SCOTTISH HOSPITALS INQUIRY

Hearings Commencing 19 August 2024

Day 20
19 September 2024
Dr David Stewart
Dr Chris Deighan

C O N T E N T S

Opening Remarks 1

Stewart, Dr David (Sworn)

Questioned by Mr Mackintosh 1-83

Deighan, Dr Chris (Affirmed)

Questioned by Mr Mackintosh 84-166

10:02

THE CHAIR: Good morning. I think we're able to continue with Dr Stewart.

MR MACKINTOSH: Yes, indeed, my Lord. The next witness is Dr David Stewart.

THE CHAIR: Good morning, Dr Stewart.

THE WITNESS: Morning.

THE CHAIR: As you understand, you're about to be asked some questions by Mr Mackintosh, who's sitting opposite you, but I understand, before we enter into questioning, you're prepared to affirm.

THE WITNESS: Indeed.

Dr David Stewart
Affirmed

THE CHAIR: Thank you, Dr Stewart. Now, I don't know how long your evidence will take. We've scheduled the morning. We will take a break at about half past eleven for coffee but if you want a break at any other time, just give me an indication, and we can take a break.

THE WITNESS: Okay.

THE CHAIR: Mr Mackintosh.

Questioned by Mr Mackintosh

Q Thank you, my Lord. Dr Stewart, firstly, if I can get your full name and your occupation.

A David Armas(?) Stewart. I'm retired.

Q And before you retired, what was your last appointed job?

A I was a consultant position in geriatric medicine. It was a clinical job, and I was also deputy medical director at Greater Glasgow.

Q Before we go into that in some detail, you provided a statement to the Inquiry.

A Yes.

Q Would you be willing to adopt that as party for evidence?

A I would. I've just-- If you forgive me, I've noticed one slight----

Q Of course.

A -- mistake.

Q If you could go by the-- Have you got a copy that's got numbers on the top right-hand corner?

A Yes.

Q What page is it on?

A It's right at the beginning, 1A, chronological professional history.

Q Yes.

A I see at the end-- sorry, the last sentence-- sorry, yes, last sentence, "Lead director for acute medical services." That actually should read, "Deputy medical director."

Q So, rather than "lead," it should be "deputy"?

A It should be "deputy medical director", yes.

Q We'll make that change and, subject to that, are you willing to adopt this as part of your evidence?

A Yes.

Q Now, I'm conscious that you're now retired.

A Yes.

Q And, as you explained in the statement, you don't remember some of the instances we're talking about.

A Indeed.

Q And, of course, in order to assist you, we provide you with a list of documents. What I'm proposing to do is to walk through some of these documents, and hope that having had the opportunity to look at them in the last few days assists you in helping us with some of the questions.

A Okay.

Q What I wanted to do first was just-- thinking of your role as deputy medical director for acute medical services----

A Yeah.

Q -- so that's from '15 to '19 when you retired.

A Yes.

Q Now, we, in the Inquiry, have been focusing on a number of particular wards in the new hospital, both in adults and children's, and what I want to do is-- I'll just mention what they are and then ask you to explain your responsibility-- what responsibility you had in respect of those four particular bits.

So the first is in the children's hospital, Ward 2A; the second is in the adult hospital, Ward 4B, the adult Bone Marrow Transplant Unit; then Ward 4C with its haematology beds; and then there is respiratory wards on 5C and 5D. So, what was your responsibility in respect of these four wards as deputy medical director, acute medical services?

A Okay. So, I think the reason it's important I said it was "deputy medical director" and struck the "acute medical services" bit was, I had, really, two roles as deputy medical director. I reported up to the chief operating officer for the acute sector, and so I was in that role – the acute, if you like – deputy medical director, but I also reported up separately to the medical director of the Board, and in that role, I had more of a board overwide role or strategic, sort of, planning type role.

Q So, you've got a mixture of what you might describe as

operational management clinical role in respect of acute services----

A Indeed.

Q -- and a slightly-- I hesitate to say “amorphous”, but general role in terms of corporate matters?

A That’s exactly right.

Q And just taking that second role first, to some extent, does that involve doing what the medical director asks you to take on?

Q To a large extent it does, yes.

Q Right. When it comes to your acute medical services role, these four wards or groups of wards fall within your responsibility?

A They do.

Q Now, we’re conscious that the Children’s Hospital is managed, if I’m understanding correctly, by a section of the Health Board that deals with women and children services.

A Yes.

Q But is that within the acute medical services world?

A It is.

Q Right, and the adult hospital, is one unit or is it multiple units?

Q I suppose-- Sorry, it’s a slightly complicated answer. Yes and no. It’s one unit in the sense that there is one director who runs the hospital and is responsible for that but in terms of the professional leads, there were-- well, it changed. It used to be that they were run as separate services, so whether----

Q Children and adults?

A Yeah, but within adults, you would have surgery run as a separate service, medicine run as a separate service. That changed so that it was run more as a whole hospital. So, as a kind of convoluted way to come back to-- your question being, was adult run separately, the answer is yes.

Q So, adult is run separately.

A Yeah.

Q Within adult, at the beginning of your time, there would have been separate-- not quite silos but systems for surgery and medical.

A That’s right.

Q But by the end of your time, there’s simply one medical lead----

A For each hospital.

Q -- for each of the two hospitals. Right. That’s helpful. Now, you explain in your statement that you’re not qualified to make judgments about infection control matters.

A Not technical infection control matters.

Q Yes. Well, that's what I wanted to understand. So, on page 138 of the PDF, which is paragraph 13 of the statement, you explain at the bottom half of the middle of the page:

> "I make no judgments about Infection Control matters [this is the context of the hospital opening] as it's not my role, and I'm not qualified to do so."

Now, I appreciate you're quite an experienced doctor by this point, so this may be half the answer, but you end up chairing the Board Infection Control Committee at points.

A Yes.

Q So, how does that work from the point of-- We're obviously not involved in running this hospital, we're learning. How does it work to have someone who's not got the technical qualifications or background in infection control chairing a Board Infection Control Committee?

A The Infection Control Committee wasn't a highly technical committee, if you like. It wasn't there to get into the fine detail, the arcana of infection control. It was there to receive reports which were relevant to the runnings of the hospital. It wasn't

even just there for the Infection Control team. There were other representatives there as well, general management, infectious diseases, etc. So it was more of a kind of general overview of infection control, rather than a technical committee.

I would say, to some extent, chairing these committees is a kind of generic duty of managers and medical managers. I mean, another example would be, I chaired the Board's Information Management and Technology Committee, but I'm not a computer scientist.

Q I appreciate that. The thing that intrigues us is that we have had some quite detailed evidence from Mr Walsh, who was the infection control manager, about the system that he set up and operated post Vale of Leven for these reports that are feeding up through IMT senior management, IPCC senior management team, acute Infection Control Committee, Board Infection Control Committee, and it does seem to be quite a structured system of reports against looking at national targets, national-- reporting microorganisms, policies, and these are all the things that you're dealing with at the committee eventually?

A Yeah.

Q Yes. One of the areas that the Inquiry is interested in is unusual microorganisms. I've asked a series of questions of various Infection Control nurses and nurse consultants, and we're asking more and more of the microbiologists and Infection Control doctors, how do you-- how does a system react to the unusual?

So what I'd be interested in knowing is how does-- from your perspective as a chair of these committees, how do these committees assure themselves that the system below them is noticing the unusual microorganisms and is not simply-- perhaps to put it simply, focusing on the targets set in the national guidance to-- missing things?

A So, I mean, the role of the chair of the committee, really, is to run the meetings to make sure that all the business gets done to make sure that everybody has their input but, at the end of the day, it's the committee that takes the view, it's the committee that approves the minutes, it's the committee that approves the actions. It's not the chair as such that does that. So, as chair, really you're relying on the experts who are attending the committee to talk to those matters. It's not something that you would expect to be conversant with yourself.

Q No, I think I-- that perhaps wasn't the question I was hoping-- Maybe I misphrased it. It's not so much, are you the person who can get into a detailed discussion about particular bacteria? I'm not suggesting that. It's more: how do you satisfy yourself that the system, of which you are chairing the top committee, is capable of spotting the unusual?

A It's based on the advice that the experts around the table at the committee are giving you. They will come and report on the situation, they will report on their analysis of it and what they're doing about it. There'll be others around the table that may wish to question them on that but, at the end of the day, you're relying on those experts to report what the situation is.

Q Because after-- I don't think it involves particular meetings that I'm going to go to but some of these suggestions are that, at times, the advice of Infection Control doctors is-- if not ignored, is challenged by those who don't have the expertise to challenge it. Now, is there not a danger in the system you're describing that a couple or an individual experienced expert can get slightly drowned out by a sort of corporate pressure not to want to hear or to see

it to minimise a problem?

A I think what I was describing was obviously opposite of that. At the committee, it would be the Infection Control expert that would be bringing papers that would be presenting the issues to you for consideration by the committee. I cannot remember a single instance of the committee then overruling or challenging that in any way.

Q Thank you, what I want to do is deal with the opening of the hospital, and you explain in your statement, if we just jump to page 1-- the same page, in fact, at the top.

A Yes.

Q You mention-- We asked if you were involved in transferring patients from the old site to the new hospital----

A Yes. Yes.

Q -- and you described your role as, “Planning the safe transfer and clinical care of patients.”

A Yes.

Q And you go on to say, “I didn’t encounter any significant problems with this process.”

A Yes.

Q And I do appreciate that you had no role in deciding which services would transfer. What I wanted to explore with you is, in order

to have a safe transfer, would it not be necessary to know that the facilities you’re transferring them into are safe?

A It would, yes.

Q And so how would you, as the person responsible for the safe transfer, ensure that that threshold was met?

A I think-- I was responsible for an element of the transfer, if you like. I was responsible for patient care during the transport-- transfer process. So were there enough doctors? Were there enough nurses? What would happen in the case of an emergency? Were the critical care facilities there? If there was a cardiac arrest, who would deal with that? It was all that side of things.

Q Right.

A My role wasn’t to assess whether the facility I was moving the patients into was safe. That was others’ to-- others’ to do.

Q Now, the-- to some extent, would it be fair to say that, in order for this system to operate smoothly, you have to assume that other people have done their job, whatever that is?

A Indeed.

Q Yes. Now, I-- obviously, you’re aware that there’s an issue arises about ventilation.

A Yes.

Q And you, as you've explained, are responsible for the practicalities of the transfer.

A Yes.

Q But if I'd asked you back then, "You're moving to this new hospital, what do you think of it?" what would you have said?

A Well, I think I've said in my statement, I mean, I did see the hospital before it opened and it looked very impressive. You know, having been used, throughout most of my career up until then, to operating out of buildings 100 years old, it looked like a significant step forward, but they were very much general impressions. I mean, I certainly wasn't getting into the detail----

Q No, I appreciate that. If we could take this off the screen because----

A Yes.

Q -- it's more sort of-- and, again, I appreciate there are many more things to an operationally safe hospital than its ventilation system. There's lots of things one has to consider.

A Yes.

Q But, again, with the benefit of, in a sense, hindsight, imagine I'm there and I come up to you and say, "Would you expect this hospital to be built in terms of national guidance?"

A I've said----

Q What would you have said?

A Of course, absolutely.

Q Yes, and, of course, you didn't know at the time that, to some extent, it wasn't?

A That's correct.

Q Yes. Now, if we can take this off the screen, and what I want to do is, you were asked questions about-- Well, in fact, sorry, go back to that document, page 139. You're asked at question 15:

> "Shortly after the hospital opened, an issue emerged regarding the adequacy of the ventilation in the Bone Marrow Treatment Ward."

A Yes.

Q And you said, "I remember only that concerns were raised. I had no direct involvement in this," and we've produced some documents----

A Yes.

Q -- that suggest that you did have some involvement in it. Have you had a chance to look at those?

A The only one I think that-

- I think there was a document referring to a meeting that Grant Archibald called that I was present at. Is that the one you have?

Q Well, let's go through them because, I mean, at one level, this isn't a memory test, but there's a couple of things where we're quite keen to get your views. If we could go to bundle 14, volume 1, document 8, page 202.

A Oh, right. Yes.

Q So this is an email from Professor Williams to you, 19 June. So this is quite-- this is almost before-- just before transfer.

A Yes. Yes.

Q And he's obviously spoken to you, and it seems the lobbied side rooms in ITU, HDU, have not got their HEPA filters fitted, and then you see in the second paragraph, there's a reference to Ward 4B1.

A Yes.

Q And so, there's also an email which I wanted to show you, which you may not have seen at the time, which is bundle 5, document 1, page 18. Yes, so this email was sent to you by a bunch of haematologists and they want to make you and Dr Armstrong and David Dunlop-- Who was David Dunlop at the time?

A David Dunlop was the-- I'm trying to remember what the title was. He was the associate medical director, I think the title was, responsible for oncology, regional services and cancer care.

Q Thank you. So, these eight are on-- haematologists----

A Yes.

Q -- well, and Professor Jones----

A Yes.

Q -- sent this document to you three----

A Yes.

Q -- and they have an attachment which is on the next page which goes into the situation in some detail. Have you an opportunity to read that since----

A I have, yes.

Q So, this seems to arise. Would you accept that, to some level, people are raising issues with you and others at this early stage?

A Can I come back to the Craig Williams one and----

Q Yes, of course. We can go back to Craig Williams. So that's bundle 14, please, volume 1, document 8, yes.

A Okay. So I think this comes back to, if you like, my dual role.

Q Yes.

A And I think it's, in what capacity is he writing to me? So at the time around the move to the hospital, I would say the great majority of my job was with my acute hat on. The operational role, the day-to-day, the week-to-week, there were huge challenges around unscheduled care, around A&E waiting times, etc., and that was consuming most of my time.

And Dr Williams has written to me quite-- as you say, to inform me of an issue in the wards. I would have expected him to do that. I think he's writing to me for my information because, as someone who is responsible for the day-to-day running, it's important that I would know these things, but I think it is for information. I don't think he's asking me for action or----

Q No, no, I don't think he is.

A So, when you say "involved with," I have been informed about.

Q Yes, so-- well, let's move on then to bundle 27, volume 3, document 12.

A Okay. Yes.

Q Previous page, page before that, yes. So this appears to an email where Gary Jenkins-- So what was Gary Jenkins' role at the time?

A Gary Jenkins' role at the time was-- I think he was the director for regional services.

Q So, effectively, he would have been Dr Dunlop's equivalent in management side.

A That's correct, yes.

Q Right, and so he is telling you and Grant Archibald----

A Yes.

Q -- about a briefing note?

A Yes.

Q And this is a discussion about the transfer of the service back to the Beatson?

A Yes.

Q So, would you say this is him just keeping you informed?

A I would.

Q Right. Okay, and if we can go on to the next document, which is bundle 13, document 117, so this appears to be a meeting that you've chaired.

A Yes.

Q And this is obviously a Board Infection Control Committee, and if we-- Do you remember this meeting?

A No, not specifically, no.

Q The reason I'm asking about this particular minute is because this is at a point when there seems to be some discussion about the movement back, and what I'm ask--

well, the reason it concerns me is that there seems to be an issue with ventilation in Ward 4B. We can take that off the screen.

If we can go to bundle 13, document 70, page 525, this is what looks like-- well, it doesn't seem to be an obvious meeting of any particular committee. I mean, I may have misunderstood this, and, if you go to-- you see that you're recorded-- Sorry, am I in the wrong place? Sorry, it's the next one, page, yes, 525. There's a discussion in the minute on page 530 where you're meeting-- a meeting of you-- chaired by you is discussed. Now, this isn't a minute of a meeting you were present at, but it's a report that:

> "A meeting was held with the Estates to discuss the BMT unit and David Stewart chaired the meeting. At the moment, these beds are being used as winter medical beds."

So this is January '16. I'm getting the impression that you're being told lots of things and you're chairing meetings that are discussing this issue----

A Yes.

Q -- and we understand the issue is that the isolation rooms haven't or didn't originally have HEPA filters. It's not possible to achieve the proper 10 pascals differential pressure, and this is considered to be sufficient an issue that the adult bone marrow treatment patients have gone back to the Beatson.

A Yes.

Q Now, of course, they can go back to the Beatson because there's a working hospital in the Beatson, and the paediatric patients, why can't they go back anywhere?

A I don't know.

Q Because there's no Yorkhill. I mean, Yorkhill's closed, so that's the difference.

A Oh, sorry. Yes, okay. Yes, I get your point, okay. Yes.

Q But the thing that I'm trying to understand is when all this is happening, when you're being told, and you're chairing meetings, about what can only be described as flaws of some level----

A Yes.

Q -- in the specification of these particular isolation rooms in an important part of the hospital, where the consequence is that the patients have moved back to their old hospital, would it not, at that point, have been a good time to start asking the question, "What else is wrong with the hospital?"

Because that doesn't seem to happen.

A So, I don't-- The meeting that that's that's minuted there, I don't remember. I don't know if you'll get minutes of that or----

Q We haven't.

A No, okay. So I don't know what was discussed and I don't remember the detail of that meeting. I think this now-- again, it maybe comes back to my dual roles and in what role am I-- am I there?

Q Yes.

A So, as I said earlier, the great majority of my time at that time was with my acute hat on, but I was still working with the medical director and, as you say, I was taking instruction from her on things to do. And there would be-- from time to time, she would say she can't go to a meeting, would I go instead, but that might be the only one of those series of meetings. I think that Board Infection Control Committee, for instance----

Q No, I think it is, you're right. Yes.

A -- I think may well be an example of that.

