SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
12 June 2023

Day 7
Thursday, 22 June 2023
Jennifer Rodgers MBE

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10:25

THE CHAIR: Good morning, ladies and gentlemen. I think we are in a position to resume with Ms Rodgers.

MR DUNCAN: That is correct, my Lord.

THE CHAIR: Good morning, Ms Rodgers. Now, as you understand, you are about to be asked questions by Mr Duncan, who is on my right, but before we begin I think you are prepared to make an affirmation.

THE WITNESS: Yeah, that's right.

Jennifer Rodgers
Affirmed

THE CHAIR: Thank you very much, Ms Rodgers. Now, the microphone in front of you should pick you up, but – I say this because I am hard of hearing – can I encourage you maybe to speak a little louder than you would in normal conversation. I mean, Mr Duncan will give you cues on that. Now, I do not know how long your evidence will take. We will have a coffee break at about half past eleven during the morning, but if, for whatever reason, you want to take a break and say-- for whatever reason, just feel you can indicate that to me and take a break. I want you to feel that you are in control of the situation.

THE WITNESS: Thank you.

THE CHAIR: Mr Duncan.

Questioned by Mr Duncan

Q Thank you, my Lord. Good morning, Ms Rodgers.

A Good morning.

Q Well, can I just begin by having you give us your full name, please?

A Yep, my name is Jennifer Rodgers.

Q MBE, I think. Is that right?

A Yes.

Q When did you get your MBE?

A 2019, the end of 2019, the New Year's Honours List, then, going into 2020.

Q Do I understand that your current role is deputy nurse director for corporate and community services across NHS GGC? Is that right?

A Yeah, that's right.

Q And that was from----?

A November 2020.

Q And, prior to that, you were----?

A I was chief nurse for hospital paediatrics and neonates

across Greater Glasgow and Clyde from September 2015 to November 2020.

Q And prior to that you were----?

A Prior to that, I was a lead nurse for medical paediatrics in Yorkhill.

Q So, probably most of what we will be interested in, as regards your evidence today, will be for the period that you were chief nurse from September 2015. Would that be right?

A Yep.

Q You have given us a lot of detail in your statement about how that works and how it fits into management and also professional structures, and I am quite interested in exploring a bit of that with you, but please be reassured we have your statement on it, so do not think this is a memory test or anything of that nature. I should have perhaps said do feel free to consult your statement at any point if you think that would assist but, just trying to take matters in a fairly broad view, as chief nurse, then, what would your responsibilities be, or rather what were your responsibilities?

A So, as chief nurse, I provided professional leadership for over 1000 registered nurses and

around 300 healthcare support workers that worked across the Children's Hospital and three neonatal units. So, a neonatal unit in the Royal Alexandra in Paisley, one in the GRI, and one in the Queen Elizabeth Maternity. So, the Children's Hospital, around 256 beds, and those three neonatal units – two of them were level three, one's a level two – they add up to about 100 cots. So I provided professional nurse leadership for all of those nurses working in those areas.

What that meant was-- My key business areas, I suppose, were quality, like quality nursing care, so I did a lot of work to ensure that babies and children and young people and families received that quality nursing care. I worked to ensure professional regulation was robust, so all nurses were on the register, they were all doing their revalidation, and I had processes and systems to ensure that was the case. Also, workforce planning was a key element of that role, so ensuring that I ran the workforce planning tools and triangulated them with professional judgment and context to ensure that we had enough nurses where they should be. Also, education was a big part of that, so ensuring that the

nurses were appropriately educated to wherever it was that they were working.

Q Yes. I mean, are we somone we should see you as having a, as it were, professional medical role as well as a managerial role?

A So, yes, in a sense. So, I was a professional leader, but I was part of the Directorate Management team and, therefore, I would be contributing to things that I felt were important professionally into any discussion within that team. So any decision making or anything, I would be coming that and saying, "Well, my professional advice on this…" to my director, who is my line manager.

Q And that was?

A Kevin Hill.

Q Yes. So, you, quite helpfully, describe this or capture it, I think, in your statement when you talk about the solid lines and the dotted lines. Can you tell us just, really, what you are talking about in that context?

A Yeah. So, as a professional, so as a nurse, if my line manager is not a nurse professional, then I would also have a professional line. So, this works right through the system. So, my direct line manager was Kevin Hill, who was the director of Women and Children's, and also

sitting alongside me was a chief of medicine. So chief of nursing, chief of medicine and operational manager. So it's triumvirates that sit at each level of the organisation. My professional line, at that point, was to the executive board nurse director, who was Mags McGuire.

Q Yes.

A And that's the dotted line.

Q That is helpful in terms of the dotted and the solid lines going up the way from you. What I am interested in, maybe just to complete that picture, is how dotted and solid lines work beneath you. So, in terms of the-- Is it the lead nurses that report into you?

A Yeah, so they didn't report into me, they-- So, their solid line was to a clinical service manager. So, you've got Jamie Redfern, I think, who you spoke to this week. He was the general manager. So Jamie and I worked closely. He was the operational manager. I was the professional lead for nurses. There was two clinical service managers, and they reported into Jamie. The lead nurses, there was four – laterally, five – and their hard line was into the CSM, who reported into Jamie, but their dotted line was to me professionally.

Q That is really helpful.

Now, maybe what we want to do then is just-- If we imagine the lead nurses, what sort of considerations would be going up the solid line from them, and what sort of considerations would be going up the dotted line to you?

A So, more operational-- The lead nurses have got a dual role almost, so operational matters would be going to the CSM. So things like our health and safety stats, and things like mandatory sort of data collection that wasn't professionally linked, so that would go through the CSM. The CSMs and I met regularly. We were a small team. So, I would say that, while I'm describing this as a divide, me and Jamie also worked really closely, so we would pretty much know what was going on from those angles for me.

I also met monthly with the lead nurses individually, as well as having a monthly meeting with all of them together, and we worked right in the next office to each other, so there was lots of opportunity for anything to come to me, but professional matters that would come to me would be around nursing quality care, workforce planning and staffing and any kind of issues that they might want to raise that are linked to that professional line. So, if they had a nurse that was maybe falling off their registration or coming or they were at risk of falling off their registration, then that would come to me.

Q Thank you, that is helpful. I think that probably does capture what I was looking for. I have one other question around this that I think may be of interest. Do you wear a nurse's uniform when you are at work?

A So, when I was chief nurse, I mostly wore a nurse's uniform. Some days I would wear clothes, like-- you know, civvies, but a lot of the time I would wear a nurse's uniform.

Q You can probably imagine why I am asking that question because, I mean, I do detect – and we will get to this, perhaps, later – that one of the concerns that you identified about the patient and family evidence was this question of who is and is not management. Throughout this period, when you were, as it were, visible, you would have been wearing a nursing uniform. Is that right?

A Yeah, mostly.

Q Thank you. Now, if we move on from there, then, what I want to do is go through matters chronologically and, as I think was indicated to you earlier, we have covered off quite a lot of this, and it probably means we can shorten

matters to just individual aspects. So, what I want to do is, first of all, cover the period from September 2015 up until what came to be known as "the water incident" in March 2018. So, if you think about that period-- I am going to take it in stages. We will start with 2015. As you have already indicated, you started at the RHC in September 2015 as chief nurse. Is that right?

A Yeah.

Q And that was, if I am right in understanding what you said-- your oversight would be in relation to a paediatric unit that was wholly on the RHC site. Is that right?

A Well, there was actually a paediatric inpatients in the RAH as well at that point in time, so that was relocated over in 2018.

Q Yes, that is what I was not sure about, and then, as far as neonates are concerned, I think you said there are three sites.

A Yep.

Q I want to, obviously, just focus on the RHC. In your statement, you described positive impressions that you had of the new hospital when you arrived. I wonder if you could maybe just explain those to us.

A So, I didn't start until September, whilst the hospital had

opened in January. That's because I was on maternity leave. So, I'd come back from mat leave and walked into the hospital, and for those of you that have been there, it's really inspiring. The atrium's, like, really quite stunning. When I worked there, I used to watch kids walking in, and their faces would light up when they came in because it's really colourful. It's just beautiful. It's a beautiful atrium. First impression's, really, of the hospital were that when you walk in. It also had really good facilities.

The Medicinema was great, and it was an added advantage that there was adults on that site that could take advantage of that Medicinema, because we didn't have that before. There was advantages like the paediatric hospital are the only centre in Scotland that do renal transplant for children, and quite often a donor will be a parent, so the parent and the child could be basically on the same hospital site, and then, therefore, see each other sooner. It's easier for the other parent to go between them both. So there was lots of advantages. That's just a few, from when I first started, that I noticed.

Q We have had, as I suspect you are aware, quite a bit of evidence about what people saw as

the downsides or not so positive aspects, and that was evidence that came from not just the patients and families but also from some of the clinical staff. I do not need to go through all of that with you. I mean, I think the task for the Inquiry is to try and work out what all of that amounts to. I think it is only fair to notice that you have some positive things to say about the site as well. Just maybe picking up on one of them that has been said on the contra-side, the smell of sewage, is that something that has bothered you?

A Not massively inside the hospital. I mean, some days, maybe walking there, you would smell it, but not every day.

Q Okay.

A And, once you're inside it, it wasn't something that I can say that massively bothered me, no.

Q Another thing that has been mentioned more on the, as it were, positive side of things that I think it is only fair to mention, were you aware of whether, as regards to the use of single rooms for patients, there was any benefit, as regards infection risk, by using single rooms?

A Well, yes. So, it is an important point for a few reasons. We'd went from a hospital where I think we had about 30 per of rooms were single rooms in old Yorkhill to about 80 per cent being single rooms in new Children's Hospital, which was a benefit for us in terms of making sure, when we needed to isolate children from each other because of infections – and we get a lot of winter viruses with paediatrics, so RSV and flu and things like that, so-- We would quite often, in Yorkhill, run out of isolation spaces, whereas, in the new hospital, we didn't have that issue.

Other advantages were the parents really liked the single rooms because they got more privacy, and they had an ensuite in the single rooms. In the previous Yorkhill, all the parents had to share one bathroom. Some challenges around it were, certainly with nurse staffing, it made visibility of your patients just a bit more resource-intensive, in terms of nursing and what you had to do, so that was something that I worked on.

Q Yes. I mean, other things-- You may or may not be able to help us with this, but I think it is only fair that I ask you for your comment. Other things that have been mentioned by the clinical staff were concerns around the distance between the ward and their offices and also the proximity of pharmacy services. Is that

something that you were aware of at the time?

A I was aware, in the background, that people wanted offices in various different places, but I didn't get too involved in that to be honest.

Q Okay. Now, one thing that you do mention in your statement is that you said that you had some awareness of what you describe as "snagging issues" when you arrived. Can you tell us what you mean by that?

A So, I was aware, in the background, that there was a kind of snagging list somewhere with Estates that people were working through, just as you would with a new build house, I think, if you moved in. The one that I remember was the blinds. The blinds are in between two bits of glass and the blinds were often breaking early on. So, the reason probably I was aware of that is because it had an impact on patient experience and, therefore, we would try and move heads around to make sure they were in a room where the blinds worked and then get Estates to fix the blinds. So there was a programme of work around that.

Q Okay, thank you. Were you aware of any-- noting that-- In all

fairness to you, noting that you arrive in September 2015 and noting also, in the evidence that I am about to mention, the events that I am about to mention mostly, I think, predate that, were you aware of issues with the BMT rooms in 2A as regards the ventilation system at that point?

A So, not really. I vaguely remember Jamie and others working on things, but I wasn't involved in it, and I couldn't describe it.

Q Okay. The other one that I will just mention to you: we are also aware of issues to do with the Adult Bone Marrow Transplant unit in 2015. Was that something that you were aware of?

A Not at that time, no.

Q Okay, thank you. Now, finally, just to complete 2015, I am going to ask you if you are able to help me clarify something. It is a reference in an IMT that I previously asked that you have a look at. Ms Ward, I wonder if we could go to bundle 1, please, and if we look at page 20? Now, if you have got that in front of you, if you just take a moment, we will see that that is an IMT minute of 24 December 2015, and I think you were there. Is that right?

A Yeah.

Q The particular passage

that I would quite like you to look at is on page 21, Ms Ward, and if we just enlarge the fourth paragraph down that begins, "CW asked…" It is really the second bit of that, the assurance around the commissioning of the water supply. I will take this in stages. Do you have any recollection of that discussion?

A No.

Q Having had-- Have you had an opportunity to look at this minute?

A Yes, yes.

Q Has that jogged any memory?

A No. I do not remember him saying that specifically. The only thing I can think of is-- it was pseudomonas, which is water, so he would be talking about water, but I don't remember that discussion.

Q Do you have an understanding of what that is about, if I can put it that way? Do you understand the question?

A I mean, all I can read from it is that there's been some other conversation around about-- there's been some kind of request for assurance that commissioning of the water supply was okay, and he's saying, I think, it was okay.

Q And are you telling us that you do not know what the request for assurance around commissioning was about?

A No.

Q And you cannot remember what was being said?

A I don't know what that was about. That would have been a conversation I wasn't involved in.

Q Right, that is fine. No, thank you, that is helpful. We can put that to one side. Now, I want to move onto 2016 and 2017, and I am going to ask you in a minute to give us some evidence about infection rates. We will come on to that in a moment but, before we do that, I just want to also just draw attention to another document and just ask you for your comments on that. Ms Ward, could we go to bundle 4, please? It is page 104, in fact, if you just take us a page back.

Now, we seem to have here, if we enlarge the top of the page-- We will just take this quite slowly because it is not an easy document to handle. An, "SBAR RE Infection Control and Patient Safety at QEUH," Dr Redding, Dr Peters and Dr Despande, dated 3 October 2017. Now, again, I will ask you similar preliminary questions. Can you recall whether that was a document that you were aware of at about the time it was written or

appears to be written?

