concern around an absence of communication of some kind from the board?

A I can't specifically remember that, although I do remember that prophylaxis generally was an issue that was of concern to parents.

Q Okay, thank you. If we go to the foot of the page, please, just above "HIIAT." "JRE", that would be you, I take it?

A Yes.

Q "…summarised that the content of today's meeting has highlighted a risk for patients on ward 6A." You see that?

A Yes.

Q Was that your recollection at the-- Well, was that your understanding at the time?

A Yes, there was a-- Obviously, the commentary within the minute articulates the concerns that were there, both from clinicians and from, as you've described, parents around the use of prophylaxis, and that that would be escalated up through the IMT process.

Q Yes, thank you. Obviously, we understand that, and without going into it, that the concern around Cryptococcus would be a part of that but, I think from what we have

just seen, are we right in understanding that on Ward 6A itself there were signs of heavy fungal growth that were not Cryptococcus. Is that right?

A Yes, that's what it's saying in the minute.

Q Yes. So, are we to understand then, as far as you recall, was it your recollection that that of itself was a concern?

A Yes, we wouldn't have been having an IMT if there wasn't a concern.

Q Thank you. If we go over the page, please, to page 258, and if we enlarge the paragraph under "Press." Now, I think I just want to give you the opportunity to read that paragraph, and then once again if you let me know once you have done that.

A Yes, I've read it.

Q Thank you. Can you confirm whether you have a recollection of saying what is more or less recorded there?

A Yes.

Q Thank you. So, I wonder if you can maybe just help us understand what it was that you were seeking to articulate.

A So, Dr Inkster was indicating that ideally, obviously, the decant of patients from a paediatric

haemato-oncology ward would go into something that replicated the infrastructure they should have. I think the "West of Scotland CC" is the-- was referring to the Beatson, but the Beatson was discounted for primarily two reasons. One of which was, as mentioned here, the adjacencies to paediatric services. We went through that process earlier and described why we reached 6A. The second part, and I've articulated that by saying that we went through that process of why we chose 6A, and that was done with full clinical engagement and the limitations that we had for any of the options. The second, or the closing lines are the reality of the situation, which was we thought we would be able to manage that decant within a shorter period of time than what we were faced with, with the extended work that was then getting carried out.

Q Okay. There are a couple of things I want to pick up from that. The first is something that you have already told us a bit about already. You say there was an extensive risk assessment. Again, just to go back to the evidence you gave earlier, are we right in understanding that it was not you personally who did that risk assessment?

A No, it was a

multidisciplinary-- Sorry, are you talking about the risk assessment around what choice we made or the risk assessment in the suitability of 6A?

Q Are those different things?

A Well, I'm articulating that position because, obviously, Dr Inkster has indicated that there was an Infection Control preference that there was a move to a potential site within NHS Greater Glasgow and Clyde which had a more improved infrastructure for the management of this type of patient, but it was ruled out because of other clinical consequences and disadvantages to them, and I think that was an appropriate decision to take. In terms of Ward 6A, I think I've articulated, and it's been articulated in minutes earlier that we've discussed, that it was not built as a paediatric haemato-oncology unit no matter what modifications we made to it. And that, ideally, we would have had a shorter period of time, but that unexpected occurrence was that that was going to be longer than what we thought. As part of this IMT, what we would have been looking to do is put further solutions in place to mitigate against any risk as a result of that, and around communication how

we would present that.

Q Okay. I just want to go back to what I took you to say at the start of that when you asked me to clarify my question, and so I am going to respond with my own question. Was there more than one risk assessment? Was there a risk assessment about-- that was specific-- Sorry, let me take a step back and make this easier to understand. At the point in September 2018 when the requirement to decant had been identified and there were a variety of options being looked at, were each of those the subject of a risk assessment?

A There wasn't a formal risk assessment against each of those.

Q Sorry, could you----

A There wasn't a formal risk assessment done against each. It was more an option-- almost an option appraisal against what was practical given the criteria that we set. So if you wanted to go through each of what those options were, you know, the criteria was clear and apparent, and the only solution, and as far as I'm concerned still the only solution which was agreed by the clinical community and all others present through that process, was that we decanted to wards-- well, we decanted to an area

within the adult hospital.

Q When you refer to the options appraisal, are you referring to the options appraisal that you prepared?

A Yes.

Q Right. So, are you saying to us that there was not any risk assessment of each of the options beyond that?

A Not that I recall because, physically, we were of the view that the size was limit-- Well, first of all, we couldn't decant into the children's hospital because of the sinks that I've mentioned. We didn't have an identified area where we could remedy the problem that we were experiencing in 2A. We couldn't move to the Beatson because of the transfer backwards and forwards of patients and the implications for them, given that haemato-oncology patients will often require ITU stay, will often require theatre, will often require access to radiology and other facilities. We've already discussed the modular build. Therefore, the relocation of patients to another haemato-oncology unit in Scotland was not possible because none were big enough. The natural option, therefore, based on all of that observation, and hopefully pretty transparent, was that it would

have to be in the Queen Elizabeth.

Q Okay. So, if we just, again, try and take this in stages, because I just want to be sure I understand this. The options in September that were under consideration were the Beatson, the adult hospital, a modular unit, or another hospital outwith GGC. Is that right?

A Yes.

Q What you have said a moment ago is that there was no risk assessment that was done in relation to all of those options. Is that right?

A There was no formal risk assessment because there was a time imperative to get this agreed and get a solution in place. I think, from how I've described, or I hope from how I've described it, it was pretty apparent why we would reject certain of those options. As I've said, those present, full clinical community, full Infection Prevention Control and others recognised that the best option within that set of circumstances, and for an early decant to resolve the problem, was to move to the Queen Elizabeth and find a dedicated space there. There was also the protection of the bone marrow transplant service which, again, was close proximity to the location of the Queen Elizabeth, and

the use of space freed up within Ward 4B.

Q Okay. If we just take, then, of the options, the particular option to go to the adult hospital. Was there or was there not a risk assessment done of that?

A Of Ward 6A?

Q Yes.

A I can't comment on the-- Well, there was a formal risk assessment in terms of what we had to do prior to moving in and changes that we had to make to the infrastructure within Ward 6A. There was obvious Infection Control and Estate involvement in terms of the fact that this was not, as I've said before, a paediatric haemato-oncology unit but, given the circumstances of what we faced, we would have to move in there.

So I think we prepared Ward 6A as best as we could within the situation faced, and we went through a number of actions to do that, and we implemented it in a safe and effective way, that transfer, once the decision was made. Whether we had went to a different ward within the Queen Elizabeth, we couldn't use Ward 4B in its entirety because it wasn't big enough. So it's an 18 bedded ward, we needed significantly more space

than that, and we needed a ward that was physically adjacent to Ward 4B because we were disaggregating our staff to manage a caseload that normally would be in the same ward over two separate wards, and therefore we wanted them as close as we possibly could come to. Through that process, Ward 6A was identified as the location of choice.

Q Okay. I will ask my question again: was there or was there not, in choosing whether to go to Ward 6A, was there or----

A Sorry.

Q If you just let me ask the question: was there or was there not a risk assessment as to whether that would be a safe option?

A So, I would say yes, that was the-- what I've just described was the risk assessment.

Q Okay, I mean, you did give some evidence on this earlier, I just want to be sure I understand it. Can you remind us, please, who it was that was responsible for doing that risk assessment?

A It was a combination of Infection Control, Service, the clinical team, and management of the directorate and Estates.

Q Well, I think the clinical team, having heard them last week,

would certainly take umbrage at the suggestion that they were involved in risk assessing whether it was safe to go to Ward 6A. So, how would you respond to that?

A I would say they were part of the decision-making that we were involved in, in how we reached that choice.

Q I think you know what I am asking, Mr Redfern.

A Sorry.

Q I am asking: who was it assessed whether or not it would be safe to go to Ward 6A?

A Well, the combination of those groups that I've mentioned ultimately would have been reached through that process and through subsequent IMTs.

Q Okay, and maybe we can approach it this way: will there be a paper trail that demonstrates that?

A I would assume there is, yeah.

Q Well, did you see one at the time?

A The decision-making around the move and the suitability of Ward 6A, there would be an audit trail of that as per what I've just described.

Q When you prepared your options appraisal, did you have documented risk assessments that you

could use to inform your advice?

A They came thereafter when we were looking at the infrastructure within Ward 6A.

Q So, after the decision was taken to move to 6A?

A Well, I didn't know it was going to be Ward 6A when we ran the option appraisal. We just knew it was going to be a ward within the Queen Elizabeth and finding physical space that could allow for that move to happen.

Q Okay, well, I think we will move on. Just staying with the entry, paragraph 258, the other thing I was going to ask you about is: it says in the minute that you "queried whether we were robust enough in our decision." Do you recall saying that?

A It's in the minutes, so I must have said it.

Q Are you able to help us with what that means?

A So, we were in an IMT and, again, we were looking at whether or not our assumptions in moving to Ward 6A were robust. I think that's pretty self-explanatory in what it's saying. Ideally, we would have been in Ward 6A for a short period of time, and we would not have been in an IMT.

Q Well, it might be thought to indicate that you were querying whether they were robust enough.

A Well, as I said, we were in an IMT, so, were our assumptions correct in terms of Ward 6A's suitability?

Q Okay. If we move on, please, I want to take us to another IMT a little later in the month. It is 16 January, and it is still in bundle 1. It is page 261. Again, it is something we have had some evidence on, but I do not think we actually looked at the minute. So, if you do not mind, it is just so that we get to see this. Again, I think we see it is a meeting of 16 January, and I think we do see that you were present. Is that right? The right-hand side?

A Yes, I'm-- I was there.

Q Yes. I will just draw you-- If we could scroll down a little on this page, please, Mrs Soska. Just pausing underneath the "Purpose of today's meeting," there's the reference to "Cryptococcus albidus." Do you see that?

A Yes.

Q If we go down the page, please, to "Current risk to patients." "TI explained that this strain of cryptococcus is less pathogenic but still a risk in haemato-oncology patients." Do you see that?

A Yes.

Q Can you say whether you have a recollection of that being Dr Inkster's advice at that time?

A Yes, I think that she felt that cryptococcus was a risk to haematology-oncology patients clinically.

Q And that it was being reported that there was cryptococcus, albeit of the species albidus, that was found in the ward. Is that your understanding?

A That's what it says.

Q Okay. If we go, please, to over the page. I just want to sort of pick up on something that might be relevant to communications in this period. It is page 262, and if we go down-- scroll down the page a little, please, and the paragraph that begins "Comms", if we can enlarge that:

> "JRE informed the group that a number of parents went to the Scottish Government on Sunday with concerns relating to the communications from the IMT particularly those provided to outpatient haemato-oncology population."

Do you have a recollection of that being discussed?

A I do.

Q Yes. Are you able to help us a bit with what that is about?

A So I think that was about the communication initially, which had focused on the inpatients at any particular time, and that we had to widen it to a much broader group of haemato-oncology patients. I can't specifically remember the timelines but, around that and the interactions with Scottish government, I think, was when we started to look at communication as part of the overall process we were in.

Q Yes, I mean, just sort of pausing there and taking a step back. Thinking about your general evidence about communication that you give in your statement, do you recall that there continued to be concerns around the way in which the organisation was communicating with patients and families?

A Up to that time?

Q Yes.

A Yeah, I think so because there were parents that obviously had went and met with Scottish Government that expressed that.

Q Okay. If we go on a bit, please, in time, I wonder if you can help us with a detail from this time. It is page 274 in this bundle. I think, again, we see it is an IMT that you are present at.

A Yep.

Q All I want you to do is help us with one reference if you are able to. You may not be able to. If you go to page 276, under the heading "Press":

> "Some members of this group may not all agree with the press statement but not everyone across the multidisciplinary colleagues who attend the IMTs will, so it is about getting the balance correct."

Do you see that?

A Yes.

Q I have got again two questions. One, do you have a recollection of a discussion of that nature? Two, are you able to help us with what that is about?

A I don't have a specific reference to remembering that particular line, but I do know that in IMTs there would be different views often articulated and, that may be a situation that would have prompted that, and that we would need to take a balance based on the different views.

Q Okay, but just to be clear, you yourself do not have a clear recollection of what that is about?

A Not that specific issue there, but I do-- I have experience within IMTs where there will be

different views between Estates, between Microbiology, Infection Control. In particular, there would be differences of view-- or the Clinical team. That would be a natural position, I think, around when you were working through hypotheses and the solutions there.

Q I will emphasise that I do not claim an encyclopaedic knowledge of all of these IMTs in framing the question I am about to frame but, I certainly do not recall an observation like that being flagged in any of the other ones that I have seen, and I am just wondering whether you have a recollection of there being a concern around a press statement around that.

A I don't have a recollection of that press statement.

Q Thank you. Now, we know from the evidence that we have already-- We can put that to one side, thank you. We know from evidence that we have already had, Mr Redfern, that there was a decant of the patient group from 6A back to the Children's Hospital to the CDU. Is that right?

A Yes.

