Scottish Hospitals Inquiry
Witness Statement of
Mr Thomas Walsh

1. My name is Thomas Walsh. I have worked in the NHS for 40 years in a career spanning both clinical and managerial roles. I officially retired on 21 March 2021. However, I still undertook some bank work for the Health Board until March 2024. My statement below combines the statement taken by the Inquiry in August 2022 and responses to supplementary points for clarification requested by the Inquiry in May 2024.

I have been asked to provide further details as to the work I undertake and the basis on which I do so. I have now fully retired from all NHS work. I formally retired from the NHS in March 2021. Between May 2021 and April 2024, I undertook some part-time bank work with the Health Board. Between May 2021 and September 2021, I worked within Corporate Services on legal claims, FOI requests, and complaints. From May 2022 until April 2024, I worked two days per week with the Programme Management Office. My remit was assisting with the sourcing and provision of documentation and information for the COVID and SHI Inquiries and the Police Investigations Operations Koper and Quadric.

Professional History

2. I started my career with the NHS as a student nurse in 1983. Following my qualification as a nurse in 1986, I worked in operating theatres as a Staff Nurse, a Charge Nurse, and then a Nursing Officer until 1994.

3. Since 1994 my career has been focused on management roles. I undertook my first health service management role in 1994 at the Royal Alexandra Hospital in Paisley. In this role, I managed operating theatres, day surgery, pharmacy, coronary care, and intensive care.

4. Thereafter, I became Assistant Director of Nursing at the previous Argyll and Clyde Health Board. I remained in that role until the Health Board was dissolved in 2006.

Following the dissolution of the Argyll and Clyde Health Board, I moved to the Greater Glasgow and Clyde Health Board (NHSGGC).

I have been asked to clarify when my role with Argyll and Clyde Health Board commenced. This was in 1994 when I was appointed to the role at RAH mentioned above.

5. Those who had held management jobs in the old Argyll and Clyde Health Board were required to apply for and were absorbed into the new structure of the Glasgow and Clyde Health Board. All Scottish Health Boards moved to single system working through the integration of health boards and clinical services in 2006/7.

6. When I moved to Glasgow and Clyde Health Board, there were no senior nursing vacancies available at the time. I was therefore appointed as a Planning Manager for regional services. I was in that role for about a year and a half.

I have been asked to clarify when I was appointed as a Planning Manager for regional services, and when I ceased to be in that role. This was from May 2006 until July 2007.

7. From July 2007 to April 2019, I held the post of Infection Control Manager (ICM), for NHSGGC. I held this role for longer than any other in my career. In my role as Assistant Director of Nursing at Argyll and Clyde Health Board, I dealt with infection control as part of my remit. In 2007, the ICM of NHSGGC retired. I subsequently applied for and was successfully appointed to, that role in July 2007.

I have been asked: to provide an overview of my specialism and role; to provide a description of the medical and non-medical facilities within my specialism; to explain the relevance of my role to patients' vulnerabilities/specialist requirements; to provide an explanation of my role in the management of infections at QEUH/RHC in the IMT structure, and to describe who I reported to and who reported to me at QEUH/RHC at all points from January 2015 to date. I have also been asked to describe my role with the Scottish Government (including when I was appointed, the terms of my appointment, how long I was in the role, my responsibilities and areas of work) and my role at HPS

(including when I was appointed, the terms of my appointment, how long I was in the role, my responsibilities and areas of work).

This was a managerial rather than clinical role. The reporting arrangements are covered later in my statement. My job description has been submitted to the Inquiry as has full detail on the Infection Prevention and Control structure. I have never worked for Scottish Govt or HPS, nor was this discussed or suggested by either party during my interview with the Inquiry Team.

8. From 2019 to 2021, I was a General Manager working for the Chief Operating Officer for Acute Services.

9. I retired from the NHS in March 2021.

Role as Infection Control Manager (ICM)

10. When I became ICM for NHSGGC in 2007, it was a new single-system health board and the Queen Elizabeth University Hospital ('QEUH') was in the planning stages. I was originally based in Dalian House in Glasgow, which was the old board headquarters. I think it closed around 2009. Thereafter, Sandra Devine and I were based at the old Western Infirmary, which also subsequently closed. Thereafter, I was based at Dykebar Hospital.

11. The key challenge for me when I first took up the ICM post was integrating the teams. That was a challenge across the whole health board because the North and South Glasgow teams were merging, and Clyde was being brought in as part of the new structure. At this time, a lot of managers, including myself, were focused on integration. At times, there was a requirement to reallocate resources across the new structure.

12. The management structure of the Infection Control Service changed in 2009. This change occurred after the outbreak of Clostridium Difficile at the Vale of Leven Hospital in Alexandria. Following the outbreak, all of the senior staff working in infection control were displaced and had to reapply for our respective jobs. Following this re-application process, I was successfully re-appointed as ICM.

13. Further integration within the IPCT began after my re-appointment. These integration works involved taking teams from diagnostics and facilities and integrating them into one single corporate team, including the staff who were previously in community care, or health and social care partnerships.

14. At that point, I became the line manager for all staff working in infection control. This included all of the nursing staff, administrative staff, and microbiologists for the sessions they provided in infection control as infection control doctors (ICDs). In this role, I did not manage any individual microbiologists. I managed their sessions, and they became part of our Senior Management Team. I directly line-managed the appointed Lead Infection Control Doctor. In 2009, the Lead Infection Control Doctor was Professor Craig Williams. The Lead Infection Control Doctor was the only microbiologist who had a majority of sessions with infection control.

    I have been asked to clarify what this role entailed, including responsibilities, numbers of staff supervised and number of sites. The main points are included in my statement. My full job description and the Infection Prevention and Control Structure have previously been submitted to the Inquiry**.**

15. The leadership of the Infection Control Service within NHSGGC comprised of myself as ICM, Sandra Devine as Associate Nurse Director, and Professor Williams as Lead Infection Control Doctor. There were other ICDs who reported to Professor Williams, but they were also undertaking microbiology roles, in which they reported to the Head of Microbiology.

16. In my role as ICM, I always reported to the Medical Director. My line manager did not change after the Vale of Leven Inquiry. It was a requirement of the Health Department Letters (HDL), which are Scottish Government instructions to health boards, that every health board was required to have an ICM who reported directly to the Chief Executive or an executive member of the health board. In NHSGGC, it was the Medical Director. In other Boards, it tended to be the Nurse Director. HDLs later became known as Chief Executive Letters (CEL). The Medical Director at the time was Brian Cowan, and when he retired, Jennifer Armstrong was appointed to the role of Medical Director.

17. The ICM role was a general management role. In terms of the HDL at the time, it specified that it was a management and not a clinical role. My job was not to know more than the clinical experts, but to coordinate and support the team in performing their roles. In my view, I had two of the best clinical experts in Scotland working for me.

    I have been asked to clarify what time I am referring to when I refer to the 'HDL at the time', who I am referring to when I refer to 'two of the best clinical experts' and what their roles were in working with me. The relevant HDL has been submitted to the Inquiry. I cannot recall the date of issue, from memory, this was perhaps around 2001. This was a Scottish Government document, (Health Dept Letter), to the NHS in Scotland specifying the requirement for, and the remit of, Infection Control Managers for all Boards within NHS Scotland.

    The clinical expert roles are those referred to in paragraph 15 above.

18. I have been asked about decision-making as the ICM. In this regard, I was responsible for ensuring that the team functioned and that we produced policy and guidance. I set the objectives for the infection control service based on national guidance. I coordinated and produced an annual infection control programme which would then set out the objectives for the service. We would deliver those objectives through the clinical teams, and we would monitor compliance regularly.

19. In my role as ICM, I procured an electronic surveillance system so that we knew the rates of infection across the area. The system linked directly to the labs system. It is called ICNET. NHSGGC were the first in Scotland to fully implement ICNET. You cannot have everybody everywhere all the time, so when we had this surveillance going on in the background we knew where to concentrate resources if rates were rising in a specific area. My role was to support the team in delivering the infection control agenda. I reported to the Board Infection Control and Clinical Governance Committees in terms of progress against the annual programme and in terms of surveillance. The team also undertook ward environmental audits and would use results and reports to assist the staff in improving practice or the environment. My role comprised both decision-making and supporting the clinical staff and infection control experts in undertaking their roles.

I have been asked: to explain, broadly, what the the function of ICNET is; what the infection control agenda is; how often I reported to the committees; what this reporting entailed, and whether I can clarify how I provided support to the clinical staff and infection control experts. As described ICNet is an electronic infection surveillance system. The committees received standard reports which have been submitted to the Inquiry, and Infection Control was a standing agenda item at every Infection Control and Clinical Governance committee meeting. My support was mainly ensuring that recommendations arising from policy, audit, and surveillance could be, and were, implemented.

20. In my role, I would require on occasion to escalate decisions that were outwith my budgetary remit or that were going to affect the Board's performance. I would be looking at all the national guidance. The only decisions I did not make were the clinical ones. I took advice from senior clinicians, and we made decisions based on that.

    I have been asked: to clarify when and to whom decisions were escalated; what my budgetary remit was; how escalated decisions would affect board performance; for what purpose(s) I would require to consider national guidance, and to be more specific in relation to the types of decisions I was required to take as part of my role. The NHSGGC Governance structure has been submitted to the Inquiry. Broadly speaking escalation was through the Infection Control Committees to the Clinical Governance Committee and NHS Board. Escalation could also be progressed via the line-management structure to the Medical Director. In terms of budget, I held the budget for all Infection Prevention and Control staff. Frequently infection control recommendations could impact the budgets of other services which is what I was referring to. All national guidance on the Prevention and Control of Infection required to be considered. As above this frequently had cost implications for both clinical and facilities services.

21. In terms of major decisions relating to Infection Prevention and Control, any such decisions would be taken in the context of an annual infection control programme and objective setting. The annual infection control programme would be approved by the Infection Control and Clinical Governance Committees, and the NHS Board. It was a live document. If something new came in, then I would add a relevant objective to the programme.

I have been asked: to clarify what I mean when I refer to ‘major decisions’; who prepared the annual infection control programme; what it consisted of, and for what purpose it was prepared. I have also been asked what I mean when I refer to ‘objective setting’: what objectives, who set them, for whom were they set, what was the purpose of these objectives? I have also been asked: to clarify when in the year the programme would typically be discussed at committee and approved; if I was solely responsible for the programme; whether others had access to it for editing purposes, and at what stage, if any, the document ceased to be 'live'. The Annual Infection Control Programmes have been submitted to the Inquiry. The Annual Infection Prevention and Control Programme exists to co-ordinate and monitor the work of the Infection Prevention and Control Committees and Teams in preventing and controlling infection through effective communication, education, audit, surveillance, risk assessment, quality improvement, and development of policies and procedures. The Programme addresses the national and local priorities for infection prevention and control and extends throughout healthcare, health protection, and health promotion. Operational delivery of the programme is regularly monitored, reviewed, and reported through the detailed work plan. The Annual Infection Control Programme was produced by the Infection Prevention and Control Team and submitted by the Infection Control Manager to the Infection Control and Clinical Governance Committees for approval. Progress was reviewed at the Infection Control Committees as a standing agenda item.