A No, I wasn't aware of this document at the time that it was written.

Q Is it a document you have had an opportunity to look at before today?

A I've had a wee look at it.

Q Yes. So, the only thing I want to do with it is-- if you just notice – it is quite helpful the way it currently is positioned – in the boxes, just notice the categorisation of date raised, type of accommodation, current situation, patient/staff, and if we just go over the page, please, to the page we were originally at, which is 105. I am just going to draw your attention-- I hope everybody can see that sufficiently well. So, if you take the left-hand side, I think we are to understand that these are said to be issues that arise from June 2015. Then, if we go into the third column, we will see we see references to the PICU, 2A, throughout the RHC. Do you see that?

A Mm-hmm.

Q And then if we go-- Can we just scroll down a little bit, please? Thank you. If we just notice the reference to, "Safe placement of patients who are immune compromised is not documented or risk assessed for either QEUH or

RHC," and if we can scroll down a wee bit further – that is fine, thank you – in the same column, "High rates of line related infections are being experienced in the 2A immune compromised population," and then-- Are you with me so far?

A I'm with you, yeah.

Q Yes. Sorry, I am maybe doing this too quickly.

A It's all right.

Q Do tell me to stop if I am going too quickly.

A Okay, will do.

Q And then, across the page, just directly across, "At the time fungal growth was demonstrated," and so on and so forth. Do you see the reference to, "Air quality has remained an issue on 2A since opening." Do you see all of that?

A Mm-hmm.

Q Now, noting what you said a moment ago about not having seen this document before, can you say whether the issues that are raised within this document were issues that you were aware of at the time?

A So, some of the issues raised are issues that I was aware of at the time but not all. So, obviously, the high rates of line-related infections was something that I was working on with the team, and I can describe that

in more detail. In terms of patient placement, we worked-- So, there was some work we did; it might have been around about that time on patient placement, so it might have been triggered by some of those conversations on the side, and I did work with, actually, one of these microbiologists and the Infection Control team on patient placement for airborne infections for paediatrics, so----

THE CHAIR: Entirely my fault, it is just an expression you used there which I did not pick up on. Did you use the expression "patient placements"?

A Yes.

Q Right. I mean, I should perhaps understand what that is. I am not really quite sure that I am. I mean, is it just where you put patients?

A Yes. So, we have lots of standard operating procedures about if you've got a chicken pox or if you've got this or if you've got RSV, what kind of room you should be in. So that's what we call patient placement.

Q Thank you.

MR DUNCAN: It is entirely my fault, in fact. If we go back to page 104-- I have taken this too quickly, as I thought I would do. If we go, please, to a little bit further down, Ms Ward, there we have it. Patient placement.

THE CHAIR: I should have, perhaps----

MR DUNCAN: Well, I think you would have if I had flagged it to you. Anyway, we have seen it now. Does that accord with-- I think it does accord with what you just said.

A Yeah.

Q If we go back to where we were, then, which was page 105, and-- Again, sorry, can we scroll back down a wee bit? Just so we get to the-- I will tell you where to stop. Yes, that is fine. Thank you. So, the high rates of-- or what-- Let us not lead on this. Rates of line infection was something you were aware of. I am going to ask you some questions about that in a minute. What I am asking you, additionally, is whether what appeared to be concerns about placement of patients-- whether those were things that you were aware of at the time?

A Just, as I say, that work that we did do with kind of writing the SOP with one of these microbiologists around children with airborne infections. So, we wrote a SOP about a pathway for them, and it must have been around about this time, and that pathway was to the GRI, I think, for children of a certain age. There was

some other plans around about that as well. CDU, I think, was part of that pathway.

Q Yes. Now, I mean-- One thing that we have been emphasising to all witnesses giving evidence is that we absolutely recognise the different specialisms and expertises that they all have and keep in mind that qualification in answering the question I am about to ask but, in a description of concerns around what might be thought to be air quality, can you say whether and to what extent your understanding would be that that would be possibly connected to line infections?

A So, I didn't have-- That wasn't on my radar – air quality and line infections – no. The Aspergillus that's mentioned there, there was an IMT, I think, for that, and I was involved in that, and I think a tile was implicated in that, so it was a specific kind of linear thing rather than a general "there's an issue with air quality."

Q It was not a very clear question from me, but I was just wondering, in terms of your general understanding of things, would you understand or is it your understanding that it is possible for there to be a connection between air quality and line infections, or is that not something that you feel competent to speak on----

A It's probably not something that I would feel that I could answer.

Q Okay, that is helpful. Thank you very much. I guess the only other question I would ask is this, and it is a question we have asked other witnesses: do you feel that this is a document that you ought to have been made aware of at the time?

A I mean, a lot of it's about ventilation, and I think it's unusual at this point how much I know about ventilation as a chief nurse. So, at that point in time, we weren't in the place that we ended up being in.

Q You mean today is-- you have knowledge of ventilation that you would not have expected you would have had?

A I wouldn't have expected to have, yeah. That's not just me. I think that's others as well, but that's because of this chain of events so, at that point in time, maybe not. I was undertaking some improvement work at that time, and the authors of this report did know that and did come to the meeting, so there was opportunity to raise things if they felt that it was linked to the work that I was leading with Tim around CLABSI.

Q Okay, well, that is helpful. We can put that to one side, and we will move now into thinking about infection issues in 2016 to 2017. Now, it might be helpful-- Ms Ward, I wonder if we might just open the statements bundle. I apologise; I did not flag this to you beforehand, but I think on balance it is probably going to be useful to do this. I wonder if we could go to page 464, where hopefully we will find paragraph 90. Yes, indeed.

THE CHAIR: Mr Duncan, just so that I am following, the statements bundle is not given a number. It is just the statements bundle?

MR DUNCAN: I think so.

THE CHAIR: Right. Thank you.

Q So, before I start asking you questions on this, Ms Rodgers, I think it is only fair that you have the opportunity just to see what you have said in your statement. So:

> "In 2016, there was a spike in line infections flagged to us by our Lead Nurse for infection control. It was thought to be attributed at the time to change of the type of central line from Bard to Vygon. Additional education was put in place …
>
> "Subsequently the rate increased in early 2017, at that point the surgeon and I met and discussed adopting a quality improvement approach. We struggled to find data from comparable UK centres against which to benchmark…"

You describe going further afield. I think we might as well just complete the paragraph, if we could go over the page please, Ms Ward. Inquiry is made with Cincinnati Children's Hospital. Now, having just identified the passage in your statement and given you the opportunity for that refresh, I just wanted to go through some of this, and I appreciate that you then set out quite a bit more in your statement on this and we might look at that. Let us maybe get some preliminary matters understood. What is a "CLABSI"?

A It's a central line associated bacteraemia blood infection, related to somebody having a central line in, which is essentially a bit of plastic that goes into a major vein.

Q Yes, thank you. Something that you mention in your statement a little further on – it is paragraph 97 if anyone wants to look at it – is something called "CDC classification."

A Yeah. So that's the

classification we tried to use around about-- and this was all about us being able to be really clear about what we were measuring because-- so, as part of us doing a quality improvement project to improve our CLABSI rates, we had to collect data. To collect data, you have to know exactly what it is you're collecting the data on, so there has to be some kind of criteria around that data. The conversation with Cincinnati-- they used the CDC classification. I think that's kind of generally used. It's essentially a primary bloodstream infection, as it says there, in a patient with a central line that's not linked to a different infection that they might have. So it's supposed to be around about that line, rather than linked to some other infection in their body.

Q And "CDC" is?

A I just can't remember that right now, what that stands for.

Q No problem. I think it is probably a term we have heard in the news from time to time, so I am sure we can pick up on it if we have to.

A Yeah, sorry.

Q Now, you say that despite-- What I want to do now then is move forward and just think about 2016, and then we will look at 2017.

A Okay.

Q When we get to 2017, I am going to ask you to look at one or two of the PAG minutes, if that is the word, just to help us identify some of the detail on this. 2016, you say the spike was reported by the lead nurse for Infection Control.

A Yeah.

Q Now, can you tell us how was that reported to you?

A She came and spoke to me about it.

Q Was that in a regular meeting, or would that have been an ad hoc meeting?

A Ad hoc. I would speak to the lead nurse for Infection Control regularly. Like, they changed throughout my tenure as a chief nurse, but I met with them routinely anyway because I chaired a Control of Infection meeting every month, so we met two weeks before that to set the agenda, pick up actions, then we met at that meeting. In between that, we met at any PAGs, any IMTs. If there was anything that was going on that they-- it wasn't all PAGs, but they would escalate things to me that they thought they should, so they were very good at that, so----

Q Are we to understand from what you have said, then, that there came a point where the lead

nurse for infection control felt there was a sufficient concern about infection rate, it had to be escalated to you. Is that right?

A She escalated it to me with the answer, if you like. So she came and said, "We've got this problem. We think it's linked to the Vygon to Bard," because the second line had an external fixator and they thought that might be creating an issue. The reason they changed to an external fixator was because, if you imagine young children and babies with central lines in, they will tug at them and sometimes they'll dislodge them. So it was to try and stop the lines being dislodged. So Infection Control came with that hypothesis already and we'd already put in some education and some changes around that and so that was that, and then the actual rate after that dropped for a wee bit.

Q So, we will come onto some of the detail of the measures that were instigated to ensure that we all understand what they are, but in terms of the point at which this reaches you, your understanding, or your recollection, is it reaches you at a point, if I could maybe summarise what you have just said, where the lead nurse is identifying that there is a

problem, there is a hypothesis and there is a proposed solution. Is that right?

A For that one, yes.

Q Yes, yes. Now, whether or not the Inquiry needs to look at any of the records and reporting around that is perhaps something to consider at a further date but, were we to want to see the record of reporting on that particular chapter, where is it we should look?

A Probably Infection Prevention and Control plus the unit. So, they had escalated that to me verbally. I don't know if they ever wrote it in an email to me, but I could easily check that.

Q I am thinking about formal reporting or formal documentation. Is there a forum on which that happens?

A So, there's the Control of Infection group that I chaired every four weeks, so any issues are brought to that group. So any PAGs or IMTs, the likelihood it would have been brought to that group – any policy changes, anything like that, and any issues different teams have because that covered the whole of Paediatrics and Neonates.

Q That is helpful, thank you. Now, the further question I have

got, again just thinking only about 2016, is are we speaking about infection rates only in relation to Schiehallion Unit patients, or are we also speaking about patients outwith that unit?

A That was just the 2A patients.

Q I might as well ask the same question at this stage. Was it the same also in 2017? Was it just those patients?

A Yeah.

Q Thank you. So, if we move then to 2017, your evidence is – I think as we have just seen – that there is a further spike in early 2017. You meet the surgeon and there is a discussion around that. I will come back to that in a little while, but I wonder if we could just identify whether we have identified the right documents on this. I wonder, Ms Ward, if we could go to bundle 2 now, please? It is page 19. Thank you. Now, this is a PAG minute. Is that the way to describe it?

A Yeah.

Q It is not one that I think records any discussion involving you. Would that be right? This would not have been a discussion with you about this?

A It doesn't look like it from the list.

Q Okay. Can you say whether you have had an opportunity to look at it before today?

A I did look at this, yes.

Q Yes. So, all I really want you to do is just help us with it if you can. So, if we go to the "Subject/situation" part and maybe enlarge it slightly so everyone can see it.

> "Clinicians reported a perceived increase in fungal infections amongst paediatric haematology patients within the Royal Hospital for Children."

If you want to then just go on and read the next paragraph, the "Background" section, and then just indicate to me once you have done that.

A (After a pause) Yeah, that's me read it.

Q Right, okay. Really the question I am going to ask is it is similar to one I asked a moment ago, and again I would emphasise that if you do not feel it is a matter for you, please do say so. Do you think the discussion about fungal infections and the concern of Professor Gibson is linked or part of the line infection concern, or is this a different concern?

A It's a different thing.

Q Yes, thank you. So, if we can put that to one side, please. If we could go onto page 22 in the same bundle. Again, if we maybe just, sort of, go to the foot of the page just to identify that once again, having seen that this is a PAG, I do not think we see your name mentioned on it. Can you say whether that would indicate that that is not something that you would have seen at the time?

A I might have seen it at some point, but it wouldn't maybe have been directly discussed with me, but I was already very much aware of this issue at that point in time.

Q I think you possibly anticipate the next question. If you go up the page, please, Ms Ward, just to "Subject/situation." Again, if you just have a look at what is said there, Ms Rodgers: "An increase in positive blood cultures in Paediatric Haematology," and so on. "General upward trend," positive cases and so on. You see all of that?

A Yeah.

Q Now, can you confirm whether this one is connected to the concern about line infections?

A Yeah.

Q It is. Well, that is helpful. What I would like to then do is-- if we can go to the "Background" section. I am just going to walk through this, if I might. I will jump in when I think there is something I would like to ask about, but if there is any particular bits you want to flag up, please do, though. It says, "Most lines are inserted by the surgeons. Line care is carried out by nursing staff or phlebotomists." What is a "phlebotomist"?

A They're a member of staff that just takes blood from people.

Q

> "Parents do not carry out line care for their children but may perform dressing changes at home. No protocol for line removal, it is a clinical judgment made by medics on a case by case basis."

What does the reference to "no protocol for line removal" mean?