Q It is, yes.

A So there were, if you like, sporadic meetings that I would be at, representing the medical director, because she may have had something else to do, but I wasn't-- I didn't have a continuing involvement in it. So, for instance, I think there's a-- you'll maybe come to the documents later for those meetings about the BMT, where I am at a meeting, but there's a whole load of subsequent meetings that happened after that.

Q Yes. No, I think I will do. Yes, that's a fair point.

A So with regard to that specific meeting, as I say, I can't remember the detail. I don't know what was discussed and I don't know what, if any, actions I had from it.

Q Yes.

A But your general point was, "Should you be asking questions?" and I guess the answer that is, yes, you should, yes.

Q Because the thing that-- the impression that I actually need to put to you is that we've heard quite a lot of evidence and seen quite a lot of documents that infection control doctors and haematologists are concerned enough to raise this issue, and ultimately to move the service back to the Beatson.

A Yes.

Q And they do that for their balance of risk discussions, and we're not second-guessing that, but

somewhere in the organisation, why does no one-- and I'm, as it were, picking on you because you're the deputy medical director in here----

A Oh, right. Okay.

Q -- why does no one go, "Gosh, they didn't build this bit as we thought they were going to. Is there anything wrong with the rest of the building?" and can you answer that?

A Well, if you're asking me why I didn't do that----

Q Yes, and that's all-- the best I can do.

A All right, yes. If you're asking me why I didn't-- I think it comes back to what I've already said, that the great majority of my time was spent not in that role, it was spent in the day-to-day operational challenges around the running of the hospital. The bigger issues with Estates and the BMT and decisions to move back were not something that I was involved with, to any great extent. I mean, you know, there's meetings referred to, but I was barely involved in that at all. That was largely the remit of the medical director and the Infection Control team that were dealing with that.

Q Because the thing that also is going on at the time – to be fair, I haven't produced all these documents for you, but you may be aware – is that other isolation rooms elsewhere in the hospital are subject to similar questions.

A Yes.

Q Not just in the Schiehallion Unit, but also there are other isolation rooms in the hospital where there are similar problems. Now, given there are something like 30 isolation rooms in this hospital when it opens, the fact that infection control doctors and, at this point, the sector infection control doctor, Dr Peters, and to some extent Dr Inkster, are raising questions about, why are the isolation rooms, in my words, flawed----

A Yes.

Q -- is that not something that, in your acute services hat, you should have been noticing?

A Yes, absolutely, and we were aware of that, but it wasn't ours to fix, if you like. It was other people who were dealing with that matter. We were being kept informed about what was going on, but it didn't fall within our remit. We didn't have the authority, obviously, to be dealing with that. This was an issue for Infection Control, Estates, and that was taking place, as I say, outside of our remit.

Q Because we've had evidence from Professor Williams that, at this point, he's asking questions of

members of the project team, he's not getting answers and, in some cases, he suggests that some of the answers he gets aren't true. And, at the same time, haematologists write to you. Now, they may write to you wearing a particular hat, and they may be informing you for information purposes, but it seems a big step in NHSGGC for a bunch of consultants to get together and write a letter to the medical director. That seems to be something that is notable.

A Yes.

Q And so it seems likely that whatever Infection Control or the project team or the Estates team had in terms of authority or interest didn't work.

A Yes.

Q So the next stop is the professional medical leads, and that's Dr Armstrong and, at this point, you.

A Yes.

Q And what you seem to be saying is that, certainly speaking for yourself, and I can speak to Dr Armstrong in a few weeks' time, you were working on the principle that other people were dealing with this.

A I was working on the principle that other people, and that "other people" includes Dr Armstrong, were dealing with this, yes.

Q Well, that's very helpful. What we'll do is we'll move on to another section, if you don't mind. In your statement, if you go back to page 140, you're asked a series of questions about Infection Control, the team, resignations and ultimately a report you produced, and so what I want to do is walk through this. I don't really need to have this on the screen anymore, and the document I'm going to end up asking you about, but I'll put it up just now so we can make the connection, is bundle 14, volume 1, document 41, page 464. So I'm going to come back to this, but I'm just putting it up, so this is where we're going to, and we've had some evidence about how this happened from other people, and you explain in your statement that this was written by you, this report, because Dr Armstrong asked you to investigate certain issues.

A Yes.

Q Now, having had the opportunity to look at the report, what were the issues she asked you to investigate?

A Okay, so, at the time, a lot of the tensions, I think, that you've probably heard already from other infection control doctors were coming to the fore. There were issues being

raised, I think to Professor Jones, the clinical director for microbiology, about the management arrangements not working particularly well. There were issues about personalities. Dr Armstrong wanted to get someone external, and I think the point being I was external. I wasn't involved in managing this team.

Q Because the closest you come to it is Board Infection Control Committee, effectively.

A Indeed. That's right, so I'm not part of any of this structure. So, she wants somebody outside, external, to come and have a look at this. So between myself and one of the senior-- used to be personnel head of people and change, we looked at that and we wrote this together. So that's the background to that.

Q And so the----

THE CHAIR: Sorry, I just missed a detail. It was the, "We wrote this together". It was-- I just missed----

A Sorry, myself and the head of people and change. HR, I guess, in old terminology.

MR MACKINTOSH: So if we go, please, to bundle 14, same bundle, now page 423. So this is 423. Thank you. So, this appears to be an email from Dr Peters to Fran, who I assume was supporting you----

A Yes.

Q -- following up from her email, the bottom down the page, to invite her to a meeting.

A Yes.

Q Now, what I think is the thing that has to be drawn out is that your email to her at the bottom of the page – there's no substantive matters on the next page-- sorry, go back one page – describes in the second sentence:

"He understands that you'll be planning to demit from infection control duties shortly and would welcome the opportunity to discuss this with you, in particular regarding the issues you have encountered which led to this situation."

Now, Dr Peters' resignation letter isn't just about what you might describe as cultural issues.

A That's correct.

Q It's about specific complaints about safety that she sees as issues, but your position appears to be that what you're looking into is just the "cultural stuff". Is that broadly right?

A That's right. That was what Dr Armstrong asked me to do. She was very specific about that, about what the scope of the investigation should be.

Q Because at the top of page 423, you get the impression from Dr Peters' email back to your assistant that she wants to discuss all the reasons.

A She does, but, as I say, that wasn't the scope of my remit.

Q So, your answer to probably quite a lot of questions I'm about to ask you will be, "I was asked to do a particular task, and so the issue around air change rates or HEPA filters isn't within my remit."

A That's right, and I think that was made very clear to participants when we did conduct the interviews, that that was what it was about. Now, I've no doubt – in fact I'm certain – that some of the infection control doctors, Dr Peters included, were disappointed by that.

Q Oh, we see emails that show that.

A Yes, but, nonetheless, that's what I was asked to do and, as you say, that's what I did.

Q So, we can probably cut this short a little bit, because effectively it's your position that you have a meeting with Dr Peters and you would have had a separate meeting with Dr Inkster, presumably.

A A number of people, yes.

Q A number of people, and then some of the people – and Dr Peters is a good example, but she's not the only one – come back to you and say, "But you haven't considered these safety issues," in their eyes.

A That's correct.

Q And that results in a series of emails that then follows through the second half of the year.

A That's right.

Q Yes. And what intrigues me-- I appreciate that you have been given a particular task by Dr Armstrong, but you're an experienced clinician and everything you do is supposed to put patient safety first because that's what-- it's all about the interests of the patients.

A Yes.

Q So what do you do, in broad terms, when you're in receipt of quite a lot of material from Dr Peters and Dr Inkster saying, "But we haven't considered this"? What do you do about that?

A What I did about it, I think you can see, is that although it wasn't within the scope, I invited them to detail in writing just what this extra concern was. As I say, I could at that point have just said, "Nothing to do with me," but I thought it would be more helpful to facilitate that just to see what their issues were.

Q Now, we'll come back to those emails in a moment, but I want to just pick up on Dr Redding before we leave this point in the story. So we had some evidence from Dr Redding two weeks ago. Now, at this point, I get the impression Dr Redding might have been the most long-serving microbiologist in Glasgow by then.

A Could well be, yes.

Q And she described how she contacted you to raise various concerns that she had. Now, one of them is in the same bundle at page 470. So, this appears to-- Well, this is an email. She's given evidence. This email is the email to you, from her, 21 October, so this is after you've produced your summary report. Is that right?

A Yes.

Q And it's quite a detailed email, and she's clearly-- first sentence, "Thank you for sparing me so much of your time last week." So she met you, or you spoke to her on the phone?

A I don't remember. I'd imagine we'd have met, but I don't remember.

Q Because what she said in her evidence – and just for the benefit of my colleagues because they all write things down, we're looking at page 101/102 of her transcript from 4 September – she says she says to you something along the lines of this:

"There are a number of microbiologists and infection control doctors who are raising issues. They've got all the detailed information; they're not being listened to; they're worried."

There are more issues, they're not being worried(sic) to-- they're worried, and she gets the impression that they can't speak for themselves. Now, firstly, is that something you remember or think she might have raised with you?

A When I see that, I have no doubt that she did. I don't remember the detail of it, but I'm sure she did.

Q But what you've done at this point is you've already asked Dr Peters and Dr Inkster to provide specification of their concerns.

A Yes.

Q Right. And so there's an email to Grant Archibald, another one, from Dr Redding, in the same volume, page 463. Now, this is from Dr Redding to Grant Archibald, and this, again, is a little bit earlier than the previous one, so it must be before you met her, but it's describing the specific problems of the isolation rooms.

A Yes.

Q And so, at this point, are you now getting involved in the issue, if in a sense you haven't been before?

A I'm getting involved in the issue in the sense that I'm listening to senior colleagues and I've worked a lot with Dr Redding in the past. I had a great respect for her. As you say, she was a very senior colleague and she had concerns, so I was happy to hear those. I would never refuse to speak to anyone about that, particularly someone like Dr Redding.

So, yes, I'm involved in the sense that I'm hearing what people are saying, but it's very clear that the issues that they're raising are issues that should be being dealt with within the infection control system, the management structure. Now, it's been said to me that they're not being, and so my response to that is to raise these issues with the medical director, who, at the end of the day, has responsibility for that service.

Q Just to get the timings right, Dr Inkster has resigned – or as Mr Walker put it, demitted office for her sessions – in July.

A Yes.

Q You produced your report. Dr Peters and Dr Inkster have come back to you quite quickly and said, "There's more." Dr Redding has come in with information that's currently-- well, just on the screen there about isolation rooms and specific stuff. Then she's met you, then she's given you more stuff about culture, and there's an email that I want to ask you about how you got the information that you've based your answer on. So this is on page 476. Now, we'll come back to Dr Peters' email at the top of the page on 2 November to you in a moment, but let's look at the bottom of the page, and this is you replying to-- If we go to the next page so you get the context, this is a series-- On 30 October, bottom of this page – page 477 – we have an email from you which I think attaches your report.

And then you get a response from Christine Peters, top of the page:

"Please can I clarify whether I'm to expect an individualised response to the concerns I raised in my resignation letter and my interview with you and HR, most particularly in relation ongoing patient safety issues."

And you've explained that of course that interview was conducted under a remit that didn't include the patient safety issues.

A Indeed.

Q So we go on to the next

page-- no, sorry, page 476, and then you've got your response to Dr Peters on 2 November at 12.27. What you seem to be saying is-- The first paragraph is you saying what you've just said to me, that:

"Much of our discussion was around communication and behaviors, clarity of roles and transparency of decision-making. These are the issues we intend to address at the meeting."

And you've said that.

A Yes.

Q That's your remit.

A Yes.

Q

"With regards to specific safety concerns, your main worry was around ... the functioning of the isolation facilities, whether they were fit for purpose and how this is validated."

And that does seem to be her main worry.

A Yes.

Q

"I understand that significant progress has been made with respect of this and, although work continues, there is now more confidence in these facilities. I am therefore concerned that you believe that there are ongoing safety issues and would be grateful if you could elaborate on what these are."

In the next-- top of the page, she offers to do that. Now, the reason that I'm-- Can we go back to 476? What I'm keen to know is, what's your source for that? Before you answer that, there's been at this point an SBAR from HPS about this unit which isn't implemented for two years, and we know some work is being done but not to all the rooms. So I'm keen to know, who's telling you that significant progress has been made?

A Well, the short answer to that is it's the medical director. I took these concerns to Dr Armstrong, and what she told me was that these were known concerns, that the Infection Control management team were perfectly aware of all these issues and that they were dealing with them. She told me that progress was being made and that I should, on that basis, get back to Dr Peters. However, as you can see, I did invite her to expand on that.

Q I think she does do that.

A Yes.

THE CHAIR: Could I just check that I've got that? Jennifer Armstrong----

A Yes.

Q -- told you that the concerns which doctors Peters and

Redding had brought to your attention----

A Yes.

Q -- were known concerns, and did you say IPC management was dealing with it?

A That was my understanding from Dr Armstrong, yes.

Q Now, we're talking about the physical condition of the hospital.

A Yes.

Q I think the reason I'm concerned with the details of the answer: one might have expected Estates to be dealing with it, or somebody with a more direct responsibility for physical infrastructure.

A Yes.

Q I'm just keen to understand what you were being told.

A So, again, forgive me if I'm rather hazy in the detail, because these were conversations some years ago.

Q Of course.

A But my understanding was that, yes, absolutely, these were matters for the estate, but my understanding was that the Infection Control management team were leading on that and would be collaborating with the Estates colleagues.

Q Am I remembering correctly, we're-- I suppose we're in the end of 2015. Was Professor Williams still in----

MR MACKINTOSH: He was, my Lord, yes.

THE CHAIR: -- post, yes. Thank you.

MR MACKINTOSH: So, just to recap and make sure we've summarised where we are, it's now November. You've done your report, and we'll come back to what it says later. Once you publish it, the people who've told you in the meetings other things that were outwith your remit, come back to you. You say, "They're outwith my remit," but you still receive information.

A Yes.

Q You go and get assurances from Dr Armstrong.

A Yes.

Q You tell them that. They're still not happy, and you invite them to put it in writing?

A Yes.

Q And they do that. So, if you look at page 478, please. So, we have rather a long letter. If you just jump onto the next page so we just get to the end of the letter to see who signed it. It's both Dr Peters and Dr Inkster. So, we go back to 478. So

this is the 9 November.

A Yes.

Q Now, the first thing that's striking about this is it's not just about isolation rooms, is it?

A No.

Q It's a bit more comprehensive.

A Yes.

Q On this page, we have a discussion of the adult bone marrow treatment facility, which you, by this point, know something about, because you've been told things by the haematologists and Professor Williams.

A Yes.

Q So that presumably wasn't a surprise to you.

A No.

Q No. The next page, children's bone marrow transplant comes up. Is that something that at this point is news to you, or is it-- Can you help me?

A I can't remember.

Q Okay. I'm going to ask the same question about (c) and (d). In the other isolation rooms, did you know about these being an issue at this point?

A Well, I think that may refer to what Dr Williams had written to me.

Q I think it does, yes.

A Yes.

Q Then the other clinical areas?

A I don't know remember whether I knew----

Q The old build's not within the remit of the Inquiry, so we'll jump over onto the next page.

A Yes.

Q Then we have some outbreaks described. Now, the NICU one is something that was in the interest of the Inquiry. Would this have been news to you, unless you'd seen it mentioned in a Board Infection Control minute?

A I would imagine that would have been news to me.

Q Yes, and Ebola is not within the remit of the Inquiry, really, so we'll move over.

A Yes.

Q That's the end of the letter. Now, so the question I wanted to see is, what do you do when you get this rather more substantial document?

A So, I escalate that to the medical director.

Q Right, and do you get a response?

A I can't remember. I can't remember the detail of it, as I say. The general response I was getting

from the medical director at this time was that these were known issues, and that the relevant team was dealing with it.

Q Because this may be a little bit unfair to deputy medical directors across the universe, but, at one level, part of your job----

A Yes.

Q It seems a really odd contrast. At one level, you are running part of a service.

A Yes.

Q Often, they have a lead responsibility for something important, and it's a field they know about and they are not quite bestriding the system like a Colossus, but they're making important decisions about difficult things. You describe waiting times and that sort of-- On the other side, to some extent, they're a bit of a gopher.

A Indeed.

Q Is that-- How would you describe it? Because that's my----

A No, I think that's exactly right, and I think my role in this was, really, I was very much a go-between between the concerns being raised and the medical director, and, yes, I think that's a fair description.

Q Because the way that Dr Redding talked about you and Grant

Archibald is she felt she could approach the two of you. Obviously, you can't speak for him but she spoke of you, because you and she had interacted at various committees and she felt she knew you, and she felt that she could bring the message that there were problems, to you. Would she not be reasonably disappointed if she realised that all that was happening is you're taking the point straight to the person she's already approached?

A But I don't think she had already approached the medical director.

Q Mm-hmm.

A No, I'm sure she hadn't. So, what I've done is I've taken it up a rung

and, also, I do remember this. I do remember being very, very clear that-- Dr Redding was a doctor I had a great deal of respect for. I'd worked very closely with her in the past, and I do remember making the point that she was someone that should be listened to seriously.

Q Because is it unfair to characterise your involvement in this issue, and there's-- apart from the report, which we'll come back to, within your remit, as, in respect the patient safety issues to being effectively a reporter, a messenger, a provider of

information, rather than an actor? Would that be how you see it?

A I think that's right, yes, but with the proviso that I was giving my opinion that this was something that needed to be taken very seriously, albeit it wasn't for me to do.

