Scottish Hospitals Inquiry

Statement of Dr Penelope Redding MBBS MRCS LRCP FRCPath

Glossary/Acronyms

AICC	Acute Infection Control Committee
BMA	British Medical Association
BMS	Biomedical Scientists
BMT	Bone Marrow Transplant
The Board	NHS Greater Glasgow and Clyde Health Board
CF	Cystic Fibrosis
CVC	Central Venous Catheter
GMC	General Medical Council
HAI	Healthcare Acquired Infection
HAI SCRIBE	Healthcare Associated Infection: Systems for Controlling Risk in the Built Environment
HEPA	High Efficiency Particulate Air
HIS	Healthcare Improvement Scotland
HPS	Health Protection Scotland
HR	Human Resources
IC	Infection Control
ICD	Infection Control Doctor
ICM	Infection Control Manager
ICN	Infection Control Nurse
ICU	Intensive Care Unit
ID	Infectious Diseases
IPC	Infection Prevention and Control
IPCT	Infection Prevention and Control Team
MERS	Middle Eastern Respiratory Virus
MDDUS	Medical and Dental Defence Union of Scotland
NICU	Neonatal Intensive Care Unit
NIPCM	National Infection Prevention and Control Manual
OD	Organisational Development
PICU	Paediatric Intensive Care Unit

PVC	Peripheral Venous Catheter
QEUH	Queen Elizabeth University Hospital, Glasgow
RHCG	Royal Hospital for Children Glasgow
SBAR	Situation Background Assessment Recommendation
SGH	Southern General Hospital
SGUT	South Glasgow University Trust
SHFN	Scottish Health Facilities Notes
SHTM	Scottish Health Technical Memorandum
SMT	Senior Management Team
SOP	Standard Operating Procedure
TB	Tuberculosis

Personal and Professional Information

Introduction

1. I am Dr Penelope Redding. I am 73 years old. I qualified as a doctor in 1974. I retired in 2018.

2. I worked as a Consultant Microbiologist and ICD. I worked in the South of Glasgow from 1984 until my retirement. When the Board was formed in 2006 it became my employer. Before that I was employed by its various predecessor organisations. I was based at the QEUH from its opening until my retirement.

3. I have prepared this statement to assist the Inquiry. I have attempted to err on the side of brevity, but I would be pleased to provide any further detail or input that the Inquiry wishes to have on any of the matters contained within this statement.

4. Some of the events detailed in this statement happened a long time ago. As I have been retired for some time, I do not have access to all of the necessary work emails and other papers to allow me to check dates. I am therefore reliant on my recollection. It is possible therefore that some dates may be inaccurate although I have done my best to ensure that this statement records events as accurately as possible.

Qualifications

5. I studied Medicine from 1969 to 1974 at University College London and Westminster Hospital Medical School, both of which are part of the University of London. Thereafter, I worked as a Junior House Officer for a year, spending 6 months in gynaecology and six months in medicine. Thereafter, I worked as a Senior House Officer for a further year, rotating through haematology, blood transfusion, microbiology and pathology. My Junior House Officer and Senior House Officer years

were both at hospitals linked to the Westminster Hospital, London. I then worked as a Junior Lecturer in Microbiology at St Thomas' Hospital for 9 months before moving to Glasgow in 1977 to take up a post as a Microbiology registrar, to follow my husband when he was appointed to a job in Scotland. I was a registrar and then a senior registrar at the Western Infirmary in Glasgow until 1984.

6. I had my first child in 1979 and I worked part time when I returned after maternity leave. I resumed full time work when I became a consultant in 1984. In 1987, I had my second child. I returned to work full time after maternity leave and, thereafter, I was a Consultant Microbiologist for the remainder of my career.

7. My qualifications are MRCS, LRCP, MBBS, and FRCPath. I have provided a CV to the Inquiry.

Overview of Professional Experience

8. I became a Consultant Microbiologist in 1984, based at the Victoria Infirmary, Glasgow. My duties included providing what would now be described as ICD cover. I remained in that role until 2008 when the Microbiology department at the Victoria Infirmary merged with the Microbiology department at the Southern General and I went to work there, also as a Consultant Microbiologist.

9. When I became a Consultant Microbiologist in 1984, IPC was not yet recognised as a standalone service anywhere in Scotland and was developing in England. Microbiologists did all of what is now referred to as IPC work and managed any outbreaks. There were no ICNs at this point to support our work.

Work History – 1990 to 2000

10. In around 1990, I was appointed as Head of Microbiology for the Southeast Glasgow area. This role included serving as what would now be known as an ICD.

11. By around 1991, what would now be referred to as the IPCT, but was then just referred to as “infection control” for Southeast Glasgow, consisted of me doing the job that would now be described as ICD working alongside a single ICN. I don’t believe that the role of ICD had been formalised at that stage. A microbiologist performing infection control duties acting alongside an ICN was the entire infection control team at that point and we worked very closely together as a team, albeit a small one.

12. The then ICN (Maggie McCowan) and I wrote the first IPC policy manual for the local area in around 1991/1992, which was distributed across the Southeast Glasgow hospitals. To ensure that the policy was followed we built good working relationships with all the relevant directorates, including Estates/Facilities, and management as well as clinicians.

13. In approximately 1996, I was appointed as Clinical Director for the Victoria Infirmary Laboratory Directorate. This was a senior management role and included responsibility for the whole Southeast Glasgow Laboratory Directorate. My responsibilities included managing and delivering a quality clinical laboratory service (serving Biochemistry, Haematology/Blood Transfusion, Microbiology, and Pathology), which met the needs of the clinical services in the hospitals we served and in general practice. In this role the Heads of Haematology, Biochemistry and Pathology would report to me professionally (there were separate reporting lines for their management rather than clinical roles). I was also still the Head of Microbiology at this point.

14. Being the Clinical Director made no difference to my Microbiology and infection control responsibilities which continued. The role of the IPCT was developing and more ICNs were appointed over the coming years as the ICN role became more established and accepted.

15. I resigned from my role as Clinical Director in around 2001 because of problems which had partly been caused by the merger of the Victoria Infirmary and SGH Trusts and discussion about shutting down and rationalising the Victoria Infirmary laboratories to the SGH. The plan was that there would no longer be on site Microbiology. In my view, that meant we were not providing the same level of service. My colleagues and I had raised concerns about this, but they had not been accurately recorded. Meetings would be held but our concerns would not be minuted. I recall writing down a note of my concerns and handing it to a minute taker to try and make sure what I was saying was actually recorded. In the circumstances, I was not prepared to continue in my role as Clinical Director.

16. After resigning as Clinical Director, I continued as a Consultant Microbiologist and ICD for SGUT until March 2008, when I was appointed Clinical Director for GGC's Laboratories Directorate. At some point, I stopped being Head of Microbiology; I cannot recall when. In 2008, the Victoria Infirmary Laboratory closed and moved to the SGH site. This resulted in challenges in delivering the Clinical Microbiology service to southeast Glasgow.

17. GGC's laboratory directorate was, and still is, one of the largest in the UK, with a budget of around £100 million at that time. When I took over, I was personally responsible for all of the laboratories (over 30 at that point). We then underwent an extensive centralisation programme with rationalisation of services.

18. By this point, I was also covering the whole of SGUT as an ICD, although I think there might also have been ICD cover within the SGH. There were also about six ICNs and the service was continuing to develop. After I was appointed Clinical Director, I continued to work as Lead ICD for SGUT until around August 2008. At that point, Professor Williams was appointed to what was then the new post of "Lead ICD" for GGC.

19. Thereafter, I did not do any formal ICD work as I did not have the capacity. Tom Walsh, who had been appointed as the ICM at around about the time I was appointed as Clinical Director in 2008 had asked me if I would be interested in the Lead ICD role, but I declined, and Professor Williams was appointed. I did not feel I could carry on being Clinical Director and have an ICD role as part of my Microbiology duties and also be Lead ICD for GGC. I really enjoyed infection control work and I didn't want to give it up.

20. Structural changes were made in the aftermath of the Vale of Leven report. The IPCT structure was put into place at that point and the managerial function was removed from the laboratory directorate and I believe it was given to the ICM and the lead ICN. In my view, these changes were the start of the fundamental problems within infection control in Glasgow. I can provide further detail about this if that would assist the Inquiry. Dr Brian Cowan, Medical Director at the time of the Vale of Leven Inquiry, said in his statement to the Vale of Leven Inquiry that he believed the problems would not have arisen had myself and Ms Isabel Ferguson, Laboratory Directorate General Manager, had been involved in infection control and still been in the laboratory directorate.

21. I was finding it increasingly hard to work as ICD within the IPCT with Sandra McNamee as Lead ICN. At times, I did not feel that some of the ICNs wanted to work as part of a team. I felt that the ICDs were often only asked to be involved to rubber stamp a course of action that had been decided by the senior ICNs. Sandra McNamee was not open to genuinely collaborating and listening to arguments that did not align with her preferred approach. There were obviously occasions, such as outbreaks, when the ICDs and ICNs worked together to investigate, manage, and resolve the problem. However, it was sometimes a challenge to get the senior IPCT to accept there might be a problem that needed to be investigated. Sometimes a concern might be raised, and on investigation turn out not to be an issue. Sometimes a concern needs to be fully investigated to understand the problem that needs to be managed appropriately.

The genuine collaboration that had existed between the ICNs and ICDs was being eroded as the ICNs seemed to be increasingly moving towards working autonomously. There is overlapping expertise shared by ICNs and ICDs, but they also have individual training that should be used to work in collaboration as a team. One obvious example is the ability of microbiologists to understand the interpretation of microbiology results that are not "straightforward". This does not mean that the service provided by the hardworking ICNs on a day to day basis was not essential to the provision of routine infection control services.

22. In March 2011, I resigned from the Clinical Director role after careful consideration. The role was very demanding and I was thinking of retiring. As a Clinical Microbiologist, you could find yourself working a very heavy on-call which could include working 11 straight days without a day off, and often being woken up two or three times a night by phone calls asking for advice. Professor Williams took over as both Clinical Director and Lead ICD when I resigned. I think Professor Coia was Head of Microbiology for a while around this time. Thereafter, Professor Williams took over that post as well. In my view, it is not appropriate for a single person to be simultaneously in post as Clinical Director, Lead ICD and Head of Microbiology. There should be independence of thought between these three posts which is obviously very difficult if the same person simultaneously performs all of the roles.

Work History – 2011 to retirement

23. From 2011 to 2014 I continued to provide IPC advice as a Microbiologist, including providing IPC advice out of hours, but I did not have any ICD sessions as part of my job plan.

Appointment of Dr Peters

24. In around 2014 Dr Peters was appointed as a Consultant Microbiologist and ICD.

25. Dr Peters did not want to work full time. We did not do a formal job share but I reduced my sessions from 10 to 4.5, which equated to 2 days per week, with no out of hours commitment, and Dr Peters worked the other 3 days and did the out of hours work. I might have dealt with some IPC issues during this period, but I think I mostly would have passed them to an ICD for South Glasgow to be resolved. I worked very flexibly at this time, and I did extra sessions when required to ensure that the Microbiology service continued to be delivered safely. I also covered out of hours when there was no one else available to cover.

26. Dr Peters was very experienced, both as a Consultant Microbiologist and as an ICD, and she immediately started identifying concerns and reporting them both through the IPCT reporting lines and at consultant meetings.

Timing of First Meeting to Raise Concerns

27. For the reasons set out more fully below, I became very concerned about the safety of patients at the QEUH. I have thought carefully about when I first raised these concerns. I think that the first meeting I had with a Medical Director (David Stewart) and the then Chief Operating Officer (Grant Archibald) to highlight multiple problems with infection control was around about the time when Dr Peters was appointed but before she actually started in her post.

28. I am fairly sure of the timing because I remember saying to them that they were fortunate that Dr Peters had been appointed because I knew she was very experienced. I told them that I thought there was clinical risk arising from the number of inexperienced ICDs who were in post at that point, so I was very pleased that someone experienced had been appointed.

29. The concerns that I raised at this meeting included issues with the ventilation, with air sampling, and with consultant microbiologists and ICDs not being listened to when

raising concerns. I also described the increasing problems with the culture within IPCT. I was raising the concerns that my experienced consultant colleagues were identifying and reporting. I did agree with and understand these concerns.

Last Years in Practice

30. I found that between 2011 and my retirement in 2018 there appeared to be a worsening culture within Microbiology and IPCT of not recording information, being told not to take minutes of meetings, and being told not to send emails on particular incidents. I believe this was to avoid there being a written audit trail of the reporting of any problems at a later stage. This included a direct instruction from both Professor Williams and Professor Jones (who had a poor working relationship with each other) to stop putting things in writing on more than one occasion. I continued to put things in writing and I advised all my colleagues to do the same. I continued to have serious and increasing concerns about patient safety at QEUH and RHCG, and what I felt was the failure of the organisation to deal with concerns which were raised.

31. There was a profound culture of fear and bullying in which people were terrified of speaking up. By way of an example, when our Microbiology trainees produced a document detailing their concerns (after I had told them to put things in writing) a meeting was held which I attended at which I heard Professor Williams say he was going to "destroy their careers". I reported this to Rachel Green, the Medical Director for Laboratories. As far as I know, nothing was done, as there was no feedback. The document highlighting their concerns is available.