A So, that's around-- and I think they did have guidance on it actually, at the time, but it was a clinician judgment. So that's around if you have a line infection, what you then do with that line. Do you take it out, or do you leave it in and, you know, treat it with antibiotics, or not use it? So, now, the reason that's a clinical judgment is because children might not have many veins left to use, so if you're maybe early in your treatment, they might take it out, but if

you've come some way or you haven't got a lot of veins left and you really need that treatment, it's all a balance of risk. So I think every decision we make in healthcare has a risk: has a risk if you do it, has a risk if you don't do it. So that's describing that risk.

Q Yes, that is helpful, thank you. Then we have got a part that is probably self-explanatory: "Perceived increase in lines being removed and replaced due to suspected/confirmed line infections," and then the reference to the change in the type of lines used. Is that the bit that you were flagging up in your witness statement?

A Yeah.

Q Yes. Okay, if we go on then, please, to a further item in this bundle. It is page 44. Now, while we have got the top half of this page enlarged, I will just mention something to you that was flagged to you before today's hearing and we have been flagging to everybody who has been giving evidence. One of the things we have been trying to do is not get into individual patient cases here, if we can avoid it. I certainly do not anticipate my questions take us into that sort of territory, but I just mention that. So, if we go down the page, please. Having seen that this is a PAG of 22 July 2017 – just pausing there, Ms Ward –

having seen again that you are not on the list of people with whom it was discussed, but asking you again the question, given your awareness of the line infection concern and work around that, is this a discussion that you would have been aware of at the time?

A Yeah, I think I would have been aware of that at the time.

Q Okay, that is helpful. On that basis then, if we look at the recommendations and options, can you just walk us through these? So, if we take the first one, "Actichlor plus clean of ward on a daily basis"?

A Yeah, so it's like a chlorine-based product for cleaning, so it's enhanced cleaning than what your normal standard cleaning would be.

Q Yes. I think the next two appear to be self-explanatory, "Hand hygiene" and "Enhanced supervision by IPCT." Is there anything more that needs to be said than that, do you think?

A So, the "enhanced supervision" is actually something we introduced then and then kept building on over the, sort of, years that went after that. It was essentially where our lead nurse from the Infection Control team, and the lead nurse from Paediatrics, and Estates and Facilities would come round and they would look

at hand hygiene. They would look at a room. They would look in detail at all the cleaning specification – "Is everything clean enough?" They would look at kit, bedside kit like IV stands and pumps and make sure they were clean. So it was just a really-- putting a magnifying glass actually on the unit just to make sure, "Is everything as clean as it should be and do we need to take any action?" That's what enhanced supervision was.

Q Okay, and can we do the same with the next one, please? "QI group focusing on line infection in 2A." Can you walk us through that, please?

A Uh-huh. So, you've mentioned a bit about the change of line, and then thinking that, "Oh, that's better now," and then actually the line infection rate going up again early '17. So Tim Bradnock and I met, and with some others, and discussed what we could do. He'd done some literature search. We tried to get some information. I was a member of the UK Chief Children's Nurses Association. I tried to get some information from them about what their CLABSI rates-- but it was tricky because people measure these things in different ways in different places, and people often don't publish their

rates if they're bad.

So, it was kind of difficult to get that information, so we connected with-- and just to state a note on that: Great Ormond Street, for example, we looked at. Their GOSH-acquired CLABSI was for their inpatients and we were looking at CLABSI for all our patients, whether they were inpatients or not, so inpatients and Day Care patients and outpatients. The reason I think that's important is because we weren't looking at this as a, sort of, "There's something wrong with the environment." We were looking at this as, "Our children's CLABSI rate is high. We need to look at every aspect that we can do to improve that and bring it down for all our children, no matter where they are." So that was important for us.

So, anyway, we connected with Cincinnati. They had some published work on CLABSI. I had a quality improvement paediatric group that I chaired then. In March 2017, we presented our CLABSI project to that group. We started the work before we had our first meeting in May, but we had our first formal meeting in May 2017. Essentially, our aim was to match the Cincinnati best in class rate, which was one per thousand line days. So our median-- we then collected the

data retrospectively back to when we'd been at Yorkhill, around six months of a period of time we were at Yorkhill and then after. So we didn't have that CLABSI chart before that. That's when we generated that chart.

So, we got the chart. We spoke to Cincinnati on some conference calls and then we pulled a group together. The group had surgeons. It had anaesthetists. It had PICU people. It had Infection Prevention Control. It had the Paediatric Outreach Oncology nurses because they look after the kids in the community. They had ward nurses. There will be more people there that I've missed, but it essentially had all the people that we thought were key stakeholders for that work. So, our aim was the one per thousand line days. We were at a median from Yorkhill at 3.25 per thousand line days, but in May 2017 we were above that median, so we were all concerned about that and we all wanted to put in actions rapidly to improve it.

So we set up subgroups and the first subgroup was about line insertion. So, lines are inserted in theatres, so, "How do we insert the lines? Let's review how we do that." That group were tasked with going away, getting best possible evidence of line insertion and coming back and applying it to our

context, so we changed the way that we, kind of, managed the theatre. So we made the theatre a closed theatre. We had everybody-- mandatory wearing masks. Nobody was allowed in the theatre for line insertion unless they had to be there, and we re-did the kind of bundle that we had around line insertion in theatre. We also looked at dressings and changed the dressing to a superior dressing product that would be put on in theatre.

The second group looked at line maintenance and line care, so that's the, kind of, big nursing part of that, so we done a range of things for that. So we introduced aseptic non-touch technique, so a different way for nurses and Phlebotomy to care for the lines. So we trained everybody on that. We introduced port protectors, so if you imagine the end of a central line, it's got a little hub on the end of it. On top of that hub, we added a port protector. So it's an alcohol-impregnated cap, essentially, so it's 70 per cent alcohol in it. So it means that that line has got another protection on the end of it. I think that's important to note with children because, as I said, they're young. They're crawling around and they're playing, and sometimes they've got a nappy and the end of their line might go in their

nappy, so all of those things. So we introduced them, and the way that we washed around about the line and the dressings that we used. We also looked at the number of times we accessed the line, so we tried to minimise the amount of times we accessed the line. So, these kids are getting a lot of medication, a lot of fluids, and so you can try and clump what you can together so you're accessing the line less times.

So we looked at those things, and the third group looked at staff education. So, did a range of education in terms of the aseptic non-touch technique training, just infection control work. We had a kind of meeting. I want to call it, "truth and reconciliation," but I know that's not the right word for it. It was a meeting where we spoke to the nurses and the teams and the Phlebotomy that accessed the lines to just say, "What do you think we could do differently? What do you think are barriers to us doing best possible evidence, if there are any? What do you think about aseptic non-touch technique?" So we had that. The surgeon was at that as well, and it was a really positive discussion.

Fourthly, we had a focus on family education, so we did family

sessions. Infection Prevention and Control did family sessions as well. We made kind of a little poster for the rooms about how to look after your child's line and line care and line guardianship, almost.

Q Yes, that is really helpful. I think you have probably covered off all of the matters that you mentioned in your statement around this. For those who wish-- the reference, it is really around paragraph 86 that we see Ms Rodger set all of this out. There is just one or two of them that I would like to maybe just have you help me with a little bit. So, I think you have told us about the paediatric QI group, and you have told us about a new dressing. Is that right?

A Yeah.

Q Yes. We have heard-- is it Mr Bradnock? We have heard his name being mentioned. Was his involvement around really thinking about the way in which surgery was being carried out and also maybe the question of when and in what circumstances a line would be removed?

A So, Tim Bradnock was a key leadership in the whole CLABSI group, so him and I worked closely around about that. So, he did much more than the theatre part, although

the theatre part was his part because he's a surgeon.

Q Yes. Now, a couple of points that I want to pick up on just to be sure I have understood them and because one of them at least was something that got quite a bit of attention from the patient and family evidence. Let us deal with that one first. A number of parent witnesses talked about seeing a change with caps being put onto the lines, and you described to us that that is indeed something that happened, and you have described that these were alcohol-impregnated to add, as it were, a further barrier. Is that right?

A Yeah.

Q Yes. I think I have you noted in your statement as saying that was around August 2017?

A It was, yeah.

Q Yes. Can you say whether-- I mean, I think you have already covered this in your evidence, but it is really just to pick up on a perception that some of the parents possibly had. Can you say whether, as at August 2017, the decision to introduce caps onto the lines was anything to do with a concern about an issue with the water supply?

A Yeah, absolutely not. So, it was something that Cincinnati

had done, and we spoke to them about the types of caps they used, and we had been looking and engaging with UK companies for a wee bit before that to try and get a cap that would fit onto our needle-free devices that we had used at the time. There was nothing about the water.

Q Yes. Aseptic non-touch is what?

A So, if you're accessing a central line, you want to make sure obviously you're doing it in as clean a way as possible so you're not getting any-- introducing any bacteria in your process. So, aseptic non-touch technique is where you have key points that you don't touch, that nothing touches. So, say, the end of a syringe, or, as I say, the needle-free device. You would clean it, let it dry, make sure nothing touches that. You've drawn up whatever it is you're putting in your line, so your medicine. You make sure that you haven't contaminated the end of your syringe in doing that, and then you inject that into the line. So, it's basically non-touch. It is as it's described.

Q I mean, if you were to capture your understanding of the overall hypothesis over 2016 and 2017, how would you describe the hypothesis over that period about what

the issue with infections might have been?

A So, from the QI group, it would really work so much on hypothesis. It's taking best possible evidence and putting that into practice in your context. So, part of it was line insertion and part of it was line care. Part of it is how you live with the line, so the kind of lived experience around about having a line. You don't really have-- and I certainly wouldn't have supported having the luxury of doing one thing and seeing if it worked and then waiting, and we wouldn't do that when kids were getting line infections. You throw everything you can and so, therefore, sometimes you don't always know if it was this or if it was that, but if you've fixed the problem then that's a good thing because then kids aren't getting infections.

Q So, I mean, overall, the focus of the work at least-- I understand the point. You were not waiting to find out whether or not a particular hypothesis was correct. Your focus was on the work, but the work was focused around line care, hygiene, that kind of thing.

A Yeah, and families and basically how we live with the line. So, yeah, and insertion.

Q I suppose----

A It was a range of things, I would say, but line care was definitely part of it.

Q Yes, and is that where the truth and reconciliation discussion comes in with staff?

A Yeah.

Q Yes. Perhaps not an easy conversation to have. Is that right?

A It was okay, actually. I think, in the context of the time as well, we were doing a lot of scrutiny, and so you can understand that maybe I didn't want the nurses to feel like they were being blamed and it was their fault. So, we wanted to make sure we were having a really open conversation about that and working together on it, so that was what that was about.

Q Yes. Then, in terms of the waiting-- or rather in terms of the end result of all of that work, are we to understand from your statement that rates did drop?

A They did, yeah. So, they dropped when we started putting in-- Well, they dropped after the interventions. As I say, you can't-- it's not a linear process. Then, the next spike was the March 2018 spike, and then after that the CLABSI graph, if you look at it, the rates continued to drop and in 2019 were lower than they

had been in Yorkhill and towards the end of 2019 were under one, so on par with global best in class.

Q Okay. If we just take that in stages perhaps. The position was that as we move forward then into 2018, by that stage rates had dropped. Is that right?

A Twenty-what sorry?

Q 2018. So, by the end----

A Yeah.

Q I will rephrase the question so you are absolutely clear what I am asking. By the end of 2017, is it your recollection that rates had gone back to normal, if I can put it that way?

A So, by the end of 2017 rates had started to drop. I wouldn't say they had come back to normal. I think there wasn't enough data points to put a new median, but I think it would be around about four-ish. So, they were coming down, but they hadn't come down to our aim.

Q That is helpful, thank you. I detect from your statement that there was a presentation of some kind by you to the Board itself at the end of 2017, or have I got that wrong?

A Yeah. That's right. No, it wasn't the Board itself. It was the Board Infection Control group that was chaired by Jennifer Armstrong at the

time, as the exec director for Infection Control.

Q If we were looking to find out what the overall recorded reporting at that time was on this matter, would that be where we would look?

A Yeah. Absolutely. It's there in the minute of that meeting, and I went back to that meeting again in 2018, yeah.

Q That is helpful. Thank you. Thank you.

THE CHAIR: Mr Duncan, if you would excuse me, can I just interrupt on a pretty basic matter? This is median rates, and you made a-- there was a reference there to normal rates, but I think you explain – going back to paragraph 94 of your statement – that at the beginning of the QI project, which was to reduce CLABSI rates, at 94 you identify the RHC median rate at 3.25 incidents of the infection over a thousand line days. I think that is it, paragraph 94.

A Oh. This has got different paragraph numbers.

Q Oh. You may not need the statement for my question.

MR DUNCAN: I can give the page number if we want it up on the screen. That might----

A Oh wait. I found the CLABSI section. Okay. I've got it.

THE CHAIR: Now, my first question is-- I think there is a reference at 95 to benchmarking and the world centres and Cincinnati. Now, I think it is pretty clear from what is set out there. At the beginning of the QI project, you wanted to see where the Children's Hospital stood or sat in comparison to world rates. Is that right?

A Yeah. I mean, I think at the beginning of the project we wanted to find who had done work on this, who was really good at it, who we could learn from, yeah, and what we can be aiming for.

Q Right. Your conclusion was that, at 3.25, you were-- well, "above" and "below" raises a question, but I suppose "above" is that the hospital was higher than other world centres or just higher than your aspiration?

A So, 3.25 was Yorkhill and it was-- if you look at published data, then three-ish was probably-- for areas that hadn't done any additional improvement work, then three-ish would have been about their starting point, I would say.

Q Right. So that is helpful to me. So, 3.25 was the experience in Yorkhill, using that as one sort of base. Now, in later questioning you used the-- I think this is in relation to 2017 going into 2018, either you or Mr Duncan introduced the expression of normal. Now, if I am right in my recollection, what is meant by normal in the context of 2017 and 2018?

