SCOTTISH HOSPITALS INQUIRY

Bundle of documents for Oral hearings commencing from 19 August 2024 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow

Bundle 14 – Further Communications

Volume 3

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91. email Re RHC6A Environmental swabs 7_01_20

Julie Rothney

From: BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND) [redacted]
Sent: 14 January 2020 11:48
To: Shepherd L (Lesley)
Cc: PETERS, Christine (NHS AYRSHIRE AND ARRAN); INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE); Greig.Chalmers[redacted]
Subject: Re: RHC6A Environmental swabs 7_01_20

Yes I will pick this up.

Christine, I will find out a bit more and come back to you.

Best wishes
Marion

Sent from my iPhone

On 13 Jan 2020, at 14:21, "Lesley.Shepherd[redacted]"
[redacted] wrote:

Thanks Christine.
Mariion, are you happy to take this up with Christine please? Our understanding is that these rooms in 4B are closed due to other reasons and not due to potential fungal infection cases which does raise concerns for me.
Also, in terms of the governance route around environmental results and comms to Micro colleagues (advise on how these issues should be handled), I am in the process of asking the Board for clarification around this in reference to the issue on Friday with 6A.
Thanks again Christine / Marion.
Kind regards,
Lesley
Lesley Shepherd
Professional Nurse Advisor, HAI AMR Policy Unit
Chief Nursing Officer's Directorate | The Scottish Government
St. Andrew's House | Regent Road|Edinburgh | EH1 3DG
Telephone: [redacted] | Mobile [redacted] | Email: Lesley.Shepherd[redacted]

From: PETERS, Christine (NHS AYRSHIRE AND ARRAN) [redacted]
Sent: 13 January 2020 13:59
To: Shepherd L (Lesley) [redacted]; INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted]
Cc: BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND) [redacted]
Subject: Re: RHC6A Environmental swabs 7_01_20
Thanks Lesley ,

I appreciate both you and Marion's forbearance with me as we seek to bring about mending to the admittedly broken systems.

The blocked toilet and heat issues are news to me. The comments re the rooms being out of action were made in the context of discussing a couple of possible fungal infection cases . If there was dampness in the rooms due to a blocked toilet and any air sampling raising

concerns that would be important to know for me. Which species isolated ? Particle counts? HAISCRIBE measures in place ? This pertains to risk and medical management of both paediatric and adult cases.

This may all be very well managed - indeed I really hope so and no reason not to be, it's a fairly routine scenario for QEUH. It's then simply a matter of getting the comms to Micro colleagues fixed / re established so we don't feel the need to alert you and Marion to risks.

In a longer term analysis, the issues are; what is the air quality on 4b over time, where do infectious immune compromised patients get accommodated and how often have leaks /overflow/ blocks occurred which may point to structural issues with drainage ? In terms of heating it's important to note that work on services usually in the past have required ceiling access in the rooms. This breaks the seal of the room and required revalidation, proper scribe measures and a consideration of risk on the entire unit.

This may all have happened - I'm not in a position to know - but the last twice I have tried to deal with HAISCRIBEs on an immune compromised setting I was not satisfied with outcomes and I know in a recent issue in the north of city similar issues were encountered.

In short my aim in writing is simply to share whatever expertise/experience I have with you both in case of organisational learning not being followed through. Hopefully this kind of communication will rapidly become unnecessary.

Kr

Christine

From: Lesley.Shepherd[redacted]
Sent: 13 January 2020 13:30:42
To: PETERS, Christine (NHS AYRSHIRE AND ARRAN); INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Cc: BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND)
Subject: RE: RHC6A Environmental swabs 7_01_20

Hi Christine,

Thanks for this follow-up. Very concerning. I'm sure that Marion can take this forward on your behalf.

I'm also planning on following this up with the Programme Management Office at GGC today. In terms of 4B, we are aware that there have been issues with two rooms. One of them was a blocked toilet and the other was heating. Problems. Do you know what the specific issues are?

Thanks again Christine.

Kind regards,

Lesley

Lesley Shepherd
Professional Nurse Advisor, HAI AMR Policy Unit
Chief Nursing Officer's Directorate | The Scottish Government
St. Andrew's House | Regent Road|Edinburgh | EH1 3DG
Telephone:[redacted] | Mobile[redacted] | Email: Lesley.Shepherd[redacted]

From: PETERS, Christine (NHS AYRSHIRE AND ARRAN)[redacted]
Sent: 13 January 2020 12:39
To: Shepherd L (Lesley)[redacted]; INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)[redacted]

Cc: BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND) [redacted]
Subject: Re: RHC6A Environmental swabs 7_01_20

Hi Lesley ,
Thanks for the follow up and information on actions which certainly had not been communicated to the Microbiology team by the IPCT . This is worrying as firstly we cover IC out of hours including over the weekend , and secondly we give daily advice on antibiotic therapy , and timeous communication on environmental threats is imperative for clinical management of these patients . The information was not included in the Friday handover. You will note that the list of results was only communicated to me via my operations manager and actually just knowing results is not enough . A full handover from ICD microbiologist to OOH microbiology team would be best practice . Furthermore the screening was not complete - ie what evidence is there that other rooms are not affected ? Perhaps Teresa can comment further given her water and drain experience regarding what actions she would consider In these circumstances .

I have also heard that there are "issues" with the isolation rooms in 4B from the clinical team . The nature of these has not been shared with the Microbiology team.

Thanks for your offer to continue to contact you if required . As discussed on Thursday the interim period of changeover has and will be difficult . Please be assured I will never hesitate to raise concerns when I feel patients are at risk.

Kr
Christine

From: Lesley.Shepherd [redacted]
Sent: 13 January 2020 12:08:37
To: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE); PETERS, Christine (NHS AYRSHIRE AND ARRAN)
Cc: BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND)
Subject: RE: RHC6A Environmental swabs 7_01_20

Hi Christine / Theresa,
Hope you had a lovely weekend. Just wanted to follow up on this with you.
I spoke with Marion on Friday who then had a conversation with the IPCT. I understand that 2 of the rooms which had positive isolates were not in use at the time and being dealt with now and the other had a patient who was moved out to another room in order for the Team to deal with that room. Marion, I'm sure, will follow this up today.
I'm thoughtful now that Marion is in post and the conversation we had on Thursday, if it would be easier if you forward on any issues you have to her rather than me to ensure that they are actioned timeously and appropriately within the Board .However, equally, if you would like to raise anything with me, please give me a call.
Thanks Christine.
Kind regards,
Lesley
Lesley Shepherd
Professional Nurse Advisor, HAI AMR Policy Unit
Chief Nursing Officer's Directorate | The Scottish Government
St. Andrew's House | Regent Road|Edinburgh | EH1 3DG
Telephone: [redacted] | Mobile [redacted] | Email: Lesley.Shepherd [redacted]

From: PETERS, Christine (NHS AYRSHIRE AND ARRAN) [redacted]
Sent: 10 January 2020 17:47

To: Shepherd L (Lesley) [redacted]
Subject: Re: RHC6A Environmental swabs 7_01_20
Thanks . You are having a busy time . Hope u have good weekend .

Kr
Christine

From: Lesley.Shepherd [redacted]
Sent: 10 January 2020 17:18:14
To: PETERS, Christine (NHS AYRSHIRE AND ARRAN)
Subject: RE: RHC6A Environmental swabs 7_01_20
I've spoken to her now Christine.
Kind regards,
Lesley
Lesley Shepherd
Professional Nurse Advisor, HAI AMR Policy Unit
Chief Nursing Officer's Directorate | The Scottish Government
St. Andrew's House | Regent Road|Edinburgh | EH1 3DG
Telephone: [redacted] | Mobile [redacted] | Email: Lesley.Shepherd [redacted]

From: PETERS, Christine (NHS AYRSHIRE AND ARRAN) [redacted]
Sent: 10 January 2020 16:55
To: Shepherd L (Lesley) [redacted]
Subject: Re: RHC6A Environmental swabs 7_01_20
Please do , Its difficult as I have no formal role and Im acting outwith normal routes, but have to until normal is mended.
teresa comments its interesting to see Cupriavaditis re emerge . ? what is the water testing like currently
C

From: Lesley.Shepherd [redacted]
Sent: 10 January 2020 16:51
To: PETERS, Christine (NHS AYRSHIRE AND ARRAN)
Subject: RE: RHC6A Environmental swabs 7_01_20
Would you mind if I also called Marion as don't want to leave over the weekend?
Kind regards,
Lesley
Lesley Shepherd
Professional Nurse Advisor, HAI AMR Policy Unit
Chief Nursing Officer's Directorate | The Scottish Government
St. Andrew's House | Regent Road|Edinburgh | EH1 3DG
Telephone: [redacted] | Mobile [redacted] | Email: Lesley.Shepherd [redacted]

From: PETERS, Christine (NHS AYRSHIRE AND ARRAN) [redacted]
Sent: 10 January 2020 16:51
To: Shepherd L (Lesley) [redacted]
Subject: Re: RHC6A Environmental swabs 7_01_20
sure

From: Lesley.Shepherd [redacted]
Sent: 10 January 2020 16:48
To: PETERS, Christine (NHS AYRSHIRE AND ARRAN)
Subject: RE: RHC6A Environmental swabs 7_01_20
Hi Christine,
Would you mind also following this on to Marion too please? Thanks.

Kind regards,
Lesley
Lesley Shepherd
Professional Nurse Advisor, HAI AMR Policy Unit
Chief Nursing Officer's Directorate | The Scottish Government
St. Andrew's House | Regent Road|Edinburgh | EH1 3DG
Telephone: [redacted] | Mobile [redacted] | Email: Lesley.Shepherd[redacted]

From: PETERS, Christine (NHS AYRSHIRE AND ARRAN) [redacted]
Sent: 10 January 2020 16:46
To: Shepherd L (Lesley) [redacted]
Subject: Re: RHC6A Environmental swabs 7_01_20

I do not know anything anout actions unfortuantely - I just have my Laboratory Operations Manager sending me the updated results so I can be sure of my facts.
kr
Christine

From: Lesley.Shepherd [redacted]
Sent: 10 January 2020 16:38
To: PETERS, Christine (NHS AYRSHIRE AND ARRAN)
Subject: RE: RHC6A Environmental swabs 7_01_20

Thanks for this Christine.
Heard that they were not swabbing the outer drain as well as inner drain. This is worrying.
Do you know if these affected rooms have been closed or any actions undertaken as a result of this?
Kind regards,
Lesley
Lesley Shepherd
Professional Nurse Advisor, HAI AMR Policy Unit
Chief Nursing Officer's Directorate | The Scottish Government
St. Andrew's House | Regent Road|Edinburgh | EH1 3DG
Telephone: [redacted] | Mobile [redacted] | Email: Lesley.Shepherd[redacted]

From: PETERS, Christine (NHS AYRSHIRE AND ARRAN) [redacted]
Sent: 10 January 2020 16:34
To: Shepherd L (Lesley) [redacted]
Subject: Fw: RHC6A Environmental swabs 7_01_20

From: REYNOLDS, Fiona (NHS GREATER GLASGOW & CLYDE)
Sent: 10 January 2020 16:28
To: Peters, Christine; PETERS, Christine (NHS AYRSHIRE AND ARRAN)
Subject: Fw: RHC6A Environmental swabs 7_01_20

FYI
Fiona Reynolds
Laboratory Operational Manager
South Sector Microbiology Laboratory
Level 4/B/040
Laboratory Medicine and FM Building
Queen Elizabeth University Hospital
Glasgow
Telephone: [redacted]
Direct Extension [redacted]

From: Raeside, Janice [redacted]
Sent: 10 January 2020 15:18

To: Sandra [redacted]; Devine, Sandra; Joannidis Pamela (NHS GREATER GLASGOW & CLYDE); Mallon John (NHS GREATER GLASGOW & CLYDE); Jordan David (NHS GREATER GLASGOW & CLYDE); Leanord Alistair (NHS GREATER GLASGOW & CLYDE)
Cc: Bowskill Gillian (NHS GREATER GLASGOW & CLYDE); REYNOLDS, Fiona (NHS GREATER GLASGOW & CLYDE); Small, Nicola; Storrie, Christine
Subject: RHC6A Environmental swabs 7_01_20

Hi All.

Please see attached the results for the environmental swabs received this week. We had one isolate which we failed to identify despite repeated testing by more than one method. It has been stored together with the other significant isolates. The scanned images of the completed result sheets have also been saved on the shared drive: GGC Micro/SGH/Environmental samples.

Kind Regards,

Janice

100. RE Environmental sampling SOP for 6A

Julie Rothney

From: Peters, Christine
Sent: 20 January 2020 15:03
To: 'Alistair Leanord'; Inkster, Teresa (NHSmail); BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND); Joannidis, Pamela; Devine, Sandra; Bowskill, Gillian
Subject: RE: Environmental sampling SOP for 6A

Hi AL,

I think key to enacting the SOP is clarity around the intent in doing the sampling in the first place. This kind of sampling is usually for :

1. Outbreak source investigation – triggered by cases in which location specific samples should be taken in a timely manner and isolates typed as soon as possible – all the remit of the ICD as part of the IMT and IC governance structures. Given there have been no gram negative cases for a couple months (in itself fascinating epidemiology) this is not the current case
2. Quality assurance for cleaning – in which case this should not really be ICD requests but embedded in a cleaning SOP with clear parameters for actions . I think this is the aim of the current SOP?
3. Research – which requires appropriate governance, eg testing the hypothesis that the WGS diversity of a species in a drain associated biofilm varies over time, and is related to water isolates, for the sake of argument.

Page 2: Is Contents page but reads as an instruction manual
Page 3: responsibilities : Microbiologists – I suggest this is the ICD role, as they will have instigated the testing
Estates and facilities – would be helpful refer to the water policies which already exist for the water results, it is not clear why this is part of this SOP. If this is a broader environmental SOP rather than cleaning assurances, then ventilation and air quality parameters should be included.

Communications : at present the environmental isolates are left for the ICD to authorise as they are best placed to interpret and act upon especially if novel organisms are isolated and to decide if antibiotic sens testing would be helpful. I think this should continue . the rest of the cascade really depends on the final structure and roles /responsibilities of the IPCT. I would suggest that the ICD dealing with the situation would write an interpretation of the findings and what actions they think necessary in the form of an SBAR. It is important that the Clinical Microbiology colleagues are also informed so that clinical advice can be made with a full understanding of the IPCT approach and findings. This includes possible CPE isolates in the future.

Page 4 ; the environmental sampling as described in the SOP does not give assurance as Teresa has indicated . Negative samples at the level we are currently seeing suggests sampling methodology is not sensitive. These sites are not expected to be sterile therefore when they appear so it raises questions re sampling methodology and a false sense of security is given. Is this SOP in fact an attempt to quality assure the cleaning processes? If so the timing and a quantitative method would be more scientific . a recent paper for GOSH suggested 4 hours post cleaning. This would asses WHICH organism are still surviving the cleaning methodology which may or may not be clinically relevant.

Page 5
Resampling post action – needs a time frame as per above (would be useful to validate)

Decanting – what assurance is there that unsampled rooms do not currently have the same organisms, but were simple negative at last test?

In summary I do not think this approach is actually achieving much and we are committing to a cycle of testing and cleaning and more testing , without a clear rationale.

Much more interesting is the fact that zero rates have been achieved prior to this testing commencing . What has changed?

Kr
Chrisitne

From: Alistair Leanord [redacted]
Sent: 20 January 2020 13:21
To: Inkster, Teresa (NHSmail) [redacted]; BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND) [redacted]; Joannidis, Pamela [redacted]; Devine, Sandra [redacted]; Bowskill, Gillian [redacted]; Peters, Christine [redacted]
Subject: [ExternaltoGGC]Re: Environmental sampling SOP for 6A

Thanks Teresa

The SOP, as written, is to give us a working document that we can enact fairly quickly (days) after sharing it with HPS and SG.

I accept and agree with all the issues you highlight re: how to break the chain of transmission, some of which we could implement fairly quickly. I appreciate we will need to look at other interventions in the longer term. Some of this will hopefully be obviated by the move back into 2A.

The 4 target organisms are mentioned as they are part of the National manual, however, the SOP does recognise that we can target other organisms as befits the environment and the patient risk if and when required.

I am currently not aware of the condition of the pipework, but am mindful of the report you shared. We are looking at using foaming cleaner as per the recent paper you shared as one element in trying to decrease the bacterial load within the drain.

Cheers

Al

From: "INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)" [redacted]
Date: Monday, 20 January 2020 at 12:49
To: Alistair Leanord [redacted], "BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND)" [redacted], "Joannidis Pamela (NHS GREATER GLASGOW & CLYDE)" [redacted], "Devine, Sandra" [redacted], "Bowskill Gillian (NHS GREATER GLASGOW & CLYDE)" [redacted], "Peters, Christine" [redacted]
Subject: Re: Environmental sampling SOP for 6A

Hi Al

I have read this and have the following comments;

I think the key in providing assurance is to recognise the mechanisms/routes of transmission and implement control measures to break those. Drains will always contain bacteria but can become a source if aerosolisation or retrograde biofilm creep occur. It is these mechanisms which need to be addressed. The way this might be achieved is via regular drain cleaning, alteration of drain structure and reduction of splashing risk i.e. installation of shark fin sink, removal of filters, adequate spacing between sinks and beds/equipment

I think these measures coupled with sink hygiene measures (cleaning method that reduces risk of contamination from drains, signs to prevent decanting of products, storage being provided to prevent products being stored on sinks) are what is required.

I note the focus is on the common four environmentals but we know our water system has had a multitude of Gram negatives isolated from it all of which can be pathogenic in an immunosuppressed patient. What is concerning to me is the continued presence of organisms like Cupriavidus on sampling. Children do not carry organisms like Cupriavidus and will not be shedding them into drains, equally the water coming through filters has counts of 0. To me this would indicate well established biofilm in the drains which needs to be the focus of any control measure . Do we know the condition of pipework?

kr
Teresa

Dr Teresa Inkster
Consultant Microbiologist, QEUH
National Training Programme Director Medical Microbiology
Dept of Microbiology
Queen Elizabeth University Hospital
Glasgow
Direct dial : [redacted]

From: Alistair Leanord [redacted]
Sent: 17 January 2020 15:44
To: BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND); Joannidis Pamela (NHS GREATER GLASGOW & CLYDE); Devine, Sandra; Bowskill Gillian (NHS GREATER GLASGOW & CLYDE); Peters, Christine; INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Subject: Environmental sampling SOP for 6A

Marion

Please see latest version of environmental sampling SOP for 6A.

I have sent round for comments and being aware that we would like to finalise the document at the end of next week, it would be useful to get comments back by the end of Tuesday coming to allow for this to be endorsed.

Cheers

Al

Cabinet Secretary for Health and Sport
Jeane Freeman MSP

Scottish Government
Riaghaltas na h-Alba
gov.scot

T: [redacted]
E: [redacted]

Dr Teresa Inkster
[redacted]

Our ref: 201900008554
20 January 2020

Dear Teresa and Caroline

Thank you for your letter of Monday 2 December and its two attachments.

It was very helpful to meet you in early December and to be able to hear your significant concerns first hand. I would like to thank you again for your work and for the efforts you have made to offer your valuable insights, which will help us to ensure that actions to improve infection prevention and control at NHS Greater Glasgow and Clyde are robust and effective.

I understand that on Thursday 9 January you were able to meet with Professor Marion Bain, who has taken over responsibility for infection prevention and control at NHS Greater Glasgow and Clyde. I am keen that you are both involved with future work in addressing these issues, not least through the Oversight Board.

Thank you again for taking the time to meet with me, and please do not hesitate to contact me if there are any further issues you feel are not being adequately addressed.

Kind regards

[redacted]

JEANE FREEMAN

pjredding[redacted]

From: Haynes, Jennifer [redacted]
Sent: 23 January 2020 10:40
To: Penelope Redding
Subject: RE: Step3 meeting
Attachments: 08 - Infection control.pdf; 03 - CCG(M) 1704 final.pdf; Item 03 - CCG_M_19_01 - TBR.PDF; Item 03 - DRAFT CCG(M)19_02.pdf; Dr Peters and Redding.doc

Dear Penelope

Thank you for your email.

I have linked with colleagues here, and I am afraid that neither 30 January nor 3 February are possible due to existing and unmovable commitments, but we could offer p.m. on 29 January if that would suit you? We would need to make that in JB Russell House rather than city centre I am afraid, but because it is afternoon, that might pose less of an issue, as would allow more time to get from Queen Street Station to the Gartnavel campus if this date did suit. As I am sure you will know, Hyndland Station is right next to the Gartnavel campus, and there are very regular trains from Queen Street to that station. Please can you advise me if this date and time would be suitable, and also confirm who [redacted] is?

In terms of information requested prior to the meeting, I can confirm the following:

We still think there would be value in pulling together the proposed meeting with some urgency, which is why [redacted] January has been offered as an alternative date. We very much hope this will be suitable for you and [redacted]

In relation to previous concerns raised, and following the SBAR submitted by yourself and colleagues , while not viewed as stage 1 whistleblowing, the concerns were actioned by the introduction of a 27 point action plan which was subsequently discussed at various governance committees including the Clinical and Care Governance Committee of the Board in December 2017

I include the minutes of the meeting convened by the Board Medical Director on 4th October 2017, where you were in attendance, and the action plan that was developed is attached (08-infection control.pdf).

You outlined that you previously had access to this data while employed by the Board. It would be helpful if we use this as the basis for our discussions at the proposed meeting.

Also included is the paper and minutes of the 5th December 2017 Clinical and Care Governance Committee, where the action plan that was developed from the SBAR was discussed (03-CCG(m) 1704 final.pdf). As you state, this was previously shared with you and other colleagues, and was presented to the various committees of the Board, including the Board Infection Control Committee.

The updated action plan was again updated and baselined to outline the position as of January 2019, and taken through the Clinical and Care Governance committee in Feb 2019 by the Lead Infection Control Doctor to assess progress on each action as agreed in 2017. The March and June minutes are attached (item 03 -CCG M 19 01 TBR.pdf & item 03 - Draft CCG(M) 19 02.pdf) and changes were suggested by Dr Inkster and later agreed in June 2019. You will note that "Mr Ritchie asked if colleagues were reassured by the actions that had been taken to address the issues and if there any further concerns raised in relation to recent events. Dr Inkster advised that one colleague has since retired; other colleagues had not raised any further issues with her".

Furthermore, in relation to the Stage 2 whistleblowing case in January 2018, we have linked with Dr deCastaeker, who is happy to discuss your concerns about your previous case when you meet if you feel anything outstanding. I attach the report Dr deCastaeker previously issued (Dr Peters and Redding.doc)

We think it would be useful for you to review the documentation, and for us to use it as the material to support the basis for discussion with those Mr Edwards and Mr Ritchie have asked to attend.

I hope this email is helpful, and I will wait to hear from you regarding the proposed date of 29 January 2020 p.m. to meet.

Kindest regards

Jen

Jennifer Haynes
Board Complaints Manager
Phone: [redacted]
Mobile: [redacted]
Email: jennifer.haynes[redacted]

-----Original Message-----
From: Penelope Redding [redacted]
Sent: 21 January 2020 09:18
To: Haynes, Jennifer [redacted]
Subject: [ExternaltoGGC]RE: Step3 meeting

Dear Jen

Thank you for your email.

[redacted], who supported me when I gave evidence to the Independent Review, will be accompanying me. She will be happy to do a non disclosure agreement.

As I mentioned before [redacted] has to travel from Dundee and a time after 11 am would be best for [redacted]. The dates most suitable for both of us would be Thursday 30th January and Monday 3rd February. I can ask [redacted] for other dates if these are not suitable. [redacted] asked if their was any possibility of meeting, as we did with review, in the city centre to save her a journey from [redacted].

I look forward to hearing from you.

Kind Regards

Penelope

-----Original Message-----
From: Haynes, Jennifer [redacted]
Sent: 20 January 2020 16:54
To: Penelope Redding [redacted]
Subject: RE: Step3 meeting

Dear Penelope

Thank you for your email, and I apologise for the delay in responding.

We know you were keen to get some information in writing prior to a meeting, so we are in the process of coordinating that. I will be in touch with you later this week, and we can arrange a suitable date and time for a meeting.

97. Fw Critical care patient placement

Julie Rothney

From: PETERS, Christine (NHS AYRSHIRE AND ARRAN) [redacted]
Sent: 24 January 2020 16:13
To: CabSecHS
Cc: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Subject: Fw: Critical care patient placement

Dear Cabinet Secretary,
Thank you for meeting with Penelope, Teresa and me a few weeks today and for your supportive words in parliament regarding whistleblowing.
I am writing to make you aware that I continue to have concerns regarding the IPCT situation in GGC.
1.in the light of the current global alert to a novel coronovirus I have written an SBAR as per below regarding isolation facilities. The reponse to sorting this has been too slow considering that it has been central to IC concerns since the moment the building opened.
2. every time there is a public statement about infection related issues I find myself astonished regarding the obvious deviations from fact and have felt the need to raise objections in writing repeatedly.
3. there is no sign of the GGC management culture changing with communications, decision making and treatment of QEUH MIcrobiology entirely unaltered.
I note that the the entire Board is now on level 4 , however the embedded infection control aspects of the organisation remain fairly intact .
I very much appreciate the time that Prof McQeen and Prof Bain have taken to engage with Teresa and I, and we have been doing our very best to help in this difficult situation. My concern is that infection control issues can escalate rapidly and from my position I remain sceptical regarding the functioning of the team.
kind regards,
Christine Peters

From: PETERS, Christine (NHS AYRSHIRE AND ARRAN)
Sent: 24 January 2020 15:41
To: BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND); Fiona.McQueen[redacted]
Cc: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE); Jason.Birch[redacted];
Lesley.Shepherd[redacted]
Subject: Re: Critical care patient placement
Hi Marion and Fiona,
Situation
I am writing to you to emphasise the urgency and grave seriousness of the current situation in GGC with regards to placement of patients.
Background
Microbiology Consultants including ICDs have repeatedly raised concerns regarding the management and provision of appropriate standard isolation facilities for the complex patient cohort treated at the QEUH and RHC site since 2015 and especially as part of the 2017 whistleblow, evidence to Review, to SG, to HSE, HFS, HPS and finally in many recent discussions with MIcrobiology, Infection Control and operations management.
There are Infectious Diseases unitis in both paeditric and adults hospitals as well as the largest acute admissions units in Scotland . Infectious patients can be expected to be admitted on a regular basis. The chances of imported Coronovirus patients arriving here , being next to an international aerport is as reasonably high as other cities in UK.
There are both adult and paediatric BMT and haem onc units on site. We can therefore predict a large number of patients who will require appropriate HEPA filtration including at ITU level (this is why the Beatson moved over in the first place)

Assessment

Currently there is a global alert regarding a novel coronovirus with very detailed and helful advice from both WHO and PHE available. The critical point of control is the first few cases in any country. There needs to be a fail safe strategy for isolation of patients who may meet the criteria as POSSIBLE cases - not for implementation after the positive result is found.

Today I have the following worrying information:

1. one of the negative pressure rooms in ITU that has been mentioned as a validated room has had repeated alarms going off and recent filter changes (key question _ was there an HAISCRIBE in place for the work - were patiens moved, why were Micro on call not informed of deftects despite numerous communications asking for clarity?)? why would filters need changed so soon after validation?
2. A severely immune compromised patient has been isolated in a NEGATIVE pressure room on ITU. This is the exact oppositie of what is required and poses a significant risk to the patient. This was only discovered by Teresa who did a walk around at the request of the ITU consultants.
3. There is a significant level of concern amongst ITU medical staff regarding communication from IPCT regarding patient placement in the light of the coronovirus threat. They do not understand the different types of room and have not had guidance regarding them.
4. We have been told that our responsibility as Microbiologists is simply to advise the type of room that is required, irrespective of whether this is available of not. I do not agree. This may/may not exempt us from responsibility but does not actually help patients. Sometimes situations arise where JUDGEMENT is required eg when capacity is reached. This involves understanding the situation.
5. Furthermore it is repeatedly indicated to us that it is not really our job to advise re patient placement. And yet every day, often out of hours one of us is called regarding this - even by ID consultants
6. One ICD was contacted today by the ID consultant regarding [redacted] positive AAFB positive patient. Given the issues on ITU it was decided to place this patient on 5C. This is a ward without negative pressure, houses other [redacted] patients, and has 3ACHs , no ante room. Ie it is worse than many DGH facilites for open TB in a " flag ship " hosptial. Please be aware of the risk this poses. It is no fault of those making the decision - as the conditions here are designed to force us into such compromised decisions on a regular basis which I find unacceptable after this length of time.

Therefore I conclude :

- the patient placement policy is not fit for purpose
- members of the IPCT do not understand the requirements nor the risks of the different types of room eg ICN advising negative pressure ok for immune compromised, missing out on estates communication regarding current status of all rooms which should have occurred as an urgent action as soon as WHO gave a warning re novel coronovirus. (and routinely due to MERS risks)
- there is a real risk of misplacement and therefore crosstransmission events if the following heirarchey of control is not rapidly established as per best practice:
    - administrative - plans are tested and rooms funnctioning and actions on failures documented
    - engineering- all rooms fully evidenced as correctly functioning
    - PPE - including fit testing recors and training documentation
-
-

Recommendations

1.Roles need to be clarified with regard to WHO is best qualified to firstly sign off on a policy and secondly advise on patient placement in the event of complex situations. This would normally be the ICD who undersatands all matters ventilation.

2. those MIcrobiologists giving advice need to be able to ask questions to enable sound judgement and get answers in real time from estates and IPCT

3.In terms of preparedness for pandemics there needs to be unequivicol readily available plans which are communicated with training to front line teams.
Please be assured this is not being alarmist , simply a matter of following very basic and well established methods of infectoin prevention.
kr
Christine

From: Peters, Christine [redacted]
Sent: 24 January 2020 14:40
To: PETERS, Christine (NHS AYRSHIRE AND ARRAN)
Subject: FW: Critical care patient placement

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted]
Sent: 24 January 2020 14:33
To: Leanord, Alistair [redacted]
Cc: BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND) [redacted]; Cadamy, Andrew (NHSmail) [redacted]; Ramsay, Sarah [redacted]; Binning, Sandy [redacted]; WRIGHT, Christopher (NHS GREATER GLASGOW & CLYDE) [redacted]; Peters, Christine [redacted]; Balfour, Alison [redacted]
Subject: [ExternaltoGGC]Critical care patient placement
Importance: High

Dear Al,
I am the microbiologist covering ICU this week and attended the ward round today. There are a couple of concerning issues regarding patient placement;
1) A [redacted] patient who is immunosuppressed with lymphoma is in a negative pressure room and has been for several days. Unfortunately this patient has been placed at risk of infection when they should have been in protective isolation in a PPVL room. The patients consultant Dr Wright was going to inform the family as per duty of candour and was planning to call you regarding this . I have requested this patient be moved into a HEPA PPVL room
2)It is not clear which negative pressure rooms are suitable for ? coronavirus patients. There are 4 negative pressure rooms on the critical care floor; 4, 24, 43,44. These were signed of by myself last year however it is not clear what the current validation status is off these rooms. Room 24 has been alarming and apparently there was work done on changing filters recently - did this room require revalidation and has it been signed of by IPCT? One of the rooms has an XDRTB patient who will need to remain there.
I did a walk round with the ICU consultants and the rooms are as follows;
3 - non hepa PPVL
4 - negative pressure
11- non hepa PPVL
23- non hepa PPVL
24 - negative pressure
31 - Hepa PPVL
40- non hepa PPVL
43- negative pressure
44- negative pressure
50 - hepa PPVL
The three room types are confusing and are made complicated by the pressure gauges reading different things ie. PPVL measures lobby, negative pressure measures patients room. It would be useful to have signage which makes it clear which patient group can go into each room to avoid a similar patient placement error in the future

In light of the current Coronavirus issue has the possiblity of ring fencing these negative pressure rooms been discussed? You will be aware of the emails from Pauline Wright recently regarding the difficulty in placing a ? MERs patient
It would be useful if some urgent guidance on placement could be issued to critical care ahead of the weekend as I am aware that ID colleagues are receiving lots of calls re possible Corona.
Lastly and not as urgent, in light of CAR-T cell therapy two hepa PPVL are unlikely to suffice and I wonder if consideration has been given to upgrading some of the non - hepa PPVL to hepa PPVL to accomodate this patient group
Kr
Teresa

Dr Teresa Inkster
Consultant Microbiologist, QEUH
National Training Programme Director Medical Microbiology
Dept of Microbiology
Queen Elizabeth University Hospital
Glasgow
Direct dial : [redacted]

101. email ExternaltoGGCFW GGC report

Julie Rothney

From: MORRIS, Keith (NHS FIFE) [redacted]
Sent: 31 January 2020 15:36
To: Peters, Christine; Inkster, Teresa (NHSmail)
Subject: [ExternaltoGGC]FW: GGC report
Attachments: Report GGC.docx

Teresa/Christine,

Please find attached a copy of the report I sent Fiona McQueen. Regarding the restructuring of ICD roles and responsibilities; you may not agree, but I wanted to open a discussion on how microbiologist interact with the nurse led part of the IPCT. What you have in GGC at present is obviously not functioning.

R
Keith

Keith Morris FRCPath, FRCP(Edin)
Consultant Microbiologist & Infection Prevention Doctor, North Laboratory, Victoria Hospital, Hayfield Road, Kirkcaldy, Fife, KY2 5AG
Tel [redacted]

NOTE: I only work 3 days per week for NHS Fife and these days are flexible. I can only reply to emails during my working days. All urgent or clinical enquiries should be discussed with the duty microbiologist. Infection control issues should be directed to the infection prevention & control team.

From: Keith.Morris[redacted]
Sent: 30 January 2020 13:35
To: MORRIS, Keith (NHS FIFE)
Subject: GGC report

FYI

Keith Morris
Medical Advisor to ARHAI Policy Unit, CNOD
[redacted]

101b. Report GGC

Report: Meeting of 17th January 2020 with Drs Teresa Inkster and Christine Peters
Author: Dr Keith Morris (CNOD medical Advisor)

SITUATION

Drs Inkster and Peters asked for a meeting with Dr Morris to discuss their concerns regarding infection prevention and control (IPC) in the Queen Elizabeth II University Hospital (QEUH) plus their professional vulnerability given the history within the infection control service in QEUH since 2015. Dr Morris also consulted Dr Leonard regarding the structure of the IPC service in GGC and the involvement of microbiologists in the Infection Prevention and Control Team (IPCT)

BACKGROUND

The Microbiology service is divided in to two sectors:
The South sector providing a diagnostic service for the QEUH, Royal Hospital for Children (RHC) and the Victoria infirmary. The laboratory is based in the QEUH with eight consultant microbiologists
The North sector providing a diagnostic service for the Royal Alexandra Hospital, Inverclyde hospital, Vale of Leven, Glasgow Royal Infirmary and the Golden Jubilee hospital. The diagnostic laboratory is situated in the Glasgow Royal Infirmary and there are ten consultant microbiologists

The Infection Prevention & Control Structure is split into four teams
The North sector team covers Glasgow Royal infirmary and Stobhill.
The South team sector covers QEUH, RHC & Victoria infirmary..
West sector team covers Gartnavel hospital
Clyde sector team covers The Royal Alexandra hospital, Vale of Leven and Inverclyde hospitals.
The tables 1 & 2 and the accompanying text provide details of the number of programme activities of microbiology time given to the infection control doctor role.

Table 1

Microbiologists with ICD role for South sector		
Name	PA time for ICD	Comments
Dr Pepi Valyraki	5	
Alison Balfour	2	
Total	**7**	

Table2

Microbiologists with ICD role for North sector		
Name	PA time for ICD	Comments
Aleks Marek	2	
Linda Bagrade	3	Also covers Clyde sector
Marie Macleod	2	Also covers West sector
Total	**7**	

NOTE: 1PA =4 hours of work. This needs to cover clinical ICD work, meetings plus education and training

The lead ICD (Alistair Leonard) has 7 PAs for ICD work (these are all clinical)
Michael Murphy has 2 PAs for decontamination

Dr Brian Jones retired, but has come back with 2 PAs for infection control management

Governance

The four infection control teams report to the Infection Control Senior Management Team which reports to the Acute Infection Control Committee (AICC). The AICC reports to the Board Infection Control Committee.

ASSESSMENT

The current structure of the infection prevention control service does not support an efficient and resilient service. While the south sector team provides support to the hospitals with the most vulnerable group of patients at risk from infections; the number of PAs of microbiology time for infection control is not proportional to the other sectors. This maybe mitigated if the Lead ICD (Dr Leonard) PAs are for support to the South sector. However Dr Leonard has a number of other clinical roles which may mean not all seven PA to be given to the ICD role

Dr Murphy's role is clearly defined with an obvious area of responsibility. However I am not clear if this covers only the central sterile services department (CSSD) or includes local decontamination units.

The structure of the ICD role does not provide clear areas of responsibility. Which ICD is responsible for the ventilation, water or HAI-SCRIBEs? If all the ICDs in a sector cover these areas then none of the ICD has knowledge required when incidents occur related to specialist functions such as ventilation or water. **Example**: Dr Bagrade is the ICD for Clyde sector. Does this imply she is the microbiologist responsible for environmental microbiology, local decontamination, New builds & refurbishments plus clinical infection control and alert organisms?

The lead ICD role in the Governance structure is not clear with Dr Brian Jones having a managerial role. Dr Jones was a clinical microbiologist in GGC until very recently, but had no role in infection prevention. I am unclear why Dr Jones has been re-employed by GGC for a role which he has limited experience. I would have expected a Health Board with a progressive mentality to possibly bring in an individual with no history associated with GGC. In the view of public and critical opinion, it could be argued there is a risk of nepotism within the microbiology department and those appointing Dr Jones .

Due to the recent problems associated with the QEUH and RHC there is a toxic environment with in the microbiology department with microbiologists refusing to take on ICD roles and microbiologist resigning from the ICD role due to lack of support from microbiology colleagues and the Health Board senior management. The toxic nature of microbiology in GGC has led to individuals being appointed to roles in which they may not be comfortable. The number and severity of infection control incidents has resulted in the advice of the most experienced ICDs to be ignored because the truth is inconvenient. In such an environment there is a risk bullying, mysogeny and nepotism could take place.

The Governance structure for IPC within GGC is inefficient and sufficiently complex to allow areas of concern to be escalated in an efficient manner. The Healthcare Associated Infection (HAI) Standard 2015 Standard 1 makes clear Infection prevention and control is the responsibility of the Executive Board with clear lines of accountability to the Chief Executive. Responsibility for HAI Executive lead maybe delegated to another individual at Board level. In the present infection prevention control governance structure it is unclear who has what roles and the responsibility for incidents between microbiologists, senior infection control nurse or the infection control manager. Furthermore there needs to be a mechanism whereby the HAI Executive lead can be alerted to any significant IPC issue to prevent obfuscation. There is a risk infection prevention incidents could be down played by individuals with competing interest if the Executive Lead for infection prevention and control is not directly informed of incidents.

RECOMMENDATIONS

There needs to be a complete overhaul of the IPCT structure and the roles and responsibilities of the microbiologists who provide infection control advice. This requires the microbiology service to be re-assessed.

1. The infection prevention and control service should be split into two teams to mirror the microbiology laboratories. Each team should be managed by an infection control manager. The manager determines the number of infection control nurses, and surveillance nurses etc required to deliver the service and manage the budget.
2. The roles and responsibilities of the ICD need to be restructured around infection prevention specialties. Specialty areas to be covered are
    i. mandatory surveillance/alert organisms
    ii. new builds/refurbishments
    iii. environmental microbiology including ventilation and water
    iv. decontamination.

    Consultant microbiologists taking on these roles should be given adequate time in their job plan to fulfil their responsibilities and provide time to maintain their knowledge and skills.
3. The clinical microbiology service need to be equitably divided between the north and south sectors with sufficient weighting given to those hospitals dealing with the most complex patients at risk from infection.
4. Given the toxic nature with in microbiology and the ICD roles it maybe that an outside individual with no link to GGC is required change the clinical service and review all the microbiology job plans.
5. The number of individuals covering each specialty and the number of PAs required would be for GGC to decide with the microbiology dept.
6. Which individual covers which specialty would be with agreement of GGC and the employee.
7. The Organisational structure and governance reporting would need to be reviewed if the roles and responsibilities of the ICDs are more clearly defined. The present structure which is in place has not prevented a number of severe incidents and the loss of public confidence in GGC.
8. Microbiologists and the infection control manager with the lead infection control nurse/consultant infection control nurse need to work in partnership

rather than infection prevention and control being seen as a nurse lead specialty with microbiology input when incidents occur.

9. The role and responsibility of the Lead ICD needs to be reviewed if there is also an additional consultant microbiologist with a managerial role for infection prevention and control. It maybe these roles need to be amalgamated into a single clinical lead for the microbiology service who can assess the total microbiology input to infection prevention across GGC and who can proportion the roles and responsibilities.
10. A microbiologist with an ICD role needs to have direct access to the Executive lead for HAI so there is no risk managers with competing responsibilities or who are not trained in microbiology down play an incident.

98. email RE 2019 nCoV patient placement

Julie Rothney

From:	Peters, Christine
Sent:	31 January 2020 14:56
To:	'Alistair Leanord'; Marek, Aleksandra (NHSmail); Inkster, Teresa (NHSmail)
Cc:	BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND); Joannidis, Pamela
Subject:	RE: 2019 nCoV patient placement

Hi Al,

Thanks for sharing this - I think the descriptions of the rooms are very good. I've copied in Teresa for her comments.

- With regard to agreeing with the table , I'm afraid I do not have the information to do that . I would need to see the documentation and walk round them – similar to what I know others are doing in other centres – a live audit of functionality of rooms and check with smoke tester . I say this because in 4.5 years I have seem numerous iterations of this table, and none to date have been accurate when checked in person . I really hope this is the first one that is.

- It would be good to have a mention of methods for room monitoring and actions to be taken in event of failure /alarm.

- Re PPVL rooms : the fact that there is no negative pressure from ensuite to patient room , 3 ACH in en suite (rather than 10) extracts placed in ceiling in bedroom are some of the derogations from validated design.

- With regard to the RHC, at the grand round a resus room was mentioned ? I do not see that in the table and I'm not aware there is a neg pressure room in reusus. Apologies if I've missed out on this information.

- With regard to the rooms in 5D for coronavirus , please be aware that 2 hours would be required before cleaning and regarding negative pressure status – this is likely to be wavering and does not make these room Air borne isolation rooms – as is described in the paragraph on "negative Pressure rooms ". Importantly negative pressure rooms also have their own AHU and ducting and extract via a HEPA filter at a certain height above the roof. This will not be the case for 5D rooms. All 5d rooms are linked via a shared duct to a shared AHU which means that pressures are linked across the rooms (I tested this with Ian Powrie years ago). At the Grand round it seems the audience were told there are many negative pressure rooms. There are currently 4 in total – one may be alarming still (I don't know) and one is occupied.

  Therefore in terms of communicating with clinical teams those rooms should not be referred to as "negative pressure rooms " but single rooms with reduced ACH and air flow thought to be from corridor to ensuite . This may seem pedantic, but it is vital to understand that 5 D rooms – while they may be the best we have available, and the only option they are NOT Airborne isolation rooms and the implication of this need to be understood. For example should a confirm case be treated there the decontamination of the room may pose an issue in the future including the chilled beams.

In conclusion this is generally a big improvement on the last iteration and hopefully you have the information at your disposal to approve it – I don't. Is there an update on the coronavirus documentation that includes updated epidemiological definitions and cleaning protocols?

Kr

[redacted]

Dr Christine Peters
Consultant Microbiologist
QEUH
[redacted]

From: Alistair Leanord [redacted]
Sent: 31 January 2020 13:20
To: Marek, Aleksandra (NHSmail) [redacted]; Peters, Christine [redacted]
Cc: BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND) [redacted]; Joannidis, Pamela [redacted]
Subject: [ExternaltoGGC]2019 nCoV patient placement

All

See the attached draft of the current iteration of the document that was seen at AICC to be shared with the OOH teams.

In QEUH, as can be seen from the role cards, patient placement will be decided by the ID Consultant who assesses the patient. See below

Direct admission QEUH with ?nCoV2019 - Role Cards for Out of Hours team

Infectious Diseases Consultant:

- ID consultant accepts a patient for admission for? NCOV2019 from the community
- Identifies the correct destination in QEUH (mHDU or 5D) for this patient and inform the nurse in charge of the area.
    - Phone mHDU on 83058
    - Phone 5D ward on 82460
- The consultant will inform the virologist, the on-call consultant Microbiologist, and the CPHM (via switchboard)

In **GRI** Aleks Marek will distribute the relevant room information for placement with the OOH team this w.e and we will put the information into the document next week.

Cheers

Al

Louise Mackinnon

From: Peters, Christine
Sent: 19 February 2021 15:24
To: 'Philip.Raines[redacted]'
Subject: OB report
Attachments: 201709011401.pdf; NHS GGC and QEUH Oversight Board - Final Report - February 2021 - draft - COmments 2.docx

Hi Phil,
I hope you are well. I am sure you are very busy indeed at present.
Apologies as I have not had time yet to go through the timeline or the interim report. I will try to get to these before we meet on Tuesday.

I attach a copy of the report with my comments on it. In summary I feel that the report still lacks an adequacy of depth and breadth to truly bring out the key learning points and actions required to ensure assurance that the past will not repeated.

1. There is no comment on the correctness or otherwise of any of the issues raised to line managers from 2015 right through to 2021
2. There is a blanking out of the fact that concerns were raised repeatedly in writing since 2015, and information sought even before the opening of the building. I find this to be absolutely unacceptable. We would never have taken a whistle blow as a first step. Is there a suggestion that our letters of resignation, documents and emails are fake? If not there is no reason to imagine that the first time higher management were aware of issues was October 2017.
3. The points around the move from 2A to 6A are opaque re the process. This is critical to document the process as per Teresa's email.
4. There is an attempt to compromise on views regarding the safety issues. I find this to fall short of the need to establish facts and take a view on what the actual status was and continues to be in regard to the multiplicity of issues with the building.
5. In relation to identifying an expertise gap – I find this odd., We had good internal expertise that regularly sought discussion outwith the organisation BUT they were not listened to. In fact Dr Inkster is teaching a masters level course – that the external experts attend to become experts. Surely this is an oddity that shines a rather dismal light on the conclusions of the report.
6. The withholding of information is a very serious matter and was the key theme that drove us to resign in 2015 and was key to all our raising of concerns throughout the last five years. How can one reasonably expect an ICD to work in such a team from top management down where information is routinely withheld. This is dangerous and needs to be called out clearly as such. Trust is lost and has not been rebuilt as there is zero evidence to show a change in primary thinking.
7. The fact that the only 3 named individuals in the entire document are the three whistle blowers in 2017 strikes me as unreasonable. Once again whistle blowers are treated in a unique and ostracising manner particularly as concerns are noted as "alleged" . [redacted] name is not in the public domain and I think this constitutes a breach of confidentiality.

There more to be said, particularly in regard to the current state of affairs and I look forward to our meeting on Tuesday.

Kind regards,

[redacted]

Dr Christine Peters
Clinical Lead
Consultant Microbiologist

QEUH
[redacted]

Julie Rothney

From:	Peters, Christine
Sent:	24 February 2020 16:37
To:	IMRIE, Laura (NHS NATIONAL SERVICES SCOTLAND); Leanord, Alistair; Inkster, Teresa (NHSmail)
Cc:	'BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND)'
Subject:	SBAR PICU Gram Negative Infections 2020
Attachments:	SBAR PICU Gram Negative Infections 2020.doc

Hi All,

I attach an SBAR of my assessment of the PICU data over the past few days. Its far from perfect but hopefully will be helpful for IMT discussions.

Please don't hesitate to contact me for clarification on anything.

Kr

[redacted]

Dr Christine Peters
Consultant Microbiologist
QEUH
[redacted]

103. SBAR PICU Gram Negative Infections 2020

SBAR PICU Gram Negative Infections

Dr Christine Peters

24/02/2020

Situation

The PICU at the RHC has been subject to IMTs investigating the incidence of environmental gram negative infections in blood cultures and BALs . HPS requested Dr Peters input into analysing the cases from a Clinical Microbiology perspective. A list of cases was sent from HPS for review and any additional cases to be added as well as the context of environmental results.

Background

Since the opening of the PICU in 2015 there have been a number of incidents with regard to environmental gram negatives, including links to a Serratia outbreak in NICU in 2016 and with an IMT in early 2018 re Acinetobacter cases, one of whom died (Green HIATT at the time).

An increase in Acinetobacter, Serratia and Pseudomonas cases in mid 2019 triggered a number of separate PAGs, but these have been brought together as a single IMT due to the unifying hypothesis that the water/ drain and ventilation issues in RHC are likely to contribute to increased number of cases.

A number of actions taken previously have been effective in reducing Serratia infections – namely use of HPV, drain cleaning and sink management.

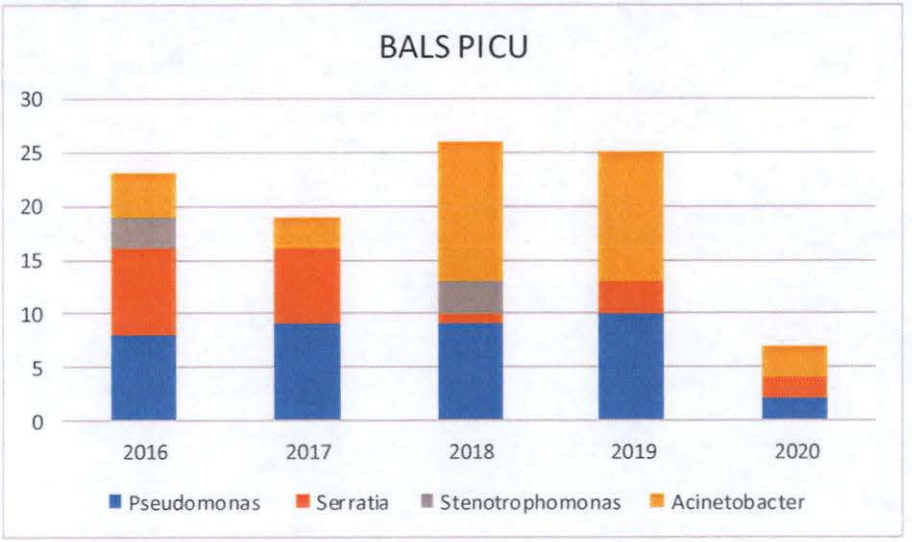
A number of actions have already been taken, but as IMT minutes have not been shared it is not possible to place in the context of the cases and timeline.

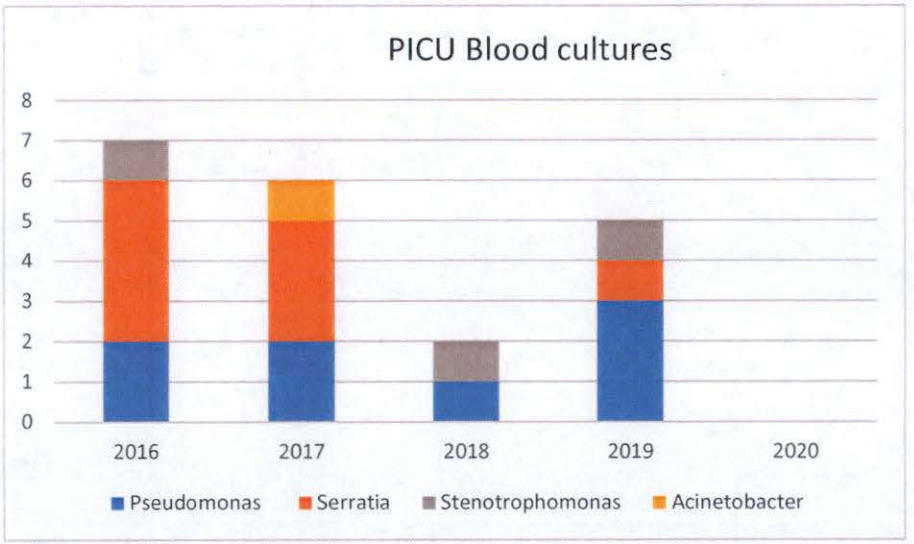
Of note two separate incidents of water ingress have occurred on the unit over the time period, with reports of water from leaking window leaking into ceiling space above nurses station and a leak into room 17 anteroom .

Assessment

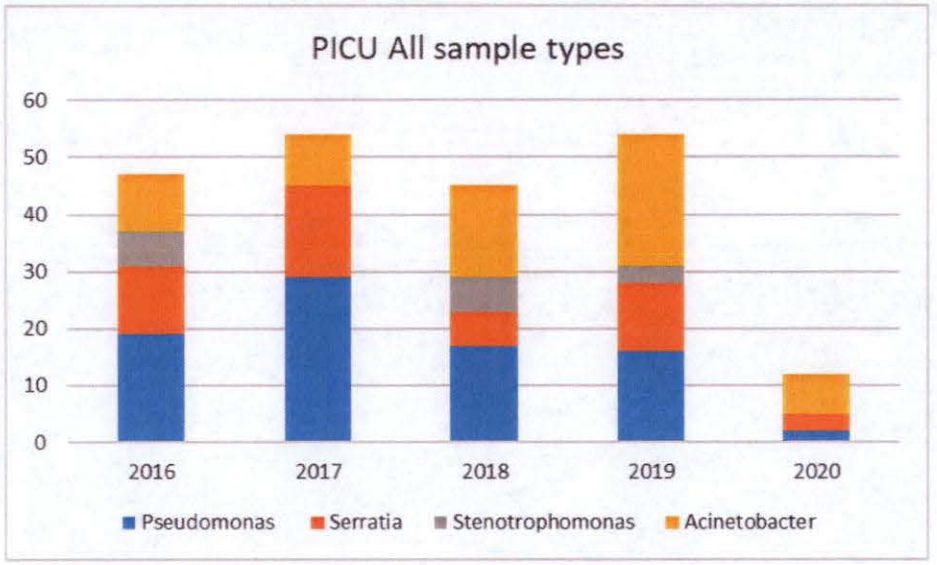
1. **Background epidemiology**

   Data was gathered from the Telepath LIMS system for all sample types taken in PICU from 2016 January to end January 2020. The Y axis is number of patients with at least one isolate in each graph.

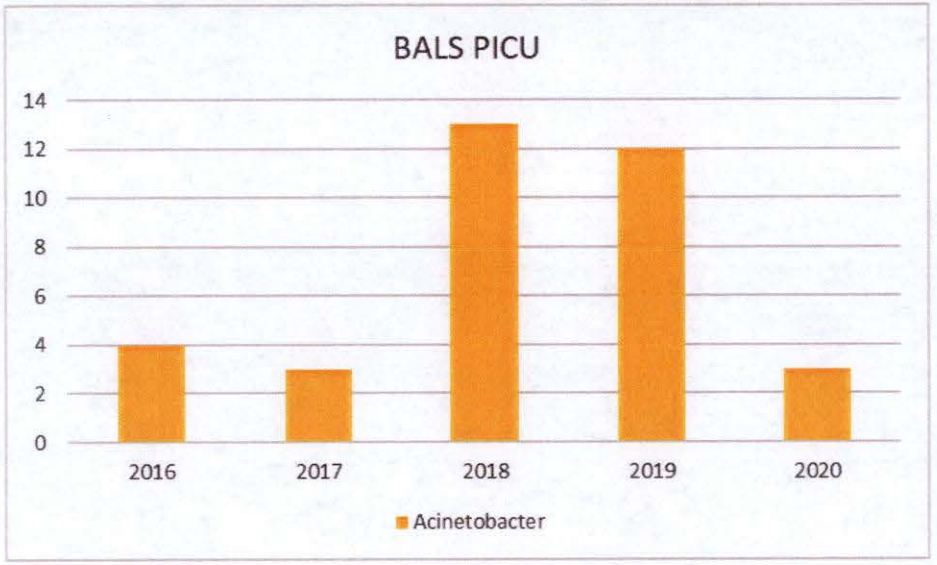

BALS PICU
30
25
20
15
10
5
0
2016
2017
2018
2019
2020
Pseudomonas
Serratia
Stenotrophomonas
Acinetobacter


PICU Blood cultures
8
7
6
5
4
3
2
1
0
2016
2017
2018
2019
2020
Pseudomonas
Serratia
Stenotrophomonas
Acinetobacter

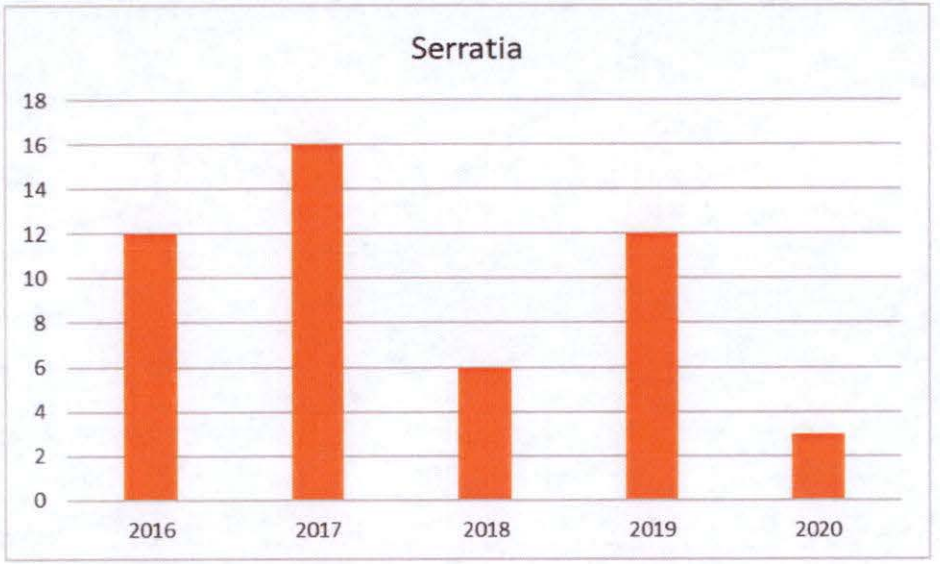
2


PICU All sample types
60
50
40
30
20
10
0
2016
2017
2018
2019
2020
Pseudomonas
Serratia
Stenotrophomonas
Acinetobacter

3


BALS PICU
14
12
10
8
6
4
2
0
2016
2017
2018
2019
2020
Acinetobacter

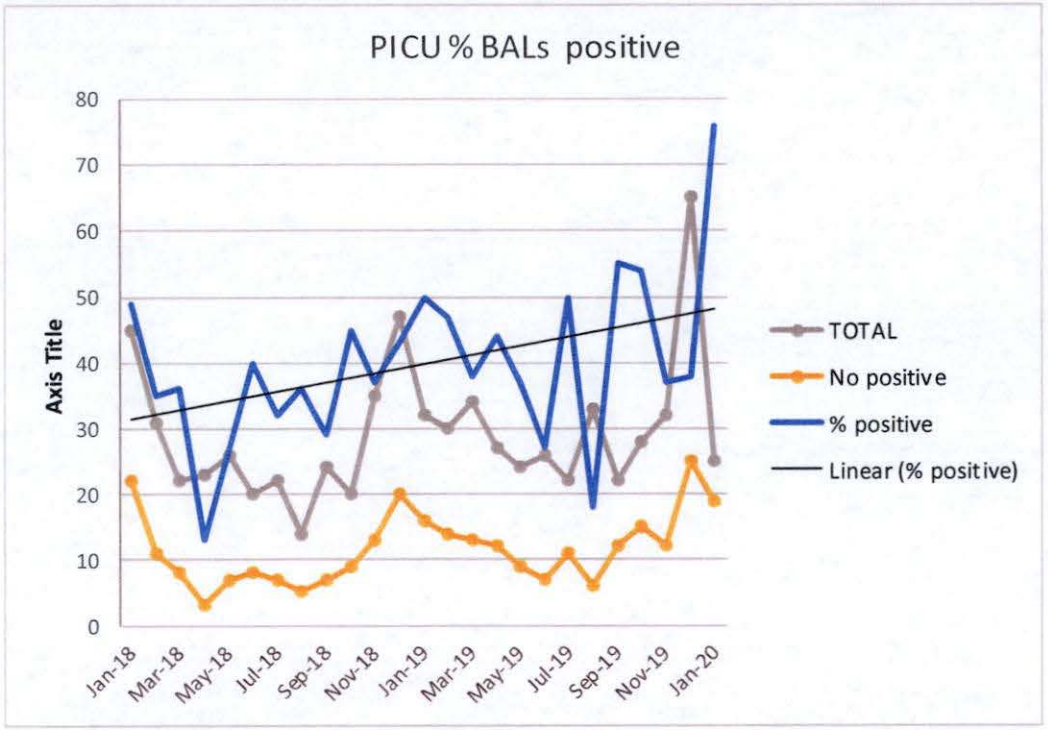
4



While Acinetobacter predominates the BAL isolates, Pseudomonas and Serratia were most common in Blood cultures. It appears that January 2020 saw a higher than expected rate of environmental gram negative being isolated from patients, however a full monthly breakdown has not been tabulated. Acinetobacter rates in BALs increased in 2018 , while Serratia decreased at the time of water incident control measures.

BAL positivity rates

There has been an increase in BAL positivity rates as per graph below, with January 2020 having the highest rate since 2015 at 76% positivity. The increase in absolute numbers of BALs in December likely reflects the rates of viral respiratory illness such as RSV .



2. Epidemiology since August 2019

The LIMS system was used to identify all sample types with Gram negatives since August 1st 2019 from samples taken on PICU. Please note this will exclude cases that may have been acquired on the unit but were discharged and subsequent samples taken elsewhere. All case histories as recorded in the Microbiology notes were used to assess briefly whether isolates were likely to represent colonisation or infection based on MDT discussions, clinical parameters and use of antibiotics. This is a rough estimate as further notes should be consulted to ascertain status of infection. The list of patients is appended. Colonisations are recorded along side HAIS on the unit as this gives the epidemiological context and can indicate burden on the unit, person to person transmission or common sources for both colonised and infected.

A total of 31 patients had HAIs with environmental gram negatives between 1st August 2019 and 31 January 2020 which includes . Table 1 shows numbers per organism, with typing clusters .

Table 1: Environmental Gram Negatives PICU 1/08/19 - 31/01/20with clustered typing subgroups

Organism	HAI	Colonised
Acinetobacter	**11**	**4**
SERN07AC-14	*4*	*1*
SERN 07AC-13	*2*	*0*
SERN07AC-12	*1*	*0*
Stenotrophomonas	**2**	**2**
Pseudomonas Total	**7**	**4**
match to appendectomy case	*1*	*0*
Cluster E	*2*	*0*
match to Cf	*2*	*0*
Serratia	**9**	**1**
SERN07SE -4	6	0
Enterobacter	**4**	**5**
Klebsiella	**5**	**2**
Other	**0**	**2**

Multiple isolates:

Patients with multiple organisms that match that are epidemiologically linked can give a strong indication to a shared source.

- One patient grew Klebsiella and *Enterobacter cloacae*
- One patient had a dual infection *Acinetobacter baumanni* and *Klebsiella pneumoniae* BAL
- One patient had *A nosocomialis* unique plus *Klebsiella pneumoniae*

- One patient grew Acinetobacter nosocomialis SERN07AC-14 (cluster type) and Enterobacter cloacae
- Two patients had HAIS BALs with the same combination of A nosocomialis SERN07AC-14 , Serratia SERN07SE-4, and Klebsiella pneumoniae

Commonalities

It is noticeable that there are commonalities within the list that warrant further delineation in:

1. Time : eg spike in numbers in January 2020
2. Place: eg bed bay 1 for Serratia case and environmental isolate
3. Person : a number of cardiac patients in the list
4. Typing Links - environmental sink isolate clusters with serratia cases SERN07SE-4

3. Environmental Samples

Accommodation on PICU

It is important to understand that there are four , four bedded bays on the unit therefore proximity to an environmental source should include isolates from CHWS within the room , not just at the bed bay.

Beds 1,2,3,4 in one bay

Room 5 negative pressure room with negative pressure cascade

Beds 6 and 7 are neutral pressure single rooms

Beds 8,9,10,11 in one bay

Bed 12 PPVL

Beds 13,14,15,16 in one bay

Bed 17 : PPVL (experienced recent leak into anteroom)

Bed 18 PPVL with HEPA supply

Bed 19,20,21,22 in one bay

Laboratory Results

During the water incident IMT in 2018 and Serratia incident in NICU in 2016, and Klebsiella in Philipshill typing of organisms in the environment matched cases in infections due to Enterobacter, Klebsiella and Serratia .

A total of 72 isolates from environmental screens from PICU were identified in the new laboratory generated database plus looking through paper reports. All of these isolates were from sinks and drain samples which would target water and biofilm type organisms and may miss Acinetobacter which is resistant to desiccation and can be found in dust and dry surfaces.

Interestingly only two samples grew *Acinetobacter species*, while 24 grew *Pseudomonas species*, 8 *Serratia* sp , 24 grew *Enterobaacter sp*, 5 *Burkholderia sp*, And while Klebsiella is not recorded in any- it is not clear whether on each occasion Klebsiella was requested to be reported as a target organism – this needs clarification.

One water sample within the last month also grew Pseudomonas and Enterobacter species. These have not been typed as far as information to date suggests.

Of the environmental isolates PFGE typing was carried out on 2/8 *Serratia* isolates, 1/20 *Pseudomonas aeruginosa* , and 2/5 *Burkholderia,* 0/24 Enterobacter, 0/1 Sphingimonas , 0/8 *Stenotrophomonas*. Therefore it is hard to e conclusive regarding the range of strain types in the environment .

Of note Theatre Environmental testing from interventional radiology and anaesthetic rooms grew *Stenotrophomonas, Serratia, Enterobacter, Klebsiella pneumoniae* on 04/06/19, and *Enterobacter cloace*, *Pseudomonas aeruginosa* and *nitroreducens*, *Stenotrophomonas* on 30/10/2018

The environmental results need to be interpreted in context of reasons why swabs were taken, what cleaning had occurred and whether patients had been colonised/ infected who had been in proximity to the sites sampled. This information is not available at this time.

Overall *Serratia, Pseudomonas* and *Acinetobacter* typing results highlight case links to NICU, Sinks and drains, and between patients, illustrating a complex interplay of potential environmental sources, in keeping with what has already been experienced in the hospital , coupled with possible patient to patient cross transmission as well as staff moving between units.

4. **Ventilation**

In July 2019 the first validation of the PICU ventilation was carried out since opening and a number of derogations from SHTM standards were noted (SBARS and options appraisals previously forwarded). Of particular importance was the presence of grills in the ceilings allowing dust from the ceiling void into the unit , gaps in validation data and pressure cascade not being the positive 10 pascals as per recommendations. It seems at present the unit is designed to work at 2 pascals positive pressure , which is a very minimal pressure and rebalancing may have altered air flows throughout he unit. This is of particular interest for Acinetobacter, but may also affect other gram negatives if aeroionisation takes place. Dates of any HAIscribes and ventilation works need to be plotted on the time line.

Furthermore during investigations for Cryptococcus sources a storage room was noted to have poor ventilation and tubing for ventilation equipment was stored there. It would be important to ascertain the current condition of this room.

5. **Sinks**

Relevant organisms have been isolated for the drains of the sinks and this is similar to the situation in 2A previously. Trough sinks exist in the unit and these were recommended to be removed previously.

6. **HPV use**

Dr Inkster can update on effectiveness in previous gram negative outbreak situations

Recommendations

1. A timeline including all colonised and infected patients for the time period is drawn up with attention to bed location and theatre visits and dates of procedures as well as significant incidents such as water leak/ingress/ HAISCRIBEs/ Ventilation parameters being altered.
2. Previous HPV experience to be investigated by discussion with Dr Inkster , noting risks of leakage if ventilation is not fully understood.
3. Reassessment of Pseudomonas cases that were categorised as colonisations and non HAIs
4. Investigation of BAL procedures for any possible route of entry into BAL sample or lung
5. Co-ordination of environmental testing to include dry sites, bacterial air sampling and to note patient locations including theatres

6. Typing of relevant environmental isolates
7. Full assessment of current status of ventilation parameters throughout the unit and theatres
8. Data on antibiotic use on unit
9. Reassessment of actions and triggers
10. Regular drain cleaning (assume in place?) in 1D and theatres
11. Sink hygiene training and signage (already in place?)
12. Sink cleaning SOPS to ensure minimisation of retrograde contamination of POU filters.

Appendix 1: Case List

IMT Gram negative isolates in Ward 1D, RHC from 01/08/19

Acinetobacter species

Environmental positive samples

05/06/2018	**/BED 8, SINK DRAIN**	**Acin. gyllenbergii**
05/06/2018	**/ROOM 17 ENAMEL SINK DRAIN**	**Aci. haemolyticus**

PATIENT'S NAME	CHI	DOA/DOD	Positive Site	Organism	Date Positive	HAI	Typing	Colonisation/Infection
[redacted]	[redacted]	[redacted]08.19 – [redacted]09.19	Blind BAL	A.nosocomialis	[redacted].08.19	Y(1D)	Sern07AC-13	Infection
[redacted]	[redacted]	[redacted].09.19- [redacted].10.19	Blind BAL	A.nosocomialis	[redacted].09.19	N	Sern07AC-14	Infection (previous NICU and PICU admissions)
[redacted]	[redacted]		WS	A nosocomialis	[redacted]/10/2019	?Y	SERN07AC-13	Cardiac patient not treated ?
[redacted]	[redacted]		BAL	A baumanni	[redacted]/09/19	Y	Unique	Infection treated
[redacted]	[redacted]		Blind BAL	~~A.baumannii~~	[redacted].10.19	Y (1D)	Sern07AC-13	Infection

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		[redacted].08.19 - [redacted].11.19 (DIED)		A.nosocomialis				
[redacted]	[redacted]	[redacted].11.19 –	Blind BAL	A.nosocomialis	[redacted].12.19 [redacted].01.20	Y (1D)	Sern07AC-14	Infection
[redacted]	[redacted]	[redacted]07.19 –	Blind BAL	A.nosocomialis (prev ~~A.baumannii~~ complex 03.11.19)	[redacted].11.19 [redacted].12.19 [redacted]/02/20	Y (3A) (HAI 3a)	Sern07AC-14	~~Colonisation~~ Patient was treated with Mero Clinically infection See PNP
[redacted]	[redacted]	[redacted].12.19 –	Blind BAL	A.nosocomialis	[redacted].01.20	Y (1D)	Sern07AC-14 ~~Sent~~	Infection
[redacted]	[redacted]		CSF	A baumanii	[redacted]/08/19	Y (3A)	Unique	EVD infection (died)
[redacted]	[redacted]		WS – burns site hand and foot	A calcoaceticus	[redacted]/08/19	Y (1D)	unique	Burns site infection (died for other reasons)
[redacted]	[redacted]		TS	A nosocomialis	[redacted]/09/19	N	Unique	Colonisation
[redacted]	[redacted]		WS BAL	A nosocomialis A baumanni	[redacted]/10/19 [redacted]/01/20	Y (1D)	Unique ? not typed	unclear
[redacted]	[redacted]		Neck wound	A pitti	[redacted]/01/20	N (1D acquired colonisation)	unique	Colonisation

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[redacted]	[redacted]		WS Also BAL 1E	A nosocomialis	[redacted]/01/2020	Y (?1D ? 1E)	SERN07AC-12 Matches 2 other patients : [redacted] [redacted] PICU [redacted]/01/19 AND ortho patient [redacted]/10/19	Cardiac wound infection
[redacted]	[redacted]		WS face	A ursingii	[redacted]/01/2020	Y 1D		Multi organism burns infection

Pseudomonas aeruginosa

05/06/2018	/ROOM 6, SINK DRAIN /ROOM 12,ANTE ROOM	Ps. aeruginosa
05/06/2018	SINK DRAIN	Ps. aeruginosa
05/06/2018	/BED 8, SINK DRAIN	Ps. aeruginosa
05/06/2018	/BED 8, SINK DRAIN	Ps. fluorescens
05/06/2018	/BED 3, SINK	Ps. aeruginosa
05/06/2018	/BED 3, SINK	Ps. fluorescens
05/06/2018	/ROOM 18, ARK ROOM SINK	Ps. aeruginosa
05/06/2018	/BED 19, ENAMEL SINK	Ps. aeruginosa
05/06/2018	/BED 4, SINK DRAIN	Ps. aeruginosa
05/06/2018	/BED 12, SINK INSIDE ROOM	Ps. aeruginosa

05/06/2018	/BED 10 SINK	Ps. aeruginosa
05/06/2018	/BED 17, ANTE ROOM SINK /BED 14, ENAMEL SINK	Ps. aeruginosa
05/06/2018	DRAIN /ROOM 18, SINK DRAIN	Ps. aeruginosa
05/06/2018	MAIN ROOM	Ps. aeruginosa
05/06/2018	/052 SLUICE ENAMEL SINK /ROOM 17 ENAMEL SINK	Ps. aeruginosa
05/06/2018	DRAIN	Ps. aeruginosa
09/12/2019	/Bed 2, Drain	Ps. Nitroreducens
17/12/2019	/Bed 10, CHWB Drain	Ps. aeruginosa
17/12/2019	/Bed 11, CHWB Drain	Ps. Aeruginosa UNIQUE
17/12/2019	/Bed 14,CHWB Drain	Ps. Nitroreductens
17/12/2019	/Bed 16,CHWB Drain	Ps. aeruginosa
15/01/2020	Bed 3 inner drain	Ps aeruginosa
20/01/20	/bed 10 drain inner	Ps aeruginosa

20/01/2020 bed 8 Ps aeuruginosa

PATIENT'S NAME	CHI	DOA/DOD	Positive Site	Organism	Date 1st Positive	HAI	Typing	Colonisation/Infection
[redacted]	[redacted]		TS	*P aeruginosa*	[redacted]/08/19	Y (3C)	Unique	Colonised Renal transplant patient

[redacted]	[redacted]	[redacted]/09/19 – [redacted]/09/19 (Died)	BBAL + Wound swab cardia	*P.aeruginosa*	[redacted].09.19	~~N~~ Y (admitted [redacted]/9 , positive [redacted]/09)	Match with 2C Patient [redacted] post appendectomy pus [redacted]/04 ~~Unique~~	~~Colonisation~~ Cardiac ECMO patient s
[redacted]	[redacted]	[redacted]/10/19 – [redacted]/11/19 (Died)	Blood Culture Central line, ECHMO line, peritoneal fluid	*P.aeruginosa*	[redacted].11.19	Yes – 1D	~~Unique~~ Matches CF patient [redacted]	~~Colonisation~~ Blood stream infection (previous negative cultures)
[redacted]	[redacted]	[redacted]/11/19 - [redacted]/12/19	BBAL	*P.aeruginosa*	[redacted].11.19	Yes – 1D	Unique	?Infection - unclear
[redacted]	[redacted]		CCU/TS	*P aeuriginosa*	[redacted]/12/19	Y (1D)	cluster E similar [redacted]	Infection treated
[redacted]	[redacted]		Groin TASP	*P aeriginosa*	[redacted]/10/19	N	Matches CF patient [redacted]	Long term colonised
[redacted]	[redacted]		BAL	*P aeriginosa*	[redacted]/11/19	N	Clone C	Long term colonised
[redacted]	[redacted]		BAL	*P aeriginosa*	[redacted]/12/19	Y (1D)	cluster E similar [redacted]	Infected
[redacted]	[redacted]		BAL	*P aeriginosa*	[redacted]/10/2019	Y (1d in june 2019)	Sent	Colonisation first then infection treated

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[redacted]	[redacted]		BAL	*P aeruginosa*	[redacted]/01/2020	N	Unique	Long term colonised CF
[redacted]	[redacted]	[redacted]/09/2019	TS/ BAL	*P aeruginosa*	[redacted]/09/2019 [redacted]/09/2019	N	PA14 CLONE	Long term colonised Intermittent treatment

Serratia marcescens

05/06/2018	**/SINK OUTSIDE BEDS 18-22**	**Ser. marcescens**
05/06/2018	**/BED 22 TROUGH SINK DRAIN**	**Ser. marcescens**
04/07/2018	**/TROUGH SINK DRAIN**	**Ser. marcescens**
09/12/2019	/Bed 1, Drain	Ser. Marcescens SERN07SE-4 Cluster s
17/12/2019	**/Bed 11, CHWB Drain**	**Ser. marcescens**
17/12/2019	/Bed 13,CHWB Drain	Ser. marcescens
15/01/20	/ Bed 1 drain inner + outer	Ser marcescens SERN07SE-4 CLUSTERS with cases
20/01/2020	/bed 11, drain outer	Ser marcescens

PATIENT'S NAME	CHI	DOA / DOD	Positive Site	Organism	Date 1st Positive	HAI	Typing	Colonisation /Infection
[redacted]		[redacted].11.19 – [redacted].11.19	Blood Culture Dialysis line and CL and PV	Serratia *marsecsens*	[redacted].11.19	Y(1D)	SERN07SE-21	~~Unknown~~ Yes, died, serratia isolated from multiple PM sites
[redacted]		[redacted].12.19 – [redacted].12.19	BBAL	Serratia *marsecsens*	[redacted].12.19	Y (1D)	SERN07SE-4	Infection
[redacted]		[redacted]10.19 –	BBAL	Serratia	[redacted].01.20	Y(1D)	SERN07SE-4	Infection but multiple

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				marsecsens				bacteria, not clear which is causative ? Repeated serratia in BAL, treated with antibioticic indreased secretions and thought o be infection.
[redacted]	[redacted]		BBAL	Serratia *marsecsens*	[redacted].01.20	Y (1D)	SERN07SE-4	Colonised the treated with mero – multiple organisms involved
[redacted]	[redacted]		Eye swab	Serratia *marsecsens*	[redacted]/08/2019	Y (1D) since 01.19	SERN07SE-4	No Long term colonised
[redacted]	[redacted]		Eye and tons	Serratia *marsecsens*	[redacted]/11/2019	Y (1D)	Unique	Infection treated with cipro , post RSV infection
[redacted]	[redacted]		BAL	Serratia *marsecsens*	[redacted]/06/19 (previously positive [redacted]/02/19)	Y (1D)	SERN07SE-4	Long term colonisation and repeat treatment courses . Also PA and P stutzeri previously
[redacted]	[redacted]		TS	Serratia	[redacted]/06/2019	Y (1E)	SERN07SE-19	Cardiology

				marsecsens			(1E) **Matches neonatal isolate from 2017**	patient . ? colonisation
[redacted]	[redacted]		Eyes/TS	Serratia *marsecsens*	[redacted]/01/2020	Y (NICU)	SERN07SE-4	Cardiac patient , also klebsiella and acinetobacter treated to cover all.
[redacted]	[redacted]		Pus ETA	Serratia *marsecsens*	[redacted]/08/2019	N Ex NICU	Unique (2018)	Lomg term colonised then wound infections

Klebsiella pneumoniae

Patient ID	CHI	DOA/DOD	Positive site	Organism	Date of positive	HAI	Typing	Colonisation/Infection
[redacted]	[redacted]		BAL	*Klebsiella pneumoniae*	[redacted]/10/2019	Y		Multimicrobial treated with antibiotics to include kleb cover

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[redacted]	[redacted]		BAL	*Klebsiella pneumoniae*	[redacted]/09/2019	Y		Infection ECHMO , multimicrobial treated with mero
[redacted]	[redacted]		BBAL	*Klebsiella pneumoniae*	[redacted]/10/2019	Y		Infection, multimicrobial ECMO
[redacted]		[redacted].01.20 – [redacted].01.20 [redacted].01.20 – [redacted].01.20 [redacted].02.20 -	BBal	*Klebsiella pneumoniae*	[redacted].01.20 *Multiple sites positive since [redacted].03.19	Y		~~Colonisation~~ Treated with mero to cover all organisms.
[redacted]	[redacted]	[redacted].12.19 – [redacted].02.20	BC	*Klebsiella pneumoniae*	[redacted].01.20	Y (1D)		Infection line infection Cardiac patient
[redacted]	[redacted]		BBAL	*Klebsiella pneumoniae*	[redacted]/01/2020	?		Complex long term patient , infection CSF with klebsiella
[redacted]	[redacted]		BBAL	*Klebsiella pneumoniae*	[redacted]/01/2020	N		Long term cardiac complex patient

Burkholderia cenocepacia

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Environmental samples

	/BED 22 TROUGH SINK	
05/06/2018	**DRAIN**	**Burk. cenocepacia**
04/07/2018	**/TROUGH SINK DRAIN**	**Burk. cepacia**
17/12/2019	/Bed 9,CHWB Drain	Burk. Cepacia UNIQUE
15/01/2020	Bed2 drain inner	Burk cepacia B cepacia UNIQUE
20/01/2020	/bed 11, drain outer	

Patient ID	CHI	DOA/DOD	Positive site	Organism	Date of positive	HAI	Typing	Colonisation/Infection
[redacted]	[redacted]	[redacted].01.20 – [redacted].01.20	BBal	*Burkholderia cenocepacia*	[redacted].01.20	N	Unique	Colonisation acquired 1D

Enterobacter

Environmental Positives

05/06/2018	**/ROOM 6, SINK DRAIN**	**Ent. cloacae**
05/06/2018	**/BED 8, SINK DRAIN**	**Ent. cloacae**

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05/06/2018	**/BED 8, SINK DRAIN**	**Ent. kobei**
05/06/2018	**/BED 3, SINK**	**Ent. cloacae**
05/06/2018	**/BED 19, ENAMEL SINK**	**Ent. cloacae complex**
05/06/2018	**/BED 4, SINK DRAIN**	**Ent. cloacae**
05/06/2018	**/BED 10 SINK**	**Ent. cloacae**
05/06/2018	**/BED 14, ENAMEL SINK DRAIN**	**Ent. cloacae**
05/06/2018	**/ROOM 18, SINK DRAIN MAIN ROOM**	**Ent. cloacae**
09/12/2019	**/Rm5, ANTE-ROOM DRAIN**	**Ent. cloacae**
09/12/2019	**/Rm5,Main Room Drain**	**Ent. cloacae**
09/12/2019	**/Rm5,Main Room Drain**	**Ent. kobei**
09/12/2019	**/Room 6 Drain**	**Ent. kobei**
09/12/2019	**/Bed 2, Drain**	**Ent. kobei**
17/12/2019	**/Bed 11, CHWB Drain**	**Ent. cloacae**
17/12/2019	**/Bed 14,CHWB Drain**	**Ent. cloacae**
17/12/2019	**/Bed 14,CHWB Drain**	**Ent. cloacae**
17/12/2019	/Bed 15, CHWB Drain	Ent. horm
17/12/2019	**/Bed 16,CHWB Drain**	**Ent. cloacae**
15/01/20	**/Bed 5 anteroom drain inner**	**Ent cloacae**
15/01/2020	**Bed 3 drain inner**	**Ent cloacae**
20/01/2020	**/bed10 Drain inner**	**Ent cloace**
20/01/2020	/bed 11, drain outer	
20/01/20 / bed 6, drain inner		

Patient ID	CHI	DOA/DOD	Positive site	Organism	Date of positive	HAI	Typing	Colonisation/Infection
[redacted]	[redacted]		BAL	Enterobacter	[redacted]/12/2019	?N		Infection , treated, but long term patient

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[redacted]				cloacae				difficult to interpret
[redacted]	[redacted]		BAL	Enterobacter cloacae	[redacted]/08/2019	N		Admitted with cryptic infection, not specifically treated but acquired on unit
[redacted]	[redacted]		BAL	Enterobacter cloacae	[redacted]/12/2019	Y		Multi microbial infection treated with mero
[redacted]	[redacted]		BBAL	Enterobacter cloacae	[redacted]/9/19	Y 1D		Cardiac patient , multi microbial sternal wound and ? chest infection
[redacted]	[redacted]		BAL	Enterobacter cloacae	[redacted]/09/2019	Y		Infection ECHMO , multimicrobial treated with mero
[redacted]	[redacted]		BBAL	Enterobacter cloacae	[redacted]/09/2019	Y (NICU) previously		CARDIAC, NICU acquired
[redacted]	[redacted]		Line site swab	Enterobacter hormaechei	[redacted]/102019	N		Colonisation
[redacted]	[redacted]		ETA	Enterobacter cloacae	[redacted]/09/2019	N		Colonisation
[redacted]	[redacted]			Enterobacter cloacae	[redacted]/09/2019	N		Cardiac patient, respiratoryinfection,

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								causative org unclear

Stenotrophomonas

Environmental positive sites

05/06/2018	**/BED 3, SINK**	**Steno maltophilia**
05/06/2018	**/ROOM 18, ARK ROOM SINK**	**Steno maltophilia**
05/06/2018	**/BED 19, ENAMEL SINK**	**Steno maltophilia**
09/12/2019	**/Rm5, ANTE-ROOM DRAIN**	**Steno maltophilia**
09/12/2019	**/Room 6 Drain**	**Steno maltophilia**
10/12/2019	**/Water from leaking ceiling**	**Steno maltophilia**
17/12/2019	**/Bed 8,CHWB Drain**	**Steno maltophilia**
11/02/20	**Bed5 , ante room dtrain outer**	**Steno maltiphilia**

Patient ID	CHI	DOA/DOD	Positive site	Organism	Date of positive	HAI	Typing	Colonisation/Infection
[redacted]	[redacted]		WS	*Stenotrophomonas maltophilia*	[redacted]/12/2019	N	Unique	Colonisation wound site
[redacted]	[redacted]		BBAL	*Stenotrophomonas maltophilia*	[redacted]/09/2019	Y	SERN07SM-13 matches [redacted] QEUH [redacted].04.19	VAP treated with levo

[redacted]	[redacted]		BC	*Stenotrophomonas maltophilia*	[redacted]/08/2019	Y (6A)	Unique	Yes
[redacted]	[redacted]		TS	*Stenotrophomonas maltophilia*	[redacted]/10/2019	N(1D)	Not done	Colonisation

OTHER

05/06/2018 /BED 7 SINK Sphinob. thalpophilu
10/12/2019 Water leak ceiling Sphingimonas paucimobilis

Patient ID	CHI	DOA/DOD	Positive site	Organism	Date of positive	HAI	Typing	Colonisation/Infection
[redacted]	[redacted]		CSU	*Sphingomonas paucimobilis*	[redacted]/01/2020	N		Colonisation

Cabinet Secretary for Health and Sport
COMMS : Ministerial Private Offices

Scottish Government
Riaghaltas na h-Alba
gov.scot

T : [redacted]
E : [redacted]

Dr Christine Peters
[redacted]

Our Reference: 202000016124
Your Reference: Meeting at Queen Elizabeth University

27 February 2020

Dear Dr Peters,

Thank you for your letter of 6 February. I am very glad to hear that you are holding regular meetings with Professor Bain and that you are beginning to see a change for the better.

I would be happy to meet with you and Dr Inkster. I plan to visit the Queen Elizabeth University Hospital on Monday 2 March and I expect that colleagues in NHS Greater Glasgow and Clyde will be in touch with you to arrange a suitable meeting time.

Thank you again for writing to me and for all your efforts to improve infection prevention and control at the QEUH.

Yours sincerely,

[redacted]

[redacted]
Private Secretary

107. RE Summing up

Julie Rothney

From: BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND) [redacted]
Sent: 01 March 2020 17:26
To: PETERS, Christine (NHS AYRSHIRE AND ARRAN); INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Subject: RE: Summing up

Many thanks for doing this Christine, it's really helpful. I have added a few comments (in blue) to your notes below.

Both Angela and Jenny are keen to get meetings with you over the next week or so (possibly together for the first meeting might be more efficient for you both?). I will send an introduction email so that they have your contact details.

As you know I will be away from Wednesday and back w/c 16 March. If you both can let me know suitable times for you it will be good to get a catch up set up for that week.

Kind regards
Marion

Professor Marion Bain
Director of Infection Prevention and Control
NHS Greater Glasgow and Clyde

Senior Medical Consultant
NHS National Services Scotland

Mob: [redacted]

From: PETERS, Christine (NHS AYRSHIRE AND ARRAN) [redacted]
Sent: 28 February 2020 16:56
To: BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND) [redacted]
Cc: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted]
Subject: Summing up

Hi Marion,
I thought it may be useful to summarise where I think we have got to with all the discussions and actions around IPCT .

1. Patient placement policy:

We have both had input into commenting on draft policy and the
most recent iteration was circulated last Friday, with come comments taken on board. I have not sent further comments as I still think my previous comments are valid. It is not clear if the policy has been widely circulated given that ITU manager was querying yesterday.
One critical piece of information this week has been the recognition of GGC that there are issues with the PPVL design and building that the court summons refers to this . In the light of this my comments pertaining to the acceptability of PPVL for airborne infection is even more important.
Furthermore although there is no reference to the AHUs themselves in the court summons, it is important for anyone making the risk assessment on patient placement to fully understand the status of these AHUs.

Angela is now actively taking forward the additional areas. She has the outstanding requirements and I know that progress is being made. She will be keen to cover this and update you when she meets with you.

2. Water damage policy

Teresa submitted her draft policy and this week there is clearly a need for this implementation in light of court summons as already agreed and this has already been taken forward by IPCT

A SOP has been prepared (based on Teresa's work) and is with various colleagues for comments by end of this coming week. Again it is part of what Angela is ensuring progress and completion around.

3. Water actions
No mention of taps in court summons, however outstanding actions from the water technical group included replacement of all taps in critical care areas - incomplete. This overlaps with our comments on the public statements and outstanding actions

I wasn't aware of this – let me bring it to Angela's attention too.

4. Communications from IPCT
To be highlighted as an area for improvement. This continues to be a problem with chicken pox incident and contacts requiring VZIG not highlighted to clinical team from IPCT, and damage and leaks to rooms in critical areas- this important for diagnostic alertness and choices of therapy for non ICDS

Agree – and it will be one of my recommendations around IPC systems and processes in GGC. In the shorter term I am discussing this with Angela and we will both consider what can be done.

5. Staffing in Microbiology QEUH
to be taken forward under OD work - this continues to be a significant limiting factor for the QEUH team in terms of ability to deliver a service. As mentioned the Consultants post at QEUH which is being advertised is to include 6 sessions of ICD, and is likely to deter applicants and cannot be seen as a solution to the IPCT problems, rather this will exacerbate significantly the already toxic atmosphere in Microbiology .

Agree – important to consider within the OD work. And it will also feature in my recommendations around IPC systems and processes in GGC - workforce planning in its widest sense.

6. Governance issues

Cryptococcal group reporting and actions in the light of significant air sampling findings
SCI process
Duty of candour
Whistleblowing management - no update on the 6A IMT process

This is all to be taken forward under OD we understand.

Yes, that's right. I have also highlighted your whistleblowing process concerns again with Fiona McQueen and she has indicated she will also be raising this with GGC.

7. Cultural issues

We do not feel there has been progress in this regard, with our situation continuing to be difficult however we understand Bullying and dysfunctionality of team which has affected the safe practice of infection control is to be explored as part of OD

The cultural aspects will be key in the OD work. I have outlined this in general terms with Jenny Copeland but you will have the opportunity to expand on this when you meet with her.

8. Accuracy of Public statements

Raised multiple times and you are planning to put together proposed statement updates that we can review.

At our last meeting we briefly discussed how to do this in the most constructive way for families and patients, hopefully building on how we were able to work together to shape the recent GGC response to the Summons document - and also potentially positioning the additional information in the context of the Summons. I have asked for some drafts to be prepared which we can discuss together when I am back w/c 16 March.

9. PICU
I have submitted an SBAR to HPS and AL regarding this and Angela will take forward continuing actions

I am now chairing a regular PICU IPC Review Meeting, and Angela is ensuring the required actions are being progressed. We both welcomed the rigour of your SBAR that you prepared for HPS.

10. Case note review
I put in comments to the tool to the group and submitted all the cases identified through the LIMS system.

Many thanks for that.

That's all I can think of just now,

The other matter which I have looked into was the HSE matter that Teresa raised around 4C. I have been told that there has been a more recent meeting which involved the Haematology CD and the lead clinician to discuss the suitability of the rooms for the full spectrum of patients. As you know GGC have appealed against the HSE decision – but the outcome of that is of course still to come. We can pick this one up again when we next meet.

hope you have a good weekend,

kr
Christine

Inkster, Teresa

From:	Jenny Copeland
Sent:	03 March 2020 19:18
To:	PETERS, Christine (NHS AYRSHIRE AND ARRAN); INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE); WALLACE, Angela (NHS FORTH VALLEY)
Subject:	Confidential: Draft docs from today's meeting 3.3.20
Attachments:	Summary of converstion 3.3.20 draft 1 .docx; GGC ICT Issue and Resoluton Log.docx

Hi All.

Thank you so much for meeting us today and I do hope you found it helpful even in the smallest way.

Please accept these documents as a very early and incomplete 1st draft.

We will continue to develop them on Thursday however any work you can do in the meantime would be extremely helpful.

I think our first focus will be on the Issue and Resolution document.

This will be an iterative process and I do hope we can achieve a positive outcome for you and the patients, the team and the organisation.

Best regards.

