SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
19 August 2024

Day 8
Thursday, 29 August 2024
Susan Dodd

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10:36

THE CHAIR: Good morning. Now, Mr Mackintosh.

MR MACKINTOSH: Our next witness, my Lord, is Susan Dodd. Ms Dodd has a cold.

THE CHAIR: Right, so her voice may be lower than----

MR MACKINTOSH: It may be a little bit lower.

THE CHAIR: Right. Well, as is very familiar, I'm quite sensitive to hearing-- or the importance of volume, but I lost my voice yesterday, so I'm sympathetic to Ms Dodd. I'll just leave that matter in your hands, Mr Mackintosh.

MR MACKINTOSH: Of course, my Lord.

THE CHAIR: Good morning, Ms Dodd.

THE WITNESS: Morning.

THE CHAIR: As you understand, you're about to be asked questions by Mr Mackintosh, who is sitting opposite you, but first, I understand you are prepared to affirm?

THE WITNESS: Yes.

Ms Susan Dodd
Affirmed

THE CHAIR: Thank you very much, Ms Dodd. Mr Mackintosh.

Questioned by Mr Mackintosh

Q Ms Dodd, I wondered if you could give us your full name and current occupation?

A My name is Susan Dodd, and I'm a nurse consultant at ARHAI Scotland.

Q Thank you, and did you produce two statements for the Inquiry, a longer one from your period at Glasgow and a short one for your period at ARHAI?

A I did, that's right.

Q Would you be willing to adopt them as part of your evidence?

A Yes.

Q Now, I'm not going to go through them in detail today, but I want to focus on a few key issues, but before I do that, I'd like to get some dates clear in our mind.

A Okay.

Q I understand you worked as the lead Infection Prevention Control nurse in the Children's Hospital at the Queen Elizabeth?

A That's correct.

Q Between what dates were you there?

A So, I started there in March

2017, and I left to go to ARHAI Scotland in August 2019.

Q Was that as a permanent transfer or as a secondment?

A It was initially as a secondment in the August '19, and it became permanent in January '20.

Q So now you're a permanent member of staff there?

A Yes, that's right.

Q What's your current role at ARHAI?

A I'm a nurse consultant at ARHAI for Infection Prevention and Control. There are a number of us do that same role and each of us lead a programme of work. My programme of work is the National Policy Guidance and Evidence programme. So, really, that consists of largely reviewing the evidence around Infection Prevention and Control and populating the National Manual accordingly.

Q So do you, in a sense, have some editorial influence on the National Manual?

A Yes, I have the ultimate sign-off. There's a much bigger team that supports that work. It's not all just down to me, but yes, I have the kind of sign-off for content that goes into that.

Q In your role at ARHAI as a nurse consultant, are you one of those nurse consultants who will attend meetings with health boards when matters are being brought to your attention?

A Yeah, that's right. So, in addition to our programme work, you have your reactive work as well. We have an on-call rota, and when we are on call, we'll support boards where they request our input and that's sometimes at attendance at meetings or it's just through advice provided by email or phone call.

Q Could you explain, because you're the first Infection Prevention and Control nurse consultant to give evidence of the Inquiry, how Infection Prevention and Control nurses are trained, in general, nowadays?

A So, typically, Infection Prevention and Control nurses will first be employed as a band 6 nurse, coming from a main cohort of-- coming from the large cohort of staff nurses. They'll often start in the teams with no Infection Prevention and Control qualification, but when they get there, they'll commence their qualification at that point. That can be a diploma or a degree in Infection Prevention and Control.

Q That will generally be done whilst they're working?

A Usually, yes. Uh-huh.

Q How, from your perspective, do the skills and experience of an Infection Control Prevention(sic) nurse,

who's passed these diplomas and degrees, differ from that of a doctor carrying out Infection Prevention and Control work?

A So, the doctors carrying out IPC are typically microbiologists first and foremost. So they come from a microbiology background and apply Infection Prevention and Control with that knowledge background. The nursing cohort come from a nursing background and take the lead on a more practical level on the shop floor in terms of supporting staff on the floor with advice around good Infection Prevention and Control practices, auditing that practice and giving general advice about patient management.

Q Right, so, just to be clear, you're saying that doctors have more of a microbiology interest and the nurses will have more of a practical service delivery advice?

A Yeah.

Q Is that the right way of describing it?

A Yes, in general, I think.

Q Okay. I'd like to look at the period after you initially arrived----

A Mm-hmm.

Q -- at the Children's Hospital in March 2017. Your statement – I'm not going to go to this, but just for everyone else's benefit – from paragraph 33 describes a series of clusters or unusual infections within weeks of your arrival, and you mentioned, for example, Elizabethkingia, then some gram-negative bacteria, then Aspergillus, and then Stenotrophomonas Maltophilia. Now, the statement's a bit short of dates, but we managed to track down the summary document that you refer to in paragraph 43 of your statement, and I wonder, therefore, if we could look at bundle 27, volume 3, document 37, page 626. Now, is this the summary document that you produced and you referred to in your statement?

A Yes, that looks familiar.

Q Have you had a chance to look at it in the last day or so since we found this?

A Yes.

Q Thank you. Now, what I want to do is firstly understand why did you produce this?

A So, I suppose, first, to understand that all those incidents that I've listed there were reported in the way that they should be reported. The purpose of this wasn't about the detail of the incidents as such; the purpose of this was about trying to convey just how many there had been in that space of time and I suppose to flag my concerns around that. It appeared to me there were a lot, too many infections and clusters that had

happened in that short space of time and I wanted to report that and make senior management aware. That was creating a heavy workload for myself and the Infection Control team that were there, so I was trying to flag that concern.

Q Because before we found that I was planning to take you through each of the PAGs, which are in bundle 2, but I'm not going to do that.

A Okay.

Q So, what I wanted to do is firstly, conscious that this doesn't contain all the detail, use it as a sort of guide to discussing each of the individual event or some of them.

A Okay.

Q Then I'll ask you some questions about your idea that it should be reported to senior management and the purpose you produced it.

A Okay.

Q If we look on the first page, that's page 626, there's a discussion in the first row about Elizabethkingia.

A Mm-hmm.

Q Now, what I want to understand firstly is, from your perspective as an Infection Prevention and Control nurse-- This is your second Infection Prevention and Control job, effectively, or was it your third?

A Oh, I hadn't count-- but third.

Q Third.

A Yeah.

Q Had you come across Elizabethkingia before?

A No.

Q No, and when you came across it-- when you come across an unusual bacteria like this, what influences your decision to, as it were, investigate it and do more than simply cure the patient?

A So, every infection or isolate that is reported to us you'll investigate. We're looking at-- I suppose, first and foremost, I want to understand that that patient's been managed appropriately, and I also then want to understand has that been acquired in the hospital. So, you do that for all of them, regardless of whether it's well-known to you or whether it's unusual. From recollection, this was reported to me from the labs directly. It didn't come through our reporting computer system, because it wasn't set up to do that, because it was very unusual. Occasionally, that would happen. They would phone and let you know about an isolate that was different or unusual in some way----

THE CHAIR: Ms Dodd, can I just pick you up on that in detail?

A Mm-hmm.

THE CHAIR: You say this particular infection was reported to you by the lab.

Now, you said it's not set up to pick that up. Am I right in thinking that there are a number of infections which will, in a way I frankly don't quite understand-- but I see it as an automatic pick up through a digital system. Just, maybe, could you tease that out a little bit for me?

A Yeah, yeah. So, we have the microbiologists in the lab, who will have all the results of all the samples that they've tested, and they will put that into their own microbiology system. Our Infection Control system pulls from that the ones that are relevant, and that system is set up as managed by a data team who really entered into it, "These are all the ones we want to be aware of." That's informed by a national list of organisms, but it should also be informed by local surveillance as well. So----

THE CHAIR: Sorry, informed by?

A Local surveillance----

THE CHAIR: Right.

A -- from the hospital. So it may not be something that nationally has been a problem, but if you know that you're seeing something regularly in a unit in your hospital, you may add that organism to the list for the Infection Prevention and Control Teams to be alerted to.

THE CHAIR: Right. So, you use the expression "a relevant infection"?

A Yeah.

THE CHAIR: An infection is relevant if it is on the national----

A Organism list.

THE CHAIR: List.

A Yeah.

THE CHAIR: Yes, and a particular hospital may have additional infections which it has become interested in?

A Yeah----

THE CHAIR: Right.

A -- exactly.

THE CHAIR: Thank you, and just so I'm following.

MR MACKINTOSH: This question I was going to come to later, but I'll just complete this chapter. If you have an organism that's isolated in a patient that isn't on the national list and isn't on the list that has been thought of as worth reporting already----

A Mm-hmm.

Q -- how do you find out about it the first time?

A The microbiology labs staff will phone up and tell you about it.

Q So that relies on the lab thinking, "This is unusual"?

A Yes.

Q Okay. Now, in the case of Elizabethkingia, in this case, I wanted to look at the IPC actions.

A Mm-hmm.

Q I want to capture something that you discussed in them. There's discussion of lab sampling of vents and

water outlets and a review of vent cleaning.

A Yeah.

Q My first question is what do you mean by vents?

A The air vents that were in the room.

Q In the ceiling?

A Yes.

Q So would these be chilled beams, ultimately?

A At that stage, no, I don't think it was, the initial stage. Within a couple of weeks, we were including chilled beams. I would have referred to them as separate things, but I suppose from an engineering perspective, they're maybe similar, but----

Q So, I just want to just clarify that because we've heard various evidence and we've seen documents and we've had reports that suggest in each room there would have been a vent in the room and a vent in the en suite?

A Yes.

Q Both of those would have been serviced by, I think, what technically isn't a chilled beam but we've been calling a chilled beam system, which chills the air or warms the air depending on (inaudible) temperature. Is it those sealing ventilation vents you're talking about or something else?

A Yes.

Q Right, but at this point in February '17, was the subject of chilled beams something you had come across or were aware of at the time?

A I had never heard of one in my life.

Q Right.

A They were brand new.

Q So why did these vents, as you call them then, need to be cleaned?

A So, when we referred this organism, it was new to me. I hadn't heard of it; certainly, hadn't seen a patient case before that I could recall, and it was relatively new to Dr Inkster as the Infection Control doctor. She would have known more about it from a microbiology perspective, but my understanding is that it wasn't one that she saw in clinical isolates very often.

So, we had a look at the the literature that was out there. What is this? Where are you likely to find it? And one of the things that came up was that it was rare, but also that it was often found-- and it had been found in condensation on the NASA space station----

Q Right.

A -- of all places and it had been associated with ventilation system and condensation. So, that took us straight to look at the vents, which-- I think from recollection at that stage we'd had some concerns that they weren't particularly clean but we also had become aware of

the chill beams and the dripping, the condensation that collected on them, and the dripping.

Q So, it was a combination of the cleanliness and the dripping?

A Yes.

Q Right. Now, later on in your statement, in your statement itself, you discuss at one point chill beams in more detail. What I'd like to do is to try and jump to paragraph 99 of your statement, and then come back to this page, if I'm not going to completely confuse my colleague who's running the IT. So, paragraph 99 of your statement is on page 251. The bottom half of the page, you discuss condensation on chill beams as a recurring problem, and later, about halfway through this paragraph, you report:

> "Staff had reported condensation collecting on them and dripping on the floor below. Sometimes they drip onto the patient beds or equipment in the room. The condensate was often visibly dirty. [And then the very last whole sentence on that page,] It was described to me as appearing as if it had been raining inside the building."

What I don't have here is a good idea of when all these events are happening. So, when did what you're describing in paragraph 99 start?

A So, when we had got the Elizabethkingia results back, I was aware at that time of chill beams dripping. That's certainly something that various staff had mentioned. In terms of the incident, when it was described as raining inside the building, I can't recall the exact date. It was after that, it was definitely after that.

Q Could it have been, and there's no particular reason why you should know this, but it might work to ask you, could it have been just before you left, where a boiler seems to have failed?

A I thought-- no. I thought it was quite a long time before I left.

Q Right, okay, so maybe it's a different thing but you're not sure?

A I'm not sure.

Q Not sure, okay. Now then, if we go back to the bundle 27-- thank you. What I want to look at is water outlets you mentioned in this section. Now, I'm just using this as a hook to ask you what was your interest in water outlets at this point? So, that's February '17, just after you'd arrived.

A I don't recall being particularly concerned with the water as a potential source at that point. That was really early. I was literally just in-post.

Q Right.

A It was the first week. So, at that point, my concern around water was nothing close to what it then became further down the line.

Q Okay, if we can go on to the next page, please, and look at the second row which relates to three cases of invasive Aspergillus. Gullus?

A Aspergillus.

Q Gillus, I'll get there eventually. Now, I see it's recorded as a high, at red.

A Mm-hmm.

Q So, that's an assessment by the Infection Prevention Control team in the hospital, isn't it?

A It's an assessment by everybody who's at the IMT.

Q Right. Which is a collective process.

A Yes.

Q Yes. Now, at this point, had you been aware that there'd been a previous issue of increased Aspergillus in Ward 2A in the August of the previous year?