Q I think we understand that to be-- to have happened between 22 January and 8 February 2019. Would that chime with your recollection, yes?

A Yes. Yes.

Q Yes. What was the reason for that, as far as you recall?

A There was an incident--hopefully I will get the correct days as not dates. There was an incident identified on the Friday evening with some mould in the ward in a particular area, and some Estate work was being carried out around the investigation of that. It was felt that that could be contained through the SCRIBE and work that would be done to remedy it.

When that work was carried out on the--by the Saturday morning, I got a phone call from Dr Inkster saying that as they had investigated the area in more detail, they had found more mould than they'd expected and that our view was for the safety of patients, a cohort in that vicinity would have to be moved and would, therefore, have to be moved to the Children's Hospital. As a result of that further work and also trying to protect the service in the basis of not fragmenting it across a whole range of different areas, an area had to be identified and CDU was identified.

Q In the children's hospital?

A Yes.

Q A couple of points on that. Mr Redfern, do you have a recollection of the extent of the problem as reported by Dr Inkster or anybody else.

A I would say the extent was quite significant enough for us to carry out the actions that we did, enough for me to come in on the Saturday and enough for me, Professor Gibson and Dr Inkster to, late into Saturday evening, walk right across the hospital to all haemato-oncology families, explain to them what was happening and how we were going to take this matter forward.

Q Yes, maybe just to help you and help us understand the extent of it, if we go, please, in bundle 1 to page 291. There is an IMT of 25 January 2019 at which you are present. Is that right?

A Sorry, yes.

Q If we go on, please, to page 2-- Forgive me, if we go on to page 292 and under "Ward 6A Update":

> "Dr Inkster and Dr Hood did a walk round of Ward 6A. They met the contractor in charge of the shower work who informed her that 80 per cent of the showers were affected by mould."

Does that accord with your recollection of how extensive it was?

A Yes, it was-- As we carried out more exploratory work

around what the problem was, we identified a bigger problem than we'd first envisaged. So, as I said on a Friday night, we thought we could contain that within a SCRIBE and a piece of work but, as we carried that out, Dr Inkster-- well, it was plain for anybody to look at, we had identified that there was more mould than what we had first anticipated.

Q Yes. I think I possibly indicated that I had another question I was going to ask in relation to this stage of matters. The move back to the children's hospital, did that give rise to any particular concern on your part?

A It was a very difficult set of circumstances. Families were-- obviously had been through the move from the hospital to 6A and were now going back. I think there was an uncomfortableness about the whole environment within the campus. I had to, along with the clinical team, manage that as best we could and reassure, primarily with the purpose not for families to take children out of the hospital while they were under the care of the haemato-oncology service.

Q Yes. Just thinking back to----

A That was why we did the walkabout round every day, speaking

to everybody, explaining to them what was the cause, how we were going to manage it and how we were going to try and protect in a safe clinical environment.

Q Okay. Just thinking back to the references or the reference that we saw in the IMTs from September 2018 about a perception that it would not be safe to have the children in the children's hospital at that time. Was the prospect of moving them to the CDU something that concerned you?

A In terms of moving from 6A to CDU?

Q Yes.

A It wasn't an ideal set of circumstances, both for how we used CDU at the time, which was part of our emergency plan during that period in the winter. It was obviously not ideal. It had moved the haemato-oncology patients again, but it was a necessary action we had to take. So these were not ideal situations, but we had to operate on the best information we had available. We had moved-- nobody moved into 6A thinking that there was going to be the mould that we had found in that environment at that time, and that what we had to do was similar to what we had to do in September was have as robust a process in place that protected those

families and children as much as we possibly could, given the circumstances we had.

Q What was your assessment of the impact of all of this, all of the events that you have been describing, culminating in this decant to the CDU? What was your assessment of the impact of that upon patients and families?

A It was very challenging. The natural position would be, I think, for anybody to take was, "We have moved from A to B. We are now moving from B back to A and, you know, when will we ever get this right?" I think that would be something that I had to best manage as much as I could with Dr Inkster and the Clinical team.

Q Yes.

A But I can understand why families felt how they felt.

Q What about as far as the staff were concerned?

A Again, yes, there was a confidence-- The natural impact of that will be a confidence in the environment that we have within the campus, I would assume.

Q As we move a little further into 2019, into the summer of 2019 when I asked-- I put to Professor Gibson evidence that had been given by the patients and families that they were at breaking point at that stage, and she responded that she accepted that, but that staff were at breaking point as well. Would that be how you saw matters?

A I don't know whether I would use the words "at breaking point" but, we were trying to manage staff morale, and the fact that we were in another detailed IMT, and around that time, we were actually making pretty big decisions which I'm sure you'll come on to in your questioning to me, that would not have made-- You know, it wasn't-- it just wasn't not an ideal set of circumstances to be faced with, so I could see the challenges both for parents and families and also for staff.

Q Yes. Well, let us move a little further into 2019. Now, we have had quite a bit of evidence that has set out the narrative of what happened from the perception of the clinicians and the concern that they had around the return of, as they saw it, and as Dr Inkster saw, unusual infections, and how that then played out over the next weeks and months until-- Sorry, let me pause, including effectively a restriction on Ward 6A for new patients and then the reopening of it. Now, I am not proposing to ask you anything

in particular about that because we have got your position in your statement and we have had all of that evidence. There is one aspect of that stage that I would like to clarify with you, though. That is about your involvement in relation to a particular matter, and that was communication around cases of Mycobacterium chelonae, okay? Now, I want to begin with some context, and I will put some context to you and ask you to say whether or not you accept this context. An IMT from 2018, which we did actually look at briefly, indicates one or perhaps two cases of Mycobacterium chelonae being identified among patients and reported to an IMT at which you were present. Do you have a recollection of that?

A Yes.

Q Yes. Now, we have had evidence from the patient's father, and also we have statement evidence from the treating clinician that they had wished for the water to be sampled and tested, but this was not done. Do you have a recollection of that?

A Sorry, what time period are you talking about, 2019 or

Q 2018?

A I don't have a formal recollection of that.

Q We have evidence in

statement form from the treating clinician that the 2018 patient had mainly been in a hospital prior to contracting their infection, and that the treating clinician believed the source of the infection to be environmental. Now, is that something that you have any recollection of?

A Sorry, I have a recollection of meeting with the parent we're talking about. I have a recollection that there was an unhappiness that the case was not included in the cases that were considered core to the IMT at that time, but it was classed as a case of interest. I have a recollection that Professor Inkster explained why that was, and it was a technical issue around the definitions and working practices of an IMT, which she referred to. But I also have a recollection that Professor Inkster carried out investigations thereafter around that particular case and hence why it was a case of interest.

Q Thank you, and just to be clear, you are talking about discussions in 2018, I assume?

A I can't remember the timelines of what year it was but it would have been around then, I think.

Q Yes, okay.

A I do remember the parent

being extremely unhappy that his child was not classed as part of the core IMT caseload, but as a case of interest.

Q Okay. Now, again I am just trying to set the context, and the understanding that we have is that the events that I have just been describing took place in 2018. There is a couple of other aspects to that context I just want to ask you whether you recall. Do you have a recollection of whether you agreed to be, as it were, a single point of contact for the----

A I did.

Q For the patient's father. Is that right?

A Yes.

Q Again, forgetting events in 2019 – we will come to those – do you have a recollection of whether there were further discussions in the later part of 2018 between him and you, regarding the question of whether the hospital was safe, and in which he highlighted concerns about the possibility of further cases of Mycobacterium chelonae?

A I think that-- my recollection is that there were concerns around the safety of the hospital environment. That ranged from a variety of different things, from the infections that were occurring, to

the wider infrastructure in the hospital, the glass falling off the building, or whatever other, sort of, unfortunate occurrence that happened on the campus. I cannot remember him specifically saying that there was a whole host or potential-- of other cases, although he was unhappy with how that particular infection was being treated, as I said, as a case of interest. But my understanding was that Dr Inkster, although it was classified as a case of interest, did carry out further investigation. As you know, subsequent to that, a second case was clearly identified.

Q Well, we will come on to that in a minute. I think it is important that we do not conflate things. All I was really asking is-- I will just clarify my question. The understanding, or rather the suggestion, that has been put to me is that there may have been a conversation with you in which the patient's father – and this is in late 2018 – raised a concern about the possibility that there would be further cases of mycobacterium----

A I think he did raise that concern.

Q Yes, thank you. Now, I want to move to the summer of 2019, and what I am going to try and do in a minute is get an understanding of your

recollection of events. I want to try and do this in a way that is easiest for us all to follow. So what I want to do at the start is really just to understand the nature of any investigations that you have made about what went on in the summer of 2019 in relation to communication with this particular family, the 2018 family.

A Yes.

Q Okay, so I am only interested in that in a minute and I am going to ask you some questions about that. In a little while, I am going to look at an email that you wrote to-- and we are going to have to name the patient's father, Professor Cuddihy.

A Yes, I know who you're talking about.

Q Yes. In a while, I am going to ask you to look at an email that you wrote to him after he had expressed his unhappiness. You said that you had made inquiry with "senior colleagues." Do you know the email I am talking about?

A Yes, I think so, yes.

Q Yes. We also know that Professor Cuddihy subsequently raised concerns with the chairman and with the chief executive about communication over that piece. Is that right?

A I wasn't party to the

direct communications that Professor Cuddihy had, but I can make the observation that that happened.

Q Yes. thank you. Again, it is helpful that you do confine your answers in the way that you just did. I just want to understand what you understand.

A I fully understand the circumstances to this situation.

Q Yes. I think you are aware that he gave evidence to the Inquiry in October 2021 and expressed grave concerns about what he saw as a failure by the Board, by the organisation, in its duty of candour to a patient. Do you understand his position?

A Yes, I understand the situation, yes.

Q Now, at the time in 2019, were you still the general manager for paediatrics and----

A Yes.

Q Yes. You are now Women and Children's director. Is that right?

A I am, yes.

Q Yes. As we have established, you are aware that one of the patients and families makes, as he sees it, a grave allegation of a failure by the organisation in its duty of candour. So, thinking about what you

said in your email about speaking with senior colleagues and thinking about all of the profile that this matter has had, and thinking about the senior position that you adopt and that you have in the organisation, what investigations have you made, prior to today, as regards what actually happened over this period of time?

A So, I think-- Can I explain the context of how we got here? Because I think it's helpful in terms of answering your----

Q If we just take a step back. I will take you through all of this.

A Okay.

Q I just simply want to know, have you made investigations as to the issue around the allegation of an absence of candour, arose?

A I have not formally asked for an investigation from the Board chief exec or the chairman. I didn't think that was my place to do that given the circumstances I'm going to describe around this.

Q Okay. Well, we will just go through it in detail, then. So, if we begin please by going to the bundle of IMTs and we go to page 320 of bundle 1, please. Now, this is a IMT at which you are not present, I think, Mr Redfern, 19 June 2019. Is that right?

A Yeah, I can't see my

name on the----

Q No, and if we go over the page to page 321, you see the heading "Atypical mycobacteria"? You see that?

A Yes.

Q If you just take a moment to look at that paragraph.

A Yes.

Q Okay. So, I think with the key points maybe being that the IMT had been alerted to a case of Mycobacterium chelonae. Is that right?

A Yes. Yes, the reference here was, as I said, that at the time when we had earlier looked at why the first case was considered a case of interest, because there was only one case. Dr Inkster had explained to the parent the process it would fall under, such circumstance and why she was classifying that as that. This articulates that a second case has came, because back to the point that you're saying that said parent thought that there was a risk that a second case or a third case could occur. At this point in time, that is suggesting that a second case did occur.

Q Yes, and I think Dr Inkster seems to be indicating that----

A Her position would change in terms of the way she was

treating the original case to this case.

Q Yes, well, we will come on to that in a minute, but if we just stay----

A Sorry.

Q It is quite difficult, especially with the redaction. So, if we call it the 2019 case, as far as the 2019 case is concerned, in the context of a discussion on that, I think she is saying that Mycobacterium chelonae had been isolated from sampling on 6A. Is that right?

A Yes.

Q I think maybe this is the point that you are making. She is now saying----

A She's changing her position.

Q Yes, two in one year is data exceedance. Is that right?

A Yes. She's changing her position.

Q Yes. Yes, and there is to be a timeline done on the recent case. Is that right?

A Yes.

Q Yes. Now, again the redacted----

A As there would be because it's a case-- a reference to the IMT.

Q Yes. In the redacted section, I can tell you that there is an indication that there is to be a review of the previous case. I mean, you have obviously looked at this matter before. Can you say whether that accords with your recollection?

A My understanding was that there already had-- as I've said, based on the meeting we'd had with the parent, Dr Inkster had carried out earlier work on that particular case, but then reinforced it with further work.

Q Yes.

A Which I think is entirely appropriate on the basis of what is mentioned in the minute.

Q Thank you. That is exactly in line with what is underneath the redaction, that there was going to be further investigation because of this. Would that be your understanding?

A Yes, I think that is appropriate based on the reference, "Two cases in one year considered to be a data exceedance."