Jenny

Jenny Copeland
Principal Lead CNO SEND
Leadership and Talent
NHS Education for Scotland
T: [redacted]
E: Jenny.copeland[redacted]

Organisational Development, Leadership & Learning

GGC ICT Issue and Resolution Log

	Theme	Desired Outcome and	Desired state and actions	Owner	By date	Status
1	**Patient safety**	**Objective: Patients safety and convincingly evidenced risk mitigation**				
1.1		Acknowledging all that has been done there remain concerns relating to the original 27 issues raised in 2017 1. Original 2017 response has inaccuracies (Jennifer Armstrong, Sandra McNamee, Brain Jones) Viewing this document in Feb '18 triggered WB Stage 2 by PR, CP 2. June '19 draft update has inaccuracies. No final version has been provided Lack of clarity of issues The risks are not mitigated to date and there continue to be risks of infection. This is the biggest reason to continue to raise concerns	A collaborative approach to reviewing the 27 points with a view to creating a full sign off resolution and action plan for each point that meets the scrutiny and provides assurance to the original report authors			
1.2		6a: BMT: Patients continue to be at risk due to: 1. ACH 2.5 – 3 2. No positive pressure 3. Hepa filtration not at point of supply 4. Aire sampling results above BMT standards	Revisit option appraisal in order to assure current arrangement is optimal given 2A status and to craft patient communication that explains current scenario			
1.3		4c: Mould in bathrooms. HSE improvement notice 1. ACH 2.5 – 3	Review the HSE recommendations and report progress against them			

	Theme	Desired Outcome and	Desired state and actions	Owner	By date	Status
		2. No positive pressure 3. Hepa filtration not at point of supply 4. Aire sampling results above BMT standards				
1.4		**PICU**: Ventilation outstanding actions	Review of outstanding actions providing assurance of patient safety			
1.5		**Water system**: Outstanding actions tap replacement and overview of all results	Review of outstanding actions providing assurance of patient safety			
1.6		**Cryptococcal:**				
1.7		**Mucor:**				
1.8		Poorly defined roles and responsibilities that impedes effective team working and service provision: ICD: Medically trained, Royal College of Pathologists accredited and GMC appraisal assurance – **current, evidenced based, clinically relevant, expert management of situation and outbreak management** ICN: Qualified and skilled to implement and maintain a safe IC system Are the IC team able to do their job? - Surveillance - Responses	Clear roles and responsibilities for governance and reporting structures			

	Theme	Desired Outcome and	Desired state and actions	Owner	By date	Status
1.9		IPC workplan has had responsibility for work packages changed without agreement	Clear role for the ICD			
1.10		Multiple lines of uncoordinated advice to the CE impairs clean evidence-based ICD informed decision making	ICD has a direct line of communication and decision making with the CE			
1.11		The team is not openly communicating with all constituents	An open and transparent communication structure based on professionalism and mutual trust			
1.12		Due to lack of clarity and R&R rules advice is not valid pre 5pm but is after specifically to Christine and Teresa	Clinical Microbiologists role to be clarified and understood in relation to IC			
2	**Duty of Candour**	**Objective: Duty of Candour to patients and public**				
2.1		Culture of not documenting information				
2.2		Press releases and public comms are not accurate	Chair of IMT (ICD) agrees press releases with Comms department ensuring accuracy			
		Information on web site carries inaccuracies	Joint review of web information to agree acceptable wording CP/TI and CW to jointly review supplementary wording (suggestion)			
3	**Learning System**	**Objective: Evidence of embedded, transparent and shared learning**				

	Theme	Desired Outcome and	Desired state and actions	Owner	By date	Status
3.1		Does the Board understand the role and value of ICD in advising of evidence-based risk, status, mitigation and resolution plan?	ICD presents in person evidence-based risk, status, mitigation and resolution plan and ongoing status			
3.2		Lack of closed loop learning and development on the back of systemic learning	Transparent SAER / AER process applied and adhered to			
3.3		Proposal to be world class not supported ICNs not supported to attend conferences	Opportunity to be World Class IPCT driving research and innovation to IP and C			
4	**Sustainable service**	**Objective: A sustainable and future proofed IPCT service**				
4.1		Under resourced Lack of continuity and insufficient resource to support specialties and areas of responsibility resulting in a lack of expertise and firefighting within the service Lack of research, development and University status activities	Proposal for 6 ICDs plus 1 Lead ICD across the city e.g. 25 sessions			
4.2		Status dashboard did exist weekly and during outbreaks not sure if it still exists however site-specific distribution not widespread	Daily service dashboard that facilitates decision making and actions for the ICD and distributed to relevant teams: • Incidents • Staffing			

	Theme	Desired Outcome and	Desired state and actions	Owner	By date	Status
4.3		Medical Handover non-existent for Microbiologists in ICT	Daily quality medical handover for Microbiologists			
4.4		The CMs are awaiting a safe environment in order to embrace ICD status	Qualified IC practitioners are ICDs			
4.5		Since the formal Whistleblowing the treatment of WBs has been detrimental Microbiology team at QEUH have expressed concerns regarding culture and behaviours	Transparent process to assess culture for Microbiology and IPCT and conduct a stress survey Develop and deliver IPCT staff engagement and OD plan			
5	**Staff experience**	**Outcome: WBs feel appreciated for their courage and future WBs understand due process and are not disadvantaged for doing so**				
5.1		Dubiety regarding process and confidentiality of process and impact to people accessing policy	Review WB experience to derive learning and ensure future WBs do not experience detriment			
5.2		Professional and career impact for CP and others that raise contentious issues e.g. TI	Acknowledgment of value of willingness to raise issues Review of impact of escalation on career and progression			
5.3		Breakdown in line-management arrangements and relationship	Explore root cause and potential for mediation			

Inkster, Teresa

From: Peters, Christine
Sent: 23 April 2020 17:38
To: Hunter, Terri; INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Cc: BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND); WALLACE, Angela (NHS FORTH VALLEY); Jenny Copeland
Subject: RE: IPCT - Organisational Development Sessions

Hi Terri,

I am actually very intrigued by this selection of recipients, it looks like a list that I could have predicted. If these names are representative of the kind of people you requested to be included I would add (in order to be a bit more comprehensive is possible views presented)

1. Current Microbiologists
   Nitish Khanna, Pauline Wright, [redacted], Kam Khalsa, Kathleen Harvey Woods from south (can ask for all the north consultants to be added too)
2. Laboratory staff
   Janet Young, Fiona Reynolds (just left organisation, but I can provide phone number) ,
3. Previous management (based on Isobel Neil being included)
   Anne Cruikshank
4. Previously employed ICDs/ Microbiologist (based on John Coia who is now in Denmark)
   John Hood, Penelope Redding, James Cargill, (I can provide contact details if required)
5. ICNS – Susie Dodd, Sophie French, Kirsty McDaid, Haley Kane (all previously employed by GGC) ,
6. ID consultants (based on Al McConnichie being included)
   Conner Docherty, Rosie Hague, Erica Peters, Andrew Seaton, David Bell, Neil Ritchie, Emma Thomson
7. Public Health Consultants (based on Ian Kennedy and Emelia Crighton)
   Gillian Penrice

I would add Rona Wall from Occupational Health

Thanks for the opportunity to add these names and for the helpful meeting today. We can but move forwards !
Kind regards,

[redacted]

Dr Christine Peters
Consultant Microbiologist
Clincial Lead Department of Microbiology QEUH

[redacted]

From: Hunter, Terri
Sent: 23 April 2020 15:33
To: Peters, Christine [redacted]; Inkster, Teresa (NHSmail) [redacted]
Subject: Fw: IPCT - Organisational Development Sessions
Importance: High

As requested

Warmest wishes
Terri

Dr Terri Hunter
Senior Organisational Development Advisor
Chartered Organisational Psychologist, AFBPS
NHS Greater Glasgow & Clyde
Acute Services, South Sector | Finance |Communications
M: [redacted]
E : terri.hunter[redacted]

From: Gardiner, Robert [redacted]
Sent: Thursday, 23 April 2020 15:30
To: Law, Leanne; Neil, Isobel; Mallon, John; Jamdar, Saranaz; Findlay, Bernadette; Green, Rachel; Armstrong, Jennifer; Kennedy, Iain; Crighton, Emilia; Gunson, Rory; MacConnachie, Alisdair; John.Eugenio.Coia[redacted]; Devine, Sandra; Leanord, Alistair; Joannidis, Pamela; Bagrade, Linda; Balfour, Alison; Marek, Aleksandra (NHSmail); Macleod, Mairi (NHSmail); Edwardson, Alison; Marshall, Elizabeth; Paterson, Elizabeth; Brown, Mhairi; Mallon, Nicola; Hay, Marlene; Barrett, Jennifer; Wallace, Helen; Buchanan, Claire; Griffith, Oudwin; Dryden, Julie; Quigley, Graham; Gallagher, Anne; Montague, Margaret-Ann; McKenna, Thomas; Turner, Carrie; Mcallister, Donna; Barmanroy, Jackie; Black, Katrina; Gallagher, Fiona; Walker, Janice; Kelly, Allana; MacLeod, Calum; Brodie, Helen; Kennedy, Susan; Dickson, Teresa; Joannidis, Yianni; Sharkey, David; Inglis, David; Johnson, Angela; Anderson, Kathryn; Carlton, Sharon; Morton, Stefan; Robertson, Angela; Mills, Gillian; McConnell, Donna; Pritchard, Lynn; Kerr, Ann; Bowskill, Gillian; Hamilton, Kate; Valyraki, Kalliopi
Cc: Jenny Copeland; Hunter, Terri; Williams, Arwel
Subject: RE: IPCT - Organisational Development Sessions

Dear all,

Initial feedback seems to indicate that there have been very few follow up contacts following this e-mail that was sent on behalf of the IPCT leads.

I thought I would take the opportunity to encourage you all to participate in this process and make use of this invaluable resource. It is an entirely confidential process with all themes being captured impartially and coherent workstreams being devised as a result.

It's intent is to capture and articulate all of the current issues you may have, as well as devising a longer term strategy to ensure that the department is as effective, efficient and cohesive as possible. It cannot produce anything of value unless we all participate in this process. I would implore you to be as candid as possible, as this will assist the team in identifying recurring themes and possible solutions etc

Jenny and Terri have both kindly identified dates when they will be available for 1 to 1 confidential discussions, both here on the QEUH campus and the GRI site. The rooms that have been booked for this purpose and the dates are as follows:

GRI

27 Apr 2020 – Video Conference Room, Level 1, Lister Building, from 0900 to 1700 hrs

QEUH

28 Apr 2020 – L1/A/008A, Level 1, Labs Building from 0900 to 1700 hrs
29 Apr 2020 – L3/A/018, Level 3, Labs Building from 1000 to 1700 hrs

If you wish to book an individual slot, then please e-mail either Terri or Jenny on the following e-mail addresses:

Jenny.copeland[redacted]
Terri.Hunter[redacted]

Many thanks

Kind Regards,

Rob

From: Law, Leanne
Sent: 06 April 2020 16:25
To: Neil, Isobel[redacted]; Mallon, John[redacted]; Jamdar, Saranaz[redacted]; Gardiner, Robert[redacted]; Findlay, Bernadette[redacted]; Green, Rachel[redacted]; Armstrong, Jennifer[redacted]; Kennedy, Iain[redacted]; Crighton, Emilia[redacted]; Gunson, Rory[redacted]; MacConnachie, Alisdair[redacted]; John.Eugenio.Coia[redacted]; Devine, Sandra[redacted]; Leanord, Alistair[redacted]; Joannidis, Pamela[redacted]; Bagrade, Linda[redacted]; Balfour, Alison[redacted]; Marek, Aleksandra (NHSmail)[redacted]; Macleod, Mairi (NHSmail)[redacted]; Edwardson, Alison[redacted]; Marshall, Elizabeth[redacted]; Paterson, Elizabeth[redacted]; Brown, Mhairi[redacted]; Mallon, Nicola[redacted]; Hay, Marlene[redacted]; Barrett, Jennifer[redacted]; Wallace, Helen[redacted]; Buchanan, Claire[redacted]; Griffith, Oudwin[redacted]; Dryden, Julie[redacted]; Quigley, Graham[redacted]; Gallagher, Anne[redacted]; Montague, Margaret-Ann[redacted]; McKenna, Thomas[redacted]; Turner, Carrie[redacted]; Mcallister, Donna[redacted]; Barmanroy, Jackie[redacted]; Black, Katrina[redacted]; Gallagher, Fiona[redacted]; Walker, Janice[redacted]; Kelly, Allana[redacted]; MacLeod, Calum[redacted]; Brodie, Helen[redacted]; Kennedy, Susan[redacted]; Dickson, Teresa[redacted]; Joannidis, Yianni[redacted]; Sharkey, David[redacted]; Inglis, David[redacted]; Johnson, Angela[redacted]; Anderson, Kathryn[redacted]; Carlton, Sharon[redacted]; Morton, Stefan[redacted]; Robertson, Angela[redacted]; Mills, Gillian[redacted]; McConnell, Donna[redacted]; Pritchard, Lynn[redacted]; Kerr, Ann[redacted]; Bowskill, Gillian[redacted]; Hamilton, Kate[redacted]; Valyraki, Kalliopi[redacted]
Cc: Jenny Copeland[redacted]; Hunter, Terri[redacted]
Subject: IPCT - Organisational Development Sessions

Email sent on behalf of Sandra Devine, Alistair Leonard and Brian Jones

Dear colleague

Jane Grant has asked that Jenny Copeland and Terri Hunter, two Organisational Development (OD) colleagues, meet with members of the IPCT team including the Labs and microbiology teams.

They are seeking the views of all team members with regard to the following objectives:

Facilitate a series of conversations and interventions with a view to ensuring that we work in:
- A positive working environment that promotes staff wellbeing for all
- A quality operational environment that ensures service effectiveness and patient safety

• A clear governance framework that facilitates clinical reviews and debate allowing differing clinical opinions to be heard and acknowledged and provides clear accountability for decisions made
• A team ethos of continuous learning and improvement ensuring sustainable change where beneficial

We are very proud of our service and would encourage you to both participate and be open.
All meetings will be confidential. Outputs will be summarised and themed If you have suggestions for improvement we are keen to hear them.

We appreciate that we are in the midst of this most challenging period however this work is important and we would ask for your participation.
Some of you may have interactions with IPC in the past. However, the team would still like to understand your perspective on this important issue.

Meetings will be with either Jenny Copeland or Terri Hunter.
They will last for approximately 30 minutes.
They will be by phone or facetime. Face to face meetings can be arranged if you would prefer this.

Meeting agenda:

- Welcome and introduction
- Purpose and confidentiality
- With regard to the objectives:
- What is working well?
- What could be improved?
- Next steps

Please contact Jenny or Terri directly on

Jenny.copeland[redacted]
Terri.Hunter[redacted]

To arrange a convenient time and method to meet.

Best regards.

Jenny and Terri
Jenny Copeland Terri Hunter

Jenny Copeland
Principal Lead CNO SEND
Leadership and Talent
NHS Education for Scotland
T: [redacted]
E: [redacted]

Organisational Development, Leadership & Learning

108. email RE Review and Investigation

Julie Rothney

From: BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND) [redacted]
Sent: 24 April 2020 16:13
To: PETERS, Christine (NHS AYRSHIRE AND ARRAN)
Cc: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE); WALLACE, Angela (NHS FORTH VALLEY); Jenny Copeland; Hunter, Terri
Subject: RE: Review and Investigation

Hi Christine

I am meeting with Andrew Fraser and Brian Montgomery on Monday so will check with them their timescales for the External Review reporting. Depending on that we could hopefully use our next scheduled meeting to pick up your points below - or if we need something sooner I'd be happy to get that set up.

Let me come back to you on Monday Christine, and in the meantime hope everyone gets the chance to enjoy their weekends.

Kind regards
Marion

Professor Marion Bain
Director of Infection Prevention and Control
NHS Greater Glasgow and Clyde

Senior Medical Consultant
NHS National Services Scotland

Mob: [redacted]

From: PETERS, Christine (NHS AYRSHIRE AND ARRAN) [redacted]
Sent: 24 April 2020 15:40
To: BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND) [redacted]
Cc: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted]
Subject: Review and Investigation

Hi Marion,

I have been mindful that the review is due to report soon and as you mentioned there are some issues that are still unresolved that we have not yet had time to revist.

I think its important to highlight the areas of biggest concern to me regarding the extant GGC position on some issues that I think would be very useful to explore before the report comes out.

1. the whistleblow not being a whistle blow - I would really appreciate a clear written explanation of the evidence for this asertion by GGC .
2. that concerns were not raised via appropriate channels - again I would appreciate an explanation as to what those appropriate channels are considered to be.
3. the Action Plan in response to the SBAR - it was not accurate at either points in time that I viewed it and it is not Teresa's document . this is also a matter that will need full exploration .

4. Has there been any progress on the website information ?
5. regarding 6A IMT - has there been any progress on those investigations and conclusions given the striking disappearance of environmental gram negative bacteraemias from the cohort.

kr
Christine

110. FW LW (15015334600) Enterobacter aerogenes

Julie Rothney

From: Peters, Christine
Sent: 02 June 2020 10:23
To: 'Jenny Copeland'
Subject: FW: LW (15015334600) Enterobacter aerogenes

From: Peters, Christine
Sent: 06 May 2020 11:37
To: 'WALLACE, Angela (NHS FORTH VALLEY)' ; Christine Peters
Cc: BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND) ; Inkster, Teresa (NHSmail)
Subject: RE: LW (15015334600) Enterobacter aerogenes

Hi Angela,
From my perspective having discussed with the other consultants involved in ITU rounds (I've added in Teresa for a cross check)

Name	Date of admission	Sites positive	?HAI	Typing	Outcome
[redacted]	[redacted]/04/20	BC [redacted]/04	yes	Yes match [redacted]	Died [redacted]/04
[redacted]	[redacted]/04/20	[redacted]/04 ETA / BC [redacted]/04 Line tip	yes	Yes Match [redacted]	Treated with antibiotics , line removal Died [redacted]/04 after step down
[redacted]	[redacted]/04/20	[redacted]/04 ETA Followed by BC in [redacted]	yes	awaited	Treated with antibiotics , line removal
[redacted]	[redacted]/04 /20	[redacted]/04 ETA [redacted]/04 Line tip	Yes	awaited	Treated with antibiotics , then serratia infection died [redacted]/05
[redacted]	[redacted]/04/20	[redacted]/04 tracheal site and sputum	Yes	Awaited	Treated with mero, improving after being severely ill [redacted]

I am going to try to catch up with the ITU data again this week.

The cases have all been referred to IPCT as far as I am aware. I am happy to discuss these on the phone . There is clearly a dichotomy of opinion regarding HAI status, as previously with PICU and 6A, and outcome and I hope these facts are in keeping with the information you have already been given.
Kr
Christine

From: WALLACE, Angela (NHS FORTH VALLEY) [redacted]
Sent: 05 May 2020 18:09
To: Peters, Christine [redacted]
Cc: BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND) [redacted]
Subject: [ExternaltoGGC]RE: LW (15015334600) Enterobacter aerogenes

Hi Christine
The info i have is that 2 patients...HAI one died and 1 stepped down from itu to hdu
Then these 2 patients colonised
Angela

From: Peters, Christine [redacted]
Sent: 05 May 2020 17:11
To: WALLACE, Angela (NHS FORTH VALLEY)
Cc: BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND)
Subject: FW: LW (15015334600) Enterobacter aerogenes

HI Angela ,

FYI
I saw in the board papers that 2 current Enterobacters were considered to be colonisations and still on the unit , this does not agree with the handover from Pauline sent to IPCT two days ago – one died at the weekend.
Kr
Christine

From: Wright, Pauline
Sent: 03 May 2020 08:53
To: Balfour, Alison [redacted]; Valyraki, Kalliopi (NHSmail) [redacted]; Valyraki, Kalliopi [redacted]; Leanord, Alistair [redacted]
Cc: 'SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE)' [redacted]; Peters, Christine [redacted]; 'KHANNA, Nitish (NHS GREATER GLASGOW & CLYDE)' [redacted]; [redacted] (NHSmail) [redacted]; 'KHALSA, Kamaljit (NHS GREATER GLASGOW & CLYDE)' [redacted]; Inkster, Teresa (NHSmail) [redacted]
Subject: RE: LW (15015334600) Enterobacter aerogenes

FAO ICT

Of the 4 patients who have been colonised / infected with Enterobacter aerogenes, 3 have now died and the 4th [redacted] is not doing well.
I don't know what this means in the context of a very poor outlook anyway once ventilated and the likelihood of becoming colonised with something during ITU stay

Susie Daisley mentioned a different type of gown that was being used in ED and thought that might be worth looking at

Pauline

Dr Pauline Wright
Consultant Microbiologist
Queen Elizabeth University Hospital

From: Balfour, Alison
Sent: 30 April 2020 14:26
To: Brown, Derek; Khanna, Nitish; Valyraki, Kalliopi; Leanord, Alistair; Pritchard, Lynn
Cc: 'SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE)'; 'KHANNA, Nitish (NHS GREATER GLASGOW & CLYDE)'; Wright, Pauline
Subject: RE: LW (15015334600) Enterobacter aerogenes

Hi Derek

The initial x2 bacteraemia isolates ([redacted] and [redacted]) that went to PHE and not to yourself were automatically assigned a PHE ref number but not a billing reference (so I will keep quiet about that). Sorry don't have any detail re NSD SLA and charges therein.
The isolates should be on their way to you now for WGS, in addition to [redacted] and [redacted] that you already have (and the latter 2 have gone to PHE for PFGE).

Thx for all your help

Best

Alison

From: Brown, Derek
Sent: 30 April 2020 13:56
To: Balfour, Alison; Khanna, Nitish; Valyraki, Kalliopi; Leanord, Alistair; Pritchard, Lynn
Cc: 'SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE)'; 'KHANNA, Nitish (NHS GREATER GLASGOW & CLYDE)'; Wright, Pauline
Subject: RE: LW (15015334600) Enterobacter aerogenes

Hi Alison,

We are happy to continue to process these for WGS in the meantime. We have the two isolates, and I believe there is a third on the way. The first two will be going on the run this weekend.

Our turnaround times would normally be 5 to 10 days, depending on the day of arrival in the lab. COVID may cause a slight delay in those.

I would also be interested to know if the PFGE carried out at PHE is under the NSD SLA, and how much PHE will be charging Scotland. You might not have this info.

With best regards,

Derek

Derek J Brown
Principal Clinical Scientist
Scottish Microbiology Reference Laboratories
Level 5
New Lister Building
Glasgow Royal Infirmary
Alexandra Parade
Glasgow G31 2ER
Scotland

Direct Dial: [redacted]
Fax: [redacted]
Email: derek.brown[redacted] or derek.brown[redacted]

Please Consider the environment before printing this Email

From: Balfour, Alison
Sent: 29 April 2020 10:09
To: Khanna, Nitish [redacted]; Valyraki, Kalliopi [redacted]; Leanord, Alistair [redacted]; Pritchard, Lynn [redacted]
Cc: 'SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE)' [redacted]; 'KHANNA, Nitish (NHS GREATER GLASGOW & CLYDE)' [redacted]; Wright, Pauline [redacted]; Brown, Derek [redacted]
Subject: RE: [redacted] Enterobacter aerogenes

I have sorted

From: Khanna, Nitish
Sent: 29 April 2020 10:08
To: Balfour, Alison; Valyraki, Kalliopi; Leanord, Alistair; Pritchard, Lynn
Cc: 'SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE)'; 'KHANNA, Nitish (NHS GREATER GLASGOW & CLYDE)'; Wright, Pauline; Brown, Derek
Subject: RE: [redacted] Enterobacter aerogenes

In this case, could someone on site liaise with CL3 (I spoke to Josh yesterday) to ensure isolate below is sent to both PHE and GRI as currently it is only going to GRI.

KR

Nitish

From: Balfour, Alison
Sent: 29 April 2020 09:42
To: Valyraki, Kalliopi; Leanord, Alistair; Khanna, Nitish; Pritchard, Lynn
Cc: 'SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE)'; 'KHANNA, Nitish (NHS GREATER GLASGOW & CLYDE)'; Wright, Pauline; Brown, Derek
Subject: RE: [redacted] Enterobacter aerogenes

Isolates from [redacted] and [redacted] went to PHE and not to Derek for WGS.
As attached, both by PFGE match and designated SERN07KA-1. Took just under 3 weeks for TAT to result.
Let me sort through most recent isolates, and I suggest we continue to send to PHE for PFGE continuity, but also WGS if you happy to additionally process Derek (might be quicker depending on your workload)?

Alison

From: Valyraki, Kalliopi
Sent: 28 April 2020 17:01
To: Leanord, Alistair; Khanna, Nitish
Cc: Balfour, Alison; 'SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE)'; 'KHANNA, Nitish (NHS GREATER GLASGOW & CLYDE)'; Wright, Pauline; Brown, Derek
Subject: RE: [redacted] Enterobacter aerogenes

Hi Al,

I will ask Alison tomorrow to see with whom she has spoken to last week.

Bw
Pepi

From: Leanord, Alistair
Sent: 28 April 2020 16:33
To: Valyraki, Kalliopi; Khanna, Nitish
Cc: Balfour, Alison; 'SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE)'; 'KHANNA, Nitish (NHS GREATER GLASGOW & CLYDE)'; Wright, Pauline; Brown, Derek
Subject: Re: [redacted] Enterobacter aerogenes

Folks

I checked with Derek

The original ones haven't arrived. Can you check they were sent?

Ta

Al

Sent from my BlackBerry 10 smartphone on the EE network.

From: Valyraki, Kalliopi
Sent: Tuesday, 28 April 2020 15:21
To: Khanna, Nitish
Cc: Balfour, Alison; Leanord, Alistair; 'SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE)'; 'KHANNA, Nitish (NHS GREATER GLASGOW & CLYDE)'; Wright, Pauline
Subject: RE: [redacted] Enterobacter aerogenes

Thanks
Pepi

From: Khanna, Nitish
Sent: 28 April 2020 15:21
To: Valyraki, Kalliopi
Cc: Balfour, Alison; Leanord, Alistair; 'SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE)'; 'KHANNA, Nitish (NHS GREATER GLASGOW & CLYDE)'; Wright, Pauline
Subject: RE: [redacted] Enterobacter aerogenes

Will do

Nitish

From: Valyraki, Kalliopi
Sent: 28 April 2020 15:20
To: Khanna, Nitish [redacted]
Cc: Balfour, Alison [redacted]; Leanord, Alistair [redacted]; 'SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE)' [redacted]; 'KHANNA, Nitish (NHS GREATER GLASGOW & CLYDE)' [redacted]; Wright, Pauline [redacted]
Subject: RE: [redacted] Enterobacter aerogenes

Oh no, another one!

Could we send it for WGS at GRI with the other three isolates?

Thanks a lot
Pepi

From: Khanna, Nitish
Sent: 28 April 2020 15:13
To: Valyraki, Kalliopi
Cc: Balfour, Alison; Leanord, Alistair; 'SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE)'; 'KHANNA, Nitish (NHS GREATER GLASGOW & CLYDE)'; Wright, Pauline
Subject: RE: [redacted] Enterobacter aerogenes

Hi Pepi,

FYI...Another Enterobacter aerogenes...

Name: [redacted] Order No: [redacted] |
|[redacted] Lab No: [redacted] |
|Location: [redacted] |
|Spec. Type: Sputum Date col'd: [redacted].04.20 |
|Spec. Site: TRACHEO Date rec'd: [redacted].04.20 |
Date auth:
* FINAL REPORT *
GROWTH:
a) Enterobacter aerogenes Isolated
b) ANTIBS. a) b) c
c) Trim S
d) Co-amox R
e) Cipro S
f) Gent S
Amikacin S
Tobra S

Assume you want this sent to GRI for WGS as well?

Kind Regards

Nitish

From: Valyraki, Kalliopi
Sent: 28 April 2020 10:19
To: 'jamiemcallister[redacted]' [redacted]
Cc: Khanna, Nitish [redacted]; Balfour, Alison [redacted]
Subject:

Hi Jamie,

I think that you are covering ITU today.
I was wondering if you wouldn't mind asking from the blood cultures bench to send an enterobacter for WGS at GRI.
We sent 2 more samples some days ago at GRI for WGS and we want this sent as well for IC purposes.

The patient/isolate details are

GGC MICROBIOLOGY
Report type (RCS) RC POS SOFT (BMS) 05/09/17 Page 1 frame A1

|Name: [redacted] Order No: [redacted] |
|[redacted] Lab No: [redacted] |
|Location: [redacted] |
|Spec. Type: Line tip Date col'd: [redacted].04.20 |
|Spec. Site: Central venous line Date rec'd: [redacted].04.20 |
Date auth: [redacted].04.20
** INTERIM REPORT - Further report to follow **
CULTURE RESULT:
GROWTH: ANTIBS. a) b) c
a) Enterobacter aerogenes Isolated sFluclox R
b) Staphylococcus epidermidis Isolated sClari R
c) sClinda R
d) sIn.Clin.R -
e) sVanc S
f) sDapto S

Earlier \ Later specimen - append S for same type

Thank you
Pepi
Quit \ PHoned comment \ frame: + > \ imaGe ..

Inkster, Teresa

From: WALLACE, Angela (NHS FORTH VALLEY)
Sent: 13 May 2020 13:55
To: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE); PETERS, Christine (NHS AYRSHIRE AND ARRAN); BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND)
Subject: RE: Fiscal PM Question

Hello
Thanks everyone
Sounds like a plan thank you and if any areas that need wider support or action please do let me know and I am happy to undertake to ensure follow through and agreed
I hope that these types of key areas will flow out of the consultants meetings into the weekly joint meeting and actions and agreed updates logged
I will keep close and happy to be guided
Angela

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Sent: 12 May 2020 19:16
To: PETERS, Christine (NHS AYRSHIRE AND ARRAN); WALLACE, Angela (NHS FORTH VALLEY); BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND)
Subject: Re: Fiscal PM Question

Thanks Christine,

Agree there remains confusion regarding the Serratia case . We agreed at the consultant meeting it was an HAI but its not clear whether this status has been amended and communicated to pathology.

Given that we are seeing more of these types of enquiries I think it is essential we have a robust process in place. Christine has suggested we discuss significance and status at the Consultant meeting and I think this is a good idea as these cases can be very complex. Once there is agreement regarding HAI status I would suggest that if it is an HAI;

ICD communicates this to pathologist
Pathologist and ICD discuss with patients clinician
Patients clinician is responsible for duty of candour and any discussion with family (supported by ICD if needed). N.B regardless of HAI status they will be discussing PM report with family
Lead ICD or ICM to provide incident update to HPS/SG (not all HAI will require to be reported in this way but they do if part of an incident)

Im not sure what has happened to the duty of candour policy I was working on but a section in there on dealing with PM results and roles/responsibilites would be a useful way forward .

Kr
Teresa

Dr Teresa Inkster
Consultant Microbiologist, QEUH
National Training Programme Director Medical Microbiology
Dept of Microbiology
Queen Elizabeth University Hospital

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Sent: 07 May 2020 10:54
To: WALLACE, Angela (NHS FORTH VALLEY)
Subject: Re: post-mortem cases for advice.

Thanks. I dont think case 2 is relevant for IC but will leave that for someone to look into. I was concerned re case 1 as I had emailed IPCT at the time the patient was in in PICU. I was told that Pepi Valyrkai (ICD) discussed my email with Sandra who agreed that case 1 was infact an HAI , but this is via a colleague and I dont know the details or whether there were any subsequent actions.

kr

Teresa

Dr Teresa Inkster

Consultant Microbiologist, QEUH

National Training Programme Director Medical Microbiology

Dept of Microbiology

Queen Elizabeth University Hospital

Glasgow

Direct dial : [redacted]

From: WALLACE, Angela (NHS FORTH VALLEY)
Sent: 07 May 2020 09:41
To: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Subject: RE: post-mortem cases for advice.

Hi teresa,

I don't have much info yet and will do now but i think the second case may have been from a PM done in GGC but the patient was from ayrshire?

I will find out though

Kindest

A

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Sent: 06 May 2020 19:57
To: WALLACE, Angela (NHS FORTH VALLEY)
Cc: BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND); KHALSA, Kamaljit (NHS GREATER GLASGOW & CLYDE); PETERS, Christine (NHS AYRSHIRE AND ARRAN)
Subject: Re: post-mortem cases for advice.

Yes thats fine.
kr
Teresa

Dr Teresa Inkster

Consultant Microbiologist, QEUH

National Training Programme Director Medical Microbiology

Dept of Microbiology

Queen Elizabeth University Hospital

Glasgow

Direct dial : [redacted]

From: WALLACE, Angela (NHS FORTH VALLEY)
Sent: 06 May 2020 19:55
To: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Cc: BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND); KHALSA, Kamaljit (NHS GREATER GLASGOW & CLYDE); PETERS, Christine (NHS AYRSHIRE AND ARRAN)
Subject: Re: post-mortem cases for advice.

Hello thanks Theresa

It may be helpful to explain that

I have not shared this email with anyone .

I did as explained last week when I saw your email I asked about these 2 cases background and I would need colleagues to get information for me to understand.

If your content I will now share the detail that I may agree next steps and I will feedback as quickly as I can

Hope that's ok

Kindest

Angela

Sent from my iPhone

On 6 May 2020, at 19:46, INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted] wrote:

> Hi,happy for email to be forwarded. I understand from a colleague that it was already forwarded or discussed with Sandra last week. I have only had prior involvement with the Serratia case. I don't know anything about the other case the pathologist refers to , it sounds like community onset.
>
> kr
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> Teresa
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> Dr Teresa Inkster
>
> Consultant Microbiologist, QEUH
>
> National Training Programme Director Medical Microbiology
>
> Dept of Microbiology
>
> Queen Elizabeth University Hospital
>
> Glasgow
>
> Direct dial : [redacted]
>
> ---
>
> **From:** WALLACE, Angela (NHS FORTH VALLEY)
> **Sent:** 06 May 2020 14:06
> **To:** INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE); BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND)
> **Cc:** KHALSA, Kamaljit (NHS GREATER GLASGOW & CLYDE); PETERS, Christine (NHS

AYRSHIRE AND ARRAN)
Subject: RE: post-mortem cases for advice.

Hello all,

Many thanks for your email and as briefly shared on receiving this email, i asked colleagues in IC and senior management to look into the detail of the 2 sad deaths.

I am keen to progress this further and wondered if you are content that i share your email that i may action?

Re ITU we started the conversation yesterday and similarly are you content i progress in this way too?

Kindest

Angela

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Sent: 30 April 2020 16:14
To: WALLACE, Angela (NHS FORTH VALLEY); BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND)
Cc: KHALSA, Kamaljit (NHS GREATER GLASGOW & CLYDE); PETERS, Christine (NHS AYRSHIRE AND ARRAN)
Subject: Fw: postmortem cases for advice.

Hi both

I am concerned regarding the email trail below. My colleague Dr Khalsa has been contacted by a pathologist regarding PM results for a child . This case was referred last November by myself to the IPCT as a hospital acquired Serratia bacteraemia, and was part of the wider environmental incident in PICU. The PM results show Serratia from multiple sites.

The pathologist is asking re the signficance of the typing report. I am concerned that the response from IPC is that the child was only in a few days and that the infection is not linked to RHC. This is factually inaccurate . As per my email below this is a very clear HAI by definition and the typing result has been misinterpreted. Furthermore the pathologist has not been copied in to the response so her query is outstanding. My email is also unnaswered

Whilst the primary cause of death is [redacted], this child had an HAI and was part of an ongoing incident. This is a duty of candour event and we would need to check what the parents have been told already.

You will be aware that I sent several emails at the time expressing my concern regarding this PICU incident particularly with respect to definitions and interpretation of typing. I remain concerned .

We have another incident ongoing in adult ICU with Enterobacter and we have been told the isolates will undergo whole genome sequencing. Whilst typing is a useful part of any outbreak investigation we appear to have lost focus on basic epidemiology , source investigation and control measures. I have reiterated many times that typing in an environmental incident reveals many different strains . Regardless, the interpretation locally is that different strains equate to no issues. This is despite me backing my opinion by scientific literature and international experts confirming such.

Kind regards

Teresa

Dr Teresa Inkster

Consultant Microbiologist, QEUH

National Training Programme Director Medical Microbiology

Dept of Microbiology

Queen Elizabeth University Hospital

Glasgow

Direct dial : [redacted]

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Sent: 30 April 2020 10:33
To: SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE); KHALSA, Kamaljit (NHS GREATER GLASGOW & CLYDE); Valyraki, Kalliopi
Subject: postmortem cases for advice.

Hi , I am confused re this case. I was covering paeds around that time . I have checked my records and I had referred this as an HAI Serratia to the IPCT

The child was admitted from home [redacted]/11 and had a positive blood culture for Serratia on [redacted]/11. Thats a full 6 days, well beyond the standard HAI definition of > 48 hours

The typing result does not mean the infection was not an HAI. It means that this case cannot be linked to another patient or a previously sampled environmental source but it does not exclude RHC as the source of infection . We would always go by definition

Unless I am missing something, by definition this is an HAI and given the PM results a duty of candour event .

Kind regards

Teresa

Dr Teresa Inkster

Consultant Microbiologist, QEUH

National Training Programme Director Medical Microbiology

Dept of Microbiology

Queen Elizabeth University Hospital

Glasgow

Direct dial : [redacted]

From: VALYRAKI, Kalliopi (NHS GREATER GLASGOW & CLYDE)
Sent: 30 April 2020 09:58
To: SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE); KHALSA, Kamaljit (NHS GREATER GLASGOW & CLYDE)
Subject: Re: postmortem cases for advice.

Hi Kam,

This first [redacted] was known to us and fully investigated as a cluster of cases in PICU. This was reported to both HPS and SG. it is good to know that the serratia was not linked to RHC although [redacted] was only in a few days before being positive.

Best wishes
Pepi

From: SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE)
Sent: 29 April 2020 15:40
To: VALYRAKI, Kalliopi (NHS GREATER GLASGOW & CLYDE)
Cc: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE); Peters Christine (NHS GREATER GLASGOW & CLYDE); PETERS, Christine (NHS AYRSHIRE AND ARRAN); SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE); dawn.penman[redacted]
Subject: Fw: postmortem cases for advice.

Hi Pepi,

Just to let you know received an email from Dawn Penman today regarding patient [redacted] (see trail below with my response). Thought I had better let you know in case you had more to add from an infection control perspective.

Thanks

Kam

From: SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE)
Sent: 29 April 2020 15:36
To: dawn.penman[redacted]
Subject: Fw: postmortem cases for advice.

Dear Dawn,

In relation to [redacted], further to my previous email just wanted to add that Serratia marscences can be environmentally acquired which is probably why the isolates were sent for typing. I will forward this email onto infection control colleagues in case they have more to add.

Kind Regards,

Kam

From: SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE)
Sent: 29 April 2020 14:46
To: Penman, Dawn; Microbiology Virology; Rory.Gunson[redacted]
Cc: Wood Kathleen (NHS GREATER GLASGOW & CLYDE)
Subject: Re: postmortem cases for advice.

Hi Dawn,

1. [redacted]

I note this patient had a number of pre-mortem samples which isolated *Serratia marcescens* including peripheral blood cultures ([redacted]/11/19), dialysis line blood cultures ([redacted]/11/19) and arterial line blood culture ([redacted]/11/19). Blood cultures prior to this were no growth and [redacted] had 2 negative BC's at Raigmore hospital ([redacted]/11).

Post-mortem samples isolated *Serratia marcescens* from multiple samples including spleen tissue, BC (splenic), heart blood (BC), bronchial swabs and lung fluid. This is a significant organism, especially in an immuncompromised patient on chemotherapy with long lines.

The isolates were sent to Colindale for typing and although all four isolates matched in the patient, these were unique among reported isolates from this hospital.

Potential sources could have included lines, urinary system, intra-abdominal or chest. Am unclear how long [redacted] long lines were in situ.

2. [redacted]

I note this patient isolated *Streptococcus constellatus* from heart blood ([redacted]/12). This is an organism belonging to the *Strep milleri* group and is often associated with collections and abscesses.

[redacted] also isolated *Group A streptococcus* and *Haemophilus Influenzae* from a bronchial swab. All three of these organisms are significant especially if the URT showed evidence of infection.

Inkster, Teresa

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted]
Sent: 07 May 2020 10:54
To: WALLACE, Angela (NHS FORTH VALLEY)
Subject: Re: post-mortem cases for advice.

Thanks. I dont think case 2 is relevant for IC but will leave that for someone to look into. I was concerned re case 1 as I had emailed IPCT at the time the patient was in in PICU. I was told that Pepi Valyrkai (ICD) discussed my email with Sandra who agreed that case 1 was infact an HAI , but this is via a colleague and I dont know the details or whether there were any subsequent actions.

kr
Teresa

Dr Teresa Inkster
Consultant Microbiologist, QEUH
National Training Programme Director Medical Microbiology
Dept of Microbiology
Queen Elizabeth University Hospital
Glasgow
Direct dial : [redacted]

From: WALLACE, Angela (NHS FORTH VALLEY)
Sent: 07 May 2020 09:41
To: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Subject: RE: post-mortem cases for advice.

Hi teresa,
I don't have much info yet and will do now but i think the second case may have been from a PM done in GGC but the patient was from ayrshire?
I will find out though
Kindest
A

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Sent: 06 May 2020 19:57
To: WALLACE, Angela (NHS FORTH VALLEY)
Cc: BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND); KHALSA, Kamaljit (NHS GREATER GLASGOW & CLYDE); PETERS, Christine (NHS AYRSHIRE AND ARRAN)
Subject: Re: post-mortem cases for advice.

Yes thats fine.
kr
Teresa

Dr Teresa Inkster
Consultant Microbiologist, QEUH
National Training Programme Director Medical Microbiology

Dept of Microbiology
Queen Elizabeth University Hospital
Glasgow
Direct dial : [redacted]

From: WALLACE, Angela (NHS FORTH VALLEY)
Sent: 06 May 2020 19:55
To: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Cc: BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND); KHALSA, Kamaljit (NHS GREATER GLASGOW & CLYDE); PETERS, Christine (NHS AYRSHIRE AND ARRAN)
Subject: Re: post-mortem cases for advice.

Hello thanks Theresa
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> Dr Teresa Inkster
> Consultant Microbiologist, QEUH
> National Training Programme Director Medical Microbiology
> Dept of Microbiology
> Queen Elizabeth University Hospital
> Glasgow
> Direct dial : [redacted]
>
> **From:** WALLACE, Angela (NHS FORTH VALLEY)
> **Sent:** 06 May 2020 14:06
> **To:** INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE); BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND)
> **Cc:** KHALSA, Kamaljit (NHS GREATER GLASGOW & CLYDE); PETERS, Christine (NHS AYRSHIRE AND ARRAN)
> **Subject:** RE: post-mortem cases for advice.
>
> Hello all,

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From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Sent: 30 April 2020 16:14
To: WALLACE, Angela (NHS FORTH VALLEY); BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND)
Cc: KHALSA, Kamaljit (NHS GREATER GLASGOW & CLYDE); PETERS, Christine (NHS AYRSHIRE AND ARRAN)
Subject: Fw: postmortem cases for advice.

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We have another incident ongoing in adult ICU with Enterobacter and we have been told the isolates will undergo whole genome sequencing. Whilst typing is a useful part of any outbreak investigation we appear to have lost focus on basic epidemiology , source investigation and control measures. I have reiterated many times that typing in an environmental incident reveals many different strains . Regardless, the interpretation locally is that different strains equate to no issues. This is despite me backing my opinion by scientific literature and international experts confirming such.

Kind regards
Teresa

Dr Teresa Inkster
Consultant Microbiologist, QEUH
National Training Programme Director Medical Microbiology
Dept of Microbiology

Re: In confidence: PICU patient result [redacted]

INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted]

Wed 09/09/2020 15:13

To: Wallace, Angela [redacted]

Cc: Claire Peacock (NHS Forth Valley) [redacted];PETERS, Christine (NHS GREATER GLASGOW & CLYDE) [redacted];Devine, Sandra [redacted]

Thanks Angela

The issue is not the ventilation rather it is the water damage and the environment that creates i.e. growth of mould.
Given that the light fittings were affected I assume the leaking pipe is in the ceiling void. The key question is whether the ceiling void was inspected for visible mould or if damp areas were still present 48 hours later, and was any plaster checked with a moisture meter.

Aspergillus and other fungal spores disperse in bursts and will do so regardless of the ventilation specification of the unit. The spores travel far from the source as they are spiculated and very buyoant. Distance between spaces is irrelevant. We have guidelines for construction on hosptial sites and immunosuppressed patients for this very reason, that demolition remote from the site can lead to fungal infection.

Due to the burst phenomenon air sampling can be unreliable . The key is identifying any water ingress and dealing with rapidy as per water damage policy.

The other thing to consider with this case is ECMO and the water as we have grown Aspergillus in the water supply before.

From a microbiology perspective the patient was treated with Ambisome, in fact we had to increase to the maximum 5mg/kg dose . Given that the fungus was in both tissue and a swab it is odd that the wound was not considered infected. We do occaisionally see Aspergillus colonisation in ICU patients but Aspergillus is not something you want to see in cardiac wounds because the outcome is always devastating. Given that there are babies with open chests on the unit and haem onc patients , any potential source needs addressed to prevent future infections.

kr
Teresa

Dr Teresa Inkster
Consultant Microbiologist, QEUH
National Training Programme Director Medical Microbiology
Dept of Microbiology
Queen Elizabeth University Hospital
Glasgow
Direct dial : [redacted]

From: Claire Peacock (NHS Forth Valley) [redacted]
Sent: 09 September 2020 14:52
To: PETERS, Christine (NHS GREATER GLASGOW & CLYDE); INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)

Cc: Angela Wallace (NHS Forth Valley); Devine, Sandra
Subject: In confidence: PICU patient result [redacted]

On behalf of Professor Angela Wallace,

Dear Colleagues,

thanks for the opportiuty to discuss this on email and apologies for the delay in sending but please find below the most recent update on the actions in support of our discussion:

I would be happy to discuss and Sandra is constantly updating the situation.

Kind regards

Angela

Situation

Small infant who had undergone cardiac surgery with aspergillus in mediastinal tissue. This child had surgery on [redacted]/8 with a return to theatre on [redacted]/8 for exploration of the mediastinum. Tissue taken on the [redacted]/8 isolated aspergillus. [redacted]/8 ward reported that the wound did not look infected. Nursed in Bed 1-4 in PICU and in room 14 in PICU.

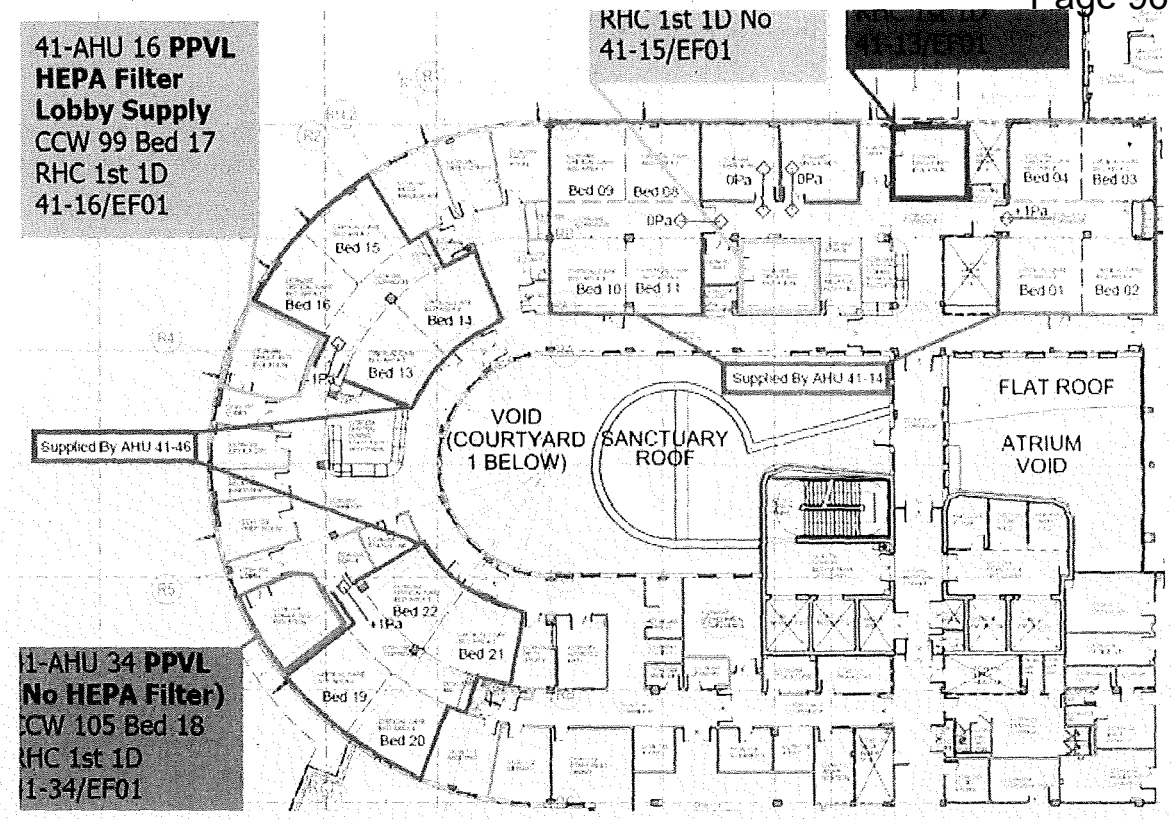
Water Leak
On 25/8 a valve failed and there was a hot water pipe which leaked all over lights and centurion2000 beds 1-4 oxygen dousing point panel AVSU175 controlling outlets 175/001to175/004.

Single room adjacent (room 5) was also affected.

Action
Case review

Ventilation review from EFM Colleagues summary below:

"I have looked into this for you and can provide some reassurance hopefully. Both areas you mentioned are served via separate ventilation systems therefore the risk of cross contamination through thermal recovery is impossible as demonstrated by my attached diagram, ACH Rates within the corridor transfer area are extremely low 0.8 Ach/hour so there will be next to no defined pressure cascade for the corridor in question therefore air movement will be defined via variable door orientation and adjacent thermal buoyancy of air, in my humble opinion the source of this potential contamination is extremely unlikely due to the current ventilation set up and the distance between the spaces in question."



In addition air sampling of both areas of unit was undertaken on Friday 4th September and the cath lab and theatres were done on 8th – this was the first date these area were available for sampling.

From: PETERS, Christine (NHS GREATER GLASGOW & CLYDE) [redacted]
Sent: 01 September 2020 09:58
To: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted]
Cc: WALLACE, Angela (NHS FORTH VALLEY) [redacted]
Subject: Re: PICU patient result [redacted]

Thanks Teresa that's helpful, I will raise these issues at the meeting today,

kr
Christine

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Sent: 01 September 2020 09:55
To: PETERS, Christine (NHS GREATER GLASGOW & CLYDE)
Cc: WALLACE, Angela (NHS FORTH VALLEY)
Subject: Fw: PICU patient result [redacted]

Hi Christine

I am covering paeds this week and there are a couple of things that I wondered if you could discuss at the IC meeting today

- Mediastinal wound with fungus ? Aspergillus - see email below. Very worrying to see this in a cardiac wound , I understand the chest has been open in the unit. As you will know the water leak is highly relevant even if at the opposite end of the ward. Also wonder re theatres and watersupply , child has been on ECMO.

- ?Cryptococcal case , 6A . I understand this was considered to be a repeatedly false positive CrAg result , however the child has been treated with antifungals and the CrAg is now negative and confirmed as such by Bristol. This would suggest true infection.

- I have sent an email to Prof Gibson to clarify the use of Cipro prophyalxis on 6A after recieving a call about this yesterday. I was under the impression we had moved to taurolock

kr
Teresa

Dr Teresa Inkster
Consultant Microbiologist, QEUH
National Training Programme Director Medical Microbiology
Dept of Microbiology
Queen Elizabeth University Hospital
Glasgow
Direct dial : [redacted]

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Sent: 31 August 2020 10:00
To: Valyraki, Kalliopi; KHALSA, Kamaljit (NHS GREATER GLASGOW & CLYDE); Bowskill Gillian (NHS GREATER GLASGOW & CLYDE); angela.johnsor[redacted]; Brown Mhairi (NHS GREATER GLASGOW & CLYDE)
Cc: Wood Kathleen (NHS GREATER GLASGOW & CLYDE)
Subject: Re: PICU patient result [redacted]

Thanks Pepi

Aspergillus spores are buoyant , released in bursts and will travel remote from source, so the leak at the other side of the unit might be relevant

kr
Teresa

Dr Teresa Inkster
Consultant Microbiologist, QEUH
National Training Programme Director Medical Microbiology
Dept of Microbiology
Queen Elizabeth University Hospital
Glasgow
Direct dial : [redacted]

From: Valyraki, Kalliopi [redacted]
Sent: 31 August 2020 09:52

Re: Cryptococcus CONFIDENTIAL

PETERS, Christine (NHS GREATER GLASGOW & CLYDE) [redacted]
Thu 10/09/2020 12:50

To: Claire Peacock (NHS Forth Valley) [redacted];INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted]

Cc: Wallace, Angela [redacted]

Hi Angela,

Thanks so much for responding and processing my concerns. I am on a day off today so if you don't mind I'll take a bit of time to put thought into your summary and suggestions. I do think the current gap in all the situations we are grappling with is learning be it MM or IMT debrief and that is where history collides with current patient care.

With regard to the clinician - this is highly sensitive as you compassionately identify, and something I have seen and reported on extensively - concerns expressed to me, but a level of fear/reticence in speaking to authority. This is culture and a result of toxicity in the system which I think is being recognised increasingly. The question becomes how can you in your position hear and understand this without the clinician feeling exposed. I don't know. Every time I raise a concern I feel a hammer nailed into my career coffin so to speak so I cannot judge anyone else for not knowing how to proceed.

I will be happy to try to help with any conversation you are willing to have because I think this is so key Angela, other voices need to be heard for you to get under the skin of a situation. Otherwise it's back to Teresa and I being "troublemakers" in the parlance I have heard so many times.

Believe me when I say I long to feel encouraged as you are. But that evidence is entirely lacking from where I sit, not that I doubt that a huge amount of effort is being made on your part.

I will reply tomorrow to your categorisation of my concerns after some reflection as well as concrete and hopefully helpful suggestions as to next steps /ways forward- whether I continue to be involved or not.

Kind regards

Christine

From: Claire Peacock (NHS Forth Valley) [redacted]
Sent: 10 September 2020 10:50:04
To: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE); PETERS, Christine (NHS GREATER GLASGOW & CLYDE)
Cc: Angela Wallace (NHS Forth Valley)
Subject: Fw: Cryptococcus CONFIDENTIAL

On behalf of Prof. Angela Wallace,

Hello Christine and Teresa,

I am glad you are well Christine and i hope on call was not too busy.

Thanks for sharing this further detail as promised and i would be happy to agree how we understand and proceed.

I agree Christine that the opportunity by understanding the pathway of this child is key both in terms of care for patients today and as you highlight how we ensure learning about care is systematic and informs care moving forward.

Teresa kindly shared with me high-level concerns which I have begun to build into a written update and current position. I think from your email and this is key and raised within your concerns that having clarity and an accurate basis in which to move our conversations and next steps forward.

I will therefore address these concerns and have identified key strands below, these are:

- Sensitive areas of concern
    - particularly the pressure on a clinician in communication with the [redacted] and how staff ensured they had the correct information and in turn supported the communication with [redacted] child (1 and 4)
- Communication, follow up and agreeing the position in relation to this case during the lead up and post IMT. This included the accuracy of your position within the IMT minutes. The issue of how this process has been featured at the weekly Multi speciality meeting. (2,3,5,6,7)
- Wider learning and position on the understanding of cryptococcus in GGC, current and future (8)

  Let me know Christine if have captured these in a way that is ok, and I will proceed on that basis. My suggestion therefore would be to build these into the update and current position paper already underway albeit I will need a little more time to complete.

Christine re the clinician do you think they have raised this within the system already or do you think they may share their experience? if not, I would be happy to be guided how best I can address. I agree this is a serious concern.

I had shared with you at our meeting the information I had re the family discussions which was reported as very open, positive. I had also asked that the conversation [redacted] continued to ensure [redacted] had an easy route to us if further questions came to mind or [redacted] needed time to reflect and return to speak to colleagues. I will investigate the difference in both areas. I must say I had felt so encouraged and staff spent so much time trying to get this correct, both from the clarity of the diagnosis and treatment and ensuring mum was able to have all of [redacted] questions answered.

I wondered if I complete the report as suggested and perhaps we could have a wider discussion in the spirit of learning in a case review/mm type approach with key colleagues and allow us to have a full report and agreed consensus position? In addition, any changes to clinical practice as a result could be part of the next steps along with any learning

happy to discuss and please feel free to change and suggest alternatives

kindest regards

Angela

From: PETERS, Christine (NHS GREATER GLASGOW & CLYDE) [redacted]
Sent: 06 September 2020 19:45
To: Angela Wallace (NHS Forth Valley) [redacted]; INKSTER, Teresa (NHS GREATER GLASGOW

& CLYDE) [redacted]
Subject: Re: Cryptococcus CONFIDENTIAL

Dear Angela,

I am much better now thankyou and am on call today. Thanks Teresa for filling in on the meeting we had on Wednesday.

Essentially, I am concerned that :
1. there was pressure put upon a clinician to change the diagnosis when having to speak to [redacted]
2. there was a lack of dialogue with RHC micro (all dialogue with IC was initiated and pursued by me and not reciprocated),
3. the follow up regarding the current understanding of the case has been marked by absence of response and follow up. This is the second case in a [redacted] child in 18 months. This makes us very unique in Uk , not in a good way.
4. That information regarding an infection risk was put to [redacted] without discussion with Micro - I refer to what I understand was an announcement on [redacted] that there was Cryptococcus isolated on a ward ? 4b and that there were no cases. It would be good to ascertain if this is garbled or infact what happened as I understand [redacted] was deeply upset by the claim there were no cases as [redacted] had been informed her child was being treated for this.
5. The importance of the epidemiology of cryptococcal infection in this cohort has been obscured due to the multiple layers of disagreements and incomplete information
6. The IMT findings were not shared with me and there is direct contradiction of what my position was at the time - false positives are rare
7 there are no minutes of me raising the cases multiple times at the buzz meeting - this meeting is recorded is just action points and if no action point agreed/offered the communication capture opportunity is lost
8. The stance taken by GGC regarding previous crypto cases makes it difficult to explore the possible connections of pigeon infestation with the most recent case - essentially a first step in understanding what is happening in Glasgow .

I will work on a timeline of all micro communications re this case if you would find this helpful.

I remain thankful that we picked up this case early and were able to treat and prevent dissemination despite profound immune suppression. I worry that this could happen again unless we really get to grips openly with what is happening and has happened.

Kr

Christine

From: Angela Wallace (NHS Forth Valley) [redacted]
Sent: 04 September 2020 12:38:35
To: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE); PETERS, Christine (NHS GREATER GLASGOW & CLYDE)
Subject: Re: Cryptococcus

hello Teresa many thanks
Christine i hope you're feeling a little better?

A chat at any time would be welcomed.
Thank you for this and i have brought colleagues together to better understand why these differences remain. I have asked that we clearly describe the process, the discussions, the IMT and the subsequent and ongoing work that Christine has continued and the then Board position.

As i explained on the call my clear understanding is that this was a positive case and on this basis the family discussions happened by pead clinical staff. As explained i was determined that we

approached all aspects of this as openly as possible to avoid these types of concerns and i am happy to quickly share when i have it this write up.

i appreciate that this email is confidential and i will not share but i will ensure that these points are addressed. If i can have thsi early next week does that sound a reasonable approach and timescale to give us the basis for discussion?

i am happy to discuss of course
i do appreciate you raising this with me
kindest regards
Angela

I

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted]
Sent: 04 September 2020 12:06
To: Angela Wallace (NHS Forth Valley) [redacted]; PETERS, Christine (NHS GREATER GLASGOW & CLYDE) [redacted]
Subject: Re: Cryptococcus

Strictly confidential

Hi Angela, Christine is off sick today but I will elaborate on the key issues;

1) The patients clinician and the three Consultant Microbiologists present agreed that this case should be treated as a confirmed case of Cryptococcus neoformans. This is on the basis that the clinical picture fits, radiology changes fit, the successive positive CrAg tests have now been negative on two occasions following treatment with antifungals (these negatives have been confirmed by Bristol) I will leave Christine to discuss this further at the IPC meeting on Tuesday.

2) We were concerned to hear that the microbiology opinion in the IMT was that false positives CrAgs happen and are seen 'all the time' . This is not in fact the case. This goes back to what I said about differences of microbiology opinion . Pre 2015, I cannot recall such divergent views amongst microbiologists, which appear to have started during the 6A IMT of 2019. As mentioned in my email yesterday , this needs resolved.

3) Reference to duty of candour , whereby managers were suggesting the family be told this was not a case of Cryptococcus. I really hope we have misinterpreted this, but having been placed in a similar situation myself with a [redacted] last year, I am not confident that this is in fact the case.

Happy to discuss any aspect further if you wish. Mobile is [redacted]

kr
Teresa

Dr Teresa Inkster
Consultant Microbiologist, QEUH
National Training Programme Director Medical Microbiology
Dept of Microbiology

Queen Elizabeth University Hospital
Glasgow
Direct dial : [redacted]

From: Angela Wallace (NHS Forth Valley) [redacted]
Sent: 02 September 2020 18:40
To: PETERS, Christine (NHS GREATER GLASGOW & CLYDE)
Cc: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Subject: Re: Cryptococcus

Dear Christine,
Thank you for your email and i hope your meeting this afternoon with clinician colleagues was a positive one. I am sorry to hear of your concerns and that there are discrepancies in relation to the IMT, our team call and how the [redacted] were informed. I would be keen to understand these issues and support in any way I can. I look forward to hearing from you on Friday
Kindest regards
Angela

From: PETERS, Christine (NHS GREATER GLASGOW & CLYDE) [redacted]
Sent: 02 September 2020 17:17
To: WALLACE, Angela (NHS FORTH VALLEY) [redacted]
Cc: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted]
Subject: Cryptococcus

Dear Angela,
By way of follow up to our discussions this afternoon, I have just come off the call with Dr Sastry and I am in a bit of shock regarding discrepancies in what I have been told re the IMT and how the [redacted] were informed and what was revealed today.

I will reflect on this tonight and write to you on Friday regarding a series of serious concerns with regard to this situation.

kr

Christine

Fw: PICU patient result [redacted]

Inkster, Teresa [redacted]
Thu 10/09/2020 18:36
To: Inkster, Teresa (NHSmail) [redacted]

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted]
Sent: 03 September 2020 15:59
To: Angela Wallace (NHS Forth Valley) [redacted]
Subject: Re: PICU patient result [redacted]

Thanks Angela, I look forward to an update re this.

When I was lead ICD my aspiration was to have an open , transparent and proactive IPCT. I'm not saying that hasn't happened, I just don't see much evidence of such from the communications.

Regarding the difference of opinion with respect to the 6A bacteraemias in 2019, we have been asking for resolution of the difference of opinion since October 2019. It is a worry that there seems to be no way to address differences of clinical opinion within the organisation. There appears to have been similar differences of opinion regarding the recent Cryptococcal case , although I have not been involved. Moving forward we need a way to facilitate discussion when differences of opinion arise. What concerned me most was colleagues from another site attending an IMT last year without discussing any backround with QEUH microbiologists, and this has led to mistrust from the clinicians on a unit that we provide cover to every day.

I have this afternoon just chaired the National Consensus Group at HPS .There is an agenda item whereby boards can share learning from incidents . This is where GGC could shine and inform future policy as we have had so many complex incidents. It is frustrating that there has been no debrief from either the Cryptococcal or 6A IMT and opportunity for this learning to be shared nationally. Not to mention the outstanding Cryptococcal advisory group report

kr
Teresa

Dr Teresa Inkster
Consultant Microbiologist, QEUH
National Training Programme Director Medical Microbiology
Dept of Microbiology
Queen Elizabeth University Hospital
Glasgow
Direct dial : [redacted]

From: Angela Wallace (NHS Forth Valley) [redacted]
Sent: 03 September 2020 14:04
To: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Subject: Re: PICU patient result [redacted]

hi Teresa

thank you, i have met this am with senior ICT and other clinical leaders to ensure all actions that have been taken in relation to this can be communicated to key colleagues as you suggested and if any additional or further actions may be required. I will ensure this is made available quickly.
I hope you are well and wanted to check in if you were ok?
regards
Angela

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted]
Sent: 02 September 2020 15:00
To: Angela Wallace (NHS Forth Valley) [redacted]
Subject: Fw: PICU patient result [redacted]

Email trail as discussed .
kr
Teresa

Dr Teresa Inkster
Consultant Microbiologist, QEUH
National Training Programme Director Medical Microbiology
Dept of Microbiology
Queen Elizabeth University Hospital
Glasgow
Direct dial : [redacted]

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Sent: 31 August 2020 10:00
To: Valyraki, Kalliopi; KHALSA, Kamaljit (NHS GREATER GLASGOW & CLYDE); Bowskill Gillian (NHS GREATER GLASGOW & CLYDE); angela.johnsor[redacted]; Brown Mhairi (NHS GREATER GLASGOW & CLYDE)
Cc: Wood Kathleen (NHS GREATER GLASGOW & CLYDE)
Subject: Re: PICU patient result [redacted]

Thanks Pepi

Aspergillus spores are buoyant , released in bursts and will travel remote from source, so the leak at the other side of the unit might be relevant

kr
Teresa

Dr Teresa Inkster
Consultant Microbiologist, QEUH
National Training Programme Director Medical Microbiology
Dept of Microbiology
Queen Elizabeth University Hospital
Glasgow
Direct dial : [redacted]

From: Valyraki, Kalliopi <Kalliopi.Valyraki[redacted]
Sent: 31 August 2020 09:52
To: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE); KHALSA, Kamaljit (NHS GREATER GLASGOW & CLYDE); Bowskill Gillian (NHS GREATER GLASGOW & CLYDE); angela.johnsor[redacted]; Brown Mhairi (NHS GREATER GLASGOW & CLYDE)

FW: In confidence: PICU patient result [redacted]

Peters, Christine [redacted]
Fri 18/03/2022 16:21

To: Inkster, Teresa [redacted]

This was a very weird one
C

From: Devine, Sandra
Sent: 10 September 2020 09:35
To: PETERS, Christine (NHS GREATER GLASGOW & CLYDE) [redacted]; INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted]; Angela Wallace (NHS Forth Valley) [redacted]
Cc: Claire Peacock (NHS Forth Valley) [redacted]; Leanord, Alistair [redacted]
Subject: RE: In confidence: PICU patient result [redacted]

Hi Teresa/Christine

Thank you for your e mail and helpful suggestions regarding this very sad case. I have set out below the answers to some of your questions however, I will also raise this at the ICD buzz tomorrow and discuss any additional measures that may be considered.

- The ceiling void was inspected and no damp/mould was identified so a check with a moisture meter was not indicated.
- Water samples are not routinely tested for aspergillus. Pall filters are in present in outlets in PICU and theatre areas.
- There is no ongoing work with the ventilation system but some work is scheduled for next week and I will ask estates to visibly inspect any areas they work on for the presence of damp or mould. As you know they did some work pre pandemic and did not report anything untoward.
- HAI SCRIBE was completed by the IPCT.
- Air sampling has been done.
- This [redacted] was discussed with a Consultant Paediatric Intensivist, the surgical team and the PF who all considered that the presence aspergillus did not contribute to the sad death of this child.
- We are waiting on results from the air sampling before advising clinical colleagues of additional control measures that they might consider.

Thanks again.

kind regards
Sandra

Sandra Devine
Acting Infection Control Manager
NHS Greater Glasgow & Clyde
[redacted]

If you require an urgent response can I please ask you to telephone me as I am often in meetings and away from the office and unable to check voicemail until the end of the day. Thank you

From: PETERS, Christine (NHS GREATER GLASGOW & CLYDE) [redacted]
Sent: 09 September 2020 16:56
To: Inkster, Teresa (NHSmail) [redacted]; Angela Wallace (NHS Forth Valley) [redacted]
Cc: Claire Peacock (NHS Forth Valley) [redacted]; Devine, Sandra [redacted]
Subject: [ExternaltoGGC]Re: In confidence: PICU patient result [redacted]

HI Sandra and Angela,

We discussed this case again at the QEUH Consultant meeting this afternoon and there was unanimous agreement that this was a Fungal infection (ID yet to be confirmed by Bristol ref lab) and that on the [redacted] August Dr Khalsa

discussed the case and at that time ID, Clinicians and Micro were in agreement regarding this being a post operative wound infection and Ambisome was started. On the [redacted] August the plan was mediastinum clean out, and [redacted] was septic. The CRP was raised, the wound was described as grotty - hence the sending of the tissue sample in the first place, and pyrexial. Sadly the patient deteriorated despite maximal antifungal dosing. Haemorrhaging, friable wound is very much a sign of fungal infection. All these discussions are documented on Telepath.

I am unclear as to what the current understanding from an IPCT point of view re the status of the Fungal culture and the fact that this was an invasive fungal infection and as such would be an IFI HAI on a cardiac thoracic unit with ventilation issues.

kr

Christine

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Sent: 09 September 2020 15:13
To: Angela Wallace (NHS Forth Valley)
Cc: Claire Peacock (NHS Forth Valley); PETERS, Christine (NHS GREATER GLASGOW & CLYDE); Devine, Sandra
Subject: Re: In confidence: PICU patient result [redacted]

Thanks Angela

The issue is not the ventilation rather it is the water damage and the environment that creates i.e. growth of mould.
Given that the light fittings were affected I assume the leaking pipe is in the ceiling void. The key question is whether the ceiling void was inspected for visible mould or if damp areas were still present 48 hours later, and was any plaster checked with a moisture meter.

Aspergillus and other fungal spores disperse in bursts and will do so regardless of the ventilation specification of the unit. The spores travel far from the source as they are spiculated and very buyoant. Distance between spaces is irrelevant. We have guidelines for construction on hosptial sites and immunosuppressed patients for [redacted] very reason, that demolition remote from the site can lead to fungal infection.

Due to the burst phenomenon air sampling can be unreliable . The key is identifying any water ingress a[redacted]dealing with rapidy as per water damage policy.

The other thing to consider with this case is ECMO and the water as we have grown Aspergillus in the water supply before.

From a microbiology perspective the patient was treated with Ambisome, in fact we had to increase to the maximum 5mg/kg dose . Given that the fungus was in both tissue and a swab it is odd that the wound was not considered infected. We do occaisionally see Aspergillus colonisation in ICU patients but Aspergillus is not something you want to see in cardiac wounds because the outcome is always devastating. Given that there are babies with open chests on the unit and haem onc patients , any potential source needs addressed to prevent future infections.

kr
Teresa

Dr Teresa Inkster
Consultant Microbiologist, QEUH

From: Inkster, Teresa [redacted]
Sent: 30 September 2020 17:20
To: Angela Wallace (NHS Forth Valley) [redacted]; INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted]; Peters, Christine [redacted]
Subject: Re: Gent R Staph aureus

Confidential;

Hi Angela,

Re the MSSA PAG, my concern is that I first highlighted the gent resistant MSSA in NICU on Sept 8th and the PAG was not held until last Friday. There is a missed opportunity to put in control measures and prevent further cases. We don't normally await typing for such an obvious incident, as this takes time. The fact the strain was introduced into the unit in 2019 has been missed in the PAG with reference to only 4 cases.

Re the Cryptococcus , the meeting with the family was this afternoon . I have yet to see the report, I understand it is still in draft form. However, John did discuss his findings. Of particular concern was his reference to pigeon guano only being found in one plant room. This is not the case and there continues to be misinformation with regards to the Cryptococcal incident . His theory that Cryptococcus was acquired from a wide open space is not one I can concur with given all the evidence I have seen . Once again this highlights the inability to resolve differences of opinion between microbiologists and those with alternative views are able to make such statements without robust scientific evidence. Re governance, I would hope that the report once complete will come the IMT members for comment, I would be appreciate if you could help ensure that happens.

kr
Teresa

From: Angela Wallace (NHS Forth Valley) [redacted]
Sent: 25 September 2020 17:18
To: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted]; Inkster, Teresa [redacted]; Peters, Christine [redacted]
Subject: Fw: Gent R Staph aureus

Hello Teresa and Christine,
It is good to hear from you and many thanks for your email. I appreciate you sharing the typing results you had sight of these quickly and i will way of an update provide the most up to date info from the PAG. I would be happy to receive your feedback. I am not sure why the updates from the consultant's meetings are not available but happy to understand more.

I note the pre meeting Teresa with the family of the [redacted] cryptococcus case, I do hope the meeting went well. I am sorry there is a difference of opinion between you and John and i wondered if this was discussed in the meeting and how this will be able to be explored prior to the meeting, you may have this in hand? is the meeting soon?

I knew the report was pending and I am not aware if it is yet complete? I have from our most recent meeting the detail where you described to me governance steps that the report needs to follow, and I had taken this as an area to follow up together.

May i ask if you have asked to discuss or see the report? I would be happy to pick this up together if that would be helpful

Cryptococcus

Inkster, Teresa [redacted]

Thu 01/10/2020 15:11

To: Hood, John [redacted]; HOOD, John (NHS GREATER GLASGOW & CLYDE) [redacted]

Cc: Peters, Christine [redacted]; Angela Wallace (NHS Forth Valley) [redacted]

Hi John,

The meetings we have had over the past two weeks have raised more questions rather than answers re Cryptococcus;

1) Yesterday you stated to the patient's family that only one plantroom (123) had evidence of pigeon guano. The microbiologists involved at the start of the incident have photographic evidence to the contrary. Is the group not aware of this?
2) Reference to the pigeon guano only being wet. Again the photographic evidence and the guano witnessed by my own eye was dry in many places. There is also a photo from the pest control company with what looks like pressure hosing equipment in it , which we discussed previously risking aerosolisation . What was the reason for wet guano in the plant room, were they hosing it? You also mentioned the Scotland has a wet climate, given that cases have occurred in Scotland I do not understand the relevance of this statement.
3) You mentioned HAI was unlikely as renal patients unaffected. Renal patients are at less risk and we quickly implemented control measures in this group including prophylaxis and portable HEPA. Is the group aware of this? I don't think is a scientific approach, we wouldn't not attribute an environmental source just because another high risk group did not develop infections.
4) You have suggested the adult patient acquired Cryptococcus from a wide open space and you mentioned Queens park. Given that there are many [redacted] patients ,would we not expect to see this frequently? If we are saying there is a risk to lymphoma patients from public parks what is the public health advice to this patient group? Is there evidence of a pigeon issue at Queens park? What is the explanation for Cryptococcus in the child?
5)With respect to investigations, was a tracer gas released in the plant room? was thermal imaging employed given issues in Edinburgh with pigeons in walls? What was the outcome of the investigation into the risers and voids?
6) Is the group aware that the original epidemiology report from public health has omissions with respect to patients being admitted to the QEUH?
7) what is the theory behind the most recent case in a 2nd paediatric patient and is there any history of recurrent issues with pigeons?
8) At the start of the incident we recommended increasing the number of HEPA filtered rooms for high risk patients. Yesterday however you stated that the air quality in ward 4C is good. Given that air quality is only an assurance check, is the spec of ward 4C with less than 3 ACH in your opinion suitable for immunosuppressed haem onc patients? (it differs from that of the equivalent Beatson ward, so the same patient group is in a unit with better spec)

Can I have a copy of the groups report as per the terms of reference. It will need to be circulated to all IMT members for comment.

kr
Teresa

Re: Gent R Staph aureus

Inkster, Teresa [redacted]
Tue 20/10/2020 11:49
To: Peters, Christine [redacted]; Angela Wallace (NHS Forth Valley) [redacted]
Confidential

Apologies Angela, I have been on annual leave and just back today.
It is some time now since the MSSA PAG and I understand there have been more cases whilst I was on leave.

My concern was the time taken from the initial notification on Sept 8th to having a PAG and also no mention in the PAG or the Friday report that the MSSA strain was isolated in the unit as far back as Nov 2019. This gives valuable epidemiological information and points to a likely staff carrier.

Despite me alerting the team to this issue on 8th Sept a number of weeks passed before a PAG was held losing valuable opportunity to implement control measures and prevent further cases. I have heard phrases such as ' its not the same strain as last years outbreak' and'its not a toxin producing strain' . This is irrelevant, it is a new strain that has been introduced into the unit with the potential to cause HAI SABs.

It is rare to see resistance to S aureus in neonates as they are antibiotic naive. You will see sporadic acquisition from time to time from a colonised parent or staff member. However, this strain is persisting which fits with a staff carrier as the source.

I also understand there has been a further case of B stabilis whilst I have been away and another Aspergillus in PICU. These were two other incidents where I highlighted the need for early intervention.

As per Christines email, I do not understand what our role is here and remain concerned re the lack of proactive approach , something I raised at the very beginning. The concept of prevention is forgotten.

kr
Teresa

From: Peters, Christine [redacted]
Sent: 02 October 2020 17:07
To: Angela Wallace (NHS Forth Valley) [redacted]; Inkster, Teresa [redacted]
Subject: RE: Gent R Staph aureus

Thanks Angela,

Its good to be thinking about positive ways forward. I guess we have been trying to fulfil the expectation given to us by Jean Freeman and Fiona McQueen that we would be treated as part of the team looking to solve the recognised infection control issues due to our historical correct identification of the problems as well as qualifications in the field. This has not transpired and instead, as we all recognise, trying to work within the unchanged systems, or directly going to you due to that pathway being opened to us can be seen as cutting across the system.

Re: MSSA NICU

Jenny Copeland [redacted]
Wed 02/12/2020 14:07

To: Inkster, Teresa [redacted]; Angela Wallace (NHS Forth Valley) [redacted];
Peters, Christine [redacted]

Thanks I'll have a proper read later but a valid point from what we observe.

Thanks for sharing.

Jenny

Get Outlook for iOS

From: Inkster, Teresa [redacted]
Sent: Wednesday, December 2, 2020 12:18:57 PM
To: Angela Wallace (NHS Forth Valley) [redacted]; Jenny Copeland
[redacted]; Peters, Christine [redacted]
Subject: MSSA NICU

Confidential

Hi, I have attached an interesting paper from colleagues in Tayside - you only need to read the abstract to get the jist of it. Im not sure when we are next scheduled to meet but I would like to discuss this further

One of the things that I noted from the action plan sent out, was reference on several occasions to national guidance either awaited or unavailable.

This paper highlights the very different approach by colleagues taken in response to two cases of gent resistant SA , without any bacteraemias. They have no national guidance either but despite that they implement aggressive measures and publish.

kr
Teresa

RE: SMVN ¦ PHE S. capitis briefing note

Peters, Christine [redacted]
Wed 10/03/2021 10:54
To: Inkster, Teresa [redacted]; Macleod, Mairi [redacted]

Thanks Teresa,

I think you raise fair points. I try to communicate each and every issue the team identifies as they arise through the weekly buzz meetings. These have included:

Enterobacter in ITU, Fungal infections on PICU, increased gram negatives in NICU, CF rates of gram negatives, neuro infections, the new Cryptococcus case, mucor not being a contaminant, HAI Covid from early on, Staff testing going missing, in addition to the incidents you mention as well as implications of estates events such as leaks, water results with Delftia etc, lack of ACH in side room in neuro ICU, all in the past year while the OB has been operational.

I have been very clear about communication gaps, and differences of opinion both with the OD team and Mairi, and we have minuted in our consultants meetings issues arising as well as emailed information in real time to the IPCT.

I agree that issues are not fully resolved and I would be keen to find solutions going forward . I am particularly disappointed that it seems that your expert view is so readily set aside when you have such a wealth of knowledge and experience and I am unsure how this could be considered reasonable. We have over the past year been encouraged to give direct input to Angela but as the OB report is due out I think a new phase will be moved to and so it is really important to iron out these problems sooner rather than later.

Kr
Christine

From: Inkster, Teresa
Sent: 10 March 2021 10:26
To: Macleod, Mairi [redacted]
Cc: Peters, Christine [redacted]
Subject: Re: SMVN ¦ PHE S. capitis briefing note

Hi Mairi,

Thanks for getting back to me

Re S capitis - since 2016 we have had further outbreaks. In NICU at RHC in 2019 we had a Teico R strain which was discussed with PHE at the time by Alison with regards to the same clone in England . So given previous experience I would have thought notification of two cases in 2020 would have led to investigation.

Regarding the wider issues , Angela , Terri and Jenny are all aware of this. I have raised this many times . See attached emails re MSSA for another example. What concerns me is that one person suggested action was not being taken as I was the one raising the issue - I really hope that is not the case. You will also see in this email trail repeated requests by me to resolve differences of opinion

B stabilis is another example whereby I stated at the morning handover that we should not be applying standard HAI definitions and that the most likely source was a contaminated solution/fluid. If someone comes to A+E and has a contaminated infusion for example , that is not a community

and subsequently there have been more cases. The recent, fungal infections in PICU/NICU are a clear data exceedence and warrant investigation collectively, not to mention two cases of Cryptococcus in paediatric haemonc patients . How do we address this culture?

kr
Teresa

From: Mackenzie, Fiona M[redacted]
Sent: 26 February 2021 11:58
To: Mackenzie, Fiona M[redacted]
Subject: [ExternalToGGC]SMVN ¦ PHE S. capitis briefing note

Dear SMVN Member,

PHE issued the attached briefing note recently; some of you may have seen it already.
It advises of an increase in *S. capitis* infections in neonates in England and requests that isolates meeting the case definition are sent to the reference lab in PHE for the next year. In addition, if any Scotland sites are concerned they have an increase in *S. capitis* infections in neonates they are requested to make contact with ARHAI Scotland.

Many thanks,

Mairi

Dr Mairi Macleod
Consultant Microbiologist
Head of Service Microbiology an Virology, Greater Glasgow and Clyde

Chair of the SMVN AMR Diagnostics Sub Group

Re: Re ESBL NICU

Inkster, Teresa [redacted]

Tue 18/05/2021 12:09

To: Angela Wallace (NHS Forth Valley) [redacted]

Confidential

Hi Angela ,

Thanks for getting back to me

I would prefer not to have emails labelled confidential shared with the IPCT team.

I have continued to raise the issues with NICU in my role as a Consultant microbiologist via the agreed reporting structure. I escalate issues with Christine as HOD to take to the Buzz meeting and also with yourself as we had agreed. In addition, I inform the site ICD members of the IPCT who are present at morning handover meetings and the weekly consultant meetings. I also raised the NICU drain concerns at our meeting with Tom Steele in January this year and NICU ventilation in the action plan

If I was to contact any other member of IPCT or a member of the clinical team to discuss IPC concerns that would be outwith the reporting structure. It would be more appropriate for IPCT to request involvement or info from those with local knowledge or previously involved rather than be dependent on us contacting clinical teams/IPCT outwith an IMT process. I do not seek to undermine the IMT chair.

It is reassuring that ARHAI are aware of the increase in Gram negatives in the unit. As we are all aware from 2A/6A and the Case note review, it's not just numbers that are important but the nature and I'm sure the mention of Stenotrophomonas/Enterobacter/ ESBLS in addition to Serratia will be focusing their attention on the most likely source

The triggers you mention were developed by me locally but are not mine as such. They are a result of published work from the Oxford Radcliffe hospital in relation to detection of neonatal outbreaks. There has been a suggestion that they are over sensitive in the past. I would disagree with this as on all occasions they have detected an issue, we have found areas for improvement /sources and implemented control measures. I would suggest these are much more reliable than SPC charts for example which are not ideal for environmental organisms. Deriving baseline data when there have been outbreaks in the unit is problematic as the UCL is set too high. This was also a point made by the recent case note review.

I understand there has been a Serratia bacteraemia on the unit over the weekend and another IMT is planned for today. Rather than have individual microbiologists sending emails to clinicians and IPCTS in an uncontrolled fashion perhaps the paediatric microbiologist for the week should be invited to the IMT.

I remain concerned with regards to the approach with water testing. Following cases of Pseudomonas, Roseomonas and Stenotrophomonas in ward 4B water testing was only undertaken for Roseomonas. Yesterday we had another patient in the ward develop a Stenotrophomonas bacteraemia. I discussed this at the handover meeting and water testing will be requested again.

kr

Teresa

From: Angela Wallace (NHS Forth Valley) [redacted]

Sent: 17 May 2021 15:56

To: Inkster, Teresa [redacted]

Subject: Fw: Re ESBL NICU

Good afternoon Teresa,

Thank you for your email, it is good to hear from you and looking forward to summer. I appreciate you taking the time to share with me the clinical information from covering NICU last week.

Confidential

Hi Angela

I am covering NICU this week from a clinical perspective and it is a concern, as is the email below. The IMT seems focused on Serratia when in fact there is also a problem with Stenotrophomonas (4 in 4 weeks) , and ESBLs/Gent resistant organisms (some bacteria previously sensitive to gentamicin are now resistant). There are many publications pertaining to ESBL outbreaks in a NICU setting. It would be important to discuss all these organisms at IMT

The situation feels like deja vu. Similar to 6A where microbiologists from other sites chair the IMT and do not fully engage with the local microbiologists or myself as previous ICD. We have detailed knowledge of the local epidemiology and I have managed outbreaks in the unit for the last 3 years. It is a worry that no-one has asked us regarding that experience and what was found. Whilst fresh eyes are a good thing , knowledge of what has taken place historically is also relevant particularly with reference to the drains.

Serratia in this unit dates back to 2015 and an outbreak that resulted in IPCT members having to attend a meeting with SG to discuss SG concerns. I was not involved but my first task as the newly appointed lead ICD in April 2016, was to write a report of the lessons learned (attached). The outbreak was declared late, environmental screening was not undertaken in in a timely fashion and sadly there were baby deaths. So there is a long history of Serratia in this unit with a number of subsequent outbreaks since then.

Currently the colonisation burden is very high and this could therefore result in cases of bacteraemia/sepsis

kr
Teresa

From: Peters, Christine [redacted]
Sent: 11 May 2021 13:32
To: Harvey-Wood, Kathleen [redacted]; [redacted]; Inkster, Teresa [redacted]
Subject: Re ESBL

HI All,
At the buzz meeting today I was told IC are not interested in gent resistance on the unit and it has nothing to do with the other gram negative issues on the unit.

Do we have data for last 5 years on ESBLs and gent res and any previous outbreaks that were managed on NICU?

Kr
Christine

Fw: 4BMT

Inkster, Teresa [redacted]
Tue 22/06/2021 09:59
To: Peters, Christine [redacted]
FYI

From: Inkster, Teresa [redacted]
Sent: 22 June 2021 09:59
To: Stewart, Jackie <Jackie.Barmanroy[redacted]
Subject: Re: 4BMT

Hi , yes 4B should have monthly air sampling and also regular water testing done . I would suggest contacting Alison or Pepi regarding this so that they can arrange with the GRI environmental lab. The results would go to the ICDs for interpretation

kr
Teresa

From: Stewart, Jackie <Jackie.Barmanroy[redacted]
Sent: 22 June 2021 09:27
To: Inkster, Teresa [redacted]
Subject: 4BMT

Good morning Teresa,

Hope all is well. I received a phone call from Lisa Halliday the SCN in 4BMT.
Lisa asked if her ward should have water and air sampled regularly? If so who would do this and who interprets the results?

Thanks,
Jackie.

Jackie Barmanroy
Senior Infection Prevention and Control Nurse
QEUH
[redacted]

RE: Ward 4B particle count

Peters, Christine [redacted]
Thu 11/11/2021 13:17
To: Bagrade, Linda [redacted];Inkster, Teresa [redacted];Macleod, Mairi [redacted]
Cc: Joannidis, Pamela [redacted];Wallace, Angela [redacted];Bal, Abhijit [redacted]

Any implication was that Teresa was misrepresenting her role is unwarranted. She is not and any inference otherwise is unfair.

Kr

Christine

From: Bagrade, Linda
Sent: 11 November 2021 13:11
To: Inkster, Teresa [redacted]; Macleod, Mairi [redacted]; Peters, Christine [redacted]
Cc: Joannidis, Pamela [redacted]; Angela Wallace (NHS Forth Valley) [redacted]; Bal, Abhijit [redacted]
Subject: RE: Ward 4B particle count

Teresa,

As Abhijit has already stated in his email – he is discussing this with Lisa and Andrew.

As to the roles and responsibilities – I am referring to the fact that the email asking for interpretation of the results is sent to you without Abhijit being included. That's all.

Linda

From: Inkster, Teresa
Sent: 11 November 2021 12:36
To: Bagrade, Linda [redacted]; Macleod, Mairi [redacted]; Peters, Christine [redacted]
Cc: Joannidis, Pamela [redacted]; Angela Wallace (NHS Forth Valley) [redacted]; Bal, Abhijit [redacted]
Subject: Re: Ward 4B particle count

Sorry Linda, I am not sure what you are getting at with regards to roles and responsibilities. The clinical team are fully aware that I am not an ICD and that this is not within my remit. I stated that on the phone to them on Monday and again in an email to Andy this morning. I am however the designated microbiologist for BMT and therefore require information with regards to the environmental conditions on 4B. I would appreciate if I could be afforded the same respect that Brian Jones was with regards to this and copied into results and comms as previously requested.

Once again can we bring this back to the fundamental issue here which is the safety of this unit for admission of BMT patients? With regards to the ongoing issues you may not be aware but the abnormal results date from the end of August . Repeat air sampling is not a control measure, neither is a new policy or setting up a QM meeting. It is not clear as to whether any investigations into elevated particle counts/fungal growth and subsequent remedial measures have taken place.

I cannot comment on exclusion of IPCT from the email thread between Lisa and the clinicians. However ,I do feel it is entirely reasonable for a SCN to escalate this issue to clinicians when faced with decisions regarding admissions and no clear advice with respect to suitability of these rooms.

kr
Teresa

From: Bagrade, Linda [redacted]
Sent: 11 November 2021 10:59
To: Inkster, Teresa [redacted]; Macleod, Mairi [redacted]; Peters, Christine [redacted]
Cc: Joannidis, Pamela [redacted]; Angela Wallace (NHS Forth Valley) [redacted]; Bal, Abhijit [redacted]
Subject: RE: Ward 4B particle count

Hi Teresa,

Reading the e-mails below it is quite clear that Abhijit and Lisa have been discussing this and there is a plan in place to gather more information before the decision can be made. I cannot understand what exactly has changed in 1 day?

I am very surprised to see that IPCT has been excluded from this discussion in the middle of this e-mail thread.

I also do respect you position to exclude yourself from any involvement in IPC regarding ward 4B (and I assume in general) and I would really appreciate if you could make your position known to the clinical teams please so we can avoid misunderstandings about roles and responsibilities in future and all the questions related to IPC can go to the appropriate team directly.

Happy to discuss this further. I have also copied Abhijit in this response for information.

Kind regards,

Linda

From: Inkster, Teresa
Sent: 11 November 2021 09:23
To: Bagrade, Linda [redacted]; Macleod, Mairi [redacted]; Peters, Christine [redacted]
Cc: Joannidis, Pamela [redacted]; Angela Wallace (NHS Forth Valley) [redacted]
Subject: Fw: Ward 4B particle count

Morning, see email trail below. Can someone from IPC please get in touch with the team in 4B with regards the air sampling results.

There is discussion in this email thread about a new policy and a QM process - what they really need right now is a decision to be made as to whether they can admit transplant patients safely or not .

Sorry for email to all but awaiting clarity as to the escalation process for IPC issues following the Buzz meeting

kr
Teresa

From: Clark, Andrew [redacted]
Sent: 10 November 2021 22:32
To: Halliday, Lisa [redacted]; McQuaker, Grant [redacted]; Parker, Anne [redacted]; Inkster, Teresa [redacted]
Cc: Slowey, Bernadette [redacted]
Subject: RE: Ward 4B particle count

Well.... they are a bit lower. Ithnk they are OK but....
We need someone to be interpreting these or at least giving us some guidelines
Is this done routinely and I've just missed it or do I need to speak to micro

From: Halliday, Lisa
Sent: 10 November 2021 17:32
To: Clark, Andrew [redacted]
Cc: Slowey, Bernadette [redacted]
Subject: FW: Ward 4B particle count

Hi Andy,

Can you have a look at the particle counts below.
Rooms 79 and 91 are still currently being used for low risk patients and I just wanted to check if you are happy for them to be reopened for use to any patients.

Thanks

Lisa Halliday
SCN Ward 4B
BMTU
QEUH
Regional Services
[redacted]

From: Bal, Abhijit
Sent: 10 November 2021 16:29
To: Halliday, Lisa [redacted]
Subject: Re: Ward 4B particle count

Hi Lisa,

I have made this table for quick understanding. See attached, I am not sure if room 79 (but 91 was) has been rechecked ever.

We should all rooms with fungi sampled again.

Regards,

Abs

--

Abhijit M Bal
MBBS, MD, DNB, MNAMS, FRCP, FRCPath, FISAC, Dip Med Mycol
Consultant Microbiologist
Queen Elizabeth University Hospital, Glasgow
Honorary Clinical Associate Professor, University of Glasgow

From: Halliday, Lisa [redacted]
Sent: 10 November 2021 12:13
To: Bal, Abhijit [redacted]
Subject: RE: Ward 4B particle count

Hi Abs,

Can I double check if we are able to open rooms 79 and 91 to full high risk transplants as we discussed last week.

