Scottish Hospitals Inquiry

Witness Statement of

Dr Alan Mathers

This statement was produced by the process of sending the witness a questionnaire with an introduction followed by a series of questions and spaces for answers. The introduction, questions and answers are produced within the statement.

Personal Details and Professional History:

1. Full name

A. Dr Alan Moncreiffe Mathers

2. Occupation

A. Consultant Obstetrician and Gynaecologist / Chief of Medicine Women and Children Greater Glasgow and Clyde Health Board

3. Qualification(s)

A. MBChB., F.R.C.O.G.

4. Please list your professional qualifications, with dates

A. 1979 MBChB.(Glasgow); 1986 M.R.C.O.G. Royal College Obstetricians and Gynaecologists ;1998 F.R.C.O.G.

5. Please give your chronological professional history, detailing all roles held where and when- please also provide an up-to-date CV

A. See CV supplied.

6. What specialist interest / expertise / qualifications in any area of Infection control do you hold? E.g., hospital ventilation, water Legionella control and infection control related to the built environment, and epidemiology and outbreak management.

A. None

QEUH and the Infection Control Team:

7. Please describe your role in the management of infections at QEUH/RHC in the IMT structure. Who did you report to, and who reported to you? In essence we need a "mini-CV" covering this period role by role.

A. Not applicable

8. Did you have any experience with QEUH prior to this? If so, please give details.

A. Not applicable

9. What was your impression of QEUH when you saw it for the first time? Did you have any concerns from an infection control perspective?

A. Not applicable

10. Are you aware of any concern any of your colleagues had from an infection control perspective? If so, please give details.

A. Not applicable

11. The Inquiry requires to consider whether the choice of sites was appropriate or gave rise to an increased risk to patients of environmental organisms causing infections. Please explain any view that you had in this regard?

A. As far as I understand, the process deciding the site was conducted through a robust option appraisal, as presumably was the tendering process. I have been involved in the commission of other buildings in GGC HB (for example the Princess Royal Maternity tower and the North Ambulatory Hospital, plus

smaller building alterations) and had a favourable impression that these processes were conducted in a fairer and professional manner. I wasn't involved in the QEUH / RHC Commissioning process.

12. From an infection control perspective, do you have a view on whether the proximity of the hospital to sewage works causes a risk to patients? Please explain why you take this view.

A. I am not an expert in Infection Control and take no view on the matter.

13. What were your first impressions of the IPC team? Were you aware of any of the following issues:

a) existing tensions between staff?

A. I never, to my recollection met an IPC "team" as such. Without a list of individuals it is difficult to be specific, but I did meet individuals from that service in various meetings relating to infection control / management. By hearsay, I was aware that there were issues within the Microbiology / Infection Control "Team", in the same way that I was aware that the consolidation of other services on the QEUH campus had resulted in some need to agree a unified working practice, shared guidelines, etc. etc. This happens with any amalgamation of teams and of course change is difficult for many. In the context of the QEUH, as an amalgamation of 3 hospital services, it is not surprising that there were a range of perspectives crudely divided into "winners and losers". I was also aware that some internal issues were present in Microbiology regarding the then Clinical Lead, Professor Craig Williams, and other Consultants, but I was not aware of the specifics. I am not inclined by nature to participate in rumour and in my managerial role I am exposed to multiple expressed diverse opinions and have had to assess and investigate a variety of information sources, triangulate such information and address any matters if it is within the scope of my role, or escalate upwards or across the system on a "need to know" basis, as one cannot ignore such information. I was told nothing that I reckoned to need any intervention from myself, as I was contemporaneously told that processes to address any issues were in train.

b) lack of clarity around roles and decision making?

A. See above

c) relationships (i.e., between ICM and ICD)?

A. See above

d) Issues with record keeping-?

A. No

e) culture and bullying; and

A. See above. I don't know specifics but I would have considered bullying to be a serious matter and was not aware that the issues might be of that nature.

f) attitude of senior management and board to infection control issues?

A. I have been in a medical management role since 1995. GGCHB evolved from individual Trusts and 2 separate Health Boards. So over the years I have seen a number of infection control events and the wider infection prevention strategies, both on a day to day basis and when the building works I previously alluded to, and unrelated to the QEUH, were in development and realised. The majority of memorable cases involving infection control issues were within the Maternity and Neonatal Services, often in the Neonatal Intensive Care environment, some related to individual practitioners as advising / investigators and others with respect to wider system issues such as surgical prophylaxis. I have benefited from the insight and expertise of these various Clinicians (Special Nurses and Doctors) and Managers (Clinical and Non-Clinical) and have found the Senior Management to be appropriately concerned and engaged in addressing the issues on every occasion. I cannot recall coming across complacency in such matters from the highest level down.

Infection Control in General:

14. What is your understanding of how infection within the QEUH/RHC was and is monitored, investigated, reacted to and reported both internally and externally. Please provide full details.

A. I would refer to the Board Policies, which have been created and / or modified over my career and in response to evolving challenges. I note the external scrutiny provided from national bodies in Scotland (many of whose names and functions have changed over the years). I have not had a specific designated role within either of these systems.

Water System:

15. The water supply in General:

a) What concerns, if any, did you have about the water supply?

A. I had no knowledge of any concerns until made aware of same when issues arose and evolved.

b) Do you consider there to have been a risk of infection from the water supply? If so, explain.

A. As a Doctor, water borne infections to my mind are associated with matters out with a normal UK NHS Health Care environment, for example natural disasters, wars, pollution events, public health managed outbreaks, etc. So, at the basic level, I would expect water supplies to meet basic standards and be safe to use in the UK.

c) Are you aware of whether a risk assessment was carried out prior to handover in 2015? If not, are you aware of why one was not carried out?

A. I did not know of any risk assessment as specified in 2015, I am not aware of why one was not carried out if that is the case.

d) Are you aware of remedial measures being taken: e.g. room closure and cleaning; ward closure; investigative and remedial works? What were these and when were they taken?

A. Yes, as the issue unfolded in the RHC. I cannot supply a detailed time line but expect this information will have been supplied regarding the various mitigations attempted as the infection control concerns involved, as there were many meetings and interventions.

e) What is your understanding of whether any issues with the water system (including drainage) have been resolved. Are you satisfied with this, or do you still have concerns?

A. I have been reassured that the water quality is no longer an issue and have seen no data to suggest otherwise.

f) What were the impacts on staff and on patients overall?

A. It is quite impossible to underestimate the impact on patients, parents and staff (all clinical types and all non-clinical, from domestics, administration, porters, right up to senior managers). The RHC team (as a universal Paediatric service) have my highest admiration with regards to their dedication in every aspect of their care to their patients, relatives and their colleagues. They are focused on the little details that make such a difference to clinical outcomes. That they continued to excel amongst this background of uncertainty and changing spaces, rules and procedures, is a testament to their professionalism, resolve and personal strengths. There was genuine and consistent concern and at no point did this move into the type of "downwards re-set" that would beset, for example, the mid Staffordshire Hospital system: a demonstration of the RHC staff's resilience. I note that some colleagues demonstrated their concerns outward and vocally, others in different ways, and at all times they were making carefully judged risk assessments on what was in the best interest of their patients, not least in the Haemato-Oncology Service. There was a universal desire to find an answer, engage in a collegiate manner and intelligently look at potential short and long term mitigations. Of course there were some meetings in which people

robustly challenged information given, but this was always, to my mind, in a respectful way, as befits professional people. As my clinical practice is in the Glasgow Royal Infirmary, I am aware of wider impacts having been asked on many occasions “is QEUH / RHC safe?”, when people were going to have relatives treated there. I had relatives, colleagues and their children managed through the great phase of uncertainty within the QEUH / RHC, so had a personal awareness in the matter and also because my domicile is within the QEUH catchment area. The media attention (TV, radio and newspapers), in addition to the social medical activity, were additional strains to staff. Although I believe the Board through the Core Brief structure were supplying information, I would judge the impact of mainstream media to be greater than internal communications of any kind. I reiterate that my impression was that the impact was throughout the service, “management and non-management”.

g) When were you first made aware of the DMA Canyon report of 2015? How did you become aware of the report?

A. I was not aware of this report. The name is completely unfamiliar to me and doesn’t come up in any email search on my system until the Public Inquiry.

h) The report makes several recommendations. Do you know what was done to follow up on these recommendations between 2015 and 2017?

A. See g above

i) Do you know if/when the works suggested in the 2015 report were actioned?

A. See g above

j) What is your own view of the findings of the 2015 report? Do you agree with it or not? Explain your rationale.

A. Not applicable

k) The 2015 report highlights several actions required to be taken, are you aware how these actions were managed by estates? If so, please provide details of the management of the recommended actions.

A. See g above

l) DMA Canyon prepared another report in 2017. When did you become aware of this report? Do you know what works, if any, recommended in the 2015 were carried out prior to the 2017 report? What actions did you or other take in relation to the 2017 report's recommendations?

A. See g above

m) What was the impact, if any, of the failure to implement the 2015 recommendations on patient safety?

A. I cannot comment

n) We understand that Infection Control were only advised about the 2015 DMA Canyon Report in 2018. Do you know why this was the case?

A. No

o) Do you have any concerns about the way in which the water system was managed?

A. I cannot comment as I was not involved in this. My involvement was in the consequences of any clinical matters that followed.

p) What risk assessments have been undertaken in respect of the water system since the DMA Canyon Reports? Please provide details.

A. I cannot comment as I was not involved in this.

q) Following the DMA Canyon Reports, what water maintenance strategies were put in place? Who is/was responsible for these? Please provide details of any applicable strategies which were put in place.

A. I cannot comment as I was not involved in this.

r) Some witnesses (e.g., Christine Peters) have said that, had they had sight of the 2015 DMA Canyon report at the time, they would not have allowed the hospital to open. Do you agree?

A. I cannot comment as I have neither the expertise nor information about the reports cited.

Ventilation System:

16. The ventilation system in general:

a) What concerns, if any, did you have about the ventilation system?

A. None until the issue was raised through ICT / Clinical Cases

b) Do you consider there to have been a risk of infection from the ventilation system? If so, explain.

A. Not until it was raised as a potential issue

c) Are you aware of remedial measures being taken: e.g. ward closure; investigative and remedial works? What were these and when were they taken?

A. Yes, as I was an active part of the Women's & Children's (W&C) Directorate Management Team. I expect that a precise time line and details will have been supplied. Various Minutes provided and discussed in later questions describe these matters.

d) What is your understanding of whether any issues with the ventilation system have been resolved. Are you satisfied with this, or do you still have concerns?

