Scottish Hospitals Inquiry

Witness Statement of Questions and Responses

Dr Christopher Deighan

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

1. Full name

A. Dr Christopher Deighan

2. Occupation

A. Doctor

3. Qualification(s)

A. MBChB: University of Glasgow, 1989. MRCP: Royal College of Physicians, U.K. 1992. M.D: University of Glasgow, 2000. FRCP: Royal College of Physicians, Glasgow, 2004.

Professional Background

4. Professional role(s) and experience

A. Executive Medical Director, NHS Lanarkshire January 2023 to Date. Consultant Nephrologist, Renal Unit, Glasgow Renal and Transplant Unit: April 2000 to January 2023. Deputy Medical Director- Corporate, NHS Greater Glasgow and Clyde: June 2019 to January 2023. Chief of Medicine, North Sector, NHS Greater Glasgow and Clyde: June 2015 to end May 2019. Clinical Director, Renal Services and Centre for Integrative Care, Regional Services, NHS Greater Glasgow and Clyde: October 2009 to June 2015. Lead Clinician for Forth Valley Renal service: April 2000 to October 2009. I left NHS GG&C in January 2023 when I commenced my role as Executive Medical Director, NHS Lanarkshire.

5. Professional role(s) and experience within NHS

A. See Response to Question 4

6. Professional role(s) and experience within GGC

A. See Response to Question 4

7. Professional role(s) and experience within QEUH/RHC

A. Consultant Nephrologist, Renal Unit until January 2023.

8. Area(s) of the hospital in which you worked

A. Renal In-Patient wards, primarily Wards 4A and 4D in my clinical role as Consultant Nephrologist

9. Role and responsibilities within the above area(s)

A. In my clinical role as Consultant Nephrologist, I was senior clinician responsible for the renal in-patients allocated to my clinical team in the renal in-patient wards. In my Chief of Medicine and Deputy Medical Director-Corporate roles, I did not have any direct management responsibility for GG&C Acute Division or QEUH / RHC.

10. If you had more than one role how was it split?

A. From June 2015 to June 2019, my role was split between my clinical role as Consultant Nephrologist (7 PAs* / sessions and Chief of Medicine for North Glasgow Sector 5 PAs*/ sessions. In my clinical role, I worked in a team of 4-5 consultants, with my clinical activity divided into: In-patient work in Renal Unit Wards 4A & 4D, Level 4, QEUH, 6-7 weeks per year (including 3 ward rounds per week); On Call - 1 weekend in 8, overnight 1 in 16; Out-patient clinics: Stobhill Hospital – average 1.5 clinics per week (Wed & Thurs am); Haemodialysis - Cohort of 20 patients at Stobhill Hospital (Thurs am); In-patient renal reviews at Glasgow Royal Infirmary (GRI) on a 1 in 7 rotational basis. My Chief of Medicine (CoM) role for North Glasgow Sector was based at Glasgow Royal Infirmary (GRI), with responsibility for GRI, Stobhill Hospital and Lightburn Hospital. From June 2019 to January 2023 my role was split between my clinical role as Consultant Nephrologist (6 PAs* reducing to 5.5 PAs* from January 2022) and Deputy Medical Director: 6

PAs*. In my clinical role, I continued to work in a team of 5 consultants, with my clinical activity divided into: In-patient work in Renal Unit Wards 4A & 4D, Level 4 QEUH: reduced to 4 weeks per year (including 3 ward rounds per week); On Call-1 weekend in 8, overnight 1 in 16, reducing in January 2022 to 1 weekend in 16 & overnight 1 in 32; Out-patient clinics: Stobhill Hospital, average 1.5 clinics per week (Wed & Thurs am); Haemodialysis - Cohort of 20 patients at Stobhill Hospital (Thurs am). My Deputy Medical Director: Corporate (DMD:C) role was based at GG&C Board Headquarters at JB Russell House reporting to Dr Jennifer Armstrong: Medical Director. This role did not have any direct management responsibility for GG&C Acute Division or QEUH / RHC. (* PA = programmed activity: defined by the 2003 Consultant Contract as : 'a scheduled period, nominally equivalent to four hours, during which a consultant undertakes Contractual and Consequential Services')

11. How many hours per week did you spend in your role at QEUH/RHC?

A. See response to question 10 above. My role at QEUH was clinical as Consultant Nephrologist. From June 2015 to June 2019, I was based at QEUH for 6-7 weeks per year. For my in-patient weeks, the majority of my working week would have been based at QEUH but during these weeks, I would still have out-patient clinic and haemodialysis responsibilities at Stobhill Hospital and meetings at GRI in my CoM role. These activities would vary on a week to week basis. From June 2019 to January 2023, my clinical activity for renal in-patients, reduced to 4 weeks per year. For these 4 in-patient weeks, the majority of my working week would have been based at QEUH but I would still have out-patient clinic and haemodialysis responsibilities at Stobhill Hospital and attendance for meetings at JB Russell House and other locations in my DMD:C role.

12. Who did you report to?

A. In my clinical role as a Consultant Nephrologist at QEUH, I reported to the Clinical Director for Renal: Dr Scott Morris. In my role as Chief of Medicine for North Sector, GG&C, I reported to the Director for North Glasgow Sector. In my role as Deputy Medical Director: Corporate, I reported to Dr Jennifer Armstrong: Medical Director, GG&C.