Q Right. What I want to do now, I think, is to show you a document which you may not have seen, but it's important that I think we ask you. This is bundle 20, document 68, page 1495. Thank you. So, if we just step up-- zoom a little bit less. This is an email from 26 May 2016, so it's the next year, and it's to Dr Inkster and Shiona Frew, copying David Loudon and Anne Harkness and Mr Walsh, from Mr Powrie, and it confirms, it seems, that the Health Board had derogated the generalised ventilation of the hospital from 6 air changes an hour to something less than that.

Now, some people are surprised when they found this out in summer, 2016. Did you ever discover that there had been this change while you were working at the Health Board?

A I don't remember this.

Q You don't remember this, either at the time or later, or----

A Well, I don't remember it. I don't remember knowing or not

knowing about it. I just genuinely don't remember.

Q The reason that I ask, if can we take that off the screen, is that when it comes to a section we'll talk about in a moment, which is in February 2019 when you're asked to mentor, in some way, Dr Inkster-- we'll talk about that in detail in a bit----

A Good.

Q -- but, at that point, you're getting back involved with some of these issues, in the sense that Dr Inkster is now the lead Infection Control doctor. There'll be lots of events and lots of discussions about ventilation, the Cryptococcus has just happened, and I'm wondering when it is that you, as deputy medical director with a responsibility for acute services, realise that your hospital had a derogated ventilation standard.

A I don't remember, sorry.

Q It just seems like it's something that's quite striking if you found out.

A I can't say anything more. I don't remember, sorry.

Q What I want to do is go back to your report, so that's at bundle 14----

THE CHAIR: Sorry, just so I've got the answer. You can't recall when you learned that the----

A I can't recall when or if I learned that.

Q All right, and we're talking about what's described as general wards, in other words, the great majority of the single rooms in the hospital.

A Yes.

Q Right.

MR MACKINTOSH: You are aware now that this is something the Inquiry is interested in?

A I am.

Q And we were set up in 2019/2020, so was it not until then that you became-- or after then, that you became aware of this problem? When did you first discover that there was a suggestion that general wards in this hospital weren't built to guidance?

A I can't remember the answer to that question.

Q I mean, it wasn't last week, so----

A No, it wasn't last week, but I did retire in 2019. So, if I had known, it would have had to have been prior to that, but I can't give you a specific answer.

Q Well, let's go back to your report. So, it's bundle 14, volume 1, document 41, page 464.

A Yes.

Q So, you described, at the top of the report, that you met informally with nine people. Now, I'm not going to ask you who they are, but we know they include Dr Inkster and Dr Peters.

A Yes.

Q You produce some general findings. Now, you're only talking about culture, because that's your remit. You've explained that, and we can obviously read this report, but I want to look at item 2.

A Yes.

Q So, in essence, are you here reporting that of the nine people you spoke to, those who were unhappy didn't want to use the Dignity at Work policy at the time? Because that's effectively why I'm reading into that, and I wonder if that sounds right.

A To be honest, I'm just reading that as well. I can't remember what the thinking was at the time.

Q Sections 3 to 5----

A Yes.

Q -- you describe issues of communication.

A Yes.

Q Now, one of the things that strikes me about this report is it's quite general. It's not very directed.

A Okay.

Q If it's the case that there was, at the time, quite a lot of

unhappiness in the Infection Control team-- not all in one direction, as far as I can tell. So, some of the doctors are saying one thing and some of the nurses are saying something else, and some of the other doctors are saying something completely different, and people seem sad---

A Yes.

Q -- about what's going on. Does this report provide enough information to cause change, or will it require someone to action it?

A No, I think this report is highlighting that there is a need for action. It's not describing the-- It's making some suggestions about actions, but I think at the end it has a list of things that need to be done. So, this report is not describing in detail the solution. What it's saying is, is that we looked at this and, yes, there is an issue, and this is something that needs to be addressed.

Q So, this goes back to the medical director for her to----

A Yes.

Q In fact, the meeting that you suggest should take place doesn't actually take place.

A No, that's just-- Yes, that's true.

Q The bit that's thrown me slightly is paragraph 6, the bottom of the page.

A Yes.

Q I wonder if we can zoom in on that, because it's easier to read that way, and so this sort of seems to stand out a little bit. The way I read it is you've got 3, 4, and 5, which talk about the team in general.

A Yes.

Q Then 6, it talks about accountability.

A Yes.

Q So, I'll just read that:

> "There is also the need for greater clarity around levels of accountability in the decision-making process, especially where there are conflicting views/opinions."

Then you say:

> "On the one hand, there are reports from ICDs of having their professional authority undermined by the over-turning of decisions by the IC Management Team..."

Now, to be fair, we've had evidence about that.

> "...whilst on the other, there are reports of ICDs not taking decisions when given authority to do so."

Now, I think we may have had

evidence about that and I'm going put to you what this might be, and if you can remember it, that would be great.

A Okay.

Q It seems to be a suggestion that there have been points when ICDs have been asked by the IPC management team to sign things off, to approve changes, but not wanting to do so. Is that what you think you're talking about here, or is it something else?

A I'm not sure about that, to be honest. I don't know.

Q Okay, but the final bit is this:

> "Whilst it's clear that concerns for patient safety is the primary motivator for ICDs when arriving at decisions, there appears on occasion to be a lack of appreciation by some ICDs of the need to risk-assess decisions from an organisational/political perspective."

What did you mean by that?

A So, I think what that means is that if a situation arises, there might be a – if I can use the word – "purist" Infection Control solution or opinion, but that needs to be translated into the real world. So, if I can give an example, if there were an infection outbreak in a ward, from a purely Infection Control point of view, the best thing might be to close that ward, stop any further admissions until the issue is dealt with. That's fine, but healthcare is a series of interconnected, moving parts and you can't look at any decision in isolation.

So, it's a bit like a machine, you know? If you say, "This cog isn't working," you can't just say, "Well, let's just take that cog out. What you have to say is, "Well, what will the effect of that be on the machine as a whole?" So, if you shut a ward, what effect will that have on A&E waiting times? What effect will that have on ambulances outside the hospital? What effect will that have on patients being nursed in corridors? What is the greater-- What's the bigger picture here? Taking that whole context, what is the bigger risks to patients? So, should we just take that cog out, because that's the purest infection control thing to do, or are there ways of mitigating the risk such that we don't take the cog out, we keep the machine running, recognising that that will be the lesser risk in the broad scheme of things?

Q So, that explanation would be similar to the decision process that seems to have taken place with the adult bone marrow

treatment. They had a problem, they looked at the options and because the Beatson was still there, they could go home----

A Yeah.

Q -- as it were, but for the pediatric bone marrow treatment isolation rooms, there was nowhere to go because Yorkhill had shut, and the bone marrow transplants had to happen. So they went ahead. Is that the sort of thing you're discussing about----

A Yes, it wasn't specifically that I was referring to, but that's the sort of thing, yes. That's right. Yeah.

Q And is it similar to something that Dr Redding was talking to us about-- It wasn't Dr Redding. It was Pamela Joannidis talking about the historical practice of sometime having to treat a infectious patient in a bay of four, and move a bed in order to sort of keep the service going. I know they don't do that anymore, but it's a similar sort of balancing process.

A That's right.

Q Okay. Now, the reason that this stands out is that what then happens after your report makes people interested in this sentence because, subsequently, it is suggested that when decisions have to made in this hospital about decanting patients, about moving patients from one ward to the other and knock-on effects –this is 2018/2019 – eventually, the chair of the IMT is removed in 2019, Dr Inkster, after you'd gone. There is much discussion about, why is this being done? Is this people putting the reputational reputation of the Health Board ahead of infection management, in its purest sense? So it's the presence of the word "political" that rather screams out there. So why is the word "political" in there?

A That's a very good question because when I reread this after many years, it screamed out at me as well. I'm not sure why "political" is there because what I'm describing is-- It's not about reputational risk at all. What I'm describing is very much about patient safety, and that was my very clear understanding. The word "political" is there-- I honestly cannot, at this stage, explain why that's there because that was not-- reputational damage was not in my thinking at all.

Q The context of this is that Dr Peters and Dr Inkster have resigned or demitted their infection control sessions in an environment which they claim, at the time, they are not being listened to by an organisation and an Infection Control team that doesn't want to hear them.

A Yeah.

Q As you said earlier in the paragraph, "I've been undermining their professional authority." Can you see how that paragraph as a whole, on the whole report, might be rather undermined as a piece of – I think you didn't use the word "neutral" – independent review? Because it seems to suggest that when you-- the way-- it could suggest to some people, that infection control requires consideration – although it didn't quite say this – of the organisational-- reputation of the organisation. That's quite close to what you might read into it.

A I can see that, and that-- certainly from my perspective, that was not ever anything that I was concentrating on. I hesitate to do this because I don't want to put the blame onto anyone else. As I say, this was a co-production, and I doubt that the word "political" went in from me, but, on the other hand, it's my document. I have to take responsibility for it.

Q Indeed, and so if we just step onto the next page, you then-- go onto the next page, you then discuss-- at 7, there's a sense that:

> "Infection control does not have the same degree of senior managerial oversight as applies to other acute service directorates."

Now, that's an odd thing to come up because Mr Walsh, in his evidence, is quite adamant that his direct line of communication to the medical director is a creature of the Vale of Leven Inquiry. It's actually a specific recommendation. In many ways, it reads like Lord MacLean saying, "Make sure Mr Walsh has direct line of communication."

So, is this you suggesting that it might benefit having somewhere-- some other management role connection than just this direct line of communication?

A As I say, it's been a few years since I wrote this. I can't quite remember the context. I think what you might read into that is, yes, Mr Walsh has a direct line to the medical director but that's quite a gulf.

Q Right.

A So, you know, it being such a gulf, is there a need for something in between, maybe not to take away the responsibilities from the medical director but at least to provide some extra oversight and support.

Q Because, at one level, a criticism that one could make of you at this point is that there's a problem.

You've been given a relatively tight remit, you've produced this report, which has this slightly strange previous paragraph, but you've produced the report, and then you've received further representations on specific safety issues. You've reported all of these straight up to the medical director, and from the point of view of Dr Peters and Dr Inkster, nothing's changed.

A Okay.

Q And so, here, at paragraph 7, you're suggesting that what you really need is someone who's got an eye on this or is supporting-- How would you describe this level of support?

A Yeah, I think that's right. I think if you think of other services, as well as general managers, there are directors of the services as well. Not board directors but operational directors. I suppose-- I can't remember if Infection Control reported up through-- I think they maybe did through regional services. So there may have been that----

Q Is this you having your contribution at the time? And then things have changed since then, of course.

A Yeah. I'm struggling to remember, to be honest.

Q Right. Now, if we could go on, please, to bundle 14, volume 1, page 490. So, I want to take this email thread in bits. So, again, what we have at the top is a reply to you from Dr Peters on 29 December. So this is a month later than the letter. Remember, we looked at the letter, 9 November?

A Yeah.

Q And on 22 December, bottom of the page, we have an email from you. Now, I want to look at the whole thing, and then we'll ask you a question. So, the email is 1.10 on 22 December:

> "Dear Christine and Teresa, I'm conscious that we have not yet applied formally to your letter [which must be the one on 9 November] in which you documented your outstanding concerns regarding infection control at the ... campus. I [am] mindful that events moving on at some pace and that many issues you've raised are being actively looked at. Pertinent … of course is the recent involvement of HFS and HPS... "

Over the page:

> "Given the work ... undertaken or ... planned, could

you please confirm your concerns have been addressed or if anything remains an outstanding issue?”

Now, Dr Peters described your letter as somewhat disingenuous. The reason that I think she might have done that is because this is only a month-- well, it’s six-- five weeks after their rather large letter, which we’ve just been through, with lots of points, some of which might have been new to you at the time. It’s a couple of days before Christmas. We all know how hospital gets a bit busy at Christmas, and doctors are desperately trying to clear things up, and on-calls are happening and it’s a time for clearing inboxes in some senses.

A Yeah.

Q So, is this request-- is it all fine, effectively, entirely honest on your part?

A Well, I mean, the short answer to that has to be yes, because I’d never knowingly do anything dishonest.

Q I mean, do you think there’s any realistic possibility that everything on that letter would have been sorted without you knowing about it in the previous six weeks?

A I guess this comes back to what I was saying earlier in my

previous response to their queries. These were matters that I was raising with the medical director. As I say, they weren’t my direct responsibility. However, I had entered this dialogue and, therefore, you know, I didn’t want to be-- I still wished to be facilitative, if you like, but I’m relying on the information given to me, and I’m passing that on. So I guess it came back to what you said, I mean, you used the word “gopher”. I suppose I kind of feel a wee bit like this, in this context.

Q So, would it be-- I mean, you may not remember but would we be reasonably entitled to assume that some point between the November-- 9 November letter and this email, you will have had a conversation or an exchange of emails with Dr Armstrong, and she would have-- you would have told her what’s in the letter, and you may have received some form of a reply but you don’t remember?

A I don’t remember. What I do remember is, I mean, I met Dr Armstrong regularly, I mean, at least weekly, if not more often. So these were matters that would be important. I’d be bringing it to her attention on a regular basis.

Q And if we just go back to the previous page, we see at this point

that Dr Peters, just after Christmas, tells you that there are still problems and there are more.

A Yeah.

Q Right. Now, if we go back to your statement-- page 144 of your statement, question 28, bottom of the page, Dr Inkster and Dr Peters suggested that a certain expert be brought in to address these issues. We asked you, did it occur, and you said you do not know.

A Yeah.

Q Effectively, is this back to your same answer? You would have passed that up to the medical director and that's----

A Correct.

Q Yeah, and I added into the documents list – you can take this off the screen – a long number of BICC meetings you either attended or gave apologies to, and if I reference back to your earlier evidence about the BICC, that wouldn't have been the place where you expected to see that reported at all? Because we don't see that happening anywhere.

A Yes, I think I would have expected to see that there. Yes, I think I would have.

Q So, we'll have to ask Dr Armstrong----

A Yeah.

Q -- but if there had been one appointed, it would probably turn up somewhere like the BICC on the report.

A I would have imagined so, yes.

Q Okay. Now, what I want to do now is to turn to events of 2019 but what I might suggest, my Lord-- why don't we break for our coffee break now because it would give me an opportunity to see if there's any issues arising from what I've just dealt with for my colleagues now. It might short-circuit matters.

THE CHAIR: Well, I'm more than happy to----

MR MACKINTOSH: Because I've only got about 10 minutes left with the rest of the material in 2019.

THE CHAIR: I'm more than happy to be guided. So, take a break until half past eleven.

MR MACKINTOSH: Yes, very helpful. We'll come back to 2019 at half past.

THE CHAIR: Dr Stewart, if you could be back for half past eleven, and you'll be taken to the witness room.

(<u>Short break</u>)

THE CHAIR: Mr Mackintosh.

MR MACKINTOSH: Thank you.

I want to ask one group of questions about the end of 2015, and then move on to 2019.

A Okay.

Q And so before-- the last document we had on the screen was the email that you sent Dr Peters on 22 December and her reply on the 29th, and I think, at this point, your evidence is that you were asked in the summer to do the piece of work on what you might broadly describe as culture. Now, at that point, you would have known because, presumably, you'd have seen Dr Peters and Dr Inkster's resignation letters. Would you have seen them beforehand?

A I can't remember. Presumably, I can't remember.

Q Right. It's quite possible that you'd have known their issues are wider than culture at that point.

A Yes.

Q But you were given a specific remit by Dr Armstrong.

A Yes.

Q You do your piece of work, you speak to the nine people, you report it back-- beginning of October, and you get pushback from Dr Peters and Inkster.

A Yes.

Q And they tell you more problems about adult bone marrow transplant and you say, in broad terms, "These are being addressed."

A Yes.

Q Or you understand they're being addressed----

A Yes.

Q -- and your evidence is that's what you were being told by Dr Armstrong?

A Yes.

Q And they say, effectively, "Oh, no, they're not."

A Yes.

Q So you say, "Give me a letter."

A Yes.

Q So they produce this four-page letter on 9 November.

A Yes.

Q And am I right to assume that, by the time we get to 22 November, you've again gone to Dr Armstrong with that letter and, presumably, although you can't remember, she would have said, "These are being addressed."

A That is my understanding, yes.

Q Yes.

A As I say, I can't remember details of individual conversations, but I-- yes.

Q But that's the sort of assumption----

A That's what I understand to have happened, yes.

Q So, your position is you wouldn't have written that letter on 22 December----

A Yeah.

Q -- unless you'd received some form of information.

A Oh, absolutely.

Q Yes.

A I mean, the reference to HPS and-- I mean, I didn't know anything about that. That didn't fall within my understanding at all.

Q There's two ways to take on this. The first thing is your role at this point is as-- it's the sort of corporate side of your task. You're being asked to do things by the medical director to help her, effectively.

A Yes.

Q Acting for her.

A Yes.

Q Right. Now, if we just look at the situation we find ourselves in, that letter of 9 November, there's two possibilities about any of the facts in there. They're either right or they're wrong. If we just, for the purposes of this question, assume that they're right and you send that to Dr Armstrong and she comes back and provides you with some assurances, then there are two

possibilities happening here, aren't there? One is that either she's misunderstood, or she's being misled is one-- or some range of options around there. Or, what seems rather unlikely, she's actively misleading you. So we put that one aside.

A Yes.

Q So if we-- in a position where her response to you after these two pushbacks from Dr Inkster and Dr Peters is to tell you these issues are being addressed.

A Yes.