Kind Regards

Lisa Halliday
SCN Ward 4B
BMTU
QEUH
Regional Services
[redacted]

From: Bal, Abhijit
Sent: 09 November 2021 09:25
To: Halliday, Lisa [redacted]
Subject: Re: Ward 4B particle count

Hi Lisa, what was the name of the contact person for your quality meetings? Just so I can write to them for taking the policy on particle counts and fungal counts forward.

Thanks,

Abs

--

Abhijit M Bal
MBBS, MD, DNB, MNAMS, FRCP, FRCPath, FISAC, Dip Med Mycol
Consultant Microbiologist
Queen Elizabeth University Hospital, Glasgow
Honorary Clinical Associate Professor, University of Glasgow

From: Halliday, Lisa [redacted]
Sent: 19 October 2021 14:57
To: Bal, Abhijit [redacted]
Subject: RE: Ward 4B particle count

Lovely to meet you today.
I have forwarded to my team for discussion.

Many Thanks
Lisa

From: Bal, Abhijit
Sent: 19 October 2021 14:55
To: Halliday, Lisa [redacted]; Pritchard, Lynn [redacted];
Edwardson, Alison [redacted]
Cc: Devine, Sandra [redacted]
Subject: Ward 4B particle count

Hi Lisa,

Thanks for seeing me on 4B to discuss the air sampling related issues. As discussed, it would be worth having a regular monthly (or may be once in 6 weeks) meeting in order to have an oversight of the particle count and fungal count for the unit. We can then look at the process we follow and any intervention that may be needed. I have spoken to Lynn from infection control who is in agreement.

You might want to add people from your unit including medical staff.

Thanks,

Abs

Abhijit M Bal
MBBS, MD, DNB, MNAMS, FRCP, FRCPath, FISAC, Dip Med Mycol
Consultant Microbiologist
Queen Elizabeth University Hospital, Glasgow
Honorary Clinical Associate Professor, University of Glasgow

Re [redacted]

Inkster, Teresa
Wed 05/01/2022 11:54

To: Macleod, Mairi [redacted]

Hi, thanks, I will send a separate email re the environmental Gram negatives. It would also be useful to also discuss how we resolve differences of opinion as this is something that is outstanding from discussions with Jenny and Angela. Just wondering if it is better under IPC as the ICDs often have to leave for meetings before we get to AOB

kr
Teresa

From: Macleod, Mairi [redacted]
Sent: 31 December 2021 09:02
To: Inkster, Teresa [redacted]
Subject: [redacted]

Hi Teresa,
Still to put round dates for this year's cons meeting but will try and do this today (on lab slot with no trainee as they have COVID – hectic this week!).
I can add 'environmental Gram negatives' to agenda of next meeting under AOB for you to speak to.
You've marked the email as confidential but think it would b[redacted]air for ICDs to be given an indication of wha[redacted] you wish to discuss. Do you want to summarise it and I can [redacted]en share that with them in advance of the meeting?
Thanks,
Mairi

From: Inkster, Teresa [redacted]
Sent: 24 December 2021 10:36
To: Macleod, Mairi [redacted]
Subject: Fw: [redacted]

Confidential

Hi Mairi

I am concerned re the email trail below and the one attached. It is clear that there remains a difference of opinion between microbiologists in the QEUH and IPC regarding the management of environmental Gram negatives. I have been asking for a means to resolve differences of opinion for over 2 years now and would like to request that this is an agenda item on the next Cons meeting.

It is concerning to see an inconsistent approach with regards to investigation and reporting of such incidents and what constitutes an HAI after the number of incidents we have experienced, an independent review, OB report and a case note review. The comment in the attached email with regards to scrutiny is alarming, there is a need for an open and transparent approach and duty of candour at all times.

kr
Teresa

From: Peters, Christine [redacted]
Sent: 23 December 2021 16:53
To: Bagrade, Linda [redacted]; Inkster, Teresa [redacted]
Cc: Harvey-Wood, Kathleen [redacted]; [redacted]; Bowskill, Gillian [redacted]
Subject: RE [redacted]

Linda please do not frame a comment on your response to Teresa's email as an "attack" – it certainly was not written as such .

Teresa contacted you in good faith to inform you of results that she came acrossin her work load. She was not asking you about the original question, she was highlighting and communicating with you the discussion and typing she received were of relevance you as ICD for RHC.

The reason we are discussing it is that there is a difference of opinion emerging as to the assessment of that information . I suggest we discuss this at the next Consultants meeting in order to avoid further accusations of attacks.

Kr
Christine

From: Bagrade, Linda
Sent: 23 December 2021 16:44
To: Peters, Christine [redacted]; Inkster, Teresa [redacted]
Cc: Harvey-Wood, Kathleen [redacted]; [redacted]; Bowskill, Gillian [redacted]
Subject: RE: [redacted]

Christine, I really don't understand why you are attacking me like this?

If the original question has been dealt with – why are we having this discussion?
Teresa has not alerted me, IPCT was aware of this as soon as it is reported on ICNET. Also, you are misinterpreting my assessment of the significance of these cases. The situation was assessed and dealt with appropriately.

Have a nice Christmas,

Linda

From: Peters, Christine
Sent: 23 December 2021 16:15
To: Bagrade, Linda [redacted]; Inkster, Teresa [redacted]
Cc: Harvey-Wood, Kathleen [redacted]; [redacted]; Bowskill, Gillian [redacted]
Subject: RE [redacted]

Hi Linda,
I am not sure what you are implying here regarding the original question – that has been dealt with by [redacted].

Teresa has rightly alerted you to the fact that there has been a Pseudomonas death in NICU caused by an HAI Pseudomonas, with a second pseudomonas colonisation within 2 days.

This would meet the definition of an outbreak at the time – colonisations would count as a case with regard to gram negatives – and previously put in the context of other gram negatives on the unit. As there was no note

of this in the Friday reports she kindly highlighted this in case it had been missed. You have made your view clear on the significance of this and the assessment that single cases are not reported. This is a new practice, but this is still entirely appropriate of Teresa to highlight to you as the paediatric micro on this week dealing with the results. Thankyou Teresa for doing so.

Hope you have a good Christmas holiday.
Kr

[redacted]

Dr Christine Peters
Clinical Lead
Consultant Microbiologist
QEUH
[redacted]

From: Bagrade, Linda
Sent: 23 December 2021 15:39
To: Inkster, Teresa [redacted]
Cc: Harvey-Wood, Kathleen [redacted]; [redacted]; Peters, Christine [redacted]; Bowskill, Gillian [redacted]
Subject: RE [redacted]

No Teresa, we have not missed this and both cases were dealt with appropriately.

I also note that the original question was if microbiology team had any notes regarding the decision not to treat colonisation....

Kind regards and merry Christmas,

Linda

From: Inkster, Teresa
Sent: 23 December 2021 14:12
To: Bagrade, Linda [redacted]
Cc: Harvey-Wood, Kathleen [redacted]; [redacted]; Peters, Christine [redacted]; Bowskill, Gillian [redacted]
Subject: Re [redacted]

Hi , I thought individual cases of HAI bacteraemias from environmental Gram negs were reported . I recall sporadic Serratias being reported but perhaps this has changed.

As per email below there were two cases of Pseudomonas two days apart in NICU. I note on last weeks Friday report that there were two Pseudomonas isolates 7 days apart in RAH ICU with reference to water testing and the safety checklist. So I wondered whether you had missed the 2nd Pseudomonas in NICU as I imagine they would be dealt with and reported the same way ,particularly given the death of one of the patients.

kr
Teresa

From: Bagrade, Linda [redacted]
Sent: 23 December 2021 13:09
To: Inkster, Teresa [redacted]
Cc: Harvey-Wood, Kathleen [redacted]; [redacted]; Peters, Christine [redacted]; Bowskill, Gillian [redacted]
Subject: RE: [redacted]

Thank you, noted.

We wouldn't put individual patient case on Fri report normally.

Linda

From: Inkster, Teresa
Sent: 23 December 2021 12:23
To: Bagrade, Linda [redacted]
Cc: Harvey-Wood, Kathleen [redacted]; [redacted]; Peters, Christine [redacted]
Subject: Fw: [redacted]

Hi Linda- I am on for paeds this week and just making you aware of the discussion below from an IPC perspective with regards to this HAI Pseudomonas bacteraemia in NICU. The ref lab report has just come back to me today for authorising.

I note ano[redacted]r baby in NICU became colonis[redacted]with Pseudomonas two days later. I don't recall these case[redacted]eing on the Friday report so jus[redacted]ant to ensure IPCT are aware .

kr
Teresa

From: McGlone, Laura [redacted]
Sent: 22 December 2021 19:56
To: [redacted]
Cc: Harvey-Wood, Kathleen [redacted]; Inkster, Teresa [redacted]; Peters, Christine [redacted]
Subject: Re: [redacted]

Many thanks [redacted], that's very helpful and in agreement with what we thought,
Kind regards
Laura

From: [redacted]
Sent: 22 December 2021 19:51
To: McGlone, Laura [redacted]
Cc: Harvey-Wood, Kathleen [redacted]; Inkster, Teresa [redacted]; Peters, Christine [redacted]
Subject: Re: [redacted]

Hi Laura - sorry - forgot to copy in colleagues.
Best wishes
[redacted]

Inkster, Teresa

From: WALLACE, Angela (NHS FORTH VALLEY)
Sent: 07 May 2020 15:04
To: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Subject: RE: post-mortem cases for advice.

Brilliant
Perfect thanks teresa Claire and i will craft if you can work alongside me on this and i think using my OD colleagues on the zero meeting to create the space i am hoping will work well
I will certainly do all i can
A

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Sent: 07 May 2020 13:23
To: WALLACE, Angela (NHS FORTH VALLEY)
Subject: Re: post-mortem cases for advice.

I think the fundamental issue right now is that communication is not happening between IPC and the microbiology team at the South for whatever reasons. Ordinarily the ICD who is also a microbiologist should be the link and there shouldn't be a need for the meeting I have suggested below. I have attached a couple of examples of previous minutes from our microbiology consultant meetings and you can see under infection control the incidents discussed. That has completely diminished.

So ,until this is rectified and colleagues have confidence in the communications I see the meeting I suggested as something that can bridge the gap and it may be that it continues indefinitely if it works.

I think ideally the chair for the first few would be yourself and then following that the lead ICD or DIPC.

I think it would be worth discussing communication issues at the first meeting . Standing agenda items could be ; ongoing incidents across the city - summary of incidents and ongoing actions
any relevant laboratory issues
any new policies that might impact on labs or IC
any relevant research studies/audits

I think the minutes or action notes could then be disseminated to the microbiology consultant meetings on both sites to the IPC SMT and labs MMT for noting. Having site of the actions I think would reassure microbiology colleagues of close working between IPC and micro and transparency of issues.

Dr Teresa Inkster
Consultant Microbiologist, QEUH
National Training Programme Director Medical Microbiology
Dept of Microbiology
Queen Elizabeth University Hospital
Glasgow
Direct dial : [redacted]

From: WALLACE, Angela (NHS FORTH VALLEY)
Sent: 07 May 2020 12:33

To: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Subject: Re: post-mortem cases for advice.

This is brilliant Teresa thank you
I agree re the key areas and once we have agreed the right forum I can wrap around the governance and accountabilities and would have a rolling action type approach so there is visibility for all.
So if you were recommending to me what would work best most effective right now... what would you think?
Are you ok to work with me on this Teresa?
Kindest
A

Sent from my iPhone

On 7 May 2020, at 11:27, INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted] wrote:

> Hi Angela
>
> Previously we had a microbiology management team meeting (MMT) and a full IPC SMT monthly as separate meetings. Myself and Brian Jones attended both although due to other commitments I rarely made it to MMT and vice versa for Brian and SMT. These are also large meetings with long agendas , MMT was very lab based with other disciplines such as virology and ref labs attending. So, not the place to have focused discussion on IPC/micro matters . Also too retrospective as monthly frequency.
>
> In addition I attended a weekly smaller SMT IPC meeting with Sandra Devine/Pamela Joannidis/Ann Kerr/Kate Hamilton. If this meeting still happens I wonder if microbiology attend for part of it at least. I would suggest clinical leads for North (Mairi) and South(Christine) and John Mallon as over all technical lead. I think this would be the best forum to discuss ongoing incidents, concerns,any implications for micro in terms to sampling etc.
>
> In terms of communication in the department , I think attention to 3 areas would help hugely;
>
> Handover ;
>
> I think the handover situation needs resolved quickly. As mentioned this is a basic GMC requirement for doctors and they should be doing this from day 1 as an FY1. Its not happening currently for IPC for one of the ICDs. We have morning handover meetings at 9am everyday . I used to give a brief update of any ongoing incidents. I think it might be worth you discussing with Alistair re this so he can discuss with the onsite ICD the importance of doing so. Some days there will be nothing to report and thats fine.
>
> Ongoing communication;
>
> Outwith handover there also needs to be ongoing communication should any new issues arise during that day e.g. abnormal air sampling results, water damage impacting on patient placement,new outbreaks . Essentially anything someone covering out of hours needs to know. This communication is particularly important at weekends and I sent you examples whereby I had attached minutes from IMTs so colleagues have info to hand if needed

Consultant meetings;

Finally , there are regular updates at consultant meetings under the infection control heading of the agenda. This is the place to summarise and discuss incidents. It should be viewed as a useful opportunity for discussion and input from colleagues. Again this isn't happening very well currently . As I mentioned the other day I think there would be governance issues bringing IPC actions to this meeting as there is no structure and these meetings don't feed into any other committee.

An unresolved issue is how much information microbiology colleagues require and there will be differences of opinion here. Some wish only minimal info others want a lot more detail. We decided not to give access to all IPC minutes previously and I would share the info I thought was relevant for on call.

Hope this is of some help

kind regards
Teresa

Dr Teresa Inkster
Consultant Microbiologist, QEUH
National Training Programme Director Medical Microbiology
Dept of Microbiology
Queen Elizabeth University Hospital
Glasgow
Direct dial : [redacted]

From: WALLACE, Angela (NHS FORTH VALLEY)
Sent: 07 May 2020 11:00
To: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Subject: RE: post-mortem cases for advice.

Hi Teresa am grateful and i am happy to look into areas as i explained, so thank you.

I was so pleased by you help and support re setting up or reinstating ways of working, handovers and information sharing.

So, this group or way of micro and IC working together in the care of people in GGC....what do you think would work best....re how things were previously...SMT or Mmt....not sure i got these right....who needs to be there who best to chair in the current tentative steps needed to move forward.....what would a good agenda be...or should it be a board round?

Happy to be guided and thank you for your help

Kindest as always

Angela

From: [redacted]
Sent: 12 May 2020 10:08
To: Peters, Christine; Inkster, Teresa (NHSmail)
Subject: RE: Step 3 Whistleblowing Report

Thanks Christine,
I see that you were speaking to Marion yesterday but I have only just opened this now. I will read through and email Marion directly with any thoughts.
Best wishes,
[redacted]

From: Peters, Christine
Sent: 11 May 2020 09:47
To: Inkster, Teresa (NHSmail); [redacted]
Subject: FW: Step 3 Whistleblowing Report

Hi Teresa and [redacted],
Please find attached the report from the Whistle blow stage 3 . Please send me your thoughts/comments and I am discussing with Marion Bain this afternoon on how we can feedback formally .

Kr
Christine

From: Penelope Redding [redacted]
Sent: 08 May 2020 15:23
To: Peters, Christine [redacted]
Subject: [ExternaltoGGC]FW: Step 3 Whistleblowing Report

Here is attachment I hope

From: Haynes, Jennifer [redacted]
Sent: 07 May 2020 16:22
To: Penelope Redding [redacted]
Subject: Step 3 Whistleblowing Report

Dear Penelope

Please see attached the report into your whistleblowing concerns raised at Step 3 level, investigated by Mr Ian Ritchie, supported by Mr William Edwards

Kindest regards

Jen

Jennifer Haynes
Board Complaints Manager
Phone: [redacted]
Mobile: [redacted]
Email: jennifer.haynes[redacted]

From: Peters, Christine [redacted]
Sent: 18 May 2020 15:40
To: MacLeod, Allan (NHSmail)
Subject: RE: Confidential

Dear Mr MacLeod,

Thank you for your reply, and I remain happy to be contacted as necessary if required in the future.

Kr

Christine

From: MACLEOD, Allan (NHS GREATER GLASGOW & CLYDE) [redacted]
Sent: 18 May 2020 15:24
To: Peters, Christine [redacted]
Subject: [ExternaltoGGC]Re: Confidential

Good afternoon Dr. Peters,
Thank you for your offer to speak with me regarding the issue which has been raised by your former colleague Dr Redding.
I am anxious also not to add further to what is already a complicated situation.
Dr Redding has forwarded me a copy of a supporting statement dated May 2020 ascribed to both of you which details your joint understanding of the process that was initiated in September 2017. The contents were the main focus of my discussion with Dr Redding this morning and I am content that I have a full understanding of your joint position. Consequently I do not think it necessary to contact you in this regard at this time.
I am however at the very early stage of my review and as it progresses and issues arise which I consider you might be able to assist with I would look to make contact with you again.

Regards,
Allan MACLEOD

From: Peters, Christine [redacted]
Sent: 18 May 2020 13:01
To: MACLEOD, Allan (NHS GREATER GLASGOW & CLYDE)
Subject: Confidential

Dear Mr MacLeod,

Dr Redding has been in contact with me regarding a whistle blow Step 3 that she has initiated. She indicated that she had a conversation with yourself this morning and that it was suggested that it may be useful for me to be willing to discuss the matter with yourself or anyone else investigating as I took part in the original step 1 and step 2.

To be clear I have not seen the whistle blow wording, and I am not party to bringing it to Step 3, however I am happy to be approached to speak to any relevant persons as and when considered to be appropriate. Of note I have also raised concerns regarding the report she received re the other Step 3 with Dr Marion Bain and asked for advice on the correct procedure to take this forward. Dr Inkster has also seen that report and has written to Dr Ian Ritchie regarding her concerns.

There is therefore a lot of overlap in investigations, and I am keen to avoid accusations of following inappropriate channels and would seek clarity rather than confusion regarding how I should be engaging with any/all processes. Marion Bain has discussed this with Jane Grant and I await direction on what would be the appropriate way to proceed with concerns regarding the output from the Dr Ritchie investigation.

Please feel free to call me on my mobile (below). I will be free after an ITU ward round at 3pm , or from 4:30pm today, or another time this week if that is useful for you.

Kind Regards,

[redacted]

Dr Christine Peters
Consultant Microbiologist
Clincial Lead Department of Microbiology QEUH

[redacted]

109. Current issues

Julie Rothney

From:	Peters, Christine
Sent:	19 May 2020 17:51
To:	WALLACE, Angela (NHS FORTH VALLEY); PETERS, Christine (NHS AYRSHIRE AND ARRAN)
Cc:	INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE); Jenny Copeland
Subject:	Current issues

Hi Angela,

As requested

NICU
Staph capitis – note 2 cases – IPCT say not in adjacent bed spaces, however we have had issues with this organism before – and one is not considered an HAI due to missing the definition by 2 hours ! Main concerns are : this is patient to pateitn , can be environmental dust associated, and may have a few strains at the same time – Teresa can forward information from outbreak management before and relevant literature.
Immediate Actions should include : hand hygiene and environmental audit .

Stenotrophomonas – 2 cases , thought not be outbreak by IPCT as only one HAI , however this fails to recognise that first could transmit to second (indirect) and has an impact on the burden on the unit.

Decontamination room

This was raised since 2015 and is relevant as still not sorted and recent impact on PPE decontamination options

ITU
Enterobacter – not clear what actions taken – initial response despite 2 BCs was that as ITU busy and under stress not being persued. However this has potential to impact significantl on our COVID mortality rate

Overall increase in gram negative infections and MRSA – has this been picked up by surveillance

Water results and actions post pseudomonas bacteraemia in ITU – no update to the Micro team

PICU

Ventilation – note from action plan is being followed up
Trough sinks were to be removed – is this followed up?
Note roof leaking – no clear analysis of issue

Would like to view the data on which the conclusion "no environmental links " is based important to grasp that direct typing matches in environmental outbreaks is rare.

Klebsiella Philipshill – national IMT with a local new case – what actions have been taken ?

PPE for porters – only use one pair of gloves all day – still in place – repeatedly raised by lab staff

Historical Issues with current potential consequence

1. PPVL - we now note this has been recognised as an issue in the issue log that you sent today – however getting HPS and HFS involved again is circular as they have previously reported – there is now an AECON report that should be alluded to and Jim Leiper report neither shared with Teresa while lead ICD (? Unsure

why that would be) Teresa infact requested an assessment by Prof Noakes which would be more useful. OF note the Court summons to Brookfeild identifies as an issue the flaws in the PPVL rooms that we identified in 2015

2. 4C – SBAR was approved by the specialist ventilation group for upgrade, however HSE request for upgrade challenged by GGC , of note residual risk to all high risk patients (Haematologists in agreement) of the current parameters.

3. 6A IMT – need a review of the epidemiology and the interventions in a timeline as to the correct lessons learned (I will forward an SBAR from the team here at the time)

4. Water group – taps – agreement re maintenance schedule – no evidence this is in place, replacement taps – where have they been put in? POC filters were originally meant to be in place on ITU – what is risk assessment re this not being carried out (as it never was), NiCU taps and sinks were to be replaced as follow up to Serratia.

5. Drain cleaning policy – outstanding

6. Education and awareness around sink hygiene in all areas.

7. Specialist ventilation group – NICU , SCBU, adult ITU – had failed validation – has this got an action plan in place

8. Endoscopy suites deviation from standards - ? followed up with action plan

9. 4B – we are aware of grave concerns expressed by John Hood due to significant levels of fungi in air sampling – has this been followed up and what is the system in place to alert Microbiology team when these are out of spec. ? is there a finalised air sampling SOP (Teresas was scrapped and HPS asked to write a new one, and they promptly asked Teresa for her advice . we can talk more about this , but I would recommend re instating Teresa's evidence based policy)

   Upgrade with ante room to ward was considered – is this being followed up?

10. Duty of Candour policy (as noted)

11. Cardiac Heater Coolers – is air sampling in place and results followed up?

12. Theatres QEUH – door shutting replacements and final validation

13. Cleaning SOPS – there was due to be a methodology review – was this completed and recommendations actioned

14. Surveillance – SPC charts do not pick up problems in real time with environmental and non endemic organisms . Trigger points or time from last isolate are more useful in this regard. What are the triggers in place for critical areas can these be shared with Micro

15. Chilled beams – is there evidence that cleaning rates and alterations to dew points have ensured no further leaks , how are condensation and leak events being reported to IPCT ?

That's all I can think of just now and we can forward documents that we have previously written which may help with the detail for your background.

I can't help but note a lot of the actions now taken forward in the circulated action log were initiated by us , and while it is good to see follow through , it is a little hard to see that our ability to assess the implementation is

severely limited by our current position. Of particular concern I am not convined that the ICNs would have the expertise to assess all the isolation rooms – having not long ago assisted in room assessments with ICNS.

Thanks for being willing to look at these issues.

[redacted]

Dr Christine Peters
Consultant Microbiologist
Clincial Lead Department of Microbiology QEUH

[redacted]

Julie Rothney

From: Peters, Christine
Sent: 19 May 2020 17:58
To: 'WALLACE, Angela (NHS FORTH VALLEY)'; 'Jenny Copeland'; Inkster, Teresa (NHSmail)
Subject: documents for background
Attachments: SBAR 6A incident data.doc; SBAR PICU Gram Negative Infections 2020.doc; SBAR PICU Gram Negative Infections 2020PDF.pdf; SBAR PICU Ventialtion Vaidation.docx; Infection Control SBAR6.12.17 final.doc

Hi Angela, some light reading :)

[redacted]

Dr Christine Peters
Consultant Microbiologist
Clincial Lead Department of Microbiology QEUH

[redacted]

Inkster, Teresa

From: Jenny Copeland [redacted]
Sent: 19 May 2020 16:48
To: WALLACE, Angela (NHS FORTH VALLEY); PETERS, Christine (NHS AYRSHIRE AND ARRAN); Inkster, Teresa
Cc: Hunter, Terri; marion.bain[redacted]
Subject: Actions from review meeting 19.5.20

Apologies:
Marion Bain; Terri Hunter

Please see below actions from today's meeting and completed action log from our last meetings.

Many thanks

Jenny

No	Topic	Action	Owner	Progress
1.19.5	WB process	Follow up and feedback loop required. MV awaiting JG response	MB	
2.19.5	Patient placement policy	AW to progress accordingly	AW	
3.19.5	Outstanding issues	All to consider how best to conclude the issues and define a way forward.	AW	
No	Topic	Action	Owner	Progress
1.5.5	Microbiology Meetings	JC and CP to meet re Consultant meetings and handovers and subsequent governance	JC	Planed 20.5.20
2.5.5	Meetings	AW to liaise with TI and CP to explore how to organise a "zero" meeting, agenda and working agreement with a view to holding a meeting w/c 11/5/20. TI and CP to consider who should chair and co chair this and wider membership.	AW	Completed
3.5.5	Email issues	AW to share action plans relating to outstanding email issues.	AW	Completed
4.5.5	Issue log	JC and Th to cross-reference with themes and colour code accordingly. Clinical issues to be also coded post "zero" meetings collectively.	JC	CF post discovery write up
5.5.5	WB policy	MB to review WB issue raised and advise of appropriate channel for resolution	MB	CF
No	Topic	Action	Owner	Progress
1	Discovery email	Copy of original call up email to be sent to CP and TI	TH	C: 23.4.20
2		CP to provide additional names to be invited	CP	C: 23.4.20
3		JC to ensure email is sent to wider distribution	JC	C: 15.5.20

4	Communications	CP to provide AW with further detail relating to communications issues	CP	C: 23.4.20
5	Check-ins	AW to arrange for weekly email check-ins through Claire	AW	C: 27.4.20
6	Review meetings	MB to arrange 10 day review meetings via Pauline	MB	C: 24.4.20

Jenny Copeland
Principal Lead CNO SEND
Leadership and Talent
NHS Education for Scotland
T: [redacted]
E: [redacted]

Organisational Development, Leadership & Learning

Inkster, Teresa

From: Jenny Copeland [redacted]
Sent: 19 May 2020 15:24
To: PETERS, Christine (NHS AYRSHIRE AND ARRAN); Inkster, Teresa
Subject: Fw: [External] Action Plans
Attachments: PICU Action Plan 13 05 20 SD docx FINAL.pdf; IPC Overall Action Plan Version May20 docx FINAL.pdf

As agreed on call.

Jenny

Jenny Copeland
Principal Lead CNO SEND
Leadership and Talent
NHS Education for Scotland
T: [redacted]
E: [redacted]

Organisational Development, Leadership & Learning

From: PEACOCK, Claire (NHS FORTH VALLEY) [redacted]
Sent: 19 May 2020 14:24
To: BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND) [redacted]; Jenny Copeland [redacted]; Hunter, Terri [redacted]
Cc: PEACOCK, Claire (NHS FORTH VALLEY) [redacted]
Subject: [External] Action Plans

On behalf of Professor Angela Wallace,

Dear all,

Please find attached a copy of the GGC Operational and PICU Action Plan. This was an action from a previous meeting and I wondered if it would be helpful to share prior to our meeting?

Kind regards

Claire

hello my name is...

Claire Peacock
PA to Executive Nurse Director / Admin & Clerical Supervisor
Nursing Directorate
Forth Valley Royal Hospital / Stirling Road / Larbert / FK5 4WR

[redacted]

PICU
Action Plan May 2020

Date	Action	Action Required	Lead	Timescale	Update
12/03/20	HPS PICU Inspection	HPS to provided SBARs following the initial assessment and these have to be shared with the group	HPS		Circulated to the group in January. HPS to provide and update. Information sent as requested. COMPLETE
12/03/20	Reduction in ventilated days from 2017 – 2019	• Data to be shared with the group.	J Rodgers	Ongoing until group is stood down	This data is being updated and submitted as requested.  VAP DATA.docx COMPLETE/ONGOING
12/03/20	Environmental sampling of the drains	• Testing will be carried out once a month until the Water Technical Group • Agree a protocol which will be forwarded to the Board Water Safety Group and then ICBEG for agreement.	A Leonard		Environmental sampling of the drains was carried out for 6 weeks. No linkage to organisms in the drains. HPS agreed to stop sampling while there was no ongoing incident and no new cases for 6 weeks. No guidance received re interpretation. COMPLETE
12/03/20	Environmental Audit Results	• Discussed with a third party, DXC.Technology, who run a lab system and have an analytical programme platform. This will allow them to analyse over 20,000 environmental samples.	A Leonard		Information sent. COMPLETE

PICU
Action Plan May 2020

Date	Action	Action Required	Lead	Timescale	Update
12/03/20	Typing Results	• Increased incidence of *Acinetobacter* Consider "fogging" which is a way to decontaminate environmental surfaces or disinfect the air in patient rooms e.g. ozone mists, vaporized hydrogen peroxide (HPV).	All		Not feasible in current situation. This will be reviewed again post first wave of pandemic. COMPLETE
		• If another case of *Acinetobacter* is identified consider sourcing company in from Coatbridge to look at the area. • Decision making to be made soon if possible considering the potential increase in COVID-19 patients and ITU potentially having additional patients. • Pre work would need to be carried out before implementation	Group		No new cases Please see above COMPLETE
12/03/20	Person to Person	• To be forwarded to the Clinical Review Group to review or update. • The Clinical Review Group meet weekly and discuss any actions.	GB/MS/JR		Ongoing. Group has now been stood down. Action plan will now be completed and forwarded. COMPLETE

PICU
Action Plan May 2020

Date	Action	Action Required	Lead	Timescale	Update
12/03/20	Antimicrobial Prescribing Patterns	• There is historic data from 2009 – 2017 - no update of the analysis – Timeline to be produced.	A Turner	Complete	This is historic data from 2009 – 2017 and a timeline will be produced within the next month. Review of antimicrobial prescribing in PICU undertaken and data will be available 15/05/20
12/03/20	Changes in Patient Characteristics in Particular around Technology Dependencies	• Reviewing pathway for patients from Ward 3A as there is delayed movement.	RHC SMT	Complete	RHC SMT is looking at a better pathway for patients from Ward 3A as there is delayed movement. The capacity of Ward 3A, ventilation and transmission to adults is being discussed. This has been entered on to the directorate's Risk Register and noted at the Clinical Governance Committee. COMPLETE
12/03/20	Staffing	• As part of the weekly Clinical Review Group a review of all vacancies in place ensuring they have been signed off with all aspects of the recruitment process	J Rodgers	Complete	All vacancies have been looked at ensuring these have been signed off with all aspects of the recruitment process. PICU is commissioned to have 19 beds and that there are discussions with the Commissioner to increase to 20 beds by April and then to 22 beds thereafter. A paper has been circulated to the Chief Operating Officer regarding this. If accepted that will mean an additional 30 nurses for PICU. A recruitment campaign would be launched and focus on experienced adult ITU nurses as well as new graduate paediatric nurses. Other issues have an indirect impact on nursing staff in PICU and this has been escalated. At the present time they have the correct ratio of nurses to patients with 17.8 beds. If they go above 17.8 beds then other measures are put in place e.g. transfer resources from other areas, postpone or cancel non urgent elective cases to keep the correct ratio.

PICU
Action Plan May 2020

Date	Action	Action Required	Lead	Timescale	Update
					COMPLETE
12/03/20	VAP analysis	• Circulate feedback from Professor Bain, Keith Morris and Lesley Shepherd regarding improvements • Review VAP information and feedback comments prior to conclusion	A Wallace L Imrie		Evidence around the QI for VAP and the analysis that supports sent to HPS. HPS to review the VAP information and feedback comments. COMPLETE
	BAL Blood Culture	• Continue to compile charts for blood cultures • Root Cause Analysis report complete and one page SBAR being developed • Root Cause Analysis executive summary to be developed and added to the CNO Framework.	KH/NS		No further cases of blood culture since 23th January 2020. There have been Three further cases of BBALs all investigated and have been included in statistical control charts (below) all of which are within expected limits. PDF 2020_05_06_PICU-SPCs_BAL and BCs-up SBAR PICU.docx RCA report completed and was sent as a paper at the last formal meeting of the group.
	The range of hypotheses identified are being worked through (in collaboration with HPS). For most, the evidence collected suggest they	• Water as a source looks very unlikely based on current data *Historical data and examination of potential linkage to previous clinical*	A Leanord	Ongoing	Scoping contract with contractor being drafted Meeting with HPS team occurred. COMPLETE

PICU
Action Plan May 2020

Date	Action	Action Required	Lead	Timescale	Update
	are unlikely to be the cause and/or they could potentially have contributed previously but actions to address this have been or are being undertaken. Further work is being undertaken in several areas.	*isolates is very complex to undertake but some external input/ consultancy to assist is being progressed – further details and timescales to be provided.*			
		• Previous person to person spread is a potential route but current hand hygiene audits show high compliance. Weekly enhanced visits are continuing. *For clarification – how long will these continue for?*	G Bowskill S Devine	Suspended 17.03.20	Weekly enhanced supervision and hand hygiene audits suspended from 17.03.20 due to COVID-19. Hand hygiene compliance was very good throughout. Minimal issues highlighted on weekly enhanced supervision. COMPLETE
		• Staffing (in particular not numbers but specific PICU expertise) could have been a potential contributor. •	J Rodgers		Vacancies are being actively addressed along with adjustments to staffed bed numbers to reflect needs. COMPLETE
		• The VAP hypothesis has robust information showing significant focus and improvement after the VAP bundles were been put in place	A Turner		Some further work is being undertaken looking at linkages to antibiotic prescribing. Review of antimicrobial prescribing in PICU undertaken and data will be available 15/05/20 COMPLETE

PICU
Action Plan May 2020

Date	Action	Action Required	Lead	Timescale	Update
		• There has been further clinical discussion with international colleagues about BALs and there appear to be no agreed standards to work to for this. *There is a specific question outstanding from SG colleagues as to whether there is variation in practice from what is described in the SOP.*	N Spenceley		The SOP for BAL's has been revised and appropriate education delivered  Guideline Blind Bronchoalveolar Lava COMPLETE
	There is still outstanding work to be done on the ventilation hypothesis.	• Confirmation of the date of the meeting to discuss this is required.	S Devine A Leanord		A meeting has been scheduled with HPS/HFS – Wednesday 20th May 2020 IN PROGRESS
Ay		• An additional question is whether something has changed in the ventilation since January which would explain why there were cases in January but none since then?	J Rodger J Redfern		This meeting with HPS/HFS will explore this.
	There is a specific question outstanding from SG colleagues about whether there was any relevant learning		S Devine A Leanord		• Parents and staff were asked not to pour water or other fluids down sinks and that sinks should be dedicated for HH. • Fans were removed from the area. • Theatre was reviewed and no issues re

PICU
Action Plan May 2020

Date	Action	Action Required	Lead	Timescale	Update
	from the similar A. baumanni BAL incident in PICU which occurred in late 2017.				cleanliness were identified. • Observation of BBAL procedure – no issues identified. COMPLETE

Professor Angela Wallace
Executive Nurse Director

Greater Glasgow & Clyde

Infection Prevention Control

Action Plan

Action	Requirements	Lead	Timescale	Position	Status
Finalise Patient Placement SOP's	Approval of final SOP. EFM develop a system which continually updates validation information. This in turn should be linked to the SOP rather than stated within.	ANDIPC	28/02/20	Update May This SOP has been approved by the Board Infection Control Committee and is now available on line. Patient Placement SOP Final.doc	Complete
Patient Placement SOP in place	For final approval	SD	12/05/20	Update May This SOP has been approved by the Board Infection Control Committee and is now available on line	Complete
Additional signage for ventilation rooms	Signage to be added at doorways for RAH and GRI.	ANDIPC	28/02/20	Signage already available at door to all ventilated rooms in GGC. Signage added to SOP Patient Placement to support correct patient placement 25/02/20 HEPA FILTERED PPVL Room Poster.dc Negative Pressure Room Poster.doc NON-HEPA FILTERED PPVL Room	Complete
Physical check of ventilation rooms and	To be undertaken by estates and IPCN,	IPC Lead	02/03/20	Walk round to be completed by 28/02/20. ICNs will:	Complete

Professor Angela Wallace
Executive Nurse Director

Action	Requirements	Lead	Timescale	Position	Status
confirmation that they are fit for purpose	however it should be noted that this will be a visual inspection. Ongoing operation of the system is validated yearly to confirm they are fit for purpose. This process is ongoing.	Nurses & EFM		1. Check description of room in SOP against validation document 2. Check signage correct 3. Check no concerns raised by ward staff re room (failed pressures, leaks etc.) 4. Check staff know what room is and what used for. Crib sheet being developed by NCIPC (draft attached) and will issued by 04/03/20. Patient Placement Aide Memoire (Feb 2 The assessment of the rooms will be based on the criteria set out in the cribsheet. A report on this will be submitted to the ICM by 03/03/20. Update April Report from ICNs that no issues were identified.	
Action	**Requirements**	**Lead**	**Timescale**	**Position**	**Status**
Specified questions relating to the use of CDU Room 17	Consideration to use of room for suspected Convid-19 case	Lead ICD & ANDIPC	06/03/20	Review of SBAR by Dr Inkster and Dr Hague (2018) re use of PPVL rooms for airborne infection (Not HCID) circulated to IPCT for comment. 25/02/20 Review by ID Consultant team 26/02/20 SBAR RHC airborne infection (final).docx	No comments received. This document is out of date due to changes in estates –

Professor Angela Wallace
Executive Nurse Director

Action	Requirements	Lead	Timescale	Position	Status
				Any comments received will inform patient placement but it should be noted that some of the information in this is not extant as some of the rooms have been updated to negative pressure rooms. Comments received will be mapped against the patient placement document,	patient placement doc should supersede this.
Forward Plan for Convid-19	Include daily checking of room pressures in the ID ward and plans for decontamination.	SCN and EFM	Complete 27/02/20	HPS guidance for the decontamination of rooms is available on each desktop via the IPCT site. NB this is the same precautions as those outlined in the SOP for the terminal clean of a room.  sop-terminal-clean-of-ward-and-isolatio There is no specialist ventilation in the ID wards so daily checking of room pressures is not applicable. NB Advice from HPS is that chilled beams should be decontaminated as per manufacturers instructions.	Complete
Gram negative incident in PICU.	Weekly PICU Clinical Review Group Meetings (CRGM)	GM Paediatrics and neonatology	Complete End of March	PICU CRG set up by W&Ch Directorate. Two weekly meetings held to date (17/02/20 and 24/02/20) Enhanced supervision will be carried out weekly for next 4 weeks and reported at PICU CRGM. Stood down but action plan still live and continues to be updated.	Complete

Professor Angela Wallace
Executive Nurse Director

Action	Requirements	Lead	Timescale	Position	Status
Water Damage SOPs	Progress with documentation based on microbiologist version	ANDIPC	06/03/20	Update May Approved by BICC May 2020 SOP Water Damage.doc	Complete
Annual IPC Programme 2020-2021	For final approval		28/04/20	Approved May BICC Annual IPC Prog 2020-21 - Final.doc	Complete
Outstanding work to understand how PPVL rooms are working	Work required to ensure we know what patient groups these rooms are suitable for given that they deviate from the recommended specification with extract modifications 2016-06-29 QEUH isolation rooms report	EFM	12/05/20	There are a number of derogations in relation to the PPVL rooms which should be part of a formal scoping exercise involving EFM, IPCT and external experts (HFS). The report attached is from 2016 and some of the issues raised will have been resolved including the conversion of some rooms to negative pressure isolation rooms but this report should be updated with new information available. This should enable GGC to determine which rooms should be used for specific groups of patients. HPS/HFS on emergency footing re COVID-19 we have been unable to progress. This SOP has been approved by the Board Infection Control Committee and is now	Complete

Professor Angela Wallace
Executive Nurse Director

Action	Requirements	Lead	Timescale	Position	Status
				available on line.  Patient Placement SOP Interim - v1.4.doc	

Inkster, Teresa

From: Peters, Christine
Sent: 21 May 2020 19:37
To: WALLACE, Angela (NHS FORTH VALLEY); Jenny Copeland
Cc: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE); PEACOCK, Claire (NHS FORTH VALLEY)
Subject: RE: IPC Overall Action Plan Version May20 docx FINAL.pdf CONFIDENTIAL

Thanks Angela, I know there will be a lot to take in and concentrated work to cover all the details. Lots of coffee.

I think from our point of view; we were told back in January that we would have input at the oversight Board level, that we would be able to influence the way forward through that , that our expertise would be listened to in sorting out what was acknowledged to be a defective situation with regard to IPC in GGC with full and direct engagement . This morphed into meetings with Marion, which while useful, served to create an even bigger distance between us and the IC machinery in terms of seeing through a problem solving approach, making use of our expertise and historical knowledge base. Of note we have not been at any of the oversight meetings or subcommittees - we were told we would have input into the comms, the IC and the estates aspects and only saw the action plan on Tuesday (thanks for sending though !) .

Given the assurances by the Health Minister in Parliament that the whistle blowers were welcomed in their actions, and assurance that they would assist in bringing about changes – the way this has evolved has not met with my expectations. Honestly, it feels like the briefing to all those involved is that the dysfunctional team is the safety issue (not the issues) and that Teresa and I are the root problem. This may not be the case , however it does feel like that from this angle.

We were also told we would meet with Sandra Bastillo regarding our questions about public statements(some of which included personal statements regarding us, or included our emails). This has not occurred either – and we have not complained as we understand entirely that COVID came along , and as I said in emails at the time , we wanted to ensure all energies were focussed on that unprecedented challenge. This may come into the meeting with Johnathon Best .

We were also given to understand we would meet with Prof Craig White re the statements to parents of Paeds Haemonc. This has not occurred. I think this will be taken up with Johnathon Best .

We also requested a meeting with Brian and Al and the Board to go over the details of the 6A epidemiology and results, I think this has evolved into a meeting with Johnathon Best.

Likewise the issues raised with Fiona McQueen regarding the HPS WB investigations and report were to be taken forward – I think this is also to be incorporated into a discussion with Johnathon Best.

Let me be clear – meeting with JB in these circumstances is not an easy ask, and we only agreed with the intent of being helpful – again – in the hope that patients safety will be served well by this process.

Teresa was informed she would have input into the case note review for 2A, but this ended with me simply sending a list of CHIS .

We were told we would get backfill to enable us to do this role in bringing about change – this became me getting paid for 2 sessions a week on my day off for a month with no help coming from GRI for my backfill. Again thats ok in that COVID came along – but not OK in that there was clearly no buy in from my management to this process.

In summary – I can see how hard you and Marion and Jenny have worked and are working , I appreciate it very much indeed. However it feels like GGC have been managing the agenda and keeping us in as impotent and uncomfortable a position as possible . Certainly there has been zero evidence of any GGC personnel recognising either the validity

of our concerns, nor the unacceptable nature of our treatment on many levels. Since October I have had zero contact with my line manager bar 6 or so emails, one meeting with my Clinical Director re PICU with no feedback, seen my General manager maybe 4 times , and had only an apology email from our Laboratories manager for having missed us off a rather important email list (which also missed off most of my QEUH collegues). Hopefully the OD process will tackle the more thorny issue of post traumatic stress following repeat incident of targeted behaviours,

I speak for myself that when I say that I was expecting a more externalised approach to the Board IPCT management , and to feel a recognition of the failures that led to patient harm. Instead I feel less and less confident of real heart change – with recent evidence of deep seated and entrenched ideation eg its better to call an infection not an HAI, ignore possible index cases, misinterpret environmental testing, hide information, if there is no national agreement we cannot do anything, better to discuss matters in corridors not meetings where minutes happen, ensure minutes are circulated late so no one remembers, cancel uncomfortable meetings and so on. That is what we are unpicking and working to sort. I am fully onboard with that . However I am not on board with repetitions of misinformation going unchallenged or poor IC practice and I know you certainly are not either ! Neither can I accept a narrative re behaviours that I do not recognise re the 6A IMT and the subsequent management of the concerns raised.

I understand that the Review report will be released soon . Our level of expertise of what has happens means we will be in a position to assess its conclusions from a position of knowledge, and I think that final conclusions may be yet sometime in the future.

Finally thank you for your thoughtful approach to this situation . I am committed as ever to finding a way forward and will help in any way I can. It is complex, it is detailed , the science is not readily accessible, and there is fog around facts but we have made a start.

Kr
Christine

PS the WB scenario is a whole other email ... i will spare you that tonight

From: WALLACE, Angela (NHS FORTH VALLEY) [redacted]
Sent: 21 May 2020 16:24
To: Peters, Christine; 'Jenny.Copeland[redacted]'
Cc: Inkster, Teresa (NHSmail); PEACOCK, Claire (NHS FORTH VALLEY)
Subject: [ExternaltoGGC]RE: IPC Overall Action Plan Version May20 docx FINAL.pdf

Hello Both,
Many thanks for doing this for me, i have just printed these and will look at these first thing tomorrow.
If its ok i may need to pop back or get your help.
Thanks for taking the time, i will pull all the process re development of this to help me re the comments
Regards as always
Angela

From: Peters, Christine[redacted]
Sent: 20 May 2020 17:19
To: WALLACE, Angela (NHS FORTH VALLEY); 'Jenny.[redacted]'
Cc: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Subject: IPC Overall Action Plan Version May20 docx FINAL.pdf

Hi Angela,

Please find attached our joint comments on the IPC Action plan .

Hope you have had a good day,

Kr
Christine

Whistleblowing Report
Step 3
Case 1-2020/21

1. Introduction

On 20 April 2020, Dr Penelope Redding, a retired Consultant Microbiologist, emailed Ms Jennifer Haynes, Board Complaints Manager for NHS Greater Glasgow and Clyde (GGC), who supports the whistleblowing process, requesting that a new Step 3 investigation be undertaken in line with the Board's Whistleblowing Policy. The subject matter was regarding Dr Redding's belief that there had been an attempt to cover up that in September 2017, three Consultant Microbiologists raised a Step 1 concern under the Whistleblowing Policy.

2. Background

At the time of raising this concern, another Step 3 investigation was underway and nearing conclusion, regarding concerns Dr Redding had raised in November 2019 about infection control issues at the Royal Hospital for Children (RHC) and Queen Elizabeth University Hospital (QEUH). Whilst the Step 3 infection control investigation was primarily regarding patient safety issues, concern around an original Step 1 Dr Redding said was submitted (in terms of how it was recorded, rather than how it was handled) was referred to several times throughout the process.

Dr Redding has noted that her belief there was a cover up regarding a Step 1 complaint stems from:

- When Dr Redding and her colleagues first raised concerns in September 2017, they were asked to complete an SBAR, which was then taken to a senior meeting in October 2017, and an action plan was produced and taken forward. Dr Redding noted that retrospectively, she realised that there was no reference to whistleblowing in the minutes of that meeting;

- The action plan produced as a result of the SBAR and meeting also made no reference to whistleblowing;

- During the Step 3 investigation into her concerns regarding infection control, Dr Redding felt she had to vigorously defend herself to prove that the Step 1 concerns had been raised via the Whistleblowing Policy;

- Dr Redding took part in the Independent Review about the RHC and QEUH. In finalising her evidence, Dr Redding was asked to provide details of the whistleblowing procedure that had been followed, leading her to believe that NHSGGC informed the Independent Review that the process had not been followed;

- When Dr Redding was interviewed by the Independent Review, she noted that the whistle-blowers were criticised. Dr Redding further noted that it is the responsibility of NHSGGC to support whistle-blowers using the process, and not to use any technical failures to cover up a whistle-blow took place. Dr Redding noted that there has never been a formal acknowledgement by NHSGGC that the Step 1 whistleblowing process was started;

- Dr Redding was clear that she explicitly followed the Whistleblowing Policy, and raised Step 1 after normal line management channels had been ineffective in resolving her concerns to her satisfaction.

As the infection control Step 3 investigation intended to address the Step 1 issue in its final report, Dr Redding was asked if she would like to await the outcome of that investigation before proceeding with this case. Dr Redding confirmed she wished to proceed with this case separately, which NHSGGC were happy to accommodate. However, this did not negate the fact that the other Step 3 investigation had already considered the concern about whether a Step 1 case had been recorded, and therefore offered a position on this matter within its final report. This will be discussed more fully later in this paper.

It is important to highlight that there is no written evidence to confirm that a Step 1 concern was initiated. There is no doubt that Dr Redding and her colleagues raised concerns, given the SBAR, meeting and action plan that followed, however, there is no explicit written evidence which details that these were raised as a Step 1. Dr Redding requested access to her employee email account, as she felt in doing so, she would be able to supply evidence that she had submitted a Step 1 concern. Regrettably, due to the passage of time that has elapsed since her retirement, Dr Redding's email account had been disabled, and there is no record held of her emails.

3. Investigation

To investigate this case, a telephone meeting (convened in place of a physical meeting, as a result of social distancing measures during the COVID-19 pandemic) was held on 18 May 2020 between Dr Redding, Mr Allan Macleod, Non-Executive Director and investigating officer for this whistleblowing case, and Mrs Haynes. Notes were taken of the meeting, and shared with Dr Redding.

In addition, Mr Macleod discussed the case with Mr Ian Ritchie, Non-Executive Director, who investigated Dr Redding's infection control Step 3 case, and reviewed the excerpt from that report. Mrs Haynes also reviewed the formal whistleblowing records, and sought information from senior members of the Board's management team regarding the Independent Review.

4. Findings

Whilst the actions taken to deal with the concerns raised are not in question, as Dr Redding felt these were reasonable, the issue is whether a Step 1 under whistleblowing was recognised and recorded as such. Although no explicit detail is given, bi-annual reports on whistleblowing activity are produced by the Board, and are considered at formal committees of the Board. A Step 1 case on the subject matter Dr Redding has described is not present in past reports. Ms Haynes also confirmed that there is nothing in the whistleblowing records from that period that demonstrate that a Step 1 was brought to the attention of the staff member who managed the whistleblowing process at that time.

As noted in the infection control Step 3 whistleblowing report, on 4th January 2018, Dr Redding wrote to Dr Armstrong (Medical Director), Dr Rachel Green (Chief of Medicine for Diagnostics), Dr Brian Jones (Head of Service within Diagnostics) and Mr Tom Walsh (Infection Control Manager) and noted that she was trying to decide whether or not to escalate her concerns to Step 2 of the Whistleblowing Policy. Given this reference of escalation to Step 2, it is reasonable to conclude that the previous concerns being raised as a Step 1 was inferred, even if it was never explicitly said. The actions taken to deal with the initial concerns appears to be thorough and timely, and therefore it is likely safe to conclude that there was no ill intent or lack of willingness to deal with the points made. Given the reference to Step 2, it would, however, have been helpful if there was any dubiety about the reference to whistleblowing, for clarity to have been sought. Again, there is no evidence that not doing so was deliberate, as the focus appears to have been on the subject matter of the issues raised, rather than how the concerns were recorded.

In terms of Dr Redding's belief that there had been a deliberate attempt to cover up that the initial raising of these issues had been done under the Whistleblowing Policy, there was no

evidence this was the case. The aforementioned email of 4 January 2017 was supplied by Dr Armstrong, and was passed over in an attempt to be helpful during the investigation of the infection control Step 3 case.

In addition, whilst the SBAR, meeting notes and action plan do not explicitly mention whistleblowing, they do go into a great deal of detail on the issue at hand. The conclusion of this report is therefore that again, the focus appears to have been on the issues, and not on which process they should have been recorded under.

Whilst this report cannot comment on Dr Redding's involvement with the Independent Review, during the course of the investigation into this case, there was nothing to suggest that anyone from the Board had advised the Independent Review that due process had not been followed, as Dr Redding alleged. This is supported by the fact that the Independent Review report has now been published, and details in section 8.37.18:

> *In late September, three microbiologists then wrote to the Medical Director with a detailed list of concerns, covering a range of IP&C related matters. This communication became the material that constituted Stage 1 of the whistle-blowing process.*

Similarly, during meetings Dr Redding had in the course of the investigation into the infection control Step 3 case, there was fairly detailed discussion about Step 1. It was confirmed that this was not because of any advice given that a Step 1 did not occur, but simply to try to further explore Dr Redding's position. It is therefore very regrettable that Dr Redding perceived this as her having to vigorously defend her position to prove that the Step 1 case took place.

5. Conclusion

Regrettably, due to the absence of written evidence, it has not been possible to give a definitive conclusion as to whether the initial concerns were submitted as a Step 1 case. However, on the balance of probability, it is my finding that this was the intention, especially given the reference to escalation to Step 2 in Dr Redding's email of 4 January 2018.

There is not, however, any evidence that suggests that anyone within the Board made a deliberate attempt to cover up that a Step 1 whistleblowing case had been raised. Recording that a Step 1 case had been raised would have resulted in there being a formal entry in the Board's whistleblowing logs that this case had occurred, and the case being noted in reports which go to formal committees of the Board. The other whistleblowing cases Dr Redding has been involved with have all been formally recorded, and either have, or will be, reported in the aforementioned formal reports for committees of the Board (this and the other Step 3 case are recent, and so have not yet had an entry in these reports). Whilst it is recognised that appropriately recording whistleblowing is very important, formal recording of the Step 1 would have made no difference to how the issues were handled, which is arguably of much greater concern.

It is recognised that the current Whistleblowing Policy, and Board wide knowledge, understanding and confidence in it, likely played a part in the avoidable distress and upset this matter has caused to Dr Redding. The Board's Whistleblowing Policy will be updated in line with nationally agreed standards, to be issued by the Scottish Public Services Ombudsman, who will take on the additional new role of Independent National Whistleblowing Officer. This work was scheduled to 'go live' in Summer 2020, but unfortunately has had to be delayed due to the COVID-19 pandemic. It is important that in NHSGGC's preparation to comply with these national standards, the lessons from this case are taken into account.

6. Recommendations

	Issue	Person/s Responsible	Due date
1	The new National Whistleblowing Standards are an opportunity to tighten and publicise processes across the Health Board	Jen Haynes / Elaine Vanhegan	TBC
2	Any recommendations that come out of the impending review about to be undertaken, and led by the Whistleblowing Champion, are carried out to improve Board wide knowledge, understanding and confidence in the whistleblowing process	Jen Haynes / Elaine Vanhegan	TBC

Allan MacLeod
Non-Executive Director
June 2020

RE: QEUH - Precognition for release to witness CRM:

Martyn Ramsay
Mon 29/06/2020 14:44
To: teresa inkster

Good a. ernoon Teresa,

Just a couple of points and maybe we can catch up in detail later in the week.

Re the email purge. We can certainly ask why there was such a dele on, so soon after her leaving the review, and what policy governed such ac on but it's not going to give us the relevant evidence. Nor is any search for the verbal conversa on about your status at GGC likely to bring clarity.

Personally I think that it is yet another concern about the standard of the inves ga on to add to the list that will go to All we can do here is paint it exactly as you have done: this is a shambles and it lacks a convincing explana on.

Ul mately, whatever the excuses/reasons, your valuable contribu on to the Review has been significantly affected and thus, the outcome itself.

I also wonder if it is worth making a Subject Access Request?

Kind regards,

Martyn Ramsay
Employment Relations Manager
Member Services
BMA Scotland

British Medical Association
| 14 Queen St, Edinburgh, EH2 1LL

From: teresa inkster
Sent: 29 June 2020 13:20
To: Martyn Ramsay
Subject: Fw: QEUH - Precogni on for release to witness

Hi Martyn, thanks for your me last week.

Below is an email I got from the independent review this morning regarding issues with email traffic and someone within NHSGGC sta ng that I was off sick or had left the organisa on. I have a ached the ini al emails in the trail for your info also. This email trail was ini ated following the release of my precogni on just days before report publica on . It does not pertain to the lack of right to reply which I was not afforded, I have wri en to the Cabinet Secretary directly regarding that aspect, and not to the review themselves.

The response below is concerning. I find it odd that IT systems have already been purged just two weeks after report release. Furthermore , with respect to the comment re upset /inconvenience the bo om line is that I was not given the opportunity to submit sufficient evidence to the review and I

believe that has impacted upon the conclusions. Based on the fact I was reported as being off sick/ le. the organisa on the independent review assumed I was disengaged from the process, which is not in fact the case.

I wish there to be further inves ga on into this ma er and also as to why I did not receive a right to reply. Myself and Chris ne are s ll working on a response to the review which we will send on to you in due course. In the mean me can the BMA provide support regarding the further inves ga on of these emails and conversa ons between the review and NHSGGC.

I am on [redacted] if you wish any further info

Kind regards
Teresa

From: Shalinay.Raghavan[redacted]
Sent: 29 June 2020 10:31
To: teresaink[redacted]
Subject: RE: QEUH - Precogni on for release to witness

Dear Dr Inkster

Thank you for your email.

I can confirm that we conducted a search last week and a further search this morning of both our centralised inbox and document storage system and could not find the email you have identified that was sent on 3 April 2020. I note this email was sent to us from your nhs.net address. As per my previous narrative, we received an undeliverable message from your nhs.net address back in February 2020 and so we sent further correspondence to you on 1 April 2020 to your personal email address. It is unclear whether the failure to receive your email of 3 April was due to it being sent from your nhs.net address. Unfortunately I am not able to offer you any further explanation on this point.

In respect of the information regarding your absence from NHS GGC: Kerry acted as our main point of contact with external stakeholders; much of the work undertaken by Kerry was by telephone or email. Since leaving the Review, Kerry's IT systems have been purged and therefore it is not possible for us to interrogate any communication that she had with GGC. However my recollection is that the issue around your email address was discussed verbally between Kerry and myself; Kerry subsequently contacted the main GGC switchboard to verify your contact details. You will appreciate that the contact with GGC took place several months ago and it has not been possible to ascertain who Kerry spoke to.

I appreciate this leaves your questions unanswered but we have explored the matters you have raised as far as we can. I can assure you that it was not the intention of the Review to

exclude you from our processes and it is regrettable that the email systems appear to not have been working as they should have. I apologise for any upset or inconvenience caused to you in this respect.

Regards
Shalinay

Shalinay Raghavan | Head of QEUH Independent Review | Atlantic Quay 4, York Street, Glasgow | Tel: [redacted]

From: teresa inkster [redacted]
Sent: 26 June 2020 18:24
To: Raghavan S (Shalinay) [redacted]
Subject: Re: QEUH - Precogni on for release to witness

Dear Shalinay,

Thanks for your email. I have commented on some of your points at the bottom of this email with respect to email communications.

I have two main concerns:

1) Issues with emails from the review not reaching my nhs.net inbox and similarly an email from my nhs.net account not reaching the review that was sent on April 3rd. Can you please check whether you received this email dated April 3rd 2020. Screenshots of this email in my sent items and the email content itself are attached.

2) I am very concerned to hear that Kerry on contacting NHSGGC was told that I was either off sick or had left. Neither of these are true. I continue to work at NHSGGC with the same nhs.net account and my last period of sickness was 3 days in August 2019 for a minor viral illness. Whilst I appreciate Kerry has now left is it possible to contact her to ask if she recalls who she spoke to and when and what they said? I have previously raised concerns within the organisation with regards to attitudes towards my health so this information is very important to me. Do you know who Kerry's named contact at NHSGGC ?

(2) *On 13 January 2020 you wrote to us regarding (a) IMT information and processes and (b) requesting a copy of your statement transcript.*

0n 13 January, I wrote to you as follows;

’ Dear Review Team, I was recently involved in reviewing the response to a letter to a patient’s father from NHSGGC where it stated that the independent review is investigating IMT processes. I don't think I was aware of this remit at the time I was interviewed by you and as someone who has chaired many of the recent IMTs I would imagine that I would be someone you would want to speak to regarding this. I cannot recall if I was asked anything specifically about the IMT process so I may need to be re-interviewed. Is it possible for me to get a copy of my interview transcript as I have not received this yet?’

(3*) On 22 January 2020 we wrote to you explaining the that we did not have the specific IMT information you mentioned and requested if you could send this on to us. We also explained the process of being able to see your transcript and instead suggested that due to data protection/GDPR regulations then a precognition would be made available to you to view at our offices. We requested that you get in touch with dates indicating your availability.*

The review responded to me to say ‘Thank you for your email. I can confirm the Review has to date not discussed IMT processes with NHSGGC and have not been sighted on the letter you are referring to. Would you be able to provide us with a copy of the letter so that we may consider its content and be in a better position to respond?’

(4*) You responded on 23 January 2020 with a copy of a document and email trails regarding the IMT process. There was no mention or response in that email to our invitation to view your precognition.*

My response on 23rd January included the letter which I was asked for to demonstrate the reference to the IMT process being investigated by the review and correspondence around the handling of the letter and its content. This content did not relate to IMT process as I was not asked for that, only the letter

(5) *On 30 January 2020 we wrote thanking you for sending on the relevant IMT information and also asking if there was anything you wished to raise regarding this then the co-Chairs would be happy to consider further comments from you. In the same email a further request regarding your availability to view your precognition was made suggesting that dates for doing this would now be from mid-February onwards.*

The email response from the review was ‘

'The co-Chairs have noted the reference to the Review in the letter. The co-Chairs have indicated they are looking at the IMT in the round as part of the Infection Control function and relationships with others (who are usually IMT members) but there was no intention to devote specific attention to this particular aspect.

If however there are any related issues you wish to raise with the co-Chairs in this respect then they would be happy to hear any concerns or other comments you may have when they re-interview you (dates still to be confirmed).'

You will be aware that my follow-up interview was cancelled so I was not given the opportunity to discuss this further. I did not submit further evidence as I was told initially that the review hadn't looked at IMT process yet and that there was no intention to devote specific attention to that particular aspect.

11) *Between 01 April and 12 June 2020 we received no further correspondence from you regarding your precognition or any additional evidence you wished to provide to the Review. We were of the opinion that you had received the email dated 1 April 2020 as we had not received an "undeliverable" message for this. Given the time that had elapsed and the lack of response, it appeared to us that you were indisposed in some way or did not wish to continue to engage with the Review.*

I was neither indisposed or disengaging as per my comments at the start of the email. As stated above, I sent an email on 3rd April 2020 to which I did not receive a reply. Given that both myself and the Independent Review are claiming non-receipt of emails, can you please confirm the emails sent to me and those received from myself in addition to clarifying the response from NHSGGC when Kerry contacted them?

Kind regards

Teresa

From: Shalinay.Raghavan [redacted]
Sent: 24 June 2020 17:04
To: teresaink [redacted]
Cc: informa_on [redacted]
Subject: FW: QEUH - Precogni on for release to witness

Dear Dr Inkster,

Further to my email below.

I've now been apprised of the various correspondence in relation to your precognition and have summarised this below:

(1) It appears that from the period October 2019 until February 2020, the main correspondence address utilised by the Review to correspond with you was **teresa.inkster[redacted].**

(2) On 13 January 2020 you wrote to us regarding (a) IMT information and processes and (b) requesting a copy of your statement transcript.

(3) On 22 January 2020 we wrote to you explaining the that we did not have the specific IMT information you mentioned and requested if you could send this on to us. We also explained the process of being able to see your transcript and instead suggested that due to data protection/GDPR regulations then a precognition would be made available to you to view at our offices. We requested that you get in touch with dates indicating your availability.

(4) You responded on 23 January 2020 with a copy of a document and email trails regarding the IMT process. There was no mention or response in that email to our invitation to view your precognition.

(5) On 30 January 2020 we wrote thanking you for sending on the relevant IMT information and also asking if there was anything you wished to raise regarding this then the co-Chairs would be happy to consider further comments from you. In the same email a further request regarding your availability to view your precognition was made suggesting that dates for doing this would now be from mid-February onwards.

(6) You wrote to us on 14 February stating that you were available to view your precognition on either the 20th or 24th February 2020.

(7) On 21 February 2020 we wrote to you explaining that due to work and annual leave commitments we would be unable to offer you either the 20th or the 24th of February. The email explained that we would come back to you with further suggestions for dates to visit our offices.

(8) On Monday 24 February 2020 there was an message in our inbox stating that the email to your **teresa.inkster[redacted]** was "undeliverable". Inquiries were then made by Kerry Faichney with GG&C to ascertain if there had been a change to your email address; it appears that at some point in early March 2020, Kerry had been told you were no longer working at GG&C or alternatively you were off sick; given data protection issues we were unable to progress our inquiries any further.

(9) During March our approach to the Review had to be significantly altered given the impact of the Coronavirus pandemic. Kerry carried out a further search within our email systems and documentation and was able to source the **teresainkster[redacted]** email address for you.

(10) On 1 April 2020 we wrote to you at this email/hotmail address explaining that we had been unable to contact you at your work email. We also explained the changes we were making to our processes due to Covid-19. This meant that (a) we no longer required to re-interview you; (b) if you had additional information you wished to submit to the Review we would be happy to receive this by email; (c) that no-one would now be able to come into our offices to view their precognitions; (d) that given the sensitive data contained within many of the precognitions, we would have to take external advice as to how to provide these legally and securely to anyone who had requested their precognition.

(11) Between 01 April and 12 June 2020 we received no further correspondence from you regarding your precognition or any additional evidence you wished to provide to the Review.

We were of the opinion that you had received the email dated 1 April 2020 as we had not received an "undeliverable" message for this. Given the time that had elapsed and the lack of response, it appeared to us that you were indisposed in some way or did not wish to continue to engage with the Review.

(12) Despite the lack of ongoing communication, it was determined that, given your previous request, you should have a copy of your precognition released to you prior to the publication of the Review report. This was sent to your **teresainkster**[redacted] email address on 12 June 2020 which you have indicated was received.

I hope this provides an explanation of our position. If you have any further questions then please get in touch.

Regards
Shalinay

Shalinay Raghavan | Head of QEUH Independent Review | Atlantic Quay 4, York Street, Glasgow

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From: Raghavan S (Shalinay) **On Behalf Of** QEUH Mailbox
Sent: 24 June 2020 11:33
To: 'teresa inkster' [redacted]
Subject: RE: QEUH - Precogni on for release to witness

Dear Dr Inkster,

Thank you for your email. Kerry is no longer working with the Review.

Just by way of clarification - the precognition is a narrative summary produced by our statement taker and is not a verbatim account of the questions and answers that took place during your statement session. Therefore there may be variations in the wording of the precognition as it is prepared through the perspective of the statement taker.

My recollection is that correspondence had been sent to you earlier this year regarding your precognition and we received no response to that correspondence; a colleague is looking into this currently and I will be able to revert to you later today with a fuller response on this.

I have considered the point made about Chronic Fatigue and it appears that the capitalisation was a typing error than a specific reference to a medical condition that you have mentioned.

Regards
Shalinay

Shalinay Raghavan | Head of QEUH Independent Review | Atlantic Quay 4, York Street, Glasgow | Tel: [redacted]

From: teresa inkster [redacted]
Sent: 22 June 2020 20:01
To: QEUH Mailbox [redacted]
Subject: Re: QEUH - Precogni on for release to witness

Dear Kerry,
A49529391

Thank you for sending this to me.
Unfortunately I was sent it too late to make any amendments ahead of the report being released. Some of the language I don't recognise and I think there are some omissions. My ex colleague who was interviewed on the same day told me her recording was poor quality , was that also the case with mine?
In par cular I wish to point out for item 69 where it states I had 'Chronic Fa gue' I had chronic fa gue secondary to undiagnosed lymphoma and not Chronic Fa gue Syndrome as the capitalisa on implies. The two are very separate clinical en es.

Kind regards
Teresa

From: Kerry.Faichney [redacted] on behalf of informa on@queenelizabethhospitalreview.scot <informa on@queenelizabethhospitalreview.scot>
Sent: 12 June 2020 16:25
To: teresaink [redacted]
Subject: QEUH - Precogni on for release to witness

Dr Inkster,

Please find attached your Precognition from the statement you gave to the Queen Elizabeth University Hospital Independent Review.

Kind regards.

Kerry

Kerry Faichney
Executive Assistant | QEUH IR

[redacted]

Queen Elizabeth University Hospital Independent Review

website: https://www.queenelizabethhospitalreview.scot
email: information@queenelizabethhospitalreview.scot
Twitter: @QEUHReview
Address: PO Box 27152, Glasgow G2 9LX

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****

From: Peters, Christine [redacted]
Sent: 22 June 2020 10:42
To: Inkster, Teresa (NHSmail)
Subject: FW: Comments On Whistleblow Document

From: Peters, Christine
Sent: 22 June 2020 10:41
To: Haynes, Jennifer
Subject: RE: Comments On Whistleblow Document

Dear Jennifer,

Thank you for your email at this busy time and confirmation that the report is expected to stand as written as the GGC HB position on the matters covered with regard to Dr Redding. .

I am indeed engaging, as I have always done, with all processes that I am invited to participate in, and will continue to do so.

Kind regards,

[redacted]

Dr Christine Peters
Consultant Microbiologist
Clincial Lead Department of Microbiology QEUH

[redacted]

From: Haynes, Jennifer
Sent: 16 June 2020 11:49
To: Peters, Christine [redacted]
Subject: RE: Comments On Whistleblow Document

Dear Christine

Thank you for your email of 22 May 2020, in which you raise some concerns about a whistleblowing report that was recently sent to Dr Penelope Redding, which I am aware she shared with you. I sincerely apologise for the delay in fully replying to you, and I thank you for your patience and understanding whilst awaiting my reply.

As you note at the end of your email, the whistleblowing report was the final version. That does not in any way mean that we do not take what you have said seriously, but the report was in response to specific concerns raised by Dr Redding, so it wouldn't be appropriate for us to now change that based on further information, some of which was not within the scope of the investigation. I can see from your email that you were speaking to Professor Bain

about this. I realise that Professor Angela Wallace is now taking forward this work, and I have been advised that you are engaging with her, which we would encourage you to continue to do.

With regards to your reference to bullying and culture, I am so sorry you feel that way. We all spend so much of our lives at work, so to feel this way whilst working must be very upsetting for you. As you know, in the whistleblowing report, explicit reference and recommendations were made around this subject. We recently heard from Dr Redding, whereby she made reference to the Organisational Development work underway, and indicated it was her impression that this was being well received within the department. I sincerely hope you feel that way too, and that it makes a positive difference. In addition, work is going to be undertaken imminently to look at the whistleblowing process itself, to try to improve Board wide awareness, understanding and confidence in it.

I hope this email is helpful.

Kindest regards

Jen

Jennifer Haynes
Board Complaints Manager
Phone: [redacted]
Mobile: [redacted]
Email: [redacted]

From: Peters, Christine
Sent: 05 June 2020 15:30
To: Haynes, Jennifer [redacted]
Subject: RE: Comments On Whistleblow Document

Hi Jennifer,

Thanks for your email. I totally understand that COVID has put pressure on every aspect of the NHS, and really I am very content to wait as long as it takes. I only contacted you in response to the circulated findings , and not to put further pressure on you or anyone else in the Board.

I hope things settle down and thanks again for taking the time to be in touch,

Kr
Christine

From: Haynes, Jennifer
Sent: 05 June 2020 15:22
To: Peters, Christine [redacted]
Subject: RE: Comments On Whistleblow Document

Dear Christine

Further to our emails below, I just wanted to make further contact with you to apologise sincerely that we have not got back to you in detail yet. COVID-19 has brought many challenges to all parts of the Board, which has impacted on why I have not replied yet, but I wanted to assure you that I have not forgotten, nor does the lateness of my response mean that I don't realise how important this matter is. I will aim to get back to you in detail next week, and I apologise again for the lateness of my reply.

Kindest regards

Jen

Jennifer Haynes
Board Complaints Manager
Phone: [redacted]
Mobile: [redacted]
Email: [redacted]

From: Peters, Christine
Sent: 26 May 2020 14:51
To: Haynes, Jennifer [redacted]
Subject: RE: Comments On Whistleblow Document

Thank you for your acknowledgement of my email, and I look forward to a full reply,

Kind Regards,

[redacted]

Dr Christine Peters
Consultant Microbiologist
Clincial Lead Department of Microbiology QEUH

[redacted]

From: Haynes, Jennifer
Sent: 25 May 2020 20:25
To: Peters, Christine [redacted]
Subject: RE: Comments On Whistleblow Document

Dear Christine

Thank you for your email. I can confirm safe receipt, and I will reply more fully soon.

Kindest regards

Jen

Jennifer Haynes
Board Complaints Manager
Phone: [redacted]
Mobile: [redacted]
Email: [redacted]

From: Peters, Christine
Sent: 22 May 2020 12:09
To: Haynes, Jennifer [redacted]
Cc: Inkster, Teresa (NHSmail) [redacted]
Subject: Comments On Whistleblow Document

Dear Jennifer ,

I understand that the investigation report into Dr Redding's Whistleblow step 3 is a final document of the conclusions of the investigating leads.

I have requested advice regarding the due process to raise my points on accuracy of the document you kindly circulated, and await guidance on this from Dr Marion Bain.

In the meantime, for feedback to the authors I would like to highlight:

1. Water testing in Summer 2017 – of the 118 samples taken for Stenotrophomonas only a small proportion were taken in the relevant location to the case in question, with the majority sampling an entirely different water system (NICU) according to reports I received from Estates later in 2017. Of note only one shower outlet was tested on the ward. All testing was undertaken weeks after the cases of interest and there is suggestion in the public domain that shower heads were changed around that time which could have been a source that was effectively deal with. Negative tests in this context are misleading as a rule out for water / outlets being the likely source. Suggestions for the reason for the delay in testing being the need for appropriate agar are unfounded as stenotrophomas and indeed other environmental gram negatives had been adequately isolated PRIOR to this testing by the same lab. This is backed up by the technical manager in charge at the time. A 6 week delay in testing is not helpful for an acute IC investigation and was one of the main reasons for embarking on the step 1 process.
2. Patient placement policy has been repeatedly raised as an issue over the years – in fact at a meeting with senior management present this was highlighted in October 2019 as a key area of concern for the entire QEUH Microbiology team, and formed a large component of the work that Dr Bain has undertaken with Microbiology this year in agreeing a fit for purpose policy. There are many written examples of evidence to back this up. Many current members of staff have raised this as a concern , repeatedly. I am surprised that this was not known by the investigators .
3. Chilled beams – no mention is made of the water leaks in 2019 , and numerous condensation events dating back to 2015 . Hundreds of rooms affected. No mention is made of the dirt collecting , or the positive environmental sampling. Likewise the recirculation issue is misleading – the recirculation within the room is relevant for appropriate pathway of clean to dirty as a basic principle of infection control. This is not relevant when there is no source of infection in the room, but becomes rapidly relevant when there is – eg coronavirus positive patients coughing copiously. The 3 ACH then also becomes highly relevant as a slow risk reduction engineering mitigation. 5% of infectious particles being a risk will depend on the pathogen, the host and environmental factors as well as interventions carried out in the space.
4. Air sampling post clean up of significant amounts of pigeon guano in the plant rooms , in their thousands, have been carried out. Zero grew *Cryptococcus neoformans*. The conclusion from that could be that the source was removed.
5. Self contradictory paragraph re rates of infection. Inter hospital comparisons in HPS report showed clear outlier for blood cultures with environmental gram negatives. More importantly the epidemiology of the unit demonstrated a classic epi curve for environmental source. 9months of no cases after move, significant reduction post move to 6A and again significant reduction post 6A interventions (including putting detergent into chilled beam water , and fixing chronic leak in kitchen , and numerous other interventions like drain cleaning and filters)
6. The whistleblowing process investigated by Dr DeCasteker report did not mention the claim made in this report. As one involved in the process I can confirm that I have raised my concerns regarding that WB investigation process (including the selection of people interviewed and a mismatch between the intended aims of investigation and outcomes) and conclusions with Fiona McQueen and Marion Bain and expect further advice on how this will be dealt with. I am surprised to see this so represented here.
7. Regarding other being encouraged to come forward – it would seem due process for the investigators to approach those who would legitimately be able to give information relevant to the WB . To expect others to come forward , given the experience to date, the notable mentions of bullying and toxic culture is not realistic.
8. The 27 point action plan has been challenged with regard to its accuracy and adequacy , again further progress on this is awaited through other processes
9. I do not agree that Step 1 was not a step 1 – but this is the subject I understand of a further Whistle blow , so will be followed through that process

In conclusion I understand this to be a final report and thus am taking advice on how to raise my concerns.

Regards,

[redacted]

Dr Christine Peters
Consultant Microbiologist
Clincial Lead Department of Microbiology QEUH

[redacted]

Cabinet Secretary for Health and Sport
Jeane Freeman MSP

Scottish Government
Riaghaltas na h-Alba
gov.scot

T: [redacted]
E: [redacted]

Dr Teresa Inkster

[redacted]

30 June 2020

Dear Teresa

Thank you for your letter of 20 June 2020 regarding the QEUH Independent Review.

I fully understand the range of concerns you have in relation to the processes and procedures adopted by the review, the content of the Independent Review report and the implementation of its pre-publication protocols. The Review was entirely independent of the Scottish Government and both the content of its final report and the procedures it undertook were entirely a matter for the co-Chairs. That means that I cannot answer your questions directly but urge that you raise your concerns and seek answers directly from the co-Chairs because only they can explain the reasons for reaching the conclusions they did and the procedures they undertook in respect of publication.

I understand your concerns regarding the lack of clarity for patients and families and that this may be a distressing time for them. As you know, I appointed Professor Craig White in October 2019 to ensure that parents and families' questions and concerns were addressed through the various processes established. Professor White provided the co-Chairs of the Review with a themed summary of their concerns about the hospital building and environment in December 2019 and has continued to provide updates on the work of the Oversight Board to around 170 families in contact with the paediatric haemato-oncology service at NHS Greater Glasgow and Clyde. The Communication and Engagement Subgroup of the Oversight Board has also concluded its work. The Board will be reporting over the summer, and will ensure its findings and recommendations are shared with patients and families. I have also asked Professor Fiona McQueen to engage with you on preliminary findings so that she can take account of your views prior to the Oversight Board conclusions being finalised given your role in helping to raise the concerns initially. I would also be happy to speak to you regarding these findings if that would be helpful.

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot

I have understood and borne in mind your concerns regarding the importance of transparency and a culture of openness, and appreciate you sharing your own experiences as a patient. They are points that you made when we met last year and which have shaped the work of the Oversight Board. I understand that you have continued to pursue these concerns by working to support improvements in NHS GGC. I know, for example, that Professor Angela Wallace passed the work you had initiated on duty of candour to Professor Craig White. He has considered this as part of the work being undertaken by the Communication and Engagement Subgroup of the Oversight Board, and has confirmed to me that this was appreciated and a helpful contribution in respect of the Subgroup's findings and recommendations.

Work is continuing on setting up the Public Inquiry, which will be chaired by the Right Honourable Lord Brodie QC PC, and I was pleased to announce the set-up date of 3 August in my recent statement to Parliament. The Inquiry's Terms of Reference are detailed and comprehensive. It will assess whether the buildings provide a suitable environment for the delivery of safe, effective person-centred care and will make recommendations to ensure that any past mistakes are not repeated in future NHS infrastructure projects. The Inquiry will also examine whether disclosures of information were encouraged, including through implementation of whistleblowing policies, within the organisations involved. Lord Brodie has told me that he will issue a call for evidence shortly after the setting up date.

I remain unequivocal in my view that you and others have raised very important issues and in my appreciation of your courage and persistence in doing so. I know that has not come without personal cost and I am grateful to you for your continued work to maintain the highest standards of care for patients and families.

Kind regards

[redacted]

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot

Inkster, Teresa

From: MACLEOD, Mairi (NHS GREATER GLASGOW & CLYDE) [redacted]
Sent: 03 July 2020 13:41
To: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Cc: PETERS, Christine (NHS GREATER GLASGOW & CLYDE)
Subject: Re: Issues re independent review interactions

Thanks Teresa. Apologies for questions - I'm less good at checking my junk folder (9 things in it today dating back 3 weeks).

Agree, not appropriate for IT call, just wondered if there might have been any 'global issues' known on these dates.

I am escalating request for investigation to Rachel Green, Scott Davidson and Head of Corporate Governance as believe they will be in a position to take this forward and appreciate urgency of the matter.

Will keep you updated,

Mairi

Dr Mairi Macleod
Consultant Microbiologist, Glasgow Royal Infirmary
Head of Service, Microbiology & Virology, NHS GGC

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Sent: 03 July 2020 13:30
To: MACLEOD, Mairi (NHS GREATER GLASGOW & CLYDE)
Cc: PETERS, Christine (NHS GREATER GLASGOW & CLYDE)
Subject: Re: Issues re independent review interactions

Hi Mairi, happy for you to give a brief indication of issues.

The email address for the review is; information@queenelizabethhospitalreview.scot

I check my junk mail all the time as NHS.net highlights messages in that folder in bold ,so definitely not there. Also not in blocked contacts and previous emails from review got to me ok. They eventually did send their email to my personal address as they got an 'undeliverable' message but the one from April 3rd I sent them did not get to them.

I have attached a screenshot showing the email from April 3rd in my sent box, nothing bounced back.

I have not logged a call with IT as I am on leave at the moment and also the issue is a potentially serious one, so I elected to go via the diagnostics management route. But if you want me to do this I can do, on my return.

We have also contacted the review re our failure to receive a right to reply and as such have 33 pages and possibly more to come of commentary which we now need to submit. This is eating into my annual leave which Christine can testify to, so I am hoping to be able to take some time back for this. If you are in agreement I can sort with Christine on my return. Had the review followed process this would not have been necessary. They have told us they are 'winding down' so its not something that can wait until I get back.

Thanks for your help with this

kr
Teresa

Dr Teresa Inkster
Consultant Microbiologist, QEUH
National Training Programme Director Medical Microbiology
Dept of Microbiology
Queen Elizabeth University Hospital
Glasgow
Direct dial : [redacted]

From: MACLEOD, Mairi (NHS GREATER GLASGOW & CLYDE)
Sent: 03 July 2020 10:05
To: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Cc: PETERS, Christine (NHS GREATER GLASGOW & CLYDE)
Subject: Re: Issues re independent review interactions

Dear Teresa,

Thanks for your email. I was on calls yesterday pm so looking at this today.
You've marked the email confidential but I will need to make contact with several people to get answers to Qs. I'll not forward your email without permission but will need to give brief indication of issues, are you happy with that?

With regard to email issues have you made any contact with nhs.net or IT yourself and looked at blocked list, junk mail box etc. I'm sure you have but might be useful for me to be able to confirm. Can you pass on the review email address you were corresponding with that didn't receive your email?

Give me a call if that's easier,

Mairi

Dr Mairi Macleod
Consultant Microbiologist, Glasgow Royal Infirmary
Head of Service, Microbiology & Virology, NHS GGC

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Sent: 02 July 2020 13:37
To: MACLEOD, Mairi (NHS GREATER GLASGOW & CLYDE)
Cc: PETERS, Christine (NHS GREATER GLASGOW & CLYDE)
Subject: Issues re independent review interactions

Confidential

Dear Mairi,

I am currently on annual leave but have remained in communication with the independent review team following the publication of their report. During email correspondence with them a couple of matters have come to light that I wish to escalate and request an internal NHSGGC investigation for.

1)My first concern relates to email correspondence between myself and the review. A quote from an email dated 29/6/20 from the review to my personal email address states the following ;

'I can confirm that we conducted a search last week and a further search this morning of both our centralised inbox and document storage system and could not find the email you have identified that was sent on 3 April 2020. I note this email was sent to us from your nhs.net address. As per my previous narrative, we received an undeliverable message from your nhs.net address back in February 2020 and so we sent further correspondence to you on 1 April 2020 to your personal email address. It is unclear whether the failure to receive your email of 3 April was due to it being sent from your nhs.net address. Unfortunately I am not able to offer you any further explanation on this point. '

I would like an investigation into why there were issues with email traffic and a review of data from the servers of all emails sent and received between myself and the review. I sent screenshots to the review confirming the presence of the April 3rd email in my sent items.

2) Communication from NHSGGC that I was either off sick or had left in early March, neither of which was the case. An extract from an email sent by the review on 29/6/20 states ;

'In respect of the information regarding your absence from NHS GGC: Kerry acted as our main point of contact with external stakeholders; much of the work undertaken by Kerry was by telephone or email. Since leaving the Review, Kerry's IT systems have been purged and therefore it is not possible for us to interrogate any communication that she had with GGC. However my recollection is that the issue around your email address was discussed verbally between Kerry and myself; Kerry subsequently contacted the main GGC switchboard to verify your contact details. You will appreciate that the contact with GGC took place several months ago and it has not been possible to ascertain who Kerry spoke to. '

And from June 24th

'On Monday 24 February 2020 there was an message in our inbox stating that the email to your ***teresa.inkster*** [redacted] *was "undeliverable". Inquiries were then made by Kerry Faichney with GG&C to ascertain if there had been a change to your email address; it appears that at some point in early March 2020, Kerry had been told you were no longer working at GG&C or alternatively you were off sick; given data protection issues we were unable to progress our inquiries any further.'*

This information led the review to believe that I was disengaged from the review or otherwise indisposed neither of which were true. Quote from review email dated 24/6/20 ;

'Between 01 April and 12 June 2020 we received no further correspondence from you regarding your precognition or any additional evidence you wished to provide to the Review. We were of the opinion that you had received the email dated 1 April 2020 as we had not received an "undeliverable" message for this. Given the time that had elapsed and the lack of response, it appeared to us that you were indisposed in some way or did not wish to continue to engage with the Review. '

I do believe that as a result of issues with emails and misinformation regarding my sick leave or employment status, my contribution has been affected and that this has impacted on the reviews conclusions.My followup interview with the review was cancelled. As such I would like both matters to be investigated. I would like to request the following info;

1) Details from servers of all email traffic between myself and review
2) Who the NHSGGC internal contact for the review and in particular Kerry Faichney was
3) What information was released to the review regarding sick leave/employment status and on what basis

Please let me know if you require any further information.

kr
Teresa

Dr Teresa Inkster
Consultant Microbiologist, QEUH
National Training Programme Director Medical Microbiology
Dept of Microbiology
Queen Elizabeth University Hospital
Glasgow
Direct dial : [redacted]

Inkster, Teresa

From: MACLEOD, Mairi (NHS GREATER GLASGOW & CLYDE) [redacted]
Sent: 09 July 2020 09:59
To: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Subject: Re: Issues re independent review interactions

Dear Teresa,

Further to your email last week, I have escalated the issues you raised within the board. I highlighted your 3 information requests and explained
- you were concerned incorrect information regarding your leave/employment status was communicated to the review team
- had recently become aware of non-receipt/delivery of emails between your nhs.net email and the review
- feel both contributed to the cancellation of your follow up interview with potential impact on review findings.

The Head of Corporate Governance has responded stating these issues should be considered by the independent review team and the board cannot investigate the review team's actions. There was no single point of contact in GGC for the review team and they do not have documentation at board level regarding communication around sick leave or a change in employment status.

With regard to your email query, investigation of an employees's email system is not straight forward and I wonder if it would be worthwhile you exploring retrieval of email traffic history with nhs.net as an individual.

Kind regards,

Mairi

Dr Mairi Macleod
Consultant Microbiologist, Glasgow Royal Infirmary
Head of Service, Microbiology & Virology, NHS GGC

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Sent: 03 July 2020 13:30
To: MACLEOD, Mairi (NHS GREATER GLASGOW & CLYDE)
Cc: PETERS, Christine (NHS GREATER GLASGOW & CLYDE)
Subject: Re: Issues re independent review interactions

Hi Mairi, happy for you to give a brief indication of issues.

The email address for the review is; information@queenelizabethhospitalreview.scot

I check my junk mail all the time as NHS.net highlights messages in that folder in bold ,so definitely not there. Also not in blocked contacts and previous emails from review got to me ok. They eventually did

Julie Rothney

From: WALLACE, Angela (NHS FORTH VALLEY)
Sent: 06 July 2020 14:33
To: PETERS, Christine (NHS GREATER GLASGOW & CLYDE)
Subject: Re: IPC Sector Reports - 03/07/20

Hi Christine
Happy to discuss when suits of course
I am on leave today, I have asked the question re the notes earlier and I understand these were not minutes but Dr Mathers notes
I am not aware of the detail you raise but happy to discuss and will of course when we chat what more I need to do.
I had done quite a bit of support prior to the IMT I am happy to make sure it is correct and I will continue to focus on this
Let me know when suits you Christine
Kindest
Angela

On 6 Jul 2020, at 09:43, PETERS, Christine (NHS GREATER GLASGOW & CLYDE) [redacted] wrote:

> Hi Angela,
>
> I would appreciate being able to speak wiht you directly if that is ok . It seems that despite me having a documented conversation with Dr Liz Johnston (witnessed by Kahtleen) regarding false positivity of the result, Alister also discussed separately and had emails in which I was excluded.
>
> This is extremely poor communication and I would like to explore how this is considered to be acceptable.
>
> kind regards
>
> Christine

From: WALLACE, Angela (NHS FORTH VALLEY)
Sent: 06 July 2020 06:25
To: PETERS, Christine (NHS GREATER GLASGOW & CLYDE)
Subject: RE: IPC Sector Reports - 03/07/20

Good morning Christine

Apologies for the delay in responding. I do hope you had a good day off on Thursday.

I was not at the IMT but i will quickly ask for the minute to be reviewed thank you for letting me know.

I understand that the child was well and was discharged home on [redacted] i know everyone will be pleased.

I will come back to you as soon as possible

Kindest regards

Angela

From: PETERS, Christine (NHS GREATER GLASGOW & CLYDE)
Sent: 03 July 2020 17:26
To: WALLACE, Angela (NHS FORTH VALLEY)
Subject: Fw: IPC Sector Reports - 03/07/20

Hi Angela,

I think this is a very important point . the results were confirmed by Bristol on Monday and I reported this on Tuesday so the inaccuracy in the IMT is concerning.

kr

Christine

From: PETERS, Christine (NHS GREATER GLASGOW & CLYDE)
Sent: 03 July 2020 17:20
To: Hamilton Pauline (NHS GREATER GLASGOW & CLYDE); WALLACE, Angela (NHS FORTH VALLEY); BAGRADE, Linda (NHS GREATER GLASGOW & CLYDE); alison.balfou[redacted]; Bowskill Gillian (NHS GREATER GLASGOW & CLYDE); COTTOM, Laura (NHS GREATER GLASGOW & CLYDE); [redacted] (NHS GREATER GLASGOW & CLYDE); Devine, Sandra; Dhillon, Raje; Edwardson Alison (NHS GREATER GLASGOW & CLYDE); Hamilton Catriona (NHS GREATER GLASGOW & CLYDE); teresa.inkste[redacted]; INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE); JAMDAR, Sara (NHS GREATER GLASGOW & CLYDE); Joannidis Pamela (NHS GREATER GLASGOW & CLYDE); Khalsa, Kamaljit; KHALSA, Kamaljit (NHS GREATER GLASGOW & CLYDE); Khanna Nitish (NHS GREATER GLASGOW & CLYDE); Leanord Alistair (NHS GREATER GLASGOW & CLYDE); MACLEOD, Mairi (NHS GREATER GLASGOW & CLYDE); MAREK, Aleksandra (NHS GREATER GLASGOW & CLYDE); Marshall, Elizabeth; McConnell, Donna; Mills Gillian (NHS GREATER GLASGOW & CLYDE); Murphy, Michael E; Peters, Christine; POLUBOTHU, Padmaja (NHS GREATER GLASGOW & CLYDE); Pritchard Lynn (NHS GREATER GLASGOW & CLYDE); Smith, Andrew; SMITH, Andrew (NHS NATIONAL SERVICES SCOTLAND); Valyraki, Kalliopi; Weinhardt, Barbara; Wright Pauline (NHS GREATER GLASGOW & CLYDE); Arbuckle William (NHS GREATER GLASGOW & CLYDE); Boyd Luanne (NHS GREATER GLASGOW & CLYDE); Cassidy Annemarie (NHS GREATER GLASGOW & CLYDE); Crawford Louise (NHS GREATER GLASGOW & CLYDE); Doherty Denise (NHS GREATER GLASGOW & CLYDE); Donnelly Michael (NHS GREATER GLASGOW & CLYDE); Douglas Kirsty (NHS GREATER GLASGOW & CLYDE); Fleming Alistair (NHS GREATER GLASGOW & CLYDE); Glancy Joan (NHS GREATER GLASGOW & CLYDE); Henderson Karen (NHS GREATER GLASGOW & CLYDE); Love Elizabeth (NHS GREATER GLASGOW & CLYDE); Macleod Alison (NHS GREATER GLASGOW & CLYDE); Mathieson David (NHS GREATER GLASGOW & CLYDE); Moore Marie (NHS GREATER GLASGOW & CLYDE); Murphy Deborah (NHS GREATER GLASGOW & CLYDE); O'neill, Julie Anne; Ozegemen Margaret (NHS GREATER GLASGOW & CLYDE); Smyth, Elaine; Spalding Jane (NHS GREATER GLASGOW & CLYDE); Wilson Gary (NHS GREATER GLASGOW & CLYDE)
Subject: Re: IPC Sector Reports - 03/07/20

HI,

Clarification regarding the CRag testing referred to in the RHC update - this was reported as a clear positive on a second sample on Monday and confirmed as positive on Tuesday by the Bristol lab on two samples as reported to the meeting on Tuesday .The PCR was awaited - not the CRAG repeat.

kr

Christine

From: Hamilton, Pauline [redacted]
Sent: 03 July 2020 14:14
To: WALLACE, Angela (NHS FORTH VALLEY); BAGRADE, Linda (NHS GREATER GLASGOW & CLYDE); alison.balfour@[redacted]; Bowskill Gillian (NHS GREATER GLASGOW & CLYDE); COTTOM, Laura (NHS GREATER GLASGOW & CLYDE); [redacted] (NHS GREATER GLASGOW & CLYDE); Devine, Sandra; Dhillon, Raje; Edwardson Alison (NHS GREATER GLASGOW & CLYDE); Hamilton Catriona (NHS GREATER GLASGOW & CLYDE); teresa.inkster@[redacted]; INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE); JAMDAR, Sara (NHS GREATER GLASGOW & CLYDE); Joannidis Pamela (NHS GREATER GLASGOW & CLYDE); Khalsa, Kamaljit; KHALSA, Kamaljit (NHS GREATER GLASGOW & CLYDE); Khanna Nitish (NHS GREATER GLASGOW & CLYDE); Leanord Alistair (NHS GREATER GLASGOW & CLYDE); MACLEOD, Mairi (NHS GREATER GLASGOW & CLYDE); MAREK, Aleksandra (NHS GREATER GLASGOW & CLYDE); Marshall, Elizabeth; McConnell, Donna; Mills Gillian (NHS GREATER GLASGOW & CLYDE); Murphy, Michael E; Peters, Christine; PETERS, Christine (NHS GREATER GLASGOW & CLYDE); POLUBOTHU, Padmaja (NHS GREATER GLASGOW & CLYDE); Pritchard Lynn (NHS GREATER GLASGOW & CLYDE); Smith, Andrew; SMITH, Andrew (NHS NATIONAL SERVICES SCOTLAND); Valyraki, Kalliopi; Weinhardt, Barbara; Wright Pauline (NHS GREATER GLASGOW & CLYDE); Arbuckle William (NHS GREATER GLASGOW & CLYDE); Boyd Luanne (NHS GREATER GLASGOW & CLYDE); Cassidy Annemarie (NHS GREATER GLASGOW & CLYDE); Crawford Louise (NHS GREATER GLASGOW & CLYDE); Doherty Denise (NHS GREATER GLASGOW & CLYDE); Donnelly Michael (NHS GREATER GLASGOW & CLYDE); Douglas Kirsty (NHS GREATER GLASGOW & CLYDE); Fleming Alistair (NHS GREATER GLASGOW & CLYDE); Glancy Joan (NHS GREATER GLASGOW & CLYDE); Henderson Karen (NHS GREATER GLASGOW & CLYDE); Love Elizabeth (NHS GREATER GLASGOW & CLYDE); Macleod Alison (NHS GREATER GLASGOW & CLYDE); Mathieson David (NHS GREATER GLASGOW & CLYDE); Moore Marie (NHS GREATER GLASGOW & CLYDE); Murphy Deborah (NHS GREATER GLASGOW & CLYDE); O'neill, Julie Anne; Ozegemen Margaret (NHS GREATER GLASGOW & CLYDE); Smyth, Elaine; Spalding Jane (NHS GREATER GLASGOW & CLYDE); Wilson Gary (NHS GREATER GLASGOW & CLYDE)
Subject: IPC Sector Reports - 03/07/20

Please find attached the IPC Weekly Sector Reports dated 3 July 2020.