A. My understanding is that they have been resolved in the RHC and have no data to suggest differently.

e) What were the impacts on staff and on patients overall?

A. See answer to Section C, Question 15f.

f) To what extent were you consulted or briefed about the specifications of the ventilation system of the hospital before it opened – perhaps by attending meetings or workshops run by the contractors or being sent or shown plans or specifications for particular wards?

A. I was not involved in the design and build of the RHC. I took over the Chief of Medicine's role in June 2015 but remained in post as the Clinical Director of Obstetrics & Gynaecology, until that post was filled in September 2015. I was in attendance at one meeting held at the Queen Mother's Hospital between the contractors and representatives of the Microbiology team (I recall Dr J Hood and Dr B Jones, Microbiology Consultants, both of whom I had previously met over the years, being there), Estates and non-clinical senior management. I was very much new to the specific development. From recollection, this meeting focused on a difference in understanding between the specifications of rooms dedicated for Haemato-Oncology patients and the differences between the specifications provided at the Beatson site, the QEUH adult facilities and the specialised rooms within the Haemato-Oncology Paediatric Ward (2A and Paediatric Intensive Care Unit). There was a clear difference of opinion between the construction companies understanding of the specifications and others within the room. Much of the argument focussed on a specific set of room specifications, set against National standards. Whilst this meeting was conducted in a professional manner, my recollection was that the atmosphere was quite tense, the matter unresolved and that it was elevated to (presumably) further up the project board ladder. As described elsewhere, I neither recall nor have been able to find out, whether I was cited in a minute, but wish to record this answer as my name may appear as a participant. My recollection was obviously also in the context of being new to my more senior managerial role and the project. My past experience with building projects in hospital, are that there are instances when national recommendations / specifications are changed within the timespan of a hospital construction, and so "retro fits" or other accommodations are sometimes required, areas repurposed (sometimes post-commissioning) or some form of formal acceptance that any new recommendations cannot be achieved and a risk assessment made for clarity and assurance regarding the

impact of non-compliance. An example might be that a new build Paediatric or Maternity Unit could be required to provide some or additional parental accommodation, more than was initially planned for when the building was commissioned or the building work completed. It might be an impossible aspiration after a build is completed. Returning to the meeting described above, my impression at the time was that the matters discussed could only be resolved by experts in Microbiology building systems and Contractual Law as something as an impasse had been reached.

Particular events:

17. The Inquiry understands that between July and September 2015, you attended at two meetings with Jamie Redfern and Jennifer Armstrong where concerns about the ventilation in Ward 2A were discussed. Please provide us with details of these meetings, including details of:

a) The dates and times of the meetings?

A. My diary at that time was managed by 2 now retired personnel: Ms Kathleen McGrath (O&G Directorate Personal Assistant, retired 2023) and Mrs Janice Hackett (Personal Assistant to the Directorate Team, including myself and Mr Kevin Hill, the then Director of Women & Children). IT systems have changed and my Email Archives were affected so I am unable to confirm the dates and times of this meeting from my calendar and both personal assistants' accounts are inactivated. It is possible that the meeting was never formally in the Diary as it might be at a time I would be in the Management Corridor (I shared an office with the Director, Mr Kevin Hill), was at short notice, and during a time I was known to be at the Children's Hospital. As described, my Email Archive (I tend to archive rather than delete) lost functionality during various IT changes and so, whilst I have searched, no memo or note has been retrieved.

b) Who do you recall called for these meetings?

A. Without a minute I cannot recall details of this meeting

c) Who do you recall had raised concerns about the ventilation in Ward 2A?

A. My recollection is that at this time, concerns were about whether Ward 2A treatment rooms were fit for purpose with regards to general Infection Control and practical matters rather than specifics about “the ventilation system”. So, there was interest in the control of external barriers to infection (e.g. from visitors, clothing, the optimal use of the space between corridors and actual room a patient would be in, water seals and such-like. Ventilation of air “in and out” concerns were discussed in terms of filters but we were not Estates or Infection control experts and so these discussions were not going to lead to a decision as such, but probably informed questions to pose with experts in the relevant area. For my part, I was learning a lot about things that were previously not part of my clinical or managerial experience. I also recall that at that time, the focus was very much on Fungal infection risks in general in this “at risk” population and not solely related to the ventilation system. There was a broad concern about environmental fungal spores (for example brought in on visitor’s footwear) because of the older areas of the site. I particularly remember these concerns being illustrated by Dr Inkster (at a separate meeting) regarding the yet to be demolished “old” Southern General Management Offices, because it was an area of the Hospital I had visited on many occasions (Senior Managers had offices there) over the years and was in a state of some disrepair and I understood to be scheduled for de-commissioning.

d) What were the specific concerns discussed?

A. From recollection the main issues were related to minimising risk and the type of environmental monitoring required, by this I mean using culture plates and other techniques to ascertain particle counts and grow fungi if present. Mitigations such as prophylaxis (at a completely different level than later) would have been part of these discussions.

e) What, if any actions arose from those meetings?

A. Again from recollection, expert advice had been sought regarding the potential risks described in 17D, and what monitoring practices were practiced in comparable sites.

18. On 10 August 2015, you attended at a 'RHSC BMT Meeting'. Please provide details of this meeting, including:

a) Who attended at the meeting?

A. There is no reference in any of the bundles to a minute of this meeting, hence I am unable to answer. If details can be retrieved I would appreciate sight of these.

b) What was the purpose of the meeting?

A. There is no reference in any of the bundles to a minute of this meeting, hence I am unable to answer

c) What was discussed at the meeting?

A. There is no reference in any of the bundles to a minute of this meeting, hence I am unable to answer

d) What actions arose from the meeting?

A. There is no reference in any of the bundles to a minute of this meeting, hence I am unable to answer

19. On 7 September 2015, you attended a meeting to discuss the BMT Unit in the RHC (See SHI Bundle 6, Miscellaneous Documents at page 20)

a) Who attended at this meeting?

A. There is a minute with attendees

b) What was the purpose of the meeting?

A. As per the Minute: To determine bone marrow transplant position, room status and the position from the Clinicians on starting to treat new patients.

c) What was discussed at the meeting?

A. As per the minute provided.

d) What actions arose from the meeting?

A. As per the minute provided.

20. On 11 September 2015, you exchanged e-mails with Dr Teresa Inkster regarding anti-fungal prophylaxis **(See SHI Bundle 6, Miscellaneous Documents at page 25)**

a) Why did you seek Dr Inkster's views on anti-fungal prophylaxis?

A. From reviewing the emails provided and from recollection (as previously stated I knew only a few microbiologists and they were probably all at the GRI site). I believe Dr Inkster attended and advised, either in lieu of another Practitioner, or because she was an available member of the Infection Control Team, or similar. These matters were well beyond my area of expertise, I will have made contact either by instruction or because they were the designated responsible individual for that day, or possibly assigned to the project by someone other than myself.

b) What was her view?

A. Her view is expressed in an email 11th September 2015 at 15.58 **(A 40364475- Bundle 6 – Miscellaneous Documents - Page 30).**

c) Did you agree with her view? If not, why not?

A. I took her view as presented. Appropriately, she stuck to her area of expertise and, as she describes knew that there was "a difficult risk assessment" to make.

21. On 11 September 2015, you attended at a meeting involving senior management of the RHC. The Inquiry understands that air sampling results taken by Dr Inkster were discussed at this meeting. Please provide details of this meeting, including:

a) Who attended at this meeting?

A. I cannot recall and have not found a minute of this meeting.

b) What was the purpose of the meeting?

A. From recollection of what such meetings were generally about, the purpose would be to discuss the risks associated with bone marrow transplant treatment at RHC.

c) What was discussed at the meeting?

A. See above.

d) What actions arose from the meeting?

A. For my part, I spoke to Dr Brian Jones, Consultant Microbiologist, and almost certainly from the outcome of that meeting, further weekend testing was advised (email 11.09.2015 @ 17.52) **(Bundle 6 – Miscellaneous Documents – Hearing commencing 12 June 2023 – Page 35)**

e) On what basis did you consider that infection control should sign off Ward 2A? Did others take a different view? If so, who? Please provide details of any discussions or debate which may have taken place on this issue.

A. It has always been my view that a decision with relation to infection control (or, indeed, any specialist matter) should be left to expertise in that area with necessary collaboration in "shared areas" so that a "counsel of experts" is required to achieve a measured consensus. If the question seeks to suggest an instruction was made to "sign off" the area, then I can confirm I was not privy to any such instruction and would not consider that to be something that I would be in a position to do. It has not been my experience to be exposed to such commands in my managerial career. To my mind the issue was a balance of risks relating to potential patient harm from a known lethal and progressive illness versus what seemed to be a divided opinion regarding the microbiology monitoring process and risk. The environmental testing process and results were a necessity for same, and from recollection, these were problematic: there appeared to be no consensus from comparable units

regarding a monitoring / testing regime. In addition there was appreciation that fungal infections were a risk to anyone whose immune system was severely compromised as Bone marrow transplant and cancer chemotherapy and other immunosuppressant therapy will inevitably do. The risks and benefits were debated at length and I believe in a constructive and collegiate manner and taking into account expert opinions on all sides. There appeared to be a spectrum of opinions on the microbiological side.

f) What view did you take of Dr Inkster's concerns regarding the safety of the ward considering the results of her air samples? On what basis did you reach your views?

A. Dr Inkster is an expert in her area, her concerns were clearly articulated. I recall a debate about what weight her concerns should be given in the context of other microbiological opinion and the final risk assessment regarding the Unit treating patients had to balance multiple risks. My view as such was informed by all of the risks and benefits presented. I need to emphasise that the decision making process here was not, as far as I know, down to a single member of the Woman and Children's Directorate Team.

22. From 11 to 14 September 2015, you were involved in a number of e-mail exchanges concerning re-sampling in Ward 2A of the RHC **(See SHI Bundle 6, Miscellaneous Documents, pp 29-35).**

a) Why did Professor Jones consider there was no advantage to re-sampling cubicles 18 and 19?

A. From recollection is that it related to how further testing would inform the situation. From my email he obviously described his knowledge of how pathogenic (and potentially lethal) some fungi might be. I recall much general debate about the utility of various testing approaches; the main issue was about what link could be inferred from findings on an environmental monitoring plate versus the risk of an actual organism being detected in an individual patient's body that correlated with that environmental testing.

b) Why did you disagree with this view?

A. I did not have the expertise to agree or disagree.

c) There is reference **(Bundle 6 – Miscellaneous Documents – page 29)** to a call between yourself and Professor Jones. What was discussed in that call? What was the outcome?

