SCOTTISH HOSPITALS INQUIRY

# Hearings Commencing
# 19 August 2024

Day 35
Thursday, 24 October 2024
Professor Craig White

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**10:02**

**THE CHAIR:** Good morning. Now, Mr Connal, we have, as our witness this morning, Professor White. Is that----

**MR CONNAL:** We do, yes.

**THE CHAIR:** Good morning, Professor White.

**THE WITNESS:** Good morning, Lord Brodie.

**THE CHAIR:** As you know, you're about to be asked questions by Mr Connal, who's sitting opposite, but first, I understand you're prepared to affirm.

**THE WITNESS:** Yes, that's right.

## Professor CRAIG WHITE
## Affirmed

**THE CHAIR:** Thank you very much, Professor. Now, you're scheduled for the whole day. We may or may not take all that time. We usually have a coffee break at about half past eleven, but if at any stage, for whatever reason, you want to take a break, just give me an indication and we'll take a break.

**THE WITNESS:** Thank you.

**THE CHAIR:** I'll now hand you over to Mr Connal.

## Questioned by Mr CONNAL KC

**MR CONNAL:** Thank you, my Lord. Now, good morning, Professor.

**A** Morning, Mr Connal.

**Q** I'm aware that, through your representative, you've sent in some minor details of correction to your witness statement. In the interests of not diverting into these matters, I'm not proposing to go to them at this stage, but I suggest I can simply ask you the general question of whether you're prepared to adopt the statement, subject to these minor corrections, as your evidence.

**A** Yes, I am. Yes.

**Q** Thank you very much. Now, I want to ask you a few things about your CV because we need a little bit of help in understanding some of the things that you've done during your time. I think it's probably the longest CV we've had so far, so bear with me for a minute or two.

I see you start your statement by thanking the families you engage with and Professor Cuddihy, and also the Board for responding to the things that you were asking of them which, in a way, must have been quite challenging for the Board because, in effect, you had been imposed over them, in one sense.

**A** Yes. I think it was challenging

to have somebody suddenly appear in the midst of an already challenging situation.

**Q** Now, as I say, your CV then carries on on the following pages. We'll take the witness statement as our sort of guide through the evidence, and we'll bring it up on the screen now, if we could, at page 388. If you have your own copy with your own notes, then feel free to follow it or you can follow it on screen.

Can I ask you, purely for the understanding of those of us who don't know, in paragraph 8 on that page, you use the phrase, "Psychosocial Oncology." What is psychosocial oncology?

**A** It's an academic discipline primarily which is concerned with the study of the psychological and social aspects of all aspects of cancer. So, at the time, the Cancer Research campaign offered a fellowship for clinicians working in mental health specialties mostly, if they wished to train and undertake further academic study in that area, but, broadly, the psychological and social dimensions of cancer.

**Q** Thank you, and then you held a post in what was then NHS Ayrshire and Arran, which sounds a bit like a sort of management role, in a way, covering a range of different topics, is that right?

**A** So, following the completion of the Cancer Research campaign fellowship, it was set up-- So, at that-- when I started that, I was three years post-qualification in 1998, and the aim of the fellowship was that the fellows should have the option to-- two exit points at the end of it. They should be able to exit to a full-time academic career or to return to a clinical career.

I opted for the latter, mainly because I left my NHS job to pursue the fellowship, partly through frustration that some of the research evidence didn't appear, to me, to be being implemented in the NHS. So I saw trying to influence the system from the outside, so to speak, in an academic role as perhaps a way of improving things for people living with cancer.

After a lot of reflection, I left the university and I returned to the NHS, initially in the Macmillan Cancer Relief-funded job, which was to set up new services broadly around what's called supportive and psychological care for people living with cancer.

Then, as you rightly say, Mr Connal, I subsequently moved more into a senior management role, initially in the mental health services and then, subsequently, more broadly across the health board in a range of areas outside of my professional sphere.

**Q** Then you appear thereafter to have had a number of engagements with

government bodies, if I can just generalise it in that sense. I see on page 389, in paragraph 10, you were providing a service as divisional clinical lead focusing on palliative and end-of-life care, so does that link into your earlier academic interests?

**A** It links, yes, to the academic interests but also to the clinical roles that I mentioned as the Macmillan consultant. I was subsequently appointed NHS Ayrshire and Arran's clinical lead for palliative and end-of-life care, and the paragraph that you refer to on page 389 relates, really, to my move from the NHS to Scottish Government in December 2013. The Scottish Government has an arrangement whereby if there are NHS staff who have a skill set or an experience set that they believe doesn't exist in the civil service, they can commission what's called a service, so a service level agreement.

I was identified to have the knowledge and experience to be brought into government, and at that point, I had two roles. One was to lead the development of what was known at the time as the strategic framework for palliative and end-of-life care; and secondly, it was to lead the government's policy development on organisational duty of candour, which subsequently became legislation. But that was that move, as you say, signalling a move from the NHS into the government role.

**Q** I just wanted to ask you about the duty of candour because we're going to return to that later in your evidence in relation to the circumstances we are dealing with. It might be thought that you wouldn't need an organisational duty of candour if the kind of things that that now contains were, in any event, being done routinely and always by those involved in the health care sector. So, as a person involved in developing it, was there thought to be a gap, something that wasn't being done?

**A** At the time I commenced that role in government with a request to lead the policy development on organisational duty of candour, the questions and the challenge that you've just posed had been identified in principally the public inquiry into the events at Stafford Hospital – so the Mid Staffordshire Foundation Trust Public Inquiry – where there were concerns that open disclosure of information had not occurred.

One of the recommendations was-- and there was a lot of lobbying of all the UK governments at the time from a range of organisations that there was a need to put this on a legislative footing. The professional regulators – so the General Medical Council, the Nursing and Midwifery Council – had also published

specific guidance for their registrants on a professional duty of candour.

And I suppose picking up, Mr Connal, that link between individuals working in an organisation and the organisation's obligations, a lot of that early work involved me looking at what the professional regulators were saying, and looking at how policy proposals for an organisational duty could be aligned to that. But, yes, it primarily emerged from observations in other inquiries.

**Q** That is something that ultimately appeared – and I'll just say this so it's in the notes and because I can never actually believe that it's in a document with this name – in the Health (Tobacco, Nicotine, etc. and Care) (Scotland) Act 2016, and the regulations which followed that.

**A** Yes. The duty of candour provisions were in the primary legislation that you mentioned, and then the secondary legislation were The Duty of Candour Procedure (Scotland) Regulations.

**Q** Yes, thank you. Now, your CV goes on to tell us about your role in something I suspect many of us will remember from the pandemic: test and protect and so on. Then, if we go on to page 390, this probably brings us up to date. Am I right in understanding, essentially, you now do three things? You're Associate Director, Health Care Quality and Improvement in the Directorate of the Chief Operating Officer of NHS Scotland.

**A** That's my current role title, yes.

**Q** What is that? What do you do?

**A** So, I report to the chief operating officer of the NHS in Scotland, who's also a director within the Scottish Government's Health and Social Care Directorates. I lead on a range of what I would describe as delegated areas, so the director or the chief operating officer and I will agree areas where my leadership or involvement is required on specific issues.

Perhaps if I give you a specific example, it may assist. The Lord Advocate had identified last year, I believe, some concerns about how the NHS investigated significant adverse events, particularly the time scales that are taken. So there's a national framework that requires Category 1 adverse events, which are the events that are the most significant in terms of death or harm. The national framework requires those to be investigated, reviewed and reported on within 140 working days.

The Lord Advocate had raised concerns that, on some occasions, the

time taken to conclude this process was significantly longer and it was having a negative impact on decision making within the Scottish Fatalities Investigations Unit, so decisions, for example, around discretionary fatal accident inquiries. It was having a knock-on effect, understandably, on relatives who find themselves in the midst of these processes.

So, in concluding my commitment to giving an example, I was asked by the Chief Operating Officer to co-lead with the head of the Scottish Fatalities Investigations Unit a review into why this takes so long across NHS Scotland; where it is being delivered within 140 days; and, most importantly, how that can be improved for the benefit not only of the-- to improve the issues that the Lord Advocate had identified but also the experience of families and staff who find themselves in the midst of the processes.

So that's one example. That, as you can imagine, is a fairly significant piece of work, but that would be the sort of thing I'd usually be asked to lead on on behalf of the Chief Operating Officer.

**Q** Well, perhaps we can look forward to fatal accident inquiries which take place much more quickly than they do at the moment, which I suspect families might like as well. But that's an aside, not a question, Professor, so I apologise for that. The other two things that I think I'm picking up from your CV that you do is you do sessional work as a clinical psychologist in the private sector, essentially, is that right?

**A** Yes, so the service that I provide to the Scottish Government is provided on a 37-hours-a-week contract and, outside of that, I have retained my professional registration as a clinical psychologist. I still undertake some assessment and treatment work with adults and also act as a skilled witness and, as I've outlined at paragraph 15, mostly in civil claims relating to the areas that I've outlined.

And that's been throughout my career, particularly when I moved into senior management roles. I have-- I've always retained a practice as a clinician outside of the NHS. I sometimes refer to it as my backup plan. Having been invited sometimes to be involved in a range of contentious and challenging areas, it always felt prudent to have a Plan B.

**Q** Thank you. Now, if we can turn to the circumstances under which you came to be involved in the matters that the Inquiry is considering. You point out in paragraph 17-- and the way you put it is:

> "[You were appointed] to lead and direct work … to ensure the voices of

the families affected by the infection outbreaks at NHSGGC were heard and that they would be provided with information as a matter of priority."

Now, is that your words or is that what you were told?

**A** That's what I noted in the draft remit document that I was given sight of, I believe, while it was being commented on between officials in the Chief Nursing Officer's Directorate and the cabinet secretary's office.

But that was broadly-- I think I initially received a phone call to make me aware that my name had been identified and that this was likely to be announced imminently by the cabinet secretary. That call was very much in terms of, I think, giving me the-- I think the phrase that's sometimes used is "the heads-up" that I might need to divert from all of the other objectives I was working on at the time and move to something else very quickly, i.e. the next day.

**Q** Right, and it derived, according to your statement, from, at least in part, a meeting that the cabinet secretary had had with a number of relatives, is that right?

**A** Yes, it became known as "the 71 questions," and those 71 questions were, as I understood it, a summary prepared by Scottish Government officials of a range of matters and questions that, as you say, Mr Connal, were raised by families that the cabinet secretary and the Chief Nursing Officer, I understand, had met on 28 September and 2 October 2019.

**Q** Perhaps we might just look at a document. Can we have bundle 27, volume 12, page 12? We'll just see what we've got here. Now, this is "Scope, Role and Remit." Is this the document that essentially outlines what it is that you're being asked to do?

**A** Yes, this was the document that I received outlining what the cabinet secretary had asked me to progress further.

**Q** Yes. You probably saw an early draft of that before it was finalised. This is what you were indicating earlier?

**A** Yes, I did, and in preparing for my oral evidence today, I noted that there's reference to my having discussed a draft, for example, with the chairman of NHS Greater Glasgow and Clyde, so I think I was provided with an advanced version of that. I can't recall if I was aware at the time, but certainly in reviewing the bundle of documents, I think I then became aware that the cabinet secretary had been providing comments back to officials on what she wished to see in the final document.

**Q** Right, so given this is the background to your evidence, we might

just touch on it briefly. So the series of bullet points, the first one essentially reviewing the concerns of patients and families. Now, this is focused specifically on the paediatric oncology/haematology service, is that right?

**A** Yes, that's right.

**Q** "… ensuring that these are addressed" and then "consider the work of the ... IMTs," is that right?

**A** Yes, at that point, that was included within the role and remit. I'll perhaps let you go through the document. There may be a general comment that would be useful for the Inquiry around the remit and----

**Q** That's probably the best way to do it.

**A** Sure.

**Q** We'll just go through this briefly. You're then asked to "establish ... channels of communication ... with patients and families... Ensure the issues raised ... are addressed by NHSGGC." Then we go on to the next page: a series of points there about infection control and works and so on, and then, in the way that these things are sometimes written:

> "Professor White will: Agree with the Chief Executive and Board that he will be provided with [basically what he asks for in relation to this matter]."

You will act as a point of contact, meet with any one of those affected who want to do so, liaise with NHS staff and NHSGGC staff and so on. Now, is there anything on the next page? Yes. Then you've got, "Ensure ... actions are ... informed by best practice" and "report directly to the Cabinet Secretary" and "make recommendations [ultimately] to the Chief Executive and Board of NHSGGC." So that would be, at that time, what was envisaged by your role, is that right?

**A** Yes, that's right.

**Q** I think, if you have a comment that you would like to add on at this stage, please do so because that might be of help.

**A** Okay, thank you. So, yes, that confirms what I was asked to do and reflects the various amendments that the cabinet secretary had asked officials and the Chief Nursing Officer's Directorate to make to the remit. Her intention was to respond to a government-initiated question which would relate to that remit.

It's always interesting in processes where you're thinking about what you knew at a particular time point and what was happening at a particular time point--with then what you subsequently learned. And I think, on reviewing my remit, at that point, both the cabinet secretary and the Chief Nursing Officer were clear-- It

would be helpful if we could go back, please, to page 13-- sorry, to page 12.

**Q** Yes.

**A** Yes. So, on page 12, on the second bullet point down that I referred to earlier around considering the work of NHSGG&C's incident management team-- So, my initial priority, and it had been made very clear by the cabinet secretary, was the so-called "71 questions" that families had said they'd been seeking answers to for several months prior to meeting with her. But there were, as we've noted, references to other dimensions of the remit.

So, I did begin-- my priority was on the-- for shorthand, and if it's acceptable, I'll call it "the 71 questions." That was my initial priority, but also to establish communication channels. But during that time, I did start to review what was in my remit, and so, for example, I asked NHSGG&C colleagues if I could be invited to a couple of incident management team meetings in order that I could be present to observe those. I think, at the time, I conducted a literature search on Infection Prevention and Control, how it relates to organisational culture, leadership, management and so on.

So I was beginning to engage with those other dimensions of the remit, though then, when NHS Greater Glasgow and Clyde was escalated, my focus and day-to-day responsibilities changed as there was an Oversight Board infrastructure developed and an Infection Prevention and Control Subgroup that was specifically going to look at some of the matters that were outlined in the remit in the previous month.

**Q** I think we'll see, if I'm correct in picking up from your statement overall, that there was an infection control subgroup at the Oversight Board, but your primary responsibility was on what I'll call for short the Communications and Engagement Subgroup, is that right?

**A** Yes, I was asked by the chief nursing officer, who was the lead Scottish Government director associated with Stage 4 escalation. I was asked by Fiona McQueen, who was chairing the Oversight Board, to chair a subgroup of the Oversight Board, which was, as you say the Communications and Engagement Subgroup.

As a subgroup chair, I also attended the Oversight Board. I think I also asked and did attend some meetings of the Infection Prevention and Control Subgroup. I haven't reviewed documents on that specifically, though.

Around that time, if I was aware – through the ongoing communications with some families, for example – of issues, I would really make it my business to be

present at other meetings and continue to act as the voice of the families in a range of fora, including the Infection Prevention and Control Subgroup.