Kind Regards

[redacted] [redacted]

[redacted]

PA to Pamela Joannidis, Acting Associate Nurse Director Infection Prevention and Control

Gartnavel General Hospital

GLASGOW

G12 0YN

Tel: [redacted]

[redacted]

[redacted]

RE: Letter regarding Independent Review CRM: [redacted]

Martyn Ramsay [redacted]
Fri 26/03/2021 09:17
To: teresa inkster [redacted];Christine Peters [redacted]

Good morning Teresa,

Thank you for the update, really appreciated.

Perhaps there is a chance next week for us to join a Teams call or a general conference call to discuss the processes and any way forward? I have Monday and Wednesday morning and all day on Thursday free.

Kind regards,

[redacted]

Martyn Ramsay
Employment Relations Manager
Member Services
BMA Scotland

British Medical Association
[redacted] | 14 Queen St, Edinburgh, EH2 1LL

From: teresa inkster [redacted]
Sent: 25 March 2021 15:36
To: Martyn Ramsay [redacted]; Chris ne Peters [redacted]
Subject: Re: Le er regarding Independent Review CRM: [redacted]

Hi Martyn

Just wanted to update you that two reports into the QEUH were published earlier this week, The Oversight Board Report and the Case note review. They have reached a very different conclusion from the Independent review in that two deaths and approximately one third of infec ons in paediatric haemonc pa ents were most likely linked to the environment with only 8 out of 84 felt to be definitely not linked. This report does vindicate whistleblowers and we were correct to challenge the Independent review. There do remain inaccuracies in both reports and misrepresenta on in places, so we will write to point this out. We had some engagement with the oversight board and they took on board some sugges ons for changes to factual accuracy from us, but not all. We had less engagement with the CNR, we were very much an a. er thought and spent only 1 hour with them (only 30 mins of that with the microbiologist) and that is reflected in the report. We have concerns regarding the validity of the data they received and used to reach conclusions.

This lack of engagement with doctors at the heart of an incident is a con nuing theme . There is missed opportunity for learning. Is there anything the BMA can do to support in this regard. Whilst the CNR was sent to NHSGGC for comments on factual accuracy it was not sent to either of us. Our exclusion from the process is a further example of con nuing detriment.

Kind regards
Teresa

From: Martyn Ramsay [redacted]
Sent: 27 July 2020 12:48
To: teresa inkster [redacted]; Chris ne Peters [redacted]
Subject: RE: Le er regarding Independent Review CRM: [redacted]

Good a. ernoon,

Sorry, I was ini ally meaning that I would discuss with Donald or Jill about lending their weight to that email to the Cab Sec but it went out on the 16th. Let's see what we get back from that.

Might be best if we can arrange a conference call this week some me to properly discuss what we want to try going forward? I am busy tomorrow morning but the rest of this week is fairly quiet for a change.

Kind regards,

[redacted]

Martyn Ramsay
Employment Relations Manager
Member Services
BMA Scotland

British Medical Association
[redacted] | 14 Queen St, Edinburgh, EH2 1LL

From: teresa inkster [redacted]
Sent: 27 July 2020 12:33
To: Martyn Ramsay [redacted]; Chris ne Peters [redacted]
Subject: Re: Le er regarding Independent Review CRM: [redacted]

Hi Martyn, just wondered if you had any update re the email below.

By means of an update; on Friday afternoon I a ended a mee ng with Fiona Mcqueen and Philip Raines from SG, both of whom are part of the oversight board (OB) for NHSGGC. They have sent me two reports to review wri en by the oversight board and they plan to send same to Chris ne when they meet her later this week.

These reports relate to IMT processes over 4 years ,which both of us have been involved with. The introduc on states that they interviewed key members of the IMT. Once again this is an example of lack of engagement with key clinicians and myself as IMT chair, which has impacted on the conclusions. Once again the reports are full of omissions and inaccuracies. They have now asked for comment at this very late stage, I suspect only because they have noted our public concerns re the IR. I have asked for a mescale for response and we will follow due process by responding and see whether they are willing to engage with our concerns/comments. I thought I would highlight this to you as an ongoing theme. We were given assurances by the Cabinet Secretary that we would be involved with the OB

I do con nue to believe we are suffering detriment as a result of the IR report. You may have seen the press coverage in the Herald at the weekend . The first ques on the journalist asked me was ' had concerns been raised about your work when you were based in Glasgow Royal Infirmary' . Again

there is commentary from a member of the public with regards to the infec on control team referring to chapater 8 of the report as ' a damning indictment'.

Kind regards
Teresa

From: Martyn Ramsay [redacted]
Sent: 16 July 2020 11:07
To: teresa inkster [redacted]; Chris ne Peters [redacted]
Subject: RE: Le er regarding Independent Review CRM: [redacted]

Hi Teresa,

Donald is off this week and then I'm off on Monday so I'll catch up with him on Tuesday to see what poli cal support/pressure we are able to give. That side of it is really outside of my remit.

The frustra ng thing for me is that it is not about us demanding a par cular conclusion or that they agree with everything you've said. It is the absolute lack of engagement with your issues that I find completely unacceptable for a public body.

Kind regards,

[redacted]

Martyn Ramsay
Employment Relations Manager
Member Services
BMA Scotland

British Medical Association
[redacted] | 14 Queen St, Edinburgh, EH2 1LL

From: teresa inkster [redacted]
Sent: 16 July 2020 11:46
To: Martyn Ramsay [redacted]; Chris ne Peters [redacted]
Subject: Re: Le er regarding Independent Review CRM: [redacted]

Hi Martyn,

The response is dreadful and its very concerning that they won't engage and take into account our evidence/comments nad are willing to accept an inaccurate report.

I am about to draft a le er to the Cab sec which I will share with you in due course .

Is there anything further the BMA can do to support, par cularly in rela on to the failure of a right to reply and the poten al for career detriment. I have a ached a screenshot of a comment in the Sunday herald by a member of the public, who discusses the infec on control team and disciplinary ac on etc. , not an easy read.

kr
Teresa

From: Martyn Ramsay [redacted]
Sent: 15 July 2020 17:08
To: Chris ne Peters [redacted]
Cc: teresaink [redacted]
Subject: Re: Le er regarding Independent Review CRM: [redacted]

One for Tim I think Chris ne.

We can discuss the internal routes tomorrow morning perhaps? I'm happy to respond to that as a ma er of completeness because I think it's a disgrace but happy to chat through more.

Martyn

Get Outlook for iOS

From: Chris ne Peters [redacted]
Sent: Wednesday, July 15, 2020 6:05:54 PM
To: Martyn Ramsay [redacted]
Cc: teresaink [redacted]
Subject: Re: Le er regarding Independent Review CRM: [redacted]

It's all go tonight . BBC are doing a piece on the news tomorrow night - Lisa Summers got in touch - parents also wrote to review and v unhappy with process . They wonder re if we got a response re right to reply and want quotes for tomorrow night .

I think we should say we wrote , we got no response to detailed comments and it's now closed up, IT system purged and that's the unsa sfactory end of it .

If we don't take this opportunity I don't think there will be another one as the PI about to start .

Any reason not to comment to direct BBc ques ons ?

Bw

Chris ne

Sent from my iPhone

> On 15 Jul 2020, at 17:27, Martyn Ramsay [redacted] wrote:
>
> To not even engage with a single point that you raised is beneath contempt.
>
> It needs to go back to the Cab Sec now as the commissioner I think.
>
> Kind regards,
>
> [redacted]
>
> **Martyn Ramsay**
> Employment Relations Manager
> Member Services
> BMA Scotland

British Medical Association
[redacted] | 14 Queen St, Edinburgh, EH2 1LL

From: Shalinay.Raghavan [redacted] **On Behalf Of** [redacted]
Sent: 15 July 2020 17:22
To: teresaink [redacted]; [redacted]
Cc: chrispeaters [redacted]; Martyn Ramsay [redacted]
Subject: RE: Le er regarding Independent Review CRM: [redacted]

Dear Dr Inkster and Dr Peters,

Cc: Mr Ramsay

Please find attached a response to your email of 7 July 2020 from the co-Chairs of the QEUH Independent Review.

Kind regards
Shalinay

Shalinay Raghavan | Head of QEUH Independent Review | Atlantic Quay 4, York Street, Glasgow | Tel: [redacted]

From: teresa inkster [redacted]
Sent: 07 July 2020 09:10
To: QEUH Mailbox [redacted]
Cc: Chris ne Peters [redacted]; Martyn Bma [redacted]
Subject: Re: Le er regarding Independent Review CRM: [redacted]

Dear Mark,

Please find a ached our comments on the report.

Kind regards
Teresa

From: mark.dorrian [redacted] on behalf of [redacted]
Sent: 03 July 2020 14:20
To: MRamsay [redacted]; [redacted]; chrispeaters [redacted]
Cc: teresaink [redacted]
Subject: RE: Le er regarding Independent Review CRM:0010600002557

Dear Martyn, Christine, Teresa,
We plan to complete closedown of the operational areas of the Review by Wednesday, 15 July. We hope to resolve all outstanding issues by then. Reviews are by their nature, operational for a finite period of time and we cannot stay open indefinitely for a range of practical reasons and financial reasons.
Regards
Mark

From: Martyn Ramsay [redacted]
Sent: 03 July 2020 14:09
To: QEUH Mailbox <informa_on@queenelizabethhospitalreview.scot>; chrispeaters[redacted]
Cc: teresaink[redacted]
Subject: RE: Le er regarding Independent Review CRM:[redacted]

Good afternoon Mark,

I understand that the final checks are being done on the commentary document and will be with you soon.

I note your comment that the Review will be closing shortly however, given that a fundamental part of the concerns here is a failure to get an adequate right of reply, I would very strongly request that the Review stays open un l such me that it can be concluded fully and properly.

Kind regards,

[redacted]

Martyn Ramsay
Employment Relations Manager
Member Services
BMA Scotland

British Medical Association
[redacted] | 14 Queen St, Edinburgh, EH2 1LL

From: mark.dorrian[redacted] **On Behalf Of** informa_on@queenelizabethhospitalreview.scot
Sent: 03 July 2020 11:59
To: chrispeaters[redacted]; informa_on@queenelizabethhospitalreview.scot
Cc: teresaink[redacted]; Martyn Ramsay [redacted]
Subject: RE: Le er regarding Independent Review

Dear Dr Peters,

Thanks for your email.

I don't see any value in sending you a previous version of the report which has been superseded by the published report. Your issues are with the published report and your commentary relates to the published report. We did have a process prior to publication where we invited comment from specific parties on the draft report but this is not that process.

Regards
Mark

From: Chris ne Peters [redacted]
Sent: 03 July 2020 09:19
To: QEUH Mailbox <informa on@queenelizabethhospitalreview.scot>
Cc: teresaink [redacted]; MRamsay [redacted]
Subject: Re: Le er regarding Independent Review

Dear Mark ,

I hope you are well.

Given that we were not given the right of reply it would be helpful to understand the length of time others were given to respond to the pre published format ,and if we can have that version sent to us also in the interests of parity.

Kr
Christine Peters

Sent from my iPhone

> On 3 Jul 2020, at 08:48, information@queenelizabethhospitalreview.scot wrote:
>
> Dear Dr Inkster
> I would be grateful if you would send your commentary as soon as possible. The Review is winding down and will formally close soon.
> Regards
> Mark
>
> ---
>
> **From:** teresa inkster <teresaink [redacted]
> **Sent:** 02 July 2020 13:46
> **To:** QEUH Mailbox <informa on@queenelizabethhospitalreview.scot>
> **Cc:** Chris ne Peters [redacted]; Martyn Ramsay [redacted]
> **Subject:** Le er regarding Independent Review
>
> Dear Independent Review Chairs,
>
> Please find a ached a le er from myself and Dr Chris ne Peters.
>
> BMA copied in as an interested party.
>
> Kind regards
> Teresa
>
> **********
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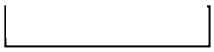

Julie Rothney

From: Peters, Christine
Sent: 06 July 2020 15:17
To: 'WALLACE, Angela (NHS FORTH VALLEY)'; 'Jenny Copeland'
Subject: FW: CRAG

For discussion tomorrow

From: Peters, Christine
Sent: 06 July 2020 09:55
To: 'Elizabeth.Johnson[redacted]'
Cc: Leanord, Alistair ; Valyraki, Kalliopi ; Harvey-Wood, Kathleen
Subject: CRAG

Good Morning Liz,

Thanks for discussing the case of the [redacted] with positive CRAG testing on 3 serial samples, last week. As we discussed at the time with Kathleen, , the performance of the test is very good in determining early cryptococal infection and we agreed that fluconazole would be worth starting pending the CSF samples to exclude meningitis. As far as I understood from our discussion the latex agglutination is less sensitive a test and the fact that 3 separate samples were positive by Crag indicated that a false positive was less likely.

I now understand that this interpretation has changed and that there is now a view that the results were false positives on 4 separate samples? I would be grateful to be included in discussion going forward as to whether a follow up sample becoming negative post treatment would be a helpful way to understand the pathophysiology of a potential early infection being detected.

Kr

[redacted]

Dr Christine Peters
Consultant Microbiologist
Clincial Lead Department of Microbiology QEUH

[redacted]

Queen Elizabeth University Hospital Independent Review

Email: information@queenelizabethhospitalreview.scot
PO Box 27152, Glasgow, G2 9LX
Tel: 0141 242 0391

Sent by email to:
chrispeaters[redacted]
teresaink[redacted]
MRamsay[redacted]

15 July 2020

Dear Dr Peters and Dr Inkster,

Thank you for submitting your commentary on the final report which we received on Tuesday 7 July and which we have considered carefully. As you know, the report was published on 15 June 2020 and the Review will be closing down operationally as of today.

The Review was conducted on an independent basis and as such considered evidence from numerous sources and a variety of perspectives – including evidence submitted by both of you. The report represents our sincerely held views; we reached conclusions and made commentary on the totality of the evidence that we had before us. We believe the content of the report is an accurate reflection of the findings of the Review and these findings are a product of a number of processes where fairness was a core guiding principle.

We accept that not everyone will agree with all aspects of the report and of course, that is their prerogative. The Review report is now published and we do not consider that there is anything in your commentary that compels us to retract chapters of the report or make any alterations or additions to the narrative.

We remain grateful for your contribution to the Review.

Yours sincerely

[redacted]

[redacted]

Dr Andrew Fraser **Dr Brian Montgomery**

Co-Chairs, Queen Elizabeth University Hospital Independent Review

Dear Cabinet Secretary,

It is with much regret that we must write to you again regarding our experience with the Independent review. Following your response to us we contacted the Chairs of the review as you had suggested. We sent them an initial letter encompassing the main themes of our concerns and we followed this up with a 31 -page document of commentary (both attached). We also requested retraction of Chapters 8 and 9 due to omissions and inaccuracies.

We received a letter of response last night at the review close of play (also attached). It is clear from this that the review does not wish to further engage with us or consider our comments or indeed the scientific evidence that underpins them. It is most disappointing that as a public body they have declined to engage with us.

We therefore felt that we must write to you again as the Commissioner of the review to highlight our ongoing concerns.

Dr Inkster has been told that emails between herself and the review were undelivered and that the review were informed that she was off sick or had left her organisation. Efforts to investigate these issues thus far have not been fruitful and it is astonishing that the review purged an IT system just 10 days after publication of the report.

As you will be aware neither of us received a right to reply. We quote the review itself ‘a person made subject to an adverse finding will be provided a fair opportunity to respond to it’ (section 1.4.5). We are both identifiable and subject to adverse findings but have had no explanation as to why we did not receive a right to reply. As such there is potential for us to suffer career detriment and one could argue that has already started given comments to the Herald newspaper at the weekend suggesting disciplinary action for infection control staff.

We would welcome your advice on how to take this further and whether we should submit further evidence we have directly to the Lord Advocate. We have evidence pertaining to cases being investigated and neither the police or procurator fiscal have contacted us.

Kind regards,

Fw: Following up phone call with Fiona McQueen

teresa inkster [redacted]
Tue 20/12/2022 15:52
To: Inkster, Teresa [redacted]

1 attachments (42 KB)
Comments on oversight board paper.docx;

From: teresa inkster [redacted]
Sent: 30 July 2020 18:31
To: Philip.Raines [redacted]
Cc: Fiona.McQueen [redacted]
Subject: Re: Following up phone call with Fiona McQueen

Hi both, please find attached my comments on the report and timeline
Kind regards
Teresa

From: Philip.Raines [redacted]
Sent: 24 July 2020 15:54
To: teresaink [redacted]
Cc: Fiona.McQueen [redacted]
Subject: Following up phone call with Fiona McQueen

Hello Teresa

It was excellent to have an opportunity to meet with you, albeit via Microsoft Teams, today. During our call, Fiona McQueen asked if you would be interested in seeing some of the material we have assembled for the Oversight Board work, and offer any comments/views that might guide the final stages of our work.

Several reports are still being prepared, but we were keen to share this 'super-timeline' of infection incidents and relevant meetings for the period from 2015. It's been prepared by a KPMG colleague seconded into the Scottish Government, and very much represents her independent views. I hope it's of interest, and would ask that you don't share these any further, as they have still to be considered in full by the whole Oversight Board.

My apologies for the file size – I hope this doesn't cause any difficulties with your inbox.

With thanks

Phil Raines
Scottish Government

Comments on Internal report to oversight board paper and Incident timeline

Dr Teresa Inkster

29/7/20

Dear both,

Thank you for giving me the opportunity to comment on these documents, I have attached commentary below. Regarding the incident timeline itself I am afraid it would take me weeks of time to go over this for accuracy. For both documents I have extracted what I feel are the key points and there is enough for me to doubt the accuracy and validity of the information that has been given. There are some fairly significant omissions in terms of evidence but also in terms of governance e.g. no mention of the Executive advisory group to the water IMT or the 2A/B task group. There are also some inaccuracies surrounding some of the incidents themselves and some unscientific views expressed. Once again, I have to question why I as lead ICD or none of my QEUH colleagues were interviewed as part of this process? One of the recommendations is that I am reintegrated into the organisation so that they can take advantage of my expertise, why then was such expertise not sought for this report? I await clarification as to whether the authors of the report were told I was off sick or unavailable. I cannot comment on the events dating from June 14th 2017 to January 6th 2018, but I am aware you plan to meet with Dr Peters, so it would be crucial to get her input there.

You will be aware of the issues I have experienced with the Independent review, particularly around a lack of engagement and consideration of all relevant evidence. This continual lack of engagement has significant implications for patient safety. Without talking to the clinicians involved how does one ensure all the learning is captured?

For each of the points I have made I have evidence associated with it, please advise how best to submit this

Kind regards

Teresa

Internal report

Slide 3

Introduction

- fungi are not bacteria, suggest remove the phrase fungal bacteria and simply state fungi

- wards were not closed due to an inability to find a source, they were closed to implement water control measures safely including Chlorine dioxide dosing, investigation of drains etc

- from the beginning the hypothesis was a water contamination incident. This incident in 2018 was triggered by a rare and unusual bacterial infection in a child, which led to water sampling and confirmation that water was the source. The hypotheses being generated in 2018 all related to the source of contamination within the water system.

Information sources

Why was the lead infection control doctor and chair of the incident management team meetings not interviewed?

How is it possible to truly understand the incident and capture any learning without interviewing the microbiologists involved? i.e. those based at the QEUH/RHC

Who of those interviewed were qualified to comment on what was a complex incident? How many of those interviewed had a FRCPath qualification?

There is no reference to the Executive Control Group established during the 2018 incident to which the IMT and WSG reported to or the 2A/B task force group

There is no detailed reference to the findings of the HFS water report, neither to the reports produced by Intertek confirming the contaminated components of the water system. This is a significant omission.

Limitations

No expert microbiology input

Failure to capture the extensive discussion between clinicians and microbiology out-with IMT meeting minute

Key documents omitted

Failure to consider the role of the Infection control Senior management team meeting (SMT), the Executive control group and task force

Slide 5 - Introduction and Summary of Timeline

'The timeline shows that an increasing number of incidents were recorded in Wards 2A from 2017 onwards – GGC advise that this was a direct result of the update to the National Infection Prevention Control Manual (NIPCM) which occurred in June 2017 to include environmental organisms (which include GNB and Fungi) as alerts. GGC further advise that this resulted in processes being put in place to capture these organisms even although there was no guidance as to what to do with them or how to implement surveillance.'

Comment: In 2015 there was significant outbreak of *Serratia Marcescens* in the NICU requiring SG intervention. As the new lead ICD in April 2016 I was tasked with a review of this incident. As part of the learning I implemented' triggers' for environmental organisms and as Chair of the National Consensus group proposed the addition of environmental Gram negatives and fungi to Chapter 3 of the national manual which was endorsed nationally. These alerts are subject to the same surveillance as all other alerts on the list and the triggers within NHSGGC are clearly defined. Due to the fact these organisms are non-endemic SPC charts are not an appropriate surveillance tool hence why triggers were developed.

These triggers (evidence based) are in the NHSGGC environmental Gram-negative policy and are;

1) Single HAI bacteraemia
2) Two infections other than BSI of same organism in a 2-week period
3) Three colonisations of the same organism in a 2-week period
4) General increase in environmental organisms at discretion of ICD

The increase in incidents reported by NHSGGC relate to the sensitivity of these triggers detecting a true issue. During all incidents evidence of issues with the environment were found followed by a reduction in infection rates after implementation of targeted control measures. NHSGGC was flagged as an outlier by HPS and SG compared to other Scottish Health boards working from the same National Manual. This resulted in the HPS ward 2A situational assessment report.

The alerts added to the manual were for the 4 major Environmental gram negatives- *Serratia marsecens,Stenotrophomonas maltophilia,Acinetobacter baumanii, Pseudomonas aeruginosa.* Some of the organisms found in water and in patients blood cultures were exceedingly rare Gram negatives which were not classed as alert organisms.

With respect to guidance for such incidents they are no different to any other organism and the outbreak guidance in the national manual should be adhered to, in conjunction with the HPS guidance on Pseudomonas. There is a failure to acknowledge the role, skill and expertise of the microbiologist in managing such incidents, this is what they are trained to do. It is impossible for a guideline to cover every eventuality.

Evidence available

NHSGGC environmental Gram-negative policy

Chapter 3 of National Manual

HPS Situational assessment ward 2A

NHSGGC Serratia outbreak report

Emails re trigger levels/alerts/ surveillance

'Prior to the closure of Wards 2A and 2B a number of hypothesis were investigated to determine the source of the infections and colonisations. The hypothesises investigated included research and work to reduce line infections, review of hand hygiene, ward cleanliness and operating practices and issues with the water and ventilation systems. GGC advise that a definitive source of the infections/colonisations was never definitively determined and that the source of such incidents can be difficult to determine.
One of the hypothesis explored was the potential contamination of the water system as GNB can originate in water. However GNB are contained throughout the environment and also in the human body where they generally remain harmless and do not affect a normal healthy individual. Those such as haemato-oncology patients are however at risk from GNB as their immune system is compromised and as a result they are more susceptible to infections from. Such infections can therefore be obtained both from organisms in the patient's own body as well as from an external source. GGC have advised that endogenous infections i.e. from the patient's own flora (body) is a very common source of infections in patients whose immune system is compromised. '

Comment: Haemato-oncology patients are more susceptible to infections which is why prevention in this group is key. There is a misunderstanding above re endogenous vs exogenous bacteria. Endogenous bacteria are those that are part of normal flora and include Staphylococci, Streptococci and gut coliforms. It is challenging to prevent infections from normal endogenous flora but strategies exist to minimise these e.g. line care, screening for S aureus, skin hygiene. Exogenous bacteria on the other hand are acquired from the environment and include organisms found in 2a patients such as *Stenotrophomonas maltophilia, Sphingomonas paucimobilus, Delftia acidovorans, Cupriavidus pauculus*. These are not carried on patients in skin or gut and when found indicate an external source. Strategies to target endogenous and exogenous bacteria differ but there is overlap with hand hygiene and environmental cleanliness strategies being critical and employed for both. The microbiology in the paediatric haemato-oncology patients differs from other centres. Initially there were concerns regarding endogenous infection rates and these have dramatically reduced with the quality improvement work on lines and other infection control measures such as cleaning and hand hygiene. The predominant nature of the infections in this patient group then became exogenous bacteria.

It is unclear why it is stated there is 'potential 'contamination of the water system when in fact this was confirmed with water testing and detailed analysis by Intertek confirming the presence of biofilm in the taps, on sponges within the tanks and around spigots in drains. There was also local laboratory analysis of tap components corroborating these findings. Furthermore, there is evidence of high TVCs at the time of opening and of issues with temperature control and uncapped pipework being fitted as well as taps that underwent pressure testing overseas prior to installation but not on delivery to the QEUH. There was also a period of a bypass of filtration to the mains supply allowing low level seeding of bacteria to come in via that route. There were therefore multiple routes of entry for organisms and a failure to undertake maintenance sufficiently, resulted in proliferation of these within the system and establishment of biofilm. The microbiology and number and range of organisms in the water indicates well established biofilm. This is supported by the analysis undertaken by Intertek

There is a failure to take into account the unique nature of the paediatric microbiology patient group. Children are smaller in stature and are therefore much closer to sinks, outlets, drains and toilets enabling line sites /skin to be splashed by water. Furthermore, they do not undertake hand hygiene in the same manner as an adult in that they have a tendency to splash hands together. They are also inquisitive and will poke fingers down drains, indeed we found small toys pushed down drains.

The source for many of the incidents reported in ward 2A/B is the built environment. There is clear evidence of a contaminated water supply. Incidents of viral outbreaks and faecal organisms such as

VRE were prolonged despite aggressive infection control measures. They are now explainable by the findings of the ventilation report which indicated mixing of dirty and clean air taking place.

In summary the built environment issues that explain the incidents in ward 2a are;

- Contaminated water system including water supply itself, tanks and drains
- Inadequate ventilation system exacerbating outbreaks of faecal organisms
- Mould from bathrooms and in one occasion in a ceiling void following water ingress

Evidence available

Epidemiological papers from other centres regarding typical microbiology in this patient group

Local laboratory analysis of taps

Intertek reports on taps, drains and tanks

Ventilation report from Innovated Design Solutions

Photos of fungal growth behind panels in ward 2A

See also DMA reports, HFS water report, HPS water report and HPS 2a situational assessment

The decant of patients from Ward 2A and 2B was in order to allow a thorough investigation of the wards to understand what the cause of the infections/colonisations was and if indeed it was the water supply

Comment: At this point it was clear the issue was the water system. There was positive water testing, reports from Intertek supporting contamination of components including drains and work had commenced on installing Chlorine dioxide. The children were moved so that this could be undertaken safely. The opportunity was also taken to assess the ventilation system and on receipt of the ventilation report that is when the decision was made that this was no longer a short-term move. Subsequent to that issues with extensive mould were found.

Governance Structure and Reporting The timeline also includes details of when incidents were reported to the various committees and ultimately the Board. In summary incidents will be reported at Sector level, then up to the AICC, then up to the BICC. The AICC also reports to the ACGF which is the senior management group.

Comment: Whilst sector reports were produced these were initially reported to the SMT meeting before AICC and this was the main route for infection control doctors to escalate issues. The role of this SMT meeting is omitted. Neither is there mention of the Executive control group for the water incident and its reporting structure or the 2A/B taskforce group

Evidence available

Intertek reports as previous

Ventilation report and mould images as previous

Executive control group comms

Task group minutes

Slide 7 – reflections on governance

There are omissions in 2015 regarding the issues raised by microbiologists and ICDs in relation to water testing, risk assessments and the environment in ward 2A. Neither is there mention of the background to ward 2a and the issues with the paediatric BMT rooms in 2015. There is no mention of the letter to an Associate Medical director from Drs Inkster/Peters highlighting a range of concerns including ward 2a and incident/outbreak management in NICU.

Note that the background on the timeline to the 2016 Cupriavidus is wrong. This investigation was initiated not by a patient case but by abnormal results in the aseptic pharmacy unit. The aseptic pharmacy has stringent control limits for water and undertakes regular testing. The results were out of control on repeat occasions with higher than acceptable TVCs. This led to identification of the organism as Cupriavidus pauculus. The incident was managed by removal of one outlet and subsequent negative water testing in the remaining one. The case was detected retrospectively and not detected whilst the patient was in hospital. Due to abnormal water test results being the trigger the initial governance route would be via the sector water safety to board water safety groups

Evidence;

Emails regarding water testing and risk assessments from ICDs

Issues within ward 2a identified in 2015 in paediatric BMT

Aseptic pharmacy communications

Slide page 11 – governance 2018

Comment: Again, no mention of the Executive control groups role and its reporting structure

Slide page 18 – reflections on governance

The IMT minutes reflect differing of opinions of MBs and Clinicians around whether levels of GNB infections had risen and what was the source of these organisms

Comment: There was no debate amongst the microbiologists based at QEUH and clinicians, they were in agreement re an increase in infections. Crucial to note that this was not just about numbers but the nature of bacteria. Debate arose when two male microbiology professors from GRI attended an IMT and stated that there was no increase in infection rates or environmental risk. This was challenged by the entire department of microbiologists at QEUH in the form of an SBAR. To this date no evidence for this alternative theory or anything in writing has been issued to back it up. Despite repeated requests to debate these issues with these microbiologists' requests for facilitation of such a meeting within NHSGGC have been declined. Was this alternative evidence reviewed for this report?

Evidence available

SBAR issued by microbiologists in 2019

Slide 19 – reflections on governance

It is noted that there is a lack of expertise and external guidance around the issues that GGC were facing in relation to GNB being identified in the water and the potential for such bacteria to cause infections, and this may explain the lack of debate and challenge in these meetings

Comment: Cultural issues are not discussed in this report. As lead ICD I had water incident experience having managed Legionella and Pseudomonas incidents and previously instructed on

Chlorine dioxide and Kempar control systems. I was also the microbiologist who advised on taps and flow straighteners whilst working at HPS and had recommended taps to be removed due to risk of an outbreak. There is failure to mention the national Pseudomonas and the Legionella L8 guidance, which are applicable in the situation NHSGGC faced. There is literature on outbreaks of GNB from water which the lead ICD was familiar with. Literature on contamination of flow straighteners by Pseudomonas dates back to the 1960s. Part of the issue was a failure of some individuals to listen to the ICD and continual challenging. This been a recurring theme through the incidents from 2018 onwards and not just for the lead ICD but for other microbiologists. When there was the Stenotrophomonas incident in 2017 another ICD requested water testing which was not done in a timely fashion. The lead ICD reported to the BICC and advised on relevant control measures, as early as March 2018 before establishment of the WTG. She highlighted at this very early stage problems with relying on typing of organisms in water incidents and that different strains were typical.

Evidence available

HPS correspondence and SBAR re taps

National Pseudomonas guidance

Literature relating to Gram negative infections from water

Literature relating to Pseudomonas from flow straighteners and Stenotrophomonas typing

Report from lead ICD to BICC March 2018

Slide 24 conclusions

This was also one of the conclusions in a report produced by HPS ""Summary of Incident and Findings of NHS GGC QEUH/RHC." although it also concluded that contamination could have been the result of bio-film building up in the flow straighteners of taps and regressing into the water system.

Comment: At the time the HPS report was undertaken not all reports were available. As before, evidence emerged on uncapped pipes, bypass of mains filtration and contamination within drains and storage tanks.

DMA 2015 report and lack of clarity over roles and responsibilities in the E&F team

Comment: Note that these reports were requested by microbiologists in 2015 but the request was declined. This report mentions the ball was dropped in 2015. What was the reason the report in 2017 was not shared and acted upon?

Slide 25 – conclusions

In addition, knowledge on how the organisms are transmitted from a water system to a patient does also not appear to be understood other than by water experts.

Comment: This is in fact very basic and these routes of transmission are well understood by the lead ICD and microbiology colleagues. Routes of transmission are direct and indirect. Direct when children have direct contact with water vis showering or splashing, indirect when the contact is via the hands of a health care worker, a contaminated environment or from a contaminated piece of equipment. This was poorly understood by some IMT members again with an unwillingness to

accept what the lead ICD was saying. Drains in particular were contested despite scientific evidence for both retrograde biofilm creep and disruption of biofilm from spigots due to increased splashing as a result of filter application

Evidence available

Review article on water incidents

National Pseudomonas guidance

Scientific papers on drains

However it is also noted that through the course of the timeline, MB reports comparing infection rates at the hospitals previous location of Yorkhill did not show that the level of infection rates had increased.

Comment: Microbiologists at QEUH were of the opinion there was an increase in infection in RHC. Occasional incidents occurred in Yorkhill but we are not aware that infection rates stayed the same. Would it be acceptable for a new build to have the same rates of infection as a building decades old with high Legionella counts in water indicative of poor water control? With improvements in infection control practice is it acceptable to have infection rates remain the same as they were up to a decade ago? This is an inappropriate benchmark. A more useful comparsion would be with a centre such as Great Ormond Street over the same time period. Publicly available date is available which demonstrates low levels of environmental Gram-negative infections in GOSH and other centres

Evidence available

GOSH annual reports

Epidemiology papers from other centres

The lack of research and guidance that was available in this area hindered GGC's response and the organisation was on a "learn as you go" footing. Much of its actions seem reactive but given the lack of policy and guidance this is to be expected

Comment: Not so much a lack of research and guidance but a series of unintended consequences and events that very few others managing such incidents will have been faced with. Examples include;

1) Failure of Silver Hydrogen Peroxide to bring about rapid reduction in bacteria as expected. This was due to the extensive contamination in the system that was not anticipated for a new build. Initially the IMT believed the issue to be localised to ward 2A and an outlet problem. There was nothing to suggest otherwise. There was also an incompatibility of Silver hydrogen peroxide with the taps in situ
2) Application of filters lead to a problem with drains materialising. Reduction in the distance between the tap and drain resulted in increased splashing. Given that the spigots were

corroded and had biofilm on them this splashing disrupted the biofilm, releasing bacteria. The presence of biofilm so close to the sinks also likely resulted in retrograde biofilm bacteria i.e. bacteria crawling up into the sink. This was an unintended consequence of filters and may not have happened had the drains been in an intact state.

3) Ventilation issues. No one at IMT could have comprehended that the ventilation system was designed so that dirty and clean air could mix and increase the risk of transmission of faecal pathogens in particular. Toilet plume factor coupled with poor ventilation strategy
4) Extensive mould in showers and bathrooms. Again no one was aware that the gyprock was in fact not water resistant as had been stated on the plans. A point of weakness in the shower join led to water ingress and extensive mould contamination.

However, GGC has advised that the whole genome sequencing that was performed confirmed that many of the infections were unrelated to each other or to the environment.

Comment: Unless samples from the environment are taken at the same time as those in the patient this statement is meaningless. Typing of environmental incidents is complex. Biofilms contain multiple strains of the same organism meaning that strains from patients and water don't always match. That does not exclude the water as a source. An analogy is the cystic fibrosis lung where on the same agar plate whilst colonies of bacteria look the same multiple different strains can be detected and this is dependent on how many colonies are selected. This view on typing is supported by two water experts, the lead ICD and scientific literature but continues to be refuted by NHSGGC. Small numbers of Enterobacter were typed and it's not clear where, when and how many from the drains and water were included. Scientific papers on Enterobacter have shown a diversity of strains in outbreaks linked to the environment

Evidence available

Susanne lee report

Intertek report

Papers on typing of strains in environmental incidents.

A report produced by HPS entitled "Review of NHS GG&C paediatric-oncology data" also appears to advocate a more "holistic" view when it recommends characterisation of cases in terms of "person" and "place" to support identification of when there are more cases than normally expected

Comment: Epidemiological links in time place person is a basic outbreak management concept established decades ago and is applied to every incident as per National manual. The time is incorporated in the triggers. In terms of person these are patients belonging to the haemonc cohort so share a common characteristic.

It is noted from the timeline that the hypothesis around the water system did not start to develop until 2018. Any actions taken before then in connection with water outlets, wash hand basins or any other connection to the water system either appears to have been a precautionary measure or the link had been made specifically to that

outlet. This was the case in the aseptic pharmacy in 2016 when a patient had CU following food being prepared in that area of hypothesis

Comment: The key here is that water results and risk assessment were not shared with ICDs. It would be highly unlikely to have a contaminated water system in a new hospital which Is why focus was on the outlets and retrograde contamination. There was failure to consider the concerns raised by microbiologists in 2017 with respect to increased line infections, concerns re water testing and concerns re antifungal prophylaxis on ward 2A. These were escalated to the acting lead ICD and senior management at the time followed by a formal whistleblow process

Evidence available

Escalation emails

Whistleblow SBAR

Slide 26 – Conclusions

While it is clear that there was an issue with the water system, in that it did contain bio-film and GNB, it is less clear that this was the cause of, or contributed to, the infections and colonisations seen in Wards 2A of the RHC and 6A of the QEUH.

Comment: It is incomprehensible that this is not the case. Biofilm from the water system contained the diversity of organisms identified in patients with some typing matches. There is clear evidence as stated previously regarding the different routes and sources of contamination within the water system. Following the move to ward 6A in September 2018 there was a period of several months with no environmental Gram-negative infections. This is a test of theory. Prior to entry to the ward filters were applied and all drain spigots replaced and drains cleaned.

In 6A in 2019 new risks and sources such as leaking chilled beams, exposure to unfiltered water along the patient pathway and water ingress in the kitchen were all investigated and addressed. Infection rates are now extremely low. Little emphasis has been given to the importance of water ingress in the ward kitchen of a long-standing slow leak. This coupled with the ventilation strategy is a plausible source of infection that has not been given prominence.

If not the water system in 2018 and other environmental sources in 2019 what would the alternative source be and what evidence has been sought for this? Where else would you expect to find the diversity of these environmental Gram negatives associated with biofilm? How does one dispute typing matches such Cupriavidus and M chelonae? If carried on skin and in gut why would children suddenly stop carrying these and why did we not see these numbers in 2015 and 2016. If found in the home environment why no issues in centres elsewhere or other patient groups?

This is dangerous conclusion, one that rewrites basic outbreak management, epidemiology and science and sets a dangerous precedent for management of future water incidents. It is highly likely contamination built up in the water system reaching critical levels in early 2017 when infections started to rise. It is possible infections before this time were also water related.

Issues with drains – although it is noted in the timeline that a survey revealed that no issues had been found with the drainage system for either hospital.

Comment :The drainage survey would not and did not identify the local issues with drains detected immediately at the back of the sink where there was evidence of corrosion and heavy biofilm around spigots and pools of stagnant water. The Intertek report contains more details on this. Drains are well established sources of Gram-negative outbreaks via the mechanisms delineated earlier.

Issues with ventilation systems and chilled beams – this was in relation to the fungal incidents seen in the wards;

Comment: Water dripped from beams. Issues with chilled beams relate to both Gram-negative infections and fungi. Testing of the circulating water system and water dripping on to the ground was contaminated with the Gram-negative organism Pseudomonas Olevovorans. Surface swabs from some beams revealed Gram negative organisms, fungi and skin flora.

Slide 27

Contingency plans if CD is no longer viable

Comment: Lead ICD raised concern regarding low dose Chlorine dioxide exacerbating levels of M Chelonae and other atypical mycobacteria by selecting these out. She had discussed with Dr Katzemi a water expert and they had both reviewed the work of Falkenham et al from University of Western Virginia on this matter. This was subsequently discussed at a WTG meeting but not minuted, the water experts present had minimal experience with NTM. The lead ICD asked for an amendment of the minutes, it is not clear if this was made or if in fact this concern has been investigated further. Current levels and extent of NTM in water is unknown. Similarly it is not clear what the status is with fungi in the water as they were proving resistant to Chlorine dioxide. No update has been given regarding the programme of tap replacement in high risk areas.

Evidence available

Email re minute

Literature on Chlorine dioxide and atypical mycobacteria

Slide 29, lessons learned

It is unclear to what extent IPCT/ICD/ICN are educated in this field and what true knowledge and expertise they possess in relation to these bacteria and how they should be managed.

Comment: Perhaps a starting point would be to ask this question. The lead ICD has membership of two Royal colleges and a Master's in Public Health in addition to other degrees. She had extensive built environment and outbreak experience prior to this incident. In addition, she is an FRCPath examiner, Chair of the National Consensus group, Module lead for outbreak management at Master's level, Assistant Editor of JHI, National Training Programme Director for microbiology and has several peer reviewed outbreak publications. A significant issue is culture and lack of respect for internal expertise with failure to listen and continual challenge which impedes progress. Microbiologists by the nature of their job are experts in Gram negatives, they are best equipped to

pattern spot and detect issues locally. What are the qualifications of those from the IMT who were interviewed for the report?

It is noted that the ICD who first put forward the hypothesis that the water system was potentially contaminated ultimately withdrew from the IMT process. This may be a way to reintegrate this ICD into the organisation and capitalise on the experience and knowledge that they gained. The importance of their knowledge and experience of these matters should not be ignored.

Comment: This is very true but what assurance does that ICD have that she will be listened to and respected moving forward.

Comments on timeline

I have pulled out the main issues/themes, but as stated a significant amount of time would be required to check all the details

Slide 26

A key question would be why was the SOP for environmental organisms in high risk areas withdrawn in August/September 2017 when the Lead ICD and author was off sick. What was the substitute?

Slide 28

Cryptococcus neoformans is found in **soil contaminated with pigeon droppings** and pigeon droppings.

Air samples did not support the plant room hypothesis

Comment :3000 air samples were undertaken after the pigeons were removed and plant rooms cleaned. The priority was to remove the source. One set taken just before cleaning were heavily overgrown with environmental fungi making it impossible to establish whether the yeast like form of Cryptococcus was underneath these.

During investigation a separate issue was identified with the sealant in some of the shower rooms

Comment: This was more than just a problem with sealant. There was extensive mould in these shower rooms caused by water hitting a defective join and water damage to Gyproc which was supposed to be water repellent but was not, the wrong type had been installed. There was significant risk to children from pathogenic fungi

Short life expert advisory group is convened which will report to the IMT

Comment: Despite this stated in TOR this group has not reported to the Chair of the IMT. No report has been produced to this date yet extracts from said report have appeared in board papers. This is a governance failure. Pictures of dead birds and guano from the plantroom, with pest control reports were recently shared with the IMT chair which she hadn't seen before, by a colleague concerned

about a cover up. These pictures and concerns re the governance of this group were shared with the DIPC in 2020 but no action is evident.

Evidence available

Pictures of fungal plates from air sampling in plant room

Picture of mould in 6A bathrooms

Picture of bird and guano and plant room

Email to DIPC

Slide 29

CCGC asked ICD if they and their colleagues were content with progress of actions to address their concerns and ICD confirmed they were content with the good progress made on all areas

Comment: this is inaccurate. Draft minutes not circulated to the ICD for comment and placed in the public domain had to be amended to what the ICD actually stated. This was, that one colleague had retired and the other had not raised any issues with her. This is not the same as colleagues being content with good progress in all areas. It is concerning that this set of draft minutes is referenced, this questions the reliability of minutes used for this timeline. How confident are the report authors that the agreed minutes and not drafts were submitted for all incidents?

Evidence available;

Email sent requesting minute change
Revised set of minutes issued

IPCT advised that following a conversation between them about the complexities of being the Chair and an active participant, the Chair was in favour of another chair.

Comment: this is inaccurate. The lead ICD was asked whether she required any support with IMTs. She requested minutes be recorded due to concerns re inaccuracies and she asked for microbiology colleagues to be in attendance. A few days later she was told by the acting ICM'I am really sorry but you will have to give up the Chair, you will be replaced by Dr X'. Different reasons were given for this decision to various people. The lead ICD sought clarification which was not given.

Evidence available

Emails to acting ICM
IMT minutes

Fw: Meeting: Dr Teresa Inkster/Phil Raines

teresa inkster [redacted]
Tue 20/12/2022 15:53
To: Inkster, Teresa [redacted]

From: teresa inkster [redacted]
Sent: 21 August 2020 11:24
To: Philip.Raines[redacted]
Subject: Re: Meeting: Dr Teresa Inkster/Phil Raines

Hi Phil,
Happy to discuss those questions when we meet. I have discussed 1 and 2 many times over the last year with others from SG and offered to send in the relevant emails. I have attached those now for your information. Re question 2, I was off sick in 2017 when colleagues were asking to have water testing done so that question would be better answered by Drs Christine Peters and [redacted].
I have seen relevant emails but it would be better to speak directly with those involved.

Kind regards
Teresa

From: Philip.Raines[redacted]
Sent: 21 August 2020 08:19
To: teresaink[redacted]
Subject: RE: Meeting: Dr Teresa Inkster/Phil Raines

Hello Teresa

For our meeting next Thursday, I said I would provide a list of specific issues I'm keen to explore with you further, if you feel able to help.

1. We have heard from a number of folk that there is a history of concerns being raised by clinicians about potential problems with the 'water system' before the autumn 2017 SBAR and Stage 1 of the whistleblowing procedure. It would be good to know more about how and when those concerns were raised, and how the health Board responded (or as indeed, didn't respond).

2. Throughout the period, there seemed to be repeated requests by ICDs and others for water testing results and risk assessments, and those requests not being addressed. I would like to further more about how (and why) this didn't happen, if possible.

3. The 2019 SBAR on Ward 6A did not appear to receive a formal response from the health Board, despite what appears to be assertion that this did occur in the IMT minutes. It would be good to know more about how that SBAR was received and responded to.

I look forward to speaking with you.

Best regards

Phil

-----Original Appointment-----
From: Raines P (Philip)
Sent: 20 August 2020 09:53
To: Raines P (Philip); teresa inkster
Subject: Meeting: Dr Teresa Inkster/Phil Raines
When: 27 August 2020 10:00-11:00 (UTC+00:00) Dublin, Edinburgh, Lisbon, London.
Where: MIcrosoft Teams

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Fw: Meeting: Dr Teresa Inkster/Phil Raines

teresa inkster [redacted]
Tue 20/12/2022 15:56
To: Inkster, Teresa [redacted]

From: teresa inkster [redacted]
Sent: 27 August 2020 15:13
To: Philip.Raines [redacted]
Subject: Re: Meeting: Dr Teresa Inkster/Phil Raines

Hi Phil - some further info attached as discussed this morning ;

- Email to Dr Stewart re patient safety which was the trigger for our letter to him
- My statement of resignation (attempted!) Summer 2015
- Minutes from a paediatric BMT meeting in 2015 sent to me only recently which demonstrate senior colleagues were aware of issues so Im not clear why this could not simply be acknowledged at the time of our letter in 2015
- Emails pertaining to the planned transfer back of the adult BMT unit which did not happen once HPS became involved
- Case note review emails
- Emails regarding the DMA reports and an SBAR produced by Tom Walsh. Looking at the email dates it would appear Dr Armstrong called me the last weekend in June 2018 re DMA reports.

I hope you find this useful and let me know if you require anything further. I have lots of emails but do not wish to bombard you!

kr
Teresa

From: Philip.Raines [redacted]
Sent: 27 August 2020 09:08
To: teresaink [redacted]
Subject: RE: Meeting: Dr Teresa Inkster/Phil Raines

Hi Teresa

It just doesn't seem to be working for me, and unfortunately I don't have the ability to send out a new Teams link via my computer. If it's OK with you, let's move the meeting to phone – I'm happy to call you, or if you prefer, my mobile number is below.

Sorry about this –

Phil
[redacted]

From: teresa inkster [redacted]
Sent: 27 August 2020 10:06
To: Raines P (Philip) [redacted]
Subject: Re: Meeting: Dr Teresa Inkster/Phil Raines

I am on teams but its told me to wait for meeting to start. Im happy to call you if easier

Get Outlook for Android

From: Philip.Raines[redacted]
Sent: Thursday, August 27, 2020 10:04:58 AM
To: teresaink[redacted]
Cc: Philip.Raines[redacted]
Subject: RE: Meeting: Dr Teresa Inkster/Phil Raines

Hello Teresa

The Microsoft Teams link doesn't appear to be working for me. I'll try once more, but failing that, I wonder if you would be OK if we moved the meeting onto phones? I could phone you, or if easier, you could call my mobile?

My apologies for the delay –

Phil
[redacted]

-----Original Appointment-----
From: Raines P (Philip)
Sent: 20 August 2020 09:53
To: Raines P (Philip); teresa inkster
Subject: Meeting: Dr Teresa Inkster/Phil Raines
When: 27 August 2020 10:00-11:00 (UTC+00:00) Dublin, Edinburgh, Lisbon, London.
Where: MIcrosoft Teams

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Inkster, Teresa

From: Philip.Raines[redacted]
Sent: 15 February 2021 12:16
To: Inkster, Teresa
Cc: Peters, Christine
Subject: [ExternaltoGGC]RE: Publication of the Oversight Board Interim Report

Hello Teresa

Thank you! For your comments, for the supporting material – and indeed, for the time you're continuing to commit to supporting our work. We greatly appreciate this, and I will review all of this carefully for the next version of the draft report. Indeed, depending on your availability, I may come back for further clarifications.

I'm sorry that there has been this confusion about your role within GGC – I have to say, I'm not aware of this formally coming up at any of the Oversight Board meetings, and it hasn't been put into the final report. Nevertheless, I will certainly alert Fiona, as chair of the OB, to this issue, if only for her information.

Best
Phil

From: Inkster, Teresa[redacted]
Sent: 15 February 2021 11:33
To: Raines P (Philip)[redacted]
Cc: Peters, Christine[redacted]
Subject: Re: Publication of the Oversight Board Interim Report

Confidential

Hi Phil,

Thanks for sending these. The report is very comprehensive and the recommendations welcome. I have attached some comments. I note that there is reference in the timeline to other ventilation issues such as Adult BMT and isolation rooms. There is still some missing information with regards adult BMT and ward 2A in particular . I have attached the evidence that I submitted to the Independent review with regards to these areas. I would be happy to meet to discuss further and indeed submit any further evidence you require.

I also wish to raise a concern re a discussion that took place at an oversight board meeting. After the meeting in January I was contacted by two members of the OB for other reasons. Both expressed surprise regarding my apparent status as ICD for RHC and recently returning to work after shielding. This was stated by Prof Wallace in response to a query from the CNR team. I have raised this internally via line management processes and been assured that Prof Wallace will contact me to explain the misunderstanding. I have yet to be contacted. However, it is not me that requires an explanation rather the OB need the following facts clarified 1) I have had no role in IPC within NHSGGC since mid-August 2019. 2) I have been back at work full time since Jan 2018 and I currently work full time in my role as a consultant microbiologist.

You will be aware that the Independent review put in writing that they were told by NHSGGC that I was unavailable or off sick and I am concerned that there is continual narrative regarding my leave status. I also question the confidentiality of announcing I was shielding . Whilst it is obvious within my own department, Im not sure it is appropriate to discuss this at an OB meeting.

Kind regards

Teresa

From: Philip.Raines[redacted]
Sent: 09 February 2021 15:36
To: Inkster, Teresa[redacted]; Peters, Christine[redacted]
Cc: CNO[redacted]
Subject: [ExternaltoGGC]RE: Publication of the Oversight Board Interim Report

Christine, Teresa

With apologies for the further delay, I attach a draft of the Oversight Board's Final Report. This is contained in two files: a Word draft of the Final Report, and a PDF of the incident timeline, which will form one of the annexes to the Final Report. Both of you have commented on the timeline before, and the draft has been altered on the basis of those comments. You won't have seen the Final Report draft before; it doesn't cover the issues that were addressed in the Interim Report.

We would welcome comments from yourselves, and any clarifications you wish to raise with us. I'm also keen to organise a further meeting between yourselves and Fiona McQueen, the chair of the Oversight Board, to pick up those views formally, but would be keen to receive any points you would want to make earlier. If you want to discuss with me, I'd also be happy to arrange something for ourselves. We are looking to finalise the draft by the end of this month.

I'm conscious that this is making yet further demands on your time, so any consideration you can give to these drafts would be much appreciated.

With thanks

Phil

From: Peters, Christine[redacted]
Sent: 22 January 2021 14:01
To: Raines P (Philip)[redacted]
Cc: Inkster, Teresa[redacted]
Subject: RE: Publication of the Oversight Board Interim Report

Hi Phil,

Thanks for getting back to me, and I am sorry to hear about your mother being ill. I hope she is better now. It is a difficult time for so many just now.

We would be happy to meet sometime in mid-February, to discuss the draft. I think it is crucial that the facts are correct and given the last iteration was fairly inaccurate in many points, I hope that gives enough time before the final issue date.

Look forward to hearing from you and the Case Note review panel.

Kr

Christine

From: Philip.Raines[redacted]
Sent: 21 January 2021 18:19
To: Peters, Christine[redacted]
Cc: Inkster, Teresa[redacted]
Subject: [ExternaltoGGC]RE: Publication of the Oversight Board Interim Report

Hello Christine

My apologies for any prolonged silence on our side. It was unintentional, and reflects a combination of both personal issues (my mother was in hospital and I am transitioning into a new post) and work (we have all had to divert time to responding to the upsurge in covid).

When we spoke before, I indicated that we'd benefit from you and Teresa informing the final report. That work has been slightly delayed, but Fiona and I would be keen to share a draft of that report and to meet with you to discuss it. I expect to have a draft ready to share by the end of this month, and wonder whether we can meet with you and Teresa in, say, mid-February. Our aim now is for a publication towards mid-March, at the same time as the Case Note Review's report, as it makes sense to us for both reports to be released together.

Let me know if you would both be willing to meet with us at that point.

I hope you're both well, despite the current onslaught (or so it feels).

Best
Phil

Sent with BlackBerry Work[redacted]

From: "Peters, Christine"[redacted]
Sent: 21 Jan 2021 16:47
To: "Raines P (Philip)"[redacted]
Cc: "Inkster, Teresa"[redacted]
Subject: RE: Publication of the Oversight Board Interim Report

Hi Phil,

I am aware that the timetable for publication of reports is now looking tight.

I would like to mention that neither of us have had an opportunity to talk to the Oversight Board as a group, nor any of the sub groups, nor the case note review to date. Which, as we have both been available all this time is a disappointing repeat of the Review.

We have yet to have answers to a number of concerns raised over the past year and continue to have concerns re the functioning of the IPCT.

We had a meeting with Angela Wallace and Tom Steele as recently as last Friday. There are a number of outstanding actions from the lists of issues raised, and it was helpful but not conclusive on the subjects of ventilation and water.

With all this in mind, I wonder if you are still planning to have a meeting with us before publication?

Kr

Christine Peters

From: Philip.Raines[redacted]
Sent: 21 December 2020 12:03
To: Peters, Christine[redacted]
Subject: [ExternaltoGGC]Publication of the Oversight Board Interim Report

Hello Christine

At noon today, the Oversight Board published the first of its outputs – an Interim Report. This principally captures the work of the Communications and Engagement Subgroup, headed up by Craig White, and the Peer Review, led by Lesley Shepherd. The Final Report will cover the remaining issues examined by the Oversight Board, including the work progressing from our own discussions. We are aiming to publish that in early 2021, and if you are willing, I would be keen to test out some of our findings with yourself in January.

I attach a PDF version of the report, and the weblink: [redacted]

I hope you are well, and Christmas brings a welcomed break.

Regards

Phil

Inkster, Teresa

From: Philip.Raines[redacted]
Sent: 22 February 2021 18:46
To: Peters, Christine
Cc: Inkster, Teresa; Shepherd L (Lesley)
Subject: [ExternalToGGC]RE: OB report

Hi Christine

Indeed, this has been an exceptionally busy time – but nothing compared to what you've been experiencing working through the pandemic!

Again, let me repeat my thanks for your extensive review of the report. I'm keen to pick up several issues you raise, and indeed, your more recent experiences, in the discussion tomorrow. For that reason, I've taken the liberty of inviting Lesley Shepherd to the meeting as well.

As part of the response to your comments, I would note a few points, which, of course, we can discuss tomorrow.

- The purpose and scope of the Oversight Board needs to be borne in mind. While many of the issues that you and Teresa have evidenced and raised need to be investigated, our process was not the place to do that as comprehensively as you seem to suggest – I hope I have always been clear in my discussions with you and Teresa that some of these matters are properly the responsibility of the Public Inquiry. Clearly a judgement needs to be made about how many of these issues need to be bottomed out before the Oversight Board can make its recommendations – and I accept that there will be different views on how that judgement is applied – but that context is important to understand.
- However, there are a number of points in the final report where the text needs to change as a result of your comments. A good example is the naming of individuals you reference in point 7 – something that was not intended to create alarm, and which should and will be changed.
- Your concerns about the current state of affairs are important to hear, which is why I have asked Lesley to take part.
- I note in several of your comments concerns about lack of engagement with the Oversight Board. I hope I have demonstrated my willingness on behalf of the Oversight Board to discuss these issues with you on several occasions and fully consider all the evidence that you, Teresa and Dr Redding have provided (though I accept you will not always agree with how that evidence has been deployed). Of course, you might feel that this engagement may not have been sufficient, and I hope tomorrow's meeting and next week's with Fiona will help to address any concerns around this.

I look forward to speaking with you –

Regards
Phil

From: Peters, Christine[redacted]
Sent: 19 February 2021 15:24
To: Raines P (Philip)[redacted]
Subject: OB report

Hi Phil,
I hope you are well. I am sure you are very busy indeed at present.
Apologies as I have not had time yet to go through the timeline or the interim report. I will try to get to these before we meet on Tuesday.

I attach a copy of the report with my comments on it. In summary I feel that the report still lacks an adequacy of depth and breadth to truly bring out the key learning points and actions required to ensure assurance that the past will not repeated.

1. There is no comment on the correctness or otherwise of any of the issues raised to line managers from 2015 right through to 2021
2. There is a blanking out of the fact that concerns were raised repeatedly in writing since 2015, and information sought even before the opening of the building. I find this to be absolutely unacceptable. We would never have taken a whistle blow as a first step. Is there a suggestion that our letters of resignation, documents and emails are fake? If not there is no reason to imagine that the first time higher management were aware of issues was October 2017.
3. The points around the move from 2A to 6A are opaque re the process. This is critical to document the process as per Teresa's email.
4. There is an attempt to compromise on views regarding the safety issues. I find this to fall short of the need to establish facts and take a view on what the actual status was and continues to be in regard to the multiplicity of issues with the building.
5. In relation to identifying an expertise gap – I find this odd., We had good internal expertise that regularly sought discussion outwith the organisation BUT they were not listened to. In fact Dr Inkster is teaching a masters level course – that the external experts attend to become experts. Surely this is an oddity that shines a rather dismal light on the conclusions of the report.
6. The withholding of information is a very serious matter and was the key theme that drove us to resign in 2015 and was key to all our raising of concerns throughout the last five years. How can one reasonably expect an ICD to work in such a team from top management down where information is routinely withheld. This is dangerous and needs to be called out clearly as such. Trust is lost and has not been rebuilt as there is zero evidence to show a change in primary thinking.
7. The fact that the only 3 named individuals in the entire document are the three whistle blowers in 2017 strikes me as unreasonable. Once again whistle blowers are treated in a unique and ostracising manner particularly as concerns are noted as "alleged" . [redacted] name is not in the public domain and I think this constitutes a breach of confidentiality.

There more to be said, particularly in regard to the current state of affairs and I look forward to our meeting on Tuesday.

Kind regards,

[redacted]

Dr Christine Peters
Clinical Lead
Consultant Microbiologist
QEUH
[redacted]

Inkster, Teresa

From: Philip.Raines[redacted]
Sent: 08 March 2021 16:10
To: Peters, Christine; Shepherd L (Lesley)
Cc: Inkster, Teresa
Subject: [ExternalToGGC]RE: Meeting Follow Up

Many thanks, Christine – for this, and again for the time you and Teresa gave us on Friday.

Regards
Phil

From: Peters, Christine [redacted]
Sent: 08 March 2021 16:07
To: Raines P (Philip)[redacted]; Shepherd L (Lesley) [redacted]
Cc: Inkster, Teresa [redacted]
Subject: Meeting Follow Up

Hi Phil,
Thanks for your time and setting up the meeting with Fiona and Lesley to discuss the OB report. It was helpful to be able to discuss how little we feel things have changed from our perspective in terms of IPCT, although Microbiology staffing and bullying culture are very much improved indeed.

I wanted to pick up on a couple of details in the timeline that I referred to at the meeting with regard to points of information accuracy :

1. The two cases of Stenotrophomonas in 2017 referred to were part of an increase in the run chart that I pointed out before and was available to the IMT at the time that included 6 cases in total (from memory) but it is worth checking .
2. I have previously mentioned the numbers of water samples for Steno, not actually being relevant to the cases as some were taken from a different water system.
3. Stenptrophomonas HAD previously been isolated from the water system as per the HPS report Apendix 4 which states that in October 2015 – Cupriavadis, Stenotrophomonas and Pseudomonas had been isolated from water
4. The Meeting in October 2017 was chaired by the medical director and was NOT intended to agree an action plan (that is obvious as there was no action plan to discuss and it was developed later by the Lead ICN and Lead ICD) rather the invite was to discuss the SBAR that the medical director had instructed me to write. I have been asked as of Friday to go through the original SBAR and check for any outstanding items for OD – 3.5 years later.
5. INHERENT in the SBAR is the repeated statements regarding when issues were raised. Ie if the SBAR was accepted it is therefore accepted that issues were previously raised.

We agreed that in order to discuss current issues and those that have presented challenges over 2020 under the OB , we would have a meeting with Angela , Fiona, Teresa and myself. I look forward to hearing when that will be.

Thanks again for all your time and input into the OB ,

Kr

[redacted]

Dr Christine Peters
Clinical Lead
Consultant Microbiologist
QEUH
[redacted]

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[ExternalToGGC]RE: Meeting Follow Up

Philip.Raines [redacted]
Tue 09/03/2021 12:41

To: Inkster, Teresa [redacted];Peters, Christine [redacted];Shepherd L (Lesley) [redacted]

Thanks, Teresa. I'll clarify in the text.

Regards
Phil

From: Inkster, Teresa [redacted]
Sent: 09 March 2021 12:40
To: Raines P (Philip) [redacted]; Peters, Christine [redacted]; Shepherd L (Lesley) [redacted]
Subject: Re: Meeting Follow Up

Ok that makes sense but it reads to me that it was the water technical group that failed to do this , perhaps this section could be made clearer

Similarly, there was no comprehensive review of the infection risks to the whole site from systemic water contamination. While the Technical Water Group did consider vulnerable patient groups in its deliberations – for example, to guide the installation of point-of-use filters – there was no review of the implications of this risk for the whole hospital. This is considered in more detail in the Governance section, but it meant that there were missed opportunities for full learning from these incidents. Granted these were unprecedented circumstances, but there was an absence of the pro-active approach to addressing such unusual bacteria that would seem to be at the very least the spirit of national guidance

Again, I highlight the role of the Executive control group , the existence and function of which no-one seems willing to acknowledge.

kr
Teresa

From: Philip.Raines [redacted]
Sent: 09 March 2021 11:43
To: Inkster, Teresa [redacted]; Peters, Christine [redacted]; Shepherd L (Lesley) [redacted]
Subject: [ExternalToGGC]RE: Meeting Follow Up

Hi Teresa

The Oversight Board starts from the perspective that a contaminated water system would have significant, hospital if not Board-wide implications and these should be considered as a whole, not just in terms of specific issues relating to (say) infection control or building repairs. There is the question of reviewing the clinical risks to all vulnerable patient groups, and putting in place both measures to reduce risk and closely monitor what is happening with those groups. There are the implications for short-term facilities actions – such as the point-of-use filters – as well as longer-term investigations and remedial action on the infrastructure and a need for a hospital-wide water testing policy that explicitly is designed to address this risk. There are the financial and public assurance consequences. There are the implications for staff working in such an environment and addressing patient and family concerns. While many of these actions were taken forward, we did not see a strategic overview that considered the risks and responses to water contamination as a whole. The

closest that exists is the three-fold review commissioned by the Chief Executive in early 2019 and which reported to the full Board that December (and which led to the legal action against the builders), but that didn't demonstrate the awareness of the different linkages and need for overview that we felt this risk deserved. That would be the expectation of a governance system that sees the whole picture rather than just focusing on elements of it.

That, at least, was the Oversight Board's view (and indeed, my own take of the text in report). I hope that helps.

Phil

From: Inkster, Teresa [redacted]
Sent: 09 March 2021 11:09
To: Raines P (Philip) [redacted]; Peters, Christine [redacted]; Shepherd L (Lesley) [redacted]
Subject: Re: Meeting Follow Up

Hi Phil,

There was an additional point in the OB report that I wished to query. It is stated we did not consider the impact of the water incident on the rest of the hospital.

As far as IMT/WTG were concerned we implemented site wide dosing, identified all high risk areas , applied filters outwith 2a/b, ICNs visited all wards to do drain surveys and identify all sources of water . I also met with the acute services director and estates, to put detailed contingency in place for times when the water supply was off due to dosing in both hospitals e.g. portable sinks/toilets , ensuring minimal impact by dosing at night, comms to patients/staff etc

We also discussed the impact as a whole in a TC with SG - see minutes attached.

Is it possible to get an explanation as to what that means and what we should have done - this is important to know for future learning.

Thanks
kr
Teresa

From: Philip.Raines [redacted]
Sent: 08 March 2021 16:09
To: Peters, Christine [redacted]; Shepherd L (Lesley) [redacted]
Cc: Inkster, Teresa [redacted]
Subject: [ExternalToGGC]RE: Meeting Follow Up

Many thanks, Christine – for this, and again for the time you and Teresa gave us on Friday.

Regards
Phil

From: Peters, Christine [redacted]
Sent: 08 March 2021 16:07
To: Raines P (Philip) [redacted]; Shepherd L (Lesley) [redacted]
Cc: Inkster, Teresa [redacted]
Subject: Meeting Follow Up

Hi Phil,
Thanks for your time and setting up the meeting with Fiona and Lesley to discuss the OB report. It was helpful to be able to discuss how little we feel things have changed from our perspective in terms of IPCT, although Microbiology staffing and bullying culture are very much improved indeed.

I wanted to pick up on a couple of details in the timeline that I referred to at the meeting with regard to points of information accuracy :

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We agreed that in order to discuss current issues and those that have presented challenges over 2020 under the OB , we would have a meeting with Angela , Fiona, Teresa and myself. I look forward to hearing when that will be.

Thanks again for all your time and input into the OB ,

Kr

[redacted]

Dr Christine Peters
Clinical Lead
Consultant Microbiologist
QEUH
[redacted]

Inkster, Teresa

From: Philip.Raines[redacted]
Sent: 25 March 2021 15:45
To: Inkster, Teresa
Cc: Peters, Christine; pjredding[redacted]; McQueen F (Fiona)
Subject: [ExternaltoGGC]RE: Publication of Oversight Board Final Report and Case Note Review Overview Report

Hello Teresa

Thank you for your comments.

As you know, the Oversight Board was never intended to be a full consideration of all the issues that you and your colleagues have rightly and consistently raised over the years. You may, of course, feel that it should have been, but our view has been that the Oversight Board needed to remain focused on the issues that gave rise to its creation – the escalation of the Board to Stage 4 for specific issues – while being clear that it would not overlap unnecessarily with other reviews. In that latter context, we did not seek to duplicate the work undertaken by the Independent Review – though I note that there are different views about the completeness of that work – and we would not try to emulate the more forensic, comprehensive approach to be taken by the Scottish Hospitals Inquiry.

Striking that balance means having to make judgement about the issues on which there was sufficient evidence to reach conclusions, and the issues where contested views and incomplete evidence would limit those conclusions. Some of the issues you raise fall into the latter category, and we were not in a position to collect all the relevant evidence for those issues to make those firm judgements. In some cases, evidence has not been easy to identify or has been forthcoming. Again, that should be a matter for the Inquiry.

I can appreciate that may not be satisfactory for yourself, as there will be issues that are not yet resolved. I can only note your views, and hope that you feel your participation in this work has at least substantiated more than been done publicly hitherto, and through these findings and recommendations, help to support change going forward. As my work on the Oversight Board is now concluded, I would like to leave it with that optimism.

Best regards
Phil

From: Inkster, Teresa[redacted]
Sent: 25 March 2021 14:51
To: Raines P (Philip)[redacted]; pjredding[redacted]; Peters, Christine
[redacted]
Subject: Re: Publication of Oversight Board Final Report and Case Note Review Overview Report

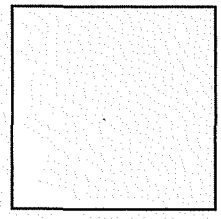
Thanks for sending the reports in advance Phil and apologies for the delay in responding, it has taken me some time to go over them.

I note that some of our comments have been taken on board which is reassuring, but not all. If there is a contraview to what we have suggested as amendments it would be useful to be able to consider this. There are still issues with factual accuracy e.g., it continues to state that 'certain microbiologists have advised it was a raised TVC in the aseptic pharmacy unit' acted upon first and not a patient case. However, from my involvement and documented

evidence this remains fact and would have been easy to establish as such. In using the term 'certain' it suggests others may have a different view .We now have two reports, this one and the HPS that have the facts of this incident the wrong way round. I highlight this as these documents inform the public inquiry and factual accuracy is therefore important. We also miss a valuable learning opportunity with regards to the importance of TVC testing and identifying other bacteria when the typical water quality indicators are indeed negative.
Secondly, I'm sure you are aware that I have previously raised significant concerns regarding extracts from the internal Cryptococcus advisory group report being quoted at board meetings and in the media despite the fact the report was not even in draft form at that stage. I note reference to this internal report in relation to Cryptococcus in the OB report, where it states that the internal report concluded the hypothesis was highly unlikely. However, this internal report is still not in final draft form and has still not been returned to the IMT who commissioned it for comment. This is a governance failure. At our meetings it was stated that Cryptococcus would be left for the Public Inquiry however there is now a very definitive statement being made with regards to it in the OB report without assessing or discussing all the evidence. This is an integrity issue and undermines the report as it is founded on incomplete data.
There remains no mention of the Executive Control Group to whom the IMT reported, despite minutes and terms of reference being available and its existence being highlighted many times. Not to include them is a misrepresentation of the governance structures

With respect to the timeline there is no mention of the initial environmental condition-that 2A was found in – ie. holes in the ceiling of transplant rooms with patients in the ward. This is a significant omission; it denotes negligence and a failure of the commissioning and validation process and also sets the scene for what transpired on this ward. Commissioning and handover is an area to be considered by the public inquiry and again there are now two reports (Independent review and Oversight Board report) that do not highlight these events despite evidence being submitted .
With regards to the case note review I have concerns re the validity of the water sampling data supplied . I note that initially drain samples were not included and that the positive Stenotrophomonas results were submitted with no location (subsequently established that it was 2A). Therefore, in these early stages it would appear there were no positive samples for Stenotrophomonas or Enterobacter linked to 2a and available for the CNR in their assessment, this must have made things difficult for them.
The description of the percentage tested for only Cupriavidus does not appear accurate, either the other organisms have not been reported or there has been a failure to filter out data for Legionella and other testing on the retained site. I offered to send in the data to the HAI policy unit and I am concerned that the opportunity was not taken to cross check the data . Furthermore, there is reference to data for M chelonae not being available which myself and Christine have. This data was requested in December 2019 and was forwarded to the IPCT.
Finally, on reading the reports together one of the prominent themes emerging is that of a difference of opinion , within NHSGGC . I am surprised there is no recommendation with regards to this aspect. It would be important to understand how these differences of opinion arose and assess the strength of evidence and documentation available for each . We have been requesting a process for resolution of differences of opinion amongst microbiologists for over a year now, both internally and externally to no avail . At a recent meeting with Fiona McQueen, we highlighted ongoing/current concerns with respect to investigation and reporting of HAI. Without a means to resolve differences of opinion risks to patient safety remain.
Kind regards

Teresa



From: Philip.Raines[redacted]
Sent: 21 March 2021 10:48
To: Inkster, Teresa[redacted]; pjredding[redacted]; Peters, Christine[redacted]
Subject: [ExternalToGGC]Publication of Oversight Board Final Report and Case Note Review Overview Report

Christine, Penelope, Teresa

I attach (with some personal relief) the final version of the Oversight Final Report, which will be published tomorrow (Monday) at 2pm on the Scottish Government website. I also attach an accompanying, separate file – the timeline, which is one of the report's annexes.

From the Scottish Government perspective, the report represents a significant milestone in efforts to drive improvements in NHS GGC as a result of the QEUH incidents. This achievement would not have been possible without you – through dialogue, challenge and your continuing reminder of the passion and commitment that needs to run through this work, I know the Oversight Board has hugely benefitted from your involvement and insights. On a personal note, it has been an absolute highlight of this work – at times, a sobering one, given what we've talked about – and I am particularly grateful for your assistance.

On behalf of Professor Mike Stevens, I also attach the Case Note Review Overview Report, in case you have not yet received this. This will also be published at 2pm on the Scottish Government website tomorrow.

All of these documents are embargoed until publication, and I ask you to respect this confidentiality.

My apologies also for the size of these files.

In gratitude

Phil

Phil Raines
Head of Rural Economy and Communities
Agriculture and Rural Economy Directorate
Scottish Government

Mobile: [redacted]

From: Vanhegan, Elaine
Sent: 20 August 2020 13:03
To: Haynes, Jennifer
Subject: FW: Whistleblowing

[redacted]

Head of Corporate Governance and Administration
Greater Glasgow and Clyde
JB Russell House Gartnavel Royal
Glasgow
[redacted]

From: Brown, John
Sent: 30 July 2020 23:00
To: Grant, Jane [Chief Exec] ; Vanhegan, Elaine
Subject: FW: Whistleblowing

Jane / Elaine

I'd welcome your thoughts on my proposed response to Dr Redding's email below.

Dear Doctor Redding

I am writing in reply to your email of 25 July 20 regarding the handling of your recent whistleblowing case. I am reassured that you were able to confirm that not only were your concerns listened to and investigated, you feel you were treated with courtesy and respect. However, I am sorry to hear that you are dissatisfied with how your case was handled at the final stages and I apologise for the concern and distress this has caused you.

I want to reassure that I consider an effective whistleblowing system an essential part of the Health Board's corporate governance system and it has an important part to play in ensuring the safety of our patients and service users. It is a safety valve that ensures that when all else fails, the voice of our staff is still heard by the senior management and the Board. That helps the organisation learn from mistakes and improve the quality of the services being delivered. I also recognise the response to whistleblowing can have a negative impact on the people involved. It is for these reasons the Board has commissioned a review of the current arrangements for whistleblowing to ensure that they remain effective and fit for purpose.

The review will examine the current approach to whistleblowing across NHS Greater Glasgow & Clyde and identify any actions required to ensure the ongoing effectiveness of the existing systems and processes, including any that will support the implementation of the new whistleblowing standards for NHS Scotland. The review will consider and report on staff awareness of the whistleblowing process and the investigation and reporting of whistleblowing cases during the period from April 2017 to March 2020. It will specifically consider the experience of individuals involved in whistleblowing cases and review the implementation of recommendations from whistleblowing investigations.

The Board Member appointed by the Cabinet Secretary as whistleblowing champion will lead the review and he will be advised and supported by an independent Human Resource Management Specialist. In addition to providing advice and support on the methodology and conduct of the review, the independent HRM specialist will assist in the examination of the cases and other information available to the review

team. This will include reviewing your case and the other cases concerning the impact of the design, build, handover, and maintenance of the QEUH campus on the Infection Prevention & Control arrangements in the South Sector of NHS Greater Glasgow & Clyde. This reflects the whistleblowing champion's declaration of interest in your whistleblowing case and will ensure there are no conflicts of interest in the conduct and reporting of the review.

Therefore, the issues you have raised around the handling of your case, including the classification of your concerns as whistleblowing will be included in the review and you will have the opportunity to discuss your experience with the review team. This will ensure that you have another opportunity to have your dissatisfaction with the current system recorded and reported to the Board. This will include the points you made in your email to me about the existing process for dealing with challenges to the accuracy of the investigator's reports. As you know, this requires any disagreement to be recorded and attached to the report, rather than the report being amended after it has been finalised by the investigator. I would expect the review team to come to a view on whether that approach remains appropriate or requires to be changed.

The review team's report will be published as a Board paper and will be publically available following the Board Meeting that received the report. This will ensure that the Board will be able to come to a well-informed and evidence-based view on the effectiveness of the existing system and demonstrates our willingness to approach this subject in an open and transparent manner.

I have asked the Head of Corporate Governance and Board Administration to review your emails to Ms Haynes and consider what further response, if any, is appropriate given what I have said in this letter about the review of the whistleblowing system in NHS Greater Glasgow & Clyde.

Finally, I want to thank you again for raising these issues around whistleblowing with me and I hope this response gives you the reassurance you seek that lessons will be learned from the review and this will help us to avoid other whistleblowers experiencing the dissatisfaction that you clearly feel about your own situation.

Yours sincerely

I intend issuing this as a letter, copied to Fiona McQueen and forwarded via an email from Gillian tomorrow. So I'd appreciate your comments by lunchtime , if possible.

As always, your support and advice is much appreciated.

Regards

John

Professor John Brown CBE | Chair | NHS Greater Glasgow and Clyde
JB Russell House | Gartnavel Royal Hospital | 1055 Great Western Road | Glasgow | G12 0XH
[redacted]

From: Penelope Redding [redacted]
Sent: 25 July 2020 20:55
To: Brown, John [redacted]
Subject: [ExternaltoGGC]Whistleblowing

Dear Prof. Brown

At the end of a recent conference call with Prof. Fiona McQueen I asked who I should contact about my concerns about my recent Step 3 whistleblows and she told me that I should approach you. As the whistleblowing champion is my son, I am unable to discuss any concerns with him and I have not had a reply to my last emails to Jennifer Haynes at the end of June requesting clarification as to who I should contact. As I retired in March 2018 I no longer have any other contacts within NHS GGC.

Due to confidentiality I assume you are not aware that I raised two Step 3s under the GGC whistleblowing policy. The first in December 2019 and the second in April 2020.I am disappointed that I feel the need to contact you. My concerns were listened to and investigated. I was treated with courtesy and request. However, I am disappointed with the final stages.

When I received the final report of the first Step 3 whistleblow relating to errors in press statements, I was surprised that, after all the time spent explaining and clarifying the facts, the report contained significant factual inaccuracies. I was allowed to share the report with two ex-colleagues, who understood some of the information I did not have access to. We all sent in our amendments / corrections. I have been told that the report was final and would not be corrected, as the recommendations would not be affected. I believe that the recommendations are far reaching and will hopefully improve practices in the long term. However, I cannot accept the errors in the report itself.

I emailed Jennifer Haynes on 18.6.20 and 23.6.20 saying I felt this was unacceptable and asking who I should contact to raise my concerns as I could not go to the whistleblowing champion, because of the conflict of interest. I have not received a reply.

I find it incredible that NHS GGC are not prepared to ensure the factual accuracy of a report, which might be referred to in the future. I do not think this would be helpful when information in reports is challenged in the Public Inquiry, as I intend to do. I believe that there are other reports within NHS GGC that are inaccurate. How can NHS GGC Board make the right decisions when information is either withheld or misleading?

The second Step 3 related to the fact that myself and two colleagues raised a Step 1 in September 2017 and this resulted in Dr Jennifer Armstrong asking us to provide an SBAR which resulted in an Action Plan to address our concerns. Both the Independent Inquiry and the executives, hearing my original Step 3, believed that we had never raised a Step 1 which resulted in the Action Plan. I had to vigorously argue that we followed the whistleblowing policy to the letter to avoid any challenges in the future. It was accepted that there had been ‘confusion’ within NHS GGC, but no intention to cover it up. I had requested that the NHS GGC Board were informed the SBAR and Action Plan resulted from the Step 1 of a whistleblow, as was found in the Independent Inquiry and the Step 3 investigation. I believe this is important in understanding the facts of why the Action Plan was drawn up, after the concerns raised by a number of microbiologists and infection control doctors ,since 2014-2015, were not being fully addressed. I emailed Jennifer Haynes on the 18th June asking if the Board had been informed. I have not received a reply and do not know if this has happened.

I believe that it is not in the interests of NHS GGC to have reports containing facts that can be challenged in the future. This will cause distress to patients and relatives and further undermine public confidence, which should be avoided.

I am sure NHS GGC wants to have confidence in the information contained in reports.

Kind Regards,

Penelope Redding

Greater Glasgow and Clyde NHS Board

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NHS
Greater Glasgow and Clyde

Private and Confidential

Date: 31st July 2020
Our Ref: JJB/GD

Dr Penelope Redding

Enquiries to: John Brown
Direct Line: [redacted]
E-mail: [redacted]

By email: [redacted]

Dear Dr Redding

I am writing in reply to your email of 25th July 2020 regarding the handling of your recent whistleblowing case. I am reassured that you were able to confirm that not only were your concerns listened to and investigated, you feel you were treated with courtesy and respect. However, I am sorry to hear that you are dissatisfied with how your case was handled at the final stages and I apologise for the concern and distress this has caused you.

I want to reassure you that I consider an effective whistleblowing system an essential part of the Health Board's corporate governance system and it has an important part to play in ensuring the safety of our patients and service users. It is a safety valve that ensures that when all else fails, the voice of our staff is still heard by the senior management and the Board. That helps the organisation learn from mistakes and improve the quality of the services being delivered. I also recognise the response to whistleblowing can have a negative impact on the people involved. It is for these reasons the Board has commissioned a review of the current arrangements for whistleblowing to ensure that they remain effective and fit for purpose.

The review will examine the current approach to whistleblowing across NHS Greater Glasgow and Clyde and identify any actions required to ensure the ongoing effectiveness of the existing systems and processes, including any that will support the implementation of the new whistleblowing standards for NHS Scotland. The review will consider and report on staff awareness of the whistleblowing process and the investigation and reporting of whistleblowing cases during the period from April 2017 to March 2020. It will specifically consider the experience of individuals involved in whistleblowing cases and review the implementation of recommendations from whistleblowing investigations.

The Board Member appointed by the Cabinet Secretary as whistleblowing champion will lead the review and he will be advised and supported by an independent Human Resource Management Specialist. In addition to providing advice and support on the methodology and conduct of the review, the independent Human Resource Management Specialist will assist in the examination of the cases and other information available to the review team. This will include your case and the other cases concerning the impact of the design, build, handover, and maintenance of the QEUH campus on the Infection Prevention & Control arrangements in the South Sector of NHS Greater Glasgow and Clyde. This reflects the whistleblowing champion's declaration of interest in your whistleblowing case and will ensure there are no conflicts of interest in the conduct and reporting of the review.

Therefore, the issues you have raised around the handling of your case, including the classification of your concerns as whistleblowing, will be included in the review and you will have the opportunity to discuss your experience with the review team. This will ensure that you have another opportunity to have your dissatisfaction with the current system recorded and reported to the Board. This will include the points you made in your email to me about the existing process for dealing with challenges to the accuracy of the investigator's reports. As you know, this requires any disagreement to be recorded and attached to the report, rather than the report being amended after it has been finalised by the investigator. I would expect the review team to come to a view on whether that approach remains appropriate or requires to be changed.

The review team's report will be published as a Board paper and will be publically available following the Board Meeting that received the report. This will ensure that the Board will be able to come to a well-informed and evidence-based view on the effectiveness of the existing system and demonstrates our willingness to approach this subject in an open and transparent manner.

I have asked the Head of Corporate Governance and Administration to review your emails to Ms Haynes and consider what further response, if any, is appropriate given what I have said in this letter about the review of the whistleblowing system in NHS Greater Glasgow and Clyde.

Finally, I want to thank you again for raising these issues around the whistleblowing process. I hope this response gives you the reassurance you seek that lessons will be learned from the review, helping us to avoid other whistleblowers experiencing the dissatisfaction you clearly feel about your own situation.

Yours sincerely

[redacted]

Professor John Brown CBE
Chair
NHS Greater Glasgow and Clyde

cc: Professor Fiona McQueen, Chief Nursing Officer, Scottish Government
Elaine Vanhegan, Head of Corporate Governance and Administration, NHSGGC

Re: Information re QEUH

teresa inkster [redacted]
Wed 12/08/2020 13:53
To: Mundell, Laura (Deputy Procurator Fiscal, Specialist Casework) [redacted]
Hi,

My mobile number is [redacted]. My colleague Dr Peters is [redacted].

Kind regards
Teresa

From: Mundell, Laura (Deputy Procurator Fiscal, Specialist Casework) [redacted]
Sent: 12 August 2020 12:43
To: teresa inkster [redacted]
Subject: RE: Informa on re QEUH

Dear Dr Inkster

Thank you very much for providing this summary of the information.

I will now pass this information on to my immediate colleague, Alistair Duncan who is the Head of the COPFS Health & Safety Investigation Unit (HSIU). After that, it is likely that we will need to arrange for a witness statement to be formally taken from you.

Can I ask if you have a mobile telephone number that we could use to contact you for this purpose please ?

Kind regards.

Laura

From: teresa inkster [redacted]
Sent: 12 August 2020 12:33
To: Mundell, Laura (Deputy Procurator Fiscal, Specialist Casework)
Subject: Re: Information re QEUH

Dear Laura , I have summarised below;

1) I chaired the Cryptococcal incident team mee ngs from December 2018- February 2019. At the me I was not told regarding an addi onal three pest control callouts to the plant room prior to establishment of the incident team mee ngs. Neither were photos which include pictures of dead birds and guano in the plant room shared with me. These were given to myself and Dr Peters by a re red colleague as he felt we should see them. He has phoned me on numerous occasions sta ng there is a 'coverup' and informa on has been deliberately withheld. That is not something I can comment on and it may be that you have all this informa on already, but we did not feel we could take no ac on.

2) I was sent an email from a PA where a senior director had requested changes to be made to minutes of incident team mee ngs before submission of the documents to the HSE. As Chair of the incident I instructed the PA not to make changes , however I did not see final versions that were submi ed. The reason I bring this up now is that I have recently been sent minutes that were submi ed to the oversight board by NHSGGC in rela on to the 2018 water incidents. There have been changes made

to one set in par cular involving a sec on that discusses Stenotrophomonas and contamina on of taps, it is removed from the version sent to the oversight board.

3) Dr Peters has emails regarding water tes ng that was requested for Stenotrophomonas in the RHC in 2017. Statements made by NHSGGC are inaccurate in this regard. Water tes ng was undertaken but the numbers quoted by NHSGGC differ from those actually taken in the relevant area of the hospital. Furthermore reference is made to the laboratory taking six weeks to develop a test for Stenotrophomonas. This is inaccurate. The laboratory had iden fied Stenotrophomonas previously in the water supply and this is detailed in the report produced by Health Protec on Scotland. We have raised these inaccuracies repeatedly internally and requested amendments to a re red colleagues whistle blow report regarding such, to no avail.

Kind regards

Teresa

From: Mundell, Laura (Deputy Procurator Fiscal, Specialist Casework) [redacted]
Sent: 11 August 2020 15:03
To: teresa inkster [redacted]
Subject: RE: Informa on re QEUH

Dear Dr Inkster

Thank you for your email.

I would be grateful if you would outline by email, in general terms, the information that you wish to provide.

Depending on the nature of the information you wish to provide, it may be the case that I will require to direct the police or the Health & Safety Executive (HSE) to take a witness statement from yourself and from Dr Peters to allow any relevant evidence to be properly recorded and investigated.

Would you be content to proceed on that basis ?

Kind regards.

Laura

Laura Mundell
Deputy Procurator Fiscal, Specialist Casework
Head of the Scottish Fatalities Investigation Unit (SFIU)
Crown Office & Procurator Fiscal Service

Direct Dial: [redacted]
Blackberry: [redacted]
Email: [redacted]

From: teresa inkster [redacted]
Sent: 11 August 2020 13:21

To: Mundell, Laura (Deputy Procurator Fiscal, Specialist Casework)
Subject: Information re QEUH

Dear Laura,

I hope you don't mind me emailing you , your details have been passed to me by someone I trust. I am the previous Lead Infec on Control Doctor at the QEUH and s ll work there as a Consultant Microbiologist. A few months ago I was given informa on with regards to the 2018/19 Cryptococcus incident there, by a concerned colleague . He was worried because as Chair of the Incident Team this informa on had been withheld from me. Similarly my colleague Dr Peters has informa on on water tes ng in rela on to the 2017 case of Stenotrophomonas, that has been well publicised. Would it be possible to discuss further with you what we should do with this informa on, assuming you don't already have it.

Kind regards
Teresa

Dr Teresa Inkster
Consultant Microbiologist
Tel ; [redacted]

pjredding[redacted]

From: Vanhegan, Elaine [redacted]
Sent: 21 August 2020 16:55
To: 'pjredding[redacted]'
Subject: Response to previous correspondence
Attachments: EVHResponse_Redding.21Aug20.docx

Dear Dr Redding, Please find attached letter in response to your recent emails to Mrs Jennifer Haynes and Mr John Brown, Chairman of NHS GGC.
Kind regards
Elaine

[redacted]

Head of Corporate Governance and Administration
Greater Glasgow and Clyde
JB Russell House Gartnavel Royal
Glasgow
[redacted]

Greater Glasgow and Clyde NHS Board

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Private and Confidential

Dr Penelope Redding

By email: [redacted]

Date: 21st August 2020
Our Ref: EVH/GD

Enquiries to: Elaine Vanhegan
Direct Line: [redacted]
E-mail: [redacted]

Dear Dr Redding

As you know, Professor John Brown has asked me, as Head of Corporate Governance and Administration, with overall responsibility for the whistleblowing process in NHS Greater Glasgow and Clyde (NHSGGC), to review your concerns about the factual accuracy of the report you received regarding your Step 3 case about infection control. I am sorry this has been a source of concern, and I hope you will find my email helpful.

Firstly, I apologise that you did not receive a response to your email from Jennifer Haynes. Please be assured that this was not deliberate, and I acknowledge a holding note should have been sent. As you know, your question was around who in the whistleblowing process you should contact, given that there is a conflict of interest with the Whistleblowing Champion, who is your son. This is an unusual position, and not one we have come across before, and I regret that the delay in clarifying how to proceed led you to believe your email was being ignored, as that was not the case.