A No.

Q I will ask her, but are you any awareness of whether Dr Inkster would have been aware at this point?

A I think she would have been aware, yes.

Q I will ask her when we come to her. I see also there's a section, three bullet points from the bottom, "inspection of cooling beams which are reported to leak periodically." Are you able to help here whether this is condensation or leaking from the beams from your memory?

A I can't.

Q You can't?

A I'm sorry. I can't remember the difference, which one it was.

Q Now, before I go to the where this was taken, I want just to ask a general feel from you about what the situation was in these early months in your job, put a few concepts to you and see which one seems to be closest to your position. In respect of the whole ward, the children-- Schiehallion unit as a whole for example, were you focused on specific places or objects and things in the ward, or was your concern more pervasive about the ward as a whole?

A The ward as a whole.

Q And why is that?

A Well, when I say my concern was about the ward as a whole, my focus was about looking at the ward as a whole. The picture is only starting to build at this point I suppose, we've got a number of things going on so in those first two months, really the time was spent trying to look at all possible routes by which infection may be spreading or occurring in these patients. Amongst those lists, there are some infections

which spread easily between patients. So, typically your diarrhoeal illnesses----

Q Yes.

A -- they spread more easily. So, you're looking at practices, you're looking at where the patients are moving.

Q So, this is hand washing, line safety.

A Yes, all that kind of thing.

Q Yes.

A When you've got blood cultures, you're looking more at line care. That's not something that's spreading between patients directly. You're looking at the practices that are going on around the line care, around wounds, around any invasive devices in the body. So, we were looking wide----

Q Right.

A -- I suppose. Rather than it being that my concern was wide, I was looking wide to make sure that we were considering, or to make sure that we were going to find, whatever the issue was.

Q And maybe we can cut some things short here. Is this before the particular work I think is the CLABSI line programme started?

A I think the CLABSI line started possibly before I came in to post.

Q Right, okay.

A I didn't know much about it, and I think that had been developed after there was a slight increase in gram-positive bacteraemia.

Q In the previous year, perhaps?

A I think so, yes.

Q Yes, and in terms of the hand hygiene, were you trying to organise any particular efforts on that in this early part of '17?

A Yes, there was efforts on that. We looked at hand hygiene, we looked at their PPE use, we looked at the cleaning of equipment, the cleaning of the environment, and we put actions in around all the practices we felt needed improvement.

Q Okay, well, I want to ask you one question which relates to something you said in paragraph 43 about where, and you mentioned in your evidence, that you produced this partly to assist in ensuring that senior management were aware of what was going on.

A Yes.

Q How did you anticipate that senior management would learn about the contents of this summary document?

A My understanding-- so, I reported it by email – from memory – to Sandra Devine and Tom Walsh, and then----

Q So, what role did Sandra Devine hold at that time?

A Associate nurse director for IPC.

Q And Mr Walsh? What role did he hold?

A He was infection control manager.

Q Right.

A So, I reported it to them. I also reported it at my weekly lead nurse meeting, where all lead nurses from across Greater Glasgow and Clyde would meet every week, and we would discuss the concerns we had on site. And I think from memory, I also reported it at our monthly senior management team meeting there as well. So, I talked at each of these meetings.

Q At the risk of slightly going off piste, this is produced in March, or was it May? Perhaps it was May, I think, of----

A I think it was May.

Q Right. Well, if we can just-- What I'll do is during the break, I'll ask my colleague here to go through, look at three documents for me. Was there any suggestion it would be reported higher within the organisation? In the statement, you mentioned the Board Infection Control Committee.

A Yes, I was under the impression it would go to AICC, and I'm sure the discussion said it was going to BICC as well, from memory.

Q We will have to ask Mr Walsh and Ms Devine if they can recollect this but from looking at the Board Infection Control Committee minutes that follow, I don't see a reference to it.

A Yes.

Q Would it have been reported back to you that it had gone there?

A No, I don't think we-- no.

Q Right. What I'd like to do now is go to bundle 1, document 9, page 35, which is an IMT from 7 March 2017, and this appears to be an escalation from those early (inaudible). Can we look at page 37, please? Now, we've obviously redacted out quite a lot of information about-- just going to make sure I've got the right page. Yes. That page is the right page. I notice in this IMT minute, there's a discussion of a report from Dr Inkster about various aspects of the ventilation in the ward which she describes there, and I notice, for example, the first bullet point is-- The second bullet point refers to portable HEPA filters. The large second paragraph discusses the possibility of increasing the specification of the ventilation in Ward 2A.

Now, what I wanted to do was ask you what your recollection was of what you learned and knew at this point about what the specification of ventilation was for Ward 2A. I'll go through the sort of categories that we understand it and see if you can recollect whether you knew what it was, and if so, what you thought it

was. So, in respect of air changes per hour in 2A, not counting the BMT isolation rooms, did you at that point know what the air change rate was?

A I may have been aware at that point that there were three air changes.

Q Per?

A Per hour.

Q Per hour. In the bone marrow transplant isolation rooms, were you aware what the air change rate was there at the time?

A No, I was just aware that it wasn't adequate.

Q Right. When it comes to to HEPA filtration other than the portable units, looking at the whole ward, were you aware of whether the ward was HEPA filtered in its ventilation?

A I don't think I was at that point, no.

Q When did you discover what the situation was?

A From memory, around about this time, and obviously at the IMT, we were starting to discuss concerns around ventilation. Dr Inkster was a lot closer to that than I had been and was able to talk to her concerns with the ventilation. So, I was beginning to understand it's not right here, this ventilation.

Q Yes, because the reason I want to ask you is because you weren't involved in the procurement for the hospital at any level.

A Yes.

Q So, it's quite interesting to see what you knew. If we go to the HEPA filters, or not HEPA filters, for the isolation rooms at this point, would you have known whether there were any?

A No.

Q Were there pressure gauges outside the bedrooms that weren't isolation rooms at this point?

A That weren't isolation rooms?

Q Yes.

A I don't think so.

Q Were there pressure gauges for the isolation rooms? It's quite a cruel question, but it's quite helpful.

A I think there were digital ones, yes.

Q Digital ones, right. The final question relates to the entrance to the ward.

A Mm-hmm.

Q At this point, we understand the ward didn't have a lobby entrance arrangement and that might well have been different to what was at Yorkhill. Was that something that you you saw as unusual when you were there or was it----?

A Yes, immediately. Uh-huh.

Q And why would that be?

A I had come from working at the Beatson.

Q That's the cancer centre?

A That's the West of Scotland Cancer Centre, yes, where they cared for the same patient group but in the adult.

Q So, it's the same illnesses, effectively?

A Yes.

Q Or not the same illnesses but broadly the same.

A Broadly the same diseases, and in those wards where they were cared for in the Beatson, they had these double door entries. We were very much used to that. You would enter the first set of doors and you would be closed in the lobby for a second or two before the second set of doors opened----

Q Right, okay.

A -- to allow you into the ward.

Q Now, I'd like to go to paragraph 42 of your statement, please. The reason I want to go here is that you-- which is on page 233. You mention in paragraph 42, you discuss Aspergillus.

A Mm-hmm.

Q Now, this particular paragraph describes later in it, inspecting a ceiling void.

A Yes.

Q Is this event close in time to the IMT in the summary paper in the early part of your job or is it an event that happens later on in the in your time at the unit?

A I don't think I mention it in the summary.

Q You don't? No.

A No. So, it's possible that that was after as part of investigation. So, with when you have a case of Aspergillus, you're often thinking about has there been water ingress somewhere. That's where it likes to grow. So, we would have asked the questions around has there been any leaks, has there been any water ingress in this area. I do remember one of the staff nurses telling me that there had been this leak in the corridor which was for the Teenage Cancer Trust patients.

Q Right.

A And that sparked our interest. Could that be a reason for the infections? And that's what led us inspect.

Q Many years after-- this is quite difficult question to answer but it may matter. When you're in that space describing what you described here are you can you see the place the leaks come from?

A No, because it'd been repaired at that point.

Q And do you know whether it was a leak of domestic water system or chilled water systems?

A I don't know.

Q Don't know, right. Over what period was there a concern about

Aspergillus infections in Ward 2A?

A So, at that point, I think the case that had----

Q This is March 2017?

A Yes. The case that we had got, from memory----

Q Can you take this off the screen?

A I-- Dr Inkster did a look back to see if there had been other cases and discussed that with the clinicians also. The reason why is because Aspergillus is difficult to diagnose. It doesn't necessarily come as a result of a positive test. It can be difficult to grow in the laboratory. So, the absence of positive laboratory results doesn't mean that you've got an absence of cases. So, Dr Inkster engaged with the clinical team to say, "Have you had any cases that have been here?" And my understand-- so we had three, and I think from memory that dated back to 2016. So, it would have been over a period of a year or less that we'd had three cases, which seemed excessive.

Q Now, I want to look at-- well, in your statement on paragraph 51 - again, just putting a date to something in your statement, which is on page 237 - you discuss cases of Stenotrophomonas Maltophilia.

A Yes.

Q When would that have been? Could it have been July, August '17? Because we have some PAGs and they relate to that for that date.

A That sounds reasonable. Yeah.

Q I won't take you to the documents. Now, you say in that paragraph, the end of it:

"Having seen improvements with the practice issues identified, it was at this point that I felt there may be some significance with the 2A environment causing these infections."

Could you explain-- If this is August '17, could you explain what your concerns were at this point?

A So, suppose we were at a stage where we had a lot of time spent on Ward 2A, we put in a lot of interventions, and we were at a place where, despite all that routine interventions that we would normally put in, we were still seeing-- or we were seeing infections of concern but the origin of those infections in terms of where these organisms like to grow, they're environmental, and so I felt personally these keep popping up. Why do these keep popping up despite what we've done, despite the action we've put in place? Now, I think at that point there may still be some issues ongoing with the domestic cleaning but, to be honest, domestic cleaning issues can exist across NHS estate. It still didn't feel right.

It didn't-- it stood out.

Q And so these aspects of the environment that you were concerned about, what were they?

A So, as I say they had concerns with the domestic cleaning at that stage and had reported them and that was ongoing in terms of discussions and monitoring. If I'm completely honest, at that stage, I was unsure as to where this was coming from and questioning a lot in discussion that the IMTs and discussion with Dr Inkster, where might the source of this be? If we're addressing the cleaning problems, where might the source be in the environment and how may it be getting to the patients?

Q So, your position is more of a "there's something up here, I don't understand what it is."

A Exactly.

Q Right, I understand, okay. Now, this particular infection, the Stenotrophomonas Maltophilia, is seemingly relatively unusual in this hospital at this point, but there have been cases and we discussed with Elizabethkingia, it was an unusual infection. We've discussed with Aspergillus, there was an infection before; none of these are on the list of infections that you have to have reported. How, in practice, do you react-- how should you react to small, these small unusual infections in best practice terms? What's the best practice approach?

A So, I suppose the best practice approach, regardless of whether how they're reported, you act on them. You are-- as I kind of touched on before, you're looking to see, first of all, do suspect this has possibly been acquired in health care? So, that's your first thought, and coinciding with that is contacting the ward, informing them of the result and making sure that they know how to manage that patient in accordance with the result that's come back.

Q Yes.

A So, there may be additional controls we ask them to put in place to make sure it doesn't spread. So, I suppose there's the immediate controls in terms of prevention of onward spread or further cases, and then there's the investigative part that comes thereafter. So, you're looking at that. Could this have been acquired in health care? If it has been acquired in health care, where am I going to look? What is this pointing to in terms of an acquisition route?

Q So, if we think about that as your reaction in the ward team, the Infection Control team, and you're obviously told this already that you reported these sort of events to your weekly meeting with your sector

colleagues and your site colleagues and sometimes you would report things to Mr Walsh and Miss Devine to go up within the system. I understand, because I've read a lot of them, that acute Infection Control minutes and board (inaudible) will have the numbers of cases that have been reported. They will report the HIIORTs. They will report the data, but how does this sort of, if I put it-- the anxiety that you've just described of not knowing what the answer is, how does that get reported up into the organisation?

A So, I suppose that-- that comes from dual route in terms of IMTs, the outputs from IMTs that we will send by email updates to senior management and and the HIIORTs that we completed for HPS, but largely it was at the weekly lead nurse meetings that I attended.

Q So, all of those would be-- how many people would be at a lead nurse meeting?

A There was the five sector leads, lead nurses, and Pamela Joannidis as the nurse consultant and Sandra Devine as the associate nurse director.

Q I should probably ask them about how they would react to any anxieties that you're describing.

A Yeah.

Q I will do that.

THE CHAIR: Entirely my fault, Mr Mackintosh. We're talking about reporting anxieties and “largely at the,” and I just failed to----

MR MACKINTOSH: The weekly stand-up you were saying? The weekly--

A Lead nurse meeting.

Q Lead nurse meeting. That's the five sector nurse.

A Yeah.

THE CHAIR: Right. The five sector lead nurse stand-up. Thank you.

A Just the lead nurse meeting it was called, yeah.

MR MACKINTOSH: And they would be attended by the five sector nurses of which you were one.

A Yes.

