Scottish Hospitals Inquiry

Witness Statement of Questions and Responses

Anne Cruickshank

This statement was produced by the process of sending the witness a questionnaire with an introduction followed by a series of questions and spaces for answers. The introduction, questions and answers are produced within the statement.

Personal Details

1. Please list your professional qualifications, with dates

A. MBChB 1982, FRCPath 1991, MD (hons) 1993, FRCP (Glas) 2005

Professional Background

2. Please give your chronological professional history roles held where and when- please also provide an up-to-date CV, if you have one

A. Retired June 2019; Consultant Clinical Biochemist, Southern General Hospital / QEUH, 1992-2019; Clinical Director Laboratory Medicine, NHSGGC, 2013-2017; Interim Clinical Director for Infection Control Doctors, Nov 2015-May 2016.

3. What specialist interest / expertise / qualifications in any area of Infection control do you hold? E.g., hospital ventilation, water Legionella control and infection control related to the built environment, and epidemiology and outbreak management.

A. I hold none.

Infection Control in QEUH

4 Please briefly describe the role you held within the formal infection control management system in QEUH: your involvement with infection control procedures and governance, who you reported to and who reported to you.

A. In November 2015, I was appointed as interim Clinical Director for Infection Control Doctors primarily to improve working relations between the Infection Control Senior Management Team and microbiology staff including infection control doctors. In this capacity, I reported directly to Dr Jennifer Armstrong, the Board Medical Director. The Lead Infection Control Doctor was professionally accountable through me to the Board Medical Director, and managerially accountable to the Infection Control Manager.

5 Were you involve to any extent with the specification, design, or construction process before January 2015? If so, were you asked to sign off any aspect of the process?

A. No, I was not

6 What were your first impressions of the hospital when it opened in 2015? Did you have any immediate concerns from an infection control perspective?

A. My first impression was from the perspective of a consultant biochemist and Clinical Director for Laboratory Medicine. The scale of the new hospital posed challenges in terms of sample transport and communications. I had no knowledge of or concerns about infection control at that time.

7 Were you aware of any of your colleagues having immediate concerns from an infection control point of view? If so, please specify.

A. No, I first became aware of such concerns on 7th July 2017 because their concerns led to a request from Doctors Inkster and Peters to Dr Brian Jones (Head of Microbiology) to relinquish their infection control responsibilities. Dr Jones informed me.

Particular Issues

The Inquiry understands that the whistle-blowers (Drs Peters, Inkster and Redding raised particular issues about the water supply / ventilation system with you. For each issue can you comment on

a) The nature of the concern – specifically what was thought to be wrong with the building system in question

b) The nature of the risk posed to patient safety and care

c) What action was taken and

d) Whether the action was sufficient to address the concern?

8 Missing patient information, or information not being shared

A. I have no knowledge / memory of this.

9 Missing water results

A. My understanding of this was based on conversations with, emails from and documents provided by Doctors Inkster and Peters in 2015. I understood that water sampling in the new QEUH had either not been performed or that results had been withheld from Doctors Inkster and Peters despite repeated requests between 19th June and 7th July 2015. Dr Inkster stated that she had received a verbal report that legionella was present within the hospital. I am not qualified / able to comment on b, c, d.

10 HAI Scribes not being signed off

A. I have no knowledge / memory of specific HAI Scribes, but I knew from our meeting on 7th July 2015 that Doctors Inkster and Peters were concerned that due process had not been followed in the specification for and commissioning of certain areas in the new hospital. I am not qualified / able to comment on b, c, d.

11 M-Abscess in Cystic Fibrosis Patients

A. In January 2017 I met with Dr Peters and Dr Inkster separately. Dr Peters outlined her concerns relating to lack of collaborative working, insufficient consideration of epidemiological evidence, inappropriate handling of microbiology data, and deficiencies in document control and decontamination procedure. She had compiled an extensive chronology of events and Dr Inkster (as Lead Infection Control Doctor) sought my advice as to how she should proceed (although I was no longer Clinical Director for Infection Control, I remained Clinical Director for Laboratory Medicine). We agreed actions, most of which she had initiated and some of which were for the Head of Service for Microbiology. She advised that there was dubiety about the clinical impact of instigating these actions earlier.