Q They clearly think they're not being addressed.

A Yes.

Q What did you do to help Dr Armstrong by effectively challenging her, "Oh, no, they're not, Dr Armstrong"? What did you do about that, in that way?

A Well, as I say, I can't remember the detail of the conversations I had with Dr Armstrong around this, but I think all I can say is that I did bring these matters to her attention, that we had these conversations. I robustly-- I was an advocate, if you like, for Dr Peters and Inkster. I can't remember, these would have been covered in the conversation. I guess all I can say is, at the end of the day, you know, I was

not in a position to hold the medical director to account. You know, that wasn't my role, nor was I, you know, able to do that.

Q But, ultimately, I mean, at this point, you're quite a senior doctor.

A Yes.

Q You've got a lot more clout in the organisation than Dr Peters and Dr Inkster.

A Yes.

Q Doesn't it behove you, at that point, when it's been pushed back by them twice now, at least----

A Yes.

Q -- to do more than simply send another email on 22 December saying, "Is it all fine now?" effectively? What I'm worried about is whether this is, in some sense, an abrogation of your responsibility as a clinician.

A No, I don't think it is at all. So, again, it comes back to context, if you like. So, around at this time, although we're dealing in detail with infection control matters, my-- I am dominantly up to my eyes in managing other aspects of the service. The unscheduled care, the A&E challenges are severe and that is consuming pretty much all of my time.

These issues are brought to me. They're not something that I've chosen not to deal with, they're something I cannot deal with. They're not something that fall within my ambit of responsibility at all, nor do I have any authority in this matter.

I bring them to the medical director, there's coming and goings, I have conversations with her, I pass on all the information I've got and, at the end of the day, I think that's all I can do. As I say, I can't hold the medical director to account for this and, frankly, I'm kind of almost caught in the crossfire here, but I've got other things that I'm doing.

Q I understand that----

A Yes.

Q -- but the thing that's different about the 22 December email is it reads like a simple pass through of a message----

A Yes.

Q -- when you're not a gopher.

A Yes.

Q You're the deputy medical director.

A Yes.

Q And so I'm putting to you that, in some way, that email is you, effectively, not stepping up when someone needed to and taking this seriously.

A Well, I'm not really quite sure what I could have done, to be

honest. I mean----

Q Well, one thing you could have done is not send the 22 December email in the way it's sent.

A Well, if that was the information that I had and that was my understanding then, you know, I don't see why I wouldn't have sent it. I mean, I can't-- as I say, I don't really know what else I can do. The medical director has responsibility for this service. She's senior to me. I've raised it with her, I think, on a number of occasions, and she has told me that she's dealing with it. She's perfectly aware of it. I don't know-- I don't know what you're suggesting I could do at that point.

Q Okay. Well, what I'm suggesting is that the audience for this email----

A Yes.

Q -- is Dr Peters and Dr Inkster, effectively. And so we know that in the summer of that year, they resigned or demitted their sessions.

A Yes.

Q There's a measure of distress because you've observed that in your meetings with the nine people. You know it's a dysfunctional team.

A Yes.

Q They've come back to you with quite substantial pieces of

work.

A Okay.

Q This is now the third time, or possibly the fourth, but the third time when they've had to set out their concerns about patient safety in a written form. The week before Christmas, day before Christmas Eve, two days before Christmas Eve, this surely gives the impression to them that they're just not being listened to, not being taken seriously. I recognise you're the conduit, but you're the conduit for them getting the impression that the organisation is not taking their concerns seriously. How would you react to that?

A I don't think I can add anything to what I've said. You know, I've done what I can do, in my view. I believe I've represented their concerns appropriately to the person who appropriately should be dealing with them. And as I say, I'm not in a position then to hold that person to account.

Q Right. Well, I want to move on to 2019. So this is obviously four years later. Well, not quite. Just over three, because I'm talking about January 2019.

A Okay.

Q So, can we look at bundle 1, document 59, page 270?

So, with a bit of luck, this is a IMT meeting which you attend.

A Yes.

Q And it's 17 January, and I think it might be the first or second-- second IMT meeting of this sequence.

A Yes.

Q And there's clearly been the unfortunate deaths of two patients in the latter part of the previous year, and there's much discussion in these IMTs. Now, I think I now know what the answer is going to be, but the question is why are you here?

A Because the medical director asked that I go there.

Q And so, whilst, in a sense, she go-- say go, and you go, presumably, she doesn't just tell you to go to a meeting. She briefs you about what you might expect.

A I guess-- I don't remember, but I guess she probably would have, yes.

Q Yes, so the thing that I'm quite keen to understand from you is this deputy medical director role, where a senior clinician with experience and authority----

A Yes.

Q -- is sent to an IMT by the medical director and, occasionally, although I don't think you do it in these ones, comes out with action points.

A Yes.

Q But they also often ask questions, your successor asked questions.

A Yes.

Q And am I right in assuming that you would have had some form of briefing? In the sense, a phone call, "Please go. I can't go. Keep an eye on this," that sort of stuff?

A Yes, except Dr Armstrong was there.

Q Exactly.

A Yes, I know. No, to be honest, that-- I mean, it's a good question and it's sometimes a question I used to ask myself, you know, "Why am I here?" I think Dr Armstrong liked me to go to meetings, even if she was going be there. I think, partly, it was about kind of situational awareness, just so that I could hear what was going on. Sometimes I think it might have been for a bit of moral support, sometimes it might be so that I could be, you know, a bit of a sounding board afterwards.

There would be various reasons but, to be honest, my specific remit at this meeting, I don't really know why I was there. I'm not referenced at all as contributing and I don't come away with any actions, and I think I don't go to any other ones.

Q There's an issue that arises around these IMTs, which you might be a good person to ask about. We've been through not this one, but previous IMTs and looked at the different classes of people who turn up, and it seems uncontroversial that you'll have infection prevention control team members, doctors, nurses and sometimes Mr Walsh; you will have the treating clinicians of various flavors, depending on who the patients are; you'll have some Estates people, if there's an Estates angle; you'll have Callum, the minute taker; you might have someone from the laboratory side, either a data person or a microbiologist, but then you get the medical director, the deputy medical director, the director of Estates, quite senior people, turning up.

Now, your position seems to be that you're there probably to listen and to see what's going on. Would you be conscious of the idea that you being there changes the meeting because the weight of your presence as senior people influences what's going on at the meeting?

A Well, whilst that's very flattering, I don't believe that is the case. No, I don't believe so. I mean, I've been to many of these meetings and I've never felt that my presence in particular has inhibited discussion.

Q Would you necessarily know if it was?

A I suppose not, but I would like to think I wasn't such a scary person that, you know, people----

Q I think I'm using you as a representative of a class of people.

A Yes, okay, in general.

Q But if we look at this meeting, we can see on the list managers whose service is involved, so Mr Redfern and Mr Jenkins, for example. We see microbiologists, Dr Kennedy. We see a relatively senior nursing manager, Ms Rodgers, we see Tom Walsh, we see Professor Steele, we see the medical director. We see a lot of people who are quite senior in the organisation. Do you have any view on whether the weight of seniority turning up to these meetings might in some way be influencing what goes on?

A Yes, I think it could, but I think it could influence it either way. It might inhibit discussion, although as I say, that's not been my experience, not just with me; but it, also, I think, gives out a message that this is something that is being taken seriously and there is significant management interest in it, and I think that's

potentially a good thing.

Q And the other thing to ask about these is, I think, you're here for three of them.

A Yes.

Q In these three IMTs in January '19, were you aware of there being a pre-meeting?

A No.

Q There wasn't a meeting or you weren't aware of it?

A I wasn't aware of it.

Q Right. Now, the final thing I want to do – I'm going to take this off the screen – is that we gave you access to Dr Inkster's statement. Now, she hasn't given evidence yet, but in her statement she described how in February 2019 – I'm going to put this in some detail, I understand you disagree – you were assigned by Dr Armstrong to be a mentor to Dr Inkster. Had you, at that point, had any training about mentoring?

A Yes.

Q Yes. Right. And had you mentored people before?

A Yes.

Q Many, or----

A Yes. Yes. Many times in my-- largely-- well, in both my clinical job and in my managerial job, yes, I had.

Yes. And so what Dr Inkster describes is that the meetings involve you raising with her what she sees as inappropriate subjects – now, I recognise you want to respond, but I'm just going to give a rough summary of what it is – and she suggests that the focus seems to be on establishing who was the whistleblower rather than dealing with the issues she had and asking questions about who was talking to the press and who was near to retirement. Now, firstly, what's your recollection of these meetings?

A Okay, so the context of this is that-- Well, I wasn't assigned to her. Dr Armstrong felt that it might be helpful to Dr Inkster if she had some form of mentorship to assist in her role. As I say, I had quite a lot of experience in mentorship and I had had previous training.

One of the absolute fundamentals of mentorship is that it's a mutually agreeable process. You can't impose a mentor on anyone. So, my first question to Dr Armstrong-- And I do remember this with quite a lot of clarity about this whole process, firstly, because it's towards the end of my time but, secondly, because it was a rather unusual situation, so my memory is very clear in this. I asked Dr Armstrong whether Dr Inkster had signed up to this, whether she was

happy with it, it was something she wanted, and I was assured she did.

Furthermore, at the first meeting with Dr Inkster, as is standard practice, I was very clear with her what the rules of engagement were: that this was entirely voluntary; that if she was unhappy with me as a mentor, that was absolutely fine and with no detriment she could she could ask for another mentor; if at any time she was unhappy with the way things were going, she could call a halt in this. I made it very clear that it was about her and about her setting the agenda. I wasn't there to coach her. I wasn't there to appraise her. I was there as a sounding board to help her identify her development needs. So it was all about her and it was very much focused on her. So I'm very, very clear, to start with, that that was the context that I went forward.

The allegations that she goes on to make in, I think, paragraph 747 about whistleblowing and mortgages is completely and utterly untrue. It is an absolute fabrication. None of that happened. I'm very, very clear about that. I have to say, I read that with absolute astonishment and, I would add, some anger because it is completely untrue.

Q Can you recollect what you did discuss at the meeting, in general terms?

A In general terms, it was basically about-- As I say, Dr Inkster would set the agenda. It would be about how-- you know, encourage her to reflect on how she was coping with the job; what she thought her development opportunities were; what bits of the job she was finding more challenging; what she might do to address that; what learning opportunities there might be. It was all of those sort of things. The content in 747 is astonishing.

Q I'm just checking for a date, if you don't mind. I just want to check one thing before we understand anything. So, we have an event going on that you might or might not be aware of, so I wondered if we could just connect the two. So I have some evidence that on the beginning of February of that year, 7 February, there's a discussion between Dr Inkster and Professor Jones about bringing in some more help to the team, additional sessions, and this is approved of by Dr Armstrong. Is that something that would have come up in that mentoring session?

A I can't remember. I'm unaware of that specific interaction with Professor Jones, but we would

have discussed things like workload and support and so on, so it may well have as a general point, yes.

Q Well, look, we'll ask Dr Inkster about that when she gives evidence.

A I would be very grateful if you did because without, you know, overdoing this, it's absolutely a fabrication.

Q Okay. Right. Now, my final thing is you retired before Dr Inkster was removed as the chair of the IMT, which was in August 2019. Now, what I wanted to do is just finally explore with you some understanding of what you see, looking back at 2019 and '20, and what you can remember. I don't think we asked you this in your statement, but effectively this is the context. We have a decant from the Schiehallion Unit in September 2018 to Ward 6A which, wearing your acute services hat, must have been a thing you had to worry about; and like you said, the organisational impact of infection control issues would have had knock-on effects all over the system.

A Yes.

Q So that's something you knew about.

A Yes.

Q You would have

presumably known about the fitting of the chlorine dioxide dosing to the water system and the appearance of point-of-use filters around the hospital, because that would have affected some of your wards, effectively.

A I'm not sure if I knew the detail of that. I don't't----

Q But you definitely knew about the decant, and obviously you knew about the Cryptococcus cases because you were in the IMT.

A Yes.

Q And what's intriguing to me is that, in 2018, the impression I get is that although there's some moments of tension about what's the best solution, ultimately, the advice of Dr Inkster to decant is followed through, and a senior management team group, which doesn't include you, make a decision to go ahead with that decant. And then, over that winter, it's the view of Dr Inkster and others that the problems don't go away.

Now, are you able to help us with the point where you think, if you think at all, when relations between Dr Inkster and the hospital corporately might have broken down? Because they seem to have done at some point. But I wonder what your perspective is of that, as someone who's in and around these events, albeit not directly

involved in most of them.

A Certainly when I was engaging with Dr Inkster around the mentorship side of things, it was clear that she was thoughtful about her role, that she was struggling, I think, with elements of her role, and that was the whole point of the mentorship, to try and help her with that; and I guess it wouldn't come as a surprise to me to hear what you're saying, but I have no direct knowledge of what, if you like, brought it to the final tipping point.

Q And so if we can-- given that you have a strong recollection of these events, how would you characterise the way that Dr Armstrong asked you to take on the mentorship role? How did she put it in the context? Because obviously if you ask someone to mentor a colleague, you have to tell them to some extent what's going on with the colleague at the time. So how did Dr Armstrong set out, in a sense, your task of mentoring Dr Inkster?

A Well, it was to support Dr Inkster. Dr Armstrong recognized that Dr Inkster was struggling with parts of her role and Dr Armstrong had hoped that by helping Dr Inkster identify development needs, learning needs, training opportunities, whatever, that that would strengthen her in her role, because I think Dr Armstrong-- certainly at that point, my impression was Dr Armstrong was very keen that Dr Inkster didn't continue in the post and, therefore, that the mentorship thing was supposed to be supportive towards that.

Q Because the thing that strikes me-- and I may just have the wrong perspective because I'm just seeing bits of information and missing out other data points, but you have some involvement, which we've discussed, in the events of 2015 when Dr Inkster resigns her ICD sessions and there are these exchanges in the second half of 2015 about patient safety, albeit it's not your remit and you're reporting back to Dr Armstrong. You leave these events. You come back to these events in the early part of 2019. Are you the right person to be helping someone when, effectively, to some extent, it feels like the end of a long story or the same thing is still going on?

A Well, I suppose, I should say it had been some considerable time that I had any direct involvement in this. As I've made the point repeatedly, I actually wasn't directly involved in the whole management structure or management of the Infection Control team, so, to a large

extent, I had been external to this. I guess you could debate, was I the right person or not? I suppose in my favour, without blowing my own trumpet, I was senior, I had a lot of experience, and, in my view, I did potentially have something that I could offer to Dr Inkster that would be positive. In hindsight, might somebody else have been better? Possibly. But, to be very clear, this was a mutually agreed arrangement and Dr Inkster had the opportunity, at any point, without any detriment to call time on it.

Q My Lord, I think I've asked all the questions I need to ask, but normally we take a few minutes to see whether anyone else has any further questions they'd like me to ask.

THE CHAIR: Yes. Dr Stewart, what I need to do is check with the room, as it were, to see if there's any additional questions which might be asked. So if I could ask you to go back to the witness room for what I would hope is no more than 10 minutes.

(Short break)

MR MACKINTOSH: I've got one question, my Lord. Dr Stewart, one question. If we think back to the mentoring process----

A Yes.

Q -- from your memory of the process, how would you describe, from what you remember of the meetings, what Dr Inkster saw as the main issues for her at the time? It may be a confidential process, but I think both of you have probably broken that confidentiality now.

A Well, yes. Well, it is a confidential process. I think she had issues around workload. I think she had issues around support generally, I think, you know, from a number of people. I think she was finding the position quite stressful and was having some difficulty dealing just with the demands that were placed upon her. I can't really remember any more detail than that. These would be the general themes, I think.

Q No more questions from me, my Lord.

THE CHAIR: Can I just clarify, in your role as mentor to Dr Inkster, was it one meeting or a series of meetings?

A Dr Inkster refers to three meetings in her statement, and that could well be right.

Q All right.

A Yes.

Q Thank you, Dr Stewart.

A Okay.

Q These are the questions

we had to ask you today, and, therefore, you're now free to go, but before you do go, can I just express my thanks for your attendance here today, but also for the work that you've obviously been involved in, in preparing your statement and looking at documents in preparation of your evidence. I'm grateful for that, and thank you for that, but, as I say, you're now free to go.

THE WITNESS: Thank you.

MR MACKINTOSH: So, my Lord, Dr Deegan, who's our afternoon witness, isn't due to arrive in the building until half past one, so I'm afraid we can't start early.

THE CHAIR: Well, I think we'll, in that case, adjourn until two o'clock.

(Adjourned for a short time)

THE CHAIR: We have Dr Deighan.

MR MACKINTOSH: Deighan this afternoon, my Lord, yes.

THE CHAIR: Good afternoon, Dr Deighan. As you appreciate, you're about to be asked questions by Mr Mackintosh, who's sitting opposite but, first, I understand you're prepared to affirm.

THE WITNESS: Yeah.

Dr Chris Deighan
Affirmed

THE CHAIR: Thank you, Dr Deighan. Now, I don't know how long your evidence will take. It might-- We've scheduled you for the two hours between two and four. If, on the other hand, you wish to take a break at any stage, please feel free to give me an indication, and we can take a break. The other thing I would say is, perhaps when you're answering questions, maybe speak a little louder than you would in normal conversation. The microphones are there to help but for those hard of hearing, like myself, I appreciate a little bit-- just a little bit louder than you might speak in normal conversation.

THE WITNESS: Will do.

THE CHAIR: Thank you. Now, Mr Mackintosh.