32. I would have retired earlier than I did but I felt that I could not leave things in the state they were in; others were too frightened to speak up. Many of these colleagues were people I had worked with for more than 30 years. People feared for their careers. Based on my experiences with Professor Williams, I thought they were right to be worried. I knew that I was at the end of my career and so there was not much that

could be done to me in practical terms. I spoke to senior managers when others did not.

33. I eventually retired in March 2018.

Background and Introduction to Microbiology and Infection Control

The Role of a Consultant Microbiologist

34. Medical Microbiology is a laboratory-based discipline involved in the diagnosis, treatment, and prevention of the spread of infection in hospitals and in the community. As a Consultant Microbiologist, I worked closely with clinicians on the wards, making a significant contribution to clinical infection management.

35. The duties of a Consultant Microbiologist are considerable and varied. The job requires close working with the BMS and other lab staff, ward clinicians, the IPCT (comprised of ICDs and ICNs), Estates/facilities, management and various other departments in the hospital. Microbiologists ensure the effective and accurate identification, diagnosis, analysis, risk assessment and management of infectious diseases and the prevention of the spread of infection, the effective running of the labs and the appropriate use of antimicrobial treatment.

36. Medical Microbiologists require both clinical skills and laboratory knowledge. Duties typically include a daily visit to the ICU and visits to other wards as required. The laboratory aspects of the role require close working with BMS staff in the Microbiology department.

37. Microbiology analysis of specimens usually requires culture, followed by the identification of organisms and sensitivity testing. It may take 48 hours or more to formally report a result, but at each stage there may be some action that can be taken and advice given on treating a patient to the clinicians on the ward.

38. All Microbiologists generally have IPC as part of their responsibilities, with some having formal ICD sessions/responsibilities. All Microbiologists have out of hours responsibility for IPC and give advice as required even if they do not have ICD sessions included in their job plan. Microbiologists identify infection concerns and ensure that these are reported to the IPCT. Even though they may not be directly involved in the management of incidents or outbreaks, they need to be briefed on what is happening to enable them to alert IPCT of new cases and incidents and to manage any problems out of hours. In serious outbreaks, members of the IPCT may be brought in to the hospital to assist in the management of an outbreak out of hours. This is usually at the weekends when the Consultant Microbiologist on call would otherwise be overwhelmed.

39. IPC must be a pro-active service to minimize the need for a reactive response. It is impossible to eliminate all infection risks to patients, but every effort should be made to reduce the risk of HAIs for the benefit of patients, visitors and staff. Incidents and outbreaks are very resource intensive and protecting these resources by reducing the occurrence of incidents and outbreaks insofar as possible ensures they are available when absolutely needed. The more incidents there are, the greater the resource required. Caring for infected patients creates more work for ward staff. Outbreaks and incidents create more work for the IPCT. It is therefore critically important that the IPCT minimises the number of incidents to prevent services from becoming stretched. There is also a financial cost, and more importantly, a cost to patients.

The Relationship between IPC and Construction/Refurbishment Projects

40. There are standards in place produced for the NHS in Scotland known as SHFN which are intended to provide guidance and advice on how to safely build and maintain/refurbish the hospital estate in Scotland.

41. As detailed throughout these notes, the IPCT should be involved at the planning, building, commissioning, and maintenance stages of any project or refurbishment. During my time at the Victoria Infirmary this was not always the case. For example, I recall an occasion when a toilet was installed within the gastroenterology unit without a wash hand basin. This gives rise to obvious infection risk and resulted in extra costs to rectify, which could have been avoided if they had consulted with IPCT before installation. There were numerous similar examples of things but this one particularly sticks in my mind because it was so obvious. Because of the reoccurrence of incidents like this a pro-forma plan document was created for all projects which required documented consideration of whether any project required IPCT input before proceeding.

42. Building designers can only produce a specification that meets the needs of different patient groups if specialist ward clinicians and IPCT are involved from the outset, so that the requirements can be properly understood. No single professional has all of the knowledge required to ensure the right specification is agreed. It was recognised by GGC that IPCT should be involved in the planning and commissioning of all projects (minor and major) to ensure all standards were met and the needs of each particular group of patients were met. Estates and the IPCT both need to use their individual knowledge and expertise to get this right. Service users should also be consulted.

43. At the early stages of IPC being integrated into hospitals, the involvement of the IPCT was not always welcomed. IPC is often seen by others as a speciality that makes demands and requires unnecessary standards to be met, by putting obstacles in place. There is a tendency to think that involving IPCT will cause delays in signing off the plans and will have cost implications. My experience is that, even if you do have good working relationships, these can become strained when the pressure is on. Lines of communication and respect must be maintained and the ethos of team working promoted.

44. Plans can go wrong or be changed unilaterally during a project and IPCT plays a critical role in identifying any problems that may result from this. IPCT have to be pro-active

and ensure that they are embedded within the team overseeing a project. It is easy to become marginalised but, in my view, it is the duty of IPCT to ensure that they remain closely involved throughout. It is only through collaborative working involving ward clinicians, Estates, and IPCT that the correct decisions can be made by those overseeing a project to ensure a safe environment is delivered as described in SHFN.

Infection Control Nurses

45. Understanding the role and remit of the ICN is essential in understanding the importance of IPCT. They should liaise daily with ICDs and/or Microbiologists, ensuring the ICD is briefed and up to date with any significant incidents and outbreaks. It is also their responsibility to deal with referrals from Microbiologists, clinical staff on wards, and from Estates and management.

46. ICNs provide guidance on IPC to patients, relatives and staff to reduce the risk of infection. They identify hazards and risks and prevent, control, and manage HAIs. They should ensure that the appropriate IPC policy is in place and is kept up to date, and rely on evidence based guidelines, standards and current legislation in delivering the IPC service.

47. It is the role of the ICN, acting as part of the IPCT along with the ICDs, to investigate and manage the source of outbreaks and incidents as they arise, which may include providing advice on ward closures and re-openings.

48. In addition to embedding themselves in project teams in the manner outlined above, the ICN will also participate in the application of HAI SCRIBE, which is a risk management tool designed to identify infection risks and provide for collaboration with others to mitigate the risks.

Infection Control Doctors

49. An ICD is normally a Consultant Microbiologist who has IPC sessions allocated to them as part of their job plan. The ICD should ensure the delivery of an evidence-based IPC service, based on the current legislation, standards, and guidelines. They should have expertise in IPC, which may include ventilation and water, but should also understand their limitations and when there might be a need to ask for expert advice, which may be within the Health Board or externally through other agencies or specialists such as Public Health Scotland, Health Facilities Scotland, Health Protection Scotland, or other experts.

50. Microbiologists and ICDs provide a crucial link between the laboratory and the IPCT. The interpretation of results and their significance is crucial. The Microbiology department may be the first to alert the IPCT of a problem, with an interim report before the result is ready to be finally reported. The BMS staff also play a role in reporting 'Alert Organisms' to a Microbiologist before they are formally reported. Immediate action and precautions may be required which may stay in place or be removed if they are not needed once the final result is reported.

51. There is an automated reporting link between Microbiology and the IPCT for organisms which are on the HPS list of Alert Organisms in relation to which there is compulsory reporting. The responsibilities for managing and investigating these organisms are outlined in Chapter 3 of the NIPCM for health and care settings and also within the Management of Public Health Incidents Guidance. This is all part of the day to day workload for the IPCT. However, it is important to be clear that it is not just Alert Organisms that need to be carefully considered; the IPCT need to be on the lookout for any unusual pattern of infections or incidents regardless of whether an Alert Organism is involved or not.

52. The ICD has responsibilities similar to the ICN and there is some overlap. The ICDs remit will also include, (i) ensuring on-going training in IPC throughout the Health Board, (ii) ensuring that the IPCT and medical staff work together and share information, (iii) identifying risk and managing risk using the Risk Register at the appropriate level, (iv) using the escalation management reporting lines within GGC, (v) engaging outside agencies in reporting infections as required, (vi) following the direction of the Medical Director, and (vii) maintaining GGC's clinical governance arrangements, including risk management.

The relationship between Microbiology/ICDs/ICNs

53. There must be good working relationships between Microbiologists, ICDs and ICNs. There must be professional respect, drawing on the expertise of the individuals involved. It is essential for ICDs and ICNs to work as a team. This did not always happen. In my opinion, there was some problematic autonomous working by ICNs. This was probably relevant to what subsequently happened and the attitude of ICNs to the role of ICDs.

Pre 2008 Planning for the new QEUH and RHCG

54. At the very early planning stages for the QEUH and RHCG, Dr David Stewart, who was at that time the Acute Services Medical Director, chaired a large multidisciplinary committee, which was intended to deal with the complex planning for the new hospitals. IPC was included at these preliminary stages. GGC had learnt lessons during the construction of the New Victoria Hospital where costly errors had been made and needed to be rectified before they opened because IPC had been excluded from the early planning stages. This had caused issues which Dr Stewart was keen to avoid at QEUH.

55. I am not exactly sure when I became involved in this committee, but I think it was around 2004. This was part of my role as Lead ICD for South Glasgow. A number of ICNs were also involved. There were lots of representatives from different hospitals and departments within GGC at these meetings because there was going to be a merging of services. Consultation with all stakeholders was seen as essential.

56. I recall a discussion at this early stage about whether to move the Brownlee Infectious Diseases Unit over to the QEUH from Gartnaval General Hospital. The decision not to move the Brownlee Unit was against the advice of IPC and the ID Consultants who thought that the ID unit should be on the same site as an ICU, which the Brownlee Unit at Gartnaval General did not have. These two services required specialised isolation facilities, which needed to be planned for and which were not part of the original specifications as the decision had been taken not to move them.

57. Document SHFM 30 Part B HAI-SCRIBE outlines the importance of IPC involvement at all stages of building or refurbishment. The Standards and Regulations in place at the time were followed in the planning that was done.

Ventilation Planning

58. It is important to identify room specifications at the planning stage. There are different kinds of isolation rooms for different kinds of patients. Protective isolation rooms are for those patients who are immunocompromised in some way and vulnerable to infection. The protective isolation room specification would require the air to be as clean as possible, with no air coming in from the outside that is potentially contaminated. This would effectively be a sealed room with air coming through a HEPA filter in the ceiling and with no air leaking in through the edges.

59. Source isolation rooms would be for those patients who are contagious and may have an infectious disease such as TB, salmonella, Clostridium difficile, Norovirus, MERS, or

Covid, which pose a risk to other patients, visitors and staff. Most patients with antibiotic resistant organisms also need isolation. Depending on the nature of the infection, a further level of source isolation may also be required. For example, for some infections a single room would suffice but for others single rooms with lobbies would be needed.

60. For departments such as Accident and Emergency, where admissions are largely unplanned, some isolation rooms would be required in case someone arrived who was suspected to have an infectious disease. We had discussions with the clinicians to understand their patient demographic so that we could decide what the requirements for a particular ward were. For example, for the ICU, we reached a decision on the number of open bays, source isolation rooms and protective isolation rooms. The clinicians made the decision on the rooms they needed for their area. The room specification for each particular type of room requires clinical input. This is not a decision for Estates or planning to make as they would have no understanding of the different patient groups and clinical needs.

61. I attended the first meeting which took place to discuss ventilation. There were two or three people present from the ventilation contractor, plus people from Estates and the building contractor. I remember that they commented on the awful smell from the neighbouring sewage works and that led to lots of debate about whether the windows should be capable of being opened, or whether it should be a fully sealed building with air conditioning and what that would mean in terms of how EC Regulations could be complied with. I only met with them once and I recall that they were going to think about how they would deal with the ventilation challenges and gain an understanding of the regulations. I did not have any further input with them as I then stood down as an ICD.

Water Planning

62. At the time of the planning of the new hospital, I know that there were discussions around the water supply at the multidisciplinary meetings. The poor quality of the water supply to the SGH, which had been known for years, was discussed. There was a history of water contamination.

63. I did not have involvement with the water situation as I did not have the necessary knowledge and training. My colleague Dr Lewis, a Consultant Microbiologist at the Victoria Infirmary, was the person who was the Lead Microbiologist dealing with water. He sat on the Water Committee, which hospitals are required to have.

64. He would keep me updated on what was being discussed at the Water Committee and I am aware that, even before the planning of the new hospital began, he was having problems with routine testing of the water in the old SGH and the Victoria in relation to legionella and bacterial counts. He told me that routine testing would be done, and the results would be reported to Estates but not passed on to Microbiology even when they required a response. For example, Dr Lewis would find out six to eight weeks after the results had become available that there was legionella in the water supply to a particular ward. He often had to chase up results to be notified at all.

65. He also told me that, around the time of the planning of the new hospital, there was discussion at the Water Committee about the need for a completely new water supply for the new hospital. This should be minuted somewhere. Dr Lewis resigned in around 2008 – 2009 because of the problems with working culture. By this point, things were so bad that he felt compelled to resign with immediate effect and without a new job to go to. He was a really good microbiologist and it was very unfortunate that we lost his expertise.