Q Yes. Okay. So, if we go now please to page 323. I am looking at the communications section. Just enlarge-- Yes, that is helpful. I am not interested in the reference to GNBs. It says of M. chelonae:

> "Further information to be gathered in respect to timeline and water testing. Comms will

then be prepared for parents. It was agreed that parents of the current case would be spoken to by Professor Gibson on her return from leave next week."

Do you see all of that?

A Yes.

Q I just noticed a little further down, under "duty of candour," it says, "Discussed under comms for patients/parents." Yes?

A Yes.

Q I appreciate you were not there, but I am assuming this is an IMT minute that you will have seen before.

A Yes.

Q Yes. Are you able to help us with what, if anything, we take from the reference to duty of candour?

A That the patient who was part of the IMT, as I've described before, should be given all full reference to the fact that their child has an infection, and what is happening to them as a result of that, and what may have caused that infection, as been discussed at the IMT.

Q That latter bit you would expect to be part of the discussion as well? Is that what you are saying? With the patient, I mean.

A Yes.

Q Yes.

A I'm a bit surprised that it's Professor Gibson that this minute says is doing it because my understanding was the patient came under Dr Sastry, but if the minute says Professor Gibson----

Q I think this is why it is going to be quite important to go through this quite carefully. I think the reference to Professor Gibson is because Professor Gibson was involved with the 2019 patient. Dr Sastry was involved with the 2018 patient. Does that help?

A Right, sorry. Yes, yeah, you're correct. Sorry, that's my mistake.

Q No, no, not at all. In terms of that section on duty of candour, do we take anything from the fact that there is a reference to "patients," plural?

A Sorry, where are you again? Sorry, just so I'm clear.

Q Just where the cursor is, Mr Redfern.

A Yes, because I think that we were moving into the position that we should be having a discussion with both parents of case 1 and case 2.

Q Okay, that is helpful.

A And I think that is entirely appropriate given what we've just described.

Q Yes, that is helpful.

Thank you very much. Now, could we go to bundle 8, please? I just want to try and walk us through the steps

as we have seen them, and I emphasise as we have seen them. I absolutely acknowledge that there may be more bits of correspondence out there that we have not seen. So, if we go to bundle 8 please and go to page 68. Now, as ever with emails, you have to jump about slightly but, if we start at the top of the page, we see it is an email of 19 June to, among others, Jennifer Armstrong and you. If we go over the page, we see it is from Dr Inkster.

A Yes.

Q Do you see that?

A Yeah.

Q If we can take us back up towards the top of the page again:

"Presumed source is areas outwith Ward 6A without filters on where patients may have been."

Do you have a recollection of seeing that email at the time, or have you had cause to look at it since?

A In terms of this overall episode that we're covering, it's not an email that I recall as being fresh in my mind but, I am copied into it, and therefore would confirm that I have seen it and read it.

Q That is great. Thank you for that. It is really just to try and understand the chain of events. If we move then to page 67 in this bundle. If we go to the foot of the page, that looks as if it is an email from you on 19 June forwarding Dr Inkster's email. If you want to go over the page just to check that, we can do that.

A No, I take it that that's what I'd----

Q Yes. It then goes up to Mr Dell. We see there is a reference under 19 June 2019, Mark Dell, "Sitting with Jamie and he passed this on," and then at the top of the page there is emails involving Sandra Bustillo and Mark Dell. Mr Dell says:

"I've just spoke with Kevin. He's letting Jane and Jonathan know."

Do you see all of that?

A Yes.

Q Now, do you know what it was that he was letting Jane and Jonathan know about?

A I can't be specific because I don't think I was copied into this email conversation but, I can make an assumption that it was-- we had a second case and that it was linked to discussions that we had previously had and previously described around the fact that this would involve Professor Cuddihy.

Q Okay. Just so we are all clear, Jane and Jonathan would be Jane Grant and Jonathan Best?

A Yes.

Q Was it usual for the most senior members of the organisation to be

alerted about individual infection cases?

A Only through the IMT process.

Q Was it usual for that to happen?

A Not for this email exchange, I don't think.

Q So, what we are seeing here----

A Well, I can only see what I oversee, so I don't know whether that has happened in the past or not, that I've not been privy to being copied into it but, in terms of my expectation, I wouldn't necessarily have expected that to happen.

Q Okay, thank you. Now, if we go please to bundle 1 to page 325, and again just take a moment to satisfy yourself that that is an IMT of 25 June. I think we see in the second line that you are present.

A Yes.

Q Again, if you will forgive me, what I want to do is pick up some of the

details in the IMT, and then I am going to ask you for your recollection of what happened, and hopefully that assists you in what you say. So, if we go please to page 326. I am interested in the section that is underneath the heading "M.chelonae." I am interested in the second paragraph and the final two sentences. Now in all fairness to you, Mr Redfern, if you want to take the opportunity to read both paragraphs, that is absolutely fine by me. So would you want to do that?

A Yes, I will.

Q Yes. Thank you. Now, I mentioned that I am interested really in those last two sentences, and I think it is maybe just to ensure that we all understand what was being said. It says:

> "Dr Inkster informed the group that the incubation time for Mycobacterium chelonae is 15 days to 8 weeks. This puts the second patient present in RHC theatres where they had their line manipulated."

Would we be right in understanding that Dr Inkster is indicating that the 2019 patient is being-- No, let me ask you, what do you say that means?

A I think that if we are

looking at why-- if there was an environmental link to the infection that has been discussed at the IMT, then Dr Inkster's timeline would suggest that that environmental link would be around the patient's activity within theatres and what was happening to them in the theatres, but you would really need to speak to Dr Inkster about anything further. I would be speaking completely out my education zone. That's what my reading of that is.

Q Yes. That is mine too, that effectively she is saying the timeline on

this puts the patient----

A As part of an IMT process, what they will always do is look at a timeline of a patient and try and identify where the potential source of the infection has come from, if classed as environmental. As a result of that, I think that's what she's saying there.

Q Yes. So what she is saying is the timeline is putting this patient, as it were, outwith 6A and in the RHC theatres at a time that would match the incubation period for the infection.

A I think that's what she's saying, yes.

Q Now, if we go over the

page, or rather two pages, I think, page 328. If we look at the "Hypothesis." It is just that first paragraph, and again just take your time and read that first paragraph and indicate to me once you have.

A Is it okay if I read the whole section?

Q Absolutely, absolutely. If you want to scroll down, tell us, but if I help you, Mr Redfern, I am going to take you down and show you some bits in the communications section.

A Yes, so I've read it now.

Q That is helpful, thank you. Now as I say, I am still just interested in the first paragraph:

"The M.chilonae(sic) patients have had contact with unfiltered water. It has built up in the water system as it takes years for biofilm to be created."

We possibly do not need to take it any further than that. What is it that you understood, or understand now, was being communicated in this hypothesis?

A That the patient had contact with unfiltered water and therefore was at risk of the water-- or how the water was presenting, I suppose.

Q Did you say "the patient" or "the patients"?

A I can't recall whether it

was “patient” or “patients,” but I would assume it says “patient,” so I assume it’s both.

Q Yes. I think-- Yes. If we go down the page to the foot of the page. Now, I will help you a bit here. The redacted section is about the 2019 patient. One thing I can tell you without any concern about the patient confidentiality aspects is that it indicates that Professor Gibson is going to be speaking to that patient’s family the next day. The bottom part, in which you are mentioned, if you take a moment to look at that and indicate once you have done that.

A Yes.

Q Now, if we just take this in stages and then I will ask you just to give us your recollection of anything else at this stage that you consider pertinent. Can you confirm whether that indicates that you will be speaking with the 2018 family?

A It does.

Q Yes. Can you say whether it indicates-- the bit about a process in how we contact the first patient’s family, what do we take from that?

A I think what we were, from my perspective was that I’ve described the unhappiness that that parent had in terms of how the hospital

was perceived to be handling it, and that he had indicated that, you know, that unhappiness could lead to-- as not carrying out investigation that might prevent a second case and we now had a second case. I think that’s what the summary of position was, and that was how we would be looking at how we would communicate the circumstances of that to that parent.

Q Can you confirm whether, at this point, you understood during the IMT that you were to be speaking with the----

A My understanding was that I would, given the trigger point of when it was the right time to speak to said parent, was I would speak to them, yes.

Q Sorry, just so I understand that, are you saying-- Can you confirm----

A There had to be a sequence of events, so we had to make sure that the first patient-- sorry, the second patient was aware of, you know, following duty of candour through the IMT process and then as a result of that, we would speak to the first patient. There’s a degree of confidentiality within all of that, but my understanding was that following the IMT’s natural process for the second patient, there would be a discussion

with the first patient.

Q Okay. So-- Sorry, on you go.

A Parents, I meant discussion with parents.

Q Can you say whether-- just to be clear we understand your evidence on this. Can you say whether-- Are you indicating to us, therefore, that the instruction, at the time of the IMT, was or was not for you to proceed now to speak with the first patient's father?

A I don't think I'd been given the go-ahead to do it, but the implication was that Dr Inkster and I would speak to him.

Q Okay. Now, the next thing I want to look at is some correspondence from that day. If we go back to bundle 8 and if we go, please, to page 73. We have got an email from Sandra Devine to Jennifer Armstrong on 25 June 2019. Do you see that?

A Yes.

Q If we over the page, please, to page 74, and if we enlarge the section underneath "M. chelonae." It says, "Clinical team" or "Women and Children's senior management team," would that be? You see it?

A Yes.

Q "We will speak to the families of both cases tomorrow." See that?

A Yes.

Q So, would that indicate that Sandra Devine's understanding was that on the day after the IMT, there was indeed going to be a discussion with the first patient's family?

A I think that's what it says, yeah, and I would expect that to happen. My understanding was that there would be a formal discussion with both parents: patient two first, patient one second.

Q But just on the particular observation by Sandra Devine that she expected both of these conversations to happen on the following day, can you say whether that is or is not the same as what you understood to have been said at the IMT of 25 June?

A I can't remember the specifics of what the timeline would be in terms of what day it was going to be, but it would be relatively one straight after the other, yeah.

Q That is helpful. So, your expectation would be that----

A I was never of the understanding that we would ever not speak to patient one-- parent one, sorry.

Q Your understanding was

once parent two was told, parent one can be told.

A I've articulated that to said parent of parent one(sic).

Q Just so we are clear, are you saying that, as you saw it, at that time, in relation to both patients, there was an engaged duty of candour obligation to say something?

A That would be my position.

Q Thinking about what we saw in the IMTs and the reference to duty of candour, was it your understanding that that is how the IMT saw it as well?

A Yes.

Q Now, if we turn then to the next day, which is 26 June 2019-- You can put the document to one side. Thank you. Now, we have had evidence in the Inquiry already from one of the parents of the second patient, and the evidence that she gave would fit with a meeting with Professor Gibson around that day. She says, in her evidence, that she was advised about the nature of the infection, its rarity and the need to investigate treatment options. Okay? Now, so we are absolutely clear, I do not think I took her to say that she was told at that point about the cause of the infection.

A I don't know. I wasn't part of it.

Q No, I know that. I just want you to be sure----

A Okay.

Q -- you understand. That is my understanding of the timeline on the second patient, but there was a conversation that fits with it being about 26 June, and according to the patient's parent, the content is as I have described. Now, the evidence of Professor Cuddihy is that there was no similar conversation with him or his family at that point. Is that your understanding?

A No, I never spoke to Professor Cuddihy about it, as indicated in the previous iterations you've said. I never had that-- As we will come on to later, I never had that conversation with him.

Q I will give you the opportunity, Mr Redfern. I promise to let you give your explanation of all this, but the timeline is tricky. It needs to be nailed down. So, your position is certainly, at least as regards to 26 June, you, yourself, have not had any conversation at all. Do you know whether anybody else had had such a conversation?

A My understanding was-- Sorry, I think I'm still doing what you

don't want me to do, but my understanding was that, as it became apparent in a further meeting with parent one, somebody else was going to have that conversation.

Q We will come on to that. Let us just try and take this day by day.

A Sorry.

Q No, it is difficult. So, if we go back to bundle-- rather, if we stay on bundle 8 and we go to page 80. As ever with emails, it is never easy. So, if I ask you to go, please-- I do not know if your Lordship has that in front of him, but page 80, at the very foot of the page, we see from Jamie Redfern.

THE CHAIR: Yes.

Q If we then go to page 81, I will just ask you to-- I mean, I assume you agree that seems to be an email from you to Mr Hill and Mr Dell(? 02:04.45). Is that right?

A It looks like that, yes.

Q Thank you. Now, I have got two questions, one of which is self-evident. We see you telling Mr Hill that family number one has to be urgently notified. Is that right? Or urgently dealt with?

A Yeah, I would never like the situation where a family is in a position where they don't feel that they are being informed of the appropriate

information that they think they should have. If we feel that that is a risk then that is part of the job I had, which was to test the temperament of whether or not we were experiencing such risks as that, then we should deal with it.