A. I did not have the expertise to agree or disagree.

d) What actions were taken in respect of re-sampling cubicles 18 and 19?

A. I requested that sampling was performed as per the email.

e) Why were such actions taken?

A. To further determine risk or for assurance purposes.

f) What was the result of any re-sampling undertaken?

A. The results informed further actions between the Estates and ICT (as specified in other emails)

g) What actions were taken following on from these results?

A. I do not have specific details, but simply observe that my impression was that there was always an assessment and action from the sampling processes.

23. On 15 September 2015, you wrote by e-mail to Jamie Redfern and Jennifer Armstrong in respect of two SBARs which were to follow **(See SHI Bundle 4, SBAR Documents, p13.).** Please provide details as to the discussions and debates referred to.

a) In respect of SBAR 1:

i) What was the purpose of this SBAR?

A. I believe the SBAR outlines my observations regarding the extensive discussion and debates that I had been privy to in a fair and logical manner. As described in the “situation” section, there was a need to determine if bone marrow transplant therapy could be offered as a viable treatment option in the current service at RHC for a critically dependent case that had been through the clinical multi-disciplinary team process and had an available donor. From

recollection the donor was only likely to be available for a relatively short window and therefore there was a time imperative decision required.

ii) What prompted the drafting of this SBAR?

A. The urgent need to address a specific case.

iii) On what basis did you reach your conclusions?

A. I set out the issues as described to assist in achieving the executive decision that was required. I believe I represented a logical interpretation from my listening to various debates and after reflecting on multiple pieces of information. The option was, in a narrowing window of opportunity for the index patient, to either treat at RHC or seek treatment elsewhere. Hence my "conclusion" rested on whether other expert individuals (much more expert in these matters than myself) were in accord and that the Board could determine what was to follow. I reiterate that I made it clear that I was not an expert in the matters of infection control or haemato-oncology. I was seeking what is sometimes described as a "Go / No Go" decision.

iv) How was the SBAR received?

A. It was received as a positive contribution to the situation from verbal feedback.

v) What was the outcome of production of this SBAR?

A. The Board Medical Director and, I expect, the Chief Operating Officer and/or Chief Executive made a decision on the basis of further information that indicated was necessary (i.e. presumably the opinion of the Head of Microbiology and Dr Brenda Gibson's Team as mentioned).

b) In respect of SBAR 2:

i) What was the purpose of this SBAR?

A. As described there were other patients awaiting treatment.

ii) What prompted the drafting of this SBAR?

A. My concerns about the need to plan treatment and ensure any outstanding estate mitigations were progressed. I was not alone in the view that everyone involved needed the uncertainty about Estates matters to conclude and matters had come to a binary "start treatment in RHC or seek to refer (with all of the difficulties inherent in this for potential receiving units and the families involved)". There was also an issue with the capacity of appropriate accommodation as the rooms were being altered to a different (higher) specification.

iii) On what basis did you reach your conclusions?

A. There was a need to plan evolving cases. The issues were the same ones addressed in SBAR 1.

iv) How was the SBAR received?

A. SBAR 2 reflected the need for more capacity to be made available (i.e. an expansion of the serviceable treatment rooms) and again was positively received.

v) What was the outcome of production of this SBAR?

A. From recollection Estates work continued to the point that capacity was increased.

24. Please refer to IMT 5 August 2016 concerning the increase in Aspergillus Infections in the Schiehallion Unit **(SHI Bundle 1, IMT Meeting Minutes, pp 22-26)**.

a) What do you recall about this incident?

A. It is described in the minutes. Two Aspergillosis cases had been identified in the Schiehallion Unit.

b) What was your involvement?

A. I received a minute and this would have resulted in discussion and a response from the Directorate Management Team.

c) When and how did concerns first arise?

A. See Minute.

d) What Investigations were done?

A. See Minute

e) Was there a hypothesis?

A. As I understand the term in ICT terms, a hypothesis is not precisely described in one sentence but areas of potential risk were described, as were potential mitigations

f) If so, was it borne out?

A. See 24E above

g) Were any interventions recommended? If so, were they sufficient?

A. See minute

25. On 19 April 2017, you attended at a meeting with Dr Teresa Inkster.

a) What was the purpose of the meeting?

A. I do not have a record of this meeting, but informal meetings to discuss the situation were not unusual and welcomed.

b) What was discussed at the meeting?

A. I do not recall specifics but I expect it was triggered from an IMT process or data.

c) What actions arose from the meeting?

A. I cannot recall specifics other than what can be inferred from the subsequent question.

d) Why did you ask Professor Gibson to conduct a review?

A. The Haematology Oncology service is data rich and has a designated clinical governance process. If I sought a review from Dr Gibson it would pertain to

whether any illumination could inform the emerging situation, or the request had arisen from a clinical governance perspective.

e) Did you take this action forward? If not, why not?

A. There were frequent discussions and exchange of data throughout the Directorate Team and with the clinical experts about the progressive actions required. These were sometimes passed on to other members of the team to follow up. I cannot be more specific other than to state that the Schiehallion service had the highest attention and would wish to dispel any thought that there was a passive approach to issues there.

g) Why did you propose Dr Armstrong explore escalation processes within microbiology/infection control with Dr Inkster?

A. I presume that Dr Inkster raised the issue about team dynamics in her Service. I was already aware that there were difference of opinion and approach to monitoring and design specifications. My routine response to any individual who raise concerns is to empower them to escalate these through the appropriate channels within their management structure, and where necessary they should involve non-clinical managers or skip a step above the hierarchy of their immediate Line Managers if this is perceived to be an issue. Microbiology and ICT functions were within another Directorate. If necessary I would facilitate an introduction but that was not necessary in this circumstance.

h) Did you take this action forward? If not, why not?

A. In the absence of a minute, or more information, I cannot answer precisely but the action needed was from the individual with concerns as described above.

26. Refer to IMT 2 March 2018- This IMT concerned Cupriavidus infection in a patient which was matched by typing from a sample in aseptic pharmacy **(SHI Bundle 1, IMT Meeting Minutes, p 54)**

a) What do you recall about this incident?

A. It was prompted by concerns about water contamination in Ward 2A

b) What was your involvement?

A. Participant in IMT that day representing Directorate Team

c) When and how did concerns first arise?

A. See minute of meeting

d) What Investigations were done?

A. See minute of meeting

e) Was there a hypothesis?

A. Yes: see minute of meeting

f) If so, was it borne out?

A. This is beyond my areas of expertise

g) Were any interventions recommended? If so, were they sufficient?

A. See minutes of meeting, all interventions were subject to subsequent testing and control processes.

h) What was your view about communication in respect of this incident?

A. There was an established communication strategy. I don't recall concerns being raised about the communications strategy, or the quality of communications, either at or after the meeting. My long standing belief is that how effective any communication is can only be determined by the recipient rather than the author.

27. Refer to IMT 9 March 2018- This IMT concerned the water incident in Ward 2A of the RHC **(SHI Bundle 1, IMT Meeting Minutes, p 60)**

a) What do you recall about this incident?

A. This was a follow up meeting from 6th March 2018

b) What was your involvement?

A. Member of group, Women and Children Directorate Team representative

c) When and how did concerns first arise?

A. See minutes of previous meeting

d) What Investigations were done?

A. See minutes

e) Was there a hypothesis?

A. The taps remained a key concerns related to biofilm build up.

f) If so, was it borne out?

A. This is beyond my area of expertise

g) Were any interventions recommended? If so, were they sufficient?

A. Yes. See minutes. As mitigations and challenges continued, it is easy in retrospect to determine these were unsuccessful

h) What was the purpose of your question concerning whether the water system could sustain an old fashioned hot/cold water mixing tap?

A. I am not an expert in water systems etc. and was simply asking if an alternative arrangement was possible, simply because, in my experience in other fields, not all innovations prove to be improvements. I can assure you that the question arose from my thoughts only and out of curiosity. I imagine that I would have prefaced the question with clarity that it might be naïve. I have never shied away from asking questions be they simple or complex.

i) What was your view about communication in respect of this incident?

A. See 26H answer.

28. Refer to IMT 16 March 2018- This IMT concerned the water incident in Ward 2A of the RHC **(SHI Bundle 1, IMT Meeting Minutes, p 63)**

a) What was the purpose of this meeting?

A. This was a follow up meeting.

b) What was your involvement?

A. I am not recorded as having attended but will probably have had access to the Minute or been informed of the outcome.

b) What was your view concerning the additional patients presenting with Cupriavidus and Stenotrophomonas?

A. Either the hypothesis was wrong or the mitigations ineffective.

c) What was your view concerning the results of testing at taps and a shower head which were discussed?

A. I was not privy to these discussions.

d) What was your view on the concerns expressed by Professor Gibson in respect of the lethality of the pathogens to immune-suppressed patients and the safety of the patients in rooms where positive test results had been returned?

A. I would defer to Prof Gibson's expertise.

e) What was your view on the situation wherein patients were unable to wash themselves?

A. This was a profoundly sub-optimal situation.

f) Did you consider that the control measures in place were sufficient?

A. This isn't my area of expertise, but the evidence suggests not. It is notable that the hypothesis was changing.

g) Did you consider the confirmed action plan to be sufficient? If not, why not?

A. The IMT process is informed by experts in infection control and those who can instruct corrective measure.

h) What was your view about communication in respect of this incident?

A. See answer to 26H

29. On 18 March 2018, you attended at a teleconference with GGC/HPS/HFS and Public Health Scotland. The Inquiry understands that an update was provided on the Cupriavidus contamination in Ward 2A **(See SHI Bundle 5, Communications Documents, p 116)**. Please provide details of this teleconference, including:

a) What was the purpose of the teleconference?

A. I do not recollect attending this tele conference, but have received the synopsis by email (18.03.18 @ 16.51) **(A38662162 - Bundle 5 – Communications Documents – Page 59)** from Dr Jennifer Armstrong, Board Medical Director

b) What was discussed on the teleconference?

A. See answer 29a

c) What was the nature of the debate referenced in respect of longer-term changes in terms of filters, shower heads, taps, water treatment and testing?

A. See 29a

d) What actions arose from the teleconference?

A. As per Dr Armstrong's email, cited above

e) What was the nature of any discussions surrounding communications?

A. See 29a and d

30. Refer to IMT 29 May 2018 **(SHI Bundle 1, IMT Meeting Minutes, p 91)**. You were not present at this meeting. However:

a) On p 92 it is noted that Dr Inkster was to e-mail you concerning the number of visiting medics. Did you receive any such e-mail from Dr Inkster? If so, when? If so, what was your view on the suggestion that numbers be kept to a minimum? What, if any, action did you take as a result?