**Q** Thank you. That shift is touched on in paragraph 26 of your witness statement, if we go back there just to catch up with the paragraphs. You then go on to say that you wrote to all the patient family representatives that presumably you were aware of at that time, explaining that you'd been appointed and you'll be getting on with things. Is that right?

**A** (No audible response).

**Q** You mentioned, I think, in an earlier answer, that there was going to be a-- I think they call it a sort of "placed question" in parliament to which the cabinet secretary would then respond, and you've identified that as well.

Now, paragraph 30, you say – I was about to use the word "laconically" – that you met with the chief executive, chair and directors of the Board and:

> "… discussed with them the fact that patients' representatives had raised … concerns ... to which they [the patient representatives] had indicated they had not received satisfactory responses. I provided advice to the Chief Executive … on what I saw as the required approach to address the ongoing concerns and dissatisfaction of [that group]."

Now, I say "laconically" because this is you speaking to the Board saying, "There's a whole bunch of people who are not happy." How was that received by the Board?

**A** So the members of staff mentioned in paragraph 30, I think, were very aware of the ongoing distress and dissatisfaction of a range of families involved with the paediatric haemato-oncology service. I think they recognised why I had been appointed to the role that I had been appointed to, because I was aware that they had knowledge of the meetings that the cabinet secretary had had at the end of September and earlier in October, and I believe may have provided briefings or responses to questions the cabinet secretary had asked at that time.

So they recognised the need for this and were supportive to work with me, to meet regularly with me, and were aware that I was-- had not been actively involved in these issues before. And, therefore, I was very dependent upon background information and detail in order to get up to speed quickly on what I learned fairly soon after my appointment was a very complex issue that spanned back a lot longer than I had appreciated when I said "yes" to the-- I'm not sure I would have had an option to say "no," but

when I noted that I was being diverted to this role the following day.

**Q** Now, I don't want you to give me an answer which comprises the whole of your witness statement, but in that paragraph, you say again:

> "I provided advice to the chief executive on what I saw as a required approach to address the concerns."

What was that advice?

**A** So, at that point, it would have been a distillation, really, of my career-long experience, both, as we talked before, as a clinical psychologist and then, by that point in my career, I'd worked in roles that didn't require me to be a clinical psychologist longer than in ones that did require that.

So it would have been a distillation of general principles around the importance of compassionate, open, ongoing, supportive dialogue with families, even if that was difficult or there were strong emotions or a range of other factors that might be influencing people's thoughts and responses.

So, at that point, I would have imagined it would have been general advice. And a lot of that early phase was spent with me-- yes, I was asking these questions, but partly because it's my style, I would have been closely observing responses that I received. I almost do that without thinking now, so even things like latency of response to questions and the like, that would all have been informing my commitment at the time to try and get a sense of this system that I had just-- I think you used the word "dropped into."

So I would have been-- sorry, in summary, I would have given generic advice around best practice as I understood it and had experienced it in my career. And yes, it was very much at that point still trying to make sense of this complex, historical set of events and circumstances I found myself in the midst of.

**Q** In the next paragraph, you say that you wanted to "quickly establish an awareness of the issues of most concern to the families." Were you successful in working out what was of most concern to the families? There's obviously a lot of complex detail, but----

**A** So, at that point-- and I believe it is referenced in the bundle 27. Let me get the volume number correct. I want to say volume 12, but in the documents I was asked to review prior to today, there was at the time reference around the cabinet secretary saying "at pace" – “The families need responses to these 71 questions swiftly and at pace” – and so that, as I said earlier, was my priority.

But I also started in those early weeks to become aware that some of the

families had pre-existing communications with NHS Greater Glasgow and Clyde. Some were already in contact with the Scottish Government and, of course, at that time, because of the announcement in parliament and, I think, media coverage at the time, I was starting to be contacted also by families.

So, yes, I was aware of the need for pace and the prioritisation, but at that point, I also was trying to gain a sense of, "How many people beyond those people who attended the meetings with the cabinet secretary have been in touch with Scottish Government? Is there an ongoing process? Who's involved?" That was-- if-- and we may come on to this-- that was quite difficult to start with, but then I set up a process to assist me in having more effective oversight of that.

**Q** Yes, because I think the next passages of your witness statement essentially say that you realised you needed to know, basically, who was saying what to who within that area that you were looking at.

**A** Yes, that's correct.

**Q** Because, otherwise, you couldn't have anything that you would describe as "oversight" of it. You set up, I think you say, an electronic system that would allow you – in particular, anyone you wanted to assist you – to find out what communications were taking place, is that right?

**A** Yes, that's correct. As I began to appreciate some of the complexities operationally of my remit, I had made the case for and had agreed a full-time executive support assistant back at St Andrew's House so that we could set up that she would have a telephone line that could be given to families, and she would support with the then significantly increasing volume of incoming communications, requests for briefings and so on.

As I say in my statement at paragraph 34, and this is a bit of a latter career theme, I had experience – in my role as assistant director of Quality, Governance and Standards in NHS Ayrshire and Arran, before government – of significant external scrutiny and criticism of the Board's Significant Adverse Events Review Process.

I was appointed in part to lead and improve those processes. Subsequently, other departments were added to that role. I think I was then asked to take on a similar role with the complaints team in the Board, but I had a lot of experience working with IT professionals in the Board because, at that point in that role, I needed, in effect--

It's interesting, 10 years on, to reflect and, going back to what I said about the Lord Advocate earlier and one

of my current objectives, what that system enabled me to do then and what it enabled me to do with the families who were in touch with government, myself and GG&C was, at a glance, see where everything was in process terms, who was owning an action, how long it was taking to respond.

So back in the adverse event review days – I mentioned the 140-day window – in Ayrshire I could see: were we on target on the 140 days? Was there slippage? If so, where? And I also had a document repository for that, so I could see emails. And so I asked colleagues--

I subsequently learned, actually, that the colleague in Ayrshire and Arran who helped with that now worked for NHS Greater Glasgow and Clyde. So I had a telephone call with him, having received approval to ask for this to be developed, and that was the way I started to track the increasing number of incoming requests or contacts.

**Q** I think you say that, at that time, you were dealing with about 70 individual families who had had communications?

**A** So, at that point, when it was established, it wouldn't have been as many as 70. I think by mid-November 2019 that there were 70. The reason I've said "approximately" was because I noted in preparing my witness statement that there were some entries where there might have been different parents who had made an inquiry, but it related to the same child. So I think there was about 74 actual entries in the database by mid-November, but it's around 70 families.

**Q** The idea was that you were to be the point of contact to get information, rather than having families, as the cabinet secretary put it, "getting stuff piecemeal."

**A** Yes, so it was very much described as point of contact, also described as liaison person. I think that was slightly confused subsequently when NHSGG&C also nominated their point of contact because I think and I know some families have, I think, rightly commented that that was potentially confusing to be told, “Well, Craig White's your point of contact” and then to have communications to say that Jennifer Haynes was point of contact.

But equally, I understood why NHSGG&C would want to a single colleague who we could link with and, indeed, Jennifer regularly was in touch with my executive assistant in St Andrew's House at the time, in terms of trying to make sure there was that single view of where things stood in the various processes of response.

**Q** So, moving on a little, how did you come to meet Professor Cuddihy?

**A** So Professor Cuddihy, I think,

had emailed requesting a meeting with me, and that was in response to the letter that I had issued to the families who had met with the cabinet secretary. So I met with him. By that point, I was based in the corporate headquarters of NHS Greater Glasgow and Clyde, and we agreed that I would meet him at an agreed date and time then.

**Q** You narrate in your witness statement at paragraph 39 on page 397 that you met with him on 23 October, and obviously you reached some kind of accommodation with him to work together on this, is that right?

**A** Yes. That, that was really my-- the first parent of a child or young person that had been treated in the paediatric haemato-oncology service and who had questions and concerns that I had engaged with directly. I found that a very upsetting meeting to hear the-- what I guess I would describe as the compounded distress, so the distress of the questions of the secondary issues and concerns that he and his daughter and the wider family were having to deal with, on top of the diagnosis and treatment of cancer.

As the meeting progressed, again, I was, of course, still very much in this mode, as I said earlier, of seeking to understand, listening very carefully to what NHSGG&C staff were saying, what Professor Cuddihy and the other parents who were contacting me were saying.

I was becoming aware, I think, by that point, that the feelings of mistrust that had been referenced before – for understandable reasons – extended also, in part, to me. So, you know, you're part of the system, you're part of the Scottish Government. Reasonable questions: who do you report to? Who do you work for?

So, at that point, it became clear in the meeting with Professor Cuddihy that he had connections with a range of the families that were present at the meeting. He appeared, to me, to have a very good understanding of some of the historical complexities that I was still getting my head around.

And yes, we did agree at that point that there may be ways in which I was already thinking at that point of the need for a more prominent family reference group, for example. There were discussions with the Board about – and this goes back to your earlier question – advice to the chief executive.

I think early on I was saying, “There needs to be a meeting that you and the chairman and accountable directors are present at.” So there were those sorts of discussions at that point.

**Q** Thank you. One of the next things you did, I think, was to send the

families not your document but an NHSGGC document, which sought to respond to a series of questions that had been raised with the families, is that right?

**A** So, yes, this is the NHS Greater Glasgow and Clyde's response to the 71 questions that I referred to.

**Q** Yes, perhaps we could just put that up. It's bundle 27, volume 12, page 26. Oh, maybe we haven't got that. Then there's a series of questions with detailed responses. I mean, I think you instanced a minute or two ago, Professor, that it's sort of interesting now, some years on, to look back at some of these things because, for instance, if we just look at the first topic, which is ventilation, and there's a mention of Ward 2A, we know now that a lot of the issues in Ward 2A were identified a long time before 2019, certainly by 2018 and, arguably, in various measures long before that.

Anyone involved in these exercises might then say, "Well, why did it take them so long? It's all very interesting they're doing it now, but why so long?" So, these are interesting answers to look at. What was your purpose in sending them on? Just straightforward communication?

**A** So, if we go back to the remit, as we discussed earlier, the priority was to get responses to what, as I said earlier, were the officials' distillation of what was discussed at the two meetings but were framed as questions. It may assist the Inquiry if I describe and expand on my witness statement about the process around how we got to the point of these questions then being issued on behalf of NHS Greater Glasgow and Clyde to the families.

My first point was I was-- my focus, at that point, consistent with the remit about being the voice of the families, was to understand what families were beginning to tell me during those early meetings – we referred to some of the emails, what they'd said to the cabinet secretary – and to look at that in terms of, "Is this answer clear? Is it-- does it make sense? Is it compassionate? Is it respectful?"

So, this document that you see went through, I want to say, around 13 iterations based on my feedback to previous versions. The reason I say “around 13” is, when I reviewed my records, the version numbering went at some point to 7.1, 7.2, 7.3.

But I have reviewed, in preparing today, well, knowing what I knew – let's say a few days after appointment – what questions did I pose when the first draft came through? I also have looked at everything else I said in all the subsequent iterations, but they're broadly

around, "That doesn't make sense. Families won't understand that word. I don't think you should say that."

I should also say that officials in the Chief Nursing Officer's Directorate were looking at some of these iterations, too, including the Chief Nursing Officer's professional advisor on healthcare-associated and -acquired infections, because I don't have any expertise in that area and therefore the responses were being reviewed there.

I could perhaps give an illustrative example. I know this was something the Inquiry was considering yesterday. I looked back at what were the first comments I made on the first proposed drafts to the questions on ventilation and water, and I'll just, if it's acceptable, refer to my notebook on that. So, in relation to the first proposed drafts of responses to ventilation and water, as you'll probably be aware, in a Microsoft Word document, you can put a comment in the margin, so my comment in the margin was:

> "Insert something in respect of any evidence or reports."

So, even at that point, I had no knowledge of some of the things that I learned later in 2020 or have subsequently learned through the Inquiry.

Looking at it purely through what I understood the families had gone through, what their concerns were, what was keeping them awake at night, I was starting to learn about the distress that they were experiencing. I noticed I was saying, "Well, insert something in respect of any evidence or reports," so that was in the ventilation and the water sections.

In relation to ventilation, I noticed one of my early comments was, "Why is an upgrade necessary?" So, at that point, from the perspective of being the voice of families, these were the sorts of things that were occurring to me. But with all the iterations, there were, as you can imagine, a number of further comments, challenges, questions for clarification that I made before this was issued.

**THE CHAIR:** Can I just, at risk of just saying back to you precisely what you've said to me, just see if I can crystallise in my own mind the process that produced the document we have on screen? The questions which are stated in bold on the document, as I understand it, were compiled by Scottish Government officials, having listened to the meeting that the Cabinet Secretary was present at.

**A** Yes, I don't know for certain, but I assume officials would have been present, and yes, the summary of what they heard the families discuss with the cabinet secretary and the Chief Nursing Officer on the two meetings – end of

September and start of October – were reflected in their summary.

Now, I don't know if that was sent back to the families for accuracy checks. I just know I was handed it and said, "There's your 71 questions. Ms Freeman wishes those to be responded at (sic) at pace."

**THE CHAIR:** The questions go to GGC for their first draft response, is that right?

**A** Yes, so those questions were passed over to GG&C from-- I can't recall from who, but certainly I would have assured myself that they had them when I was appointed, and then they would send back to me their proposed response.

**THE CHAIR:** And then?

**A** And then I would send back comments on said proposed responses, questions.

**THE CHAIR:** Right, and as you go through the 13 or thereby iterations of the draft, you are presumably editing for clarity and comprehensiveness of answer.

**A** Predominantly clarity and whether it seemed to me that the-- based on my understanding of the family's concerns, that it was answering the question posed.

**THE CHAIR:** Right, thank you.

**MR CONNAL:** Could we just scroll on to the next page of that document, just so we can see a few more? There's a heading, "Water." Yes. So, at this point, I think, in fairness to you, you're the new kid on the block, if I can use that colloquialism. You're still starting to gather information, you don't have the years of involvement with the system that some of the families had, so you were presumably still short of a lot of the technical knowledge that you ultimately acquired as you went about your job. Is that fair?

**A** Yes, that's fair in terms of, to use your words, being the new kid on the block. In terms of knowledge of the history of the events, yes, that's also fair. I had an emerging understanding.

In terms of technical knowledge, that was not something I was ever seeking to take forward in my remit. I was always clear – and I think it was in the remit – that if I needed advice from the policy or the professional advisory officials and the Chief Of Nursing Officer's Directorate--

I was very dependent on what came back from colleagues in NHS Greater Glasgow and Clyde. It would be difficult for me to say with certainty because of processes like retrospective reattribution and knowing what I know now that I mentioned earlier, but I do think I did have a sense that there was a drip-feeding of information, and I did feel it

shouldn't take as many iterations of my clarifying or challenging to provide responses to questions.

But I was, I think, at that point, very aware that it appeared-- I think I did have a sense that it wasn't the complete picture, perhaps, and made that known in briefings to the cabinet secretary, and I think, ultimately, that may have been an issue that the Health and Social Care Management Board considered when they made the recommendation on escalation.

**Q** Thank you. Given that you, at that time, were not equipped with the factual information to know whether everything said in that document was or was not correct or full or anything else, I don't think I'll ask you to go through it today.