Q We do not need to go too much, I think, into what is said in the paragraph, but it is certainly obvious from it that you certainly were aware that the second family had now been told. Is that right?

A I think so, yeah. Sorry, the delay of speaking to the first-- Sorry, it's tricky. The delay of speaking to the second family-- the longer the delay not speaking to the to the first family, to my view, was a risk.

Q Yes. I think, if we take the sentence, "I was also informed that the parent immediately following the meeting with Professor Gibson and Teresa." Just stop there. Would it be fair to say that you understood, by this point, that the second family had had their meeting with Professor Gibson?

A I think so, yeah. That's what that's saying.

Q And thus would be aware of the infection in the second patient's case, yes?

A Yes.

Q This is you saying to Mr Hill, "We need to deal urgently with the

first family."

A Yeah, that's what it says.

Q Now, there is a reference to an email earlier today, and that is not one I have identified in the bundle, and I am just wondering whether there might be other email correspondence involving you that might help us understand what was going on here. Can you help us with that?

A Sorry, presenting emails to you?

Q No, hold on. It just says, "We need to urgently deal with this family, noting my email earlier today." Do you see that?

A Yeah, so that's saying that I've-- basically sent an email earlier.

Q Prior to giving your evidence today, have you had a look at correspondence from this time to help refresh your memory?

A Yeah, I have but I'm clear in my mind of what the key events were around this. I've maybe not specifically-- I haven't been into the forensic level of hour by hour, day by day of what you've said, but I do know the fundamentals around this and what I had expected to be achieved and what was carried out and where the concerns from Professor Cuddihy came from.

Q Are you able to say what it was that you had noted in your email from earlier in the day?

A That the risk of-- My general position would have been that the risk of not carrying out function of the IMT and the longer we did not do it, was creating a problem for us.

Q Are we to understand that you had a concern that it was not being pushed on quickly enough?

A I had a concern that the parent had a concern, and it was being articulated to me and that it was a situation that I wanted to try and resolve so that we didn't have that concern and that the parent was fully informed.

Q Okay, thank you. Now, if we go to bundle 1 again, please. It is page 330. The IMT, 3 July 2019, and you are not recorded----

A I was on holiday, which I think is pertinent to this whole bit of episode.

Q I will ask you about that in a moment, I promise. The evidence that we have had from Professor Cuddihy is that, up until this point – again just working through the timeline – up until this point, he still had not had a notification from the organisation about the second infection. Would that be your understanding?

A Yes. Well, I was on holiday, so I don't know what was going on when I was on holiday, but and-- Sorry, I'm jumping ahead again, but by what he had described to me at that time then, in reflection back, yeah, he hadn't been informed of it.

Q So, if we look, please, at the IMT of 3 July. Although you were not there, is this an IMT that you have had cause to look at subsequently?

A Yes, I have.

Q So if we go, please, to page 331. Go to the foot of the page. Do you want to just read the paragraph, the "Water samples" one?

A Yes.

Q Now, mindful of what you said about not being a microbiologist and I have the same issue, obviously. I would just be interested to know whether you yourself have made any investigations about what that paragraph should be taken to mean.

A I haven't spoken to Dr Inkster about it specifically, but what I would suggest that is saying is that she's still carrying out typing or other investigations around the infection, and every bit of information she gets will help present the picture but that she is classifying this as an environmental infection, HEI. So, she is saying as part of the IMT process this patient is classified as an HEI. I think that's pretty explicit.

Q Okay, thank you. If we go over the page, please, to page 332 and if we go to the foot of the page, "Hypothesis." Obviously I'm only interested in the M. chelonae cases. The M. chelonae cases, the group is working on the assumption that it is due to patients/staff having access to unfiltered water throughout different areas of the hospital. Can you confirm whether it is your understanding that the use of the plural is deliberate, i.e. that this referred to the 2018 and the 2019?

A I think, at that time in the IMT, we were talking about the two cases. Although, I think this is the IMT that I was on holiday, but I think that's what we were-- what they would be doing.

Q Okay. So, if we then go over the page, please, to page 333, and if we go under "Communications Public," we see "duty of candour." "Prof. Gibson is speaking to the most recent M. chelonae patient parents on Tuesday. The chairman of NHS GG&C is in communication with the father of the first case." You see that?

A Yes.

Q Now, if we take the second patient, the 2019 patient. As I

have said, the evidence we have got and confirmed by your email, I think, indicates that there has already been one conversation with the second patient's parent about there having been an infection. Is that right?

A Yes, yes.

Q So there's now to be a further conversation?

A Yes.

Q And that is in the context of duty of candour. Is that right?

A Well, it's under duty of candour, and I never took the minute and I wasn't at the meeting, but that's what it's there as.

Q Yes. Again, I will-- it may or may not assist. This IMT took place on a Wednesday, and so it is indicating that on the Tuesday of the following week, so Tuesday 9 July, the second patient is going to have a discussion with Professor Gibson. Is that what you would take from that?

A Yes. As part of the IMT process and as a child having an infection and what we've described, at the time, now with the duty of candour, there's new legislation that had come into force, then the doctor of the patient would explain the whole process around the infection that would meet the principles of duty of candour. I think Professor Gibson,

although you've mentioned that they had said they didn't, the reason for infection hadn't been described. I don't want to contradict him, it wasn't up-- but Professor Gibson, from my experience, always follows duty of candour to the letter of the law.

Q Yes. As I have made clear previously, there is no question of any clinician in this Inquiry, certainly as far as I am concerned, being under the microscope, as far as their clinical conversations are concerned, but just on that point, the further evidence of the second patient's parent is that there was, indeed, a second conversation with Professor Gibson in which Professor Gibson indicated that the infection was understood to have come from the theatres in the RHC.

A I think that is what has been described in the minutes and I think that would follow the duty of candour process.

Q Okay, so that is this 2019 patient. Now, still looking at the duty of candour section in this IMT minute, and if we can just confine ourselves to this stage of things, what would you understand the bit about the first case to indicate in relation to the duty of candour?

A That the first parent should be spoken to in a similar

context to what we have just described on the duty of candour.

Q So, you would take it to indicate that there is to be a similar conversation?

A I would have felt entirely comfortable when the scenario that was presenting, that the first parent had an experience of being unhappy about how his child had been treated through the IMT process and investigations carried out. He had indicated that there could be a second or further cases and that we had been presented, through an IMT process, with a second case and that Dr Inkster had indicated that two cases were, you know, they were what she described them as. I can't remember her specific words, but was worth further investigation and on the basis of that we would be notifying both parents. That's my understanding of the circumstances.

Q Sorry, yes, and I think as we have seen in this IMT, at least by this stage, and I think Dr Inkster's hypothesis was that that there was a connection to unfiltered water. Is that right, in both cases?

A I cannot recall what she was referring to with the first case, but certainly in the second case, she's clear about that, but as you say, the word "patients" is used, so I assume she's relating to both.

Q Yes, thank you. So, staying then with this duty of candour section of the IMT, you have indicated that there is to be a communication of that sort with Professor Cuddihy. Is there anything on this that indicates to you who it is that is to do that?

A Well, under the minute, it says duty of candour, the chairman of NHS Greater Glasgow Clyde's communication with the father of the first case. Whether that is devolved to somebody else while I was in holiday, I don't know.

Q Is that something that you have investigated?

A I have asked since the events not have-- at the time, as we're going to explain the sequence of events, I asked for explanation at that time.

Q Do you know whether or not the position at the IMT was that the chairman was to handle the duty of candour communication?

A I don't know whether it was, as I said, the direct responsibility-- the chairman would do that or whether it was devolved via the chairman to somebody else. I don't know the answer to that.

Q I mean, obviously, we

have got to proceed with some care here because, as I say, I absolutely acknowledge that I will not have all of the correspondence or reports that bear on this, but you have indicated that you had made some investigation.

A There was a sequence of events that prompted me to do it through my own personal sort of professionalism.

Q Was one of the things that you investigated the question of whether or not it was for the chairman personally or for the chairman to delegate?

A No, I didn't ask specifically. It was a more general position around the situation and events unfolded as----

Q Okay. Well, we might come back to that, but certainly the evidence of Professor Cuddihy is that there was no equivalent conversation to the one I have just described as having happened with the second parent. Would that accord with your own understanding?

A Yeah, because I had correspondence with Professor Cuddihy thereafter, which he clearly illustrated that.

Q Now, the evidence before the Inquiry is that, on the following day, there was a letter from the chairman to Professor Cuddihy in which the chairman discussed with Professor Cuddihy aspects of his daughter's case but said nothing about the further case. Is that a piece of correspondence that you are aware of or have seen?

A No, not that I'm aware of.

Q Are you indicating that you are not even aware that such correspondence happened?

A There was correspondence. I am aware there was correspondence between the chairman and Professor Cuddihy and I'm aware that there have been meetings since then with other key senior officers with Professor Cuddihy and members of the exec team. I wasn't part of any of those meetings.

Q So, I am just thinking about where we have got to in the timeline. Your understanding is that the duty of candour, communication – and please, say if I am not understanding your evidence – the duty of candour obligation sits with the chairman or will be delegated to the chairman to somebody else? Is that right?

A That's what my understanding of what the minute says, but I wasn't at the meeting, so I don't know the context of the

conversation. What I am clear about is, prior to going on holiday, there needed to be a conversation with parent one.

Q Yes, and we saw your email emphasising that to Mr----

A I don't deviate from that whatsoever. It is who has that conversation and at that time I went on holiday. That is my knowledge of that particular time of events and I can pick up, when we get to it, of when I came back from holiday and what happened thereafter.

Q I will do that with you in a minute. We are just about there.

A I know I'm desperate to get to that, but I think it explains the situation.

Q We are nearly there, I promise you, but we are quite anxious to get a timeline, so if you will forgive me, I will keep proceeding in that way. The evidence that we have had, Mr Redfern-- and I appreciate, especially as you are on holiday, you may not have known about this. The evidence that we have had around that this time – and this is evidence from Professor Cuddihy and his daughter – is that around this time in a clinic with Dr Sastry, Dr Sastry mentioned that there had been this further infection.

A Yeah, I was aware of

that.

Q Something else that no doubt you are aware of is that he then, as he put it in his evidence, he waited for a spell because he assumed that there would be a communication about this, and then eventually he wrote to you in pretty strong terms.

A Yes, that's correct.

Q Again, you have indicated that you have made some investigations into this matter. I'll be right in understanding that—sorry, take a step back. The email he sent to you----

A I was extremely upset by that email.

Q Yes. As he put it in his evidence, he did not miss and hit the wall in it.

A Yes, and I found it very unfair to me, personally, and that was the conversation I had with Mr Hill.

Q We will come to that in a minute. Are we right in understanding that, from the investigations that you made that there had still been no communication, official communication, by the organisation by this stage?

A No, that's not entirely correct. Sorry, what timeline are we on? Am I back from holiday?

Q At the point that Mr

Cuddihy wrote to you on the 17th.

A Right, so I'm back from holiday, then.

Q So, in the period when you are on holiday in other words.

A When I came back from holiday, the first thing I did was say, "Is this situation sorted?" Part of why I did that was because I, earlier, before going on holiday, was told that I wasn't to speak to Professor Cuddihy, which came out in the meeting with him later on, which I'm sure you'll get to. As a result of that, I was keen to know that the matter was resolved. I was told the matter was resolved by Mr Hill, and that-- I took no further action, and then got a-- I had no reason to doubt Mr Hill. I then got the email that he didn't miss me, as you say, from Professor Cuddihy, and picked up thereafter with Mr Hill and subsequently Mr Best.

Q Thank you. Now, that is helpful because it helps us with the timeline. You indicated an instruction from Mr Hill not to speak to----

A He told me it was being dealt with through other aspects of the organisation.

Q Are you indicating to us that that was an instruction that took place before you went on holiday?

A Yes.

Q And----

A It was-- I mean, these events were all right on the cusp of holiday, but it was not referred to me that there would be a deviation of what the IMT had requested, it was just who was doing it. I was told not to do it, and alert Dr Inkster, of which I did.

Q Can you remember how it was he told you this? Was it in a----

A Informal conversation.

Q Was that at an IMT?

A No.

Q Was it immediately after an IMT?

A I can't remember. It would have been round about all these things. I think it was follow-- it was part of a formal management meeting within Women and Children's, if I'm----

Q What was----

A -- if I remember.

Q Sorry. What was it he said?

A My memory was, it would be a formal MDMT within Women and Children's, that we would be talking about an update in Infection Control and, as a result of an update in Infection Control, we would come onto Ward 2A. And that we were having a conversation around the implications of the IMT and the actions that we were following through, one of which was that we had this situation of the

two cases, and that outwith that discussion, I was told that that request to carry that particular action out was being taken forward by others and I hadn't to do it. I said, "Fine, I'm going on holiday the next day," or whenever it was. "That's fine, I'll leave it." When I came back from holiday, as I said, I asked, "Is the matter dealt with?", and was told yes. So I never took any further action with Professor Cuddihy on this.