Q Along with Pamela Joannidis who was the nurse consultant----

A Yep.

Q --and Sandra Devine who was the associate nurse director.

A Yes.

Q Right.

A And one other lead nurse who was the lead for data and surveillance.

Q So, there'd be about seven or eight of you at that meeting.

A Yeah.

Q Okay, what I'd like to do is to move on to 2018 to what we've come in the Inquiry to describe as "the water incident." I think people refer to it. Is that how you refer to it yourself?

A Yeah.

Q What do you understand to be the water incident?

A So, I suppose in my own head, the incidents are broken up into three parts. There was the water incident whereby we had found the organisms of concern in the patients. We had also found it in the water. We then move on to the drains, and we then move on to the ventilation. So, the water incident, in my head, was the initial incident when we had tested the water and found some of these bacteria in the water.

Q And this is in the early part of 2018?

A Yes.

Q Now, in paragraph 61 of your statement, which is on page 240, you make reference to increased amounts of water testing. What I wanted to do is ask you a question that follows on from that is, who would have received the water testing results?

A Microbiologists and Dr Inkster is the lead for the incident.

Q And so who would set what was out of specification?

A That would be determined by the labs-- in terms of what should be found in the water?

Q Yes, so if you're doing a test in water-- well, what tests are we going to carry out and what is out of specification, who would set that?

A So, I suppose the guidance-- the SHTMs at the time outlined what should be tested for on a routine basis. I suppose what it didn't outline was what you should test it for in scenarios like this where you had an outbreak. So, in terms of those parameters, I'm not aware that that was documented clearly anywhere.

Q Was it eventually constructed into a list by Dr Inkster and Mr Powrie, as you understand it?

A The findings would have been-- she would have had all those----

Q If you don't know then we can we can move on.

A I don't know I suppose what what I'm trying to say is her expertise would be applied to what should be in that water.

Q Well, I'll ask her when it gets to her.

A Yeah.

Q Now, the----

THE CHAIR: Again, just so I'm following, the-- Mr Mackintosh's starting question was, if I've got it correctly, who set the parameters which defined whether a sample was out of spec or not out of spec? Now, I don't think I got an answer. or atleast----

MR MACKINTOSH: No, I think I got the impression that Miss Dodd doesn't know exactly who set it, but it

would probably have been Dr Inkster, right? Have I got that right?

A Yes.

THE CHAIR: It would probably be Dr Inkster?

A Yes.

THE CHAIR: Right. Thank you.

MR MACKINTOSH: Now, would nurse leads-- nurse consultants receive the results or would it just go to microbiologists?

A We didn't receive the results.

Q You didn't receive the results, right. I'd like to move on to paragraph 64 on the next page, where you talk about flow straighteners in taps. Would these be the Horne optitherm taps that were fitted widely in the hospital?

A I believe so.

Q Right. Now, if you go back to 2018 and think about what you knew then because you may know something now that you didn't know at the time, did you know that there'd been discussion about whether these taps should actually be fitted before the hospital was built?

A I remember when our concerns were building around the water. I recall Dr Inkster telling me that there had been some concern. Beyond that, I didn't know the detail----

Q So, that was the first time you'd have about it anyway.

A Yes.

Q And approximately when would that have been? Some time in '18 or----?

A Sometime in '18 and probably relatively early in 2018.

Q So, before you learned from Dr Inkster that there'd been some discussion in the past, had there been, as far as you're aware, any regular maintenance or planned preventive maintenance of the taps in the children's hospital since arrived as lead infection control nurse?

A I'm unaware of any. I don't know whether that would have been in place. What was----

Q I was wondering whether you literally had seen it being done. Had you seen any maintenance being done?

A No.

Q We understand that the process would involve removing the tap. Would that have been happening on a regular basis?

A No.

Q No. Were you aware of whether there were flushing regimes-- regular flushing for those taps before you learned from Dr Inkster that there was some sort of issue in the past?

A So, there was a-- flushing was considered as part of domestic cleaning across all of the Greater Glasgow and Clyde estate, from memory, and that would be that when the domestics were

in carrying out the cleaning of the sink and the taps they would turn it on for, I think, originally it used to be three minutes and then it was a minute, or I may have got that the wrong way round, but my understanding before I moved into post was that that was done routinely.

Q So, before you learned from Dr Inkster that there had been a problem in the past, there was flushing by the domestic team of some sort----

A Yes.

Q -- but there wasn't some form of more invasive maintenance going on?

A Not that I'm aware of, no.

Q Right, right. Before you left in the summer of 2019, did any form of more invasive maintenance start, on a regular basis, on those taps?

A Not that I'm aware of in terms of maintenance that would happen at the actual tap, no. There was-- I'm aware of the chlorine dosing, etc. that was going on in the system but I don't recall there being regular maintenance at the tap other than the application and regular changes of the point-of-use filters.

Q Yes, so the point-of-use filters would have happened to the taps----

A Yep.

Q -- and the chlorine dioxide would have happened to the water system----

A Yep.

Q -- but there wasn't a regular maintenance programme going on?

A Not that I'm aware of, that I can recall.

Q Well, I mean, is it that you don't remember or that you didn't know? Can you be a bit more specific about what your knowledge is?

A I suppose I'm unsure as to what that regular maintenance would look like----

Q Okay.

A -- beyond cleaning and beyond ad hoc requests to remove flow straighteners, to remove spigots that were damaged, all that stuff. In terms of regular maintenance, it would be the cleaning of the external and it would be the flushing. I'm not aware----

Q Why don't I put to you some of the evidence we've received about what that might involve? So, one piece of evidence we've received is there was some form of rig constructed, where the tap could be physically removed, taken away and cleaned away from its location and then put back.

A Yeah.

Q Is that something that you saw happen before you left?

A I think that had happened as part of the response to the incident. I wouldn't call it a regular routine thing. I'm not aware that that was happening

routinely, but it had happened.

Q But if it happened, it would have happened after some time in '18?

A Yes.

Q Right. That's really helpful, thank you. Now, I want to move on, in your statement, to paragraph 75 and onwards. It's a long section, so we're not going to-- I mean, I'll put it on the screen by all means, but it was more-- we've obviously read it. So, it's on page 244. It's about the drains and what's going on with them over time because you've described in this section some concerns you have, or had at the time, about the drains, and I want to understand how it evolved over time.

A Okay.

Q So, what I'm going to try and do is ask you some questions about, as it were, the drains in '17 and then another question about the drains during the water incident, another question about-- the same set of questions about after the chlorine dioxide system was fitted.

A Okay.

Q So in '17, was there any suggestion that you could see black grime in drains just by looking at the drain at the sink?

A I personally didn't, no. What I would say to that is that I didn't go inspecting drains, but nothing stood out to me as part of review of----

Q If we look at 2018, the period before the decant-- well, before the chlorine dioxide system was fitted is a better point. In that period of 2018, were you aware of any black grime or anything else in drains?

A At which point, sorry?

Q January '18 to the point that the chlorine dioxide systems turned on?

A I don't think it had been pointed out, no. I hadn't seen any, I don't think. I'm struggling probably with exact dates, but no. My recollection of when I first recognised it was when we had started to see more blood cultures despite the actions we'd taken for the water.

Q Would that have been in '19?

A Yes.

Q We can come back to '19 when we get to '19 in the evidence session, and so you've got an opportunity to check that then, but could you describe what you became aware of at this point that you're talking about?

A So, black grime and the drain had been flagged either by the senior ICN that worked in my team or one of the senior charge nurses – I can't remember who it was that flagged it but it was pointed out – and, when we went to have a look at a number of drains, it was quite-- it was marked. It stood out as-- if that had been there before, I'm pretty sure we

would have seen it, we would have picked up on it at audit or when we'd been in the rooms if it had been to that extent. So yeah, so it stood out. It was----

Q Now, we obviously-- Some of us in this room have seen a sink in the children's hospital. How would you describe it? Where was this described?

A So, unlike a lot of sinks where the drain drains away vertically, in these clinical hand wash basins, there is a 3 or 4-inch kind of horizontal drainage first before it then drops away into the waste pipe. So, without too much effort, you can see down the drain.

Q You can look down the drain?

A You can look down the drain, and some of them were very black, slimy grime that was built up in the entirety of that drain, and in some----

Q You're gesturing with your finger; so the entirety of the circle of the drain?

A Yes, but in some extreme examples when we first found it, it was starting to creep out----

Q Into the sink?

A -- into the sink.

Q Now, I'll come back to discussions about causation when we discuss 2019. What I want to do is ask you about your knowledge of something, so if you don't know about this, then please tell me. If we think of the period, the first half of 2018, at that point, had you heard of something called the DMA Canyon report?

A No.

Q When did you first become aware of it?

A I'm not sure I was formally aware of it, even when I worked in Glasgow.

Q Right. When you say "formally," that sounds like a little-- did you know something? What did you know?

A So, I was aware that there were concerns about positive water results prior to the hospital opening and that these had-- concerns around this had been flagged by Dr Inkster and others, they were aware of these results. I couldn't have told you that they were contained within a report called the DMA Canyon report.

Q Right. Well, in that case, I won't ask you any more questions about that. What I want to do is look at the decant. So, you discussed this-- I won't go to it, but just for everyone else's benefit, first in paragraph 108, 115 of your statement. What I want to do instead is look at the IMT of 14 September. So that's bundle 1, document 38 to page 164. So, this appears to be an IMT in September 2018,

and I think you're present and, by this point, has point-of-use filters been fitted in the ward, September?

A Oh gosh----

Q Well, why don't we look at the page, because I don't think that was a trick question? 165 please, and we have--

A So, I think-- Yes, I think-- Have we moved on to the drains by this point? So, I think, yeah, the point-of-use filters are in place. Yes, they are. They're in place. We've moved on to the drains, and the drains are our main hypothesis.

Q I want to just start with point-of-use filters because, does a point-of-use filter have any effect on the way the sink works as a useable sink?

A From a practical level, yes. If you imagine the water coming out of the outlet to the sink, there's a space between the outlet and the handwash basin where your hands fit in to wash. The point-of-use filter is quite large and it really reduces the amount of space that you have to clean your hands, so from a practical level, there was a risk of staff re-contaminating their hands by touching the filter or touching the handwash basin because there wasn't much room to carry out their hand hygiene.

Q Was there any difference in the volume or speed of the water between the previous-- before that, when the filters were put in?

A So, it was slower. There wasn't as much pressure when the filters applied of the water that's coming out.

Q There's a discussion-- I think it's actually a suggestion that Annette Rankin had the observation in this minute about aerolysation risk. Is that something that you were aware of at the time or would this just----

A Yes, so I think this was feeding into our hypothesis, so I think the other thing that's important to note is that the point at which the water now leaves the outlet is closer to the drain and I think Annette's suggestion was that, so close to the drain, might it be hitting the contents of the drain and aerosolising what's there, or certainly dispersing the content of those microorganisms that are in the drain to a place where they shouldn't be?

Q Had you noticed, as a person who uses these sinks and is looking at them professionally, any change in whether there was extra dampness around the sinks or spray or anything like that?

A So, I think, by the very nature and the fact that there was limited room to carry out hand hygiene, it did create a lot more splash trying to do all that in that smaller space. Probably the floors were

more wet because of that practice being a bit more difficult. If you take away that practice and you're just talking about the water coming out, I can't remember thinking that it made more splash as a result of the point-of-use filters, but it's hard to compare.

Q No, you've got-- (inaudible) understand, that's helpful. What I wanted to-- I think I'll show you the page because it seems a bit-- seems to be something that was being discussed. At this point on 14 September, what was the hypothesis being investigated by the IMT, or being considered by the IMT, for the cause of these infections?

A So, I think we were strongly leaning towards drains at this point.

Q Okay, and there's a discussion at the foot of this page about a contingency of a decant, and I'm not going to ask you about the contingency because we've already heard Mr Redfern's evidence last year, and we can read his risk assessment.

What I want to do is go onto the next page and look at the top. There's an observation from Dr Kennedy, which I will ask him about when he comes to give evidence, but from your point of view, if a decant was being arranged from Ward 2A to another ward, and there was obviously a range of options being considered, some of which were in the hospital, how would the concern that the issue was around the whole hospital have affected that decision?

A So, I suppose part of the decant considerations did consider places outside of the hospital but, for reasons that'll have been explained already, we didn't go with that option, so we accepted that there may be risks associated with other wards and in Royal Hospital for children, and therefore, if we're going to decant the patients to those other wards, we need controls in place before they get there.

Q What about the question of whether the same risks applied to the adult hospital next door? Was that something that you remember being discussed at the time?

A There was discussion. So, because we were going to be going to 6A, because we were considering 6A----

Q To be fair, 6A comes up a few days later, this is a little bit before the point.

A Okay. I can't remember whether I'd remember discussion at that specific IMT around the Queen Elizabeth. I'd be unsurprised if I did have-- if there was discussion around the Queen Elizabeth, and I would be unsurprised if the same concerns existed in that building as well.

Q Yes, because I wanted just to--

I appreciate that the decision to move to 6A involved balancing lots of different factors----

A Yeah.

