SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
19 August 2024

Day 20
Friday, 13 September 2024
Mr Thomas Walsh

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10:03

THE CHAIR: Morning. I think we're able to begin with Mr Walsh.

MR MACKINTOSH: Yes, my Lord. Mr Walsh is our witness for this morning.

THE CHAIR: Please sit down, Mr Walsh. Good morning.

A Good morning.

THE CHAIR: Now, as you understand, you're about to be asked questions by Mr Mackintosh, who's sitting opposite you, but first of all, I understand you're prepared to affirm.

A Yes.

Mr THOMAS WALSH

Affirmed

THE CHAIR: Thank you, Mr Walsh. Now, I anticipate that your evidence will go through the morning. We generally take a coffee break at 11:30, but if you want to a break at any other point, please just indicate to me and we can always take a break.

A Thank you.

THE CHAIR: Now, Mr Mackintosh.

Questioned by Mr MACKINTOSH

MR MACKINTOSH: Thank you, my Lord. Mr Walsh, can I ask first your full name?

A So it's Thomas Dougal Walsh.

Q And what's your current occupation?

A I'm retired.

Q Did you produce a written statement for the Inquiry?

A I did, yes.

Q Are you willing to adopt that as your evidence?

A Yes.

Q Thank you. I'd like to ask just a few questions about your background just to get the context. I know it's covered in the statement, but you originally trained as a nurse, I understand.

A That's right, yes.

Q When did you, if ever, cease to be on the nursing register?

A I was on the nursing register until approximately 2006 or 2007.

Q And you became the Infection Control Manager for NHS Greater Glasgow in 2007, in the summer of that year?

A Yes, that's correct.

Q And you held that role until April 2019?

A That's correct.

Q And, thereafter, you were a general manager working for the Chief Operating Officer for acute services?

A That's correct.

Q Until you retired in March '21?

A That's correct.

Q Just because it always helps

with the names, who was the Chief Operating Officer for acute services when you worked for him?

A It was Jonathan Best.

Q Thank you. Now, what I want to do is take a few sections and start off with the Infection Prevention and Control team and how it works.

A Yes, okay.

Q Or, even more accurately, how you planned it to work, because I get the impression that created you the structure.

A The infection control structure was revised after the Vale of Leven Inquiry and the current format was created in 2009. Really, a lot of that related to the recommendations of the Vale of Leven Inquiry.

Q So I wanted to go through a few aspects of it.

A Okay.

Q So that involved, at the heart of it, a direct reporting line between you as infection control manager and, in the Glasgow's case, the medical director?

A Yes, yes. There was government guidance that an infection control manager should report directly to a Board member or the chief executive.

Q Whilst a direct reporting line is a-- was a government recommendation, did you not consider it would also been useful for the infection control doctor to have direct access to the medical director as well?

A That was the case in the professional sense, not in the managerial sense.

Q Because we're all lawyers in this room, what do you mean by that?

A So, Greater Glasgow and Clyde operated a general management structure where, not just in infection control but across the board, general managers were in place for most services and sectors, and they had general management responsibility, which included the doctors and other clinicians within their remit. However, every professional, including medical professionals and nurses, would also have a professional lead.

Q So you consider that the lead infection control doctor had direct access to the medical director as her-- his or her professional lead?

A Yes.

Q Right. Now, you've described in your statement how there is a-- was a regular reporting system that builds from the ICNET system upwards----

A Yes.

Q -- through a series of reporting lines and, ultimately, committees to get up to the Board at infection control, and you've described that in some detail.

A Yes.

Q I wanted to raise an issue

that's come up repeatedly and see if you can help us with it, and that is how this system copes with the unusual. Now, I'll explain what I mean by "the unusual" before I ask you to respond to that.

A Okay.

Q So, what I mean by unusual is an unusual microorganism which has been described by various people who've given evidence as something that you see very, very rarely that is definitely not on the national reporting list.

A Yes.

Q I'm going to add in an extra qualification to this: something that's not yet emerged in the hospital, so not the scenario where, for example, there's been a couple of infections of a particular thing and everyone's a little bit alert to that thing. So, in a scenario where you have-- an unusual infection emerges in patient group that's not on the national list, hasn't been around before, how does the system that you described notice that?

A So, the electronic surveillance system would not necessarily pick that up. However, the backup to that is our microbiology laboratories, and the infection control doctors and microbiologists would pick up the types of organisms that you're describing and they would create an alert and the investigation-- the problem assessment group and the IMT, if necessary, would flow from that. So we had more than one source of information. So the electronic system that I've described was predominantly a surveillance system which linked to the laboratory system. However, we still relied, for these types of organisms, on them being picked up in the microbiology lab or, indeed, by individual clinicians----

Q Well, indeed.

A -- doing tests in the wards.

Q I want to use one example----

THE CHAIR: Sorry, Mr Walsh, you said – I'm just getting my note correctly – electronic surveillance would not necessarily pick it up. I mean, did you mean that it might sometime pick it up? Because if you did, I don't understand how that works.

A No, no, so you're absolutely right.

THE CHAIR: Score out "necessarily."

A Score out "necessarily."

THE CHAIR: Right, thank you.

A Unless we put the organism into the system and ask it to report on it, then it wouldn't report on it. You're absolutely correct.

THE CHAIR: Thank you.

MR MACKINTOSH: Right, so I want to use a particular example, and I recognise it's a relatively extreme one

and I recognise it's only one example, so one can't draw obvious, immediate conclusions without some thought, but I'm going to just put this to you and try and understand whether this fits in with your previous answer. So this is Mycobacterium chelonae.

A Yes.

Q Now, in 2019-- in the summer of 2019, after you'd ceased to be Infection Prevention and Control manager, there is discussion of a case in an IMT sequence in June of 2019 that you might well be aware of. I can take you to the document, but is that something that you've heard about?

A The organism, I've heard of in the past. The IMT, I'm sorry. I'll----

Q I'll go through my elements and you can see where-- Well, the first point I want to make is that there's definitely an IMT, which we can put up on the screen: bundle 1, document 72, page 320. So this is 19 June. It's the very ongoing gram-negative bacteria in a IMT sequence that starts earlier that year.

Dr Inkster's in the chair, and I want to go on to the next page and you will see there's a discussion in the middle of this page about atypical Mycobacteria and what is being reported is two things: one is that "IPCT have been alerted to a patient case a short time prior to the IMT," so that's 2019. And then, two lines further on, "A previous case identified in 2018." So----

A Yes, I can see that.

Q Then we're aware, because the Inquiry was provided with a full set of bloodstream infection tests for the hospital, that there was a 2016 positive as well, in the early part of '16. Now, my first question, before I get to the details, is were you aware of either the 2018 or 2016 cases?

A I don't recall either of these as specific incidents reported or cases reported.

Q Yes, I appreciate that, and so if it's the case that there are three cases in a row – so '16, '18 and '19 – some of the microbiologists who've either given evidence or will give evidence and produce statements and reports have given the view that this is rather unusual; it's striking and remarkable. What I want to be clear is that your position would be that catching the first or, indeed, the second or the third of these only-- the only way to do that is for the microbiologist to be sufficiently aware to notice it when it comes across their lab, effectively.

A That is the case and, depending on the patient group, there would also be an opportunity for the clinicians looking after-- If it was all within a patient group treated in a single ward,

then there is also an opportunity for three cases to be noted by the clinicians----

Q Indeed.

A -- who would receive the microbiology results. Yes.

Q But what's striking about this sequence, and a question flows from this, is that whilst the '19 one is noticed in '19 and the '18 one is noticed in '18 – because there's another email I won't take to you from Dr Inkster picking it up – the '16 one doesn't appear to have been noticed at all.

A Okay.

Q So how would you respond to the suggestion that a system that relies on the microbiologist spotting things will only work if the microbiologist is sufficiently well informed to notice things are important, they're informed about the risks? So if we take this off the screen. What I mean by that is that, if you have a microbiologist or, indeed, a scientist in the lab and they look at something and they see something, do they not need to understand what's going on in the ward and the hospital as a whole in terms of infection risks in order to see that things are strange or unusual?

A I'm not sure I would fully agree with that. I mean, if we're saying that this particular organism or if what you're describing to me is a fairly unique organism, then I would expect a fully qualified and experienced microbiologist to be aware that that is a very unusual organism as a one-off rather than waiting for a sequence.

So I understand the point you're making, but we're talking about consultant-level clinicians and if we're talking, as we appear to be, about extremely rare organisms, one episode of which should actually create a Problem Assessment Group and go through the various governance processes and reporting processes, then my take on that is any consultant microbiologist should know what one single case of a very rare organism is.

I take your point about the further presentation two years later and then another year later, but, if the question as I have understood it is if there is an extremely rare organism identified in a patient group, I would expect the microbiologist to pick that up, and I would expect the clinicians looking after the patients who receive the microbiologist reports to pick that up as well.

Q So, the question that I suppose follows on from that is, we now know – and, indeed, you know because you were involved in the action plan to address it – that when the hospital opened, the water system had received a high-risk assessment from DMA Canyon in respect of Legionella risk.

Do you consider it would have helped the microbiologists in the lab – and not just the infection control doctor but the microbiologists in the lab – to have been aware that there was an issue of the water system being at high risk for Legionella when they're looking at all the data that's coming through and looking at all the test results? Or do they just not need to know, they just need to be on their guard?

A No, I believe they do need to know. I mean, we had a water safety group, which I know we were probably going to discuss later on, and there was two senior microbiologists on the water safety group. So, yes, it is reasonable.

The process for Legionella control normally – and across all Glasgow and Clyde, not just for the QEUH – works on an exception-reporting basis. As infection control manager, part of my responsibility was to nominate infection control doctors for each of the geographical sectors and where they included acute hospitals.

So, Estates and Facilities undertake the regular testing, which is by an externally accredited lab, and receive the results. The interaction between infection control and Estates in the matters of higher-than-expected or sporadic spikes in Legionella as an exception-reporting basis for them to consult----

Q No, because that's not what the report says, is it? The DMA Canyon report doesn't describe that there are exceptional numbers of Legionella cases, does it? It describes that the water system was at risk of Legionella cases.

A Okay.

Q I think I'd better to take you to an example in your statement. Could we go to page----

THE CHAIR: Mr Mackintosh, just so I'm following, a-- Mr Walsh, just could explain to me what you mean by, "On an exception basis"?

A So, the process for Legionella testing is led by our Estates colleagues, and there are regular tests taken in various areas across all hospitals in Glasgow and Clyde, not just the QEUH. Those testing results are fed back to Estates and Facilities colleagues and only where there are either total viable counts or Legionella, low counts of Legionella noted in those routine tests, that would then be discussed with the nominated infection control doctor for that sector and an action plan and actions progressed on the basis of any out-of-specification test results.

THE CHAIR: Thank you.

MR MACKINTOSH: Can I take you to paragraph 34 of your statement, which is page 234 of the statement bundle? You're discussing the period in the middle

of 2015 when Dr Peters resigned her sessions as infection control doctor and she had previously been, I think, the South sector lead ICD at that point?

A Not lead ICD. She was just an infection control doctor.

Q But she was ICD-- Yes, and you describe in your third sentence:

> "Despite this [and I'm assuming this is from the middle of '15] she continued to make what I would describe unnecessary and inappropriate interest in infection control."

What do you mean by that? What was unnecessary and inappropriate about the request she was making?

A So, she was having-- Perhaps, for context, I should start with her resignation. Although described as resignations throughout a number of statements, I suspect, this was not resignation in the traditional sense. It was demitting from voluntary sessions which microbiologists undertake for the infection control service.

Q Mr Walsh, whether she called it demitting or resigning, and she called it resigning in her-- We can take her (sic) to the resignation letter, if it would help?

A No, no.

Q She stopped doing it. The question I asked you is not, "Why did she resign?" The question I asked you was, "What were the unnecessary and inappropriate interest she was taking?"

A So, these are covered in the whistleblowing report that you've got.

Q No, I can read that. What I'm trying to get is your understanding because in the whistleblowing report – we can go to that, too – again, it's quite high level. I'm trying to understand what is it in the second half of 2015 into 2016 that Dr Peters is asking which you consider to be unnecessary?

A So she was asking the infection control nurses for details of patients on wards. She was sending information that we would already have gotten through our surveillance systems, and she was demanding updates on information that, not just in my view but in the view of others, she did not need for her role as a microbiologist as opposed to when she was working as an infection control doctor.

Q And you're not a microbiologist, Mr Walsh, are you?

A No, I'm not a microbiologist.

Q So why don't we look at the example of events in-- Well, look at another thing in your statement. Go back a previous page to paragraph 31 in which you describe, at the top of page 233, "She's not using appropriate structures for escalating issues."

A Yes.

Q What were the appropriate structures that she should have been using?

A So that would be-- So this was while she was an infection control doctor, I believe I'm referring to at the time, and at that time would be through myself or Professor Williams as the lead infection control doctor.

Q So she was contacting other people?

A Yes.

A Now, the thing I wanted to take you to at this point is some documents that relate to the specialist ventilation facilities in the hospital, and if we could take that off the screen. What I want to understand is when did you first become aware of suggestions that the isolation rooms in both the adult and paediatric bone marrow transplant wards – that's 2A in the children's hospital and 4B in adult hospital – might not, in the eyes of some people, have sufficient HEPA filters, positive pressure or air changes? When did you first become aware of that?

A I think it would be June/July to October 2015. After the hospital opened.

Q Indeed. Were two of the people who were drawing that to your attention two ICDs at the time, Dr Inkster and Dr Peters?

A My recollection was yes, but also Professor Williams as the lead infection control doctor.