A Where did we say normal?

Q Well, that is my recollection of it.

MR DUNCAN: Probably my not very precise use of language that may have produced that.

A Okay. Oh, you said "back to normal." Yeah, "Did you feel like you were back"-- No, no. We weren't back to normal at that point that you're asking me about.

THE CHAIR: Oh, aha. It was just my very pedestrian way of thinking. What is normal? I mean, when one uses the word "normal," what does that mean?

A Yeah. It's a great question because, I mean, we're an improvement organisation, so I don't like the, "Oh well, it's normal, so, therefore, it's okay." We want to be the best. We want to be the best. So, the 3.25, we wanted to be better than that, so I don't think normal is probably, yeah. I'm not a fan of normal.

Q Right. Okay, so I come

away with it. I think my takeaway from that is that "normal" is not a very useful word.

A No. "Normal" is not an aim. Yeah.

Q Yes, right. Sorry, Mr Duncan.

MR DUNCAN: Thank you. I think maybe then just to try and capture what you had said, though, that rates had certainly improved by the end of 2017. Is that right?

A They were improving, I would think.

Q Improving, yes. So, moving then into 2018, I am going to ask you to look at one or two of the IMTs in a moment. Just some general questions about IMTs. First of all – we have had a bit on this already – what is the nature and purpose of an IMT?

A Well, so, an IMT, an Incident Management Team, is brought together when we either have an outbreak of infections or have a really unusual infection. So, an outbreak is two or more of same infection or one really super-unusual infection. It's chaired by an Infection Control consultant and also-- or it could be a Public Health consultant, and it brings together all the key clinicians from that area and key managers from that area. The focus of

the IMT will be to seek hypothesis and then put mitigations in to, essentially, control the incident. So, bring the incident under control-- put the mitigations in, bring the incident under control and then stop that incident happening again, if possible, so yeah.

Q Okay. In your statement you say that an IMT has delegated authority to make decisions and recommendations.

A Yeah. That's right.

Q What do you mean by delegated authority?

A So, it has delegated authority from the Board as part of the kind of governance set up to make decisions, whether it's closing a ward or whatever those decisions are. Well, I say closing a ward. Some decisions would be a recommendation that would have to go further up the system, but the IMT has got delegated authority to make quite a lot of decisions to do mitigations around whatever incident it is they're dealing with.

Q Does the delegated authority extend to making decisions around what communications should be made after an IMT?

A Yeah.

Q Is there a scheme of delegation that is recorded anywhere?

A So, there is a standard operating procedure on IMTs. It's like an IMT kind of framework outbreak document. It's got a section on communication in it, essentially, and there's, of course, the HIIAT tool that's used at every IMT. So, essentially, it's the Chair's decision and the Group's decision around what communications. If you look at the document – I don't know if you've got it – there's a list of people that should be informed about specific IMTs, whether it's rated green, amber or red, and there's sections on communication through the IMT at the IMT's discretion.

Q Thank you. Now, moving then into March and April 2018, and I will just try confine us to that period, if I may. Now, we have had a lot of evidence already on this, and I certainly feel we have had the chronology set out really clearly and consistently, so I do not need to trouble you with a lot of this. There are just one or two bits of it that I want to have you help me with, and I have been asked to clarify one or two points on behalf of other core participants. One of the things that you mention in your statement – I will just deal with this just now – is that you described that when you heard about the water incident-- and for those who want

references in the statement, it is round about paragraph 120. You mention in your statement, I think it is at paragraph 120, that water is routinely subject to testing for Legionella monitoring.

A Yeah.

Q Can you tell us what your knowledge of that process is and what its importance is?

A Yeah, very little. So, I just know that it happens and it's part of the rules, and other people do that, and I just know it to happen.

Q Okay. Thank you. That is helpful. Now, you set out for us, helpfully, at paragraph 121 to 122, your recollection of how you heard about the issue that had arisen. I wonder if you just want to take a moment to have a look at it and maybe just if there is any more you feel you want to say about what you heard at the time and the measures that were instigated at the time to address and mitigate it.

A Yeah. I mean, I specifically remember this moment in time because it was the Beast from the East on 28 February, and I'd went to work at seven o'clock in the morning that morning, and I was still in work the next day on 1 March because lots of people couldn't get to work. Nurses

couldn't get to work, and people couldn't get away from work. So I was trying to-- or I was the only senior management team that had managed to get into the Children's Hospital that day for those couple of days as well, so I had quite a lot to manage. There was theatre lists to manage. There was all sorts of things. So, then the next day, 1 March, Teresa phoned me about one o'clock and said, “I've found Cupriavidus in the water, and we need to stop the 2A patients being exposed to the water.”

So, I vividly remember being in my office, sitting down and really trying to think through what do we need to do right now to make sure we keep these patients safe? So, Teresa and I discussed that. We couldn't call a proper IMT at that moment in time, and it's funny to say this now, but it was pre-Teams. Like, Teams would have maybe changed that, but it was pre-Teams. People were scattered all over the place, so Teresa said, “Right. These are the things.” I said, “Okay. I will follow this conversation up with an email, so we treat this like not an IMT but a kind of formal conversation,” and she said, “Okay,” and that is the email that I followed up with. Now, in the----

Q Can I just interrupt, just so we're clear?

A Yeah.

Q Is that what is set out in paragraph 122?

A Yeah.

Q Thank you. Sorry. Please continue.

A So, meanwhile, the Lead Nurse for Infection Control was communicating with Teresa. So everybody's at home and communicating on phones, so there's quite a lot of-- people weren't actually in. It was just the snow made that challenging. So, the Lead Nurse was communicating with the ward, and also there was the Paediatric Lead Nurse that went up to the ward. So, between us we put these measures in place that day that are listed there on 122.

Q Okay. That is helpful. Now, I have been asked to clarify one aspect of them with you. As regards the reference to silver hydrogen peroxide being used, can you recall-- It may be implicit, but can you recall who it was that was recommending that?

A I think it was Teresa as the IMT Lead but also the lead Infection Control doctor.

Q Do you know whether that is a proposition that she had come up with or whether it had been suggested to her by somebody else, or

are you not able to help us with that?

A I don't know that.

Q Do you recall any discussion about the appropriateness of that measure?

A Not really, no.

Q Okay.

A I remember at the time we thought, "We'll do this and then it'll be fixed." so we didn't foresee this as like----

Q Okay. Just on this particular measure, a further thing that I have been asked to clarify with you is can you recall whether you understood HPS to be aware that this measure was being used?

A Oh. I don't know that at that time, but the Infection Control Team would have escalated that in their normal routine paperwork to HPS, so that should be documented.

Q That would be your expectation?

A Yeah.

Q Thank you. Now, if we can look at one or two of the IMTs and, as I say, if you will forgive me, it is really just to complete bits of the jigsaw that we have already been given. So, if we go, please, to the IMT of 2 March, Bundle 1, page 54, please, Miss Ward. So, we have an IMT of 2 March 2018, and we see you recorded

as being present, okay?

A Yeah.

Q Do you see that?

A Yeah. It just disappeared, but it's back.

Q Yes. It has been doing that on my screen as well, so concentrate while it is there, I think, is the lesson. So, 2 March, IMT, we see you are present. If you go further down the page, please, Miss Ward, really to the foot of the page, "Hypothesis is that…" Have you got that?

A Yeah.

Q Yes. If you just take a moment to read that and tell me when you have done it.

A Yeah.

Q Can you recall a conversation about flow straighteners?

A Yes.

Q Can you tell us a wee bit about that?

A Yes. So, I'd never heard of flow straighteners before, and I really can't describe exactly what they are, but they're mechanisms inside the taps, and the hypothesis was that this was generating an area an area for biofilm to live and, therefore, that was causing the bacteria in the water. There was a meeting. It wasn't this one, but it was during this IMT period

where we-- someone from Estates actually brought some of the connections from the taps in little bags so that everybody could have a look at them and try and understand it better.

Q It may be implicit in what you have said, but just so I am understanding correctly, can you recall whether there was any suggestion that there was understood to be a risk with the use of flow straighteners, or is that not something you can help us with?

A That's not something that I'd be able to help you with.

Q Okay. Thank you. Now, if we go on, please, just to look at another one, please. Is it page 60 in the same bundle? Again, just taking a moment to identify it. We see that it is an IMT meeting on 9 March, and I think we see your name in the second line.

A Yeah.

Q Again, maybe I should have said this before we looked at the first one. Are these documents you have had an opportunity to look at again?

A Yeah.

Q Is that right? Thank you. Now, if we go down the page, again, please, to the section on investigations, and if we stop now. If you take a moment to read the

paragraph, “Dr Inkster informed the group,” and tell me when you have done that.

A Yeah. I've read that.

Q Okay. Thank you. Now, again, I will take it in the same order of questions. Do you have a recollection of a discussion about taps at this point?

A Yes.

Q Well, let us take a further question; are you able to indicate whether what is recorded there accords with the recollection?

A I don't remember anything about cost implications. I remember some discussion about the taps, and I know that there was processes the Infection Control Team and Estates went through around that, but I just don't have the detail on it to be able to add much more.

Q Well, let us take it in stages. What is your recollection, if any, about a discussion about taps?

A So, my recollection is there might have been some-- I apologise if I'm not quite exactly right on this. There might have been some guidance put in about taps, but I think it was after either the hospital had been built or it was all sort of-- the time frame of it was-- I don't know that the guidance was in before the work was

done, I'm trying to say, in the new hospital, but that's all I remember about it. I think there was some chat about the guidance, when it went in and what should be done, and that was really led by Teresa Inkster and Estates. I was trying to focus, in these IMTs, on my role as Chief Nurse and not get too sucked into things that I didn't understand, probably.

Q Thank you. Then, if I ask you again, then, about what is set out in the minute and whether or not what is set out accords with what was said, you have said that you do not recall a discussion about cost implications. Is the rest of it in line with what you recall?

A I think so, yeah. I found during this whole process that cost has not been a limiting factor to anything that we've done, so any of the mitigations that we've put in, whether it be filters, HEPA filters, whatever it is that's needed done, it's been done. Nobody's really mentioned anything about cost. It was a given that if we needed to do it, we needed to do it.

Q It is possible. I mean, this is something, no doubt, we will explore with other witnesses and we have explored with some already. It is possible that what this relates to was a discussion not about mitigations but

about events before September 2015.

A Yeah.

Q So, the investigations that you have just mentioned about the approach to cost, do they extend to that period as well?

A Well, I don't know because I wasn't involved in any of the pre-2015 conversations.

Q Are you saying, therefore, that the comment you just made about cost not being an issue is not one that you apply to the pre----

A Not pre that I know of.

Q Thank you. Now, if we go over the page, please, to page 61. Again, I am going to ask if you can help me with the top paragraph in the same order. Do you recall a discussion of that nature?

A Yeah. I mean, this is a kind of broad question that I would bring to whatever issue I was dealing with, like, as I've described a wee bit in CLABSI, say, “Well, what's everyone else doing? What are other places doing? Where are we against best in class?” So that's what I would have been trying to get at there.

Q Yes. What was the particular purpose in-- sorry. Let me take this in steps. Is what is set out there, is that in line with what you recall seeing at the time? Is that right?

A Yeah. I think so.

Q Yes. What was the purpose in contacting other health boards?

A So, other health boards with similar high-risk patients to see if they had taps that were the same as us or not, if taps was the hypothesis.

Q Can you recall what, if any, response that inquiry elicited?

A I think Teresa took that on board because she said she was going to contact Ireland, so I can't remember much else about that, yeah.

Q Okay. That is helpful, thank you. The final part of this chapter that I want to look at if I might, Ms Rogers, is at page 75 of the bundle, an IMT of 21 March 2018. Again, we see a reference to you being present. Is that right?

A Yeah. Mm-hmm.

Q If we just go, please, to page 78. If we go down the page, please, to the third bottom paragraph please, Ms Ward. You will see the one that has got your name in it, and just take a moment to have a look at it and tell me when you have done that. Again, I will take it in stages. Does that set out what you recall being discussed at the time?

A Yeah, so I think what this was about was the filters. So, we were having a conversation about whether we know if the filters will work. So, we're about to implement these filters, so how that fitted into that conversation was, "Will we wait until we get post-filter water samples before, like, taking away the other mitigations that we've got in place, or do we know the filters are 100 per cent guarantee?" as Mary Ann Kane's saying there. So what I'm saying is, "Well, hold on a sec. We thought the silver nitrate was definitely going to work and then it hasn't, so do we definitely know that the filters will work? Should we take away the precautions before we definitely, definitely know that?" That's what I'm saying there.

Q Thank you, that is very helpful. Thank you. My Lord, very slightly before the usual break time, but I was about to move to a different chapter.

THE CHAIR: Right. As I said, Ms Rodgers, we usually take a coffee break, so let us try and be back here by ten to twelve.

THE WITNESS: Okay.

THE CHAIR: You will be taken to the witness room, where I hope you will have a chance for a coffee.

(Short break)

THE CHAIR: Now, Mr Duncan.

Q Thank you, my Lord. Ms Rodgers, I was about to move onto September 2018 and the decant, and the reason I am going to jump from March until then is because we have had quite a bit of evidence already about the return of infections over the summer period, and we have got a pretty clear and constant story of what happened. There is one bit of context that I am going to ask to see whether you can help us with – and you may not be able to do so – and it is-- If we could go to bundle 4, please, and go to page 126.

Now, we have got before us an SBAR, I think, or something of that nature, from an Infection Control manager to the interim chief operating officer, and if you could perhaps just answer this question, Ms Rodgers. Can you recall whether this was a document that you saw at the time, being July 2018?

A No, I don't think I saw this at the time.