So can we move on back to the witness statement, please? Just so that I can touch base on page 398, where, again, you're quite properly in your witness statement laying out a sequence of events, different communications that you make from time to time, and we won't ask you to look at all of them today.

In 43, you say you wrote again, and you say that this was prompted by some media coverage of an unfortunate event. Interestingly, the point you seek to highlight in that is that you:

> "... referred to NHSGGC's recognition ... that they needed to improve their approach to communication and engagement..."

Is that something you felt able to see at that time, that there was that recognition?

**A** I'm just going to read the----

**Q** It's the middle of paragraph 43.

**A** Yes, yes. I was just-- Excuse me, I was just reflecting on the use of the word "recognition." So, yes, I think that's accurate. There was a recognition. It was starting to be referenced in written communications from the chair and the chief executive.

In the interest of fairness, I should also say that, subsequently, when I became chair of the Communication and Engagement Sub Group, there had been recognition of distress and impact, to a certain extent, for some families for some of the issues previously also.

I don't think I would have been aware of that at the time because I hadn't asked for historical documentation of the sort that the Communication and Engagement Group had asked for at that point. But, yes, I did see some recognition at that point, though "not always consistently demonstrated in interactions" would be my caveat to that.

**Q** The next topic that seems to have come up is concerns or issues

relating to water safety that continued to be the subject of communications. I just want to check; there may be some duplication, as there sometimes is in documents that we have. Can we have bundle 5, at page 391? We may have the same document twice. In any event, what was happening here in this series of communications? Were you trying to provide some reassurance?

**A** There had been a response from NHS Greater Glasgow and Clyde in the 70-- Well, there were 70 responses issued to the 71 questions, so one of those 70 responses was about water that we had discussed previously. When I was in touch with the families, the response from NHS Greater Glasgow and Clyde in relation to water safety prompted a number of follow-up questions, points of clarification.

So, initially, the response to the question on water safety had referred to water being "wholesome" and I think there was then the reference to, "That means the water is safe." I'm not quoting verbatim, but "wholesomeness" of the water equalled safety. Families were coming back to me as the liaison person and point of contact with further questions about that statement, also further requests, for example, for historical water sample tests.

So this email, certainly the one at the top, is-- I also wanted, in addition to liaising with the families, to make sure that the relevant directors in GG&C and the chairman were aware when I was communicating with the families and what I was saying and what the position was--

So that email from me on page 391 is, as it says-- I had issued something on the 6th – that day – and I specifically say-- moving beyond generic statements about "water is safe," "water is wholesome" by starting, really, to expand upon this, which is what the families were asking me to do.

**Q** So, we see that at the foot of that page, and I think it then continues on to page 392, if we just go there. Then you reference this word, "wholesome." Then you list a number of the actions that are being taken.

Were you aware, at that time, of concerns – for, in particular, patients in that cohort who were particularly exposed compared to the average member of the public – that you needed to be careful about what you were saying to them about safety for that group?

**A** So, perhaps it would assist the Inquiry – and it will also respond to your question, I believe – if I set out how my understanding of wholesomeness and the sensitivities to the particular group of children developed over time. So I think, initially, I think I asked questions around,

"What does wholesomeness mean?"

So, as part of that process that you and also Lord Brodie mentioned of iterative commentary, I asked around wholesomeness. I think, as I then started to get questions from the families, I thought, "Well, there are two issues arising here: wholesomeness, who says so? Because some families were saying, “Is that an independent assessment? Against which criteria? Where is it defined?"

But then also the supplementary questions saying, "Well, what does that mean in terms of water safety? What does that mean if your child is immunocompromised? What does that mean about water in a range of different locations?"

So, over time, I think-- initially, my responses were, "Well, this is my understanding of where 'wholesome' comes from." I emailed and asked Tom Steele, the director of Estates and Facilities, who undertook that assessment. He would get back to me saying it was the authorising engineer that undertook that assessment. I would pass that on to families.

I think, at that point – you'll recall I've mentioned a couple of times now that I was dependent and reliant on officials and the Chief Nursing Officer's Directorate – it was raised with me as part of the, I suppose, day-to-day business of government of ensuring that the people that I need to be aware of what I'm doing to take forward what I've been asked to do, were aware.

I actually became aware of a division in government I never knew existed, the water safety division. I was advised that officials were looking and noticing that I was providing comments on wholesomeness’ effects on immunocompromised children.

At that point, my understanding started to develop in terms of, an official in water safety division was saying, "Well, yes, it's for an authorising engineer to assess water as wholesome, but it's for the NHS Board to make the separate assessment around water safety, and therefore you need to make sure that, in your communications with families, that there is not a confliction," which I, by that point, could see had perhaps happened around “wholesomeness equals safety” for this particular group of children.

That's why you see me starting to-- as was my commitment, whenever I had new information or I'd asked for things, I would seek to update the families in the growing contact list of families that I had. So, at page 392, what you have in the bullet points are what colleagues in NHS Greater Glasgow and Clyde were telling me were the additional processes in

place that informed their response that they believed the water to be safe, which, of course-- and I know the Inquiry covered this in evidence with Dr Crighton.

When I read that, I also, of course, was aware that these were, to all intents and purposes, what I understood to be control measures that had been put in place. But, nevertheless, they did reflect what-- the Board's decision making, as they described it to me, about the wholesomeness and safety decisions. Sorry that was a lengthy answer, but I hope it helps.

**Q** Yes, so what you actually have is, if you like, a regulatory term, which is "wholesome water," but then, once the water enters the system of the hospital, you were told that, "Well, it's the hospital's job to make sure that water within the hospital systems is safe for the patient cohorts that they're treating," is that right? That's what you were told by the experts?

**A** Yes, that's correct.

**Q** What your bullet points indicate is that there's sampling taking place and so on and, in any event, there's also chlorine dioxide dosing taking place generally and point-of-use filters in areas which you described as high-risk areas. Are these those such as the paediatric oncology patients that you had a particular concern for?



**A** So, one of the things I think it would be appropriate to point out in responding to that question is, in areas where I have no specific professional expertise, I would be very careful-- So, those words that appear in the bullet points, where it was something that I can't personally say is within the scope of my knowledge, experience or expertise, those would be the words I would have been provided with perhaps in emails when I've asked questions on behalf of the family. So, I would be conscious to try and make sure that, where I was providing information from families, it was on the basis of what I'd been given by colleagues in NHS Greater Glasgow and Clyde.

**Q** Thank you. I think we can leave that document now and return to your witness statement because what you then did was you sent a further update letter, and I don't think we'll dig that one out.

In paragraph 46, you're narrating that you sent a further update letter, and the reason you did that I think you've set out in paragraph 47 – that wonderful buzzword, "proactive." But, nevertheless, you're seeking to make regular communications. Is that essentially what you're saying there?

**A** I was mindful of providing families with updates, not solely when

they asked for them or through some sort of predetermined process or time scale, but when I felt there was something based on my understanding of developments or decisions or information, I would want to make sure that that was given to families quickly.

Increasingly, as we may see as we go through my written statement, there was-- the word "proactive" that you highlighted did become particularly important when there were then a whole range of intersecting processes that I was, again, in the midst of those, the independent review, the setup of this Inquiry, the Oversight Board.

Again, that's where the proactivity, I think, started to come in, in terms of ensuring that families knew if there was a parliamentary statement in providing them. I mean, I remember sitting at the computer waiting for the cabinet secretary to sit and stand up in the chamber so that I could immediately provide families with the actual speech that was going to be made, embargoed copies of the doctor's Fraser Montgomery review, and agreeing with them that we would be proactive in providing it to families an hour before wider release. So, yes, I think that's what I meant in paragraph 47.

**Q** Then, in paragraph 48, you record that you issued a series of further communications on a range of topics that, by this time, were starting to emerge. It wasn't simply water but a whole range of different topics. I'm not going to ask you to look at all of these, but we might just have a look at one of them. Can we have bundle 27, volume 12, page 90, please? It's the last in the list. So, in list terms, it appears over the page in your witness statement. What are you doing here? This is both communication which talks about points of detail but also makes a general point about improved communication, is that fair?

**A** So you're-- Just to clarify, Mr Connal, your first question was what's the point of this----

**Q** Well, you seem to be doing more than one thing in this email. There's some general points, but there's also some specifics.

**A** Okay, I'll just read it. (Pause for reading) Yes, okay, so I think there are two purposes of this communication. Again, part of my approach in any communication, be it written or verbal, will be to try and think, "Well, what's the purpose of this?"

I think the purpose here was to respond to two issues. One was-- I mentioned earlier, families sending me follow-up questions. So, one purpose was to respond to those follow-up questions around-- there must've been

questions about water temperature – I'm looking at the first paragraph – questions about immunocompromised patients and also questions about chlorine dioxide. So that was the first purpose.

The second-- from memory, this was a parent who contacted me regularly and not only, as I said before-- similar to Professor Cuddihy, he was hugely distressed by the situation they had found themselves, not only in relation to their child's cancer diagnosis and treatment but all the, what I referred to as compounded distress, and that-- My sense at the time was not being helped by concerns this parent had about could I be trusted, who did I report to.

So, there were two purposes: one was to follow-up and the second was to reiterate that I was independent from the Board, and the cabinet secretary had been quite clear. Of course, 20 November, I was still in that pre-escalation period and still working to that remit, and it was quite clear that I could do whatever was necessary to discharge that responsibility of being the voice of parents and patients.

**Q** Thank you. So, if we leave the document and go back to the witness statement. We're now at page 400 of the witness statement because, as you've just helpfully trailed in paragraph 50, you identify that you then got in touch with the



families to advise them of the escalation and thus of the new Oversight Board that was going to be in existence. I think I really have one question about that: what reaction did you get to telling parents that there was going to be this Oversight Board on top of the existing board structure, as it were?

**A** I don't recall any specific reactions, though, sitting here at the moment, my thought is that the families, I think, welcomed a recognition of the fact that there might be additional external individuals who were going to become involved in reviewing and considering the range of issues that they, for so long, had been raising and had been distressed about but that is-- often occurs.

That was, I think, being reported in the media as "special measures," which is not-- which is, as I understand it, something that relates to the English health care regulatory system, but I think some of the families who are particularly angry welcomed that because they told me that they lost confidence in the Board more widely and in some of the officials and staff there.

**Q** One of the things you did at this time – I just wanted to ask you about this – was you sent out a survey for comment. We see that mentioned at paragraph 51, which runs onto page 401. Now, was this a-- not the old-style survey

you get through the post. This was an online survey that people should access, is that right? Is that how it was done?

**A** Yes, that's correct. It was-- Yes, the families were provided with a link that they could access. I can't recall specifically; I think there may have been – and if there wasn't, there should have been – an emphasis that if someone had preferred to complete it in another format, to get in touch. But yes, it was a survey.

At that point, having been asked to chair the Oversight Board Communication and Engagement Subgroup, it seemed essential to me to have some way of-- And, of course, by that point, I had the oversight of the range of people who were in touch with GG&C, with the government, with myself, and I thought this is an opportunity for me get some form of structured feedback around effectiveness of communication, feedback on communication to date and historically, to inform discussions around the remit and the terms of reference of the Communication and Engagement Subgroup.

**Q** This is an open question: apparently, there were 208 what are described as "survey visits," so that's presumably somebody recorded – whether it's one person or more than one person – as getting in touch with the site that you've identified.



**A** So, in anticipation of this question, I have also noted that. I think that number of 208, at the point at which that was printed, reflects the number of times the survey link has been clicked. So that might include, sometimes, that I've clicked it more than once to check it's still functional. It may be that if officials have been briefed that there's now this survey and they're interested to see what's being asked. So I don't know if that 208 figure-- I have no way of knowing who clicked and how many times they clicked.

**Q** Yes. I think what I was trying to assess was what you thought about 20 replies to a survey of this kind.

**A** Yes. Initially I thought that was-- and I think to all sort of external benchmarks or parameters would not be regarded as a high response rate to any survey, in terms of at that point being told that there were in excess of 400 families who had some contact and that the letter that contained the survey link had gone to over 400 families. So, initially that's not a high response rate.

Subsequently, however, there were a number of things that resulted in my reflecting and reviewing that initial assessment of being a poor response rate. One was Professor Cuddihy – who, by that point, had joined the Communication and Engagement

Subgroup – who had really helped me to understand the fact there were a number of families that he was in touch with who did not wish to be named, who didn't wish to provide feedback through some of the other routes, including that, but did wish that to be provided through their contact with him and other parents.

So that did cause me to reflect on-- I also became aware that there were some parents who referred to, "Well, I'm speaking on behalf of X number of parents." I think I had a recollection of a response, for example, of a parent saying that she and other parents were in discussions with solicitors, and she was giving their collective views on an issue.

So that was the first point that caused me to reflect on-- maybe it contextualised and I understood why it was 20. And then, subsequently, during the course of the Communication and Engagement Subgroup, I started to become concerned that having been told a number – so, "Yes, this went to 450 families" or "This went to all 500 families" – I was starting to get-- or the executive assistant who was in touch was starting to get queries from families.

I would see it in that overview I had of Comms, occasional families saying, "Well, I didn't get the letter about Lord Brodie's appointment from the cabinet secretary" or "Well, I don't have that



letter." So those two things caused me to think, "Well, did everybody that I thought and was advised were getting this link get it or not?" But yes, I think if we assume, with all those caveats and further reflections, 20 is not a high response rate when the sample, the overall sample, is greater.

**Q** You had 20 responses and you had discussions with Professor Cuddihy and others, possibly, about people who were reluctant to communicate, perhaps, with any kind of official, by that stage, directly?

**A** That was my impression and, of course, the context there was that they were incredibly grateful and very confident that he was taking forward their individual and collective views.

**Q** Let me just ask you a slightly different question, and it may not be correctly placed in chronological sequence, but I just want to ask it as a general question, rather than based on anything very individual: we heard evidence, and we had written evidence from the Board's communication director, basically expressing unhappiness with some of the ways in which that she felt the Oversight Board – and the communications mechanisms that the Oversight Board used – treated the Board's communications side.

I thought, since you're the nearest

we have to a representative of the criticised party, I should ask you whether you accept that the way you treated the Board's communications was poor.

**A** So, I'll perhaps answer that personally and then, in so much as I'm able to assist more broadly around Scottish Government, I will endeavour to do so. Personally, as we've heard today, my role in Scottish Government is determined a lot by decisions of ministers or through senior staff, such as my line manager in this situation. My understanding is that the cabinet secretary decided that she wished to clear external communications from NHS Greater Glasgow and Clyde following the Health and Social Care Management Board's escalation decision.

I think Sandra Bustillo's statement refers to-- her written statement refers to clearance of communication to individual families. That's not my recollection or understanding. The Chief Nursing Officer and I would review, provide advice and commentary when asked to around that, but the cabinet secretary clearance element was on responses to the media.

So my role, when I was advised that the Chief Nursing Officer and I were to comment on proposed responses, external responses, to the media, would be very much informed by that dimension



of my remit throughout all of the different phases of my involvement, around what do I understand the families have experienced? Is this accurately reflecting/seeing it from their perspective? What will this mean? Would that word potentially-- There's no intention for it to be distressing or traumatising; might it be? So, a lot of my personal communications as part of that process would have been around the voice of the families. In terms of more----

**THE CHAIR:** Sorry, it's my fault, Professor. I didn't quite follow that last part of your answer.

**A** Okay.

**THE CHAIR:** I mean, you're addressing Mr Connal's question, first of all, from a personal point of view, and I think we're still on the personal point of view.