Proximity to Water Treatment Centre

66. I submitted a paper to the Independent Review about research that had been done on the impact of the proximity of the sewage works. This was dated 2002 and stated

that sewage works nuisance was being addressed by West of Scotland Water. There were 29 sewage plants across Scotland being rated as poor because the sewers were overflowing, leaking and breaching environmental limits and Greater Glasgow was included in this list. I was beginning to ask myself whether this could have been a contributing factor to the contamination of the water supply to the hospital if there was seepage into the ground. I do not know whether this concern is well founded or not as I do not consider myself qualified to reach a final view. I do know that the Independent Review report states that they had a walk round the sewage works and they were happy that it was working okay. I don't see how they can be qualified to reach that conclusion simply from walking around it.

Conclusions on the Planning Stage

67. I have described the extent of my involvement with the planning stage of the new hospital. As far as I was concerned, IPC were fully involved and working closely with the team. This should have continued after my involvement ceased.

68. Professor Williams' attitude to some aspects of the planning and commissioning process was that it was not the job of IPC to become involved. He was of the view that it was up to Estates to make sure that the commissioning, building and monitoring of ventilation met the required standards. I disagree with this approach. An ICD needs to make sure that Estates know what they are supposed to deliver and make sure that it is actually delivered so that the needs of the patients are met. The SHFN 30 and HAI SCRIBE make it quite clear that IPC should be involved at all stages of a project like this.

69. At the time, there was definitely a lack of specialist knowledge in relation to the ventilation. Dr Hood, Consultant Microbiologist at Glasgow Royal Infirmary, was the person with the most experience in employed by the GGC, but I'm not sure if he had the knowledge for such a large project. Dr Inkster and Dr Peters would later have

expertise in ventilation. External experts should have been consulted. It is not, in my view, acceptable simply to leave all of this to Estates/ Facilities.

Post 2008 Planning for new QEUH and RHCG

70. I was not involved in the planning of the new hospital after 2008. I would have expected the same level of IPC input to continue after my involvement ended to ensure that the relevant standards were met. The standards are intended to be followed and that is what should have happened.

2012

Ongoing Issues with Workplace Culture

71. As mentioned above, throughout the period which the Inquiry is concerned with there were significant problems with workplace culture and relationships within Microbiology and IPC. There were numerous concerns about bullying at every level and the previous good working atmosphere within Microbiology had been destroyed. Some Consultants were criticising their colleagues' professional capabilities in meetings and in front of BMS staff, which created an unpleasant atmosphere and made working within Microbiology very challenging, but there was much more than this. There was a general fear of speaking up.

72. As I continued in the role of Clinical Director, I became increasingly concerned about the culture within IPC and it became clear that it had deteriorated with the new structure from when I had worked in that area.

73. The reporting from staff continued for months and I appeared to be the lone voice escalating the concerns to senior management (Isobel Neil and Bernadette Finlay). It seemed that no one else wanted to step forward or put anything in writing, even as a

group, about what was going on within Microbiology. After months of raising the concerns myself on their behalf, I persuaded the senior managers to allow the staff to speak individually and anonymously to HR and OD, as I felt most staff would be more comfortable doing this. The HR manager responsible for laboratories engaged with trainee medical staff, Consultants, biomedical scientists and secretarial staff and then told me that he had formed the view that the working environment was like 'an abusive marriage'. A report was produced in relation to his findings which I was never shown. It was clear that a poor working culture had developed under Professor Williams as head of microbiology. I know that he was careful to ensure that the tenor of any written material such as emails was conciliatory and benign, but he was very different when dealt with face to face.

74. The impression I was being given from staff was that Professor Williams, Tom Walsh and Sandra McNamee were key contributors to the poor working culture in IPC. There was a spike in ICNs leaving allegedly due to the culture and behaviours within IPCT. During this time, Professor Williams told me that he would move me to another hospital to make me unhappy. I told him to go ahead and do it. He then asked me what he could do to make me so unhappy that I would retire. On another occasion, he also threatened to report me to the GMC. Again, I told him to go ahead and do it. He didn't make a complaint; he would have had no basis for doing so.

Late 2014/Early 2015 Pre-Opening Concerns

75. In mid to late 2014/early 2015, my Consultant colleagues began reporting concerns about ventilation and other issues in relation to the new hospitals. These concerns were being expressed sufficiently forcefully and frequently that I arranged a meeting with Grant Archibald and David Stewart to advise them. As noted above, this was at around about the time that Dr Peters was recruited. I only did this because my colleagues felt that reporting their concerns via the usual reporting lines was not resulting in the necessary action.

76. Because of my previous management experience and understanding of processes within GGC, my colleagues felt that I had a clearer understanding of the workings of management and I may have had easier access to senior managers and be more able to influence them in addressing these concerns. I kept emphasising to them the need to follow the GGC management reporting lines and said that they should put things in writing, despite being told not to put things in writing by management.

77. The results of the air sampling that had been done in the new hospital as part of the commissioning process were giving rise to concerns. The Microbiologists had discovered that, during the air sampling process, there were only three air changes per hour as opposed to the six air changes which were required according to the standards. They had also isolated micro-organisms, including Mucor in the paediatric haematology/oncology ward. These concerns were being raised through the recognised management reporting lines, including at Microbiology meetings and through IPC. There was a general concern that they were not being listened to.

78. I initially reported the Microbiologists' concerns about the ventilation and air sampling to the Director of Diagnostics, Aileen McLennan. Her predecessor was Jim Crombie. I cannot remember exactly when she took over from him but it was between 2008 and 2011. I spoke to her because that was in keeping with the reporting lines in place at that time. Her response to me was to ask if I really "wanted to end my career like this". She should have then taken the matter to Grant Archibald and the Medical Director herself, but by then I had lost faith in the system and I decided to take the concerns to them directly.

79. I met with Mr Archibald and Dr Stewart and I explained the concerns that my colleagues were reporting through the IPC management lines and the fact that appropriate action did not appear to have been taken. I explained that my colleagues had the details of all the concerns that had been raised. I do not know if the concerns were escalated after the meeting. I did not receive any update from them to tell me about any actions arranged in light of what I had told them. After any meeting like that I would usually send an email thanking them for taking the time to meet and listing

the concerns that we had discussed. I don't have access to those emails now. GGC should have access to the emails of those still employed. I would have thought they should also have my old emails, although I have been told by William Edwards that the emails of previous employees were routinely deleted when the employee left the organisation. I cannot now recall the detail of what was discussed. Based on my previous experience of working with Mr Archibald and Dr Stewart, I would have expected that they would have taken my concerns seriously. I would not expect them to simply ignore what I was saying.

80. I do recall that I discussed the ventilation problems, and in particular I advised them about the air changes and the Mucor. I told them (based on the advice I had been given) that Mucor had a mortality rate of up to 85% in children. The Mucor had been detected within the protective isolation rooms where immunocompromised children would be placed. I don't know who had carried out the air sampling. These sampling results are likely to have been recorded on the Telepath system or by Dr Inkster and she would probably still have access to these results.

81. Mr Archibald disputed the mortality figure in relation to the Mucor, stating that it was a 65% mortality rate. From the literature, I knew that this varied between 50-85% depending on the patient cohort. Mr Archibald said that the ventilation concerns were merely "my opinion", although I was not the only microbiologist with concerns. I agreed and suggested that an external expert should be asked to evaluate the differences in opinion. I said I would accept any evidence-based opinion if I was wrong. I also asked if there was a warranty with the contractors to address the concerns, but did not receive an answer. I also recall telling them about the issues with the working culture, and that this was leading to a loss of expertise because people did not want to continue as ICDs. This is a risk to patient safety.

82. I received no feedback from senior management addressing the issues. I continued to tell them that they still had a problem. I sent further emails to Mr Archibald, Dr Stewart, Jane Grant, and Dr Armstrong. Again, I do not have access to these emails but GGC should have them, for those still employed. I took more of a back seat once

Dr Peters started in her role as she identified the same concerns I had reported and began reporting them herself, in her role as ICD. She was also identifying new concerns.

2015 - Post Opening Concerns

83. Following the opening of the QEUH and the RHCG, the same concerns persisted in relation to the ventilation, the air quality and patient safety and care, and Dr Peters and the other Consultant Microbiologists were also identifying new issues.

84. Dr Peters identified a problem with Exophiala amongst patients with CF. Exophiala is a fungus that was linked to dishwashers on the CF ward. This can be significant for CF patients as they often have to get lung transplants and, if they were to get Exophiala in their lungs, then their chances of getting a transplant are significantly reduced. There are also cross infection risks to other patients. I do know that, as a result of this incident, the dishwashers were removed, as these were found to be the source. That is an example of IPCT doing the right thing; there is a problem, it is identified, and measures are put in place to deal with it. What I don't understand is why the dishwashers were installed in the first place as I would always have been wary of having dishwashers on a ward with high risk patients because they can carry a risk of infections and they have to be properly maintained. I subsequently discovered (in 2017) that the dishwashers had never been cleaned. I believe that guidelines said they were meant to be cleaned three times a day in this type of unit.

85. I am also aware that Dr Peters identified issues with Mycobacteria, again in relation to CF patients. I know that she wrote an extensive report in relation to this and sent it through IPCT and then to the Clinical Director for Laboratories. I believe she may have sent it to the Medical Director for Laboratories (Rachel Green) as well.

86. In addition, Kathleen Harvey-Wood, who was a clinical scientist working within Microbiology, was concerned about the high level of resistant organisms in her group

of paediatric patients. She only dealt with paediatrics, so she knew her patients well and her view was that there was a higher level of resistant organisms and unusual organisms than she would have expected and that this was not the pattern that she had previously seen at the old hospital at Yorkhill. On one occasion Kathleen Harvey-Wood was told that she should stop reporting problems like this by Sandra McNamee. I believe this was in an email. I don't have access to the email but others should have it.

87. Another big issue that came up was that Microbiologists did not know which rooms within the hospital were suitable for different categories of patients. It is very common for Microbiologists covering IPC during the day and out of hours to get calls from wards asking where patients should be placed when they have particular suspected or confirmed infections. We needed to have information about which rooms met which standards so that we could isolate patients with suspected or confirmed infections (for example those with conditions such as Norovirus, Salmonella or TB). We could not get the necessary information on which rooms were safe to care for infectious patients. That was a problem that went on for years, even after I retired. Some patients had to be moved to other hospitals and health board areas because South Glasgow did not have the facilities to care for certain conditions, such as multidrug resistant TB.

88. Dr Inkster was appointed to take over from Professor Williams who had resigned as Lead ICD and Consultant Microbiologist. The pressure on Dr Peters became so unpleasant that she felt that she had to give up her ICD sessions. Dr Peters should never have been placed in that position in my view. I expressed my concern that Dr Peters' departure was a serious problem because of the huge loss of expertise. This expertise continued to be used to support the IPCT, even though she was no longer an ICD.

89. After Dr Inkster's appointment as Lead ICD, Consultant Microbiologists were still raising ongoing issues. I could see the stress it was putting my colleagues under, so I

thought I would try to take the attention from them and get management to focus on me. I was nearing retirement so there was very little that could be done to me. My colleagues still had a career in front of them. That being the case, I decided to speak to Senior Management again. I spoke with Dr Stewart at least once, explaining there was still a problem with IPCT. I was sending intermittent emails. I also remember having a meeting with him. He thought that the departure of Professor Williams would solve the problems. I knew that it wouldn't, and I told him that. I cannot recall if I spoke to Mr Archibald again.

90. Microbiologists felt that issues were still not being addressed or managed. The isolation rooms did not meet the required standards, and there were ongoing sewage leakages in the neuro-sciences theatres and building. I can't really remember all of the concerns that my colleagues and I had regarding patient safety and care in relation to these issues. I just recall that there were outbreaks and there were issues with the water and ventilation. We also had concerns about where we could isolate patients and which rooms were safe. This was creating a possible risk of spreading infections to other patients, visitors, and staff. There was an increase in the number of resistant organisms in our paediatric patients.

91. The details of these conversations were supported by emails, which I also copied to several senior managers. I no longer have these emails as discussed above. GGC should have them stored on their email servers somewhere.

2016

92. During 2016, there were weekly Consultant meetings held and we began recording all of the IPC issues. These concerns were a regular agenda item for each meeting. It was at these meetings that I requested that minutes be taken. This was done by Pauline Wright. However, we were subsequently instructed by Professor Jones not to minute the meetings. I was a CPA (Clinical Pathology Accreditation) inspector (a qualification for delivering a lab service) and part of the standards was a requirement to record and

minute meetings as part of the accreditation criteria. One of the clinical scientists attending these meetings was Kathleen Harvey-Wood, who had received the email from Sandra McNamee telling her to stop reporting concerns.

93. Throughout 2016 and early 2017 I noticed that an unusually high number of ICDs were resigning from their ICD sessions, and I felt that senior management should be looking into this. Dr Inkster, Dr Peters, Dr Wright, and [redacted] will all be able to explain themselves why they resigned from their sessions, but I was concerned that this led to a huge loss of expertise and, therefore, was of itself a risk to patient and staff safety.