13. Who reported to you?

A. In my clinical role, I had no Direct Reports although I would be responsible for clinical oversight of medical trainees. In my role as Chief of Medicine for North Sector GG&C, the Clinical Directors (7) in the North Sector would report to me. In my role as Deputy Medical Director: Corporate, the only Direct Reports would have been (1) the Clinical Lead for Realistic Medicine and (2) the secondary care appraisal leads in my role as Deputy Responsible Officer for Secondary Care.

14. Describe an average working day in your role.

A. A typical working day would be from 8am through to around 6pm unless I was Consultant on call for the renal unit in which case my working day may finish later depending upon the volume of clinical activity. In addition, I would spend a number of evenings a week reading papers for meetings or catching up on emails. From June 2015 to June 2019 my role was split between my clinical professional role as Consultant Nephrologist and my management role as Chief of Medicine (CoM) for North Sector GG&C as outlined in my response to Qs 10 & 11. There is no day that could be described as an average day, as each would vary day to day and week to week. The clinical activity is outlined in my response to Question 10. In my CoM role, my typical day would be dealing with professional, operational and governance issues, providing professional advice to the Director for North Sector, GG&C, and liaising with my Direct Reports. From June 2019 to January 2023, similar to the position noted above, my role was split between my clinical professional role as Consultant Nephrologist and my management role as Deputy Medical Director: Corporate (DMD-C) GG&C. There is no day that could be described as an average day as each would vary day to day and week to week. The clinical activity is outlined in my response to Question 10. In my DMD-C role, my activity focussed around supporting the Medical Director (MD) & activities / tasks & work allocated by the MD. I was Deputy Responsible Officer for Secondary Care and provided leadership within areas of Medical Staff Governance, Corporate Planning, eHealth, Clinical Governance, Medical Education, Realistic Medicine and areas of Corporate Governance, supporting the Directors of Planning, eHealth & Clinical Governance. I provide clinical leadership support to the eHealth clinical leads, Realistic Medicine Leads and Chief of Dentistry. I contributed to the GG&Cs

response to the Covid-19 pandemic across a number of areas including acting as Deputy Medical Director for the NHS Louisa Jordan.

15. Which of your colleagues did you work with most closely on a daily basis?

A. In my clinical role, I worked most closely with my Consultant Nephrologist colleagues. In my Chief of Medicine role, I worked most closely with the Senior Management team for the North Sector and my Clinical Director reports. In my Deputy Medical Director: Corporate role, I worked most closely with Dr Armstrong as I reported directly to her. I also worked closely with the Director of Planning, Director of Clinical Governance, Director of Pharmacy and Medical Staffing Lead but not on a daily basis.

Gram Negative Bacteraemia

16. Describe your involvement in the Gram Negative Bacteraemia Outbreak

Refer to IMT Bundle Documents 72 -88; 90, 92-93, 103

A. I had very limited involvement with the Gram Negative Bacteraemia Outbreak. I commenced my role as Deputy Medical Director: Corporate in June 2019 and as noted in my response to Q10, this role did not have any direct management responsibility for GG&C Acute Division or QEUH / RHC. Apart from the IMT in January 2019 related to Cryptococcus (see response to Q 47-49), in total I believe I attended the IMT on 4 of the 21 meetings documented in IMT Bundle Documents 72 -88; 90, 92-93 & 103. The first meeting I attended was on 25/06/2019 and it is likely that I attended at the request of the Medical Director, Dr Jennifer Armstrong. I subsequent attended 3 further meetings on 14/08/2019, 23/08/2019 & 08/10/2019, deputising for the Deputy Medical Director: Acute, when not available, as noted in response to Q75 and in the document 'Report of Issues raised by Dr Teresa Inkster to Medical Director'

Refer to IMT 25 June 2019, Bundle 1 – IMT pg 325

17. What is mycobacterium chelonae?

A. I am not an expert in microbiology or infectious diseases and therefore, this is not my area of expertise. My limited knowledge is the Mycobacterium Chelonae is an Atypical Mycobacterium.

18. What was your involvement with the m.chelonoae outbreak?

A. See response to Q16. I had minimal involvement. I attended one IMT meeting where M Chelonae was discussed (25/06/2019). Reviewing the IMT Bundle information, I cannot identify any other IMTs that I attended where this was discussed.

19. Three hypotheses are discussed as potential sources of contamination causing the infections during this meeting. What is your view on each hypothesis?

A. I did not have enough involvement to form a view.

20. The minutes mention a requirement to refer unusual episodes to HPS? Did this happen?

A. See responses to Q16 – Q 18. Given that I had minimal involvement, I am unable to comment.

21. Who made this referral?

A. See response to Q 20

22. What was the outcome of this?

A. See response to Q 20

23. What actions were required to be taken?

A. See response to Q 20

24. Under what circumstances would HPS normally become involved?

A. See response to Q 20

25. What was the extent of HPS involvement?

A. See response to Q 20

26. What is your view on the adequacy of the actions taken by HPS?

A. See response to Q 20

IMT 14th August 2019

Please refer to IMT Bundle Document 77

27. Do you recall this meeting?

A. Yes, I recall attending this meeting

28. What was the purpose of this meeting? Describe the circumstances leading up to this meeting.

A. As noted in the minute of the meeting (IMT document 77 pg 343 of IMT Bundle), this was an Incident Management Team meeting looking into episodes of Gram Negative Bacteraemia in Paediatric Haemato-Oncology patients.