Q And so----

THE CHAIR: Okay, could I just make that point? I missed the month in 2015.

A I'm sorry, your Honour, I can't be absolutely specific, but I think one was June or July 2015 and the other may have been around October 2015, but I honestly can't be specific.

MR MACKINTOSH: I think that might well be right, from emails that we've got.

THE CHAIR: All right, so Professor Williams was drawing to your attention that there was at least a question over the specification of the isolation rooms?

A So, my understanding-- my recollection is Professor Williams drew my attention in particular to the missing HEPA filters in the paediatric bone marrow transplant unit. I think Dr Peters may have been the one who expressed concerns about some aspects of the adult bone marrow transplant.

THE CHAIR: These aspects would be air change rates?

A I think-- My recollection, again, initially was that the rooms-- that there was HEPA filtration, but the filters were missing from the HEPA filtration units, and that the sealings of the ceilings weren't fully intact and therefore they weren't-- they failed subsequent air

permeability tests.

THE CHAIR: Right.

MR MACKINTOSH: Because the question I wanted to ask is, at this point, this is June to October 17, we have a new hospital.

A Yes.

Q It's less than a year since handover. These three ICDs have drawn to your attention possible weaknesses in the ventilation system of these key wards. Various decisions have been made about risk and assessment, and the adult patients have gone back to the Beatson.

A Yes.

Q A risk assessment has been carried out by others – and I can discuss it with them – where, in essence, bone marrow transplants can take place in the children's units. You'd accept that all happens?

A Yes.

Q Then, in the following year or after the summer-- So this is after Dr Peters has resigned or demitted office an ICD, so what's wrong with her raising these issues?

A There was nothing wrong with her raising those issues and those-- I don't think that's what I said and I don't believe that's what I intended.

Q So you don't think there was anything wrong with the way that she was behaving and raising issues in 2015?

A No, I think more operational issues she was interfering where it wasn't helpful and, when we get to the whistleblowing report, we'll see that that was an opinion held by others. However, I think-- my recollection is that all the issues raised by the-- the major issues raised by the infection control doctors were both appropriate and important and were dealt with as such.

Q Well, okay, there's a lot in there. Let's start with-- In respect of the isolation rooms, when you say they were dealt with, is it not correct that, by the time we get to the whistleblow by Dr Redding in the autumn of 2017, the rooms are not-- all the rooms are not still-- have not been upgraded to the necessary standard? So there's not-- all been dealt with, has it?

A No, sorry. Again, it's terminology. Everything they raised was being actioned – being taken seriously and being actioned.

Q Because it might be put-- I'm going to put to you that, in the period between '15 and Dr Redding's whistleblow – so that's Dr Peter's whistleblow with Dr Redding in October '17 – two more years have passed.

A Yes.

Q In respect to the specialist isolation rooms, whether things are being actioned, they haven't actually been

actioned, have they?

A It took considerable time to do the remedial and refitting work. So they were being actioned and, in fact, again, if my recollection of the timeline is correct, Professor Williams resigned entirely from his job in GGC rather than demitting sessions. He resigned early in 2016 and, in fact, from March or April 2016, one of the ICDs you've mentioned, Dr Inkster, then became the lead infection control doctor and, in fact, took a significant lead role in the review and the remedial works of the bone marrow transplant units.

Q Indeed, but the thing that I didn't put in your document list, but I can go to them if I need to-- We have in bundle 3 a large number of NSS SBARs, and the evidence of Ms Imrie or Ms Rankin was that, in 2015, NSS recommended various changes to the isolation rooms in the adult bone marrow treatment facility and they weren't carried out, and, in fact, they renew their recommendation in late '17.

So, is it fair to describe the changes being actioned when the SBAR from NSS in '15 hasn't been actioned two years later in '17, and their evidence is they're not told why?

A I can't recall these specific SBARs. I am not being evasive in any way, but my understanding and my recollection, while it's not detailed, is that there were ongoing works and reviews. One of the challenges, or one of the many challenges, and I think a challenge that still faces us today is conflicting expert opinion, and some of that, perhaps, played out, but I can't remember it all at the time.

My recollection is the issues were raised. It took longer than originally planned to undertake the remedial works within the bone marrow transplant units. Some of that – and, again, I can't recall the full detail – related to starting the work and then finding that, actually, there was more extensive work needing to be undertaken. So, I accept what you're saying in terms of how it appeared. I'm not aware and I don't recall a point at which work was halted for no good reason.

Q Well, we have the differential recollection, but we'll deal with that separately, that's fine. We can discuss matter with other doctors who are still in practice and therefore I have access to their emails and things. What I want to do is move on to the role of the Infection Prevention and Control Team in the procurement of the new hospital.

A Yes.

Q There does seem to be some conflict of various bits of evidence, and I want to clarify that. So the first thing, if we go to your statement, page 251. We

are looking at paragraph 77. Now, it's quite a long paragraph, but you'll see at the top that-- so:

> "[You] had some involvement in the planning and design process. The [team]'s role included seconding a Nurse Consultant, Annette Rankin, full-time to the project at the planning stages, to go through the plans."

Now, we've had the advantage of hearing Ms Rankin's evidence last week.

A Yes.

Q She's described how, although she doesn't remember very much – it's a long time ago-- We showed her documents from the Competitive Dialogue stage----

A Okay.

Q -- which took place in July. Do you remember the Competitive Dialogue (inaudible)?

A I wasn't involved in any of that.

Q Well, just to put it in context, there were various bidders, they are reduced to three and there's series of structured meetings. It's called a Competitive Dialogue----

A Yes.

Q -- and Ms Rankin was in the design-- she was in laboratories, too, but at this point, the design thread of that-- and she attends a series of meetings. I put to her what was in the minutes, and she has no memory of what's happened. But I think she would accept being in meetings in July 2009, but the thing that's interesting is that she moves to what becomes HPS in August. So soon after the Competitive Dialogue, she leaves----

A Yes.

Q -- she goes off and she is, I think, replaced by Jackie Stewart.

A That's correct.

Q What I want to check with you is-- So it's not just Annette Rankin, it's Jackie Stewart, who's effectively-- she's her successor. I want to be clear about that first.

A Yes, yes. Absolutely.

Q Yes? Absolutely, right.

A Yes.

Q You've also said elsewhere in your statement that you don't think the infection control nurses have any expertise in the design of ventilation systems.

A Yes.

Q Yes, so how could Ms Rankin, before she left, or Ms Stewart, after she took over, influence the ventilation system specification and the design at the hospital if they didn't have any expertise?

A There was no expectation that they would.

Q Right, okay, and Professor Williams is adamant that he had no involvement in the specification and

procurement of the hospital. Is that consistent with your recollection?

A It's consistent with my understanding, yes.

Q Yes, so the thing that I'm----

A While limited, we were involved in commissioning aspects of it, yes----

Q I absolutely get commissioning, but we'll come back to that.

A -- but, no.

Q But in terms of the simple "what should be built" bit, as it were, what I wanted to do was to take you to a meeting in bundle 23, document 6, page 46, which is a meeting which, to be fair to her, Pamela Joannidis can't remember very much about either, so you might not be able to help us either, but it's from 18 May 2009.

A Yes.

Q It's described as an infection control meeting and it doesn't look like it's one of your regular IMT-- SMTs because of who's attending.

A Yes.

Q And you'll see the purpose of the meeting was to review advice given to date by infection control and agree a final infection control position with regard to the New South Glasgow Adult Hospital in respect of a list of things. Now, one of the things is isolation rooms.

A Yes.

Q Do you see how, in discussion of the adult hospital – so not, presumably, the children's hospital – it says in the middle:

> "The group reviewed the paper produced by Drs Redding, Hood, Annette Rankin."

Now, neither Dr Redding or Ms Rankin can remember producing this paper, but it is described that various things were agreed.

A Yes.

Q One of which is haemato-oncology, a sealed ward with HEPA filtration positive to the rest of the hospital. So this is my question: would it have been the case that, in May 2009 at least, your team were providing advice as to what the specification the ventilation system should be?

A I'm not sure that the-- Yes, I can understand what you're saying in terms of the sealed rooms with HEPA filtration. That would have been taken from a building note. In terms of the----

Q Well, it doesn't say sealed rooms. It says sealed wards, doesn't it?

A Sealed wards, sorry, yes, "with HEPA filtration to the rest of the hospital." That would be correct. I can see I was at that meeting, although I have little recollection of the meeting itself.

Q The reason I'm more concerned is not so much what happened at the meeting, because all I think we can do is rely on the words no one remembers----

A Yes.

Q -- and I'm drawing a slight inference from the fact that your name's at the top that you might have chaired it, but again, that might not----

A No, it was chaired by Heather Griffin, I believe.

Q Well, that's helpful.

A Yes, so----

Q But the point is that it reads as if, in May 2009, your team are giving advice as to what the standard should be for what ultimately becomes Ward 4C, I think, because that was haemato-oncology, ultimately, in that you wanted it to have a sealed ward with HEPA filtration positive----

A (Inaudible).

Q -- to the rest of the hospital. Is that not what we should take from that?

A That's correct. However, in terms of context, there is no recommendation there around air changes or mechanical (inaudible) ventilation----

Q That wasn't the point I'm----

A So it is correct, but the other point that I think I would want to set in terms of context: at that point, the bone marrow transplant unit was not moving from----

Q (Inaudible), so let's just----

A -- the Beatson. But yes, as you present the document, I accept your interpretation.

Q So, there's two things you can take from this, one of which is quite complicated and probably, as you rightly say, there are issues around it, which is what's actually being suggested here, and you're right that it doesn't mention air changes.

A Yes.

Q You're also right that adult BMT doesn't move, in anyone's minds, until '13.

A Yes.

Q So this isn't adult BMT, this is something else, and this is a long time before the hospital opens.

A Yes.

Q So I accept all that. It's more that you are giving advice----

A Yes.

Q -- in May. So if you are giving advice in May as a team about ventilation, is that not slightly inconsistent with the approach taken in your statement that you didn't have any involvement as a team in the ventilation system?

A Yes, I accept that they appear to be at odds with each other.

Q Before I ask you to see if you can explain that, I wonder if we can go to look at a particular document which sort of crystallises this. This is bundle 20, document 68. Now, this is an email from 26 May 2016. Page 1495. Yes, so we can scroll to that. It's in the middle of the page.

A Yes.

Q So do you see-- you've obviously had a chance to look at this email. I appreciate you didn't remember it before, but it's an email, 26 May, from Mr Powrie----

A Yes.

Q -- addressed to Dr Inkster and Shiona Frew, who I think was Mr Loudon's secretary, possibly, at that point?

A I think she was more of a project manager, but yes, she worked with his team, yes.

Q Right, maybe I'm getting confused and I'm being unfair to Ms Frew, but it's copied in David Loudon, Anne Harkness and you.

A Yes.

Q And it describes, in tones which don't give the impression it's of any surprise to Mr Powrie-- The subject is "Respiratory ward ventilation," so that's, presumably, the wards on the fifth floor?

A Yes.

Q For context:

> "I can confirm that a typical single room with an en-suite is supplied with air at a rate of 40 l/s (equating to 3.19 ACH) and an extract derived by the en-suite at 45 l/s. The move away from the requirement SHTM 03-01 for 6 ACH was agreed by the Board prior to formal contract award, the justification for the proposed variation to that specified and its acceptance is provided in the following attached documents."

Now, before we go to the documents, I want to ask you a question about what knowledge you had about this agreement because if it's the case that, in May 2009, you are, to some extent, providing some advice about ventilation in that minute, and this decision is made in December 2009, it seems not unreasonable to ask what involvement the Infection Prevention and Control Team had in the acceptance of this derogation.

A Yes.

Q Can you help me?

A We had none. We had none, except there was in 2009 a question from the project team to, I believe, Professor Williams and John Hood, which related purely to an area of the Renal Dialysis Outpatient Unit. They did identify, for that area only, a derogation which John Hood,

as the Board's ventilation expert, if I can call them that, consulted with Peter Hoffman and the Health Protection Agency in NHS England, and they accepted that for that area that derogation would be acceptable for that group of patients given the risk. I have looked at the attachments that you sent me.

Q Yes.

A One and two I have never seen before, and three I can't see who signed that off on behalf of NHS GGC.

Q So, we'll come to the attachments in a moment, but just-- I'm grateful for the explanation about the Renal Outpatients Unit.

A Yes.

Q And so, because we can't ask Professor Hood, I'm just clarifying what you're saying the position was, that there is a derogation but for a relatively small part of the hospital for its own particular reasons.

A Yes.

Q And you're not aware of Infection Prevention and Control being involved in any other derogations?

A For the ventilation system.

Q Ventilation system, yes, indeed. Now, I'd like just to look at the attachment, the ventilation design strategy, which is bundle 17, document 70, page 2857. Now, so, you haven't seen this before until when? When did you first see this?

A Well, I would've said-- I was on the email, too, so I would have seen it in 2016.

Q Yes, and so that's what I wanted to understand here, is that this is May '16, so we're now 16 months, 17 months after handover. You receive this email. You open the attachment.

A Yes.

Q What's your reaction?

A So, my initial reaction is why haven't we met the standards on the SHTM in terms of air changes? My recollection – apologies again, I'm not being evasive – is unclear, but I believe I requested information from David Loudon on the process by which we reached this position, but actually, what was explained to me is what's in these documents, and that is it related to temperature control and chilled beam technology.

Q Because Dr Inkster knows this now?

A Yes.

Q And she starts thinking about the consequences?

A Yes.

Q The consequences, to some extent, appear to be relevant to some of the things she's looking at. So, there's Aspergillus in various----

A Yes.