22. The Infection Prevention and Control Team (IPCT) also operated a risk register to manage these matters. When a particular risk was identified it would be entered into the risk register. Entries were then scored for impact and likelihood. I led a group on the risk register and the scoring process. We decided which risks were escalated from our risk register for Infection Control to the Corporate Risk Register.

I have been asked: to clarify what I mean when I refer to ‘matters’ in the above section’; what the function of the risk register was; who had access to it; how additions to it were scored; how decisions to escalate were taken, and for further details on my reference to the ‘group on the risk register’. The Board’s Risk Register Policy and the IPCT Risk Register have been submitted to assist the Inquiry.

The group comprised nominated ICNs and ICDs to review and score existing and new risk entries. The risks with the highest scores would be escalated for inclusion in the corporate risk register as per policy.

23. Infection Control was a high priority at the time. As such, there was a significant amount of nationally directed guidance to which we had access. We translated that national direction into tangible actions within the Health Board. The delivery of those actions was then carried out through the annual work programme.

I have been asked to provide further clarification as to the 'tangible actions' that I refer to above, how those actions were monitored and the function and purpose of the annual work programme. I have also been asked to explain the extent to which infection – whether endogenous or arising from the environment (in or out of hospital) – is always a risk for certain sorts of patients, whether there is a limit to what can be done to prevent this and whether there are certain sorts of infection that can be expected to arise no matter the level of care taken in relation to IPC/hygiene. This was primarily delivered through the Annual Infection Control Programmes and associated work plans. These documents set out both objectives and identified who would lead the delivery of each of the objectives. These documents have been submitted to the Inquiry.

The detailed considerations concerning infection risk will be better addressed by clinical experts.

24. I was a member of the Clinical Governance and Board Infection Control Committees. As part of my role on those committees, I would take the initial objectives paper on behalf of the Medical Director to the relevant Committees. We were provided with bi-monthly updates on progress against the objectives or any changes. We also had a Senior Management Team (SMT) meeting, and this is where any clinical issues could be discussed.

I have been asked to clarify the period in which I was a member of these committes, what my position/role on the committees was and what the 'initial objectives paper' was (including its purpose). I was a member of these committees whilst in the role of ICM. The objectives paper described is the Annual Infection Control Programme.

25. Every geographical area had a Lead Infection Control Nurse (ICN). The other ICDs had sessions that were allocated to a sector. I had an SMT that consisted of our triumvirate and all the lead ICNs, which would be six or seven, depending on how the sectors were defined, and two or three other ICDs.

I have been asked to clarify what is meant by 'triumvirate'. This is the Senior Manager, Associate Director of Nursing, and Lead Infection Control Doctor. This is set out below in paragraph 28.

26. When I came into the Infection Control Manager role in 2007, it was a changing picture because of the national change in health boards to single system working (i.e. the integration of health boards and clinical services). Within NHSGGC this resulted in the integration of North, South, and Clyde, which at the time became Sectors. At the beginning of the period of integration, and on a temporary basis, they were split into specialist clinical directorates. For example, surgery across NHSGGC was one clinical directorate across all the hospitals that provided surgery. I cannot recall the exact date we moved back to North, South, and Clyde as sectors.

I have been asked to clarify the precise time period referred to here. I cannot recall precise dates, but the Board has provided this information to the Inquiry.

27. We have always produced a series of reports from Board to Ward, and there is a diagram in the annual reports which shows how we reported at all levels within the organisation. We did not just provide reports. Our remit was also to support the management teams with intelligence on where they were with their ward environment or their infection rates. We worked directly within the sites and sectors. As part of this work, we would utilise an ICD and/or ICN to assist with the interpretation of their reports at their Directorate or Clinical Governance meetings. I took the view that it was not enough to simply provide the reports, we had also to support the interpretation and advise on actions required.

I have been asked to clarify the purpose of these reports, who they were produced for, how they were considered, and how they were used. I have also been asked to clarify:

who is referred to as 'management teams'; what sort of intelligence is referred to and what purpose it was used for; how infection rates were monitored and how any data was utilised in that respect; how I supported the interpretation and advice on actions and for what purpose, and to whom the interpretation and advice was provided and for what purpose. The board-to-ward reporting structure for Infection Prevention and Control has been submitted to the Inquiry. The reports and extensive evidence have also previously been submitted to the Inquiry.

Relationships within the Infection Control Team (ICT)

28. As noted above there was a triumvirate, with me as ICM, a Lead Infection Control Doctor, and the Associate Nurse Director. The Associate Nurse Director had line management and professional responsibility for seven or eight Lead Infection Control Nurses, who then in turn each managed a team. The Lead Infection Control Doctor had responsibility for the sector ICDs.

29. My engagement with the sector ICDs and ICNs was through the Senior Management Team. We also had Organisational Development (OD) events, but the main route was a monthly Senior Management Team meeting which all ICDs and all Lead Infection Control Nurses from each of the sectors attended. There was not a fixed agenda for the meetings. However, one of the standing agenda items was the provision of updates from the sectors by a doctor or nurse who would provide us with information as to what was happening in their area. It was also open to the doctor or nurse to ask for advice from the SMT or colleagues around the table. So, the SMT was the way for us to engage directly with the broader group. Everyone had a good relationship, and it worked well.

30. However, in 2015, difficulties began to develop between two ICDs. These ICDs were Dr Christine Peters, who had recently been appointed to infection control in the South, and Professor Williams, the Lead ICD.

31. Dr Peters is a very intelligent individual with a lot to offer, but she did not like the way we were set up. Further, she did not appear to be willing to accept the leadership of Professor Williams. While Dr Peters had a considerable amount of theoretical knowledge, it appeared to me that any challenge or questioning of her expertise would

result in her disengaging from recognised processes for dealing with issues or concerns. That made working with her quite a challenge because you were dealing with someone who was then going in several directions and not using any appropriate structure for escalating issues or problems. Consequently, the team became quite fractured, and some aspects of relationships became difficult.

I have been asked: to clarify what Dr Peters' issue was with the set-up of the SMT and what issue Dr Peters had with the leadership of Professor Williams; to clarify what precisely I am alleging that Dr Peters would do; to provide specific examples and explain why this was problematic; what is meant by 'several directions and not using any appropriate structure', and in what way the SMT became fractured, what relationships became difficult, and the significance of that. The full history and background has been submitted to the Inquiry within the whistleblowing reports. These reports reflect my recollection and understanding of the issues.

32. I think the best way I could describe it is there were differences of professional opinion, which can happen anywhere. However, the way that they manifested, and the way that Dr Peters approached those differences, became increasingly difficult to manage. I have dealt with differences of clinical opinion throughout my entire career. Professor Williams and Sandra Devine did not always agree, but there was a way to resolve any issues on clinical matters professionally. However, it was not only the difficulty within the ICDs. Dr Peters also caused significant concern and stress among the senior nurses.

I have been asked if I can be any more specific as to the differences of professional opinion that I am referring to, how Dr Peters was difficult to manage and whether I can clarify in what way Dr Peters caused concern and stress among the senior nurses. This is set out in paragraph 34 below and covered within the whistleblowing reports submitted.

33. As a manager, I tried initially to hold the team together through the SMT. That could be quite challenging, to find common ground and try to build forward. We looked at OD processes and they were generally successful. I met with Dr Peters and Professor

Williams to try and identify what the problems were and settle some of this down. I also engaged with senior colleagues in microbiology.

34. Around the middle of 2015, Dr Peters decided that she did not want to be an Infection Control Doctor anymore. She might describe this as having resigned. However, she just gave up those sessions and reverted to a full-time microbiology contract. Despite this, she continued to take what I would describe as an unnecessary and inappropriate interest in infection control. For instance, Dr Peters demanded updates on infection control. Further, Dr Peters interfered in the running of the Infection Control Service, even though she no longer had any legitimate remit to be involved in such matters. I discussed this with both her professional lead, Dr Rachel Green, and my counterpart in diagnostics, Isobel Neil, who was the General Manager for that area. The purpose of those discussions was to see if we could do something about it. However, even after I left, my observation was that behaviours did not change.

    I have been asked to clarify from whom Dr Peters demanded updates, whether she got them and, if so, on what basis. I have also been asked to clarify how Dr Peters interfered in the running of the infection control service, what the outcome of this interference was and whether I can be more specific as to the basis of my observation that behaviours did not change. This is covered in the whistleblowing reports submitted to the Inquiry. These reports reflect my recollection and understanding of the issues.

35. The different management structures made it more difficult to manage the situation, but I did not have any difficulty in managing Infection Control Doctors until then, and they all had the same structure. I do not think I would pin it on dual reporting alone. It comes down to individual behaviours and the willingness of people to engage in a dual management structure.

Standard Operating Procedures

36. Local infection control policy was very much part of the IPCT objectives until about 2016/2017 when Health Protection Scotland moved to develop a National Policy Manual. Our job was very much about setting objectives and Sandra's role was about expert input to the production of our local policies and guidance. My understanding is

that between Boards, even for outbreaks or infection control, policies would vary slightly in content, and because of this, Health Protection Scotland were asked to develop a national policy manual. Our role moved to monitoring the national policy and its implementation, rather than writing policy. We were still involved in policy, but it was now a different approach.

37. Where the infection control experts were needed was to support staff in implementing the policy. A policy statement to me is what must be done, and you also need something that says; here is how you do it. Our view was that we had National Policy but some of our staff on the ground needed a bit of support for some of those policies. We agreed that we would develop Standard Operating Procedures (SOPs) that would support them in the local implementation of national policy. It was a clinical role to develop SOPs. Sandra would take all the national guidance and work with the IPC policy group in the production of the SOPs.

Role from 2019 onwards

38. I ceased to be the Infection Control Manager at NHSGGC in March 2019. Thereafter, I worked as a General Manager for the Chief Operating Officer of NHSGGC who managed all acute services and all the Acute Directors across NHSGGC. In this role, I did not have any involvement or remit with Infection Control.

I have been asked to specify the timeframe that I worked as a General Manager for the COO of NHSGGC. This was from April 2019 until I retired in March 2021.