A Yes.

**THE CHAIR:** The – as I understand – criticism from GGC was that they were prevented from communication that was not approved by Scottish Government. I think that's what we're talking about. Now, I'm not just quite sure where we are in your answer, and it's entirely my fault. What I'm hearing is that we're speaking about your role in approving the terms of communications, is that right?

**A** So, I was speaking about my role in providing comments on proposed

media responses from NHS Greater Glasgow and Clyde, which, along with the Chief Nursing Officer's comments, would then determine what was passed to Miss Freeman. Well, actually there's a process, which-- I would agree, that that does add additional steps in a process around clearance.

So, yes, I would provide some comments, the Chief Nursing Officer would provide comments, and that might then lead to amendments, or we might suggest an amendment. So, often I would suggest, "I think there should be a more prominent acknowledgement of the distress and impact on families here," or I might suggest a change of word.

I think, in issues around healthcare-associated and -acquired infection – and I noticed it was in Sandra's written statement – the Chief Nursing Officer might say, "I can't approve" or "I don't approve that being issued." I think that was very challenging for the Board, particularly when they were continuing to be-- receiving a number of requests with deadlines that were imposed by the media. Does that----?

**THE CHAIR:** Yes, I've now caught up.

**A** Okay, and secondly, in terms of government, I think I am limited in what I can say, other than I know Ms Freeman in, I think, the Edinburgh hearings was asked questions around similar issues around decisions about clearance of communications when there was some oversight process in place, so-- But I did what I was asked to do by the cabinet secretary: "You're now going to start to get proposed media lines. Please provide comments and feedback."

**MR CONNAL:** Just so I don't lose it, I think you said in the midst of one of your earlier answers that, in making the comments that you did on proposed communications, you had in mind this role as the sort of voice of the patients, assisting the patients, that you felt you'd taken on, is that right?

**A** Yes, I had that very much in mind. I did read with interest Sandra's written statement around, you know, "Professor White" -- I'm paraphrasing, but, "Professor White gave too much detail" and people having to then speak to Fiona McQueen about that. That doesn't surprise me because I was there as the voice of families, and families were often saying they wanted more detail, albeit this was a media response, but some families were getting that.

And, not wishing to be flippant, but I do know – I have some insight through years of feedback processes – that Professor White can be very pedantic and over-expansive at times, so I have enough self-awareness that my

suggestions to expand a media release might have been at odds with what usual custom and practice is. But I felt that, sometimes, more comprehensive responses would be helpful and serve the needs of the families better.

**Q** Thank you. Let me just touch briefly on a completely different topic, the closed Facebook group. Did you think that was a useful addition to communications?

**A** When I heard about that, I did. At the first-- one of the first meetings of the Communication and Engagement Subgroup, there had been-- I – again, around January, I think – had asked the two parent representatives at that point to give me feedback on how they felt the subgroup – their role, the communication that supported the subgroup – was working. There were concerns expressed that the closed Facebook group wasn't working the way-- I can't recall the specific words, but, you know, it wasn't-- there's perhaps opportunities for improvement.

So I hadn't seen anything on the closed Facebook group at that point, and I had initially asked if I could have access to it, initially in order that I could get a sense of what families were saying there and how colleagues in NHS Greater Glasgow and Clyde were responding to that. Then I subsequently started to post responses as they related to questions about the Oversight Board and the various other dimensions of my role that had developed over time.

**Q** So this was a positive innovation taken, in the round?

**A** I thought it was. I think there was perhaps concern and I think it relates to some of your questions earlier, Mr Connal, around how did colleagues react of you coming in and it was a very difficult situation. I think there were concerns about that, and I think there was some feedback at some point around, "Your direct messages to parents on the closed Facebook group are causing confusion."

I think I asked for examples and in preparing to give evidence I was looking at minutes of meetings and thinking why did I focus specifically on asking the parent representatives for feedback as part of my feedback. I think I wanted to try-- I'm trying not to use the technical word 'triangulate,' but cross-check that by getting feedback from the families. They said they were finding the messages I posted useful and helpful, but I think there was concern about that.

**Q** Now, I think we can then move forward because we know there was the independent review, and you helped the families by putting questions to the independent review, which you explain in paragraphs 58 to 60 of your witness

statement on 402 to 403.

Then we move on to where you've headed the section of your communication "The Oversight Board and Communications and Engagement Subgroup." I suspect that might be, my Lord, an appropriate time to pause.

**THE CHAIR:** Professor White, as I said, we usually take a coffee break about now and that's what we're going to do. Can I ask you to be back for ten to twelve?

**A** Of course.

**(Short break)**

**THE CHAIR:** Mr Connal.

**MR CONNAL:** Thank you, my Lord. We got to the point of your witness statement where you put in the heading of the "Oversight Board and Communications and Engagement Subgroup," which allows us to have yet another acronym, CESG.

So you were the chair of that group and a member of the Oversight Board, and you set out in your witness statement the way in which that group was set up to operate. You explain the number of occasions on which it met and then you set out – another management word – deliverables for the group at page 405, including, now, not just the question of you communicating with parents, but you're now part of a group that's making conclusions and findings about what has or hasn't been done, so one additional role that you're now taking on.

**A** Yes, that, Mr Connal, I think you correctly state, was the significant change there. Two points, I guess, that come to mind: one is I had a specific role within an Oversight Board structure as a chair of a subgroup, and, as the word "subgroup" would suggest, there were other people who were going to be working with me in terms of the terms of reference.

And, of course, colleagues from NHS Greater Glasgow and Clyde would be invited to be, as was-- I think the approach taken for all the Oversight Board – the Oversight Board and its subgroups – was that GG&C colleagues would be in attendance, though not members of the governance structure of the Oversight Board. But, yes, it moved very much from me to having a group that I could work with and delegate actions to and rely upon their expertise and experience.

**Q** The way this then proceeded in terms of communications, which is the topic we're primarily dealing with today, is that the main conclusions on communications – not all of them but the majority of them – by the Oversight Board

were contained in the interim report of the Oversight Board, which was issued in due course, is that right?

**A** Yes, I thought it was important that-- You'll see from my evidence statement that there were, I think, seven meetings that I-- Well, at the point we're talking about, maybe it was six because we called a special meeting in June, I think, of 2020.

But I spoke to some of the Scottish Government officials who were supporting the group and thought that, given the number of meetings we had in a relatively short space of time, the volume of information, NHSGG&C colleagues who were in attendance had provided a lot of really useful background information.

Sandra and colleagues gave a useful, detailed account of some of the challenges, the complexities, the approach that had been taken, so we felt that there was a need for a standalone communications and education subgroup report.

As a group, we were very keen that we recognised how hard the team had been working, the complexity of the situation, and therefore it was framed in terms of “what worked well,” were the words that were used, and what required improvement. But you're right, Mr Connal, that then was submitted through the Oversight Board infrastructure and featured in the interim report.

**Q** Yes, because I think in terms of communication-type topics, one of the main topics picked up in the final report was duty of candour, which I'd like to deal with separately so it doesn't get wrapped up in the same question. But I think you set that out very fully in your witness statement. The minutes are all listed on page 404, and then the subgroup findings, which then made their way in large part into the interim report-- the documents are identified there on page 406, as is the final report.

**THE CHAIR:** Professor White, there's an acronym – I maybe should have picked it up – at 66.2 which I don't recognise: "PACT." P-A-C-T.

**A** Paediatric Adolescent Cancer Team.

**THE CHAIR:** Thank you.

**MR CONNAL:** The way you've dealt with your witness statement is, in fact, to first of all pick up some feedback and then to go back, as it were, to look at the conclusions that the group reached on communications and set them out in more detail in your witness statement, so I'll come to that just in a second after I ask you about the feedback, which appears on page 407 in paragraph 70. Now, this is you, in effect, saying, "Well, what do you think so far?" if I can be

colloquial again, to the parent and families group.

**A** Yes, that's right. I was eager to seek feedback on the two family representatives' experiences of not only being members of the group but the effectiveness of communication before, during and following each subgroup meeting.

**Q** What you say in paragraph 70 is that you were told by Professor Cuddihy that parents had provided positive feedback on the arrangements put in place for him to provide an information sheet, particularly those parents who were reluctant to communicate by other means, appreciated that, and that you'd responded and posted updates, which provided a confidence that, in effect, somebody was listening to them. So they would make a point, and then they would see a response from you on the Facebook group, which was a positive, from their perspective. That's one of the feedbacks, is that right?

**A** Yes, that's my understanding. I think Professor Cuddihy was commenting specifically on discussions at the Communication and Engagement Subgroup, where he, perhaps through his contact with families, would say, "I will raise that. I will represent that."

He had had feedback from families, but when they then saw some action that I took, for example, on a closed Facebook posting, they were seeing that, I suppose, that loop-- communication loop was being closed, and I suppose that two-way process of communication and engagement was operating.

**Q** As you just told us a moment or two ago, what you set out in paragraph 72 on page 408 is that-- Let's just make sure we're clear. When you say "the report," is that the interim report or is that the CESG report?

**A** So the CESG report. Sorry, Mr Connal, are you asking me, am I referring to a report in a paragraph?

**Q** Paragraph 72.

**A** 72, okay. Yes.

**Q** I just want to double check which one it is.

**A** Yes, so the report at paragraph 72 is the Communication and Education Subgroup report.

**Q** Thank you. As you just told me a minute or two ago, what you did there was you-- in the way that investigation organisations often set out: what worked well and then what needs to improve.

**A** Yes, I thought that was important for the reasons that you imply, in terms of any learning or inquiry-based process may have things to learn from where things have worked well.

Particularly for colleagues from NHS Greater Glasgow and Clyde, when you're in a process of escalation and you have new groups and oversight and all the challenges that they'd had, I, as chair of the subgroup, wanted to make it clear that this had to also be about what had worked well, and that, as subgroup chair, I wanted to make sure that all those in attendance – members or not – had an opportunity to comment on that.

I think, from memory, at one of the subgroup meetings, as opposed to the traditional style of meeting where one chairs a meeting and goes through an agenda, I became more of a facilitator of a mini workshop with colleagues, and it was structured around what's worked well. Because, as you would imagine, not everybody around that table had the same view or experiences around what had worked well.

**Q** Ultimately, the group's report recorded – and I think you start to deal with these in paragraph 75 – the things that had worked well: "Good communication at point of care." That's, presumably, by clinical staff and nurses and doctors?

**A** So, by that, it was certainly-- yes, it was Professor Gibson, Dr Murphy, the clinicians. That was a consistent theme, but also Jen Rogers, the chief nurse, and Jamie Redfern, the general manager – again, at the point of care. Although members of the Directorate management team-- we heard lots of examples of where that was valued and good.

**Q** Then the next thing that worked well was making new mechanisms, including the closed Facebook page and so on. Questioned could it have been done earlier, but otherwise a positive.

**A** Yes, I think there was-- that was good, the recognition, and there was-- as with any complex process, there was learning as we worked together on these issues around how do you capture communication preferences when you've got a range of dimensions; the age of the young person; which part of the service someone's in touch with; sadly, the families who might have had contact with the service where their child had died.

So there were complexities around how do you capture that when you're needing to-- I think, the technical term that I understand is segment your communication, so you need to work out who the key people are.

**Q** Now, I won't go through all of these, but I see 75.5, staff impact and wellbeing was considered, although “more targeted approach” could have been adopted. Can you just help me with that qualification?

**A** (Pause for reading) “A more targeted approach"? I don't have a recollection specifically of that wording. Reading it now, I think it would have related to the discussions that we would have around, I suppose, a personalisation and a flexing of response based on interaction and dialogue with people, as opposed to a generic set of (inaudible). So I think that's-- from memory, anyway, I think that's what the targeting relates to.

**Q** Then we move on in 76 to the "Needs to be improved" box. An interesting point, perhaps, in 76.1, having recorded the consistent-- statement of consistent lack of transparency, creating an impression there was something to hide. I'm interested in your take on the second half of that paragraph, where you say:

> “While a minority may have voiced their views, that did not make addressing their concerns any less essential, nor could it be read that their views were not shared by the larger, silent group…”

Is this something that you say from-- I know I'm saying “you,” although this is the group's conclusions. But, given that we have you here, as it were, as representing that, is that something that was borne of knowledge of how people react in these circumstances? That some people are-- they agree but they don't say anything?

**A** Yes. I think-- so, two points, I think, in response: one, yes, and secondly, Professor Cuddihy was just reviewing my note in relation to this section of my witness statement, and I think what I've noted down is that Professor Cuddihy had said, "You cannot assume that silence equals satisfaction."

So I think the family representatives were part of that group discussion, where-- not just in that process, but concerns had been raised with me that this is not representative; it's only 20 responses to the survey. Of course-- let me just pause and think of time scales if-- Yes, by that point, NHS Greater Glasgow and Clyde had undertaken some-- what are called care experience conversations with, I think, around 40 families. So the overwhelming majority of feedback that the Board had collected around that, it was and continued to be positive about the quality of care.

But even in that work, there was a small but significant number who had ongoing concerns about the wider environment. So, you're right that, as a subgroup chair, my job as a good chair was to make sure that all felt they could contribute to the group's process. Then, you're right, ultimately, I'm accountable

for sign-off of any outputs of the subgroup.

But that certainly was a theme where certainly the subgroup's view and definitely the Scottish Government's group's view was that, irrespective of the numbers, the policy position is that any number of families – whether it's 10 or whether it's 50 – anyone who has the concerns of the nature that are being expressed should not have those concerns, and they need to be engaged with personally, compassionately, supportively and promptly.

**Q** Then, 76.2 records frustration at what was perceived-- it would appear a reluctance to address questions about some incidents because of what was thought to be the pending litigation that was preventing that. Was that causing concern as well, then?

**A** The families were particularly concerned that-- The metaphor "legal shield" was one that I recall being used at the time. I think it was John Cuddihy and I were having a discussion, and he-- not only representing the broader group of families but was concerned that-- and it was starting to appear, I think, in--

If we link up these various processes, perhaps, in proposed communications to media lines, the reference around, "We can't say anything about this due to legal action," did start to be referred to. And certainly, the families did express their frustration of that occurring against a backdrop of already feeling that there was more that could have been provided previously.

**Q** The next point that comes up is this issue as to who was the priority for communications. Is it the media? Is it the wider public? Is it the families? 76.3 appears to record the view that communications with the families wasn't always the priority.

**A** So, yes, it does record that view. In the report, there were several examples of where colleagues in NHS Greater Glasgow and Clyde, in my personal view – and I think the subgroup also recognised this – did recognise that there was a need to sequence communications.

There was a need to make sure that the Directorate managers who were going to the ward had the information, but I think generally – again, it's my personal reflection around where we're at in the witness statement – I think there was sometimes an unhelpful conflation of the media public statements and the separate communication to families. There, of course, needs to be links between the two, but my own reflections are maybe sometimes that made it more difficult to respond to some of the unresolved concerns of families.