Q -- patient groups at this point. I'm concerned to know what you do in terms of the risk register because all organisations have risk registers.

A Yes.

Q Would you accept that it's somewhat surprising that the Infection Prevention and Control Team didn't appear to have been told of this derogation until, by chance, this comes up years later?

A Yes, I believe we should have had sight of that level of derogation.

Q Yes, because the other thing that's interesting about this moment, to go back to our earlier discussion about Dr Peters and Dr Inkster and Dr Redding as well, I suppose, is that this is an example of their suspicions having some validity, isn't it, that the ventilation system isn't right?

A In terms of air changes?

Q In terms of air changes. And they were right, to some extent, about the pressure differentials and the HEPA filters, as, indeed, was Professor Williams when he (inaudible).

A Yes.

Q So we have what sounds like a repeated example of Dr Peters, Dr Inkster, having had drawn to your attention and other people's attention – because of course, as you say, they're going outside structure, so they're telling lots of people – that the hospital has, to some extent – other people who are experts can debate how true it is – a flawed, whatever the consequences are, ventilation system. And they seem, at this point-- or Dr Peters particularly, seems a little disconnected from the rest of the team. You'd accept that?

A In 2016, she wasn't part of the team.

Q But aren't the microbiologists part of the team?

A The microbiologists who undertake infection control doctor duties are part of the infection control team. Microbiologists who aren't work within the microbiology laboratory, so they wouldn't be-- For example, all nominated infection control doctors were part of my senior management team and they came to the regular meetings. Dr Peters, for example, as a microbiologist who had demitted or wasn't an infection control doctor, would not be on that team.

Q Can we take this off the screen, please? That intrigues me. You've explained at the beginning of your evidence that the way to spot the unusual is that microbiologists spot it, and that your systems can't spot the unusual.

A Yes.

Q Is it, therefore, a good idea not to see the microbiologists as part of the Infection Prevention and Control Team in

a global sense?

A Sorry, I was talking within my sphere of management control sense. You're absolutely right. Microbiology is an important part in a global sense of the control of infection.

Q Because, to go back to Dr Peters, this is May '16. It's a year or so later that we have the SBAR of 3 October '17 from Dr Redding and Dr Peters and others. The way that SBAR reads is-- it raises lots of issues. You'd accept that it's quite a long document, and the action plan that arises from it has 27 action points.

A Yes.

Q And quite a lot – but not, by any means, all of – the action points relate in some way to the ventilation system. Would you agree with that?

A Yes, I do----

Q I mean, not the majority, but a large number.

A There are many, yes.

Q So, what I'm trying to suggest to you is that, by the time you get to October '17, when relations between Dr Redding and Dr Peters and the other whistleblower have presumably deteriorated to the point that they feel obliged to sort of raise it in this way, quite a lot of the issues they are raising are about ventilation, and they've been shown to be substantially right by this point. Would you accept that?

A Yes.

Q Yes? And so do you see why they might be a little bit concerned that they're getting a lot of pushback from the organisation about these changes?

A I'm not sure that I would recognise it as pushback. My recollection is that, yes, in 2017, the medical director, I think quite sensibly, said, "There are a number of things going on. We need to get this all down in one list and we need to have a meeting and we need to make sure we are addressing all these concerns."

I would not want to think or suggest nothing happened between 2016 and 2017. A number of the issues in the action plan were already being dealt with or mitigated through SBARs very helpfully provided by Dr Inkster, in terms of areas where the air changes weren't what she or what the SHTM recommends and where she thought there be a risk.

So there were actions and mitigations being taken forward between 2016 and 2017. What happened in 2017, as I recall, is various actions were being taken. Dr Redding wrote to me to ask for an update on these various recommendation-- actions that were being taken on the basis of the concerns and, unfortunately, I was on holiday----

Q Her email to you is the start of

what she describes as her Stage 1 whistleblow, and then you're on holiday and she's on holiday----

A Yes.

Q -- and actually, by the time you get back from holiday and she gets back from holiday, Dr Armstrong has requested the SBAR. Is that roughly right?

A That's actually correct yes.

Q Just to cut in on you, I absolutely accept that between '16 and '17 there are things being done to address some of the things that end up in that SBAR in October '17.

A Yes.

Q Would you accept that it's possible that Dr Peters, particularly, didn't know they were being done? Because she's not, as you say, in the structure, so she's not being told there are actions being taken. Would you think that's possible?

A My understanding is, when Dr Inkster took over as the lead infection control doctor, she was keeping her microbiology colleagues in the South up to date, and I have seen some evidence of that.

Q Because the thing that I'm trying to understand here is, I appreciate things might have been different after '17, but in the period between '15 – opening the new hospital – and October '17, the impression that I get from Dr Peters' evidence, particularly, and to a lesser extent from Dr Redding, is they feel they're not being listened to.

They're raising issues. Many of these issues turn out to be true. They're raising issues, and things aren't happening. At the same time, you're saying – and you're not the only person saying it, to be fair – that they are, to some extent, speaking out of turn; they shouldn't be raising these things. Is that right?

A No, I would really want to clarify that point there. I am not saying they should not be raising the types of issues we're talking about. As I previously mentioned, there was a level of interference at an operational level which caused difficulty and duplication of work within the core infection control team, and that we will see described in the whistleblowing report when we get there.

But I would want to delineate these two things. Everything, as far as I'm concerned, any of these microbiologists or ICDs brought up in terms of the items you're describing were both taken seriously and actioned, or actions at least commenced around them. So there is no suggestion from me that Dr Peters should not be saying, for example, "I am concerned there's only three air changes

in Ward X." I have never had any issue with that.

Q Right, so let's----

A We're talking about operational interference rather than actually very important points, which they all raised and which Dr Inkster, as the lead infection control doctor, took up on their behalf.

Q Let's try and understand what you mean by "operational interference" because I think it's important. It doesn't come across from your statement. So, I'd like to see if you could think of an example. I mean, I can put one to you first, but-- I'll put one to you and if it's not a good one, pick another one.

So an example would be, during '16/'17 there begins to be a suspicion we hear in Dr Peters' mind, at least, and others' as well, that there's an issue with the chilled beams.

A Yes.

Q And, effectively, she starts climbing around up at the chilled beams, having Estates people come and take samples off beams, clean beams-- There's much activity around beams. At this point, she's a microbiologist.

A Yes.

Q Would this be the sort of thing you're talking about?

A I don't think it's the best example, but it's not a bad example.

Q What would be a better example?

A In my view, if she had a genuine concern, it should have been referred to Dr Inkster as the lead ICD and to her Estates colleagues, but I think – and I don't know if this is the way you want to go – I think it would be more helpful to bring up the relevant section of the whistleblowing report rather than look at individual examples, because I'm not sure--

Q Well, you didn't write the whistleblowing report, did you, Mr Walsh?

A No, but----

Q No, and so I'll come to it in a moment----

A Yes.

Q -- but I wanted just to focus on this issue around, "The correct thing would have been to take things through with Estates or to take things to Dr Inkster."

A Yes.

Q So how would you react to the suggestion that what you're describing is an overly rigid, systematic approach to these problems? So you're being overly rigid about the requirement to go through channels in a hospital where there are lots of different clinicians and technically qualified people who are doing various things and, indeed, the microbiologists are on call and providing, in effect,

Infection Control and Prevention advice out of hours. Are you not being overly rigid by this requirement to follow channels?

A I don't believe so. I believe systems and processes exist for a place-- for a reason. And, taking out the whole example, if people start-- and I'm not talking about Dr Peters, but if people start investigating, treating or dealing with issues without going through the appropriate management and governance channels, then there is a chance that I won't know what's going on, even though I may have been accountable for that particular action.

So, no, I agree we should avoid being over rigid, but systems and processes are in place to make sure that the types of issues you've been describing to me actually go through the correct management and governance channels.

Q Well, that's helpful. We're going to come to the whistleblowing report after the coffee break, I think----

A Okay.

Q -- and we'll do that then, but I wanted to just pick up a few things that I've slightly missed out in the session so far. So I'd like to take you to page 242 of the statement bundle, paragraph 54, which discusses Dr Inkster.

So this page is discussing after Professor Williams leaves. Of course, we can ask him why he left, but you report that Dr Inkster was appointed lead ICD in April '16 and you were part of the panel, and that relations between you, Ms Devine and Professor Williams were good, and were initially good with Dr Inkster.

A That's correct.

Q Yes. Now, you described challenges continuing with Dr Peters, and you described how Dr Inkster found some aspects of her intervention unhelpful. Indeed, yesterday Dr Peters gave evidence about that and how she discussed things with Dr Inkster and responded. So we've asked them and we'll ask Dr Inkster, but what I want to understand is, at the end of that paragraph you've got:

> "Teresa and Sandra were making a significant effort to work with each other. That continued until Dr Inkster unfortunately went off on long-term sick leave."

That would have been 2017? Have I got the dates right there?

A I think it was the middle of 2017, but, again, I don't recall.

Q So she actually misses out on-- or at some point Professor Jones steps up to----

A Yes.

Q -- to do this. Professor Jones didn't have many sessions to offer at this point, is that-- have I got that right?

A As a----

Q To you.

A -- himself?

Q Himself to be the lead ICD. He didn't have as much capacity to offer to the task as, perhaps, Dr Inkster.

A As Dr Inkster had. No, that's correct, yes.

Q Were there no other ICDs in the-- microbiologists in the Board who could have offered more sessions?

A So, my recollection is that Professor Jones did, in fact, allocate some extra sessions from-- I'm really sorry, I can't remember the consultant's name, but he was known as Sully. That wasn't his name----

Q Right, okay.

A -- but he was known as Sully. So we got extra input from an ICD in the North, a microbiologist and ICD in the North, Sully, as well as Professor Jones. Professor Jones, while he couldn't offer fixed sessions, when he came in to support the team in Dr Inkster's unfortunate absence, he was really coordinating where we perhaps needed help, and much of that, at that time, was around the ongoing development and remedial works to the bone marrow transplant unit.

Q Yes.

A But he did arrange additional sessions. He did arrange for people to meet, to attend or chair meetings when we were short.

Q Well, you've discussed that in paragraph 55, I think.

A Yes.

Q What I wanted to ask is, it then says at the beginning of paragraph 55, "Things begin to break down a bit after that," and you discuss the dual reporting management system. What's that? What's the dual reporting management system?

A So----

Q Two lines-- second line of paragraph 55.

A Yes, I've got it. So, it's in my statement, and I accept it’s my statement, but it was a direct question put to me in the interview. What I'm describing there is that we had a group of very good infection control doctors across the patch who covered their sectors, were part of our senior management team, but they were also still microbiologists.

The nature of infection control, as I'm sure you understand, is that outbreaks instance Problem Assessment Groups happen when they happen; they can't be planned. And, for some of the infection control doctors, sometimes they had simultaneous microbiological and

infection control cover----

Q Yes.

A -- commitments, and that could normally be managed in that they could deal with their microbiology work and if it was just a phone call from a senior infection control nurse clarifying something to do with that--

When we perhaps had a situation – and I'm not talking about all the time, I'm talking in the round – where we needed an infection control doctor in the RAH in Paisley to chair an infection-- an incident management team or a Problem Assessment Group, they couldn't always immediately be released from that, from their microbiological commitments, and attend to a significant proportion.

So, that-- what I'm describing there is they'd-- dual reporting in that, as microbiologists, they reported through a diagnostic director and through Prof Jones as the head of service. So infection control, they reported through me or professionally through Professor Williams as the lead infection control doctor. But actually, there were occasions-- and I'm not saying it happened all the time, but there were occasions when there was a conflict of their combined duties.

Q The reason I wanted to ask that is because Dr Redding – obviously, by the time she retired, a very

experienced microbiologist – had a similar concern and she explained, I recollect, that she felt it was unfortunate that microbiology and the infection control were being managed separately.

A Yes.

Q Now, she had a different reason. It wasn't the same reason to do with that allocation of tasks, it was to do with the feeling that microbiologists needed to know what was going on in infection control in order to do their jobs properly. But whether it's her concern or your concern, do you have any views about whether it's wise to have separate reporting lines for microbiologists and Infection Prevention and Control?

A I don't believe it is. And, in fact, I don't know if it's one of the documents we're going be taken to, but I-- while Professor Jones was acting in post, I worked with him and with the general manager, Isobel Neil, and we looked at a hybrid of that. So we didn't look at combining the teams, but what I looked at----

Q Is this when Mr Morris produced a paper?

A Yes.

Q Right, okay.

A So we looked at a hybrid of that where, in fact, Professor Jones or the head of microbiology could actually be the professional lead for both the

microbiologists and the infection control doctors, and, therefore, they would both be going through the same professional head, which would allow the types of enhanced communication that might come with that but also over--

The angle I was coming at was from shared oversight of the workload so that this being pulled in two directions from microbiology and infection control, albeit an occasional rather than regular thing, could be managed. So I'm perhaps describing it clumsily, but we looked at the paper from Keith Morris----

Q Did that happen?

A It didn't happen.

Q Any particular reason why it didn't happen?

A So, it was scheduled-- my recollection is it was scheduled to happen. We had agreed it with Professor Jones and Rachel Green, who was the head of medicine for diagnostics. It's unfortunate that these conversations took place while Dr Inkster was unfortunately on sick leave. However, it was scheduled to be put in place when Dr Inkster returned from sick leave.

One unintended consequence, and I think I've covered that in my statement, of producing that paper was that it changed the reporting line for Dr Inkster. Well, it's the lead infection control doctor, if I take the personalities out of it. My understanding was Dr Inkster was to be consulted about the proposed changes just before or when she came back from sick leave.