ICNET System

39. As ICM, I appointed a Project Manager to set up the ICNET system. Prior to ICNET, the ICNs would physically go up to the labs, see what relevant results were in, and transcribe the information to deal with it later. The team had multiple homespun Excel databases, and it struck me that we needed to coordinate this better. In terms of robustness, ICNET gave a live link to the lab system, and we could decide which key organisms we wanted to monitor, record, and report. It was much more robust in terms of what results were coming in and did not rely on somebody going and looking at the

lab result but fed the results to the ICNs in their office through a live link. The lab data also allowed us to do more surveillance. One of the other developments was to put together a data team, who would then provide the ward, directorate, sector, and ad hoc reports and data analysis. Sandra Devine was instrumental in putting in a quality improvement process that related to surveillance. These are called Statistical Process Control charts (SPCs). Sandra had worked with HPS on these SPCs. ICNet supported this work. With ICNet we then had a database that allowed us to do proper retrospective research or analysis on infections.

I have been asked: to confirm who the Project Manager appointed was; what relevant results I refer to above; to clarify which key organisms were monitored; how they were monitored, recorded and reported; to clarify the type of surveillance carried out in relation to lab data; to clarify what quality improvement process was implemented by Sandra Devine, and to clarify how ICNet supported Sandra Devine's work.

The project manager was Debbie Forsyth, now sadly deceased. Debbie left NHSGGC around 2014. I cannot recall the precise details on organisms and results, and I no longer have access to these reports or resources. Extensive evidence around this has been submitted to the Inquiry.

40. Like any IT system, you cannot buy it off the shelf and expect it to work straight away. The system needed a lot of customisation for our use and practice and that is where the project manager came in. We ran it as a formal project and consulted with all the teams on the functionality of the system. There was a very comprehensive project built around it.

41. If there was an unusual organism or an outbreak, the alert could also come from the labs, the microbiologists, or ICDs. So, the IPCT has ICNET, but there are also the microbiologists in the labs who interpret the results that come in. If they are concerned about something, it can then be added as an alert to ICNET. The IPCT may get intelligence from labs or the nurses on the ward that there is something that needs to be added to the alerts. Therefore, as well as dealing with the immediate outbreak or incident, we can add it as an alert for a fixed period.

Governance Structure

42. When I was in post there was an Acute Infection Control Committee, and there was a Partnership Infection Control Support Group that dealt with community-related infections or those hospitals that have non-acute patients, such as care of the elderly hospitals or those with mental health issues and learning difficulties. Then there was a Board Infection Control Committee. The Partnership Infection Control Support Group and Acute Infection Control Committee report to the Board Infection Control Committee, which reports to the Care and Clinical Governance Committee (which used to be called the Clinical Governance Committee) which in turn reports to the NHS Board. There was a requirement for the Infection Control Manager to report to the NHS board every two months. There was an HAI reporting template issued nationally so that would also go to the NHS Board, Infection Control, and Clinical and Care Governance Committees.

    I have been asked to clarify what the post was that I referred to in my first sentence above. This is not a post. It is an equivalent infection control group for community and mental health settings. This is set out in the governance structure documents submitted to the Inquiry**.**

43. In terms of governance, the Acute Infection Control Committee covers all the hospitals that have patients in beds being treated for acute illnesses, whereas the partnership group is more community based including mental health and care of the elderly inpatients. The role of the Acute Infection Control Committee is to oversee the implementation of policy within Acute Services and to receive reports. They would get all the sector or directorate reports, depending on how they were structured at the time. They would oversee and manage the implementation of infection control policy and monitoring and surveillance across Acute Services.

44. As Infection Control Manager, I sat on that committee as did Sandra Devine and Prof Williams. We were reporting to, as well as advising, the committee. It was usually chaired by the Associate Medical Director. We would report on progress against the objectives that I have described, and where needed we would obtain their support, guidance, and advice. We would consult on any new policies for implementation, and we would also report on infection rates and incidents. The committee would also get

copies of the SPCs, outlining how the key infection rates were going, as well as ward environmental reports.

I have been asked: to clarify which committee I refer to having sat on; what I would have been reporting to and advising on at that committee; to expand on the support, guidance and advice that I would receive from that committee, and what the committee would do in respect of reports of infection rates and incidents. The committees I sat on are referred to elsewhere in my statement and the committee structure has been submitted to the Inquiry. Reporting is also discussed elsewhere, and the board-to-ward reporting model has also been submitted. I cannot recall precise details on committee meetings between 5 and 16 years ago, but all minutes, papers, and reports have been submitted to the Inquiry.

45. I reported to the Board Infection Control Committee. The Committee was chaired by the Medical Director, who was also my line manager. The committees had broadly similar agendas for about two-thirds of the business. In the Acute and Partnership Committees, there would be consultation about the approval of policy and SOPs. The chairs of the Acute Infection Control Committee and the Partnership Infection Control Support Group sat on the Board Infection Control Committee. They led the feedback from their respective committee.

46. The Clinical Care and Governance Committee would get the high-level HAI reporting template and the minutes of the Board Infection Control Committee as part of the standing agenda item. I believe that was a requirement following the Vale of Leven Report recommendations.

HAI Reporting

47. The HAI reporting template was developed around 2009/10. Before this, there was variation in what boards were doing in terms of reporting infections. There was a national consultation, and the HAI Policy Unit within the Scottish Government worked with HPS to devise a reporting template. It specified what information to collect and the format in which this should be presented.

48. The result was that every two months every NHS Board was reviewing the same data for their area. This allowed for national comparison and demonstrated the variability of what was reported. The data team was responsible for making sure the report data was collated, and Sandra Devine and I approved it. Usually, Sandra would provide the final sign-off on the report. We had the standard data set, and then we had to describe any recent significant outbreaks and incidents that would appear in the Healthcare Infection Incident Assessment Tool (HIIAT) reports.

The Healthcare Infection Incident Assessment Tool (HIIAT) (National Infection Prevention and Control Management - NICPM – Healthcare Infection Incident Assessment Tool (HIIAT) – Appendix 14 – NHS NSS ARHAI - v2.0 – 24 January 2022 - **A49394507 – Bundle 27 (vol 1), Page 662,** is an assessment tool for outbreaks and incidents. During my role as ICM, it would be prepared at the Incident Management Team (IMT) or Problem Assessment Group (PAG) meeting and would usually be produced by a Senior Infection Control Nurse. The standard process was for an Infection Control Doctor or a Consultant in Public Health Medicine (CPHM) to chair these meetings. The HIIAT was reported to HPS. These are national tools, which means everybody was reporting the same information in the same way.

I have been asked to expand on how the HIIAT functioned and on the purpose of reporting the information in the HIIAT. This is a National tool developed by HPS, (now ARHAI), and is part of the National Infection Prevention and Control Manual.

All HIIAT reports from NHSGGC have been submitted to the Inquiry.

49. I also sat on the board Water Safety Group. I had two main functions, the first being to make sure our Estates and Facilities teams and Legionella teams were supported by the nominated ICNs and ICDs. The other function was in connection with Pseudomonas. One of the reasons the Water Safety Group was set up was to implement a system for testing and monitoring for Pseudomonas. In general, the Director of Estates and Facilities was accountable and responsible for Legionella, while the ICM was accountable and responsible for Pseudomonas. However, there was a clear crossover between our teams.

50. There is clear policy and process around Legionella, and we had an action plan for implementing the Pseudomonas guidance. Our remit as the IPCT was to support the implementation and the education around the Pseudomonas testing guidance. I cannot recall if my involvement in the group changed after issues started to arise in Ward 2A in 2018. My recollection is that it was being progressed by the IMT outwith the Water Safety Group, which usually only met every two or three months. Things were moving so fast that, if there were Incident Management Team meetings (IMTs) three or four times a week, there would be no time for the Water Safety Group to get actively involved, although there would be reports back to the Water Safety Group. The Water Safety Group's operational role was particularly challenging given the speed at which issues were developing.

I have been asked: to expand on the Legionella policy I refer to above; to expand on the action plan for implementing Pseudomonas guidance (what the plan contained, how it was carried out and what its purpose was), and what guidance I refer to above. The relevant Legionella and Pseudomonas policy and guidance documents have been submitted to the Inquiry**.**

Involvement of Infection Control in Adult Bone Marrow Transplant Unit

51. When services moved over to the QEUH, Professor Williams was the Lead Infection Control Doctor, I was the Infection Control Manager, and Sandra Devine was the Associate Nurse Director. At that point, Dr Peters was the South sector ICD, while Dr Inkster was the ICD for the North.

I have been asked to clarify whether, at the point of taking occupation of QEUH/RHC on 26th January 2015, the following wards were fully handed over from Multiplex to NHS GGC: Ward 2A/2B, Ward 4B, Ward 4C, Ward 6A and Ward 6C. I have also been asked to confirm my understanding of the ward specification and patient cohort to be located in each ward, and, if a ward or wards were not handed over on 26th January 2015, or were partially handed over, why they were held back. I cannot assist with any detail on this. Records from the Project Team may be of assistance**.**

52. My recollection is that, shortly after occupation, there was concern about the number of air changes and the absence of HEPA filters in some of the air handling units in the adult BMT unit. This was looked at, and the concerns were taken seriously including, where possible, retrofitting HEPA filters. Thereafter, concerns developed about the design of the isolation rooms in Ward 4B. My understanding at the time was that there was no Scottish building guidance on the specification for a bone marrow transplant unit isolation room. In the absence of that, there was a proposal that the Board could follow the guidance on building an isolation room for multidrug-resistant tuberculosis (MDR TB).

I have been asked to clarify: why there was concern about the number of air changes and the absence of HEPA filters in the Adult BMT unit; what concerns there were regarding the design of the isolation rooms in Ward 4B, and the basis upon which it was suggested that guidance be followed for the BMT isolation rooms which mirrored those for MDR TB isolation rooms.
This and other concerns were fully set out in the SBAR and action plan referred to in paragraph 66 below. These documents have been submitted to the Inquiry.

53. Some expert opinions, including that of Peter Hoffman (external advisor from Public Health England), supported doing that. However, Dr Peters and Dr Inkster disagreed. The overall specification was considered below that of the existing unit, which was at Gartnavel. It was again a difference of clinical opinion and interpretation of guidance that did or did not exist.

I have been asked to clarify: the basis on which Dr Peters and Dr Inkster disagreed with the expert opinions which suggested that the isolation rooms could mirror those for MDR TB; the basis on which it is suggested that the specification for the isolation rooms at the QEUH were lower than those at Gartnavel, and what I mean in the final sentence above regarding a difference of opinion in respect of guidance which may not have existed. This is covered in paragraph 53 above and the SBAR referred to in paragraph 66. The key issue was the absence of a de facto national specification for a BMT unit. In the absence of such guidance differing views existed as to what the specification should be.