12 Use of Horne taps

A. I have no knowledge / memory of this.

13 Lack of IPC input into design of ventilation

A. I understood from conversations with and emails and documentation from Doctors Inkster and Peters that their view was that the specification and commissioning processes for specialised ventilated areas within the new hospital had lacked Infection Control input and sign off. I am not qualified / able to comment on b, c, d.

Water Supply

14 Insofar as not dealt with in Section C can you advise what concerns, if any, you had about the water supply at QEUH while you were involved with Infection Control ?

A. Please see answer to question 9.

15 Do you consider there to have been a risk of infection from the water supply? If so, explain.

A. Please see answer to question 9.

16 What remedial measures were taken: e.g. room closure and cleaning; ward closure; investigative and remedial works? What were these and when were they taken?

A. Please see answer to question 9.

DMA Canyon report

17 A company called DMA Canyon produced a pre-occupancy water risk assessment. Were you aware of this a) at the time or b) subsequently. If b) when did you become aware of this, and how?

A. I have no knowledge / memory of this.

18 What do you understand to be the findings of the DMA Canyon report in 2015?

A. I have no knowledge / memory of these.

19 Some witnesses (e.g., Christine Peters) have said that, had they had sight of the 2015 report at the time, they would not have allowed the hospital to open. Do you agree?

A. Even if I had knowledge of this report, I am not qualified to answer this.

VENTILATION REFER TO BUNDLE 13 pg. 268, 271 278,275 277 278 285 849

20 Shortly after the hospital opened an issue emerged regarding the adequacy of the ventilation in the BMT Unit. What is your understanding of the issue?

A. I understood (from a meeting with Doctors Inkster and Peters on 7th July 2015 and from documents I received from Dr Inkster between 10th and 13th July 2015) that they were concerned about the lack of information on specification, validation / commissioning and on-going air quality monitoring in specialised ventilated areas within the new hospital. Urgent air testing from 29th June 2015 had revealed high particle counts in the adult BMT indicating a problem with the ventilation system. It was the opinion of Doctors Peters and Inkster along with microbiology colleagues that this was not safe for patients.

21 What was the nature of the concern – specifically what was thought to be wrong with the building system in question?

A. Doctors Inkster and Peters were concerned that the adult BMT might not have been built to an appropriate specification.

22 What was the nature of the risk posed to patient safety and care?

A. I am not qualified to answer.

23 What action was taken? Was it sufficient to address the concern?

A. I'm aware that the decision was made on 3rd July to transfer patients back to the Beatson. I do not know what corrective action was taken at QEUH. From my perspective, I was not qualified to judge the validity or likely clinical impact of these concerns. My responsibility was to support Doctors Inkster and Peters in their professional obligation to raise these concerns, but also to ensure continued microbiological input into Infection Control. Dr Jones, Head of Service for Microbiology, and I met with Dr David Stewart, Lead Director of Acute Medical Services, on 10th July to highlight these concerns and their request to relinquish infection control responsibilities. Dr Stewart indicated he would set up a review of Infection Control. Doctors Inkster and Peters agreed to continue with their infection control duties meantime. On 30th October

2015, Dr Stewart reported that the review had identified issues with culture and behaviours, leadership and governance, and team functioning / structure. A facilitated workshop in November 2015 was proposed to explore these issues and identify actions. I know (from a letter dated 9th November 2015 that Dr Stewart shared with me after I was appointed interim Clinical Director for Infection Control Doctors) that Doctors Inkster and Peters believed this to be an inadequate response to the issues they had raised in relation to the QEUH newbuild.

Other Ventilation Issues

24 Other than the issue with the Adult BMT unit what concerns, if any, did you have about the ventilation system during your involvement with the ICPT?