Whatever happened around those meetings, because I wasn't involved in those – it was Professor Jones and Rachel Green – my understanding is that Dr Inkster herself had some issues with the change in the reporting line and it was reverted on the basis of that.

Q Well, thank you. Now, what I want to do, however, is-- I get the impression from this page – and it's merely an impression, so I want to just see if I've got it right – that at some point between the point when things were initially good when Dr Inkster was lead ICD and, I'm assuming, roughly the time you move on to your new job and she resigns in '19, things must stopped being good and started being less good.

A No, that's not my recollection at all. I mean, I have had some access to some of the information from Dr Inkster and that was helpful. When Dr Inkster returned we continued what I had understood to be the way the core senior management team worked, and that was myself, the lead infection control doctor and the associate nurse director, Sandra Devine, for infection control.

My recollection is we continued, where possible, to meet every Thursday

as we always had done and, in fact, to facilitate working side by side with Dr Inkster, I'd got an extra computer installed in my office so that she could work from there and we would be there together. So, I think issues start to develop around the IMT, not necessarily (inaudible) with me----

Q So when would that have been?

A That was probably much later in 2018. I can't remember when----

Q Because the reason I ask the question is because, five lines from the top of this page, you say, "Initially things were good within the team when Dr Inkster was appointed." Now, I took from that that if there is a change, it's closer to '16.

A No, sorry. It was further away and, again, it's maybe the way I've described it. I understood I had a relatively good working relationship with Dr Inkster as she was the lead ICD, as did my colleague Sandra Devine. My recollection is sometimes, for clinical reasons, Dr Inkster couldn't make the regular Thursday morning meeting. But the Thursday morning meeting was when the three of us got together to debrief and to discuss anything that was coming up, anything that was of concern.

We also were, when in busy periods-- and these were very busy periods, we would divide up the some of the work for the week. So, if we had simultaneous committee meetings and infection and IMTs or whatever, clearly, we couldn't all go to every one of those, so part of our Thursday morning meeting was to actually say, "Right, well, who should and who is best placed to cover this?" So we were catching up. So, no, I apologise if that's the impression here, but I considered I had a good working relationship with Dr Inkster.

Q The impression that we got from-- Well, Dr Inkster will give evidence in a few weeks' time, but her statement's been produced and there's some evidence from Dr Peters yesterday that that might not have how Dr Inkster saw it. She might have felt it was a bit more tense than you're saying at the moment. Why might she think that if that's her-- it turns out to be her position?

A So, that's why I'm saying that it's much later than perhaps the inference that can be taken from this. I believe, and I'm sure it's been covered in another evidence, that Dr Inkster, during the latter IMT – and I'm talking about maybe September, October 2018, but I can't be certain – felt that she wasn't being fully supported.

Q Well, indeed. I was going to come to that because the thing that struck me as interesting – and I think we

should explore this a little bit – is that there's a number of different people who have different takes on the events of the summer of 2019: in the IMT, about her replacement as chair, the end of the Cryptococcosis IMT, the setting up of those subgroups. Now, to be fair, at this point, this is towards the end of your period in responsibility.

A Yes, I wasn't there in the summer of 2019.

Q Yes, indeed, but just-- for me, just to put this in context, some people – Dr Inkster, Dr Peters, some people from ARHAI – see one perspective on that, and other people, who met before 23 August to discuss the replacement of Dr Inkster as IMT chair, have a different perspective on that. But all of whatever's going on turns on what's going on in the IMT.

A Yes.

Q We then have the decant, which we'll come to in detail after the coffee break, in 2018 and the CDU decant in early 2019 from 6A. And, again, you get the impression from various people that there are issues around the IMT. I think you've just said that, actually, a moment or two ago, that "it's around the IMT that issues"-- Have I got that roughly right, that the issue is around the IMT?

A They're where I recall some of these issues manifesting, yes.

Q Because the thing I don't understand is that it's still Dr Peters. She has been chairing IMTs for you since '16.

A Is this Dr Inkster?

Q Sorry, Dr Inkster. She's been chairing IMT for you – thank you – since 2016 and possibly, in some cases, before that, and she's been chairing lots of them.

A Yes.

Q Some of them have been quite substantial.

A Yes.

Q And so what the Inquiry's got to understand is what's going on later on when the relations break down. So are you wanting us to take the view that in some way Dr Inkster's behaviour changes as chair of the IMT?

A My recollection is that there were differences of opinion around some of the high-- It was a complex IMT and I think everybody obviously recognises that, but some of the-- some of the challenges were around hypothesis and the acceptability of the hypothesis to Dr Inkster and challenges to those hypothesis to Dr Inkster as the chair. That's my broad recollection.

Q Yes, because the thing that strikes me as interesting is some of the earlier IMTs in '16 and '17 or even before then around Cupriavidus and those issues-- around aspergillus, they clearly

also have hypotheses in there, and they have hypotheses that, looking back at it now, in some ways seem precursors of later problems because they are hypotheses around water or around ventilation.

Then, in '18 and '19, again, we have hypotheses around water and ventilation. The difference, however – and I wonder what you thought about this – is the impact of these hypotheses because now they're causing macro changes, not just a case of removing a sink in the aseptic pharmacy.

A Yes.

Q Or cleaning the chilled beams every six weeks. Now, it's a decant of the Schiehallion unit and a re-decant of the Schiehallion unit and a possible third decant of the Schiehallion unit, and cryptococcus. So could it be that the reason that there is a breakdown in the IMTs is not necessarily because of the way the chair is behaving but because the whole thing has got more tense and more important for the organisation?

A I can see how that could be inferred. It's not my recollection.

Q So you firmly believe it's somehow a change in Dr Inkster's behaviour, or is it just it's different issues, different behaviours?

A No, I wouldn't say-- sorry to cut across you. I wouldn't say necessarily a change in Dr Inkster's behaviour. It's a complex IMT. I think there were so many hypotheses. Some of them were considered-- and, again, I don't have the clinical or the engineering expertise, but some were considered perhaps to be even technically infeasible by some of our engineering colleagues, and my collection of some of the issues was on-- that alternative hypothesis sometimes wasn't----

Q Right, well, we'll talk to people who are at those meetings and we'll pick out one or two of them with you after the break. What I want to do before is pick up some other small things. So Dr Inkster's statement contains a suggestion that, at some point in the new hospital, you would give Professor Williams access to your email inbox. Is that something that's true?

A No. I'm going to be blunt and say that's a complete embellishment. So what happened was, on one occasion, while I was in the office and Professor Williams was there and he was obviously several miles away from his own office, he wanted to send an email. So he sent an email to a number of people. Clearly, Dr Inkster was included.

He clearly stated on it, "This is Professor Williams from Tom Walsh's email" because the email would have come from me and then put the message

on. It was one occasion. Professor Williams had no access to my inbox. He sent one email in an exceptional circumstance because he didn't have local access.

Q Okay. Right, the next thing I want to do is to pick up the issue of IMT minutes.

A Yes.

Q I think we can deal with a couple of things at a high level, and then we'll use one example.

A Okay.

Q So I'm not going to put it on the screen, but within Dr Inkster's statement – at paragraph 134 for my colleagues who are looking at their own computers – she describes that occasionally you would approach her PA to seek changes to IMT minutes. Now, she's seeing that as it involving changing those minutes without her involvement or that of the IMT. How do you respond to that?

A I don't accept that. It's standard-- relatively standard practice in my experience and, while Dr Inkster's chaired a lot of IMTs, I've chaired a lot of meetings in my many years as a manager in the NHS. I don't believe it's unusual for someone to review the minutes and request a change given that the final minute is not approved until the next meeting of the IMT or whatever committee it is.

If I use my own senior management team as an example, if anybody requested a change to the minutes, I would not necessarily expect them to seek my approval first. I would see the requested changes the next time I chaired that meeting, and they would be accepted or otherwise as an accurate record. So I believe that's fairly common practice, and I don't really understand the point Dr Inkster's making.

Q Can I ask you to look at bundle 1, document 16? It's IMT at 12 March 2018, page 63. This is an IMT minute from 12 March 2018. I'm not necessarily convinced you're present in the meeting.

A I don't think I am, no.

Q So, in her statement, Dr Inkster specifically raises a circumstance that the minutes, these minutes, significantly differ from her finalised copy as chair. Now, she's referring to an absence of detail about Stenotrophomonas and issues with taps, and that this isn't the final version that she approved. How might such a change take place? Do you have any knowledge about how it might happen?

A I can't offer any comment on that. I wasn't at the meeting.

Q Now, there's also the question of the role of an IMT chair.

A Yes.

Q You can take that off the

screen. We've heard a lot of evidence about IMTs and because this is an inquiry and we're lawyers and we like paper, we look at bundle 1, we look at the IMTs we have and I want to make sure we understand what we're looking at.

A Of course.

Q So we've heard evidence from Ms Dodd, who was, of course, lead ICN in the children's hospital working for you and now is, well, I suppose, the editor of the National Infection Prevention and Control Manual. We've heard from Ms Imrie and from ARHAI, and we've heard from (inaudible). Lots of people.

What I want to understand is your take on the role of an IMT chair and what decisions they can take. So what is the limits of the authority of an IMT Chair? What can they actually do?

A So I can't remember the guidance because it's five or six years since I've actively used that, but the IMT chair has, yes, very broad powers within that and they-- My understanding of the IMT chair is that they can commission work on behalf of the IMT, they approve any media statement that relates to the IMT and, ultimately, they produce the report on the work of the IMT.

Q I think, in terms of the media statement, I think Dr Inkster would probably want me to ask this point: could it be that other people, particularly in the Board, might also have approval over the media statements? It might be a dual key system in some sense.

A I would suggest it's review rather than approval.

Q Yes, but let's imagine the IMT chair wants to say one thing and the corporate communication side of the Health Board review it or want to make suggestions. There's a sort of power imbalance there, isn't there, about what gets changed? You'd accept that maybe it isn't always (inaudible – overspeaking)?

A No, I-- Sorry to cut across you again. I have chaired IMTs when we couldn't get an ICD. My recollection of that process as the chair of an IMT myself was that we would produce – in conjunction, with not in isolation of the communications team – the draft media statement. If our communications colleagues wish to make any changes, they would be discussed and agreed with me as the chair of the IMT, not changed without my knowledge.

Q Okay. I think there's also an area of debate-- Well, let's look at your statement first, page 258 of the statement bundle. This is about the decant in 2018, and it's paragraph 96. Now, I absolutely accept that you say you were not involved in discussions about the decant, but it's quite a good case study about what the limits of an IMT's chair power is.

So what I first want to understand is who, ultimately, or actually, decided that Ward 2A would be decanted in September 2018?

A Who decided?

Q Yes.

A I couldn't tell you that.

Q Fine. In that case, I don't need to ask all those questions. You have no knowledge about who decided it?

A I believe-- Now, it was reported to them-- because I don't want to be seen to be evasive or unhelpful. It was reported back to the IMT at some point by Kevin Hill, who was the director for those services, that the decant would be taking place. Now, my understanding was that there was a group including Mr Hill. I can't----

Q Could this be a water review meeting that might have taken place on the same day, involving quite senior people in the Health Board?

A It would be senior people in the Health Board. I wouldn't like to say whether----

Q No, that's fine.

A -- who was there. My understanding around this-- Because I think I understand the point you're making and I'm trying to be helpful. My understanding is that given, as you've already described, the magnitude of the decisions that we've been taking, that I don't see that as the recommendation by the IMT being taken away from the IMT to be decided somewhere else.

I see that as very senior officers in the Board seeking full assurance from the IMT that this is the right thing to do before, as I say, a move, a decant or whatever of that magnitude is enacted. So, I don't see it as a decision being taken away from the IMT. I see the IMT making that recommendation and in the magnitude, quite rightly, senior officers of the Board seeking assurance that this is the right thing to do.

Q Thank you. Now, it's been suggested that I should ask this question: so, imagine an IMT has made a decision to remove some parts of the building like a sink, or change cleaning. You can imagine the sort of things they might decide to do.

Is there anyone within the GGC system, and I use that very loosely, any part of the system which can effectively countermand such a decision? If that's too vague a question, answer the slightly more precise question that's forming in your mind. Is it possible that somebody like a manager in a particular service could say, "No, we're not going to do that"?

A It would need to be on the balance of risk, so, I-- Again, it sounds slightly vague, but if, in the event that an

IMT made a recommendation on isolation perhaps for, I don't know, the neurosurgical operating theatre, but if, in fact, taking that out of commission meant that anybody helicoptered in with a serious head injury could not, therefore, be treated, then I don't think it would be a case of, "Well, anybody's countermanding that." I think another review of the relative risks and the broader risks around that would need to take place.

So I don't think it's a case of anybody saying, "No, we're not doing that" without actually explaining there is a broader risk and we need more assurance, as I've just described for the other IMT around that, so----

Q That's helpful.

A Yes. I don't know if that's helpful.

Q No, no, it is. This is sort of small, little questions around IMTs (inaudible), so it's slightly dittying around, but, towards the end of an IMT-- We have a meeting you didn't attend, which is a wrap-up meeting, a debrief, in May 2018 after what was thought to be the end of the water incident. Were there any smaller wrap-ups being done for IMTs? Was that a normal part of your processes?

A Of other IMTs?

Q Yes.

A Yes. So, depending on the

size of the IMT, my recommendation is not only did they have-- not necessarily a wrap-up meeting; I think that might have related to the size and the complexity. But there are two processes at the end of an IMT which are led by the chair. For a smaller IMT you do a hot debrief, which is distributed within the organisation and sent to the national agencies, HPS, ARHAI or whatever.