Questioned by Mr Mackintosh

Q Thank you, my Lord. Dr Deighan, if I could take your full name and your current occupation.

A Christopher Deighan, and I'm medical director for NHS Lanarkshire.

Q Thank you. Did you produce a statement?

A I did produce a statement.

Q Are you willing to adopt that as your evidence?

A I am, yes.

Q Thank you. Now, what I want to do is focus on a role that you held at Greater Glasgow between June 2019 and January 2023. I understand that was as the deputy medical director corporate.

A That's correct, yes.

Q Could you perhaps assist us by explaining what a deputy medical director corporate does, or what you did as your general role?

A Yeah. So, I was a deputy to Dr Jennifer Armstrong, who's the medical director in Greater Glasgow and Clyde, and, as the name suggests, my role was related to corporate and strategic issues rather than operational issues, primarily. So I was involved with staff governance, clinical governance; I chaired our e-health strategy board; laterally, I was deputy responsible officer; and I was also involved in supporting medical education and realistic medicine. Those were-- and so they're-- planning as well-- corporate planning as well, and that was kind of the portfolio that I had.

Q Now, we have just heard, this morning, evidence from Dr David Stewart, and he was deputy medical director until just before you arrived, and it may help our understanding if you can compare your responsibilities to him. Are you, in some sense, a replacement for him or----

A Not exactly. So, when Dr Stewart retired, his post was split into two, and there were two deputy medical director posts appointed at that point. There was the deputy medical director corporate, which was the post I had with the portfolio that I have described. Then there was the deputy medical director for acute services, which was a separate appointment which Dr Scott Davidson was appointed to.

Q That's very, very helpful. Now, what I want to do is just take you to a few-- well, not many events in the areas this Inquiry is interested in, mainly in 2019. Could we look at bundle 1, document 73, page 325, which is a minute of the gram-negative IMT from 25 June 2019. Now, we see from this minute that this is a minute of a meeting on 25 June '19, chaired by Dr Inkster. Susie Dodd is reported as being present. I think that's her last meeting before she moved to HPS. Sandra Devine is there. A number of clinicians are there. Some managers:

Mr Hill, Mr Redfern, Mr Steele from Estates-- Professor Steele is there. Darryl Conner from Estates, Annette Rankin from HPS. We see you mentioned there as well, before we get to Dr Kennedy, and a number of more-- of treating clinicians. This must have been-- This wasn't your first IMT. You'd attended one in January to do with Cryptococcus, I understand.

A I had attended one in January which, when I saw the bundles, came as a surprise to me because I had no recollection of the January visit at all, and that was obviously long before I took the role as deputy medical director. To be honest, I've got very little recollection of this meeting, which looks as if it was about three weeks or so after I commenced the job.

Q Well, indeed. The January one, as far as I can see from the minutes, is that-- you must have been there probably because of your clinical role in renal.

A Yeah, and when I had the questionnaire to respond, that was my thought as well.

Q So, this one-- the reason I'm asking about this is because, as you say, it's only three weeks after you arrive. We've heard from Dr Stewart how, on occasion, it would be Dr Armstrong's practice to encourage him to go to IMT sometimes with her and sometimes by himself, and he described how he would go to, sort of, take the temperature, listen, to show support, various other things. What was your purpose in going to this meeting and the ones that follow?

A For this meeting, to be honest, I don't have a clear recollection. I assume that Dr Armstrong asked me to go to the meeting, as you say, potentially to take the temperature and to feed back, but I can't specifically recall if there was a specific ask, in terms of going to that meeting.

Q So, were you aware of her giving you any form of preliminary briefing or instruction about what it was that she thought was interesting about this IMT?

A I don't have a recollection, sorry.

Q Now, at an IMT like this, as a deputy medical director, what's your role in a meeting-- or IMT of this sort? How does that distinguish from your role in the January one?

A So, I don't think I had a particular role at the IMT, apart from feeding back to Dr Armstrong. I only attended a limited number of the IMTs, and most of the IMTs, I recall, I

probably attended when my colleague, Dr Davidson, wasn't available. I think, from recollection, that I started in post before Dr Davidson did, and therefore that may be-- that's why I attended this meeting, but there wasn't a specific role or remit for me at the meeting.

Q So, one of the things that's important to the Inquiry about this meeting, if we can go on to the next page, is a discussion at the top of the page about the fact that there had been two cases of Mycobacterium chelonae in the hospital in the previous 12 months, and the redacted section is details of the patients involved. Then, in the middle of the page, we have two paragraphs about Mycobacterium chelonae. Would this probably be the first time you come across this microorganism in your practice?

A As far as I can recall, yes.

Q Yes. The reason I-- There's a discussion in these two paragraphs reporting that there had been no pediatric cases reported within the past 10 years, two cases in the last 12 months. There's a discussion of what Annette Rankin is doing about acquiring some data, and Mycobacterium chelonae has been added to the infection control alert organism list. Then there's a discussion about whether any other health boards currently test for the organism. You see that in the second section.

Now, if we go onto the next page, it's other matters. If we go to the page after, we see a hypothesis where we understand that there's a discussion at this meeting about whether the drains were contaminated. Does that-- Is that something that rings a bell with you?

A Only when I was reading the IMT minutes.

Q Right, but I noticed that you are recorded, as an action point, with Mr Hill, to take forward, executive level, whether other hospitals sample their drains, and if any clinical cases have been reported within England. Why might you and Mr Hill end up dealing with this issue?

A I don't know the answer to that but it wasn't something specifically I ended up taking forward.

Q Right. You think it might be something Mr Hill might have done, if it was done at all.

A I assume so. Potentially, it might have been Dr Davidson, but it wasn't an action that I ended up taking forward.

Q Right. So, it's going to be-- and if you go onto the next page,

do you see:

"AOCB
[Professor] Steele asked if he should inform Edinburgh Royal Infirmary, who are about to open a new hospital [which is also within the remit of this Inquiry] to test the water before opening."

Then the next sentence is:

"It was agreed that Dr Jennifer Armstrong will take this forward without informing the executive management."

I take it-- in Lothian. Would you have been involved in, as it were, having Dr Armstrong volunteered in this way, which seems to be recorded here?

A Extremely unlikely that I would have volunteered my new boss to take something forward, if I'm going to be honest.

Q Do you think it's more likely that Professor Steele would have volunteered?

A I can't answer that.

Q You can't answer that question. Right. The reason I asked you all these questions is because this is the second case of Mycobacterium chelonae that, at this point, people are aware of in the children's hospital in a year. It's something that you will later come on to do a piece of work on and, at this point, what was your state of knowledge about what was going on about Mycobacterium chelonae in the hospital, at this point, in June?

A I don't think I had any detailed knowledge or awareness at all. As I said, at that point, I was about three weeks into the role.

Q Because I put to Dr Stewart this morning the idea that-- well, to ask him what effect it has on an IMT having senior clinicians and managers who aren't directly responsible for the unit involved attending IMTs, and he gave an answer. What's your view? What effect does it have on an IMT to have people like yourself, Professor Steele, others, senior people, even Dr Armstrong occasionally at the meetings? What do you think it has as an effect?

A To be honest, I'm not sure.

Q I mean there's two versions, which could be that it shows the members of the IMT that people take the matter seriously and that the senior management are interested. That's one option. The other option is it might cause some people to be a bit more reticent or nervous because senior people are around. How would

you comment on those two possibilities?

A I think both of them are distinct possibilities. It might depend upon the personality of the senior manager and how well they know people around the table but, yeah, both are possibilities.

Q Because the way that you're-- and I appreciate you're doing this from a limited amount of memory. The way that you seem to be describing you're involvement in this meeting is you're just new to the job, you've turned up, you don't remember the meeting, but you're suspecting you didn't know about the background to Mycobacterium chelonae, and this IMT has been going on for a bit. Do you feel it would be helpful to be better informed when you arrive at these IMTs?

A I think it would depend upon what the specific ask of attending the IMT would be, but I think-- so, yes, I think it would depend upon what the specific ask----

Q But in this case, you can't remember what the specific ask-- No. Now, we'll come back to what you knew about this particular case and these two infections when we come back to your review. What I want to do is to move on to a follow-up IMT, which you weren't at, but which you might have seen the minutes. So it's the next IMT which is on the page 330, and this one is a meeting where Scott Davidson has attended. So this may support your conclusion that you're there previously as a substitute for Scott Davidson. You see he's on the second list-- second name on the attendance list?

A Yes.

Q In this meeting, there is a report that Kevin Hill, and it's on page 310-- No, not-- sorry, that's the wrong page. It's on page-- Sorry, I'm going to have to just check something. Yes. On page 333, do you see under duty of candour, "Professor Gibson is speaking to the most recent M. chleonae parent-- patients on Tuesday." And the next sentence, "The Chairman of NHSGGC is in communication with the father of the first case." So what-- is that something you remember being told at the time-- knowing at the time or is it-- only comes up in your review later, because you weren't at this meeting?

A I wasn't at this meeting and it's not something that would have been on my radar at all.

Q Okay. What I want to do is to look now at the next meeting you attended. Now, the next meeting you

attended, I understand, is 14 August, and that is bundle 1, document 77, page 343. So this appears to be a meeting on 14 August. Again, it's chaired by Dr Inkster, there's a slightly larger attendance this time, you're present, and the issue in the meeting is you'd not attended the previous two meetings and Scott Davidson had. And I'm wondering what your practice was on ensuring that you are up to date when you go to these meetings. Would you have read the minutes, would you discuss them with Mr Davidson, would you have found that-- Dr Davidson found out other ways?

A I don't recall.

Q Do you have a pratice when you go to IMTs about finding out what's happened?

A I really don't recall. I wasn't a regular attendant at the IMTs and I don't recall.

Q Yes, I appreciate that now. But, I mean, if you are a deputy to medical director corporate, you're going to an IMT, it's clearly-- it's a complicated meeting. I think you'd agree with me about that. You're sort of blinking in a sort of vaguely approving way. Would you agree it was a complicated sort of----

A Oh, 100 per cent, yes.

Q Yes. Right. Now,

because the transcript doesn't get your gentle head gestures, we do need you to say-- use words. Would you accept that it's unlikely you would have gone to an IMT without doing at least a small amount of preparation?

A So, the minutes of the previous IMT will have been sent out as papers for it and, therefore, minimally, I would have read the minutes of the previous meeting so I was up to date, and also it's recorded in this meeting here, reference to a paper that I'd read from Dr Iain Kennedy, and so----

Q Yes, because he raised that at the previous meeting.

A -- and so, clearly, I'd read that paper in advance of the meeting as well.

Q Yes, and this meeting on 14 August, are you aware of there being a pre-meeting of any participants in the IMT?

A Not that I can recall.

Q So we know that there's a subsequent meeting which you're not present at, where there seems to be quite a lot of evidence there was a pre-meeting beforehand.

A Right.

Q And we're still talking to all the participants. So the reason I'm asking is because had there been a

pre-meeting of the one that I-- and seeing if it happened, you were likely to be involved in it, but you're not-- you don't recollect there being a meeting? Or you don't know there was a----

A I really don't recall attending a pre-meeting for that one.

Q Now, if we go to your statement, page 160-- If we go to the statement bundle, please, page 160, the minute of the meeting, which we'll go back to the moment, so we'll go page 160-- No, that's definitely the wrong bundle. That's from the last hearing. So while this is coming up on the screen, Dr Deighan, effectively, what I'm going to try and do is I'm going to put to you what's in your statement, but you might want to go back and look at what's in the IMT minute before you answer my question. So that's an opportunity there. So, we go to the statement.

A I've got my statement in front of me here.

Q I know, but it's the audience----

A Oh, sorry.

Q -- sitting to my right who need to see it. So you're looking for the statement bundle, page 160, from this week, Tom. Yes. That should be the right one. No, that's the wrong one. That's-- I'm looking for a

previous statement bundle. This is Dr Kennedy's there, so it's the same bundle for this week. While you're doing that, I'll set up the question with Dr Deighan. So, what I have taken is two things. So, in the IMT minute, which we'll go back to and look at----

THE CHAIR: Sorry, can I just interrupt, so that-- just to make sure that everyone knows what you want them to be doing. The last note that I have of what you said, Mr Mackintosh, was referring to a Dr Deighan's----

MR MACKINTOSH: We have it, my Lord.

THE CHAIR: -- witness statement. Was that what you were----

MR MACKINTOSH: Yes, that's what I'm looking for.

THE CHAIR: Right, fine.

MR MACKINTOSH: And I'm grateful to my colleague who's now----

THE CHAIR: I'm glad I'm keeping up. I just wondered if you were wanting something else from us.

MR MACKINTOSH: No, no, I've got what I wanted, and page 160 was there a moment ago.

THE CHAIR: Yes.

MR MACKINTOSH: Perfect. So, what we have halfway down this page-- Well, at the top of the page, we have IMT, 14 August 2019, and you say you recall attending the meeting

and you describe the purpose of the meeting by reference to the document itself. And then at 29, it states, "I think in the minutes"-- it should say, "In the minutes, you disagree with Dr Inkster that the numbers of bacteraemia have increased," and we ask you, "What is this opinion based on? Please provide reasons for your conclusion. Have you since changed mind? Please provide reasons for it." And then you've answered:

> "As noted in the minute of the meeting, I referenced an epidemiology report from Dr Kennedy that I had seen. There is nothing in the meeting that suggests that I disagreed with Dr Inkster. The minute notes that my comment was in response to a comment from one of the consultants and it would seem reasonable to seek clarification. The minute goes on to note that Dr Inkster and Dr Peters went on to state that it was the nature of the bacteria that was a concern and that it was likely that the CLABSI work and excellent practice had driven rates of typical pathogens down."

Now, if we go back to the IMT bundle, bundle 1, page 343, and then

if we go to the section we're talking about, which is the middle of the next page, I think what might be the point that we should have been making to you is this. It seems to be a possibility that there was some, I hesitate to use the word "disagreement", but some lack of entire agreement about what was going on at this point and that Dr Kennedy's report and you, in this minute, seem to be suggesting that there's no increase in infection numbers, and Dr Inkster is raising the possibility that the whilst there has-- that in some way there's been a reduction caused by CLABSI and practice. Do you remember why it was that you raised this issue in this meeting, the Dr Kennedy report?

A So, as the minute notes, one of the consultants, according to the minute, said that there had been an increase in infections. The information I had at that point clearly was based on the report by Dr Iain Kennedy that I'd read, which had suggested that there wasn't an increase in infections. In response to that, Dr Inkster and Dr Peters, according to the minute, clarified that it was the nature of the bacteria that was a concern. I'm not sure, and I don't recall there being a disagreement there. I think what I was looking for

was clarification based on the knowledge that I had, at that point in time, following the comment from one of the consultants.

Q Thank you. At this point, Dr Kennedy's paper, which we can go to if we need to, has been produced-- the 2019 version, which has the 2018 version as an annex. So you, presumably, saw the 2019 version with the 2018 version as an annex to it. Does that sound right to you?

A I haven't seen Dr Kennedy's paper in a number of years and, therefore, I wouldn't be able to-- you know, I can only reference what's in the minutes rather than anything else.

Q Because at this point, there are other epidemiology bits of work out there. There are two HPS-- There's one HPS piece of work particularly from early 2019. Had you seen that?

A I don't recall.

Q Right, so this is just a question based on the paper that you've got attached to the previous minutes, in essence.

A Yes, so it's seeking clarification following the consultant's comment, based on the information that I had at that point in time, and when I sought clarification on that, then Dr Inkster and Dr Peters responded, as is in the minute. That would seem to be what I'm----

Q So, the impression that they have formed, and Dr Peters has given evidence and Dr Inkster is still to give evidence, is that this point that you've raised is not dissimilar to a point raised with Dr Inkster two days before by Dr Armstrong. And so I have to put it to you, would this have been something that you'd discussed with Dr Armstrong in advance of the meeting and sort of come ready to make as a point?

A I honestly don't recall.

Q Because this meeting is the last paper you-- the IMT you attend before Dr Inkster is removed as chair, isn't it?

A So, I think I only attended three or four IMT meetings. I'd need to go back to my notes to see exactly when they were and the timing of the change of the chair, but I think that's correct, yes.

Q Right. So, what I want to do is to look at an email that you received on 16 August 2019. That's bundle 14, volume 2, document 144 at page 568. So this appears to be an email from Ranjit Bajwe, who I think is the support person for Dr Armstrong or Dr Caestecker – I can't really

remember – to a series of people including you, inviting them to a meeting on 20 August at three o'clock in the learning and teaching room, the subject of which is, "Haemato-oncology: assessment of current position and understanding additional support requirements," albeit this may be a forwarded email so that may not be the original-- that may be an original subject from a previous part of the thread. And you see the text:

> "Dear colleagues, as you will be aware, there are a number of issues regarding the haemato-oncology units at Queen Elizabeth University Hospital and I'd like to take this opportunity to invite you to a meeting to discuss these issues. The aim of the meeting is to set out the current position [I don't know why the Ts have disappeared] and discuss additional support to address current issues. I'm aware that this is short notice for this meeting and would ask if you are able to flex your diaries to accommodate the meeting. I will chair the meeting. The meeting will take place"--

And it gives time and place. Now, when you receive this email--

Firstly, do you remember receiving this email?

A No.

Q No. From this email, what would you understand the purpose of this meeting was to be?

A Exactly what it says on the tin, being invited to a meeting to discuss a number of issues regarding the haemato-oncology unit at the QE. I'm not sure I would necessarily read into it any more than what the email says.

Q Right, and you don't remember receiving this email?