Q Thank you. I wonder if you want to just maybe push your microphone a bit nearer to you. I

did not----

A It was switched off there.

Q Yes, thank you. Okay, have you had an opportunity to look at it before today?

A Yes.

Q Thank you. Now, I am going to ask you if you can help me with one aspect of it. If we can scroll down-- sorry, scroll down the page. Do you see the reference to, "Reports relating to the commissioning of the water systems have been identified…"?

A Yes.

Q Do you know what that is about?

A So, I can assume now that that would be the report that required some actions, the DMA report.

Q So would that be the DMA report from 2015?

A Potentially, but I wasn't-- I didn't see this at the time, and I wasn't in the communications around about those kind of reports.

Q Okay, and as far as the reference to having been "identified in recent days," from your own direct knowledge, is that something that you are able to help us with?

A No.

Q Thank you. If we can put

that to one side then, please. I want to now move forward to September 2018, and to the decant in particular. Now, we have had, again, quite a bit of evidence about the reasons for that, and we have been through all of the IMTs, so I am not going to take up your time on that. Ultimately, what I am looking to do is to get us to the point where you can describe to us the work around doing the decant, and I would quite like, in due course, to get your description of how it all happened, and we will get to that in a minute.

But there is another matter that I would quite like to just be sure I understand to do with the communication around this. If I take you, please, to bundle 1, and if we go to page 165. My apologies, can we go to page 164, just to identify what this is? Well, it is another IMT minute, and I think we see you in attendance, and I think we know-- We can see later in the IMT that this was a Friday. Is this one that you remember?

A Yes.

Q Yes, and it sets out-- and actually maybe we should just identify this without taking the time

to walk through it all. If we go to page 165-- Have you got anything on your screen?

A No. (After a pause) I have now. Oh, not now.

MR DUNCAN: Ms Ward, is there anything we can do? Or do we need to adjourn to-- Well, that is the right page, so, if we stay-- "No signal" is the message I am getting. My Lord, I am not sure whether it is worth – I see Ms Browne looking at me – rising for a few minutes?

THE CHAIR: Okay, so Ms Ward has got her a laptop?

MS WARD: Yes.

THE CHAIR: Right. I mean, I do not know either-- Okay. Right. What is being suggested to me, Mr Duncan, is that Ms Ward can provide Ms Rodgers with a view of the document on her laptop. Now, I do not know if that helps. Does that help you?

MR DUNCAN: Well, Mrs Rory(? 02:30:57) was proposing an adjournment to sort this out. I will just ask her if she still thinks that is-- I think we are happy just to proceed.

THE CHAIR: Right. Now, that means, first of all, people in the room do not have access to----

THE WITNESS: I think they can see it on the big screen.

THE CHAIR: The large screen. I

will just designate Mr Lough(? 02:31:30) as my informant. Are you seeing the page that Mr Duncan would wish you to see?

MR LOUGH: (Inaudible 02:31:48).

THE CHAIR: Right, I cannot hear you. Is that a yes or a no?

MR LOUGH: It is a yes, largely, my Lord, but there is a box in the middle of the second paragraph that has blocked some of the----

THE CHAIR: Okay. Subject to the box, you can see.

MR LOUGH: Yes, my Lord.

THE CHAIR: Anyone following on the YouTube stream, I understand, if they are conscientious enough, can access the document from the website. Right. This is suboptimal, but my general judgment, subject to guidance, Mr Duncan, is that probably we can manage in the sense that if a word or two is missed, it is probably not critical.

MR DUNCAN: I think that is right, my Lord. I think we should just proceed and see how we get on.

THE CHAIR: I have the luxury of a paper copy.

MR DUNCAN: Now, what I was going to ask us all to do is to scroll down – this might be the proof of the pudding – and to look at-- There does not seem to be anything happening.

UNKNOWN SPEAKER: It's not going to work.

MR DUNCAN: No, it is not going to work because there is no connection.

UNKNOWN SPEAKER: We need someone driving.

MR DUNCAN: You mean we need the break? My Lord, I think we probably do need an adjournment, unfortunately.

THE CHAIR: Okay. Right. Sorry about that but, as anyone will identify, I cannot do anything about it. We will take a few minutes.

(Short break)

THE CHAIR: I am advised that the alternative measures should work, and we shall discover whether I am right about that. Could you bring in Ms Rodgers? Thank you. (After a pause) Well, I am told, Ms Rodgers, that things are about to work, so we will see whether that is the case. Mr Duncan.

MR DUNCAN: Thank you, my Lord. Ms Rodgers, I think we were at the 14 September 2018 IMT, so if we could have that back up on screen if that is possible. That is bundle 1, page 164. I think that is actually 165,

but not to worry. Can we just go maybe one page back, just to make sure we have identified the document again? Okay, have you got it in front of you, Ms Rodgers?

A Yeah.

Q Yes.

A IMT, 14 September 2018.

Q Okay. I think I will just proceed, and if anybody is concerned that it is not on the screen, I am sure they will let me know. Yes, so we have got the IMT of 14 September 2018. Page 165 is what I was going to look at, just to identify things. Have you got that in front of you?

A Does it start "Control Measures Contd"?

Q It does.

A Yeah.

Q I am going to proceed on the basis that, although it is not-- appears to be showing on the screens, core participants will indicate whether they consider that is a problem. I do not know who has got this on their laptops and who does not. So, all I am doing really is identifying that the contingencies are set out as regards to decanting. Do you see the "Phase One Contingency"?

A Yes.

Q Yes, there is to be "restrictions with regard to patients being admitted to Ward 2A."

A Yeah.

Q Then if you go over to page 166, we see that the Phase Two contingencies is the decant. Is that right?

A Yeah, that's right.

Q Yes. Hopefully this will help those who do not have it in front of them. We have been through this with Mr Redfern, all the various options, A, B, C and D, mobile unit through to sending patients to England. He has explained the process of elimination to us, and I do not need to trouble you with that. I think the only detail to mention is that it says:

> "The following are the recommendations from the IMT for Executive Management to decide and have not yet been confirmed."

It is really, in terms of the chronology, just getting you to confirm that that really means what it says, I think. At that point, a decision was yet to be taken as to what was to happen. Is that right?

A That's right. So, I remember that meeting very well and we had actually met the clinical team that morning as well at 8.30. We had

the IMT at one. In the afternoon, the chronology of that is we had said to the clinical team we would meet them again at 4.30 that day. It was a Friday. So, Kevin, Jamie and I-- Jamie went and met the clinical team, whilst I accompanied Kevin to a meeting with the executive team, so that was the chief executive and some other-- I think the chief operating officer and some other people at 3.30 that day.

Q That is helpful, and I am about to come to that. Just before we do, just to identify-- and to be clear, where I am going with this is just to nail down the timeline on the communication with this. That is all I am interested in. We have been over it with Mr Redfern. I think we have got it. I just would like to get your perspective on it. So, if we go over the page, just to help with that – page 167, Ms Rodgers. For those who are able to follow this on laptops currently, it is in the "Communications" section, underneath "Patients," third paragraph, "There will be more communications to patients/parents once a decision has been taken by the Senior Management Team this afternoon." Is that right?

A Yeah.

Q Is that that further meeting----

A Yeah.

Q -- that you were mentioning? So, can you tell us what was decided at that meeting?

A Yes. So, at that meeting, it was quite Estates focused.

Q "Quite" sorry?

A Estates, kind of, focused.

Q Sorry, can I ask, is your microphone turned on?

A Yeah. Is that better?

Q Slightly.

A Is that better?

Q I too am slightly hard of hearing, so it is probably just me.

A So, is that better?

Q Yes, thank you.

A Okay. Yeah, it was quite an Estates focused meeting. We talked about-- There was a drain survey, if I remember, going on at the time and we were waiting on some results from the drain survey. Also, there was a bit of discussion about the options, as discussed with Jamie, you know, his appraisal of options paper and some of the work around about that. So, those were the things that were discussed at that meeting. So there was a few things that Estates were looking to, kind of, action and then there was a plan to regroup on them the following week after the weekend. So, on that day, there wasn't a final decision made, but there

wasn't also a, "No, you're not doing that." It was a, "There's just a few more things in planning we need to do if we're going to move," because it was a pretty big decision, so there was a few more loose ends that they wanted just tied up before that decision was made.

Q Thank you, that is helpful. Now, just one detail that we tried to explore with Mr Redfern, and I just want to be sure I understand. We certainly have seen Mr Redfern's, as it were, options appraisal. What I want to be sure I understand is, thinking about 14 September, I would like to know what your understanding was by that stage as regards to any actual risk assessment of the various options, if you understand what I mean?

A Yeah, so my understanding-- So before this, like, in the lead up to this, around about this time we had met with the consultants, and actually pre-Jamie's paper, went through, in a sort of dynamic risk-based approach, systematically each of the options that people brought to the table as potential options to decant to, measured against each of the potential impacts against, say, the children in the service, you know, the wider teams, the access to PICU, those various things. So, there was a

clinical and managerial-based, risk-based discussion about that. I remember the meeting very well, and that led to that paper and that discussion, and I think Jamie already described-- the preferred option was actually stay in the RHC, so decant into a ward in the RHC, but Infection Prevention and Control – Teresa, at the time – said she was not content with that option because she didn't have confidence in the other wards in the RHC not just replicating the same problem again. So the second preferred option, therefore, was to stay on the site, because the PICU – access to the Paediatric Intensive Care – was really essential.

Q Yes. As we have started doing it, we might as well complete. I think the evidence we had from Mr Redfern was going to other sites, i.e. out with GGC, were considered not to be options.

A That's right.

Q What was your recollection as far as not proceeding with a modular unit?

A Yeah, it was about the lead time. So, I clearly remember-- I think Estates looked into it and said it would be 12 weeks, and it couldn't be fast-tracked, but there was all sorts of other-- People who were a wee bit

concerned as well about how would that work; would kids, if they were deteriorating, have to go outside? You know, to get to PICU. There was also water and ventilation discussions about a modular unit, but a modular unit lead-in was 12 weeks, and at that point, Mr Duncan, we felt like we had real time criticality to make that decision and act on it.

Q Yes, thank you. Just to go back, then, to what I began asking you about, to be sure I understand your recollection of things. If I ask the question, really, in two parts, as far as there being any concern about whether Ward 6A would pose a risk of infection to patients and families, particularly in relation to anything to do with the water or the drainage, my question in two parts is this: One, can you remember whether there was advice on that? And can you remember from which department, as it were, that advice came from?

A So, part of the criteria around the dynamic risk assessment was it's got to be safe from an infection control perspective. Wherever we move to, it's got to be safe from an infection control perspective, and so Teresa deemed that area safe. They also did a walk round of it. They asked Estates to do some work on it. They

did all the kind of mitigation things, like CyanoSol in the drains, and I'm sure they HEPA filtered the ward as well before we moved over. So there was a number of things done to assure our lead Infection Control doctor that that was a safe area to move to. In terms of the drain aerosolisation hypothesis that we were dealing with at the time, it was thought – now, my recollection of it is – the issue wasn't in the adult hospital the way it was in the kids' hospital because there was a greater distance between the end of the filter and the sink than there was in the children's one.

Q We had some evidence from Mr Redfern about the sinks being different in the adult hospital. Can you say whether that is your recollection as well?

A That is my recollection, yeah.

Q Thank you. Just when we are discussing these matters, can you recall being told anything about whether or not the adult hospital had the same water supply as the one in the children's hospital?

A Yeah, it had the same water supply. I knew that it had the same water supply. I knew that the Neonatal Unit, which was in the retained estate, had a different water

supply.

Q Yes. We have had some evidence from-- really from the clinical staff, but also from one or two of the patients and families, that they felt that they had been led to believe that there was a separate water supply. Is that something that you can help us with at all?

A I don't know where that would have come from. It was clear that it was the same water supply----

Q Can I, just picking up on something----

A -- to me.

Q -- that you said about the dynamic risk assessment. Is there a document, or body of documents, that records a dynamic risk assessment or a risk assessment of any kind?

A I mean, the day that I'm describing that we met, there was a spreadsheet on the projector and we updated that as a sort of dynamic risk-based discussion at the time. So, that spreadsheet may be available for you.

Q Yes. In terms of signing off on the decant, do you know whether the sign off on that happening was all internal to GGC, or do you know whether there was any external body involved in that?

A Yeah, so HPS were involved in that. HPS were very much

part of that decision making.

Q Do you know whether there was any testing done of the drainage of the water in 6A prior to the decant, or is that a question for somebody else?

A It's probably a question for someone else, and I do know that the Infection Control team did a comprehensive check of 6A, so they looked at drains. They did, like, a drain inspection, I think they called it, and they didn't see the issues that they thought we were having in 2A.

Q Okay, thank you. Now, in light of the challenges we are having around documents, I am trying to focus my questions a little, and I will lead you through my understanding of what some of these documents say, but you must say if you do not think it accords with your recollection, and we will get to the bits that I do want to ask you about more quickly, perhaps. We have looked at Friday the 14th, and you have said there was then the discussion afterwards, at senior level, around what was to happen. So, if we go into the Monday 17 September, the IMT of that date – and do say to me if you want to turn this up – it looks like the matter was still being recorded as being under consideration at that point. Is that your recollection?

A Yes.

Q Do you want to turn it up? The document?

A No, no, it's fine. So, yeah, I remember the IMT on the 17th. That was the Monday. The matter was under consideration. The IMT met and said we are content to continue making this recommendation. Kevin Hill was at that IMT, our director, and he discussed a wee bit of feedback from the Friday meeting, and the next day, on the 18th, Grant Archibald came to the IMT and said the decision has been agreed and passed through. So that was 18 September.