A. See previous commentary about emails and archive access. I cannot determine whether I received an email from Dr Inkster about this matter. I have previously described my email arrangements. As nosocomial infection is a constant risk in any hospital, there are frequent reminders regarding restricting the footfall and the numbers of visitors: this includes clinical staff and teams.

31. Refer to IMT 8 June 2018 **(SHI Bundle 1, IMT Meeting Minutes, p 111).** You were not present at this meeting. However:

a) On p 111 it is noted that Dr Inkster sent you a memo which you disseminated to medical and nursing staff concerning sink hygiene. Did you receive any such memo from Dr Inkster? If so, when? If so, when did you disseminate it? What, if any, action did you take as a result of the memo beyond disseminating it? Did you agree with the terms of the memo? If not, why not?

A. The Directorate Team met regularly and agreed actions regarding such communications. These could be prompted by verbal or email information. Advice from infection control was followed and only questioned if they posed practical issues that needed further advice or clarification.

32. Refer to IMT 19 September 2018- This IMT concerned the water incident in Ward 2A of the RHC **(SHI Bundle 1, IMT Meeting Minutes, p 182)**

a) What was the purpose of this meeting?

A. This was a continuation of the incident management team, process already in train.

b) What was your involvement?

A. I attended as a representative of the Women and Children Directorate Team.

c) What was your view concerning the additional patients presenting with Cupriavidus and Stenotrophomonas?

A. This was an unresolved mystery, resisting mitigation attempts. I recall that there was clinical memory of Stenotrophomas from the Yorkhill site (it was referred to in shorthand as “Steno”, although the second part and subtype of organisms is important and there are, I expect, variations in pathogenicity). I don’t recall anyone clinically having experience of Cupriavidus species.

d) What was your view of the actions which has been undertaken following the previous meeting on 18 September 2018?

A. They were informed by ICT and clinical advice.

e) Did you consider that the control measures in place were sufficient?

A. The problem remained so the mitigations proved to be insufficient.

f) What was your view on the contingency/decant debate which was undertaken at this IMT? What view did you take in connection with decanting BMT patients to Ward 4B? What was your view concerning the proposed cleaning of Ward 6A?

A. All of this was informed by experts in the relevant areas and the debates were informed by these professionals demonstrating what appeared to me to be appropriate diligence and concern.

g) What was your view about communication in respect of this incident?

A. See previous comments about communication. It was disappointing that some families apparently received their information from external media, ahead of our in-house communication, despite this usually being constructed in a relatively short timeframe (i.e. same day and within hours of any particular need for such communication).

h) What was your view on the suggestion that the IMT no longer be chaired by a member of the ICT?

A. I could see the logic of Dr Inkster's expressed view, as the meeting was moving to a logistics emphasis. I did not interpret it as the infection control (microbiology team ceasing to be involved and the minutes reflect their continued need to be so). My observation is that in many infection control (and other clinical "hot issue") situations the Chair may be wearing both the "hat" of the meeting manager and also as an expert: this is not unique to Infection Control, I frequently Chair meetings that I also have expertise in the area: it is always an additional pressure on the Chair.

i) Do you consider that all of the actions proposed following this IMT were complete and sufficient? If not, why not?

A. Under the circumstances, yes.

33. On 9 January 2019, you attended at a meeting called in response to an IMT Cryptococcus meeting on 7 January 2019 **(See SHI Bundle 5, Communications Documents, p 162).** Please provide details of this meeting, including:

a) What was the purpose of the meeting?

A. To address matters arising from the finding of Cryptococcus infection.

b) Why was it called on an urgent basis?

A. Significant issues were raised at an IMT on Monday 7th January 2019.

c) What actions arose from the meeting?

A. See Minute.

d) What was your view on the use of prophylaxis medication?

A. I accepted expert advice.

e) What was your view on the efficacy of using HEPA filters?

A. I could not give an expert view. In general anything that might be beneficial seemed appropriate, if there were no significant dis-benefit. The effectiveness of HEPA filtration had been discussed on numerous occasions and in different contexts.

f) Did you visit the ward on 9 January 2019 as suggested? What cleaning regime was agreed?

A. I believe the AM referred to was Dr A Marek, the infection control doctor. I couldn't usefully contribute to this action myself. I am usually referred to in Minutes as AMM

g) Explain the ward sampling results which you are noted as reporting on at point 4 on page 162.

A. See 33(F). This refers to Dr Marek, the matter is not an area I could interpret or comment upon.

h) Was any re-sampling undertaken? If so, what were the results?

A. I cannot answer this.

i) What was the nature of any discussions surrounding communications? Did you consider communications to be sufficient?

A. See previous comments about communication.

34. On 9 January 2019, you received an e-mail from Jennifer Rodgers with a 6-bullet point note for consultants to use in communicating with families **(See SHI Bundle 5, Communications Documents, p 165)**

a) Was this briefing note provided to consultants? If so, when?

A. All such communications were disseminated via the Directorate Secretariat, I do not have a record on when this was done. My experience was that it was efficient and prompt.

b) What was your view on the briefing note? Did you consider it to be appropriate and sufficient? Did you consider it to be accurate?

A. My only view is that it was useful to have a consistent agreed briefing note knowing that the Consultants and other member of staff would be responding to specific questions from individual patients and relatives. I have no reason to doubt its accuracy and it covered the key points as I understood them.

c) Did you consider communications with families in general to have been sufficient? If so, why? If not, why not?

A. See previous comments about communication: only families can have an opinion on how effective were any of the communications.

35. On 9 January 2019, you received an e-mail from Jennifer Rodgers with draft lines for communication with parents **(See SHI Bundle 5, Communications Documents, p 167)**

a) What was your view on the suggested lines of communication? Did you consider it to be appropriate and sufficient? Did you consider it to be accurate?

A. Yes to all of these questions.

b) Did you consider communications with parents in general to have been sufficient? If so, why? If not, why not?

A. See previous comments about communication. I believe the whole team tried to communicate effectively.

c) Did you provide any comments on the proposal? If so, when? What were your comments?

A. Unless I was off site, I would usually have contributed to discussions about communication and how it was to be conveyed during team meetings in the Directorate management area.

36. On 13 January 2019, you received an e-mail from Jennifer Rodgers with a final briefing note for families **(See SHI Bundle 5, Communications Documents, p 169 and 170)**

a) What was your view on the briefing note? Did you consider it to be appropriate and sufficient? Did you consider it to be accurate?

A. Yes to all of these questions.

b) Were you part of the team which agreed to this briefing note? If not, who was?

A. I expect so, as there was usually a collective approach.

c) Did you consider communications with families in general to have been sufficient? If so, why? If not, why not?

A. See previous comments.

d) Did you agree with what was stated about the rigorous quality of water testing? If not, why not?

A. I was informed that the water testing remained reassuring. I recall the water supply was described as “potable”, which seemed a rather archaic term but as I am not an expert in water quality might have a significance beyond my understanding of the word.

e) Do you agree with what is stated in connection with the additional measures to ensure water quality? If so, what additional measures do you consider having been successful? If not, why not?

A. This information was accurate, as far as I was aware, by data available to the microbiology and infection control team.

f) Did you consider the use of HEPA filters to have had an impact? If so, on what basis did you reach that view?

A. Any impact could only be assessed by microbiological testing and clinical events.

37. Refer to IMT 16 January 2019- This IMT concerned Cryptococcus in Wards 6A and 4C **(SHI Bundle 1, IMT Meeting Minutes, p 261)**. Please provide details of this IMT, including:

a) What do you recall about this incident?

A. This IMT presented information about Cryptococcus details that had been identified.

b) What was your involvement?

A. I attended as a representative of the Women and Children Directorate Team

c) When and how did concerns first arise?

A. See Minutes.

d) What Investigations were done? What were the results?

A. See Minutes.

e) Was there a hypothesis?

A. Yes, that the duct work was contaminated and needed HPV cleaning as per the minutes.

f) If so, was it borne out?

A. I cannot comment.

g) Were any interventions recommended? If so, were they sufficient?

A. See Minutes.

h) What was your view about communication in respect of this incident?

A. Again these were challenging matters to communicate to non-experts but a communication was necessary.

i) Do you consider that all of the actions proposed following this IMT were complete and sufficient? If not, why not?

A. It seemed these were appropriate from my non-expert perspective.

38. Refer to IMT 17 January 2019- This IMT concerned Cryptococcus in Wards 6A and 4C **(SHI Bundle 1, IMT Meeting Minutes, p 266)**. Please provide details of this IMT, including:

a) What was the purpose of this meeting?

A. See Minutes. I was not in attendance.

b) What was your involvement?

A. I would have seen the Minute and discussed matters with the Directorate team.

c) What was your view concerning the proposed cleaning of the ventilation ducts and use of HEPA filters?

A. I am not an expert in such matters. I would accept the consensus view arrived at from drawing on available expert advice.

d) What was your view of the proposed movement of high-risk patients to Ward 4B?

A. I would accept the consensus view arrived at from drawing on available expert advice.

e) What was your view of the proposed use of mobile HEPA filters in the corridor areas of Ward 6A and 4C?

A. I would accept the consensus view arrived at from drawing on available expert advice.

f) What was your view of the proposed continued use of prophylaxis in Ward 6A?

A. I would accept the consensus view arrived at from drawing on available expert advice.

g) What was your view on the use of point of use filters in Wards 2A and 2B?

A. I would accept the consensus view arrived at from drawing on available expert advice.

h) What was your view on the proposed discontinuation of paediatric BMT and high-risk patients use of Ward 4B?

A. I would accept the consensus view arrived at from drawing on available expert advice.

i) What was the basis for your comment concerning the risk of Cryptococcus within an area the patients are being moved to (See p 272)? What, if any, was the response to this comment?

A. This relates to a later meeting from that day (1600 – 1800). The construction of the sentence recorded in the minute is poor, but I was simply asking whether we could be assured that the move to another ward had evidence that it was safer (that would be safety in all relevant risks including patient segregation and suchlike). I don't recall the comment being met with anything other than a reasoned and reasonable answer (this might have been from a number of contributors as it was an open question).

j) Did you consider that the risk management and control measures in place were sufficient?

A. In the circumstances I believe so.

k) What was your view about communication in respect of this incident?

A. See previous comments.

l) Do you consider that all of the actions proposed following this IMT were complete and sufficient? If not, why not?

A. I had no reason to believe otherwise.

39. Refer to IMT 18 January 2019- This IMT concerned Cryptococcus in Wards 6A and 4C **(SHI Bundle 1, IMT Meeting Minutes, p 266)**. Please provide details of this IMT, including:

a) What was the purpose of this meeting?