A I honestly don't, no.

Q No. Well, let's look at the meeting minute. So, that's bundle 6, document 22, page 70. So this is a meeting on the same day, albeit described as being in the boardroom, and it has the same attendance list as the invitation list that we've just seen in the previous email inviting people to a meeting on 20 August, albeit Dr Inkster has given her apologies. Do you remember going to this meeting?

A I do remember going to this meeting, and I remember it because, up until June of that year, I'd been chief of medicine at Glasgow Royal Infirmary, and I remember-- I think it was probably the first time I'd been back in the management area at

GRI since I'd taken on my new job, so that's specifically why I----

Q Yes, so you're still going back to your old haunts?

A Yes, absolutely.

Q Now, let's look at the people who are present. I want to just make sure, at this point, is there anybody at this meeting who you wouldn't have met before this meeting?

A I can't recall whether I'd met Mr Forrester before or not. I may have done, but the rest of the names would all have been familiar to me at that time, yes.

Q And if we look at this list, I've checked across and I'm happy to go back and check, but five of the attendants at this meeting were at the IMT on 14 August. That is you, Sandra Devine, Jamie Redfern, Jennifer Rogers and Professor Steele, and Dr Kennedy had, as you already mentioned, been at an earlier meeting, but Dr Mathers hadn't attended one since January, and I wondered if you knew whether Dr Greene, Mr Best and Dr McGuire had attended any of these gram-negative or Cryptococcus IMTs.

A I don't know.

Q You can't help me. Right. And you see that Dr Inkster gave her apologies?

A According to the minutes, yes.

Q Do you remember her being there or not there, from your point of view?

A I honestly don't remember.

Q Right. Well, let's look at the background:

> "Professor de Caestecker opened by outlining the purpose of the meeting as considering recent experience of IMT meetings, the appropriateness of using this mechanism to manage the complex issues which are ongoing in the Queen Elizabeth University Hospital, and identifying learning from experience which might be beneficially applied to re-setting the IMT process. Professor de Caestecker reminded the meeting that the national guidance states that the director of public health has a role in reviewing the functioning of IMT if there are any concerns."

Now, my first question is, to what extent do you think the background and subject of this meeting is properly indicated in the invitation that we've just looked at?

A Sorry, I'm not sure if I follow your question.

Q Well, let's go back to the invitation. It's on bundle 14, volume 2, page 568. This appears to be the invitation to attend the meeting that was sent to Dr Armstrong, Dr de Caestecker, you, Sandra Devine, Rachel Green, Dr Inkster, Iain Kennedy, Margaret McGuire, Jamie Redfern, Jennifer Rodgers and Professor Steele. This invitation does not mention that the subject of the meeting is to be what has just been described in the minute as the background of the actual meeting that took place, does it?

A It doesn't appear to be.

Q No. So, given that you can't remember receiving the email, looking at it now dispassionately from, what is it, five years on, if you received this invitation and then turned up to the meeting that's described in that minute, would the subject come as some form of surprise to you?

A I'm not sure.

Q Well, this meeting doesn't-- If we go back to the minute of the meeting, which is bundle 6, document 22, page 70, there's nothing in that previous email to indicate that the purpose of the meeting is to discuss the appropriateness of using IMTs to manage the complex issues ongoing at the hospital, is there?

A That would appear correct, yes.

Q And there's nothing about identifying learning from experience that might be beneficially applied to re-setting the IMT process, is there?

A That would all appear to be correct, yes.

Q In fact, there's no mention of IMTs at all.

A Not in the email, no.

Q Now, we can hear from Dr Inkster, and I'm sure we will, as to why she didn't attend this meeting. Now, if we go and look at the rest of the meeting, issues of concern-- And stop me at any point if you think the minute's wrong from your recollection, because obviously you went back to your old haunts, first time you're back there, you're in the boardroom. Professor de Caestecker invited those present to give feedback on their experience of IMT meetings. At this point, you've been to two-- three, sorry.

A Well, it depends whether you count the one I'd been in, in January, which was the second one.

A I was being generous. You've been to three. Yes. And so

did you give any substantive feedback at this meeting?

A So, as I've said in my statement, I recall feeding back relating to the-- one of the rooms. So the first meeting I was at, which was the one in June, I think I noted in my statement that the set out of the room really wasn't conducive to having a meeting with a small table and people being scattered around the room and, to be honest, that's my overriding memory of that meeting, rather than the content of the meeting itself. The only thing that I recall feeding back about the second meeting wasn't related to the comment about the infections which you noted earlier but was related to behaviors which, again, I've noted in my statement.

Q Okay. So, actually, we can see in the second sentence:

> ""Two themes of feedback were raised: practical issues relating to membership, room [which I'm assuming to some extent must have its origin in you, and then] … behavioral issues in recent IMT meetings."

Which you've just explained as one of the things you might have mentioned, and then:

> "The group [I'm assuming "the group" is the people at the meeting] also highlighted the need for an IMT to work within a safe and confidential environment in order to manage the situation and protect patient confidentiality."

And then there's discussion of press leaks. Had you been aware of press leaks at this point?

A I may have been aware of them. I can't remember any specifics.

Q So, the thing that's interesting to me is this meeting doesn't appear to have as its membership all the members of the IMT. They're not all being consulted, are they, Dr Deighan?

A Well, certainly the chair of the IMT is not being consulted because the chair of the IMT at that point was Dr Inkster and she's clearly given her apologies to the meeting.

Q Well, she hasn't, has she? She's given her apologies to a different meeting, because she's not been told that this meeting is about the IMT, has she?

A Well, I'm not sure I can comment on that.

Q Okay, well, let's make it about you instead. Let's imagine that you had been chairing a series of

meetings in one of your many jobs in the hospital and an invitation had been circulated by senior managers inviting you to discuss something completely different, and you've given your apologies for some other reason, and then you discover later when you get the minute that they're discussing you and your conduct. How happy would you be about that?

A If it was me, I would not be happy.

Q Because one of the things that interests me here is you're not someone who had a lot of experience with this IMT, are you?

A No.

Q Because if we look at the other people here, Professor Steele has been to lots of these IMTs, as has Mr Redfern and Ms Rodgers and Ms Devine and Dr Kennedy, and they appear in many of them. So they have some experience to contribute to this discussion, but you have a limited experience because you've only been to three meetings. You'd agree about that?

A Oh, absolutely, yes.

Q So, you're the deputy medical director corporate. How do you feel about a meeting being held to discuss one of your senior clinicians, of which they have not been given

practically any notice that they are the subject of the meeting? Do you feel that's suitably respectful of a colleague?

A I can certainly see how it might be viewed.

Q Viewed as what?

A So, if the discussion was centered around me and a series of meetings that I was chairing, then I could see that I would be unhappy in that context.

Q Because one of the obligations on a doctor is to be respectful of your colleagues, isn't it? Is that a yes?

A That's an absolute yes.

Q Yes. And so you'll be familiar with the idea that whilst the person who calls a meeting in many ways is very responsible for what happens at the meeting, people who just go along and sit quietly are also responsible for what happens at meetings, aren't they?

A I think that is correct, yes.

Q So, in a sense, you are, I accept, completely new to this environment. You've not lived through the last four years. I mean, we've been talking to-- about and to the people listed at this meeting for some time in this Inquiry, and we will hear

their stories in the next few weeks. You're new to this.

A Absolutely. So, the meeting's on 20 August, so I've been in the post for a couple of months.

Q So, at one level, I'm being slightly unfair to you, but I do have to put to you: is it really proper for a bunch of doctors and nurses to hold a meeting to discuss the then-lead infection control doctor's conduct of her meetings without giving her notice and in her absence?

A So, I can certainly see the argument that you're putting forward. I think that question probably needs to be directed to the chair of the meeting that called the meeting rather than myself in that circumstance.

Q Because I think I will direct this question to you as well, and I'll direct it, if I remember, to everybody else who is still to come in the witness list, but is there not some obligation to have said, once that opening had been delivered, "Excuse me, I didn't get an invitation to that meeting. I thought this meeting was issues in haemato-oncology"?

A So, as previously noted, I don't recall the email and, therefore, I don't recall the context in which the meeting was called.

Q Now, let's go through the

rest of the minute. So, we've discussed the big paragraph after "Issues of Concern" and the concern about press leaks, and then there's an observation:

> "Regarding practical issues, those present raised concerns regarding the number of people who are present at IMT meetings, and the uncertainty as to who might attend and the 'coming-and-going' of people once the meeting is underway."

And then the room issue is raised, and it ends, the page:

> "It was noted that guidance for IMTs provides for 'required' attendees and 'discretional' attendees, who may change depending on the nature of the issue. It was noted that one role of the Chair would be to identify who should attend, and who is required for any particular discussion within an IMT."

You've obviously only attended a few IMTs at this point. Do you have any thought about whether it helps the IMT process to have additional senior people attending those IMTs or whether you think it's a benefit?

A So, my thoughts would be that you should have a consistent

core participant, so that there is a regular thread throughout the meetings, but that you may on occasion want to invite additional people if they're presenting specific areas or linking in with specific issues that arise.

Q The next paragraph deals with behavioral issues, and it describes in the first sentence:

"Those present raised concerns regarding the nature of communication within the IMT ('confrontational', 'uncomfortable dialogue', 'off-the-scale-bad', 'totally disrespectful', 'inappropriate language')."

Putting aside whether it's "totally disrespectful" to discuss the IMT in the absence of its chair, are you aware of any whether anyone in this meeting had taken the soundings of the members of the IMT who weren't present at this meeting?

A I'm not aware, no.

Q Now, the last sentence, "It had been reported that some people felt unable to speak up at the IMT because of this culture." Can you recollect whether that is discussing the views of the people at the meeting or other people who aren't at the meeting to whom it's perhaps been reported back?

A I don't recall. This meeting was five years ago, and I simply don't recall.

Q The rest of the meeting discusses a potential way forward. Do you see the third paragraph:

> "Consideration was given to the benefits of holding a small group pre-meeting to ensure the Chair is fully informed of the circumstances ... is prepared for chairing the IMT, and ... consider discretional attendees."

Are you aware of whether that's consistent with the National Infection Prevention Control Manual?

A It's not my area of expertise, and therefore I wouldn't be able to make an informed comment on that.

Q All right, and then the actions. Now, am I to take you that everybody at the meeting would have agreed to these actions?

A I don't recall.

Q Well, you're not minuted as disagreeing, Dr Deighan. Should we take it from this that, at the end of this meeting, if I'd asked Dr Caestecker, "Did everyone agree?" she'll say, "Yes," or do you think you've dissented in some way?

A I honestly don't recall.

Q There seems to have

been a decision made to change the chair of the IMT process to an experienced public health doctor, or an ICD from another area. Do you remember that?

A It's noted in the minute. As I said, the meeting was five years ago. I'm heavily reliant on reading the minute to have recollection of the meeting.

Q So, I'll come back to that bit in a moment. What I want to do is move on to talk to you about your review but, before I do that, I think we'll just touch one IMT, which I didn't give you notice for, but I want to give you an opportunity to explain something that I realise I don't understand, which is bundle 1, document 83, page 371. It's October, and I was reading this again, 371, and I realised, if we go onto page 373, this is an IMT after the chair has changed on 8 October.

There's a large attendee, so they obviously haven't got on top of the attendance problem by this point, but on the second page there's a discussion about the definition of a hospital acquired infection. I recognise I'm bouncing this on you, but do you have any recollection of this discussion?

A Vaguely.

Q Because what I'm trying to understand is-- I get the impression that your perspective is that of a nephrologist, or a renal doctor.

A Yes. So, I had read this because it was noted in the questions from the questionnaire to start off with, and, yes, I'm presenting here my experience from a renal clinician perspective, because infections in dialysis patients is something that we track on a regular basis.

Q Yes, and indeed somewhere within this section you observed that they're actually at a slightly higher risk of infections than some other classes of patients.

A Certainly the presence of dialysis access and plastic lines in the necks of dialysis patients gives them a propensity to infections, added to their comorbidity.

Q The thing that intrigues me about this intervention is – and I may be corrected by other witnesses, or indeed possibly my colleagues when I finish asking this question – that it seems that what's happening is that there's an attempt to create almost a bespoke definition for cases at this point in time to understand something that's going on at this point, and that you're commenting that's different from national policy for dialysis patients. Does that seem

roughly right?

A Yes, I think the point I'm making here is if you change the definition, then you negate the ability to compare your rates with rates elsewhere, because you're no longer comparing apples with apples?

Q That seems a very sensible point, but I suppose the question to ask back is that, at this point, we are now October and this is about the time when the Health Board gets taken to stage 4 and there's lots of senior people involved. I think Professor White's attending these meetings at this point. It occurs to me that your observation comes with the weight of authority of the deputy medical director but, actually, it's really the professional opinion of a long-experienced nephrologist.

A I think the minute notes that to an extent----

Q No, it does, yes.

A -- because it does say, "Although he was happy to be corrected on this by haemato-oncology colleagues, and therefore"-- and the minute notes that I'm talking about hospital haemodialysis patients.

Q Yes.

A But, again, I can totally acknowledge what you're saying in terms of, you know, sometimes the

role brings with it a certain level of gravitas, and I think we always need to be aware of that.

Q Well, indeed, and so I think the question I'm making is, might there be an issue in the way that IMTs work, or were working here, that senior people are there, they are showing the hospital's concerned, they are asking questions, but, occasionally, because of their own experiences, their own professional background, they sort of have the potential of slightly influencing stuff that wouldn't have been influenced if the medical director had been an A&E doctor or something, or am I making something out of nothing?

A Well, I think, as I said, I'm reading this on the go, but the minute does note, under point 3 there at the bottom of the page, that I'm specifically referring to hospital acquired infections and hospital healthcare associated infections, rather than the definition of an outbreak of an IMT, which is something completely different. There's a clear definition of a hospital acquired infection and a healthcare associated infection rather than, you know, the group of infections that are being followed by the IMT, and I'm specifically making that point.

Q Thank you. Well, that was helpful. I just wanted to clear that up because it confused me. Let's go where we were mainly going, which is back to your review. So, if we go to bundle 27, volume 6, document 6, page 91, this is a report by you from May 2021.

A Correct.

Q Now, I want to ask you quite a lot of questions about this. So what I thought we should do is take a moment just to walk through it, just so we can remind ourselves of the sections, and then ask you some questions. Then I might come back to something from the previous topics. So, can you explain how this report from you came about?

A Yes. So, as it says in the background, at the beginning of October 2019, Dr Armstrong emailed me regarding the three issues that are raised there, which had been raised by Dr Inkster in her letter of resignation to Dr Armstrong, and Dr Armstrong, subsequent to that, asked me to take forward a review of these three issues.

Q The fact that it took you a year and a half has probably got something to do with the pandemic, I'm assuming.

A That, to be honest, made the completion of the review really quite tricky, simply because the COVID pandemic hit in February/March of that year, all sorts of things changed at that point, and then by the time it came to completing the review, as is noted in the substance of the report, a number of things had taken place, a number of changes had taken place.

Q Indeed, and so what I wanted to do was just make sure we understand what the three issues were. So, the SCI process, that's a significant clinical incident?

A Yes.

Q Yes, and that relates to Cryptococcus neoformans and the death of a patient.

A Correct.

Q Or two patients, in fact, but I think the SCI might only have been about one.

A So, the SCI was about one patient.

Q Yes. The duty of candour regarding infection control incidents: now, that relates to a duty of candour issue raised by Professor Cuddihy.

A That relates to communication to Professor Cuddihy regarding an infection control incident, yes.

Q All right, and then the

governance issue, in very short terms, relates to an issue about whether the group working on addressing the problems of the water system should or shouldn't have reported in some way to Dr Inkster. That's a very shorthand version of it, but it's roughly that.

A No, it primarily related more to Dr Inkster's concerns about specific actions not being followed, and the link between the Water Technical Group and the IMT and, really, the governance of decision-making within the broader IMT and Water Technical Group.

Q Right, and then in the next paragraph we see that you report that you asked Dr Green, chief of medicine for diagnostic services, to interview Dr Inkster to get a fuller account of these issues. The interview took place on 6 January 2020 and is detailed in appendix B. I might go to that in a moment but, before I do that, I think I could probably usefully go to the invitation to that meeting, which is in bundle 14, volume 2, page 509, document 128.

So, one of the things that has arisen in Dr Inkster's statement is that she didn't realise he was doing this review. That's her position, in very short terms, and this is the invitation. I recognise you didn't send this, and it may be that, simply, a confusion has happened, but do you see how the invitation says, "Chris has asked me to meet with you to investigate some concerns you have regarding those three issues"?

So, do you see how it might appear to Dr Inkster that it's Dr Green who's carrying out the investigation?

A Yes, I can see how that would appear, yes.

Q Because, actually, by the time you've finished the investigation, Dr Inkster has moved on to NSS.

A Yes.

Q Yes. Now, if we go back to your statement at page 173-- We'll go to 172, actually. We'll get a better answer. You see question 73? You're asked about the review, "What were the key factors considered and why?" Now, you clearly think this paragraph is important because you reference back to it later on, and I wanted to understand what you're trying to say. So, your answer is:

> "This was not an investigation underpinned by any policy framework, rather a review of the issues raised. As noted in Section (4)- Summary of the report [which we'll go back to if

we need to], given the multiple investigations and enquiries that were ongoing, the key factor was to get clarity and a fuller account of the issues raised under the broad headlines, in order to provide a clear focus for the review."