29. In this meeting, you disagree with Dr Inkster that the numbers of bacteraemia have increased. What was this opinion based on? Please provide reasons for your conclusion. Have you since changed your mind on this? If so, please provide reasons for this.

A. As noted in the minute of the meeting (IMT document 77 pg 343 of IMT Bundle), I referenced an epidemiology report from Dr Ian Kennedy that I had seen. There is nothing in the minute of the meeting that suggests that I disagreed with Dr Inkster. The minute notes that my comment was in response to a comment from one of the consultants and it would seem reasonable to seek clarification. The minute goes on to note that Dr Inkster and Dr Peters went on to state that it was the nature of the bacteria that was a concern and that it was likely that the CLABSI (central line-associated bloodstream infection) work and excellent practice had driven rates of typical pathogens down.

30. Did you agree with Dr Inkster and Dr Peters that the nature of the bacteria was a concern, in that they were all environmental and associated with water/soil? If not, why not? Please provide reasons for your answer.

A. I am not an expert in microbiology or infectious diseases, this is not my area of expertise and therefore I was not able to give an informed view.

31. What was your understanding of the chilled beams? Did you have a view on the hypothesis that they were leaking and therefore the source of the bacteraemia?

A. This is not my area of expertise. I was not a core member of the IMT and only attended a limited number of meetings, as such I was unable to give an informed view.

32. What was your view on the effectiveness of the environmental testing which was taking place?

A. See my response to Q31

33. The minutes of the IMT of 14th August 2019 list two hypotheses for the increase in the gram negative bacteraemia. Please provide your comment in respect of each hypothesis.

a) The chilled beams

A. See previous responses to Q30-32. This is not my area of expertise, this was only the 2nd IMT I had attended. I was not a core member of the IMT and only attended a limited number of meetings, as such I was unable to give an informed view.

b) Patients accessing unfiltered water

A. See my response to (a)

34. To what extent were you involved in communications with patient/parents and/or staff? If you were involved, what was your brief in terms of information sharing? Were you asked to withhold any information? If so, what were you asked to withhold and who asked you to do this?

A. I was not involved in communications with patient/parents and/or staff and have not been asked to withhold information. As noted in my response to Q 75, I

contributed to the writing of the letter from Board Medical Director to the parent involved in Duty of Candour Incident.

35. The minutes note that Tom Steele requested an alternative to photos being sent to the group due to the sensitivity of some of them: Did you agree with this? What was the sensitive nature of the photographs?

A. I do not know what the sensitive nature of the photographs was. I note that, in the welcome and introduction section of the minute it records that everyone was reminded of the confidentiality surrounding IMTs.

36. The accuracy of these minutes has been disputed by some witnesses who attended this IMT. What is your recollection of what was discussed and are these minutes an accurate reflection of this? If there are any inaccuracies, please provide details.

A. This meeting was almost 5 years ago and as such, I am unable to comment on whether these minutes are an accurate reflection of what was discussed.

IMT 8th October 2019

Refer to IMT Bundle Document 83

37. Do you recall attending this meeting?

A. Yes, I recall attending this meeting

38. What was the purpose of this meeting?

A. See response to Q28: As noted in the minute of the meeting **(IMT Bundle Document 83, pg 373)** this was an Incident Management Team meeting looking into episodes of Gram Negative Bacteraemia in Paediatric Haemato-Oncology patients.

39. The minutes refer to an action plan, what was this action plan? What were the actions to be taken? Who was responsible for this plan?

A. I am unable to comment as I do not have access to the action plan. In addition, as noted in previous responses, I was not a core member of the IMT and only attended a limited number of meetings. I had not attended a meeting since 23/08/2019. I

note that Dr Davidson, Deputy Medical Director: Acute had given his apologies. He is noted as attending at the previous 4 meetings and I may have been attending in his absence.

40. Professor Craig White attended this meeting, do you recall his level of engagement at this meeting?

A. This meeting was almost 5 years ago. I do not recall the level of engagement from Professor Craig White.

41. Dr Peters and Dr Inkster produced an SBAR for this meeting (Refer to Bundle 4, document 44), do you recall the discussions around this SBAR? Please provide details. What was your view on its recommendations regarding broadening the outbreak definitions?

A. This meeting was almost 5 years ago and I do not recall the details of the SBAR or the discussions around this SBAR. I have not been sent Bundle 4, document 44. However, as noted in the minute of the meeting (IMT Bundle Document 83, pg 373), regarding consideration be given to the HAI definition of haem/oncology patients, my view as documented, based on my clinical nephrology experience, was that any change to the HAI or HCAI definition of haem/oncology patients would need to be agreed nationally otherwise there would be a clear risk of a unit being an outlier compared with other units purely due to difference in definition rather than due to differences in infection rates or infection control issues.

42. In your view was the case definition adopted by the IMT adequate? Please explain.

A. This is not my area of expertise and, as such I was unable to give an informed view.

43. What is the HIIAT?

A. As noted in the minute, the HIIAT is a Healthcare Infection Incident Assessment Tool.

44. Describe the HIIAT process?

A. This is not my area of expertise, I only attended a limited number of IMTs and I would defer to experts in this area.

45. What documentation is produced or considered during and after the HIIAT process?

A. This is not my area of expertise, I only attended a limited number of IMTs and I would defer to experts in this area.

46. How clear and comprehensible is the HIIAT process?

A. This is not my area of expertise, I only attended a limited number of IMTs and I would defer to experts in this area

Prophylactic Medication

Refer to IMT Bundle, Document 58

47. In the IMT of 16th January 2019, you undertake to discuss the use of prophylactic medication for renal transplant patients with colleagues. What was the outcome of these discussions? Explain.