Or, in the case of a bigger IMT, there would be an IMT report – again, authored by the chair – and it would not be unusual to pull together a small group to actually say, "Let's pull this all together so the Chair can actually produce an effective report."

Q So, clearly, I'm not going to ask you to tell me all the IMT reports that have been produced in six years, all that time ago, but, if we're looking for them, not the hot debriefs because, I mean----

A They exist.

Q They exist and they're quite unusual names, so they're easy to see.

A Yes.

Q If there was a more formal report done after a bigger IMT, would that be reported, for example, to the IMT senior management team or-- would it go anywhere?

A Yes, it would go to the senior management team, the Acute Infection Control Committee, and it would appear

in the----

Q So we should see them in the minutes?

A And in the HAIRT, yes, the hospital-- the reporting-- the national reporting template.

Q If we ignore external.

A If you ignore that, you should see them in the Acute Infection Control Committee minutes. Bearing in mind what I've just said, and that is that it would be a larger, more complex IMT (inaudible)----

Q Yes, and we won't see all of it.

A -- obviously would produce a full report, and it would be the responsibility of the chair, normally the infection control doctor, to produce that report.

Q So we should see, scattered through the AICC and senior management team, there's been a report from that IMT sometimes. We will look for that. Right. Yes. I've passed over this, and I think the answer to the question is that you won't know, but I feel it's important to check.

You'll recollect that we discussed earlier on the role of your team in the procurement of the hospital, and we looked at the May 2009 meeting. We've discussed the role of Ms Rankin, Ms Stewart and Professor Williams. We've discussed your, I think you could fairly

say, surprise in May 2016 when you read about the derogation. You've already mentioned that Professor Williams was involved in some commissioning tests.

A Yes.

Q You've described them in your statement, and we can ask him about them in more detail.

A Yes.

Q Are you familiar with the context of HAI-SCRIBE?

A Yes.

Q We've had evidence from Estates people that HAI-SCRIBE is used a lot for cleaning, repair work, getting behind panels, and there seems to be a relationship where the Estates write the SCRIBE and a nurse ICN checks it. Does that ring a bell?

A Sometimes ICGs are involved, but yes----

Q Indeed, yes, for the big ones, yes.

A -- they definitely-- That's a good summary, yes.

Q In the document that underlies HAI-SCRIBE, the HSFN04, I think it is, Part B, there is discussion of a Stage 4 HAI-SCRIBE for new facilities.

A Yes.

Q Is that something you've come across?

A I don't recall it specifically, no.

Q Because one of things that

we've noticed, and it may be we're just not looking and therefore you might be able to help us, is that there doesn't appear to be an HAI-SCRIBE done just before the hospital opens to confirm that all the risks have been assessed.

Similarly, and this perhaps more-- in fact, I want to ask you about both before you get to respond. There wasn't one done around some, but not all, of the refit work to the isolation room. Some of them did have them, some of them didn't.

A Yes.

Q So what I'm trying to find out from you is whether-- Did you see any form of high-level HAI-SCRIBE when the hospital was handed over?

A No. My understanding and my recollection of HAI-SCRIBE is that it's for use, as you have described, right up to refurbishing a unit, and I would have expected them all to be there for the refurb you've described. I personally do not feel the HAI-SCRIBE would be a useful document for an entire hospital. I think it would be hugely unwieldy and, similarly, the project-- the scale of the project and the contract of the project was different.

So, my understanding of the role of the IPCT, HAI-SCRIBE included or aside, was that commissioning and validation was the responsibility of the project team supported by external contractors rather

than, if refitting a ward, our Estates team and our infection control team and the ward team getting around the table and producing the document that you've described.

Q Because the thing that occurs to me, and I want to get your response to this, is that if it's the case, and it does seem to be the case, that there was a derogation around the air changes----

A Yes.

Q -- and that somehow there's a disconnect between what the Health Board got for the isolation room as what it was expecting-- I know that's a subject of dispute, but just those two things seem to be true.

A Yes.

Q Would it not have been helpful for your ICNs and your ICDs – and, indeed, you – to know that this hospital ventilation system, to a greater or lesser extent, wasn't built in accordance with guidance? One of the ways to find that out would have been to have HAI-SCRIBE.

A So the answer to the first question is yes. Yes, if HAI-SCRIBE had been applied then perhaps we would have known that. However, we would also have expected to be informed during the commissioning and validation process of any derogations, as we were with the minor derogation to the Renal Dialysis

Outpatients area.

Q Once you realised that the isolation rooms were-- they didn't have HEPA filters, the ceilings weren't sealed and those other issues in 2015, shouldn't you have asked by being a bit suspicious about the whole ventilation system? Shouldn't they have been on your notice, at that point, as a team, that there was a problem? That might've been wider than just the one you were looking at around the unsealed light fitting or something.

A Yes, I think that's a reasonable suggestion, and the short answer is I'm not sure that we were. We were dealing with the problems as we found them.

Q Okay. Well, this is probably a good time, my Lord, to stop for the morning coffee break, if that-- I'll set up the next set of material.

THE CHAIR: Mr Walsh, as is indicated, we usually take a break about this time. Can I ask you to be back for ten to twelve?

A Course.

(Short break)

THE CHAIR: Mr Mackintosh.

MR MACKINTOSH: Yes, my Lord. Thank you. Mr Walsh, before we go on to the next topic, I want to just pick up something. I want to make sure I understood what you were saying correctly. We were talking about the utility of HAI-SCRIBE for a new hospital.

A Yes.

Q I think I need to clarify, get clear from-- exactly what your position is. So, I'm worried that there's two things mixed up in your answer, so I'll ask you two separate questions. Would you accept that in January 2015, when the hospital was handed over, there was at that point a requirement for an HAI-SCRIBE to be done for a new building?

A No, that's not my understanding for an entire building, no.

Q So you don't think that was then the requirement?

A I don't believe that was a requirement then, no.

Q Okay, but your position is, therefore was also that you didn't think it would be much use. It would be too complicated, effectively, was your evidence.

A I think it would be a hugely unwieldy document for a building, particularly a full building that size.

Q Who would you consider in the Health Board is the most appropriate expert or witness to give a clear position as to whether HAI-SCRIBE is required for new buildings?

A I would have thought somebody in the project team would be able to advise on----

Q Well, they will be giving evidence in due course, and so we can ask them that, right.

A Yes, but whether they did and didn't and if not, why?

Q Thank you.

A No, that's okay.

Q What I want to do is move to the Water Safety Group.

A Okay.

Q So, if we can go to paragraph 49, page 239 of your statement. This, at the bottom of the page: "I also sat on the Board Water Safety Group."

A Yes.

Q And you describe your role over the next few paragraphs.

A Yes.

Q I'd like to understand-- press you on this because I get the impression that your first responsibility was "to make sure the Estates and Facilities Teams and Legionella teams were supported by the nominated ICDs and ICNs," and the other function was in connection to Pseudomonas. Now, was that your responsibility as a member of the Water Safety Group just to do those two things?

A No, those were my-- those were my remit as the infection control manager in the water safety policy.

Q Well, can we look at the water safety policy? So that's bundle 27, volume 2, document 1, page 5. So this

policy is the May 2015 version.

A Yes.

Q The bits I'm going to take you to don't change through to the '17 version.

A That's correct.

Q So that's helpful. Right, so if we can go to the foot of the second page of the policy, so that's page 7, we have the "Duty Holder," the Chief Executive, being discussed.

A Yes.

Q And then, if we go on to the next page, we have you, the infection control manager, and you're the "Designated Person (Pseudomonas)"?

A That's correct.

Q You are described as being responsible for five things, and the first is:

> "Ensuring that Infection Control Teams are fully aware of current guidance on Legionella control matters and the minimisation of the risk of Pseudomonas aeruginosa infection from water."

Now, am I right in thinking that if a water system has cold water that is too warm or warm water that is too cold in a way that would cause a risk of Legionella, it would also potentially cause a risk of Pseudomonas as well?

A I don't think I'm clinically qualified to-- I believe that to be the

case, but I couldn't----

Q But that's what you understand?

A Yes.

Q Well, that's helpful because do you see how the fourth bullet point is to co-chair the Water Safety Group?

A Yes.

Q So what could a water safety group do to ensure that, in a new hospital, Pseudomonas infection risk was reduced?

A So, we were implementing the national guidance on the control of Pseudomonas. Again, my knowledge and my recollection of the policy and the guidance is sketchy, and I think Pamela Joannidis might have covered some of this, but really, for Pseudomonas, it was more about testing at the tap end and management of waste and awareness of the staff in high-risk areas.

Q Indeed, she gave evidence about that a few weeks ago. The thing that struck me and I felt to ask you about was that this was a new hospital. Now, there's no statutory requirement, that we're aware of, to carry out a Pseudomonas risk assessment on a new system, but there was a requirement to carry out one for Legionella – you're nodding – and one was carried out by DMA Canyon in 2015, wasn't it?

A That's my understanding, yes.

Q You actually ended up, in 2017, being the lead of the project to implement its recommendations. You describe that in your statement.

A Was that into 2018?

Q 2018, rather.

A Yes.

Q 2018. So, by the time we get 2018, to cut the story short, the '15 report's been done. It isn't actioned or escalated. The '17 report has been done. It might be being actioned to some extent, but it's not been escalated, and in June or thereabouts of '18, both emerge to somewhat some surprise at higher management levels. Is that roughly the story?

A That's a reasonable summary.

Q Yes, and you're then involved in implementing a project to address the concerns?

A Yes, so there was an SBAR written. I mean, my remit within that changed slightly in that the medical director had asked me to produce an SBAR on how we might progress this. However, as it was predominantly Estates, our Estates colleagues would have to deal with the remedial recommendations. The group that was set up was Jonathan Best, the chief operating officer; Mary Anne Kane, who I think at that time was the Deputy Director of Facilities; and myself.

My main role in that group was actually more around the communications, making sure that all the questions from Health Facilities Scotland, Health Protection Scotland and Scottish Government were being fulfilled as they undertook their own reviews of the situation.

Q Again, to cut a story short, Mr Leiper did a review----

A That's correct.

Q -- and one of the issues in that review – that review draws attention to – is that there wasn't a designated person (water) for the new hospital when it opened. It took a little bit of time for that person to be appointed.

A Okay.

Q Do you understand that?

A I do, yes.

Q Yes, and we've had evidence from Mr Gallagher in which the Inquiry challenged him about whether it was his responsibility to designate such a person, and I think it's fair to him that he also suggests it might have been a responsibility, in some way, of Mary Anne Kane. Have you heard about that evidence, or did you come across----

A No, no, I've, for a lot of time, been concentrating and preparing myself.

Q Yes, but the basic gist is that one of the responses of Mr Gallagher, one of the issues that he has to deal with, is this question of, "Should there have been a designated person (water) in place?" Because if there had been, maybe they would have spotted the DMA Canyon report. That's the hypothesis that's being investigated. Now, can we look at the term of reference for the Water Safety Group itself?

A Yes.

Q That's bundle 11, document 1, page 5, and you see that it reports to the Board Infection Control Committee and to the Facilities Directorate Governance Committee, but if you look at the term of reference, it has to fulfil the remit of a Board Water Safety Group in SHTM 04-01, at part B, in fact, and CEL 03 (2012). It talks about other things it has to deliver, but it also at four points says:

> ""Identifying and monitoring appropriate control measures for water safety in high risk clinical areas."

Now:

> "Effective planning and management for any clinical incidents where the water supply is implicated."

Now, you were co-chair of this group.

A I was co-chair of that group when it was first set up, but, in discussion with Mary Anne Kane, we agreed that I

would demit from that role and that the interests and-- the Infection Prevention Control team would be represented by the lead infection control doctor, another infection control doctor and Pamela Joannidis. I appreciate that that change doesn't appear until the terms of reference in 2017, but actually, it was agreed fairly early on in the life of the group.

Q Because that would involve not applying the policy of the Board water safety plan, which placed you in responsibility as the co-chair of this group to implement various things, wouldn't it?

A It could be interpreted that way, yes.

Q Yes, and Ms Joannidis has given very clear evidence that she was only involved in Pseudomonas, largely, as you say, at the tap end.

A Yes.

Q I've been through bundle 11, and you've had the opportunity to look at it, and you not only do not chair the meeting, you barely attend any of the meetings.

A No, that was the agreement, yes.

Q Yes, but that would mean that, contrary to the Board water safety plan, the infection control manager isn't there and you're not doing the things that you're asked to do in the plan.

A So my primary responsibility was around Pseudomonas and it was fully delivered.

Q Well let's go back to bundles 27, volume 2, page 8, which is-- you're at the bottom of the page, 3.3.

A Yes.

Q Do you see the third bullet point:

> "Ensuring that the designated person (water), that the Water System Safety Policy is regularly reviewed and updated."

Could it be that, if you'd been there, you might have noticed there was no designated person (water) for the hospital site? The system would have worked; you might have helped catch it.

A I'm sorry, but I'm interpreting that as my remit in relation to Pseudomonas, not in relation to the-- The designated person-- My recollection and my understanding, and I appreciate what's in front of us in the policy-- My understanding is the designated person for water safety is appointed by and as a member of the Estates and Facilities team.

I am reading that slightly different to you in that-- and it says later on that I had to designate infection control team members to oversee and implement the Pseudomonas policy. So, for me, this is

a question of interpretation. I would not be involved in the appointment of, the management of the designated or authorised person for water.

Q No, because the response to that might be this: this policy sets up a structured system from the duty holder down, which includes the Water Safety Group, and it nominates all the members, it gives them particular responsibilities, but they're all members of the Water Safety Group, and you're designated as its co-chair.

A Yes.