2017

February 2017 meeting with Robert Calderwood

94. In February 2017, I decided to raise the ongoing concerns with the then CEO Robert Calderwood, who was due to retire at the end of March 2017. I had worked with him over many years, and we knew each other quite well. He agreed to see me to discuss the issues. During this conversation, I raised the concerns about ventilation, and he told me that I could not expect to reach a "gold standard" with everything. He said "that Peters woman is creating problems". I was struck by this comment as I knew he had never actually met Dr Peters at this stage. He had obviously already formed a very negative view of her, presumably based on reports he had received from others and seemed to have made up his mind about the concerns she was raising. I felt there was no point in carrying on the conversation as I knew I was not going to get anywhere. I decided to wait and speak with Jane Grant, who was taking over as the new CEO in April 2017 and who I had worked with in her previous role as COO.

April 2017 – Communications with Jane Grant

95. In April 2017, Jane Grant took over as CEO. After allowing her time to find her feet, I approached her to raise my colleagues' concerns about the issues with IPC.

96. I had worked closely with Jane Grant in the past when I was an ICD, and she was the COO. She had previously been diligent in understanding the problems with the theatres, listening to advice and warnings, and efficient in ensuring that everything was put in place to resolve the problems as quickly as possible. As I was only working two days a week and not always available, I exchanged a number of texts and emails with her during which I highlighted my concerns. I specifically told her that I was giving consideration to starting the Whistleblowing process.

97. I initially contacted her by email. She phoned me and we discussed my concerns and I felt that she listened to me.

98. I don't think I went into a lot of specifics with Jane Grant about the risk to patient safety, but I did speak to her generally about the recurrent problems with the ventilation that had been ongoing since the hospital opened. I mentioned the issues with water leaks and more generally the issues with the building which I thought should not be happening in such a new facility. I also raised the concerns about patients being put inappropriately into rooms as the Microbiologists did not know which rooms reached the standard required for particular patients. I emphasized that I felt there was a fundamental problem with IPCT.

99. After we had this phone call, I sent a text to her dated 21/4/17 and I told her that I had documents and reports available if she required them and I offered to have a meeting with her. I don't recall what I was referring to there, but it would have been information around the outbreaks. Jane Grant then sent me two text messages, both dated 21/4/17. The first one indicated that she had spoken to colleagues and asked them to consider appropriate issues/actions. The second text stated: "*Just to let you know that a review of the paed ward situation is under way to ensure appropriate learning is taken on board. I have asked the managers to ensure that you have the opportunity to contribute. Hope that's Ok. Jane*". This was the first of several occasions

when Jane suggested that someone would be in touch to discuss my concerns with me; in fact no one ever contacted me.

100. I can't remember exactly what she was referring to in relation to the paediatric ward. There were multiple known issues at that time, and it could have related to any of them.

101. I did not have the opportunity to contribute, although all I was looking for was to be reassured that action was being taken. I do not know whether people like Dr Peters and Dr Harvey-Wood were specifically asked to contribute. It would have been more productive to have spoken to them as they would have had a better command of the detail at that time than I had.

102. I sent a further text to Jane Grant on 28/4/17 thanking her for her update by text and saying that I had heard things were happening. At this time, I also sent her emails which would have had more detail around what we were discussing. I don't have access to those emails now. I can't recall if I sent her any of the documents or reports. Dr Peters may have done so.

Summer 2017

103. Between April and September 2017, there continued to be issues with concerns still being raised within IPC and they were being reported to me, as well as being reported through the appropriate channels and discussed at consultant meetings. I do not recall exactly what discussions I had with Jane Grant, but we were occasionally in contact over this period of time.

104. [redacted] was beginning to think that there may be links between infection and the water supply because of the bacteraemias that we were seeing in the paediatric patients. [redacted] was asking for enhanced water testing to be done and [redacted] was having difficulty getting IPCT and Estates to agree. This issue was referenced in the SBAR that we subsequently produced, which is discussed in more detail below.

105. Around this time, [redacted] was also reporting to me that [redacted] was concerned that [redacted] was being put under pressure to sign documents, but I cannot recall exactly what these documents related to. [redacted] did not feel comfortable signing off the work as [redacted] did not feel that [redacted] had all of the necessary information despite several requests. I told [redacted] that [redacted] could not sign off on a document if [redacted] did not know that it was factually correct, but [redacted] felt a lot of pressure to do so though I believe [redacted] ultimately refused. I had a discussion with Professor Jones about this and stressed that we should not be asked to sign off on any works/projects etc without being given all of the necessary information to be satisfied that sign off was appropriate.

106. ICDs also felt that they were not being kept up to date with issues that were arising, for example, they were not told about the sewage leaks in the neurology building which I believe were affecting areas including operating theatres. The potential risks to patient safety arising from a sewage leak, particularly in these areas, are obvious. I believe Dr Peters told them that they should stop using these theatres until the leaks were fixed. I remember her suggesting using the new theatres in the QEUH before the hospital opened to allow the remedial work to be carried out.

September 2017 – Stage One Whistleblow

107. At this stage some of my colleagues wanted to raise concerns directly with the media. We took advice from MDDUS and BMA and were told that we needed to properly exhaust internal procedures before escalating things in that way. We obtained GGC's Whistleblowing policy. Stage 1 of the policy involved contacting the same people we had already been reporting our concerns to, so we felt that it would not be particularly fruitful to do this again, but we did not want to be criticised for not following the policy to the letter, so we started with Stage 1 even though this was largely an exercise in repetition.

108. I cannot remember the chronological order of the specific concerns about the risks to patient safety and care from the built environment which we had already

raised. Current staff should still have access to the data. The issues included ICDs resigning as they did not feel able to carry out their duties safely, ICDs failing to be provided with information to allow them to make decisions about IPC issues, Consultant Microbiologists not being given information as to which rooms were safe to isolate patients in, concerns about the rising numbers of unusual infections in patients within ward 2A and the PICU in the RHCG and an increase in resistant organisms. No one was sure what the exact cause of the problems was at this stage, but we knew that several lines of investigation had to be carried out.

109. At this point, we were not convinced of any relationship with the infections and the built environment. We felt this was one of a number of possible causes. There were clearly problems and we did not know what the causes were. We wanted them to be properly investigated to see if any causes could be identified and dealt with. The water as a source was one of the possible causes of infection which had to be investigated. So was the ventilation.

110. I had contacted senior managers during May/June 2017 and advised them that we were considering following the Whistleblowing procedure in the hope that they might engage with us. I still fail to understand why they would not engage with us in order to attempt to find a resolution to the obvious increasing tensions. I had contact with Tom Walsh, Sandra McNamee, Jane Grant, Grant Archibald, Dr Stewart, Dr Armstrong and Aileen McLellan amongst others. I spoke to Jane Grant on the phone. I emailed Dr Armstrong. I met face to face with Grant Archibald, Dr Stewart and Aileen McLellan and outlined our concerns. On 5 September 2017 I emailed Tom Walsh, Sandra McNamee and Professor Jones. On 15 and 21 September 2017 I emailed Jennifer Armstrong and Dr Stewart specifically saying we were going to use the Whistleblowing procedure. I do not recall receiving a response to these emails. Having received no satisfactory response, Dr Peters, [redacted] and I began the Whistleblowing process at the end of September 2017.

111. I located the GGC Whistleblowing policy on the intranet, although I think it was two years out of date as most of the people listed for the Stage 2 process no longer worked for GGC. We followed it to the letter. I have produced the two Whistleblowing policies that I used in 2017 and 2019.

112. Staff were not encouraged to use the Whistleblowing procedure. Prior to either the Stage 1 or the subsequent Stage 2 Whistleblow (I cannot now recall which), I was urged not to Whistleblow by the Jane Grant. I recall her specifically saying to me that she "urged" me not to do it. When I subsequently said I was going to raise a Stage 3 Whistleblow about the fact that GGC would not acknowledge the raising of a Stage 1 Whistleblow and that I thought it was a cover-up, a non-executive director (Ian Ritchie) spent 45 minutes trying to talk me out of it during a phone call, which was not appropriate. He repeatedly asked me "what can we do" to stop me doing it.

113. The culture and perception within GGC at that time was that a Whistleblower should be seen as a troublemaker who was to be criticised for raising concerns and causing stress to patients and relatives. The Independent Review personnel made a statement to this effect during my interview with them. I was accused of causing stress to patients and relatives. They obviously already had a very fixed and negative opinion of me before they met me. As whistleblowers, we considered this very carefully, but still felt that we had no choice but to proceed in order to ensure the safety of patients in the long term. This is why we followed all the possible options within the GGC organisation and took advice from the BMA, GMC and MDDUS. We gave them numerous opportunities to engage with us and reassure us that things were being addressed and improving, but we all continued to see the same and new problems arising.

114. We sent an email to Dr Armstrong setting out our concerns. This was the start of our Whistleblow. In response to our email, Dr Armstrong asked us to put the concerns in an SBAR and a meeting was fixed to discuss our concerns on 4 October 2017. SBAR is a structured communication tool used by the NHS and consists of

standardised prompt questions in four sections, namely **S**ituation, **B**ackground, **A**ssessment and **R**ecommendation. I have produced the SBAR dated 3 October 2017 which was produced by Dr Peters and myself and also included the concerns raised by [redacted].

115. I sent a further text message to Jane Grant on 27/9/17 as follows: "*I feel I need to let you know that I have had to contact Jennifer Armstrong and David Stewart to alert them of my concerns in relation to infection control. The number of problems are increasing and I have been in twice from my annual leave to contact them. They are not expecting me to be back until 5th October so have not responded in writing.*

Today I alerted them that I feel I will need to go to stage 2 of the Whistleblowing Policy if a meeting is not arranged by 11th October to ensure that there is a record of all the current concerns being raised by a number of Consultants with an action plan.

I have offered to speak to them with a colleague before any meeting. I will make myself I available to come in from leave. I am abroad Friday and Monday.

I felt since you were kind enough to listen to my concerns previously it wouldn't be reasonable if [sic] me not to keep you up to date.

A meeting needs to happen as I have outlined. I do not want to take this to Stage 2.

Sorry to add to your pressures but these issues need to be understood and reasonable action plan put in place. This is not the situation today. Regards Penelope Redding"

SBAR of 3 October 2017

116. I have produced the SBAR which we prepared. The concerns are detailed in full within the document so I will not rehearse them here for the sake of brevity. They included patient placement, cleaning, Estates, water quality and testing, the plumbing

within the neurosurgical block, decontamination arrangements, and the infection control structure.

Meeting on 4 October 2017

117. The meeting to discuss our SBAR took place on 4 October 2017 and was chaired by Dr Armstrong. Dr Peters, [redacted] and I all attended. The other attendees as I remember were; the Director of Facilities, Deputy Director of Nursing (Morag Gardner), Dr Rachel Green (Medical Director of Diagnostics), Professor Brian Jones (Head of Microbiology), Tom Walsh (IPC Manager), Sandra McNamee (Associate Nurse Director IPC), Jonathan Best (Chief Operating Officer), David Louden (Director of Property and Procurement), Ian Powrie (Depute General Manager, Estates), Anne Harkness (Director, South Sector), and Gary Jenkins (Acting Director, North Sector). They are all very senior members of staff.

Patient Placement

118. I had an active role in the meeting, and I tried to speak as much as I could to explain the issues. I spoke about source isolation and the isolation rooms not being built to the correct standard. I explained that we were concerned that they would not provide protection for patients and staff, especially in high consequence infections such as MERS and multi drug resistant TB. David Louden told us that the rooms did conform to SHTM 04-01 and that it was incorrect to state that they didn't conform. I am not sure that he was right about that.

119. There was also discussion about the fact that the ID unit was a late amendment to the QEUH project and so was not commissioned as an ID unit at the outset. The ID Consultants and the Microbiologists were keen for ID to move to the new hospital at the planning stage because there was no ICU on site. We were told that this could not be done because it would be too expensive, and instead a smaller sum would be dedicated to upgrading the existing unit at Gartnaval General Hospital. I don't know

why the position was then changed and the ID unit was moved. Sandra McNamee stated that they were awaiting advice from HPS as to what standard the rooms needed to be to accommodate ID patients and said that when this information was received, Estates colleagues would assess whether these modifications were feasible. I do not know why this discussion with HPS hadn't happened at the time the decision was being made to move the ID unit to the new hospital which was over two years earlier. Anne Harkness stated that unless the existing rooms could be modified in some way, the only alternative would be to build a new ID unit and that would require significant resource.