Also, perhaps, my other reflection is-- and I don't know the answer to this, but was there a feedback process each time? So did that inform the next iteration of the next briefing to parents, or was there way of saying, "Some families have said that they've got these unanswered questions"? Did that go back to others to then keep that cycle going? I think sometimes, but maybe not always as reliably as it might have.

**Q** Now, I think the Board might suggest – and, again, just trying to take this generally – that on at least some occasions, their intentions had been to put communications with the families first, but the timing of releases to the media and who had leaked what to the media and when the media was commenting had made that difficult. But I take it that would have been a point that was made during discussions that took place at that time?

**A** Yes, that would have been reflected in the discussions of the subgroup. I don't recall specifically that being raised during the time that the Chief Nursing Officer and I were commenting on the proposed media responses before going to the cabinet secretary. It may have been. There was so many incoming requests.

My reflections around that, though, are that – and it maybe also relates to



something in Sandra's written statement – I recognise sometimes that there was-- the media want to know this, the media want this by this time. My own view would be, well, sometimes they may have to have a response that says that they won't get it by then because this organisation's priority will be to do X, Y and Z with the families. But that----

**Q** The sort of thing you get when there's an accident and people say, "Well, we're not going to tell you any more about it until relatives have been informed first"? A version of that?

**A** I have reflected that. I wonder if sometimes that might have been helpful. I've also – and I suppose if we're on a similar theme – reflected around whether a regular press briefing might have been helpful in terms of shifting things from reacting to-- and it may have occurred.

I was aware-- I'm aware I perhaps didn't always know what discussions there were with the media, but I have reflected and wonder if regularly, proactively having, if not-- I know this is not always a popular suggestion when I've made it across my career, but I have sometimes suggested to people, "We'll call a press conference about it," and that's not always something people feel confident with. But I do wonder if there was something--

some learning in that also.

**Q** We'll just move on, just so we pick up at least most of these. Page 410 is a good example of a communications piece of phraseology: "clear person-centred tone." Now, is what you mean by that what you say in the rest of the sentence, about recognising the nature of concerns, apologising for their impact and taking action? Is that what you're referring to by referring to a "person-centred tone"?

**A** Apologies, Mr Connal, I can't locate the paragraph.

**Q** I'm sorry, we're at page 410, at paragraph 76.4.

**A** Okay, thank you. And your question was, does the sentence----?

**Q** I'm just trying to understand – make sure that we understand – what you mean by, or what the group meant by, "a clear person-centred tone" that the Board didn't always demonstrate.

**A** Okay. I can't recall specific examples-- Well, I can actually recall a specific example, but I guess I'm hesitating to say there would be lots of others. But the one that I recall at this moment would be, for example, being asked to comment on a proposed communication where a family had stated that there was a concern or an issue, and the proposed response was, "The staff have confirmed there are no issues." I went back and said, "I'm not comfortable with that. That's like saying their experience is not reflected."

There was then a discussion around how could we make that more person-centred to their experience and concern, while also reflecting the fact that the staff-- when the staff were asked, there was no issues at that point, and then having, "Here's the process to continue the dialogue to deal with that."

Then there would be more simple elements of person-centred tone. I think you may-- the Inquiry may have picked up on this. I think there was a thing about-- you know, there was talk of words "jarring." So things like, was it "expected levels" was sometimes used? So sometimes you would say, "Well, that maybe doesn't feel fully person-centred" in terms of that seeing it through their----

**Q** I think the phrase was "acceptable levels of infection."

**A** "Acceptable." Yes, apologies.

**Q** It was a question whether from a family, the family of an ill patient, saying there's an acceptable level of infection might jar.

**A** So, that-- and I'm not commenting specifically on that in relation to paragraph 76.4, but that would be an example of person-centred tone where a suggestion might be made to say if we know of all of the demands and additional

worries, concerns, distress and trauma that the families have told us – on top of those of being in the midst of a difficult set of circumstances with cancer treatment – to then say "acceptable" doesn't feel fully person-centred, in that it sees it from their perspective, and what that might mean or what that might say to them.

**Q** Thank you. I won't read through all of these. There's some obvious ones like "Timeliness" in 76.6; 76.7, where we have the word "Management" in inverted commas. This is the question that has been discussed elsewhere about whether it's right to make the ward staff explain the position about the hospital environment, essentially, is that right?

**A** Yes, that's right. I think-- Yes, that was a very strong theme in families' feedback, as they-- I think a lot of the families developed relationships, particularly with the chief nurse and the general manager, who did an excellent job of visiting the ward when there were updates or with feedback or to provide support.

I think, certainly, the families did express concerns about that, and increasingly were wishing to engage with and have-- I think the word "visibility" is used, but wanting to see or engage or interact with people who were



accountable, not just for the operational delivery of the service, but broader corporate accountabilities.

**Q** Thank you. So there are other findings that I won't trouble to get you to read through. Then, having had the "what worked well/what needs improvement section," there were then what you describe as "key recommendations," which are covered in paragraph 77, which starts on page 411. These are, one, "more active and open transparency." Is that fair, 77.1?

**A** Yes.

**Q** 77.2, leadership: "more from the leaders."

**A** Yes, that was what I had in mind a moment ago when I mentioned what was described in the subgroup report as "early, visible and decisive."

**Q** Yes, and then we come back to this "person-centred approach" that needs to be embodied in everything.

**A** Yes, that was certainly another key theme, which is why, as you'd expect, it was reflected in the subgroup report. And really, there – I think, for me, from the early days of my appointment – was this theme around how it's very deliberative that it says, "corporate to [the] point of care" to reflect the expectations of person-centredness, person-centred tone, really pausing to think about the experience, the impact,

and seeing it, before doing anything, through the lens of those people who have that experience.

**Q** Yes, that's an interesting comment because, in the course of evidence on quite different issues, we had evidence from Dr Mathers who, when asked about the effectiveness of communications, basically said, "Well, don't ask somebody like me who drafts them; ask the person who receives them, what their perspective of whether it's an effective communication. Look at it from their perspective." Is that a similar point to the one you're making?

**A** Yes, and I think that reflects some of my thinking around the-- Notwithstanding the points about the engagement with the survey, that was in my thinking about the survey in terms of seeking feedback. That was in my thinking around asking the two parent representatives for feedback.

Because I guess that, by its very nature, communication is two-way, as is engagement, and therefore it goes back to my statement previously: you need to have some means of finding out the impact. Increasingly, it's recognised in healthcare settings there's-- certainly in healthcare communication, there's a process of getting people to tell you back what they think you've said so that you can have this iterative process. So, yes, I think that was all reflected in 77.3 around person-centred approaches.

**Q** Then I can't leave this section without noticing on page 412, in 77.8, a recommendation that the Board "should learn from other health boards that have developed good practice in addressing the demand for speedier communications" in, I suppose, the new social media world that we're all living in.

Would you accept that the world of social media and the speed of social media spread, if I can call it that, does present challenges for an organisation like a health board in responding?

**A** Yes, without a doubt, absolutely. And having been-- having experienced that personally in governmental roles, I can certainly understand and appreciate that that does add a dimension to that.

**Q** Yes.

**A** But also, I guess, it brings with it opportunities, and I think the wording of our specific recommendation is not there, but from memory, it was around-- rapid and effective communication with social media was the-- I think it was in the-- It was in the report that you're going through but also in the interim report of the Oversight Board. So the recommendation specifically said, around-- It was focused on communication, and it was rapid and

effective use of social media.

**Q** Now, can I just turn to organisational duty of candour as distinct from the duty of candour imposed on medical practitioners of various levels by their own professional responsibilities? I touched on this briefly, but you had particular understanding of the organisational duty of candour, having been involved in the preparation of what became the Act under which it was introduced in section 22(1) and 22(2) of the Health Blah Blah Blah Act.

You deal with this on page 413 of your witness statement, or start to deal with it there, and you set out the statute in paragraph 78 and then a paraphrase, essentially, of the wording that's required. You say that one of the things you think it does is recognise that openness and transparency are fundamental. Is that correct, in paragraph 79?

**A** Yes, that's-- The provisions as set out in the secondary legislation are what I broadly had in mind there in terms of the actions that are required if the procedure is activated.

**Q** Given what this Inquiry has heard about the impacts of issues – if I can use that generically – on patients, on patients' care or (audio cut out)?

**A** (Audio cut out) on parents and families. Yes, when I was first advised that, I did find it surprising.



**Q** You then list some issues that IMTs deal with on page 414 and then return to the duty of candour on page 415, in particular in paragraph 85. If I may suggest, you express it quite kindly in that you say the policy in respect of organisational duty of candour "did not fully reflect the legislation." Is the answer that it didn't appear to have read it?

**A** Apologies, I didn't hear you there.

**Q** It rather looks as if the Board hadn't read the words in the legislation because of the approach they took, or am I wrong about that?

**A** So, two points of response: I do recall a meeting early on in my appointment with Dr Armstrong, the medical director. It was when I was in the phase of seeking to understand the history, asking for background documents, and I know that during that meeting I did raise the fact that, based on Dr Armstrong's articulation of the policy, it didn't seem, to me, to reflect my understanding of the primary or secondary legislation.

We had an interesting discussion. I remember saying "I'm a human being, therefore I am subject to memory retrieval errors like anyone else. But having led the policy development and then the bill team who developed it, I'm pretty certain that what you're suggesting to me is in

the legislation isn't."

But I think, whether I did it on my phone or on a computer, I said, "Let's go to legislation.gov.uk and get it up just now, so I can a) check that I haven't had a retrieval error, and b) then discuss that." So I think that did reveal that I hadn't had a retrieval-level error and there was nothing about causation or avoidability that was set out in the legislation.

So I think-- and as reflected in what I've said there when I say it didn't fully reflect-- I mean, it did reflect other statutory obligations that are in the legislation, such as provision for support for staff involved in the procedure, but in terms of those specific aspects around-- So the legislation states-- the primary legislation talks of an "unintended or unexpected incident" and the words are "appears to have or could result in harm."

So those words were very deliberately chosen at the drafting stage and as it went through Parliamentary process because it was not to review these sorts of unexpected or unintended incidents using concepts such as causality or thresholds that might be applied in other processes. It was very much around "appears to have" or "could have."

Those points that I mentioned didn't appear in NHS Greater Glasgow and Clyde's policy document and they also included the term "patient safety incident," which is actually a term that appears in the English duty of candour legislation. It's not one that in-- the legislative drafting-- appears in the Scottish legislation.

**Q** The reason I'm pausing a little bit on this is that we know from the legislation-- and I won't ask you to bring up legislation.gov.uk on this occasion. But we know, broadly speaking, that the consequences of the duty of candour being triggered are quite specific in that, broadly, we're talking about notification, apologies – which are not to amount to admissions or liability – meetings and so on. There are a series of steps. It's not simply a sort of tick box, "This has happened." You have to do certain things.

**A** Yes, and I suppose expanding slightly, if I may, the "and so on" at the end, I think the "and so on" aspect in the context here is that there are-- Again, I may be incorrect, but I think it may be section 6 of the secondary legislation, but there are specific requirements around what the-- So, in this context, the relevant person would be the parent or, if the child was-- so the person affected by the incident. But there are specific obligations in the secondary legislation around the opportunity to ask questions,

the opportunity to have-- so it certainly sets out the rights of the relevant person.

I think that's where there are potentially, or would have been potentially, advantages for those families if that procedure had informed things, because they would see set out what they should expect and were entitled to in terms of the process of review.

**THE CHAIR:** Mr Connal has described the terms of your statement as "light." Can I perhaps use slightly less delicate language? What I understand you to be saying – and the information is there in paragraphs 78 and 85 – is that, as a result of a process that you were involved in, Scottish Government imposed specific duties on healthcare authorities, with effect from 2018 – am I right so far? – in relation to disclosure of information in the event of an occurrence which could have resulted in harm. Am I right so far?

**A** Mostly, Lord Brodie.

**THE CHAIR:** Right, just correct me where I'm wrong.

**A** So you're correct in terms of when the Act came into force on 1 April 2018. You're correct in terms of it applied to providers of-- you said "health services." Yes, a lot more, too, but for our present purposes, that. And yes, it does set out the obligations on the responsible person, but only if the procedure is activated.

**THE CHAIR:** Right, okay. Help me a little bit with that. How do you "activate" a procedure?

**A** So this is where, being slightly removed now and having not had a senior management role in an NHS board for 10 years, I'm relying upon those that I see or what I'm involved with, but my understanding on speaking to colleagues and boards is there would be a decision that the organisational duty of candour procedure applies to what the organisation then does. So there would-- Most NHS----

**THE CHAIR:** So this is a sort of general policy as opposed to in relation to a specific instance?

**A** Yes, my understanding is that a lot of NHS boards will-- I know the Inquiry has had-- Datix has been mentioned, which is an incident-reporting piece of software, so I think the way they operationalise this is, let's say if I was a member of staff on a ward and there had been some sort of significant concern about harm or an event. I may report that as the organisation requires me to do so, and it may be Datix, it may be another provider of incident-reporting software. And if the reporter believes that it meets the threshold for a duty of candour, then they would denote that.

Then someone in usually what

would be described as a clinical governance and risk management-type team – usually the clinical managers of the service, like the associate medical director or clinical director – would then review it, and there would be a decision: "Is this something the organisation is going to progress through the organisational duty of candour procedure or not?"

**THE CHAIR:** Right. Now, you've identified two triggers, I think. First of all, a trigger for the particular board employee who notices something, and then a trigger for the clinical manager who makes a decision as to what's to be done. Now, again, am I following you correctly?

**A** Yes.

**THE CHAIR:** Right. Now----

**A** Sorry, Lord Brodie, to interrupt, but it's subject to the caveat that I don't have a comprehensive knowledge of the operational procedures across all health boards.

**THE CHAIR:** I think I've come to expect that you probably would have that knowledge, but-- Right. However, am I right in saying this system requires two triggers, or at least two triggers? What I'm trying to get at is what you identified as a discrepancy between what the legislation – which you happen to have been responsible for – provided for, and GG&C's policy.

**A** Okay. If I may, I think I can answer that in two ways that would assist the Inquiry. One is to recap around the policy document, and secondly is to provide a response in relation to what I and colleagues were advised about the decision not to activate it, why it wasn't activated. I think that might address what you're asking.

**THE CHAIR:** Well, I may have to go back to this question of what "activation" means, but carry on.

**A** I may-- so I will carry on, but also I may be limited in what I can advise because there'll be 22 different versions of activation.

**THE CHAIR:** Well, you spotted something which you thought wasn't quite right.

**A** Yes, so, if I may, I'll proceed and then, as we've been talking about, you can give me feedback if my communication has been effective. But point one would be the policy included reference to "patient safety incident" in the policy, which is not in the Scottish legislation and seems to have references to avoidability of the death or harm and causation, neither of which are concepts that are required in the legislation in making that decision about activation or not. So those were the three main areas in respect of the policy document as

presented to the subgroup.

**THE CHAIR:** Right, so I'll abandon my metaphor of triggers and introduce the metaphor of hurdles.

**A** Yes, okay.

**THE CHAIR:** The GG&C policy introduced perhaps three hurdles as preconditions of activation, which are not to be found in legislation. Have I got that right?