Turning to the content of the report itself, I have thoroughly read both the final report, and your commentary/additions on that final report. I have also reviewed relevant emails, and minutes from meetings you had as part of the whistleblowing process. Having undertaken this work, I can offer you the below by way of response. I have purposely kept my response to each point succinct and clear so there is no dubiety, but please be assured that in doing so, I do not underestimate your professional knowledge and strength of feeling, as I can see at various stages that you convey that your primary motivation is patient safety.

Section 2A:

- I note you have made reference to first raising concerns with two other Consultants. I don't think that is in dispute, but does not make a material difference to the final report, which is accurate when it states that you raised concerns in 2017.

- You make reference to the concerns being related to infection control and the risks to patient safety. Again, I don't think that is in dispute within the report, which is clear at various points on the specific subject matter, and is clear that your motivation was patient safety (for example, on page 9, it reads: *Dr Redding was thanked by Mr Ritchie and Mr Edwards for her courage in bringing her concerns forward, especially as she made clear that these matters had impacted her significantly, and that her motivation was patient safety.*

- You have re-worded a section which states why you escalated your concerns to Step 2 following an SBAR. I feel that the message is the same; you were dissatisfied with the response, so you escalated your concerns, and therefore the final report is not factually inaccurate.

- You make reference to Dr Inkster having a period of sick leave. Regardless of the reason, you were dissatisfied with the responses you had received, and therefore escalated your concerns to Step 2, so the final report is not factually inaccurate in that regard.

- You make references to some SBAR concerns remaining. I feel that is implied, given your escalation of concerns, so the report is not factually inaccurate

- You re-worded a section with regards to press statements, but the meaning did not change, as the final report made reference, as an example, of concerns about issues in the media, and later in the report details this saying it was to do with factual accuracy of statements. I therefore do not feel this wording change makes a material difference to the content of the report.

Section 2B:

- For point IV, you changed it from reading '*Concern about data being considered from HPS and HFS, which stated that infection rates in QEUH/RHC are reasonable and in line with other sites*' to ' *Concern about a report from HPS and HFS, on infection rates in RHC with incomplete and missing data*'. This point was a direct lift from the minutes of the meeting you had with Mr Ritchie and Mr Edwards, which you reviewed, made comments on, and did not change. I therefore do not think it was unreasonable that the investigators used this as a point of concern, and the detail of the point is discussed in more depth later in the report.

Section 4i:

- You have added in that the water was asked to be tested for Stenotrophomonas. Given this whole section was dedicated to Stenotrophomonas, and is referenced several times, I do not think it is inaccurate not to have the word here. Similarly, you reference that it was part of your SBAR, but this does not make a difference to the factual accuracy of this section.

- You make reference to Stenotrophomonas being previously isolated from the water supply. The investigation was considering water testing at a particular point in time, so it was not factually inaccurate not to look into previous history.

- You have added in information about a second press statement about a delay for testing due to lack of protocol. As you know, the final report noted that testing had been requested in summer 2017, and carried out in September 2017, and, as you correctly point out, this was not part of routine water testing. The specialist lab therefore established a process, and tested samples between 4 September and 14 September 2017. These samples were negative for Stenotrophomonas. This was confirmed in a press statement that we released.

Section 4ii:

- You make a statement about being astonished about the 27 point action plan. This is how you feel, and whilst this is acknowledged, your comment does not make a material difference to the factual accuracy of the report.

Section 4iii:

- You have added in the word Cryptococcus, but given that the header is 'Whether the plant room was tested for Cryptococcus', your addition does not affect the factual accuracy

- You added in that air sampling had not been done 'prior to cleaning'. In this same section, two lines above, it explicitly stares 'prior to cleaning', and then elaborates, so I do not feel this affects the factual accuracy.

Section 4iv:

- You have added in 'haemato oncology', but having reviewed the final report, this was already specified

- You note that you did not say NHSGGC presented false data. However, you did make reference to inaccurate data, so I do not feel it is unreasonable that the investigators took this to mean you

'false', which has the same meaning as 'inaccurate'. In any event, it was confirmed that all relevant data was shared.

Section 4i:

- You note that you are not sure if information regarding another whistleblowing case is relevant to include. I consider that is matter for the investigators of your case to decide, and I can see from the content why they chose to include this, as it directly related to an issue you had raised.

Section 5a:

- You add a comment about you having spoken to a number of individuals about being approached by the investigators, but I can see that Mr Ritchie and Mr Edwards had already made clear that other staff were welcome to contact them. This was further clarified in an email you received from Jennifer Haynes on 16 June 2020, which stated: *In terms of approaching other microbiologists to seek their views, that was a matter for the investigators to determine as part of the process. As you know, the investigators' position on this was explained within the report, and we are satisfied that the investigation into the issues was robust'.* I think this position is reasonable, as it would not have been appropriate for the investigators to invite people to whistleblow, and rather explicitly stated to you that staff were welcome to contact them if they wished to do so.

In terms of the comments from ex colleagues of yours, who did not raise concerns as part of this investigation, the final report was in response to specific concerns raised by you, so it would not have been appropriate for that to have been changed based on further information from another party, some of which was not within the scope of the investigation. This was confirmed directly with a member of staff who made comments after the final report had been concluded, and that person was encouraged to take any concerns forward with Professor Angela Bain, who is now overseeing Infection Control within NHSGGC.

In conclusion, I hope I have demonstrated that I have thoroughly considered all of your points, but I do not believe there is anything you have raised that makes a fundamental or material difference to the factual accuracy of the final report, which was undertaken objectively, and in good faith. To that end, I was very pleased to read you felt you were listened to, treated with courtesy and respect.

I realise you may be disappointed with the outcome of my work, but I would like to clarify that your additions/comments to the report have been kept on the case file and will be available for any review, thus ensuring there is complete transparency.

You also asked about your other Step 3 case, which related to your original concerns raised in September 2017. I can confirm that this case was open and concluded within the financial year of 2020/21, so will be reported on to the Staff Governance Committee, which is a formal committee of the Board.

Kindest regards.

Yours sincerely

[redacted]

Elaine Vanhegan
Head of Corporate Governance and Administration
NHS Greater Glasgow and Clyde

Greater Glasgow and Clyde NHS Board

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Private and Confidential

Dr Penelope Redding

By email: [redacted]

Date: 27th August 2020
Our Ref: JJB/GD

Enquiries to: John Brown
Direct Line: [redacted]
E-mail: [redacted]

Dear Dr Redding

Following receipt of your reply to my letter of 31st July, I have given further consideration to the concerns you raised around the accuracy of the report that Mr Ritchie and Mr Edwards completed following their review of the handling of your whistleblowing case.

I can confirm that the issues you raised form part of the permanent record in the case file and are available to anyone reviewing your case, either as part of the Board's latest review of our whistleblowing system or any other external review - such as the Public Inquiry into the construction of the Queen Elizabeth University Hospital Campus.

It is important to note that I have also established that Mr Ritchie and Mr Edwards remain of the view that the concerns you have raised around the accuracy of their report do not materially affect the conclusions and recommendations included in that report. Having reviewed the papers, including the report, your response and Mrs Vanhegan's letter to you of 21st August, I share that view.

As I mentioned in my previous letter, I will ensure that you will have the opportunity to discuss your experience of the whistleblowing system with the NHS Greater Glasgow and Clyde review team and that will include your concerns with the current system for recording challenges to the accuracy of investigator's reports.

The review team's view on whether that approach remains appropriate or requires to be changed will be considered by the Board in due course and the outcome of these discussions will be published as part of the normal reporting of Board business. To ensure you are aware of the outcomes of the Board discussion, I will arrange for a copy of the review team's report and the minutes of the Board's discussions to be sent to you by the Head of Corporate Governance and Administration.

While I understand your concerns around the accuracy of Mr Ritchie and Mr Edwards' report may remain, for the reasons stated above I am not proposing to take any further action in your case at this point in time.

I want to apologise again for the distress the handling of your case has caused and I want to repeat my thanks to you for raising this particular issue around the whistleblowing process. Like you, I believe it is important that we learn from the experience of individuals involved in whistleblowing cases and continuously improve our systems and processes to reflect that experience.

I hope that this letter and my previous response gives you some assurance that your concerns have been recorded, are continuing to be taken seriously, and will inform the Board's thinking on the way forward for responding to whistleblowing in NHS Greater Glasgow and Clyde.

Yours sincerely

[redacted]

Professor John Brown CBE
Chair
NHS Greater Glasgow and Clyde

cc: Professor Fiona McQueen, Chief Nursing Officer, Scottish Government
Mrs Elaine Vanhegan, Head of Corporate Governance and Administration, NHS Greater Glasgow and Clyde

From: Raines P (Philip)
Sent: 26 March 2021 08:22
To: Scottish Hospitals Inquiry
Subject: FW: Oversight Report
Attachments: OversightInterimDIPCreportversion2 (1).docxVersion 4 28Aug20.docx 1542.docx

From: Raines P (Philip)
Sent: 25 March 2021 20:28
To: Raines P (Philip)
Subject: FW: Oversight Report

From: Angela Wallace (NHS Forth Valley) [redacted]
Sent: 28 August 2020 16:26
To: Raines P (Philip) [redacted]
Cc: Claire Peacock (NHS Forth Valley) [redacted]
Subject: Oversight Report

Dear Phil,

please find enclosed my progress update report. I do hope that it is helpful and happy to be guided in respect to what the Oversight Board needs.

Apologies again for the delay and I appreciate your on-going support.

Kind regards

Angela

Professor Angela Wallace
Executive Nurse Director
[redacted]

Oversight Board

Greater Glasgow and Clyde (GGC) Interim Director of Infection Prevention and Control and HAI Executive Lead Progress Report

1.0 Purpose

The purpose of the report is to provide an update on the current activity across NHS GGC in support of the ongoing focus, delivery and development of Infection Prevention and Control.

2.0 Background

As part of the Oversight Board arrangements Professor Marion Bain, in discussion with Jane Grant CEO and Fiona McQueen CNO, recommended, that additional leadership at operational director level was required. This was secured and effective from 17th February 2020. During April and May 2020 this role was further clarified as Interim Director of Infection Prevention and Control (IDIPC) and Healthcare Associated Infection (HAI) Executive Lead, and approved by NHS GGC Interim Board on 5th May 2020.

3.0 Interim Role

This interim role reports directly to NHS GGC Chief Executive (CEO), Jane Grant, who has ensured that this role and approach has been supported readily and is positioned with the Senior Executive Group (SEG) COVID-19 Pandemic emergency footing structures. The IDIPC attends the NHS Board to present the HAIRT. The role position and clarity has been communicated across all necessary internal and external structures and networks and continues to evolve as the interim role is established.

From the outset the IDIPC has had the brief from the CEO to direct all aspects of Infection Prevention and Control, with the freedom and authority to identify system learning and improvement to ensure safe care for patients and to support staff across the GGC Health and Social Care System.

4.0 Context and climate

In assessing required action, it is important to highlight that there are a range of factors that need to be accounted for and are noted below:

- Scale and scope of external scrutiny processes over a prolonged time scale including Independent Review (IR) Oversight Board (OB) reports and Public Inquiry (PI)
- The intense external stakeholder and media commentary regarding the QEUH and RHC impacting on organisational reputation
- Ongoing communication and engagement with key families who have raised historical concerns
- The Whistleblowing impact on the system from an internal and external locus
- The complex and challenging relationships that staff are managing whilst endeavouring to deliver and improve care and services.
- The considerable time and leadership capacity required in managing and responding to this novel and unprecedented situation, including ensuring all staff psychological safety, whilst delivering the organisations business objectives, additionally responding as part of NHS Scotland's COVID -19 Pandemic response
- The work that had already been taken forward by Professor Marion Bain

Having undertaken an assessment of the relevant functions, it is clear that the IPC Team and microbiology teams are highly skilled professionals, providing safe patient care in a supportive system, which is in line with other Board areas. It is also evident however, that there are a number of internal

and external factors, as described above, that created a significant challenge. However, despite these challenges, the clear focus has been on safe care whilst working through the complexities and dynamics. The role of the IDIPC has afforded the opportunity to objectively stabilise the relevant teams which has been of significant value. The priority for the teams now is to evolve with a collective narrative and purpose identifying all opportunities for improvement and further enhancing patient safety. A key element of this update will report on the significant further OD work undertaken commissioned by CEO since February 2020.

5.0 Key areas of focus for the IDIPC

The below points cover the key areas of focus over the past 5 months. A detailed Action Plan is noted at Appendix 1

- **Leadership Capacity and establishing Interim Director of Infection Control Role (IDIPC)**
    - Reporting Directly to CEO
    - Corporate responsibility and HAI executive lead providing assurance to the Board
    - Leadership and responsibility for the Infection Control Team
    - Acting on relevant legislation, national policies and guidance ensuring infection prevention control
    - Support and continue to develop systems around IPC to ensure care safer still
    - Develop, with the ICT and wider organisation, a future desired state

- **Understand the current system and performance across IPC**
    - Leading and working alongside colleagues in the current system
    - Undertaking a rapid SWOT analysis
    - Internal and external stakeholder analysis
    - Review of operational ways of working
    - System IPC performance
    - Consider new ways of working

- **Planning to Change**
    - Building a collective narrative and purpose
    - Identifying Goals and ways to pursue them
    - Develop a system plan to improve and build

- **Organisational development**
    - Designing and develop 5 stage OD plan
    - Deploy “OD in action” to support staff now
    - Discovery recommendations to inform the future

6.0 Future Direction and whole system transformation approach

A dedicated Delivery “Gold Command” Programme Board, ‘*Better Every Day’*, has been developed and implemented, led by the CEO and key Directors including the IDIPC. There are four key areas of focus that have dedicated Silver Command work streams, which map to NHS GGC business objectives 2020/21 and are designed to deliver across the range of recommendations from External Scrutiny process including the independent review. They are as follows and can be found at Appendix 1:

- Performance
- Communication & Engagement
- High Quality Care (Safe and Person Centred)

- Transformation and Service Improvement to support the aim of best in class IPC system

6.1 Key Results

- Visible enabling additional leadership to stabilise the environment for staff
- System engagement to support safe care today and plan for future
- Dedicated Organisational Development covering the past, present and the future. Additionally the provision of Organisational Development “in action” to support staff today
- Collective vision, delivery programme and whole system IPC organisation wide improvement programme developed - Launch September 2020.

7.0 Recommendations

The Oversight Board is asked to note the approach and progress made by the IDIPC.

8.0 Acknowledgements

It is important to acknowledge the support received since taking up the role. I would like to underline that all staff, specifically the infection control team and the microbiologists, as well as managerial and executive colleagues have been nothing but professional, receptive and supportive throughout. Can I add further thanks to the external and internal OD colleagues who have been exceptional.

Area	Focus	Results
Leadership Capacity and establishing Interim Director of Infection Control Role (IDIPC)	• Clarified operational requirements and key operational priorities from CE and SG	• Established the role of Operational Director of IPCT and clarified working relationship between post and DPICT
	• Handover of operational priorities from Prof Bain developed action plans to deliver key areas	• Action plan completed and presented to GGC Board Infection Control Committee (BICC) 5th May 2020 • Operational priorities • PICU escalation action plan
	• Providing additional leadership capacity to immediately support and stabilise the environment highlighted in situational and climate present due to external factors	• Quickly integrated into the CEO's Strategic Executive leadership team (SEG) • Confirmed as Interim Director of Infection control and HAI Executive Lead • 1-1 and ICT team meetings • ICM and ICD Post holders interim positions extended to aid stabilisation and leadership • ICM and Lead ICD Team Meetings
	• Strategic context and focus to create collective vision for Success	• Pre post discussions with CNO,CEO and the then Acting GGC Director of Infection Control re priority and approach
	• Brief and direction from the CEO to ensure that the drivers for the system must deliver: o Safe Care for patients and staff o High quality person centred services o A learning and adaptive organisation where change and improvement was at the centre o All staff equally supported to achieve these goals o Organisational development and psychological safety for **all** to be provided.	• Brief translated across the OD design, and leadership approach whilst establishing the IDIPC role • Tested by feedback (internal and external), OD process and stakeholder engagement
	• Building additional profile and positioning of all aspects of IC with the ICM and wider infection control team and ensuring their contribution at operational strategic and national levels	• ICM and the ICT Team positioned in all aspects of the current emergency footing structures including the acute tactical group and scientific technical cell (STAC)
	• Framing the current Board performance across AOP standards and current infection prevention and control activity and actions	• Refreshed Board HAIRT • IDIPC attends NHS Board and Clinical Care governance presented meeting

Area	Focus	Results
	• Team review of existing IPC governance and reporting • Identified areas for development and planning to change	• Board provided with detailed information for assurance regarding GGC IPC: • Performance at a glance • Risk and key challenges with associated actions • Performance against national IC targets • Management of incidents and outbreaks • Action and improvements work in place to sustain and further improve performance
Understand the current system and performance across IPC	• Identified and met with all key internal and external stakeholders • Building and shaping the internal and external alliances and networks • Systematic engagement and opportunities to ensure all aspects of IPC further integrated into the Board's operational structures	• All stakeholders have contributed to the collective GGC narrative and future vision and goals • Collaborative leadership commitment gained from key staff • Formal and informal meetings and regular contact with multiple external stakeholders to ensure this feedback actively influenced current ways of working and the planning to change plans. • Acted and responded to feedback and intelligence to support ways of working
	• Clarified key strengths and opportunities for developing new ways of working across IPC, service and key networks	• Undertook SWOT analysis and the results used to assist the senior team to identify key priorities • Secured commitment and support from all levels to develop a new future state.
	• Creating the conditions to evolve from learning and experience	• Through operational engagement and working alongside identified where opportunities for learning can be captured and maximised.
	• Day to day support enablement and empowerment of the IC leadership team • To stabilise the system around the IPC agenda to ensure senior leaders could practice at top of their licence to deliver safe care • Continual to understand current teams challenges to build collaborative and shared working	• Building resilience of the team to deliver whilst managing the situational and external factors • Professional and personal development opportunities stated and secured • Leadership support to ensure system capacity to re manage the complex environment and deliver safe care • Established weekly SMTs and Daily IPC Updates

Area	Focus	Results
		• All key posts have committed leaders who are determined to ensure success
Planning to Change	• Building a collective narrative and purpose	• Underway as part of the IDIPC role and OD work due for completion during September 2020
	• Identifying Goals for system working and ways to pursue them	• Team review of communication and ways of working • Weekly multi specialty team meeting created and maintained to ensure joint focus and contributions to IPC across GGC • Further team communication process mapping complete in support of IPC • Development of an Infection Control Heat Map
	• Develop a system plan to affirm and build IPC and organisational roles and responsibilities • Build capacity and organisational support across IPC and lab directorates	• Mapping as part of OD in action work • GGC has developed a Organisational structure to support IPC and wider speciality teams
Future Direction and whole system transformation	• Define strategic intent • Strategic approach to delivery of the transformation plan **Better Every Day Gold Command** • A unified and cohesive approach to Breakthrough Improvements - Collaboration - Momentum - Programme management	• Developed and in place July 2020 • CMT support for the Better Every Day • Communication plan and approach • Programme management support in place • Dedicated two weekly Gold Command chaired by Chief Executive • Whole system improvement programme development that focuses on IPC – being everybody's business • Launch planned for Sept 2020
	• A solid basis for moving forward as a unified team utilising the OD stages of past, present and future • Opportunity to create a collective vision	• Collective vision and focus in place across Better Together and Gold Command supporting OD Plan to GGC business objectives • OD work has established the collective commitment and vision work scheduled for September 2020

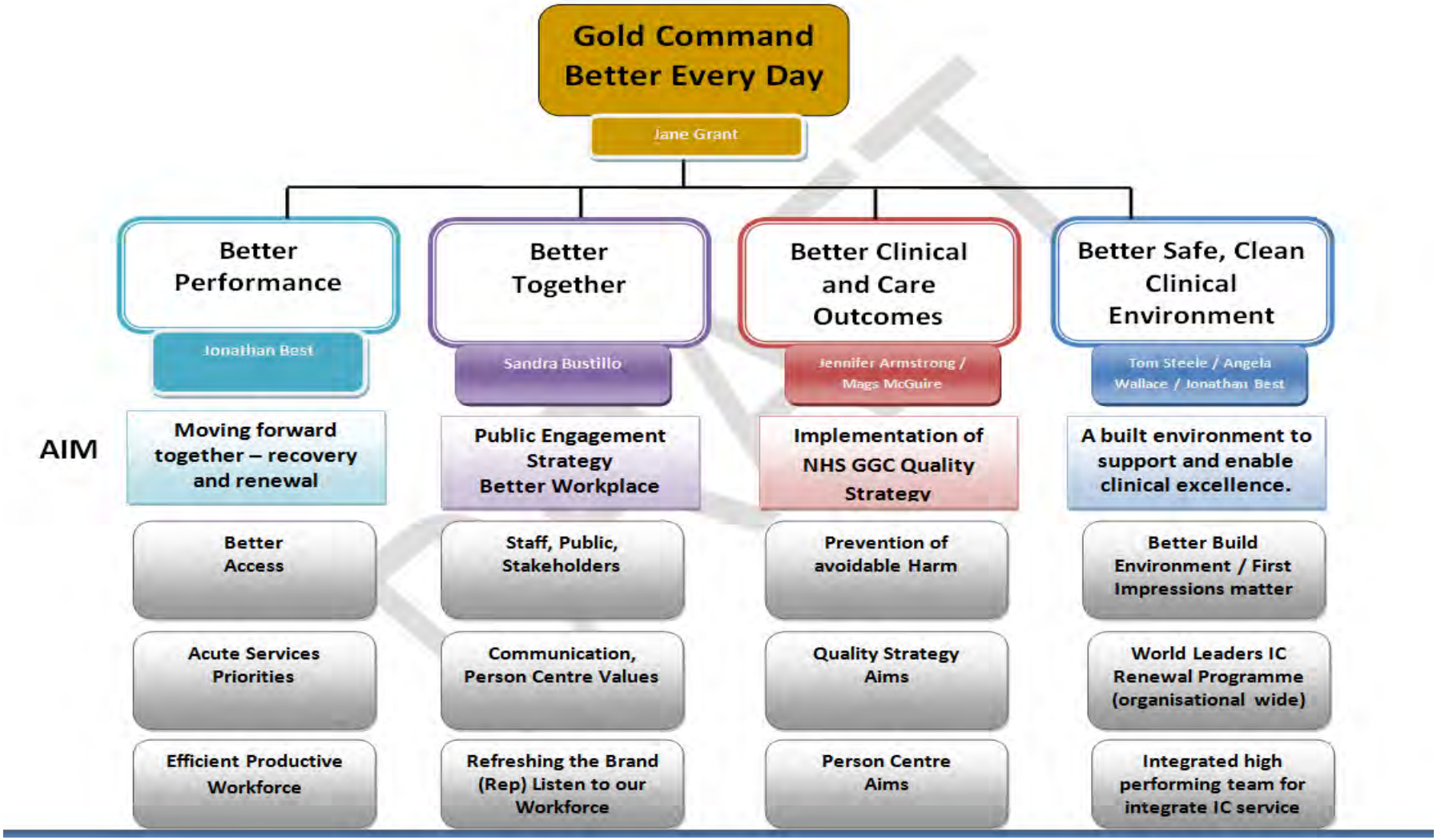
Area	Focus	Results
Develop and deliver a comprehensive organisational development plan to support staff now and build the foundations for change and future focus	• Commission external support for the OD work • Design and develop a 5 stage OD Plan • Establish clear objectives for the OD discovery work: • Creating the conditions for change • Ensure that the discovery work is seen as safe, neutral and confidential resulting in a wide and deep participation	• OD work commissioned by Chief Executive in place from February 2020 • IDIPC indentified as OD work lead • Significant individual and team meetings to ensure the principals of safe, neutral and confidential would be delivered
	• Facilitate a series of interventions with a view to ensuring that we work in: • A positive working environment that promotes staff wellbeing for all • A quality operational environment that ensures service effectiveness and patient safety • A clear governance framework that facilitates clinical reviews and debate allowing differing clinical opinions to be heard and acknowledged and provides clear accountability for decisions made • A team ethos of continuous learning and improvement ensuring sustainable change where beneficial	• These objectives allow for either validation or commentary of the existing system whilst, either way, inviting comments for improvement. • They have provided a clear and unifying basis on which all stakeholders and participants can agree and work towards • A clear governance framework and team ethos are areas for action in the next stage of the Organisational OD work

	• Direct design and Conduct discovery: all IPCT members were invited to participate, all microbiology consultants, ICNs and key stakeholders
	• Simultaneously work with senior leaders to design and support the OD work delivery at an organisational level
		• Discovery complete: 40 people have participated in an open and collaborative way:
		  • 10 stakeholders
		  • 30 IPCT / Micro members

	Create opportunities to model collaboration and deliver OD in action	• Organisational development external and internal experts working alongside all levels of staff in scope on a day to day basis since February 2020 • 1:1 coaching follow up and feedback to significant numbers of staff during this process • Team coaching and facilitation including feedback at multiple meetings and interventions including the newly established week multi speciality meeting • Process mapping and system learning and preparing for change sessions
	• Distil outputs and present findings and	• Discovery report completed and presented to CE

Area	Focus	Results
	recommendations	and COO and IDIPC • Subsequent 1 to 1 senior leadership debrief have been conducted • A full schedule of staff debrief sessions are planned during August and early September 2020
	• Utilise findings to underpin leadership approach to further reinforce the Learning Organisation philosophy and preparing to change plans	• Better Every day: Beacons of Hope sessions are planned to allow for the learning from the Discovery to enrich the improvement aspirations for the service in early September 2020

Appendix 1


Gold Command
Better Every Day
Jane Grant
Better Performance
Jonathan Best
Better Together
Sandra Bustillo
Better Clinical and Care Outcomes
Jennifer Armstrong / Mags McGuire
Better Safe, Clean Clinical Environment
Tom Steele / Angela Wallace / Jonathan Best
AIM
Moving forward together – recovery and renewal
Public Engagement Strategy Better Workplace
Implementation of NHS GGC Quality Strategy
A built environment to support and enable clinical excellence.
Better Access
Staff, Public, Stakeholders
Prevention of avoidable Harm
Better Build Environment / First Impressions matter
Acute Services Priorities
Communication, Person Centre Values
Quality Strategy Aims
World Leaders IC Renewal Programme (organisational wide)
Efficient Productive Workforce
Refreshing the Brand (Rep) Listen to our Workforce
Person Centre Aims
Integrated high performing team for integrate IC service

Louise Mackinnon

From: PETERS, Christine (NHS GREATER GLASGOW & CLYDE) [redacted]
Sent: 09 September 2020 15:22
To: Claire Peacock (NHS Forth Valley); INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Cc: Angela Wallace (NHS Forth Valley); Devine, Sandra
Subject: Re: In confidence: PICU patient result [redacted]

HI Angela, and Sandra,
Firstly thankyou for updating and taking the time to put together the information.
Secondly I have some real concerns over this :
1. Aspergillus in a Tissue sample is indicative of infection, invasive fungi do not generate inflammatory response in all patient groups
2. The ventilation schemes are immaterial to the issue of water damage . The risk of mould in the air is not in this case due to mould coming in from outside through the ventilation system, the thermal wheels should not be there, but are not the main concern in this particular situation, but the wide dispersal of spores from water damaged materials in the building is. These will go far and wide.
The key issues to cover in managing such and incident are:
1. identify the risk that there is mould in the unit . When there is water ingress this is a risk (there is even a water policy in GGC to cover this - evidence based) . It is not a matter of humble opinion, but fact that air in that unit is not in a consistent clean to dirty pathway. Spores travel vast distances as they do not settle due to buoyancy and therefore the entire unit will likely be affected by spore bursts, and the absence of a pressure cascade absolutely matters in that the rooms are therefore in no way protected from ingression air.
2. Rapidly seal off the area and inspect for signs of water damage- often leaks have been longer in the making than the time at which they are noticed (was this done)
3. risk assess patients in the unit and close vicinity of the unit - document
4. Consider air sampling immediately in order to assess levels of contamination - the nature of the organisms is as important as the numbers
4. Consider mitigation measures - moving patients, prophylaxis for those most at risk (this was suggested at the Consultant's meeting 26/09
5. Ensure all work in the high risk area is done under strict HAISCRIBE - given due consideration to the patient groups (open cardiac wound would be the highest possible level of risk patient) and possible moving of such patients
6. Communication to the Clinical teams and microbiology colleagues regarding the assessment of the mould levels and need for alertness to cases and suggestions re prophylaxis, and this would ensure appropriate fungal biomarkers and prompt treatment is instigated.
7. Follow up on clinical status of patient identified with fungus - the prognosis is very poor in high risk patients
A timeline of the incident should include the clinical details and progress, assessment of other patients, history of other ventilation work going on, on the unit, the time and nature of work to fix the leak issue, inspection report and actions taken regarding preventing further incidents.
As I understand it there are still ventilation work going on in PICU - this will need assessed also with regard to adequacy of SCRIBE measures in place.
kr
Christine

From: Claire Peacock (NHS Forth Valley) [redacted]
Sent: 09 September 2020 14:52

To: PETERS, Christine (NHS GREATER GLASGOW & CLYDE); INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Cc: Angela Wallace (NHS Forth Valley); Devine, Sandra
Subject: In confidence: PICU patient result [redacted]

113

On behalf of Professor Angela Wallace,

Dear Colleagues,
thanks for the opportiuty to discuss this on email and apologies for the delay in sending but please find below the most recent update on the actions in support of our discussion.
I would be happy to discuss and Sandra is constantly updating the situation.

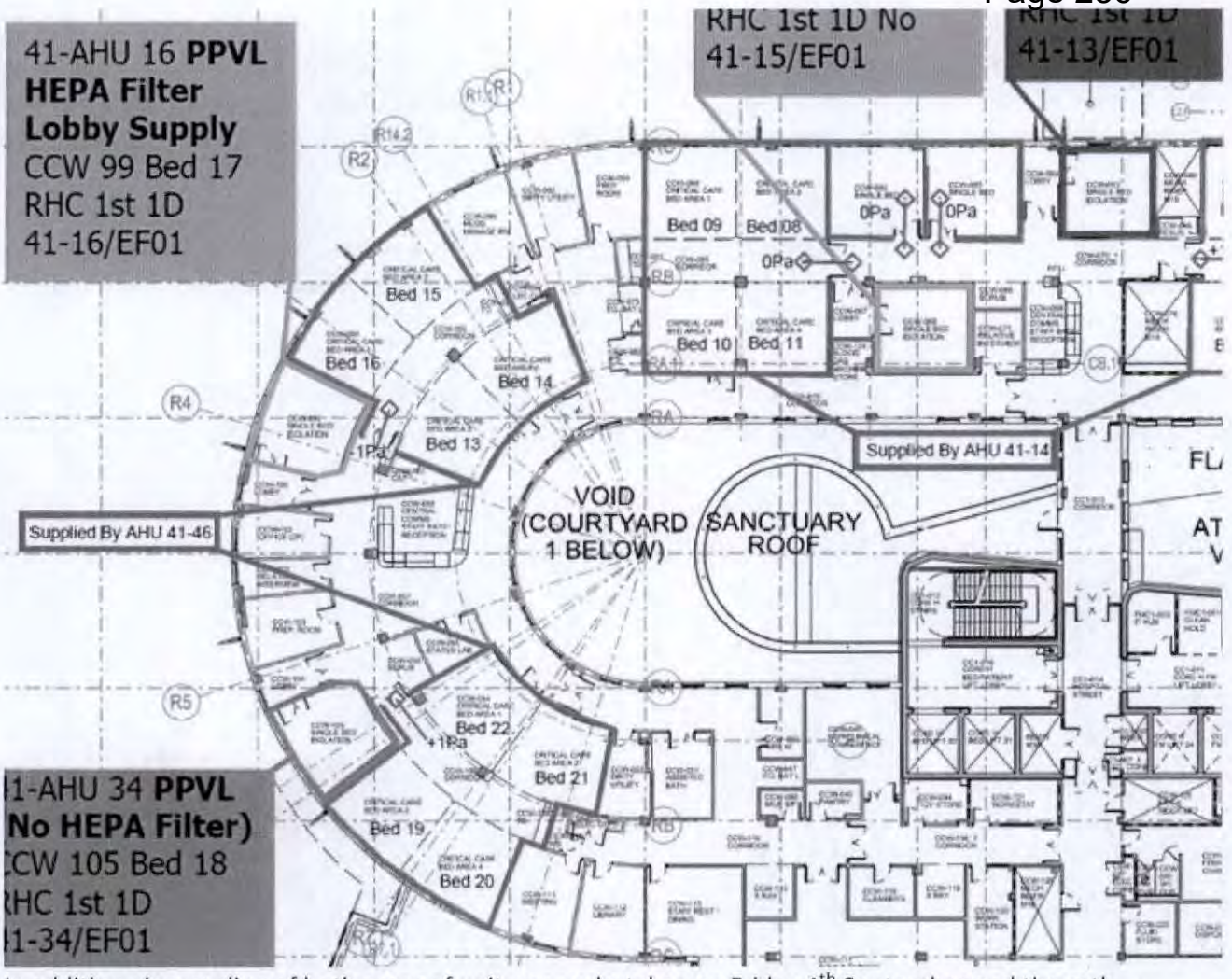
Kind regards

Angela

Situation
Small infant who had undergone [redacted]. This child had surgery on [redacted]/8 with a return to theatre on [redacted]/8 for exploration of the mediastinum. Tissue taken on the [redacted]/8 isolated aspergillus. [redacted]/8 ward reported that the wound did not look infected.
Nursed in Bed 1-4 in PICU and in room 14 in PICU.

Water Leak
On 25/8 a valve failed and there was a hot water pipe which leaked all over lights and centurion2000 beds 1-4 oxygen dousing point panel AVSU175 controlling outlets 175/001to175/004.
Single room adjacent (room 5) was also affected.

Action
Case review
Ventilation review from EFM Colleagues summary below:
"I have looked into this for you and can provide some reassurance hopefully. Both areas you mentioned are served via separate ventilation systems therefore the risk of cross contamination through thermal recovery is impossible as demonstrated by my attached diagram, ACH Rates within the corridor transfer area are extremely low 0.8 Ach/hour so there will be next to no defined pressure cascade for the corridor in question therefore air movement will be defined via variable door orientation and adjacent thermal buoyancy of air, in my humble opinion the source of this potential contamination is extremely unlikely due to the current ventilation set up and the distance between the spaces in question."



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To: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted]
Cc: WALLACE, Angela (NHS FORTH VALLEY) [redacted]
Subject: Re: PICU patient result [redacted]

Thanks Teresa that's helpful, I will raise these issues at the meeting today,
kr
Christine

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Sent: 01 September 2020 09:55
To: PETERS, Christine (NHS GREATER GLASGOW & CLYDE)
Cc: WALLACE, Angela (NHS FORTH VALLEY)
Subject: Fw: PICU patient result [redacted]

Hi Christine

I am covering paeds this week and there are a couple of things that I wondered if you could discuss at the IC meeting today

- Mediastinal wound with fungus ? Aspergillus - see email below. Very worrying to see this in a cardiac wound , I understand the chest has been open in the unit. As you will know the water leak is highly relevant even if at the opposite end of the ward. Also wonder re theatres and watersupply , child has been on ECMO.

- ?Cryptococcal case , 6A . I understand this was considered to be a repeatedly false positive CrAg result , however the [redacted] has been treated with antifungals and the CrAg is now negative and confirmed as such by Bristol. This would suggest true infection.

- I have sent an email to Prof Gibson to clarify the use of Cipro prophyalxis on 6A after recieving a call about this yesterday. I was under the impression we had moved to taurolock

kr
Teresa

Dr Teresa Inkster
Consultant Microbiologist, QEUH
National Training Programme Director Medical Microbiology
Dept of Microbiology
Queen Elizabeth University Hospital
Glasgow
Direct dial : [redacted]

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Sent: 31 August 2020 10:00
To: Valyraki, Kalliopi; KHALSA, Kamaljit (NHS GREATER GLASGOW & CLYDE); Bowskill Gillian (NHS GREATER GLASGOW & CLYDE); angela.johnsor[redacted]; Brown Mhairi (NHS GREATER GLASGOW & CLYDE)
Cc: Wood Kathleen (NHS GREATER GLASGOW & CLYDE)
Subject: Re: PICU patient result [redacted]
Thanks Pepi

Aspergillus spores are buoyant , released in bursts and will travel remote from source, so the leak at the other side of the unit might be relevant

kr
Teresa

Dr Teresa Inkster
Consultant Microbiologist, QEUH
National Training Programme Director Medical Microbiology
Dept of Microbiology
Queen Elizabeth University Hospital
Glasgow
Direct dial : [redacted]

From: Valyraki, Kalliopi[redacted]
Sent: 31 August 2020 09:52

To: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE); KHALSA, Kamaljit (NHS GREATER GLASGOW & CLYDE); Bowskill Gillian (NHS GREATER GLASGOW & CLYDE); angela.johnsor[redacted]; Brown Mhairi (NHS GREATER GLASGOW & CLYDE)
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Subject: Re: PICU patient result [redacted]
Hi Teresa,

There was a leak in PICU last week but at the other end of the unit.
This child must have had a movement in the hospital and I am in the process of gathering all the info.

Thanks
Pepi

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Sent: 31 August 2020 08:47
To: KHALSA, Kamaljit (NHS GREATER GLASGOW & CLYDE)[redacted]; Bowskill, Gillian [redacted]; Johnson, Angela [redacted]; Brown, Mhairi [redacted]; Valyraki, Kalliopi [redacted]
Cc: Harvey-Wood, Kathleen [redacted]
Subject: [ExternaltoGGC]Re: PICU patient result [redacted]
Thanks Kam , unusual and worrying to see in mediastinal tissue.
Pepi - any recent water leaks or issues with theatres? Are there plans to air sample?
kr
Teresa

Dr Teresa Inkster
Consultant Microbiologist, QEUH
National Training Programme Director Medical Microbiology
Dept of Microbiology
Queen Elizabeth University Hospital
Glasgow
Direct dial : [redacted]

From: KHALSA, Kamaljit (NHS GREATER GLASGOW & CLYDE)
Sent: 30 August 2020 11:34
To: Bowskill Gillian (NHS GREATER GLASGOW & CLYDE); angela.johnsor[redacted]; Brown Mhairi (NHS GREATER GLASGOW & CLYDE); Valyraki, Kalliopi
Cc: Wood Kathleen (NHS GREATER GLASGOW & CLYDE); INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Subject: PICU patient result [redacted]
Hi,
Just to make you aware of the following result for a [redacted] in PICU (on cardiac ECMO). Isolate to be sent to Bristol Mycology lab for confirmation of ID.

AIX Version 7
GGC MICROBIOLOGY
Report type (RCS) RC POS SOFT (BMS) 05/09/17 Page 1 frame A1

|Name: [redacted] |
|[redacted] Lab No: [redacted] |
|[redacted] |
|Spec. Type: Tissue Date col'd: [redacted].08.20 |
|Spec. Site: Mediastinum Date rec'd: [redacted].08.20 |
Date auth:

|** INTERIM REPORT - Further report to follow ** |
| |
|CULTURE RESULT: |
| GROWTH: |
|a) Aspergillus species Isolated |
|b) |
|c) |
|d) |
|e) |
|f) |

Earlier \ Later specimen - append S for same type
Quit \ PHoned comment \ frame: + > \ imaGe ..
Kind Regards,
Kam
Thanking you,

Dr Kamaljit Khalsa
Consultant Medical Microbiologist
Queen Elizabeth University Hospital
Glasgow

****

****

****
****

Louise Mackinnon

From: PETERS, Christine (NHS GREATER GLASGOW & CLYDE) [redacted]
Sent: 10 September 2020 13:27
To: Devine, Sandra; INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE); Angela Wallace (NHS Forth Valley)
Cc: Claire Peacock (NHS Forth Valley); Leanord, Alistair
Subject: Re: In confidence: PICU patient result [redacted]

Thanks Sandra for taking the time to fill in the details- much appreciated.

I think the point re the case is not regarding cause of death (that should be discussed with MDT morbidity and mortality type meeting to include the liaising Clinical Microbiologist to contribute to a thorough understanding of the laboratory results as well as clinical aspects given the extensive experience of fungal infection diagnosis and treatment) but the fact that an HAI IFI occurred - rare but well described in the literature and certainly associated with very high levels of mortality .

https://academic.oup.com/icvts/article/23/3/431/1749924

[redacted]

[redacted]

in keeping with this we In Micro will-
-Be on the look out for any more cases and alert IPCT immediately
-look forward to the air sampling results with interest
- report on the confirmed ID of the organism
- discuss the case further with the clinical team
- recommend damp readings in the unit and theatre
- consider if any wound dressings may be implicated
- think about any improvements re diagnosis of IFI in these high risk patients by discussing at complex case meeting

Thanks again for your dialogue

Kr
Christine

From: Devine, Sandra [redacted]
Sent: 10 September 2020 09:34:59
To: PETERS, Christine (NHS GREATER GLASGOW & CLYDE); INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE); Angela Wallace (NHS Forth Valley)
Cc: Claire Peacock (NHS Forth Valley); Leanord Alistair (NHS GREATER GLASGOW & CLYDE)
Subject: RE: In confidence: PICU patient result [redacted]
Hi Teresa/Christine

Thank you for your e mail and helpful suggestions regarding this very sad case. I have set out below the answers to some of your questions however, I will also raise this at the ICD buzz tomorrow and discuss any additional measures that may be considered.

- The ceiling void was inspected and no damp/mould was identified so a check with a moisture meter was not indicated.

- Water samples are not routinely tested for aspergillus. Pall filters are in present in outlets in PICU and theatre areas.
- There is no ongoing work with the ventilation system but some work is scheduled for next week and I will ask estates to visibly inspect any areas they work on for the presence of damp or mould. As you know they did some work pre pandemic and did not report anything untoward.
- HAI SCRIBE was completed by the IPCT.
- Air sampling has been done.
- This [redacted] was discussed with a Consultant Paediatric Intensivist, the surgical team and the PF who all considered that the presence aspergillus did not contribute to the sad death of this child.
- We are waiting on results from the air sampling before advising clinical colleagues of additional control measures that they might consider.

Thanks again.

kind regards
Sandra

Sandra Devine
Acting Infection Control Manager
NHS Greater Glasgow & Clyde
[redacted] (PA Ann Lang)
[redacted]

If you require an urgent response can I please ask you to telephone me as I am often in meetings and away from the office and unable to check voicemail until the end of the day. Thank you

---

From: PETERS, Christine (NHS GREATER GLASGOW & CLYDE) [redacted]
Sent: 09 September 2020 16:56
To: Inkster, Teresa (NHSmail) [redacted]; Angela Wallace (NHS Forth Valley) [redacted]
Cc: Claire Peacock (NHS Forth Valley) [redacted]; Devine, Sandra [redacted]
Subject: [ExternaltoGGC]Re: In confidence: PICU patient result [redacted]

HI Sandra and Angela,

We discussed this case again at the QEUH Consultant meeting this afternoon and there was unanimous agreement that this was a Fungal infection (ID yet to be confirmed by Bristol ref lab) and that on the 29th August Dr Khalsa discussed the case and at that time ID, Clinicians and Micro were in agreement regarding this being a post operative wound infection and Ambisome was started. On the 30th August the plan was mediastinum clean out, and baby was septic. The CRP was raised, the wound was described as grotty - hence the sending of the tissue sample in the first place, and pyrexial. Sadly the patient deteriorated despite maximal antifungal dosing. Haemorrhaging, friable wound is very much a sign of fungal infection. All these discussions are documented on Telepath.

I am unclear as to what the current understanding from an IPCT point of view re the status of the Fungal culture and the fact that this was an invasive fungal infection and as such would be an IFI HAI on a cardiac thoracic unit with ventilation issues.

kr

Christine

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Sent: 09 September 2020 15:13
To: Angela Wallace (NHS Forth Valley)
Cc: Claire Peacock (NHS Forth Valley); PETERS, Christine (NHS GREATER GLASGOW & CLYDE); Devine, Sandra
Subject: Re: In confidence: PICU patient result [redacted]

Thanks Angela

The issue is not the ventilation rather it is the water damage and the environment that creates i.e. growth of mould.
Given that the light fittings were affected I assume the leaking pipe is in the ceiling void. The key question is whether the ceiling void was inspected for visible mould or if damp areas were still present 48 hours later, and was any plaster checked with a moisture meter.

Aspergillus and other fungal spores disperse in bursts and will do so regardless of the ventilation specification of the unit. The spores travel far from the source as they are spiculated and very buyoant. Distance between spaces is irrelevant. We have guidelines for construction on hosptial sites and immunosuppressed patients for this very reason, that demolition remote from the site can lead to fungal infection.

Due to the burst phenomenon air sampling can be unreliable . The key is identifying any water ingress and dealing with rapidy as per water damage policy.

The other thing to consider with this case is ECMO and the water as we have grown Aspergillus in the water supply before.

From a microbiology perspective the patient was treated with Ambisome, in fact we had to increase to the maximum 5mg/kg dose . Given that the fungus was in both tissue and a swab it is odd that the wound was not considered infected. We do occaisionally see Aspergillus colonisation in ICU patients but Aspergillus is not something you want to see in cardiac wounds because the outcome is always devastating. Given that there are babies with open chests on the unit and haem onc patients , any potential source needs addressed to prevent future infections.

kr
Teresa

Dr Teresa Inkster
Consultant Microbiologist, QEUH
National Training Programme Director Medical Microbiology

Dept of Microbiology
Queen Elizabeth University Hospital
Glasgow
Direct dial : [redacted]

From: Claire Peacock (NHS Forth Valley) [redacted]
Sent: 09 September 2020 14:52
To: PETERS, Christine (NHS GREATER GLASGOW & CLYDE); INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
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Kind regards

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[redacted] who had undergone [redacted] with [redacted]. This [redacted] had surgery on [redacted]/8 with a return to theatre on [redacted]/8 for [redacted]. Tissue taken on the [redacted]/8 [redacted]. [redacted]/8 ward reported that the wound [redacted].
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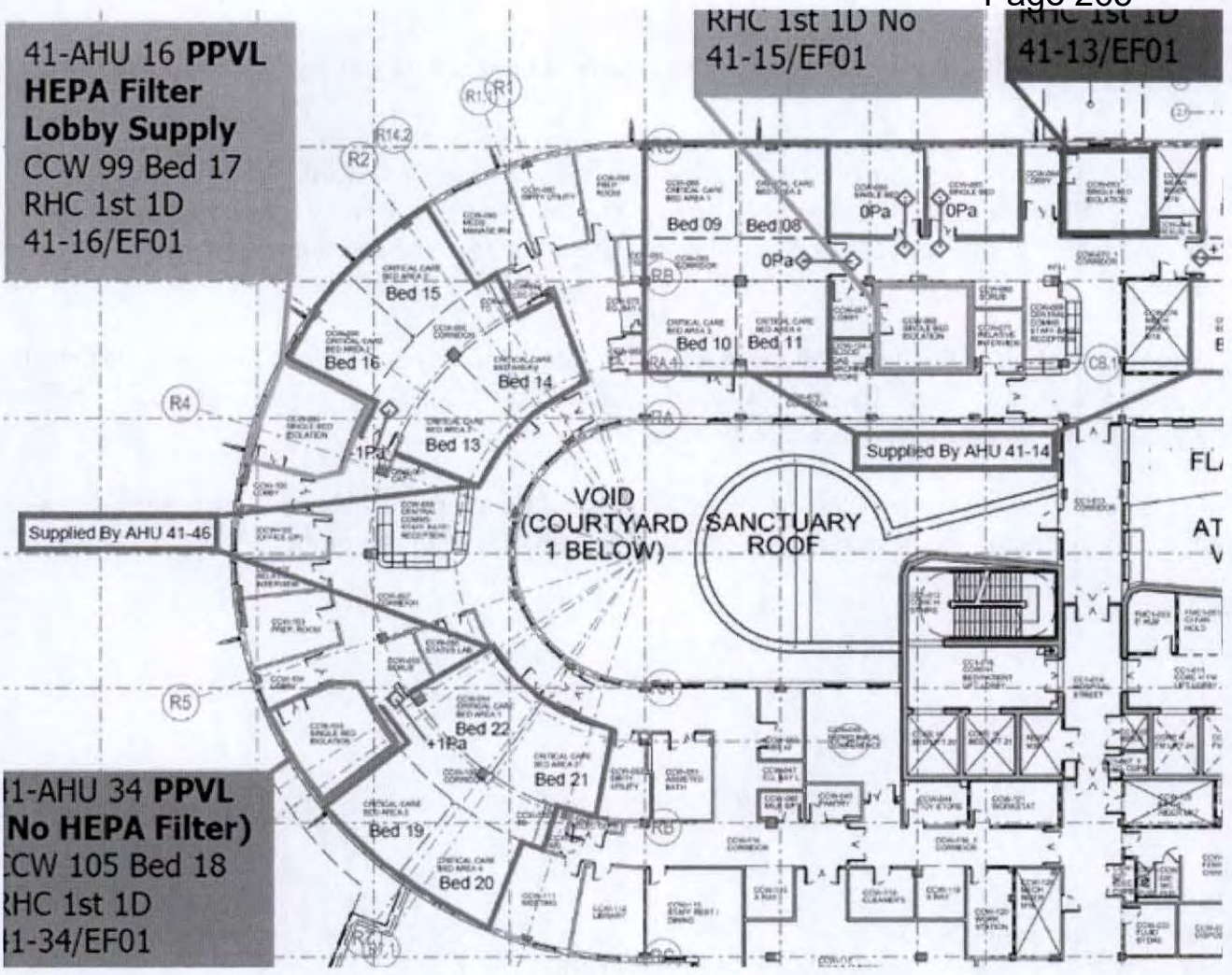

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Direct dial : [redacted]

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|Name: [redacted] |
|CHI: [redacted] Lab No: [redacted] |
|Location: [redacted] |
|Spec. Type: Tissue Date col'd: [redacted].08.20 |
|Spec. Site: Mediastinum Date rec'd: [redacted].08.20 |
Date auth:
** INTERIM REPORT - Further report to follow **
CULTURE RESULT:
GROWTH:
a) Aspergillus species Isolated
b)
c)
d)
e)
f)

Earlier \ Later specimen - append S for same type
Quit \ PHoned comment \ frame: + > \ imaGe ..

Kind Regards,

Kam
Thanking you,

Dr Kamaljit Khalsa
Consultant Medical Microbiologist
Queen Elizabeth University Hospital
Glasgow

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112. Re Cryptococcus CONFIDENTIAL

Julie Rothney

From: PETERS, Christine (NHS GREATER GLASGOW & CLYDE) [redacted]
Sent: 06 September 2020 19:45
To: Angela Wallace (NHS Forth Valley); INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Subject: Re: Cryptococcus CONFIDENTIAL

Dear Angela,

I am much better now thankyou and am on call today. Thanks Teresa for filling in on the meeting we had on Wednesday.

Essentially, I am concerned that :
1. there was pressure put upon a clinician to change the diagnosis when having to speak to parents
2. there was a lack of dialogue with RHC micro (all dialogue with IC was initiated and pursued by me and not reciprocated),
3. the follow up regarding the current understanding of the case has been marked by absence of response and follow up. This is the second case in a haemonc child in 18 months. This makes us very unique in Uk , not in a good way.
4. That information regarding an infection risk was put to parents without discussion with Micro - I refer to what I understand was an announcement on [redacted] that there was Cryptococcus isolated on a ward ? 4b and that there were no cases. It would be good to ascertain if this is garbled or infact what happened as I understand the parent of this child was deeply upset by the claim there were no cases as [redacted] had been informed [redacted] child was being treated for this.
5. The importance of the epidemiology of cryptococcal infection in this cohort has been obscured due to the multiple layers of disagreements and incomplete information
6. The IMT findings were not shared with me and there is direct contradiction of what my position was at the time - false positives are rare
7 there are no minutes of me raising the cases multiple times at the buzz meeting - this meeting is recorded is just action points and if no action point agreed/offered the communication capture opportunity is lost
8. The stance taken by GGC regarding previous crypto cases makes it difficult to explore the possible connections of pigeon infestation with the most recent case - essentially a first step in understanding what is happening in Glasgow
.

I will work on a timeline of all micro communications re this case if you would find this helpful.

I remain thankful that we picked up this case early and were able to treat and prevent dissemination despite profound immune suppression. I worry that this could happen again unless we really get to grips openly with what is happening and has happened.

Kr

Christine

From: Angela Wallace (NHS Forth Valley) [redacted]
Sent: 04 September 2020 12:38:35
To: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE); PETERS, Christine (NHS GREATER GLASGOW & CLYDE)
Subject: Re: Cryptococcus
hello Teresa many thanks
Christine i hope you're feeling a little better?

A chat at any time would be welcomed.

Thank you for this and i have brought colleagues together to better understand why these differences remain. I have asked that we clearly describe the process, the discussions, the IMT and the subsequent and ongoing work that Christine has continued and the then Board position.

As i explained on the call my clear understanding is that this was a positive case and on this basis the family discussions happened by pead clinical staff. As explained i was determined that we approached all aspects of this as openly as possible to avoid these types of concerns and i am happy to quickly share when i have it this write up.

i appreciate that this email is confidential and i will not share but i will ensure that these points are addressed. If i can have thsi early next week does that sound a reasonable approach and timescale to give us the basis for discussion?

i am happy to discuss of course
i do appreciate you raising this with me
kindest regards
Angela

I

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted]
Sent: 04 September 2020 12:06
To: Angela Wallace (NHS Forth Valley) [redacted]; PETERS, Christine (NHS GREATER GLASGOW & CLYDE) [redacted]
Subject: Re: Cryptococcus
Strictly confidential

Hi Angela, Christine is off sick today but I will elaborate on the key issues;

1) The patients clinician and the three Consultant Microbiologists present agreed that this case should be treated as a confirmed case of Cryptococcus neoformans. This is on the basis that the clinical picture fits, radiology changes fit, the successive positive CrAg tests have now been negative on two occasions following treatment with antifungals (these negatives have been confirmed by Bristol) I will leave Christine to discuss this further at the IPC meeting on Tuesday.

2) We were concerned to hear that the microbiology opinion in the IMT was that false positives CrAgs happen and are seen 'all the time' . This is not in fact the case. This goes back to what I said about differences of microbiology opinion . Pre 2015, I cannot recall such divergent views amongst microbiologists, which appear to have started during the 6A IMT of 2019. As mentioned in my email yesterday , this needs resolved.

3) Reference to duty of candour , whereby managers were suggesting the family be told this was not a case of Cryptococcus. I really hope we have misinterpreted this, but having been placed in a similar situation myself with a parent last year, I am not confident that this is in fact the case.

Happy to discuss any aspect further if you wish. Mobile is [redacted]

kr
Teresa

Dr Teresa Inkster
Consultant Microbiologist, QEUH
National Training Programme Director Medical Microbiology
Dept of Microbiology
Queen Elizabeth University Hospital
Glasgow
Direct dial : [redacted]

From: Angela Wallace (NHS Forth Valley) [redacted]
Sent: 02 September 2020 18:40
To: PETERS, Christine (NHS GREATER GLASGOW & CLYDE)
Cc: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE)
Subject: Re: Cryptococcus

Dear Christine,
Thank you for your email and i hope your meeting this afternoon with clinician colleagues was a positive one. I am sorry to hear of your concerns and that there are discrepancies in relation to the IMT, our team call and how the parents were informed. I would be keen to understand these issues and support in any way I can. I look forward to hearing from you on Friday
Kindest regards
Angela

From: PETERS, Christine (NHS GREATER GLASGOW & CLYDE) [redacted]
Sent: 02 September 2020 17:17
To: WALLACE, Angela (NHS FORTH VALLEY) [redacted]
Cc: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted]
Subject: Cryptococcus

Dear Angela,
By way of follow up to our discussions this afternoon, I have just come off the call with Dr Sastry and I am in a bit of shock regarding discrepancies in what I have been told re the IMT and how the parents were informed and what was revealed today.
I will reflect on this tonight and write to you on Friday regarding a series of serious concerns with regard to this situation.
kr
Christine

From:	Peters, Chris ne on behalf of [redacted]
To:	Polubothu, Padmaja (NHSmail); HOOD, John (NHS GREATER GLASGOW & CLYDE);
Cc:	Inkster, Teresa (NHSmail); Jamdar, Saranaz;
Subject:	RE: Message from "[redacted]"
Sent:	07/09/2020 16:45:16

No problem, I am interested that the Haemonc unit was clearly HEPA filtered as well as the BMT unit, and s pulated no Chilled beams in these rooms. 2004 knowledge was very good.
Bw
Chris ne

From: POLUBOTHU, Padmaja (NHS GREATER GLASGOW & CLYDE) [redacted]
Sent: 07 September 2020 16:08
To: Peters, Chris ne [redacted]; HOOD, John (NHS GREATER GLASGOW & CLYDE) [redacted]
Cc: Inkster, Teresa (NHSmail) [redacted]; Jamdar, Saranaz [redacted]
Subject: [ExternaltoGGC]Re: Message from "[redacted]"
Thank you all for your help.
Kind regards
Padma

From: Peters, Chris ne [redacted]
Sent: 07 September 2020 15:09
To: HOOD, John (NHS GREATER GLASGOW & CLYDE)
Cc: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE); Jamdar, Saranaz; POLUBOTHU, Padmaja (NHS GREATER GLASGOW & CLYDE)
Subject: FW: Message from "[redacted]"
Hi John,
AS discussed here is a copy of that document - looks like the 1 in 200 done with infection control with an sheet inset stating HEPA details and no chilled beams. The Architects are Boswell Mitchell & Johnston.

Hope this helps Padma,

Bw
Christine

-----Original Message-----
From: [redacted]
Sent: 07 September 2020 15:03
To: Peters, Christine [redacted]
Subject: Message from "[redacted]"

This E-mail was sent from "[redacted]" (IM C5500).

Scan Date: 09.07.2020 15:02:57 (+0100)
Queries to: [redacted]

Re: Checking in

Inkster, Teresa [redacted]
Mon 21/09/2020 11:17
To: Jenny Copeland [redacted]
Confiden al

Hi Jenny, apologies for the delay in ge ng back to you, my email migrated last week and I lost some emails for a bit, all fine now. Hope you had a good holiday

Yes, you had asked me to reflect on your presenta on ahead of further discussion on your return from leave. Some thoughts below;

The analogy of different ways of interpre ng the same informa on is something that I find extremely challenging to understand. There is no room for such misinterpreta on in microbiology/IC as the risks are high and consequences great. There is a requirement for informed decision making , enabling appropriate iden fica on , management and mi ga on by relevant experts. Where there is a contra view this must be deconflicted through reasoned and scien fic discussion keeping pa ents at the heart of all decisions. Decision making requires to withstand scru ny as this will be required by the Crown Office and Public Inquiry.

Re the feedback that some colleagues considered whistleblowing unnecessary and unprofessional. As you know, the term 'whistleblowing' is defined under statutory legisla on developed to protect workers who report wrong-doing that affects others. Indeed, such conduct must be in the public interest and my decision to embark upon this process was a. er seeking advice and guidance from the General Medical Council. My reasons, whilst difficult and challenging, both personally and professionally, pale in comparison to the impact and implica ons for an extremely vulnerable pa ent group whose lives were at risk. In addi on, I am protected in law and should not be treated unfairly or feel that by job is at risk because I acted in accordance with the law and advice given. I hear a lot about whistleblowers but nothing about bystanders .

The reference to me 'taking love away' leaving people' sad hurt and abandoned' and without the info to understand. You had asked me to think about communica on to others surrounding my resigna on. The reasons for such were many and are complex, rela ng to pa ent safety, the work environment I found myself in and personal health issues. At every stage I have acted with the utmost respect and with due regard to others. I have tried to effec vely manage my work life balance and whist recognising and catering for the needs of others, I have also had to consider my own health and wellbeing and that of my family during extremely challenging mes both professionally and personally. Communica on is a two-way process and my inten ons and ac ons have been nothing other than open, honest and transparent

Happy to discuss further

kr
Teresa

From: Jenny Copeland [redacted]
Sent: 15 September 2020 17:36
To: Inkster, Teresa [redacted]
Subject: Checking in

Hi Teresa

I am just emailing to see how you are and conscious we le. a few loose ends the last me we spoke.

Time passes so quickly and with everything moving along I feel like I've been away for months not weeks.

Would you like to arrange a call? If so, please suggest some dates and we can do a Teams.

Best regards.

Jenny

Jenny Copeland
Principal Lead CNO SEND
Leadership and Talent
NHS Education for Scotland
T: [redacted]
E: Jenny.copeland[redacted]

Organisational Development, Leadership & Learning

114. FW IPC Sector Reports - 180920 CONFIDENTIAL

Julie Rothney

From: Peters, Christine
Sent: 18 September 2020 15:51
To: Angela Wallace (NHS Forth Valley); Jenny Copeland; Inkster, Teresa (NHSmail)
Subject: FW: IPC Sector Reports - 18/09/20 CONFIDENTIAL
Attachments: IPC Report - West HSCP - 18.09.20.doc; IPC Report - Clyde - 18.09.20.doc; IPC Report - North - 18.09.20.docx; IPC Report - South Adults - 18.09.20.docx; IPC Report - South Paeds - 18.09.20.doc

Hi Angela,

Hope you have had a lovely break.

I just thought I would feedback confidentially on the communication gone out today above

1. Re the Pseudomonas HCOI – Green (surprised not Amber as source/route not identified as well as concern given the context)
2. Mouldy wall in outpatients area in RHC not mentioned – this required HAISCRIBE and of note immune compromised and CF patients would pass this area so significant
3. Re MSSA gent resistant in NICU and PICU – not mentioned and no update since Teresa raised it 2 weeks ago.
4. VREs – new 4C case – different ward, but similar cohort and often in Beatson the VRE colonisation would reach levels across all the wards when bacteraemias occur.
5. Follow up – wondering if both the Aspergillus case and the Cryptococcus case have been reported to HPS as confirmed cases?
6. ? update on air sampling in PICU

Thanks and hope to catch up next week,

Kr
Christine

From: Lang, Ann
Sent: 18 September 2020 14:53
To: Hamilton, Pauline [redacted]; WALLACE, Angela (NHS FORTH VALLEY) [redacted]; Bagrade, Linda (NHSmail) [redacted]; Balfour, Alison [redacted]; Bowskill, Gillian [redacted]; Cottom, Laura (NHSmail) [redacted]; [redacted] (NHSmail) [redacted]; Devine, Sandra [redacted]; Dhillon, Raje [redacted]; Edwardson, Alison [redacted]; Hamilton, Kate [redacted]; Inkster, Teresa [redacted]; Inkster, Teresa (NHSmail) [redacted]; 'Jamdar, Saranaz' [redacted]; Joannidis, Pamela [redacted]; Khalsa, Kamaljit [redacted]; 'KHALSA, Kamaljit (NHS GREATER GLASGOW & CLYDE)' [redacted]; Khanna, Nitish [redacted]; Leanord, Alistair [redacted]; Macleod, Mairi (NHSmail) [redacted]; amarek [redacted]; Marshall, Elizabeth [redacted]; McConnell, Donna [redacted]; Mills, Gillian [redacted]; Murphy, Michael E [redacted]; 'Peters, Christine' [redacted]; Peters, Christine [redacted]; Polubothu, Padmaja (NHSmail) [redacted]; Pritchard, Lynn [redacted]; Smith, Andrew [redacted]; andrew.smith [redacted]; Valyraki, Kalliopi [redacted]; Weinhardt, Barbara [redacted]; Wright, Pauline [redacted]; Arbuckle, William

[redacted]; Boyd, Luanne [redacted]; Cassidy, Anne Marie [redacted]; Crawford, Louise [redacted]; Doherty, Denise [redacted]; Donnelly, Michael [redacted]; Douglas, Kirsty [redacted]; Fleming, Alistair [redacted]; Glancy, Joan [redacted]; Henderson, Karen [redacted]; Love, Liz [redacted]; MacLeod, Alison [redacted]; Mathieson, David [redacted]; Moore, Marie [redacted]; Murphy, Deborah [redacted]; O'neill, Julie Anne [redacted]; Ozegemen, Margaret [redacted]; Smyth, Elaine [redacted]; Spalding, Jane [redacted]; Wilson, Gary [redacted]; Robertson, Angela [redacted]; MacLeod, Calum [redacted]

Subject: IPC Sector Reports - 18/09/20

Please find attached the IPC Weekly Sector Reports dated 18 September 2020.

Kind Regards

Ann

Ann Lang
PA/Data Manager to Acting Infection Control Manager
Office Block
Level 2
Queen Elizabeth University Hospital

[redacted] *(internal* [redacted]*)*
email: ann.lang[redacted]

happy to discuss of course
kindest regards
Angela

Date:

From: Inkster, Teresa [redacted]
Sent: 23 September 2020 15:40
To: Angela Wallace (NHS Forth Valley) [redacted]
Cc: PETERS, Christine (NHS GREATER GLASGOW & CLYDE) [redacted]
Subject: Fw: Gent R Staph aureus

Hi Angela , just wanted to mention a couple of things to you .

Firstly , the email thread below re gentamicin resistant MSSA in NICU. I first raised this on 8th Sept. At the two subsequent consultant meetings there was no update available. As you will see below the typing is back and matches. It is not clear to me as to whether any control measures have been implemented.

Secondly, I attended a meeting chaired by Jonathon Best this morning , this was a pre-meeting ahead of a meeting with the family of the adult Cryptococcal case at the end of the month. John Hood was there as chair of the advisory group. I have pointed out previously my concerns re the governance of this group and quotes from an unwritten report in board meeting minutes and the public domain. I commissioned this report as the IMT chair, and according to the terms of reference it should be sent to myself and the full IMT for comment. We are now in the position of a family being given information from a draft report that has not subject to any scrutiny. There is a difference of opinion between myself and John and I would like to resolve that ahead of any meeting with the family. Are you able as operational Director to request a copy of this report for me?

kr
Teresa

Kr
Teresa

From: Inkster, Teresa [redacted]
Sent: 23 September 2020 13:57
To: Peters, Christine [redacted]; Valyraki, Kalliopi [redacted]; Harvey-Wood, Kathleen [redacted]; Deshpande, Ashutosh [redacted]; Balfour, Alison [redacted]
Cc: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted]
Subject: [ExternaltoGGC]Re: Gent R Staph aureus

I have the timeline now. [redacted] was a BC from Nov 2019 so strain has been circulating since then at least . not sure how far the lookback went

kr
Teresa

From: Inkster, Teresa [redacted]
Sent: 23 September 2020 13:48
To: Peters, Christine [redacted]; Valyraki, Kalliopi

Re: QEUH [OFFICIAL]

teresa inkster [redacted]
Fri 25/09/2020 09:29
To: Henry, Julie [redacted]
Hi Julie, I could take a call this afternoon, anytime after 2.30pm. My mobile is [redacted]

Kind regards
Teresa

Get Outlook for Android

From: Henry, Julie [redacted]
Sent: Friday, September 25, 2020 9:29:11 AM
To: teresaink [redacted]
Subject: QEUH [OFFICIAL]

OFFICIAL

OFFICIAL

Good morning Dr Inkster,

I have been contacted by Crown Office and Procurator Fiscal Service (COPFS) in rela on to informa on you have with regard to the Queen Elizabeth University Hospital in Glasgow.

I have had sight of the emails you previously sent to Laura Mundell, Procurator Fiscal and have a general awareness of the nature of your concerns. I have been asked by COPFS to make contact with yourself to gain further informa on and to take a statement from you in order to decide how best to proceed.

I am happy to meet with you face to face (obviously with COVID measures in place) or via TEAMS or phone call in the first instance and we can decide how to progress?

If you could let me know a good me to call, we could make ini al arrangements?

Kind Regards

Julie

Julie Henry
T/ Detective Superintendent
Specialist Crime Division
Major Investigation Teams
Osprey House
Paisley
[redacted]
julie.henry[redacted]

[redacted]kster, Teresa [redacted]
Sent: 30 September 2020 17:20
To: Angela Wallace (NHS Forth Valley) [redacted] INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted]; Peters, Christine [redacted]
Subject: Re: Gent R Staph aureus

Confidential;

Hi Angela,

Re the MSSA PAG, my concern is that I first highlighted the gent resistant MSSA in NICU on Sept 8th and the PAG was not held until last Friday. There is a missed opportunity to put in control measures and prevent further cases. We don't normally await typing for such an obvious incident, as this takes time. The fact the strain was introduced into the unit in 2019 has been missed in the PAG with reference to only 4 cases.

Re the Cryptococcus , the meeting with the family was this afternoon . I have yet to see the report, I understand it is still in draft form. However, John did discuss his findings. Of particular concern was his reference to pigeon guano only being found in one plant room. This is not the case and there continues to be misinformation with regards to the Cryptococcal incident . His theory that Cryptococcus was acquired from a wide open space is not one I can concur with given all the evidence I have seen . Once again this highlights the inability to resolve differences of opinion between microbiologists and those with alternative views are able to make such statements without robust scientific evidence. Re governance, I would hope that the report once complete will come the IMT members for comment, I would be appreciate if you could help ensure that happens.

kr
Teresa

From: Angela Wallace (NHS Forth Valley) [redacted]
Sent: 25 September 2020 17:18
To: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted]; Inkster, Teresa [redacted]; Peters, Christine [redacted]
Subject: Fw: Gent R Staph aureus

Hello Teresa and Christine,
It is good to hear from you and many thanks for your email. I appreciate you sharing the typing results you had sight of these quickly and i will way of an update provide the most up to date info from the PAG. I would be happy to receive your feedback. I am not sure why the updates from the consultant's meetings are not available but happy to understand more.

I note the pre meeting Teresa with the family of the adult cryptococcus case, I do hope the meeting went well. I am sorry there is a difference of opinion between you and John and i wondered if this was discussed in the meeting and how this will be able to be explored prior to the meeting, you may have this in hand? is the meeting soon?

I knew the report was pending and I am not aware if it is yet complete? I have from our most recent meeting the detail where you described to me governance steps that the report needs to follow, and I had taken this as an area to follow up together.

May i ask if you have asked to discuss or see the report? I would be happy to pick this up together if that would be helpful

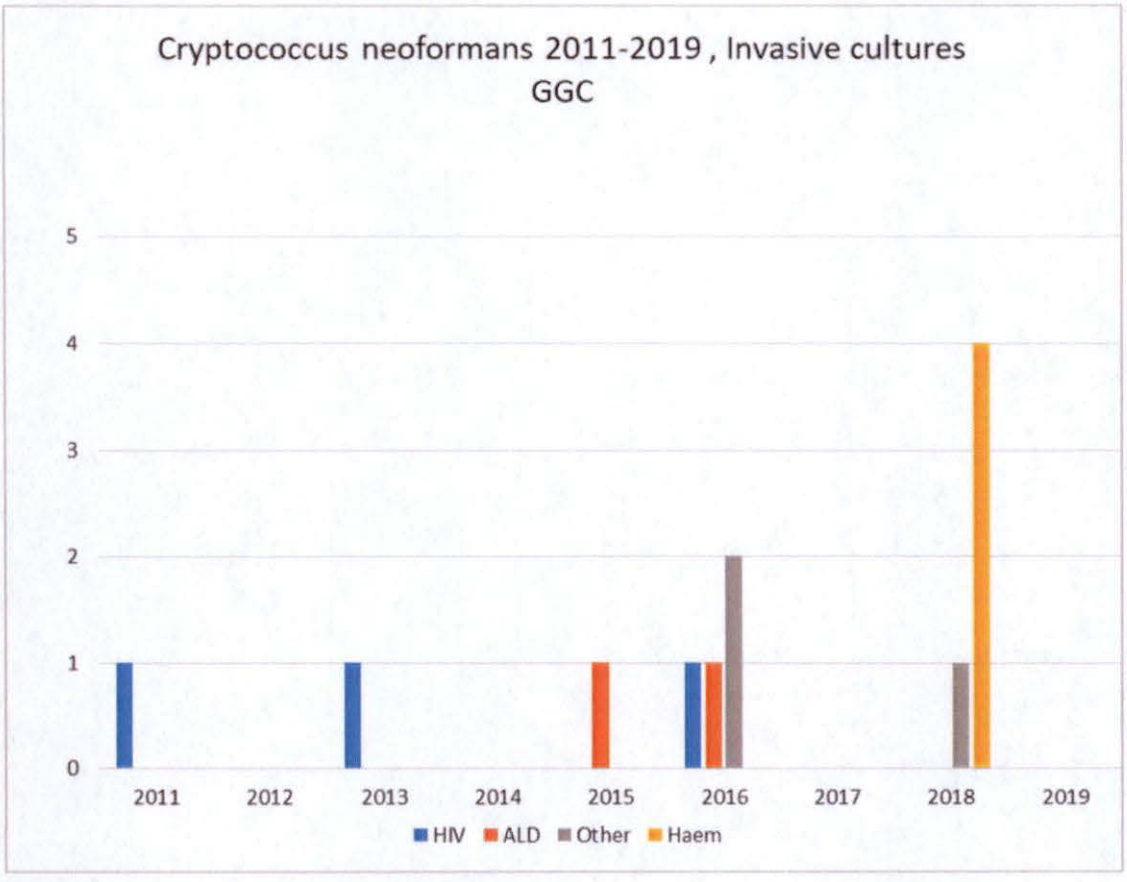
116. RE Cryptococcus

Julie Rothney

From: Peters, Christine
Sent: 01 October 2020 18:08
To: Inkster, Teresa
Subject: RE: Cryptococcus

Hi Teresa,
Thanks for copying me in as I was involved with the initial investigations of the plant room with Estates personnel as well as with the recent case in paediatrics.

1. It was very clear at the beginning that there was contamination in all four wings of the plant room, it is impossible to tell the extent and duration given the time gap and the differing accounts we were given over time. Certainly a fellow Consultant, yourself, estates personnel and BMS doing sampling all reported contamination in more than one plant room. On the weekend I organised cleaning I was informed that it had taken large number of staff from the company many hours to do a clean up in all the plant rooms. I can find the emails if necessary. Therefore I am surprised that the family were not informed regarding this.
2. The majority of the guano in the photos I have seen was dry and the left over patches I saw were very dry. Furthermore the question as to why there was wetness in a ventilation plant room needs to be addressed – I witnessed leakage from the roof which is a mould hazard. And this occurred on many occasions according to verbal information I was given. If this was coming through a guano covering on the roof this is significant.
3. There is a striking occurrence of cases in Haematology patients. Very much unseen in Scotland at least over the last decade with 4 occurring in 2018. Renal patients may not have been exposed to the same event in the same way and are immunologically at a lower risk group.
4. Wide open space is shared with everyone and is not an epidemiological discriminating factor. Did any other cases have epi links to Queens park? I understand no Cryptococcal species, including neoformans were ever isolated from the many samples taken out doors. This may not be correct, but it would be good to understand the interpretation of the 3500 or so samples.
5. I suggested this at the start and so would be interested in the investigations since regarding void and ingress of birds on a multiplicity of occasions.
6. I have done a look back for invasive C neoformans and this is the graph I have : (note will not capture CRAG/Antigen only diagnosis and so liable to underestimate true incidence)



What is striking for me in this epidemiology is :

Over 9 years there have been 12 cases in Glasgow, 5 (42%) accounted for by ALD and HIV. One is an inoculation. Average annual average incidence of one a year before 2018.

Prior to 2018 no haemonc patients had been seen with Cryptococcosis in blood cultures. Then there were 4 cases within 7 months and 3 of these plus a non haemonc patient had inpatient stays at the QEUH in a feasible time frame for acute infection to have occurred. I had mentioned this fact previously in our discussions with Dr Hood. There is a longer incubation in these potentially less immune compromised patients before presentation at another hospital with cryptococcaemia. Of note the 2018 paediatric case was the first described in this cohort, and furthermore no ID or paeds micro consultants can recall a paediatric case in Glasgow over 20 years. This is of course in keeping with international studies of rarity in children. We have now recently had another case.

Furthermore a close look at the clinical histories is in keeping with acute and overwhelming infection in the 2 cases at the IMT, and more indolent presentation of the other two with possible exposure to QEUH environment. Whilst not conclusive, it is certainly a significant fact to note in the context of understanding a new presentation of an infection that is environmentally acquired.

7. I understand that the air quality in 4C is inferior to the equivalent accommodation at the Beatson. Furthermore there are chilled beams and 2.5 ACH. This was specifically disallowed in the Beatson spec for this cohort of patients over 16 years ago. I am unsure how the HSE improvement notice has been concluded upon, but from basic first principles, what is inadequate for standard patients re 2.5 ACH , would be compounded by chilled beams and would be far from satisfactory for an immune compromised patient group.

In addition to the AHU supplying the wards directly there is corridor ingress from other sources that may be relevant including the common corridor which may/may not have been supplied by AHU in Plant room 123 – the most contaminated plant room (I think) in which an AHU was accessed during the important time period. At least that is my understanding from the fragments of information I had at various points. I think it would be important to

understand the full findings of the investigations and conclusions when conversations with family take place, and in anticipation of a Public Inquiry it is vital to have facts acknowledged, even if interpretations differ.

Kind regards,

Christine

From: Inkster, Teresa
Sent: 01 October 2020 17:12
To: Peters, Christine [redacted]
Subject: Fw: Cryptococcus

From: Inkster, Teresa
Sent: 01 October 2020 15:11
To: Hood, John [redacted]; HOOD, John (NHS GREATER GLASGOW & CLYDE) [redacted]
Cc: Peters, Christine [redacted]; Angela Wallace (NHS Forth Valley) [redacted]
Subject: Cryptococcus

Hi John,

The meetings we have had over the past two weeks have raised more questions rather than answers re Cryptococcus;

1) Yesterday you stated to the patient's family that only one plantroom (123) had evidence of pigeon guano. The microbiologists involved at the start of the incident have photographic evidence to the contrary. Is the group not aware of this?
2) Reference to the pigeon guano only being wet. Again the photographic evidence and the guano witnessed by my own eye was dry in many places. There is also a photo from the pest control company with what looks like pressure hosing equipment in it , which we discussed previously risking aerosolisation . What was the reason for wet guano in the plant room, were they hosing it? You also mentioned the Scotland has a wet climate, given that cases have occurred in Scotland I do not understand the relevance of this statement.
3) You mentioned HAI was unlikely as renal patients unaffected. Renal patients are at less risk and we quickly implemented control measures in this group including prophylaxis and portable HEPA. Is the group aware of this? I don't think is a scientific approach, we wouldn't not attribute an environmental source just because another high risk group did not develop infections.
4) You have suggested the adult patient acquired Cryptococcus from a wide open space and you mentioned Queens park. Given that there are many [redacted] patients ,would we not expect to see this frequently? If we are saying there is a risk to lymphoma patients from public parks what is the public health advice to this patient group? Is there evidence of a pigeon issue at Queens park? What is the explanation for Cryptococcus in the child?
5)With respect to investigations, was a tracer gas released in the plant room? was thermal imaging employed given issues in Edinburgh with pigeons in walls? What was the outcome of the investigation into the risers and voids?
6) Is the group aware that the original epidemiology report from public health has omissions with respect to patients being admitted to the QEUH?

7) what is the theory behind the most recent case in a 2nd paediatric patient and is there any history of recurrent issues with pigeons?
8) At the start of the incident we recommended increasing the number of HEPA filtered rooms for high risk patients. Yesterday however you stated that the air quality in ward 4C is good. Given that air quality is only an assurance check, is the spec of ward 4C with less than 3 ACH in your opinion suitable for immunosuppressed haem onc patients? (it differs from that of the equivalent Beatson ward, so the same patient group is in a unit with better spec)

Can I have a copy of the groups report as per the terms of reference. It will need to be circulated to all IMT members for comment.

kr
Teresa

Re: Gent R Staph aureus

Inkster, Teresa [redacted]
Tue 20/10/2020 11:49
To: Peters, Christine [redacted]; Angela Wallace (NHS Forth Valley) [redacted]
Confidential

Apologies Angela, I have been on annual leave and just back today.
It is some time now since the MSSA PAG and I understand there have been more cases whilst I was on leave.

My concern was the time taken from the initial notification on Sept 8th to having a PAG and also no mention in the PAG or the Friday report that the MSSA strain was isolated in the unit as far back as Nov 2019. This gives valuable epidemiological information and points to a likely staff carrier.

Despite me alerting the team to this issue on 8th Sept a number of weeks passed before a PAG was held losing valuable opportunity to implement control measures and prevent further cases. I have heard phrases such as ' its not the same strain as last years outbreak' and'its not a toxin producing strain' . This is irrelevant, it is a new strain that has been introduced into the unit with the potential to cause HAI SABs.

It is rare to see resistance to S aureus in neonates as they are antibiotic naive. You will see sporadic acquisition from time to time from a colonised parent or staff member. However, this strain is persisting which fits with a staff carrier as the source.

I also understand there has been a further case of B stabilis whilst I have been away and another Aspergillus in PICU. These were two other incidents where I highlighted the need for early intervention.

As per Christines email, I do not understand what our role is here and remain concerned re the lack of proactive approach , something I raised at the very beginning. The concept of prevention is forgotten.

kr
Teresa

From: Peters, Christine [redacted]
Sent: 02 October 2020 17:07
To: Angela Wallace (NHS Forth Valley) [redacted]; Inkster, Teresa [redacted]
Subject: RE: Gent R Staph aureus

Thanks Angela,

Its good to be thinking about positive ways forward. I guess we have been trying to fulfil the expectation give to us by Jean Freeman and Fiona McQueen that we would be treated as part of the team looking to solve th recognised infection control issues due to our historical correct identification of the problems as well as qualifications in the field. This has not transpired and instead, as we all recognise, trying to work within the unchanged systems, or directly going to you due to that pathway being opened to us can be seen as cuttin across the system.

From: Raines P (Philip)
Sent: 06 October 2020 10:55
To: McQueen F (Fiona); Murray D (Diane); Shepherd L (Lesley); White C (Craig)
Subject: Papers/materials from Angela Wallace re: GGC IPC improvements
Attachments: OversightInterimDIPCreportversion2 (1).docxVersion 4 28Aug20.docx 1542.docx; GGC Gold Command Template.docx Version 2.docx; Better Safe Clean Clinical Environment V2.docx Final.docx; SWOT- PESTLE V1.docx Final.docx; 5 Stages of OD Plan.pptx; GGC Discovery Debriefs and Engagement Events.pptx; PICU Action Plan 13 05 20 SD.docx FINAL.pdf; IPC Overall Action Plan Version May20 docx FINAL.pdf

All

Angela has provided some papers to give more detail to her paper for the Oversight Board on the improvements in place in GGC.

I've not reviewed in detail, but there's a clear desire in these papers to shake things up, from Jane on down. Some positive references include plans for a GGC-wide IPC improvement collaborative and a 'transformational delivery plan' which would include external review recommendations (mentioned in the 'Better Safe Clean Clinical Environment' document) – but overall it still feels somewhat aspirational and vague at this stage. The SWOT is of some interest, in that the weaknesses appear to be overwhelmingly external rather than any sense of internal shortcomings – which suggest our criticisms of their IPC won't match their view of themselves.

Not surprisingly, there's no inclusion of the Discovery materials on the OD work – my feeling is that if I can't get access to any of this, I'm not sure if 'culture' issues can be covered in the Oversight Board's reports. We can't just rely on what the concerned clinicians have told us. That will require a judgement call by yourselves after meeting with Jenny?

Also attached is what I take to be the latest draft of the PICU action plan – again, I haven't reviewed, but will be of interest.

Phil

From: Angela Wallace (NHS Forth Valley) [redacted]
Sent: 06 October 2020 09:38
To: Raines P (Philip) [redacted]
Cc: Jenny Copeland [redacted]; Angela Wallace (NHS Forth Valley) [redacted]
Subject: Oversight Board

Dear Phil,

please accept my apologies for the delay in responding to you.

As promised, please find attached some information which I hope you find helpful.

The findings of the discovery have not been shared; however, I have taken the liberty of copying Jenny in as she may wish to elaborate.

You will be aware that the meeting between Fiona, Jane, Jenny and myself re Culture is scheduled this week.

I hope you find this helpful.

Kind regards

Claire - **On behalf of Professor Angela Wallace**

Claire Peacock
PA to Prof. Angela Wallace, Executive Nurse Director /
Admin & Clerical Supervisor
Nursing Directorate
NHS Forth Valley
Forth Valley Royal Hospital
Stirling Road
Larbert
FK5 4WR
[redacted]

Julie Rothney

From: Valyraki, Kalliopi
Sent: 07 December 2020 16:43
To: Peters, Christine
Subject: Re: PF

Great
Thanks
Pepi

Get Outlook for iOS

From: Peters, Christine [redacted]
Sent: Monday, December 7, 2020 4:30:56 PM
To: Valyraki, Kalliopi [redacted]
Subject: RE: PF

Hi Pepi,

The Chi is [redacted] . Acquired on 4B I assume?

Bw

Christine

From: Valyraki, Kalliopi
Sent: 07 December 2020 15:30
To: Peters, Christine [redacted]
Subject: Re: PF

Hi Christine

I just finished a meeting for the neuro pathways
Do you have the chi number if the patient?
I will speak with Lynn and will what we will organise.

Thanks
Pepi

Get Outlook for iOS

From: Peters, Christine [redacted]
Sent: Monday, December 7, 2020 3:27:14 PM
To: Valyraki, Kalliopi [redacted]
Subject: PF

Hi Pepi,
Just to follow up re the case we mentioned this morning at the handover who died with HAI COVID. On the round the Dr had spoken to the PF who was asking regarding the investigation/PAG around that case. I suggested they get in touch with you to discuss.

Kr

Christine

Dr Christine Peters
Clinical Lead
Consultant Microbiologist
QEUH
[redacted]

Inkster, Teresa

From: Angela Wallace (NHS Forth Valley)
Sent: 11 February 2021 12:52
To: Peters, Christine; Inkster, Teresa
Cc: Jenny Copeland
Subject: Re: IPCT and role s

Hello Christine and thanks as always for your response and suggested way forward. I also appreciate you and Teresa discussing and i know Jenny may wish to add her thoughts on ensuring any outstanding areas that we can come together. I would be pleased to contribute in any way that would be helpful.
I look forward to hearing from you both on Teresa's return.
Kindest regards as always
Angela

From: Peters, Christine [redacted]
Sent: 09 February 2021 12:10
To: Angela Wallace (NHS Forth Valley) [redacted]; Inkster, Teresa [redacted]
Cc: Jenny Copeland [redacted]
Subject: RE: IPCT and role s

Dear Angela,

Thank you for your response and all your hard work in pulling together the attached actions update. Teresa is on annual leave this week and so I will discuss the information with her next week, particularly your kind offer to take forward the outstanding issues with senior management.

Overall, a vision for a new way of working is a great way to go forward, and as ever I remain committed to patient safety and a robust and first class microbiology service.

Kind regards,

Christine

From: Angela Wallace (NHS Forth Valley)
Sent: 09 February 2021 10:18
To: Peters, Christine [redacted]; Inkster, Teresa [redacted]
Cc: Jenny Copeland [redacted]
Subject: Re: IPCT and role s

Hi Christine,

Thank you for your reply, much appreciated. I hope the following is helpful as means of follow-up.

Re Historical and Current Operational ICs/Estates issues - review meeting on 15th January 2020 follow up:

- I am pleased that you have read the actions update from the estates meeting. The outstanding IC updates will be added during February, when IC team are available to provide updates. Following these updates, I would be happy to discuss if a meeting would add value or be required after the updates

Future Roles

- Thank you for sharing your views on the potential way forward in ensuring that the expertise of colleagues working in and across the IC agenda. As we discussed in the meeting, in this email response, Mairi's work and the new approach dove tailing with the ongoing ICT leadership direction and transformational plans including estates colleagues will be vital in achieving, a new whole system way of working.

  The committed leadership team have created a shared vision from which the new way of working will stem. I was however sorry to read of the views you expressed about IC colleagues, key to the work we have been building is team working and non-negotiable mutual respect. We know this fundamental respect and team working is key to patient safety and reduction in avoidable harm along with creating the conditions for staff to feel safe and flourish. I remain dedicated to this being afforded to all staff.

OD Work Feedback

- As highlighted above, I agree that this is important for a range of reasons, including Mairi's team and staff development work, and despite this unforeseen delay due to service pressures this is planned to be delivered during February 2020

Log of Issues Outstanding

  - 6A IMT process and resultant WB investigations and output.
  - Public Comms re Teresa
  - Comms to public on a number of issues
  - Website answers to parents
  - Senior Management handling of the situation arising in Teresa's resignation
  - Recognition of correctly raising issues and subsequent treatment and exclusion

Thank you for highlighting the areas that you are looking to be addressed. These areas would require discussion with senior GGC leaders re a way forward and I would be happy to raise these if that would be helpful and acceptable to you and Teresa.

I note in your closing paragraph the ongoing work that you highlight in relation to the Case Note Review, Oversight Board, Cryptococcus Group, Whistleblowing review and Public Inquiry and the impact this has on your time. I am pleased to hear Teresa, the work you are leading on the master's level module on IC and your ongoing focus on the built environment. NHS GGC is fortunate to have a number of staff who are involved in research, or working groups at a national level across a number of professional backgrounds.

Thank you for your kind words and I agree the vaccine is giving us all hope for a better 2021.

In closing I thought it would be helpful to provide you with a list of the additionl areas and supporting updates from our meeting on the 15th January. I would be happy to discuss this with you.

Yours sincerely

Angela

From: Peters, Christine [redacted]
Sent: 26 January 2021 14:48
To: Claire Peacock (NHS Forth Valley) [redacted]; Inkster, Teresa [redacted]; Angela Wallace (NHS Forth Valley) [redacted]
Cc: Jenny Copeland [redacted]
Subject: RE: IPCT and role s

Hi Angela,

Thanks for your email. By way of an update :

- I have received the actions from the Estates meeting and am trying to find the archived emails re Theatres going back a number of years. Thanks for that.

- Re future roles, I think that depends on the IPCT and engendering a visible change towards a proactive approach to issues arising. It seems that there is a built environment group that Al, Sandra and others sit on, and it was not clear to me how this has functioned since August 2019 to date and this is critical in going forward. Our ability to input has been largely hampered by a lack of visibility on the issues and developments since the time we raised all the issues with the Health Secretary and CNO. The estates meeting was the first and very welcome opportunity to get the updates and to see where the gaps still exist. As I expressed it is fundamentally important to recognise that those with roles – such as Aleks and Al have the responsibility for these areas since Teresa stepped down and we cannot cut across them or work in a parallel manner. Teresa already has a national role re Water which is really good and a positive development and perhaps GGC issues are best taken up to that group for her expert input?

- Re infection control issues more generally – Teresa's expertise is way broader than just water and estates issues – she is an outbreak management expert who teaches the Masters Course in IC , and over the year we have frequently raised the issue of speed, over reliance on typing, and lack of systematic proactivity in response to identified issues.

- Regarding the current issues – *B stabilis* and fungal infections on PICU, I have not received any updates since last week – until I raised at the Buzz today and Mairi had to push for a response. I am glad there are IMTs occurring now.

- Re the log of issues – those on the list are some, but please recall that we have outstanding :

    - 6A IMT process and resultant WB investigations and output.
    - Public Comms re Teresa
    - Comms to public on a number of issues
    - Website answers to parents
    - Senior Management handling of the situation arising in Teresa's resignation
    - Recognition of correctly raising issues and subsequent treatment and exclusion

- The OD work has not been fed back to the QEUH Consultants yet - we had agreed that it was important that this should occur but should not hold up the progression of Mairi's strategy and team development. I think it is really crucial that it is fully fed back to the team to gain trust that the future has chance of being different.

Finally thanks for taking the time to meet. We are very aware that the Case Note Review, Oversight board, Cryptococcus group and whistleblowing review are all due within a couple months, all of which have a huge impact on us and we have also the need to keep records up to date for the public inquiry investigations. Teresa

continues to work full time at home and has been able to set up a Masters Level Module on Infection Control and the Built Environment as well as submitting papers for publication as well as working fully on the duty rota, which is incredible – especially with a rubbish laptop!

Hope all is well with you and I know we are all looking forward to the vaccine having an impact on the COVID rates which will herald the return of normality.

Kind regards,

Christine

From: Claire Peacock (NHS Forth Valley)
Sent: 25 January 2021 16:29
To: Peters, Christine [redacted]; Inkster, Teresa [redacted]
Cc: Jenny Copeland [redacted]
Subject: Fw: IPCT and role s

Good afternoon all,

many thanks for your email Christine and apologies for my delay in responding. It was good to spend the time week past Friday on the estates and facilities area, which was i hope helpful. We gave a commitment to update and agree any further steps to progress the issues log, i hope that you have received this if not I am happy to ask Claire to share.

We touched on how we can moving forward ensure that we can use skills and expertise across the agenda, and i would suggest that it would be good to hear what you and Teresa would think good looks like, i would commit to then discuss with key colleagues how we can take this forward. I know Mairi will have plans for the wider team and i do think this would be excellent timing to dove tail this approach as job planning, as you mentioned, will be vital.
I was grateful for your openness in the meeting of potential challenges as IPCT approach has changed during the last year and any new way of working would need to take cognisance of this for sure. Happy to take this as an action and explore this opportunity.