A. I have little, if any, recollection of attending this meeting which took place more than 5 years ago. I note that the date was 16th Jan 2019, which is when I was Chief of Medicine for North Sector GG&C, before I was appointed to my role of Deputy Medical Director: Corporate, and my clinical management role as Chief of Medicine for North Sector GG&C did not include management responsibility for the QEUH or RHC. Reviewing the minutes and content (to IMT Bundle, Document 58, pg 261) it is likely that I attended in my clinical role in the renal unit as Consultant Nephrologist. I do not recall taking forward discussions but would note the minute from the meeting that took place the next day (17th January, IMT Bundle, Document 59, pg 266) which identifies that this meeting was attended by Dr Scott Morris who was Clinical Director for Renal at that time. In addition, the minute from 17th January states 'Prophylaxis for renal in patients on the other side of Ward 4C is going to be discussed with other clinicians within ward 4C Renal and Dr Scott Morris will liaise with Dr Inkster regarding this'. It is therefore likely that following the meeting on 16th January, I linked with Dr Morris who took this forward in his role as Clinical Director for Renal.

48. You undertake to consider the need for HEPA filters for renal transplant patients. What was the outcome of this?

A. See answer to Q47

49. Why was there an increased requirement for HEPA filters? Please explain.

A. This is not my area of clinical expertise and my clinical role did not involve management of Acute Renal Transplant patients in Ward 4C. As noted in response to Q47, the minutes of the meeting of 17th January, note that 'Prophylaxis for renal in patients on the other side of Ward 4C is going to be discussed with other clinicians within ward 4C Renal and Dr Scott Morris will liaise with Dr Inkster regarding this'.

Meeting with Dr Linda de Caestecker

Refer to Bundle 6, Document 22 – Meeting 20th August 2019

50. Do you recall attending this meeting?

A. Yes, I recall attending this meeting.

51. What was the purpose of this meeting?

A. The note of the meeting included in Bundle 6, Document 22, outlines the purpose of the meeting as described by Professor de Caestecker in the section under 'Background'. I have no other recollection.

52. On what basis were you invited to the meeting?

A. I do not recall exactly, however I had commenced my role as Deputy Medical Director: Corporate in June 2019 and subsequently had attended two IMT meeting (25/06/2019 & 14/08/2019). It is likely that I was invited in that context.

53. 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 main concerns raised are outlined in the note of the meeting included **in Bundle 6, Document 22 under 'issues of concern'**. Prior to the meeting on 20th August 2019 chaired by Professor de Caestecker, I had only attended two IMT meetings in my role as Deputy Medical Director- Corporate (25/06/2019 & 14/08/2019). I recall that at one meeting (25/06) that the facility was inadequate with a very small table, attendees sitting scattered around the room, some sitting behind others including sitting behind the Chair. At the second meeting I attended (14/08), I recall a difficult atmosphere with some confrontational behaviours. My limited involvement in the IMTs meant that I did not have the requisite knowledge of the concerns being raised to comment further.

54. 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 only recall behavioural issues at one IMT that I had attended (14/08/2019) as noted in my response to question 53. I seem to recall at the time, not knowing who the individual was but was later advised that it was Dr Christine Peters who exhibited some confrontational behaviours

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

A. I have no recollection of the discussion other than, as is recorded in the note of the meeting **(included in Bundle 6, Document 22),** a decision was made to identify a new chair for the IMT going forward **(see Action 1, of Document 22 in Bundle 6).**

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

A. I don't recall having a view.

57. 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 don't recall having a view.

58. 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. In terms of Action 1: I was aware that Dr Emilia Crighton took over as Chair of the IMT as I attended the next IMT on 23/08/2019. Under Action 2: I was also aware that an updated policy document, 'the Greater Glasgow and Clyde Outbreak and Incident Management Plan was revised (4th Edition) and was approved by NHS GGC Corporate Management Team on 5th March 2020 as I refer to this in the Document 'Report of Issues raised by Dr Teresa Inkster to Medical Director Dr Jennifer Armstrong - SCI process, infection control incidents and IMT Governance - by Dr Chris Deighan, Deputy Medical Director, NHS Greater Glasgow & Clyde - May 2021.doc' Other than this, I was not involved with or responsible for the implementation or tracking of these actions or the operational delivery or governance of IMTs or IMT staff so am unable to comment further.

Whistleblowing and Communication

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

A. The publication 'Good Medical Practice 2024' is the General Medical Council's core guidance on professional standards. This has guidance under 4 key Domains, and in Domain 4 - entitled 'Trust & Professionalism', the guidance notes under 'Communicating as a medical professional' that for all professional communication • You must be honest and trustworthy, and maintain patient confidentiality in all your professional written, verbal and digital communications. • You must make sure any information you communicate as a medical professional is accurate, not false or misleading. This means: you must take reasonable steps to check the information is accurate; you must not deliberately leave out relevant information; you must not minimise or trivialise risks of harm; you must not present opinion as established fact.