Q You have a different perspective from Mary Anne Kane, who's a Facilities manager.

A Yes. Could I interject here and just say I think this policy is inaccurate. If you look at 3.2 and .2 of the "Director of Facilities":

> "Ensuring the responsible person (Pseudomonas) that the Water System Safety Policy is regulated."

I actually think they have been mistranscribed and, in fact, the role of the Director of Facilities, in relation to the nominated person, has been designated to me in this version of the document. And, in fact, I would not expect the Director of Facilities to have been ensuring anything around Pseudomonas because, if you look at the first line of each, it clearly designates the Director of Facilities as responsible for Legionella and the infection control manager as responsible for Pseudomonas. So, both those sections or those bullet points don't make sense in the context of the responsibilities.

Q I suppose the question that pushes back from that is, if you've got a structure----

A Yes.

Q -- that brings together Estates and Facilities people with Infection Prevention and Control people and designates the leads of both on this group as the co-chairs, does not the structure sort of require both of them to be engaged in the project for it to work?

A That would make sense, other than, quite clearly here, the Director of Facilities also delegated the responsibility because he was never at the meeting either.

Q You didn't delegate the responsibility, you sent Ms Joannidis. She wasn't there as a co-chair.

A No, I sent-- The main process was to send the lead infection control doctor and, actually, if you look at the top of the-- under the "Infection Control Manager":

> "The Infection Control

Manager, supported by the Board Infection Control doctor, is the responsible person for Pseudomonas."

I sent the Board infection control doctor to the meeting with another infection control doctor, who was Dr Inkster herself. Ms Joannidis's role was, as she described, primarily as the nurse consultant leading on the implementation and guidance around Pseudomonas, which is my designation within the policy.

Q I suppose the point to end this section is that, effectively, your position is that you took, with agreement, I accept that-- you delegated your responsibility to a series of other people, partly to lead infection control doctor, partly to Ms Joannidis and partly to the other co-chair. Would that be a fair summary?

A Yes, yes. Yes, with agreement. However, also the first bullet point, "Ensuring that Infection Control teams are fully aware of current guidance in Legionella," by having two senior infection control doctors round the table, we were fulfilling that particular requirement as well.

Q Yes, but you're the infection control manager. You have direct access to the medical director. No one else on the Water Safety Group has that direct access. You're there for a purpose, and what you've done is stepped out for reasons that make sense at the time, and I'm not disagreeing with the idea. It's not like you woke up one morning and a mere caprice didn't turn up.

I accept that you have a reason, but what I'm putting to you is that that process of stepping out of this and being replaced by delegated people is weakening the ward safety group, which is covering a new hospital where we subsequently discover that, as Mr Purdon put it, Estates dropped the ball and didn't tell anyone about the risk assessment. Do you see why we might be therefore pressing people who, on the face of it at least, haven't been there when they should have been?

A I accept that interpretation, yes.

Q Right. What I want to do now is to move on to-- Take this off the screen and-- It's unfair to say-- I've just been reminded it wasn't Mr Purdon who said here, "They dropped the ball," it was Mr Powrie. I think I should correct that.

I want to just ask about the value of the DMA Canyon reports to people who didn't have them. Now, I think it's pretty obvious that there's clearly a problem to the senior Estates people if they don't know they've been done because they can't action direct action, but you're not an Estates person, so I want to ask you about Infection Prevention and Control

implications.

Do you think, or do you accept, that it would have been of value to your infection control nurses and those doctors with infection control sessions, and the lead infection control doctor, to know about the DMA Canyon report when it happened in 2015?

A I would expect we would have been informed, particularly as we had-- each sector had a designated infection control doctor, so for the South sector, yes, I think it would be useful to know that.

Q So you accept that you think that Dr Peters should have been told, and presumably also the nurses----

A Yes.

Q -- in the hospital as well, but I'm more-- it's the utility of telling them I want to understand. So would it have helped their practice for them to have known about this issue?

A That's difficult and I know you will ask others around this. My own opinion, which isn't clinically informed, is that the majority of the actions detailed in the 2015 report were really related to systems and processes around water control.

In the background, there was ongoing testing for Legionella, which we talked about earlier today, and I don't recall there being significant indications

that, in fact, there was a problem with Legionella or with other testing within the unit. So, I'm not sure how directly helpful it could have been to their practice, but I accept we should have known.

Q Well, the reason that I think I should press you is because in 2015 and 2016-- in 2016, there is the incident around the aseptic pharmacy.

A Yes.

Q And the way that Ms Dodd described it was a focus on the pharmacy: the sink, the hand-washing sink.

A Yes.

Q A localised investigation, I think. She didn't use those words, but I'm just summarising it. What we subsequently discover at the time of the decant and afterwards is there's actually a system-wide problem, and the water technical group in March 2018 is describing that there's a systematic problem with the water supply. You weren't on the water technical group, I don't think.

A No.

Q Presumably, you would have heard about that.

A I was aware of it and there was updates at various other committees, yes.

Q So, effectively, Ms Dodd and her team are looking at that sink, that tap, in 2016, and Dr Inkster and the water

technical group are looking at the whole system, and eventually it becomes the chlorine dioxide project and the points-of-use filters.

Given the DMA Canyon report describes how the water system is out of temperature range in certain locations, both in 15 and, to a lesser extent, in 17, some of the people involved with a microbiological water engineering background have commented that the system might have been growing contamination or colonisation during that period because it was inadequately set up. Is that your understanding of part of the criticism of the DMA Canyon report?

A I would have to defer to the clinical experts on that. I'm aware of some of what you've described, not all of it. I'm also aware that there are clinical differences of opinions in some of these matters, so I'm not sure I can assist there.

Q I appreciate there's clinical-- I think I can-- Would you accept this small part, that part of what the DMA Canyon report is saying is that the water system was being managed in a high-risk way, where the risk is that there will be microorganisms growing in the water? Would you accept that was part of what the DMA Canyon reports were saying?

A Yes, yes.

Q Right, so would it not have assisted the nurses-- the infection control nurses and the infection control doctors to have known that the water system behind the taps in the hospital had that risk?

A I'm sorry, I'm not making that connection.

Q Well, I'm asking you that you should do. They're managing infection control incidents.

A Yes.

Q They're asking questions and, in 2016, they're asking questions about the aseptic pharmacy.

A Yes.

Q They ask questions in a way that involves thinking about localised risks, but at the time, there is out there a report from DMA Canyon which talks about systemic risk. Do you consider it would have helped them to know there was a systemic risk in 2016?

A So, systemic risk-- I'm sorry, I'm not being evasive, but there were other tests going on that didn't necessarily indicate-- So I understand what you're saying about risk, but actually, in terms of the water quality, I'm not sure that the risk and the water quality are connected in the way that you're perhaps suggesting. I would have to defer to engineering and clinical experts around that.

Q Because the way that Mr Watson described it is he saw there was

a real risk that Legionella would grow in the water.

A I understand the concept that you're describing around risk. However, with the ongoing water testing for both Legionella and Pseudomonas, I'm not sure that the potential risk and the actual outcomes that you're describing are connected in the way that you seem to be suggesting.

I absolutely accept that the DMA Canyon report identified the potential risk, but I'm not sure, and I would need to defer to clinical experts, whether the actual water testing that was going on at the same time gave a level of assurance because I am not aware of a direct connection between these things.

Q I'm not saying there's a direct connection because that's not your expertise.

A Yes.

Q And I'm not asking you whether there is an answer to what is the risk assessment as a whole because I appreciate that, when you carry out a risk assessment, you consider all the available information. What I'm trying to understand is whether it in some way harmed the practice of your team that you didn't know this particular piece of information.

A Only an infection control expert could answer that. I can't answer it. I'm not being evasive, but----

Q All right, that's fine.

A -- the evidence I have both in terms of the risk and the water tasting is inconclusive.

Q Right. We talked in your evidence about sign-off of the hospital, and I think I was reminded by my-- I was reminded of a document that's in bundle 14, so you may have seen it. Bundle 14, volume 1, page 204. So, if this is a complete surprise to you, please say so.

So this appears to be an email, which-- If we go to the next page, because it's in reverse order, it makes more sense. So it's an email from Christine Peters, sent to somebody. We'll come to who in a moment:

> "How was the design of the new build signed off from an infection control point of view? Who would be the most appropriate person to speak to to get an overview of the design in regard to ventilation from a construction control point of view?"

That's from Dr Peters. Go to the bottom of page 204. We see that is sent to you on 23 June 2015, so that's before she resigns or demits office.

A Yes.

Q You have replied, "Craig led on most of this with some input from John

Hood." That, I'm assuming, is about the commissioning.

A Sorry, could you go back to the first page again?

Q Yes, of course. Yes, top of the page. So, the question is, "How was the design of the new build signed off?" This is about design; this is not about commissioning.

A Yes.

Q And you've replied, "Craig led on most of this with some input from John Hood." You appear to be saying in that sentence that Craig led on most of the issue of design sign-off, and then the next sentence is:

> "Design sign-off was by Jackie in the South team while she was seconded to the project."

A Yes.

Q Is that entirely consistent with your position that, (a) Professor Williams had no involvement in design, and your acceptance a few moments ago this morning that Jackie Stewart and Annette Rankin didn't have the professional skills to approve ventilation?

A Sorry, could you take me back to the first one again?

Q Yes, of course. Previous page, next page:

> "How was the design of the new build signed off from an infection point of view? Who would be the most appropriate person to speak to to get an overview of the design with regard to ventilation [so, it's ventilation from infection control point of view]?"

You've replied – this is before Dr Peters has resigned – that:

> "[Professor Williams] led on most of this with some input from John Hood. Design sign-off was Jackie in the south team while she was seconded to the project."

A So I'm clear on the second bit. The design sign-off was actually more about the general building, which is included in the question, and not specific to ventilation. I don't recall this email exchange. I hadn't seen it before. Is this the complete email?

Q She then forwards it on Dr Inkster at the top of the page. That's all we have.

A Okay.

Q All I'm suggesting is that there is at least some suggestion that in the summer of 2015, your position was that ventilation, to some extent, had some sign-off from your team, and that's not right.

A Yes, well, all I can think of is the incidents that we mentioned earlier on relating specifically to the renal dialysis

outpatient area, but I can't recall the email or the context, and if there's any more emails before or after, it might be helpful.

Q Well, there is an email that follows it and that is Dr Peters' resignation letter, but since you described it as a demission, I think we probably look at it. So it's page 414. So it's to Professor Jones. Have you ever seen this before?

A Professor Jones may have-- I'm not sure I saw the letter, but I had a discussion with Professor Jones after she sent the letter to him.

Q The first thing is you'd accept that she calls it a resignation, even if you call it demitted office.

A Yes, yes, yes. No, I accept that.

Q Fine, all right. Her immediate reason is that she has issues about a document she's asked to sign about the bone marrow treatment accommodation for senior management. Now, she's given evidence about that; I'm not putting that to you. What I want to do is go to the next paragraph and do you see at the fourth line down, the paragraph is describing, "In the last two weeks--" This is July, so your email is in that two weeks:

> "… I've discovered a host of issues pertaining to the new build and the process of validation of the building. I worked conscientiously to ensure patient safety was prioritised and that actions were taken to protect the most vulnerable patients in accordance with the guidelines and discussions with experts. On three occasions, I was told that the issue was initially not considered to be serious as it was 'just Christine' or a 'hyper-vigilant local ICD,' and it was only with written support of other microbiologists the actual extent of the problem was accepted."

Now, my question of you is she seems to think that the person who said, "It's just Christine" or that she's a "hyper-vigilant local ICD" was you. I think she said so yesterday.

A All right. Well, I don't remember saying any of that.

Q Is that something you would have thought at the time?

A No.

Q Because, if we could take that off the screen, it might be suggested-- but I think it can be suggested that she feels that she has an obligation as a doctor to raise issues about patient safety. You'd accept that?

A Absolutely.

Q Yes, so could it be the case that her actions that you find-- that you discussed-- we'll discuss in the

whistleblowing reports in a moment-- that you'd found problematic, to use that as a shorthand that you haven't used, are driven by her motivation to improve patient safety. Would you accept that that's her motivation?

A In some instances, yes.

Q What's her other motivation, from your point of view?

A Why don't we go to the whistleblowing report?

Q Well, I understand what position is. You didn't write the whistleblowing report, Mr Walsh.

A No, no, but it reflects my understanding of the situation and it will help jog my memory in terms of----

Q Well, it seems an important thing that you think there's a motivation other than patient safety for Dr Peters. What is it?

A I think Dr Peters, at times, sought to undermine the infection control service.

Q That would be-- why would she do that?

A I think perhaps just to prove that she's right and any other hypothesis is wrong.

Q So let's look at the hypotheses that-- What's the biggest hypothesis that she generated in 2015?

A I'm sorry, I'm not talking about the high-level stuff. I think we're

conflating two issues here, and that is Dr Peters' interference in the day-to-day running of the infection control nurses----

Q Well, let's go to the whistleblowing report.

A -- because I think I've already said that the main issues Dr Peters and others raised were all extremely important.

Q Let's go to the Stage 2 whistleblowing report, bundle 27, volume 4, document 6, page 81. Now, my screen has gone a bit strange, just so you know. I can't see it fully. Can't see that. I've got a panel on the left-hand side with a list of microphones. Well, that didn't work. No, I can't move. (After a pause) Well, I'll look off my copy on here. So this is a report that was repaired (sic) by Dr de Caestecker.

A Yes.

Q And you didn't write it?

A No.

Q But you're one of the people she spoke to?

A Yes.

Q Right, so let's start with what it is. So what time-- when is this?