Turning to infection control on the issues log, I wasn't sure if this needed a meeting or if we could initially respond to any questions and if a meeting is helpful after that happy to arrange and Sandra as i explained was happy to meet as is I am sure other colleagues would be too if required.

Re the buzz conversations on in relation to current IC issues, i had followed up at my 1-1 with Sandra last week and she had explained she was following these up re the actions underway with you, if you could let me know if you have the updates that would be helpful.
regards
Angela

From: Peters, Christine [redacted]
Sent: 21 January 2021 16:53
To: Angela Wallace (NHS Forth Valley) [redacted]
Cc: Jenny Copeland [redacted]; Inkster, Teresa [redacted]
Subject: IPCT and role s

Hi Angela,

As a follow up to our discussions, I would like to raise a few things for further thoughts

1. Re the outstanding matters that do not pertain to estates – is there a plan to meet and get answers?
2. It is very unclear to us how input in the future would take place, and it seems that Aleks has not been involved (given the Specialist Ventilation Group only met last week for the first time in 18 months) despite her role. It is also important to note that neither of us have had any input into the IC management of estates or outbreaks since August 2019 other than via conversations with Marion Bain and yourself and so there is a massive gap in information flow in real time that needs to be factored in.
3. There are some issues that I raised at the Buzz (not minuted or appearing in actions) that are important – namely the fungal PICU infections, B stabilis reappearance, the CF cases, and MSSA in NICU.

It would be good to have a meeting with yourself at your convenience to run through these.

Kr

Christine

Dr Christine Peters
Clinical Lead
Consultant Microbiologist
QEUH
[redacted]

Inkster, Teresa

From:	STEVENS, Mike (UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST) [redacted]
Sent:	23 January 2021 12:01
To:	Peters, Christine; Inkster, Teresa
Cc:	Marie Brown; Philip.Raines; WILCOX, Mark (LEEDS TEACHING HOSPITALS NHS TRUST); EVANS, Gaynor (NHS ENGLAND & NHS IMPROVEMENT - T1520)
Subject:	[ExternaltoGGC]Re: Introductions

Dear Christine

Many thanks for your prompt response. I understand your concern about timescale and perhaps I could have been clearer about my intent in seeking this meeting and the background to our work.

We have been charged with undertaking an independent case note review. To this end we have taken care not to engage with anyone with a view to discussing the circumstances of the individual cases that form part of our review. We have needed, as I am sure you will understand, to have had considerable contact with GGC to identify and understand the information (data, documents, policies, SOPs etc) that we believe we required to inform our assessment of each eligible infection episode in every child included in the review. This has brought us, at various times, into contact with members of the GGC management, microbiology, facilities and IPC teams. I have also held meetings with the RHC haem onc clinicians to keep them informed of the progress of the review, and have provided similar updates, in writing, to the families concerned.

As we were aware that the Oversight Board has a focus on the wider issue of whether there had been organisational and systems failure, and understand that you have engaged with Phil Raines in discussions on that basis, we did not feel it appropriate to seek wider contact with those, such as yourselves, who had particularly detailed engagement with the challenges imposed by the incidence of gram negative environmental infections in the paediatric haematology patients until we had completed our review of each case. We achieved this only shortly before Christmas and have since re reviewed all cases because of the delayed receipt of important information. The work has been very time consuming and we have been affected, as everyone else, by the working restrictions imposed by Covid and by the responsibilities carried by members of the panel to Covid related work in England. As a result the review has taken longer than we had hoped and we now find ourselves working to an increasingly tight timeline.

In the course of the primary work we have done to review the cases, we have formed a number of observations about how IPC has operated. Our purpose in asking to meet with you is not to enumerate details of individual children or infections but to gain your perspective on the overall approach to the investigation of these infections, and the

response that followed. It is, I suppose, more to paint in a background to our understanding than to re-evaluate the specific conclusions we have reached.

For example, we would be interested to hear from you how the IMTs operated; how actions agreed were logged and followed up; and how environmental testing, including water sampling, was effected and reported back. We would of course be pleased to hear of any other issues you may feel to be relevant and, as one of our tasks in undertaking this work is to try to suggest how things might be done better in the future, your experience would be particularly helpful.

I very much regret the short notice of my invitation but your suggestion of a meeting w/c February 15th will not work for us. If this coming Tuesday (26th) still proves impossible, the very latest we could have the meeting will be Tuesday 2nd February, at the same time (or any other time between those dates). Perhaps you could let me know if this may yet be possible?

With kind regards

Mike

Professor MCG Stevens
Emeritus Professor of Paediatric Oncology,
University of Bristol
Tel. [redacted]

From: "Peters, Christine" [redacted]
Date: Friday, 22 January 2021 at 13:55
To: "STEVENS, Mike (UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST)" [redacted], "Inkster, Teresa" [redacted]
Cc: Marie Brown [redacted], "Philip.Raines" [redacted], "WILCOX, Mark (LEEDS TEACHING HOSPITALS NHS TRUST)" [redacted], "EVANS, Gaynor (NHS ENGLAND & NHS IMPROVEMENT - T1520)" [redacted]
Subject: RE: Introductions

Dear Professor Stevens,

Thank you for your email, I must admit that I have been surprised that we have not been contacted by the panel since I sent over 100 CHIs for review and suggestions on the information that could be looked at over a year ago.

As this is such an important topic, the fact that we have not had input for such a long time, our key roles in the cases both giving clinical microbiology advice and infection control as well as whistle blowing on the problems encountered at the QEUH and RHC, I think that Tuesday is too short notice to meet with the panel.

It would be helpful to have an indication of the kind of information you already have accessed as well as particular questions you may still have as we have not been privy to any of the discussions to date. We would need a couple of

weeks to refresh our memories on these cases and the associated complex of issues. Please could you clarify which cases are being looked at ?

With some annual leave upcoming , the earliest we can make it would be the week of the 15th February. I also suggest that you consider speaking to my colleagues who were ICDS in 2017 as well.

I hope that this is helpful for the panel.

Kind regards,

Christine Peters

Clinical Lead Clinical Microbiology

[redacted]

From: STEVENS, Mike (UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST) [redacted]
Sent: 22 January 2021 12:04
To: Peters, Christine [redacted]; Inkster, Teresa [redacted]
Cc: Marie Brown [redacted]; Philip.Raines [redacted]; WILCOX, Mark (LEEDS TEACHING HOSPITALS NHS TRUST) [redacted]; EVANS, Gaynor (NHS ENGLAND & NHS IMPROVEMENT - T1520) [redacted]
Subject: [ExternaltoGGC]Re: Introductions

Christine, Theresa

I realise this is late in the day but we have been focusing on getting our case reviews done. Now that we have formulated some views and are starting to write our report, I thought it would be helpful to meet with you and hear your perspectives of what happened in response to the infection challenges at RHC.

The ideal time for us to get together would be on Tuesday morning between 08:30 and 10:30 when we have our weekly Panel meeting. If there is any chance you could give us some time then, that would be fantastic. Failing that, perhaps you could suggest an alternative day / time next week. I think, if you are happy, it would be best to speak with you together.

I also copying in Marie Brown who is the Programme Manager for our review, and Mark Wilcox and Gaynor Evans who are my fellow panel members.

Look forward to hearing from you

Mike

Professor MCG Stevens

Emeritus Professor of Paediatric Oncology,
University of Bristol
Tel. [redacted]

From: "Philip.Raines[redacted]"
Date: Friday, 22 January 2021 at 11:53
To: "Christine.Peters[redacted]"
"Teresa.Inkster[redacted]"
Cc: "STEVENS, Mike (UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST)"
[redacted], "Marie.Brown[redacted]"
Subject: Introductions

Christine, Teresa

With apologies I didn't pick this up in my email yesterday, as it happens, Professor Mike Stevens – head of the Case Note Review's Expert Panel – had already spoken to me about speaking to yourselves. Rather than be an intermediary, I have copied Mike into this email, so you can make direct contact. He agrees that there would be value in liaising on the Case Note Review's work.

With regards
Phil

Inkster, Teresa

From: Angela Wallace (NHS Forth Valley)
Sent: 26 March 2021 11:15
To: Inkster, Teresa; Jenny Copeland; Peters, Christine
Cc: Hunter, Terri
Subject: Re: Discovery Closure Documents

Good morning,

apologies for the delay in responding. Thank you for spending time on the 2nd of march to review the issue and resolution log. This action was agreed by us following the helpful meeting and discussion with Tom Steele, on Friday the 15th of January 2021.

I can see from Jenny's email that you have had discussions in relation to suggested ways in which we move this forward and how this is best developed and agreed given the need for particular expertise and knowledge.

I made a commitment post your review meeting to work together to develop an approach that would set out a possible way forward. This will allow me to engage with key colleagues who would be critical in progressing things. We also positively discussed and agreed with Tom from the environmental activity and improvements how we connect and use the expertise we have to support the wider patient safety and IPC Community across GGC and beyond.

Teresa thank you for raising the challenge that these areas would not be forgotten and although I appreciated Jenny is retiring as stated above, I am committed to progressing an agreed way forward.

Kindest regards

Angela

From: Inkster, Teresa [redacted]
Sent: 24 March 2021 16:39
To: Jenny Copeland [redacted]; Peters, Christine [redacted]
Cc: Hunter, Terri [redacted]; Angela Wallace (NHS Forth Valley) [redacted]
Subject: Re: Discovery Closure Documents

Hi Jenny,

Whilst I appreciate you are retiring I am surprised and shocked to read this email , in the week that the OB and CNR independent experts have highlighted significant failings and concluded children died and others developed infections as a result of environmental risk.

Whether these issues are historic or not is irrelevant, the question is does risk remain and how will it be mitigated? We have an action plan post the 2017 whistleblow by colleagues that is not yet complete 3.5 years later! The fact that issues from 2015 have been identified and referenced within the OB report as having effect on the environment demonstrates a need to ensure all issues raised historically have been dealt with.

Angela - are there plans to take this forward given that Jenny is retiring or will it simply be forgotten about now that the reports have been issued? We must ensure the events of the last few years are not repeated , not least of all for the patients and families who have suffered so much.

Kind regards
Teresa

From: Jenny Copeland [redacted]
Sent: 24 March 2021 13:30
To: Peters, Christine [redacted]; Inkster, Teresa [redacted]
Cc: Hunter, Terri [redacted]; Angela Wallace (NHS Forth Valley) [redacted]
Subject: Fw: Discovery Closure Documents

Hi Christine and Teresa

Please find attached the most recent Issue and Resolution log which we, together with Terri, reviewed on the 2nd of March 2021.

After our email exchanges and suggestions to remap them against other documents, I need to conclude that due to the historic nature of some of the issues and confusion relating to others, this activity is onerous, and I do not have the capacity or technical expertise to do any more to it.

I am saddened that we find ourselves in this situation however with my imminent retirement I can only reassure you that every effort was made to seek clarity and resolution.

I wish you both well for the future and thank you for your time and input throughout the process.

Kindest regards

Jenny

Jenny Copeland
Principal Lead CNO SEND
Leadership and Talent
NHS Education for Scotland
T: [redacted]
E: Jenny.copeland [redacted]

Organisational Development, Leadership & Learning

Inkster, Teresa

From: Inkster, Teresa
Sent: 18 May 2021 12:10
To: Angela Wallace (NHS Forth Valley)
Subject: Re: Re ESBL NICU

Confidential

Hi Angela ,

Thanks for getting back to me

I would prefer not to have emails labelled confidential shared with the IPCT team.

I have continued to raise the issues with NICU in my role as a Consultant microbiologist via the agreed reporting structure. I escalate issues with Christine as HOD to take to the Buzz meeting and also with yourself as we had agreed. In addition, I inform the site ICD members of the IPCT who are present at morning handover meetings and the weekly consultant meetings. I also raised the NICU drain concerns at our meeting with Tom Steele in January this year and NICU ventilation in the action plan

If I was to contact any other member of IPCT or a member of the clinical team to discuss IPC concerns that would be outwith the reporting structure. It would be more appropriate for IPCT to request involvement or info from those with local knowledge or previously involved rather than be dependent on us contacting clinical teams/IPCT outwith an IMT process. I do not seek to undermine the IMT chair.

It is reassuring that ARHAI are aware of the increase in Gram negatives in the unit. As we are all aware from 2A/6A and the Case note review, it's not just numbers that are important but the nature and I'm sure the mention of Stenotrophomonas/Enterobacter/ ESBLS in addition to Serratia will be focusing their attention on the most likely source

The triggers you mention were developed by me locally but are not mine as such. They are a result of published work from the Oxford Radcliffe hospital in relation to detection of neonatal outbreaks. There has been a suggestion that they are over sensitive in the past. I would disagree with this as on all occasions they have detected an issue, we have found areas for improvement /sources and implemented control measures. I would suggest these are much more reliable than SPC charts for example which are not ideal for environmental organisms. Deriving baseline data when there have been outbreaks in the unit is problematic as the UCL is set too high. This was also a point made by the recent case note review.

I understand there has been a Serratia bacteraemia on the unit over the weekend and another IMT is planned for today. Rather than have individual microbiologists sending emails to clinicians and IPCTS in an uncontrolled fashion perhaps the paediatric microbiologist for the week should be invited to the IMT.

I remain concerned with regards to the approach with water testing. Following cases of Pseudomonas, Roseomonas and Stenotrophomonas in ward 4B water testing was only undertaken for Roseomonas. Yesterday we had another patient in the ward develop a Stenotrophomonas bacteraemia. I discussed this at the handover meeting and water testing will be requested again.

kr

Teresa

From: Angela Wallace (NHS Forth Valley) [redacted]
Sent: 17 May 2021 15:56
To: Inkster, Teresa [redacted]
Subject: Fw: Re ESBL NICU

Good afternoon Teresa,

Thank you for your email, it is good to hear from you and looking forward to summer. I appreciate you taking the time to share with me the clinical information from covering NICU last week.

From your email you have a confidential heading, and I would be grateful if you could advise me if you are content I share your concerns with NICU colleagues and the IPCT as I explore the areas you have raised?

I am keen to encourage any colleagues to actively be involved in improving patient care and experience and robust conversations and challenge is vital. As we discussed in our meeting with Tom, Christine, Jenny and Terri creating space and ways of working across micro, infection control and the clinical teams continues to be a focus and although I think there is much more to do I am encouraged by the current plans and ideas to progress.

Can I check if you have shared your information and insight with IPCT colleagues or the Directorate clinical teams? I agree Teresa we must of course all be focussed together in reducing harm from infection and be ahead of any possible bacteraemia or sepsis

Thank you for sharing both the literature and the experience you have, and this is essential for keeping everyone safe, and the commitment that has been made to learn from the past to inform care today.

I note in the email trail below the feedback from the buzz call and I know there was a clinical discussion and sharing of opinion, but this meeting does not go into detail of the IPCT approaches and work underway this format is the same for the other buzz members respecting everyone's skills and contributions, therefore am sorry to read that colleague felt IPCT were not interested. This is difficult to read and this is concerning and as stated above the need to work together and find ways of ensuring that contributions are valued, and we have robust, positive and respectful challenge that ensures we make the best possible decisions for patients.

I appreciate you will know this, but we have ensured systematic involvement of ARHAI in our IPC work and approaches including IMT,s Sandra and I have 2 weekly meetings with Lesley Shepherd and the IPCT are working together pan GGC to ensure the balance of lived experience, broadest team involvement to IPC. I have confirmed with the team that during the IMT the burden of GN in the unit was discussed and that IPCT have approached ARHAI to assist them to develop an early warning system for the unit not only based on positive specimens but acuity, occupancy and staffing as some examples of possible indicators. I have also been informed that the unit themselves would like to take a more proactive approach to collecting and analysing their own data an approach which I would also support. The method currently employed to trigger a process in the unit I believe was developed by yourself and I am also aware that the HPS methodology adopted by PICU is also used in a modified way as an additional surveillance mechanism. I hope this is helpful and I know you are passionate about the IPC in GGC going from strength to strength.

It is my intention Teresa to explore all of the areas you have raised, and I will be happy to feedback, also if you wish to be part of this in any way, I would be happy to discuss as would the other members of the team.

I look forward to hearing from you

kind regards

Angela

From: Inkster, Teresa [redacted]
Sent: 13 May 2021 15:50
To: Angela Wallace (NHS Forth Valley) [redacted]
Subject: Fw: Re ESBL NICU

Confidential

Hi Angela

I am covering NICU this week from a clinical perspective and it is a concern, as is the email below. The IMT seems focused on Serratia when in fact there is also a problem with Stenotrophomonas (4 in 4 weeks) , and ESBLs/Gent resistant organisms (some bacteria previously sensitive to gentamicin are now resistant). There are many publications pertaining to ESBL outbreaks in a NICU setting. It would be important to discuss all these organisms at IMT

The situation feels like deja vu. Similar to 6A where microbiologists from other sites chair the IMT and do not fully engage with the local microbiologists or myself as previous ICD. We have detailed knowledge of the local epidemiology and I have managed outbreaks in the unit for the last 3 years. It is a worry that no-one has asked us regarding that experience and what was found. Whilst fresh eyes are a good thing , knowledge of what has taken place historically is also relevant particularly with reference to the drains.

Serratia in this unit dates back to 2015 and an outbreak that resulted in IPCT members having to attend a meeting with SG to discuss SG concerns. I was not involved but my first task as the newly appointed lead ICD in April 2016, was to write a report of the lessons learned (attached). The outbreak was declared late, environmental screening was not undertaken in in a timely fashion and sadly there were baby deaths. So there is a long history of Serratia in this unit with a number of subsequent outbreaks since then.

Currently the colonisation burden is very high and this could therefore result in cases of bacteraemia/sepsis

kr
Teresa

From: Peters, Christine [redacted]
Sent: 11 May 2021 13:32
To: Harvey-Wood, Kathleen [redacted]; [redacted]; Inkster, Teresa [redacted]
Subject: Re ESBL

HI All,
At the buzz meeting today I was told IC are not interested in gent resistance on the unit and it has nothing to do with the other gram negative issues on the unit.

Fw: New steno 4B

Inkster, Teresa [redacted]
Mon 17/05/2021 15:01
To: Peters, Christine [redacted]
For buzz meeting.

From: Inkster, Teresa
Sent: 17 May 2021 14:24
To: Valyraki, Kalliopi [redacted]; Balfour, Alison [redacted]
Cc: Pritchard, Lynn [redacted]
Subject: New steno 4B

Hi, just to let you know that patien[redacted]n 4B has a Stenotrophomonas in a blood culture from [redacted] We also have [redacted] on the unit who we are treating for a Steno/Pseudomonas chest infection .

I understand the recent water testing done on the unit was only for Roseomonas and not for Steno or Pseudomonas .

We discussed the two Steno cases at the 4B MDT and I mentioned that I was referring to IPC

kr
Teresa

4B/C patients

Inkster, Teresa [redacted]
Tue 13/04/2021 10:02
To: Peters, Christine [redacted]

Hi - 4B/C patients with waterborne orgs below for discussion at Buzz

Patient [redacted]
PsA [redacted]
Hospital acquired

Patient [redacted]
Roseomonas mucosa [redacted]
Hospital acquired

[redacted]
Cupriavidus pauculus [redacted]
Links to 4C and clinic P VIC ACH
Water testing results for these locations? haemonc docs trying to chase again at weekend as patient brought in letter from Scottish water re home testing results negative

Thanks
Teresa

RE: water testing query

Peters, Christine [redacted]
Wed 12/05/2021 11:21
To: Inkster, Teresa [redacted]
HI Teresa, Yes I will get clarification today I hope.

Bw

Christine

From: Inkster, Teresa
Sent: 11 May 2021 18:46
To: Peters, Christine [redacted]
Subject: water testing query

Hi Christine

Wonder if you clarify at your meeting tomorrow re water testing. I can see results that state 'no Rosemonas mucosa isolated' . I assume these are for 4B but dont know for sure as they are not decoded. My question is whether we are testing for all Gram negatives or not. There was also Pseudomonas and Steno cases so it would be important to know if water was tested for those also

kr
Teresa

FW:

Inkster, Teresa [redacted]
Wed 30/11/2022 15:23
To: Inkster, Teresa [redacted]

2 attachments (74 KB)
IPC Report - South Adults - 25.06.21.docx; VRE 4B;

From: Inkster, Teresa
Sent: 25 June 2021 16:38
To: Peters, Christine [redacted]
Subject: Fw:

For next Buzz meeting

- still no water results for Steno in 4B , this has been a very long time now , since April

Also no mention of VRE bacteraemias in ward 4B (email attached) , would be useful to get an update on these.

kr
Teresa

From: Lang, Ann [redacted]
Sent: 25 June 2021 16:06
To: MacLeod, Calum [redacted]; Marek, Aleksandra [redacted]; Andrew Smith [redacted]; Angela Wallace (NHS Forth Valley) [redacted]; Arbuckle, William [redacted]; Bagrade, Linda [redacted]; Balfour, Alison [redacted]; Bowskill, Gillian [redacted]; Boyd, Luanne [redacted]; Carson, John [redacted]; Cassidy, Anne Marie [redacted]; Chofle, Awilly [redacted]; Cottom, Laura [redacted]; Crawford, Louise [redacted]; Davis, Peter [redacted]; [redacted]; [redacted]; Devine, Sandra [redacted]; Dhillon, Raje [redacted]; Doherty, Denise [redacted]; Donnelly, Michael [redacted]; Douglas, Kirsty [redacted]; Farmer, Eoghan [redacted]; Fleming, Alistair [redacted]; Glancy, Joan [redacted]; Hamilton, Kate [redacted]; Henderson, Karen [redacted]; Htwe, Su Su

[redacted]; Inkster, Teresa [redacted]; Jamdar, Saranaz [redacted]; GILLIES, Jenna (NHS GREATER GLASGOW & CLYDE) [redacted]; Joannidis, Pamela [redacted]; Jones, Timothy [redacted]; Kerr, Ann [redacted]; Khalsa, Kamaljit [redacted]; Khanna, Nitish [redacted]; Leanord, Alistair [redacted]; Love, Liz [redacted]; MacLeod, Alison [redacted]; Macleod, Mairi [redacted]; Mathieson, David [redacted]; McConnell, Donna [redacted]; McDaid, Kirsty [redacted]; McLintock, Bruce [redacted]; Menzies, Lisa [redacted]; MURPHY, Michael (NHS GREATER GLASGOW & CLYDE) [redacted]; Mills, Gillian [redacted]; Moore, Marie [redacted]; Murphy, Deborah [redacted]; O'neill, Julie Anne [redacted]; Ozegemen, Margaret [redacted]; Padmaja Polubotho [redacted]; Peters, Christine [redacted]; Pritchard, Lynn [redacted]; Robertson, Angela [redacted]; Smyth, Elaine [redacted]; Spalding, Jane [redacted]; GALLACHER, Stuart (NHS GREATER GLASGOW & CLYDE) [redacted]; Valyraki, Kalliopi [redacted]; Weinhardt, Barbara [redacted]; Wilson, Gary [redacted]; Wright, Pauline [redacted]

Subject: IPC Sector Reports - 25/06/2021

Good afternoon

Please find attached the IPC weekly sector reports dated 25th June 2021.

Regards

Ann

Ann Lang
PA/Data Manager to Acting Infection Control Manager
Office Block
Level 2
Queen Elizabeth University Hospital

[redacted] *(internal* [redacted]*)*
email: ann.lang[redacted]

Louise Mackinnon

From: Peters, Christine
Sent: 02 June 2021 13:06
To: CNO[redacted]
Cc: cno
Subject: RE: Meeting on Friday

Dear Amanda,

Thanks for your email.

I think this is a significant change in the purpose of the meeting at short notice. If you recall at the end of our last meeting with Fiona McQueen we agreed to have a follow up within two weeks to assess if the recommendations of the OB report and the CNR would cover the issues that Teresa and I raised as current and as a continuum to our whistleblowing concerns. This was to be supportive in recognition of the difficult circumstances we continue to find ourselves in.

Of note there has been no venue for us to respond to either report either internally or externally in a formal manner which I find incredibly disappointing. We agreed that we would not do written/pubic responses till after our meeting.

I understand that you now have a different view of the way forward and I would like to clearly understand this change in positioning.

To be frank, given that neither Teresa nor I have had any contact with the senior management since October 2019 , no OD work involved working interactions with them, I am emphatically not comfortable with this proposal. I understood Teresa was to be invited to the meeting too but she is not on the invite list and I know she also thinks this would be a very difficult position to be thrust into for her. I think there has been and continues to a lack of understanding of the root causes on the issues within this organisation and I continue to have concerns as expressed numerous times.

I am happy to discuss on a phone call if that is useful to you in order to understand how I can help to move matters forward for mutual benefit, or to do a written submission to yourself/ oversight board/ Cabsec for Health if that would be useful to lay out my current concerns and responses to both the reports.

Kr

Christine

Dr Christine Peters
Clinical Lead
Consultant Microbiologist
QEUH
[redacted]

From: Kathryn.Stewart [redacted] **On Behalf Of** CNO [redacted]
Sent: 02 June 2021 12:50
To: Peters, Christine [redacted]
Cc: cno [redacted]
Subject: [ExternaltoGGC]Meeting on Friday

Dear Dr Peters

We have a meeting taking place on Friday at 1300, for me to explain how we will continue to monitor progress following the publication of the recent reports. I think it would be helpful if there was senior representation from GGC also in attendance, as well as myself and Angela Wallace. This is with the view that as we look to move forward the role of the senior team is vital, therefore I would like to propose Jonathan Best, Chief Operating Officer and Scott Davidson, Deputy Medical Director join us in the meeting. If you can let me know if you are in agreement with this proposal, that would be much appreciated.

I look forward to speaking to you on Friday.

Kind regards

Amanda

Amanda

Professor Amanda Croft | Chief Nursing Officer |
Chief Nursing Officer's Directorate | Scottish Government | 2ER St Andrew's House |
Regent Road | Edinburgh | EH1 3DG | CNO [redacted]

Visiting Professor Robert Gordon University

RE: water results

Macleod, Mairi [redacted]
Tue 21/09/2021 15:07
To: Inkster, Teresa [redacted];Peters, Christine [redacted]
Cc: Leanord, Alistair [redacted]
Dear both,

I approached Alistair following receipt of your emails as think he will be best placed to advise on this. Realise I hadn't looped him into the email thread so doing so now.

Thanks,

Mairi

From: Peters, Chris. ne [redacted]
Sent: 02 September 2021 15:55
To: Inkster, Teresa [redacted]; Macleod, Mairi [redacted]
Subject: RE: water results

Hi Teresa,

It is a matter I have raised repeatedly at SMTs and MMT and consultant meetings and as you know with Angela, AL and CNO.

We never saw WGS results for Enterobacter, steno or serratia all investigations which we were involved in and I consider this to be a serious issue which will no doubt be explored in future scrutiny. Or indeed futerh Mycbacterium and Cupriavadis cases.

Currently my concern, as discussed at SMT, is that the work taken by our department (to which I actually contributed as you did with supplying our previous data work) is available for real time information for Microbiology practitioners. It is now clear that a database that is searchable is some time off and will initially only be for 2021 results onwards.

I too consider it embarrassing to be at meeting where it has to be declared that we have no idea about the results pertaining to our own patient cohort and our hospital epidemiology. I would think it would be a straightforward matter to have access for all micro as we do for eg lists for NICU etc.

I cannot think of any time in 20 years in Microbiology where simple access to laboratory generated data collection has been considered to be a Caldicott issue which has been mooted in this instance. I am perplexed and greatly disappointed in the barriers to what should be a very clear cut situation.

I can confirm that on contacting the chair of the Case Note review – he was clear that the review had fully intended and hoped that the work in getting the data to them would be used in real time to improve the ability of our team to keep on top of the results that pertain to our medical practice.

Kr

[redacted]

Dr Christine Peters
Clinical Lead
Consultant Microbiologist
QEUH
[redacted]

From: Inkster, Teresa
Sent: 02 September 2021 15:44
To: Macleod, Mairi [redacted]; Peters, Chris. ne [redacted]
Subject: water results

Hi both, I have been at a meeting this afternoon which reminded me about the discussions at SMT regarding the water database or data sheets submitted to independent case note review. I was asked what the results of the Cupriavidus sequencing showed and there was surprise that I was not aware of the findings as chair of the IMT. Can I ask what is the process for gaining access to both the water results submitted to the independent review and the WGS results? To whom do I need to ask permission? As Chair of the IMT I requested the sampling so it does seem preposterous that I don't have access to the results.

kr
Teresa
[redacted]

Inkster, Teresa

From: Peters, Christine
Sent: 09 November 2021 10:24
To: Inkster, Teresa
Subject: RE: 4B rooms/ air sampling results

Thanks Teresa I share your concerns and will raise at the Buzz meeting .

Kr
Christine

From: Inkster, Teresa
Sent: 09 November 2021 09:03
To: Peters, Christine [redacted]
Subject: Fw: 4B rooms/ air sampling results

Hi , please see email thread below. Can the situation in 4b be raised at the Buzz meeting. The unit require advice as they have admissions to accommodate and rooms are either out of use due to a leak or are being used for low risk patients due to air sampling results.

The particle count at the end of August in room 91 was 68352 , thats 60 x the limit and Aspergillus and Cladosporium grew on the plates. I have a sense of deja vu. Rather than deal with the abnormal result the immediate response appears to be to question the existing policy/procedure (I have a series of messages regarding the limit of 1000 particles). Furthermore whilst there is a role for quality management (they collect data for JACIE on air quality) there is an immediate need for investigation and risk assessment by an ICD.

It would be useful to have an update on the water leak, that room has been closed now for over a week .

Lisa Halliday told me repeat air sampling had been undertaken, but I have not been copied in despite requesting to be , in the same way BJ was
Thanks

kr
Teresa

From: Inkster, Teresa [redacted]
Sent: 09 November 2021 08:43
To: Bal, Abhijit [redacted]
Subject: Re: 4B rooms/ air sampling results

Hi Abs,

Agree IC advice should come from the ICD which is why I have communicated this issue on to you and declined to give them advice (despite my ten years of experience of interpreting the results for this unit, which I expect is why Lisa asked me) . Air sampling results and water ingress on a BMT unit are highly relevant to the microbiologist covering the unit. Brian Jones was copied into all results and comms with regards to these issues and I would expect the same and have indeed requested this.

When I was ICD there was a policy in place for monthly sampling , rooms were sampled on rotation and for quality management purposes relevant staff were copied in. Risk assessment and investigation was undertaken in real time by the ICD. Perhaps this process needs reinstated.

kr
Teresa

From: Bal, Abhijit [redacted]
Sent: 08 November 2021 16:18
To: Inkster, Teresa [redacted]
Subject: Re: 4B rooms/ air sampling results

Hi Teresa,

This is something we need to streamline. I have discussed the need to scrutinise these reports with ward 4B as part of their quality report. We also need a fixed schedule for a set of rooms to be screened at particular intervals. These meetings should commence sometime this month or next month. I had also had emails with Jim Gray (Birmingham) about their protocol.

A more general issue is the communication between 4B (and any other unit), microbiology, and infection control. One of the things which I feel needs clarified here is who amongst us is responsible for what. I feel IC advice should come from ICD and microbiology advice from the microbiologist so that there is clarity of roles. As an ICD, I would be entirely happy to share any information which affects decision making in clinical microbiology just as we in IC get relevant inputs from microbiologists. As I realise, in a big department with several stakeholders, this is not always obvious or possible!

Why not we both have a chat about this some time?

Cheers,

Abs

From: Inkster, Teresa [redacted]
Sent: 08 November 2021 15:37
To: Bal, Abhijit [redacted]
Cc: Halliday, Lisa [redacted]; Clark, Andrew [redacted]; Pritchard, Lynn [redacted]
Subject: 4B rooms/ air sampling results

Hi Abs

I was on the phone to the BMT unit earlier and it was mentioned that there are two rooms (78 and 91) being used for low risk patients due to elevated particle counts . The last air sampling results I have are from the end of August where particle counts in room 91 were > 60000 with Aspergillus and Cladosporium on the plates .

Is it possible to give an update as to where things are with the further investigation of these rooms, the results of repeat air sampling (I have not been copied into any) and whether they can be safely used for transplant patients other than Melphalan autografts

Thanks

kr
Teresa

Inkster, Teresa

From: Peters, Christine
Sent: 11 November 2021 09:45
To: Inkster, Teresa
Subject: FW: Ward 4B particle count

From: Peters, Christine
Sent: 11 November 2021 09:44
To: angela.wallace[redacted]
Subject: RE: Ward 4B particle count

Good morning Angela,

I would like to highlight that this trail is not indicative of a system that is functioning despite us raising the need for a proper system time and again. I also note Sandra Devine was copied in at the beginning and yet yesterday when I asked about it she and Linda said they did not know about the rooms on 4B- it was the first they heard about it. Disappointed is an understatement of how I feel today - my trust in current IPCT arrangements with regard to environmental issues is at an all time low.

Kr

Christine

Dr Christine Peters
Clinical Lead
Consultant Microbiologist
QEUH
[redacted]

From: Inkster, Teresa
Sent: 11 November 2021 09:23
To: Bagrade, Linda[redacted]; Macleod, Mairi[redacted]; Peters, Christine[redacted]
Cc: Joannidis, Pamela[redacted]; Angela Wallace (NHS Forth Valley)
[redacted]
Subject: Fw: Ward 4B particle count

Morning, see email trail below. Can someone from IPC please get in touch with the team in 4B with regards the air sampling results.

There is discussion in this email thread about a new policy and a QM process - what they really need right now is a decision to be made as to whether they can admit transplant patients safely or not .

Sorry for email to all but awaiting clarity as to the escalation process for IPC issues following the Buzz meeting

kr
Teresa

From: Clark, Andrew [redacted]
Sent: 10 November 2021 22:32
To: Halliday, Lisa [redacted]; McQuaker, Grant [redacted]; Parker, Anne [redacted]; Inkster, Teresa [redacted]
Cc: Slowey, Bernadette [redacted]
Subject: RE: Ward 4B particle count

Well.... they are a bit lower. Ithnk they are OK but....
We need someone to be interpreting these or at least giving us some guidelines
Is this done routinely and I've just missed it or do I need to speak to micro

From: Halliday, Lisa
Sent: 10 November 2021 17:32
To: Clark, Andrew [redacted]
Cc: Slowey, Bernadette [redacted]
Subject: FW: Ward 4B particle count

Hi Andy,

Can you have a look at the particle counts below.
Rooms 79 and 91 are still currently being used for low risk patients and I just wanted to check if you are happy for them to be reopened for use to any patients.

Thanks

Lisa Halliday
SCN Ward 4B
BMTU
QEUH
Regional Services
[redacted]

From: Bal, Abhijit
Sent: 10 November 2021 16:29
To: Halliday, Lisa [redacted]
Subject: Re: Ward 4B particle count

Hi Lisa,

I have made this table for quick understanding. See attached, I am not sure if room 79 (but 91 was) has been rechecked ever.

We should all rooms with fungi sampled again.

Regards,

Abs

--

Abhijit M Bal
MBBS, MD, DNB, MNAMS, FRCP, FRCPath, FISAC, Dip Med Mycol
Consultant Microbiologist
Queen Elizabeth University Hospital, Glasgow
Honorary Clinical Associate Professor, University of Glasgow

From: Halliday, Lisa [redacted]
Sent: 10 November 2021 12:13
To: Bal, Abhijit [redacted]
Subject: RE: Ward 4B particle count

Hi Abs,

Can I double check if we are able to open rooms 79 and 91 to full high risk transplants as we discussed last week.

Kind Regards

Lisa Halliday
SCN Ward 4B
BMTU
QEUH
Regional Services
[redacted]

From: Bal, Abhijit
Sent: 09 November 2021 09:25
To: Halliday, Lisa [redacted]
Subject: Re: Ward 4B particle count

Hi Lisa, what was the name of the contact person for your quality meetings? Just so I can write to them for taking the policy on particle counts and fungal counts forward.

Thanks,

Abs

--

Abhijit M Bal
MBBS, MD, DNB, MNAMS, FRCP, FRCPath, FISAC, Dip Med Mycol
Consultant Microbiologist
Queen Elizabeth University Hospital, Glasgow
Honorary Clinical Associate Professor, University of Glasgow

From: Halliday, Lisa [redacted]
Sent: 19 October 2021 14:57
To: Bal, Abhijit [redacted]
Subject: RE: Ward 4B particle count

Lovely to meet you today.
I have forwarded to my team for discussion.

Many Thanks
Lisa

From: Bal, Abhijit
Sent: 19 October 2021 14:55
To: Halliday, Lisa [redacted]; Pritchard, Lynn [redacted]; Edwardson, Alison [redacted]
Cc: Devine, Sandra [redacted]
Subject: Ward 4B particle count

Hi Lisa,

Thanks for seeing me on 4B to discuss the air sampling related issues. As discussed, it would be worth having a regular monthly (or may be once in 6 weeks) meeting in order to have an oversight of the particle count and fungal count for the unit. We can then look at the process we follow and any intervention that may be needed. I have spoken to Lynn from infection control who is in agreement.

You might want to add people from your unit including medical staff.

Thanks,

Abs

Abhijit M Bal
MBBS, MD, DNB, MNAMS, FRCP, FRCPath, FISAC, Dip Med Mycol
Consultant Microbiologist
Queen Elizabeth University Hospital, Glasgow
Honorary Clinical Associate Professor, University of Glasgow

Inkster, Teresa

From: Inkster, Teresa
Sent: 11 November 2021 12:23
To: Inkster, Teresa
Subject: Fw: Ward 4B particle count

From: Inkster, Teresa [redacted]
Sent: 11 November 2021 09:30
To: Clark, Andrew [redacted]; Halliday, Lisa [redacted]; McQuaker, Grant [redacted]; Parker, Anne [redacted]
Cc: Slowey, Bernadette [redacted]
Subject: Re: Ward 4B particle count

Hi Andy,

I didn't get the attachment with the results but an ICD would usually interpret these and provide advice. We used to accept particle counts of < 1000 but I note reference to a new policy so that may have changed.

I have emailed IPC this morning again to ask that someone contacts Lisa and makes a decision re these rooms. If you don't hear from anyone I would suggest emailing Linda Bagrade who is the lead ICD

kr
Teresa

From: Clark, Andrew [redacted]
Sent: 10 November 2021 22:32
To: Halliday, Lisa [redacted]; McQuaker, Grant [redacted]; Parker, Anne [redacted]; Inkster, Teresa [redacted]
Cc: Slowey, Bernadette [redacted]
Subject: RE: Ward 4B particle count

Well.... they are a bit lower. Ithnk they are OK but....
We need someone to be interpreting these or at least giving us some guidelines
Is this done routinely and I've just missed it or do I need to speak to micro

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Lisa Halliday
SCN Ward 4B
BMTU
QEUH
Regional Services
[redacted]

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We should all rooms with fungi sampled again.

Regards,

Abs

--

Abhijit M Bal
MBBS, MD, DNB, MNAMS, FRCP, FRCPath, FISAC, Dip Med Mycol
Consultant Microbiologist
Queen Elizabeth University Hospital, Glasgow
Honorary Clinical Associate Professor, University of Glasgow

From: Halliday, Lisa [redacted]
Sent: 10 November 2021 12:13
To: Bal, Abhijit [redacted]
Subject: RE: Ward 4B particle count

Hi Abs,

Can I double check if we are able to open rooms 79 and 91 to full high risk transplants as we discussed last week.

Kind Regards

Lisa Halliday
SCN Ward 4B
BMTU
QEUH
Regional Services
[redacted]

Inkster, Teresa

From: Peters, Christine
Sent: 11 November 2021 13:18
To: Bagrade, Linda; Inkster, Teresa; Macleod, Mairi
Cc: Joannidis, Pamela; Angela Wallace (NHS Forth Valley); Bal, Abhijit
Subject: RE: Ward 4B particle count

Any implication was that Teresa was misrepresenting her role is unwarranted. She is not and any inference otherwise is unfair.

Kr

Christine

From: Bagrade, Linda
Sent: 11 November 2021 13:11
To: Inkster, Teresa [redacted]; Macleod, Mairi [redacted]; Peters, Christine [redacted]
Cc: Joannidis, Pamela [redacted]; Angela Wallace (NHS Forth Valley) [redacted]; Bal, Abhijit [redacted]
Subject: RE: Ward 4B particle count

Teresa,

As Abhijit has already stated in his email – he is discussing this with Lisa and Andrew.

As to the roles and responsibilities – I am referring to the fact that the email asking for interpretation of the results is sent to you without Abhijit being included. That's all.

Linda

From: Inkster, Teresa
Sent: 11 November 2021 12:36
To: Bagrade, Linda [redacted]; Macleod, Mairi [redacted]; Peters, Christine [redacted]
Cc: Joannidis, Pamela [redacted]; Angela Wallace (NHS Forth Valley) [redacted]; Bal, Abhijit [redacted]
Subject: Re: Ward 4B particle count

Sorry Linda, I am not sure what you are getting at with regards to roles and responsibilities. The clinical team are fully aware that I am not an ICD and that this is not within my remit. I stated that on the phone to them on Monday and again in an email to Andy this morning. I am however the designated microbiologist for BMT and therefore require information with regards to the environmental conditions on 4B. I would appreciate if I could be afforded the same respect that Brian Jones was with regards to this and copied into results and comms as previously requested.

Once again can we bring this back to the fundamental issue here which is the safety of this unit for admission of BMT patients? With regards to the ongoing issues you may not be aware but the abnormal results date from the end of August . Repeat air sampling is not a control measure, neither is a new policy or setting up a QM meeting. It is not clear as to whether any investigations into elevated particle counts/fungal growth and subsequent remedial measures have taken place.

I cannot comment on exclusion of IPCT from the email thread between Lisa and the clinicians. However ,I do feel it is entirely reasonable for a SCN to escalate this issue to clinicians when faced with decisions regarding admissions and no clear advice with respect to suitability of these rooms.

kr
Teresa

From: Bagrade, Linda [redacted]
Sent: 11 November 2021 10:59
To: Inkster, Teresa [redacted]; Macleod, Mairi [redacted]; Peters, Christine [redacted]
Cc: Joannidis, Pamela [redacted]; Angela Wallace (NHS Forth Valley) [redacted]; Bal, Abhijit [redacted]
Subject: RE: Ward 4B particle count

Hi Teresa,

Reading the e-mails below it is quite clear that Abhijit and Lisa have been discussing this and there is a plan in place to gather more information before the decision can be made. I cannot understand what exactly has changed in 1 day?

I am very surprised to see that IPCT has been excluded from this discussion in the middle of this e-mail thread.

I also do respect you position to exclude yourself from any involvement in IPC regarding ward 4B (and I assume in general) and I would really appreciate if you could make your position known to the clinical teams please so we can avoid misunderstandings about roles and responsibilities in future and all the questions related to IPC can go to the appropriate team directly.

Happy to discuss this further. I have also copied Abhijit in this response for information.

Kind regards,

Linda

From: Inkster, Teresa
Sent: 11 November 2021 09:23
To: Bagrade, Linda [redacted]; Macleod, Mairi [redacted]; Peters, Christine [redacted]
Cc: Joannidis, Pamela [redacted]; Angela Wallace (NHS Forth Valley) [redacted]
Subject: Fw: Ward 4B particle count

Morning, see email trail below. Can someone from IPC please get in touch with the team in 4B with regards the air sampling results.

There is discussion in this email thread about a new policy and a QM process - what they really need right now is a decision to be made as to whether they can admit transplant patients safely or not .

Sorry for email to all but awaiting clarity as to the escalation process for IPC issues following the Buzz meeting

kr
Teresa

From: Clark, Andrew [redacted]
Sent: 10 November 2021 22:32
To: Halliday, Lisa [redacted]; McQuaker, Grant [redacted]; Parker, Anne [redacted]; Inkster, Teresa [redacted]
Cc: Slowey, Bernadette [redacted]
Subject: RE: Ward 4B particle count

Well.... they are a bit lower. Ithnk they are OK but....
We need someone to be interpreting these or at least giving us some guidelines
Is this done routinely and I've just missed it or do I need to speak to micro

From: Halliday, Lisa
Sent: 10 November 2021 17:32
To: Clark, Andrew [redacted]
Cc: Slowey, Bernadette [redacted]
Subject: FW: Ward 4B particle count

Hi Andy,

Can you have a look at the particle counts below.
Rooms 79 and 91 are still currently being used for low risk patients and I just wanted to check if you are happy for them to be reopened for use to any patients.

Thanks

Lisa Halliday
SCN Ward 4B
BMTU
QEUH
Regional Services
[redacted]

From: Bal, Abhijit
Sent: 10 November 2021 16:29
To: Halliday, Lisa [redacted]
Subject: Re: Ward 4B particle count

Hi Lisa,

I have made this table for quick understanding. See attached, I am not sure if room 79 (but 91 was) has been rechecked ever.

We should all rooms with fungi sampled again.

Regards,

Abs

--

Abhijit M Bal
MBBS, MD, DNB, MNAMS, FRCP, FRCPath, FISAC, Dip Med Mycol
Consultant Microbiologist
Queen Elizabeth University Hospital, Glasgow
Honorary Clinical Associate Professor, University of Glasgow

From: Halliday, Lisa [redacted]
Sent: 10 November 2021 12:13
To: Bal, Abhijit [redacted]
Subject: RE: Ward 4B particle count

Hi Abs,

Can I double check if we are able to open rooms 79 and 91 to full high risk transplants as we discussed last week.

Kind Regards

Lisa Halliday
SCN Ward 4B
BMTU
QEUH
Regional Services
[redacted]

From: Bal, Abhijit
Sent: 09 November 2021 09:25
To: Halliday, Lisa [redacted]
Subject: Re: Ward 4B particle count

Hi Lisa, what was the name of the contact person for your quality meetings? Just so I can write to them for taking the policy on particle counts and fungal counts forward.

Thanks,

Abs

--

Abhijit M Bal
MBBS, MD, DNB, MNAMS, FRCP, FRCPath, FISAC, Dip Med Mycol
Consultant Microbiologist
Queen Elizabeth University Hospital, Glasgow
Honorary Clinical Associate Professor, University of Glasgow

From: Halliday, Lisa [redacted]
Sent: 19 October 2021 14:57
To: Bal, Abhijit [redacted]
Subject: RE: Ward 4B particle count

Lovely to meet you today.
I have forwarded to my team for discussion.

Many Thanks
Lisa

From: Bal, Abhijit
Sent: 19 October 2021 14:55
To: Halliday, Lisa [redacted]; Pritchard, Lynn [redacted]; Edwardson, Alison [redacted]
Cc: Devine, Sandra [redacted]
Subject: Ward 4B particle count

Hi Lisa,

Thanks for seeing me on 4B to discuss the air sampling related issues. As discussed, it would be worth having a regular monthly (or may be once in 6 weeks) meeting in order to have an oversight of the particle count and fungal count for the unit. We can then look at the process we follow and any intervention that may be needed. I have spoken to Lynn from infection control who is in agreement.

You might want to add people from your unit including medical staff.

Thanks,

Abs

Abhijit M Bal
MBBS, MD, DNB, MNAMS, FRCP, FRCPath, FISAC, Dip Med Mycol
Consultant Microbiologist
Queen Elizabeth University Hospital, Glasgow
Honorary Clinical Associate Professor, University of Glasgow

Louise Mackinnon

From: Peters, Christine
Sent: 16 November 2021 18:32
To: Angela Wallace (NHS Forth Valley)
Subject: RE: Meeting

Tracking:	**Recipient**	**Delivery**
	Angela Wallace (NHS Forth Valley)	Delivered: 16/11/2021 18:32

Thanks Angela,

At the meeting I raised three situations which present real and live patient safety risks, of environmental nature and relevant to findings of the CNR and the ongoing PI. The response was not as I would expect from such a high level group. Thank you for taking those issues forward as stated in your email.

I am sure there will be varying interpretations of the meeting, as mentioned I do not feel the meeting has been a safe place for me since its inception and I am in a very vulnerable position when attending. I will not be re attending and I have raised my concerns clearly and in writing primarily relating to how infection risks are managed.

Kr

Christine

Dr Christine Peters
Clinical Lead
Consultant Microbiologist
QEUH
[redacted]

From: Angela Wallace (NHS Forth Valley)
Sent: 16 November 2021 17:02
To: Peters, Christine [redacted]
Subject: Re: Meeting

Dear Christine,

Thanks for your email and for responding to my text.

I was checking in to see how you were, as you explained you had to leave the meeting and I was concerned about you and wanted to make sure that you were ok, hence my text. I also explained in the txt message that I have picked up the areas that you have raised with colleagues, but unfortunately as you left the meeting you didn't have the opportunity to hear the outcomes. However, I will respond to them in turn.

It was discussed how we would feedback to you and other colleagues in the meeting. I was also pleased to hear that there was a meeting lead by Mairi including IPC Team colleagues to support further ways of

improving communications and collaboration between micro and the ICT . As you are aware this is an ongoing area of Organisational Development and work continues across the silver and gold strands.

I am sorry to read of your experience in the meeting last Tuesday. As you know, this is meeting is intended to create an informal space for colleagues to come together to support all aspects of clinical care and practice in relation to IPC and to enable open discussions about any emerging issues.

A number of colleagues have spoken to me, and it is important that I hear other colleagues feedback. The feedback raised concerns about the tone of some of the discussion in the meeting. To support all colleagues, it is vital that I gather and respond to all colleague's feedback, and I appreciate you sharing yours with me.

I have spent time with my IPC colleagues and others last week, and as outlined in the beginning of my email I will ensure that all areas you have raised will be considered and responded to.

Again, just wanted to check in with you and thank you for your email.

kindest regards

Angela

From: Peters, Christine [redacted]
Sent: 11 November 2021 09:39
To: Angela Wallace (NHS Forth Valley) [redacted]
Subject: FW: Meeting

Apologies as this was sent to wrong email initially,

Kr

Christine

From: Peters, Christine
Sent: 09 November 2021 17:08
To: Angela Wallace (NHS Forth Valley) [redacted]
Subject: Meeting

Dear Angela,

Thank you for your text. I do not think it would be helpful to have a chat. As you know there have been many chats and many outstanding issues that were never closed off with regards to the concerns and learning Teresa and I raised over the extended and long duration of the OD work stream.

With regard to today's meeting I would like to highlight a number of factual issues:

1. Re 6A

Last week there was a very clear instruction from yourself that there should be a "hot debrief" . I relayed this to my team member [redacted], however instead there was a series of emails between him and the IPCT which generated further concerns :

- firstly that the HIATT which he wanted to complete on the Sunday night (but was advised not to by the IPCT members)– was filled in and he was asked to agree to. He did not agree to the text or the rating and it is still

unclear if his views have been taken account of in the final communications with ARHAI. Further Prof Gibson expressed her disagreement with the rating which in the context of 6A is extremely significant .

- communications to parents have been a really important aspect of the PI testimonies and the fact that the chair of the IMT has not seen the comms on this occasion is a matter of concern – especially as [redacted] asked in writing for this, and as his name is the only one mentioned in the HIATT summary.

At the meeting I was advised that there was no need for a hot debrief as it is no longer timely (please recall it was not me who asked for one) and that an incident form would be completed. I asked that [redacted] be involved in this. The response from Linda was to challenge the results of the environmental sampling. She said they were of "no clinical significance" . That is not the view of the Paeds Microbiology team .

But it is worth noting (and I did not raise this at todays meeting) that I had an urgent email on Monday morning from [redacted] asking me to attend his office as Linda was there and she was repeatedly telling him he should not have taken samples and they should be discarded. While there is clearly room for disagreement it is inappropriate to harangue a consultant colleague into changing their mind on actions taken in an acute incident setting.

It is still not clear to me what the plans are regarding the prevention of future leaks as I was repeatedly informed that "they cannot be prevented" by Linda which I do not think is an appropriate attitude to a BMT unit accommodation , nor the final risk assessment of the risk posed at the time of the incident *which certainly raised the risk of an acute fungal exposure – I can send scientific papers should you require them) and nor how the views of [redacted] as ICD on call will be taken into account for the learning.

2. Re 4B

I was accused of not following due and appropriate process in raising Teresa's concerns at the Buzz. I am frankly aghast at this and felt bullied and gaslit at the meeting. I was repeated told by Rob that acute issues should be raised day to day, there was "no business" raising the at this meeting as it is a once weekly meeting – thus insinuating we had been negligent in raising any concerns in a timely manner. He jumped to conclusions without even asking . I find this to be in keeping with the last 2 years of management attitudes towards me. This is very far from the truth. If you need evidence of how many times I and others have raised queries re 4B I can supply you with emails, and minutes of meetings not to mention the fact that the air sampling protocol was on the list of outstanding issues we had written prior to Jenny leaving.

I do NOT accept that it is fair or reasonable to accuse me of inappropriately raising concerns. It is bang out of order and frankly rude to have spoken to me as a clinician regarding the need to speak to the IPCT. The issue all along is not raising the concerns in a timely manner , but the lack of response or action taken in response to those communications. This point of the meeting turned into what I perceived to be bullying into not raising concerns openly. I do not appreciate it and do not accept it as be in in keeping with the GGC values as advertised.

The facts are these:

2 rooms are closed to BMT patients and air sampling in August was 60x the upper limit. There is no evidence, despite asking , of actions of repeat sampling since August. This has significance for us as both OOH ICDs and microbiologist giving day to day advice on complex and vulnerable patients.

1 room had a water leak 10 days go and is also closed.

Neither Aleks nor Abs are in possession of an air sampling policy or protocol . I find this in the face of all the reviews and inquiries to be staggering. Teresa had supplied AL and Aleks with help and information last year on this if you recall our discussions.

The irony of this whole thing is that a vehement "how dare Teresa write to you about these issues " attitude I received today (bare in mind I am her line manager and in fact we were informed this IS the route to raise

issues) , her expertise is being routinely ignored (being told her expert opinion regarding the environmental risks and incidents is not right - again) and yet now we have a request for her to dig out a policy that was meant to have been replaced over a year ago and she sits on ASSURE Scotland and will be working on air sampling policies nationally. I am struck by the ground hog day nature of the situation and it is not in keeping with a learning culture.

3. NICU

I have not received any update since my SBAR written on Sunday night until I had to ask at the meeting today. The response from Linda and Rob shook me to my core. To imply blame at me for a NICU consultant being second on call ("that's a ridiculously expensive on call arrangement") having to come in to "observe a drop of water" before babies can be moved is utterly bizarre. That is not what happened and frankly is derogatory to me and my NICU colleague, as I explained the clinicians assessment was crucial for organising a safe solution to an immediate risk. A thanks would have been more appropriate.

At the meeting I was assured that a roof defect was the cause of the leak and that there was no evidence of water damage from above. The relevant water damage is the above ceiling space area. You may recall I have 20 years of experience of managing leaks in clinical and laboratory settings and it seems reasonable to be asking for follow up information for an incident I managed late on a Sunday night.

I raised the case of aspergillus and was subjected to a explanation re honey. This is not relevant to the situation of a leak of unknown duration into the accommodation for the most vulnerable group of children in the hospital. There is also the ongoing issue of gram negatives on the unit.

In conclusion I would like to summarise my situation :

1. I whistle blew in 2017 on issues that seem to me to remain unresolved
2. My input and that of Teresa into the learning outcomes of the CNR and OB and External review has not been sought.
3. I have consistently been open and engaged in every OD event, every meeting, every effort I have been invited to through in order to make things work.
4. I have previously asked not to attend the Buzz meetings as their aim has not been consistently communicated and its remit shifted. I have previously found them to be oppressive and bullying in nature. However you persuaded me that we should continue with them and again , I complied – in good faith communicating with the meeting members and my team members as a conduit of information.
5. I am not in a position of confidence in the IPCT as things stand
6. I will not be attending the Buzz meeting s again and should this be a requisite of being clinical lead I will be effectively forced to give up that role by this circumstance

I am deeply disappointed that even in the midst of a public inquiry I am subjected to repeatedly having to chase information that is relevant to my clinical practice, and to have to put up with accusations and pressure not to raise concerns at the very venue set up to alleviate the communication issues that were supposed to have been taken seriously.

Kind regards,

Christine

Dr Christine Peters
Clinical Lead
Consultant Microbiologist
QEUH
[redacted]

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Louise Mackinnon

From: Peters, Christine
Sent: 12 November 2021 16:41
To: Bagrade, Linda
Cc: Khanna, Nitish
Subject: RE: IPC Sector Reports - 12/11/21

Tracking:

Recipient	Delivery	Read
Bagrade, Linda	Delivered: 12/11/2021 16:41	
Khanna, Nitish	Delivered: 12/11/2021 16:41	Read: 12/11/2021 16:46

Linda ,

A PA death on a NICU unit is significant incident and I am astonished that it is not on the weekly report, hence the query. And I have not been informed of a significant Legionella incident this week and it is entirely within my remit to ask for updates in the absence of communications.. I assume this has been HIATTd given you have indicated all normal measures have been taken.

Further more the Serratia typing from the PICU (one death) which did not match each other, do in fact match previous isolates and this is not clear on the report.

You may have a different interpretation of this , however I will record here that I consider this to be evidence of an environmental link irrespective of the recent sampling.

Hope you have a good weekend,

Regards,

Christine

Dr Christine Peters
Clinical Lead
Consultant Microbiologist
QEUH
[redacted]

From: Bagrade, Linda
Sent: 12 November 2021 16:34
To: Peters, Christine [redacted]
Cc: Khanna, Nitish [redacted]
Subject: RE: IPC Sector Reports - 12/11/21

Hi,
As always, all the investigations in relation to Pae cases have been done and no issues have been identified. I would have informed you if there was something significant.

L

From: Peters, Christine
Sent: 12 November 2021 16:26
To: Bagrade, Linda [redacted]
Cc: Khanna, Nitish [redacted]
Subject: FW: IPC Sector Reports - 12/11/21

Hi Linda,
I notice the NICU pseudomonas death is not on the report. Has this had a PAG/actions associated with it?

I am handing over paeds issue to Nitish for the weekend

Kr
Christine

From: Lang, Ann
Sent: 12 November 2021 16:09
To: MacLeod, Calum [redacted]; Marek, Aleksandra [redacted]; Andrew Smith [redacted]; Angela Wallace (NHS Forth Valley) [redacted]; Arbuckle, William [redacted]; Bagrade, Linda [redacted]; Balfour, Alison [redacted]; Bowskill, Gillian [redacted]; Boyd, Luanne [redacted]; Carson, John [redacted]; Cassidy, Anne Marie [redacted]; Chofle, Awilly [redacted]; Cottom, Laura [redacted]; Crawford, Louise [redacted]; Davis, Peter [redacted]; [redacted]; Devine, Sandra [redacted]; Dhillon, Raje [redacted]; Doherty, Denise [redacted]; Donnelly, Michael [redacted]; Douglas, Kirsty [redacted]; Farmer, Eoghan [redacted]; Fleming, Alistair [redacted]; Glancy, Joan [redacted]; Hamilton, Kate [redacted]; Henderson, Karen [redacted]; Htwe, Su Su [redacted]; Inkster, Teresa [redacted]; Jamdar, Saranaz [redacted]; GILLIES, Jenna (NHS GREATER GLASGOW & CLYDE) [redacted]; Joannidis, Pamela [redacted]; Jones, Timothy [redacted]; Kerr, Ann [redacted]; Khalsa, Kamaljit [redacted]; Khanna, Nitish [redacted]; Leanord, Alistair [redacted]; Love, Liz [redacted]; MacLeod, Alison [redacted]; Macleod, Mairi [redacted]; Mathieson, David [redacted]; McConnell, Donna [redacted]; McDaid, Kirsty [redacted]; Menzies, Lisa [redacted]; MURPHY, Michael (NHS GREATER GLASGOW & CLYDE) [redacted]; Mills, Gillian [redacted]; Moore, Marie [redacted]; Murphy, Deborah [redacted]; O'neill, Julie Anne [redacted]; Ozegemen, Margaret [redacted]; Padmaja Polubotho [redacted]; Peters, Christine [redacted]; Pritchard, Lynn [redacted]; Robertson, Angela [redacted]; Smyth, Elaine [redacted]; Spalding, Jane [redacted]; GALLACHER, Stuart (NHS GREATER GLASGOW & CLYDE) [redacted]; Valyraki, Kalliopi [redacted]; Weinhardt, Barbara [redacted]; Wilson, Gary [redacted]; Wright, Pauline [redacted]; Gardner, Morag [redacted]; Thomson, Iain [redacted]; Gillespie, Con [redacted]; Loudon, Lorna [redacted]; Friel, Patricia [redacted]; Frame, Evelyn [redacted]; Bal, Abhijit [redacted]; Pybus, Simon [redacted]; Morrison, Jennifer [redacted]; Digby, Amanda [redacted]
Subject: IPC Sector Reports - 12/11/21

Good afternoon

Please find attached the IPC weekly sector reports dated 12th November 2021.

Also attached are a note of the ward closures/updates for the sectors (please note there are no ward closures/updates to report for South Paeds and HSCP).

If there is difficulty getting through to the wards at the weekend the best person to contact is as follows:-

GRI – Clinical co-ordinator/site flow manager
QEUH – Clinical co-ordinator
Clyde – Bed manager for either RAH or IRH (you can pass on message re VOL to either of the bed managers).

Regards

Ann

Ann Lang
PA/Data Manager to Sandra Devine, Acting Infection Control Manager
PA/Data Manager to Pamela Joannidis, Acting Associate Nurse Director IPC
Office Block
Level 2
Queen Elizabeth University Hospital

[redacted] *(internal* [redacted]*)*
email: ann.lang[redacted]

Julie Rothney

From: Peters, Christine
Sent: 17 November 2021 14:23
To: Marek, Aleksandra
Subject: Press Inquiry CONFIDENTIAL
Attachments: RE: Aspergillus fumigatus PCR positive; Re: Aspergillus fumigatus PCR positive; Aspergillus; Re: PF

Tracking:

Recipient	Read
Marek, Aleksandra	Read: 17/11/2021 14:30

Hi ALeks,

Re Press inquiry : [redacted].
I have looked back at information re Aspergillus that may be of use to you in communications re the COVID and Aspergillus :

This patient was on 4B and at the time there was a Paediatric case (see attached emails) ([redacted] died), and there was an adult case on ITU [redacted]/11/20.

I am unsure about actions taken re the Aspergillus cases by IPCT

I cannot get into the patient notepad – not sure if you are still in it ? to check the clinical advice over this time.

Kr

[redacted]

Dr Christine Peters
Clinical Lead
Consultant Microbiologist
QEUH
[redacted]

[redacted]

From: Peters, Christine
Sent: 18 November 2021 17:54
To: Angela Wallace (NHS Forth Valley)
Subject: Press today

Tracking: **Recipient**
Angela Wallace (NHS Forth Valley)

Hi Angela,

I am sure the last 24 hours have been difficult for you and the IPCT regarding the adverse publicity and headlines once again, as I know this is so difficult for the clinical teams as well. I hope you are all ok.

I was involved in the microbiology advice for the patient that is being discussed in the press and recall the case very clearly.

We were treating the patient for presumed Aspergillosis based on clinical findings and galactomannan (antigen) positive tests. This is not a definitive diagnosis, but was the most likely cause of infection at the time of demise and [redacted] was on full treatment with antifungal agents. The negative PCR that came back after death does not rule out the diagnosis.

There are a few issues to bring to your attention as I recall we discussed the case extensively at the time in handovers and Buzz meeting:

1. Re hospital acquired COVID, at 8 days the probability of it being hospital versus community is very high (up to 0.75), being immune compromised the incubation could be quicker and I recall discussing this particular case at the time and given the negative testing and isolation prior to admission HOCI seems highly likely. I do recall there were staff in the unit infected in 2020 but unsure as to the timing or the when policy to screen was put in place. There was discussion re WGS, and I am not sure if that could really be interpreted fully without screening being in place.

2. Re aspergillus I am aware that in Nov 2020 there was a paediatric haemonc case who died of aspergillosis who had also been housed in 4B, and we highlighted fungal infections in the paeds group to the IPCT at the time. I think this may be relevant in any retrospective assessment of the fungal infection risk as well as the fact that [redacted] was not housed in a positive pressure room throughout [redacted] neutropenic stage. Of course this was at the peak of the second wave when beds were very tight, but I assume that one of the reports that claimed he had been housed in a negative pressure room was wrong as that would be against the patient placement policy.

It is so sad to hear of the passing of any person from COVID and its complications and thoughts are with the family and also the teams who work so hard throughout the whole pandemic to treat and save patients' lives.

Kind regards,

Christine

Dr Christine Peters
Clinical Lead
Consultant Microbiologist
QEUH

Greater Glasgow and Clyde NHS Board

JB Russell House
Gartnavel Royal Hospital
1055 Great Western Road
GLASGOW
G12 0XH
Tel. 0141-201-4444
Fax. 0141-201-4601
Textphone: 0141-201-4479
[redacted]

Private and Confidential

Date: 25th November 2021
Our Ref: JB/GD

Dr Penelope Redding

By email: pjredding[redacted]

Enquiries to: John Brown
Direct Line: [redacted]
E-mail: JJBrown[redacted]

Dear Dr Redding

I am writing in response to your recent emails to Mrs Susan Brimelow concerning the flow of information to the Board of NHS Greater Glasgow & Clyde (NHSGGC). As the issues you have raised concern the effectiveness of the governance arrangements at Board level, we decided it was appropriate that I should reply as Board Chair on behalf of the NHS Board.

I have discussed the concerns you raised in both your emails with the Chair and Vice Chair of the Clinical & Care Governance Committee and have to advise you that we do not share those concerns. I should reassure you that before we came to this conclusion, we carefully considered the points you have made and reviewed them with the NHSGGC Chief Executive and the Director of Infection, Prevention & Control. As you know, Professor Angela Wallace was appointed by the Scottish Government to this role and reports to both the NHS Board and the Scottish Government.

Our review focused on the existing arrangements that are under the direction and oversight of Professor Wallace and I can confirm we have complete confidence in the information provided, both to the Board and the Clinical & Care Governance Committee, and that the information systems are effective, proportionate and in accordance with the requirements and standards set by the Scottish Government. We did not look beyond the current system in place for reporting information to the Board as we expect the Scottish Hospitals Inquiry will be considering the previous arrangements as part of their remit.

While we appreciate that your experience of working in NHSGGC prior to your retirement has caused you to be concerned by comments made by patients' families in the media recently, I would advise you that the Board is assured by the information we receive that our hospitals are a safe environment for the care and treatment of our patients.

We believe that the current infection prevention and control arrangements are being operated in an open and transparent manner that manages and mitigates the ever-present risk of infection within the risk appetite set by the Board. We are also assured that the staff in NHSGGC are following the policies and procedures determined by the Scottish Government for the prevention, control and reporting of healthcare acquired infections. The benchmarking of the levels of infection in the NHSGGC hospitals with the information provided by other NHS Boards adds to our confidence that we have good governance in place for this important part of our organisation's work.

We do agree with you it is important that public confidence is restored in the measures in place to mitigate the risk of healthcare acquired infection and it is our expectation that the Scottish Hospitals Inquiry will provide that assurance in relation to our existing arrangements. As a clinician, you know it is not possible to remove the risk of infection but we must do all we can to minimise and reduce that risk as far as possible. That's a difficult message to get across to the public but hopefully, this letter gives you the assurance you were seeking when you contacted Mrs Brimelow.

Yours sincerely

PROFESSOR JOHN BROWN CBE
Chair
NHS Greater Glasgow and Clyde

Louise Mackinnon

From: Peters, Christine
Sent: 03 December 2021 14:32
To: CNO[redacted]; cno; Inkster, Teresa
Subject: RE: Follow up

Tracking:

Recipient	Delivery	Read
CNO[redacted]		
cno	Delivered: 03/12/2021 14:32	
Inkster, Teresa		Read: 03/12/2021 14:34

Thankyou.

Have a lovely weekend

Kr
Christine

From: Douglas.Imrie[redacted] **On Behalf Of** CNO[redacted]
Sent: 03 December 2021 14:20
To: Peters, Christine[redacted]; cno[redacted]; Inkster, Teresa
[redacted]
Subject: [ExternaltoGGC]RE: Follow up

Dear Dr Peters

Thank you for your email. Please accept this as acknowledgement of receipt and thank you for the clarification of the purpose of the request to meet. We are looking into the points you raise and will be back in touch as soon as possible with advice on how best to follow up your request.

Kind regards

Douglas Imrie | Executive Assistant for Deputy Chief Nursing Officer |
Chief Nursing Officer's Directorate | Scottish Government | 2ER St Andrew's House |
Regent Road | Edinburgh | EH1 3DG |[redacted]

From: Peters, Christine[redacted]
Sent: 26 November 2021 16:53
To: Chief Nursing Officer[redacted]; Chief Nursing Officer[redacted]; Inkster, Teresa
[redacted]
Subject: RE: Follow up

Dear Gaye,

Thank you for your email.

To clarify, the meeting we had with Amanda in June was not in relation to the Public Inquiry. I am very clear about the PI process and will be asked to give a witness statement in due course. The outcomes from the Public Inquiry I understand will take years and is unlikely to be the appropriate route for acute problem solving in infection control in the interim.

It is rather the key learning and implementation of critical changes that was the subject of the dialogue we had over the past 2 years with various members of the Oversight Board and CNOs.

Originally Fiona McQueen and Jeanne Freeman had indicated to us that we would be part of the OB to ensure our input would not be side lined as it had been in the run up to the whistle blow, in recognition of the fact that we had correctly been raising concerns about the building and infections, but had not been listened to. This did not in fact occur and we were not involved in any OB committees or meetings. We understood because GGC Board were not happy for us to attend. Therefore we contacted Fiona McQueen and asked to be able to respond to her directly regarding the findings of the OB and CNR reports.

The issues we raised with Amanda were to do with the then current and ongoing actions. We commented on risks that we had assessed as continuing - within the scope of our expertise and experience. These had also been discussed repeatedly with Marion Bain and Angela Wallace, and finally in relation specifically to the Oversight Board and the Case Note Review reports. The final meeting therefore covered a combination of outstanding actions and new observations/concerns.

The action/outcome was simply that CNO would

1. speak to the organisation regarding how our input into IPCT would be embedded going forward
2. Gain answers to specific questions re patient risks
3. Think of a process seeking to alter the situation we found ourselves in within GGC at the time - being disbelieved and expertise being repeatedly ignored – perhaps as a result of being whistle blowers and despite having correctly raising concerns.

That is the follow up we are waiting for.

I hope this clarifies the history for you and I await to hear who is best placed to take this forward and how,

Kind regards and hope you have a pleasant weekend.

Christine

Dr Christine Peters
Clinical Lead
Consultant Microbiologist
QEUH
[redacted]

From: Gaye.Williamson[redacted] **On Behalf Of** CNO[redacted]
Sent: 25 November 2021 13:23
To: Peters, Christine[redacted]; cno[redacted]; Inkster, Teresa
[redacted]
Subject: [ExternaltoGGC]RE: Follow up

Good afternoon Christine

Thank you for your emails, my apologies that a response has not been forthcoming before now.

Professor McMahon is excluded from any correspondence relating to the inquiry due to a potential conflict of interest. The directorate continues to work on the Public Inquiry under the appropriate governance, but I would not be able to arrange a discussion regarding inquiry matters with the interim CNO. I do not have any confirmed detail

of the actions that you had discussed with Professor Croft, are you able to provide these and thereafter it can be determined who may be best placed to respond?

Thanks and regards

Gaye

Gaye Williamson *(she/her)* | Private Secretary to Chief Nursing Officer | Chief Nursing Officers Directorate | Scottish Government | [redacted] | cno[redacted] | Teams |
I am working from home

From: Peters, Christine [redacted]
Sent: 10 November 2021 09:53
To: Chief Nursing Officer [redacted]; Chief Nursing Officer [redacted]; Inkster, Teresa [redacted]
Subject: RE: Follow up

HI Gaye,

I am resending in case this was not received.

It would be helpful to have a formal note from CNO to terminate the communications we were invited to take part in.

Kr

Christine

Dr Christine Peters
Clinical Lead
Consultant Microbiologist
QEUH
[redacted]

From: Peters, Christine
Sent: 28 October 2021 11:52
To: 'CNO[redacted]' [redacted]; cno[redacted]; Inkster, Teresa [redacted]
Subject: RE: Follow up

Dear Gaye,

I am sure you have been incredibly busy over the past few weeks.

In listening to the testimony at the public inquiry yesterday I was reminded of the fact that we have not had a follow up meeting since our meeting with the previous CNO at the start of June when it was suggested that we would be contacted within a couple of weeks to further the conversation of a number of issues that continued despite all the various strands of work that had been put in place and of relevance irrespective of the ongoing Public Inquiry.

There were a number of outstanding issues at that time which we were given to understand would be explored, followed up and we would have a further opportunity to discuss.

It would be very helpful to have a clear communication from yourselves regarding the formal termination of this line of communication following the publication of the Oversight Board Report, the Case Note Review and our communications regarding outstanding issues from whistle blow and issues arising since. That would leave us in no doubt as to next step options.

Kind regards,

Christine

Dr Christine Peters
Clinical Lead
Consultant Microbiologist
QEUH
[redacted]

From: Gaye.Williamson[redacted] **On Behalf Of** CNO[redacted]
Sent: 30 September 2021 16:43
To: Peters, Christine[redacted]; cno[redacted]; Inkster, Teresa
[redacted]
Subject: [ExternaltoGGC]RE: Follow up

Good afternoon Christine

Thank you for your email. I hope you are well.

Firstly, Kathryn has moved on with Scottish Government, I have since replaced in this role - it is lovely to 'meet' you ☺.

Professor Alex McMahon will take up duty on the 4th October as Interim CNO and as you can imagine, the diary is a little full at the moment with first meetings/briefings and introductions.

I have added this to my agenda for the forward look with our diary manager next week, where we can look to give you the relevant detail. Your patience is greatly appreciated.

Thanks and regards

Gaye

Gaye Williamson *(she/her)* | Private Secretary to Chief Nursing Officer | Chief Nursing Officers Directorate | Scottish Government | [redacted] | **cno**[redacted] | Teams |
I am working from home

From: Peters, Christine[redacted]
Sent: 30 September 2021 11:21
To: Chief Nursing Officer[redacted]; Inkster, Teresa[redacted]
Cc: Chief Nursing Officer[redacted]
Subject: RE: Follow up

Hi Kathryn,

I understand that there is a new CNO in post now. It would be helpful, as the Public Inquiry is ongoing with fresh revelations each day , to have an update on all the issues Teresa and I raised with the CNO at our last meeting as promised.

Kr

Christine

Dr Christine Peters
Clinical Lead
Consultant Microbiologist
QEUH
[redacted]

From: Kathryn.Stewart[redacted] **On Behalf Of** CNO[redacted]
Sent: 18 June 2021 15:12
To: Peters, Christine [redacted]; Inkster, Teresa [redacted]
Cc: cno [redacted]
Subject: [ExternaltoGGC]Follow up

Dear Drs Peters and Inkster

Amanda has asked me to email you, just to let you know that she is still following up on the issues you discussed at your last meeting and she will be back in touch in due course.

Best wishes
Kathryn

Kathryn Stewart| Private Secretary to Chief Nursing Officer|Chief Nursing Officer's Directorate
[redacted]

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RE: 2a meeting

Annette Rankin [redacted]
Fri 04/02/2022 16:01
To: Inkster, Teresa [redacted]

Thanks Teresa
I think Mike should have the papers: ill check tho

Totally agree with your points: not sure if we ask for an excel spreadsheet before or just wait until on the day...
And I can suggest the SLWG again: although it was rejected due to time pressures

Keep you posted

Thanks for this

Annette

From: Inkster, Teresa [redacted]
Sent: 04 February 2022 15:44
To: Annette Rankin [redacted]
Subject: Re: 2a meeting

Hi - I haven't had a lot of time to look at these as duty microbiologist today but some comments below. Agree we should see excel sheets and I am still of opinion this needs a SLWG to fully assess with external input. Need to evaluate all control measures

- Concerned that taps were changes 10-12th Jan and rpt sampling complete by 17th Jan. Thats very soon after tap change and new ones fitted ,so I am not surprised the TVCs were better, need to monitor what happens over time to properly evaluate that intervention
- Increased flushing and cleaning to clinical standards implemented in Dec - concerning that normal ward conditions not mimicked before this time , was any flushing or cleaning taking place during construction?
- The **main** bacteria are displayed in slide 11 - some of these are of no or minimal pathogenicity , we need to see if any of the **significant** pathogens are present rather than just the main ones and in what concentrations e.g. Pseudo/Steno/Acineto/Elizabethkingia
- Not sure why using Silver hydrogen peroxide as ineffective during incident and thought Cupriavidus was resistant to it.
- Any data on expansion vessels - have these been changed, they previously had Cupriavidus present, potentially seeding outlets and were of wrong type recommended in guidance
- Curious as to why this ward had higher TVCs during the incident and up until recently. They now comment levels are the same as other wards , I would not be reassured by this given the high risk haemonc population. Not appropriate to benchmark

- Looks like a higher proportion of TVCs in this ward > 100 cfu compared to elsewhere. Any count a risk if immunosuppressed enough but would worry about this. We are still seeing Cupriavidus results of > 100cfu which is a worry given previous bacteraemias.
- Were Marwick taps replaced with same tap
- Still fungi post filtration in basement tanks including some pathogenic - what is hypothesis for that, looks like Aspergillus detected in outlets too which is a concern for this patient group
- What condition are the drains in ? Lots of construction work going on, were they adequately protected? Have they resolved the structural abnormalities , what is their maintenance plan?
-

If I think of anything more before the meeting I will let you know.
Also would recommend asking Mikes view

kr
Teresa

•

From: Teresa Inkster [redacted]
Sent: 04 February 2022 13:49
To: Inkster, Teresa [redacted]
Subject: Fwd: 2a meeting

Get Outlook for Android

From: Annette Rankin [redacted]
Sent: Friday, February 4, 2022 1:47:13 PM
To: Teresa Inkster [redacted]
Subject: 2a meeting

Hiya

Have received papers for Tuesdays meeting. I would have liked to have seen the excel spreadsheets updated since we last saw them in November or do you think these are enough?

Any thoughts

Annette
-----Original Appointment-----
From: Devine, Sandra [redacted]
Sent: 02 February 2022 14:02
To: Devine, Sandra; Bagrade, Linda; Steele, Tom; Clarkson, Kerr; Leanord, Alistair; Ian Storrar; Huddleston, James; Leiper, Jim; 'dkelly[redacted]'; Chaput, Dominique; Michael Weinbren; Annette Rankin; Lang, Ann
Cc: Dennis Kelly; Cox, Gerry
Subject: Review Water Results Ward 2AB, Royal Hospital for Children
When: 08 February 2022 14:00-16:00 (UTC+00:00) Dublin, Edinburgh, Lisbon, London.
Where: Microsoft Teams Meeting

Good afternoon

Please see MS Teams link below for a meeting to review the water results for Ward 2AB, Royal Hospital for Children on Tuesday 8th February at 2.00pm.

Please find attached an agenda and papers for discussion at the meeting.

Fw: wards 2a/b RHC

Michael Weinbren [redacted]
Fri 28/01/2022 17:44
To: Inkster, Teresa [redacted]

Hi Teresa,

not sure if you've had a chance to read the emails below.

Surely the water standard required for these patient groups is that any water reaching the patient should be sterile?

Looking at their water results in isolation to practices, would only seem to be looking at part of the picture. There needs to be a thorough review of all practices relating to water/drainage and the route of transmission blocked.

This focus on water quality alone is concerning. Equally comparing the results between units – the patient's on this unit are highly susceptible. If Cupriavidus is found in other hospitals water systems (we know it is in a small number of cases) it still does not justify accepting it. An analogy perhaps is if before 2012 levels of pseudomonas in water were compared between augmented care, and just because
it was present in other units it should be accepted does not make sense.

A proper working group could have been set up by now and well into progressing with the work. However at least a week has been wasted.

Best wishes,

Mike

Dr M J Weinbren
Consultant Microbiologist
AMR Diagnostic Clinical Lead

Medical Directorate I NHS England and NHS Improvement
Skipton House | 80 London Road | London | SE1 6LH
england.cso[redacted]
www.england.nhs.uk

From: Annette Rankin [redacted]
Sent: 28 January 2022 17:18
To: Ian Storrar [redacted]; Michael Weinbren [redacted]
Cc: Laura Imrie [redacted]; Teresa Inkster [redacted]
Subject: FW: wards 2a/b RHC

Hi all,

I received a response from GGC (below). Not sure why it wasn't copied to all.
Would be helpful to get your thoughts on how we progress and respond particularly as it appears GGC do not wish our support via a SLWG, however the information requested would appear more about benchmarking,

standards for testing once repatriation complete rather than reviewing work undertaken and review of results(in light of the water contamination issue) to ensure a safe environment for repatriation .

There is one comment in particular that I intend to respond to :

We believe that you mentioned in the meeting that the recent review of the data would suggest that this position continues to improve which would suggest that GGC is performing well despite treating the most vulnerable patients in this cohort in Scotland.

I hope you agree that I did not at any stage in the meeting refer to the review of data, say or suggest that GGC was performing well (or otherwise) and therefore I wish this statement removed. As the email has only come to me, it would appear this means they are referring to me making the statement however I also do not recall either Ian or Mike saying this, unless I am mistaken?

Happy to set up a call early next week to discuss?

Annette

From: Steele, Tom [redacted]
Sent: 28 January 2022 11:41
To: Annette Rankin [redacted]
Cc: Devine, Sandra [redacted]
Subject: RE: wards 2a/b RHC

Annette, many thanks for attending and contributing to the meeting with the team in GGC and you subsequent email. We are keen that we are able to demonstrate that we are taking on board your guidance and value the opinions of the subject matter experts in whom we hope to rely on to help us deliver this project for this highly specialist and vulnerable group of patients whilst at the same time managing as far as possible avoidable risk.

In order for us to achieve this , we would ask if you would consider the following questions to allow us to work towards what we would all consider to be a system that is fit for purpose and as safe as practicable. We feel that they are the key questions that we would require your guidance on to complete this project. This will in turn enable us to provide you with assurances that we are compliant with the established guidance. We are happy to share information on the results of recent water testing and other relevant investigations undertaken in order to inform this process but feel that there is now an urgency and that even a SLWG may delay the project significantly with the resultant patient harm.

Can we therefore ask specifically:

1. **What is the standard that needs to be met, in terms of water microbiology?** Please provide details for QEUH as a whole, and specifically for RHC 2A (e.g. percent routine samples with out-of-spec TVCs, presence/absence of specific organisms).
2. **What level of routine water testing would be sufficient?** Please provide details for QEUH as a whole, and for RHC 2A (e.g. frequency, number/location/type of tests, counts versus organism ID).

As you point out in your e mail there are no other paediatric BMT units in Scotland and therefore we have no baseline, so in order for us to benchmark our rates in the general patient population (as a proxy) we would ask that you consider the request for data in question 3; this will allow us to have a baseline which could indicate if the system is comparable to that of other hospitals which would provide some reassurance.

As you also be aware mandatory reporting of many of these types of infections is not in place in NHS England or Scotland so no inference we believe can be taken from the suggestion that there is a clinical indication for wider water testing in our system when compared to others. Indeed, the in the

ARHAI report from October 2019 *"when comparing the overall hospital rate of positive blood cultures since the move to RHC (June 2015 to September 2019) to the combined rate of the other two Scottish children's hospitals (Royal Aberdeen Children's Hospital (NHS Grampian) and Royal Hospital for Sick Children (NHS Lothian)), ...there was no difference in the rates of Gram-negative group (RR=1.18, 95%CI 0.96-1.42, p=0.07) or environmental group (RR=1.42, 95%CI 0.94-2.16, p=0.11)."*

We believe that you mentioned in the meeting that the recent review of the data would suggest that this position continues to improve which would suggest that GGC is performing well despite treating the most vulnerable patients in this cohort in Scotland.

3. How many of the following environmental organisms (list of bacterial and fungal taxa embedded below) have been isolated from sterile sites, e.g. blood cultures, tissue, sterile fluids and CSF separated and reported to ECOSS over the 10 year period 2011-2021?
    - For NHS Scotland in total
    - NHS GGC
    - Other comparable boards

Environmental_bacterial_fungal_taxa.xls»

We are, as you will understand, keen to move this group of patients into this unit in order that we continue to provide this National Service to Scotland, your assistance will allow us to do this.

Kind regards Tom

Tom Steele | Director of Estates and Facilities
| NHS Greater Glasgow and Clyde | JB Russell House | Gartnavel Royal Hospital | 1055 Great Western Road | Glasgow | G12 0XH
t: [redacted] **| e:** [redacted]

From: Annette Rankin [redacted]
Sent: 21 January 2022 11:34
To: Steele, Tom [redacted]; Devine, Sandra [redacted]
Cc: Ian Storrar [redacted]; Michael Weinbren [redacted]; Laura Imrie [redacted]
Subject: RE: wards 2a/b RHC

Tom/Sandra

Following on from our meeting on 17th January I thought it would be helpful to do a summary and to ensure we are all clear on the requests from NHSGGC.

- NHSGGC are in the final refurbishment stages of wards 2a/b and looking towards the repatriation of the children from ward 6A.
- Validation for ventilation is currently being undertaken. No ARHAI/HFS support has been requested for this.
- Water: Further testing is underway in wards 2A/B following further rounds of disinfection/taps changed and some pipework replacement. A robust flushing regime to simulate an operational ward has been in place since December 2021. Results shared with ARHAI/HFS in November 2021 highlighted significant challenges. No further results have been shared since then.
- As a result of the initial water contamination incident (2018) NHSGGC undertook a wider than routine spectrum of testing and NHSGGC are keen to benchmark against other NHS Boards.

- There are currently no other NHS Boards in Scotland that are or have reported gram negative bacteraemias in the same/similar paediatric cohort and therefore no clinical indication for these boards to do wider water testing. There are also no other paediatric BMT units across Scotland. Great Ormond Street was raised as being a comparative unit however whilst it is unclear the level of testing that is undertaken there are no reports of similar levels of gram negative bacteraemias and therefore it is possible that similar to the other boards in NHS Scotland there is no clinical indication to do wider water testing.
- An informative presentation on water testing overview QEUH campus 2015-2020 was delivered which included information on the number of water tests per month across QEUH site 2015-2020, count thresholds, out of spec result and bacterial taxa. A copy of the presentation was requested at the meeting.
- Discussion took place on water temperatures, filters, chlorine dioxide dosing. This included a discussion on the level of organisms present at point of entry. It was agreed that as the entry point to the QEUH water system is filtrated with 0.2 micron filters it is possible the contamination may be occurring within the water system. Further detail on any sampling results undertaken before and after the main filtration system will be provided by NHSGGC.
- Point of use filters were removed during the refurbishment works but will be replaced.
- NHSGGC are keen to understand if the current water system in wards 2a/b is better than "normal, normal" or worse than "normal"

ARHAI/HFS are offering NHSGGC to establish a SLWG facilitated by ARHAI/HFS which includes microbiology, clinical and scientific input to work with NHSGGC and review the work undertaken, results being obtained, risk mitigations in place in an attempt to support NHSGGCs repatriation of children back to wards 2a/b. If this request is accepted by NHSGGC, timescales, terms of reference and membership will be established. Would it be possible to advise us if you wish to work with ARHAI?HFS in this manner by 28th January 2022.

[redacted]

Annette Rankin
Nurse Consultant Infection Control
Clinical lead Infection control built environment and decontamination (ICBED) programme

ARHAI Scotland
NHS National Services Scotland
4th Floor
Meridian Court
5 Cadogan Street
Glasgow
G2 6QE
T: [redacted]
Reception: [redacted]
www.nhsnss.org

From: Steele, Tom [redacted]
Sent: 16 December 2021 10:53
To: Annette Rankin [redacted]; Devine, Sandra [redacted]
Cc: Ian Storrar [redacted]
Subject: Re: wards 2a/b RHC

Annette as you might imagine there's a lot going on at present and having reviewed your queries, most, if not all, have been previously provided to the Oversight Board, or more recently AARG.

The exception to this is around thresholds for levels of GNB within DWS. In this regard we are meeting with Julie and other colleagues within NHS Assure next week to understand other comparative data sources and also explore how we agree threshold levels, not only for NHS GGC, but more widely within NHS Scotland.

In addition, we are seeking information from Scottish Water regarding incoming mains sampling as well as source.

Regards Tom

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From: Annette Rankin [redacted]
Sent: Wednesday, December 15, 2021 10:25:56 AM
To: Devine, Sandra [redacted]; Steele, Tom [redacted]
Cc: Ian Storrar [redacted]
Subject: RE: wards 2a/b RHC

Morning Tom/Sandra

I wonder if you've had an opportunity to consider the questions regarding ward 2a sent last week (below)?

Happy to discuss

[redacted]

Annette Rankin
Nurse Consultant Infection Control
Clinical lead Infection control built environment and decontamination (ICBED) programme

ARHAI Scotland
NHS National Services Scotland
4th Floor
Meridian Court
5 Cadogan Street
Glasgow
G2 6QE
[redacted]
Reception: [redacted]
www.nhsnss.org

ARHAI Scotland
Antimicrobial Resistance and Healthcare Associated Infection

From: Annette Rankin
Sent: 07 December 2021 13:29
To: Devine, Sandra [redacted]; Steele, Tom [redacted]
Cc: Ian Storrar [redacted]
Subject: wards 2a/b RHC

Hi Tom/Sandra

Many thanks for including us in your meeting yesterday to review water sampling results in wards 2A/2B RHC. As mentioned yesterday we have a number of questions (below) to help us understand the current picture.

- Can you advise the sampling results from wards 2A/B prior to both chlorine disinfections that have been undertaken?
- Can you share the sampling results that were shown on screen for the floors above and below
- Can you advise of any water sampling undertaken and results over past 6 months across QEUH/RHC
- Can you advise of any water sampling undertaken and results over past 6 months in ward 6a and 4b
- What is the current chlorine dioxide dosing concentration across the QEUH/RHC both centrally and at the outlets
- Has chlorine dioxide dosing continued in wards 2a/b throughput the closure
- Can you advise of the water sampling results from the water tanks and risers
- Given the patient population: what are the board considering acceptable levels of gram negative organisms/TVCs for re-opening of wards 2A/b
- Can you confirm the scope of works undertaken in wards 2a/b with regards to water and ventilation.

HFS/ARHAI provided support with the remobilisation of patients from the Beatson to ward 4b in which there was an air sampling protocol agreed.

- Has an air sampling protocol been agreed for wards 2A/B, if so what is the duration and frequency
- Have there been any air sampling undertaken: if so what do the results show?

HFS/ARHAI are happy to provide support if requested into wards 2A/B. Can you advise if support will be requested?

Many thanks

Ian Storrar / Annette Rankin

Internal file note: DO-001
Date: 03rd December 2021

High level review of the ward 2A/B water quality at QEUH Glasgow:

1.0 Background

NHS GG&C approached HFS in November 2021 to attend Microsoft TEAMS water group discussions (23/11/2021 and also 30/12/2021) regarding recent water quality concerns raised by the validation engineers (DMA), specifically in connection with enhanced microbiological results for wards 2A/2B. Since the meetings, multiple emails have been issued by NHS GG&C and their project team, including DMAs proposed RAMS for back flushing and disinfection procedures. HFS have issued a document comments tracker (01/12/2021) to consolidate our responses, these comments have yet to be responded to. Since the TEAMS meetings HFS have attended site (02/12/2021) for a general ward walk round (as pre-arranged) and not solely specific to water. The AE(water) has not attended the two meetings the HFS has attended. It is acknowledged the AE(water) has been responding to emails.

The purpose of this internal file note is to highlight concerns and identify where NHS GG&C may require further assurance to be provided.

2.0 Review of information provided by others

2.1 Micro-bacterial sampling: HFS have received sampling results for ground, 1st, 2nd, 3rd and the 4th floor of the Royal Hospital for Children as a means to compare the differences between results.

- We have raised via the HFS comment tracker a request for further information for the QEUH as a whole, as the water is all sourced from the central basement tank room (to identify if any out of spec results are present elsewhere), this has yet to be answered.
- We have also raised via the HFS tracker whether the current micro-bacterial results have been compared to sampling results taken before the ward closed, this has yet to be answered.
- We have also asked what benchmarks are being used for the *'non-compliant'* sampling results, this has yet to be answered.
- The DMA micro-bacterial results indicate pseudomonas, we have not seen MPMH's water sampling results. We have been advised the contractor tested for legionella, TVC and pseudomonas. It is unclear if the pseudomonas was present in the MPMH results and if so who reviewed these and what discussions were undertaken.

2.2 Control measures: members of NHS staff have referred to pressure to get the water quality issue resolved quickly on the TEAMS calls. As a result of conversations and the piecemeal nature of the emails and separate emails with the disinfection method and back flush, we have a concern that items worthy of consideration are being missed with the main objective being time. There has been little commentary in regards to comments and reviewing of DMAs backflush or disinfection RAMS by others (e.g. NHS GG&C stakeholder group, including technical and IPC). HFS comments are within the excel comments tracker.

There is currently no single bundle of proposed works. There is also no systematic process documented for the procedures that the water team are discussing/ considering. Sampling times are noted in emails, yet RAMS for disinfection and back flush are separate with no detailed cross-referencing. HFS within our comment tracker have also queried whether RAMS for proposed auto-flushers being attached or sampling procedures have been reviewed. As yet this is to be answered.