60. 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. Duty to communicate when it comes to telling patients about an infection should be approached in the same way as is outlined in the GMC's core guidance on professional standards as is outlined in my response to Q 59.

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

A. The publication from the GMC & Nursing Midwifery Council (NMC) entitled 'Openness and honesty when things go wrong: The professional duty of candour' (guidance published 2015, updated 2022) is the core guidance to professionals when something has gone wrong during care or treatment. It states that every health and care professional must be open and honest with patients and people in their care when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This means that health and care professionals must: • tell the person (or, where appropriate, their advocate, carer or family) when something has gone wrong, • apologise to the person, • offer an appropriate remedy or support to put matters right (if possible), • explain fully to the person the short and long term effects of what has happened. Health and care professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested. They must also be open and honest with their regulators, raising concerns where appropriate. They must support and encourage each other to be open and honest, and not stop someone from raising concerns.

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

A. Yes, I am aware of the duty of candour. This can be divided into 2 aspects. (1) Professional duty of candour – which is duty of every health and care professional to be open and honest with patients and people in their care when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This is outlined in my response to Q61. (2) Organisational duty of Candour: (from April 2018) the organisational duty of candour legislation created a legal requirement for health and social care organisations to inform people (or their families/carers acting on their behalf) when they have been harmed (physically or psychologically) as a result of the care or treatment they have received. In my current Health Board, The NHS Lanarkshire Duty of Candour guidance (2019) notes that: The purpose of the new duty of candour provisions is to support the implementation of consistent responses across health and social care providers when there has been an unexpected event or incident that has resulted in death or harm that is not related to the course of the condition for which the person is receiving care.

63. 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

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

A. My knowledge of how concerns about wrongdoing, failure or inadequacy within a healthcare setting has developed incrementally over the course of my professional career.

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

A. A culture of openness, honesty and professional duty of candour is always one that I have practised and promoted throughout my career as a consultant nephrologist and in my medical leadership role. This was something that was promoted and instilled in me by the nephrology consultants that I trained with in GG&C.

64. 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. I am aware that the GG&C whistleblowing policy was updated following the introduction of the National Whistleblowing Standards as I sat on the Short Life Working Group which re-drafted the GG&C policy to be in line with the National Whistleblowing Standards and subsequently was involved in investigating a number of whistleblowing concerns in my role as Deputy Medical Director: Corporate. I do not have enough detailed knowledge of the previous policy to compare and therefore am unable to comment further. Across the NHS in Scotland there are multiple ways (both internal & external) in which concerns can be raised.

Whistleblowing – QEUH

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

A. I recall being interviewed in the Teaching & Learning Centre at the QEUH by Professor de Caestecker along with a second clinician, external to GG&C, in relation to an Infection related whistleblowing episode, as I had attended some of the IMT meetings. I do not recall the date or the details.

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

A. I was not aware of, and do not believe I have seen (or recall seeing) the specific whistleblowing concerns other than the issues that Dr Armstrong, Medical Director asked me to review related to Dr Inkster's resignation letter and are detailed in the Document 'Report of Issues raised by Dr Teresa Inkster to Medical Director Dr Jennifer Armstrong - SCI process, infection control incidents and IMT Governance - by Dr Chris Deighan, Deputy Medical Director, NHS Greater Glasgow & Clyde - May 2021.doc'

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

A. I am unable to respond to this question as I was not involved with this process other than as noted in my response to Q 66.

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

A. See my response to Q 66 & Q67.

Review of Process following Dr Inkster's resignation

Refer to Report of Issues raised by Dr Teresa Inkster to Medical Director Dr Jennifer Armstrong - SCI process, infection control incidents and IMT Governance - by Dr Chris Deighan, Deputy Medical Director, NHS Greater Glasgow & Clyde - May 2021 details - Objective ECM (scotland.gov.uk).

69. What is this report?

A. As noted in the Section (1) Background, of the report entitled 'Report of Issues raised by Dr Teresa Inkster to Medical Director'. On 01/10/2019, Dr J Armstrong Medical Director GG&C, emailed Dr C Deighan, Deputy Medical Director: Corporate GG&C, regarding issues raised by Dr Inkster, Consultant in Microbiology & Infection Control in the context of whistleblowing communication to Health Protection Scotland (HPS) and Dr Inkster's letter to Dr Armstrong in which she resigned as Lead Infection Control Doctor for GG&C. Initially, it wasn't clear if these issues were being taken forward as part of the internal whistleblowing investigation

however subsequently I was asked to review the issues outlined in the report, namely • SCI process • Duty of candour regarding infection control incidents • Governance relating to specialist groups reporting to Incident Management Teams (IMTs). A fuller account of these issues is in Appendix B of the report. This report is a review of these three issues.

70. What was the purpose of preparing this report?

A. I was asked to review the issues outlined in my response to Q69 by Dr J Armstrong, Board Medical Director, GG&C.

71. Who instructed you to prepare this report?

A. Dr J Armstrong, Board Medical Director, GG&C

72. Did you have experience in undertaking similar investigations previously? If so, please provide details?

A. In my previous role as Clinical Director for Renal Services and Centre for Integrative Care, October 2009 to June 2015 at NHS GG&C, I previously led a number of conduct related investigations. I do not recall previously undertaking a review similar to this.