A I can't actually remember the publication date of the report. It's 2018 something.

Q So when do you say publication date----

A Or-- sorry, it wasn't published.

Q No, it wasn't even given to Dr Peters, was it?

A I don't remember getting the full report myself either.

Q No. All right, okay. So when did you read it?

A The full report?

Q Yes.

A Probably when it had arrived in this bundle.

Q Oh, excellent. Right, so let's go and look at this. So, I want to look on the second page, which is page 82, at the people she interviewed.

A Yes.

Q Now, she interviewed Dr Kennedy, Dr Jones, you, Ms Devine, Dr Green, Dr Inkster and Mary Anne Kane. She then describes the documents she reviews. She then describes her findings. Now, what I'm going to do-- we're going to walk through this and we're going to look at the sections that deal with Dr Peters. I don't feel the need to put the stuff about Dr Redding to you today.

A Of course.

Q So the first thing is a brief summary that:

> "Drs Redding and Peters have clearly identified their concerns about infection control and Estates issues on the QEUH and RHC site over three years, and they sent an SBAR."

A That's correct, yes.

Q Yes, and that some of the SBAR-- and we discussed some of the SBARs are ventilation issues and some of them are management issues and some of them are patient placement issues. Some of them are cleaning as well. A range of things.

A Dishwashers, yes.

Q Yes, and then there's a meeting on 4 October, which you were present at.

A Yes.

Q Yes, and then there's minutes.

A Sorry, I think you might be on a different page to the one on my screen.

Q Page 82? Findings? Bottom of the page?

A Yes, sorry. No, I'm with you now. Apologies.

Q Right. Then there's three sets of issues they raise, and they're listed in three bullet points. Then she's reassured that the issues are being addressed. We're over onto page 83, and then there's a paragraph which we'll come back to.

Then, Ms Kane confirms there's an expert being recruited. Then, there's issues about sewage pipe described. Then, Health Improvement Scotland were involved about sewage ingress. Then, there's a paragraph beginning, "Despite

the legitimate concerns about patient safety, there are no increased levels of infection." Do you see that one?

A Sorry?

Q On page 83.

A Yes.

Q Four paragraphs from the bottom, "Despite the legitimate concerns…"

A Yes.

Q Yes, so that describes a response to the concerns that are being raised. Then, regular communication for on-call microbiology is organised weekly by the infection control team. That's described in the next paragraph, and then the heading is:

> "Drs Redding and Peters raised concerns that they were not being updated on progress to resolve their concerns. I discussed these concerns with everyone I interviewed. I heard an unfortunate but consistent circumstance about the situation summarized below."

You've got six bullet points and we'll come back to this paragraph. I want to just go to the end of the document. Then, we have, "I could find no evidence of issues of ventilation beyond the risk register." The paragraph about Dr Inkster. Then there's a paragraph, Dr Inkster's view about Dr Peters, which begins, "She also confirmed". Do you see that?

A Yes.

Q Then there's an organisational development, mentoring support, and then there's a conclusion.

A Yes.

A There's an inclusion, which we'll come back to, and it says, "Dr Peters is not an infection control doctor". Do you see that one on there?

A Yes.

Q Right. Now. Then there's a series of recommendations and a signature on the next page. If we go back to the bottom of page 83, you were explaining to me that there were good examples of operational interference by Dr Peters, and we wanted to come to this document to understand-- help us understand what they were. Do you remember I asked you about chilled beams and taking samples and you thought there was a better example? So can you help me, what's a better example?

A I'm sorry, I really can't because I'd be doing an injustice in terms of recalling incidents when we're going back six, seven years ago in a job I left five years ago. However, what I would say about this is it's a consistent view, not just my view, and the impact mostly fell on the senior infection control nursing team and

it relates to demands for updates on specific cases that were already being dealt with by another infection control doctor, duplicating information, saying there's organism X has been found in Ward Y, when we have systems and processes in place to pick that up anyway.

So I'm probably not articulating this particularly well-- and it's the volume of the interference, not just the nature of it that was a real problem. It particularly impacted on the day-to-day running of the infection control service. I accept everything earlier in this report about the important points that her and colleagues have raised; that's not the point that is being made. The point that's being made is an independent review has found and supported the view, as far as I can read, that there was unnecessary interference.

In fact, even the lead infection control doctor at the time, Dr Inkster, is saying Dr Peters was sometimes working outwith her remit and demanding information outwith her remit. That's coming from a fellow microbiologist who is also the lead infection control doctor.

So while I can't really dredge up specific examples that are going to help, I stand by my recollection as this being an accurate record, and I'd refer you to the fact that, yes, she's a microbiologist. Yes, she raised specific concerns and

nobody has ever doubted or failed to acknowledge that. However, there was a level of interference that didn't just impact on the infection control team but also on a microbiological and lead infection control doctor colleague.

Q So there's a lot in there and I'll come to your main point in a moment, but you just said nobody has ever doubted that she's raised specific concerns. But she resigned as your sector ICT in a resignation letter to Professor Jones specifically raising the issue of her concerns not being taken seriously about isolation rooms when, we subsequently find out, she's right. Is that fair?

A It's a fair summary of the written evidence. However, it's about perception. I will still stand by the fact that the concerns raised were important and they were being dealt with.

Q Taking your other, broader point, which I understand is that you want to get across the impression to us that your concern is more about the volume than the detail. It's the constant requests for information, going outside channels. These are the issues you're emphasising.

A Yes.

Q Now, given that this Inquiry is not investigating the management of your team, it's investigating issues arising out of the buildings, what I'm also intrigued to see is that it's not just Dr Peters who –

we can take this off the screen – not just Dr Peters who is-- has whistleblown. There are other whistleblowers who haven't sent lots of emails and, indeed, didn't give evidence yesterday of how they were taken to task slightly about that by Dr Inkster and changed the way they sent their emails, which is what her evidence was yesterday.

So, we also have Dr Redding's evidence about the problem of the way that the team was managed affecting infection prevention control predating the hospital opening. We also have Dr Inkster's concerns later, I accept, and we have the other whistleblower as well. So, would you accept that there may be a little bit more to this than the volume of emails that Dr Peter sends?

A In terms of?

Q The dysfunction, if that's-- No, dysfunction's probably not the right word. What would you use to describe the overall impact of all these events on the Infection Prevention and Control team?

A So, this was localised to the South sector. There were perfectly good working relationships in every other sector across Glasgow and Clyde between the infection control manager, the infection control doctors, and the infection control nurses. So, it's localised because we have a vast area to cover, not just the QEUH.

I believe the infection control team functioned well outwith the concerns that are questionable around some of Dr Peters' claims. Dr Redding never worked with the infection control team while I worked there. She was an infection control doctor until 2008 and I took over management of infection control in 2009, so I would respectfully suggest that, while she has extensive experience of infection control, she has never actually worked as an infection control doctor with the infection control team in the last, well, since 2009.

No team is perfect, and I'm not trying to defend this, but the team was considered functional in all other areas except where the infection control doctor cohort in the South behaved or expressed their concerns about the operation of the team in the way they did.

Q Because there is another difference between the South and the rest of the Health Board, isn't there, in that the Health Board didn't have any other new hospitals where there'd been a derogation of the ventilation and there were concerns about the water system, did it?

A So, there'd be concerns about the water system and GRI at some point, not significant. We also had two new-build hospitals. We had the ambulatory care hospitals at Stobhill and at the

Victoria, and there were no issues raised and no specific concerns or actions for the infection control team around any of these areas.

Q What I need to put to you is that, in this hospital, this is the hospital where the Health Board appear without consulting your team, which is your position, to have varied, derogated from guidance on the ventilation system. You'd accept that? That doesn't happen anywhere else, as far as you're aware?

A As far as I'm aware, yes.

Q Yes, and this is the hospital where the isolation rooms haven't been built to what people expected them to be built, or where there's a dispute about whose fault that is. You'd accept that's an unusual factor?

A Yes.

Q This is the hospital where there seems to have been a widespread acceptance of contamination in the water system, at least by 2018. You'd accept that, albeit the causal impact is debatable?

A Yes.

Q So, then, no one's agreeing about what the cause is or what the effect is, but they're all agreeing that the water system was sufficiently problematic that chlorine dioxide had to be fitted. Do you accept that?

A Yes.

Q Yes, and this is unfortunately also a unit where there were-- while it might be debatable about the numbers, there were a certainly surprising, distressing number of deaths from potentially environmental-associated infections. Do you accept there was at least an issue that required to be considered?

A Yes, yes.

Q Yes, and so, whilst you are right that this hospital is different from your other ones in that these particular microbiologists and doctors are a common factor for it, these are also other factors, aren't they? They're not the only thing that distinguishes you at this hospital from the rest of the hospitals in Glasgow, are they?

A No.

Q No, because----

A But infection control doctors have come from other hospitals and settled into the South, and Professor Jones-- his view would be interesting in terms of having worked in the North and then overseen the running of the infection control team as it applied across the whole Board and to the South.

Q Well, indeed. We have a statement from Professor Jones and so we can read that.

A Yes.

Q What I want to, before I pick up

a final few little things, is just pick up one question, which is that, given that microbiologists are doctors and given that they feel obliged to raise issues of what they see as patient safety, would it not be better for them to be within your team in a sense that they're fully informed, they feel empowered to raise issues, and they're not fighting, as it were, either to your disturbance or their disturbance, to raise issues?

Would that not be better to integrate them in and have them part of the family rather than constantly warring, as what seems to have happened here?

A So, I wouldn't describe it as warring and there was this process in place where they had regular meetings with the lead infection control doctor, who was Dr Inkster herself. So, there were briefings on what was going on and what was being developed and what incidents were taking place between the microbiologists.

We did instigate for-- Although the SBAR I wrote about the type of integration of the microbiologists and the lead ICD through the head of microbiology, which Dr Inkster herself found unacceptable-- That was an attempt to do just what you described.

But, having had that rejected, there was still a move to then have joint meetings between infection control and microbiology, and they took place and Dr Inkster, as lead ICD, had regular meetings with her ICDs and updated them.

But, going back to the whistleblowing thing – and I don't mean to-- I don't particularly want to emphasise the point and I don't want to be overly critical of anyone – Dr Inkster herself was struggling as a microbiologist and the lead infection control doctor to keep up with the information demands from Dr Redding and Dr Peters.

So, it's not-- I'm not taking myself out of it in terms of my responsibility – I know exactly where that lies – but what you're describing is a synergy between microbiology and infection control, and, actually, attempts were made to do that and Dr Inkster herself at a time attempted to do that.

But even she in her own-- or what appears to be what she has described in the whistleblowing report could not meet and did not accept that the demands made by Dr Peters in particular, but also by Dr Redding, were reasonable and could be met. That is not my judgment, that is a judgment within the microbiology and infection control body themselves.

Although steps were taken to try and do that by having the extra meetings, I would still like to have seen the SBAR

that I had produced progress properly and for the head of microbiology to actually have had professional oversight for both groups because I think that would have taken us further to where you're describing.

Q Thank you. Let's just move on to one final topic, which is Cryptococcus.

A Okay.

Q So, that's in your statement, if we can go to page 265 of the statement bundle, paragraph 122. Now, you've expressed the view in paragraph 122--123, in fact, that the chair of the IMT for Cryptococcus, who was Dr Inkster, was unwilling to look at alternative hypothesis and that debate was unacceptable to her. What were the alternative hypotheses that you remember?

A Okay, so this is out of sequence in my statement and relates to----

Q 2019.

A No, it relates to the order in which I was asked the questions, and although I asked for the questions to be included, most of them were taken out. So, actually, 122 relates to Cryptococcus; 123 actually relates to the water IMTs that we already discussed in 2018.

Q In 2018?

A Yes.

Q Oh, I see. Right, okay.

A Unfortunately, having the questions removed has removed that context.

Q Okay, well, that's helpful. That clarifies that. So what I probably just need to work out here is, if it's 2018 and the water matter----

A Yes.

Q 2018 seems to be divided into three parts, so you have the period between the start of the year and the review meeting at what is thought to be the end the water incident in May.

A Yes.

Q We then have the period from then until the decant.

A Yes.

Q And we then have the period from the decant to the end of the year.

A Yes.

Q Now, you weren't at the water review debrief following the water incident. Well, you're not recorded as being in the minutes.

A I don't recall being there.

Q No.

A What was the timing of that?

Q I think it's a date late in May 2018. It was chaired by Ms Imrie.

A Right, so around-- No, no, it would've been June. No, I wasn't at that meeting.

Q Yes, but the reason I raise that is because, having read that document, I think I can put to you what seems to have

been the mood of the meeting.

A Yes.

Q That at that point, there was a recognition that there was a problem with the water supply and that point-of-use filters were going to be part of the solution. Now, in that first half of the year, are you telling us that Dr Inkster wasn't willing to listen to alternative hypotheses in the first half of-- up to May 2018?

A No, that's not my recollection.

Q No. Right, okay, so we have the second part. That's between then and the decant.

A Yes.

Q At the end of that, the senior officers, who described how that might have happened, approved a large, disruptive and, I presume, expensive decant----

A Yes.

Q -- of Ward 2A. So in that period between May of 2018 and the decant, was that the period when Dr Inkster is not willing to look at alternative hypotheses?

A That's difficult for me to say because I was doing something else between June-- I was taken out to look at the background history and implementation of the recommendations on the 2018-- the 2015 DMA report. I believe that was between June and

September, which is why----

Q Right.

A -- you won't see me at any IMTs----

Q Indeed, so----

A -- in that period.

Q -- you can't tell us what she was doing with the hypotheses because you weren't there?

A Yes, correct.