Q -- and they're set out in Mr Redfern's paper, which we've seen, but I want, in a sense, to be clear – and you may not be able to help me – whether at the time the decant was being discussed, everyone was acknowledging that the risk was that, wherever you went in the campus in the new buildings, the same water would be there to meet you. Is that something that you think was aware of?

A Yeah. Dr Inkster had reflected that in IMTs before.

Q Right, okay----

A She did say it is likely that the issues affecting the water in Ward 2A exist across the site.

Q Indeed, the chlorine dioxide system eventually came to be fitted across the whole site.

Can we look at document 39 in the same bundle, page 169? So, this is an IMT from 17 September, so it's three days later, and you're there. I just need to see if I can understand – and I may not need to take you to the document – who, ultimately, as far as you understand, made the decision to decant the patients from 2A to 6A and some to 4B?

A So, I've reflected on that since I've left, and I think at the time, we agreed collectively where we felt the right place was for these patients based on the options.

Q And so, "we" as the IMT?

A As the IMT, yes.

Q Yes.

A Where that proposal was then taken to, I'm not clear. I do know that by that point, there were many more senior managers having discussions with Jamie Redfern and with Dr Inkster, but I'm not absolutely clear on who signed that off.

Q So, I won't take you to that minute, because I can ask the people who were there, but what I want to just see, as it were, is where it left the IMT. So, if we could go, please, to page 171. There's a report here at the bottom----

A Yeah.

Q -- that Kevin Hill-- Who was Kevin Hill at the time? If you don't remember, it's obviously fine, but----

A The director for Women's and Children's, I think.

Q Right. So, he fed back from the executive meeting, which happened on the Friday afternoon after the IMT, so I'm assuming that's the IMT of the 14th we've just been looking at?

"The group looked at the recommendations from the IMT meeting and had lengthy discussions about ... one."

And:

"Giving consideration to the options the executive group will wait until drainage expert will give a preliminary scope on how to carry out their work and see what they did."

Then you're noted as saying:

"Susie Dodd raised her concerns that waiting on a decision to decant the ward would lead to anxiety to staff."

Can you expand on what your concern was at this point? This is on the 17th.

A So, by this point, the anxiety was pretty high amongst everybody at the IMT – excuse me – and those on the ward who I was visiting-- seeing daily, and I think the feedback from Professor Gibson and the senior charge nurses reflected extreme anxiety amongst the staff. That anxiety was that they didn't feel patients were safe anymore, and they didn't feel assured that patients were safe. That was being conveyed quite clearly from the staff, and I was concerned that-- not that we were taking too long; I don't know if I could say that. We were moving as fast as we could with decisions, but I suppose I was flagging that whilst executives were discussing this, we have staff here who are really concerned and don't feel assured.

Q I appreciate that, and over the next page, we can see that Mr Hill reacts and he assures the group that decant's not off the table.

A Yeah.

Q Then there's a discussion about how to do it, which I won't go through in detail because we can read it there. If we can go on to the next IMT, which is page 175, just to complete the story. There's a further IMT on the 18th, and there's obviously no decision yet at this point, by reference to the minutes of the last meeting. What I wanted to do was to jump forward, if possible, to the IMT-- to the page 177, and then there's a reference here to Grant Archibald in Item 6. So:

"Grant Archibald informed the group that following a water meeting this morning it was agreed that BMT patients currently in Ward 2A will be..."

Then there's a discussion of the rest of the decant. How did the staff that you were discussing react to the news of the decant?

A I wasn't the one to deliver the news----

Q Right.

A -- but I think from my discussions that I had with them around that time, when I was on the ward, I would say that it was probably mixed emotion in some way. They were still distressed that they were going to have to move; they were still anxious that patients weren't safe, but I think there was

probably an element of, "Okay, if we move out here, we can maybe address this problem, whatever it is. This may be a way to resolving the concerns." So I think it was probably mixed, would be my impression.

Q So, I'm asking this question of you because you're not someone who's involved in the procurement of the hospital.

A Yeah.

Q At this point, as you described in your statement, and as we've seen in the IMTs, there's been discussion about the water system. There's been a discovery, which you don't know about – we've asked you about that, about the discovery of the DMA Canyon report – and there are ongoing decisions that sooner or later will result in the fitting of the chlorine dioxide system.

Point-of-use filters have been fitted, and there's some discussion, which we've just talked about, about a fear that the water system would be equally affected in whichever ward they end up in. Do you have any opinion about whether that risk that the water system will be equally affected was communicated to the staff in the Schiehallion unit?

A I don't, but what was communicated to the staff in the Schiehallion unit was that the ward that they would be moved to would have control measures in place as a catch-all, as a preventative, just in case. So, I suppose what had been said to them is, "You've got point-of-use filters in place here. Expect to see them where you're going. They're going to remain in place."

Q Right.

A So whether they were told directly that that meant there was still a risk with the water in that ward or not, I don't know----

Q But they were told to expect point-of-use filters?

A Yeah, yeah.

Q Yes.

A They were told that all that would be put in place for arrival.

Q Now, you were involved in getting Ward 6A ready for arrival, and you've described that in your statement from paragraph 116 and I'd like to just go there if possible. That's on page 256. Now, you've described then a need in these sections for "intense remedial work". What do you mean by "intense"?

A So, there was quite a number of things that needed to be fixed, with the fabric of the building; we were going to have to get all the vents cleaned, all the drains cleaned, point-of-use filters fitted. It's a large area and we needed it done fast. So the volume of work that went in by Estates colleagues was intense in terms of the numbers-- or the number of

hours and the efforts to which they applied to bringing 6A up to a standard that was suitable.

Q 6A had been an in-use ward until this point?

A Yes.

Q But did this extent of the work surprise you at the time, that was required?

A I think it did, yeah, to an extent, because when wards start to function, the nature of NHS care is such that they come under quite a lot of abuse, if you like. There will be problems with the fixtures and fittings, but this was a hospital that was pretty new and despite that, there was quite a lot of work required around showers that were damaged, that had leaks, etc.

So this wasn't necessarily damage that had been caused by high throughput of patients. It felt like it was issues that demonstrated equipment and fabric that didn't live up volume of use it was getting, if that makes sense.

Q And it'd be a geriatric treatment or care of the elderly ward? Sorry----

A Pardon me?

Q -- it'd be a care of the elderly ward, as far as you know?

A I think so.

Q Right.

A I think it'd been a care of the elderly, yes.

Q Now, you may not feel able to answer this question, and I'd like you to answer it by reference to your experience level at time. So, I appreciate that you've acquired a lot of experience since then, but I want to ask you what you thought at the time. So, at the time, as the lead infection control nurse for this cohort of patients, did you feel it was a safe place to put the children?

A Ward 6A?

Q Yes.

A Taking account everything that had been considered, I felt it was the best option. In terms of it being absolutely safe, I was nervous. I knew there was problems with the water. We were now seeing there problems with the drains. I didn't really feel assured about anything in terms of the building, if I'm honest, but there's a lot of things to consider. If it had just been about IPC, I'd have said, "Move them to the Beatson," but it wasn't just about IPC----

Q Because if they went to the Beatson, there wouldn't have been a pediatric ITU?

A Exactly.

Q (Inaudible) right.

A Yes.

Q Now, there was a small further decant to Ward 6, so the CDU----

A The CDU.

Q -- in February 2019?

A Yeah.

Q Now, I'm going to hope to do this without taking you to the document. Do you remember that second decant?

A Yes.

Q It seems to have arisen because issues emerged in 6A?

A Yeah.

Q How would you react to the suggestion that those issues have been spotted before 6A was opened?

A So, it was in reaction to air sampling that had been undertaken. So, the order of events was that we had-- I think it was when we had our Cryptococcus cases. There was an ask for us to provide assurance that the air in 6A didn't contain Cryptococcus in the air or fungal pathogens that were harmful. We had HEPA filters in place. From memory, I think testing had been done and the air counts were satisfactory, but we were now finding from this repeat sampling they weren't satisfactory anymore.

Q So, these HEPA filters, are these the portable ones?

A Yes.

Q Were you given any instructions or did you work out any instructions about where to place the HEPA filters in the rooms?

A Not that I recall. Colin Purdon led on most of that. There was a specification required in terms of these portable HEPA filters. I wasn't familiar with what that should be, but I understood that Estates were looking at the most suitable ones to use and what the maintenance of them would be, but I don't remember discussions around placement of them.

Q You see, it's more about the use rather than the maintenance because the Inquiry's expert, Mr Bennett, has observed in his reports that where they get placed in the room really makes a difference to the efficacy, and so as far as you were aware at the time, there was no discussion about where they should be placed?

A Not that I recall, no.

Q I mean, he observed to me in a consultation that they often go where the nurse doesn't want to go because it's the most convenient place in the room. Is that----

A Correct.

Q That's not something that you were thinking about at the time?

A No.

Q No. Right. Now----

A Not personally.

Q -- I'm going to move on to healthcare infection issues in 2019, and we've almost, in a sense, stepped into that already because we've started

talking about the CDU decant.

Now, the Inquiry has minutes for 22 gram-negative bacteria IMTs in 2019. They're all in bundle 1, and the first meeting is on 19 June 2019. I'm not going to go to them at this stage. I'm going to ask to look at the PAG that preceded them, which is bundle 2, document 50, page 130.

Now, this obviously has a lot of redactions. On the second page-- third page, rather, we can see you're present.

A Mm-hmm.

Q What I wanted just to try and understand is what's different compared to the previous year at this point. So, chlorine dioxide's been in place for six months. If we go onto the previous page, 131, we can see that water sampling is seeing no gram-negative organisms outside the filters.

So, from your point of view – and we've obviously, some five months after the micro decant, as it were, to the Clinical Decision unit – what's different between this beginning of a problem in June 2019 and the beginning of the water incident in January 2018?

A So, I think it's fair to say that with these cases there was dread again, "Here we go again," but because the cases were redacted, I can't remember exactly whether all of them were HAIs-- considered HAIs or not. What's different

is that we've got controls in place for the water. The sampling is telling us that the water's clear. We've got controls in for the drains; they're being cleaned appropriately.

Q Because this is they're using a Hylax or something to clean out the drains?

A Hysan was being----

Q Hysan, sorry.

A -- poured down the drains, yes. So there was a manual cleaning methodology and then there was chlorine-- or this Hysan was poured down at the back of it. So we had that in place. There was still a massive amount of work going on in terms of infection prevention control presence on the ward.

So, I suppose the difference was we were struggling to think, well, where is this coming from? And I can't recall if it's this set of minutes or perhaps one after, but I do I think Dr Inkster suggests that, is this some kind of background rate? Is this perhaps what we might expect to see? By no means were we accepting that, but we were forced to consider, is this normal background rate of infection?

Q Because if it was normal background rate of infection, that wouldn't stop you trying to reduce it?

A Absolutely not.

Q We can take this off the screen for a moment. I want to just explore this

a little bit because you-- I've been focusing on case after case or paragraph after paragraph after IMT, and we will come in a moment, or the IMT comes in a moment, to that question of whether it is background or whether it is something unusual.

If it had been background, if it had been within the normal range for this hospital and its predecessors or comparative hospitals in England, would that change your approach to looking for causes?

A So, every case is still considered in their individual right. You're still-- every single one, you'll still look at and consider whether this is potentially healthcare-associated or not. Timeframes and care within the healthcare setting, either in day visits or inpatient stays, are considered as part of that, but also when you get a positive blood culture, in review of the case notes you're considering, “Is there any signs of infection anywhere that may suggest the way in which the blood's become infected?”

And I think that's-- so we're always considering that. It may be that patients develop it as a result of an infection somewhere else and it's less avoidable. So, they may have a pneumonia and it moves into the bloodstream or a urinary tract infection that moves into the bloodstream, or it's the invasive device again, or a surgical wound or something like that.

So, when we're looking at the case notes, we would have considered, “Is there any signs of infection around the wound? Is the line infected? Have the clinicians got concerns with the line?” So, that's informing our investigations and whether or not we feel there's any action to be taken.

Q Because the interesting thing about the way you've been describing this that you're looking at lots of different things.

A Mm-hmm.

Q How do you either exclude something as a cause or decide that you've addressed it so that it's no longer having the effect? How do you make the decision that that's something to either exclude or we dealt with it? What's the process there?

A So, suppose in terms of dealing with it there's a-- we accept we've done everything once we've done all those checks and once we have acted upon the findings that we have found, but you don't forget about it completely. You've got it in the background there's been a case, so if another like this comes up, the red flag needs to go up again. We need to go back to the scratch and say, “Is there anything similar between

these? Is there anything we missed the first time round?"

So, I think for a lot of blood cultures – and I'm talking about routinely rather than 2A – you may find practices that flag a concern and you flag them to the clinical teams, you make sure that their processes and procedures are as they should be. To an extent, you need to leave that to them now to get with and do.

Q Yes.

A But our job is to now monitor. "Is that going to recur or is it not?"