54. I believe that Prof Williams moved on from the lead ICD role partly due to issues within the team. Dr Inkster was then appointed Lead ICD in April 2016, and I was part of the appointing panel. Relationships within the IPC Senior Management Team (i.e., Sandra Devine, Professor Williams, and me), were good when Professor Williams was part of the team. Initially, things were good within the team when Dr Inkster was appointed. However, challenges continued with Dr Peters for a period, and Dr Inkster also found some aspects of Dr Peters' intervention unhelpful and challenging. Particularly as by that time, Dr Peters had stood down as an Infection Control Doctor. She continued to ask for information that she did not require in her role as a Microbiologist. Sandra Devine, Dr Inkster, and I all initially got on well and worked as a triumvirate. I certainly noted that, at that time, Teresa and Sandra were making a significant effort to work with each other. That continued until Dr Inkster unfortunately went off on long-term sick leave.

    I have been asked to clarify: what issues within the team I am referring to above; what information Dr Peters was said to ask for which was beyond her remit as a microbiologist, and when Dr Inkster went off on long-term sick leave. I cannot recall when Dr Inkster went on long-term sick leave, but I understand this detail has been submitted to the Inquiry.
    Further details on the interventions and actions of Dr Peters are set out in the Whistleblowing reports submitted to the Inquiry.

55. Things seemed to break down a bit after that. Even before Dr Peters, Dr Inkster, and others were part of the team, the dual reporting management system could be a challenge. I had noticed for some time that our Infection Control Doctors could be pulled in two different directions. The other issue that we recognised was that the sessions were not working. Infections and outbreaks do not always happen when, for example, Dr X is in on a Tuesday morning. They happen when they happen, and we need an ICD to chair the meeting. I consulted with a colleague, Keith Morris, who I think was in NHS Fife. I proposed that we find a way to provide a better, more flexible Infection Control Doctor service without depleting the microbiology service. This was not directly concerning the challenges within the team but for better integration with microbiology colleagues.

I have been asked to clarify what the multiple directions were in which I felt infection control doctors could be pulled. As described, The nominated ICDs could, at times, have simultaneous Microbiological and Infection Control commitments. This is set out in the SBAR document submitted to the Inquiry.

56. In my SBAR on Infection Control Doctor sessions, I suggested that we look at the Head of Microbiology having more oversight in terms of Infection Control. I had discussed this with a colleague, who was also the General Manager covering microbiology.

I have been asked to clarify: what I had suggested the role of the Head of Microbiology be, specifically; what the purpose of this elevated role was, and who the General Manager covering microbiology referred to was? The General Manager at the time was Isobel Neil, now retired.
The SBAR has been submitted to the Inquiry. Essentially the main proposal was that the Head of Microbiology would also be the Professional Lead for Infection Control Doctors providing effective oversight of both functions.

57. I drafted a paper with three recommendations and discussed it with Professor Brian Jones, who was the Head of Microbiology at the time. He agreed with my suggestions. Whilst Dr Inkster was on sick leave, Professor Jones stepped into aspects of the Lead ICD role, particularly around the BMT. Professor Jones perhaps had a degree of preconception about how the infection control team operated. However, when he came to work with us, he saw that it was quite different, in a positive way. He enjoyed working with us, as did we with him. Some of that was around recognising that there were gaps in the system that we currently operated. Brian and the Chief of Medicine for Microbiology were both broadly in agreement with my recommendations.

I have been asked to clarify what the three suggestions were in the paper I drafted and when I drafted it. I have also been asked to clarify: what aspects of the Lead ICD role Professor Jones stepped into, and for what period; who the Chief of Medicine for Microbiology was at the time; how the recommendations that I had made were considered; by whom, and in what forum. Having now retired I no longer have access to the SBAR and cannot recall the full details as requested. More detail was provided during my interview and is set out in paragraph 61 below.

58. We took some actions from the 27-point action plan (which is referred to in more detail below), around the remit of the Infection Control Doctor. Everything that the microbiologists had raised was an important point, and that is why there was a comprehensive action plan on how we would deal with it.

Concerns Regarding the Structure of the Infection Control Team

59. Around this time [redacted] raised some concerns about the structure of the infection control team. [redacted] did not raise [redacted] concerns directly with myself or anyone on the team, and I have not had any direct input regarding this. I cannot offer comment on concerns about Prof Brian Jones' role whilst Dr Inkster was away, other than Brian did an excellent job in difficult circumstances. My recollection is that the Infection Control Doctors in the South sector, primarily Dr Peters and [redacted], had disengaged. They still took some active, but not always helpful, interest in infection control. They set up a generic inbox which caused the clinical teams' operational problems in terms of who was dealing with issues. I would say that there was confusion caused by the actions of the Infection Control Doctors in the South for the whole of the Infection Control team, rather than the other way around. Professor Jones could not cover everything Dr Inkster did. He did not have the clinical sessions or the time. He was there to see that we had enough microbiologists to provide ICD cover and oversee the bone marrow transplant unit refurbishment.

I have been asked to clarify: what time is being referred to in the first sentence above; what issues with the infection control team were raised by [redacted]; who these concerns were raised with; what I mean when I say that Dr Peters and [redacted] disengaged, and how the generic inbox caused the infection control team issues. Much of this is covered in the SBAR, meeting of 4th October 2017 minutes and subsequent action plan which have all been submitted to the Inquiry. I believe these documents to be very important to the work of the Inquiry. In terms of the generic inbox, in the absence of a named individual, the ICNs did not know if, or by whom, an issue would be dealt with when submitting a request for assistance or information via e-mail.

60. I have been asked what became of the SBAR I authored, and whether anything changed as a result of it. Things did change as a result. Further discussions were held with our colleagues in microbiology, including Dr Rachel Green who was the Chief of Medicine, Isobel Neil who was my counterpart as General Manager, and Professor Brian Jones. We agreed that we should look at adopting that structure as described in the SBAR, with the Head of Microbiology taking an active interest in Infection Control. More significantly, although it did not strike me as hugely significant at the time, would be a change of the reporting line for the Lead Infection Control Doctor. This would change to going through the Head of Microbiology rather than straight to the Medical Director, as had previously been the case. The agreement was that we would implement the proposed changes when Dr Inkster came back from sick leave. Her absence was managed through microbiology. My understanding is that it was agreed, and Professor Jones offered to meet with Dr Inkster. I do not know if that meeting took place. I understand that Dr Inkster was unhappy about the proposal as presented in the SBAR and was particularly concerned about the change in her reporting line. She felt that she had not been fully consulted.

    I have been asked to clarify: when I authored the SBAR referred to; the structure described in the SBAR; the precise role that it was envisaged the Head of Microbiology would take on in respect of infection control; why the change in reporting line for the Lead ICD would change, and the purpose of that change; why Dr Inkster was unhappy with the proposal, and how I became aware that Dr Inskter was unhappy with the proposal. Some of this is covered in the preceding paragraphs. The detail requested is set out in the SBAR which has been submitted to the Inquiry.

61. Dr Inkster came back from sick leave in January 2018. However, she very quickly demitted from her Infection Control sessions. I understand that she subsequently met with the Medical Director and agreed to continue in post, although I was not involved in this process.

Awareness of Infections in 2A

62. I am not aware of concerns about organisms in the water beyond what was discussed at the IMTs. That is not to say nobody ever told me, but I have no recollection of that.

Even if I had, I would have looked for expert opinion from Sandra Devine and/or Dr Inkster.

63. I have been asked if I am aware of [redacted] highlighting to Sandra Devine the need to have water testing regarding Stenotrophomonas. I am not aware of that, and I would go further and say that it is not a decision for the Infection Control Nurses. For context, water and ventilation systems are two areas that Infection Control Nurses do not deal with.

64. I have been asked to comment on Sandra Devine's opinion that, whilst Dr Inkster was off sick, she had set the trigger threshold for Stenotrophomonas testing too low. That is purely a clinical decision. I am not qualified to answer that, but I would trust Sandra's judgment on the matter if this was the case.

October 2017 SBAR

65. I have been asked about my recollection of the meeting that was held on 4 October 2017 - **A42959603 – Bundle 4 Hearing Commencing 12 June 2023 – NHS GGC: Situation, Background, Assessment, Recommendation (SBAR) Document – Page 104**. The meeting was chaired by Dr Jennifer Armstrong, who was my line manager and the Board Medical Director. In the build-up to the meeting, some microbiologists raised concerns with the Medical Director about the built environment and the structure of the IPCT, which they have the absolute right to do. The number of concerns reached a point where Dr Armstrong had requested that these be set out in writing. The Microbiologists put together the concerns in an SBAR document, and Dr Armstrong arranged the meeting to respond to the issues identified.

I have been asked to clarify who the microbiologists referred to are; what concerns they had raised; when they prepared the SBAR referred to, and whether the concerns they raised pertained to any wards in particular. I have also been asked to provide as full a recollection as I can of: the discussions which took place during the meeting of 4 October 2017; what issues were discussed in relation to ventilation; what issues were discussed in relation to the water supply and taps; whether I formed any particular views in relation to the issues discussed, and the basis on which any such views were

reached. As mentioned earlier this is extensively covered in documents submitted to the Inquiry. These include the SBAR submitted by microbiologists, the minutes of the meeting held in October 2017, and the subsequent action plan.

66. Along with others, I produced the action plan arising from that meeting. We took the concerns expressed in the SBAR and at the meeting, and we agreed on a number of actions. Not all were for the Infection Control Team; some of them were Facilities or for our OD colleagues. My role was to develop the action plan. Subsequently, there were a couple of rounds of monitoring progress against the action plan with those who were designated to lead each of them. The meeting showed that important issues were being raised, albeit not necessarily always in the right way. The issues were being taken seriously with the aim of reaching a position where, with the microbiologists, we agreed on what we were doing about each of these twenty-seven points. Sandra and I would deliver on the actions for the infection control team, while Tom Steele or a nominated deputy from Facilities would deal with the Facilities' actions.

    I have been asked to clarify: who else was involved in preparing the action plan; what actions were agreed, by whom and when; by what mechanism they were agreed; to whom the action plan was circulated; whether that action plan was amended at any stage; how and by whom the actions were to be implemented; how progress against the action plan was monitored; the outcome of this monitoring; how often progress was monitored; how frequent each round of monitoring was, and what I mean by issues not always being raised in the right way. The action plan, mentioned above and submitted to the Inquiry, sets out the nominated leads for each of the agreed actions together with timescales. Progress against the action plan was noted and reviewed at Infection Control and Clinical Governance Committees. All relevant minutes have been submitted to the Inquiry.

67. The action plan and updates went to the Care and Governance Committee. Dr Inkster was back by this time, and she presented it to the Care and Governance Committee and confirmed she was happy with progress. That is my recollection, but I cannot remember specific dates. It took a few weeks to get the action plan up and running and then there were a couple of rounds of progress updates. The final update went to the Care and Clinical Governance Committee, although I was not at that meeting.