Q Right. Then the decant happens, and we're looking at the period after the decant up till the end of the year, the start of Cryptococcus, and into March, where the gram-negative IMT starts and you leave. Is that the period you're suggesting that she wouldn't have looked at?

A So, my recollection-- and the reason this appears is around September/October 2018, and I can't recall the detail, but some of the hypothesis-- some of our engineering colleagues felt they just technically weren't possible and they found it difficult to challenge anything other than the hypothesis that was being presented by Dr Inkster. That's my recollection.

Q Were you at these IMTs?

A I was at these IMTs, yes.

Q Because we can probably look at some of them. So, if we go to bundle 1 and we go to-- let's start in 2018, so we'll start just after the decant's been

announced, so that's page 180. So the IMTs continue through the rest of 2018. Is that your recollection?

A Yes, in so far as I was present, yes.

Q Yes, so your position is simply that, at these IMTs, engineering colleagues were raising hypotheses that Dr Inkster wasn't prepared to count. That's your position?

A That's as an example, yes.

Q Is there any other examples, because I can put them----

A Yes, I can't offer detail. This statement was taken two years ago. I can't recall the specifics to assist you, I'm sorry.

Q Because if I approach engineering and Estates witnesses who were present and ask them about this problem, that's probably the best place I'll find details, is it?

A I believe it is, and I believe you will.

Q Right, but one of the things before we leave IMTs because I haven't asked you this question and I've asked a lot of other people: an IMT brings together lots of different people.

A Yes.

Q It's been described to me as a "consensus-building body."

A Yes.

Q I can absolutely see how

Infection Prevention and Control team members should be there, and I can absolutely see how clinicians should be there, and I can see that there's a strong role for Estates as enablers, information gatherers, to be there.

A Yes.

Q I can see how engineering-qualified people in the more complex IMTs need to be there, but I get a bit confused about some of the other attendees within the management structure, who might well be doctors, they might be managers, but there does seem to be that IMTs get more senior people as we get into '18, '19, yes?

A Yes.

Q Reading their statements, they seem to explain that's because it was serious things being discussed and they want to find things out and they want to be-- but how do they contribute to a consensus? What are they bringing to the decision-making process?

A So, if I use an example of, perhaps, Kevin Hill and the Children's Ward----

Q Yes.

A -- so, I would have thought, in terms of the risk of the decant, if I can pick that as a broad example, then, as the responsible director for that service, then he can listen and understand the purpose and the reasons for the

recommendation of the decant. So, yes, it's about understanding the operational and strategic direction in which a large IMT and a significant recommendation might take you.

Q But when it comes to the question of hypotheses----

A Yes.

Q -- and causal connection, and I recognise that IMTs don't often go to say, "That's the cause"----

A Yes.

Q -- but they do talk about it a lot. Again, Infection Prevention and Control people, microbiologists, clinicians, some Estates people, some engineers all seem to have specialist knowledge they can contribute to that discussion.

A Yes.

Q What are the – and I accept quite senior – managers, executive directors contributing to that hypothesis part of an IMT?

A I don't-- Unless they've got any specialist knowledge either of the clinical area or the subject, I don't think that's their purpose at the IMT. I would agree with the description that you've described of others. If it's a serious or significant issue, then they want to understand and, indeed, they've got a role in supporting their clinical teams and implementing the recommendations. I'm not-- I don't recall anybody offering a hypothesis outwith their clinical engineering or qualified remit.

Q Excellent. Well, can we go to page 748 of your statement, paragraph 69? Because you say something which I think-- well, helpfully, a little bit more information. Page 248, paragraph 69. It's a long paragraph, and I'm looking at a very small screen, but you seem to be saying:

> "For me, the biggest issue was how difficult it was for the IMT members to challenge some of the hypotheses and some of the proposed actions of the IMT chair."

Do you see that?

A Yes.

Q Yes, so I'm assuming, from what you've just said, that these would be the suitably qualified members at the IMT?

A Yes.

Q Right.

A Which is why I used engineering as an example.

Q Yes, and so, in that context, who else might it be: epidemiologists? Public health doctors?

A Public health doctors in terms of epidemiology. Equally, we've got infection control giving advice, but we have senior clinical colleagues who are looking after the patients who may have a

perspective, so that's (inaudible)----

Q But you don't see it as the people who are there because of the importance of the issue but don't necessarily have anything to contribute to the technical side?

A I would have thought so. I personally wouldn't seek to contribute to a hypothesis where I had no technical note. I may ask a question in relation to a hypothesis, but I would not report to actually change or alter or offer an alternative hypothesis.

Q Are you aware of whether a practice developed in the Health Board of-- in this hospital, rather, of holding pre-meetings before IMTs?

A No, I'm not aware of that. I think, in relation-- I think there was some reference in the IMT minutes that I did see to----

Q Well, there's one in 23 August 2019 we've heard evidence about, so that's after you'd left, which is why I haven't asked you about it.

A Right, okay. I wasn't aware of it being a practice. I'm not sure what the content would've been, but, equally, I can see where responsible directors may wish to understand the implications of some of the recommendations, but I'm going outwith my knowledge. I haven't been involved in any, I'm not aware of any and, as you say----

Q You're the infection control manager, at least you are until you move on to a new job, and I absolutely understand how, after a meeting, the people who've got to actually make it happen might have a huddle in the corridor or have a meeting and discuss, "Where do we go from here?"

A Yes.

Q I get that, but if it's not normal practice, why would you hold a pre-meeting, not including any of the clinicians or any infection control doctors, to discuss the business of an IMT beforehand?

A I can't think of a specific reason.

Q Right. Now, I think, my Lord, I've got to the end of my questions. I still fear there's one left, but I'll have a hunt through my list, but might we take our 10-minute break at this point to see if anyone else has any questions?

THE CHAIR: Yes. Yes. We'll do that. Mr Walsh, what I need to do is discover whether there are any more questions in the room other than Mr Mackintosh's one question, so can I ask you return to the witness----

A Course.

THE CHAIR: -- room for what should be no more than 10 minutes?

A Thank you.

(Short break)

THE CHAIR: Mr Mackintosh.

MR MACKINTOSH: My Lord, I have my one question and I've been suggested another one. Now, just to say, it is like a question that arose yesterday, about an email that's not in a bundle, but it arises directly out of evidence that we heard, and I will try and repeat what Mr Connal did by reading out an email and then we'll add it to the bundles in due course, but I think-- It's about an IMT we've already almost discussed, so I'll see whether it's fair to Mr Walsh.

THE CHAIR: Right. Well, see how it goes. (After a pause) I understand, maybe two questions?

MR MACKINTOSH: Yes. I wonder if we can put on the screen bundle 1, document 42, page 186. We'll do the previous page for context, 185.
So this is an IMT meeting minute from 20 September 2018. So this is in the period we were just discussing, in fact----

A Yes.

Q -- in which you're present. Dr Inkster is in the chair. For context, this is about a month-- around the time of decant, just after decant, and Calum MacLeod is taking the minutes. On the next page, we have item "Patient Update."

A Yes.

Q And:

> "A new positive gram-negative patient has been identified. [Then some redacted text, which I'll come back to. And then] It is unknown if this case will be counted as the gram-negative is still unknown, and the full results of this organism won't be available until tomorrow."

Just for completeness, the redacted text describes the location of the patient, the antibiotic they're on and how long they've been there. Now, the question that arises is that I have just been provided with an email thread----

A Okay.

Q -- which is from Calum MacLeod to Dr Inkster on 21 September, so that's the day after this meeting, which he reports to Dr Inkster:

> "Hello, Teresa. Tom has asked me not to include the potential case in the minutes, so I will just delete most of the patient update and state no patients are giving cause for concern and no new confirmed cases have been reported."

Dr Inkster decided not to do that, and that's why we see what's here. We see the text and we don't see, "No patients are giving cause for concern and no new confirmed cases have been

reported." Now, I think what's being suggested here is that you might have been in the practice of suggesting substantive changes to IMT minutes in the days or so after meetings. Would that be fair?

A No, I can actually recall this, and I can explain it. So, if we look at the "Patient Update":

> "It is unknown if this case will be counted as the gram-negative is still unknown and full results of this organism won't be available until tomorrow."

What I suggested-- I don't know what that email trail says. What I suggested was, "Should we wait until tomorrow until we know whether or not this is to be included in the case definition and the cases that were to be counted?" So it was a question about do we actually include this today or should it be in tomorrow's IMT? It's as simple as that.

Q Well, the next IMT is the 25th.

A Right, so-- but it was-- So I wasn't suggesting the next IMT. What I was suggesting was, "If we don't have a definitive result just now, should we be including this?"

Q Why would that be a sensible thing to do? I mean, surely it's a possible case? It was presumably said in the meeting. I'm assuming it was said in the meeting?

A I assume so. I mean, I don't recall the meeting with any particular clarity.

Q At this point we're on meeting-- They've stopped numbering them, but it's about meeting 7 of this sequence. If a meeting hears, presumably from somebody present, that there is a potential new case – doesn't really matter which one it is, whether it's this or anything else – and the meeting hears that and, to some extent, reacts to it in that it either says-- it either does something or it says, "We'll wait" or it decides it's not important – but, to some extent, the meeting reacts – shouldn't the minute just reflect that?

A It absolutely should, and I'm at a disadvantage because I can't see the email you've got.

Q No, I get that, and it's not from you exactly.

A So, from my view---

Q It's obviously been a verbal message.

A Yes, so my recollection is that's not-- I did ask for a change to reflect the fact that we wouldn't know the result until tomorrow. I did not ask for the whole thing to be deleted. So they were keeping a cumulative tally of the number of known positive cases related to whatever this incident was, and what I

was getting across was, "If we don't know the result till tomorrow, it shouldn't be added. It shouldn't be added to the tally just now."

A new positive gram-negative case, I would never have suggested that that was taken out. It's the second bit about not knowing the result-- Sorry, I've touched my screen and it's all disappeared. It was about the, "We don't know and, therefore, in terms of the ongoing tally of cases absolutely connected to whatever the incident was, should we wait until we get the result?" That is my recollection.

I did not ask for that entire bit to be taken out, and it was because it wasn't known at that time and we would know the next day. Then, if we knew the next day, then, if it was 12 whatevers, it would now be 13.

Q So, given that you recollect the incident, even though you disagree about the communication you sent----

A Yes.

Q -- is this at a point when there is beginning to be, as you described it, a unwillingness of Dr Inkster to take on a new hypothesis, or is this independent of that?

A That's got nothing to do with hypothesis. In my mind, anyway.

Q All right, okay. Thank you. Well, we'll take that off the screen, and I want just to go back to the Stage 2 whistleblowing report because I completely forgot to do something. If we go to bundle 27, volume 4, document 6, page 81. If we could zoom out, please, to the second page, and then to the third page. You see at the top, I said before we'll come back to this paragraph?

A Yes.

Q Now, if we look at the previous page, we see what we're talking about. What we're talking about is issues around ventilation.

A Yes.

Q I'm not going to go through the whole thing, but it's basically a series of concerns that they have about the ventilation. So the next page, we have, "I discussed with the lead infection control doctor the 3 versus 6 air changes." Now, at that point, that would have been Dr Inkster, wouldn't it?

A Yes.

Q Yes, and so I can ask her about that conversation----

A Yes.

Q -- where, "The Scottish hospital building note recommends 6 air changes per hour." Again, I can ask her about that, but what strikes me as a little bit strange here is there's a change in the next sentence, because it now says, "However, the infection control team," not "the infection control doctor..." So the

previous sentence is about what we know Dr Inkster thinks, because she's the only one, and now it's a collective viewpoint.

Now, I'm not going to get you into what the rest of that paragraph means and whether it's sensible because it's not your area of expertise, but who would, do you think, Dr de Caestecker be talking about?

A I have no idea. If you-- I have no idea.

Q Because the only members, if we jump back to the previous page, the only members of your team being discussed is you, Ms Devine and Dr Inkster, and I'm wondering whether, if we go back to the top of the next page, whether you're the source of the second half of that paragraph?

A No.

Q No? Well, that's very, very helpful. I think I have no more questions.

A I-- Could you go back to the list of people that were interviewed?

Q Yes, of course.

A I think that-- You'll be able to ask him himself. I think that list is missing Professor Williams. I think he may have been interviewed.

Q He was working in Dorset at the time. This is 2018.

A Oh, of course it was. No, my apologies. I got that completely wrong.

Q But the top of the next page isn't you? We'll have to find out from somebody---

A Its-- Do you know, I'm 99 per cent certain it's not me because it's a technical explanation that I probably still couldn't offer.

Q Fair enough. Thank you very much. My Lord, I've got no more questions for Mr Walsh.

THE CHAIR: Mr Walsh, that's all the questions you are to be asked and, therefore, you're free to go. But before you go, can I thank you for your written statement but also the work that has gone behind that written statement? And, indeed, thank you for your attendance here today. But, as I say, you're now free to go. Thank you very much.

A Thank you, my Lord. Thank you.

(<u>The witness withdrew</u>)

THE CHAIR: Well, as I think we identified yesterday, we are not sitting this afternoon.

MR MACKINTOSH: We're not sitting this afternoon, and our next witness is on Tuesday; it's Professor Williams. But I would observe, just for the benefit of those interacting with the Inquiry, that Monday is a public holiday, and whereas members of the counsel team and some members of the legal

team may be responding to emails, we might not be quite as dynamic as we normally are on a Monday. Therefore, if anyone has any issues for us that are urgent, they'd probably better contact the counsel team on Monday.

THE CHAIR: Right. Well, Mr Mackintosh has made his position quite clear. Enjoy the weekend. Thank you.

(Session ends)

13:14