Q So, let's just think for a moment – we're going to have a break in a moment here – about this point in June '19, at the beginning of this series of IMTs, and we might usefully look at the next document, which is document 50, page 130. Same bundle. Bundle 2, document 50, page 130. Have we just been there? Sorry. Have I done that twice on my notes? I have. Fantastic. Can we go to IMT bundle 1, document 72, page 320?

So, I want to just look at this IMT meeting as a way of having a conversation about a few more factors. So at this point, early in this sequence, there'd always been point-of-use filters in Ward 6A. The chlorine dioxide has been in place for six months. You were doing the Hysan (inaudible). The CLABSI exercise was last year, in a sense.

Where were you with hand hygiene and sort of general----?

A We're still all over it, in that sense. We're still in the ward a lot.

Q Where were you with the cleaners and their cleaning processes?

A From memory, we were quite content that the cleaning was being maintained.

Q Where were you with the chilled beams and the vents?

A There was a programme of cleaning for the vents.

Q So, what form did that (inaudible) programme take?

A So, to clean-- so there was a programme when they moved into 6A, all the vents were cleaned while the room-- while the ward was unoccupied, and then there was to be a system of each vent being cleaned thereafter.

Now, I can't remember the timescales we put on it. To do so, the patient has to be out of the room. So that has to be quite a planned process of cleaning them.

Q And everything has to be covered?

A Everything has to be covered.

Q And then they're cleaned.

A We put a scribe in place, seal up doors, damp dust afterwards, yes. So, it's not a straightforward----

Q And then where were you with

the hand wash basin drains at this point?

A So, again from memory, I think----

Q Is this the point we were talking about, about half an hour ago, about when you could see the grime down the drains and you (inaudible) drains?

A We've discovered that by then, that's-- we could see the grime down the drains. By June '19, we were well using Hysan in the drains. We'd established the drains were an issue. We were cleaning them----

Q Right.

A -- we were maintaining them. Yes, definitely, because I left not long after that, so that was in place.

Q And you had the portable HEPA filters in the room.

A Yes.

Q So what is it, if anything, that in your mind at that point is possible-- maybe more than one cause/possible causes, of these infections?

A So, I think we were exploring a lot in terms of, “Is it possible these cases have been somewhere else in the building during the process of admission? Have they come through a route that wasn't designated for these patients? Might they have been exposed somewhere where we don't have controls in place?”

I remember questioning whether these point-of-use filters actually work. I was content with the response. I was content with the response and that yes, the samples taken with point-of-use filters in place were negative, so they were working. “Might they be getting knocked off?” I remember us having a lot of discussion around that, they could be knocked off at times where parents or patients using the wash hand basins without a filter in place, and maybe that exposure happened. To be honest, we were struggling to find----

Q In this IMT on page 321, there's the discussion of a Mycobacterium chelonae----

A Yes, mm-hmm.

Q -- case. Now, this was of course turns out to be the second case in two years. We see it in the middle section here. So, there'd been a case a short time prior to the IMT in June----

A Yes.

Q -- and then it's reported that M.chelonae had been, "isolated from most recent water sampling of Ward 6A," and there'd been a previous case identified the year before, before the decant, and then there was a suggestion that exceeds-- that's data exceedance, discussion of incubation.

Now, at this point-- and then the bottom of the page, there's some

discussion about where the samples are coming from. I think over the page, on the next page, top of it, there's a suggestion that there's a marked reduction in gram-negative bacteria, but:

"Atypical Mycobacterium has been isolated form a number of points... These samples were taken with point-of-use filters off."

Do you remember the atypical mycobacterium being found in the water without the filters at this point?

A Sorry, did that say the samples have been taken with the filters off?

Q Yes.

A Oh, yes.

Q And then there's Dr Inkster's suggestion that there's a differential effect for chlorine dioxide----

A Yes.

Q -- which we'll come back to with her. But what I wanted to understand firstly is, is this the first case, these two cases, were these the first two cases of Mycobacterium chelonae that you were aware of in the hospital?

A Yes, so this one I had heard of it, but I hadn't-- I couldn't recall having dealt with a patient isolate. But again, that said, it wasn't on the alert organism list, so I was unaware as to how commonly this might have come up, but I hadn't dealt with it in my time.

Q So, you'd been here since

March '17.

A Mm-hmm.

Q And there'd been a case the previous year in May. Had you known about it at the time?

A No. My recollection is this is the first time I heard about this.

Q And it's not on the reporting list?

A Yes.

Q So, that would have required a microbiologist in the lab to go (inaudible)----

A To flag.

Q -- and tell them. And presumably, that didn't happen.

A I presume so, yes.

The Inquiry's experts have access to the bloodstream infection results for the hospital and they report – Dr Mumford and Ms Dempster report in their report – that there was another infection of mycobacteria in a patient in early 2016. Is that something you knew about?

A No.

Q So, at the time this IMT is coming up in '19, you know about the active case there. The previous case is, effectively, a surprise to you, and you didn't then know about the 2016 case.

A No.

Q Dr Peters states in her statement that she grew Mycobacterium chelonae from a shower head in Ward 7D

in October '17. That's in the adult hospital, so you wouldn't have had a reason to know about that.

A No.

Q Just to be clear, would you have any responsibility for children being treated in 7D?

A No.

Q No, you're geographically constrained, in a sense. You just do the children.

A Well, I would have responsibility for children, but I don't think there would be any children in 7D.

Q Fine. Well, that might be just confusion on my part.

A Yes.

Q But what I want to do before we break is ask this question. In fact, I might give you the opportunity of the break to think about your answer.

A Okay.

Q You've described in your statement how there had been some cases of Cupriavidus in the aseptic pharmacy in 2018. We haven't gone to them, but do you recollect that?

A Yes.

Q And there was a connection made then back to an earlier case in a patient in 2016.

A Mm-hmm.

Q I get the impression, is it fair to say that that information was of assistance and trying to work out how to respond?

A Yes.

Q There's two questions to ask here: one of which is easy to answer, I suspect, and one of which is probably much harder. The hard one is: would it have made a difference, do you think, to the team's response to the Mycobacterium chelonae infections to know about the earlier ones when they occurred? And the possibly easier question is: is it as simple as presumably a microbiologist didn't flag it? Is there anything more complicated to the explanation about why you didn't learn about it? And do you want to answer those now? Do you want to think about the answer?

A No, I think I'm happy to answer them. I suppose actually the one that you suggest is easy, actually, I can't be absolute. I don't know if the labs had a system to flag certain organisms to us that weren't normally flagged or if it was just everything or what's-- I'm not sure how that breakdown might have happened----

Q Right, we'll have to ask someone. Okay.

A -- but in terms of would it have been helpful, I think in the grand scheme of things, had I known there had been so many incidents associated with these

unusual pathogens, it would have helped me to formulate more quickly concerns or investigations around environmental aspects. That said, I don't think we were slow to investigate them. I think for wherever you work when you're investigating something, I think if you've got context in terms of the history, it's always helpful.

Q Right.

A But as soon as we received these results, we acted based on the findings for that patient, and it's not always to say that a case a year ago, three years ago, that they're linked----

Q No, of course.

A -- that's not necessarily-- but given the nature of these and the fact that they, I think, from memory, chelonae was something that there hadn't been any cases in a decade before the 2016 one. So, to now have 2016, which I hadn't been aware of when I got this result, plus one in between time, to have three in that space of time stood out.

Q I suppose the final question is-- to complete the story is: how I understood correctly that eventually the hypothesis was that the particular patients who had-- 18 and 19 patients might have been exposed elsewhere in the building, was that the hypothesis that seemed to be reached?

A That was certainly something I can considered, yes.

Q A consideration of that.

A Yes.

Q My Lord, I think this is an appropriate point to break, if that would assist?

THE CHAIR: Yes, we'll take a coffee break. Could I ask you to be back for ten to twelve?

(<u>Short break</u>)

THE CHAIR: Mr Mackintosh?

MR MACKINTOSH: Thank you, my Lord. Ms Dodd, I've been back and found, in bundle 13, the meetings of the Infection Control Management team from March ’17. I'll ask you just to look at them. Bundle 13, document 79, page 601 please. 601, sorry. Page 601, please. Thank you. So, this appears to be a minute of a meeting on 30 March 2017, and this is the Infection Control Senior Management team, so this isn't the weekly meeting of you and your colleagues----

A No.

Q -- however, you are present----

A Yeah.

Q -- and if we go on to page 602, we see at the bottom that you're reporting three cases of Elizabethkingia and, in fact, if we were to jump on to the next two meetings, we would see the other PAGs

in that sequence all individually reported. So, this is another means by which you can report it up the system effectively?

A Yes.

Q I just wanted to make sure we connected those together. Could I ask you, please, to look at-- Take that off the screen. I want to ask you some general questions about unusual infections because we've talked about unusual infection as a term that people-- we've seen in documentation. What do you mean by an "unusual infection"?

A Unusual in the sense that they are not organisms that you see commonly in certain patient groups.

Q So, if you have a patient cohort, such in this case, haemato-oncology paediatric patients, you would see certain infections as unusual?

A Yeah.

Q Their not being on the list, your awareness is because either the treating clinician told you or microbiology told you?

A Yes.

Q So, there's a certain amount of opportunistic learning going on there?

A Yeah.

Q Yes. Now, if you have a number of unusual infections happening in a unit that are different species, different types of microorganism, how does the existence of a number of different unusual ones-- what does it tell you, if anything at all, about what's going on in your unit? Or is that the wrong question?

A No, I suppose-- If you take the report that I did in May, that shows the seven or eight different----

Q That we looked at at the beginning?

A Yeah.

Q Yes.

A The way in which those infections spread are different. So, I think I'd said that, you know, there was some kind of gastrointestinal outbreaks and amongst that, that's typically an environment that's not clean – it's hands, dirty hands, it's contact which aids spread of the pathogen – but the number of outbreaks we were having, there was different ways in which these outbreaks would be spreading, and I suppose, to me, that was saying there's potentially not just one problem here, there's maybe multiple things going on. Sorry, I forgot your original question.

Q The question is: if you have, in a ward-- what you would see is a large number of these----

A Yeah.

Q -- so enough to produce a report, I'm assuming more than a handful, of these unusual infections which you've just defined.

A Yeah.

Q What does that tell you, if anything, about what's going on in your ward?

A Yeah, so I suppose the important thing there is the "unusual" part. Not everything that was in that initial report after my first eight weeks was unusual. The number, the volume, the frequency of which they were occurring was unusual but not all the organisms that we're seeing. Some were though, the Elizabethkingia, for example, the Aspergillus less so but still not something you should see that often. If I'm seeing unusual organisms and they're all different, then that's telling me there's something going on. I need to understand what the source of those might be.

Q So, can you have unusual organisms that have their root in the patient?

A Yes.

Q Also, presumably, you can have unusual organisms that might have their root in the environment?

A Yes.

Q So, the unusualness doesn't tell you that it's environmental?

A No.

Q No, and what are the usual infections there? Is this the Scottish Government list effectively?

A The list that's in the national manual that we produce is a long list of infections. Some are commonplace that we would be used to dealing with on a day-to-day basis, some are more unusual, and that's the point I was making about surveillance helping us understand that. So, that's a big part of where reporting comes in from the boards. We use the reports that are coming in to understand what's emerging, and we use that to inform that list alongside the literature that's out there, alongside anecdotal evidence. We consider, "Right, we're seeing more of that; we should this to the list," so that the boards are on alert. So, there can still be unusual ones on that list is what I'm saying.

Q Because I'm wondering, and this may be unfair, whether "unusual" is just, "We don't see it very often," or is there more to it than that?

A No, I think that would probably be fair. We don't see it in clinical isolates very often.

Q We might see it in samples in drains or we might see it in samples in cleaning material----

A If you were sampling them, yeah.

Q Yes, but you wouldn't see it in patients?

A Yes, it's where they exist that's

unusual as well, so it's the organism plus where you find it.

Q Because an organism of these sorts might be in the soil outside and it wouldn't be unusual there----

A Yeah, exactly.

Q -- but it's unusual because it's in a patient.

A Yes.

Q Right. Now, I want to explore a little bit more your investigatory process and actually take advantage of the fact that you now have this role with a manual. So, I'll start, I think, by asking you about, if you're looking as an Infection Control nurse, working with the Infection Control doctor, trying to work out what's going on with a group of infections or an infection in a ward, what's your process in terms of your investigatory structure? How do you structure an investigation?

A So, you would start off by looking at the epidemiology of the cases. You would look at: how many cases did you have; when were the samples taken; versus what date did the patient come into hospital; or what dates did they attend for treatment on a day case basis; and where they had been placed. So, we would typically refer to that as a "time-place-person" link. If there was a positive case in Queen Elizabeth and there's a positive case in Gartnavel, straight away you're saying they're unlikely to be linked, but if there's two positive cases in Queen Elizabeth and they're both in the same ward and they're both around about the same time, your epi investigation is telling you there that there's a risk that there has been cross transmission somewhere.

Q So once you, as it were, focus on a case where there is some connection in time, place and person, what's the next stage in trying to work out what the cause is?