Q And did his----

A I never asked for any formal investigation of it or saw evidence of that, I didn't see that as my place. I would take people at face value as part of that process.

Q Yes. Did Professor Cuddihy's email that we have just been speaking about, the fairly direct email, did that arrive after you had been told that it had been dealt with?

A Yes.

Q Yes. So, who was it you had the conversation with about whether it had been dealt with?

A Kevin. Mr Hill.

Q Can you remember, was that in a formal meeting or was it in passing?

A No, that was just me inquiring on us coming back from holiday, saying, "I've read the minute

of the meetings, there's actions to be taken. Has this situation been dealt with?" Because I have expressed in previous emails that you've brought up and showed that there was concern around how we were handling this, and that I was told it was sorted.

Q Yes. Were you told how it had been sorted?

A No, I just was told it was sorted and I didn't need to do anything.

Q Were you----

A And I dropped the matter.

Q Were you told-- Well, if I just pursue this a little, were you told who had sorted it?

A No, I just assumed that it was dealt with corporately.

Q Were you told what had been said?

A No.

Q Okay. So, you then received Professor Cuddihy's email?

A Yes.

Q What investigation did you make after you had received the email?

A I went straight to Mr Hill and showed him the email, and said, "How am I going to respond to this? This is extremely unfair. I've been put in a really difficult position and I'm not happy about it", because of the two

events that I've just described. I was told that I would then meet with Professor Cuddihy. An email was drafted to invite him to the meeting, of which Dr Inkster and I would do it, and we had that meeting.

Q We are going to look at an email you-- Before you had the meeting, you sent an email to Professor Cuddihy which set out the explanation as you have understood it, and we will look at that in a minute but, what I am interested in before we get to that is, what was it that Mr Hill offered by way of explanation as regards how this had happened?

A He never really gave me an explanation.

Q Did you----

A I remained extremely unhappy, right through this whole process, that I was put in this position. That is something that I've expressed to Mr Hill and to Mr Best before.

Q Well, what I am interested in in particular is, I mean, we have seen that you were anxious that this thing was moved on, and we have seen, as you said, that you were the point of contact, in fact, going back into 2018, and you have agreed that there had been warnings from Professor Cuddihy. So it is obvious that you, even before you went on

holiday, you had some concerns.

A So, I work on the basis, and this is part of the job I see as my job, which is that there are actions within an IMT that have to be followed through. If they are under the responsibility of me, then I want to make sure those actions are followed through timeously and correctly. Coming back from that, there was an action of the IMT that I felt was the responsibility of a combination between the consultant, Dr Inkster and myself to clarify the situation with Professor Cuddihy, and I was told that it had been dealt with. The action was closed.

Q Well, what we saw was that the duty of candour obligation referred to the chairman, and what you have said is you do not know whether it was him personally or----

A I don't know whether he-- That's what I'm saying, I've never had a conversation with the chairman on this.

Q Yes. Before we look at the email to Professor Cuddihy, I am just thinking about the exchange that you had with Mr Hill when you came back from your holiday, or rather when you received Professor Cuddihy's angry email. Did you ask Mr Hill on what basis he had told you that this

was sorted?

A On the basis that a communication had been exchanged with Professor Cuddihy, and that explanation had been given, and the action of the IMT was concluded.

Q That is what he said to you before----

A Well, he----

Q Sorry, sorry, Mr Redfern. That is what Mr Hill had said to you before you got Professor Cuddihy's email. Is that right?

A Yes.

Q So, after you got the email and, as you say, you were unhappy, and you went to see Mr Hill, presumably you would ask him, "Why did you tell me this was sorted?"

A I did, and I never-- as I've said, I never got a formal response contrary to that. I just got an instruction to meet with----

Q Sorry, if you do not mind my interrupting, that is not what I am asking you. Did you ask him why it was he had previously said it was sorted when, upon receipt of Professor Cuddihy's email, it was obvious that it was not?

A I think my conversation with Mr Hill at the time was, "I thought we had said this was sorted. How am I going to respond to this? I'm

extremely unhappy with it." That was the process we followed thereafter.

Q But you said that Mr Hill had told you before, "It is sorted." Yes?

A Yes.

Q It is obvious that it was not. So you would ask him, presumably----

A Well----

Q No, hold on. You would ask him, presumably, "Why did you tell me it was sorted?" Did you ask him that question?

A As I said, yeah, because I was wanting to know how I was going to handle----

Q So, did he explain the basis upon which he had told you it was sorted?

A He said it had been dealt with corporately.

Q But obviously----

A I didn't ask for the exchange of communication, the date of the meeting, I didn't ask for any specifics around that.

Q But at the time of Professor Cuddihy's email and this further conversation with Mr Hill, it is obvious it has not been dealt with corporately. Is that right? So, did you ask him why it was he had previously told you that it had been?

A No.

Q You did not ask him?

A No, I was more interested in the time of how I was going to handle the situation with Professor Cuddihy.

Q Were you annoyed with Mr Hill?

A I was annoyed with-- Yeah, yeah.

Q But you did not ask him how this all happened?

A I can't remember everything that I had with Mr Hill. It was more about how I was going to handle the situation with Professor Cuddihy in response to his email.

Q Okay. If we move on then, please, I want to-- My Lord, I am conscious of the time. I think I could probably conclude this chapter within half an hour or so, but it is a matter for your Lordship.

THE CHAIR: How are you doing, Mr----

A I'm fine.

THE CHAIR: Are you content? I am not seeing any dissent. Carry on.

Q Thank you, my Lord. Now, if we go to your email of 25 July 2019, which is at page 58 of bundle 6. So, I am assuming, as we have been speaking about this email quite a bit, this is the email in which you set out the explanation to Professor Cuddihy. Is that right?

A Yes.

Q As you understood it. Is that right?

A Yes.

Q So, "I have discussed with senior colleagues and can now provide an update." Who were the senior colleagues?

A Mr Best, Mr Hill and, to a certain extent, Dr Alan Mathers, the Chief of Medicine.

Q Okay. Then, in the next paragraph, you say:

> "…we believe that we have been open about what we have known, and what we have been seeking clarification and scientific data on. However, we acknowledge that this may have complicated effective and timely communication, but this should not be misconstrued as obfuscation on our part. Both myself and Dr Inkster have been on annual leave and this has been a further factor."

You say, "I do not agree with your suggestion that there has been any 'cover up'", but you then go on to say at the foot of the page-- If we could scroll down. Yes. There was clearly "an action to update you." Yes?

A Yes.

Q It says:

"It is important to be clear that whoever is nominated to carry out this action and when it takes place, is at the instruction the IMT chair."

Now, pausing there, I think we have agreed that the IMTs indicate that the settled position of the most recent pertinent IMT was that there had to be a duty of candour communication to Professor Cuddihy. Is that right?

A Yes.

Q

"Normally this action would be undertaken by Dr Inkster and/or myself [and then you say] there were mitigating circumstances that need to be considered when reviewing how this action has been progressed." [The first is] We were waiting on some bacteriological typing results pertinent to what we might say in such discussion with you and your family. [Next is] We needed to be very careful around patient confidentiality."

Then there is the reference to not wanting "to cross the ongoing communication between our Chairman." Do you see all of that?

A Yes.

Q Now, how was it you came by those three bullet points? Was that from your investigations with your senior colleagues?

A Yes.

Q Now, thinking back to the IMT that we looked at, do any of those appear there? Was there any indication that the duty of candour communication would be postponed until typing results were obtained?

A No, not at the time of the IMT.

Q Yes. As regards patient confidentiality, as I have indicated to you, there had already been one communication with the second patient's parent, and there was a second one, according to the parent, very soon after the IMT. So, can you help me with why that is an explanation for why, by the time you got back from holiday, there still had not been a communication to----

A I can't-- I can't tell you why. There was a sequence of events that came thereafter, which were that Professor Cuddihy was prompted to write his email on how we got into that position.

Q That is helpful, Mr Redfern. I think, essentially, you are setting out what you had been told the explanation was. Is that right?

A Yes.

Q Yes. If we take the first one, waiting for typing results, the evidence you have already given is that the IMT had decided that, although there was further investigation going on in relation to typing, it was time to move on with duty of candour discussions. Is that right?

A Yes.

Q Yes. So that cannot be-- well, that is difficult to square, those two things. Is that right?

A I think what we were trying to say-- there was a whole set of circumstances around why we might have came in the position that we found ourselves in.

Q Okay, I am just trying to take them one by one. I think I am taking you to indicate that the first explanation is not consistent with what I took you to be saying as regards to the settled position of the IMT. Is that right?

A The emails suggest that there would have been a conversation and the IMT was comfortable with the instruction that there should be a conversation with Professor Cuddihy.

Q On the second one, patient confidentiality, if it was the position that by early July there had been two conversations with the parent of the second patient, at least by the time of the second discussion, confidentiality could not have been an explanation. Is that fair?

A Yes, I would say that's fair.

Q So, the only bit that, I think, we can see that links back to the IMT is a reference to a communication with the chairman. Is that right?

A That's what it says, yeah.

Q Can you say whether-- you know, thinking about the evidence you have already given, did you know any more than that about what the ongoing communication was with the chairman?

A Just that Professor Cuddihy was extremely unhappy about the whole situation around the infections and the safety of the campus and how the board was managing that.

Q Okay. Now, we are moving, finally, towards the meeting and just about there. In fact, there is really just three bits of this that I wanted to look at, with the meeting being the second one. There is just one more bit of the timeline that I want to just make sure that we have all got. If we go to the IMT on the 1 of August – which is in bundle 1, Mrs Soska, it is

page 334. I just want to go-- I am sorry. This is one, I think, that you are present at. Is that right?

A No, I don't think I'm present on 1 August.

Q No, I am sorry, I do apologise. What I wanted you to help me with is in page 337-- Sorry. Underneath "Duty of candour", if we scroll down, "This will be covered under the communications meeting tomorrow morning." You know what that was?

A I have no idea.

Q Okay, thank you. Now, finally, you have a meeting with Professor Cuddihy and Dr Inkster. Is that right?

A Yes.

Q Now, for my purposes, I have covered off all of the bits of the timeline that I feel are pertinent but, you must feel that you have had the opportunity to tell your story of what happened at that meeting, if that is what you want to do. There is only one bit of it that I want to ask you about and it is a further concern that Professor Cuddihy had raised. He said in his evidence that he had asked you to-- Well, let me take a step back. Is it correct that at the meeting that you-- Well, the better way to do this is you tell me what you want to tell me about the meeting.

A Well, I'll just describe what happened at the meeting. The purpose of the meeting-- I wanted the purpose of the meeting to explain the sequence of events that you have went through. I wanted to clarify any issues around duty of candour if there were still things outstanding. I wanted to apologise for the delay in the timeline of, obviously, what had happened because Professor Cuddihy's view of the meeting had not-- Sorry, not his view of the meeting, his experience or position was, as articulated in his email, that he had given me time to contact him as part of the duty of candour process and that had not happened. Therefore, he had prompted it by the email he sent.

So I wanted to go through all that with him, but most of all I wanted him to be clear that we were explaining everything that had happened between the two cases. So, I can't go back in time in terms of what the time-- you know, the time limit that it has taken to get us to this point, but that's what I wanted to do. That was what I really wanted out of the meeting. However, in trying to describe how we had got to this delay in timeline, Dr Inkster broke into conversation and said, "We were told not to speak to you," and

Professor Cuddihy got extremely upset in the meeting and basically stopped the meeting and said he was taking it up with the senior corporate management team and that, frankly, was probably the last involvement from recollection I had had in this, except updating Mr Hill that was the outcome of the meeting.

Q I mean, I will just-- I do not know what Dr Inkster's position on the meeting is and I do not know.

A She was there as normally what we would do around duty of candour, and what would have probably happened normally under the IMT if we had followed the instruction at the time.

Q We have not had her evidence is what I mean, but we have had the evidence of Professor Cuddihy. I do not think we need to take up a huge amount of time on this but, I think he-- his recollection was that you started offering an explanation, and she said something along the lines of-- Dr Inkster said something along the lines of, "Tell Professor Cuddihy the truth, Jamie." Do you remember her saying anything like that?

A It may have been those words. I don't think I was telling lies.

Q I think----

A I wouldn't go into a meeting to tell lies.

Q I think one of the other important aspects of this was that I think Professor Cuddihy's recollection was that he asked you and I think Dr Inkster to see who it was had given the instruction not to speak to him, and his recollection was that you were not prepared to do so.

A I can't remember that. If I did do that, I'm not sure why I did that. I'm sorry.

Q Okay.

A I have no reason to dispute Professor Cuddihy, his version of account-- of that meeting. It was a very challenging meeting. It was incredibly difficult, and it did not go the way that I had hoped it would go.

Q There is just one further bit of the jigsaw as known to me at least. There may be other documents that I am not aware of about all of this, but we know from the correspondence that we have got, and I will not take up too much time on this, that Professor Cuddihy wrote to the chairman and ultimately to the chief executive. I do not know whether you know this but, in his correspondence he, ultimately, came to say that he believed that you had acted in good faith, and he was concerned about the instruction that

you had had. Is that something that you were aware of?