Q Okay, and we will come to that in a minute. Just to complete the narrative, and as I say, do please say if you want to turn any of this up. The IMT records on the 17th that the statement that is going to go to the patients and families will be updated after that meeting. Does that accord with your recollection?

A Yeah, I think it might be helpful to go to----

Q Yes, let us do that. It is at page-- It is bundle----

A I think they may have been referring to-- Yeah.

Q It is bundle 1, and it is at page 173 is the particular reference that we want. Have you got that in front of you?

A Yeah.

Q And, for those who have access to this on their laptops, it is underneath the heading "Communications." It is at the reference to "Patients." Second paragraph, it says, "It was agreed that the statement created on Friday but not shared with parents can be updated." You see that?

A Mm-hmm, yeah.

Q Who was involved? Or rather, which areas of the organisation were involved in the creation of a statement?

A So, that would have been Teresa Inkster, as the chair of the IMT, and various people. Generally, how that went was various people would input, as required, onto a statement or a briefing for families and staff.

Q Okay. As far as you can recall, were management and more senior management involved in the process of creating this?

A Yeah. So, Comms were at every IMT as well, and Comms would coordinate that process at that point.

Q Okay, that is helpful. Thank you. While we are looking at this document and at this page, can I just ask you to have a look, please, at

the discussion under the heading "Staff," and there is reference to anxiety and frustration and staff turning to their union. If you have a read of that and tell me once you have done that.

A Yeah, I see that.

Q Now, were these concerns that you were aware of by that time?

A Yeah. So, I had worked with the nurses and involved the Royal College of Nursing, and actually worked with the RCN around about the decant as well, and various other IMTs, including Crypto, when things were particularly challenging for staff as well, the RCN were involved. So, yes.

Q I mean, I may speak for----

THE CHAIR: Sorry, Mr Duncan. This is probably entirely obvious to everyone. When you use the expression "the Royal College of Nurses," one's mind tends to move to the headquarters in London, whereas what you are referring to is – and I mean no disrespect for this – you are looking for cooperation and assistance from the local union----

A That's exactly right, yeah.

Q I mean, that is-- As I say, I do not wish to-- The local professional organisation. Sorry, I am sure everyone else was aware of that.

MR DUNCAN: Thank you. Thank you, my Lord. In terms of just understanding the levels of anxiety at that point-- I mean, it may be that it speaks for itself, but I wonder if you can help us a bit on that.

A Yeah, so there was building anxiety. So, we had gone through the March incident, then the sort of over-the-summer kind of incident linked to the drains and the aerosolisation, and then we had closed that after. We had done HPV cleaning in June as well, which was really quite a disruptive process for the nurses and the families, so that was quite a tough-- June was quite a difficult month for the team and the families, and then, with each thing, you think, "This has come to an end. It'll be okay after this." So, then to have the IMT reopened in early September, I think it was, maybe 2 September-- Yeah, people were getting quite anxious, and it was really difficult for the team.

Q Yes, thank you. Now, let us just identify the point in time, then, where the decision to decant is recorded. If we go onto the next IMT, which is at page 175 of bundle 1 – and hopefully you have got that in front of

you – with you being one of the attendees. If we go, please, to page 177, and hopefully people have got this in front of them; as I say, I will read out what is there, just in case they do not. It is page 177, underneath the heading "Contingency/Decant." So, that is item 6. Have you got that in front of you, Ms Rodgers?

A Yeah.

Q It says, in the second paragraph-- I think this is what you just alluded to:

"Grant Archibald informed the group that following a water meeting this morning it was agreed that BMT patients currently in Ward 2A will be decanted to Ward 4B BMT unit within QEUH."

And, if we skip to the next paragraph, it says, "The majority of patients (Haematology/oncology) will go to an alternative 28 bedded ward within the QEUH." See that?

A Yeah.

Q So is this the point of where we see the recording of the decision to decant, at least within the IMT? Is that right?

A Yes.

Q The reason for turning this up was just to see if you could help us with something. It says at the beginning of the part I just read that there was a water meeting in the morning. Is that when the decision was reached? I.e. at that meeting?

A I wasn't at the water meeting, but there may have been discussion there that contributed to the overall decision-making of the executive team, but I wasn't at it, so.

Q I see. Does it follow, from what you have just said, that you yourself would not know what that meeting was about and what it decided?

A No.

Q Thank you. Finally, getting to what it was I was going to ask you about all of this, if we go over to page 178, and, under the heading of "Communications," it says, in the third of the paragraphs under that heading:

> "It was agreed a statement for staff/parents/patients and the press will be drawn up out with this group. Each communication should have the same common narrative with strict disciplines."

So, I think the two questions I have are, first of all, does this record that there is to be a communication to staff, to parents and to the media?

A Yeah.

Q And does that indicate as to how that is to be done? That will be decided by a different group. Is that

right?

A It would be pulled together by the Communications person, with the chair of the IMT's input and others that they deemed relevant.

Q Yes. You will recall, I suspect, that there was quite a bit of evidence from the patients and families about the timing of the media announcement and that to the patients and families, so that is where we are headed with this. If I could just ask you this question before we get there: can you recall whether it was intended that communication would be simultaneous?

A It was intended that the patients and families would get the communication first.

Q Yes. As you indicate in your statement, it appears that that did not happen.

A That didn't happen.

Q And are you able to say why?

A Well, I can tell you what happened from my perspective.

Q Yes, please do.

A So this was agreed. The comms was getting written, as it says here. My role there was to go to the ward and talk to each of the families and give them the comms and talk about it and take any questions. So, I did that, and I was sitting in the Sisters Office. It was about six, quarter past-- Well, it must have been six because Brenda Gibson came into the office and said, "Jen, it's on the TV. It's on STV news." So I was like, "Oh, right."

So, I got the comms emailed to me about ten past six or something, and by then it had already been on the news, but I went round every family anyway, and Emma was there, the senior charge nurse. Brenda was there. So we went round all the people that were there. I spoke to the families and kind of apologised for the sequencing, because the sequencing we hadn't got as intended. I later found out that STV had been giving Comms a kind of strict timeline, I think, to get a statement back, and they'd been speaking to a family. So there was all sorts of stuff going on with comms that I didn't know about, and so the sequencing of that communications was just out by maybe half an hour, an hour.

Q Can you help us – and it may not be for you to tell us about this – can you tell us how it was proposed to communicate with outpatients in relation to the decant?

A Yeah, so we used that same communication for----

Q Sorry, you used----?

A I think the same communication for Day Care. It also went onto the IPN, so, like, a kind of-- people that are registered to get communication from NHS GGC will just automatically get that update, and, yeah, we would update Day Care. Brenda Gibson also wrote a letter to all the outpatients detailing where they should go and how it impacted them, so we had that letter as well from the lead clinician.

Q Yes, I think we have seen that letter. At the IPN-- sorry, I missed that. What is the IPN?

A I think it's the Involving People Network, so it's-- Comms will need to correct me. I think it's got about 50,000 followers, if you like. People registered, the information updates about GGC just automatically gets emailed to them.

Q Okay, thank you. Thank you. So, if we move on, then, to the preparations for the decant, please. You have got quite a bit in your statement around that, and for those who want the references, really paragraphs 183 to 184 are really what we are looking at here. Maybe I will just pick up on a few of those. By all means, have that in front of you, Ms Rodgers, if you think it would assist.

We have had evidence on some of this, so we do not need chapter and verse, I suspect. The Hospital at Night team; what was the-- Well, again, let us take it in two parts. What was the concern, and what was done to address the concern?

A So, the Hospital at Night team are essentially the doctors and advanced nurse practitioners that covered the night shift, so, if anybody needs to be seen by a doctor, then they would do that. We wanted to bolster that service to make sure that they could accommodate the needs of the patients in what would be 6A. So we did a bit of work with the clinical lead at the time to do that, and we also put some of our advanced nurse practitioners that are in Paediatric Haemato-oncology – ANPs – we changed their shifts so that they would be on later, I think, till midnight, and I think some of them did night shifts as well, so we had additional cover in that regard.

Q Maybe picking up on Lord Brodie's question from a moment ago, when we see the reference to the Royal College of Nursing, would that, again, be a reference to local union reps? That is paragraph 184.

A Yes.

Q Now, I am going to come

back to you on the question of pathways, which you deal with at paragraph 189, but just some other points of details. At paragraph 190 – have you got that in front of you?

A Yes.

Q **"**The resus team set up a mock resus." Could you help us with that, please?

A Yeah. So, we worked through a whole range of things for the decant. I'm just going to go back a little bit, if that's okay.

Q Please do. Do this in the order you think is best to do it in.

A So, on the 17th or so, I wrote a list in my jotter about what did we need to do to decant this ward. That list then got taken by the clinical service manager who added to it and made a huge spreadsheet. At that point, we didn't know where we were going. Once we knew where we were going, we had three parts in that spreadsheet. So one was BMT patients to 4B, from 2B to 4B. One was----

Q Sorry, from 2A to 4B?

A Yeah, so one was 2A non-BMT patients to 6A, and one was 2B Day Care patients to 6A.

Q Yes.

A So, each of them had its own nuances and things that had to be

considered. One of the things that we considered, aside staffing, and-- I haven't mentioned the nursing staffing yet. We had an obvious diseconomy of scale, going from 2A nurses looking after people and kids in one area to 4B and 6A, so we were challenged around that and had to have a plan to put additional nurses in to be able to cover that diseconomy at scale.

Resuscitation is essential, so we linked with the Paediatric Intensive Care consultants, the Resus team, and the anaesthetists to make sure we had the right kit in both 4B and 6A and to make sure we had the right routes between there and PICU, and to make sure everyone had the right kind of passes and knowledge. We ran several mock resuses from both those places prior to the move, and the Resuscitation team, with the input of those doctors from Paediatric Intensive Care, and also the Haemato-oncology team, wrote a standard operating procedure for staff around about that.

Q Thank you. I mean, just to get an idea of the scale of planning on your part on this, I mean, there is a reference in an IMT, dated 25 September 2018. I do not think we need to turn it up, but there is a reference at page 190 to the 12th version of the pathways. Is that

something you recall?

A Yeah, I think that's maybe the operational log, decant log. I think maybe we got to more than 12 versions, actually, so maybe 13. But, yes, there was a whole range of work done in a very short period of time. That was 18 September we got the agreement to decant, and we moved on the 26th. Within that time, the team looked at the Rights of the Child, making sure that there was parents' beds so that a parent/carer could stay with every child. We didn't have that in the adult hospital.

We looked at, like, wall glamour, making it a friendly place, making sure we had play cover. We looked at-- The fire people did a sort of-- make sure they updated the evacuation plan. We needed to make sure the special feeds kitchen had the right kit in 6A that they needed, and the right processes. Same with catering, because paediatrics is different from the adult catering food choices. From an e-health and telecomms perspective, the whole floor plan of 6A had to be redone and switched over, and the phone numbers, and even in terms of emergency calls.

That's just some of the work. There was the pharmacy and having the right kit, having a bit of situational

awareness so that we understood if our SOPs worked in a kind of different environment and what needed changed. Also, from a safeguarding and child protection perspective, we met with the Child Protection team who gave us some advice on how to manage that. We had to get a new lock for the back door so people couldn't walk through that ward and put some safety briefing around about the fact that there was paediatrics in that ward. But, just to be clear as well, it was the children's nurses and the children's team that were in 6A. There was never any adult staff or adult patients in 6A. We moved to an empty ward, so we just decanted with our own team.

Q That is helpful because I was about to ask you a question, I think, that might be connected to that. You mentioned additional nursing resource being required, and you mentioned that in your statement also, and the question I was going to ask you is whether that additional nursing staff came from Paediatric Haemato-oncology nurses?

A Yeah, on the whole, it did.

Q On the whole.

A On the whole, it did. So, on the whole, that was our existing

staff that were maybe part-time that were doing additional hours, or it could be bank staff that are coming in but are our regular bank staff. That's generally what it was. We might have had some other nurses from the children's hospital picking up some bank shifts, but on the whole it would be Haemato-oncology nurses.

Q So, just to be clear on that, if we take this in stages, are you saying that, as far as you can recall, all of the nursing staff were paediatric nurses?

A They absolutely were. Absolutely.

Q And the second-- So, the reference to "on the whole," on the whole is they would be Haemato-oncology nurses?

A No, I meant on the whole it would be their own nurses, but if it wasn't their own nurses, it would be children's nurses from the children's hospital that were picking up some bank there, which would happen, actually, in any ward.

Q What I am asking is whether those would be nurses that had a haemato-oncology specialism.

A So, they may or they may not, but they would be a paediatric-trained nurse that knew how to look after sick children.

Q Okay, thank you. The other thing I wanted to just pick up on in what you said was the Rights of the Child, something I have been asked to clarify with you. Was that something that was embedded in the plan?

A Yes, it was in the operational decant log.

Q It was in the----?

A It was on the operational decant log.

Q Thank you.

A It was in the plan.

Q And in particular I have been asked to clarify with you whether the Scottish Government Child Rights and Wellbeing Impact Assessment was part of that.

A I can't remember that.

Q Okay.

A I don't know if we did that, but we tried to look at the UNCRC guidance, and we tried to make sure that we had met the charter for the Rights of the Child. We may not have done a separate document on that but, as I said, it was a sort of time-critical situation, and we did all that in the space of eight days.

Q And-- Sorry, my Lord.

THE CHAIR: Mr Duncan, no doubt my fault, it is just that reference to that document. It is not one I am familiar with.

MR DUNCAN: No, which one, my Lord? Sorry, the log? Which document?

THE CHAIR: The Scottish Government's-- I think you said, "Childhood and Wellbeing"?