Now, in a sense, what's the distinction you're trying to make by saying – and you say it again in paragraph 75 – that it's a review of the issues raised rather than an investigation underpinned by any policy framework? Because I'm afraid I'm missing that.

A Well, I suppose there are a number of investigations that have policy framework underpinning them – for example, a serious adverse events review, or an SCI review, or a whistleblowing review, or an investigation related to staff governance issues. You know, there are plenty of investigations that can be done that are underpinned by policy frameworks. This was simply Dr Armstrong asking me to review these issues and draft a report accordingly.

Q So, in essence, it's an informal report is the point you're making. It's not part of any system.

A I think that's absolutely right, yes.

Q Right, okay. Now, can we go back to the report itself, yes, to page 92? So, I appreciate you're writing this in May 2021. You report that you attended three of the IMT meetings, deputising for Dr Davidson.

A So, in fact, in retrospect, I'd actually attended slightly more than that.

Q Yes, but three in the summer. You had others in October.

A Yes.

Q As a result, you were interviewed as part of the internal whistleblowing investigation, and you contributed writing of the letter from the board medical director to the parent involved in the duty of candour incident, and you say that you worked with Dr Inkster as a colleague in the past and that you've co-authored two publications in 2017. I'm intrigued to know why you don't mention your attendance at the meeting of 20 August at this point.

A Clearly, I either felt that it hadn't been important, or it's completely slipped my mind.

Q Because I think I have to put to you that you might not be the ideal person to write this report, because Dr Inkster probably wouldn't have raised these three issues had she not resigned as the lead Infection

Control doctor, and that, to some extent, the reason she resigned as a lead Infection Control doctor – and she'll explain exactly the connection because it may be health as well – is because she was removed as the IMT chair. So, do you see that there may be a suggestion that you were actually probably the wrong person to be doing this, from her point of view?

A And that is-- The question about bias, be it conscious or unconscious bias, was flagged in the questionnaire that I was sent. I can completely understand how it might be perceived that I may not be impartial in that context.

Q Well, indeed, because we've got to work out what weight to give to your report. So, what I want to do is look at the three issues at, sort of, top level and really try and understand what information you had available to you because I appreciate you didn't write this report with the idea that lawyers will be asking you questions about it three and a half years later. So, if we look at the section on the SCI process, what were your conclusions on this particular issue?

A So, in terms of the SCI process, I specifically asked Mr Andy Crawford, who's the head of clinical governance in GGC at that point to review the governance here because, in many ways, in the context of the three issues that Dr Inkster noted there, I was asking myself, "Right, what's the exam question here," and the exam question really for the SCI process really was: was due governance followed and was due governance appropriate in the knowledge that, clearly, Dr Inkster disagreed with the way that the SCI had been progressed? Had GGC followed appropriate governance in terms of the processes that appplied?

Q So, your section here, which is about governance and process, is to some extent grounded on this supplementary-- this separate report by your colleague?

A Yes.

Q Right, and what I'm concerned about is that we have the email exchange that takes place when the first draft of this SCI is produced, and we have Dr Inkster commenting on how she's not, in short terms, happy with the changes, and we have the attached document with the track changes. Would you have had access to the original document with her comments on it?

A So, that was sent to me as an additional bundle late yesterday,

and that's the first time I had seen it.

Q So, you didn't see her actual complaint?

A I was working on the narrative that she gave to Dr Green when Dr Green interviewed her.

Q Because what----

A What I would add, sorry----

Q Yes.

A What I would add is, when I read that yesterday, it very much aligned to the feedback that she'd given Dr Green when Dr Green had interviewed her.

Q Because one of the points that you make at the end of your conclusion, and I recognise it may be more complicated than I'm saying it, is that you didn't feel that you could corroborate her complaint. Now, I suspect you might have-- mean confirm or agree or find out that it's true as opposed to what we as lawyers would see as corroborate. What do you mean by that as "corroborate a complaint"?

A I think you're absolutely right there. So, I wrote this report something like three and a half years ago, and I've not seen it for two years. You reflect on the language that you put in these reports, and when I read the report again, I think it's probably fair to say that the use of the word "corroborate" is probably not the--correct at that point.

Q Because in some senses, your position – in many ways, there's only wrong with that – is that you disagree with her views.

A So, I tried to do a report that was detailed and narrative and took things through in a logical process because, in many ways, that's the way my mind works, and the-- basically, the report said that-- I can totally and absolutely sympathise with, and understand the view that Dr Inkster had in the context of her feelings about the SCI and also in terms of her feelings about the duty of candor, but I didn't feel that the findings of the report necessarily supported them as-- you know, difficult to prove one way or the other. Yeah.

Q Well, can we go on to the next page of this bundle which is page 93? Now, I'm interested in the second paragraph. I mean, there may actually be nothing wrong with a-- we don't know really yet, with a corporate interest being taken about an SCI. That's something that I'm quite keen to hear what you had to say about, but I do notice that one of the things you draw out is that there were organisational sensitivities. So, what

I'm really trying to capture here is, looking at it dispassionately from now backwards, is it legitimate to think that an SCI like this should actually be, in a sense, under control of the IMT chair, or is it better to take the view that this is something for the board as a whole at a sort of governance level?

A So, I think that's a very reasonable point, and if you go down to the last paragraph of page 93 there, it does highlight that, subsequent to this, the revised SCI policy – or serious adverse events review policy, as it became known as – when it was updated, introduced a couple of processes in the update. The first was corporate commissioning of an SCI, where it was felt that there were issues which would be-- not simply local to a service but would be wider beyond that. Then, secondly, a process that underpins resolution of disputes similar to what's identified in this. So, in fact, some of the learning from this SCI was embedded within the updated SCI policy, which was due for revision in 2020.

Q Might that not support the conclusion that, at the time this SCI started life in 2019, whether it was right or wrong, the policy rather required this to be a local decision and, therefore, whether it's the right decision or not, to some extent, Dr Inkster's right that this decision has been pulled from the local team, up to a corporate level, when the policy at the time didn't then require that?

A So, I think that the issue about the complexity of this SCI was-- So, the SCI was very complex to start off with, and was made more complex by the fact that separate to the SCI and an additional independent investigation into the source of Cryptococcus and the potential role of pigeons and ventilation, was then put in place by the organisation. Therefore, you could potentially, therefore, have two separate investigations running in parallel, which could conceivably come up with completely different conclusions.

Therefore, given that the additional investigation was put in place, the view of Andy Crawford was that it was entirely reasonable to revise the terms of reference of the SCI to focus on the clinical care of the patient in Ward 4C and to have the separate investigation which would be fed back to the family, looking at the role of ventilation. In fact, I am aware of that and I know that because I've seen correspondence, which is in appendix C of the report, which notes from the commissioners of the SCI that they

have discussed this with the head of clinical governance, who felt that this was an entirely appropriate thing to do in the circumstances.

Q Thank you. The point that-- I suppose, to wrap up this section is that if you have a incident where the issue is not practiced in a ward or decision of an individual clinician or an error by anybody but it is something to do with the very infrastructure of the hospital, it's a consequence, whether expected or unexpected, of a decision that was made years before at some vast expense, then there is at least the suspicion that the corporate response, further you take it away from the experts, might want to protect the reputation of the organisation rather than get to the bottom of what went wrong. Do you see that as a risk about corporate governance taking, shall we say, a lead or at least a senior role in SCIs?

A That is a risk but, at the same time, there's a-- as I've said, if you've got parallel investigations going on, looking at the same issue, then there is always risks that these parallel investigations then come up with completely different viewpoints and completely different output. So in the-- that is why the commissioner of this investigation-- of this here spoke to the head of clinical governance, who agreed that the terms of reference for this SCI should be revised to focus on the clinical care, because there was a parallel investigation that was ongoing.

Q Well, is that right? I mean, let's choose a different example. Let's imagine the clinician makes an error in an operation and something bad happens to a patient. People who know about that piece of medicine investigated, reached a conclusion, and that's a reality the Board has to deal with. No one would suggest at that point a corporate investigation happens in parallel, would they? They would just rely on the individual investigation. Have I got that right?

A Yeah.

Q Yes, but why is this different? Why is it that if somebody or some people or an organisation made a mistake in maintenance or procurement of a ventilation system many years and before, why does the organisation get to take over the process? It wouldn't do that if the organisation had hired a very-- a not very good doctor, would it? That would still be an issue for the local team to work out what had happened.

A So, as I said, in this

circumstance related to this SCI, there was an additional independent investigation that had been commissioned.

Q This is what became Professor Hood's report?

A That's what I believe they're referring to, yes, and, therefore, given that that additional independent investigation is ongoing, that was the rationale to revise the terms of reference. In terms of the remit of this review, I was asking myself, "Was due governance followed?" It appeared to me that due governance was followed because, at the end of the day, it's the commissioner that has to finalise and agree what the report is, and the commissioner of this liaised with the head of clinical governance. Therefore, it appeared to me that in terms of the process that was followed for this SCI, that due governance was followed, whilst accepting that not everybody agreed with that.

Sometimes, occasionally, that happens with SCIs. Sometimes there is not an agreement in terms of the output of an SCI, and the commissioner of the SCI has to make a call as to what they're going to accept for the SCI, which led on to the revision of the SCI policy to ensure that there was a procedure to underpin resolution of disputes.

Q I suppose the question that flows from that is: why do you think that the report of the Cryptococcus expert subgroup is an independent report?

A It's independent to the SCI.

Q It's not independent to the health board, is it?

A I think that's a reasonable point, yes.

Q And, indeed, were you aware that NSS, its members, didn't agree with the conclusions and made that very clear?

A I haven't seen the output of that report, and it's not something I'm familiar with. Again, looking at the wording of the report here, much of that-- as I said, I asked Mr Andy Crawford to look at this aspect of things. Independent investigation is clearly referring to an investigation independent of the SCI, not necessarily independent to the health code.

Q I'm going to try and not take you to your statement because you gave a very, very long answer. I'm going to put something to you that you said in your statement and see if you recollect saying it, and we'll work out what you meant. So, within your

statement, in answer to question 83 which is on page 178 – please don't put it up – you observe that Dr Inkster was invited to put any concerns that she had in respect of the final draft, in writing, to the director of regional services and no reply was received. The report was signed off in April 2020 and shared with the family. Now, that's something that you were expect-- that did happen.

A I've got-- That's noted in appendix C.

Q Yes. So, just to check, would the director of regional service at that point have been Arwel Williams?

A Yes.

Q Yes. So, Dr Inkster's response to this is: by this point, she had raised the issue in her original email-- (inaudible) the terms the SCI which you didn't see. She'd raised it in her resignation letter to Jennifer Armstrong. Did you see that?

A I've not seen the resignation letter to Dr Armstrong.

Q She raised it to Linda de Caestecker in the investigation, which presumably you wouldn't have seen the report from that. She raised it in an email to you, which I'm not going to put on the screen, but what I'm going to do is I ask my colleague to sidle it

across to you. It's on bundle 14, volume 2, document 174. The subject, I think, should have been redacted, that's all. So, if you look at bundle 14, volume 2, document 174 at page 655, you'll see it's an email on 3 January 2020 to you about some of the issues, albeit not the SCI, but some of the other issues in the-- in your investigation or something about your investigation. Do you know what the context of this is?

A Give me a sec while I just read this.

Q If you look over the page, you might see it's actually about the duty of candour matter.

A So----

Q Maybe it's not relevant to this point.

A So, looking at the timing of this email correspondence, which is at the end of December, beginning of January----

Q 2019/2020.

A 2020.

Q Do you think this is mainly about the duty of candour?

A I think-- So, the email says, "I enclose what I hope is the final draft of the reply to Professor Cuddihy," and therefore I'm presuming that this email is related to the letter that went from Dr Armstrong to

Professor Cuddihy in January 2020.

Q Right. Well, maybe that's not relevant then.

A I'm presuming that's the context of that.

Q But she also explained her position to Rachel Green and Rob Gardiner when they met her, and so on this occasion, this is the fifth time she's been asked to repeat her concerns. Do you think it's reasonable to assume that she's changed her mind if she doesn't reply to that email?

A I'm not sure I can comment on that----

Q Well, the reason is that what's happened is that for reasons that I absolutely understand, there's been a pandemic. During the process between you starting a review and you ending a review, at some point, the SCI was finalised and the final draft has been copied to other people, including Dr Inkster, and she hasn't cut in and said, "No, I still disagree," but she's raised it four or five other times. And you seem to be relying, in your statement, on the idea that she's sort of approved the final version. Is that what you want us to understand?

A No, I'm not relying on that at all. As I said, the exam question I asked myself was whether due governance was followed in terms of the SCI, because it is recognised in a small number of SCIs that there is disagreement and sometimes that disagreement can be difficult, if not impossible to resolve and the commissioner of the SCI, at the end of the day, has to make a call on that disagreement and, on this occasion, they spoke to the head of clinical governance who felt this was an appropriate way to go forward, in terms of the revision of the terms of reference.

Q So, effectively, what you've done with the SCI is you've checked on the person who checked. You've reviewed a review.

A No, I'm not sure----

Q Because Mr Crawford did the review and you reviewed that, or is that being a little bit harsh?

A Yes, I'm not quite sure that's the case because Mr Crawford won't have been involved with writing the SCI.

Q Right.

A All he's been involved with is the commissioner has said, "This is the process that we're going to follow. Does this seem reasonable?" and he's said yes.

Q I see. Well, let's move on to the duty of candour incident, which is on page 94 of bundle 27,

volume 6. Now, I don't want to take too much time with this but, in essence, I've got three questions. The first is, did you interview or speak to Professor Cuddihy about what he said happened at the meetings?

A I did not. I've never met Professor Cuddihy.

Q I presume the same will be true for Jamie Redfern as well. You didn't speak to him?

A I did not speak to Jamie Redfern. As I said at the beginning of the review, I didn't set out to interview lots of people for reasons that I've stated here.

Q And so there is a lot of correspondence between Professor Cuddihy, Mr Redfern, John Brown, Jane Grant and Jennifer Armstrong in the second half of 2019 into 2020 and indeed they meet on 12 November, Mr Brown, Dr Armstrong and Jane Grant and Professor Cuddihy. Would you have seen that correspondence-- Apart from the letter you were involved in writing, would you have seen that correspondence as part of your review?

A No. So, the correspondence I saw as part of the review was the correspondence from Dr Armstrong to Professor Cuddihy in January 2020, and then the

subsequent correspondence between Jane Grant and Professor Cuddihy I think which was from the February, and I think I've quoted that at the beginning of the review.

Q I think you have, yes, you've mentioned those two.

A And subsequent to that in the bundle there's also a letter from Jane Grant to Professor Cuddihy in September of 2019.

Q Yes.

A I've seen that as well, but I hadn't seen that at the time I did the review.

Q Right, you hadn't-- so the only, as it were, Cuddihy correspondence you saw are the two documents you've listed in the review?

A Yes.

Q Okay, thank you. Now, do you feel in any way that not having spoken to these-- to particularly Professor Cuddihy but also Mr Redfern, and seeing the correspondence where he describes repeatedly what happened, in some way undermines the effectiveness of your review, or is that being unfair?

A I found this aspect of the review very difficult and, again, part of the reason for that was the fact that I was writing it, you know, in May of-- or April and May of the next year as a

result of the delays following the COVID pandemic, and I can totally understand the perspective of Dr Inkster where she felt that her ability to communicate freely was being undermined.

Again, I go back to the exam question I asked myself and I asked myself, you know, was this simply poor communication, delayed communication and inadequate communication or was it any deliberate attempt to undermine Dr Inkster? And that was the question I tried to ask myself.

Q On which side of that split did you come----

A I came down on the side that this was cock-up rather than conspiracy, if you don't mind me using that kind of phrase. That this was just poor communication, delayed communication, and I think the emphasis is on the delayed communication. I think often in healthcare, we sometimes delay communication because we want to get the communication perfect or because we want all that information to be available and, in this circumstance, there was clearly the need to try and get the typing of the chelonae available in order to provide the optimal communication, and there was also the concern about confidentiality because there was more than one parent available here, and the impression I got here, this wasn't any malice, this wasn't any deliberate attempt to undermine Dr Inkster. This was just poor and delayed communication in the context of all the things that was going on. That's the side I came down on, but, I suppose, at the end of the day, that's a judgment.

Q I appreciate that. The problem that I suppose, at a high level, that there is with that is that the Inquiry has been looking into the Mycobacterium chelonae infections, and the first thing that's notable is that in 2018, in May, when Professor Cuddihy's daughter has her infection and it's reported to them in June, it is-- it doesn't end up appearing on the timeline from the Oversight Board and it's not properly reflected in the list of blood sample infections that the case notes review have and, indeed, is not properly described in the dataset we have.

Now, we've worked out it's been described at a slightly higher level within its genus as a bacteria, but there's a sort of confusion there about whether it was properly noticed at the time. It's reported by Dr Inkster to

HPS in an email as part of the gram-negative outbreak. It doesn't have its own red on HIIAT. The Inquiry has got a full set of all the bloodstream infections for the hospital back to the time it opened, and there's seemingly another case in 2016 in the dataset.

So, do you see how it might look? The two questions that seem to be-- that Professor Cuddihy wants answers to, one is, why did an investigation not follow his daughter's infection that might have prevented the subsequent one? That seems to be a quite good question to ask, and the second one is, well, why did you allow the water system to get to the point where the infection might have occurred for her? And so do you see how, whilst it might be a cock-up, it looks suspicious to the professor? Do you appreciate that?

A So, I think it's entirely understandable that if communication is poor or communication is delayed in the context of what you're describing, I can completely understand the perspective of Professor Cuddihy in terms of, you know, what you're saying, yes.