A I don't know about the letter. I haven't been shown the letter. I have a good relationship with Professor Cuddihy, and we have briefly discussed that as part of that. He did indicate in the meeting that he thought I was under pressure. I think that came retrospectively after it. I am glad that he said at the time that I was always acting in good faith because that's always what I would be expecting to do.

Q In his evidence to us, he said that he had been very concerned about you at the meeting.

A It was not an easy meeting.

Q Now, if we move on then to a response that we are aware of, I do not know whether there are others, but a response that we are aware of from the chief executive to Professor Cuddihy's concerns. This is probably the last thing we will have time to look at today, but it more or less concludes this chapter. It is bundle 6 at page 75, please, Mrs Soska. This is a letter of 27 September 2019 to Professor Cuddihy from the chief executive. Can you say whether this is something that you have ever seen before?

A I don't think so.

Q I will just draw something to your attention then. Could we enlarge the paragraph that begins during June and July 2019? Once again, Mr Redfern, could you take a moment to read it, please, and just tell me once you have done that?

A Yes.

Q Does that appear-- if we focus on the second half of the paragraph, it says:

> "It was felt that communication with you regarding this should wait until such time that the typing results of the second child's bacteria were available, and hence an understanding of any linkage to Molly's bacterial typing could be excluded."

If we just pause there, that is, I suppose, similar to one of the explanations in your email. Is that right?

A Yes.

Q But the typing that is being referred to seems to be the typing of the two patient samples. Is that right?

A Yes.

Q Do you know why that would assist in understanding whether or not either of those samples was connected to the water supply?

A No, I don't know the answer to that question.

Q Okay.

A What I do-- I think what I do-- I suppose this would be a conversation with Dr Inkster, was whether or not the relevance of the fact that the two cases were ultimately found not to be related, impacted and are observations that she made at the IMT, and I don't know the answer to that.

Q Okay. The other matter was patient confidentiality which we have spoken about already, and I think I took you to agree that, at least as far as the period from early July until your return from holiday, that does not seem to be an explanation. Is that fair?

A There was a sequence of events around confidentiality, but the timelines possibly don't fit.

Q The third thing that was in your email which is about not cutting across chairman's communications, that does not seem to be mentioned. Is that right?

A I can't comment for the construct of this letter. I don't know.

Q Okay.

A Well, it is not-- from the paragraph you have read, you have highlighted, it is not there.

Q Okay. We have now gone through the timeline, and you have had the opportunity to give your own reflections on this. Are there any bits of the timeline that you have investigated and that we have not uncovered?

A No, I think the only point I would make again is-- and I hope this doesn't come across as a contradiction, is that through the IMT process and thereafter, there was always an intention to speak to-- whether it was Professor Cuddihy or another parent, and that was clearly articulated in the IMT process and should have been followed through. The timeline with this particular case, obviously, has a delay in that of which-- well, we've been through all of that but, I would again stress that there was transparency and that this is something that should happen, and ultimately it was my intention would happen.

Q Sorry to be clear, you would describe the process that we have just looked at as one that is transparent?

A No, I'm saying that an IMT process should always be transparent and that that was my intention at the end when we were meeting with Professor Cuddihy that

we'd be able to explain that. Whether or not your view of this whole process is transparent, I suppose, is open to interpretation.

Q Well, it is really your view I am interested in. Can you say whether----

A I think there was an unfortunate delay in the timeline of speaking to Professor Cuddihy.

Q You were the one that raised the word "transparency".

A Sorry, I was trying to articulate that in good faith, at all times, I would hope that we would always speak openly and fully to parents and that is the background of everything within NHS Greater Glasgow Clyde I've found.

Q Well, I am just thinking about-- as I say, you are the one that raised the issue of transparency. Considering the timeline-- I am not looking at you as an individual, but just thinking about the timeline we have just looked at, do you consider that the communication, insofar as we know about it, could be described as being transparent in the case of the Cuddihy's?

A I think that the communication could have been better, yeah. I was talking about the interpretation of where we were going as an organisation and that there was an openness that this had to happen.

Q Okay, just a few more questions, just to wrap this up. It is just really a postscript, and you may or may not be able to help us with this. It is just to help us get this into our understanding of the narrative. In terms of other evidence that we have heard and in particular evidence from Professor Cuddihy, are you aware of whether there were, in addition to these two cases, any other cases of Mycobacterium chelonae affecting paediatric patients in the hospital?

A I can't remember.

Q For example, in the Case Note Review-- which I assume you have heard of?

A Yes.

Q Do you know whether or not there is a suggestion of three paediatric patients having had Mycobacterium chelonae?

A I can't comment. I would need to go back in and look at----

Q You do not know whether and what investigations have been made around that?

A No, I don't know.

Q The final matter on this point is Professor Cuddihy also indicated in his evidence that during the Case Note Review process, he

discovered, or he learned, that in April 2019 there had been testing done in Ward 2A, including in a room that his daughter had been in the year before, and that that had identified Mycobacterium chelonae in the water supply. Is that something that you are aware of?

A No.

Q Okay.

A I was not privy to the case review, individual cases and reports.

Q Thank you, Mr. Redfern. My Lord, I do still have some way to go, unfortunately. I cannot imagine it would be more than an hour, but we are at half past four already.

THE CHAIR: No, I do not think it is practical to continue. There is a point at which it really becomes difficult to take in information. Mr Redfern, can you come back tomorrow?

THE WITNESS: Yes.

THE CHAIR: We will complete your evidence then. I will ask Mrs Brown to take you to the witness room.

THE WITNESS: Thank you.

THE CHAIR: See you tomorrow morning, ten o'clock.

THE WITNESS: Okay.

(The witness withdrew)

THE CHAIR: Well, ladies and gentlemen, we will see each other tomorrow at 10. I think the original schedule had indicated that-- was it Dr Hart would be giving evidence tomorrow. Now, what is your position on that, Mr Duncan?

MR DUNCAN: We are not going to be asking Dr Hart to give oral evidence at this point. We are going to seek a supplementary statement from him on one or two points, and we will revisit matters in the future if we consider that is appropriate. Just on the subject of witnesses, Mr Murray, who was down to give evidence on Thursday, is in the same category. We may want to revisit his evidence and oral evidence in the future but, at this point, we are going to seek some supplementary evidence from him by way of statement.

THE CHAIR: Very well. Well, we will see each other tomorrow at 10.

UNKNOWN SPEAKER: Please stand.

(Session adjourned until the following day)

20 June 2023

10:02

THE CHAIR: Good morning, everybody. I think we are in a position to resume Mr Redfern's evidence. Good morning, Mr Redfern. Mr Duncan.

Questioned by Mr Duncan (Continued)

Q Thank you, my Lord. Good morning, Mr Redfern.

A Good morning.

Q I would like to pick up where we left off yesterday, and just to see what conclusions you would draw from the chapter that we were just looking at in relation to the communications in 2019 with Professor Cuddihy. Now, Professor-- If I just, first of all, put his position to you about those communications. In his evidence to us, Professor Cuddihy said that the communication around Mycobacterium chelonae was the point at which he saw a divide, as regards communication approach, between clinicians on the one hand and the organisation on the other.

So, if I just have you hold that thought, that was his position, and I want to look at that. I am going to ask you some questions about what we went over yesterday, and I am going to ask for your reflections and, as we did yesterday, if you could just wait till I finish the question, and if you could maybe just confine yourself to whether you agree or you disagree. So, if we think about the communications we looked at yesterday, we would, first of all, take the second case, the 2019 case. On the face of what we heard yesterday – and I think you said this – would you agree that it looks as if, in June and in July 2019, Professor Gibson appears to have had a candid exchange with the patient's family about what had happened. Is that right?

A Yes, that's what I would expect, yes.

Q Now, this is what I would ask you to reflect on and confirm. Can you confirm whether, over the same period, June and July 2019, there is the appearance of candid disclosure to Professor Cuddihy?

A From what we discussed, it doesn't seem to be that that had happened at that time.

Q Yes. Now, the Board

has known about this concern of his since 2019 and, on your evidence yesterday, it appeared that the senior manager who was the point of contact is, even today, unable to explain why it was that the communication that ought to have happened did not happen. Have I got that correct?

A I was single point of contact up until the meeting that I had with Professor Cuddihy, and then he made the decision that he was taking it higher, so I was no longer in that role.

Q Yes, but you are a senior manager within the organisation. The organisation has known of this allegation since 2019. I just want to be clear I have your position; you are unable to offer an explanation, as regards the organisation's position, as to why the communication did not happen. Is that correct?

A I don't know what communication happened thereafter with Professor----

Q You are unable to explain the Board's position on this. Is that right?

A Yes.

Q So, can I ask you for this observation. Just asking whether you agree or disagree. Can you confirm whether you think that, even now, the Board has provided a candid explanation of what went on?

A I don't know what the Board have said.

Q Well, just based on what we looked at yesterday and what we have just discussed this morning, can you confirm whether, even now, the Board has provided a candid explanation of what went on with Professor Cuddihy in June and July 2019?

A I don't know the answer to that.

Q I will ask you again. On everything we looked at yesterday, what is your assessment on the question I am asking-- Just let me finish the question. Do you think-- Are you able to say-- As a senior manager within GGC, are you satisfied that, so far in this Inquiry, we have a candid explanation of what happened over that period from what we discussed yesterday?

A I don't think that-- From the evidence that was presented, I don't think that we have that.

Q Thank you. One of the things we do not have is, from your evidence yesterday, the explanation of why Mr Hill had told you the communication had happened, and yet you discovered, when you came back from your holiday, that it had not. I

think, from your evidence yesterday, we do not know why it is Mr Hill had previously said it had happened. Is that right?

A Yes.

Q Can I just be clear? Did you or did you not ask him why he had previously told you it had happened?

A I can't recall all the conversations I had with him. What I was trying to do at the time, as I've said yesterday, was try and work out how I was going to conclude discussions with Professor Cuddihy.

Q Okay, thank you. Now, I want to move on to think about the infection situation in 2019 more broadly, and I will help you a bit to just try and put this in context so that we are clear what it is we are speaking about. I am particularly interested in the period, just now, up to mid-August 2019. Now, we know that there was a change in the chairing of the IMT in late August 2019. I am going to say something to you that I have been saying to all of the witnesses: none of the microbiologists or the Infection Control people who were part of those discussions are witnesses in this hearing, and the question of-- if it is relevant at all, the question of what happened at these meetings is for another time. So I am not going to ask

you about that. What I am interested, really, in is the position immediately prior to that, and what I am interested in is just understanding what your position is as regards the concerns in the summer, in June, July and early August 2019. So, that is the context, if you follow me.

A Yes.

Q Now, what I will do is I will set out to you our understanding of what the clinical staff said last week, and we also looked at the IMTs for this period, and it is really just to find out whether you agree with or disagree with what they have said. So, I will maybe just give you the list of the key points and you can tell me whether there are any of them that you materially disagree with. Can we do it that way?

A Yes.

Q Okay thanks. So, what we heard was that, in the summer of 2019, there was a re-emergence of gram-negative bacteraemias and, as we have discussed, also a gram-positive infection. Is that right?

A Yes.

Q Yes, and the clinicians said that they understood or considered that at least some of these were HAIs, and they said that, at this point, patients and staff were close to

breaking point. There was evidence that the staff had a perception that, by this stage, the organisation-- or were worried that the organisation had not got to the bottom of what, if any, problem there was. We saw a reference in an IMT to staff thinking there was something fundamentally wrong with the campus, and there was a restriction on entry to 6A. Now, just thinking about everything I have said, can you say whether that accords with your recollection?

A That's factually correct. The IMT were working on a series of issues which were unexplained, as described at the time, rare infections that we wouldn't normally expect to have, and we didn't have a working hypothesis for what the reason for that was.

Q Okay, thank you. So, there are two aspects of the evidence that the clinicians gave that I would like to focus on, and the evidence that we heard was, in particular, that the clinical staff and Dr Inkster, at that point, were concerned that the pattern or the level of infections was unusual. Do you recall that being----

A Yes, that's correct.

Q Yes, and that they continued to have a concern about a possible connection with the

environment. Is that right?

A That's correct.

Q And I think, in fact, we know that, at least in the second case of Mycobacterium chelonae, it was thought that the connection had been confirmed. Is that right?

A I can't remember what cases but, ultimately, what we led to was a situation the IMT instructed for what you've alluded to earlier, which was we restricted entry to the ward. So, one would assume that, as a result of that, there was environmental links to the infections.

Q Yes. Thank you. Now, what I would like to do at this point, then, is look at a briefing that was provided to-- or rather a briefing document. It is in bundle 8, please, Mr Russell, and it is page 65. Now, I wonder – before any of us make assumptions about what this is or is not – if you can help us a bit with this. I think we understand this to be an information brief for families during this period, and the date that we understand to be on it is 9 August 2019. Are you reading it just now?

A Yeah, I've read it.

Q Thank you. Are you able to-- Just in terms of what this document is, are you able to help us with what it is?