A So, the next stage is to consider where the patients are positive. So, again, this comes back to really the mode of transmission, the way in which that infection typically spreads. If we are looking at a number of patients who have developed diarrheal symptoms and a number of them have tested positive for C. diff, Clostridium difficile, or norovirus, we are looking at-- We're going to the ward; we're asking for details of symptoms.

"When did these symptoms start? Where were they when the symptoms started? Who was in close proximity? What was your practice like? Have you been cleaning this place frequently enough? Are you using the appropriate personal protective equipment?" And through that process, we're trying to understand whether the index case – so the first case – has contaminated the

environment directly, contaminated another person-- patient, whether the staff member have become contaminated and whether they've taken it to another patient. So I suppose we're looking at all these ways in which it may move.

Q So is it right to think that it's easier to investigate a larger number of cases because you can make more connections?

A It's easier to investigate things that are spread in those typical ways. So, your likes of norovirus – I'm sure most people have heard of that – you get outbreaks in nurseries and schools and hospitals. I think to most IPCNs, that's pretty black and white. We can see the symptoms in front of us; we can usually pinpoint what's going on. When it's blood cultures, blood cultures do not spread from patient to patient. So you're eliminating that as a route.

Q So, you're then thinking about what's the thing that connects these two patients?

A Exactly.

Q And----

A So----

Q Sorry, carry on.

A So, I suppose we're thinking about-- that would depend on whether they both had the same organism or the same family of organism as to, “Where did it come from?” but then you also need to think, “Regardless of where it came from, how did it get from that point to the patient?”

Q Before we get to that, thinking back to the time you were working at the Royal Hospital for Children----

A Mm-hmm.

Q -- and at that point, you come across the concept of whole genome sequencing?

A Yes.

Q Yes. Had you used it, or had it been used in investigations you'd been involved in?

A Yes.

Q When was the first time you were involved in using whole genome sequencing?

A I can't remember exactly, but I've used it from early career in IPC.

Q To what extent do you consider able to give any opinion about how it works?

A High level.

Q Well, then we'll ask-- If you don't feel it's your thing, we can move on to something else.

A No, whole genome sequencing really takes the genetic makeup of an organism and determines whether the genetics are the same or whether they're different.

Q Have you ever used whole genome sequencing to confirm there is a

connection between two cases?

A Yes.

Q Have you ever used whole genome sequencing to exclude a connection between two cases?

A You can, yes.

Q How?

A So, again, this comes back a bit. You shouldn't be considering whole genome sequence in isolation, is the first thing I would say. So, if we take something a bit more simplistic and you're looking at two patients who've got Clostridium difficile, if they are a typing match, it's highly suggestive that cross-transmission has happened. It's not absolute because you do get common strains, so there's a risk that they may just both have the common strain, and that's why I say it's important you don't treat it in isolation; you still need to think about everything else.

Q But if they don't match, what does that tell you?

A If they don't match, that means that you are-- the link to them being-- to cross-transmission is weaker, so you've got less evidence to suggest that cross-transmission has taken place, and it's unlikely to have taken place. They both have separate strains, so they've picked it up from separate places or they've developed it in separate ways, in different ways.

Q Could it just mean they've picked it up from different parts of a population that's made up of different strains?

A So, it could mean that there has been a source from which they have acquired it that has contained more than one strain of C. diff.

Q Right. You were talking, before I interrupted you about (inaudible) whole genome sequencing, about the stage of going on to look at mechanisms of connection between patients.

A Yeah.

Q Earlier on this morning, you discussed, in the context of 2018, going through a sequence of different things and the lines, hand cleaning, drains, water. Is there anything more you'd want to add to the process that you undertake to start to look at mechanisms of connection, other than what you said before about that, listing the things you just look at?

A No, I mean, I think-- No, I think, as I've already pointed to, the organisms that we were identifying were environmental in nature and there was various different families of them. So this was suggesting an environmental source and link. So my investigations-- I suppose your investigations are two-fold. It's trying to find out where the source is, but equally trying to find out how it gets

from the source to the patient. So it was multifaceted, that approach.

Q Why is it then we read the IMT minutes that the Inquiry has in bundle 1, we never see a conclusion at the end, where someone says, "The answer is X"? Why do we never see that? Because I suppose as non-medical people, clinical people, we look at that and think, "Well why isn't there an answer?"

A I think it probably demonstrates the complexity of this incident. There were strong opinions as to what that link was. There was strong opinion as to where the source was, i.e. the water, the drains; in my opinion, that's where I thought the source was, and that too of Dr Inkster, and in terms of how it got to the patient, I think that's more difficult to determine, but it would have been-- my view is that the line care practice by the staff there, I was content that it was of a high enough standard that it wasn't the line care practice.

Q So you see a process of elimination where you've reached a conclusion-- almost conclusion that eliminates some things and other----

A Yeah.

Q -- people weren't prepared to go that far. Is that what you're----

A I think not everybody at the IMT felt as conclusive.

Q Because obviously, you weren't-- I've gone through the minutes, and you leave before the end of June?

A Yeah.

Q Then soon on move on to ARHAI, and we'll come on to what you do at ARHAI in a moment, but could we just look at the IMT we were looking at before the break? So, that's on bundle 1, document 73, starts on page 325.

A I think I would maybe add something as well to----

Q Yes.

A -- what I was saying there that kind of links up to the whole genome sequencing. Perhaps part of the reason that some people weren't as conclusive in terms of that link to the environment was because the types that were being found in the water didn't always match the patient types.

Q Right. So there wasn't this absolute genetic connection between the two?

A No, and I think-- I had talked to where sometimes you can rule out with a bit more confidence and something a bit more simplistic like C. diff, but in environmental organisms it's not as easy to rule out.

Q And that was a difference of opinion you felt at the time?

A I think that opinion was growing, yes, amongst microbiologists that weren't necessarily at the IMT, who

struggled to see that there was a link when they didn't match.

Q Right, because if we look at this one. This is 25 June 2019; I think it's your last IMT at the hospital. Obviously, I can't ask you about what happens afterwards, but that does mean that I can ask you what's happening at this meeting.

So, we have a large number of people present, and what I wanted to understand is at this point, if we go forward to the next page, a section discusses epidemiology, and the first section is a discussion, which I think we've touched on before about whether these were background rates?

A Yeah.

Q Now, what I wanted to understand was: you've already explained that if they were background rates that wouldn't stop you trying to treat the patients?

A Yeah.

Q Does the fact that the number of infections that are happening in a ward is comparable to what they've always been or what they are somewhere else tell you anything, in your eyes, about whether there is a particular connection between those infections and patients, or the environment, or community, or anything?

THE CHAIR: Sorry, could you just give me that question again?

MR MACKINTOSH: So, if you have a ward where there are some infections and you discover that the number of infections is comparable to the rate you've always had there, or perhaps, you had in a previous building, or you have at another hospital doing the same thing, it is, in effect, the normal rate, whatever that means. Does that tell you anything about the individual infections and whether they have an environmental connection or, indeed, a connection to colonised patients or an infection to people's homes or anything?

A Yes, so you're still looking at the individual cases. I suppose the thing to note is that you may have-- the purpose in monitoring these rates is to be able to early identify an increase of concern. Just because a rate is considered normal, doesn't mean to say it can't be improved upon, and I think the CLABSI, Central Line-Associated Bacteremia Bloodstream Infection Group had been developed to try and drive down that rate and I believe so did effectively for gram-positives.

So you can always be working towards improving, and your rate might be normal, but what you've got to be careful is what it is that you're observing. If you're just looking at blood cultures, your rate's normal, but what if amongst those blood cultures, all of them are one

type. That's telling you something as well. Something there doesn't seem right. Why are they all one type? That maybe brings you to investigate whether something's going on. So in this situation, if there was debate around, "Actually, these are normal rates, but what are they? They're still unusual gram-negative organisms. Should we be concerned?"

Q Right. What I'm trying to think of is a way of asking a series of questions about how everyone was feeling at this point. So, at this meeting, what was the mood like between the participants?

A The tension in the IMTs by this point was very high.

Q Right. Compared to when?

A Compared to when we first started investigating the water. Over time----

Q Which would have been a year and a half before?

A Yeah. So, over time the tension got worse in the IMTs, and by the time we had got to this point, it was bad.

Q It may be too sophisticated to ask this, but had the tension changed or reduced or increased at the time the decision was made to decant the previous autumn?

A There was lot of tension then as well.

Q Did it get better afterwards or

just keep getting the same or get worse?

A I would say it stayed the same thereafter.

Q Right.

A There was probably understandable tension because that was a lot of stress and pressure being placed on everybody that was involved. Whether you agreed with the decant or not it was stressful for everyone involved, so there was a lot of tension----

Q What----

A -- but when we moved and the problem continued, I think the tension remained because I think at that point it was being questioned, "Is this really happening? Do we have a problem here? We've decanted, we've done everything we should be doing; how convinced are we that there actually is a problem?" And I suppose I felt, personally, that the views of the Infection Prevention and Control team weren't as well accepted by everybody there. Not by everyone, but by some people there.

Q If you think about this, that sequence from the early part of '18 to this meeting in June, had the nature of the participants in the IMT changed?

A In terms of the type of people being invited along?

Q Well, were there new people who you hadn't seen at IMTs before?

A Yeah, I think the numbers

were growing, and I would say that there was more senior representation at some of the meetings, I think. I----

Q Right, I want to take this away from the original one and think about practice.

A Okay.

Q So, obviously, you now are involved in editing the manual, so I'm going to attempt to ask you questions about general practice of running IMTs.

A Mm-hmm.

Q Who should be attending, as it were, a conventional first couple of meetings of an IMT?

A So, to an extent, that does depend on what the incident is, but in general terms you'll have your Infection Control team representatives. Usually, your Infection Control doctor will lead the IMT, and you'll have the Infection Prevention and Control nurses who have been on the ground doing those initial investigations. You'll have representatives from the clinical area----

Q So, they're the treating doctors and nurses?

A Yes, and depending on what you have found in your initial investigation-- So let's say, for example, you found issues with the cleaning, you'll invite along a Facilities member of staff.

Q And if the issue is in the environment, you invite along Estates.

A Yes.

Q All right.

A You may also, depending on the extent to which this is expected to impact the service, you might have service managers come along as well.

Q So, you might have the person who manages the Children's hospital----

A Yes.

Q -- or a regional services-- if you're talking about adult bone marrow, the person who's managing that service might turn up.

A Yes, particularly if you think you're going to close a ward.

Q Right, but at the beginning of a sequence, the first couple of meetings, it'll be less managers, more the first list of people who----

A Yes, I would say so in general.

Q It's been suggested to me that sometimes the attendance at IMTs is a bit informal. It's not quite the extent of walking up/down the corridor and grabbing people, but there's a certain informality about who turns up. Is that a fair description?

A I don't think I would agree with that.

Q All right, okay.

A I think certainly in those early days, sometimes throughout the latter parts, I would send out the invite for the IMT and was quite clear about who I

would seek to be in attendance.

Q And that would go through the normal sort of Outlook, Teams type system that you have at the hospital?

A Yes.

Q Right.

A I suppose in hindsight, if I look to say that I was explicit about who should be there, I emailed them directly. I don't think I laid out in the email, "I want A, B, C here and I want each of you to talk about these things"--

Q Right.

A -- but they were all emailed directly and asked to attend. This meeting is taking place and they would be asked to attend. Some of those would send deputies and there were times where others started to come along to the IMT that perhaps it's possible they weren't included in the original email, but I'm not sure I could even confirm that.

Q In terms of the length of IMTs, it's been suggested that IMTs, particularly the sequence in 2019 that we've been looking at one of here, eventually got rather long meetings.

A Yes.

Q I suspect the answer is, "How long is a piece of string?" but how long should an IMT last?

A Well, there is no fixed time, but in my national role, having supported a number IMTs across other Boards, an IMT can last anything from 45 minutes to two hours, depending on what it is, and that is-- obviously, your initial meetings often are slightly shorter whilst you send everybody off to investigate or apply controls. Your second and third meetings are maybe a bit longer as you explore findings.

Q It's been suggested that in some of the IMTs in this period, '18/'19, it was somehow unhelpful that the results were being brought into the IMT----

A Yes.

Q -- as the meeting was going on. Do you have any comment about that?

A Yes, so I think that was true. Sometimes you weren't finding out about results or issues until the IMT, which could kind of catch you unawares, I suppose. It probably was less of an issue for me, and I would absolutely say that would be an issue for a chair who is looking to come away from that meeting, having delegated certain actions, but at that meeting they're finding out new information that there's not been time to consider perhaps in full.

Q I mean, you're an Infection Control nurse in origin----

A Mm-hmm.

Q -- and you're reasonably experienced by this point.

A Uh-huh.

Q How much-- what's it like for an Estates or Facilities member of staff? Is this something they're trained to do, to attend IMTs and contribute to the discussion?

A No, there won't be formal training. It's not uncommon for them to be invited to an IMT and right from back in 2008 when I started in IPC, they've been coming along to IMTs, and the expectation is that they only come to it with their area of expertise, to give feedback on any areas that we are finding a concern, and take away action to address those concerns.