MR DUNCAN: Child Rights and Wellbeing Impact Assessment. It is not one I am familiar with either, my Lord. It was just a question I was asked to clarify, but I presume the answer would be to have a look at the log and we can take it from there. Is that right?

A Yeah, there's evidence that we have considered the Rights of the Child in the log. We also have a Rights of the Child group that I chaired as part of the-- just my role as a chief nurse, and it was also discussed there.

Q Okay, that is helpful. Thank you very much. I am just going to perhaps, as we move towards lunchtime, try and deal with a few points in relation to the early stages on Ward 6A. As far as the disadvantages of being on Ward 6A are concerned, we have got a lot of evidence on that already, and you have given us some too. I am just going to ask you about one – or two, rather – that you have mentioned. The diseconomy in having nurses split over different wards, I mean, as far as you are concerned, can you say whether that was something that gave rise to any safety issues?

A No, because we mitigated against it by ensuring that we had additional nurses, and every week-- I actually collected this on a document, with all the ones that were additionality highlighted in yellow, so I've got a record of ensuring that we had a really close watch on ensuring we had enough staff for that diseconomy of scale.

Q As far as the patient pathways are concerned, again it is the same question. In your view, did the challenges that undoubtedly there would have been in relation to patient pathways create any concerns or actual risks around patient safety from your perspective?

A So, there wasn't anything specific escalated to me around about that. There was obviously a bit of an inconvenience and, you know, it made life a bit more difficult, but there wasn't a particular safety issue raised to me, no.

Q Yes. I mean, it is unfair perhaps just to fasten on one piece of evidence, but if I mention what I took to be Dr Murphy's position, I think he said in his evidence-- and I am thinking in particular about the distance from

PICU. He did not consider that that did in fact create a risk, but he did say that did not necessarily mean that people were not anxious about it. Would that be a reasonable way of looking at it?

A I think that's fair. I think the distance-- like, on the scale of things, it was probably less than five minutes – you know, minutes. Also, because you've got a Paediatric Intensive Care team, how resuses work is that team goes to the patient. So, they come to the patient, stabilise the patient where they are, and then transfer them. So you've mitigated some of that already because you're making sure the team go to the patient, so----

Q I think that was one of the things Professor Gibson and Dr Murphy both explained to us that perhaps those of us not familiar with this had not really understood, that it is not just about the journey in an emergency situation to PICU. In a way, it is about preventing that and bringing the team there.

A That's right.

Q I think I took at least one of them to indicate that they felt the distance was a source of concern, even as regards that, but I do not think they put it any higher than that. Would

that be reasonable?

A I think that's reasonable, yeah.

Q Yes. Now, as far as, as it were, the suitability and comfort on the ward for paediatric patients, we had a lot of evidence about that from the patients and families. We can see that in your statement you talk about the steps that were taken to try and improve the surroundings. I take you to say in your statement that, at least to begin with, you felt that went reasonably well. Is that fair?

A Yeah. Initially in 6A, people-- and you know, that night, Tuesday, or 18 September, when I spoke to families about the move, although we didn't know where it was at that point, they were-- I don't know if relieved is the right word, but they were content that, "Right, okay. These issues have been going for some time and now there's this action being taken," and so there was a sense of that, I think, when we were in 6A. Remember, we thought we would be in by Christmas. So we thought we'd be back by Christmas, so people were like, "Okay, this is fine. This is where we are." You know, I was just supporting people to get on with their work, making sure we had the right staff, making sure people were

supported. It went kind of okay for the first couple of months, I would say, until the Cryptococcus situation.

Q Yes. We are just moving towards that in a moment. What I am really trying to do here, and we did this with the witnesses who gave evidence last week and indeed with Mr Redfern is-- as I think you might be aware, there were some fairly bleak assessments made of life on Ward 6A by some of the patient and family witnesses. Indeed, the word "bleak" was used at one time. Again, thinking about how that evidence might be reconciled with other evidence, Dr Murphy said something very similar to what you have just said, which is that to begin with, on a short-term basis, it was felt that it would be suitable, but I think the way he put it was, month by month, the time for going back was moved. So was there a time when perhaps life on 6A became more challenging for people?

A Yeah, it was the Cryptococcus incident.

Q Yes.

A Before that, people had been just getting on with things and we were trying to do everything we could support play and interaction. At that point kids would be, sort of, playing and up and down and walking about

and there was quite good visibility in 6A because it was just a different design to 2A. Families said they quite liked that and so did the staff, so that's kind of where we were in those first couple of months until January.

Q Okay. Well, I am about to go to that, and can I repeat the reassurance that you were provided with earlier: there is no question of going into the individual cases that might be connected to that matter, but I am afraid I am not going to complete your evidence. I can probably complete it within about half an hour, but I just think with the issues we have got around technology, it might be worth, my Lord, taking the break to see if we can do something about that.

THE CHAIR: By all means. We usually take a lunch break at one o'clock in any event, Ms Rodgers. So it is five past one. Let us take an hour. If you could be back for five past two. Technology may work differently, may not, but we have an hour for lunch. So, you will be taken to the witness room.

(Adjourned for a short time)

THE CHAIR: I am assuming that material is available on the screens. Right. Can I ask for Ms Rodgers to

come in? Good afternoon, Ms Rodgers.

Afternoon.

MS RODGERS: Good afternoon.

THE CHAIR: Mr Duncan.

MR DUNCAN: Thank you, my Lord. Ms Rodgers, I wonder if I could just clarify one bit of your evidence, which I have to say I had missed before lunch, and I just want to be sure I understand what you are saying. I think you have been understood to indicate that your recollection is that HEPA filters were obtained prior to the move into 6A? I see you are shaking your head.

A No.

Q Well, the IMTs would indicate that it was sometime around 30 January 2019 that HEPA filtration was sought for at 6A. Is that according to you----

A It was 10 January that we put the HEPA filters in. I think it was the 9th, the decision-- it was the 9th into the 10th. That's when we put the HEPA filters in, in January.

Q Maybe if we just take it this way, I certainly have seen a reference of it in an IMT minute of 30 January of a discussion about when they are going to arrive. I think it was to be the 30 January. Are you quite content that we go with the documents on this as maybe the point?

A So, I'm absolutely sure it was the 10th and it would have been additional HEPA filters that probably went in on the 30th. I think we ordered some additional ones a bit later on, but it was 9/10 January.

Q Okay, well, I suspect that probably covers the point. I think the concern that had been raised was that it might have been thought that you were indicating that they were put in before the children went to 6A. That is not your recollection though?

A No, I think I said HPV cleaning.

Q I think that is why I had not picked up on it. I think that is what I thought you were talking about as well. So that is helpful, thank you. No doubt if the point has not been cleared up, that will be raised with me later on. The other thing that I was going to ask you to do that I mentioned earlier and that we have not done yet is I wonder if you could just describe the process of the decant itself to us because we had some evidence from the patients and families on this, and it would be useful, I think, to hear your perspective on it?

A So, I didn't actually personally decant the patients, but I know the sort of procedure that people

followed. So, each child had an individualised plan for-- it was in the morning time from, you know, what they were taking, when they were going, who was accompanying them and what room they were going to. My understanding is that ran quite smoothly, and there was no real issues escalated, and they were safely decanted on that day on 26 September.

Q Thank you, that is very helpful. Now, another piece of evidence that I would just like you to help us with, if you can. We had some evidence from Professor Gibson about a request for a meeting with senior management in early January 2019, and what I just want to do is complete that piece of evidence by just understanding what the response was, and if we have before you please from bundle 5 at p.162, I think we can see minutes of a meeting with you and colleagues. Is that right?

A Yes.

Q If we go, please, to p.164-- I am sorry, if we take a step back. If we just notice that it is a meeting, and by the looks of things under reference to the introduction it looks as if Dr Armstrong is chairing the meeting. Is that right?

A Yes.

Q JLA? Do we see that among the things to be discussed is an email from Professor Gibson to Dr Armstrong. Is that right?

A Yes.

Q If we go please to p.164, I think it may be enough at this stage-- We will obviously consider the documents in due course. There may be enough just to notice, para.16, that there is a reference to "a need to meet directly with consultants and senior nursing staff," and there is a reference to 11 January. Do you see that?

A Yes.

Q Do you know whether there was a meeting on 11 January?

A Yes, I'm pretty sure there was and-- yes, there was.

Q And do you know whether that was a meeting at which, among other things, the issues raised by Professor Gibson were discussed?

A Yes.

Q Thank you. Now, another matter from this stage, and this is-- as I indicated to you before, we have covered off most of the chronology and do not want to get into the Cryptococcus case, in particular, but there is one piece of the jigsaw that it would be useful to get your perspective on. We have had some evidence and we have seen a

reference in the IMTs to concern on the part of patients, leading them to escalate things to the Scottish government. There is a bit in your statement about it, and I just wonder if you could maybe just help us a bit with your recollection of what that is about, please.

A Yes, so, this is this week that you're referring to, 9 January. There had been the IMTs about installation of the HEPA filters. In this paper you're sharing with me now, "Action 6: JRO to set out note for advising families." That was around the HEPA filter units being placed in the ward for the next day. So, I did that that night and shared it with this team of people that were-- some of the people that were attending in that meeting. After a bit of discussion, that became a kind of aide memoire for the staff to discuss with families, and I went to the board, and we had points, so I think you'll have that in your documentation. So, we had six bullet points or so, and that was around what position we were in, the actions that were taken, which was an installation of the HEPA filters and what that meant and what we were doing and, you know, happy to take any questions.

So, that was on-- I think, by the time that that was agreed, it was quite late on that on that evening, so I think we gave some of that information on the 10th and the HEPA filters went in the same day. Now, that was a Wednesday night, the 9th, and by the end of that week – I think by the Saturday – I had a call at home to say that there had been some families had went to the minister around just general concerns about the environment and this installation of HEPA filters. So, that was the 12th, and the next day we had a conference call with the executive team, myself and some others, and at that call there was a couple of actions. So, Brenda Gibson, I think, spoke to some specific families to reassure some specific families that she was a consultant for. So, she spoke to them individually, and I went to the ward and spoke to every family on the ward that Sunday, Sunday 13, and I had a written brief as well, but I also just spent as much time as people wanted discussing with them-- just the situation.

Q Did you say 16 January there?

A No, 13.

Q 13, sorry. Yes, I think the reason I mentioned 16 is that there is a-- certainly, there is a reference in

an IMT of 16 January about patients going to the Scottish government at that point, so I am just wondering if you are-- Does that fit with----

A Yes, that would have been referring to the weekend because that would have been the next-- What would that have been? Wednesday.

Q Yes, and as far as the HEPA filters are concerned, I am just sort of flicking through my IMTs just now, I certainly do see a reference on 30 January to 14 HEPA filters going to be arriving. I wonder if it is possible that HEPA filters arrived at different points. Is that maybe what happened?

A So, I think we got additional HEPA filters. That's my recollection of that. I think we might have put additional ones in the corridor as to what we'd originally had, but the HEPA filters in the rooms and in the corridor were absolutely put in place on the 10th.

Q Yes, okay, and should we be able to see that recorded somewhere?

A Yes.

Q Okay, the next thing I want to ask you about – it is still at this time – is about the move to the CDU. What is your recollection of how that came about?

A Yes, so the Cryptococcus IMT was kind of continuing. We put the HEPA filters in place, and Teresa had organised for air samples to be taken and so the air samples were taken. Now, there was nothing really to benchmark what an air sample should be when you're in a non-- I'm going to say plumbed-in HEPA filtration; I just mean when the HEPA filtration isn't a portable HEPA filtration. So, when there's not clear guidance on, “There should be so many particles or not particles,” anyway, the samples that we took were a bit higher than what Teresa expected with the HEPA filters in place, and so the issue with the bathroom was uncovered. So this was a kind of-- So, the bottom of the shower floor and the wall-- where they join there's like a slight water ingress, and so this was discovered and investigated further so that, on further investigation, there was mould under the floor of the bathrooms that we looked at.

So, at first, Estates were looking at that to maybe repair that with the children there, just putting the rooms under negative pressure and having a HAI-SCRIBE signed off with Infection Control but, with further investigation, it looked like they actually couldn't do

that with the children in the unit. So, at that point, the IMT made the recommendation, again, that we had to look at moving the children somewhere else while that mitigation-- while that work was done to fix the bathroom floors. So the move to CDU was not about Cryptococcus, it was triggered by that finding around the air samples and then finding the issue with showers.

02:31.30 Yes, I mean, having a look at my timeline here and just want to see if it squares with yours. I think it does from what you have just said. I have a note of the IMT on 17 January, where I think what is being reported, presumably by Dr Inkster, is high particle counts on 6A, even with HEPA filters. Would that square with what you think----

A Yes.

Q I think what we have had-- we have had evidence from Mr Redfern that on investigation, as you say, there was an issue found in the shower rooms, and I think the IMT records something like 80 per cent of the shower rooms were affected in that way. Is that right? Yes. We have had evidence about the decant and what was involved in that. I guess what I would be interested in hearing is your perspective on the impact of that on

patients and families and, indeed, upon staff.

A So, the second decant to CDU?

Q Yes.

A So, we resurrected the operational log for that, and this decant was quite complex because we moved. So Day Care moved to ward 1B, which was day surgery. At risk children moved to ward 4B which was-- we already had children down there. That was adult bone marrow, and then the Haemato-oncology/general population went to CDU. Now, at that same time, we had some Haemato-oncology patients in the surgical ward in 3B, and I think we had one in PICU, and when we have Haemato-oncology patients in other areas for clinical reasons, the Haemato-oncology nurses were in reach and go and check up on them and just make sure like the local nurses in those areas are supported. So the diseconomy of scale that I spoke about earlier was exacerbated in this move from 6A, and we worked through that to mitigate that and did mitigate that, but it was a very difficult time for families and staff, and I would say that was one of the hardest times throughout the duration of all of this.