A. See the minute. I was not in attendance.

b) What was your involvement?

A. I will have seen the Minute.

c) What was your view of the progress of the actions from the meeting of 17 January 2019?

A. I cannot comment.

d) What was your view of the decision to move 3 high risk patients to Ward 4B?

A. If a collective decision is reached, taking into account expert advice, then I would support that decision.

e) What was your view about communication in respect of this incident?

A. I cannot comment.

f) Do you consider that all of the actions proposed following this IMT were complete and sufficient? If not, why not?

A. I cannot comment.

40. In January 2019 you met with Dr Inkster. Please provide details of this meeting, including:

a) What was the purpose of the meeting?

A. I met Dr Inkster a number of times and if there is not minute or subsequent email I cannot comment with any precision.

b) What was discussed at the meeting?

A. I cannot recollect details but appreciate that she was anxious about the infection control situation, which was quite understandable. She was not alone in this.

d) What was your view in respect of Dr Inkster's opinion that she was being pressured to reverse the decision to relocate patients from Ward 2A to Ward 6A?

A. If that was her recollection and opinion then my advice (see elsewhere) is to ensure that she followed the tents of GMC good medical practice and raises her concerns to parties who could hear her concerns and intervene, signposting her if required.

e) Who upheld the decision to relocate patients from Ward 2A to Ward 6A?

A. I expect that such a decision would be determined by representatives of the Senior Management Team, i.e. above the Directorate Team level.

41. In January 2019, you met with Jennifer Armstrong, Professor Gibson and Dr Inkster. Please provide details of this meeting, including:

a) What was the purpose of the meeting?

A. I do not recall this particular meeting in any detail and have no minute of this, or whether it was planned or opportunistic.

b) What was discussed at the meeting?

A. I presume it would be about the continued issues within the hospital.

c) The Inquiry understands that you produced a SBAR as a result of Dr Inkster's concerns about the water in Ward 2A. Why did you do so? What did the SBAR contain?

A. I have not been able to locate this SBAR, unless it is one of the previous presented SBAR. I would generate an SBAR if there was something I wished a response to as that is its function, rather than simply to be a memo. I will be willing to comment further if this is located.

42. On 1 March 2019, you met with Christine Peters and Dr Inkster concerns were raised regarding Cryptococcus. On 1 March 2019, you sent an SBAR by e-mail to Jennifer Armstrong following the meeting **(See SHI Bundle 4, SBARS at p 151)**. Please provide details of this meeting, including:

a) What was the purpose of the SBAR?

A. To raise concerns presented to me as set out in the SBAR.

b) Who was the SBAR shared with?

A. It was to Jennifer Armstrong alone.

c) What actions were taken as a result of this SBAR?

A. Dr Gibson was asked to arrange a review of a series of cases. Dr Armstrong replied with her response in an email dated 04.03.19 @ 14.39.

d) What recommendations were carried forward?

A. From subsequent email (Dr De Caestecker 04.03.19 @ 16.17) a review was already in train with input from Dr Ian Kennedy, Public Health Doctor.

e) Who was responsible for these actions?

A. Dr Armstrong instructed the actions and my reading of the subsequent correspondence was that others had been given or were already engaged in relevant enquiries.

f) Why was this SBAR prepared at this time given that the DMA Canyon reports of 2015 and 2017 were well known at this stage?

A. As stated elsewhere I was unaware of these reports and cannot comment about them.

g) Why were these issues not raised in 2018 and 2019?

A. I cannot comment.

h) Were you aware of subsequent infections following the reports by DMA Canyon in 2015 and 2017? If not, why not?

A. I cannot comment.

43. On 4 March 2019, you received an e-mail from Linda de Caestecker in which it was noted that Dt. Iain Kennedy (of HPS) was already analysing the data and working with Dr Inkster.

a) What was your view of the response received from your SBAR?

A. The matters were in hand by Public Health experts, it was a Public Health matter in my view.

b) Did you work with Dr Kennedy and Linda de Caestecker on the assessment as suggested?

A. I liaised with Dr Kennedy and Sandra Devine (Infection Control Nurse).

44. On 15 March 2019, you attended at a meeting with Dr Iain Kennedy and Sandra Devine. The Inquiry understands that at that meeting you provided information regarding Dr Inkster's concerns.

a) What information regarding Dr Inkster's concerns did you relay?

A. I recall that she presented me with historical data as described in a previous response.

b) What response did you receive when you relayed these concerns?

A. Dr Kennedy and Sandra Devine were very knowledgeable and already involved in the epidemiological / public health aspects.

c) What was the outcome of this meeting?

A. My impression was that they felt the matters were already being looked at and the area was concern was subject to that line of enquiry but they would do the needful as requested.

d) What was the basis of your suggestion that Professor Gibson review two cases from 2017 which had been highlighted by Dr Inkster?

A. Professor Gibson had the expertise to reflect on the particular cases and was also in a position to suitable delegate these reviews if she was conflicted by involvement in the cases or the capacity for such an undertaking with her significantly busy and burgeoning workload.

e) The Inquiry understands that you were sent a copy of an epidemiology report by Dr Kennedy on 31 July 2019 by e-mail. Why did you fail to reply to this e-mail? What, if anything, did you do in response to receipt of Dr Kennedy's report? What, if any, view did you have of the contents of the report and its findings?

A. My PA might have answered the email on my behalf, as my practice was often to write by hand on printed out emails and my secretary would then compose an email. Sometimes these were not presented from my email account. I can assure you that I didn't deliberately fail to reply, I would not ever seek to ignore or suppress any information. I hope you will appreciate that a lot of information was presented and managed in various scenarios. I would need to see the report again to comment further but all information was looked at by multiple parties and made available as required for other Reviewers, etc.

45. On 27 July 2019, you received an e-mail from Professor Gibson **(See SHI Bundle 8, Supplementary Documents at p 112).**

a) What prompted this e-mail from Professor Gibson?

A. This was a follow up to the request to look at the outcome of 3 patients from 2017.

b) What was your view of the information presented concerning the three deaths?

A. That it was appropriate to raise Dr Gibson's request with senior colleagues and arrange an external review.

c) Did you respond to this e-mail? If not, why not?

A. My response might not have been by email, but an external review of these cases was undertaken.

d) What, if any, action did you take following receipt of this e-mail?

A. My normal course would be to discuss such matters with the Director (Mr Hill), other members of the Directorate Team and the Acute Board Medical Director (or higher).

46. Refer to IMT 8 August 2019- This IMT concerned Gram Negative Bacteraemia **(SHI Bundle 1, IMT Meeting Minutes, p 338)**. Please provide details of this IMT, including:

a) What do you recall about this incident?

A. This was a follow up IMT.

b) What was your involvement?

A. Participant as Women and Children Directorate team member.

c) When and how did concerns first arise? What was your view concerning the level of infections found?

A. See Minutes.

d) What Investigations were done? What were the results?

A. See Minutes.

e) Was there a hypothesis? Did you agree with the working hypothesis? If not, why not?

A. The Minutes describe this but there isn't a specified hypothesis statement.

f) If so, was it borne out?

A. I cannot comment.

g) Were any interventions recommended? If so, were they sufficient? What was your view of the environmental testing being carried out?

A. See Minutes.

h) What was your view about communication in respect of this incident?

A. See previous comments.

i) Do you consider that all of the actions proposed following this IMT were complete and sufficient? If not, why not?

A. I cannot comment on these details.

47. On 12 August 2019, you received an e-mail from Christine Peters asking for a list of outcomes for patients with blood cultures in 2017.

a) Do you recall receiving this e-mail?

A. See previous comments about email management, I don't recall this email.

b) Were you aware of what the e-mail referred to?

A. Given previous response, 2017 had become a year of interest. However I wouldn't have the information sought therefore I expect that I would have redirected this to someone who might have the information.

c) Did you respond to this e-mail? If not, why not?

A. I expect I redirected it to an individual who would be able to locate the data, or signpost to someone who could help. I believe that it would be unusual for me not to at least acknowledge the request and re-direction and would wish to record my apologies if that is the case, but keeping up with all email traffic on a daily basis can be challenging and August is a particularly difficult month as there are multiple post-Summer challenges, not least the significant change in junior Medical staffing in the first week and ramifications thereof.

48. On 20 August 2019, you attended at a meeting to consider recent experience of IMT meetings chaired by Linda de Caestecker **(See SHI Bundle 6, Miscellaneous Documents, p 70)**

a) Do you recall attending this meeting?

A. Yes.

b) What was the purpose of this meeting?

A. To discuss IMT meetings as per the minute.

c) On what basis were you invited to the meeting?

A. As the Chief of Medicine for Women & Children

d) What were the main issues of concern raised? Did you agree with the concerns which had been raised? If so, why? Please provide details.

A. The minutes reflect issues, only some of which I had observed (I didn't attend all of the IMT meetings). For example I was aware that new information could be presented (tabled) and the style and conduct of meetings varied dependent on who was in the chair, the participants and the main subject matters.

e) The minutes detail 'behavioural issues in recent IMT meetings', do you agree with this? What were these issues and who presented these behaviours?

A. I have considerable experience in attending meetings both internal and external to the organisation and have, over decades, observed the best and worst of Chairmanship (including my own on reflection: it is an acquired skill), human nature and occasionally conduct that I would deem as poor and, rarely, close to unprofessional. I have no problem in calling out bad behaviour whether as a Chair or participant. I am also aware that how an individual behaves when an authority figure is in the room might alter the dynamic and therefore I find that collective and individual behaviours tend to be less troublesome for me to manage as I moved up the hierarchy and improved again when video conferencing was introduced. However my IMT experience was, as the minute describes, that some Chairs were less experienced at maintaining focus and discipline and this was particularly noticeable when somebody had a dual function. Some robust, but in general respectful and reasonable, challenge was underpinned by real concerns about patients, staff, and unit and personal reputations and occasionally passionately presented.

The medical staff were not passive recipients of information and in keeping with their extensive knowledge base and inquisitiveness, quite rightly sought for as much information and corroborating evidence as they could. The continued uncertainty, frequent changes in aspects of "holistic" clinical care and unsuccessful mitigations were of genuine concerns and it escalated tensions. As they are want to do, sometimes doctors strayed out of their sphere of knowledge and into areas they had no expertise in (for example my previous answer regarding plumbing and estates management). However I

don't recall witnessing unchecked extreme behaviour, or anyone excluded or leaving a room in distress. How defensive or attacked someone might feel when challenged is highly individualistic. I recall how much of a learning curve I experienced in becoming an effective Chair, and I am still learning. The nature of these meetings were challenging given the subject matter, unresolved problems and the types of illnesses the patients were suffering from. The clinicians directly facing patients and relatives were often in a very difficult position, with issues of therapy response plus the various changes required and they very much had the interests of their patients at the fore-front of their concerns.

f) The role of chair of the IMT was discussed, what do you recall about these discussions?