68. I have been asked if, once the action plan was in progress, updates were provided to the group of microbiologists who had raised the concerns in the first place. Dr Inkster did update her colleagues and I know they were involved in further commentary around the action plan.

Dr Inkster's Return from Sick Leave

69. After Dr Inkster's initial concerns, things started well. However, problems resurfaced concerning the IMTs around the water incident and Cryptococcus in late 2018/early 2019. That is where we saw some differences of opinion turning into disengagement and acrimony, and this escalated as time went on. In my opinion, both Dr Peters and Dr Inkster had very strong views, and these persisted, even when their views or hypotheses were quite different. The IMT exists to explore and consider hypotheses and control measures. There were issues with some of the hypotheses from a clinical perspective, but clinical colleagues and facilities colleagues would be better able to comment. For me, the biggest issue was how difficult it was for the IMT members to challenge some of the hypotheses and some of the proposed actions through the IMT Chair.

I have been asked: to clarify what I am referring to by the 'water incident'; to provide examples of instances of differing opinions becoming disengagement and acrimony; to clarify what I mean by there being issues with some of the hypotheses from a clinical perspective (including what the issues were and when they arose); to clarify in what way it was difficult for the IMT members to challenge some of the hypotheses (with examples), and to explain the significance of those difficulties.

The reference is to the IMTs held to review and investigate the potential issues with the water supply. A full timeline, all minutes, and reports have been submitted to the Inquiry. The issues with some of the hypotheses are extensively set out in the Cryptococcus Expert Sub-group and Whole Genome Sequencing reports. Both these reports have been submitted to the Inquiry. The key issue referred to above is that Dr Inkster, as IMT Chair, did not at times appear to welcome or accept any hypothesis that contradicted her own. The reports mentioned above address in detail the varying hypotheses.

Incident Management Teams

70. The process for convening an incident management team (IMT) is set out in national and local outbreak policy. The core members are listed there, and they will depend on the clinical area in which the incident occurs. The National Infection Prevention Control Manual (NICPM) suggests that the chair be an ICD or CPHM.

71. I have been asked what happens if an IMT is not functioning properly. There is an escalation process if an IMT is not functioning well. Usually, for a contentious or major incident, we would have Health Protection Scotland, Health Facilities Scotland (especially if ventilation or water was the problem), and/or Scottish Government present at the meetings. This meant there were independent experts on hand to offer their guidance. Just as I was moving post, the IMT changed the Chair to the Deputy Director of Public Health. Most outbreak policies recommend that a Microbiologist/Infection Control Doctor or a Consultant in Public Health Medicine (CPHM) should chair an IMT. In this case, there was sufficient concern about the way the IMT was functioning, despite the involvement of HPS and the Scottish Government, that the chair was changed. The change allowed the microbiologist who had been chairing to focus better on the hypothesis rather than trying to run the meetings.

72. I have been asked whether someone external, such as someone from Scottish Government or HPS, could step in and stop an IMT. I suppose this is technically possible, but I have never known it to happen. HPS were in attendance as the national experts, and they were also the conduit to the Scottish Government and could have intervened.

    I have been asked to clarify: in what situation someone may wish to stop an IMT; the significance, for the purposes of the above paragraph, of HPS being in attendance, and the role of the Scottish Government. This was my response to a question posed by the interviewers. I cannot add anything as the question is hypothetical and I have never known this to happen. The involvement of HPS in IMTs is covered in paragraph 103 below and described in the CNO Algorithm.

73. I was not involved in the particular IMT where issues developed to the point that a change to the Chair was implemented, as I had changed roles by then, but I was aware that differences of expert opinion persisted.. The Health Board and IMT subsequently commissioned the Cryptococcus Expert Group Report. The Whole Genome Sequencing Report was also produced, which provides more information than was available at the time.

74. I have been asked about the IMT in September 2018 regarding water, which continued much longer than other IMTs. If you review the minutes, almost every meeting or every couple of meetings there were new suspected cases and some reports of unusual organisms, While there were new suspected cases of infection, I would say there is an argument for continuing as an IMT. Equally, Health Protection Scotland could at any time have advised that the IMT could be stood down.

    I have been asked to clarify what unusual organisms I refer to above and on what basis HPS would recommend that an IMT be stood down.
    I cannot recall the details regarding organisms but this information will be set out in the IMT minutes and other data submitted to the Inquiry. The standing down of an IMT is a decision for the Chair and the IMT members. As above this was a response to a hypothetical question posed by the interviewers.

75. I am not aware of anything that has changed in the IMT process, although it is more than two years since I retired and 4 years since I left the Infection Control Manager post.

Issues with Built Environment

76. I have been asked about the choice of site for the QEUH campus. I was appointed as the Infection Control Manager after the planning for the QEUH started, by which point the site had already been decided on as there was already a major hospital there and had been for decades. I cannot see any issue with this. I cannot see any particular advantage or disadvantage in locating the children's hospital on the site. However, as far as the other hospitals are concerned, it makes sense to concentrate critical care and major trauma response on the same site. It is established good practice. Some of the decisions to move subsequently, for example, the BMT, were based on that core of

critical care. Leaving the Beatson (old bone marrow transplant unit) out at Gartnavel became less viable because they did not have intensive care beds or out-of-hours anaesthetic cover. So having that core of critical emergency response care simply made sense.

77. I had some involvement in the planning and design process. The IPCT's role included seconding a Nurse Consultant, Annette Rankin, full-time to the project at the planning stages, to go through the plans. She now works for HPS. We had Infection Control Nurses and Doctors on several of the planning subgroups, such as specialty subgroups. The main conduit between the IPCT and the Project Team was the Nurse Consultant who was seconded to the project team, but still sat in our SMT and gave us regular updates on progress with what was happening. She co-opted other team members as they were needed. The IPCT supported the project with specialists, who signed off on the plans. Following that, after the planning stage, it was too much for one person to cover. As the building started to be prepared for occupation, Infection Control Nurses were involved in the snagging and those were generally the ICNs who were going to be on the new site.

    I have been asked to clarify: my role in the planning and design process; the planning subgroups that the ICNs and ICDs were involved with; who the Nurse Consultant was that is referred to above; who the specialists are that are referred to as signing off the plans, and what the plans are that I refer to? Beyond the secondment of a Nurse Consultant to support the Project Team, I had no direct role in the planning or design process. I did sit in on a few planning group meetings for the configuration of beds in critical care areas. I do not recall the details, but a paper setting out the membership of the various planning groups has been submitted to the Inquiry.
    I have named the Nurse Consultant in the paragraph above and the reference to "plans" is to the design plans at the various stages. The Nurse Consultant signed off on the design plans. I believe the Job Description for the Nurse Consultant has been submitted to the Inquiry.

78. I have been asked what my understanding was of the infection control role in the validation and commissioning process in light of the concerns raised by Dr Inkster and Dr Peters in 2015. We were involved in snagging and looking at the planning and pre-

population audits and environmental audits of the unit. However, the commissioning of ventilation and water systems requires specialist engineering knowledge. That is not to say we did not have anything to do with it, but even now our microbiologists do not have the required expertise or apparatus to test a ventilation system. You need specialist engineering equipment and a specialist engineer to do that as only they can interpret the results.

I have been asked to clarify what unit I am referring to above; what snagging issues I was involved with; the outcome of the pre-population and environmental audits referred to above, and what role I am my team had in commissioning the ventilation and water systems. I believe the interviewer was referring to the BMT unit. Environmental audits have been submitted to the Inquiry. The Infection Control Team had no involvement in the commissioning of the water and ventilation systems other than that set out in paragraph 80 below. (please also see paragraph 81). The responsibility for ensuring the quality of the water and ventilation systems was that of the Project Team, supported by external consultants appointed as part of the NEC3 contract.

79. My recollection is that Professor Williams was involved in the water testing, and I think he also quality-assured the contractors' process for collecting specimens. Along with Estates colleagues, he went through a large spreadsheet of water test results prior to occupation. There were a few areas that needed dosing, but they were within acceptable limits. They measured for total viable counts (TVCs) which involved looking at how many particles were in the water and whether the TVCs were acceptable. My understanding is that a few areas were dosed with chlorine dioxide because of this. This was instructed by Professor Williams in conjunction with Ian Powrie.

I have been asked to clarify the role Professor Williams had in water testing and the areas which required dosing with chlorine dioxide. I cannot add to my recollection above. Extensive data on water testing results have been submitted to the Inquiry.

80. An Infection Control Doctor cannot provide expert comment on the design of ventilation systems. We would comment on the interpretation of results, but in terms of designing how air ducts flow and how the pressures cascade through a unit, you need a specialist

engineer. Infection Control advice would be provided based on derogation from design specifications. The team is not qualified or equipped to test the ventilation systems.

I have been asked to clarify if there were any derogations from design specifications, what those derogations were, when they arose and what action was taken in respect of them. I am unable to assist with this, however extensive detail has been provided to the Inquiry in response to an RFI specific to ventilation.

81. At that time there was no published Scottish Health Building Note (SHBN) or guidance on how to design an isolation room in a bone marrow transplant unit. Several meetings took place to discuss options, although I was not involved in many of them. Prof Williams led on this, and a decision was made in the absence of de facto guidance. The decision was to build isolation rooms using the room specification for MDR TB. Not everybody agreed with this decision. My recollection is that Prof Williams consulted externally as well as internally and the group came to the view that this should be suitable for that type of patient. Whether what was built functioned the way it should is another question altogether. The key point, and one of the key clinical differences of opinion, is what should we have built in the absence of de facto guidance on what a bone marrow transplant unit isolation room should look like. Many people were involved in the decision, and I recall that Dr Peters and Dr Inkster did not agree with the choice of specification.

I have been asked to clarify: what time I am referring to; what a Scottish Health Building Note is; who attended meetings to discuss options for designing a BMT unit; the basis on which a decision was made in respect of the design of the BMT isolation units; who did not agree with this decision, and on what basis they disagreed. A full timeline and extensive detail on the BMT have been submitted to the Inquiry. Health Building Notes are national design specification and guidance documents. These are produced by Health Facilities Scotland.

82. The ICD responsible for the new adult BMT would not routinely do air sampling before the patients were moved in. Prior to occupation, Professor Williams went through the children's bone marrow transplant unit and recognised that some HEPA filters were missing, and this was rectified. My understanding is that air sampling in an empty room

is of limited use; not completely pointless, but it needs the patient population in it to give a proper representation. If you have thirty patients in an old Nightingale Ward, the total viable count in the air of particles or any organism is going to be much higher than if that ward is empty.