Q So, what I want to do is to go to your statement, please, which is on page 174 of the statement bundle, and you note in the second half of this page that-- at the bottom of the page:

> "However, the report clearly notes that communication during this episode was suboptimal, and that the chief executive of the Health Board has apologised for the poor communication in a letter to the parent."

Where does this poor communication happen? Does it happen at the time of what we are referring to as the duty of candour incident, or does it happen in the follow-up?

A I'm not sure I can be specific about that.

Q Well, you carried out a review, that's why I thought I'd ask you. So, I mean, you've described how there's been poor communication, you've identified that-- what you frankly described as a cock-up rather than a conspiracy. Do you see that as happening at the time that Professor Cuddihy was hoping to receive the information originally in 2019, or as happening later – as you see it – people were trying to get the communications right? Where do you see the event happened?

A I'm not sure necessarily there is one event, but I can see that communication-- I think, you know,

what I'm saying here is that communication was poor, but I'm not being specific in terms of one particular point in time.

Q Okay. Right now, what I want to do now is just to touch on the 3.3 at page 96 in the bundle 27, volume 6. You've already explained-- 96, sorry, page 96, yes. You've already discussed and you've sort of corrected me on what you thought the issue was and I won't go back to that, but are you-- obviously you make reference to the original Water Technical Group being set up in the early part of 2018 by Dr Inkster. Does that ring a bell?

A Yes.

Q Yes.

A So, I'll have got that-- As I said at the beginning of the statement, I did speak to Mary Ann Kane regarding that, so that's where I'll have got that information from.

Q Yes, but that was just very briefly about the first-- the original setup.

A Yes.

Q Because we've had evidence from a number of people who attended the Water Technical Group, that one, the one that started in March 2018, and you don't get the impression that they misunderstood what the

purpose of it was. It seems to be a technical offshoot of an IMT to try and get to the bottom of a particular problem that they were facing. Do you think it would have helped to speak to other people that attended the meetings?

A So, again, I go back to specifically what the ask was here. The ask was Dr Inkster flagged to a specific action that she felt hadn't been taken forward, which was related to the chlorine dioxide and reviewing all the minutes. It was clear that that was not correct and it had been taken forward, and then she talked about the Water Technical Group making decisions that were not minuted or discussed at the IMT, and I suppose that goes back to the link between the Water Technical Group and the IMT.

And I think the point I was making in the review was that being chair of an IMT is a very, very challenging process. You know, you have to take views from across the meeting, you have to look at hypotheses, you have to take evidence forward, and if you're going to have a subgroup of that meeting, then one of the best way forwards would be to have the chair of the subgroup reporting regularly through to the IMT, rather than take it forward yourself because then you can

question, then you can, you know, clarify, and then you can get assurance that things are being taken forward.

And if the chair of the IMT is also the link to the Water Technical Group, the-- yes, that's where my governance hat comes in here. So whenever I've been involved with meetings in the past and then you've got offshoots of the meeting, I think it's really important as a chair of a meeting that you're not then charged with being the link for that off group as well, because as chair the meeting you can provide assurance to yourself, if you follow me.

Q I do follow you. The final thing to say about this, I suppose, is we've had evidence about a debrief meeting happening at the end of May 2018, following what was, at that point, thought to be the end of the water incident. Unfortunately, it wasn't, but there was a debrief meeting chaired by a nurse consultant from HPS, and there's a detailed minute, and there's a report produced from that; and no one who's attending that debrief seems to think there's been a problem with the Water Technical Group. Did you look at that debrief or speak to anyone involved in that?

A I didn't see that debrief, but, again, I would add that-- you

know, so if you're looking at structures of meetings, it's not good governance to be reporting to yourself.

Q So, the final thing to do is just go to your summary on page 101, and we've already discussed the use of the word "corroborate" and I appreciate your comments earlier but, in essence, what you seem to be saying is you didn't deliberately set out to interview additional people. We've discussed that in the second paragraph, that Dr Inkster raised issues with Dr Armstrong and these concerns have been explored in detail, and the review is unable to corroborate the specific concerns. Are you effectively saying it's not so much that you couldn't corroborate them as you didn't ultimately agree with them, or is that putting words in your mouth?

A No, not necessarily. So, as I said already, taking Dr Inkster's perspective, particularly for the first two issues, I can totally understand where she comes from, and what I tried to go through was to go through things logically and systematically, looking at the governance where the appropriate governance was taken forward for the SCI, and come to a viewpoint about the communication. I suppose in retrospect, if I'm looking back and rewriting this review,

conscious this was looked at. This was being written through the lens of May 20-- of a year and a half later. I probably would just leave out that sentence in itself and leave the narrative to speak for itself.

Q Right. My final question goes back to-- well, it's about governance, and since you've done all this work and you're now a medical director in another health board, it seems a good opportunity to ask you a question on governance. The meeting of 20 August that we discussed earlier----

A That's the one in the GRI boardroom?

Q Yes. So, I put you on the spot and asked you some questions about what you did in a meeting that you weren't the main player in. You were the deputy medical director in a meeting chaired by the director of public health with the medical director present.

How do you answer this challenge about governance? How do you govern, successfully, a situation where senior people-- more senior than you, senior people in the Health Board are doing something that probably doesn't look fair? It must be quite difficult for someone three weeks into a job to put their hand up and say, "We shouldn't do this." Would you accept that's a reasonable defense from your point of view?

A I think that's reasonable, yes.

Q Yes. How do you regulate and govern the senior professional and managerial heads of an organisation like a health board? What is the check on them? Since they control the providing of information to the Board and they can intervene when governance justifies it, in matters like the SCI and duty of candour, who governs them?

A So, the governance of the executive sits with the Board and the non-executive members of the Board, and so good governance should be that the Board requires to be assured that the executive is performing its role appropriately, and that's, you know-- So the governance of the executive sits with the Board and with the non-executive members of the Board.

Q Now, this may be true for other types of organisations as well, I accept that, but in a health board, how do the non-executive members know they're being told everything that they need to know?

A By ensuring that papers are coming to the Board and

particularly to the sub-levels of the Board at the level of corporate governance, staff governance rather than the Board itself; but the meetings that are chaired by non-execs, to make sure that the papers there are covering all the relevant issues and are covering that broad range of issues that they would expect.

Q So, you wouldn't feel that there's a slight issue of the senior executive members of a board having significantly more information than the people who are supposed to be supervising them, the non-executive members?

A I think the executive members of the Board will always have more information, and it is-- Yes, I'm not sure I can say more than that.

Q Because I suppose that the final comment to make-- question to make before we have a short break to see if there's any other questions is, I've obviously asked you questions about 20 August, but you're not the first witness who this inquiry has asked, "Why didn't you do something? Why didn't you ask that question? Why didn't you intervene?" That has been a repetitive question we have asked of many witnesses, and the answers that we get are not dissimilar to your effective answer.

But how do you ensure in a health board, particularly a big one, that people are not just assuming that something's being done? They're not just assuming that someone else has got it out under control, that someone else has thought about the ethics, that someone else has thought about the ventilation or whatever it is. How do you stop people just assuming their colleagues are doing the thing they think their colleagues are responsible for, and their colleague either doesn't care or doesn't think it's their job?

A So, I think what you have to have across an organisation is a broad range of structures where folk, employees, colleagues, doctors, nurses, healthcare staff, all staff can raise concerns, and that can exist across a broad range of areas. So you can raise concerns through a management structure; you can raise concerns through a clinical structure; you can raise concerns through a clinical advisory structure; or you can raise concerns through statutory structures like whistleblowing and things like that; and, therefore, you have to ensure that there are appropriate ways of raising concerns across an organization, such that if things are not being presented, are not being taken forward at a higher level

from the level that you're functioning at, then there's an opportunity for those concerns to be raised accordingly.

Q Because the problem with that might be that the SCI incident that you reviewed and the duty of candour incident that you reviewed both involve somebody, a relatively senior member of staff, wanting to say something or reach a conclusion or make a statement about an area within their expertise but the governance structure is eventually deciding that a corporate position will replace it. Is there not a risk that, if that happens, people will just keep quiet, they won't speak up, they won't raise these issues, and then mistakes will be worse?

A And that's why you have other mechanisms of raising concerns that don't necessarily go through the corporate structure. So, for example, from a medical-- or from a clinical perspective, there's the clinical advisory structure, which is a statutory structure that's within health boards, and then, as I said already, there's a whistleblowing process as well, and that whistleblowing process can go outwith the Health Board as well, and therefore it is ensuring that there are other mechanisms to raise concerns if

an employee, be it a clinician or what, feels that their legitimate concerns are not being taken forward accordingly.

Q So, given that, given that the meeting on 20 August was chaired by a member of the Board who's also the whistleblowing person and was attended by the medical director who's the senior clinician, they are the people where that parallel structure ends up as well. It's the same people. So, do you feel, on reflection, that you could have done more to ensure those events of the summer of 2020 in August were fair to Dr Inkster?

A I'm not sure.

Q Because you've told us that you wouldn't have been happy if it happened to you, so what should someone do? What should a new doctor do if they're in meeting which they're invited to, which doesn't say what the invitation-- the meeting is about, turns out it's about something different, where they all want to talk about a colleague who isn't there and make a decision about them? What should a junior doctor who comes to you do in that situation? What's your advice?

A So, I have been faced with this situation in the past, and if they feel that their concerns are not being recognised then, as I outlined,

there are various structures to take that through, and that could be the advisory structure, that could be the staff-side structure or your union, or it could be the whistleblowing process.

Q Did you do that at the time, though? Did you bring this up with Dr Armstrong or Dr de Caestecker?

A With respect to what?

Q The fact that a meeting was being held about Dr Inkster to which she had been invited with an invitation that didn't tell her what the meeting was about. Did you bring that up at the time?

A So, I get back to the-- I'm not aware that the-- I don't recall seeing that email that described what the meeting was in the first place, and therefore I'm not sure I take (inaudible) of your question.

Q Well, how did you get to be in the meeting? How did you know to go?

A I get invited to meetings in various different ways, and that does include meetings being put in my diary, which I then find out I have to go to, by my PA, or alternatively I'll have said, "Yes, I'll go to that meeting." I just don't recall seeing that email.

Q Well, I'm grateful for your time. I don't have any more questions at the moment, my Lord. It may be my colleagues want me to ask further ones.

THE CHAIR: Dr Deighan, as Mr Mackintosh has indicated, I need to know if there's any more questions in the room. Now, we should be able to find that out in the next 10 minutes. So could I invite you to return to the witness room, and I hope we can bring you back within about 10 minutes to confirm whether or not there are any further questions.

THE WITNESS: Will do, my Lord.

(Short break)

MR MACKINTOSH: Well, I have a trio of questions.

THE CHAIR: A trio of questions. We have perhaps three questions, Dr Deighan.

MR MACKINTOSH: Now, one other thing I didn't do, Dr Deighan, is I didn't take you to appendix B to your report, which starts on page 102 of bundle 27, volume 6. Yes, there we are. So, this interview note, is this, as it were, a text that you received from Dr Green or your summary of what she said?

A This is what I've received from Dr Green, and I've just added

appendix B so I could include it as a separate reference as part of the review.

Q Right. I'm focusing on the duty of candour incident. Over the page, she describes that she was told, second line:

> "...by the Lead Nurse from Infection Control that she was not to tell [X] this detail."

Did you speak to the lead nurse from Infection Control?

A No. As I said in my response, you know, I didn't seek to interview lots of people as part of this review.

Q Because what I'm concerned is that what I've read of your report and what I've seen in your statement and what I've listened to you say, I don't get the impression that you actually know what the lead nurse from Infection Control would say if she was asked anything.

A So, again, I tried to look at, you know, the information that was available in the letters where Ms Grant clearly apologised for the poor communication but outlined that this was not meant to mislead or withhold information. It was just poor communication.

Q Yes, but whatever the terms of reference of your review, the point that's being made by Dr Inkster to Dr Green in a meeting that takes place at your request, is that she was told this thing by this person, and it's this thing that is the heart of her concern, there's been a breach to the duty of candor obligation. Do you appreciate that it seems strange that you wouldn't try and find out what the lead nurse for Infection Control-- what her take on these events are?

A That's a legitimate criticism, yes.

Q And, in fact, it rather undermines your conclusion, doesn't it? Because if your conclusion is this is a-- not a conspiracy but a series of unfortunate events, if the principle allegation is true, then it wouldn't be a series of unfortunate events. It would be an actual breach of a duty of candor but you didn't go and find out whether this allegation is true, did you?

A That's a fair point, yeah.

Q Right. In the summary section, the last paragraph where Dr Green makes the fair point that this obviously only one side of the story and others would need to be interviewed to get a balanced view, and perhaps this will come out in the other many processes that are currently ongoing, were you provided

information of any such process that did produce the other points of view?

THE CHAIR: Sorry, could you just ask that question again, Mr Mackintosh? It's entirely my fault. We're looking at----

MR MACKINTOSH: (To the witness) What I'm asking is, in the first sentence of the last paragraph, this is obviously only one side of the story. I'm assuming this is Dr Green's voice, and others would need to be interviewed to get a balanced view on these, and perhaps this will come out in the many processes that are currently ongoing. Now, that statement would appear to have been made in early 2020. You wrote your report 18 months later, for understandable reasons. Are you whether any of the other processes that you saw and had access to, obtained this other balanced view from the other people?

A So, the only sources I've got, I have listed at the beginning of the review, in terms of-- you'd have to go back to my review and page 1 of my review----

Q So, if we go back to page 91, let's look at what they are. 91. Yes, sorry carry on, please.

A Yeah. So, these are all the sources that I used in terms of the review. I couldn't answer your question, in terms of any other information subsequent to that. As I said, I left GGC almost two years ago now and haven't really been involved since January 2023.

Q So, if we just go to your conclusions on the duty of candor incident, which is on page 95, in the final paragraph, you've written:

> "In summary, it is clear that this was a complicated scenario that involved communication with more than one family with a need to maintain professional confidentiality. Communication during this episode was suboptimal."

So, you didn't know what the whole communication was because you didn't speak to the people who did the communicating.

A That is correct but it's clear from the information I had, that communication during this episode was clearly suboptimal.

Q Yes, but what you can't say is that Dr Inkster is right or Dr Inkster is wrong about what she was told by the lead nurse-- nurse director for Infection Control.

A That's correct, yeah.

Q Now, the final thing is

that you wrote this report in 2021. You've explained how it took more than a year because of the pandemic but by the time the pandemic hit-- or we were all beginning to get worried in January of 2020, the best part of six months had happened. Do you appreciate that this might have caused some excessive distress and concern to the family to take this long to produce letters and meetings and information, after repeated letters from the professor? This took a long time, and that will have caused extra distress.

A Are you talking specifically about this review?

Q No, I'm talking about the whole process. Because you've reviewed the process and in the period between the incident happening and you being asked to do the work and Dr Green speaking to Dr Inkster, quite a lot of time passes, I mean, a good six, seven months. Do you appreciate that might have caused-- that might have caused some considerable distress to the family?

A My understanding that-- and you already mentioned that there were multiple pieces of correspondence going to the family in that intervening period, including a letter from Jane Grant in September of 2019, and then a letter from Dr Armstrong in January of 2020 and a further letter from Ms Grant in February 2020. So----

Q You feel that's a sufficient time?

A I'm sorry, I'm not sure that I'm following the premise of the questions.

Q So, the incident happens in the summer of 2019, the alleged incident where-- which Dr Cuddihy is talking about happens in the summer of 2019. It takes until February of 2020 for the final letter of that sequence you've just listed to get to them. Do you feel that is an adequate amount of time? Could it have been quicker or is it an understandable amount of time to take to resolve these issues?

A So, if it has taken until February 2020 to resolve the issue, then I think that would be an-- understandably a very-- you know, unhappiness at the length of time, but I wasn't involved with the communication with Dr Cuddihy----

Q No, I realise that.

A -- apart from that letter in January, and therefore I'm not aware what communication was taking place with Professor Cuddihy during that period of time.

Q And I suppose the final question, then, is that-- You did this review with its particular purpose that you've described. Do you feel that the carrying out of this review will have advanced matters further for the families involved when they found out about it? Did it help from their point of view?

A So, the review, as I understood it, was to look at the three issues that Dr Inkster has raised. I'm not sure, necessarily, it can be looked at in isolation from all the other information.

Q So, from the point of view of the impact on the families who are the subject of it, you see it as part of a group of responses from the Health Board?

A This review was requested by Dr Armstrong and was, you know, a response to Dr Armstrong's request. It wasn't specifically designed to respond to requests from families and parents involved.

Q So, it's more of an internal document, in that sense?

A That was my understanding of it, yes.

Q I don't think I have any more questions, my Lord. Thank you very much.

THE CHAIR: Dr Deighan, these are the questions that you're to be asked, and that means you're now free to go but before you go, can I thank you for your attendance, can I thank you for the preparation of the written witness statement and the work that will have gone into that. I'm grateful for that, but you're now free to go. Thank you.

THE WITNESS: Thank you, my Lord.

THE CHAIR: Thank you.

MR MACKINTOSH: My Lord, the next witness is tomorrow morning, it's Mr Brattey, and that will be taken by Mr Maciver, and then next-- tomorrow afternoon is Ms Pritchard, and I'll be returning for Ms Pritchard.

THE CHAIR: Very well. We will see each other, therefore, at ten o'clock tomorrow and can I wish you a good afternoon.

(Session ends)

16:09