A. Having no direct knowledge or specialist expertise, I was not in a position to develop concerns. I had been made aware that Dr Inkster was concerned about particle counts and air sampling results in the BMT unit in the new Children's Hospital.

25 Do you consider there to have been a risk of infection from the ventilation system? If so, explain.

A. I am not qualified to answer this.

26 Are you aware of remedial measures being taken: e.g. ward closure; investigative and remedial works? What were these and when were they taken?

I know that Dr Inkster was concerned about the remedial work being undertaken in the adult BMT, and at a meeting on 12th November 2015, it was agreed that advice should be sought from Health Protection Scotland (HPS) and Health Facilities Scotland (HFS). I was present at a meeting with HPS colleagues on 7th December 2015. They made recommendations on the performance of the ventilation system and the integrity of rooms. I was also

present at a meeting with Dr Inkster on 19th January 2016 with Peter Moir, Ian Powrie and Dr David Stewart where requirements relating to ventilation and room integrity in the adult BMT were further discussed. In both of these meetings, I was there to support Dr Inkster. I cannot comment on technical details or timescale of any remedial work.

Concerns about Infection Patterns

Do you consider that infection rates at QEUH were unusual both in frequency and type? Do you consider that there were:

a) more bloodstream/ patient infections than normal?

b) more unusual bloodstream infections? (we take the point that water sampling/ environmental testing might show up rare organisms that are always present but never tested for)

c) more cases of multiple bacteriaemia in one sample?

A. I have neither the knowledge nor expertise to answer any of these questions.

28 Did you have any concerns, or are you aware of any concerns that patients were at increased risk of infection from exposure to pathogens via the water supply, drainage, or ventilation system? If so, please describe them.

A. Please see answers to questions 9 and 20.

29 Did any of your colleagues raise concerns? If so, who, and in connection with which issues

A. Please see answers to questions 9 and 20.

The IPCT Team in QEUH

30 What were your impressions of the GGC infection control team in 2015.

Were you aware of any of the following:

b. existing tensions?

c. lack of clarity around roles and decision making?

d. relationships (i.e., between ICM and ICD)?

e. Issues with record keeping-?

f. culture and bullying; and

g. attitude of senior management and board to infection control issues?

A. The management structure for the team was complex. My understanding was that the Lead Infection Control Doctor (ICD) was managerially accountable to the Infection Control Manager (ICM) and professionally accountable directly to the Board Medical Director. Infection control nurses (ICNs) reported to their Associate Nurse Director (AND). This trio of Lead ICD, (Professor Craig Williams), ICM (Tom Walsh) and (Sandra McNamee) formed the Infection Control Senior Management Team (SMT) and met monthly with the Board Medical Director, Dr Jennifer Armstrong. However, all the other Infection Control Doctors (ICDs) as microbiologists with a couple of sessions in their job plans for infection control duties were managerially and professionally accountable to the Head of Service for Microbiology, Dr Brian Jones. For this structure to work effectively, close working was required between Microbiology and Infection Control SMT but relations between the Head of Service for Microbiology and the Lead ICD were strained, and the Lead ICD had not attended microbiology meetings regularly. The Lead ICD was not good at working collaboratively or communicating with other ICDs, the monthly ICD meeting had fallen into abeyance, and ICDs were understandably frustrated at the resultant lack of consultation / discussion. The situation was exacerbated by the opening of the new hospitals, re-allocation of ICD responsibilities and formation of new local infection control teams (ICTs). The direct reporting line between the SMT and Board Medical Director effectively marginalised input from ICDs. I was contacted by both the Board Medical Director and Lead Director for Acute Medical Services to relay complaints / concerns they had received about Dr Peters, after which I sought independent input which did not support the complaints. At local ICT level, ICDs were frustrated that their clinical advice was submitted to the infection control nursing hierarchy for approval. There was a lack of clarity about their role within the local ICT and relationships with clinical colleagues and governance structures. My understanding was that the direct reporting line between SMT and Board Medical Director had been prescribed by the Scottish Department of Health. My impression was that the Board Medical Director and the Lead Director for Acute Medical Services took infection control issues extremely seriously.