120. The next issue that was discussed related to protective isolation and specifically the issues in ward 2A in the RHCG. The outbreak of aspergillus and concerns over line infections were discussed. Sandra McNamee stated that there had been cases of aspergillus in March and April associated with a leak in the ceiling space. This had been investigated, tiles were removed and replaced and there were no other cases of aspergillus. However, this did not address the question of why there were leaks in the first place in a new and apparently state of the art building. These leaks were happening in other areas – I am aware of leaks in ICU and the renal unit and was aware of other aspergillus cases. We were not told how many cases there were altogether. I do not know, but I suspect this was why all the children on the ward were put on prophylactic IV amphotericin B which is a toxic antifungal agent. To my knowledge this should only be used to treat patients who are known to have an infection. I do not know if the necessary investigation work was done to establish if the aspergillus cases had stopped due to the leaks being fixed or because all the patients were on IV prophylaxis. I believe prophylactic IV amphotericin B was given to all of the patients on several occasions despite the significant risk of toxicity. This is potentially very dangerous particularly for children who are already on a significant number of potentially toxic medications. I do not believe that it is standard practice to routinely use prophylactic IV amphotericin B in all patients in this patient cohort. When I was there, I know that on three occasions they used prophylactic IV amphotericin B for all of the patients on the paediatric haemato-oncology ward. It

would be important to find out whether this happened more than once because there were concerns about patients being infected. It was clear from the evidence of these patients and their relatives given to the Inquiry at an earlier stage that other antimicrobial drugs were also given after I left which caused some patients to suffer from very unpleasant and sometimes permanent toxic side effects. I found this very distressing to hear.

121. Ian Powrie stated at the meeting that there had been no request for HEPA filters to be installed in ward 2A, and that is why there were no filters. I find that extremely surprising given the type of patients cared for on that ward. This should have been checked before the final signing off of the specification of the rooms by IPC. I am not sure that the necessary standards were complied with.

122. I raised the concerns we had in relation to the increase in line infections within ward 2A. Sandra McNamee assured us that there was an ongoing investigation into this by IPC. Jen Rodgers was carrying out an improvement group looking at PVC and CVC bundles and Sandra's view was that this should have an impact on the number of infections. I was concerned that this approach may not accurately pick up all infections. It is very difficult to monitor line infections and it is very resource intensive, requiring the involvement of a number of staff groups. I thought it would have been better to look at unusual organisms that microbiologists were raising concerns about over a fixed period, for example, to look at how many incidences of Stenotrophomonas etc there had been over, say, a two year period and comparing the numbers with those in Yorkhill Hospital. I had concerns about whether the monitoring they were carrying out in relation to line infections was the right monitoring, and whether it would actually detect the underlying causes of infection. Obviously, putting an improvement package in place should reduce line infections, but most incidents are multifactorial and other possible risks have to be understood and addressed. If the organism is still in the environment, then the risk of infection will persist even though the risk might be reduced.

123. I think this concern was borne out when it came to light later that the deaths in 2017 were linked to the water and the central lines. [redacted] was asking Estates and IPCT to do enhanced testing of the water in 2017. It wasn't until 2018 that GGC acknowledged that there was a possibility that infections related to the water despite [redacted] having raised this concern the year before.

124. The next point that was discussed was the safe placement of immunocompromised patients. We needed to know as microbiologists which rooms in the hospital were safe for these patients. Clinicians also needed to have this information so that they could decide where a patient should be placed. I don't think the IPCT and Estates knew the standards of the rooms and that is why they couldn't make up this list, which should have been easy to do. One example was that we ended up in a situation where the Beatson was moved over to the QEUH but had to be moved back as the rooms in the adult BMT unit were not suitable for these patients. This had not been provided for in the original plans and should have been checked before they moved the patients over.

125. I then raised the point that there were infections and outbreaks that did not appear to be being taken seriously or being monitored appropriately. I think with hindsight we can see that was correct. They seemed to be very focused on specific reporting and results relating to Alert Organisms and other listed organisms and were not interested in the bigger picture and the more unusual organisms/ incidents. Infection control and outbreaks do not necessarily follow textbook definitions and infection control professionals need to have an open mind to unusual occurrences. Experience also helps alert people to risks.

Ventilation

126. The standards said that there should be six air changes per hour in a standard room, so that should have been what was installed. The QEUH and RHCG only had

three air changes instead of six. I was told by David Loudon that the air changes in particular rooms could not be changed. I didn't know if that was correct, but I did wonder why the correct ventilation system with the correct air changes was not installed in the first place. I am not sure that there is any legitimate basis for this departure from the guidelines. It would be my assumption that the purpose of the guidelines is for them to be followed.

127. I know that there were also concerns around chilled beam technology, but that is something that Dr Peters would have to be asked about, it is not my area of expertise. Dr Peters did suggest at the meeting that the issues we were having should be shared with Monklands Hospital who were at the commissioning stage of a new build hospital. I have no idea whether this was done as we got no feedback.

128. The cleaning of the chilled beams was also discussed and it seems that the fact that they needed to be cleaned had only just occurred to them. I don't know why a cleaning schedule was not already in place before the hospital opened.

129. I suggested that Microbiologists be included in the monitoring of the cleaning by looking at microbial counts. I thought we should check the counts in the air before and after cleaning had taken place to make sure that whatever measures were being put in place were effective. In single rooms there is an argument that you do not need to clean as often because, for example, the toilet is only being used by a single patient.

130. Professor Jones said at this point that rates of infection may also be a useful indicator. Sandra McNamee said that during a point prevalence survey QEUH was found to have levels of infection under the national average and that all Alert Organisms were monitored by the IPCT and that there were no indications that this site had a higher than average infection rate. This would not pick up unusual organisms. The prevalence of unusual organisms was one of our key concerns. A point prevalence study relates to a single point in time carried out every four years, and so would not pick up the line infections or outbreaks that we were concerned about. This

is where a proactive IPCT should be investigating to see whether or not there was a problem.

131. I thought that we should have looked at all of the cases of bacteraemias/line infections with unusual organisms from first to last. I understand that the first case of an "environmental" organism was in 2016. We should have looked at the infections from the time of that first case and over the following year. Instead HIS did an audit which just looked at January to September 2018. That could then perhaps be compared to a 12 month period in Yorkhill. That might reveal peaks and troughs and whether there were any trends, and whether any of these infections had also been present in Yorkhill. We could then have determined whether we had more infections and whether we had a problem. I was told that none of this needed to be done because the point prevalence survey showed there was no problem. There was a problem. We were told there was no problem every time we raised concerns about the risk of infection.

132. I do not believe that ignoring all of the infections in 2016 and 2017 could possibly facilitate an accurate analysis of the problem. This was also the period in which concerns were being raised regularly, enhanced water testing had been requested, and the Stage 1 Whistleblow raised. The analysis should have included all 2016 and 2017 data and have been compared to an equivalent period from Yorkhill.

133. I believe a lot of the patients who had infections in 2017 were part of the Case Note Review and, in my view, normal practice would be to analyse the numbers from the first case to the start of the investigation, so from 2016 to September 2018, rather than limiting the review to 2018. The HPS report also failed to compare the number of cases for the same organisms over a 6 to 12 month period for the same cohort of patients prior to the RHCG opening. This would have identified whether the infections were in line with previous experience or possibly linked to the new hospital. I felt this was another example of failing to grasp what was going on at QEUH and RHCG. This approach will have painted an inaccurate picture to the Health and Sports Committee. The Stage 1 Whistleblow included the events of 2017, yet they were also excluded

from the HPS report. There was clearly a lot going on in 2017 and this data would not have been difficult to collect and analyse.

Cleaning

134. Sandra McNamee stated that antichlor was used throughout the winter Norovirus season which is between November and April. She also said it had been introduced for general cleaning into the wards with CF patients in the QEUH and PICU, NICU and ward 2A in the RHCG. I wondered why it was not already in place for these high-risk patients. I don't know if this would have been done if we hadn't raised the Whistleblow.

135. We also discussed the dishwashers and the response was that the problems had been dealt with, but my point was that there was clearly an issue with the audit system as no one was monitoring or maintaining these dishwashers. Even the basic manufacturer's instructions were not being followed. As I mentioned above, the instructions said they should be cleaned three times a day, but they had not been cleaned at all since the hospital opened. When this was discussed, Professor Jones said it was not an outbreak. He suggested that the patients had picked Exophiala up in the community. I said that two or more cases was the definition of an outbreak. I pointed out that there had been no cases prior to the move and at least 15 since the QEUH opened, so community acquisition was unlikely.

Water quality and testing

136. At the meeting the response to our concerns over water testing was that there was a GGC water safety policy in place which had been approved by all of the appropriate governance committees, there was strict guidance on how to monitor water systems and what processes were in place and the water testing carried out was as per protocol. In addition, there was exception reporting if issues arose and an ICD requested that enhanced sampling be undertaken.

137. The reality was that Microbiologists were not getting results when they asked for enhanced sampling. They often did not even get the results of routine testing. Around August 2017, [redacted] was repeatedly requesting enhanced water sampling and did not get it. Ian Powrie mentioned that the delay might have been because of changes in staff in IPC and Estates, but I don't think that's the reason. We needed testing done and it wasn't done. A change in staff should not have affected that. I don't know what happened, or whether it was overridden by someone more senior in Estates or in IPCT. Another excuse they gave, and this was what went out in press releases, was that the link with the water was not made until 2018 and that testing could not be done. Both of those statements are incorrect. A possible link had been made by [redacted] in 2017. Routine testing looks for the numbers of organisms present. Enhanced testing identifies the particular organisms which are present. GGC said they could not do enhanced testing because they did not have an SOP in place for it. This just wasn't correct. They could have done it at the Royal Infirmary or sent it to an external laboratory to do it. GGC later acknowledged that they could have done this testing as part of their response to my Stage 3 Whistleblow.

Plumbing in neurosurgical block

138. As I mentioned above, there had been sewage leaks in the neurosurgical block and ICDs had heard through the grapevine that not all of them had been reported to IPC. Gary Jenkins responded that the issues in the building were complex and would take years to resolve. In the meantime, there were due to be new theatres opening in January 2018. He also said that nursing resource had been made available to carry out surgical site infection (SSI) surveillance in this unit. Dr Peters had raised concerns in 2015/2016 about these issues and suggested using QEUH theatres prior to the hospital opening whilst work was undertaken on the neurosurgical theatres. She had been told that some remedial work had been done. I don't know if this work actually happened.

139. My response to the surgical site infection surveillance would be why did that need to be done when it was fairly obvious that a sewage leak in theatres or the wards would be a risk to patients. I would have thought it would have been better for them to concentrate their efforts on solving those problems. I might put that surveillance in place once I had made efforts to fix the problem, but not whilst the issues were ongoing. This is a waste of valuable resource.

140. In addition, the new theatres he mentioned did not open until 2020 as there were issues with the ventilation systems there. This would suggest that lessons were not learned as a result of our SBAR and the subsequent meeting in 2017.

Infection Control Structure

141. Dr Armstrong's response to our concerns about the IPCT culture was to arrange to have a separate further meeting. I do recall that we eventually had a meeting in February 2018. This included the microbiologists, some of whom were ICDs, and Rachel Green and Isobel Neil. No action had been taken following this meeting when I retired.

Reflections on the 4 October 2017 meeting

142. It was a difficult meeting with a lot of disagreement about the issues we were raising. Some of us felt quite intimidated by the attitude of some of the attendees. I felt that issues were being diluted by dividing problems between individuals and there was no overall plan to pull everything back together again afterwards and engage with us again.

143. As set out below, an Action Plan was subsequently drawn up, so there was clearly an acceptance that a lot of what we were saying was correct and couldn't be ignored. I doubt whether they would have acted if we had not proceeded with a

Whistleblow. It is really disappointing that we had to resort to a formal Whistleblowing process to get the Action Plan prepared.

144. There was a reluctance to accept what we were saying, and we were treated as a nuisance rather than being respected for our professional experience and opinion. There was no acknowledgment or thanks that we had raised these matters which needed to be resolved. The reality is that the Action Plan was put in place and they had to take action on virtually everything we said. We were not suggesting that the solutions were not difficult, or would be resolved quickly, but they did need to be acted upon. We asked them to inform the other Health Boards of these issues so that the same problems would not be replicated elsewhere. I am not sure if this was done.

November 2017 – Consideration of Stage 2 Whistleblowing

145. In October/November 2017 the Action Plan was not yet available. I started warning Jane Grant, Dr Armstrong and Dr Stewart that we were considering a move to Stage 2 of the Whistleblowing policy. I was being told by colleagues at the regular Consultant meetings that there were still serious concerns about patients. The Microbiologists also still had concerns about the use of prophylactic IV amphoterecin B being used on a number of occasions for all of the patients on the paediatric haemato/oncology wards. My colleagues were still talking about going to the press and my concern was that nothing was changing. I had no evidence at that point that there would be any meaningful change and new issues and concerns were arising.

146. No one from Senior Management ever meaningfully engaged with us after the meeting in October 2017. Our emails were either ignored altogether or we were criticised for sending them. Where we did get a response, it was unsatisfactory. I received an email from Rachel Green, the Medical Director of Diagnostics, telling me that my emails asking for updates could be perceived as “harassment”.

147. We might have been reassured if someone had actually sat down with me and Dr Peters and [redacted] and talked about what we could do in the short term to make things better. We did not expect all of the problems to be fixed at once and some of the issues would inevitably take a long time to resolve, but there did not seem to be any effort to reassure us that immediate issues were being dealt with. In 2018, ward 2A had to be closed as there were still ongoing problems. That was a year after we had been saying that problems needed to be urgently addressed. There was no feeling that lessons had been learned and problems solved even when the Action Plan was produced.