Q I say at the risk of taking

us into the Cryptococcus issue, and I think we should tread warily, it is obvious from your statement and from others that there was a lot of media coverage around that at the time, and I am just wondering what sort of impact you felt that had on patients and families and indeed staff?

A The media impact was huge for the staff and the patients. People were so stressed about the media because-- you know and it was at that point, I think-- So, just to take back a wee bit in communications, I felt like I did my best to transparently, openly and honestly communicate with the patients and families in front of me throughout, as did Jamie and others and that was-- Those weren't particularly difficult conversations, probably up until that kind of Cryptococcus period of time where the media and the narrative that kind of got built up around about that was just much bigger than I felt anything that me and Jamie could say. We were having these little conversations with a small group of people, and then there was this huge kind of multi-dimensional network of communications going on with like a whole range of organisations and people, like whether that was government-- like different

organisations, families, journalists, and so there was a huge narrative around that that. It made everybody feel really uneasy, really worried, really stressed.

The nurses at the time, they were even worried about their own health because there was lots of things being reported in the media about Cryptococcus. So they were starting to think, “Have I got something? Is my skin itchy? Am I wheezy?” I linked in with occupational health at that time, the Royal College of Nursing again. We kind of did-- I think it around that time we put in psychology support for nurses, either one-to-one or in groups. We did a range of well-being hand massages and things. A range of things to try and support the staff, but the staff were incredibly stressed, and the families were incredibly stressed at that time.

Q Thank you. Did you hear or are you aware of the evidence that Professor Gibson gave about the communication at this stage. Is that too general?

A Can you remind me?

Q If I tell you this, what Professor Gibson said is that her recollection of this was of you and Mr Redfern doing your absolute best to assist. Picking up on what you just said about the effect of the media

attention on Cryptococcus and on the staff and on the patients, I mean-- I am anxious not to lead you on this, but I just wonder whether, from your perspective, it got to the level of people being afraid?

A Afraid?

Q Afraid of the issue to do with Cryptococcus.

A I think people were just-- I don't know if afraid is the right word. They were just so-- they were worried. They were just worried about the whole situation that we found ourselves in. We thought we were in a safe place, you know, things had settled down, and I honestly thought we were in a safe place, but this had come about, and people were-- they were just really worried.

Q When you say you were in a safe place, I mean, given that you had to decant from that place because of a concern about mould, would that qualify what you have just said?

A I mean, by all standards, we were in a place that had been approved and signed off by Infection Control, and it was generally deemed to be safe. So, yes, we had the mould issue, we had to decant for about three weeks, I think it was, and then go back again, so----

Q Did you have any

concerns about the children going back into the children's hospital during the decant?

A So, yes, we discussed some of that because obviously that hadn't been deemed a safe place in the first place-- not a safe place, but a preferred choice in the first place by Infection Control. So, by this time it was the end of January/February 2019, and we had the chlorine dioxide water for the whole site had already been put in place December/January, that sort of a time, so that was a bit of a mitigation. There was also the work on the drains done and the HEPA filters, I think, were put into CDU. They were-- So, Infection Control worked with the Estates to get to a point where they were happy that CDU was a safe move for the children for a short period of time.

Q Thank you. Now, if we move into late 2019 and, as indicated earlier, there was-- We have had quite a bit of evidence already on the chronology, which is one of the things we are trying to establish through this hearing, and we feel we have most of that already. There is just a couple of bits I want to ask you about, and then we will move towards the end of your evidence. In your statement at para. 291, you refer to-- If you want to have

a look at it, it is at p.497 of the bundle. I do not think we need it on the screen. You mentioned a supportive visit, I think, from the chairman. Is that right?

A Yes.

Q What was that about?

A The chairman actually quite often visited the children's hospital. So, he came round just as a supportive visit to talk to the staff, meet the team and just generally meet and greet.

Q Thank you. Now, another matter that we have had some evidence about at this stage is a request from the treating clinicians for an external review of the pattern of infection that had been causing them concern. Certainly, the unanimous evidence from them appeared to be that they were not aware of such an external review having been done. Do you have any understanding of that position?

A Yes. So, they had sent a letter on 30 August, I think, 2019, didn't they? And there was a meeting on 2 September with Jonathan Best, the chief operating officer at the time, and the consultants. I was at that meeting. It was called on the back of that letter to consider the concerns, and then there was another meeting on the 9th with Jennifer Armstrong and

others, and they talked about that external review, and we talked about the mitigations in place. I remember what happened with the external review. So, there was an action. I think it was the deputy medical director was maybe asked to go and find with the Haemato-oncology consultants who had expertise and networks to find an individual to do it, and they couldn't actually find somebody. I think they had a few refusals. Then we discussed it a bit later, and what ended up happening with that was HPS spoke to SG about it, and they ended up commissioning that external review, but it ended up being HPS that did it.

Q Okay, thank you.

A So that's my understanding of what happened with that.

Q That is helpful. There is one piece of that I would just be grateful for some clarification on. Did I understand you to say that as far as the process of trying to find somebody to do it, are you saying the clinical staff were involved in that search?

A Yes, my recollection is it was the deputy medical director worked with them to try and find appropriate people that would be able to do that.

Q Do you know who it was among the clinical staff, or should we ask somebody else that question?

A I don't know who it was. The deputy medical director would be able to answer that.

Q That is helpful, thank you. Now, the very last bit of the jigsaw, as far as the later stages of 2019 that I wanted to ask you about, which we have not really covered off completely so far, is you say in your statement that you were at-- or I think it was at an IMT when this happened. There was a presentation by Professor Leonard on enterobacter. Is that right?

A Yes.

Q I think you describe it as-- you thought it was groundbreaking science. Is that right?

A Yes, at the time.

Q Do you want to tell us a bit about that?

A Yes, so Professor Leonard was doing genome sequencing, which is a term you'll commonly hear now but, only a few years ago, that wasn't really a big thing. They used it in COVID, and I think that's why we hear much more about it now. It kind of rapidly grew. So, he had done genome sequencing on the enterobacter infections and found that they weren't related to each other so, yes, he presented his work on that at one of the IMTs.

Q To be clear, as far as you can recall – and I quite accept that these are probably questions for Professor Leonard – this was about comparing the infections with each other. Is that right?

A Yes.

Q Yes, thank you. That is helpful. Now, I want to go back, really, almost to the very start of your evidence, which is infection rates, and I want you to just tell us a bit about-- if we think about the period since 6A has opened up at the end of 2019, and indeed taking us right up until the period since the Schiehallion Unit has reopened in Ward 2A and 2B, and I will reassure you that I am not looking for detailed statistics. We have had some evidence on this from the clinical staff and I would be grateful if you could give us your perspective on your understanding of infection rates within the Schiehallion cohort of patients from late 2019 onwards.

A From late 2019?

Q Yes.

A Yes, so from the CLABSI graph point of view, then the CLABSI has remained under one-per-thousand line days so the infection rate has been good. So, as a median, it's

shifted down.

Q I hope I am not misremembering this, but I think I understood Dr Murphy's written evidence to be, as far as the current position is concerned, so I think post 2022, he understands the rates to be better than – and I know you do not like the word – than the Cincinnati rates. Is that something that you can help us with?

A Yes. I mean, the Cincinnati rate was getting to that one-per-thousand line days, so we were looking better than that at the end of 2019 and onwards from that.

Q Okay, that----

A So even before the move back to 2A.

Q Just thinking in terms of the period since we take things from the end of 2019 and the reopening, are you able to recall – and if you cannot, just say – how long patients remained on prophylaxis from that time onwards, or is that something we should look for an answer for elsewhere?

A Yes, I think you should look for an answer elsewhere with that.

Q Okay, thank you. I am going to ask you for your reflections on all of this in a minute but before you do, there is a couple of matters in your statement I have been asked to clarify.

If we go, please, to paragraph 339 of your statement. It might be worth putting this on the screen if we are able to do so. It is page 505 of the statement bundle. It is okay; we can probably proceed without it. It is all right. The paragraph 339 of your statement says:

> "HPS and HFS were closely involved in the IMTs. I occasionally took HPS or Scottish Government colleagues around to enable them to see the facility. They were not involved in the operational running of the service."

Now, I will reassure you and others, I am not, in this hearing, pursuing any evidence around what in particular HPS the Scottish Government were doing over this period. I just wondered if you could perhaps just explain to us what period of time you are speaking about and anything else that might assist us in understanding what this is about.

A Yes. HPS and likely HFS, but I was less involved with them, were involved right from March 2018. So, throughout this whole period of time, HPS were involved in all of this, so they were around the IMT table and active decision makers

within that group. They would come around the wards sometimes to do like their own sort of surveillance, if you like, and I would welcome them (inaudible) if there's anything else that we should be doing.

Q Thank you, and I suspect it might be a similar question that arises on the other bit I have been asked to clarify, which is paragraph 349. So, if you have a look at that, and that is page 506 in the statement bundle if anybody wants to look it up. You got that?

A Yes.

Q So:

> "Scottish Government questions could arrive through various routes, for example via the corporate governance team, communications team, infection control or nursing [and so on and so forth]."

Again, I think really what I am being asked to clarify is what period of time are you talking about, or is it not time specific?

A That's not time specific, so that's kind of how it is, and you'll see from lots of the documentation that you have that Scottish Government would be involved and they would be telephoned back with questions and answers with greater intensity at different times as we went through the time period in question here.

Q Okay. Thank you, Ms Rogers. We can put all the documents away now, and I just want to move towards the conclusion of your evidence and ask you, really, for some reflections. Maybe my question is this: overall, thinking about all of the events that we have been discussing today, how would you describe the impact of all of this, if it is possible to do that, upon your patients, upon your staff, and upon you?

A So, the patients and the families, I would not be able to put into words, I don't think, the impact on them. You're hardwired as a parent to protect your children and you're dealing with this awful situation where a child's sick, they've got a cancer--type of cancer, and so you will feel out of control anyway because of that. You're hardwired to be able to control your child and their wellbeing and then you can't, and the stress that that puts on people is massive.

Then on top of that, you're sort of in a situation where there's a water issue or there's a something-else issue, or there's a something else, and "we're doing this because of this." That makes you feel, I would say, even

more out of control. It was awful for the families, and I tried my best to support them, so----

Q Do you want to keep going?

A Yes. By communicating with them, by working all the hours in the day and night and weekends to make sure we did everything, and everybody did that, not just me. Everyone in the IMT, everyone from managers, from exec level to-- everybody did their best to do everything they could to take the advice of our infection control doctors to put in place what would make this the safest place for our children, and to communicate that with families in an open and honest way----

Q When-- sorry. On you go.

A You can't take away some of the impact of that, no matter how much you try, so really difficult for the families and equally for the staff. There was times where-- and I would say the cryptococcus time in January 19, really difficult, the decant time. So, peaks and troughs of challenging times for the staff. I just tried to work with the staff as one team and, as I have said, put in all those supports around wellbeing as I could and involve the RCN – you know, have

support there for them – but it was really difficult for them.

I tried to foster a kind of, you know, "We will not be broken" approach and "We'll do it together and keep going, and don't try and control the uncontrollable," you know, with the media and things, because they would get stressed out by horrible headlines in the front pages of papers, like "Death hospital" and things. They are so dedicated to their families and they've worked-- you know, they've went to uni, they've worked really hard to do the job they're doing, and they come to work to do a great job every day, and then they're dealing with these headlines about their ward; it's devastating for them. So, I tried to support them in that kind of, "We can't control what the media says. We can't control that. We can just control looking after your patients every day, doing the best job we can," but it was really difficult.

Q I wonder if I just mention two bits of evidence to you in that context, that Professor Gibson's assessment was that the hardest impact to the staff side of things was on the nurses, and the nursing witnesses we heard from said that they felt supported by you. That would tend to accord with what you have just said.

Is there anything else you want to add to what you have just said, Ms Rogers?

A No, I don't think so. I think that's all.

Q Well, thank you. I do not have any further questions for you at this point.

A Thank you.

THE CHAIR: Mr Duncan, shall we take a break just to check with the legal representatives that they have nothing further to raise?

MR DUNCAN: That would be suitable, I think, my Lord.

THE CHAIR: Yes. I mean, I was just asking that question in case you have already closed that off.

MR DUNCAN: I have not had that conversation, so I should probably do that.

THE CHAIR: Ms Rogers, you may have no more questions to answer, but I just want to double check with the room, as it were, as to whether there is anything that they had not anticipated would arise. So, first of all, if I could ask you to retire to the witness room for maybe 10 or 15 minutes, and in that 10 or 15 minutes Mr Duncan will have the opportunity to check with the other legal representatives as to whether there is anything that they wish to raise with you. Okay?

(Short break)

THE CHAIR: Mr Duncan?

MR DUNCAN: I do not understand there to be any further questions, my Lord.

THE CHAIR: Thank you. Could you ask Ms Rogers to join us again? Ms Rogers, there are no more questions for you and therefore you are free to go, but before you go, can I just express my warm thanks to you for not only attending today, but all the work you will have done in preparing to give your evidence. That involves being involved in the drafting of your written statement and also in reading material which provided the necessary background.

What is very clear to me is that you are a very busy person with a lot of very important things to do and you have plenty to occupy your time, and assisting the Inquiry can only have eaten into that and meant that you have been involved in additional work, and possibly diverted from important matters in relation to the management and delivery of clinical services in the children's hospital. So, I really want to undermine-- underline, not to undermine – an unfortunate slip of the

tongue – how much I very much appreciate all of that. Thank you and you are now free to go.

A Thank you.

(Session ends)

15:30