83. Migration post-handover was a huge logistic exercise, as clinical services were moving from the old Victoria and the Western Infirmary as well as the existing Southern General Hospital.

84. I am asked if there were any issues detected in the building by the ICDs at this stage. I think that while Prof Williams was on holiday, Dr Peters first raised a concern relating to the ventilation specification in the adult bone marrow transplant unit. For the rest, it was minor snagging - for example, damage to walls, surfaces, or something not done such as a hand hygiene dispenser not fitted in the correct place.

    I have been asked to clarify: what time period I am referring to in the above paragraph; whether I can clarify the concern raised by Dr Peters; when he raised such a concern, and how it was raised. I cannot recall the detail, this will be covered in the RFI response and time line on ventilation.

85. I have been asked to describe my general impression of the hospital when it first opened. I have worked in many hospitals throughout my career, and the QEUH is different from any other hospital I have worked in. From an infection control perspective, the most welcome aspect is that it is 90 percent single-room accommodation, and where there is no single-room accommodation, there is appropriate bed spacing. For instance, I had never seen as much as 3.6 meters between beds before. As far as infection control is concerned, it was a big step forward.

    I have been asked to expand on my view of the benefits to infection control in having single-room accommodation and increased spacing between beds. Single-room accommodation and adequate bed spacing reduced the risk of patient-to-patient transmission of infection.

86. In terms of issues within the rooms such as televisions not working, I read the papers the same as everyone else. In terms of my role, nobody would come to me regarding that, as it did not directly concern infection control.

Issues that led to IMTs

87. Before the IMT that took place in 2018, I was not aware of any concerns about infections that were thought to be linked to the water. I was aware of the issues with the taps that HPS had been involved with in 2014, but I was not directly involved. The taps referred to were Horne taps, and they were at one time recommended in guidance, then the recommendation changed. There was a meeting to discuss the design of the taps and Sandra Devine invited both HPS and HFS (Health Facilities Scotland) to it. The minutes of the meeting record agreement that the Horne taps could be used as they were specified at the time the relevant guidance was in place.

Stenotrophomonas Incident

88. I have been asked about my involvement in the Stenotrophomonas incident in 2017. If it were just a PAG, I would not necessarily be there. I am not sure if there were any IMTs in relation to it, but there may have been a PAG. Any input I had would be limited. I recognise the name of the organism, but if there was not an IMT that would suggest it was not being treated as an active outbreak.

Water Incident 2018

89. I attended one IMT in March 2018, and several in September 2018, in relation to the water incident. My role in these meetings was no different from any other IMT. I was there to support the team, including the chair, who is usually an ICD. I was also there to make sure that the infection control actions were taken forward. These IMTs were slightly different in that normally I would have a role in communicating significant incidents to Health Protection Scotland and Scottish Government. However, in this instance, they were in the room and HPS took on the role of broader communications with Scottish Government.

I have been asked: to provide further details of the water incident referred to; in what way I would provide the suggested support, and how I ensured actions for infection control were taken forward. This is extensively covered in the RFI responses and IMT minutes submitted to the Inquiry. Actions to be progressed are noted and reviewed through the IMT minutes.

90. The membership of an IMT is set out in the National Manual. There is a core agenda that is followed. The agenda can be varied, and the actions will differ. Generally, the actions look at describing the situation, the clinical condition of the patients, any hypotheses, and then, what mitigating measures, if any, can be taken. It tends to form a structured and standard agenda. We provided the administrative support to the Chair. One of the Infection Control administrators would send out the agenda.

91. I did not attend any IMTs between March and September 2018 because during that time I was dealing with the DMA water reports from 2015 and 2017. The 2015 report had not been escalated through relevant management or governance structure. I was asked by the Medical Director and the Chief Operating Officer to work with the Acting Facilities Director, who was Mary Anne Kane at the time. Three days a week we were looking at a remedial action plan and ensuring delivery of the actions. I was also the single point of contact between the Board, Scottish Government, HFS, and HPS. Everything regarding the water issues had to be channeled through me.

I have been asked to clarify: why the 2015 report by DMA Canyon had not been escalated; what the status of the 2017 report by DMA Canyon was at the time of the referenced IMTs, and, if a remedial plan was prepared, when it was prepared and how it was actioned? The issues and actions around the 2015 DMA report were subject to an internal investigation. The report has been submitted to the Inquiry. For confidentiality reasons, I have never seen the report. The remedial plan and process are described in paragraphs 92 to 95, this too has been submitted to the Inquiry.

92. I do not have definitive dates for this, but looking back at my electronic calendar I can see Monday, Wednesday, and Friday every week I had water report meetings. A group met concerning this, which was chaired by Jonathan Best, Chief Operating Officer. Mary

Anne Kane was dealing with the implementation of the bulk of the actions through Facilities. My role was partly action planning but mostly communications. Jim Leiper, formerly director of HFS, was part of that group as an independent expert advising us on water control systems, and he also looked at some disciplinary aspects of what happened with the reports.

93. Jim Leiper was leading in the interviewing of involved parties. Whether or not he produced a final report, I could not say. It followed a disciplinary process and therefore confidentiality would be restricted to those who needed to be involved.

94. The DMA Canyon report deals specifically with Legionella control. It is about systems, processes, and policy relating to Legionella, and it links to the Health and Safety Executive (HSE) and the regulations in L8. It impacts infection control. There is overlap, but they are not necessarily the same thing. One is looking at preventing Legionella through control of the engineering system and the other is managing infections that may or may not have arisen from the water system. We had no indication there were any cases of Legionella, so they are quite different.

I have been asked to clarify, where I refer to two DMA reports above, which one I am referring to. I have also been asked to clarify: what I mean by ‘L8’; what I mean when I say ‘it impacts infection control’, and what I mean by ‘looking at preventing Legionella through the engineering system’, and ‘managing infections’, This should be plural for the DMA reports.
L8 (Legionnaires' disease: The control of Legionella bacteria in water systems) is a legal document that outlines the responsibilities of duty holders in managing and preventing the risk of Legionella bacteria proliferation. The main methods for controlling and preventing Legionella are through the design and management of the water supply system.
Whilst there have been no cases of Legionella, any cases would require input from both the Infection Control Team and Public Health.

95. If there was more than one IMT or incident we needed to deal with, we would discuss it. Knowing that the Lead Infection Control Doctor was the Chair freed me up to attend to other matters if I was required elsewhere. There was always Infection Control

representation at the IMT. However, all three of us could not necessarily be at them all, even recognising their importance. I was not formally kept up to date with what was going on in the IMTs between June and September, and Sandra Devine stood in for me during that period. Apart from the DMA Canyon reports and actions, I had little to do with infection control for the bulk of that period.

I have been asked to clarify who would discuss more than one IMT or incident. The IPCT Senior Team would discuss and agree on which meetings we would attend if there were more than one IMT at the same time.

96. I became involved again in the latter part of 2018. I was not involved in discussions about the decant from Ward 2A to 6A. Those discussions would have been at a high level operationally. They would discuss how to get the patients and the right staff and skills into the right area. Our role in that was threaded through in terms of inspecting the area, undertaking an audit, and making sure Ward 6A was suitable for the patients and staff to move into. The actual logistics of moving in and ensuring child protection and other arrangements that are required when moving patients out of a paediatric hospital were all planned separately as we could not necessarily take up more of the IMT agenda. It was an operational procedure for the clinical service as opposed to an infection-related issue. The children were moving because of perceived or potential risk of infection. The detailed logistics of moving patients around these areas was something that progressed outwith the IMT, but the IMT was updated on progress. I believe there were papers written about the decant ward and there was a risk assessment around child protection considerations mentioned above.

97. My understanding is that the IMT put together a paper with options for a decant and a recommendation on how that should be affected, or where the best areas were. That recommendation went to a group including the Chief Executive and the Chief Operating Officer who accepted those recommendations.

98. As mentioned above, at the IMTs I attended in September, issues began to arise, such as it being difficult to challenge hypotheses.

IMT Meeting on 28 September 2018

99. I have been shown the minutes of this meeting by the inquiry. I have been asked about comments that Dr Inkster made about governance around this incident, and I do not understand the point that she was making.

100. Dr Inkster considered that other groups were trying to influence the IMT that she was chairing. Dr Inkster had concerns about the Executive Oversight Group. I believe she felt some of her recommendations were not being taken seriously, or that they had been overruled. I am talking more about perception here. I do not remember the governance of IMTs being a particular issue at the time. This was a large, complex IMT, and it is not unusual for an IMT to commission a subgroup to look at something specific (e.g. Cryptococcus). It is not unheard of, or even unusual, when it is complex, and when there are multiple hypotheses. Dr Inkster could comment further on what she meant by her comments in the IMT.

101. Everybody in the IMT was committed to doing the right thing for the patients and getting the actions completed. Some of the hypotheses were in retrospect questionable, and there were challenges around behaviours in respect of that. External experts from HPS and HFS were around the table to support the IMT.

102. It was at this time that the Chief Nursing Officer algorithm was engaged. That is when the incident is of a level of significance that the Scottish Government asks HPS to step in. They had been involved throughout, so the algorithm did not make a difference to the way the IMT was run, but it meant we had expert involvement and there would be a couple of subgroups. We had Scottish Government monitoring us quite closely and HPS were the conduit to them and part of the teleconferences. It showed that the board recognised the significance of the incident we were dealing with. It is my recollection that we invited HPS, but the algorithm would have likely been invoked anyway.

I have been asked to expand on what I mean by the Chief Nursing Officer Algorithm, whether there were a number of sub-groups and what the purpose of those sub-groups was. The CNO Algorithm, (also known as the National Support Framework), National Support Framework 2017 – NHS NSS HPS – Version 1.1 - June 2018 - **A40562750** –

Bundle 27 (vol 1) – Miscelleaneuos Documents - Page 665, is an HPS document that sets out the roles and responsibilities of organisations in the event of healthcare infection outbreaks/incidents, data exceedance, or Healthcare Environment Inspectorate (HEI) reports where additional support to an NHS Board is required.

Communication about Water

103. As chair of the IMT throughout the Ward 2A water incident period in 2018, Dr Inkster offered to follow through in speaking to some of the families and to give them more detail on the infection from an infection expert point of view. However, in general, communication was delivered by the medical and nursing staff looking after the patients. Some of the communication did come through the IMT. Therefore, we did see it, but I was not involved in the delivery of it.

104. In terms of external communications, what tends to happen is someone from the communications team is a standing member of the IMT. If we are doing a proactive press release, and if we scored it in a HIIAT as red, they would draft a press release which would be signed off by the Chair. In this case, most of the press releases probably went to the sector director, if not the medical director, for approval as well.