A. I think the Minute reflects the concerns and potential mitigations.

g) What was your view on Dr Inkster's ability to carry out the role of chair within the IMT?

A. I don't have a view with regards to this. My experience has been that IMT's tend to be Chaired by a microbiologist or a lead clinician. I appreciate the difficulty in wearing multiple hats when Chairing a meeting that you also have an expert opinion role within.

h) What was your view on the proposal to have a 'a small-group pre-meeting' in advance of IMTs and to implement an escalation process?

A. I am in favour of preparation meetings to help set and manage an agenda efficiently. I don't see that as anything other than a good thing if it is designed to ensure that everyone's time is used appropriately and all of the required information is available. Wherever possible, critical information is best not tabled and digested in real-time during a Meeting.

i) Consider Actions 1-8, are you aware if they were implemented? If they were implemented, in your view, were they successful? If not, do you know why not?

A. I don't know any details as to any implementation plan, as such. I found the IMT's I attended to be professionally conducted before and after this meeting. As matters progressed and issues became more complex, I felt the latter ones were probably more focussed and with representation from higher levels of the organisation (but the Minutes would confirm or refute that).

49. Refer to IMT 18 September 2019 - This IMT concerned Gram Negative Bacteraemia **(SHI Bundle 1, IMT Meeting Minutes, p 365)**. Please provide details of this IMT, including:

a) What was the purpose of this meeting?

A. Further management of 12 cases of Gram-negative bacteraemia.

b) What was your involvement?

A. As part of W&C Directorate Management Team.

c) Were any interventions recommended? If so, were they sufficient?

A. See the Minute.

d) Did you agree with the conclusion that Ward 6A was microbiologically safe? If so, on what basis?

A. I was not in a position to give an opinion as it is out with my expertise.

e) What was your view about communication in respect of this incident?

A. See previous comments.

f) Do you consider that all of the actions proposed following this IMT were complete and sufficient? If not, why not?

A. I cannot comment.

g) What concerns did you have regarding the number of infections which had been found?

A. They merited the scrutiny undertaken.

h) What was your view of the SBAR prepared by HPS which was discussed?

A. I don't recall seeing an SBAR before the meeting, I had no direct dealings with HPS on this matter, other than when it was represented in some way. HPS didn't give me the impression that their opinion carried authority (in terms of certainty in a very uncertain situation) but I was not close to the totality of what their involvement might have been, including other interactions with local matters out with the QEUH site. From my perspective the functional purpose of HPS was clearly established: was it for oversight and Leadership / Decision making or a collaborative associate?

i) Did you consider the risk management and control measures which were in place to be complete and sufficient? If not, why not?

A. This was beyond my area of expertise.

j) What was your view on the recommendation that all restrictions on Ward 6A be lifted?

A. The decision was arrived at through what seemed to be a reasoned consensus.

50. On 20 September 2019, you attended on a teleconference to discuss the status of Ward 6A **(See SHI Bundle 1, IMT Meeting Minutes, at p 370)**. Please provide details of this teleconference, including:

a) What was the purpose of this teleconference?

A. This was a follow up meeting as described in the Minute.

b) What was your involvement?

A. I attended as a representative of the Women and Children Directorate Team.

c) What was your view on the discussion regarding when a future IMT would be triggered?

A. This was an ICT / Public Health matter.

d) Do you recall receiving a summary report following on from the case reviews as suggested in the minutes? If so, what did that report contain? What were your views on it?

A. I would need to have any reviews linked to a specific meeting. Without that I cannot precisely answer the question.

e) Did you express any concerns regarding any of the discussions on this teleconference? If not, did you have any concerns which you did not express?

A. No and no. If I had any concerns they would have been expressed.

51. In November 2019, you prepared an SBAR in respect of three mortalities in 2017 **(See SHI Bundle 4 - NHS Greater Glasgow and Clyde – SBAR Documentation - Page 214).**

a) What was the purpose of the SBAR?

A. This was due diligence through the Women & Children's Clinical Governance structure (which I Chair). The significant clinical incident process has changed considerably over the years, it is now called a Significant Adverse Event Review (SAER), has a different framework and has also gone through a number of iterations. The Committee's secretariat has also changed as has the reporting processes.

b) Who was the SBAR shared with?

A. Members of the Women & Children's Clinical Governance Committee under strict confidentiality bounds.

c) What actions were taken as a result of this SBAR?

A. That conducting an SCI (as an internal investigation) was not appropriate, as recommended in the SBAR.

d) What recommendations were carried forward?

A. This decision would be recorded and form part of the Women & Children's Governance report to the Acute Clinical Governance Committee.

e) Who was responsible for these actions?

A. I was responsible as the Chair of the group.

f) Why was this SBAR prepared at this time given that the reports by DMA Canyon of 2015 and 2017 were well known at this stage?

A. See previous comments. I was unaware of these reports and the SCI process was used to learn from clinical incidents where possible to minimise recurrence.

g) Why were these issues not raised in 2018 and 2019?

A. I cannot answer this question.

h) Were you aware of subsequent infections following the reports by DMA Canyon in 2015 and 2017? If not, why not?

A. I was not aware of these reports.

52. Refer to IMT 11 November 2019 - This IMT concerned Gram Negative Bacteraemia **(SHI Bundle 1, IMT Meeting Minutes, p 397)**. Please provide details of this IMT, including:

a) What was the purpose of this meeting?

A. To continue management of the Gram-negative bacteremia incident

b) What was your involvement?

A. I attended as a representative of the Women and Children Directorate Team.

c) Were any interventions recommended? If so, were they sufficient?

A. See Minutes.

d) What views did you have in respect of the draft report from HPS?

A. I do not recall seeing this.

e) What was your view about communication in respect of this incident? Particularly, the letter to all parents concerning the re-opening of Ward 6A?

A. A consensus was reached.

f) Do you consider that all the actions proposed following this IMT were complete and sufficient? If not, why not?

A. I don't have enough information to comment.

g) Did you have any concerns around the introduction of Taurolock within Ward 6A?

A. There was a further intervention and in itself that was a concern. However, I believe that the use of Taurolock was thoroughly debated before implementation and that the latter required a clear standard operating procedure (SOP).

h) What was your view of the Ward 6A re-opening bundle which had been prepared? What was your view of the associated action plan?

A. This was in the hands of experts in infection control.

i) Did you have any concerns about the possible identification of a new patient case? If so, what concerns did you have? Why did you have those concerns?

A. No specific concerns beyond the issue that there was an additional case.

j) What was your view of the suggestion that the leak in the Ward 6A kitchen be included as a possible hypothesis?

A. I didn't have a view on this.

k) Did you consider the risk management and control measures which were in place to be complete and sufficient? If not, why not?

A. This was out with my area of expertise.

53. Refer to IMT 14 November 2019 - This IMT concerned Gram Negative Bacteraemia **(SHI Bundle 1, IMT Meeting Minutes, p 402)**. Please provide details of this IMT, including:

a) What was the purpose of this meeting?

A. Continuation of the IMT process regarding the Gram-negative bacteremia clusters

b) What was your involvement?

A. I attended as a representative of the Women and Children Directorate Team.

c) Were any interventions recommended? If so, were they sufficient?

A. See Minutes.

d) What was your view on the final report from HPS regarding the lifting the restrictions to admissions to Ward 6A?

A. I didn't have a particular view.

e) What was your view on the SBAR concerning the re-opening of Ward 6A?

A. I was supportive of effective communication and decision based on reasoned opinions.

f) What was your view of the future process for investigating gram negative infections?

A. That was a matter for experts in infection control.

g) Did you consider the risk management and control measures which were in place to be complete and sufficient? If not, why not?

A. I did not form a view as expert advice had been given.

h) What was your view about communication in respect of this incident? Particularly, the letter to all parents concerning the re-opening of Ward 6A?

A. This was necessary and appropriate.

54. Refer to IMT 2 July 2020 - This IMT concerned Ward 6A (**SHI Bundle 1, IMT Meeting Minutes, p 431**). Please provide details of this IMT, including:

a) What was the purpose of this meeting?

A. This was an incident management meeting after a positive Cryptococcus antigen test in one patient.

b) What was your involvement?

A. I attended as a representative of the Women and Children Directorate Team.

c) Were any interventions recommended? If so, were they sufficient?

A. See Minute.

d) What, if any, concerns did you have regarding the positive Cryptococcus antigen test?

A. I have no expertise in the matter.

e) What was your view on the environmental testing which was being carried out? Particularly, the air sampling?

A. I had no view to take as it is out with my area of expertise.

f) Were any hypotheses discussed? If so, what was discussed? Were any of the suggested hypotheses borne out?

A. Yes, and as described in the Minute

g) Did you consider the risk management and control measures which were in place to be complete and sufficient? If not, why not?

A. I cannot comment with any expertise.

h) What was your view about communication in respect of this incident?

A. I cannot comment with any expertise.

Concerns about infection patterns:

55. Do you consider that infection rates at QEUH were unusual both in frequency and type? Do you consider that there were:

a) more bloodstream/ patient infections than normal?

A. I must restrict comments to the RHC part of the QEUH site as I don't have "whole site" knowledge. To determine a frequency requires time to pass and prevalence requires specific details of infection types. The infections were unusual in variety and type (compared to the Paediatric clinician's experience) and weren't always appearing in the kind of clusters in short time period that I have experienced in other "infection clusters" identified by usual means. The normal variation of infection rates is nowadays determined by statistical process charts (SPC: sometimes referred to as "run charts"), bench marking, etc. Clinicians who worked at the Yorkhill RHC were familiar with some of the unusual bacteria, but my experience was that they were seeing an evolved pattern of microbes different from their experience or expectations and microbes that were unexpected pathogens.

b) more unusual bloodstream infections? (we take the point that water sampling/ environmental testing might show up rare organisms that are always present but never tested for)

A. See above

c) more cases of multiple bacteriaemia in one sample?

A. See above

56. Did you have any concerns, or are you aware of any concerns that patients were at increased risk of infection from exposure to pathogens via the water supply, drainage, or ventilation system? If so, please describe.

A. Concerns of mine became evident as evidence mounted and mitigations were not proving successful. My concerns were shared by others and I claim no earlier appreciation of the matter, as I believe I was receiving the same data that other were contemporaneously.