2.3 Risk assessments: It is unclear how the direct flush WCs and toilet seats have been risk assessed as part of a previous refurbishment project.

The current DMA risk assessments are missing detail, such as, when tools are sprayed to disinfect and left for 2 minutes, where does the tools go to dry? On a hygienically clean surface etc? It is unclear what pipe materials are being proposed to be put into the system as part of the cut-ins. As part of the back-flush, it is not noted that isolation valves have been checked, working and suitable. There are no mark-up drawings where isolations/temporary connections are made for clarity, no mark-ups indicating locations relating to the *'out-of-spec'* bacterial results. Overall, the HFS comment tracker has a full list of questions which may have been considered by others previously, but currently these are not documented and issued.

2.4 Visual observations from site: refer to section 4.0. It is clear from the photographic evidence that there are locations within the ward that still require cleaning. As referenced in section 4.0 there are locations of a brown/rust like substance at drains and a black substance at a WHB.

3.0 Potential matters to raise with NHS GG&C

Water

1. If the taps reinstalled by MPMH had been dosed with Sanosil during the first install, have they been effected by the CL02, Chlorine, or all disinfection?
2. What level of risk assessments were undertaken by the WSG for the reinstall of the taps?
3. What level of risk assessments were undertaken by the WSG for the reinstall of the shower?
4. It is unclear if the TMV within the staff WC has been replaced or removed, descaled etc. and reinstalled and if the WSG/ AP had risk assessed.
5. Has the WSG risk assessed the POU filters and how have the WSG done so?
6. Was POU filters previously micro-bacterially tested on the outflow side?
7. How has the WSG risk assessed the flushing regime during the ward being out of use?
8. Has the estates department reviewed the flushing records?
9. Has the current legionella risk assessment been updated?
10. Has the current pseudomonas risk assessment been updated?
11. It is unclear if regular checks are made by the AP on the competence of DMA contractors working on the system.
12. It is unclear if the WSG considered removing the TMV/TMT taps and having direct hot and cold taps. Thus scalding risk vs bacterial risk.

13. It is unclear who would be making the final decisions on any group discussions regarding the processes etc. going forward.
14. It is unclear if the WSG investigated the source causing the black water mark in the WHB?
15. It is unclear if the WSG had the black grime bacteriologically tested.
16. It is unclear if the WSG investigated whether the black water mark causes a bacteriological issue within the drainage system?

Above ground drainage

1. It is unclear if all drainage traps were removed and visually checked for debris.
2. It is unclear if the drainage system has been micro-biologically swabbed.
3. It is unclear whether consideration has been given to disinfecting the drainage pipework.

HFS created a comments tracker based on incoming information and issued 01/12/2021. A detailed list of questions/comments raised by the HFS are held within.

4.0 Visual observations from site (02/12/2021)

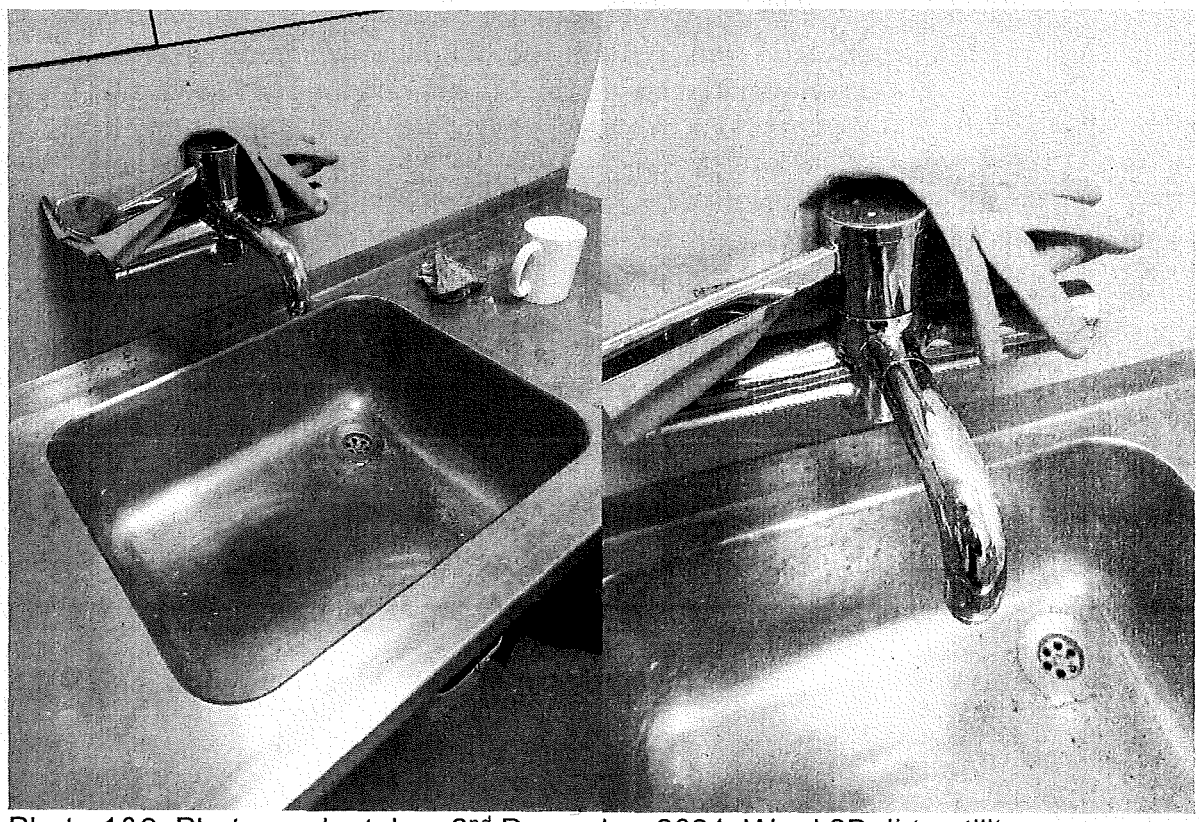

Photo 1&2. Photographs taken 2nd December 2021: Ward 2B dirty utility.

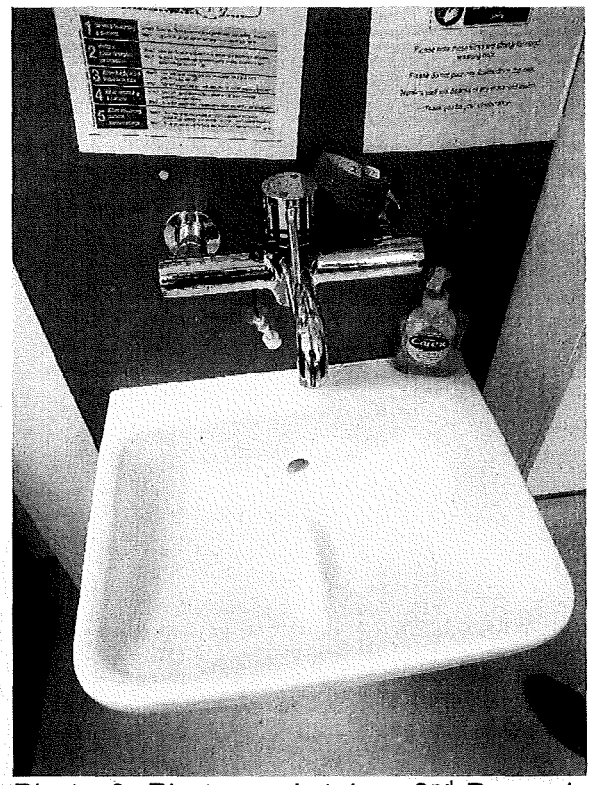

Photo 3. Photograph taken 2nd December 2021: Ward 2B clinical consultants WHB. Auto flusher tied around monoblock tap head (unclear if this is a new or old auto-flusher), unclear if auto flusher is to be attached and suitable RAMS in place and reviewed. Also hand wash gel sitting on WHB bowl lip.

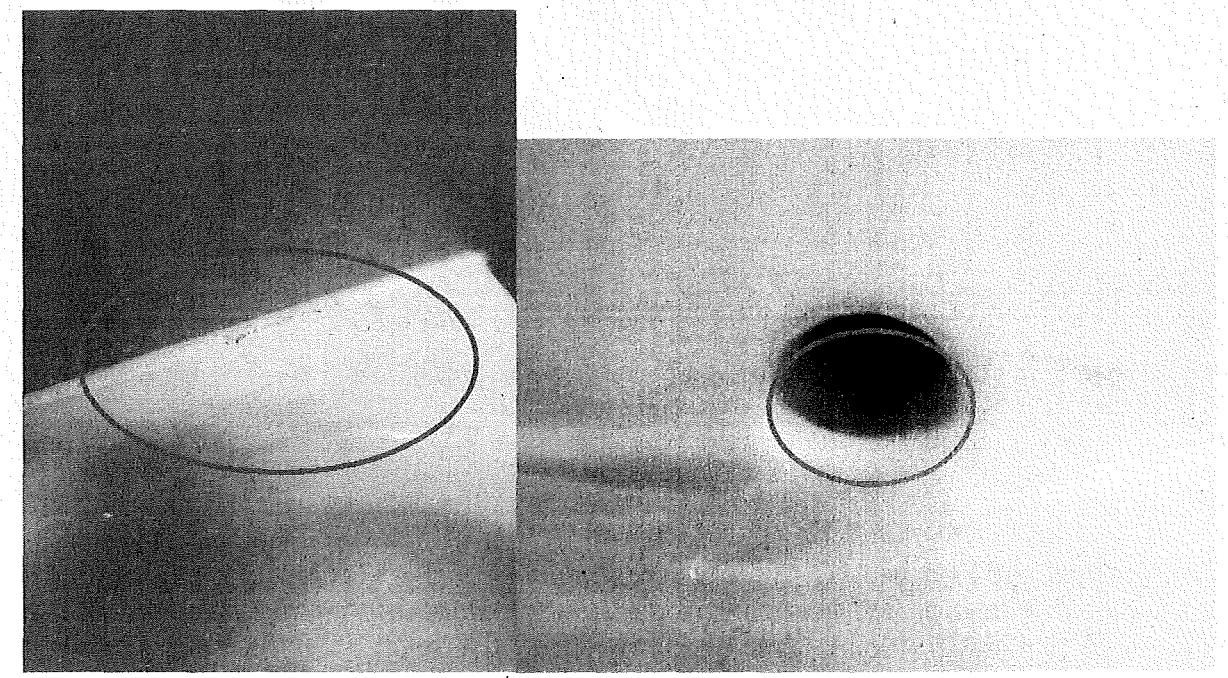

Photo 4&5. Photographs taken 2nd December 2021: Ward 2A BMT DSR WHB. Photo 1 silicon seal is rough and not smooth which could allow for mould growth. It is acknowledged this WHB was not part of the initial project, however this can still pose a risk for bacterial growth. Photo 2, black substance within drain outlet and water level marks.

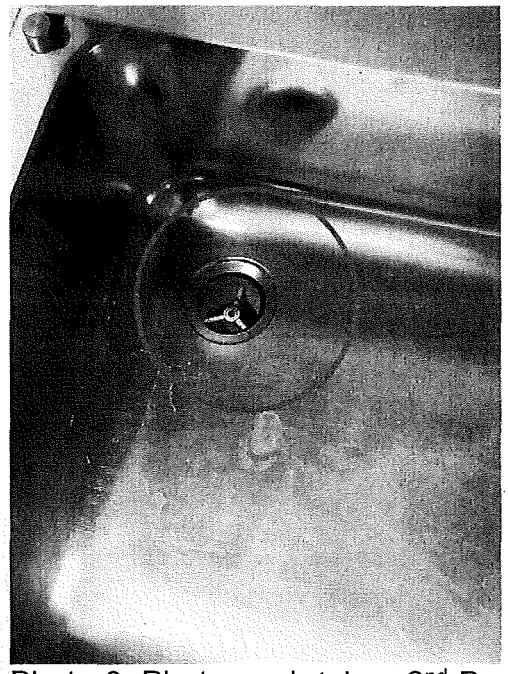

Photo 6. Photograph taken 2nd December 2021: Ward 2A BMT DSR slop sink DSR. The inside of the drain channel is stained brown, it is unclear if the drainage trap was checked and whether sampling/ drain cleaning has been considered.

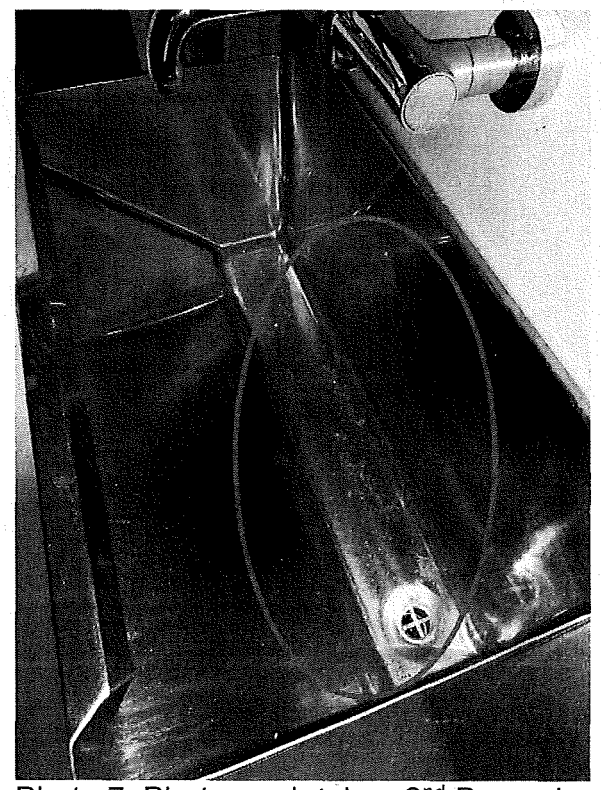

Photo 7. Photograph taken 2nd December 2021: Ward 2A BMT trough sink, treatment room. Brown/ rust like substance in trough.

Internal file note: DO-001
Date: 03rd December 2021

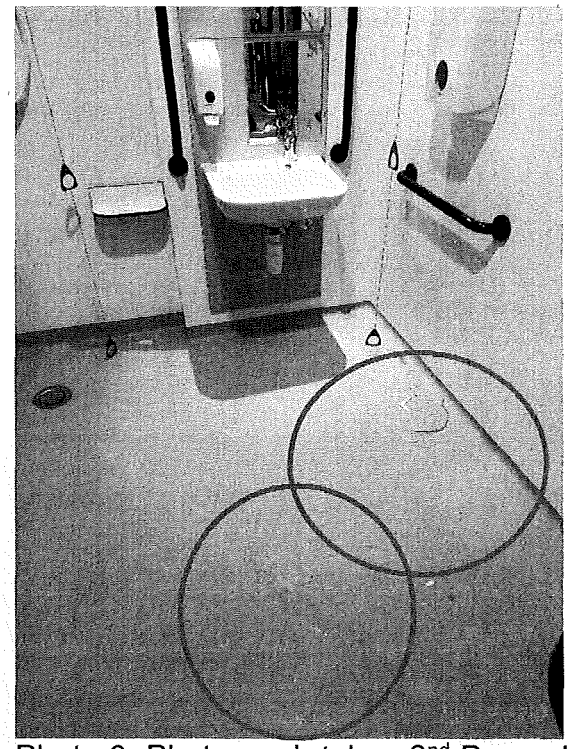

Photo 8. Photograph taken 2nd December 2021: Ward 2A patient ensuite, - site work debris on floor with shower drain in corner, not all ensuites in this condition, approx. 4. Further, water on floor, the direct flush WC was failing with constant water flow. HFS raised this onsite, response was plumber was onsite and already notified to fix.

Photo 9. Photograph taken 2nd December 2021: Ward 2A patient ensuite MIBG, but also typical WC for other ward 2A ensuite's. Remains unclear to the risk assessment for the direct flush WCs and toilet seats.

Internal file note: DO-001
Date: 03rd December 2021

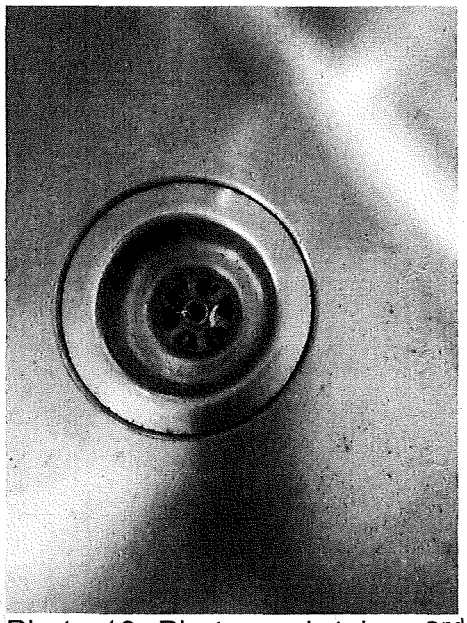

Photo 10. Photograph taken 2nd December 2021: Ward 2A BMT staff room. Brown/ rust like substance around drain.

From: Bagrade, Linda
Sent: 16 December 2021 12:25
To: Penman, Dawn [redacted]; Bowskill, Gillian [redacted]
Subject: RE: cardiac case with meningitis

Hi Dawn,

The only comment from me if I may suggest is that we cannot categorically say the Serratia is acquired in hospital. This infection is classed as hospital acquired based on the time of isolation of pathogen in connection to the time of admission to hospital but there is no way we can say it was acquired in hospital. I know it is just wording but in the current climate of scrutiny it is very important.

Sorry, I read the report very quickly and might have missed it but you mentioned in your e-mail that there were no swabs done from the meningitis affected tissues. If I may offer an opinion – it would be also important to note this in the report, sorry if I have missed it.

Thank you for letting me know,

Linda

From: Penman, Dawn
Sent: 16 December 2021 11:58
To: Bowskill, Gillian [redacted]; Bagrade, Linda [redacted]
Subject: FW: cardiac case with meningitis

Dear Linda and Gillian

I attach a postmortem report on a patient who was under the cardiology team here. [redacted] died as a result of meningitis and sepsis and it is most likely that the responsible organism was hospital acquired.

[redacted] vulnerability was [redacted] cardiac condition and also previous cerebral haematoma on ECMO which I think has acted as an infected nidus ultimately leading to the development of meningitis.

I had asked [redacted] in micro for his thoughts on this case and [redacted] has suggested I let you know

If I can help in any way just let me know

I plan to issue this final postmortem report today

Best wishes

Dawn

From: Leanord, Alistair
Sent: 16 December 2021 10:48
To: Penman, Dawn [redacted]
Subject: RE: cardiac case with meningitis

For ICN it would be Gillian Bowskill

For ICD Linda Bagrade

Al

From: Penman, Dawn
Sent: 16 December 2021 10:28
To: Leanord, Alistair [redacted]
Subject: FW: cardiac case with meningitis

Alistair

Really sorry to bother you with this.

In short, we have a baby with [redacted] whose ultimate cause of death is likely a hospital acquired infection. [redacted] has suggested I contact infection control. The global address book hasn't really helped me to find the right person

Are you able to suggest the most appropriate contact?

Many thanks in advance

Best wishes

Dawn

From: SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE)
Sent: 16 December 2021 10:04
To: Penman, Dawn [redacted]
Subject: Re: cardiac case with meningitis

Dear Dawn,

I note you mention the clinical casenotes available to you were patchy, we have fairly comprehensive ante-mortem notes of our discussions with the clinical team and communications with IPCT, and I attach these if they help.

This patient acquired Serratia and was bacteraemic for a long time as you can see from the microbiology results on Portal, indeed the final ante-mortem blood culture we have still grew this. Although one does not see many cases of Gram-negative meningitis outwith the neonatal period, it is conceivable that the Serratia is the causative organism particularly because the patient was still very young even if not a neonate, was bacteraemic for so long, put together with the history of haematoma (please read through our notes as this might help you plug some of the gaps in the clinical history). The timeline of events put together with your pathology findings, makes meningitis with Serratia, secondary to systemic sepsis a reasonable conclusion although we don't have brain swabs.

If you go through the timeline of results, you will note the Serratia acquisition and then the bacteraemias. Our understanding in the microbiology department is that this was a hospital-acquired Serratia sepsis and infection control were aware. You will also note the typing result under microbiology on Portal (dated [redacted]/10/21) that demonstrates clustering of Serratia with another patient (this result came back on [redacted]/11/21 as per the stamp on the report, so won't be reflected in our antemortem casenotes). In order to close the loop properly on this case (and given the inquiries into HAI-related deaths) we suggest it would be worth emailing infection control, as I do not know whether an IMT was conducted, how this was scored and what has been communicated from the perspective of duty of candour.

Hope this helps,

Regards,

[redacted]

From: SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE) [redacted]
Sent: 15 December 2021 16:39
To: Penman, Dawn [redacted]
Subject: Re: [redacted] with meningitis

Thanks Dawn,
This is a complex case looking at our ante-mortem notes. I'll get back to you in the next day or two.
Best wishes,
[redacted]

From: Penman, Dawn [redacted]
Sent: 15 December 2021 16:09
To: SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE) [redacted]
Subject: FW: [redacted]

I hope you don't mind I'd really appreciate your thoughts on this case.

[redacted]

[redacted] Died October 2021.

I think [redacted] has meningitis. The history is sketchy and the notes on clinical portal are even poorer with many diagnoses having been added after her death but she had a [redacted]. I think the [redacted] was evacuated [redacted]. The meningitis is most intense [redacted] but does extend over the entirety of the cortex.
Having reviewed I think this is true meningitis and I think it is likely the nidus for infection has been the [redacted] has grown Serratia marcescens and Enterococcus faecalis from heart blood and lung fluid with additional Staph haemolyticus from lung fluid. I didn't culture from the brain as this wasn't obvious meningitis grossly. What are your thoughts on this scenario?

Thank you

Dawn

Louise Mackinnon

From: Peters, Christine
Sent: 01 February 2022 14:56
To: Cooper, Elizabeth
Subject: FW: cardiac case with meningitis

The PM discussion re the patient who died with Serratia recently.

Kr
Christine

From: SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE)
Sent: 01 February 2022 13:41
To: Peters, Christine [redacted]
Subject: Fw: cardiac case with meningitis

From: SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE) [redacted]
Sent: 23 December 2021 09:47
To: Inkster, Teresa [redacted]
Subject: Fw: cardiac case with meningitis

From: SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE) [redacted]
Sent: 16 December 2021 14:54
To: SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE) [redacted]; Penman, Dawn [redacted]; Bagrade, Linda [redacted]
Subject: RE: cardiac case with meningitis

Thanks Dawn

Enterococcus is a common finding in PM samples including blood culture representing peri mortem gut flora leakage .

Given the longevity of the bacteraemia with Serratia it is the considered opinion of the paeds RHC microbiology team that Serratia is the primary pathogen involved in the sepsis and while there were no brain swabs its would be very unusual for a different organism to be responsible for the meningitis as the intra cranial haemorrhage occurred during bacteraemia phase (positive BCs on the [redacted]/9/21 and [redacted]/09/21)

Apart from the 48 hour HAI definition - Sternal and Swabs on the [redacted]/05/21 were negative for growth, 5 days later of hospital admission the Serratia was grown from the sternal wound.

Kr

Christine

Dr Christine Peters
Clinical Lead
Consultant Microbiologist

QEUH
[redacted]

From: SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE)
Sent: 16 December 2021 13:08
To: Penman, Dawn [redacted]; Bagrade, Linda [redacted]
Subject: Re: cardiac case with meningitis

Hi Dawn,

Unfortunately there are only 2 PM samples to go by. We never isolated the Enterococcus ante-mortem, so I think it is difficult to comment on it when tying things up as one generally sees it representing PM flora/translocation in the overall picture. That doesn't mean to say that it did not contribute at all, because I note that the last samples we had from this patient were on [redacted]/10/21 but date of death was [redacted]/10/21 so there is a gap in ante-mortem sampling. If in doubt you could make mention of it as of uncertain significance; our impression in the department further to discussions is that the Serratia is probably the most significant of what was isolated given the ante-mortem history and its pathogenicity (irrespective of how the infection is categorised) with the caveat that we do not have a brain swab. The Staph haemolyticus in the lung fluid is likely to represent contamination or translocation of normal flora and is generally of low pathogenicity.

Regards,

[redacted]

From: Penman, Dawn [redacted]
Sent: 16 December 2021 12:44
To: Bagrade, Linda [redacted]
Cc: SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE) [redacted]
Subject: RE: cardiac case with meningitis

[redacted] has reviewed the micro.

He might comment further. As a pathologist I would always ask the opinion of the microbiologist in such cases

Best wishes

Dawn

From: Bagrade, Linda
Sent: 16 December 2021 12:43
To: Penman, Dawn [redacted]
Subject: RE: cardiac case with meningitis

Sorry Dawn, one more thing – there is presence of Enterococcus in a few samples as well but no mentioning of this in Dg – is this dismissed completely as contaminant?

Re: minutes 090222

Inkster, Teresa [redacted]
Wed 09/02/2022 16:58

To: Bal, Abhijit [redacted];Peters, Christine [redacted];Wright, Pauline [redacted];Khanna, Nitish [redacted];Balfour, Alison [redacted];Harvey-Wood, Kathleen [redacted];Khalsa, Kamaljit [redacted]

Cc: Macleod, Mairi [redacted]

1 attachments (1 MB)
1-s2.0-S0195670121000748-main.pdf;

Hi Abs, a dry stained tile does constitute a risk to patients. The other side of the tile is within a ceiling void which is the perfect environment for mould proliferation. Small amounts of movement across ceiling tiles can increase the risk of patient exposure to the void . John Hood and myself were involved in the entire decant of an ICU at the old Western Infirmary due to this very scenario with significant disruption - relevant paper attached. As alluded to in the paper staff normalise the abnormal , it happens so frequently that it becomes accepted.
kr
Teresa

From: Bal, Abhijit [redacted]
Sent: 09 February 2022 16:24
To: [redacted]; Inkster, Teresa [redacted]; Peters, Christine [redacted]; Wright, Pauline [redacted]; Khanna, Nitish [redacted]; Balfour, Alison [redacted]; Harvey-Wood, Kathleen [redacted]; Khalsa, Kamaljit [redacted]
Cc: Macleod, Mairi [redacted]
Subject: Re: minutes 090222

Hi [redacted],

Changing of a dry stained tile is not for infection control to address. The ward would need to discuss with estates. When a tile replacement work is planned, we will get involved with the SCRIBE part of it, but we do not ask estates to change stained tiles.

In this context, infection control only review active leaks which cause infection-related risk to patients. A stain on a dry tile by itself is not a risk for fungal infection to patients.

Thanks,

Abs

From: [redacted]
Sent: 09 February 2022 16:15
To: Bal, Abhijit [redacted]; Inkster, Teresa [redacted]; Peters, Christine [redacted]; Wright, Pauline [redacted]; Khanna,

Nitish [redacted]; Balfour, Alison [redacted]; Harvey-Wood, Kathleen [redacted]; Khalsa, Kamaljit [redacted]

Cc: Macleod, Mairi [redacted]

Subject: minutes 090222

Dear all,
Minutes attached.
Best wishes
[redacted]

Re: minutes 020222

Inkster, Teresa [redacted]
Wed 09/02/2022 10:24

To: Bal, Abhijit [redacted];Peters, Christine [redacted];Wright, Pauline [redacted];Khanna, Nitish [redacted];Balfour, Alison [redacted];Harvey-Wood, Kathleen [redacted];Khalsa, Kamaljit [redacted]

Cc: Macleod, Mairi [redacted]

Thanks. Previously we would have had an investigation, PAG and HIIAT assessment for a single case as this is such a vulnerable group and it is an alert organism. Is that not the case anymore?

kr
Teresa

From: Bal, Abhijit [redacted]
Sent: 09 February 2022 09:30
To: Inkster, Teresa [redacted]; Peters, Christine [redacted]; Wright, Pauline [redacted]; Khanna, Nitish [redacted]; Balfour, Alison [redacted]; Harvey-Wood, Kathleen [redacted]; Khalsa, Kamaljit [redacted]
Cc: Macleod, Mairi [redacted]
Subject: Re: minutes 020222

Hi Teresa,

We do not trigger a full investigation unless there is a linked case. Alison has been to the ward and there were no obvious issues identified. There are no relevant issues with the air article count and fungal plates.

We are awaiting a formal identification and susceptibility from GRI. If it is resistant to isavuconazole (breakpoint is 1 mg/L from memory) (or some other antifungals as in Appendix 13), it will fulfil the criteria for investigation even if there is no linked case.

I am awaiting that report because the patient was on isavuconazole also because the prophylactic and therapeutic does are identical so it will be interesting to know.

Thanks,

Abs

From: Inkster, Teresa [redacted]
Sent: 09 February 2022 08:52
To: Bal, Abhijit [redacted]; Peters, Christine [redacted]; Wright, Pauline [redacted]; Khanna, Nitish [redacted]; Balfour, Alison [redacted]; Harvey-Wood, Kathleen [redacted];

Khalsa, Kamaljit [redacted]
Cc: Macleod, Mairi [redacted]
Subject: Re: minutes 020222

Hi Abs, I just have one query. There is a BMT patient (DM) who we are treating as a probable pulmonary Aspergillosis. Is there any IPC update regarding the investigation of the case?
Thanks
Teresa

From: Bal, Abhijit [redacted]
Sent: 09 February 2022 07:20
To: [redacted]; Peters, Christine [redacted]; Wright, Pauline [redacted]; Khanna, Nitish [redacted]; Inkster, Teresa [redacted]; Balfour, Alison [redacted]; Harvey-Wood, Kathleen [redacted]; Khalsa, Kamaljit [redacted]
Cc: Macleod, Mairi [redacted]
Subject: Re: minutes 020222

Hi all,

I am busy today with various meetings and follow ups. Apologies for the 3:30 meeting.

From the minutes, there does not seem to be any ongoing infection control issue for discussion. From my side, I don't have any clinical issues from duty 1/2/blood culture.

Please let me know if there are any questions.

Thanks,

Abs

From: [redacted]
Sent: 02 February 2022 16:36
To: Bal, Abhijit [redacted]; Peters, Christine [redacted]; Wright, Pauline [redacted]; Khanna, Nitish [redacted]; Inkster, Teresa [redacted]; Balfour, Alison [redacted]; Harvey-Wood, Kathleen [redacted]; Khalsa, Kamaljit [redacted]
Cc: Macleod, Mairi [redacted]
Subject: minutes 020222

Dear all, minutes attached
Best wishes
[redacted]

Dear Ms Brimelowe,

I am disappointed that I feel a need to contact you as the Chair of Clinical Governance for GGC. I assume that it is the responsibility of the Clinical Governance Committee to ensure that the Board is aware of significant risks to patient safety. I apologise if you are not the right person to contact and hope you are able to redirect me if necessary.

In 2018 I retired as consultant microbiologist, including 25 years as an infection control doctor. I also worked as Clinical Director for Laboratory Medicine. I therefore have an understanding of the management processes within the Board. I am also one of the whistle blowers who first raised concerns in 2017 and again in 2019 and 2020.

I have always been concerned that the information given to the GGC Board had been filtered and significant concerns about patient safety, being raised by senior staff, never reached the Board. I appreciate that the information presented to the Board has to be prioritised after an appropriate Risk Assessment.
The concerns raised by the whistle blowers have resulted in a Public Inquiry. It is impossible for GGC Board to manage identified risks within the organisation if it is unaware of the risks to patient safety. I am not sure how much the Board knew about the whistle blowers concerns.

I have been following the oral evidence being given to Public Inquiry. It has been very distressing to listen to the pain experienced by the patients and their families. This week Mollie Cuddihy and her father Prof. John Cuddihy have been giving evidence. Prof Cuddihy, a retired police Chief Inspector, and having worked with the Oversight Board, believes that some risks and incidents may not have been reported to the GGC Board. He also discussed the difficulties the case notes review group experienced in getting the information they requested. Was some information not given to this group that might have been important to a full understanding of the facts?. Listening to his testimony raised my concern level again.

The challenges NHS GGC has in resolving the environmental risks to patients cannot be underestimated. The fact that Ward 2A is still shut must indicate that there are still unresolved problems.

I hope that the Board is confident that it is aware of significant incidents now. I have concerns that there may be ongoing problems and incidents in relation to the environment and the risks to patients. Is the Clinical Governance Committee confident that they are aware of any ongoing incidents?
I am aware that Angela Wallace is reassuring the Board that GGC is meeting the Bench Marking Standards. These standards were being met when we raised the whistle blow in 2017, the incidents that have resulted in the Public Inquiry are not routinely measured. It is essential for infection control to identify and report incidents and risks within Health Board, in particular ‘unusual ones’.
I believe that the Board need to be sure that they are aware of any ongoing incidents. I may be wrong and hope I am. I am obviously not able to ask any of the current staff. My 25 years as an infection control doctor make me ask the following questions and I thought I needed to share these with GGC. I believe the GGC Board need to be confident that the information they have presented to them is comprehensive. The HAI report presented at the GGC Board meetings does not give details of the incidents.

There may be an ongoing risk to patients since the whole water supply on the campus appears to be involved in the problems. It is hard to believe that there have been no more cases, although I really hope that is the case. I have recently been told by two independent medical sources, nothing to do

with microbiology, that there is an instruction for the staff not to drink the water in either the QEUH or RCH.

The questions I am asking myself are;

How many environmental organisms have caused bacteraemias in paediatric and adult patients since the cut-off date for the case note review?

What are the dates for any environmental bacteraemias?

The organisms should include Mycobacterium chelonae, Pseudomonas species (both mentioned in the evidence), Enterobacter species, Stenotrophomonas species etc...

If these occurred, how many times was a PAG or IMT generated?
What was the alert level?

Has water testing looking for environmental organisms been undertaken since 2019? (This is **not** the routine water testing, but the specific testing looking for environmental bacteria)
Have environmental organisms been isolated from the water system since 2019?

Are microbiologists / infection control doctors still raising concerns which the Board should be aware of before they are discussed at the Public Inquiry?

It is not in the interest of NHS GGC for any such incidents to be identified by the Public Inquiry. They have told me that they will be monitoring incidents throughout the length of the Inquiry.

The pattern of behaviour within GGC has resulted in a Public Inquiry. Perhaps I am unaware of any recent changes in governance processes within GGC. Public and staff confidence needs to be restored to enable the delivery of a safe patient service.

I hope this letter can be seen as supportive of NHS GGC, who enabled me to have a long career working with other professionals to deliver excellent patient care.

Yours Sincerely

Penelope Redding

Julie Rothney

From: Peters, Christine
Sent: 28 April 2022 14:36
To: Macleod, Mairi
Subject: FW: [redacted]

Tracking:

Recipient	Delivery
Macleod, Mairi	Delivered: 28/04/2022 14:36

HI Mairi,

I am in receipt of this email from the [redacted] asking me to meet to discuss the microbiology advice given. I have seen some information in the press about this, as I mentioned in a previous email and understand there is a good deal of controversy surrounding the communications with the family.

I am happy to meet with [redacted], and indeed consider it to be good practice to answer questions families and patients have within the confines of Microbiology expertise and involvement. However I am aware that there has been dialogue between GGC, Scot Gov and the family, but only from press so am not really in a position of knowledge of what has been said or information shared or indeed what the issues actually are. Of note this will be a case that is considered in the PI.

I am therefore seeking advice on how to best go about responding and arranging a meeting within the framework of GGC processes on candour and family engagement. I propose responding just to say thanks for email and I will forward request internally in order to arrange a suitable arrangement, pending advice from yourself and management.

Kr

Christine

Dr Christine Peters
Clinical Lead
Consultant Microbiologist
QEUH
[redacted]

From: [redacted]
Sent: 28 April 2022 13:50
To: Peters, Christine [redacted]
Subject: [redacted]

Dear Dr Peters,

I hope this finds you safe and well.

I am the wife of [redacted], a patient initially admitted to ward 4B on [redacted] October 2020 for an allogenic stem cell transplant who died in ICU on [redacted] December 2020. [redacted]

From information I have received since [redacted] death, I understand that you were involved in providing microbiology advice during his admission. [redacted] medical records have raised some issues around infection, namely COVID and Aspergillus, which I would be grateful to have the opportunity to discuss with you and hopefully provide answers to some of the questions myself and the family have.

I understand that the hospitals are under enormous strain at the moment, and I would be incredibly grateful for any time you could give us to discuss [redacted] treatment in this regard.

Thank you in advance and I look forward to hearing from you.

Best wishes,

[redacted]

Fwd: NHS GG&C: RHC Neonatology Burkholderia Contaminans HIIAT Green HIIAT2022-GGC-Paediatrics-316 Update 23/12/22 Incident closed by board on 22/12/22

Teresa Inkster [redacted]
Mon 23/01/2023 10:56
To: Inkster, Teresa [redacted]

Sent from Outlook for Android

From: Teresa Inkster [redacted]
Sent: Friday, December 23, 2022 3:29:15 PM
To: Bagrade, Linda [redacted]; NSS ARHAlinfectioncontrol [redacted]; Laura Imrie [redacted]
Subject: Fwd: NHS GG&C: RHC Neonatology Burkholderia Contaminans HIIAT Green HIIAT2022-GGC-Paediatrics-316 Update 23/12/22 Incident closed by board on 22/12/22

Apologies Linda, I should have copied colleagues into my email as I am now on leave until Jan 9th. If you wouldn't mind replying to all. Thanks and have a good Christmas
Kr
Teresa

Sent from Outlook for Android

From: Teresa Inkster [redacted]
Sent: Friday, 23 December 2022, 11:04
To: Bagrade, Linda [redacted]
Subject: Fwd: NHS GG&C: RHC Neonatology Burkholderia Contaminans HIIAT Green HIIAT2022-GGC-Paediatrics-316 Update 23/12/22 Incident closed by board on 22/12/22

Hi Linda, I have been sent this update from NICU at RHC. Just wanted to clarify a few points;

1) Re hypothesis 2 and maternal colonisation, how has this been tested? B contaminans is not considered part of normal vaginal flora, how have the mothers acquired it?

2) Re hypothesis 4 , how has this been tested? Have lab processes been investigated and what were the findings?

3)What evidence has been assessed to suggest that no biofilms are present?

4) Given the rarity of B contaminans why would the most recent case not be considered part of the outbreak. There can be various routes of transmission within the same outbreak.

5) Why would an additional case of Burholderia and cases of Serratia not be considered an escalation of the previous situation i.e further cases despite control measures?

Kr

Teresa

Dr Teresa Inkster
Consultant Microbiologist/ICD
ARHAI Scotland

Sent from Outlook for Android

From: NSS ARHAIinfectioncontrol [redacted]
Sent: Friday, 23 December 2022, 09:50
To: NSS ARHAIinfectioncontrol [redacted]; Abigail Mullings [redacted]; Andrew Kalule [redacted]; Anna Munro [redacted]; Annette Rankin [redacted]; Colin Urquhart [redacted]; Declan Doherty [redacted]; Diane Stark [redacted]; Elaine Ross [redacted]; Emma Donnelly [redacted]; Emma Hamilton [redacted]; Emma Hooker [redacted]; Emma Young [redacted]; Gemma Nolan [redacted]; Gillian Smith [redacted]; Grant McPherson (CNOD) [redacted]; Hayley Kane [redacted]; Heather Wallace [redacted]; NSS ARHAIinfectioncontrol [redacted]; Irene Barkby [redacted]; Jennifer Barrett [redacted]; John Ratcliffe [redacted]; Julie Critchley [redacted]; Julie Wilson [redacted]; Allan L (Lara) [redacted]; Laura Imrie [redacted]; Lauren Blane [redacted]; Leighanne Bruce [redacted]; Mark Clark [redacted]; michael weinbren [redacted]; Mireille van der Torre [redacted]; Molly Nurse [redacted]; Nadia Palma [redacted]; NSS ARHAIdatateam [redacted]; Pamela Joannidis [redacted]; Paul Weaving [redacted]; Rachael Dunk (CNOD) [redacted]; Rebecca Andrews [redacted]; Rebekah Dunese [redacted]; Saba Affar [redacted]; Sarah Thirlwell [redacted]; Seonaid More [redacted]; Shona Cairns [redacted]; Sofie French [redacted]; Teresa Inkster [redacted]; Yasmine Benylles [redacted]
Cc: Bagrade, Linda [redacted]; Bowskill, Gillian [redacted]; Devine, Sandra [redacted]; Hamilton, Kate [redacted]
Subject: NHS GG&C: RHC Neonatology Burkholderia Contaminans HIIAT Green HIIAT2022-GGC-Paediatrics-316 Update 23/12/22 Incident closed by board on 22/12/22

Dear colleagues,

NHS GG&C held a Problem Assessment Group (PAG) on 22/12/22 in relation to the cases of *Burkholderia contaminans* isolated during a 13-month period associated with the Neonatal Intensive Care Unit (NICU) at the Royal Hospital for Children (RHC) which ARHAI attended.

The HIIAT assessment scored at the PAG remains **Green**: Severity of Illness - Minor, Risk of Transmission – Minor, Impact on Service and Public Anxiety – Minor).

For noting, the consensus of the group was that the Risk of Transmission for the HIIAT assessment was minor, however, ARHAI Scotland did not agree with this decision and suggested that consideration should be given to this being escalated to moderate. ARHAI Scotland's rationale for the proposed escalation is because the

source remains unknown. Chair of the PAG decided that this would remain minor, and it would be recorded within the meeting minutes that there was a disagreement regarding the risk rating.

Case definition (updated [redacted]/12/22)

Definite case - *Burkholderia contaminans* identified by UKHSA on typing related to outbreak associated with Clinell wipes.

Probable case - *Bukholderia contaminans* identified on lab testing awaiting typing result from UKHSA.

Cases:
4 definite cases (September 21, February 22, April 22, October 22)
1 new probable case isolated on [redacted]/12/22 – Board confirmed typing awaited.

Case summary

- 4 cases of *Burkholderia contaminans* isolated during a 13-month period associated with the NICU at the RHC in NHSGG&C.
- The fourth case was isolated from an Endotracheal aspirate obtained on [redacted]/10/22, subsequently it was confirmed by UKHSA on [redacted]/11/22 that the typing matched the outbreak strain of *B. Contaminans* identified as part of the 2020-21 investigations.
- On [redacted]/12/22 ARHAI Scotland were informed of a further case of *Burkholderia Contaminans* possibly with the same isolate type and reporting that indirect patient-to-patient transmission was suspected in this case. NHSGG&C reported this in a separate ORT (HIIAT2022-GGC-Paediatrics-330) linked with the case of *Serratia marcescens*.
- As previously reported this HIIAT2022-GGC-Paediatrics-330 incident was submitted on [redacted]/12/22 via the ORT reporting suspected patient to patient transmission of two different gram-negative organisms; *Serratia marcesscens* and *Burkholderia contaminans* involving 2 babies.
- Further information was sought from NHSGG&C on [redacted]/12/22. NHSGGC have advised that they do not currently consider this to be an ongoing outbreak of *Burkholderia contaminans* within the NICU, rather that they have a situation where they suspect patient-to-patient transmission of both *Serratia marcescens* and *Burkholderia contaminans* between 2 babies in NICU and since the transmission route is likely to be patient-to-patient the PAG are considering this to be a separate event to the *Burkholderia contaminans* incident number 316.
- No further cases of Burkholderia contaminans have been isolated since [redacted]/12/22. Admission and weekly screening remains in place for all gram negative organisms.

Working hypotheses previously reported:
1. The timeline and epidemiological information support association in time and place only partially and more information from WGS might be helpful to confirm or dismiss this association.
2. There are multiple independent sources and acquisition of Bcc are separate events in all 4 cases, possibility from maternal colonisation and transfer during delivery or care.
3. The particular clone of *B.contaminans* has established itself in the environment and should be treated as any other Bcc isolate without association with outbreak related to cleaning wipes.

(Updated [redacted]/12/22)
4. Most likely a pseudo-outbreak reflecting change in general ecology of *Burkholderia spp.* and lab processes.

ARHAI Scotland requested that the PAG consider a further hypothesis that the index case may have been in contact with the contaminated wipes which has led to contamination of the NICU environment – this hypothesis was rejected by the PAG.

Investigations:

- It has previously been confirmed that no batches of contaminated wipes were distributed to NHS Scotland. NHSGGC have previously sent packets of wipes from NICU and related clinical areas (including labs) for testing to the Reference Lab during initial investigation and no issues were identified.
- Timeline updated.

- Risk factors of mechanical ventilation were reviewed, and sample of Giraffe incubator water tray (of the current case) obtained. This was tested for *Burkholderia* – **Result negative**
- Milk preparation and storage investigated; no issues identified. Bottle warmers are waterless systems.
- Continue to monitor programme of IPC practice in NICU. No significant practice issues observed or reported.
- Hand hygiene audit carried out on [redacted]/11/22 - 2 missed opportunities observed (Board to confirm improvement plan and plans for re-audit).
- SICP's audit carried out on [redacted]/11/22 – 100% compliance reported.
- Continue routine patient screening programme in NICU.
- Review the antimicrobial consumption in NICU -Board advised that AMR review is completed as part of ongoing review of surveillance and not specific to this incident therefore will not be finalised before closure of the incident.
- Review the critical points of exposure to water during patient care – Board advised that this has been completed and that no concerns were identified.
- In relation to environmental sampling including water outlets/drains and water-based equipment especially when medical products have been ruled out as a source, the board were asked to confirm if this specific organism is looked for: Board confirmed that routine water sampling remains in place as well as drain disinfection programme and that the relevant environmental samples have been taken and the results are negative.
- Board advised that the same outlet is always tested each month (DSR on entry to unit).
- Board have ruled out any issues with POU filters.
- Board advised that the IPCT have been observing clinical practice, including ventilation care, no issues have been identified thus far.
- HAI Policy Unit requested that the board consider undertaking case-control analyses to assist with the identification of any potential risk factors/patient commonalties. (Board advised that review of the cases completed by the IPCT has not identified any common risk factors requiring further detailed investigation and that the situation will be monitored closely).
- Board asked to confirm if isolate of 5th patient case was sent to UKHSA for typing – Board confirmed that this has been sent.
- IPCT will continue to review all evidence and apply where appropriate.
- ARHAI will follow up with UKHSA for WGS results and report.

Following reporting of the additional new case of *B.contaminans* on [redacted]/12/22, ARHAI Scotland have asked NHSGGC colleagues if environmental and water sampling (pre filter) specially for *Serratia* and *Burkholderia* are now being considered by the board to rule out potential environmental reservoirs within the NICU. NHSGG&C have advised that they do not plan any additional actions for environmental sampling because they do not consider this an escalation of the previous situation. At the PAG GG&C colleagues updated that incoming water is filtered at the point of entry to the hospital system and that multiple steps of filtration including POU filters are in place within the NICU which would prevent any bacterial cells getting through, thus consider patient or staff exposure to pre-filter water extremely unlikely. Board also advised that there is no evidence to suggest that any biofilms are present or issues with the water thus far.

Control Measures

- Reported that all water outlets in the unit are fitted with POU filters with no regular testing from all outlets. However, there is regular testing of the water system for presence of *Legionella*, *Pseudomonas* and potable testing obtained from DSR room pre filter monthly and no positive samples in NICU have been identified recently.
- Drain disinfection programme in place.
- Water flushing schedules in place and up to date.
- Planned Preventative Maintenance Programme for the ventilation system reported as up to date.
- Education provided by the IPCT at ward level.
- Patients parents/carers have been informed of the result.
- Biannual HPV cleaning in place. Last completed in July 2022 and due to be repeated in January 2023. (Board advised that HPV cleaning in a busy unit caring for complex patients requires careful planning and is very disruptive and can be a risk, therefore requires to be managed appropriately).

- Board reported that enhanced cleaning is in place within the NICU, which involves using chlorine-based detergent, twice daily as a routine cleaning regime (Board to include this information within the control measures section of the ORT).
- Controls in place as per the NIPCM.

Communication

- ARHAI Scotland attended PAG 22/12/22.
- No media statement provided.
- Board have requested that ARHAI contact UKHSA to request sharing of information in relation to the whole genome and core genome testing of the isolates sent.
- No further meetings have been arranged, and board advised any new cases are identified that these will be treated as a separate incident.
- Incident closed.

Thank you, NHS GG&C Colleagues, for updating via the ORT please advise of any errors in the above summary

Kind regards

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Tel: [redacted]
Email: [redacted]
Web page: www.nhsnss.org

Infection Control Team enquiries:
Email: From 1st April this email address changed to NSS.ARHAIinfectioncontrol[redacted]
Phone: [redacted]

For urgent out of hours support phone 0141 300 1100 and ask to speak to the HPS On-Call Consultant.

From: NSS ARHAIinfectioncontrol
Sent: 19 December 2022 13:29
To: NSS ARHAIinfectioncontrol [redacted]; abigail mullings [redacted]; andrew kalule [redacted]; anna munro [redacted]; Annette Rankin [redacted]; Colin Urquhart [redacted]; Declan Doherty [redacted]; Diane Stark [redacted]; Elaine Ross (Professional Advisor) [redacted]; Emma Donnelly [redacted]; Emma Hamilton [redacted]; Emma Hooker [redacted]; Emma Young [redacted]; Gemma Nolan [redacted]; gillian smith [redacted]; Grant McPherson (CNOD) [redacted]; Hayley Kane [redacted]; Heather Wallace [redacted]; Infection Control Team [redacted]; Irene Barkby (CNOD) [redacted]; jennifer barrett [redacted]; John Ratcliffe [redacted]; julie critchley [redacted]; Julie Wilson [redacted]; Lara Allan (CNOD) [redacted]; Laura IMrie [redacted]; Lauren Blane [redacted]; Leighanne bruce [redacted]; Mark Clark [redacted]; michael weinbren [redacted]; mireille vandertorre [redacted]; Molly Nurse (CNOD) [redacted]; Nadia Palma [redacted]; nss.arhaidatateam [redacted]; Pamela Joannidis [redacted]; Paul Weaving [redacted]; Rachael Dunk (CNOD) [redacted]; rebecca andrews [redacted]; Rebekah Dunese [redacted]; Saba Affar [redacted]; Sarah Thirwell [redacted]; Seonaid More [redacted]; Shona Cairns [redacted]; Sofie French [redacted]; Teresa Inkster [redacted]; Yasmine Benylles [redacted]
Cc: Bagrade, Linda [redacted]; Bowskill, Gillian [redacted]; Devine, Sandra [redacted]; Hamilton, Kate [redacted]
Subject: NHS GG&C: RHC Neonatology Burkholderia Contaminans HIIAT Green HIIAT2022-GGC-Paediatrics-316 Update [redacted]/12/22

Dear colleagues,

ARHAI Scotland received an updated ORT from colleagues at NHS Greater Glasgow & Clyde (NHSGG&C) on [redacted]/12/22 regarding the 4 cases of *Burkholderia contaminans* isolated during a 13-month period associated with the Neonatal Intensive Care Unit (NICU) at the Royal Hospital for Children (RHC).

The HIIAT assessment reported on [redacted]/12/22 remains **Green**: Severity of Illness - Minor, Risk of Transmission – Minor, Impact on Service and Public Anxiety – Minor).

Case definition:
Burkholderia contaminans – 4 cases in 13 months associated with NICU RHC, PFGE typing matching *B.contaminans* cluster associated with outbreak in England related to Clinell wipes.

Summary
4 cases of *Burkholderia contaminans* isolated during a 13-month period associated with the NICU at the RHC in NHSGG&C. The fourth case was isolated from an Endotracheal aspirate obtained on [redacted]/10/22, subsequently it was confirmed by UKHSA on [redacted]/11/22 that the typing matched the outbreak strain of *B. Contaminans* identified as part of the 2020-21 investigations.

On [redacted]/12/22 ARHAI Scotland were informed of a further case of *Burkholderia Contaminans* possibly with the same isolate type and reporting that patient-to-patient transmission was suspected in this case. NHSGGC advised that this will be reported in a separate ORT (HIIAT2022-GGC-Paediatrics-330) linked with the case of *Serratia marcescens*.
This HIIAT2022-GGC-Paediatrics-330 incident was submitted on [redacted]/12/22 via the ORT reporting suspected patient to patient transmission of two different gram-negative organisms; *Serratia marcesscens* and *Burkholderia contaminans* involving 2 babies.
Further information was sought from NHSGGC on [redacted]/12/22. NHSGGC have advised that they do not currently consider this to be an ongoing outbreak of *Burkholderia contaminans* within the NICU, rather that they have a

situation where they suspect patient-to-patient transmission of both *Serratia marcescens* and *Burkholderia contaminans* between 2 babies in NICU and since the transmission route is likely to be patient-to-patient the PAG are considering this to be a separate event to the *Burkholderia contaminans* incident number 316. ARHAI Scotland have asked GGC to confirm the new isolate will be sent to UKHSA

In summary:

Cases:

4 confirmed cases (September 21, February 22, April 22, October 22)

1 new case of *B.contaminans* reported, however, this is currently awaiting confirmation.

Local NHS Board Hypotheses:

1. The timeline and epidemiological information support association in time and place only partially and more information from WGS might be helpful to confirm or dismiss this association.
2. There are multiple independent sources and acquisition of Bcc are separate events in all 4 cases, possibility from maternal colonisation and transfer during delivery or care.
3. The particular clone of *B.contaminans* has established itself in the environment and should be treated as any other Bcc isolate without association with outbreak related to cleaning wipes.

ARHAI Scotland have provided feedback to NHSGG&C regarding the possible hypotheses, however these remain unchanged.

Investigations:

- It has previously been confirmed that no batches of contaminated wipes were distributed to NHS Scotland. NHSGGC have previously sent packets of wipes from NICU and related clinical areas (including labs) for testing to the Reference Lab during initial investigation and no issues were identified.
- Timeline updated.
- Risk factors of mechanical ventilation were reviewed, and sample of Giraffe incubator water tray (of the current case) obtained. This was tested for *Burkholderia* – **Result negative**
- Milk preparation and storage investigated; no issues identified. Bottle warmers are waterless systems.
- Continue to monitor programme of IPC practice in NICU. No significant practice issues observed or reported.
- Hand hygiene audit carried out on [redacted]/11/22 - 2 missed opportunities observed.
- SICP's audit carried out on [redacted]/11/22 – 100% compliance reported.
- Continue routine patient screening programme in NICU.
- Review the antimicrobial consumption in NICU -Board advised that AMR is completed as part of ongoing review of surveillance and not specific to this incident therefore will not be finalised before closure of the incident.
- Review the critical points of exposure to water during patient care – Board advised that this has been completed and that no concerns were identified.
- In relation to environmental sampling including water outlets/drains and water-based equipment especially when medical products have been ruled out as a source, the board were asked to confirm if this specific organism is looked for: Board confirmed that routine water sampling remains in place as well as drain disinfection programme and that the relevant environmental samples have been taken and the results are negative. Board detailed that the Microbiology lab has specific request forms in place for environmental sampling and reasons for testing as well as testing and reporting methodology, this is always very clearly agreed and documented. Additionally, the board advised that they always look for specific isolates when sampling the environment.
- Board advised that the IPCT have been observing clinical practice, including ventilation care, no issues have been identified thus far.
- HAI Policy Unit requested that the board consider undertaking case-control analyses to assist with the identification of any potential risk factors/patient commonalties. (Board advised that review of the cases completed by the IPCT has not identified any common risk factors requiring further detailed investigation and that the situation will be monitored closely).
- Board asked to confirm if isolate of 5th patient case was sent to UKHSA for typing – Board advised that the microbiology lab is following the protocol for identification of *Burkholderia sp.* however the laboratory staff would be best placed to confirm this. – Board to internally discuss and provide update.

Following reporting of the additional new case of *B.contaminans* on [redacted]/12/22, ARHAI Scotland has asked GGC if environmental and water sampling (pre filter) specially for *Serratia* and *Burkholderia* are now being considered by the board to rule out potential environmental reservoirs within the NICU. NHSGGC have advised that they do not plan any additional actions for environmental sampling because they do not consider this an escalation of the previous situation, and all outlets in NICU are fitted with point of use filters therefore consider patient or staff exposure to pre-filter water extremely unlikely.

Control Measures

- Reported that all water outlets in the unit are fitted with POU filters with no regular testing from all outlets. However, there is regular testing of the water system for presence of *Legionella*, *Pseudomonas* and potable testing and no positive samples in NICU have been identified recently.
- Drain disinfection programme in place.
- Water flushing schedules in place and up to date.
- Planned Preventative Maintenance Programme for the ventilation system reported as up to date.
- Education provided by the IPCT at ward level.
- Patients have been informed of the result.
- Biannual HPV cleaning in place. Last completed in July 2022 and due to be repeated in January 2023. (Board advised that HPV cleaning in a busy unit caring for complex patients requires careful planning and is very disruptive and can be a risk, therefore requires to be managed appropriately).
- Board reported that enhanced cleaning is in place within the NICU, which involves using chlorine-based detergent, twice daily as a routine cleaning regime (Board to include this information within the control measures section of the ORT).
- Controls in place as per the NIPCM.

Communication

- ARHAI Scotland Support not requested. ARHAI and UKHSA support have been offered but is not required by NHSGGC.
- No media statement provided.
- Board to confirm if a further PAG has been scheduled.

The two of the babies reported across both of the above incidents remain inpatients and both are reported to be of stable medical condition. One of the babies remain in NICU awaiting transfer to SCBU and the other has previously been transferred to SCBU.

Thank you, NHS GG&C Colleagues, for updating via the ORT please advise of any errors in the above summary

Kind regards

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Email: [redacted]
Web page: www.nhsnss.org

Infection Control Team enquiries:
Email: From 1st April this email address changed to NSS.ARHAIinfectioncontrol[redacted]
Phone: [redacted]

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From: NSS ARHAIinfectioncontrol
Sent: 12 December 2022 16:38
To: NSS ARHAIinfectioncontrol [redacted]; abigail mullings [redacted]; andrew kalule [redacted]; anna munro [redacted]; Annette Rankin [redacted]; Colin Urquhart [redacted]; Declan Doherty [redacted]; Diane Stark [redacted]; Elaine Ross (Professional Advisor) [redacted]; Emma Donnelly [redacted]; Emma Hamilton [redacted]; Emma Hooker [redacted]; Emma Young [redacted]; Gemma Nolan [redacted]; gillian smith [redacted]; Grant McPherson (CNOD) [redacted]; Hayley Kane [redacted]; Heather Wallace [redacted]; Infection Control Team [redacted]; Irene Barkby (CNOD) [redacted]; jennifer barrett [redacted]; John Ratcliffe [redacted]; julie critchley [redacted]; Julie Wilson [redacted]; Lara Allan (CNOD) [redacted]; Laura IMrie [redacted]; Lauren Blane [redacted]; Leighanne bruce [redacted]; Mark Clark [redacted]; michael weinbren [redacted]; mireille vandertorre [redacted]; Molly Nurse (CNOD) [redacted]; Nadia Palma [redacted]; nss.arhaidatateam[redacted]; Pamela Joannidis [redacted]; Paul Weaving [redacted]; Rachael Dunk (CNOD) [redacted]; rebecca andrews [redacted]; Rebekah Dunese [redacted]; Saba Affar [redacted]; Sarah Thirwell [redacted]; Seonaid More [redacted]; Shona Cairns [redacted]; Sofie French [redacted]; Teresa Inkster [redacted]; Yasmine Benylles [redacted]; Kaileigh Begley [redacted]
Cc: Bagrade, Linda [redacted]; Bowskill, Gillian [redacted]; Devine, Sandra [redacted]; Hamilton, Kate [redacted]
Subject: NHS GG&C: RHC Neonatology Burkholderia Contaminans HIIAT Green HIIAT2022-GGC-Paediatrics-316 Update

Dear colleagues,

ARHAI Scotland received an updated ORT from colleagues at NHS Greater Glasgow & Clyde (NHSGG&C) on [redacted]/12/22 regarding the 4 cases of *Burkholderia contaminans* isolated during a 13-month period associated with the Neonatal Intensive Care Unit (NICU) at the Royal Hospital for Children (RHC).

The HIIAT assessment reported on [redacted]/12/22 remains **Green**: Severity of Illness - minor, Risk of Transmission – minor, Impact on Service and Public Anxiety – minor).

Case definition:
Burkholderia contaminans – 4 cases in 13 months associated with NICU RHC, PFGE typing matching *B.contaminans* cluster associated with outbreak in England related to Clinell wipes.

Summary
4 cases of *Burkholderia contaminans* isolated during a 13-month period associated with the NICU at the RHC in NHSGG&C. The latest case was isolated from an Endotracheal aspirate obtained on [redacted]/10/22, subsequently it was confirmed by UKHSA on [redacted]/11/22 that the typing matched the outbreak strain of *B. Contaminans* identified as part of the 2020-21 investigations. The patient case that remains in hospital was last reported to be of stable medical condition and now being nurse in SCBU.

Cases:
4 cases (September 21, February 22, April 22 & October 22).

Local NHS Board Hypotheses:
1. The timeline and epidemiological information support association in time and place only partially and more information from WGS might be helpful to confirm or dismiss this association.
2. There are multiple independent sources and acquisition of Bcc are separate events in all 4 cases, possibility from maternal colonisation and transfer during delivery or care.
3. The particular clone of *B.contaminans* has established itself in the environment and should be treated as any other Bcc isolate without association with outbreak related to cleaning wipes.

ARHAI Scotland have provided feedback to NHSGG&C regarding the possible hypotheses, however these remain unchanged.

Investigations:

- It has previously been confirmed that no batches of contaminated wipes were distributed to NHS Scotland. NHSGGC have previously sent packets of wipes from NICU and related clinical areas (including labs) for testing to the Reference Lab during initial investigation and no issues were identified.
- Timeline updated.
- Risk factors of mechanical ventilation were reviewed, and sample of Giraffe incubator water tray (of the current case) obtained. This was tested for *Burkholderia* – **Result negative**
- Milk preparation and storage investigated; no issues identified. Bottle warmers are waterless systems.
- Continue to monitor programme of IPC practice in NICU. No significant practice issues observed or reported.
- Hand hygiene audit carried out - 2 missed opportunities observed (Board to confirm date).
- SICP's audit carried out – 100% compliance reported (Board to confirm date).
- Continue routine patient screening programme in NICU.
- Review the antimicrobial consumption in NICU (Board to update conclusions in ORT).
- Review the critical points of exposure to water during patient care (Board to confirm findings in ORT).
- In relation to environmental sampling including water outlets/drains and water-based equipment especially when medical products have been ruled out as a source, the board were asked to confirm if this specific organism is looked for: Board confirmed that routine water sampling remains in place as well as drain disinfection programme and that the relevant environmental samples have been taken and the results are negative. Board detailed that the Microbiology lab has specific request forms in place for environmental sampling and reasons for testing as well as testing and reporting methodology, this is always very clearly agreed and documented. Additionally, the board advised that they always look for specific isolates when sampling the environment.
- Board advised that the IPCT have been observing clinical practice, including ventilation care, no issues have been identified thus far.
- HAI Policy Unit requested that the board consider undertaking case-control analyses to assist with the identification of any potential risk factors/patient commonalties. (Board advised that review of the cases completed by the IPCT has not identified any common risk factors requiring further detailed investigation and that the situation will be monitored closely).

Control Measures

- Reported that all water outlets in the unit are fitted with POU filters with no regular testing from all outlets. However, there is regular testing of the water system for presence of *Legionella*, *Pseudomonas* and potable testing and no positive samples in NICU have been identified recently.
- Drain disinfection programme in place.
- Water flushing schedules in place and up to date.
- Planned Preventative Maintenance Programme for the ventilation system reported as up to date.
- Education provided by the IPCT at ward level.
- Patients have been informed of the result.
- Biannual HPV cleaning in place. Last completed in July 2022 and due to be repeated in January 2023. (Board advised that HPV cleaning in a busy unit caring for complex patients requires careful planning and is very disruptive and can be a risk, therefore requires to be managed appropriately).
- Board reported that enhanced cleaning is in place within the NICU, which involves using chlorine-based detergent, twice daily as a routine cleaning regime (Board to include this information within the control measures section of the ORT).
- Controls in place as per the NIPCM.

Communication

- ARHAI Scotland Support not requested.
- No media statement provided.
- No further meetings arranged; however, the board have confirmed that if any further cases are identified a meeting will be scheduled.

Thank you, NHS GG&C Colleagues, for updating via the ORT please advise of any errors in the above summary

Kind regards

Kaileigh Begley
Senior Nurse Infection Control
ARHAI Scotland
Procurement, Commissioning and Facilities
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G2 6QE

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Email: From 1st April this email address changed to NSS.ARHAIinfectioncontrol[redacted]
Phone: [redacted]

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From: NSS ARHAlinfectioncontrol
Sent: 02 December 2022 16:03
To: abigail mullings [redacted]; andrew kalule [redacted]; anna munro [redacted]; Annette Rankin [redacted]; Colin Urquhart [redacted]; Declan Doherty [redacted]; Diane Stark [redacted]; Elaine Ross (Professional Advisor) [redacted]; Emma Donnelly [redacted]; Emma Hamilton [redacted]; Emma Hooker [redacted]; Emma Young [redacted]; Gemma Nolan [redacted]; gillian smith [redacted]; Grant McPherson (CNOD) [redacted]; Hayley Kane [redacted]; Heather Wallace [redacted]; Infection Control Team [redacted]; Irene Barkby (CNOD) [redacted]; jennifer barrett [redacted]; John Ratcliffe [redacted]; julie critchley [redacted]; Julie Wilson [redacted]; Kaileigh begley [redacted]; Lara Allan (CNOD) [redacted]; Laura IMrie [redacted]; Lauren Blane [redacted]; Leighanne bruce [redacted]; Mark Clark [redacted]; michael weinbren [redacted]; mireille vandertorre [redacted]; Molly Nurse (CNOD) [redacted]; Nadia Palma [redacted]; nss.arhaidatateam [redacted]; Pamela Joannidis [redacted]; Paul Weaving [redacted]; Rachael Dunk (CNOD) [redacted]; rebecca andrews [redacted]; Rebekah Dunese [redacted]; Saba Affar [redacted]; Sarah Thirwell [redacted]; Seonaid More [redacted]; Shona Cairns [redacted]; Sofie French [redacted]; Teresa Inkster [redacted]; Yasmine Benylles [redacted]
Cc: Bagrade, Linda [redacted]; Bowskill, Gillian [redacted]; Devine, Sandra [redacted]; NSS ARHAlinfectioncontrol [redacted]; Hamilton, Kate [redacted]
Subject: RE: NHS GG&C: RHC Neonatology Burkholderia Contaminans HIIAT Green HIIAT2022-GGC-Paediatrics-316

Dear colleagues,

ARHAI Scotland received a request from colleagues at NHS Greater Glasgow & Clyde to reopen the HIIAT2022-GGC-Paediatrics-316 incident first reported on [redacted]/05/22 involving 3 cases of *Burkholderia contaminans* isolated during a 9-month time period associated with the Neonatal Intensive Care Unit (NICU) at the Royal Hospital for Children (RHC). This incident was previously closed on [redacted]/05/22. Since the incident was reopened ARHAI Scotland have received 2 ORT updates on [redacted]/11/22 & [redacted]/11/22 both submissions reporting a GREEN HIIAT.

Current HIIAT Assessment: Severity of Illness - minor, Risk of Transmission – minor, Impact on Service and Public Anxiety – minor).

Background

Following initial WGS analysis of the B. *contaminans* isolates from (September 2021 and April 2022), analysis of the isolates from the bioinformatics team confirmed that the isolates belonged to a tight cluster (most

isolates <5 SNPs) associated with the National outbreak of Clinell wipes from England. The report from UKHSA confirmed that the source for the cases in RHC NICU was Clinell wipes. However, during the investigation, confirmation was given to NHS GGC by NDC and GAMA that no batches of contaminated cleaning wipes had been distributed in Scotland. Sample packets of wipes from NICU and related clinical areas (including labs) were sent for testing to the UKHSA reference lab during the investigation and no issues were identified.

Case definition:

Burkholderia contaminans – 4 cases in 13 months associated with NICU RHC, PFGE typing matching *B.contaminans* cluster associated with outbreak in England related to Clinell wipes.

Summary

One further case of *Burkholderia contaminans* has been isolated from an Endotracheal aspirate obtained on [redacted]/10/22. Subsequently it was confirmed on [redacted]/11/22 that this typing matches the outbreak strain of *B. Contaminans* identified in England in 2020-21 associated with Clinell wipes. This patient remains in hospital and was reported that their condition is improving.

Hypotheses

1. The timeline and epidemiological information support association in time and place only partially and more information from WGS might be helpful to confirm or dismiss this association.
2. There are multiple independent sources and acquisition of Bcc are separate events in all 4 cases, possibility from maternal colonisation and transfer during delivery or care.
3. The particular clone of B.contaminans has established itself in the environment and should be treated as any other Bcc isolate without association with outbreak related to cleaning wipes.

Investigations

- It has previously been confirmed that no batches of contaminated wipes were distributed to NHS Scotland. GGC have previously sent packets of wipes from NICU and related clinical areas (including labs) for testing to the RL during initial investigation and no issues were identified.
- Timeline updated.
- Risk factors of mechanical ventilation were reviewed, and sample of Giraffe incubator water tray (of the current case) obtained. This was tested for *Burkholderia* – **Result negative**
- Milk preparation and storage investigated; no issues identified. Bottle warmers are waterless systems.
- Continue to monitor programme of IPC practice in NICU. No significant practice issues observed or reported.
- Hand hygiene audit carried out - 2 missed opportunities observed (Board to confirm date).
- SICP's audit carried out – 100% compliance reported (Board to confirm date).
- Continue routine patient screening programme in NICU.
- Review the antimicrobial consumption in NICU.
- Review the critical points of exposure to water during patient care.

Control Measures

- Reported that all water outlets in the unit are fitted with POU filters with no regular testing from all outlets. However, there is regular testing of the water system for presence of *Legionella*, *Pseudomonas* and potable testing and no positive samples in NICU have been identified recently.
- Water flushing schedules in place and up to date.
- Biannual HPV cleaning in place. Carried out in July 2022 and due to be repeated in January.
- Planned Preventative Maintenance Programme for the ventilation system reported as up to date.
- Education provided by the IPCT at ward level.
- Controls in place as per the NIPCM.
- Patients have been informed of the result.

Communication

- ARHAI Scotland Support not requested.

- No media statement provided.
- No further meetings arranged; however, the board have confirmed that if any further cases are identified a meeting will be scheduled.

Please note ARHAI Scotland are awaiting response from NHSGGC regarding the follow up questions received from HAI Policy Unit

Thank you NHS GG&C Colleagues for updating via the ORT please advise of any errors in the above summary

Kind regards

Kaileigh Begley
Senior Nurse Infection Control
ARHAI Scotland
Procurement, Commissioning and Facilities
NHS National Services Scotland
4th Floor
Meridian Court
5 Cadogan Street
Glasgow
G2 6QE

To ensure a timely response, please do not send general enquiries to individuals.
ARHAI Scotland require all general enquires be directed to the generic mailbox NSS.ARHAIinfectioncontrol[redacted].

Tel: [redacted]
Email: [redacted]
Web page: www.nhsnss.org

Infection Control Team enquiries:
Email: From 1st April this email address changed to NSS.ARHAIinfectioncontro[redacted]
Phone: [redacted]

For urgent out of hours support phone 0141 300 1100 and ask to speak to the HPS On-Call Consultant.

From: NSS ARHAIinfectioncontrol [redacted]
Sent: 03 August 2022 19:52
To: Abigail Mullings [redacted]; Andrew Kalule [redacted]; Anna Munro [redacted]; Annette Rankin [redacted]; Christine.Ward [redacted]; Colin.Urquhart [redacted]; David Mcneill [redacted]; Diane Murray [redacted]; Elaine Ross [redacted]; Emma Donnelly [redacted]; Emma Hamilton [redacted]; Emma Hooker [redacted]; Emma Young [redacted]; Gemma Nolan [redacted]; Gillian Smith [redacted]; Grant McPherson (CNOD) [redacted]; Hayley Kane [redacted]; Heather Wallace [redacted]; NSS ARHAIinfectioncontrol [redacted]; Irene Barkby [redacted]; Jennifer Barrett [redacted]; John Ratcliffe

[redacted]; Julie Wilson [redacted]; Kaileigh Begley [redacted]; Allan L (Lara) [redacted]; Laura Imrie [redacted]; Lauren Blane [redacted]; Leighanne Bruce [redacted]; Lisa Powell [redacted]; Lynda Hamilton [redacted]; Lynda Hamilton [redacted]; Mark Clark [redacted]; Michael Weinbren [redacted]; Mireille van der Torre [redacted]; Molly Nurse [redacted]; Nadia Palma [redacted]; NSS ARHAIdatateam [redacted]; Paul Weaving [redacted]; rachael.dunk [redacted]; Rebecca Andrews [redacted]; Rebekah Dunese [redacted]; Saba Affar [redacted]; Shona Cairns [redacted]; Susie Dodd [redacted]; Syed Kerbalai (CNOD) [redacted]; Teresa Inkster [redacted]; Yasmine Benylles [redacted]

Cc: Bagrade, Linda [redacted]; Bowskill, Gillian [redacted]; Devine, Sandra [redacted]

Subject: NHS GG&C: RHC Neonatology Burkholderia Contaminans HIIAT Green HIIAT2022-GGC-Paediatrics-316 CLOSED INCIDENT 20.5.2022

Dear Colleagues,

ARHAI Scotland have received information in relation a final report from the bioinformaticians (UKHSA) in relation to an outstanding action to inform completion of the investigatory review of the NHS GG&C Burkholderia Contaminans closed incident.

Following initial WGS analysis of the Glasgow B. contaminans isolates (September 2021 and April 2022), analysis of these isolates from the bioinformatics team has confirmed that the isolates belong to a tight cluster (most isolates <5 SNPs) associated with the Clinell wipes. The report from UKHSA confirms that the source for the cases in RHC NICU was Clinell wipes. However during the investigation, confirmation was given to NHS GGC by NDC and GAMA that no batches of contaminated cleaning wipes had been distributed in Scotland. Sample packets of wipes from NICU and related clinical areas (including labs) were sent for testing to the UKHSA reference lab during the investigation and no issues were identified.

NHS GG& C have confirmed via the ORT:

- The last case in RHC was from a specimen obtained following transfer to RHC from Forth Valley obtained 42 hours after transfer on 04.04.22.
- Bi annual HPV treatment of unit completed 21.07.22
- Continue routine patient screening programme in NICU
- Board has ongoing surveillance in place

This incident is closed, ARHAI Scotland will undertake an internal debrief in relation to incident linkage to inform any recommendations from a lessons learned national perspective.

Thank you NHS GG&C Colleagues for updating via the ORT.

To ensure a timely response, please do not send general enquiries to individuals.
ARHAI Scotland require all general enquires be directed to the generic mailbox @NSS.ARHAIinfectioncontro[redacted]

Kind Regards
Heather Wallace
Senior Nurse Infection Control
ARHAI Scotland
Procurement Commissioning and Facilities

NHS National Services Scotland
Fourth Floor
Meridian Court
5 Cadogan Street
Glasgow
G2 6QE

T: [redacted]
E: [redacted]
Reception: 0141 300 1175

ARHAI Scotland
Antimicrobial Resistance and Healthcare Associated Infection

E: From 11 August, my email address changed to [redacted]
W: www.nhsnss.org

From: NSS ARHAIinfectioncontrol [redacted]
Sent: 20 May 2022 14:28
To: Abigail Mullings [redacted]; Anna Munro [redacted]; Annette Rankin [redacted]; Christine.Ward [redacted]; Colin.Urquhart [redacted]; David Mcneill [redacted]; Diane Murray [redacted]; Elaine Ross [redacted]; Emma Donnelly [redacted]; Emma Hamilton [redacted]; Emma Hooker [redacted]; Emma Young [redacted]; Gemma Nolan [redacted]; Gillian Smith [redacted]; Grant McPherson (CNOD) [redacted]; Hayley Kane [redacted]; Heather Wallace [redacted]; NSS ARHAIinfectioncontrol [redacted]; Irene Barkby [redacted]; Jennifer Barrett [redacted]; John Ratcliffe [redacted]; Julie Wilson [redacted]; Kaileigh Begley [redacted]; Allan L (Lara) [redacted]; Laura Imrie [redacted]; Lauren Blane [redacted]; Lisa Powell [redacted]; Lynda Hamilton [redacted]; Lynda Hamilton [redacted]; Mark Clark [redacted]; Matthew Deary [redacted]; Michael Weinbren [redacted]; Mireille van der Torre [redacted]; Molly Nurse [redacted]; Nadia Palma [redacted]; NSS ARHAIdatateam [redacted]; Paul Weaving [redacted]; rachael.dunk [redacted]; Rebecca Andrews [redacted]; Rebekah Dunese [redacted]; Saba Affar [redacted]; Shona Cairns [redacted]; Susie Dodd [redacted]; Syed Kerbalai (CNOD) [redacted]; Teresa Inkster [redacted]; Yasmine Benylles [redacted]
Cc: Devine, Sandra [redacted]; Bagrade, Linda [redacted]; Bowskill, Gillian [redacted]
Subject: NHS GG&C: RHC Neonatology Burkholderia Contaminans HIIAT Green HIIAT2022-GGC-Paediatrics-316

Dear all

NHSGGC have provided updated information via the electronic reporting system today regarding the *Burkholderia contaminans* cases in the neonatal intensive care unit.

Case Definition
Burkholderia contaminans – 3 cases in 9 months associated with NICU RHC, PFGE typing matching *B. contaminans* cluster associated with outbreak in England related to Clinell wipes.

Summary Update from IMT held 19/5/22
Incident closed
HIIAT remains GREEN

Cases
No new patient cases suspected or confirmed
Total patient cases = 3

Updated hypothesis:
1. The timeline and epidemiological information supports association in time and place only partially and more information from WGS might be helpful to confirm or dismiss this association.
2. There is a common unidentified source in NICU or associated clinical areas which has led to acquisition of Bcc in all 3 cases. Timeline and epi information does not support this statement fully and additional information from the clinical review and WGS data should help to confirm or dismiss this statement. - After further investigation, this hypothesis is felt to be unlikely.
3. There are multiple independent sources and acquisition of Bcc are separate events in all 3 cases, possibility from maternal colonisation and transfer during delivery or care.
4. The particular clone of *B. contaminans* has established itself in the environment and should be treated as any other Bcc isolate without association with outbreak related to cleaning wipes.

Investigations:
- Await WGS results from UKHSA.
- Clinical review of all 3 cases did not identify any possible common risk factors for acquisition of Bcc.
- Continue monitoring programme of IPC practice in NICU
- Continue routine patient screening programme in NICU
- Lab SOP for processing CRO screening will be reviewed By the Lab Quality Management team as part of the ongoing quality improvement programme.

Next steps & communications:
No further updates expected unless the situation changes. Incident closed

Linda/Gillian please advise of any errors or omissions

Kind regards

Kaileigh
To ensure a timely response, please do not send general enquiries to individuals.
ARHAI Scotland require all general enquires be directed to the generic mailbox @NSS.ARHAIinfectioncontro[redacted]

Kaileigh Begley
Senior Nurse Infection Control
ARHAI Scotland
Procurement, Commissioning and Facilities
NHS National Services Scotland
4th Floor
Meridian Court
5 Cadogan Street
Glasgow
G2 6QE

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Email: From 1st April this email address changed to NSS.ARHAIinfectioncontro[redacted]
Phone: [redacted]

For urgent out of hours support phone 0141 300 1100 and ask to speak to the HPS On-Call Consultant.

ARHAI Scotland
Antimicrobial Resistance and Healthcare Associated Infection

Julie Rothney

From: Redfern, Jamie
Sent: 11 July 2022 10:09
To: Peters, Christine; Gibson, Brenda
Cc: Macleod, Mairi; [redacted]; Harvey-Wood, Kathleen; Inkster, Teresa; Hackett, Janice
Subject: Re: Microbiology advice line infections

That's fine
Janice - can you arrange?

Get Outlook for iOS

From: Peters, Christine [redacted]
Sent: Monday, July 11, 2022 9:49:12 AM
To: Redfern, Jamie [redacted]; Gibson, Brenda [redacted]
Cc: Macleod, Mairi [redacted]; [redacted]; Harvey-Wood, Kathleen [redacted]; Inkster, Teresa [redacted]; Hackett, Janice [redacted]
Subject: RE: Microbiology advice line infections

Hi Jamie,
It would be good to have a meeting with all ccd in if you are in agreement with this approach?
Kr
Christine

From: Redfern, Jamie
Sent: 09 July 2022 05:46
To: Peters, Christine [redacted]; Gibson, Brenda [redacted]
Cc: Macleod, Mairi [redacted]; [redacted]; Harvey-Wood, Kathleen [redacted]; Inkster, Teresa [redacted]; Hackett, Janice [redacted]
Subject: Re: Microbiology advice line infections

Thanks for your email Christine
I am more than happy to meet with you
Advice on the matter, is it just you or is it all ccd to the email you wish to meet?

I'm very sorry you have recently had Covid
I hope you are feeling better now.

Jamie

Janice - can you arrange invites dependent on Christine's response?
Get Outlook for iOS

From: Peters, Christine [redacted]
Sent: Friday, July 8, 2022 11:20:52 AM
To: Redfern, Jamie [redacted]; Gibson, Brenda [redacted]
Cc: Macleod, Mairi [redacted]; [redacted]; Harvey-Wood, Kathleen [redacted];

Inkster, Teresa [redacted]
Subject: Microbiology advice line infections
Dear Jamie,
I am writing about the implementation of a system to record Microbiology advice on line removal in Paediatric Haemato-Oncology on an excel data sheet.
I understand this has already been implemented in response to recommendations from the external reviews, without full discussion with Microbiology Consultants involved in the unit. I apologise for the delay in raising this as I have been off with COVID and prior to that was not aware of the immediate implementation of the plan.
While I understand the impetus for this action, it does not in fact deal with the issues identified by the reviews, the emphasis of which was close collaboration, and communication, neither of which are aided by this approach.
A decision to remove a line can only be made by the Clinician looking after the patient. Microbiology can advise based on organism, guidelines, experience, antibiotic options, and taking into account specific patient circumstances. This is a common discussion across Microbiology practice on adults and paediatrics and involves close communication and explorations of the risks and benefits. We always record the content of these clinical conversations and our advice (as was noted as good practice in the Case Note Review) , however ultimately the decision to remove a line is not a Microbiology one.
I would be keen to meet to discuss this further – particularly as post CNR there has not been an attempt to engage with the RHC Microbiology team on the review recommendations or actions forthcoming – although I note the Board has been informed that all actions have been completed. Of note we are not invited to take part in the RCA of line infections.
Kr
Christine
Dr Christine Peters
Clinical Lead
Consultant Microbiologist
QEUH
[redacted]

Julie Rothney

From: Peters, Christine
Sent: 17 August 2022 10:02
To: Redfern, Jamie
Subject: Re: Microbiology representation for CG meetings

Hi Jamie,

Thanks for following up. I have not yet received an invite to the Directorate CG meeting. Had a good discussion with Jairam re the departmental one and I think it will be very positive going forward to be involved.

kr
Christine

From: Redfern, Jamie [redacted]
Sent: 17 August 2022 08:50
To: Peters, Christine [redacted]
Subject: Fwd: Microbiology representation for CG meetings
Hi Christine
Did you get similar invite to the Directorate CGF from Alan Mathers
If not, I will chase him up
Jamie

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From: Sastry, Jairam [redacted]
Sent: Wednesday, August 17, 2022 9:33:33 AM
To: Peters, Christine [redacted]
Cc: Redfern, Jamie [redacted]; McVeigh, Alanna [redacted]
Subject: Re: Microbiology representation for CG meetings
Dear Christine
Thank you for getting back to me regarding the Clinical governance meeting.
It would be very good for your input at our CG meetings as discussed.
It is on first Friday of alternate months, next one being on the 2nd of September.

Dear Alanna
Please add Christine to the group. thanks

Best wishes and Kind regards
Dr. Jairam Sastry
Consultant Paediatric Oncologist Honorary Clinical Associate Professor
Royal Hospital for Children University of Glasgow Medical School
1345, Govan Road email: [redacted]
Glasgow G514TF
Ph: [redacted]
email: [redacted]

From: Redfern, Jamie [redacted]
Sent: 21 July 2022 09:19
To: Sastry, Jairam [redacted]
Cc: Peters, Christine [redacted]; Gibson, Brenda [redacted];
McVeigh, Alanna [redacted]
Subject: Re: Microbiology
Thanks, Jairam
This is to supplement not replace IPC

Get Outlook for iOS

From: Sastry, Jairam [redacted]
Sent: Thursday, July 21, 2022 9:18:20 AM
To: Redfern, Jamie [redacted]
Cc: Peters, Christine [redacted]; Gibson, Brenda [redacted];
McVeigh, Alanna [redacted]
Subject: Re: Microbiology
No problems
I shall speak to Chrisine
currently Linda Bagrade attends the CG meetings

Best wishes and Kind regards
Dr. Jairam Sastry
Consultant Paediatric Oncologist Honorary Clinical Associate Professor
Royal Hospital for Children University of Glasgow Medical School
1345, Govan Road email: [redacted]
Glasgow G514TF
Ph: [redacted]
email: [redacted]

From: Redfern, Jamie [redacted]
Sent: 21 July 2022 07:59
To: Sastry, Jairam [redacted]
Cc: Peters, Christine [redacted]; Gibson, Brenda [redacted];
McVeigh, Alanna [redacted]
Subject: Microbiology
Hi JAIRAM
I was at a meeting with colleagues from MICROBIOLOGY who amongst a few changes we are looking at, proposed membership on the Haem Onc Clinical Governance group. Could I ask that you consider this request and speak to DR Peters in regard of how we might enact it if as Chair of said group, you are okay with it?
Jamie

Get Outlook for iOS

Re: SMT discussion re steno - to send or not to send?

Inkster, Teresa [redacted]
Fri 02/09/2022 11:22
To: Macleod, Mairi [redacted];Peters, Christine [redacted];Bagrade, Linda [redacted]
Cc: [redacted];Khalsa, Kamaljit [redacted];Harvey-Wood, Kathleen [redacted];Bryson, Gareth [redacted]

Hi Mairi, from an ARHAI perspective it would be useful to have further details on these examples and whether they pertain to AMR or IPC surveillance. To reiterate, concerns re consistency of processes at ARHAI should not dictate clinical/IPC decision making locally. No surveillance system is without pitfalls, and surveillance reports will usually include a limitations section in which these are acknowledged. There is no expectation that from an IPC perspective all units in Scotland should do the same thing with regards to screening.

Kind regards
Teresa

From: Macleod, Mairi [redacted]
Sent: 31 August 2022 12:11
To: Peters, Christine [redacted]; Bagrade, Linda [redacted]
Cc: Inkster, Teresa [redacted]; [redacted]; Khalsa, Kamaljit [redacted]; Harvey-Wood, Kathleen [redacted]; Bryson, Gareth [redacted]
Subject: RE: SMT discussion re steno - to send or not to send?

Dear Christine,

This example was raised at SMT as a situation where the SOP may need review rather than use of an ad hoc system. My interpretation was that Linda understood Steno reporting from faeces was outwith SOP but if felt valuable it's inclusion should be considered. I as well as some technical staff I have since spoken to also understood this not be included in SOP, though see in your email to Linda you state otherwise. Linda suggesting SOP review is entirely reasonable, there was little discussion of specifics at the meeting and certainly no demand for rationale or criticism of the practice. Normal process would be for this to be discussed as part of GGC SOP reviews but in your initial email you stated you would '**not discontinue either the testing, reporting or communicating as per our current practice**' which disappointingly leaves little room for discussion. Many of the GGC microbiology team are not familiar with this process and immediate questions such as which patients is this valuable in, is it for IPC or clinical purposes, what is the colonisation rate, is this predictive of clinical infection, what lab process optimises recovery if this is a target organism, if felt to be valuable should it be implemented in adult haem-onc group or high acuity units with history of outbreaks seem not to be open for discussion. I value and recognise the experience of microbiologists in the QEUH site but equally value other members of the team and what they could bring to discussion.

There is no insistence on identical processes but I would hope patients with similar characteristics submitting identical samples to both labs would yield the same result.

I'm not sure it's helpful to go through each point so have limited it to those requiring a reply.
With regard to point 5, I'm sorry this caused you deep concern and that you feel it warrants full elaboration. I'm more than happy to go through various examples of where testing and reporting bias has been problematic including national surveillance but they do not relate to reporting of Stenotrophomonas from faeces. These were general comments reflecting benefits of consistent processes. Linda has elaborated on her remark relating to ARHAI.
With regard to point 6 I'm not sure what the significance of isolating Stenotrophomonas is from the GI tract so have no cases I feel it ought to have been reported.

The SMT should be a safe space for open and transparent discussion where a difference of opinion should not lead to negative dialogue in this way. How we move forward on this issue is not immediately clear and will liaise with senior management regarding next steps.

Mairi

From: Peters, Christine [redacted]
Sent: 26 August 2022 12:48
To: Macleod, Mairi [redacted]; Bagrade, Linda [redacted]
Cc: Inkster, Teresa [redacted]; [redacted]; Khalsa, Kamaljit [redacted]; Harvey-Wood, Kathleen [redacted]; Bryson, Gareth [redacted]
Subject: RE: SMT discussion re steno - to send or not to send?

Dear Mairi,

Thank you for your email. There are a number of points that arise from your response:

1.The clear understanding of those of us present at the meeting is that Linda stated that that result should not have been reported. I asked for clarity, am glad that was not intended, and hope the minutes reflect this. I have responded to Linda's email to which you are copied in.

2. With regard to the SOP - I have covered this in email to Linda

3.It is inappropriate to insist on identical processes across QEUH, RHC and GRI as they serve very different patient groups. The microbiology expertise for this patient group is based at this site and we strive to ensure patient centred excellence in our targeted service.

4. The authorisation process picks up cases across different locations and boarding patients are picked up due to gathers daily using up to date consultant lists. This proved to be an excellent system during the water outbreaks (that are currently the subject of PI) and was commended by HPS as the best approach to surveillance in the patient cohort.

5.I do not understand what you mean by unintended consequences of reporting bias in the context of this particular result as I am very concerned about the implications both for us and ARHAI. The statement is concerning irrespective of clinical setting and warrants full elaboration for the team to understand

6.It would be helpful for you to share any specific example of a patient who you feel ought to have had steno reported and it was not so I can understand your concerns.

As Gareth has been copied in I would suggest that the commenced work on communication between IPC and Microbiology is progressed, however I would request that we have input from those involved in the case note review and ARHAI to ensure that their findings and recommendations are being correctly interpreted by us all, to avoid repetition of historic disagreements and consequences and to enable a clear road of progression ahead.

I think it is fair to say that the absence of resolution of differences of opinion is substantively compounding pressures on the team who are concurrently giving statements on criminal investigations into Steno deaths. Of note we are not being asked to justify the finding of cases. We are being asked to justify actions on the basis of finding cases. A simple email highlighting the very first steno colonisation in a immunocompromised patient on the same BMT unit was hardly an act of mal practice, and I remain extremely concerned at what has happened since that helpful email was sent.

Regards,

[redacted]

Dr Christine Peters
Clinical Lead
Consultant Microbiologist
QEUH
[redacted]

From: Macleod, Mairi
Sent: 25 August 2022 12:28
To: Peters, Christine [redacted]; Bagrade, Linda [redacted]
Cc: Inkster, Teresa [redacted]; [redacted]; Harvey-Wood, Kathleen [redacted]; Bryson, Gareth [redacted]
Subject: RE: SMT discussion re steno - to send or not to send?

Dear Christine,

Further to SMT and discussion relating to governance around ad hoc requests, Linda correctly highlighted that reporting of Stenotrophomonas in faeces is not detailed in our SOPs. She suggested that where a test was felt to be useful but not within SOP that perhaps the SOP needed reviewed. At no point did Linda state

that this organism should not have been reported. I, however, do not share your confidence in this practice. It is not mirrored in other patient groups in GGC and think it would merit wider discussion.

I don't understand your later points or think they accurately reflect discussion. Linda remarked that reporting bias can have unintended consequences including impact on national surveillance and that this had been acknowledged by ARHAI in previous incidents outside of BMT unit.

There has been no restriction on testing/reporting in South sector lab with many SOPs highlighting different process on basis of RHC location instead of on the basis of patient characteristics alone. Again, it would be useful to revisit this so that we are assured we are providing the same service to all patients in GG&C.

Mairi

From: Peters, Christine [redacted]
Sent: 23 August 2022 11:50
To: Bagrade, Linda [redacted]
Cc: Inkster, Teresa [redacted]; [redacted]; Harvey-Wood, Kathleen [redacted]; Macleod, Mairi [redacted]
Subject: Fw: SMT discussion re steno - to send or not to send?

Dear Linda,
I am writing to ask for clarity regarding your comment at SMT regarding the reporting of Stenotrophomonas in faeces in a 2A patient.

Specifically in regard to these statements that you made:

1. this result was off SOP
2. there are unintended consequences of such testing
3. that it makes GGC look bad as results are shared with ARHAI , and we are compared with other health boards
4. ARHAI have accepted they are biased with regard to results from GGC

I am deeply concerned regarding the correspondence around this particular case and the above narrative which amounts to an approach that would put pressure on the paediatric microbiology team to not test, not report and not communicate this result.