**A** Yes, and I think just as a further reflection as you've helpfully fed back to me is that – and this is I think a general point that's come up at various points in my evidence – the words "duty of candour" are sometimes used and I think that's unhelpful because it's not clear if we're referring to professional duty of candour or organisational duty of candour. And, indeed, the policy, from memory, is duty of candour policy.

**THE CHAIR:** Right, that additional subtlety. What I'm taking from this is what you discovered, I think about the beginning of 2020, was that since April of 2018, which is the coming into force of the legislation, Greater Glasgow had been imposing, by virtue of its policy, a higher hurdle on whether it was required to take the action specified in the legislation, which is described, as you rightly say-- is maybe rather imprecisely referred to as "implementation of a duty of candour." Have I got that right?

**A** Yes, and so what the subgroup learned and colleagues from GG&C confirmed was that the organisational duty of candour wasn't activated, as we've discussed. There was then discussion about why not, and the information that was provided is that the legislation sets out that it uses the term "unintended or unexpected incident."

Now, the legislation doesn't define those terms and, therefore, they are terms that the responsible person – in this case, NHS Greater Glasgow and Clyde – should interpret. But GG&C colleagues said that they didn't regard the instances of healthcare-associated and -acquired infections as unintended or unexpected incidents because it's known that children with cancer who are immunocompromised can develop infections.

The view of the subgroup was that that seems a very narrow interpretation of "unintended or unexpected incident." My challenge-- I've talked in my statement about trying to balance challenge and support in the role and in the subgroup. My challenge to colleagues was-- it would be questions like, "Is it expected for a mother of a child who has vomited due to side effects potentially of cancer treatment to not be able to clean their child because the water's off? Is that something you expect to happen or is it

unexpected?"

So the view formed by the subgroup is that perhaps there was an overly narrow interpretation about the infections being the "unintended or unexpected incident," when, actually, a series of events, things that were happening, could, we felt, reasonably have been regarded to be unexpected, to be in the midst of all of the events, the IMTs and the concerns.

**THE CHAIR:** Please correct me if I'm being unfair in what I'm about to say. An observation about GG&C's approach to "unintended and unexpected" appears to have the perspective of a population of patients. Within a population, I can see that the occurrence of healthcare-associated associations (sic) might be expected because there will be-- within a large group, there will be some instances, in contrast to concentrating on the experience of a particular patient where a healthcare-associated infection is neither expected nor intended. Is that an unfair way of looking at things?

**A** So, in your question, Lord Brodie, we're sort of going into an area outside of my expertise----

**THE CHAIR:** Right.

**A** -- because it's very much around the legislative requirement for a health professional not involved with the relevant person's care to give a view, and that's outside of my expertise. But broadly, those are the sorts of things that would be needed to be considered and weighed.

If I may, just one last thing in the theme relating to this, the subgroup, as I've said, had the discussion around, "Well, 'unintended,' 'unexpected,' how did you interpret that? What's your response to these reflections?" But also, because the organisational duty of candour legislation includes things like increases in treatment and psychological harm as potential outcomes, so appears to have or could result in those, some of the challenge was also around, "Well, we understand that some children had an increase in treatment or a return to theatre for a line removal, for example, or their treatment was affected," and I was able to say from--

By this point, of course, I had visited some families in their home – one particular family, I recalled, in their home – spoken to families at length on the telephone. I was saying, "There's some families who are clearly extremely distraught and distressed by this. How did you take into account the psychological harm?"

So I guess that would just be the final thing the subgroup were discussing. It was the lens, really, through which you look at that. It's not solely about the

infection, it's-- as the incident, nor is it necessarily only about that as an outcome. You've also got things like increase in treatment and psychological harm. I hope that's helpful.

**THE CHAIR:** Thank you. Sorry, Mr Connal.

**MR CONNAL:** Let's see if I can try to pull that together a little bit at the end. I understand the point you've made to his Lordship about the debate over the meaning of "unintended" or "unexpected incident" – and we're probably really talking about "unexpected" because we're not talking about an intended incident – but the position remains, regardless of that debate, that what you were told was the Board's approach had hurdles in place that did not reflect the terms of the statute.

**Q** Yes. If I may, Mr Connal, and you may want to pick it up later, but we're, I think, picking up a theme of realising there are certain things that emerge at some point and then later on are linked. But, related to this point, I did note when Professor Stevens and colleagues published their report, there was an element called the paediatric trigger tool that was-- formed part of their work, and I recalled they suggested that the-- as I said to his Lordship, about incident-reporting systems, and there would be a grading of severity.



I did notice in Professor Stevens and colleagues' report that there was a suggestion that some of the, if we call them infection instances, incidents relating to individual children, I think they suggested they had been downgraded or undergraded. So I remember, when I read that, wondering how that linked with the Communication and Engagement Subgroup's finding about potentially that's why it wasn't reviewed to have a threshold that was bringing it into the organisational duty of candour realms.

**Q** In many ways, am I not right in thinking that the key hurdle – forget all of these other semantic debates – is that causation, in other words that incident A had caused harm B, was part of the Board's system when, in fact, the legislation says "resulted or could result in harm"?

**A** Yes, and I think, if I recall correctly, it says "appears to have or could result in."

**Q** Yes. The precise wording is, "The incident appears to have resulted in or could result in one of the outcomes----"

**A** Yes, yes.

**Q** -- one of which is-- let's just paraphrase it as "impact on treatment of (inaudible)."

**A** Yes, so I think what you said would be certainly my assessment and the subgroup's assessment of that, that

there wasn't sufficient – that we could see – weighting given to the "could result in" and also the "appears to have." It doesn't say "establish causality on a balance of probabilities." It just says "appears to have."

Because the policy intentions behind that legislation were to make it clear to relevant persons or people affected and staff – because staff, as we know and as this Inquiry's heard, are equally distressed and affected when some of these incidents occur-- but was to set out what people can expect in terms of meetings, questions, feedback, support and also what happens at the end of the process in terms of the obligation for that to be reported publicly on an annual basis.

**Q** Yes. Thank you. We can probably move from duty of candour, unless you have anything else that you feel we should take from you on that topic.

**A** Only one brief point, which I think may assist. You'll see in my written statement the view that I've expressed and that the subgroup expressed was one I continued to express in advice to ministers in relation to Drs Fraser and Montgomery's report in relation to their observations on organisational duty of candour.

And, again, colleagues in NHS



Greater Glasgow and Clyde, as part the Oversight Board process, provided comments on drafts of reports and there were various pieces of feedback on organisational duty of candour which I considered – and I believe it's in the bundle – both for the independent review and for the feedback from GG&C.

I outlined and gave advice broadly similar to what I was responding to his Lordship and to yourself around these concepts. But I suppose that's the other part of that story, if you like, that the Communication and Education Subgroup's view and my view – which does have the benefit of having been evolved since the day it was a policy proposal – set out various disagreements with the independent review and further feedback from GG&C before the final report.

**THE CHAIR:** Can you point me to that document?

**A** Yes, I'll try. So the two documents I've just referred to are-- Actually, it'll be easier to find them in my statement, I think. Yes, so paragraph-- the first document in terms of the Scottish Government's comments on the Queen Elizabeth independent-- the Montgomery/Fraser report, that's paragraph 87, and the reference is on page 416, in the third line.

**THE CHAIR:** Thank you.

**A** Then, the other-- the second document is in the next paragraph, which is the Scottish Government's comments on draft-- on comments received from NHSGG&C, paragraph 88. The document reference there are the two documents I referred to.

**THE CHAIR:** Thank you very much.

**MR CONNAL:** So I'm not misunderstanding any of these exchanges, you've expressed a view, but the view you've expressed is the view that was formed by the CESG on that particular topic of duty of candour?

**A** Yes, it was expressed in the outputs of that subgroup report. It would also be fair to say it would be a view I would have expressed in other fora and in other interactions, too.

**Q** Thank you. What then happened in terms of the Oversight Board and the CESG report was another acronym was created, the AARG, Advice Assurance and Review Group. So this is to provide some sort of oversight of what happens with the CESG and Oversight Board recommendations, is it?

**A** Yes. By this point, the Oversight Board has published its final report and recommendations and, yes, my understanding at that point would be there was-- that this group was established to consider the actions taken in response to the Oversight Board's recommendations.

**Q** Yes. In fairness, you record that on page 418 of your witness statement, in paragraph 95, that the AARG would "report on progress to the Cabinet Secretary" and also, no doubt, as you say there, to the NHSGGC Board. That was the aim, and I think you attended, you say, two meetings of the AARG, the first of which your job, in effect, fell away after the Oversight Board CESG had concluded its work, is that right?

**A** Yes, it was agreed at the 7 June 2021 meeting that my formal role as reflected in the Oversight Board structure would end, though – I haven't included this in my statement – I did make it clear and, from recollection, communicated to colleagues that I was more than willing to be available to colleagues in GG&C who were continuing to work on recommendations to discuss or assist.

At that point in this process we've been talking about today, I had been becoming involved in discussions with the executive nurse director a lot as child-specific concerns were coming up, and I was continuing to give them advice on how they could capture, monitor and engage families as part of their improvement activities.

So, at that meeting in June,

although my formal role ended and there were certain consequences from that, I had to make sure there was clarity about having access removed from the system I'd set up before and the Facebook group access being formally closed down for me, but yes, that was when I started to exit from that previous role.

**Q** Your evidence goes on to say that in the August meeting, which is the second one that you attended, GGC reported they'd "conducted an internal audit ... and that their policy had been changed." Did you review the change to see whether it was now consistent with the legislation?

**A** Yes, I did. In advance of the August meeting, the attendees were provided with a comprehensive range of documents, and I think there was 108 recommendations in total, all with responses and documents. So, yes, I did review the new policy on duty of candour and identified that the words "patient safety incident" did not appear any longer, that the references to "avoidability" and "causation" were no longer there.

Interestingly, I also noticed that there was a new requirement for certain-- So, the previous policy had no mandatory training specifications on duty of candour. The revised policy said it would be mandatory for certain role-specific



groups. So there were changes in the document tabled at that meeting, which I reviewed before the meeting.

**Q** Just so I make sure I've got your answer, did you consider that the resulting document was consistent with the provisions of this statute?

**A** (After a pause) Yes. I'm pausing because of our earlier discussion about my use of language, and I suppose that, yes, I did. It was consistent. I think it could have been improved, but if our benchmark is, "Is it now consistent with the legislation as I understand it, relative to what went before?" then yes.

**Q** Thank you. At that point, you stepped away also from the AARG, is that correct?

**A** I had assumed at that August meeting that, having been asked to be a member of that group, I would continue to be a member of the group until its work was done. I only later became aware that I hadn't seen the draft minute of the August meeting nor been invited to a further meeting when I was copied into another email that referred to the AARG.

But you're right, after those two meetings, I didn't attend any further. There may have been some-- I don't know why that was. It may have been there was confusion that standing down from my role equalled no longer being a member of the group.

**Q** Yes, and perhaps just to try and finish this sequence, perhaps you can help us understand what you're dealing with on page 419. Because having narrated, in paragraph 98, that you weren't further involved directly in the group – although you understand there was one later meeting – you've picked up an action on your part, which also relates to duty of candour, where you were concerned with what was being said. I wonder if you could just help us to understand what you were looking at and what your concerns were.

**A** Yes. So, in my role in government, I will often be copied into a large number of emails in the course of a day, which might be briefings to ministers or proposed communications. My recollection is that I was copied into a communication which referred to the submissions that I referred to earlier, to the AARG in August.

**Q** Can you remember an email from somebody to somebody?

**A** I believe it was an email exchange-- I think it might be in the bundles, volume-- sorry, bundle 27, volume whichever-- volume 12, and in fact, it's there----

**Q** Is that the document you've highlighted?

**A** Yes, it is. It's at the end of this paragraph 99.



**Q** Well, let's just see. If you just don't mind pausing for a moment, we'll get it on screen and then it may be easier for you to take us through it----

**A** Sure.

**Q** -- and enable us to understand the point. So, it's bundle 27, volume 12, page 417.

**A** So it may be helpful to scroll down to the first point at which----

**Q** You get a substantive email.

**A** Yes, please. Yes.

**Q** Now, carry on. Ah, yes. Now, has that contained a revision that you proposed? Can we go on? Is the document-- do we actually see it?

**A** Yes, so if we keep going. Well, sorry, if it's appropriate for me to----

**Q** No, no, please. Just try and find us the part that starts the story, if we could. Now, okay, go.

**A** Yes, okay. So I think our tactic should be to keep going until I say stop and then reverse. So next page. Yes, next page. Next page. Next page. Next page again.

**Q** I'm just trying to find the email that you're concerned with.

**A** Yes, so if we could go backwards now to 425 and then to 424 and then to 423. I think now that I've seen that, if we go back again, we'll then look at the first one I actually interject into.

**Q** Right.

**A** Next one. Yes, okay. So just to pick up your-- if I may, so far, based on the benefits of seeing that and your question around what it was, it looks like it was-- as you can see, there's a very long list of recipients and copy recipients, but it appears to be discussions with a range of officials about communications with Mrs Slorance. If we go to the previous page on 420, I can-- So, at the bottom of the page at 851----

**Q** Yes.

**A** Yes, so I say:

> "I note this submission to FM [First Minister] refers to impressive evidence on organisational duty of candour."

**Q** So what was the impressive evidence? I'm not sure what that's talking about.

**A** So, if it's okay with you, I'll answer that just directly in a second, but picking up your previous question-- so I now, having seen this, know what this is. So, this would be one of our things that come across my inbox about where people might know that I've had some involvement or it's part of my remit or something I'm leading on. So, I've been copied in on a routine submission to the First Minister, which I have read and noticed it referred to the meeting. So that's the context.

The impressive evidence, when I read that I thought, "Right, that relates to all those papers that I reviewed in advance of the AARG in August." My first response is, although-- Well, it says "impressive evidence on organisational duty of candour." My own view was that it was evidence on, as I've referred to, changes in the policy, but I had a recollection of a discussion at the meeting where I'd asked a couple of questions. My concern there was I didn't feel "impressive evidence" was accurate, and I had concerns about that being documented in a briefing to the First Minister.

**Q** So the passage that's highlighted in yellow on the document that we are currently looking at is the part that you had concerns about, where it's recorded?

**A** Oh, yes. That's it.

**Q**

> "The Board presented impressive evidence including the implementation of an internal audit process by the internal auditors Azets. The revision of the covering policy in light of the commentary they have received regarding their perceived insufficiency [which may be another piece of kind wording]…"

**A** Well, my main concerns were

the use of the word "impressive evidence," and I was concerned about the use of the term "perceived insufficiency" because it had been quite clear that the policy wasn't consistent with the legislation and-- I mean, they're not my words, but if you want to look at sufficient or insufficient, there was no perception about it, in my view.

So, that was the basis upon which I said, "I'm not content with that going into a First Minister submission." Then, as you said, Mrs Barkby, who's an associate chief nursing officer, has provided me with the context saying, "Well, this has been lifted from a briefing to the cabinet secretary," and she's highlighted that, but then she says to me, "Do you have alternative wording?" I think that I then suggest alternative wording.

**Q** Yes. Now, do we find that in the previous page, perhaps 419? Proposed revision, yes. So this is you and the proposed revision, presumably, is a bit in the middle where you say:

> "The Board commissioned a review by the internal auditors, Azets. A desktop review [and so on]."