31 What were the staffing levels like in ICP team while you were there? Where did the staff come from – were they mainly transferred from old site?

A. There were six ICDs (one each for South Glasgow, North Glasgow, Clyde, Regional, Women & Children and West Glasgow) with a total nominal sessional input of around 18 sessions. I'm not familiar with all of the ICDs' backgrounds. I know Professor Williams had previously worked at Royal Hospital for Sick Children, Yorkhill.

32 Were staffing levels appropriate to manage workload?

A. By and large, my impression was that they were adequate. The dual role allowed a degree of flexibility to spend more or less time on infection control as required. The main issue seemed to be the distribution of infection control work within Microbiology where infection control responsibilities were concentrated within a minority of consultants. Out of hours cover was provided by the on-call Consultant Microbiologist, and cover of leave seemed problematic, involving ICDs with existing responsibilities rather than other microbiology consultants.

33 Did you or anyone else raise concern regarding staffing levels? If so, to whom, and what was the outcome?

A. At a meeting with Doctors Inkster and Peters, there was a suggestion that the role of Training Programme Director placed additional pressure on Dr Inkster's time. It was also suggested a bigger pool of microbiologists should contribute to Infection Control to improve resilience. At a meeting which included Dr Brian Jones, Head of Service for Microbiology, and Isobel Neil (General Manager for Laboratory Services) on 8th February 2016, I raised the issue of more robust cover from microbiology consultants to Infection Control.

34 Can you comment on the working environment at QEUH while you were there? What issues, if any, did you have?

A. I enjoyed good working relations with clinical colleagues and managers within Biochemistry, Laboratory Medicine, and the wider hospital environment.

35 Did you have concerns about the management style within GGC? If so, what were they?

A. I had no concerns about the overall management style within GGC. My concerns were primarily about management structure and working relations within Infection Control and Microbiology.

36 If you had concerns did you raise them with anyone? If so, with whom?

A. Please see answer to question 35.

37 Did anyone raise concerns with you? If so, please give details.

A. Dr Christine Peters raised issues of poor communication and lack of clarity of roles in the email (originally sent to Dr Jones on 8th July 2015) forwarded to me on 23rd November 2015, but these related to Infection Control rather than GGC as a whole.

Resignations

39 Dr Teresa Inkster resigned In July 2015. When were you advised of this? Have you seen a copy of her resignation letter?

A. I was advised By Dr Brian Jones, Head of Service for Microbiology, on 7th July 2015 that Dr Inkster wished to resign from her infection control duties. Sometime between 10th July and 13th July 2015, I received from Dr Inkster a request for job plan review along with a paper outlining her reasons for resigning dated 9th July 2015. I also received a more detailed document summarising her concerns – I think at the same time.

40 What do you understand to be her reasons for doing so?

A. Please see answers to questions 9, 13, 20 and 24. From the meeting I had with Dr Inkser and Dr Peters on 7th July, I understood that they were concerned that there had been insufficient Infection Control input and no Infection Control sign-off to the specification and commissioning / validation of the ventilation system in the adult BMT unit. The “final straw” for both was their being asked to sign a document which they said stated that Infection Control would not be expected to sign-off validation data.

41 What was the response of senior management to her resignation?

A. Dr David Stewart instigated a review of Infection Control after our meeting on 10th July 2015 (please see answer to question 23) which he fed back on 30th October 2015. I indicated to Dr Stewart that the proposed workshop could not properly address the issues identified without input from the line manager of the Infection Control Manager and Lead Infection Control Doctor, namely the Board Medical Director, or a deputy. This prompted discussions amongst senior management, the outcome of which was to appoint me as interim

Director for Infection Control Doctors for a six-month term commencing 12th November 2015.