148. In around November 2017, I told the GGC HR Director that consideration was being given to moving to Stage 2 of the Whistleblowing policy. I don't believe we had the Action Plan at this stage. I emailed Anne Macpherson, HR director. She was responsible for the whistle blowing policy and I contacted her to ask for clarification about who to contact about Stage 2, as the policy was out of date. She advised me that she could have no involvement with the process and provided me with the names of two other people that we could go to. I also contacted Jane Grant and told her I would be happy to meet with her to discuss matters, but she said that Dr Armstrong would keep her informed and up to date. Jane Grant later said the senior IPCT would arrange a meeting with us, however this never happened.

149. Around about this time I was covering a weekend on-call, which was not part of my duties, but there was no one else available to do it. At around 4pm on a Friday I got a phone call advising me that there had been a total cessation of orthopaedic services across the GGC area. The next day I received a call from one of the senior managers (I cannot recall who) asking me what had happened. I said I had not been involved in the decision making process so I did not know but that I would investigate and get back to him. He told me that services had been suspended and staff were refusing to allow patients to leave the hospital. This didn't make any sense as the patients would not have been a risk to anyone else once at home. I could have understood if they were being discharged to other hospitals, another ward or to nursing homes for example, but to refuse to allow a patient to return to their own

home didn't make any sense. Some doctors were refusing to go onto the affected wards, and elective orthopaedic surgery had been cancelled for the following week, because of concerns about infection risk as a result of what was thought to be a resistant Pseudomonas outbreak. On Saturday morning Professor Jones phoned my registrar who was meant to be assisting me with covering the on call to tell me that he needed them to stand down from clinical duties to collate information about all of the affected patients because there was a meeting taking place that afternoon for senior managers to be updated. There was a concern that the West of Scotland trauma service would have to be closed because of the cessation of orthopaedic services. I believe that Jane Grant came into the hospital on the Saturday for the meeting. I reviewed all of the data and I could see quickly that all of the cases in the "outbreak" were different types of Pseudomonas and so accordingly there was no real outbreak. I called Professor Jones who agreed and the services were re-opened. I asked for an investigation to establish who had made the decision to suspend all of the services because of the perceived outbreak. I don't know what happened about that. I suspected that the ICNs had seen six Pseudomonas cases without realising they were not the same strain of Pseudomonas and so they had triggered the closing of the wards. This is an example of a situation in which the ICNs should have discussed matters with the Lead ICD, who should have checked all of the results to ensure that all of the cases were the same resistant Pseudomonas. The role of the Microbiologist is to ensure that the interpretation of the results is correct. Something clearly went wrong in the decision-making process. In my opinion, this is an example of dysfunction within IPCT at this time, where the relevant checks had not been made. This was a costly incident for patients, staff and GGC as a whole.

2018

Action Plan

150. As mentioned above, after the meeting in October 2017, a 27 point Action Plan was drafted. This Action Plan was supposed to address all of the issues that were

brought up in our SBAR. My recollection is that I received a copy of the Action Plan by email, around the start of 2018. I sat down with Dr Peters and we went through it and noted some inaccuracies with the Action Plan and also the Minutes of the Meeting. We never got to a stage where we had an Action Plan we were able to agree on, although I do accept that sometimes there can't always be full agreement. We were not involved in the development or drafting of the Action Plan and it was presented to us as final. We did spend a lot of time commenting on it, but I don't know whether our comments were accepted or incorporated as I then retired in March 2018. Dr Peters would have a better idea about this.

151. Prior to receipt of the Action Plan, Dr Peters and I were seeking reassurance about what was happening as a result of our SBAR and the meeting that had taken place in October 2017.

152. Once we had the Action Plan and had gone through it, Dr Peters and I were then asking for updates on what was happening with taking the Action Plan forward. There was a particular issue relating to the isolation rooms and the lack of a patient placement policy. We were still being asked about where to place patients on an almost daily basis. We would get some information, perhaps about ventilation, or something that was happening with some of the rooms, but I was never reassured that Senior Management were on top of it all. It was almost as if we were given some information just to try and placate us but nothing substantive was happening.

153. I do not know who had ownership of the Action Plan, although I assume that it was Jennifer Armstrong, or possibly the GGC clinical governance committee. A version of the Action Plan was discussed at an AICC meeting and I have seen the Minutes and the attached Action Plan. Dr Peters and I prepared a detailed document highlighting its shortcomings which I have produced. I have not rehearsed those concerns here for the sake of brevity but I can provide further information if it would assist the Inquiry. Dr Peters would be able to explain the concerns more clearly than me as she has access to the paperwork.

154. I thought the Action Plan would make a difference, but I doubted that it would address all of the problems. I can't speak to what has happened subsequently as I am no longer there.

155. I had had experience in the past of being reassured that there were no problems when in fact there were, so I was wary about simply accepting assurances that the Action Plan would solve everything. I could cite numerous examples of this, but if I had to select one, then I would note that in around 2005/2006 I had been involved in investigating a series of sight-threatening eye infections which had also been seen in a clinic in the community. I was repeatedly told by Estates that there was no issue at all with the ventilation in our eye theatres at the Southern General. I was told you could eat your dinner of the ducting. I said we needed to have that independently verified because of the repeated infections and, ultimately, I had to offer to pay for an external report myself before GGC would agree to investigate. I insisted, in the face of much opposition that the theatres be shut to allow for inspection of the ventilation system and for remedial work, if required, to take place. Finally, an independent expert was engaged and the report they wrote about the theatres was damming and my concerns about the ventilation proved to be correct. The then Clinical Director for surgery and theatres told me that I could rightly say " I told you so".

February 2018 – Stage Two Whistleblowing

156. Dr Peters and I had hoped that our repeated threats to escalate to a Stage 2 Whistleblow would stimulate a bit more action, but they didn't. In February 2018, Dr Peters and I felt that we had no alternative but to go to Stage 2 of the Whistleblowing process. We felt that there were still significant safety concerns affecting patients in the hospital on a day to day basis, and believed that we had a duty to act on those concerns given that we had repeatedly raised them with senior management and did not feel they were being adequately dealt with. This next stage required us to bring

our concerns to an Executive Director of the Board who was trained in the Whistleblowing policy, and we identified Dr Linda de Caestecker, Director of Public Health, for this purpose. By this point, [redacted] had found the whole process so stressful that [redacted] had decided to take a step back.

157. We were not bringing up new issues at Stage 2. The problem was that we were still concerned that enough action had not been taken as a result of Stage 1. I accept that there was an Action Plan and I accept that our concerns were not totally ignored, but not enough was changing at the coalface and I was continually being told by colleagues that there were patients at risk and nothing seemed to be happening. We realised that some issues would require long term planning to fix, but this planning did not seem to be underway.

158. Dr Peters and I were, for the most part, lone voices and we continued to be seen as troublemakers. The culture of bullying meant that people were too afraid to speak out. Many colleagues were not prepared to openly support us, yet they continued to ask us to pass on concerns on their behalf.

159. Once we had decided to go to Stage 2, I contacted Professor Brenda Gibson looking to gain support. I asked her to contact Dr de Caestecker to tell her that she had concerns about what was happening to her patients because I knew that she was concerned. She was a Paediatric Consultant who worked on ward 2A. She emailed me to tell me that she would be unable to do that and that I would have to meet with the whole paediatric team, and get an agreement from them. This was not possible in the time scale before our Stage 2 meeting with Dr de Caestecker. Professor Gibson had asked me to make Dr de Caestecker aware that she had concerns, however I was not prepared to do this as Dr Peters and I had previous experience of passing on someone else's concerns which they then denied they had raised when confronted. Dr Peters and I had been very careful to ensure anything we said could be supported with evidence, so we were unwilling to name colleagues who had raised concerns with us if they were not prepared to go on the record themselves.

160. My understanding is that Professor Gibson later suggested that I asked her for a specific comment about ventilation which she felt unable to provide. This was not what I asked for. She could not be expected to comment or speculate on what the cause of the problems were; that would not have been within her skillset, and we were not ourselves clear as to the cause of the problems. All I wanted was for her to confirm to Dr de Caestecker that she was concerned about her patients, to make it clear that it was not just Dr Peters and me. This whole exchange took place via email. I don't have access to these emails anymore.

161. I emailed the Stage 2 Whistleblow to Dr de Caestecker in February 2018. I don't have a copy of this email but Dr Peters might. I sent a copy of the original SBAR from October 2017 and said that we still had concerns in relation to what was raised in the SBAR and that we would like to move onto Stage 2 of the Whistleblowing process.

162. In response to my email, Dr de Caestecker contacted me and arranged a meeting sometime in March 2018. I cannot recall the specific date but it coincided with the day that I was due to retire. It was attended by both me and Dr Peters and Dr de Caestecker took notes during the meeting. She listened very carefully to our concerns, and we went through the SBAR. She promised she would report back to us and supervise the actions taken. We also asked for our concerns over water and ventilation to be placed on the Risk Register to ensure the non-executive members of the GGC Board were themselves informed over potential risks to patients. It wasn't clear to us that they were aware of the problems we were raising. I continued to be concerned about this. In late 2021 and early 2022 I corresponded with Professor John Brown, Susan Brimelow, and Ian Ritchie about these issues. I received platitudinous letters from them simply stating that they did not share my concerns about the effectiveness of the governance arrangments at GGC, and that they were confident that the hospital provided a safe environment. In my view they were wrong to be satisfied about either the adequacy of the governance arrangements, or the safety of the hospital.

163. Dr de Caestecker did seem to accept in her letter to me and Dr Peters dated 4 May 2018 that the issues we had raised in relation to ventilation in the QEUH and the RHCG should be added to a Risk Register. I don't know if this ever happened.

164. I left the meeting with Dr de Caestecker in March 2018 feeling that she understood our concerns and that we had been listened to and I was hopeful that we might see some improvements. Dr de Caestecker said she would report back to us. I felt that Dr de Caestecker's response was satisfactory. She listened to our concerns, took them seriously and promised to update us. She then provided us with updates in the letters that I have produced. We were treated professionally and with respect.

165. In March 2018 I retired. Thereafter, I received two updates from Dr de Caestecker, one in May 2018 and one in September 2018. The latter followed requests for updates from me in May and July 2018.

166. Dr de Caestecker indicated in her letter of 4 May 2018 that there were plans to recruit an expert in the field of ventilation specifically to look at the issues within the QEUH and RHCG. Her letter of 21 September 2018 confirmed that an appointment had been made. I do not know who that person was. If they were from within GGC or even Scotland, then in my view they will not have been a truly independent expert.

April/May 2018 – Meeting with Anas Sarwar

167. By this point, I had retired but I was regularly seeing stories in the press that led me to believe that the issues that we had raised in the SBAR had still not been resolved. The advice from the GMC and BMA was that if you still had concerns and you had done everything you could within the organisation, then you could raise matters outside the organisation. I phoned the office of the MSP Anas Sarwar who was at that time the Scottish Labour Party spokesman for health. He had featured in some of the press articles that I had read, so I knew that he had an interest in events

at the hospital and some awareness of what had been happening. I asked if he would be interested in meeting with me to discuss matters and he said he would. I told him that I was a doctor, but I didn't give him my name or any specific information.

168. I met with him at his office, and I told him that a Whistleblow had been raised for QEUH and RHCG and that there were concerns over ventilation. I did not give him any other details. At the time of the meeting, I still had not given him my name. On receipt of this general information from me about a Whistleblow having been raised, he submitted a Freedom of Information request to recover specific information. Dr Peters had no involvement in this.

Late 2018 – Press Interest

169. Late in 2018 I was approached on a couple of occasions by the reporter Hannah Rodger from the Sunday Herald. I did not agree to speak to her until 2019. I continued to see reports in the press that I believed were confirming ongoing problems due to the issues we had reported. When I spoke to her, I was very careful to ensure that I did not discuss anything that was not in the public domain.

170. I recall seeing an article in the Sunday Herald stating that an ICM (who I now know to have been Tom Walsh) had been appointed as the GGC project manager to oversee the review and internal investigations. I think this was in response to the Independent Review. This ICM would presumably brief the press and control information given out by GGC. This meant that the GGC IPCT were investigating their own service, without any outside challenge, which looked rather like marking your own homework. I could not believe that any person or organisation involved in the decision-making process for the building specifications, commissioning or addressing the problems since the opening of the hospital could objectively oversee the review and investigation.

171. In addition to Dr de Caestecker's letters, I have also seen a Whistleblowing Report by Dr de Caestecker dated May 2018 which was shown to me by the Hospitals Inquiry team. It was not sent to me at the time of the Stage 2 Whistleblow which I believe is contrary to the Whistleblowing policy. This report contains more information than had been included in the letters of 4 May and 21 September 2018. I was never given the opportunity to review it for accuracy. I don't believe Dr Peters was either.

172. There are five points which are noted as the main points of the complaint in part 1 of the document. The five points do not cover everything that we discussed with Dr de Caestecker; we spoke to her about all of the issues in the original SBAR. The report contains factual inaccuracies. By way of an example, I can see one on the first page: "*During this time there were changes in the lead ICD as Dr Craig Williams left, TI resigned and CP took over and tried to change the whole IC structure and she resigned".* This is wrong. Dr Peters was never the Lead ICD, she never even applied for the post. She therefore could not possibly have resigned from the role.