We are the only paediatric BMT unit in Scotland - we are not comparable to other centres, ARHAI are well aware of this. If ARHAI have issues with our testing SOPS I would expect there to be formal communication regarding this or as an outcome of the CNR, which it was not. Notwithstanding infection control issues, knowledge of steno colonisation has made a clinical impact and changed management plans previously and can't be ignored in a unit that has seen fatal bacteraemias. IMTs took account of colonised cases and GOSH have a system of looking for and reporting Stenos in faeces on their BMT unit. We are an experienced group of Consultants and Clinical scientist dealing with this cohort over many years.

We will not discontinue either the testing, reporting or communicating as per our current practice as this is in line with good practice and our practice has been highlighted as "outstanding" by the CNR when over 80 cases we were involved in was scrutinised. What was however criticised was omitting to consider different species together as one environmental issue, not keeping track of historic typing, and the pressure on microbiology not to communicate.

regards,

Christine

Re: SMT discussion re steno - to send or not to send?

Inkster, Teresa [redacted]
Fri 26/08/2022 09:53

To: Bagrade, Linda [redacted];Peters, Christine [redacted]

Cc: [redacted];Harvey-Wood, Kathleen [redacted];Macleod, Mairi [redacted];Devine, Sandra [redacted]

Hi, I was not present at the SMT but I do not understand the reference to being reflected unfairly in surveillance data given that ARHAI do not have a Scottish or UK based surveillance system for BMT units.

A faecal colonisation with Stenotrophomonas was reported and recorded at the March 2018 IMT, so the approach by the lab has been consistent. I am sure you will agree that any intelligence we can get on this vulnerable patient group is valuable from both a clinical and outbreak detection perspective. How we handle such results should be dictated by that and not unfairness in a surveillance system.

kr
Teresa

From: Bagrade, Linda [redacted]
Sent: 25 August 2022 14:27
To: Peters, Christine [redacted]
Cc: Inkster, Teresa [redacted]; [redacted]; Harvey-Wood, Kathleen [redacted]; Macleod, Mairi [redacted]; Devine, Sandra [redacted]
Subject: RE: SMT discussion re steno - to send or not to send?

Dear Christine,

It is very disappointing to see my words being misrepresented so much that it makes any further discussion extremely difficult.

What I am saying is that if we are deviating from an agreed SOP and this is frequently occurring event then the SOP needs to be reviewed and changed to reflect this practice.
Also, if we are reporting differently from any other lab in Scotland or UK (for BMT units) then this reflects unfairly in surveillance data. I did not use words "GGC looks bad", I said it reflects unfairly.

Reporting bias is being discussed at the IMTs and reported to national agencies during outbreak investigations, the latest being investigation of *Burkholderia contaminans* incident where one of the patients had Burkholderia reported from a CPE screen. I did not say ARHAI are biased towards GGC results.

I find the reporting of Stenotrophomonas and Burkholderia from investigations not designed for this purpose potentially open to subjective interpretation. For this reason I would like to continue this conversation at the appropriate forum like GGC consultant meeting where we can agree on the way forward and formalise the process, which should standardise reporting.

The current LP 507 v10 for enteric investigations found on Q pulse states:
Royal Hospital for Children - Schiehallion Ward (2A / 2B):
All stool samples (diarrhoeal and non diarrhoeal) are tested for enteric pathogens and screened for yeasts, VRE, gentamicin resistant and ESBL producing coliforms.

I hope my colleagues present at the meeting will agree I never made any critical comment about professionalism or clinical management of this or any other case as this is not remit of IPCT. Reviewing communication related to this issue I cannot see any evidence of applying pressure or asking anybody not to communicate or deviate from the best practice so I find these accusations untrue.

I also note you have included a very selective group of colleagues in this email communication. I would hope we can discuss this issue in a wider group and agree on a formal change in our reporting if it is found necessary.

Taking into account the accusations you are making I have included DIPC in this response.

Kind regards,

Linda

From: Peters, Christine
Sent: 23 August 2022 11:50
To: Bagrade, Linda [redacted]
Cc: Inkster, Teresa [redacted]; [redacted]; Harvey-Wood, Kathleen [redacted]; Macleod, Mairi [redacted]
Subject: Fw: SMT discussion re steno - to send or not to send?

Dear Linda,
I am writing to ask for clarity regarding your comment at SMT regarding the reporting of Stenotrophomonas in faeces in a 2A patient.

Specifically in regard to these statements that you made:

1. this result was off SOP
2. there are unintended consequences of such testing
3. that it makes GGC look bad as results are shared with ARHAI , and we are compared with other health boards
4. ARHAI have accepted they are biased with regard to results from GGC

I am deeply concerned regarding the correspondence around this particular case and the above narrative which amounts to an approach that would put pressure on the paediatric microbiology team to not test, not report and not communicate this result.

We are the only paediatric BMT unit in Scotland - we are not comparable to other centres, ARHAI are well aware of this. If ARHAI have issues with our testing SOPS I would expect there to be formal communication regarding this or as an outcome of the CNR, which it was not. Notwithstanding infection control issues, knowledge of steno colonisation has made a clinical impact and changed management plans previously and can't be ignored in a unit that has seen fatal bacteraemias. IMTs took account of colonised cases and GOSH have a system of looking for and reporting Stenos in faeces on their BMT unit. We are an experienced group of Consultants and Clinical scientist dealing with this cohort over many years.

We will not discontinue either the testing, reporting or communicating as per our current practice as this is in line with good practice and our practice has been highlighted as "outstanding" by the CNR when over 80 cases we were involved in was scrutinised. What was however criticised was omitting to consider different species together as one environmental issue, not keeping track of historic typing, and the pressure on microbiology not to communicate.

regards,

Christine

Re: Stenotrophomonas typing results

Inkster, Teresa [redacted]
Tue 06/09/2022 08:46

To: Bal, Abhijit [redacted];Peters, Christine [redacted];Bagrade, Linda [redacted];[redacted];[redacted];Pritchard, Lynn [redacted];Bowskill, Gillian [redacted]

Cc: Khalsa, Kamaljit [redacted];Harvey-Wood, Kathleen [redacted]

Hi Abs, I am aware of the manual content as I chaired Chapters 3/4. The manual does not discuss interpretation of typing or suggest IPCT don't take ownership of typing results.

The point I am making is regardless of how the typing result came about are IPCT not concerned that the result suggests an ongoing environmental reservoir and an ongoing risk to patients?

kr
Teresa

From: Bal, Abhijit [redacted]
Sent: 05 September 2022 17:01
To: Inkster, Teresa [redacted]; Peters, Christine [redacted]; Bagrade, Linda [redacted]; [redacted]; Pritchard, Lynn [redacted]; Bowskill, Gillian [redacted]
Cc: Khalsa, Kamaljit [redacted]; Harvey-Wood, Kathleen [redacted]
Subject: Re: Stenotrophomonas typing results

Thanks Teresa. We follow the NIPCM so as to minimise individual variations in practice. We continue to rely on the guidance as laid down in the manual where applicable. We look at the specified time frames in a rolling manner based on our internal guidelines. The NIPCM itslef does not prescribe any fixed time period for linked cases.

Abs

From: Inkster, Teresa [redacted]
Sent: 05 September 2022 16:47
To: Bal, Abhijit [redacted]; Peters, Christine [redacted]; Bagrade, Linda [redacted]; [redacted]; Pritchard, Lynn [redacted]; Bowskill, Gillian [redacted]
Cc: Khalsa, Kamaljit [redacted]; Harvey-Wood, Kathleen [redacted]
Subject: Re: Stenotrophomonas typing results

The most logical explanation for these findings is an unidentified environmental reservoir within the hospital, therefore I am surprised that the IPCT are not interested. Environmental outbreaks can be subtle with long time periods between cases, this is well described.

kr

Teresa

Dr Teresa Inkster MBChB, BSc (Hons), FRCP, DTMH, MPH, FRCPath, FRSPH
Consultant Microbiologist ,NHSGGC
Consultant Microbiologist/Infection Control Doctor, ARHAI Scotland/NHS Assure
National TPD Medical Microbiology

Department of Microbiology, Level 4 labs building, Queen Elizabeth University Hospital, Govan Road, Glasgow, G51 4TF

From: Bal, Abhijit [redacted]
Sent: 05 September 2022 16:39
To: Peters, Christine [redacted]; Bagrade, Linda [redacted]; [redacted]; Pritchard, Lynn [redacted]; Bowskill, Gillian [redacted]
Cc: Khalsa, Kamaljit [redacted]; Inkster, Teresa [redacted]; Harvey-Wood, Kathleen [redacted]
Subject: Re: Stenotrophomonas typing results

Thanks Christine, we do not need typing information to find out if a particular organism is hospital acquired. Typing information is necessary to establish links between known cases within a time frame. We do not feel typing is necessary in individual cases.

My remarks in relation to Stentrophomonas and typing was in a more general sense.

We have not requested typing and we do not take an ownership of the result. If we find other patients within the epidemiological setting, we will request typing as part of our investigation.

Regards,

Abs

From: Peters, Christine [redacted]
Sent: 05 September 2022 16:35
To: Bal, Abhijit [redacted]; Bagrade, Linda [redacted]; [redacted]; Pritchard, Lynn [redacted]; Bowskill, Gillian [redacted]
Cc: Khalsa, Kamaljit [redacted]; Inkster, Teresa [redacted]; Harvey-Wood, Kathleen [redacted]
Subject: RE: Stenotrophomonas typing results

Hi Abs,
This is not a matter of speculation and salad eating is not a neonatal occupation, nor a route into ascitic fluid.

I am not sure if you are familiar with the BSI standards on Water Quality Code of Practice BS 8580- 2:2022?

There is a good section on clinical surveillance on page 71, Stenotrophomonas is consider to be a waterborne pathogen.

WGS interpretation is not the question here, the issue is a clinically invasive sample was closely typed with previous isolates in our patient population.

The information has been conveyed. Your choice on what to do with that information. My view is that it warrants thoughtfulness regarding could this have been hospital acquired.

Kr
Christine

From: Bal, Abhijit
Sent: 05 September 2022 16:18
To: Peters, Christine [redacted]; Bagrade, Linda [redacted]; Pritchard, Lynn [redacted]; Bowskill, Gillian [redacted]
Cc: Khalsa, Kamaljit [redacted]; Inkster, Teresa [redacted]; Harvey-Wood, Kathleen [redacted]
Subject: Re: Stenotrophomonas typing results

Hi all,

Data from whole genome sequencing can be used to speculate unknown links as happened in the Dutch and Danish matches for NDM-5 *Klebsiella* some years ago. For *Stenotrophomonas*, there could be several links including community links. A potential link could be consuming salad from the same supermarket. These are epidemiological data and that inform us more generally about bacterial ecology. These data are not a trigger for IPC action. IPC has not requested sequencing and take no ownership of results.

Thanks,

Abs

From: Peters, Christine [redacted]
Sent: 05 September 2022 14:57
To: Bagrade, Linda [redacted]; [redacted]; Bal, Abhijit [redacted]; Pritchard, Lynn [redacted]; Bowskill, Gillian [redacted]
Cc: Khalsa, Kamaljit [redacted]; Inkster, Teresa [redacted]; Harvey-Wood, Kathleen [redacted]
Subject: RE: Stenotrophomonas typing results

I see. Thanks for clarifying what the IPC position is with regard to Steno typing and that the database is not within the scope of IPC.

In which case it is even more important for us to highlight those that are found to be linked by typing to the IPC.

Given there have been two cases that had a striking match to a case that died in 2017, it is epidemiological information that is pertinent to understanding the microbiology of the hospital, past and present.

The recurrent matches to the CF isolates is relevant to understanding CF acquisition too, which is also within the purview of IPC.

Kr
Christine

From: Bagrade, Linda
Sent: 05 September 2022 14:45
To: Peters, Christine [redacted]; Bal, Abhijit [redacted]; Pritchard, Lynn [redacted]; Bowskill, Gillian [redacted]
Cc: Khalsa, Kamaljit [redacted]; Inkster, Teresa [redacted] Harvey-Wood, Kathleen [redacted]
Subject: RE: Stenotrophomonas typing results

Indeed...
Since it is set up by micro lab we have no control over what is included in that database/dataset therefore it wouldn't be correct to call it IPCT database/dataset

Linda

From: Peters, Christine
Sent: 05 September 2022 14:33
To: Bagrade, Linda [redacted]; Bal, Abhijit [redacted]; Pritchard, Lynn [redacted]; Bowskill, Gillian [redacted]
Cc: Khalsa, Kamaljit [redacted]; Inkster, Teresa [redacted]; Harvey-Wood, Kathleen [redacted]
Subject: RE: Stenotrophomonas typing results

Oh I thought the dataset that John Mallon had set up was the portal for keeping track of typing – glad I asked.

Kr
Christine

From: Bagrade, Linda
Sent: 05 September 2022 14:28
To: Peters, Christine [redacted]; Bal, Abhijit [redacted]; Pritchard, Lynn [redacted]; Bowskill, Gillian [redacted]
Cc: Khalsa, Kamaljit [redacted]; Inkster, Teresa [redacted]; Harvey-Wood, Kathleen [redacted]
Subject: RE: Stenotrophomonas typing results

I don't know Christine, depends which database you mean. IPCT does not hold a database for Steno typing.

Linda

From: Peters, Christine
Sent: 05 September 2022 14:18
To: Bagrade, Linda [redacted]; Bal, Abhijit [redacted]; Pritchard, Lynn [redacted]; Bowskill, Gillian [redacted]
Cc: Khalsa, Kamaljit [redacted]; Inkster, Teresa [redacted]; Harvey-Wood, Kathleen [redacted]
Subject: RE: Stenotrophomonas typing results

Will the result go into the IPCT database Linda out of interest?

Christine

From: Bagrade, Linda
Sent: 05 September 2022 14:13
To: [redacted]; Bal, Abhijit [redacted]; Pritchard, Lynn [redacted]; Bowskill, Gillian [redacted]
Cc: Peters, Christine [redacted]; Khalsa, Kamaljit [redacted]; Inkster, Teresa [redacted]; Harvey-Wood, Kathleen [redacted]
Subject: RE: Stenotrophomonas typing results

IPCT has not asked for these isolates to be typed so the e-mail is not for us.

Linda

From: [redacted]
Sent: 05 September 2022 14:01
To: Bagrade, Linda [redacted]; Bal, Abhijit [redacted]; Pritchard, Lynn [redacted]; Bowskill, Gillian [redacted]
Cc: Peters, Christine [redacted]; Khalsa, Kamaljit [redacted]; Inkster, Teresa [redacted]; Harvey-Wood, Kathleen [redacted]
Subject: Re: Stenotrophomonas typing results

Hi Linda,

I am actioning reference lab mail that has come through and did not send this particular sample for typing, so don't have more information about discussions at the point of sending it.

Regards,

[redacted]

From: Bagrade, Linda [redacted]
Sent: 05 September 2022 13:56
To: [redacted]; Bal, Abhijit [redacted]; Pritchard, Lynn [redacted]; Bowskill, Gillian [redacted]
Cc: Peters, Christine [redacted]; Khalsa, Kamaljit [redacted]; Inkster, Teresa [redacted]; Harvey-Wood, Kathleen [redacted]
Subject: RE: Stenotrophomonas typing results

[redacted],

What is the purpose of sending these Senotrophomonas to RL?

Linda

From: [redacted]
Sent: 05 September 2022 13:47
To: Bal, Abhijit [redacted]; Pritchard, Lynn [redacted]; Bagrade, Linda [redacted]; Bowskill, Gillian [redacted]
Cc: Peters, Christine [redacted]; Khalsa, Kamaljit [redacted]; Inkster, Teresa [redacted]; Harvey-Wood, Kathleen [redacted]
Subject: Stenotrophomonas typing results
A49529391

Dear all,

Please find attached an adult Stenotrophomonas typing result received today from the ref lab. There is mention of potential links to some isolates from other patients (including paediatrics and cystic fibrosis), hence am copying in colleagues covering paediatrics as well as CF today for their info. I wonder if the number [redacted] might refer to isolate [redacted] and they have just forgotten to put the dot in. There is mention of an isolate [redacted] however I am unsure which isolate this is, but can be clarified from reference lab if needed.

Regards,

[redacted]

Re: Hospital-revealed infections

Inkster, Teresa [redacted]
Thu 24/11/2022 16:50

To: Peters, Christine [redacted];Bal, Abhijit [redacted];Harvey-Wood, Kathleen [redacted];Khanna, Nitish [redacted];Khalsa, Kamaljit [redacted];Wright, Pauline [redacted];Valyraki, Kalliopi [redacted];Balfour, Alison [redacted]

Hi , it is clearly stated at the beginning of Appendix 13 that the document outlines a nationally agreed minimum list of alert organisms. Furthermore, within the environmental bacteria section it states that the list is not exhaustive.

The expectation is that boards take into account local epidemiology and can add to this list. There was no guideline back in 2016 telling us to have surveillance in place for the 'big 4' .This was local learning which we implemented after the Serratia incident and which influenced national guidance. We expect trained IPCT colleagues to have the ability to work beyond guidance.

In light of the 2018 incident and various reviews it is a concern to see several waterborne organisms omitted from this list locally, particularly Cupriavidus. If we stick to this guidance then a case of Cupriavidus bacteraemia in 2a would not result in water testing ,which is a worry.

Lastly it seems my research paper is being misinterpreted . There should be no complacency as a result of finding Cupriavidus in other hospital water systems and benchmarking is not appropriate. Cupriavidus has only ever been isolated from water sources and our conclusion was ; *'It is recommended that Cupriavidus spp. should be classed as alert organisms to act as a stimulus for water testing in the event of a patient having healthcare-associated infection with these bacteria. Consideration might also be given to water testing following infection with other rare and unusual waterborne pathogens, such as Delftia acidovorans, Sphingomonas spp.,Brevunidomonas spp., Comamonas spp. and Elizabethkingia spp.'*

kr
Teresa

From: Peters, Christine [redacted]
Sent: 24 November 2022 12:51
To: Bal, Abhijit [redacted]; Harvey-Wood, Kathleen [redacted]; Khanna, Nitish [redacted]; Khalsa, Kamaljit [redacted]; Wright, Pauline [redacted]; Inkster, Teresa [redacted]; Valyraki, Kalliopi [redacted]; Balfour, Alison [redacted]
Subject: RE: Hospital-revealed infections

Regarding the NIPCM manual – the key point is the local application of local knowledge and was written as a direct result of learning from incidents in this hospital. It was written largely by a team lead by Teresa so her views on how it should be interpreted / translated into actions are invaluable.

Kr
Christine.

From: Bal, Abhijit
Sent: 24 November 2022 12:45
To: Peters, Christine [redacted]

[redacted]; Harvey-Wood, Kathleen [redacted]; Khanna, Nitish [redacted]; Khalsa, Kamaljit [redacted]; Wright, Pauline [redacted]; Inkster, Teresa [redacted]; Valyraki, Kalliopi [redacted]; Balfour, Alison [redacted]

Subject: Re: Hospital-revealed infections

Yes, our ICD colleagues should be trusted to differentiate the potential routes of transmission taking into account the background microbiology, the antibiotic history, and assessment of the burden of the problem based on the recommendations in the NIPCM manual. We aim to take proportionate actions. ICDs should be prepared to justify those actions like any other doctors.

Abs

From: Peters, Christine [redacted]
Sent: 24 November 2022 11:25
To: Bal, Abhijit [redacted]; [redacted]; Harvey-Wood, Kathleen [redacted]; Khanna, Nitish [redacted]; Khalsa, Kamaljit [redacted]; Wright, Pauline [redacted]; Inkster, Teresa [redacted]; Valyraki, Kalliopi [redacted]; Balfour, Alison [redacted]

Subject: RE: Hospital-revealed infections

For COVID it has been "hospital associated" , and in IPC the concept of pre admission colonisation/ latency is well established.

The key to differentiating the possible routes is the epi and clinical history as well as microbiology signs.

Sadly the MRSA problem in the early 2000s was slow to be tackled due to the prevalent view that it was justa colonising staph in the community.

Kr
Christine

From: Bal, Abhijit
Sent: 24 November 2022 09:47
To: Peters, Christine [redacted]; [redacted]; Harvey-Wood, Kathleen [redacted]; Khanna, Nitish [redacted]; Khalsa, Kamaljit [redacted]; Wright, Pauline [redacted]; Inkster, Teresa [redacted]; Valyraki, Kalliopi [redacted]; Balfour, Alison [redacted]

Subject: Hospital-revealed infections

Hi all,

This is the paper where I first noticed the term "hospital-revealed" infection, which I discussed in yesterday's meeting (Until then I used the term "hospital-surfaced" but revealed is a broader term as it could refer to either hiding or hiding in plain sight, both!!).

It is a nice review on Aspergillosis.

Abs

Fwd: QEUH Independent Inspection Report

Teresa Inkster [redacted]
Tue 24/01/2023 16:12
To: Inkster, Teresa [redacted]

1 attachments (180 KB)
1-s2.0-S0195670108000856-main (1).pdf;

Sent from Outlook for Android

From: Teresa Inkster
Sent: Monday, November 28, 2022 11:02:44 AM
To: Laura Imrie [redacted]; Anne. e Rankin [redacted]; Ian Storrar [redacted]; teresa.inkster [redacted]
Cc: Julie Critchley [redacted]
Subject: RE: QEUH Independent Inspec on Report

Hi Laura,

Having read the report it is not clear how the recommenda on for na onal guidance has arisen. The report is by no means a comprehensive review of HAI Aspergillus infec ons in Scotland or within NHSGGC. It focuses on a limited me period of one year and has only reviewed one incident involving two pa ents, which in fact were not HAIs. There are some na onal and local guidelines/tools, which appear not to have not been considered. These include;

1) SHTM 03-01 – contains detail on the specifica on of ven la on systems designed to minimise the risk from Aspergillus in high risk settings e.g. ICU,BMT, haemato-oncology
2) NHSGGC air sampling policy, endorsed by an SBAR produced by HPS in 2017
3) NHSGGC water damage policy – delineates the risk from and how to safely remove mould
4) An fungal prophylaxis guidelines – would expect varia on between boards as per an bio c guidelines
5) EORTC case defini ons for Aspergillus which microbiologists u lise

We already have the Aspergillus info for staff document. It could be more specific regarding water ingress as a risk, as this is often overlooked. Nonetheless, this document includes a descrip on of pa ents at increased risk, how to iden fy an outbreak, how to manage an outbreak (including the need for an environmental assessment and a list of control measures iden fied from the literature). Furthermore, we have Aspergillus on the alert organism list and we would expect IPCT to manage an incident as per any other pathogen and in accordance with Chapter 3 of the NIPCM. We do not have pathogen specific guidance and it is not clear why we should focus on Aspergillus as opposed to other fungal threats such as Mucoraceous moulds and Fusarium spp. There is no debate that the diagnosis is complex and dependent on host factors, clinical factors and mycological criteria, however this is well within the remit of a Consultant Microbiologist/ICD. An indica on as to where there are felt to be gaps in exis ng guidance documents would have been useful.

The real issue appears to be in rela on to the management and repor ng of a single case of HAI Aspergillus. It would be worth exploring with NHSGGC why this differs from previous years. In 2016 a single case was reported and inves ga ons revealed in a tear in ven la on ductwork amongst other poten al hypotheses. In 2017, two cases occurring within days of each other were reported and linked to mould on a ceiling le and in 2018 a further single case was inves gated. It would appear that repor ng is now in response to two cases and within a defined me period – see my comment re this below.

Page 27

'We sought advice from our external independent Aspergillus expert who acknowledged that the 30 day marker was an appropriate point to establish and review all new cases. However, he suggested that when applying the review period for any potentially linked cases, NHS Greater Glasgow and Clyde may wish to consider a commencement point of 30 days from initial signs of infection rather than 30 days from identification of infection.

I disagree with this and I would be very concerned about publica on of this comment and the poten al incorpora on into na onal guidance and adop on in Sco. sh hospitals. Case ascertainment is an important component of outbreak management and ensures all cases with poten al links are iden fied. Iden fica on of the index case can be par cularly valuable with regards to source and the ming of the introduc on of a pathogen into a unit. Thirty days is a short me frame for any pathogen but par cularly those of an environmental nature. Sources of Aspergillus can be undetected or ongoing for months/years e.g. construc on on the site /vicinity, water leaks can be hidden behind IPS panels or in ceiling voids. There is no scien fic reference suppor ng this statement. It is not clear if HIS consulted any infec on control expert. I have not had me to pull out all the literature but see the meline in the paper attached which illustrates this point.

I would suggest HIS check the factual accuracy with regards to the supposed' lab error'. This is more than likely Aspergillus contamina on which is part of any inves ga on into cases. Laboratory air is not filtered, and because spores are ubiquitous we can get contamina on of agar plates in the laboratory. This is one of the first things to exclude when inves ga ng cases and should not be construed as error.

Kr
Teresa

From: Laura Imrie [redacted]
Sent: 25 November 2022 10:46
To: Annette Rankin [redacted]; Ian Storrar [redacted]; Teresa Inkster [redacted]; teresa.inkster [redacted]
Cc: Julie Critchley [redacted]
Subject: FW: QEUH Independent Inspec on Report

PLEASE NOTE THIS IS AN EMBARGOED REPORT AND I HAVE HAD TO GAIN APPROVAL TO SHARE WITH YOU – PLEASE DO NOT SHARE FURTHER

Can you please review and provide your feedback only on the sec on that references na onal guidance, ARHAI or HFS? Report due for release next week therefore can you please respond by lunch me Monday 28th November 2022? Would be helpful if you can provide the page number and comment separate to the document.

Thanks

Laura

From: Emma Smith (NHS Healthcare Improvement Scotland) [redacted] **On Behalf Of** Lynsey Cleland (NHS Healthcare Improvement Scotland)
Sent: 24 November 2022 11:48
To: Laura Imrie [redacted]
Subject: QEUH Independent Inspec on Report

Dear Laura

Please find attached letter & Independent Inspec on Report for QEUH

If you should have any queries please do not hesitate to contact me

Kind regards

Lynsey

Lynsey Cleland
Director of Quality Assurance
Healthcare Improvement Scotland

Delta House | 50 West Nile Street | Glasgow | G1 2NP
[redacted]

Pronouns: she/her

Enquiries to: Emma Smith
PA to Director of Quality Assurance
Mobile: [redacted]

Website: [redacted]
Twi. er: @
Facebook: [redacted]

Suppor ng better quality health and social care for everyone in Scotland.

Healthcare Improvement Scotland includes: The Improvement Hub (ihub), Community Engagement, the Scottish Health Technologies Group, the Scottish Intercollegiate Guidelines Network (SIGN), the Scottish Medicines Consor um and the Scottish An microbial Prescribing Group.

FW: ORT HIIAT2022-GGC-South-326

Annette Rankin [redacted]
Wed 07/12/2022 15:39
To: Inkster, Teresa [redacted]

From: Annette Rankin
Sent: 07 December 2022 15:39
To: Devine, Sandra [redacted]
Cc: NSS ARHAIinfectioncontrol [redacted]; Bowskill, Gillian [redacted]; Pritchard, Lynn [redacted]; Kelly, Allana [redacted]; Bagrade, Linda [redacted]; Bal, Abhijit [redacted]; Laura Imrie [redacted]
Subject: RE: ORT HIIAT2022-GGC-South-326

Many thanks for this Sandra.

I will include the information you have provided on air sampling to the update I will submit to the HAI policy unit

Annette

From: Devine, Sandra [redacted]
Sent: 07 December 2022 14:52
To: Annette Rankin [redacted]
Cc: Bowskill, Gillian [redacted]; Pritchard, Lynn [redacted]; Kelly, Allana [redacted]; Bal, Abhijit [redacted]; Bagrade, Linda [redacted]; NSS ARHAIinfectioncontrol [redacted]
Subject: ORT HIIAT2022-GGC-South-326

Hi Annette

Thank you for your e mail. We will share with the group ARHAI's assessment of the HIIAT. We can also confirm that the decision to sample air across the patient pathway had already been agreed and this will include theatres and imaging.

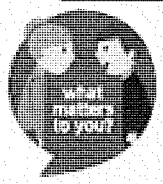
Chapter 3 of the NIPCM clearly states that it is aligned to the Management of Public Health Incidents (2020). The Public Health Guidance details the roles and responsibilities of the IMT/PAG, including the expectation that the IMT/PAG will reach collective decisions. In this case the group agreed that the HIIAT assessment is GREEN.

Regards
Sandra

Director of Infection Prevention & Control
NHS Greater Glasgow & Clyde
[redacted] (PA Ann Lang)
[redacted]

Please consider the environment before printing this email.

sandra.devine[redacted]



From: Annette Rankin
Sent: 07 December 2022 12:22
To: Kelly, Allana [redacted]
Cc: NSS ARHAIinfectioncontrol [redacted]; Bowskill, Gillian [redacted]; Pritchard, Lynn [redacted]
Subject: RE: ORT HIIAT2022-GGC-South-326

Thanks Allana,

This is helpful. Given the causative organism for the patient's condition/wound dehiscence is mucor and whilst it is a single case we would request you reconsider the HIIAT scoring particularly in the following areas:

- Severity of illness: we would consider this to be moderate given the intervention and anti-fungal treatment required
- Mode of transmission: we would consider this to be moderate as the source is being investigated and currently unknown therefore there may be a risk of ongoing exposure
- Public anxiety: we would also consider public anxiety in this case to be greater than minor given previous publicity surrounding previous fungal cases.
- Impact on service: It would appear minimal or no impact on services and we would consider this minor

Therefore our assessment of this incident based on the information provided would be amber

As part of your investigations and the review of your ventilation verification: As ventilation verification no longer includes air sampling, are there any plans to carry out air sampling particularly in the theatre area. Previously mucor reported from QEUH had a suspected link to a leaking dialysis point behind the IPS panels. Has this been explored as a hypothesis?

We inform the HAI policy unit of unusual organisms/exceptional incidents and will shortly provide a summary update on this incident however would appreciate a response on whether the HIIAT will be reconsidered prior to this?

[redacted]

Annette Rankin
Nurse Consultant Infection Control
Clinical lead Infection control built environment and decontamination (ICBED) programme

ARHAI Scotland
NHS National Services Scotland
4th Floor
Meridian Court
5 Cadogan Street
Glasgow
G2 6QE
[redacted]
www.nhsnss.org

ARHAI Scotland
Antimicrobial Resistance and Healthcare Associated Infection

From: Kelly, Allana [redacted]
Sent: 06 December 2022 15:04
To: Annette Rankin [redacted]
Cc: NSS ARHAIinfectioncontrol [redacted]; Bowskill, Gillian [redacted]; Pritchard, Lynn [redacted]
Subject: Re: ORT HIIAT2022-GGC-South-326

Hi Annette

Please find answers to your questions below and please let me know if you require any further information.

- What is considered the causative organism in the breakdown of the wound?

The causative organism is in keeping with Mucor.

- Any other organisms identified from the patients wound/drain samples

24/11/22 Corynebacterium tuberculostearicum isolated from abdominal skin swab
22/11/22 Candida albicans isolated from abdominal wound swab
14/11/22 Candida albicans isolated from abdominal fluid
07/11/22 Candida albicans isolated from bile
01/11/22 Bacteroides ovatus and E.coli isolated from bile

- Any other positive Mucor samples isolated across the QEUH site over the last 3 months?

No Mucor isolates identified from 01/09/2022 to date on the QEUH site.

Kind Regards

Allana

Allana Kelly
Lead Nurse - Infection Prevention and Control Team,
South Glasgow Sector- QEUH, GGH, NVACH
[redacted]

From: Annette Rankin [redacted]
Sent: 05 December 2022 12:06
To: Kelly, Allana [redacted]
Cc: NSS ARHAIinfectioncontrol [redacted]
Subject: ORT HIIAT2022-GGC-South-326

Hi Allana

We have received your *ORT HIIAT2022-GGC-South-326:Queen Elizabeth University Hospital: Critical care unit* 4 and wonder if you could provide some more detail?

- What is considered the causative organism in the breakdown of the wound?
- Any other organisms identified from the patients wound/drain samples
- Any other positive mucor samples isolated across the QEUH site over the last 3 months?

Many thanks

[redacted]

Annette Rankin
Nurse Consultant Infection Control
Clinical lead Infection control built environment and decontamination (ICBED) programme

ARHAI Scotland
NHS National Services Scotland
4th Floor
Meridian Court
5 Cadogan Street
Glasgow
G2 6QE
[redacted]
www.nhsnss.org

Fwd: NHS GG&C: RHC Neonatology Burkholderia Contaminans HIIAT Green HIIAT2022-GGC-Paediatrics-316 Update 23/12/22 Incident closed by board on 22/12/22

Teresa Inkster [redacted]
Fri 03/03/2023 16:10
To: Inkster, Teresa [redacted]

Sent from Outlook for Android

From: Teresa Inkster [redacted]
Sent: Thursday, February 9, 2023 8:52:18 AM
To: Bagrade, Linda [redacted]
Cc: Laura Imrie [redacted]; Devine, Sandra [redacted]
Subject: Re: NHS GG&C: RHC Neonatology Burkholderia Contaminans HIIAT Green HIIAT2022-GGC-Paediatrics-316 Update 23/12/22 Incident closed by board on 22/12/22

Hi Linda,

Thanks for getting back to me and clarifying that not all hypotheses were able to be tested. I am aware that Laura attended the IMT, however after discussing the situation update , we agreed I would contact you microbiologist to microbiologist for a peer discussion . The role of ARHAI is communication to the HAI policy unit and there were some aspects to the update that I was seeking to understand more about.

Similarly to NHSGGC, ARHAI are committed to collaboration with IPC colleagues. We recognise that guidance cannot cover every scenario and we are dependent on boards sharing information with us to inform future iterations. This is particularly the case for more rarer and unusual pathogens such as Burkholderia species.

Regarding maternal colonisation with B contaminans , this is an interesting view and not something I have encountered, hence why I asked if you had tested the hypotheses. Whilst I feel it is unlikely, if it is the case that there is vaginal carriage of environmental organisms such as B contaminans this would be an important consideration for guidance moving forward. It would also seem prudent to investigate the labour ward for a potential source.

I also asked for clarity regarding the IMTs most likely hypotheses, that of a pseudo-outbreak . This differs from the UKHSA assessment which states that on typing, isolates from RHC belonged to a cluster linked to contaminated Clinell wipes. As the opinions are disparate, I am sure you would . agree it would be important to seek clarification before communicating this hypothesis to the HAI policy unit.

The scientific literature on pseudo outbreaks highlights the importance of investigating such incidents as outbreaks, they are not without patient harm and can lead to unnecessary investigations and over treatment of patients. So I consider my questions regarding an outbreak situation to be of relevance.

My question re biofilm arose as in the NHSGGC update it was stated that the 'board also advised that there is no evidence to suggest any biofilms are present'

With regards to my role as a QEUH microbiologist and lab processes, I will address this internally as this is not a matter for ARHAI.

Your responses are noted and the incident will now be closed

Kind regards,
Teresa

From: Bagrade, Linda [redacted]
Sent: 07 February 2023 17:42
To: Teresa Inkster [redacted]
Cc: Laura Imrie [redacted]; Devine, Sandra [redacted]
Subject: RE: NHS GG&C: RHC Neonatology Burkholderia Contaminans HIIAT Green HIIAT2022-GGC-Paediatrics-316 Update 23/12/22 Incident closed by board on 22/12/22

Hi Teresa,

Thank you for your e mail.

As you know Laura was present at the last IMT and most of this was considered by the multidisciplinary team. I would like to clarify that NHS GGC has not asked for ARHAI help or support and I know Sandra has been in contact with Laura re the roles and responsibilities of both the Board and ARHAI in the investigation and management of incidents and outbreaks. As always, we are committed to maintain productive collaboration with all colleagues in IPC.

After a detailed discussion at the last IMT we agreed this situation most likely represents a pseudo-outbreak therefore I cannot comment on your questions regarding an outbreak situation. However, all patients were discussed and we are content that appropriate actions have been taken.

This situation has been developing slowly and new information has become available over a prolonged period of time therefore there have been multiple hypothesis considered and I think you will appreciate that not all of them can be tested. Again, we are content that all information has been reviewed and appropriate actions have been taken.

The lab process has been reviewed by colleagues in GGC microbiology department and, as yourself being one of the microbiologists in QEUH, you will be aware of ongoing discussions and actions being put in place to streamline and optimise the process which is ongoing.

I am not aware of any accredited method specifically testing for presence of biofilms that's available to us but would welcome your suggestions and advice on this.

Kind regards,

Linda

From: Teresa Inkster
Sent: 24 January 2023 12:58
To: Bagrade, Linda [redacted]
Cc: Laura Imrie [redacted]
Subject: Fwd: NHS GG&C: RHC Neonatology Burkholderia Contaminans HIIAT Green HIIAT2022-GGC-Paediatrics-316 Update 23/12/22 Incident closed by board on 22/12/22

Hi Linda, is it possible to get a response to the queries re this incident, so we can close the documents.
Thanks
Kr

Teresa

Sent from Outlook for Android

From: Laura Imrie [redacted]
Sent: Tuesday, 24 January 2023, 10:53
To: Teresa Inkster [redacted]
Subject: RE: NHS GG&C: RHC Neonatology Burkholderia Contaminans HIIAT Green HIIAT2022-GGC-Paediatrics-316 Update 23/12/22 Incident closed by board on 22/12/22

Hi Teresa

Did you receive a response from NHS GGC – I am looking to close the documents relating to this incident and can't find anything from the questions you raised?

Thanks
Laura

From: Teresa Inkster [redacted]
Sent: 23 December 2022 15:29
To: Bagrade, Linda [redacted]; NSS.ARHAlinfectioncontrol [redacted]; Laura Imrie [redacted]
Subject: Fwd: NHS GG&C: RHC Neonatology Burkholderia Contaminans HIIAT Green HIIAT2022-GGC-Paediatrics-316 Update 23/12/22 Incident closed by board on 22/12/22

Apologies Linda, I should have copied colleagues into my email as I am now on leave until Jan 9th. If you wouldn't mind replying to all. Thanks and have a good Christmas
Kr
Teresa

Sent from Outlook for Android

From: Teresa Inkster [redacted]
Sent: Friday, 23 December 2022, 11:04
To: Bagrade, Linda [redacted]
Subject: Fwd: NHS GG&C: RHC Neonatology Burkholderia Contaminans HIIAT Green HIIAT2022-GGC-Paediatrics-316 Update 23/12/22 Incident closed by board on 22/12/22

Hi Linda, I have been sent this update from NICU at RHC. Just wanted to clarify a few points;

1) Re hypothesis 2 and maternal colonisation, how has this been tested? B contaminans is not considered part of normal vaginal flora, how have the mothers acquired it?

2) Re hypothesis 4 , how has this been tested? Have lab processes been investigated and what were the findings?

3)What evidence has been assessed to suggest that no biofilms are present?

4) Given the rarity of B contaminans why would the most recent case not be considered part of the outbreak. There can be various routes of transmission within the same outbreak.

5) Why would an additional case of Burholderia and cases of Serratia not be considered an escalation of the previous situation i.e further cases despite control measures?

Re: B contaminans incident- QEUH lab investigations

Bal, Abhijit [redacted]
Wed 08/02/2023 12:07

To: Peters, Christine [redacted];Inkster, Teresa [redacted]
Cc: [redacted];Khalsa, Kamaljit [redacted];Valyraki, Kalliopi [redacted];Khanna, Nitish [redacted];Balfour, Alison [redacted];Harvey-Wood, Kathleen [redacted]

Perhaps we are talking of different cases here? I am referring to the *Aspergillus* from tissue samples in vascular surgery in November/December 2021. We were told by the laboratory that one of them is a contaminant after which the report was amended. A nonconformance/error form was filled by Margaret.

Abs

From: Peters, Christine [redacted]
Sent: 08 February 2023 12:04
To: Bal, Abhijit [redacted]; Inkster, Teresa [redacted]
Cc: [redacted]; Khalsa, Kamaljit [redacted]; Valyraki, Kalliopi [redacted]; Khanna, Nitish [redacted]; Balfour, Alison [redacted]; Harvey-Wood, Kathleen [redacted]
Subject: RE: B contaminans incident- QEUH lab investigations

Last time we discussed this you said you had not said it was a contaminant. To be honest I'm not even sure which case you are referring to now.
The point is not that contamination never occurs. The point is accuracy and joined up thinking in each and every case. There is huge difference between "contamination in the lab" and "colonisation" in terms of inferences for monitoring, case definitions and environment.

Christine

From: Bal, Abhijit
Sent: 08 February 2023 12:00
To: Peters, Christine [redacted]; Inkster, Teresa [redacted]
Cc: [redacted]; Khalsa, Kamaljit [redacted]; Valyraki, Kalliopi [redacted]; Khanna, Nitish [redacted]; Balfour, Alison [redacted]; Harvey-Wood, Kathleen [redacted]
Subject: Re: B contaminans incident- QEUH lab investigations

It was the laboratory that informed me that the *Aspergillus* was a contaminant. That is why it is in HIS report. I do not see it as a blot on the laboratory just because there was contamination. We just had TB contamination - these things happen from time to time.

Shortly after that particular *Aspergillus* was another incident of *Aspergillus* contamination in a patient with necrotising fasciitis.

Abs

From: Peters, Christine [redacted]
Sent: 08 February 2023 11:04
To: Inkster, Teresa [redacted]; Bal, Abhijit [redacted]
Cc: [redacted]; Khalsa, Kamaljit [redacted]; Valyraki, Kalliopi [redacted]; Khanna, Nitish [redacted]; Balfour, Alison [redacted]; Harvey-Wood, Kathleen [redacted]
Subject: RE: B contaminans incident- QEUH lab investigations

Thanks Teresa, I would be astonished if the Burkholderia contaminans cases that matched and matched the national outbreak strain was termed a "pseudo outbreak". Although the term has been inappropriately used before.

In terms of screening – I am only aware of accusations at consultants meetings that we are "off SOP" in lding steno which as I have pointed out is not appropriate. [redacted] was involved in discussions re NICU screening, as was I at a national level pre COVID with no alteration to our practice recommended. To my knowledge there has not been discussion with this team regarding investigations of lab procedure regarding the B contaminans. Nor regarding our NICU screening.

This narrative at a national level really concerns me – as it is once again implied that this microbiology team are not doing something correctly. Echos the statement in the HIS report of an aspergillus being a "lab contaminant".

I hope this confusion can be openly sorted out. I feel very uncomfortable with any suggestion that there has been a "pseudo outbreak" and this team should have a full opportunity to comment on this conclusion.

Kr

Christine

Dr Christine Peters
Consultant Microbiologist
QEUH
[redacted]

From: Inkster, Teresa
Sent: 08 February 2023 10:15
To: Bal, Abhijit [redacted]
Cc: [redacted]; Peters, Christine [redacted]; Khalsa, Kamaljit [redacted]; Valyraki, Kalliopi [redacted]; Khanna, Nitish [redacted]; Balfour, Alison [redacted]; Harvey-Wood, Kathleen [redacted]
Subject: Re: B contaminans incident- QEUH lab investigations

Hi Abs, I am not privy to incident meeting minutes. Perhaps you should clarify with Linda, as it appears that the information submitted to ARHAI regarding lab processes is not factually accurate.

kr
Teresa

From: Bal, Abhijit [redacted]
Sent: 08 February 2023 09:31
To: Inkster, Teresa [redacted]

[redacted]

Cc: [redacted]; Peters, Christine [redacted]; Khalsa, Kamaljit [redacted]; Valyraki, Kalliopi [redacted]; Khanna, Nitish [redacted]; Balfour, Alison [redacted]; Harvey-Wood, Kathleen [redacted]
Subject: Re: B contaminans incident- QEUH lab investigations

Hi, I am not aware of any laboratory related contamination issues. It has not been discussed at consultants' meetings and unlikely that such a matter would be discussed at handovers. I was at one of the meetings (ARHAI team was there too) but that was several weeks ago. May be the minutes of the *Burkholderia* meeting (s) have captured something?

Abs

From: Inkster, Teresa [redacted]
Sent: 08 February 2023 08:47
To: Bal, Abhijit [redacted]
Cc: [redacted]; Peters, Christine [redacted]; Khalsa, Kamaljit [redacted]; Valyraki, Kalliopi [redacted]; Khanna, Nitish [redacted]; Balfour, Alison [redacted]; Harvey-Wood, Kathleen [redacted]
Subject: B contaminans incident- QEUH lab investigations

Hi Abs , in my role at ARHAI I have been in correspondence with Linda regarding the recent Burkholderia contaminans incident in NICU. This incident was initially detected by UKHSA when typing revealed RHC strains matched a national outbreak strain traced to contaminated Clinell wipes.

Whilst the details of our email communication are confidential , it is stated in the update to ARHAI from GGC that one of the hypotheses is 'most likely a pseudo-outbreak reflecting change in general ecology of B. contaminans and lab processes'. After I asked for clarification this point Linda has stated that as a QEUH microbiologist I should be aware of the review of lab processes . Unfortunately I am not aware of any investigation in the lab with regards to this and I am puzzled as to why this incident would be classed as a pseudo- outbreak related to lab processes. Have I missed this at a morning handover or Consultant meeting? Were we using Clinell wipes in the lab, how were samples contaminated and have affected batches been removed? Have there been cases in other clinical areas?

kr
Teresa

Re: SMT

Inkster, Teresa [redacted]
Wed 22/02/2023 09:18
To: Peters, Christine [redacted];Macleod, Mairi
[redacted]

Thanks. It is accurate that concerns were raised re the HAI scribe at the BMT MDT and in a subsequent email Abs stated that 'we in IPCT came to know of the works only after the works were carried out using a generic scribe' . A generic scribe is not appropriate for such high risk work and a world apart from the measures myself and John Hood used to apply when removing water damaged material . I was not informed of either the water damage or the Fusarium case which I have followed up with Abs but it seems I am not to be included in PAGs/IMTs/air sampling results in the same way as Brian Jones was. This makes the role of BMT microbiologist difficult.

It is not easy for me to attend SMT on a Tuesday morning due to being at Assure/ARHAI . If I am not at the next meeting the following need clarified;

1)The Burkholderia incident is closed, its was closed by GGC and subsequently by ARHAI. An outstanding issue to be resolved locally is in relation to lab processes which GGC included as a hypotheses for the cases in an update to ARHAI, forwarded to SG . Linda stated in a response to myself in an ARHAI capacity , that as a QEUH microbiologist I should be aware of issues with lab processes in relation to B contaminans.When checking with Abs there have been no such issues and no investigations into lab contamination and a pseudo- outbreak that he is aware off. This requires clarification as at the moment SG and ARHAI are of the understanding there is a potential issue with lab processes . Not sure how this is related to a national outbreak strain identified by UKHSA and traced to contaminated wipes though.

2)There is inconsistency in reporting via HIIATs . It was stated that the Fusarium case did not meet the criteria for HIIAT yet two separate Mucor cases have been reported via HIIAT. Why should these fungi be treated differently and why is a Mucor case in haem-onc reportable but not a Fusarium in a higher risk BMT patient?

3)It is incorrect to say that there are active discussions with ARHAI regarding reporting of single organisms by the three networks. As I would expect to be included in this ,I sought clarification from ARHAI yesterday including Laura Imrie as the Lead and they are unaware of this. I have an email trail if this is required. As this is not currently being discussed nationally I suggest colleagues get in touch with Laura or myself to discuss.

There are potential probity issues with regards to points 1 and 3 above with respect to misinformation being provided about and to national agencies.

I normally keep ARHAI and GGC roles separate however if colleagues are going to bring my GGC role in to ARHAI communications and have discussions re ARHAI at local SMTs then I will respond accordingly.

kr
Teresa

From: Peters, Christine [redacted]
Sent: 21 February 2023 16:13
To: Macleod, Mairi [redacted]

Cc: Inkster, Teresa [redacted]
Subject: SMT

Hi Mairi,

The relevant quote from the HIS report that I alluded to at SMT today regarding the BMT Fusarium case in the context of environmental issues on 4B in case it is a useful note for minutes;

"A healthcare infection incident should be suspected if there is: • A single case of an infection for which there have previously been no cases in the facility (e.g. infection with a multidrug-resistant organism (MDRO) with unusual resistance patterns or a post-procedure infection with an unusual organism). Guidance within the NIPCM then explains that, following recognition of an incident or outbreak described above, the infection prevention and control team should undertake an initial assessment, utilising the Healthcare Infection Incident Assessment Tool (HIIAT). This should then be reported to Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Scotland through the electronic outbreak reporting tool. We sought advice from ARHAI Scotland who confirmed that a single case of healthcare associated Aspergillus-related infection would meet the definition within the national guidance and should have the HIIAT applied and then be reported through the electronic outbreak tool"

I copy in Teresa as BMT Microbiologist who was not present this morning but was informed of HAI SCRIBE concerns as I mentioned at SMT.
kr
Christine

Fwd: New incident update: HIIAT2023-GGC-South-300 (Green) and HIIAT2022-GGC-South-329 (Green)

Teresa Inkster [redacted]
Mon 23/01/2023 11:00
To: Inkster, Teresa [redacted]

Sent from Outlook for Android

From: NSS ARHAIinfectioncontrol [redacted]
Sent: Tuesday, January 17, 2023 2:48:48 PM
To: Kelly, Allana [redacted]; NSS ARHAIinfectioncontrol [redacted]; Andrew Kalule [redacted]; Andrew Saba [redacted]; Anna Munro [redacted]; Annette Rankin [redacted]; Chris Paterson [redacted]; Colin Urquhart [redacted]; Declan Doherty [redacted]; Diane Stark [redacted]; Elaine Ross [redacted]; Emma Donnelly [redacted]; Emma Hamilton [redacted]; Emma Hooker [redacted]; Emma Young [redacted]; Gemma Nolan [redacted]; Gillian Smith [redacted]; Grant McPherson (CNOD) [redacted]; Hayley Kane [redacted]; Heather Wallace [redacted]; Irene Barkby [redacted]; John Ratcliffe [redacted]; Julie Critchley [redacted]; Julie Wilson [redacted]; Kaileigh Begley [redacted]; Allan L (Lara) [redacted]; Laura Imrie [redacted]; Lauren Blane [redacted]; Leighanne Bruce [redacted]; Mark Clark [redacted]; Abigail Mullings [redacted]; Mireille van der Torre [redacted]; Molly Nurse [redacted]; Nadia Palma [redacted]; NSS ARHAIdatateam [redacted]; Pamela Joannidis [redacted]; Paul Weaving [redacted]; Rachael Dunk (CNOD) [redacted]; Rebecca Andrews [redacted]; Rebekah Dunese [redacted]; Saba Affar [redacted]; Sarah Thirlwell [redacted]; Seonaid More [redacted]; Shona Cairns [redacted]; Sofie French [redacted]; Teresa Inkster [redacted]; Yasmine Benylles [redacted]
Cc: Devine, Sandra [redacted]; Bowskill, Gillian [redacted]; Pritchard, Lynn [redacted]
Subject: RE: New incident update: HIIAT2023-GGC-South-300 (Green) and HIIAT2022-GGC-South-329 (Green)

Hi Allana,

Thanks for clarifying these dates.

Kind regards,
Abigail

Abigail Mullings
Clinical Lead
Community IPC Programme

ARHAI Scotland
NHS Assure
NHS National Services Scotland

M: [redacted]
E: [redacted]
W: https://www.nipcm.hps.scot.nhs.uk/

We kindly request that all general enquires are emailed to our national IPC Team mailbox at NSS.ARHAlinfectioncontrol[redacted] Please note we operate a 5 day turnaround timescale for responses.

From: Kelly, Allana [redacted]
Sent: 17 January 2023 14:19
To: NSS ARHAlinfectioncontrol [redacted]; Andrew Kalule [redacted]; Andrew Saba [redacted]; Anna Munro [redacted]; Annette Rankin [redacted]; Chris Paterson [redacted]; Colin Urquhart [redacted]; Declan Doherty [redacted]; Diane Stark [redacted]; Elaine Ross [redacted]; Emma Donnelly [redacted]; Emma Hamilton [redacted]; Emma Hooker [redacted]; Emma Young [redacted]; Gemma Nolan [redacted]; Gillian Smith [redacted]; Grant McPherson (CNOD) [redacted]; Hayley Kane [redacted]; Heather Wallace [redacted]; Irene Barkby [redacted]; John Ratcliffe [redacted]; Julie Critchley [redacted]; Julie Wilson [redacted]; Kaileigh Begley [redacted]; Allan L (Lara) [redacted]; Laura Imrie [redacted]; Lauren Blane [redacted]; Leighanne Bruce [redacted]; Mark Clark [redacted]; Mireille van der Torre [redacted]; Molly Nurse [redacted]; Nadia Palma [redacted]; NSS ARHAIdatateam [redacted]; Pamela Joannidis [redacted]; Paul Weaving [redacted]; Rachael Dunk (CNOD) [redacted]; Rebecca Andrews [redacted]; Rebekah Dunese [redacted]; Saba Affar [redacted]; Sarah Thirlwell [redacted]; Seonaid More [redacted]; Shona Cairns [redacted]; Sofie French [redacted]; Teresa Inkster [redacted]; Yasmine Benylles [redacted]
Cc: Devine, Sandra [redacted]; Bowskill, Gillian [redacted]; Pritchard, Lynn [redacted]
Subject: Re: New incident update: HIIAT2023-GGC-South-300 (Green) and HIIAT2022-GGC-South-329 (Green)

Dear All

In relation to **Incident 1: HIIAT2023-GGC-South-300.** Case summary point 1. The dates for the 5 patient cases are between 11/12/2022 and 08/01/23.

Kind Regards
Allana

Allana Kelly

Lead Nurse - Infection Prevention and Control Team,

South Glasgow Sector- QEUH, GGH, NVACH

[redacted]

[redacted]

From: NSS ARHAIinfectioncontrol [redacted]
Sent: 17 January 2023 13:47
To: NSS ARHAIinfectioncontrol [redacted]; Andrew Kalule [redacted]; Andrew Saba [redacted]; Anna Munro [redacted]; Annette Rankin [redacted]; Chris Paterson [redacted]; Colin Urquhart [redacted]; Declan Doherty [redacted]; Diane Stark [redacted]; Elaine Ross [redacted]; Emma Donnelly [redacted]; Emma Hamilton [redacted]; Emma Hooker [redacted]; Emma Young [redacted]; Gemma Nolan [redacted]; Gillian Smith [redacted]; Grant McPherson (CNOD) [redacted]; Hayley Kane [redacted]; Heather Wallace [redacted]; Irene Barkby [redacted]; John Ratcliffe [redacted]; Julie Critchley [redacted]; Julie Wilson [redacted]; Kaileigh Begley [redacted]; Allan L (Lara) [redacted]; Laura Imrie [redacted]; Lauren Blane [redacted]; Leighanne Bruce [redacted]; Mark Clark [redacted]; Mireille van der Torre [redacted]; Molly Nurse [redacted]; Nadia Palma [redacted]; NSS ARHAIdatateam [redacted]; Pamela Joannidis [redacted]; Paul Weaving [redacted]; Rachael Dunk (CNOD) [redacted]; Rebecca Andrews [redacted]; Rebekah Dunese [redacted]; Saba Affar [redacted]; Sarah Thirlwell [redacted]; Seonaid More [redacted]; Shona Cairns [redacted]; Sofie French [redacted]; Teresa Inkster [redacted]; Yasmine Benylles [redacted]
Cc: Devine, Sandra [redacted]; Bowskill, Gillian [redacted]; Pritchard, Lynn [redacted]; Kelly, Allana [redacted]
Subject: New incident update: HIIAT2023-GGC-South-300 (Green) and HIIAT2022-GGC-South-329 (Green)

Dear all

To advise HAI PU colleagues of 2 current incidents in NHS GGC QEUH.

Both incidents relate to Haematology Ward 4B and whilst NHS GGC have assessed both incidents as Green, as per national processes, ARHAI Scotland inform the HAI PU of unusual organisms/exceptional incidents. To note ARHAI Support has not been requested for either of these incidents.

Incident 1: HIIAT2023-GGC-South-300

ARHAI Scotland received an incident report via the electronic ORT dated 13/1/2023 from NHS GGC relating to 5 cases of *Enterococcus Faecium* VRE Blood cultures attributed to Ward 4B QEUH.

HIIAT assessment Green (Public Anxiety, Severity of illness, Impact on service – all minor, Risk of Transmission – moderate).

Case Summary:

1. 5 patient cases ([redacted] Dec 22 – [redacted] Jan 23) identified from line samples (1 case remains inpatient).
2. Additional 2 previous cases identified (Oct and Nov 22) (1 unrelated death).

3. Total number of patients giving cause for concern/deaths as a direct consequence of this incident = 0

Working hypothesis:
Antimicrobial use or patient to patient transmission via patients, staff or equipment.

Control measures:
1. In place as per NIPCM.

Investigations:
1. Investigations are ongoing.

Communications/next steps:
1. PAG to be held when sequencing results are available.

Incident 2: HIIAT2022-GGC-South-329

ARHAI Scotland received an update via the electronic ORT on [redacted]/1/23 from NHS GGC relating to 3 cases of *Stenotrophomonas maltophilia* isolated from patients attributed to Ward 4B QEUH. This is an increase of 1 case from the previous report received by ARHAI on the [redacted]/12/22 also HIIAT green (not escalated).

HIIAT has been assessed as Green (Risk of transmission moderate, Impact on service, Public anxiety and Severity of illness all minor).

Case Summary:
Total patient cases: 3 (2 discharged; 1 unrelated death).

Working hypothesis:
1. Endogenous source, possibly due to treatment with Meropenem.
2. Indirect transmission from equipment or HCW/Visitors.

Control measures:
1. In place as per NIPCM.

Investigations:
1. Investigations are ongoing.

Communications/next steps:
1. A PAG was held by NHS GG&C on 22/12/22 (No further PAG/IMT dates provided).

NHS GGC Colleagues, please advise of any errors or omissions.

Regards,
Abigail

Abigail Mullings
Clinical Lead
Community IPC Programme

ARHAI Scotland
NHS Assure
NHS National Services Scotland
M: [redacted]
E: [redacted]
W: [redacted]

We kindly request that all general enquires are emailed to our national IPC Team mailbox at NSS.ARHAIinfectioncontro[redacted] Please note we operate a 5 day turnaround timescale for responses.

RE: Message from "[redacted]"

Peters, Christine [redacted]
Tue 31/01/2023 15:52
To: Bal, Abhiiit [redacted];Harvey-Wood, Kathleen [redacted];Inkster, Teresa [redacted];Bagrade, Linda [redacted]
Cc: Khalsa, Kamaljit [redacted]; [redacted]

Hope we have all read the CNR and Board reports on which to base our discussions.

From: Bal, Abhijit
Sent: 31 January 2023 15:28
To: Peters, Chris ne [redacted]; Harvey-Wood, Kathleen [redacted]; Inkster, Teresa [redacted]; Bagrade, Linda [redacted]
Cc: Khalsa, Kamaljit [redacted]; [redacted]
Subject: Re: Message from "[redacted]"

Thanks Chris ne. We all understand our individual responsibili es. There would not have been a recommenda on that typing should be carried out for infec on control purposes but without consul ng with those responsible for delivering infec on control. Happy to discuss at the consultants mee ng.

Abs

From: Peters, Chris ne [redacted]
Sent: 31 January 2023 14:12
To: Bal, Abhijit [redacted]; Harvey-Wood, Kathleen [redacted]; Inkster, Teresa [redacted]; Bagrade, Linda [redacted]
Cc: Khalsa, Kamaljit [redacted]; [redacted]
Subject: RE: Message from "[redacted]"

Abs,

It's not a ma er of bother or concern, rather responsibility - that as an organisa on we have had three very high level reviews touching on this teams microbiology work - none of which found that we over reported typing. Indeed the opposite was found- we were commended for our microbiology prac ces and our interpreta on agreed with. We have a track record of being supported in this by the external experts appointed by Scot Gov to inves gate the outbreaks in the hospital.

My concern is that we need to ensure that all the recommenda ons are in place and that our prac ce is in keeping with the output of those external reviews. The board accepted all recommenda ons without excep on.

I am asking for resolu on of differing professional opinions through a process that is not based on individual opinions, nor na onal guidance (which are not protocols, and cannot by their nature cover every eventuality) but is in keeping with the na onal process of learning already in place.

Please can we add this to Consultant mee ng agenda?

Kr

Chris ne

From: Bal, Abhijit
Sent: 31 January 2023 13:42
To: Peters, Chris ne [redacted]; Harvey-Wood, Kathleen [redacted]; Inkster, Teresa [redacted]; Bagrade, Linda [redacted]
Cc: Khalsa, Kamaljit [redacted]; [redacted]
Subject: Re: Message from "[redacted]"

That does not concern me or bother me. If and when my opinion is sought, I will write to whosoever seeks it in official capacity. ARHAI also will have to refer to appropriate guidelines and apply their recommenda on na onally.

Abs

From: Peters, Chris ne [redacted]
Sent: 31 January 2023 12:05
To: Bal, Abhijit [redacted]; Harvey-Wood, Kathleen [redacted]; Inkster, Teresa [redacted]; Bagrade, Linda [redacted]
Cc: Khalsa, Kamaljit [redacted]; [redacted]
Subject: RE: Message from "[redacted]"

It most certainly is a an issue for external adjudica on as there is a disagreement regarding when to type and what that typing means. This has enormous relevance to the PI, the police inves ga on and the outputs from the Case Note review.

Kr
Chris ne

From: Bal, Abhijit
Sent: 31 January 2023 12:03
To: Peters, Chris ne [redacted]; Harvey-Wood, Kathleen [redacted]; Inkster, Teresa [redacted]; Bagrade, Linda [redacted]
Cc: Khalsa, Kamaljit [redacted]; [redacted]
Subject: Re: Message from "[redacted]"

This is an internal ma er of our department on how we organise typing. I do not see any role for ARHAI or CNR groups.

Abs

From: Peters, Chris ne
Sent: 31 January 2023 11:58
To: Bal, Abhijit ; Harvey-Wood, Kathleen ; Inkster, Teresa ; Bagrade, Linda
Cc: Khalsa, Kamaljit ;
Subject: RE: Message from " "

Abs,

You are right about the recurrent theme. I have specifically asked that we have an external input into this ongoing discussion – to involve ARHAI, and the Case Note Review authors. I s ll believe this is required

Kr
Chris ne

Chris jm**om:** Bal, Abhijit
Sent: 31 January 2023 11:52
To: Peters, Chris ne ; Harvey-Wood, Kathleen ; Inkster, Teresa ; Bagrade, Linda
Cc: Khalsa, Kamaljit ;
Subject: Re: Message from " "

If on an odd occasion discussion did not take place with the ICD due to failure of communica on prior to sending isolates for typing, that can be explained, and both sides can work together. But the normal process should be a prior discussion with ICD. What I am addressing is a recurrent theme.

Abs

From: Peters, Chris ne
Sent: 31 January 2023 11:44
To: Bal, Abhijit ; Harvey-Wood, Kathleen ; Inkster, Teresa ; Bagrade, Linda
Cc: Khalsa, Kamaljit ;
Subject: RE: Message from " "

Abs, a communica on that is in wri ng is the preferred route of communica on for record keeping whether urgent or not. The nonsense bit relates to being instructed that if the ICD did not ask for the result they should not have the result communicates.

From: Bal, Abhijit
Sent: 31 January 2023 11:42
To: Peters, Chris ne ; Harvey-Wood, Kathleen ; Inkster, Teresa ; Bagrade, Linda
Cc: Khalsa, Kamaljit ;
Subject: Re: Message from " "

Thanks Chris ne. As a general issue, I believe my point is valid, and not nonsense. Typing is not urgent. The decision to type can be withheld pending discussion with the ICD in order to avoid this

situa on.

About CF, it is best to address it separately.

Abs

From: Peters, Chris ne [redacted]
Sent: 31 January 2023 11:24
To: Harvey-Wood, Kathleen [redacted]; Bal, Abhijit [redacted]; Inkster, Teresa [redacted]; Bagrade, Linda [redacted]
Cc: Khalsa, Kamaljit [redacted]; [redacted]
Subject: RE: Message from "[redacted]"

Hi Kathleen,
Yes at present we are very concerned about Gram nega ves in the CF paediatric cohort – an issue raised with ICPT on a number of occasions and apart from COVID years have usually done typing. Any matches should be highlighted to IPCT and the CF team. Can someone send me the CHIS for these pa ents?

Thanks for copying me into this trail. I think this is a topic that is recurrent and deeply unhelpful to have instruc on that results from lab results with IPC relevance are to be taken ownership by the laboratory Microbiologist on for the day with regard to IPC ac ons. This is simply nonsense. We would be negligent if we did not report results.

We have a professional responsibility to inform IPC of results that we judge to have IPC implica ons.

Teresa has done that and is eminently qualified to make that decision.

Kr

Christine

Dr Chris ne Peters
Consultant Microbiologist
QEUH
[redacted]

From: Harvey-Wood, Kathleen
Sent: 31 January 2023 11:13
To: Bal, Abhijit [redacted]; Inkster, Teresa [redacted]; Bagrade, Linda [redacted]; Hamilton, Kate [redacted]; Kennea, Lynne [redacted]; Anderson, Kathryn [redacted]
Cc: Khalsa, Kamaljit [redacted]; [redacted]; Peters, Chris ne [redacted]
Subject: Re: Message from "[redacted]"

Hi Chris ne

Can I check that as the Steno.maltophilia was isolated from a CF pa ent , it would have been sent to UKHSA for confirma on
if a first isolate for this pa ent ?

Kathleen

From: Bal, Abhijit [redacted]
Sent: 31 January 2023 10:52
To: Inkster, Teresa [redacted]; Bagrade, Linda [redacted]; Hamilton, Kate [redacted]; Kennea, Lynne [redacted]; Anderson, Kathryn [redacted]
Cc: Khalsa, Kamaljit [redacted]; [redacted]; Harvey-Wood, Kathleen [redacted]
Subject: Re: Message from "[redacted]"

Hi all,

Thanks for including me in this email trail.

As Duty 1 consultants, we have the responsibility to inform the relevant departments of the results. However, ICDs should only get reports of typing that they have requested as part of an inves ga on except where there has been a clinical indica on for addi onal tes ng *e.g.*, PVL, which has an independent infec on control implica on.

In order to find a middle ground, I suggest that where the duty microbiologist feels there is an indica on for typing for infec on control purposes, they should discuss with the ICD before sending the isolates for typing. In many cases, I would imagine that we would agree to store such isolates. They can be sent for typing at a later date, if necessary, on the advice of the ICD.

Regards,

Abs

--

Abhijit M Bal
MBBS, MD, DNB, MNAMS, FRCP, FRCPath, FISAC, FRAS, Dip Med Mycol
Consultant, Clincal Lead, and Infec on Control Doctor
Department of Microbiology
Queen Elizabeth University Hospital, Glasgow
Honorary Clinical Associate Professor, University of Glasgow

From: Inkster, Teresa [redacted]
Sent: 31 January 2023 10:02
To: Bagrade, Linda [redacted]; Hamilton, Kate [redacted]; Kennea, Lynne [redacted]; Anderson, Kathryn [redacted]
Cc: Khalsa, Kamaljit [redacted]; [redacted]; Harvey-Wood, Kathleen [redacted]; Bal, Abhijit [redacted]
Subject: Re: Message from "[redacted]"

Hi Linda, the role of the duty 1 Consultant is to alert IPCT to any typing results of relevance. Regardless of which Consultant asked for typing I assumed this result would be of interest to the IPCT as it clusters with two other pa ents.

Kind regards
Teresa

From: Bagrade, Linda [redacted]
Sent: 30 January 2023 21:06
To: Inkster, Teresa [redacted]; Hamilton, Kate [redacted];
Kennea, Lynne [redacted]; Anderson, Kathryn [redacted]
Cc: Khalsa, Kamaljit [redacted];
[redacted]; Harvey-Wood, Kathleen [redacted]
Subject: RE: Message from "[redacted]"

Thank you, but I haven't asked for this typing therefore this should be sent to the reques ng consultant.
Linda

From: Inkster, Teresa
Sent: 23 January 2023 13:03
To: Bagrade, Linda [redacted]; Hamilton, Kate [redacted];
Kennea, Lynne [redacted]; Anderson, Kathryn [redacted]
Cc: Khalsa, Kamaljit [redacted];
[redacted]; Harvey-Wood, Kathleen [redacted]
Subject: Fw: Message from "[redacted]"

Hi, please find a ached a Stenotrophomonas typing result

kr
Teresa

From: [redacted]
Sent: 23 January 2023 13:05
To: Inkster, Teresa [redacted]
Subject: Message from "[redacted]"

This E-mail was sent from "[redacted]" (IM C5500).

Scan Date: 01.23.2023 13:05:02 (+0000)
Queries to: [redacted]

Re: IPC Sector Reports - 03/02/23

Bal, Abhijit [redacted]
Mon 06/03/2023 09:55

To: Peters, Christine [redacted];Inkster, Teresa [redacted]
Cc: [redacted];Khalsa, Kamaljit [redacted];Khanna, Nitish [redacted];Balfour, Alison [redacted];Valyraki, Kalliopi [redacted];Wright, Pauline [redacted];Smith, Andrew [redacted]

Thanks for sharing your concerns. We are not sitting idle in infection control. We do what is necessary and we are also an experienced team. There is nothing more I have to add.

Abs

From: Peters, Christine [redacted]
Sent: 06 March 2023 09:45
To: Inkster, Teresa [redacted]; Bal, Abhijit [redacted]
Cc: [redacted]; Khalsa, Kamaljit [redacted]; Khanna, Nitish [redacted]; Balfour, Alison [redacted]; Valyraki, Kalliopi [redacted]; Wright, Pauline [redacted]; Smith, Andrew [redacted]
Subject: Re: IPC Sector Reports - 03/02/23

Abs antibiotic advice always takes into account specific information relevant to the patient. Is there formal analysis re 4B that you have undertaken?
We have the benefit of a team that has decades experience of this patient cohort both clinically and IPC wise sharing their concerns with you. It's worth listening.
Christine

From: Inkster, Teresa [redacted]
Sent: 06 March 2023 09:17
To: Bal, Abhijit [redacted]; Peters, Christine [redacted]
Cc: [redacted]; Khalsa, Kamaljit [redacted]; Khanna, Nitish [redacted]; Balfour, Alison [redacted]; Valyraki, Kalliopi [redacted]; Wright, Pauline [redacted]; Smith, Andrew [redacted]
Subject: Re: IPC Sector Reports - 03/02/23

'We believe there was too much emphasis on standard definitions, inappropriate reassurance from the use of SPC methodology and even an unwillingness to accept that there was a problem'

'It is clear to us that the utility of the distinction offered by these two definitions is less informative in a clinical setting where , in addition to inpatient episodes , patients are attending for day care of outpatient appointments at the very high frequency seen in this patient group' ' in the event we did not find this distinction useful in our review'

Case Note Review March 2021

kr
Teresa

From: Bal, Abhijit [redacted]
Sent: 06 March 2023 08:31
To: Peters, Christine [redacted]; Inkster, Teresa [redacted]
Cc: [redacted]; Khalsa, Kamaljit [redacted]; Khanna, Nitish [redacted]; Balfour, Alison [redacted]; Valyraki, Kalliopi [redacted]; Wright, Pauline [redacted]; Smith, Andrew [redacted]
Subject: Re: IPC Sector Reports - 03/02/23

Epidemiological changes are hard to be determine when fluctuations occur on the background of small numbers. It requires a systematic analysis of data. It is best not to derive conclusions without some kind of formal analysis as it has consequences for patients: for example, it may influence antibiotic advice. This is even more important when some infections alerted to infection control by microbiology do not even qualify as HAI.

Abs

From: Peters, Christine [redacted]
Sent: 27 February 2023 11:55
To: Inkster, Teresa [redacted]; Bal, Abhijit [redacted]
Cc: [redacted]; Khalsa, Kamaljit [redacted]; Khanna, Nitish [redacted]; Balfour, Alison [redacted]; Valyraki, Kalliopi [redacted]; Wright, Pauline [redacted]; Smith, Andrew [redacted]
Subject: Re: IPC Sector Reports - 03/02/23

Quite a change in epi I agree Teresa.

From: Inkster, Teresa [redacted]
Sent: 24 February 2023 15:48
To: Bal, Abhijit [redacted]
Cc: [redacted]; Peters, Christine [redacted]; Khalsa, Kamaljit [redacted]; Khanna, Nitish [redacted]; Balfour, Alison [redacted]; Valyraki, Kalliopi [redacted]; Wright, Pauline [redacted]; Smith, Andrew [redacted]
Subject: Re: IPC Sector Reports - 03/02/23

Hi Abs, is there any update re 4B? I noticed there was another Steno bacteraemia whilst I was off on annual leave and today we have someone growing Aeromonas from a line tip. This is not typical epidemiology for this unit and I would be concerned re a water source given that we have had recent cases of Pseudomonas/Steno/Roseomonas/Fusarium and now Aeromonas

kr
Teresa

From: Bal, Abhijit [redacted]
Sent: 06 February 2023 16:24
To: Inkster, Teresa [redacted]
Cc: [redacted]; Peters, Christine

[redacted]; Khalsa, Kamaljit [redacted]; Khanna, Nitish [redacted]; Balfour, Alison [redacted]; Valyraki, Kalliopi [redacted]; Wright, Pauline [redacted]; Smith, Andrew [redacted]

Subject: Re: IPC Sector Reports - 03/02/23

Thanks, we in IPCT came to know of the works only after the works were carried out using a generic scribe, an issue I have already raised with IPCT. Risk stratification is available for HSCT patients although it is an area which is still developing. We retrospectively reviewed the scribe and found some areas of concern which is why we advised halting any work.

The Fusarium was detected in the laboratory after the works, but signs and symptoms were before the works and that particular room was not involved so I don't think it is directly related, However it is HAI with or without a direct link to the works. It can still be related to showers etc

Abs

From: Inkster, Teresa [redacted]
Sent: 06 February 2023 15:05
To: Bal, Abhijit [redacted]
Cc: [redacted]; Peters, Christine [redacted]; Khalsa, Kamaljit [redacted]; Khanna, Nitish [redacted]; Balfour, Alison [redacted]; Valyraki, Kalliopi [redacted]; Wright, Pauline [redacted]; Smith, Andrew [redacted]
Subject: Re: IPC Sector Reports - 03/02/23

Hi Abs, I attended the BMT MDT meeting this afternoon and was asked for a view on the issues with the rooms. I stated that I was not aware of the exact nature and extent of the problem nor the details regarding HAI scribe measures. I suggested they would need to check with IPC. I noted on the handover sheet that several rooms were labelled for autografts only which suggests several are involved. It was stated that there was concern regarding the way estates had undertaken the work and that areas were cut out and black material was being washed off.

The team plan to try to keep rooms vacant but will use for low risk patients with Posa prophylaxis if they need to . With what has been described I am not convinced there is any such thing as a low risk patient group in a BMT unit. Were full HAI scribe measures applied and do we know if estates removed the material under negative pressure and turned off the positive pressure in the patient rooms? I also note the Fusarium case on the ward - is this related?

It is useful for me to attend PAGs and IMTs and get updates on environmental issues on the unit as Brian Jones did. I have requested this and air sampling results on several occasions now.

kr
Teresa

From: Bal, Abhijit [redacted]
Sent: 03 February 2023 17:39
To: Inkster, Teresa [redacted]
Cc: [redacted]; Peters, Christine

[redacted]; Khalsa, Kamaljit [redacted]; Khanna, Nitish [redacted]; Balfour, Alison [redacted]; Valyraki, Kalliopi [redacted]; Wright, Pauline [redacted]; Smith, Andrew [redacted]

Subject: Re: IPC Sector Reports - 03/02/23

Hi Teresa,

We had a meeting this afternoon. I can provide more information when I am back from leave. We have advised that the rooms where works have been carried remain vacant or be occupied by low-risk patients only until we get the results of the environmental monitoring. The issue of prophylaxis has been discussed with Dr Clark and there is no change to the standard protocol or guidelines that the clinical team adhere to.

Regards,

Abs

From: Inkster, Teresa [redacted]
Sent: 03 February 2023 15:27
To: Bal, Abhijit [redacted]
Cc: [redacted]; Peters, Christine [redacted]; Khalsa, Kamaljit [redacted]; Khanna, Nitish [redacted]; Balfour, Alison [redacted]; Valyraki, Kalliopi [redacted]
Subject: Fw: IPC Sector Reports - 03/02/23

Hi Abs, I wasn't aware of the issue with shower panels and flooring on ward 4B. Is it possible to get more information regarding this. Have there been any recommendations made regarding prophylaxis and patient placement?

Kind regards
Teresa

From: Lang, Ann [redacted]
Sent: 03 February 2023 14:31
To: MacLeod, Calum [redacted]; Marek, Aleksandra [redacted]; Andrew Smith [redacted]; Wallace, Angela [redacted]; Arbuckle, William [redacted]; Bagrade, Linda [redacted]; Balfour, Alison [redacted]; Bowskill, Gillian [redacted]; Boyd, Luanne [redacted]; Carson, John [redacted]; Cassidy, Anne Marie [redacted]; Awilly Chofle (NHS Greater Glasgow & Clyde) [redacted]; Cottom, Laura [redacted]; [redacted]; Devine, Sandra [redacted]; Dhillon, Raje [redacted]; Doherty, Denise [redacted]; Donnelly, Michael [redacted]; Douglas, Kirsty [redacted]; Fleming, Alistair [redacted]; Glancy, Joan [redacted]; Hamilton, Kate [redacted]; Henderson, Karen [redacted]; Su Su Htwe (NHS Greater Glasgow & Clyde) [redacted]; Inkster, Teresa [redacted]; Jamdar, Saranaz [redacted]; GILLIES, Jenna (NHS GREATER GLASGOW & CLYDE) [redacted]; Jones, Timothy

[redacted]; Kerr, Ann [redacted]; Khalsa, Kamaljit [redacted]; Khanna, Nitish [redacted]; Leanord, Alistair [redacted]; Love, Liz [redacted]; MacLeod, Alison [redacted]; Macleod, Mairi [redacted]; Mathieson, David [redacted]; McConnell, Donna [redacted]; McDaïd, Kirsty [redacted]; Menzies, Lisa [redacted]; MURPHY, Michael (NHS GREATER GLASGOW & CLYDE) [redacted]; Mills, Gillian [redacted]; Moore, Marie [redacted]; Murphy, Deborah [redacted]; O'neill, Julie Anne [redacted]; Ozegemen, Margaret [redacted]; Polubothu, Padmaja [redacted]; Peters, Christine [redacted]; Pritchard, Lynn [redacted]; Robertson, Angela [redacted]; Smyth, Elaine [redacted]; Spalding, Jane [redacted]; Stuart Gallacher (NHS Greater Glasgow & Clyde) [redacted]; Valyraki, Kalliopi [redacted]; Weinhardt, Barbara [redacted]; Wilson, Gary [redacted]; Wright, Pauline [redacted]; Gardner, Morag [redacted]; Gillespie, Con [redacted]; Loudon, Lorna [redacted]; Bal, Abhijit [redacted]; Simon Pybus (NHS Greater Glasgow & Clyde) [redacted]; Morrison, Jennifer [redacted]; Digby, Amanda [redacted]; Frew, Stephen [redacted]; McBride, Elizabeth [redacted]; Meechan, Mandy [redacted]; Kennedy, Louise [redacted]; NORTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE) [redacted]; SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE) [redacted]; Rodger, Graeme [redacted]; Arnott Bowl, Alexandra [redacted]

Subject: IPC Sector Reports - 03/02/23

Good afternoon

Please find attached the IPC weekly sector reports dated 3rd February 2023.

Also attached are a note of the ward closures/update for South Adult and North sectors.

If there is difficulty getting through to the wards at the weekend the best person to contact is as follows:-

GRI – Clinical co-ordinator/site flow manager
QEUH – Clinical co-ordinator
Clyde – Bed manager for either RAH or IRH (you can pass on message re VOL to either of the bed managers).

Kind Regards

Ann

Ann Lang
PA/Data Manager to Sandra Devine, Director of Infection Prevention & Control
PA/Data Manager to Gillian Bowskill, Associate Nurse Director, Infection Prevention & Control
Office Block
Level 2
Queen Elizabeth University Hospital

[redacted]

[redacted]

Re: IPC Sector Reports - 03/03/23

Bal, Abhijit [redacted]
Wed 08/03/2023 13:19
To: Peters, Christine [redacted];Inkster, Teresa [redacted]
Cc: Khanna, Nitish [redacted];[redacted];Khalsa, Kamaljit [redacted];Balfour, Alison [redacted];Valyraki, Kalliopi [redacted]

Thanks Christine. These are good points that you both have raised. A national consensus is definitely needed because I wonder what other health boards do. Some of the bacterial and fungal infections may be "problems within GGC" but not "a GGC problem" (a colleague recently used this phrase).

All mould infections are rare but rare is different from unusual. We do not say that 15 days is "the" cut off for HAI. It could be shorter or longer; we just do not know what the incubation period is. In the absence of the knowledge of incubation period, it becomes more important to look for linked cases and they don't have to be the same mould. We also do not know how far back or forward we should look for linked cases. We have discussed this in our ICD group and all ICDs agreed that a single case of mould infection is not for HIIAT. More than one case within a specified time frame should definitely be reported.

The HIS report did not point out that we were out of sync with other health boards. It said there may be varying interpretations across Scotland and that needs reviewed but it was outwith the scope of their work.

Yes, the important thing is to investigate which we have done, and we did not find any mould in water, air, or surfaces. In many published papers, the source is never found. Often, when fungi are isolated from the environment, there are no cases and when there are cases, the environmental reports are negative. It is important to be vigilant.

Abs

From: Peters, Christine [redacted]
Sent: 08 March 2023 12:47
To: Bal, Abhijit [redacted]; Inkster, Teresa [redacted]
Cc: Khanna, Nitish [redacted]; [redacted]; Khalsa, Kamaljit [redacted]; Balfour, Alison [redacted]; Valyraki, Kalliopi [redacted]
Subject: RE: IPC Sector Reports - 03/03/23

I think there are a couple of issues here :

1. The purpose of reporting to ARHAI – this is a system that enables
   - a national view on infections – eg if fusarium was seen in other centres a unifying hypothesis/ source could be identified – we had a similar discussion re Burkholderia contaminans and it turned out that there was indeed a national issue. If not reported this could be missed.
   -a reassurance to gov and therefore public that there is a transparency in all HAI issues across NHS and appropriate oversight and support with resource
   -surveillance of incidents nationally
   I think the point of HIS report was that GGC are out of sync with other health boards and that needs rectified. ARHAI being clear on the reporting expected is what needs to be followed - irrespective of disagreement - until there is a change sanctioned and agreed by ARHAI otherwise it is flouting the nationally set up system of governance.

2. Specifically in regard to fungal infections
   - fusarium – it is a rare infection in this cohort – not seen one in the 7 years this unit has been open. Defacto it is a rare and unusual organism. The denominator argument is spurious when talking environmental risks. The key to management is identifying source and dealing with it – this was previously picked up as a misinterpretation of epi data in GGC with regard to environmental sources of infection
   - aspergillus incubation period – case history, epidemiology and local circumstance all need to be taken into account. 15 days in inadequate to rule out HAI as there is evidence of immune compromised disease progressing as soon as 3 days post exposure.

Kr

[redacted]

Dr Christine Peters
Consultant Microbiologist
QEUH
[redacted]

From: Bal, Abhijit
Sent: 08 March 2023 11:54
To: Inkster, Teresa [redacted]; Peters, Christine [redacted]
Cc: Khanna, Nitish [redacted]; [redacted]; Khalsa, Kamaljit [redacted]; Balfour, Alison [redacted]; Valyraki, Kalliopi [redacted]
Subject: Re: IPC Sector Reports - 03/03/23

Thanks Teresa. I did not say that cutaneous mucormycosis is the only circumstance. I only cited an example. I stick to my view that the incubation period of mould infection is poorly defined in literature. The NIPCM itself states "days to months" in relation to *Aspergillus*. The important issue is recognising outbreaks and investigating even single cases of mould infections which we do and have done in this case.

Professional opinions vary and this was picked up in the recent HIS report in relation to *Aspergillus* in 4B which was in January 2022 which we also did not HIIAT. We need to develop a national consensus, also suggested by the HIS report.

Abs

From: Inkster, Teresa [redacted]
Sent: 08 March 2023 11:08
To: Bal, Abhijit [redacted]; Peters, Christine [redacted]
Cc: Khanna, Nitish [redacted]; [redacted]; Khalsa, Kamaljit [redacted]; Balfour, Alison [redacted]; Valyraki, Kalliopi [redacted]
Subject: Re: IPC Sector Reports - 03/03/23

Hi Abs, more than happy to assist with interpretation of the NIPCM as I chaired the group that produced the guidance.

Thanks for confirming your view that a case of invasive fusariosis in a BMT patient who tested positive on day 17 of admission and is now deceased (with fusarium part 1 of the death certificate) does not constitute a Red HIIAT. This is in the context of water damage on the ward and other environmental organisms in patient samples.

Not sure I understand the point you are making re cutaneous mucor. You appear to be stating that cutaneous mucor is the only circumstance in which a single case of fungal infection would have a HIIAT assessment. However ,this is inconsistent with GGC practice as a recent single case of Mucor acquired via the inhalational route in a 2a patient which I alerted the IPCT to ,was reported and HIIAT assessed

With regards definitions of HAI applying a median incubation period of ~ 15 days is not appropriate in a high risk and profoundly immunosuppressed BMT cohort. This is reflected in published outbreaks in the literature where HAI fungal infections are classed as such from day 3 onwards.

kr
Teresa

From: Bal, Abhijit [redacted]
Sent: 08 March 2023 07:13
To: Inkster, Teresa [redacted]; Peters, Christine [redacted]
Cc: Khanna, Nitish [redacted]; [redacted]; Khalsa, Kamaljit [redacted]; Balfour, Alison [redacted]; Valyraki, Kalliopi [redacted]
Subject: Re: IPC Sector Reports - 03/03/23

Hi Teresa. A single case of *Aspergillus* or *Fusarium* in a haematology patient does not meet the criteria for HIIAT based on our understanding of the NIPCM.

There will be other situations where a single case of mould infection would be subject to HIIAT *e.g.*, cutaneous mucormycosis, given the large denominator (*i.e.* the vast number of surgical procedures), which would meet the definition of "unusual infection" in the NIPCM.

Where HIIAT is done, death would make the HIIAT red.

However, all invasive mould infections in haematology must be investigated. It is of course much more challenging when dealing with moulds because the incubation period is not clear. Hospital-acquired infections may be hospital-revealed infections and infections that occur in the community may be hospital-acquired if the patient has been discharged even if not recently.

Abs

From: Inkster, Teresa [redacted]
Sent: 03 March 2023 16:18
To: Bal, Abhijit [redacted]; Peters, Christine [redacted]
Cc: Khanna, Nitish [redacted]; [redacted]; Khalsa, Kamaljit [redacted]; Balfour, Alison [redacted]; Valyraki, Kalliopi [redacted]
Subject: Re: IPC Sector Reports - 03/03/23

Hi Abs, I note that the 4B patient with Fusarium sadly passed away earlier this week. Is this not a HIIAT red given that it is an HAI fungal death?

kr
Teresa

From: Bal, Abhijit [redacted]
Sent: 03 March 2023 16:11
To: Peters, Christine [redacted]
Cc: Inkster, Teresa [redacted]; Khanna, Nitish [redacted]; [redacted]; Khalsa, Kamaljit [redacted]; Balfour, Alison [redacted]; Valyraki, Kalliopi [redacted]
Subject: Re: IPC Sector Reports - 03/03/23

Not serogroup 1.

Abs

From: Peters, Christine [redacted]
Sent: 03 March 2023 16:08
To: Bal, Abhijit [redacted]
Cc: Inkster, Teresa [redacted]; Khanna, Nitish [redacted]; [redacted]; Khalsa, Kamaljit [redacted]; Balfour, Alison [redacted]; Valyraki, Kalliopi [redacted]
Subject: FW: IPC Sector Reports - 03/03/23

Hi Abs,
The legionella is news to me in the south report – is this a serogroup 01 do we know?

Kr
Christine

From: MacLeod, Calum
Sent: 03 March 2023 15:47
To: Marek, Aleksandra [redacted]; Andrew Smith [redacted]; Wallace, Angela [redacted]; Arbuckle, William [redacted]; Bagrade, Linda [redacted]; Balfour, Alison [redacted]; Bowskill, Gillian [redacted]; Boyd, Luanne [redacted]; Carson, John [redacted]; Cassidy, Anne Marie [redacted]; Awilly Chofle (NHS Greater Glasgow & Clyde) [redacted]; Cottom, Laura [redacted]; [redacted]; Devine, Sandra [redacted]; Dhillon, Raje [redacted]; Doherty, Denise [redacted]; Donnelly, Michael [redacted]; Douglas, Kirsty [redacted]; Fleming, Alistair [redacted]; Glancy, Joan [redacted]; Hamilton, Kate [redacted]; Henderson, Karen [redacted]; Su Su Htwe (NHS Greater Glasgow & Clyde) [redacted]; Inkster, Teresa [redacted]; Jamdar, Saranaz [redacted]; GILLIES, Jenna (NHS GREATER GLASGOW & CLYDE) [redacted]; Jones, Timothy [redacted]; Kerr, Ann [redacted]; Khalsa, Kamaljit [redacted]; Khanna, Nitish [redacted]; Leanord, Alistair [redacted]; Love, Liz [redacted]; MacLeod, Alison [redacted]; Macleod, Mairi [redacted]; Mathieson, David [redacted]; McConnell, Donna [redacted]; McDaid, Kirsty [redacted]; Menzies, Lisa [redacted]; MURPHY, Michael (NHS GREATER GLASGOW & CLYDE) [redacted]; Mills, Gillian [redacted]; Moore, Marie [redacted]; Murphy, Deborah [redacted]; O'neill, Julie Anne [redacted]; Ozegemen, Margaret [redacted]; Polubothu, Padmaja [redacted]; Peters, Christine [redacted]; Pritchard, Lynn [redacted]; Robertson, Angela [redacted]; Smyth, Elaine [redacted]; Spalding, Jane [redacted]; Stuart Gallacher (NHS

Greater Glasgow & Clyde) [redacted]; Valyraki, Kalliopi [redacted]; Weinhardt, Barbara [redacted]; Wilson, Gary [redacted]; Wright, Pauline [redacted]; Gardner, Morag [redacted]; Gillespie, Con [redacted]; Loudon, Lorna [redacted]; Bal, Abhijit [redacted]; Simon Pybus (NHS Greater Glasgow & Clyde) [redacted]; Morrison, Jennifer [redacted]; Digby, Amanda [redacted]; Frew, Stephen [redacted]; McBride, Elizabeth [redacted]; Meechan, Mandy [redacted] Kennedy, Louise [redacted]; NORTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE) [redacted]; SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE) [redacted]; Rodger, Graeme [redacted]; Arnott Bowl, Alexandra [redacted]; Lang, Ann [redacted]
Subject: IPC Sector Reports - 03/03/23

Good afternoon

Please find attached the IPC weekly sector reports dated 3rd March 2023.

Also attached are a note of the ward closures/update for South Adult, Clyde and North sectors.

If there is difficulty getting through to the wards at the weekend the best person to contact is as follows:-

GRI – Clinical co-ordinator/site flow manager
QEUH – Clinical co-ordinator
Clyde – Bed manager for either RAH or IRH (you can pass on message re VOL to either of the bed managers).

Kind Regards

Calum MacLeod
Infection Prevention & Control Administrator
Zone 1, Level 2
Office Block
QEUH
G51 4TF

[redacted]

Chat with me on teams!

[redacted]

Dear Brian,

This is really rather shabby treatment, is it not? I would never have done this to a colleague. Clearly, the 'Glasgow boys' have put the boot in (again) based on preconception, ignorance and petty jealousies. No surprises there. Did you stick up for me??

I would have made patient safety an absolute priority as well as supporting and helping the local infection control team. I'm sure you know that. As it was, even after just two visits, it wasn't difficult to get the measure of QEUH –or the culture- and I would have engineered a raft of interventions that would have immediately reduced the HAI risks for everyone. These are evidence-based and cost-effective. I'm surprised that none of your resident experts have already suggested the more obvious amendments.

There are serious environmental deficiencies at the QUEH. Protecting your patients now, and for the future, needs courageous people to speak out and resolve the problems. I would have done that for you with diplomacy and humour. I do not support, nor would contribute towards, a witch hunt or a culture of blame. I abhor irresponsible media liaison. I only wanted to help resolve issues that I understand and care about. GGC can no longer paper over the cracks in this multi-million pound flagship hospital.

Kindest regards

Stephanie

Dr Stephanie J. Dancer, Consultant Medical Microbiologist, NHS Lanarkshire and Professor of Microbiology, Edinburgh Napier University, Scotland.

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SCOTTISH HOSPITALS INQUIRY

Bundle of documents for Oral hearings commencing from 19 August 2024 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow

Bundle 14 – Further Communications

Volume 3