Q How does this idea that an IMT produces its decisions by consensus work? And the reason I say that is because at an IMT, you have infection control-trained people; you have clinicians; some of the Estates people might well be authorised persons or trained in a particular role, but not all of them; some of the managers might have no particular clinical training or background. How is it that consensus could emerge from a group of people with an eclectic, mixed background, some of whom aren't trained?

A I suppose that's the purpose of an IMT: to bring together everybody with their own area of expertise to inform the situation and the findings that you have and reach consensus that based on their

area of knowledge, it is reasonable to take the resulting actions. So, I don't think that everybody in their own right could sit there and say, "Yes, this as a result of the water, absolutely. We agree." But they could give their input by saying, "we agree that this presentation of infections is unusual," or, "We agree that there's findings in the water that are of concern," and as a collective, we present that within the IMT to result in the actions.

Q Because one of the things that I've noticed is that into 2018-2019, we begin to see more senior management appearing and, to a certain extent, communications staff or press officers. I absolutely see that communications is an important part of what an IMT is doing----

A Yes.

Q -- but how does their presence fit into the consensus, conclusion-reaching model?

A So, it was unusual to see this volume of senior staff at IMTs. I'm not saying it wasn't warranted. We had reached a level of concern and the impact was seen far and wide in terms of anxiety amongst parents, patients, etc. So, I can understand why management to that senior level would be there. I suppose I wasn't clear on exactly what role they played in being there. As I say, it's not to say they shouldn't have been,

but I'm not sure it was clear exactly what they were bringing to the IMT.

Q Because we've had one witness and he's explained himself in evidence last Friday, Mr Gallacher, talk about attending meetings to support colleagues, and I suppose we might ask other witnesses about that as well. If someone's coming to support colleagues, is that a reason to be at an IMT?

A Well, I would be asking why they need support. I suppose it's reasonable if you've got somebody in a junior position that you may come along to support with your more-- greater experience you have or your more senior position to support-- to enable actions to be taken. So, no, I suppose it's not unreasonable. I suppose it depends on why they feel they need support.

Q I think my final question about IMTs is: it's been suggested by Dr Mumford and Ms Dempster in their reports that there should probably, I think also by the case notes review, that there should be a wrap-up process at the end of IMTs. Now, I noticed one did take place at the end of the water incident in May.

A Mm-hmm.

Q It turned out of course it wasn't the end, but there was a meeting. Do you see any value in such wrap-up processes or recordings?

A Completely. So, there was a wrap-up after the water. I think probably what's less clear with this incident right through water drains ventilation is the point of which at you said it's over.

Q Yes.

A And I think that was probably one of the challenges, but we did have a wrap-up after water which was chaired by Laura Imrie, the clinical lead in ARHAI at the time so she came in from an external point of view to chair that, having not attended the IMTs before. So, we did that and that was a helpful process. The drains wrap-up, I believe there was a decision taken that we didn't need that because the Oversight Board was in place by then and it would be done through that route.

Q So, in a sense, the wrap-up is helpful but you don't know when it ends so you can't have a wrap-up?

A Yes, in this context. That's not the normal. But I would-- I suppose just to finish that point, I find them extremely valuable now that I'm in my national role. We can from those wrap-ups not only to allow us to get a feel for what is emerging across Scotland, but to better understand what controls are working effectively, what processes are working effectively, and be able to share that. But it's still not, I think, something that's well done.

Q Well, I'd like to move on to

Cryptococcus now. So, there was a sequence of 15 Cryptococcus IMTs, but I noticed that you only attended one of those. Is that correct, as far as you recollect? I mean, I only found one with your name in it and I want to just check that that's broadly right from your memory.

A I would have thought I attended more than that, but----

Q I know you attended the subgroup later, but we'll come back to that in a moment.

A So, the first cases we picked up on in the December----

Q Yes.

A -- I didn't leave until August.

Q What I did was I simply walked through the minutes----

A Okay.

Q -- but what I'll do is I'll ask you some general questions because I don't need to go through them minute by minute. I'm going to show you a document in a moment – because I want to make sure we're talking about the same cases – which the Inquiry has constructed so that it can be discussed in and amongst the Inquiry participants without having too much problem with having to redact information as we do if we look at real documents.

A Yes.

Q I'm not going to put it on the

screen. I wondered if you could be passed the document which is part of bundle 27, volume 3. It's at page 625. Sorry, it's not. It's bundle 24, volume 2 – don't put it on the screen – page 210 for my colleagues in the room. Do you have that in front of you?

A Yes.

Q It's headed, perhaps optimistically, "Statement of uncontroversial facts concerning cases of Cryptococcus."

A Yes.

Q Now, what I wanted to do is just check before we have the conversation that you understand what cases we're talking about here. I'm only going to refer to them by “Patient A.” I'm not going to read out what's on the sheet.

A Okay.

Q So, I want to be clear, Patient A and Patient B are the two cases that were identified in December of 2018, unfortunately then died.

A Yes.

Q Right, okay. Patient C and Patient D, these are patients that you might have looked-- you would have learned about when you were at the expert subgroup in November of 2020.

A I can't confirm if they were or not.

Q We can come back to that. We'll put that to one side----

A Okay.

Q -- and we'll try and get there a different way. So, what I want to do is think about the investigation into the Cryptococcus before you left.

A Okay.

Q Now, it seems that one of the issues that was alive is the question of pigeons on site----

A Mm-hmm.

Q -- and we've heard quite a lot of evidence on pigeons. I'm not going to show you photographs unless you took any.

A I may have; I probably did do at the time which were on a work phone that I left with GGC.

Q Right, so we haven't got pictures, so I won't show you the pictures. But I want to understand: you've been working at this hospital for, at this point, just more than two years.

A Yes.

Q And it's been suggested that there was a failing in some sort in that Dr Inkster didn't know there was a problem with pigeons on the site. Now, to be fair, some other witnesses maintain that there wasn't a problem with pigeons in plant rooms, and there's a debate about how bad the pigeon problem is, but at a very high level, were you aware there were lots of pigeons around the site when you worked there?

A So, before the Cryptococcus incident, I was aware of an issue with birds, not specifically pigeons I don't think, but we had an issue with birds up on the children's playground that----

Q Which is on the roof?

A This is on the roof. The issue was that – not very pleasant – the birds used to often get caught up in the blades of the helicopter and would-- the remains of those birds would land on the children's playground, and that resulted in the playground being closed quite a number of times to manage that situation.

Q How reasonable or unreasonable is this suggestion that an Infection Control clinician working in that hospital would have known there were pigeons all around the site and didn't need to be told?

A I think that's unreasonable to think that. So, I don't think it's that there was any reason why Dr Inkster would have been aware on her own merit. I think if you just looked around the site, it was not necessarily obvious unless pointed out. I think-- Is your question of whether she should have been told----

Q No, it's about you. Should you have known? Because I can ask Dr Inkster the same question.

A I suppose it would come under pest control. We weren't informed about everything to do with pest control. You

could argue that we don't need to be, unless we have got indicators amongst our patient population that it's becoming a problem.

Q Because that's an interesting question, is that if the system exists, to the extent there's a system, that you'll be told there's a problem when there's a problem but it's only a problem if you've got pest-related infections in your patient group.

A Yeah.

Q How do the people who are supposed to tell you there's a problem know you've got the patient-related infections?

A Yeah. So, I think-- and I think the other thing that's important is that prevention should be the first key and that we are trying to prevent infection in patients, and so if you've got a pest problem that is that significant, I would have thought that-- to me, once I became aware of it, it did not sit comfortably with me that a hospital site had this level of contamination and it was a risk.

Q But to be fair to Facilities and Estates staff, they're not infection trained.

A Agreed.

Q Some of them have observed to the inquiry that they don't know that pigeons cause Cryptococcus. So, how are they supposed to know to tell you?

A Yeah, I agree. I think that's a valid point because I didn't know about Cryptococcus and pigeon links when-- before we had these initial cases. So, I think that's a fair point. I suppose it would probably just come down to more general hygiene around a hospital site, but it is something that probably requires consideration for the future. “What are the triggers for informing IPCT of a risk?” And I don't think we can be completely absolute with that because it takes learning from incidents to understand what the risks are.

Q Because is it potentially the same problem with the microbiologist warning you about unusual microorganisms in that it requires somebody to know there's a problem, to tell you there's a problem?

A I suppose in some ways, yes, they're very similar. A microbiologist will know that that blood culture is a problem for a patient, and they will have phoned that to the clinical area. So, there is no doubt in my mind that treatment----

Q Will continue-- treatment will happen.

A Absolutely. Treatment will happen. In terms of every microbiologist knowing whether that's an infection prevention and control risk or flag, I’m probably not best placed to ask that. I don't understand enough about what happened----

Q No, we'll ask somebody else.

A -- but it could be compared, it could be a similar idea, but I agree, Estates probably-- they wouldn't have known that there was a direct infection control risk associated with pigeons, but I do think, in terms of general hygiene, that it was enough contamination to stand out as this isn't appropriate for a hospital or healthcare area.

Q Now, there's one further question before we move on to your time at ARHAI, which I forgot to ask you. We were discussing the IMT sequence that ended when you left on 25 June. By the point that you left, had there been pre-meetings before any of the IMTs?

A Yes.

Q And when had that started?

A I don't know.

Q Well, how did you find out that there had been pre-meetings?

A So, I do recall on a couple of occasions that we had to wait outside the room that the IMT was going to be held in for people within the room to finish their meeting and we would go in and join them. So, they were managers that were to be at the meeting, and they were having a pre-meet, if you like.

Q So, when you-- would you have sent out the call notices for these IMTs?

A I sent out some of them, yes,

admin staff would have done others.

Q Yes. So, the call notice wouldn't have said there's a pre-meeting for managers beforehand?

A No.

Q How does the existence of such pre-meetings fit with the sort of, the purpose and model of IMTs in terms of infection control?

A They could have a place. I think meetings outside of the IMT have a place because lots of people within that IMT may want to go off and discuss the particulars of their area of expertise and think about the things they want to bring back to the IMT. I suppose what's important is that all that information comes back into the IMT as a central point and that everyone within it is clear on what discussions happening where, amongst whom, and what's expected in terms of what you're bringing back to this meeting, and I don't think it was obvious who was part of the pre-meets, what they were discussing and there was certainly no formal feedback from them.

Q And I'd like to move on to your period at ARHAI. So, you started ARHAI in August 2019----

A Yes.

Q -- and you've given a statement about that. I just wanted to talk about the expert panel subgroup of which you ended up being a member on

Cryptococcus. Now, we've got your statement, so there are a few limited questions, and I'll come back to the document that we looked at earlier because I think I might be able to just connect together what's going on. You joined this expert panel subgroup in August 2019. Was it explained to you to whom it was reporting?

A Yes, and I knew that before I left GGC.

Q Who was it reporting to?

A It was to report to-- the findings of the subgroup were to report back to the chair of the IMT.

Q But the IMT had been stopped in February?

A Yeah, but an IMT can stop with actions still outstanding.

Q Oh, I see. Right, okay.

A And the intention was Dr Inkster had asked for this subgroup to allow the hypotheses to be fully explored without her being there to let other individuals consider them and then feedback in their findings to her.

Q So, I'd prefer you to give the first answer to this question purely based on your own knowledge.

A Okay.

Q And then I might ask you what you've heard from other people, but purely based on what was told to you by members of the IMT expert subgroup, do you know why Dr Inkster wasn't a member of the group?

A Again, I would have known that before.

Q I see. So, why wasn't she a member of the group?

A I think it was because I suppose my understanding was that she was the lead. It was-- When we had the IMTs, there was a lot of tension and a lot of-- she was challenged a lot on her hypothesis, I think is fair to say, and I think the intention was that, to ensure there was no bias, she wouldn't be involved in review of those hypothesis. That was certainly part of it, I think, was my understanding. There would be----

Q But other members of the IMT were part of the subgroup?

A Yes.

Q So, how did that affect their biases, whatever they were?

A I suppose that would have still allowed bias around certain areas, but as chair of the IMT, as the person who formally agreed the hypothesis, and certainly Dr Inkster was the one that strongly felt this hypothesis to be correct, I happen to agree, but as chair, she felt this was a strong hypothesis. That wasn't necessarily met with others who accepted that, and I think the point was that she would step away and let others debate it.

Q Now, in your short statement,

the ARHAI statement at paragraph 6, you discuss-- this is the second statement, if we can put that on the screen, please. That would be really helpful. You discuss concerns that you and Annette Rankin and Ian Storrar had about this, as a representative from NSS. What you've said in that paragraph:

"We had no understanding if our evidence papers had been selected or the method used to review them, and the writing style felt inconsistent."

Did you submit comments and feedback to people in respect to that?

A Yes.

Q To whom do you do that?

A To the chair, but I think we actually sent it to the whole group.

Q And did you ever receive a response?

A Eventually.

Q And what was the response?

A So, the response was a table in which all our concerns had been listed with a response next to each, but of those responses it wasn't clear exactly how they were going to act on each of our comments, that they accept them. I think we had gone back to say, "You need to be clear in telling us whether you're going to accept them or reject them." It didn't seem that there would be narrative written next to each comment, but it didn't help us in understanding if they accepted our points or-- sorry, that's not very clear but I think what came back wasn't necessarily clear.