That's what you thought might have been a more appropriate----

**A** So I highlighted that. I checked and I said, "I've searched for the minutes of the meeting and I hadn't received it." But I then say what I would have proposed would have been what I propose, and it's marked, as you say, with, "Proposed revisions start and end."

**Q** Yes, and what you say, I think, in your witness statement, and what you say in this email to Irene Barkby is, if I'm picking this up correctly:

> "[From memory, their medical director] confirmed that their [that's the NHSGGC's] review of the Organisational duty of candour work [with a desktop review that did not involve] engagement with any staff or patients and families, nor looked at outcomes... [i.e. it was an] internal audit [perspective] based on a review of documentation, which may have included [their revised policy]."

So that was your take on it? That was what your information was?

**A** Yes. That was the basis upon which I had concerns about the impressive evidence. Now, in saying that and in recognising the forum we're now in at the moment, I would not wish it to be seen that my statement is not recognising the huge and significant amount of work that was undertaken in relation to a whole range of actions.

My point really as reflected there is that it's important to look at both measures of implementation – so what

you've done, we've updated our policy – but also measures of effectiveness: how will you know when that change has made a difference and who will be our sources of evidence? Future patients, relatives, staff who have been involved. So my point was not about minimising the magnitude of the work and what had been presented. It was very much about what I believed should be an ongoing process.

Just one final piece of context: that was borne out of a piece of work I did for the government previously where I went round all health boards in Scotland and sat in various governance meetings and then wrote a resource for NHS Scotland called Improvement Focused Governance, where one of the pieces of advice was to focus on measures of implementation. So, we've updated our policy, but measures of effectiveness also. So, we've looked at the last five incident reports. They're graded appropriately. Some of that was done, in terms of the internal audit, I believe, but that was the concern that I had.

**Q** I think, my Lord-- I'm conscious of the time, so perhaps this would be an appropriate point to pause. I think there's a little bit of evidence still to come.

**THE CHAIR:** Right. Well, we'll take our lunch break now. Mr Connal, I get the impression that we probably have sufficient time this afternoon.

**MR CONNAL:** Yes. Absolutely.

**THE CHAIR:** Well, if we sit again at ten past two.

**(Adjourned for a short time)**

**THE CHAIR:** Good afternoon, Professor.

**A** Good afternoon.

**THE CHAIR:** Can I just say something to the room before we continue? Can I ask legal representatives not to have conversations while witnesses are giving evidence, for reasons which I needn't elaborate? Now, Mr Connal.

**MR CONNAL:** Thank you, my Lord. If we can bring the witness statement back, please, at page 420. I just want to ask you briefly, if I may, about a couple of communications that you mention in paragraph 102. The first of these, it appears you emailed someone in the Chief Nursing Officer's Directorate. I'd just like to understand two things: why were you involved in this exchange? So if I start with that one.

**A** So I think that would be for similar reasons to those that I explained earlier in relation to having been copied into an email. It would be routine for staff at the levels of director and deputy

director in the health and social care directorates to be copied into certain communications, and I think I was copied in because of that arrangement.

Also, I believe that there were discussions that had been referenced in communications that I wasn't copied into around organisational duty of candour, so I can't recall specifically, but it may also have been because somebody recognised that that might be something to copy me into.

**Q** Well, perhaps we should just make sure that we know what we're looking at. Can we have bundle 27, volume 12, page 428, which is the document that you've referred to? Now, can we just go further down that chain so we can find Mr White's communication? We need to go further. I'm just trying to find whatever it was that you sent.

**A** Yes, so there's-- I think there are-- So, as you scrolled through the pages, that's the second-- that's-- Sorry, I used the word "the second" – that's the second email I've seen, and just now, there was another one on the first page you showed me, but I wonder if there's a-- as we had earlier, another one further in there.

**Q** Right, because I see somebody called Roberts A----

**A** Anncris Roberts.

**Q** Anncris Roberts is saying:

> "I see that Craig was copied in further down this chain and highlighted the importance of Mrs Slorance having a named contact..."

**A** So – it may assist – Anncris Roberts at the time was the unit head for the policy unit that oversees organisational duty of candour policy, so I read this as that she has noted, in being asked something, that I had been copied in, and in being copied in previously in the email chain, that this suggests that I have emphasised the importance of Mrs Slorance having a named contact.

**Q** Yes, and then I see that this person is also saying something about duty of candour, which seems to be one of your topics, and saying certain things about what is required if something goes wrong.

**A** Yes, so by this point-- so this email is November 2021. As you know, in addition to the roles and responsibilities in relation to NHSGG&C, I was-- there's a bit of a pattern: it was a phone call one evening and asked the following day to take on a role as deputy director in one of the Test and Protect programmes.

During that time, I was involved with discussions with the NHS, who were beginning to consider how their obligations in organisational duty of candour might reflect to hospital-acquired

COVID infections and, therefore, I wonder if Anncris, my colleague, would have been aware of that, and I knew we'd had discussions about organisational duty of candour: "Is it unexpected in a pandemic that people might develop COVID?"

So I think that was probably on their radar, too, because, although I wasn't involved with everything in relation to the tragic circumstances of the death of Andrew Slorance and then his wife and family thereafter, when there were certain things, I think, popping up in communications, people would remember that they needed to ask me or--

And, as I said earlier, often a large amount of my day would be scanning emails I might have been copied into for-- which I will always try to diligently do, and if I feel I need to join up a conversation or comment-- and in this case, I thought, given all of the learning and discussions around what we discussed before lunch, I thought it right to emphasise because I didn't know if Mrs Slorance had a named point of contact in NHS Greater Glasgow and Clyde.

**Q** Yes, I see. Then you go on in the same paragraph to say that you also provided advice. Now, is that to the same person on the organisational duty of candour and state of the obligations of NHSGGC, etc.? Is that to the same person or do we need to-- will we pull up that email? Bundle 27, please, volume 1, page 540. Right, so this is from you to a variety of people, presumably colleagues at the Scottish office somewhere, is that right?

**A** Yes, so I'm reading the first sentence. The phrase "widening to include" is a phrase that's often used in Scottish Government where one makes a decision that they need to add somebody to the copy list, so widening those who are engaged in the dialogue. I think it looks like, at this point, the email that we looked at on the screen a moment ago from Anncris Roberts, I have perhaps been copied into something else and have remembered that Anncris was involved with that, and then I referenced a moment ago the discussions in the context of the COVID pandemic around hospital-acquired infections, so I've also widened to include Lesley Shepherd, who's the Chief Nursing Officer's advisor on healthcare-associated infection.

So I think, at this point, I'm seeking to assist colleagues by joining up a previous conversation but also referencing it to various discussions that I knew had taken place around organisational duty of candour and hospital-acquired COVID infection.

**Q** If I'm reading this correctly, what you're saying there is that the

hospital-acquired COVID infection might be regarded as not unexpected, which may be not what a layperson might expect to hear.

**A** So the content of that email-- I mentioned earlier, Mr Connal, that there are certain elements where, if I have had involvement in a leadership role or as part of a role, I will be dependent upon professional and specialist advice. So that paragraph is the basis of the professional advice and the discussions that took place across the NHS in Scotland and was reflected there.

Certainly the advice we'd received from medical and nurse directors and Infection Prevention and Control specialists was that a nosocomial – or, as the Inquiry, I think, has heard before, hospital-acquired, that means – COVID-19 infection can also occur despite good Infection Prevention and Control practice. That is not my personal assessment. That is me relaying what I know to be the outcome of, I think, a meeting that I might have been asked to chair or a process I was asked to oversee.

**Q** Then you comment separately on Aspergillus and reference HAI-SCRIBE assessments. I'm not quite sure where HAI-SCRIBE comes into that.

**A** So I think I also have reflected on that in referencing this email in my written statement. I think in the various emails that we've talked about that I was copied into, there was mention of that, and in the discussions in the context of COVID, often the advisors would refer to discussions about being a common infection in certain clinical groups, also being something that the NHS needs to be aware of in terms of any building works and the HAI-SCRIBE assessment.

So I think, at that point, I mentioned earlier my intention in this communication was to try and bring in various discussions that I had been aware of had taken place, as opposed to any detailed assessment of specific circumstances.

**Q** What you seem to be then saying is, in the next two paragraphs – if we can just make sure we can see them – that there might be an organisational duty of candour procedure with all that that entails, and if not, then, "Please remember there are still obligations for transparent, person-centred and supportive communication and engagement," etc., so it doesn't mean you don't talk to anybody about what's happened.

**A** No, there are long-standing directives that were issued from-- it would probably go back as far as to the Scottish Office in the 1990s. So there was a directive, I think, in around 1995 called The Code for Openness in the NHS in Scotland, which, although it's some years

ago, still applies and established directives on clinical governance from the late 1990s.

So those all are-- what I've said in the paragraph that you mentioned beginning, "If there was a decision not to," is that even if the organisational duty of candour procedure were not utilised, activated, then various directives from the Scottish Government to the healthcare delivery system have had a long-standing expectation around those principles.

**Q** I may be wrong, but I suspect that this is the first time this Inquiry has heard about mediation as an option, and it seems to have been at least floated as a possible solution. Do I take it that your response to that was, "Well, maybe, but given everything that should have been learned following the Oversight Board activity, you may not have to use mediation"?

**A** If I may, I'll read the paragraph.

**Q** Yes, please, the last significant paragraph.

**A** (Pause for reading) Yes, so I think you have correctly reflected my view. I say, "My own view is that while this could of course be a helpful development," point one. My second point was I thought that, given the previous actions described to make changes and implement learning in relation to similar scenarios, at least as I saw it, that somebody had been through a very traumatic and difficult situation and was seeking ways to make a connection with the Board, to have discussions, had unanswered questions. I remember reading that and thinking it just seems so dreadfully unfortunate that this seems to be a similar pattern to what many of the paediatric haemato-oncology families had mentioned.

**Q** Thank you. Can I ask you about a completely different topic, just briefly? Can we have bundle 27, volume 12, 339, please? Now, I'm just trying to find your-- Yes, this is a communication with a colleague, I think, on the Oversight Board, Phil Raines.

**A** Phil Raines at the time was acting unit head in the Chief Nursing Officer's Directorate who was responsible for a lot of the coordination activities to support the Oversight Board, including the subgroup that I chaired.

**Q** Yes. It's a relatively short question, but it requires me to go to the final paragraph of that email from you, where you say-- There's various discussions further up the page about professional duty of candour, organisational duty of candour and so forth and some of the issues that arise, and you then say to your colleague:

"... I wonder if this could be

discussed and considered further through the further work planned on professional and organisational duty of candour as signalled in the Interim Report, providing an opportunity if appropriate for us to seek Dr Inkster's recollections of her recommendation informed by the professional duty of candour and identify any learning and improvement opportunities for NHSGGC in respect of the balancing exercises/decisions that are necessary..."

Now, the simple question is that you've made the suggestion of involving Dr Inkster in due course – do you know what happened to that suggestion?

**A** Would it be possible for the document that's on the screen to be put down so I can see the date of it, please?

**Q** Yes.

**A** And I'll explain why the date is relevant, so I----

**Q** You should get a date.

**A** It may be on page 338 or----

**THE CHAIR:** 20 October, perhaps?

**A** Thank you.

**MR CONNAL:** Yes, so----

**THE CHAIR:** 2020.

**MR CONNAL:** -- there was a reply. There we are.

**A** Okay, and if we could go back to 339, that would be helpful. Apologies, Mr Connal, your question was-- Now that I've situated in my mind when it was, it would be helpful if you could----

**Q** The suggestion seemed to be that there would be an opportunity or there could be an opportunity to seek Dr Inkster's input on the topics mentioned there.

**A** Yes, thank you.

**Q** The question is what happened about that?

**A** Yes, okay. So, prior to this point, Professor Angela Wallace, who was involved in NHS Greater Glasgow and Clyde, had been, I believe, in discussions with Dr Inkster and had sent me through – I think either directly or via Phil Raines – work that Dr Inkster had undertaken in NHS Greater Glasgow and Clyde on duty of candour as an item for consideration in incident management team meetings.

That included-- from memory, there was a document from February 2019, which Dr Inkster, I think, had convened a meeting with various colleagues in GG&C because was keen to look at how duty of candour could be considered in IMTs. So, I had reviewed that document from February 2019, and I had commented back to Professor Wallace on that and also confirmed that that would be considered as part of the Communications and Engagement

Subgroup's discussions around duty of candour.

Perhaps if I may just pick up-- I know that Dr Inkster's written statement to the Inquiry said that she wasn't sure what had occurred with that. I did have a memory that I had been asked to comment to the cabinet secretary about that, and the cabinet secretary did write back to Dr Inkster in June 2020, acknowledging that I'd received the information and that it was very helpful and useful, and we would consider it.

So that's-- by way of context, that was why I was aware that Dr Inkster has undertaken some previous work in this area, that I had considered, fed back to Professor Wallace on, and I knew the cabinet secretary had written back to Dr Inkster about a range of matters, but he specifically mentioned that-- I think the wording was something like:

> "Professor White has asked me to thank you for the information which will be considered as part of the Communication and Engagement Subgroup."

So that's the context-- that's the background. So I was aware of that and then when Phil Raines had asked for my view and Professor Cuddihy's concerns about organisational duty of candour, I gave him my views on those concerns



but then thought, "Well I've now learned that Dr Inkster had done some work and maybe there's an opportunity to bring her into the Oversight Board more generally, maybe discussing about that."

**Q** So that's the context, but the question that you put in the email to your colleague here that we're looking at, against that background, seems to be, "Well, perhaps it would be appropriate for us to get Dr Inkster's recollections and identify learning and improvement opportunities." So it seems to suggest a further step involving Dr Inkster-- a date in the future, at least as far as that email is concerned.

**A** Yes.

**Q** Do you know what happened about that?

**A** I don't. At that point, I was aware that-- I think the Chief Nursing Officer herself-- I'm not certain, but possibly the cabinet secretary and others in the Chief Nursing Officer's Directorate had, I think, meetings, correspondence, communications with Dr Inkster.

So, I wasn't involved with what Phil Raines, as the unit head, might have done within the overall Oversight Board structure, but I guess, in writing that, I assumed that I had an awareness that there was a communication channel already established with the Chief Nursing Officer on our team.

**Q** So the opportunity you identified to your colleague, you weren't further involved in following that up, the opportunity to seek Dr Inkster's views?

**A** No. Apologies again. It's just my memory. Lord Brodie helpfully said October 2020. Yes.

**Q** We can see the reply to that, I think, if we go back, because Phil Raines says to you:

> "This is very helpful. Could be worth bringing into tomorrow's Oversight Board meeting, particularly the suggestion that you could be considered as part of our remaining work."

So, do you know what happened?

**A** I don't, without checking the Oversight Board minute. I think, by this time, of course, I was very involved with an increasing number of demands on a new team in my new role, and I would have taken Phil's reply to be, well, A.) acknowledgement he found it helpful, and the fact that he mentioned bringing it into the Oversight Board meeting, reading it now, I would have thought, well, that's that now moving into the appropriate part of the process. I can begin to deal with today's requests coming from schools or fish factories or prisons about testing pathways, for example.