Staffing levels in ICPT:

57. What were the staffing levels like in ICP team while you were there? Were they levels appropriate to manage workload?

A. I cannot comment on this as I don't know the size of the team or any contemporaneous additional pressures on their workload or manpower.

58. Who was responsible for providing staffing and or ensuring that staffing was maintained at sufficient levels?

A. I cannot comment on this beyond referring you to the management hierarchy that leads to the relevant Director (Board Official); presumably you have a contemporaneous copy of this.

59. Did you or anybody else ever raise concern regarding staffing levels?

A. I did not personally raise concerns regarding staffing levels in the ICP Team. These were not brought to me. However I was aware at various meetings that there was a significant need for additional out of normal working hours of various staff requirements (in many areas including Microbiology, Estates, Cleaners etc.) as resources poured in to try and address the situation and concerns. It was clear that the resources needed required "over-time" arrangements.

60. If levels were insufficient, why do you think this was?

A. See answer to 58 above. I am not in a position to determine if staffing was generally insufficient or only insufficient because of the increase in work load for this team. I was not aware of any Fiscal control barriers being placed but these were not matters that were within the W&C Directorate financial reports

that I had access to in my managerial role and presented at meetings of the W&C directorate.

61. Can you comment on the working environment while you were there? What issues, if any, did you have?

A. The working environment didn't impinge on me personally, other than I will have increased my workload and spent more time attending meetings, dealing with email and other correspondence, looking at Reports and undertaking various discussions and often supportive conversations with concerned medical staff. In my managerial role it is common for different areas to become focal points and require intense periods of concentrated work, whilst ensuring other areas needs continue to be addressed. I was very aware of how much more difficult it was for staff with all of the mitigations adding to an already challenging job and environment. These concerns were regularly discussed within the Directorate team and escalated to the Director and the Senior Management Team when we were unable to offer support or responses within our resources.

62. Who did you raise these concerns with, if anyone?

A. There were plenty of opportunities to discuss this within the managerial team, local and Senior (Board level).

Concerns about infection

63. Do you, or have you ever, had any specific concerns about amounts, locations, clusters, or types of infection within the hospital? Please provide details.

A. See previous answers. I have experienced many infection clusters during my career (particularly in Neonatal Departments). The issue of concern here, was the lack of a readily identified cause and set of effective mitigations. Once an infection occurred, treatment was delivered but the underlying mystery remained. My previous experience of infection clusters was that a hypothesis

was developed, investigations and mitigations took place and the matter was resolved, and subsequent monitoring demonstrated this.

64. To what extent does your experience with infections differ from what you might have expected before the hospital commencing your role at QEUH/RHC?

A. As mentioned in other answers, this was a completely different experience (see question 63 answer).

65. Do you, or have you ever, had any concerns, or are you aware of any concerns, that patients either have been or are at increased risk of infection from exposure to pathogens via the water supply, drainage, or ventilation system?

A. With respect, this question seems somewhat redundant given the evidence and nature and need for this Inquiry. In the absence of any other explanation it seems logical to accept that some function of the environment was a factor, as other causes were excluded or eliminated. At a fundamental level, we are all vulnerable when protective initiatives and barriers to harm fail: these are usually taken for granted when we turn on a tap or buy food, etc.

Communication and infection

66. Please explain your understanding of the following processes:

a) All communication from management to clinical staff regarding infection risk where there had been or was a concern about links to the hospital environment, and as regards such concerns

A. Communications were in three broad areas, local and board written communication and verbal information and informal (as in ad hoc face to face) "question and answer" opportunities at the service level. My belief is that communications were as open, factual and timely as they could be under the circumstances. They were "two way" as clinical staff had ready access to clinical managers, and parents were given the opportunity to ask questions to

staff and some made enquiries to management colleagues. There were times when there was a risk of staff and patients / relatives being overwhelmed by so much change and information, at the same time as residual uncertainty remained. A practical issue was that staff fluctuate and so keeping a whole Team contemporaneously updated could be a challenge.

b) All instruction from management to clinical staff regarding what and how to communicate with patients

A. We sought for consistency and factual / practical information cascades. Patients, relatives and staff had multiple information sources beyond the internal communication processes, some which such as social media we had no control over. So, communication was necessarily proactive and reactive.

c) All communication from management to patients

A. These were a team effort as described above.

d) All communication from management to the media

A. These were managed by the Board communication / media teams informed by contributions from the Directorate team. My experience is that these were collaborative efforts when the Directorate team were directly involved. I would occasionally be a directly involved contributor as part of the Directorate Team. I have an “editorial eye” but did not have a final sign off role.

e) The pre-broadcast advice to staff regarding the BBC programme

A. You do not specify a particular BBC programme and I don’t recall any particular advice. I don’t watch much television and did not watch any of the programmes about the QEUH / RHC site before or after the subject of the public enquiry. Given that I was working within the situation, the media’s activities were only of interest in terms of how staff and patients and their relatives responded to this, as speculation was inevitable and rumour rife. I would observe that these did not assist in managing the situation and increased workload, as well as anxiety and uncertainty. However, much as I

would prefer the presentation of more facts and less speculation, I can appreciate how the maintenance of confidentiality by the NHS hampers the needs of the News cycle and that is how things are: a free Press is something to cherish, difficult as it might be when it is activated within one's own life experience.

f) All communication between management and external bodies such as SG, HPS and HFS

A. I believe all such communications are handled by media staff and Senior Executives informed by data and information from the local teams.

Prophylactic Medication

67. To what extent if at all were there patients in QEUH and in RHC prescribed prophylactic medication as a result of concerns about increased HAIs, the water system (including drainage) and/or the ventilation system?

A. You will be aware that prophylaxis was exhibited and modified at RHC in the Haemato-Oncology Service. Wider change in prophylaxis beyond that patient group was not required but was discussed with respect to other potentially high risk groups. Prophylaxis in general terms is a subject that is discussed as a consequence of developments in medicine and the desire to reduce avoidable complications.

68. Please identify/describe:

a) The medications in question.

A. You should have this information with the relevant specific timelines related to changes and other interventions including mitigations that fall between medical devices and medications and changed care bundles. I do not hold that level of detailed information.

b) In particular, is it the case that in contrast to the general position across UK and Scotland, the following were prescribed in QEUH/RHC as a matter of course: Ciprofloxacin, Posaconazole, Ambisome, Caspofungin, Septrin?

A. We benchmarked and sought advice across other UK and international departments. Local prophylaxis is dependent on local context and evolved in a situation that was atypical. All were concerned about the additional need for prophylaxis given the patient group involved and any change was considered in great detail, prophylaxis being a preventative intervention.

c) What was the reason for the prescription of these medicines?

A. The extension of prophylaxis was to militate against the evolving situation in a population extremely vulnerable for infections and all aspects of this were debated and decisions taken on multi-disciplinary specialist advice.

d) Was the prescription of any of these medications linked to concerns about the environment, and if so, what concerns?

A. Yes: see answer to 67(C)

69. Which group of clinicians would be responsible in an individual case for the prescription of this medication to patients: i.e. would it be treating haematologists/oncologists, or would it be somebody else?

A. An individual prescribing clinician is responsible for any prescription they write. It is common for there to be agreed medicines (or a suite of medicines) to be prescribed. Sometimes these are provide as a group of measures (occasionally under group directives) but they always require an individual's sign off unless it is part of an agreed general policy / group directive.

70. Are you aware of any general decision being taken regarding whether this additional/different medication ought to be made available to patients. If so, which bodies/individuals were involved in that?

A. I am uncertain about what is being asked here. There were many decisions over a long timeline and interventions were discussed incrementally as information was accrued. The minutes of the numerous meetings would need

to be interrogated to determine when prophylaxis or other strategies were discussed.

71. How, if at all, did the way in which these treatments were used differ from the standard use of prophylactic medications (i.e. duration of use; dosage etc)

A. I defer to those experts who advised on these matters in general terms of prophylactic measures are interventions to reduce the need for treatment. Whilst these are usually single measures (for example an antibiotic given before a surgical procedure) they sometimes lie within a bundle of measures. I am aware of longer prophylactic regimes to reduce infection in certain conditions (for example post splenectomy patients receive lifelong antibiotics prophylaxis). "Treatment" follows unsuccessful or inadequate prophylaxis and is a generic term that might require a range of medicines, procedures etc. The nature of the concerns that evolved with the extremely vulnerable haemato-oncology patients group (who had general and specific risks depending on their specific illness or any comorbidities) meant that prophylaxis required to be re-evaluated and extended. This was underpinned by surveillance data and specialist input.

72. What risks did patients face if they did not receive this medication?

A. Prophylaxis was to reduce the risk of infection. Infections carry morbidity and mortality risks (these vary with the site and type of infection and unique patient characteristics). This is greater in situations when the immune system is compromised through altered physiologically (e.g. pregnancy) or through disease processes or treatments that alter the response to infection risk and response. It is worth acknowledging that all such measures have their own risks and potential additional risks by for example filtering out some pathogens and facilitating others to flourish. All medicines have potential side effects.

73. Were staff given any guidance or was there any discussion about the use of prophylactic medication?

A. There were extensive and detailed multi-speciality discussions about the use of prophylactic medication and information to staff with regards to why these measures were being deployed, or changes made.

74. Were staff given any guidance or was there discussion about how this matter was to be communicated with patients?

A. Yes.

75. What approach was taken to discussing this issue with patients?

A. An open and tailored to their needs approach was encouraged as individual patients were at different stages of their treatment journey and had unique characteristics. Therefore an individualised approach was appropriate over a general message of underlying common general information.

76. Are you aware of any withholding of information about the prescription of prophylactic medication or any suggestion or instruction that matters to do with the use of prophylactic medication ought not to be shared with patients?

A. Not at all. That seems to be counter to what we sought to achieve as an open Women and Children Directorate Team and how the treating clinicians practiced medicine.