Risk of Infection from the Water Supply

IMT 5 October 2018

105. This was the last IMT that I attended in relation to the water incident. It was more operational and more routine. I see from my notes that it was de-escalated from red to amber, so we agreed at that time that we did not need Dr Inkster, Sandra Devine, and myself at every meeting.

I have been asked to clarify the reason that the IMT was de-escalated from red to amber. This would be a decision led by the Chair, agreed by the group, and recorded in the minute. I do not recall the specific details, but this will be recorded in the minutes which have been submitted to the Inquiry.

106. I have been asked who would update the Medical Director if she was not at the meeting. If Jennifer Armstrong were not in attendance, an update would usually come from Dr Inkster or Sandra Devine as clinical experts.

Ventilation System

107. Initially, the concerns around ventilation related to the design specification, and the absence of *de facto* guidance on what a bone marrow transplant isolation unit/room should look like.

I have been asked to clarify what time period I am referring to above, who the concerns had been referred to and how they were communicated. I cannot recall the specific timescale. A full timeline and extensive details have been submitted to the Inquiry as part of a response to the specific RFI on ventilation.

108. There was an existing ventilation group, led by Professor Williams, which was a sub-group of the Acute Infection Control Committee, but it was not purely about the new build. We looked at the specifications for air handling units in all operating theatres to see if they were performing to the design standard. It is important to note that the design standard is different across all hospitals depending on the age of the buildings.

109. The ventilation group had all of the operating theatres up to date in terms of knowing where they were with their ventilation parameters and in terms of the planned preventative maintenance. There was a view that that group should look at ventilation systems in critical care areas beyond the operating theatres.

I have been asked to clarify: who considered that the group should look at the ventilation systems beyond operating theatres; to whom those views were communicated, and how. This was agreed upon and overseen by the Acute Infection Control Committee.

110. I remember the isolation rooms in A&E being part of the 27-point action plan and I remember the ventilation group, although I did not sit on it. Dr Inkster will have picked that up when Professor Williams left.

111. I have been asked about Dr Inkster's comment that I proposed several additions to the draft annual verification SOP. I don't recall this and doubt I would have offered much comment on that because I do not have any technical knowledge or expertise on ventilation.

HAI-SCRIBE

112. There were a couple of meetings about the BMT, and I was involved in signoff, but I do not recall HAI-SCRIBE being a huge issue. I believe Professor Jones signed them off. I recall that on one occasion, [redacted] felt that [redacted] was being asked to sign off on something that was beyond [redacted] competence and Professor Jones picked that up. At the time, all of the HAI-SCRIBEs came in a pre-formatted template, and you went through them deleting some parts and adding others. The system is different now.

I have been asked to clarify when the meetings referred to took place, what HAI-SCRIBE is and what Professor Jones is said to have signed off. HAI-SCRIBE is national documentation and guidance for controlling infection in the built environment during construction works. **(A33662208 – Bundle 13 Hearing Commencing 26 February 2024 – Miscellaneous – Volume 3, Page 464)**
Professor Jones signed off the HAI-SCRIBE template agreed with facilities colleagues for the construction work on the BMTU.

113. There was an instance where Dr Inkster's electronic signature or her name on the form had carried over from a pre-populated form. Professor Jones signed that off, but Dr Inkster was exercised that her name had appeared on the initial HAI-SCRIBE document. It was fully explained at the time that this was a purely administrative error, and there was no suggestion that anybody was trying to make it look as if Dr Inkster had signed something off with which she was not happy. She was not involved at all, and Professor Jones signed it off. I can understand Dr Inkster having felt the way that she did. I am not understating it, but it was merely an unfortunate administrative error.

114. I have no recollection of being involved in the review of the ventilation after the decant from ward 2A to 6A. I would have been aware of it, as it would have come up at SMT

and meetings with Dr Inkster, but I do not remember being at any specific meetings about that.

Decant to Ward 6A

115. The recommendations to decant were made at the IMT, and I was part of the group that looked at those recommendations in the context of what we were dealing with. I did not have much input on the rationale for selecting Ward 6A and Ward 4B for the decant. I do not have the clinical knowledge to say where these patients could be best placed. The issue was that we were using part of an adult BMT unit, so it was not like for like. If the whole problem was protective isolation and ventilation, then there are a limited number of places in the adult hospital where this could be provided. As I recall, the adult BMT unit gave up some of their beds to the children for urgent bone marrow transplants. I would have agreed with the logic of some of it, but I certainly could not have offered an opinion on whether it was correct or suggested an alternative option.

I have been asked to clarify my recollection of the rationale for selecting Wards 6A and 4B, despite not having had input. This was discussed at the IMT and a detailed options appraisal was undertaken. I cannot recall the details but both the Options Appraisal and the IMT minutes have been submitted to the Inquiry.

116. There was a broad discussion around the recommendation, as it is not a decision that could have been taken without the clinicians. If the clinicians found the decision unacceptable, then I believe they would have said so. It was perhaps far from ideal, but there were a limited number of alternatives. If the clinicians were unhappy with the treatment they could, and did, suggest during the IMT that specific patients should go to Edinburgh or Newcastle, on a case-by-case basis. If they felt that the area was not appropriate for a group of patients, or even one patient, then I believe they could make that decision and there is evidence that they did.

117. I did not have any concerns about the decisions being made to move to Wards 6A and 4B. Having been at the IMT and read the papers, it seemed perfectly logical in the circumstances. There were also broader considerations for the impact on the programme for adult bone marrow transplants. We are the national centre for bone marrow transplants for adults and accommodating some of the more urgent children

slowed down progress in other areas. However, it made perfect sense under the circumstances. If I had any concerns – and I am not a clinician – it would be more about whether there was an imperative to move out of Ward 2A, or if the patients would be safer staying where they were with control measures.

I have been asked: if, as suggested in the final statement above, I raised any concerns; if so, to whom they were raised and when, and what if any actions were taken as a result of those concerns. This option was discussed both at the IMT and within the Options Appraisal referred to above in paragraph 116.

118. At that time, there was no clear indication that I could see, as a non-clinical expert, that the strains of the organisms in the water were the same as the ones in the patients.

119. I can recall concerns being expressed about discovering mould in Ward 6A after the decant. My recollection is that the infection control team, including Dr Inkster, did a full environmental review of Ward 6A and recommended an action plan of things that needed to change before the children moved in. That was all done, and sometime after that, they discovered traces of mould in some of the showers. The sealing was not complete, and concern was expressed that it could lead to a fungal infection. Therefore, there was a requirement to refit several bathrooms and make sure the floors were sealed. I was aware that remedial action was being taken, and I was aware of the concerns.

I have been asked to clarify who raised the concerns noted above and to whom they were raised. I believe this was Dr Inkster in relation to mould. The environmental audit reports have been submitted to the Inquiry.

Decant from 6A to CDU

120. I attended an IMT on 21 January 2019 in relation to the decant from Ward 6A to CDU. The recommendation to be discussed at the IMT was where the patients or the children could be cared for best. All patients from Ward 6A then went to the CDU and the bone marrow transplant units. There were still patients in Ward 4B but again, that would be a decision made on clinical grounds on the advice of Infection Control and others. The

Women's and Children's team would then have planned how to move patients, staff, and all the other facilities down to that unit. The IPCT were involved in inspecting and evaluating the CDU before they moved in, in the same way that we were when they moved into ward 6A. I do not recall if this decant was approved at Board level, but the recommendation would have come from the IMT based on where the patients could be treated most safely.

121. I do not recall a meeting taking place between Jane Grant, Dr Inkster, and other senior management in January 2019. I do not recall being at the same meeting as Dr Inkster and Jane Grant on any occasion. I may be misremembering, but I do not recall any resistance or disagreement from anyone about the decision to move to CDU. I can see how there may be differing views, but I do not recall anybody saying they absolutely must not do that.

122. I have been asked to comment on the effectiveness of the IMTs that I attended, and in particular the IMT in January 2019 regarding Cryptococcus. Some of the hypotheses as to the origin were disputed by both clinicians and by Estates and Facilities colleagues. Cryptococcus is a very unusual infection to have two cases of, and it was not easy to determine the route of infection. One hypothesis was that the patient acquired the infection through the ventilation system. My recollection is that in some of the scenarios, our Estates colleagues did not believe some of the hypotheses to be technically possible.

123. I recall the Chair being unwilling to accept any alternative hypotheses. However, that is for them to answer. That is the meeting where I was most aware that the hypothesis was considered debatable, but that the debate was unacceptable to the Chair.

I have been asked to clarify who the Chair was; what the alternative hypotheses I refer to were; why the Chair was unwilling to accept alternative hypotheses, and what the hypothesis was that the Chair accepted. The Chair was Dr Inkster. The various hypotheses are discussed in detail in the report mentioned in paragraph 125 below.

124. There was a Cryptococcus expert sub-group convened to work through the hypotheses. They were looking at a difference of opinion, not just within professions but across Estates. Estates could contribute more to this because they were talking about the size of filters relative to the size of the organisms, and the potential routes through the building. Some of the hypotheses did not appear to add up, such as contaminated air being drawn in from under the helipad. There was a non-sequential logic to some of the hypotheses, which is why this became as debated as it was and why the subgroup recognised that they needed to bottom it out. Dr John Hood was a Microbiologist within the Board with extensive knowledge of ventilation systems. He was asked to lead this multi-agency expert sub-group to look at the various hypotheses and any other factors. The report suggested that the most likely route was none of the hypotheses that the IMT considered.

    I have been asked when the sub-group referred to above convened, when it provided its report and what the most likely route proposed by the sub-group was. This is fully covered in the sub-group report submitted to the Inquiry. I did not sit on this group and, having retired, I no longer have access to the report to describe the extensive detail.

125. The fact that the sub-group took so long to reach their conclusion indicates how complex the issues were. The sub-group, to my mind, was required because the IMT could not agree on what the hypotheses were and how possible they were. I was not involved in the sub-group at all. Sandra Devine attended, and my PA carried out administrative tasks for the group. I did not have sight of the report at the time.

    I have been asked when I first had sight of the report and what impressions I had when reading it. I first saw the report late in 2023 and thought it to be thorough in research methodology, and comprehensive and informative in the examination of complex hypotheses.

IMT 18 January 2019

126. I have been asked about the communications and press handling of this IMT in which it is stated that some members of this group may not agree with the press statement. Not

every one of the multidisciplinary colleagues who attended the IMTs will agree with its conclusions. It is about getting the balance correct. It is not unusual for people to have differing views on what should go out.

I have been asked: if I can recall the basis on which some members of the IMT did not agree with the press statement; whether I can clarify when the press statement was issued, and on whose authority the press statement was authored and released. I cannot now recall which press statement this question was referring to when posed by the interviewers in August 2022.