42 Thereafter Dr Peters resigned. REFER TO EMAIL DATED 8 JULY 2015.

The Inquiry understands that you were present at a debrief after Dr Peters resigned. Who else was present? Can you advise what was discussed?

A. Along with Dr Peters and me, Dr Inkster, and Isobel Neil (General Manager for Laboratory Services) were present. Please see answers to questions 37 and 40. In addition, I explained that contractually Doctors Inkster and Peters could not resign immediately from the infection control components of their job plan. They needed to request urgent job plan reviews but, in the meantime, should continue with their infection control duties.

43 What do you understand Dr Peter's reasons for resigning?

A. My understanding of her reasons initially came from the meeting and are covered in answer to question 40. I did not actually see her email to Brian Jones until 23rd November 2015 (i.e. after I was appointed interim Clinical Director for Infection Control Doctors)

44 What was the attitude of senior management to her resignation?

A. I cannot comment other than to state that Dr Stewart met Dr Jones and me as a matter of urgency on 10th July 2015 and proposed a course of action to try and resolve the situation (please see answer to question 23).

45 To what extent do you agree or disagree with the points she raises?

A. I have neither the knowledge nor expertise to comment on technical issues. I agree that communications were poor between the Infection Control Senior Management Team and Infection Control Doctors (ICDs) / Microbiology, and that the role of ICDs within local Infection Control Teams lacked clarity.

46 Professor Craig Willams resigned in Mid-2016 . What do you understand his reasons for doing so?

A. I understood (from an email from the Infection Control Manager dated 2nd February 2016) that Professor Williams' resignation letter to the Infection Control Manager was dated 28th January 2016. Professor Williams told me on 23rd November 2015 that his revalidation had not yet been recommended, but I was never informed of his reason for resigning.

47 What was the attitude of senior management to his resignation?

A. I have no memory or record of discussing the fact of his resignation with senior management other than in the context of appointing a replacement as Lead Infection Control Doctor.

48 The Inquiry understands that there was no formal handover by Professor Williams to his successor. Do you agree? If so, what was the effect of this on staff and patients?

A. I am not in a position to agree or disagree or comment.

49 Are you aware of any clinicians who resigned for similar reasons at around this time?

A. No, I am not.

B.

Termination of Your Role

50 The Inquiry understands that at around this time your role as interim clinical director was demitted. When did this occur? Whose decision was this?

A. My original appointment was temporary and due to expire in May 2016. After discussion with Dr Inkster and Isobel Neil, I suggested to the Board Medical Director that I continue in the role for a further 2 months. She requested input from the Infection Control Manager. However, I heard nothing further and so my term expired in May 2016 by default.

51 How was the decision conveyed to you?

A. Please see answer to question 50.

52 What was the reason for this? What was your opinion of this decision?

A. Please see answer to question 50. I was relaxed about leaving the role and I had made Dr Armstrong aware of this. I was confident that Dr Inkster would perform the Lead ICD role admirably.

53 After your role was demitted what further involvement, if any, did you have with IPC at QEUH?

A. I had no further formal involvement. I was briefly involved in my role as Clinical Director for Laboratory Services in January 2017 (please see answer to question 11), but other than that, I cannot remember any further involvement.

54 Do you have any ongoing concerns about patient safety at QEUH?

A. I am not qualified to answer.

55 Is there anything further that you want to add that you feel could be of assistance to the Inquiry?

A. Through my dealings with Dr Peters and Dr Inkster, I developed a very high regard for their dedication, professional expertise, and integrity. I retired in June 2019 and have had no access to my work environment for several years. Most of these questions relate to events which occurred over eight years ago. I have answered to the best of my ability based on memory, contemporaneous meeting notes and copies of emails which I had kept as a result of the independent review conducted in 2020.

Appendix A

A38176264 – Email from C Peters to P Wright re resignation – 08 July 2015

A48818504 - Bundle 13 – Additional Minutes Bundle