173. I would also comment on the last sentence under heading number 4 where it notes that "*The RHC changes are now complete and the QEUH adaptations and new rooms are on schedule to be in place by end of October 2018".* I don't think this happened, because in September 2018 the patients were moved out of ward 2A to the adult hospital.

174. On the next page there is a note that "*The risk in aerosol generating procedures is reduced by advising to keep FFP masks on whilst in the room and for a period of time after end of procedure…*". I don't know if that is accurate from a microbiology perspective.

175. On that same page, there is mention of the expert in ventilation who has been recruited specifically to look at ventilation in the QEUH and RHGC. I suppose this is the expert who was referred to in the letters from Dr de Caestecker. I don't know who this was or what their conclusions were.

176. The Report also mentions on the same page that HIS were involved with investigating the sewage ingress in the neurosurgical building and were satisfied with the measures taken and the progress being made. It refers to November 2017. I am not clear why it took so long when I believe Dr Peters first raised this issue in 2015. I wonder whether HIS had been contacted because of our Step 1 Whistleblow. They should have been asked before when Dr Peters first raised the concerns.

177. The next paragraph on that page addresses the concerns we had about infection levels. Once again it states that there were no increased levels of infection and cites the national prevalence study. As I have already explained, given that they were not measuring everything, they could not safely conclude that there was no increase.

178. I take issue with the next part of the Report. At the bottom of that same page there is a section on our concerns that we were not being kept updated and the response is as follows:

"I heard an unfortunate but consistent circumstance about the situation summarised below:

- *Dr Peters is very knowledgeable about infection control including ventilation. She finds it difficult to accept balance of risk (e.g. if theatres or wards need to close, patients may be put at greater risk)*
- *She is no longer an infection control doctor having resigned from this role*
- *She does not accept being part of team and listening to views of others*
- *She does not accept that infection control is a nurse led service*

• She sends frequent requests for updates which are not directly relevant to her role

• She has caused great anxiety to colleagues by her styles of communication particularly the persistent stream of emails to the IC team and to TI…"

179. In relation to the first point, I think this relates to Dr Peters suggesting that wards should be shut due to an infection risk and the hospital saying there was a risk to patients in closing the ward. That is a problem that you come across as an ICD. The defence unions advise us that a microbiologist has to give their advice based on their knowledge and what they perceive to be the risk and the clinician can overrule that if they feel the balance of risk favours keeping a ward open. An ICD finds themselves in that position quite often and it is a risk assessment as to what should happen. There is often disagreement and the clinicians and management put the IPCT under pressure so that they cannot be criticised for overruling the advice of IPCT.

180. I do not agree with the third point that she cannot accept being part of a team or listen to the views of others. I think we all sometimes find it difficult to listen to the views of others when we don't agree with them, but GGC were not able to manage competing views in a way that was conducive to constructive discussion. That's where I felt there were big problems and there should have been an external expert to mediate. We really reached a stage where we were saying one thing and others were saying a completely different thing, for example that there was no issue with infection rates, and we reached an impasse. I think it is unfair to target Dr Peters. She was not the only one raising these concerns, there were lots of other people who agreed with her, they just were not all prepared to speak up. Her concerns were raised by others and regularly raised at consultant meetings. I don't think that it is fair to say that she wouldn't listen to other people's views. Both of us stated numerous times that we would have been prepared to accept we were wrong if there was evidence contrary to what we were saying. I have not seen any evidence to suggest that we were not right about most, if not all, of the concerns that we were raising.

181. In relation to the fourth point, I don't think IPC should be nurse led, but I recognise that this Inquiry is not the forum in which the correctness or otherwise of that approach is going to be resolved. This factor is, however, relevant because it contributed to the breakdown of "team" working in IPC within GGC due to the desire of ICNs to work autonomously.

182. In relation to the fifth point, I would have thought that, in order for her to carry out her role as a Microbiologist, Dr Peters would need updates on what was happening with all of the concerns that she was raising and I do not think it was unreasonable for her to seek reassurance. All of the Microbiologists should be given reassurances and be briefed on what the main infection control issues are. This enables them to keep IPCT updated and receive a response or reassurance about the concerns they were raising. They also need to keep IPCT informed of new issued and updated on ongoing issues.

183. I don't know how many emails she was sending so I cannot comment on whether it was an unreasonable amount or not. I would assume that part of the volume of email correspondence was generated by her not receiving a reply at all, or a satisfactory answer to queries and, therefore, feeling compelled to escalate or repeat the query that had gone unanswered.

184. Overall, I would say that the comments about Dr Peters are unfairly derogatory. There are lots of people who would defend her ability and her willingness to put herself out for other people. Many of her colleagues do not have a problem with her, and in fact have a huge amount of respect for her and will say that she is very approachable, very good to work with and that she did work well as part of a team. There are clinicians and laboratory staff who would support this view. I think that it is utterly wrong that she has not had the chance to challenge what is said about her in the report and I fundamentally disagree with the conclusions reached.

185. The report concludes that the concerns raised in the Whistleblow are legitimate, but are being dealt with by the Action Plan. It also concludes that, as Dr Peters was not an ICD, she did not need to know everything that was happening on a day-to-day basis and should not repeatedly email asking for updates. I would argue that all Microbiologists need to know about issues that impact on our ability to do our job, both during the day and out of hours. If we are not aware of the status of ongoing issues or concerns, then we cannot ensure that the IPCT are kept fully informed.

186. The other recommendation that I would comment on is that there was to be a follow up in six months and the issues raised in the Whistleblow were to be added to the Risk Register. I don't know if either of those things were done. I also felt that it was important for the individuals on the GGC Board to be briefed about the concerns that we were raising. The SMT and Clinical Governance Committees take decisions on what information is discussed at meetings of the full board. I wonder if all of the members of the board, particularly the non-executive members, had been briefed about the concerns of the whistleblowers things would have been managed differently and going outside the organisation could have been avoided.

2019

February 2019 – Establishment of Independent Review

187. I prepared a detailed document for the Independent Review outlining the questions I felt needed to be asked and answered. It was supported by the Standards that applied at the planning stages of the project. I attended an interview with the Independent Review team which was a challenging experience for me, even though I had the support of a friend with experience of the NHS and a legal background.

188. I believe that the Independent Reviewers had already listened to a very negative picture of the Whistleblowers from GGC and started the Independent Review with a biased opinion of us. The two reviewers' opening remarks to me were criticism

for causing stress and upset by doing what I had done. There were factual inaccuracies in the final report that were not corrected.

February 2019 - HPS report

189. The HPS report in February 2019 prompted me to write to the Health and Sports Committee, who were requesting statements about QEUH and RHCG. There were two other anonymised submissions to the Committee, clearly from professional Microbiologists raising even more detailed concerns than the ones I raised when drafting the SBAR. I wanted to make it clear that I thought that HPS should have looked further back than 2018 when carrying out their data analysis on organisms. I also wanted to make it clear to the Health and Sports Committee what I thought the Independent Review should be looking at. I mentioned the Whistleblow and the SBAR and I mentioned the concerns I had about the ICM being made a GGC project manager in relation to the Independent Review. I raised the point that I did not want the Review to be a whitewash.

Meetings with Jeane Freeman

190. Dr Peters and I met with Jeane Freeman twice during 2019. The first meeting took place in the Spring. I attended along with Dr Peters and Anas Sarwar. We gave Ms Freeman an outline of our concerns and the events before and after our whistle blow in September 2017. We met her again in December 2019 at the Scottish Government after Dr Peters and I met with Professor Fiona McQueen. When the meeting with Fiona McQueen finished, we all went and had a further meeting with Ms Freeman. She listened attentively to our concerns. She thanked us for having the courage to speak up. I believe that she was concerned about what we were reporting. I think this played a part in her asking for an Independent Review, Public Inquiry and putting GGC under Special Measures.

191. Throughout 2018 and 2019 I continued to see reports in the media about the issues within QEUH and RHCG. In November 2019 I saw a press release from GGC that stated that because no tests were done at the time, it was not possible to conclude that infections were connected to the water supply, and criticising the "extremely disappointing" actions of a whistle-blower who had suggested that that there was a link with the water. I was not the whistle blower on this occasion. I knew that [redacted] had asked IPCT and Estates for enhanced water sampling to be done because [redacted] believed that a link to the water needed to be excluded as far back as the summer of 2017. I do not believe that [redacted] would have talked to the press either. There was a feeling that clinical staff were responsible for going to the press, but it was always assumed that it was one of the original whistle blowers. I thought the press release was in danger of being misleading because it clearly created the impression that there had been no suggestion at the time of a need to test the water. A second press release later the same month mentioned possible links between the water supply and infections in 2018, but again failed to mention that in fact the connection was potentially made in 2017.

192. I also raised concerns about: (i) GGC doing their own investigations and reporting to the Independent Review, (ii) the HPS report previously mentioned, and (iii) the fact that their most experienced ICDs were no longer working as ICDs and this was a risk to patients.

193. As a result of this misinformation by GGC and the continuing issues at QEUH and RHCG, I decided to continue with the Whistleblow and to move to Stage 3. I discovered that there was a slightly different process in place for Whistleblowing by that stage so I submitted an email to Jennifer Haynes, who was GGC's Complaints Manager, on 21 November 2019. In that email I highlighted that there had been an inaccurate press statement released by GGC which had omitted that Stage 1 of the previous Whistleblow had included the fact that an ICD had requested enhanced

water testing in 2017 because of a concern that the water may have been linked to infections. Stage 3 related to the original SBAR which mentioned an inaccuracy in a press statement. The original SBAR raised concerns about inaccuracies in a press statement about ventilation in the paediatric BMT Unit. This wasn't necessarily a situation where it was a risk to patient safety and care but I thought it would cause distress to families if they later found out the information was inaccurate.

Meeting with William Edwards and Ian Ritchie on 4 December 2019

194. I met with William Edwards, a Board Executive and Ian Ritchie, a Non-Executive Director who had a clinical governance role (as a retired clinician) on 4 December 2019 to discuss Stage 3. It was a difficult meeting as neither of them had made themselves aware of Stage 1 or Stage 2 of the Whistleblow. As a result, we ended up discussing issues that I had not actually raised in the Stage 3 Whistleblow. I was then sent an email dated 23 January 2020 from Jennifer Haynes which summarises what we had discussed at this meeting. This email also attached the minutes of the meeting. We discussed the following points and actions arising from them:

i. Factual inaccuracies regarding water testing. In particular there had been a report in the media that water testing had not been required and I knew that to be inaccurate. The action arising was that Mr Edwards and Mr Ritchie were going to investigate if supporting evidence existed around the water testing being carried out in summer 2017 and beyond.

ii. The planning stages of the new QEUH/RHCG and the involvement of the IPC staff. My concern was that despite the initial involvement in the planning stages, the subsequent reduction in IPC input may have had a negative impact on the final building, particularly in relation to the ventilation. The action arising was that Mr Edwards and Mr Ritchie were going to investigate

if actions had been taken to address the ventilation as a result of the SBAR in 2017.

iii. Cryptococcus and the concerns about the plant room and that it may have been tested after any mess caused by the pigeons had been cleaned. The action arising was that Mr Edwards and Mr Ritchie were to gather further information about the plant room, any associated testing and the review carried out relating to the reported pigeon fouling problems.

iv. The data considered by HPS/HFS regarding the infection rates at the QEUH/RHCG and my concerns that they did not include the infections from 2016/2017 which made the review inaccurate.

v. Bullying and working culture, particularly in relation to the IPCT and Microbiology. ICDs had been resigning due to bullying, their expertise was not being listened to and they were being put under pressure to sign off on issues where they had not been provided with the appropriate evidence to allow them to do so. The action arising was that Mr Edwards and Mr Ritchie asked me to provide some further evidence and encourage other people to speak to them so that they could carry out a more detailed review.

vi. The last action was that I would get some further information about the SBAR of 2017 and the resulting 27-point Action Plan.

195. During the meeting I also pointed out that if the errors in the press releases became public in the future, it would cause more distress to families, and I believed it was important for GGC to rebuild confidence with the public. I did not inform the press of the inaccuracies.

196. Fundamentally, the culmination of this process was that they wanted me to sign off an approval that everything raised in the Action Plan had been dealt with. I

was not willing to do that because I no longer worked there and so I did not know the full details of what had been done. I said they would need to speak to [redacted] and Dr Peters. They did not want to do that and asked me to speak to Dr Peters and [redacted] to relay the information to them. I was not prepared to do that and I felt that they needed to speak to Dr Peters and/or [redacted] themselves. They said they would not do that because they thought it would be seen as bullying unless they came forward themselves. I did speak to Dr Peters, as a last resort, and she felt she had raised the issues on numerous occasions with GGC and that they should approach her.

2020

29 January 2020 Meeting re Stage 3 Whistleblowing

197. The Actions above were agreed and a further meeting was scheduled for 29 January 2020. In the meantime, I got the email dated 23 January from Jennifer Haynes which I have already mentioned, which attached the minutes of the meeting along with minutes of a Clinical and Care Governance Meeting dated 5 December 2017 which had the 27 point Action Plan attached and further minutes from the Clinical Care and Governance meetings in March and June 2019 which provided updates on the progress of each action in the Action Plan. The email mentions that Dr Inkster had asked for there to be changes made in the March minutes and these were agreed in June. Mr Ritchie also asked if colleagues were reassured by the actions that had been taken and Dr Inkster advised that "one colleague had since retired; other colleagues had not raised any further issues with her". I don't know if that was correct or not.