127. I have been asked if it was controversial that the IMT minutes mention two letters being sent out by Jane Grant to the parents of patients without the IMT having sight of them first. I do not know what the content of the letters was, as I was not involved. Looking at the minutes, clearly, some of the clinicians were not happy, and I can perhaps understand that. I am not entirely sure why it needs to be in the minutes, but I can perhaps understand why it was raised as an issue.

128. I have been asked to clarify why some of the clinicians were not happy with the letters. The letters, together with the letters from the clinicians to the CEO have been submitted to the Inquiry. I did not see the letters between the clinicians and the CEO at the time.

129. I am not sure who was on the expert Cryptococcus sub-group, but I was aware it was not just NHSGGC staff as they had an external advisor from NHS England, Peter Hoffman. Interestingly, he also gave Professor Williams some advice pre-occupation, when he was looking at the MDR TB room specification. He has been used as an external expert, sometimes informally, and sometimes more formally by NHSGGC. I expect somebody from HPS formed part of the sub-group as well, but I do not know the full membership.

130. I provided a statement to the HSE investigation into the Cryptococcus incident. There was a BMT timeline that was developed for them by the Board. This formed the basis of the interview. I do not recall giving them anything else.

I have been asked to clarify when this witness statement was provided to HSE. Unfortunately, I cannot recall the date and no longer have access to my NHS diary. I believe it was around May or June 2019 but cannot be certain.

HIIAT Scoring

131. I have been asked what the process is if there is a disagreement at an IMT about a HIIAT score. I recall discussions about the level of whether it is red or amber in any specific category at IMT, not just with this campus, but with other IMTs. People get the opportunity to offer views on the HIIAT scoring and, generally, there is agreement on what it should be and why. The infection control doctor as the Chair is usually best positioned with their clinical colleagues to score clinical incidents and outbreaks.

132. If the score is red, and the IMT prepares a proactive press statement, we need to be sure that we are not just amplifying the public concern by putting another article out there. However, I do not recall it being a huge issue. The Chair of the IMT has the final say on how things are scored, and the subsequent press release.

133. As Infection Control Manager, I had noted the impact that the closures of the wards had on the patients, and it was discussed as part of the IMT. The clinicians are there to look after and promote the interests of the patients. The staff frequently expressed the difficulties both in terms of coping with the current situation and the decants. I was aware of this, but I had no direct knowledge, involvement, or observation of it. As a nurse myself, I can understand some of the concerns. I am aware that they were articulated at most if not all, IMTs. It was a patient-focused discussion, which is entirely appropriate.

Prophylactic Medication

134. Likewise, I have no direct knowledge of any prophylactic medication used. I know what prophylaxis is for. It is medication given to prevent illness but, beyond that, it is a clinician's remit. It is the microbiologists and the individual consultants as prescribers who would decide that because there are pros and cons for prophylaxis.

135. Prophylaxis was starting to be discussed and prescribed around the time of the mucor incident which was on the cusp of when I changed roles. I was certainly aware of some discussion about prophylaxis or antifungal agents.

Communication with Staff, Patients, and Families

136. I have been asked whether I felt that Senior Management or the Communications team were ever dictating what clinicians could say to either staff or patients and families about what was happening with the IMTs. I can honestly say that was never my perspective. We had a Communications team for a reason and sometimes they would advise on the message for broad/media release. I do not see them having any involvement in what was going to parents and patients. I do not recall anyone saying, you cannot say that, or rewrite that. I am not saying it did not happen, but it is not something of which I was aware.

137. Sometimes there is debate about what is sent out. People can read things in different ways and that needs to be explained at the IMT. In my experience, if the Communications team re-phrased something in a slightly different way, they would explain why they did so.

138. As Infection Control Manager, I was not involved in any training regarding communicating with patients and families. It is not my remit. I am a qualified nurse, so I can take a view on whether I am qualified or able to speak to patients and families. If they needed infection control information, this was provided by an infection control specialist.

139. I am aware of the NHS and the Board's approach to the Duty of Candour. My understanding of organisational duty of candour is that we have a duty to our patients and our staff, to be honest with them if a mistake or error has been made, regardless of whether they have brought it to our attention.

140. I do not recall the duty of candour being discussed at the IMTs. However, what the patients and the patient's relatives should be told would have been considered in that

context. The haematologists were clear on the honest message going out, which relates back to the duty of candour.

Whistleblowing

141. I have been asked if I was aware of the procedures to report any wrongdoing in the hospital. I was aware of the whistleblowing policy. I was also aware of the options and advice prior to whistleblowing, including what steps could be taken to raise or try to alleviate the situation within the line management structure before whistleblowing. However, staff obviously have the right to whistleblow from the onset if they choose or feel the need to.

142. I was not aware of any training on whistleblowing, mandatory or otherwise at the time. I would certainly encourage raising concerns via the line management structure and this was widely encouraged within NHSGGC. Certainly, in our team, it was encouraged. I was never discouraged from participating in that process.

Overall Personal Impact

143. It could be a challenging job, and it was difficult because of the competing clinical opinions. As a manager sometimes you could resolve those conflicts. You do not have the expertise, and when the external experts can take so long to report, then you find yourself in a difficult position. It was more difficult for other members of the team, but it was certainly challenging for me. Some individual behaviours were challenging. I think the most difficult thing was being circumvented as a manager, in that people chose to avoid the established routes to deal with matters and report issues and were either going higher in the organisation or to external agencies.

144. It was bordering on toxic for a while, which is primarily why I moved on from the job. It was not because I felt I could not do it, but I had reached a point where I thought we had been doing this for a long time and, unless something changed, we were not going to get any further forward. I take no comfort from the fact that little appears to have changed regarding the behaviours of certain individuals after I moved on.

I have been asked to provide some clarity on why I say it was 'bordering on toxic', how was it so, over what period, and what the 'behaviours of certain individuals' I refer to were. This is set out in the Whistleblowing reports submitted to the Inquiry.

Safety of the Hospital

145. In 2015, HPS carried out a periodic point prevalence study which looked at a range of infections in every hospital in Scotland. They were all audited to the same standard. Both the QEUH and the Royal Hospital for Children, in fact, every hospital in NHSGGC, was below the national average for infections. From this, I infer that there was not a systemic problem in terms of infection control, either in staff, practice, or building environment. There may be pockets of issues, NHSGGC was below the national average. This was measured by independent survey, and every infection in every ward was measured.

146. My recollection is that the national average rate of infection was 4.9 percent and the QEUH was 3.2. If you look at these as the broadest indicators, it does not look unsafe to me in the round. There are no indicators from the external evaluation of our rates of hospital-acquired infection that would make me think there is something fundamentally wrong with the entire building (or any other hospital in NHSGGC).

147. The hospital was sitting well below the national average for infection, as measured externally, at a time when it was in the middle of a crisis. The design is conducive to controlling infection by mostly having single rooms. On that basis, from an infection control perspective, I do not see the hospital as being fundamentally unsafe.

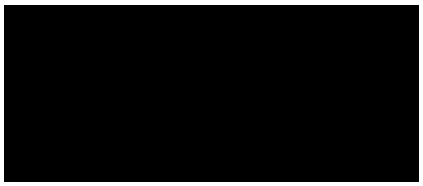
148. I have been asked for my view on the way the Board handled the whole situation. My view is that some of these issues have possibly been blown out of proportion and that there were numerous untested hypotheses. The way it has been managed has been difficult but, despite that, everything that the microbiologists raised has from my perspective been taken seriously. Every attempt was made by myself and others to deal with every concern thoroughly.

149. We got all the concerns on the table in 2017, we developed a 27-point action plan, and we followed it through to the satisfaction of the Lead Infection Control Doctor. Despite the disagreements on the validity of hypotheses, all the actions at the IMTs were followed through. As such, I think that the Board did its best in difficult circumstances to recognise the importance of many of the issues that were raised, and to do something about them.

150. I would not say that there was any suggestion that concerns were not taken seriously. I would offer the opposite view, in that quite often our Estates colleagues were investigating issues they did not deem technically possible, just to test the hypotheses. It showed in the actions in the IMTs that when we came back the next time, almost every action was followed up, even if the hypothesis was not necessarily agreed upon. I think senior people and the clinical staff in the ward bent over backward to try and accommodate all recommendations in order to investigate any potential hypotheses, given the paramount importance of patient safety.

151. I have been asked if the issues had an impact on patient care and whether staff could carry out their role. It is a big question, and for patient care, one that can be better articulated by the clinical teams looking after the patients. For the IPCT, it is one that I think is best addressed by Sandra Devine on how the microbiologists, particularly Dr Peters, had an impact on her and her team because there was significant undermining. That was a separate HR process. It involved the RCN and that is as much as I know about it. Whilst I was there to support Sandra and the staff, I do not have the details, and I do not think it would be appropriate for me to elaborate further.

152. I believe that the facts stated in this witness statement are true. I understand that this statement may form part of the evidence before the Inquiry and be published on the Inquiry's website.



30th July 2024

Annex B

A49394507 – NICPM – Healthcare Infection Incident Assessment Tool (HIIAT) – Appendix 14 – NHS NSS ARHAI v2.0 – 24 January 2022.

A42959603 – Bundle 4 Hearing Commencing 12 June 2023 – NHS GGC: Situation, Background, Assessment, Recommendation (SBAR) Document – Page 104

A40562750 – National Support Framework 2017 – NHS NSS HPS – Version 1.1 – June 2018

A33662208 – 416 SHFN 30 Part B v3 dated October 2014

Annex C

Thomas Walsh - Curriculum Vitae

Retired NHS Senior Manager

NHS Manager with extensive experience in both clinical and managerial roles spanning a 40-year career within NHS Scotland.

Qualified in Nursing, Management, and Project Management. Previous roles and experience include: Board Infection Control Manager, Assistant Director of Nursing, Hospital Manager, Planning Manager for Regional Services, and Clinical IT Project Manager.

Career Summary

General Manager

NHS Greater Glasgow and Clyde
April 2019 to March 2021

Infection Control Manager

NHS Greater Glasgow and Clyde

July 2007 to April 2019

Planning Manager

NHS Greater Glasgow and Clyde

March 2006 to July 2007

Assistant Director of Nursing

NHS Argyll and Clyde

December 2002 to April 2006

Hospital Manager

NHS Argyll and Clyde

September 2001 to December 2002

Directorate Manager

NHS Argyll and Clyde - Paisley

February 1999 to September 2001

Project Manager (Clinical Systems Integration)

NHS Argyll and Clyde - Paisley

January 1997 to February 1999

Additional relevant experience

Currently a Board member for Argyll College and Chair of the Audit Committee

Education

BSc in Health Studies
University of Paisley – Paisley

September 1990 to May 1994

Registered General Nurse
Argyll and Clyde College of Nursing

February 1983 to July 1986