A It's a briefing to the families that Jen Rodgers and I would have taken round every family in the ward.

Q Okay, thank you. Now, if you have read it, I would just ask you to notice the third paragraph, where it says, "Infection rates remain within expected levels for the patients treated on Ward 6A." You see that?

A Yes.

Q And then if you go further down the page, and-- Do you see the paragraph that begins, "At this stage"?

A Yes.

Q

"At this stage there still remains nothing to link the infections to the ward's infection control practices or the environment."

Do you see that?

A Yes.

Q Can you confirm whether you agree that that information is precisely the opposite of what the clinical staff and Teresa Inkster understood the position to be at that point?

A My recollection of that period was that infection rates were at a normal level, but there was a rarity of infections that we couldn't explain and that there was no understanding of

why we were getting them, but one of the potentials could have been the environment. I can't remember specifically it being linked to anything, because we never had a hypothesis that I can remember, and we never had solutions in place to how we would remedy it-- why we took the decisions we did at around that time.

Q Okay. If we just take the second of those things, the, "nothing to link the infection to the ward's infection control practices or the environment," I took you to agree, a moment ago, that there was a concern by this stage?

A Obviously, there was a concern because we were diverting new patients to other hospitals.

Q Mm-hmm, and I took you to confirm yesterday that, in relation to the second Mycobacterium chelonae case, it was thought by June/July that there was a connection between that infection and----

A That's what it said in the IMT.

Q So that would be something to link infection to the environment. Would you agree?

A Yes.

Q Yes, so I will ask my question again. Do you agree with that the paragraph that says there is nothing to link to the infections to the

environment appears not to be accurate?

A You could make that assumption.

Q Well, it is not an assumption. Is it capable of being read any---- Let me finish. You agree that that does appear to be inconsistent with what you understand----

A With that case, yes.

Q Well, not with that case, I mean-- I think you agreed, a moment ago, that there continued to be – hold on – a concern that there may be links between infections and the environment. You agreed with that a moment ago.

A There were concerns that it could have been environmental, yes.

Q I mean, what Dr Chaudhury said in her evidence was that she was aware of no evidence that indicated the opposite. Do you understand what I mean?

A Yes.

Q So, I ask you again, can you confirm whether you would accept that that statement is not consistent with what the clinical staff and Dr Inkster understood at the time?

A Yes.

Q And as regards the

infection rates remaining within expected levels for the patients, again, you accepted a moment ago that – if you just let me finish – the concern at that point among the clinical staff and Dr Inkster was that the situation with infections was unusual. Is that not right?

A It was unusual, but the number of infections were not out with the limits that we would have expected. That was my understanding of the presentation that Dr Inkster was putting to the IMT.

Q The evidence we have had from the clinicians is that what they were emphasising – and we can see this in the IMTs – is not the numbers.

A Yes.

Q Yes, it was the nature of the infection.

A The nature of infections, yes.

Q So, do you read that statement, “Infection rates remain within expected levels,” as being accurate?

A Yes, because the numbers of infections were within the levels, but there were types of infection within those levels that we wouldn’t-- at that time, we were being told wouldn’t have been expected.

Q Yes. It says:

"However in light of the occurrence of rarer infections, we are continuing to take precautions, including monitoring infection control practices and procedures and the ward environment."

So, do you see that bit as capturing the concern about the rarer infections?

A Sorry, what was that line you said?

Q It says, "In light of the occurrence of rarer infections, we are continuing to take precautions."

A Yes.

Q Yes.

A My understanding of the situation within that IMT were that we were in a position where Dr Inkster, at that time, was suggesting that, from an infection control perspective, we were in the control lines, but she was worried about the types of infections that we were seeing, and she couldn't explain it.

Q Okay.

A So there was no direct link to environment that I recall, but there was unexplained reasons for why we were seeing these infections.

Q Okay.

A And that's why we took the precautions that we took to try and work a solution around that and, as you know, later on, there was further Microbiology advice given to us.

Q Okay. So, just so I am clear that I understand, do you read the-- If you look at the whole of the paragraph, rates and the reference to the rare infections, are you saying that you would read that as being consistent with what the understanding was at the time?

A I think so, and when Jen and I were speaking to people at the time, speaking to parents, the narrative we gave to them was what I've just described. We have-- Our infection control numbers are within what we would normally expect. We've got a rare type of infection that we don't understand why we're getting it. At the moment, we're doing a number of investigations to understand what that is. I think that's relatively what that says, but if anybody had any questions that came subsequent to that brief individually, all of those parents, we were happy to answer it or seek Microbiology advice to assist us in terms of explaining it further.

Q Okay, thank you.

A So I don't think any parent at any time was not given the opportunity (a) to ask questions and

(b) for us to explain that narrative.

Q Okay. You can put that to one side. Now, I want to ask you some clarification questions in relation to one or two matters. One of them is about communication. I just want to be sure I understand your evidence in relation to how communication worked, or rather how agreement was reached at IMTs as to what was to happen in relation to communicating with patients and families and to staff and to the public. Now, I think I understood you to be saying that that was for the IMTs to decide. Is that right?

A Yes.

Q Were there ever occasions where it was for senior management to decide as well?

A Well-- sorry. The briefings, as I've described before-- or I think I've described before, had a process where the IMT would prepare-- or through the discussion that we had had, a statement would be prepared. Dr Inkster would be involved in that as chair of the IMT. Others would be involved, and then it would go to corporate comms for a final agreement to be reached, but Dr Inkster and others would still be involved in that process.

Q Okay. I just maybe want to pick up on one IMT that I have been asked to clarify with you, and if we could go, please, Mr Russell, to bundle 1, page 241. I think if we just-- In terms of identifying the document, it is an IMT on 30 November, page 241, and I think you were you were there. Is that right?

A Yes.

Q It is really just to identify something at the very end. So, it is page 243, under "Communications," and it is the bottom paragraph, and it says-- Can you see that?

A Yes.

Q

> "Dr Inkster wishes Comms to be released informing parents and staff that the ward will not be moving back on the 14th of December due to ventilation issues. Jamie Redfern agreed to discuss this with Kevin Hill."

See that?

A Yes.

Q What I would just like to understand is what was Mr Hill's role in the communication?

A I can't recall that particular conversation, but it would have been just to inform them as part of the escalation process that I described, but we would certainly not have been-- I've never experienced a situation where, if Dr Inkster wanted a

comm to go out, that we would not follow it through, but I would have an escalation process to say that I'll update, you know, my senior line manager with a view that the organisation was aware of what it was we were asking to do.

Q Thank you. Now, we looked yesterday, you will recall, at a communication about the ventilation system that had a quote from Mr Hill in it. Do you remember? There is the reference to the word "opportunity."

A Yes.

Q That communication comes shortly after this IMT. Now, you may not be able to help us with this, but I just wonder whether it is possible that it was that conversation that then led to the communication we looked at yesterday.

A I can't remember.

Q Okay. Thank you. We can put that to one side. Now, I am going to move on in time. We have had a lot of evidence already from the clinicians on the process of moving from the concern in 6A, the reopening of it later in 2019, and really all I am looking to do at this point is just nail down the chronology on that. There is one bit I think that you might be able to help us with, and it is in relation to an SBAR I think you prepared. So, could

we go to bundle 4, please, Mr Russell? I think we have this as being an SBAR of 14 November 2019, and I think we understand this to have been prepared by you. Have I got that correct?

A Yeah. I'd have been involved in it. I would, yeah.

Q Well, I will help you with that. If we go, please, to page 205.

A Yes. My name's there.

Q Thank you. Could we go back, please, to page 203, under "Assessment." If you enlarge that section, do you see, "Currently there remains no direct working hypothesis linking the series of infections which prompted the Incident to Ward 6A environment." Do you see that?

A Yes.

Q Is it your recollection that that is what----

A Yeah. To my memory from that whole IMT, we never got a hypothesis that was signed off and we never had solutions, therefore, to work through that hypothesis.

Q I think, in fact-- and we do not need to go over this; we have had the chronology explained to us. I think our understanding is that by this stage, in fact, the advice that was now coming from within Infection Control was that there was not a link between the infections and the environment. Is

that right?

A What happened was there was a change in the Chair of the IMT. There were alternative Microbiology/Infection Prevention Control advice given. What we were told by a separate member of the Microbiology/Infection Prevention Control team was that we were not outwith, as we've discussed earlier, our infection rates and that these were not rare infections and that, indeed, we'd had them before and, on the view of that individual, we didn't have a problem.

Q Okay. Thank you. Just staying on page 203, if we go just a couple of paragraphs down or so, we see there is a reference to the NHS GGC Water Technical Group reporting that the water on 6A is pristine and not the source of any recent infections. Are we to take from that that you are reporting information from this other group?

A When I produced an SBAR-- What I meant earlier with, "It was me that prepared it," yeah, my name is on the document, but there will have been input from a whole variety of different people, including someone from Estates/Infection Control that would have been able to give me that statement.

Q Okay. That is helpful. Thank you, because the question I was going to ask you is what does pristine mean, but is that a question for somebody else?

A Yes. It was a word that was used at the time.

Q Okay. Was it your understanding at the time that the water was now safe to drink?

A Yes.

Q Including if you were an immunocompromised patient?

A Yes, yes.

Q Against that background, why did there continue to be point-of-use filters?

A That's where I've come back in earlier questions that you said, where it was-- that's a legitimate question. We're, on the one hand, saying the water is fine. On the other, we've got point-of-use filters on the taps and showers. It was a belt and braces approach to it, and it was a reassurance because people were still unsure, as in, parents, not staff. Again, it was just, again, that reassurance of the fact that, from our perspective, the water was fine, and you could wash, you could drink from it, you could do all the natural things that you would do, but the point-of-use filters were still in place. We have

reassurance. Sorry.

Q Oh, no. I am talking over you now, so my apologies to you. Again, on the question of why there are still point-of-use filters there, would that be a question for somebody else to answer?

A I think that, yeah, you would speak to Infection Prevention Control and to Estates, but I think the answer would still be what I've just provided you.

Q Yes, and thank you. Just to maybe complete the explanation for everything you have just said about this SBAR, if we go to page 205 again, paragraph 4, we see there is the reference to advice, and it is Dr Leonard and in relation to Enterobacter infections. The advice from him is the, "Outputs from this suggested that none of these infections were hospital environment related." Is that right?

A Yes.

Q You may not be able to remember this, and please say if you cannot. Is that something that you have written based on an understanding, or will that have been a contribution from somebody else?

A That will have been a contribution from Infection Prevention Control and Dr Leonard, and they

would have all seen the SBAR before it was circulated.

Q Okay. Thank you very much. We can put these documents to one side. I have just got a few more matters I would quite like to just clarify with you. I want to go back over something quite briefly that we talked about yesterday. We are really moving towards the concluding part of your evidence. You say that you are a learning organisation with a culture of safety. Is that right?

A Yes.

Q Now, I just want to ask you again about something we spoke about yesterday to be sure I understand it. As I mentioned yesterday, the evidence to the Inquiry so far is that there is a risk assessment of the water system in the hospital done by a company called DMA Canyon in 2015 that was not acted upon until 2018, and it showed serious concerns about the safety of the water system. Now, you recall me mentioning this to you yesterday. Is that right?

A Yes.

Q I took you to indicate that you were aware of this. I think you said from the media and from the Inquiry.

A Yes. I can't remember

the specifics of when I was made aware of that document, but I certainly wasn't aware of it up until we were moving into IMTs around that time, not from my knowledge of it. I certainly never ever went into the hospital in 2015 and thereafter thinking that there was-- that document was in existence or that there were concerns about the water supply.

Q I kind of understood you to say yesterday that even in 2018 you were not aware.

A Yeah. Yeah, that's----

Q Yes. If – I emphasise if – it is true that the risk assessment is in the terms I have just described and if – and I emphasise if – it is correct that it was not acted upon for three years, can you say whether you consider that would be consistent with the culture of safety you have described?

A Certainly. I don't know why it wasn't acted upon, and I don't know the reasons for that. It would be normally something I would expect us to do.

Q Well, if you just answered the question, would you say whether it was consistent with the culture of safety if it wasn't acted upon?

A I think that there are issues for others to address why they

didn't do that, and it doesn't fit with the narrative that I would expect in terms of how we deliver services within Women and Children's, which is where I'm really speaking about in terms of----

THE CHAIR: If you listen to the question, it is put forward as a hypothesis: if a risk assessment was as described and if it was not acted upon-- So, it is a hypothetical question that you are being asked to consider.

A Okay. I agree with you that if we were a safe clinical environment and we have a document like that that refers to that, then I would expect it to be acted upon.

MR DUNCAN: Thank you. Now, the other aspect is the learning aspect and, again, I would just ask for your comment on this. I think it is obvious from-- Well, I think you indicated yesterday that you do not really know what happened in relation to this risk assessment. Is that right?

A From this document, no.