73. What were the key factors considered and why?

A. This was not an investigation underpinned by any policy framework, rather a review of the issues raised. As such, as noted in Section (4)- Summary of the report, given the multiple investigations and enquiries that were ongoing, the key factor was to get clarity and a fuller account of the issues raised under the broad headlines, in order to provide a clear focus for the review. As a result, I asked Dr Rachel Green (Chief of Medicine for Diagnostic Services and medical line manager to Dr Inkster) to interview Dr Inkster to get a fuller account of these issues.

74. Dr Green interviewed Dr Inkster for the purposes of preparing the report. Why did you not interview her yourself?

A. Dr Rachel Green was Chief of Medicine for Diagnostic Services and was the medical and professional line manager to Dr Inkster. I do not recall why I did not choose to interview her myself.

75. Did you view yourself to be impartial when undertaking this investigation?

A. As noted in my response to Q73, this was a review of the issues raised, rather than an investigation underpinned by any policy framework. As noted in my Declaration under Section 2 of the report. I had some involvement with the issues. I had attended three of the IMT meetings in summer of 2019 deputising for the Deputy Medical Director: Acute, when not available. As a result, I was interviewed as part of the Internal GG&C Whistleblowing Investigation. I contributed to the writing of the letter from Board Medical Director to the parent involved in Duty of Candour Incident. I had also worked with Dr Inkster as a colleague in the past and had co-authored 2 publications in 2017. Throughout my career, I have always tried to be objective in all my work, be guided by evidence and tried to avoid bias, however I can fully understand how I might be perceived as not being impartial and exhibit bias in this context – either conscious or unconscious bias. I would note however, that with the delay in completing the report (consequent of the Covid-19 pandemic from March 2020 onwards), as is noted in the summary, a number of issues identified in the report including issues with respect to SCI (SAER) policy and the Governance of Incident Management had already been picked up and addressed by policy reviews therefore it would appear that much of the review was consistent with others.

76. Dr Inkster raises concerns regarding the Significant Clinical Incident (SCI) process relating to cryptococcus infections. What are your thoughts on her concerns and were they justified?

A. Given the concerns raised about the SCI process, I asked the then Director of Clinical Governance, Mr Andy Crawford, to review this particular issue, given his expert knowledge in this area. The report notes that, in this circumstance, the SCI process did not proceed smoothly. In part, this was related to the complexity of the situation but also as noted in the report, because the Board initiated additional independent investigations into the hospital systems and the potential role of pigeon flock in exposing patients to the organism, thus creating multiple parallel reviews (IMT, SCI and board initiated review). The report suggests that following the creation of the Board initiated independent investigations into the hospital systems, that aspect of the SCI should have been withdrawn however it is

understandable (as is noted) that redefining the terms of the investigation might be perceived as unduly influencing the report. The report subsequently highlights 2 areas where the SCI / Serious Adverse Events Review (SAER) Policy could be strengthened (1) A process of corporate commissioning for a SCI / SAER instead of local service commission and (2) to ensure that all staff are aware that there is a process that underpins resolution of disputes and procedures in the context of an SCI / SAER. With respect to final visibility of the SCI and sharing with the family. I would note that the interview with Dr Inkster took place on 06/01/2020 however, the final draft of the report was shared with all reviewers subsequent to the interview, on 12/03/2020, the final report was signed off in April 2020 and shared with the family and that Dr Inkster attended the meeting that took place with the family in September 2020.

77. Dr Inkster raises concerns regarding the Duty of Candour Incident in 2018. Dr Inkster alleges that she was asked to withhold information from a child's parent regarding the source of an infection. What is your view on this?

A. Section 3.2 of the report, outlines Dr Inkster's concerns and also notes where this incident is referred to in a letter from the Chief Executive to the parent in question. They key aspects of the duty to communicate effectively with patients are outlined in my response noted in Q, 59-62. The report notes that it is clear from Dr Inkster's statement and GG&Cs letter to the parent, that there are differing views regarding this episode, that Dr Inkster clearly perceives that her duty to 'tell the truth and communicate freely with parents and patients was being undermined' whereas the letter from GG&C notes that the senior member of staff was 'trying to balance ensuring that your family and the other patient's family were advised of as much information as possible, whilst ensuring patient confidentiality, and in a way that was thoughtful, appropriate and timely'. As noted in the report, it is clear that this was a complicated scenario that involved communication with more than one family, with the need to maintain professional confidentiality. However, the report clearly notes that communication during this episode was sub-optimal and that the Chief Executive of NHS GG&C has apologised for the poor communication in a letter to the parent.

78. Are you aware of staff being told to withhold information from patients and or their families by Senior Management? Please provide details.

A. No

79. You note that, 'communication during this period was sub-optimal', are you of the view that there was a failing in terms of the duty of candour within GGC?

A. The report states that communication during this period was sub-optimal. The report goes on to note that the Chief Executive of NHS GG&C has apologised for the poor communication in a letter to the parent. Therefore, at the time of the incident, it would seem reasonable to conclude that communication did not appear to be in keeping with the principles of duty of candour as outlined in Q62– which is duty of every health and care professional to be open and honest with patients and people in their care when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress.

80. Dr Inkster raises concerns regarding the feedback from external meetings being fed back to the IMT. How important is communication between different teams within the hospital when managing an incident such as the one in 2019? Do you believe communication was effective in this instance?