Q And that was your primary concern with the response, the whole clarity----

A Yes, and as well as that it had taken quite a long time to get the responses.

Q In that same paragraph, paragraph 6, you say that NSS offered a-- to carry out an evidence review using a robust methodology. Did you ever receive an explanation for why that wasn't initially accepted?

A No.

Q Was it eventually accepted?

A Yes.

Q Right. Why do you think the report took two years to produce?

A It was a very complex topic area. There is no getting away from that. I don't know the resource pressures that were on the chair of that group, which may have contributed. I can't comment towards that. I suppose all I can say is that it surprises me that it took so long, but I can't explain why it took so long.

Q We discussed the way that the IMT got on. What was the tone in these meetings of the expert subgroup?

A I don't think there was as much tension in the expert subgroup, but I don't think that the meetings were constructed

in a way that allowed the content of those discussions to be followed very easily. I often felt very confused by the statements that were made. There was a lot of jumping around, there was a lot of thinking through all the theories, going away down rabbit holes. So, there wasn't the same tension, but they were very difficult to follow I think.

Q Ultimately, did NSS agree to the conclusions in the report?

A No.

Q What I want to do is-- I'm keen not to display something on the screen. Did you have an opportunity before this hearing to look at the subgroup minutes in bundle 9? They were in the document list.

A I looked at a couple of them as were pointed out, and I'm familiar with some of them from previous review of the bundle.

Q So, I'm looking at-- I'm not going to put it on the screen yet. I'm looking at page 286 of bundle 9, and I've also got in mind the document we were previously looking at, the handout copy. Do you see on the second page of the document at bundle 24, volume 2, that we printed out for you, there's a Patient C.

A Yeah.

Q Now, this is an adult patient whose diagnosis happens at a different hospital.

A Okay.

Q Do you see that in the note in paragraph 19?

A Mm-hmm, yes.

Q And then Patient D is an adult patient. Similarly-- it's also an adult patient, and the number of days that they're present in the hospital in the past is recorded at paragraph 24 and paragraph 18. Do you see that?

A Mm-hmm.

Q Now, I'm wondering if you remember a discussion of what might have been referred to at the time as Patient H1 and H2 in the expert subgroup?

A No, I don't remember that.

Q Okay. Well, I'll probably not be able to get much further with this. Do you remember discussion of-- if you look at patient—

A Sorry----

Q Sorry carry on.

A Sorry, I was going to say, what I should say is I don't remember that they were-- I remember the discussion and I don't recall H1 and H2 being discussed.

Q It's just minuted in the minute.

A Yes, and I flagged my concerns in an email afterwards to say that there had been there had been mention at the start of the meeting-- a meeting in November-- is it November?

Q It is, 26 November.

A Right. So, in fairness that they may have discussed it. I fell off this meeting halfway through, or after about half an hour, because of a laptop failure.

Q I see. So, this is, of course, is during the lockdown so you're all on Teams calls.

A Yes, it was on a Teams call, and I-- there had been a statement made by the chair or the-- Dr Hood at the start to say that there had been-- there was a couple of other patients to considered. I fell off the call, these hadn't been discussed, and I contacted Sandra Devine afterwards and said, "I missed that. Can you tell me who these patients were?" I was advised that they were historical cases, and I queried whether she meant "historical" in terms of before 2018 IMT cases or after them. She said "No, they're before them, and I think they date back as 2010. Dr Hood is looking into them."

Q So, I get the impression from the way you're describing this, that this wasn't something that was intensively discussed at the meeting of the subgroup?

A Not while I was present.

Q Right, and of course, at that point, you were the only ARHAI person present because Mr Storrar has given his apologies as Annette Rankin is not recorded as taking part.

A Yes.

Q Does the same issue about you not being on the call, "Apply discussion of a child case," which is case E on this document?

A No, so that was later. I think that was-- I don't remember that being discussed at any meetings, or whether that was slap-bang in the middle of the height of the pandemic. I had moved over to COVID response by that point.

Q So you might not have been involved that day?

A I may not have been involved.

Q Well, in that case, I don't need to trouble you further, but what I want to do is just to understand this. I think it's fair to say and to make clear at this point that NHS Greater Glasgow don't accept that the two patients, H1, H2 – or C and D – are connected to the hospital, and they don't even accept that patient E is actually a Cryptococcus case, but what I wanted to understand is: is there any value, when discussing a very small number of unusual infections, in looking at potential cases, or cases that are only slightly connected in space and time, in order to explore that as a possibility, or should you be only focused on the cases that are definite, confirmed diagnosis?

A Oh no. So, I think in any-- Your IMT is always going to start off with

your initial cases, but you may decide to do a look-back exercise, so I suppose that's where a case definition is important in defining what you're going to look for – the name of the organism – amongst what patients, what patient groups are you going to look for it amongst, and across what timeframe, and that would be what you would want to do with a normal or routine IMTs.

This was a lot more complex. We were understanding that it wasn't as clear-cut as taking a cut-off period in the last six months or in the last-- you know, we were having to look back much wider and consider all of them.

Q I suppose to wrap up this section, by the point we get to November 2020, by this point of the issues around minutes and the concerns of air started to crystallise or was this before that point?

A Before the July 2020 case? It was well before then that we had concerns about the minutes.

Q I think what I want to do now is to look at one wider topic, and then I'll break for a moment and see if my colleagues have any further questions. I want to just look at the question of patient locations. Now, I'm asking you this question because you were the lead IPC nurse in the Schiehallion unit for a period each side of decant. Now, before decant, were any haemato-oncology patients in

the children's hospital accommodated overnight in any other ward outside 2A?

A I believe, yes, they could have been.

Q Why would that be?

A So, my understanding is probably two scenarios. One would be in the occasion that there wasn't a bed available in 2A for an admission, they may place them somewhere else until a bed became available----

Q And then move them in?

A -- and then move them in.

Q Right.

A The other might be that the complexity of the conditions of these children may mean that they need input from other services, so I would say as an example, if there was renal implications, they may spend a period of time on the Renal unit, in the ward that manages the renal system. So, they may have a bed there and they may put a 2A patient up there. That doesn't mean to say that the Clinical team in 2A aren't very closely involved but, if the focus at that point in time is another system, then they may be in another area.

Q I understand. If we then look at the period post-decant. Now, ignoring for a moment the small sub-decant, the clinical decision unit, obviously taking into account the fact that the child paediatric bone marrow transplant patients were in

4B anyway, what's the answer to the same question? Would they all be in 6A or would they be dispersed around the hospital at the time?

A So, they were largely all in 6A but, for the same reasons, could still be in other areas of the Kids hospital. However, we did develop what was called a 2A pathway, and that meant that, in every ward that they may have ended up in for whatever reason, we identified a room that would undergo the same scrutiny and standards of controls that 6A had.

Q So, it would have point-of-use filters?

A Point-of-use filters, it would have----

Q It would be cleaned?

A Yes, all of that.

Q But it would, of course, have the same ventilation services as the existing ward it was in?

A Yes. I think we had HEPA filters in those rooms as well, though.

Q The portable ones?

A The portable ones.

Q Right. I'm just going to check my note. My Lord, this might be a perfect moment to break briefly just to see if any colleagues have any questions.

THE CHAIR: Yes, there may be further questions coming to the floor and we'll break for a brief period of time. No more than 10 minutes to discover whether there are. (To the witness) So, you'll be taken back to the witness room.

(Short break)

MR MACKINTOSH: My Lord, I have a couple of questions, but I'm just trying to check a note before I just ask them. Ms Dodd, I've got three groups of questions.

Now, I don't want to get into-- This is the sort of period before you left Glasgow, the IMTs at that point. I don't want to get into the exact names of "Person X said Y" because it doesn't help the Inquiry, and it's generally going to be my approach not to get into that.

A Mm-hmm.

Q But you described in your evidence before the break that there was tension and that the views of the chair were not, to your perspective – and others will have different perspectives – necessarily being listened to. Can you give some examples, without naming people, of the sort of ways you felt that this was happening in those last few meetings before you left?

A I truly can't remember words that were said. It's so long ago. I think the tension in the room was palpable in the sense that from senior managers, particularly within Facilities, that I think

the body language, the silence, the way in which they ask questions were perhaps more combative than constructive.

Q To what extent is the way the IMTs are conducted a consequence of the fact it's largely conducted by Infection Control clinicians, treating clinicians, and the Estates and Facilities people you see all the time? So you're all known people. To what extent it has an informality because of the nature of the people that's there? And therefore there's no difference when you bring in someone more senior that maybe they don't get the tone of the meeting. Is there something in it in that?

A I wouldn't necessarily say that it's informal. I think it is quite formal, but it's intended to allow discussion and allow thoughts and views, and I think-- and I would actively support that, that there is a place for healthy challenge of views. So, I wouldn't necessarily say it was informal, but there was lots of discussion, although that was in a relatively structured way.

When Senior Management were there, they hadn't been party to some of the previous IMTs, and I don't know what had taken place at pre-meet discussions and what they were aware of what they weren't aware of. So, I could-- I witnessed tension, the tone at which questions were asked, the behaviour in terms of not necessarily being accepting

of Dr Inkster's views or actions, but I was unable to see exactly where that was coming from because I wasn't party to the----

Q I'd like to move on to look at the subgroup, the group of questions around this. During of the two years the subgroup was running, did it provide any updates to Dr Inkster the person it was ultimately going to report to?

A Not that I'm aware of.

Q Now, I'm conscious here that Professor Hood isn't able to give evidence to the Inquiry. In the discussions-- How was his chairing of the meetings?

A I think-- I don't think the meeting was chaired terribly well. I don't think the discussions were structured terribly well. I think what would often happen is that we would have discussion, the minutes of that would come out but added into that minute was afterthoughts, post-meeting views of John's, and it made it very confusing to understand where he was going with these thoughts and views. We would come back to the next meeting, we would go over that. It was-- It all felt quite fractured it was difficult to follow.

Q So, to what extent was this process like an IMT, a collaborative process?

A No, I wouldn't say it was like

an IMT at all. It was a group meeting where we were all there to bring our own expertise, but it wasn't structured like an IMT to go through to consider in a clear method what had brought us here, what we were considering at this point, why, what was the strength, the evidence. It wasn't structured in that way. I came away utterly confused from most of the meetings.

Q And the report at the end, did that-- whose word should we take that as being, the report at the end?

A I assume them to be Dr Hood's.

Q Why did NSS eventually not endorse his report?

A Because we couldn't-- we did not feel assured about where the information had come from to inform those final views on each of the hypothesis. We had asked for-- We'd also asked for details of patients who were being brought up in minutes that hadn't been discussed in groups, and we just didn't feel that we had had sight of all the information that was going into that group.

Q I want to understand how we would-- how ARHAI would understand whether Cryptococcus cases were occurring in that hospital, because obviously I get that you would discover if a HAIRT process was carried out, and

you'd always have got it if it had been a red and an amber, and now you will even get it on a green.

A Mm-hmm.

Q If there's been a case, would that actually come to ARHAI if there hadn't been a HAIRT done?

A No.

Q So how do you-- So, it's your surveillance of these unusual infections, whether it's Cryptococcus or Mycobacterium chelonae, or whether it's (inaudible) or anything like that, is that actually dependent on whether the infection control team in the hospital carries out the HAIRT process?

A Yes. There are some areas of mandatory surveillance that take place, some Staphorsius bacteria(?), on Clostridium difficile, but the rest, I don't think we would necessarily know about that. Although, what I would say is that there are others in ARHAI who are much closer to data and intelligence in terms of laboratory systems, what they can have access to. I think, though, there would still have to be a trigger for us to go and look, and even if we did look, there's a limited amount of information that is----

Q Okay.

A -- available at a national level.

Q My final question is to return to the Cryptococcus subgroup report process. Do you know why the initial

offer of a literature review from NSS wasn't initially accepted?

A No.

Q I think, my Lord, that's all the questions I have for Ms Dodd.

THE CHAIR: Thank you, Mr Mackintosh. Can I take it that Mr Mackintosh has asked any additional questions that were required of him? I'm taking that as confirmation that he's asked such questions as he was asked. Ms Dodd, that is now the end of your evidence and your free to go, but before you do, can I thank you for your attendance today, but also what I suspect was quite a considerable amount of work in preparing these statements. I do not underestimate that. They will be very useful for the Inquiry, and I'm grateful for them, but as I say, you're now free to go. Thank you very much.

THE WITNESS: Thank you.

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

MR MACKINTOSH: My Lord, the next witness tomorrow morning is Karen Connelly from the Facilities team. Mr Connal will be taking her evidence.

THE CHAIR: Right, and we also have a witness----

MR MACKINTOSH: In the afternoon, Pamela Joannidis, who I'll be taking.

THE CHAIR: Right.

MR MACKINTOSH: So, it might be a 4.30 finish, I suspect, tomorrow.

THE CHAIR: All right. Very well. Can I wish you a good afternoon, and we'll see each other, all being well, at ten o'clock tomorrow.

(<u>Sessions ends</u>)

15:10