Q Yes. I just think I would ask you this question, thinking about your position as a senior manager within the Board who was at the heart of responding to the challenges that patients faced as a result of concerns with the water system. I just wonder whether you consider that the fact that you do not know what happened in

relation to this is consistent with the culture of learning that you describe?

A As I've answered in that previous answer I gave, yeah. I think that that's a position that's accurate, but what I would say when I describe the organisation and myself as one that learns from our experiences, then I think there is numerous examples we could provide where that is the case. It's certainly something in my practice that I would always do and, indeed, through the whole of this episode from 2018 onwards it's something that we have constantly tried to evaluate and learn from. I'm talking personally and within the services that I have a responsibility for.

Q Okay. Thank you. Now, I have got some further clarifications, and I will not take up very much more of your time. I did say to you at the very outset of yesterday that we would eventually go back to before 2018, and I have got some clarifications that I would ask you about as regards that. First of all, as far as the construction and the delivery of the hospital is concerned, you have got some evidence in your statement about the process of clinical staff signing off on the plans for the hospital. Now, we had some evidence about this last week, and I would just like to be sure I understand what your assessment of things is at least. The lead clinician, Professor Gibson, told us last week that she had not been prepared to sign off on the plans, and I think I understood Dr Murphy to support that. Can you help us with that? Do you think that-- Is that your recollection of what happened?

A There were certain things that Professor Gibson, in terms of discussion with myself, was unhappy with around office accommodation and other aspects of floor space. I cannot recall having discussions. I wasn't part of any discussions with her about ventilation or water.

Q Yes. I do not think she says she was part of such discussions either.

A But she was unhappy with some of the floor plan.

Q Yes. If I ask you this question: the indication we had from each of those two clinicians was that they considered that the process of consulting with them in relation to the new hospital had been sub-optimal. Were you yourself involved in that process, or do you have any direct knowledge of it?

A I was involved in it.

Q So what would your response be to the suggestion that it

was sub-optimal?

A I would say there was strong clinical engagement right across the whole hospital, and that's reflected in the steering group and sub-groups clinically led, and that documentation exists. I don't know whether you've got it or not, but it was there and across the whole build of the hospital. There were obvious discussions about things like how many beds we had, how many theatres we had, how we were going to use them, where they were located. My recollection from that was that was all clinically-led and we reached clinical conclusion on it. There was a particular issue that Professor Gibson and the Haemato-Oncology Team were unhappy about, which was that dedicated office space in the ward and not in the office block, but that was a strategic position that the organisation had taken, and we tried to work through it with the Haemato-Oncology team and make changes, and we did make changes. There were other things that we made based on Professor Gibson's input, including parental accommodation on the ward, that were unique in a certain way to Haemato-Oncology, which we tried to accommodate within the footprint. Since then, we've continued to try and

make changes to address some of the concerns that Professor Gibson has had in terms of the operational way of how the Haemato-Oncology team work in the campus.

Q Thank you. Now, as far as the hospital itself is concerned, we have had evidence in the oral evidence last week and in the statement evidence that some of the clinicians were concerned or at least surprised about the hospital being built next to sewage works. There is some suggestion in the evidence about an investigation being made in relation to the safety or risk of infection as regards that. Is that anything that you can help us with?

A I can't.

Q You mentioned, I think, there was a concern, at least from some of the clinical staff about a distance between the ward and the office space and, in that context, one of the clinicians in their evidence has said that, although there was a hot desk space, there was a concern about the phone signal in that area. Is that something that you recall?

A So, the hospital has built-in mobile technology, and there are some black spots in the hospital at this moment in time still, depending on what type of phone you use. The e-

Health team have been working through them since 2015. My understanding of it is that, in general terms, the mobile technology works well----

Q Okay. Thank you.

A -- but there are areas where we would consistently be looking, as technology improves-- Obviously, since post-COVID, we've come into a new technology. Technology is developing all the time, and e-Health work in tandem with those developments to try and maximise benefit from it.

Q Okay. Thank you. Now, just moving on then to the period after patients are-- or rather about the time that patients are arriving into Ward 2A and 2B. I think you deal with this in your statement. What is your recollection of issues that were identified in 2015 in relation to the ventilation system on Ward 2A?

A My memory is that there was an issue with the seal in some of the cubicles, which were identified through Estates, and there were discussions around why that had happened and what the remedies were to resolve that, and I think that they were put in place.

Q Thank you.

A No. I don't think. I know they were put in place.

Q Well, I think that what we have heard evidence about – and I think you do touch on this in your statement – is that it was discovered shortly before the patients arrived that an aspect of the HEPA filtration system was not in place. Is that correct?

A Yes, and they were purchased from Ireland and fitted within there before we opened.

Q We have heard evidence about concerns about fungal readings, and I think what you have just touched on, issues with sealing in the BMT rooms. Is that right?

A Yes. Yes, and work was done to resolve that, and then further work was done based on what was seen as at the time best practice from other sites, and that was implemented.

Q Okay. We have had evidence about a concern among the clinicians in particular about whether bone marrow transplants would be able to proceed over that period. Do you recall that?

A From memory there was a delay, and then there was a process of when we would start bone marrow transplant programme.

Q The evidence we had from the clinical staff was that the

particular impact on that group of patients was something that they found extremely stressful and was not what they would have expected in the new building. Do you recall that?

A I remember that-- Well, by the fact that there was a discussion of when we would start the programme there, we were having those discussions. There had to be a confidence in the building, but the work that Estates did to my point and subsequent to actually starting the programme was that the issues had been resolved, but ideally we would not have had to do that.

Q Yes. At that point, and just picking up on what you just said, can you recall whether you yourself had any concerns about the confidence in the building at that stage?

A I think until you have experienced a lengthy time where the solutions have been put in place, then you're always a wee bit anxious about something.

Q Okay. Thank you. Now, there is just something I want to ask you to help me with in your statement on this, and it might help us with our further investigations. Can I have you look at your statement, please, at paragraph 55? It might be worth

getting this up on screen, Mr Russell. It is in the statement bundle. It is at page 381, paragraph 55. Can you just take a moment to read what you have said in paragraph 55 and then tell me when you have done that?

A Yes. I have done it.

Q Can you tell me what that is about? Sorry. It wasn't a very good question. I am, in particular, interested in what the advice from Mr Louden was.

A From my memory, there was discussion with Professor Brian Jones and Mr Louden with a variety of others around the comparison between the Beatson Oncology Unit and what was in the Queen Elizabeth campus. Professor Jones thought that what was in the Beatson should have been within the Queen Elizabeth campus. David Louden, as the responsible officer for the Board, was basically saying that everything that was installed within said campus met the statutory building requirements for the services that we delivered.

Q Sorry. My apologies. You may already have indicated this. Can you recall at what point in time this discussion happened?

A I think it was just as we were entering the building, or we were moving into the building.

Q If you cannot recall, do say. Do you think there were patients there by this stage or was it before then?

A I think it was just as we had moved in.

Q Okay. Thank you. Now, just a few further clarifications. We can put the documents to one side. Yesterday, in your evidence you said-- I asked you some questions about something called the Executive Group that was referred to in an IMT. Do you remember that?

A Yes.

Q I think I understood you to say that there were not ever any meetings of the Executive Group. Is that right?

A Yeah. I don't recall any particular meetings. What I recall at the time was that the purpose of the group was to try and make the IMTs more focused and shorter and take some of the operational issues of delivery of solutions to a separate discussion. What actually happened was, on reflection, it was the same people talking about the same things, and the anticipation was that one would flow after the other, and it just basically blended into the IMT.

Q Okay. Just picking up on something you just said there, can you say whether there was a concern about the time that the IMTs were taking?

A The IMTs were very long, yes.

Q At the height of all of this-- Well, that is maybe an unfair question, but what would be the worst-case scenario as far as an IMT duration is concerned?

A There were IMT meetings that went on for at least two or three hours-- two hours.

Q How often would that happen?

A I think that was pretty regular.

Q Yes. When you say pretty regularly, do you mean really throughout the period?

A I can't remember specific-- I can’t remember one short 45-minute IMT, let me say.

Q Right. That is helpful. It has been suggested to me that there may have been a group set up called the Executive Control Group. Could that be the same thing as the Executive Group?

A It may be. I don't know. I can’t----

Q And that there were meetings that did take place of this Executive Control Group. Is that

something that you recall?

A I don't. I don't know.

Q Okay. Thank you.

A All I can remember around the reference to the group that you were asking me questions was really around the operational delivery of solutions within the-- or were being put forward by the IMT. We just followed them through in the IMT with the same people who had been envisaged might take it out with the IMT. That's just an operational process that the Directorate-- if the responsibility for those solutions were the responsibility of the Directorate, then I would expect to follow them through standard process.

Q Okay. Thank you. One further clarification on IMTs, something that you said yesterday to do with the publication of the of the minutes. Are they publicised within the boards in some way, or is there external publication of IMT minutes, or is there no publication at all?

A I don't know the forensic detail of that. My understanding is that the IMT minutes do go to the boards-- go through the Infection Prevention Control governance processes.

Q Okay. Thank you. I have just finally got a couple of questions. I want to ask you about the present day. It is my understanding from some of the documents that we have looked at that at the end of 2019 there something set up called the Clinical Review Group.

A Yes.

Q I think you mention it in your statement, in fact.

A Yes.

Q Can you tell us what that is?

A So, when we closed the IMT off, that was at the start of October, I think 2019. We were still in a position where we did not have a working hypothesis to the infections we had. We had varied Microbiology advice, the latter advice being that we didn't have rarity in the infections and we weren't outwith our control limits. We had benchmark documentation with other children's hospitals that we'd previously been sending patients to which said our infection rates were comparable-- independent from Health Protection Scotland, that we were comparable with Aberdeen and Edinburgh, and that we worked on the premise that with all of that information, we would reopen the unit and we would stand the IMT down. As a consequence of that though, we reinforced – and this is where I would reference to a learning organisation –

our processes for how we could create very strong, robust working relationships between Infection Prevention Control, Estates, Microbiology, ourselves and have-- on what were well-established and good working relationships, just something on top of that, and would work on the basis that if we got any subsequent infections thereafter, we had a process where we would deal with it through that group.

That worked very, very well, and we went through, I think, on reflection, an experience where those teams really came together. I don't mean that in a way-- please do not take it that they weren't together, but it was just a reinforcement of that. It was a development of the relationships. Everybody worked extremely closely. There was a real collectiveness in terms of how we would manage Infection Prevention Control within Haemato-Oncology thereafter. So, we have continued with a number of processes that one might have said, "You could stand down," but we haven't done that. We've continued with it. I think that there is still strong-- those relationships are still very strong, and I think that that group was a very successful group, was well represented clinically, was well

represented by, as well as the medical staff, the senior charge nurse or senior charge nurses, had very strong Estate representation and had very strong Infection Prevention Control. I think that's reflected in the infection results that came thereafter.

Q Thank you. Well, just on that last point, the evidence we had last week from all of the clinicians was that, as far as they are aware, there has been no return to concerns around patterns or rates or nature of infections. Is that consistent with what you have just said?

A Yes. I mean, children, by the nature of their illness, will have infection, but there is a standard process in place, and we've never since then worked out with controls where we've-- within the sort of IMT scrutiny that we experienced in those times.

Q Thank you very much. Just one last question. Are there any current contingency plans in the event that there ever were a return to the concerns that you had previously had?

A Well, we do not have a separate Haemato-Oncology Unit sitting unused. The contingency plans would be built on what we had implemented earlier, but they would be based on the unlikeliness that we will

ever have to do that because of the robust arrangements we have in ventilation and in water, and I would hope and anticipate-- not hope, anticipate that we would never be in that position again.

Q Okay. Thank you very much, Mr Redfern. I do not have any further questions for you at this point.

THE CHAIR: Mr Redfern, what I propose to do is give, perhaps, 10 or 15 minutes in order to ascertain whether any other questions should be asked or, at least, whether any of the legal representatives consider any unanticipated points that require further questioning. So, if I could ask you to retire to the witness room, and we'll take 10 or 15 minutes in order to bring to Mr Duncan's attention any questions that might have to be asked.

UNKNOWN SPEAKER: Please stand.

(Short break)

THE CHAIR: Mr Duncan.

MR DUNCAN: Thank you, my Lord. I don't understand there to be any further questions for the witness.

THE CHAIR: All right. Thank you. I wonder if Mr Redfern could rejoin us. Mr Redfern, we have no more questions for you and, therefore, you're free to go. Before you do, can I thank you both for your attendance and for the work you will have done in preparing your witness statement. I appreciate that that work will have been substantial, so thank you for that.

A Thank you very much.

THE CHAIR: You're now free to go. Thank you.

A Bye.

(The witness withdrew)

THE CHAIR: Now, Mr Duncan, I don't understand we have any more witnesses today or, indeed, tomorrow.

MR DUNCAN: That's correct, my Lord.

THE CHAIR: But we will sit again on Thursday with, I think, Ms Rodgers.

MR DUNCAN: That's correct.

THE CHAIR: Right. Well, we'll see each other on Thursday, thank you.

UNKNOWN SPEAKER: Please stand.

(Session ends)