A. It is essential that good communication exists across teams when managing an incident like this. The report highlights under 3.3.1, that the Water Technical Group (WTG) appears to have been established as a sub group of the IMT but without Terms of Reference, defined remit, clear membership and the Chair of the meeting was not a participant in the IMT. Dr Inkster as well as being chair of the IMT at that point, appears to have been the link from the WTG to the IMT and attended the majority of the WTG meetings. As noted in the review, the Chair of any IMT carries a significant responsibility, including considering potential hypotheses regarding the source of infections. They are also responsible for leading the discussion at meetings and considering papers tabled at the meetings. Consideration should have been made for the Chair of the IMT to have delegated responsibility of linking the WTG and IMT to the Chair of the WTG. This would have improved the reporting line of the WTG to the IMT and would facilitate both challenge from the Chair of the IMT to the output of the subgroup and also assurance from the subgroup back to the Chair when appropriate. Section 3.3.1 of the reports highlights areas where

communication could have been better. The report notes that the Estates department took forward and tabled a paper regarding Chlorine Dioxide dosing, this was tabled at the WTG when Dr Inkster was present and was also circulated to members of the IMT. Clear actions regarding plans for water treatment with Chlorine Dioxide are outlined in the IMT action plan however the Estates paper tabled at the WTG does not appear to have been tabled at one of the IMTs. On another occasion it is noted that the minutes of the WTG from 16/08/2019 did not appear to have been finalised. As noted in Section 3.3.3 of the report: In February 2020, the Greater Glasgow and Clyde Outbreak and Incident Management Plan was revised (4th Edition) - Appendix E. This revision, which had commenced in late 2018, was approved by NHS GGC Corporate Management Team on 5th March 2020. This includes guidance for the Chair of the IMT, Subgroups and escalation process in the absence of a consensus opinion.

81. Dr Inkster raises concerns regarding infection control in the built environment. In your view, were her concerns justified? In what ways have the establishment of the NHS GG&C Infection Control in the Built Environment Group improved reporting of infection control?

A. Dr Inskter's concerns regarding infection control in the built environment were not part of this review, which focussed on the concerns noted in my response to Q.69. This is not my area of expertise and so would be unable to comment further. Under 3.3.2, the review notes that the establishment of the Infection Control in the Built Environment Group (ICBEG) should enable a clear and robust governance structure linking estates and the Built Environment with infection control, with appropriate reporting into Infection Control and Clinical Governance Structures. I left GG&C in January 2023 and am unable to comment on whether this has improved reporting of infection control.

82. Dr Inkster raises concerns regarding the governance of the Incident Management process. What is your view of the new management structure of the IMT? Is this effective? Do any concerns remain?

A. As noted in the report under section 3.3.3: In February 2020, the Greater Glasgow and Clyde Outbreak and Incident Management Plan was revised (4th Edition). This revision, which had commenced in late 2018, was approved by NHS GGC Corporate Management Team on 5th March 2020. As noted, specifically with reference to the report, this updated document included guidance for the chair in the context of complex incidents, guidance on the setting up subgroups including named leads, membership, remit and reporting. The document also includes a route for escalation where consensus cannot be agreed. As noted under 3.3.4, the issues with governance highlighted in the report appear to be addressed in the updated GG&C Outbreak and Incident Management Plan. Given my limited involvement with this IMT, with no involvement with IMTs subsequent to this and having left GG&C in January 2023, I am unable to comment on the effectiveness of this document or whether any concerns remain.

83. In your review you state you were, 'unable to corroborate the specific concerns' raised by Dr Inkster. Your review picked up on situations where it was recognised that they 'did not proceed smoothly', they were 'sub optimal' and the IMT process and the reporting system for infection control were reviewed and updated. With this in mind, can you further explain the reasoning behind your conclusion that Dr Inkster's concerns were unable to be corroborated?

A. This review took place following concerns raised by Dr Inkster to Dr Armstrong Medical Director. Initially, it wasn't clear if these issues were being taken forward as part of the internal whistleblowing investigation however subsequently I was asked to review the issues previously outlined in Q69. Dr Inkster was interviewed in January 2020. Much of the background information for this report was collated in early 2020 following the interview with Dr Inkster however the writing of this review was significantly delayed by the Covid-19 Pandemic from March 2020 onwards and as a result, the report was not completed until May 2021 at which point, as noted in the summary, the broader sum of issues identified in the report had already been picked up including with respect to SCI (SAER) policy, Infection Control in the Built Environment and also the Governance of Incident Management.

As a result, this may have influenced the conclusion that noted 'this review is unable to corroborate the specific concerns that were raised in her initial correspondence'. The concerns raised were under the themes of: (1) SCI Process, (2) Duty of candour regarding infection control incidents and (3) Governance relating to specialist groups reporting to Incident Management Teams (IMTs). Following interview with Dr Inkster a fuller account of the concerns was established. Regarding (1) SCI process, when interviewed Dr Inkster noted: 'concerns were that non experts had intervened and removed what was thought to be correct detail without her being asked to agree it and this had changed the whole sense of the document. Document control had been poor. Having asked for the SCI she has not seen a final version of the SCI which was to be shared with the patients and families and nor does she know if it has been sent.' As already noted, Dr Inkster was interviewed in January 2020.