Whistleblowing and Communication

77. Can you explain the key aspects of the duty to communicate effectively with patients generally.

A. Different Professions have a Regulatory Body that defines best practice in this area. As a Doctor, the general tenets are enshrined in the content of Good Medical Practice GMC, which has been present throughout my career with the latest iteration being published in 2024. The basics about general communications with patients remain the same: confidentiality, treating

patients fairly and respecting their rights, treating patients with kindness, courtesy and respect, supporting patients to make decisions about treatment and care, sharing information with patients and encouraging dialogue about prognosis, management options, risks, benefits, harms, etc., communications with those close to a patient and confidentiality and legal guidance rules, caring for t he whole patient (Holistic care), ensuring patients who pose a risk of harm can access care, being open if things go wrong. I am familiar with the Legislative requirements of organisations regarding communication with patients (e.g. Duty of Candour). Beyond this, any communication requires the practitioner or organisation to communicate in a way that is comprehensible to the recipients and sometimes using multiple means to achieve this, ideally with feedback that demonstrates that the message has been received and understood and with a built-in period of reflection to avoid sub-optimal decision making. Professional interpreting services, pictures, sign-posting to good quality information, using Readability Index and similar tools to ensure the information is pitched at a reasonable level, being self-aware when talking of the same need, etc. all have a part to play. Finally, in the context of the subject of this part of the Inquiry, when communicating in an evolving and changing situation, there is a duty to ensure that communications build on the historical and current position is to ensure that any proposed change is contextualised in general and ensure there is room for individual concerns to be addressed.

78. Can you explain how the duty to communicate should be approached when it comes to telling patients about an infection; about the possible causes of the infection; and about the impact upon health; and upon future treatment.

A. See answer to 77. I see no distinction between the general duty of communicating details to an individual patient about an infection than with any other conditions (in terms of potential causes, treatment, prognosis, short and long term consequences). Particular to infections, there is a need to ensure the patient understands the difference between a person-limited infection, from an infectious communicable condition (i.e. can contacts be at risk, is there risk of epidemic). With any infection, this might be a predictable

consequence of an underlying illness (e.g. infections are more common in a number of chronic diseases) or an unexpected and unrelated event that might lead to an adverse effect or delay in a planned treatment, e.g.. delay in a surgical treatment to make anaesthesia safer and less chance of co-morbidity. If the infection is likely to alter prognosis or change therapeutic options then that is all part of good medical practice. Where there is uncertainty this should be shared. There will be some treatments that will interact with other medications or bodily functions (e.g. some antibiotics and blood thinning drugs, renal and hepatic function) and those should be considerations and communicate to the patient. There will be some infections that will be so severe that effective direct communication with a patient isn't possible (e.g. delirium, septic shock) and there is a duty to explain matters once the patient has recovered sufficiently. The "Art" of medicine is how to gauge when, how and what detail is necessary to provide in a way that doesn't negatively impact on the overall recovery of the patient: it isn't to keep secrets, nor is it to add to uncertainty and distress.

79. Can you explain how the duty to communicate should be approached where something has gone wrong during care or treatment.

A. See answer to 77 above. Being open is the key part of this and my long experience is that if the treating clinician does not explain, then leaving it for someone else to do so is sub-optimal for the patient and the practitioner alike. Often a fulsome explanation during the event or in the acute recovery phase needs follow and more detailed explanation. Explaining where something has "gone wrong" is language that isn't a universally applicable or helpful term. The literature around Clinical Risk Management and Human Factors is increasingly vast and the reality is that there often multi-factorial reasons for an outcome to deviate from what was intended or expected and some of that can be explained as a risk in initial counselling or when gaining consent but is only appreciated when the adverse or unexpected outcome occurs. Often an individual clinician, their Team or another party becomes the focus when the multi-factorial nature of delivering something as complex as healthcare is under-appreciated. However, in summary, an honest explanation should be

given, an apology if appropriate, a follow up opportunity or summary provided, and an account of what corrective or other measures are available by way of investigation or remediation.

80. Are you aware of the duty of candour and how would you explain that?

A. Yes. I have on occasions given lectures on aspects of Clinical Governance that included the Duty of Candour legislation and what it means in practice. The devolved nations have individual versions. In summary: clinicians have a duty to be open and honest as described above. The Duty of Candour legislation describes a similar organisational requirement. This is to ensure that organisation tells those affected that an unintended or unexpected incident has occurred. They should subsequently offer an apology, involve those affected in meetings about the incident, conduct a review about what happened with a view to identifying areas for improvement; and learn from the incident. This leaning should include the views of relevant persons, including the affected and/or their relatives. The Framework also requires that an Organisation must ensure that support is in place for their employees and for others who may also be affected by unintended or unexpected incidents.

81. If you had concerns about wrongdoing, failure, or inadequacy within the hospital:

a) were you aware of procedures to facilitate disclosure of this either to other GGC staff or to individuals external to GGC

A. Yes. I have been party to giving evidence to whistleblowing procedures separate to the issues in this Public Inquiry.

b) when – and how – did you become aware of these procedures

A. I have been aware of these processes before and after the formal whistleblowing guidance law enshrined it within the Employment Rights Act 1996 and its amendments. It has been necessary knowledge throughout my medical management (since 1995) career, and my clinical career. I have occasionally addressed the issue in Lectures about Clinical Governance and Risk Management over the last 30 years or so.

c) is disclosure in this manner something that has always been encouraged within GGC?

A. It seems to me to be so. I am not aware of it being supressed as an option: information seems readily available about how o raise concerns. As described above, I have been involved in whistleblowing investigations within GGCHB (unrelated to the public enquiry) and found it to be a thorough process, with a pre-interview, explanation and support (as a witness) and an explanation and assurance that the process is necessarily highly discreet in order to protect all involved, particularly the whistle-blower.

d) Are you aware of any changes made to the whistleblowing policy, do you consider that these changes improve the whistleblowing policy, and would the changes make you more inclined to disclose concerns, wrongdoing, failures, or inadequacies?

A. In general, Policies change and I endeavour to keep up with them. My position as Chief of medicine means that such Policies and local reviews of same are presented before publication. The reality is that I will be involved if requested to be, either as part of a consultation or when a situation arises that I have to look at the current Policy version. On rare occasions it has been necessary to look at previous iterations. From a specific whistle-blower policy viewpoint, I reserve my own rights to complain as an employee, using whatever avenues are available to me. Individuals will have different tolerances and thresholds, where concerns and their decisions to raise them, will be informed by their inclination and ability to effectively articulate any concerns: this is multifactorial. In my position I have access to a lot of data and a perception of "the bigger picture", so may be in a position to see evolving patterns or concern but I freely admit that I have been "blind-sided" at times in my career: you can never know it all. My approach has been to openly share any data or information that I can, within the bounds of confidentiality, and potentially this might assuage the concern or demonstrate the concern is reasonable and needs action and indicate by whom. I have a career long interest in Clinical Governance, pattern recognition and creating an environment where identifying issues and addressing them is welcome and normal behaviour and

there is a tangible expectation that something will be done as a consequence of this.

Whistleblowing – QEUH

82. What was your involvement in the whistleblowing process? Please provide details.

A. I have had no direct involvement in the whistleblowing process related to this Inquiry and know nothing about the matter other than a process is /was in train.

83. What is your understanding of the concerns that led to the whistleblowing process? Do you agree with these concerns?

A. Other than hearing through the hospital grapevine, or media, that there was a whistleblowing enquiry that related to concerns about infections on the QEUH / RHC site, I have no specific knowledge of this matter. I can neither agree nor disagree without specific information. In general terms I have no disagreement with individuals raising concerns, as previously recorded, I was "inside" an evolving issue at the clinical and local management interface and very much peripheral to the wider "built environment" issues that arose as concerns continued.

84. Are you aware of what steps were taken to deal with each whistle blow? What is your view on the adequacy of the steps taken/the management of the concerns raised?

A. I am uncertain if this refers to multiple whistle-blow interventions by a person or it alludes to multiple separate Whistle-blows by a number of people. Surprising as this may seem, but appropriate to the maintenance of confidentiality, I have neither sought details of this matter nor been given information from within the organisation that identifies any involved parties or what has been done with respect to their concerns. They have protected

rights and I respect that to be the case until these rights are no longer applicable.

85. Do you think that the actions taken were sufficient to deal with the concerns raised?

A. I have no knowledge to comment on this.

Current Situation:

86. Are you still involved in Infection Control at QEUH?

A. Only as a recipient of infection control data / advice.

87. (If yes) How are things at QEUH now as compared to the period under investigation? Are you now seeing fewer BSIs, fewer unusual infections and /or fewer samples with multiple infections?

A. The tracking evidence and reporting structures in place suggests so, on the Paediatric (RHC) side. As a member of the Acute Clinical Governance Committee I see the QEUH reports on a monthly basis and again, this seems to be control. There is a welcome return to a “business as usual” approach. I feel that, running in the background, there was always a more than satisfactory Infection control and microbiological infrastructure. That refers to all the areas / sites I work in, or receive Reports from, with helpful colleagues in normal, cautionary or “outbreak” times.

88. Do you have any ongoing concerns as to the safety of the QEUH? If so, what are they?

A. Specific to infection control I have no specific live concerns. Given my interest in Clinical Governance I have general concerns about the whole NHS system and specific elements within it, the nature of such concerns depending on how they are brought to my attention.

89. Do you have any further observations concerning QEUH/ RCYP that you wish to share?

A. I would simply re-iterate my view that all levels of staff that I meet are very mindful of what has taken place on the ground and those who have remained in post have shown remarkable adaptability and resilience. The consequences of the services collective experience will, for many, long endure after the conclusion of the Public Inquiry. The Paediatric service were spared much of the Covid 19 pandemic pressures and so the consequences of the events this Public Inquiry has focused on, particularly in the Haemato-Oncology service are not inconsequential and many years of "normality" will be required as something of a re-set.

Any Further Information

90. Is there anything further that you want to add that you feel could be of assistance to the Inquiry?

A. Broadly, as I have worked in the NHS for over 40 years and seen and heard of many new NHS building projects be-set with delay and problems post commissioning, I would expect that the Inquiry might wish to take a broader view of how those processes are conducted and advise accordingly. Related to this but also specific, to my role as Chief of Medicine, and others in clinical managerial and administrative roles, I would wish to draw attention to making a recommendation about what resources are required to manage a hospital site move and the "bedding in period" (years rather than months depending on the project size and complexity), the resources required to manage business continuity (particularly when this includes sub-sets of very complicated activities, such as National services), whilst managing a parallel and completely unanticipated problem with multi-factorial issues including Human Factor matters (extant, predictable or unforeseeable).

Declaration

91. I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without and honest belief in its truth.

92. The witness was provided the following Scottish Hospitals inquiry Bundles / documents for reference when they completed their questionnaire statement (Appendix A).

Appendix A

A43255563 – Bundle 1 – Incident Management Team Meeting Minutes (IMT Minutes)
A43299519 - Bundle 4 – NHS Greater Glasgow and Clyde: SBAR Documentation
A43296834 – Bundle 5 – Communications Documents
A43293438 – Bundle 6 – Miscellaneous documents
A43941023 – Bundle 8 – Supplementary documents for the Oral hearing commencing on 12 June 2023