198. On 29 January 2020, I attended the scheduled meeting with Jennifer Haynes, Ian Ritchie, William Edwards, Dr Scott Davidson (a Medical Director) and Tom Steele, Director of Estates and Facilities. I attended along with Lorna MacGregor. During that meeting, I was provided with various updates in relation to the issues that had arisen as a result of the Whistleblow and our meeting on 4 December 2019. I was informed

that I would receive a copy of the Action Plan and a timeline in relation to the water testing. I wanted to know if the water supply had been treated prior to it being tested as I am aware that they had found Stenotrophomonas in it. We also discussed the ventilation, chilled beams and Cryptococcus.

199. I also raised concerns I had over a further press statement released by GGC concerning the water supply, which I felt was inaccurate. As outlined above, GGC stated that the appropriate water testing could not be undertaken as they had to wait for an SOP to be drawn up. When I challenged this at the meeting on 29 January 2020, it was agreed that it could have been done at the Royal Infirmary or commissioned by an outside Laboratory if it was specifically requested. This enhanced testing is what [redacted], in [redacted] capacity as ICD, had requested in 2017. This press statement came out after I had the first meeting on 4 December and I raised it at the meeting of 29 January 2020, but this does not feature in the minutes. Their position was that they had to rely on the information that they were being given; I suggested that on occasion they might need to question some of that information.

200. Following on from this meeting on 29 January 2020 I received a final report detailing the outcome of my Stage 3 Whistleblow. The report covered the following points:

i. Culture and bullying: From the actions agreed at the meeting on 4 December 2019, Mr Ian Ritchie began looking at the bullying culture within GGC and said he was keen to address this. He spoke with Professor Marion Bain who planned to get some external advice on the cultural issues within the IPC and Microbiology teams within GGC. It resulted in a review of the culture within Microbiology and IPCT by organisational development, with the support of an external professional. I had the opportunity to be interviewed and had the findings presented to me by Dr Angela Wallace. I was not allowed to see the report itself. Some of ICNs would not take part in the review, but they were happy to say things had improved once the follow up review was done. Some of the ICDs and

microbiologists initially participated but then became frustrated and were no longer involved by the point of the follow up review. The conclusion was that things had improved despite the fact that the ICDs, who raised concerns in the first interviews, did not participate in the follow up and the ICNs had not participated initially. I pointed out that they needed to understand why the staff with the most concerns had not contributed to the second part of the review. HR and OD had previously undertaken an investigation about the bullying culture in Microbiology, when dozens of staff including BMS and medical staff were interviewed anonymously. They were too intimidated to do this even as a group. This was when the HR manager told me that that the situation was like an abusive marriage. No-one was allowed to see a report following this investigation.

ii. Factual inaccuracies in media statements regarding water testing: The report found that there had been water testing carried out in September 2017, after the Step 1 Whistleblow, that looked for Stenotrophomonas. The report accepted that it was regrettable that the media line that was issued implied that GGC did not test the water for Stenotrophomonas. It was true that there was no requirement to test for Stenotrophomonas, but a request was made and actioned for testing and no Stenotrophomonas was found. When this was discussed at the meeting I challenged whether the testing was done before or after they had purged the system with chlorine dioxide and they told me it was before but I think more questions need to be asked about what treatment had been undertaken before the water was tested and whether the relevant water outlets were tested. It is essential to test all the outlets that might be relevant to the possible problems, otherwise you cannot say the water is clear. Also you have to test water before treating the system, or you cannot say it was negative before the test. Dr Peters will be able to provide further information about this.

iii. Issues with the new QEUH/RHCG: I raised my concerns about the air changes being 3 instead of 6 and the report found that the IPC team had considered this and pathways were put in place for very high risk pathogens such as MERS, these patients would then have to be moved to another hospital, possibly out with GGC's geographical area.

iv. The most recent iteration of the Action Plan, dated February 2019 was made available to me. I am not sure why it had not been updated since February 2019. I would have expected it to be updated every few months.

v. I had raised an issue about Microbiologists not having information to advise clinical staff about where to put immunocompromised patients. The report stated that guidance had been provided to Microbiologists and clinicians. As I am no longer a practising Microbiologist, I do not know the up to date position.

vi. I also raised concerns about the chilled beams and the potential risk of environmental infections. The report stated that chilled beams were acceptable, according to SHTM 03-01, but that Tom Steele had confirmed that chilled beams would not be used in the newly refurbished ward 2A. This seemed to me to be contradictory.

vii. Cryptococcus, which was discussed at the meeting, had never been isolated from the plant room. It should be noted that it is very difficult to isolate Cryptococcus from the environment. I asked if samples had been taken prior to the cleaning of the plant room and I was told that they had not. It seems obvious that you cannot assume that Cryptococcus had never been in the plant room if you have not sampled it prior to cleaning. It was positive news that Cryptococcus had not been found after cleaning, but that does not eliminate the plant room as a historic source. I can understand why sampling was not done prior to cleaning as cleaning would be a priority and there was urgency in addressing a high-risk situation.

However, you cannot claim that Cryptococcus was never there if you do not test for it before cleaning. With hindsight, I should have asked whether the plant room supplied air to the ward where the adult patient with Cryptococcus was cared for as that is significant in understanding what happened. This is a rare infection and to identify two cases in a very short period of time is unusual. It is possible that there were more cases, as it might not have been looked for in the laboratory or specimens may never have been sent from the wards.

viii. Data used by HFS/HPS in their review of infection rates. The report concluded that there was no evidence that GGC presented any false data and all relevant data was shared.

201. When I received the final report I was concerned that there were a lot of inaccuracies in what had been written. I wrote to the reviewers and highlighted inaccuracies, and they refused to change anything in the report. I wrote to the Chair of the Board, Professor John Brown, to alert him to my concerns. I have produced this letter and I have not repeated the concerns here for the sake of brevity. I can provide further information on this if it would assist the Inquiry. Mr Ritchie and Mr Edwards thanked me for my courage in bringing my concerns forward, especially as I had made it clear that these matters had impacted on me significantly and that my motivation was patient safety.

202. I asked for the report with my suggested amendments to be shared with Dr Peters, [redacted] and Dr Inkster so that they could also make any comments they wished about the accuracy of the report. I never saw their responses as I did not think it would have been appropriate, but I understand that they did submit detailed responses. Part of the reason I wanted to do this was because, as part of the Stage 3 process, Mr Edwards and Mr Ritchie wanted me to confirm that I was happy that everything in the Action Plan had been completed. I refused to do that as I had no

idea. I didn't work for GGC anymore and it might have been be a breach of confidentiality for ex-colleagues to discuss anything with me.

203. After repeated emails with Jennifer Haines, Professor Brown (Chairman) and Elaine Vanhegan (Head of Corporate Governance and Administration), I was told that the original Report would not be changed to correct the inaccuracies I had highlighted as they did not materially change the outcome or the recommendations. I don't disagree with that but I was surprised that GGC were prepared to have a document in place that was factually inaccurate.

204. Professor Brown did say that the amendments I had proposed would be part of the permanent record and would be made available to anybody reviewing the case. I received a letter to this effect. However, when I spoke to the Whistleblowing reviewer, as part of the Whistleblow audit that I was later involved in, I asked my interviewer if they had seen the report with all of the comments and he said he had not. I accept that the final report was not amended, but I had been given assurances that my comments would be made available to anyone reviewing it, including this Inquiry, and that was not done. The documents raising concerns about the final report were not even shown to the whistleblowing reviewers. This is just another example of GGC not providing the full picture to an official external reviewer.

February 2020

205. Around this time, I agreed to appear in the BBC Scotland Disclosure program about the hospital. We filmed the program shortly before lockdown but it wasn't shown immediately because of the intervening COVID-19 pandemic. I was attacked and accused of not having considered the anxieties of patients and families in deciding to publicise our concerns. This was something we considered very carefully and it was a significant source of concern to us. Ultimately, we felt that we had no choice but to publicise our concerns with the media. We were aware that there would be a public inquiry in the future but we did not expect that it would provide quick solutions to the

problems and, in fact, given that another four years has passed in the interim, that expectation proved to be correct.

April 2020

206. In his email to me dated 23 January 2020, Mr Ritchie indicated that the original SBAR had not been identified as a Stage 1 Whistleblow. The Independent Review was also going on around that time and when I had been speaking to them they did not seem to appreciate there had been a Stage 1. Ultimately, I came to the view that there had been an attempt by GGC to cover up the Stage 1. This led me to raise another stage 3 Whistleblow highlighting this concern.

207. One of the non-executive directors, Mr Ritchie, who had been present at the meetings with Jennifer Haynes and I, contacted me and tried to talk me out of raising this second Stage 3 Whistleblow. I told him that I believed there had been a cover-up of the Stage 1 I had raised and he asked me if I had any idea what the consequences would be for someone if that was the case. I had to argue vigorously to demonstrate that the concerns we raised in the October 2017 SBAR were a Stage 1 Whistleblow and explained the exact process we had followed. He continued to try and discourage me from raising this, asking me what I wanted or if there was anything they could do to stop me raising it. I told him there was nothing they could do and that I didn't want anything except to see the matter investigated.

208. This Stage 3 was investigated by Allan MacLeod, a Non-Executive Director. He told me the implications if proven would be very significant for any individual who had covered it up. We had a telephone meeting and he listened to my concerns. He then issued a final report which I saw a copy of. Whilst he did find that there was nothing in the Whistleblowing records noting that the SBAR in October 2017 was a Stage 1 Whistleblow, he did conclude that because the circumstances of the SBAR were discussed at a meeting, and because Dr Peters and I indicated our intention to escalate to a Stage 2, that inferred that our initial concerns had been a Stage 1 but that there

was no evidence that there was any deliberate attempt to cover up the fact that the initial raising of concerns was done under the Whistleblowing policy. I asked him to ensure that GGC were told that the Action Plan had arisen as a result of a Stage 1 Whistleblow. I thought that both GGC's executive and non executive board members should know. It was been pointed out that I had been involved in whistleblowing since 2015, even though this was not the formal process we started in September 2017. I do not know if this was ever done, but as stated before, I thought all of the members of the GGC board should know.

209. Along with Dr Peters and Dr Inkster, I was asked to contribute to the Oversight Board established by Jeane Freeman and when we read the report and the timeline we noted that there was nothing about the Stage 1 Whistleblow in that either. We asked for it be added in and it was, which I was grateful for. There were a lot of other factual corrections that I identified and these were corrected as well.

210. My view is that the failure to acknowledge the October 2017 SBAR as a Whistleblow reflects an unwillingness to embrace the importance of the whistle blowing policy and take our concerns seriously. The later audit of the whistle blowing process clearly demonstrated the lack of knowledge about the policy, even by the managers within GGC and acknowledged that the whistle blowing process had not been a positive experience for many of the whistleblowers, managers and others involved.

Conclusions

211. I absolutely acknowledge that none of the difficulties experienced by me and my colleagues can compare to what was experienced by some of the patients and their families. However, my involvement in the events described in this statement has been extremely difficult. I have tried to do what I believed was right, and in the best

interests of the patients and families to whom I owe a duty of care, and at times I have been made to pay a very heavy price for that.

212. During the whole process, there was no recognition or understanding of the stress experienced by the Whistleblowers. We were treated as troublemakers throughout. I thought of giving up on several occasions. I promised my family that I would give up after stress resulted in my admission to coronary care in April 2019. This is a promise I later broke because I found it more stressful to stand back and do nothing, given the harm I believed had been and was being caused. I took a Hippocratic oath which includes '*Taking prompt action if you think patient safety is being compromised'*. This is what I believe I was doing.

213. I did not expect to start my retirement being involved in an Independent Review, a Public Inquiry or a Police investigation. It has taken a huge toll on my health, and on my family and I have committed enormous amounts of my time to these processes during what is meant to be my retirement and when family commitments mean there are multiple other competing pressures on my time. I continued to cooperate with everything asked of me and continued to keep on top of the problems even during treatment for cancer in the summer of 2018.

214. I have had to have private counselling, and I have suffered from stress, insomnia, and anxiety. I have also had heart problems with an admission to coronary care as noted above, and also a visit to Accident and Emergency with a heart arrhythmia. I have been started on anti-coagulants, which has seriously impacted on my life and my ability to ski and scuba-dive. On both occasions, stress was felt to be the cause. I feel this stress was caused by all of the pressures relating to my whistleblowing, and the need to at least try and drive changes to improve patient safety. My family asked me to stop and I agreed to, but then I realised that stopping and worrying about what the patients had suffered and might suffer in the future was more stressful than stepping away from this process. It is my belief that there would never have been an Independent Review or in fact this Inquiry if Whistleblowers had not continued to report problems and gone public. Maybe this is the only way future

problems and incidents will be minimised and lessons learnt for the NHS across Scotland.