The final draft report of the SCI was shared with all of the reviewers on 12th March 2020 with a view to sharing this factual report with the family of the patient. This report confined its terms of reference to the clinical care received as an in-patient, noting that the report from the Expert Advisory Group would provide additional information on the hospital systems and the potential role of pigeon flock in exposing patients to the organism. Dr Inkster and the other reviewers were invited to put any concerns they had with this approach, in writing to the Director of Regional Services. No reply was received from Dr Inkster or any of the other reviewers. The assumption therefore is that they were content with this approach. The final report was signed off in April 2020 and shared with the family. Following this, a meeting took place on 30th September 2020 between the family and senior representatives from GG&C including Dr Inkster. Prior to the meeting, the family wrote to GG&C with a number of questions regarding the SCI report. These were subsequently answered in a written reply in October 2020. As such, most of the concerns raised by Dr Inkster were no longer active by the time the report was written and the SCI/SAER policy had been revised and included a mechanism to underpin resolution of disputes.

Regarding (2) Duty of candour regarding infection control incidents. The issue raised related to concerns ‘that obligations to tell the truth and communicate freely with parents and patients is being undermined’ As noted in the report, it is clear from Dr Inkster’s statement and GG&Cs letter to the parent, that there are differing views regarding this episode. Dr Inkster clearly perceived that her duty to ‘tell the truth and communicate freely with parents and patients was being undermined’ whereas the letter from GG&C notes that the senior member of staff was ‘trying to balance ensuring that your family and the other patient’s family were advised of as much information as possible, whilst ensuring patient confidentiality, and in a way that was thoughtful, appropriate and timely’. The day after Dr Inkster’s interview, NHS GG&C Board Medical Director wrote to the parent in question. This letter outlined a review of the case of infection and how this case was reported both internally and to Health Protection Scotland. Dr Inkster along with the Lead Infection Control Doctor and the Chair of the IMT all contributed to the writing of this letter which detailed the reporting of the infection. What is clear and is noted in response to Q79 is that communication in this episode was poor and the Chief Executive apologised for this. Regarding (3) Governance relating to specialist groups reporting to Incident Management Teams (IMTs), Dr Inkster noted ‘An IMT in June 2019 asked for increased Chlorine Dioxide to be added to the water as the control measure for the atypical Mycobacterium. The Estates department did not take this forward but asked for External advice (from an expert on Legionella) who said this was not required. This message was not brought back to the IMT who had asked for it. The water technical group has made decisions where these were not minuted nor discussed at IMT. Dr Inkster was asked not to sit on any of the specialist groups as she was apparently influencing the outcomes from these groups.’ The report noted under 3.3.4 that (a) Dr Inkster raised the concern that the Estates department did not take forward a request from the IMT in June 2019 for increased Chlorine Dioxide to be added to the water as the control measure for the atypical Mycobacterium. There is clear documented evidence that this is not correct and that this action was implemented as requested (b) There was a further request to increase Chlorine Dioxide but was discounted after discussion at both the WTG and IMT and appropriate governance underpinning this decision appeared to be in place. In addition, as Chair of the IMT, Dr Inkster would have been in the position to ensure that the WTG was set up with clear remit, ToR and

reporting lines into the IMT. Subsequent guidance for this has been included in the revised GG&C Outbreak and Incident Management Plan.

84. Following this review did you have any further involvement with these concerns raised by Dr Inkster, or any other concerns raised by her?

A. Following the completion of this review, I do not recall any further involvement with these concerns. I was subsequently a member of the Board Infection control committee until I left GG&C in Jan 2023.

85. 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 an honest belief in its truth.

The witness was provided the following Scottish Hospital Inquiry documents for reference when they completed their questionnaire statement.

Appendix A

A36591625 – Bundle 1 – IMT – Hearings Commencing 12 June 2023
A36591622 – Bundle 1 – IMT Hearings Commencing 12 Juen 2023
A36591628 – Bundle 1 – IMT – Hearings Commencing 12 June 2023
A37991876 – Bundle 1 – IMT – Hearings Commencing 12 June 2023
A37991958 – Bundle 1 – IMT – Hearings Commencing 12 June 2023
A36591626 – Bundle 1 – IMT – Hearings Commencing 12 June 2023
A36591637 – Bundle 1 – IMT – Hearings Commencing 12 June 2023
A36591627 – Bundle 1 – IMT – Hearings Commencing 12 June 2023
A36591629 – Bundle 1 – IMT – Hearings Commencing 12 June 2023
A37992136 – Bundle 1 – IMT – Hearings Commencing 12 June 2023
A36591643 – Bundle 1 – IMT – Hearings Commencing 12 June 2023
A37992498 – Bundle 1 – IMT – Hearings Commencing 12 June 2023
A37992819 – Bundle 1 – IMT – Hearings Commencing 12 June 2023
A36591709 – Bundle 1 – IMT – Hearings Commencing 12 June 2023
A37993248 – Bundle 1 – IMT – Hearings Commencing 12 June 2023
A37993497 – Bundle 1 – IMT – Hearings Commencing 12 June 2023
A41890244 – Bundle 1 – IMT – Hearings Commencing 12 June 2023
A38172455 – Bundle 1 – IMT – Hearings Commencing 12 June 2023
A41890585 – Bundle 1 – IMT – Hearings Commencing 12 June 2023
A41890404 – Bundle 1 – IMT – Hearings Commencing 12 June 2023
A36690590 – Bundle 1 – IMT – Hearings Commencing 12 June 2023
A36591680 – Bundle 6 – Miscellaneous Documents – Hearings Commencing 12 June 2023
A42362240 – Bundle - TBC