**Q** Thank you. The next section of your witness statement, if we can return to that at 421, touches on the independent case note review, and I don't really need to ask you very much about that other than you appear to have been involved in discussions to provide advice on content of communications about the CNR's activities, is that right?

**A** Yes. By this point, there was a significant amount of learning through everyone that had been involved: NHSGG&C, myself, the government officials and supporting team and, of course, the patients' families that I had communicated with, been engaged with. They'd given feedback of things that were helpful, things that weren't helpful.

So it seemed to me that this was an important opportunity to ensure that that learning was reflected in the way communications and engagement was approached through the work that Professor Stevens and his team were asked to lead. Therefore, it was decided to set up yet another group with another acronym, the CNR Communication and Engagement Group, which I was asked to chair and did so, I think it says there, on four occasions.

**Q** Right, I see, and we see some of the points at which you became involved. I'm going to come now to the sort of tailpiece of your statement, where you offer some reflections. Can I, just

before I do that, take you back to something that we discussed earlier?

Because one of the points you very fairly made earlier in your evidence was that there are challenges when you're trying to state what happened at a particular date, when you know things that happened after that and you know things that happened after that again, and you're trying to recall what did or did not happen at the particular time. Earlier in the evidence, I had asked you about one of the emails that you'd sent out about water. Remember the one that talked about point-of-use filters, among other things?

**A** Mm-hmm.

**Q** We had the discussion about whether the phrase "wholesome" was particularly helpful in and of itself, as opposed to "safe." Now, looking back at that now, do you think there might have been dangers in you being the person providing what might have appeared to be reassurance on things as technical as water to the recipients?

**A** So I most definitely think there were risks in being a liaison person or point of contact, given the scope and the breadth of the issues being raised in the questions, would be my first point. Secondly, because the remit was set up in a way that it was fully dependent upon what information I received from



colleagues in NHSGG&C to inform the response-- so there will be limitations.

Yes, I can comment on it doesn't seem to fully engage with what the families have told me their experience was; it doesn't seem clear or there's jargon here. That risk was mitigated by making it clear that I should ensure that the relevant officials – so I mentioned earlier the Chief Nursing Officer's advisor on healthcare-associated infection – should have sight of, and input to, that process.

I think, in terms of my reflections, if I were in this situation again and knowing what I know now and knowing how helpful it was to not be the lone person who were in that role, it would be to have some sort of appropriately constituted group to link with with the appropriate technical expertise and perhaps externality from the history.

But certainly, at the time, I remember saying to the Chief Nursing Officer, "Goodness, I'm--" Even before I knew the history and complexity, I said, “The wording here in the remit says I have to ensure these issues are addressed.” Now, I didn't have any idea around, as I say, the complexity or the whistleblowing or a whole range of issues----

**Q** The reason I asked the question is that it's been pointed out to

me-- remember we touched on the distinction between what might be safe for an ordinary individual, what might be safe for an immunocompromised individual. We touched on that this morning.

It's been pointed out to me that, while saying that the point-of-use filters on the taps might provide reassurance that the tap water was safe, there are other water-using facilities, such as showers, which are not mentioned and didn't necessarily have point-of-use filters on them, which might therefore be a source of problems or not.

**A** Yes, and that would one of a number of illustrative examples of the sorts of follow-on, as the liaison person and point of contact, that families would be raising, and there were a range of them, and I think my sense was that was informing their requests for more information, so historical water sampling, for example.

I asked repeatedly for what the families asked for, and when I didn't receive it, I would throughout December 2019, for example, highlight, "I note that I've asked for this on behalf of the families and don't have it yet." A couple of times I know, in briefings to the cabinet secretary and to the Chief Nursing Officer – who, by this point, was chair of the Oversight Board – I've raised in early December, "I don't have this further detail."

So, yes, I think that was a potential limitation of the process, that we were dependent upon my-- I suppose, like being a go-between and being dependent on what responses came back in that, but I didn't-- although some families would say, "Well, just make them give you things."

Much as it might be nice to have some sort of magical powers to create information or to-- I was doing everything that I could to try and highlight that these were unresolved, remained unresolved, and just stick to the facts, and say, “I have asked colleagues for them on this date, this date. I'm now escalating it because it continues to be an issue.”

**Q** If we can turn now to 425 of your witness statement, where you’ve used the heading "Reflections," in which you say you think the appointment of a single point of contact was beneficial and you've had a think about what you were asked to do. In 121, it's perhaps appropriate, since this is a sort of tailpiece of what you're saying to the Inquiry, that we just let you help us to go through this. You start, I think, by saying that you believe improvements were made to reflect the Scottish Government policy, is that right?

**A** Yes.

**Q** You think it was effective in supporting a range of developments that created the conditions for more open and supportive dialogue, is that correct?

**A** Yes, and if it may assist the Inquiry, I could give you an example I had in mind there.

**Q** Of course.

**A** As the relationships developed with staff in GG&C, and as my understanding of the system I talked about earlier developed and relationships with the families that I was in touch with, there did come a point whereby feedback that was being received about-- I think quality of the food was something families were raising with me, and I was, I guess, behind the scenes with GG&C staff, advising them on what best practice would be in terms of working with families, working with the children themselves for feedback.

I think, on the closed Facebook group, families were posting pictures of food and expressing dissatisfaction. That process, which was for GG&C colleagues to lead and develop, really led to an exemplar piece of work in terms of – I think I forwarded them – guidance I had located in other children's cancer units about how they had learned and changed food choices for children. I have a memory of sending them nutrition guidance I located from the Royal College of Nursing.

But that was a collaborative learning together with families involving the children and young people. Certainly, the way that families were involved, by this point, GG&C colleagues were updating the families on the Facebook group, saying, "If you'd like to work with us, if you'd like to be involved, here's how that can happen." So it was those sorts of developments that I had in mind.

**Q** You say about halfway through that paragraph that:

> "Mrs Slorance's statement to the Inquiry reflects similar issues to those I encountered when I commenced my role."

You then comment on that. Would you just like to explain what you mean by that?

**A** So I was asked, I think, by the Inquiry, but certainly through legal representatives, to read Mrs Slorance's Inquiry and to comment. Therefore, what struck me in reviewing Mrs Slorance's-- I think this was maybe her first statement to the Inquiry, was-- the thing that struck me were the similarities in terms of having questions, not feeling that she was necessarily being heard or being able to feel involved in a process of review that put, perhaps, her experience and her family's experience at the centre

or the heart of it. So I suppose it was that that struck me, and that was why I said what I've said.

**Q** The next sentence, you used the phrase "compounded harm." Can I just check, is that a Craig White phrase or is it a technical phrase? What is it?

**A** So "compounded harm" is not a Craig White phrase, or at least not originated from me. "Compounded harm" is a concept that's increasingly been referred to in literature that looks at the consequence of adverse events within healthcare settings. It's a concept that says that the harm and distress that's experienced by the, let's call it "the index incident" is compounded by the response of the organisation to the index incident and its consequences.

In my experience in my role in government, most oftenly seen-- that's not even a word-- most often seen when people are finding it difficult to feel involved in review processes. They don't necessarily feel that their questions are being answered by reviews, or they encounter what they say to be a sort of closed – some people use the word "defensive" – practice, and they become even more distressed. So the compounding of the distress and harm is because of the organisational response.

**Q** I think you may touch on this on the next page, in paragraph 122: is this the point you're making, that it compounds distress when people feel their views are not appreciated or understood? Is that the point you're trying to make?

**A** Yes.

**Q** Then you comment in the next paragraph that you accept that some GGC colleagues may have found your challenges tough, but you think you got working relationships in due course.

**A** That was certainly my experience. I do have-- I did note-- and I think you may be hearing evidence tomorrow from a Jennifer Haynes. I think there was reference to-- I think the word "pressure" was used. So I certainly think that, you know, through my relationships I sought to, yes, challenge because that was part of my remit. Yes, scrutinise, but I always sought to be respectful and supportive as much as much as I could.

Since I've mentioned that, I'll say I did go back and review some communications because it concerned me that, you know, was there something that I may have done or said that contributed to the pressure that was already there and certainly keenly felt? But a lot of the emails I looked at were-- some of them were saying, "I hugely appreciate this. Thank you," used open questions like, "Would Friday seem reasonable?"

So I didn't identify anything, but of course, in reflecting, if there are things that, you know, the Inquiry hears in evidence where I have resulted in pressure, I would-- My lifelong career commitment has been to reflect on feedback, both positive and negative.

But it was not an easy task that I was given, and I'm just saying that in terms of the complexities, and the concept you opened with this morning about being parachuted, dropped in to things. But yes, I thought I did-- I sought at all times to be professional and respectful to colleagues, even if I didn't agree and felt that I needed to challenge.

**Q** I think probably that the final point that emerges from your reflections probably starts with the words "also reaffirmed" in paragraph 124. Then it continues in 125, and it might be helpful if you just explain to his Lordship what the key point is you're trying to make there.

**A** So I refer earlier in my written statement to two things that I'll refer to in response: one is the role I had in NHS Ayrshire and Arran as Assistant Director of Quality Governance and Standards, where I was one of the corporate lead assistant directors when we were engaging with families where there had been death or harm; and, secondly, in my government role, I chaired the Ministerial Review Group reviewing arrangements across the country for investigating the deaths of people receiving care under the mental health care and treatment legislation.

So, through that work, I've had, I suppose the-- I have come together with people affected in the most tragic of circumstances and, often either on behalf of the Health Board or on behalf of the Scottish Government, discussed how they found the process of investigating an adverse event or deaths. I suppose the shorthand would be, people want to feel personally and meaningfully involved with whatever that process is, and that will vary according to the person, the nature of the tragic death or the event.

But most people want to feel that those undertaking the investigation have paused and thought about what it might be like to be in their shoes, and that they have an opportunity to be involved meaningfully in reviews, in identifying learning, because most people say they just don't want other people to go through what they and their loved ones went through. So it was those sorts of care experiences I had in mind, of sitting down and speaking to families as part of those processes.

**Q** In the next paragraph you talk about:

"Communication and engagement ... must be more

prominently influenced by work on who has been hurt and what their needs are."

Then you talk about a "restorative inquiry framework," and just so we make sure that we understand what you're talking about there, just help us understand that, please.

**A** So, this is based on work by Jo Wailling, who works in the New Zealand health care system. She has set out what's called a restorative inquiry framework. If it's of assistance, I can pass the summary of that to the Inquiry.

**THE CHAIR:** I would appreciate having that reference.

**A** Okay, I can do that. It explains comprehensively what that means, but basically it's putting relationship-- and humanising a lot of these processes in a way that puts relationships at the centre.

So it's dealing with the human dimensions of an adverse event – the impact, the strong emotion – and realising that other elements might be necessary, so, you know, a rigorous process, a way of reviewing and investigating, but it's not sufficient if you want to try and promote healing and learning.

You need to take account-- As I would argue in most domains in life, it ultimately comes down to connections and relationships, and so this framework talks around the need for that to be at the heart of the process.

And they set out in-- I actually attended-- The New Zealand colleagues had an international conference on this. I sat in front of my computer – I didn't go to New Zealand – one evening from 7 p.m. till midnight. But there's a whole set of practitioners, there's textbooks on this topic as well, but broadly it's about, "Make it more human-connected, relational, and that's where you get the healing from."

**MR CONNAL:** Thank you. I just have one more question. You've talked about the lessons to be learned over communication and, in particular, trying to make them more patient-focused. Is there any assistance you can offer the Inquiry, having reflected on these situations, about how you actually make that happen in the absence of a Craig White-type person sitting on everybody's back prodding them to do it?

**A** So I think there are some examples where, certainly within the NHS in Scotland, there are processes that equip people with some of the skills and confidence to approach and become involved in some of these difficult conversations or where there's strong emotions.

There's two programmes that come to mind. One is a programme that's run by NHS Education for Scotland. I think

it's called Compassionate Communications, but I can check that. But it's broadly around some of the issues that we've touched upon around supporting people to think about how to approach conversations if the people who have been affected-- there are strong distressing emotions dealing with their own distress. Because often there are strong emotions: there may be anger, there may be criticism.

So that programme has been developed and there are an increasing number of people across the NHS who are now providing feedback that it is equipping them with the skills and confidence to be in these sorts of scenarios.

And then, secondly, Healthcare Improvement Scotland have also a programme where they look at ways of getting feedback from people in real time about communication, about engagement, so that you're not waiting some months down the line to capture it, but it becomes part of the way you engage with people in a process: their Care Experience Improvement Model.

So I think, like most of these things, having a guidance document, even having legislation, doesn't miraculously mean that the things that are set out in the guidance or the legislation happen in every interaction, every time. So I think it's about investing in supporting staff who have these roles and responsibilities, celebrating when they do get it right – and there are multiple examples every day across the system where that happens – but, crucially, making sure that learning from experiences, this Inquiry, and other inquiries are actually given priority in equipping skills.

I think I said, I describe it as executive directors as well. I don't know the specific professional development opportunities that are there for them to choose from, but I think that includes them, too.

**Q** It would be helpful if, following your conclusion of your evidence, you could arrange to have the reference to the Wailling paper and some kind of reference to or link to the two programmes that you've just mentioned, one in HIS and the one in the NHS in Scotland just sent in----

**A** Sure.

**Q** -- so that, as necessary, the Inquiry can have a look.

**A** If I may also, to assist the Inquiry, I did notice in preparing evidence that the Association-- well, it's an organisation called the Association of Victims of Medical Accidents-- is the name of the charity, and they have recently developed what they call the Harmed Patient Pathway, which they're

actually consulting on until the start of December this year.

That wasn't published when I submitted my written statement, but in reviewing it, which I needed to do as part of my day-to-day job, I was struck, really, by the resonance of some of my own reflections and, again, I think it might be a useful addition to what you mentioned, and if so, I can pass you a copy.

**Q** That would be very helpful, thank you. I have no further questions, my Lord.

**THE CHAIR:** Professor White, as you may be familiar from watching previous witnesses, it's my practice to take 10 minutes to find out if there's any additional questions that should be asked, so if I could ask you to retire to the witness room for, perhaps ten minutes or so. Thank you.

**(Short break)**

**THE CHAIR:** Mr Connal?

**MR CONNAL:** I have possibly three short questions, my Lord.

**THE CHAIR:** (To the witness) I understand perhaps a question or two more.

**A** Okay.

**THE CHAIR:** Mr Connal?

**MR CONNAL:** Thank you for returning, Professor. No particular connection between these questions, just individual ones. The first question is, at the point when you were engaging with GGC and – I think at one point you said – you had a suspicion you were being drip-fed or you weren't being given the whole story and so on, did you escalate your concern about that to anyone else in Scottish Government? Because they had put you in to do the job.

**A** It would have been-- So perhaps two points in response to your question: by drip-fed, I guess I was meaning that through the various iterations that were happening, as the iterations were progressing, more information that hitherto in that process hadn't been provided was then appearing.

And, secondly, I would expect I had to give regular briefings, as did everyone who was involved in the Chief Nursing Officer's Directorate. I would contribute what progress was. I think we may have been giving daily briefings to the cabinet secretary at that point, so I would have sought to provide a factual update along the lines of, "I've identified a further series of clarifying questions and received a response" or "not received a response" or "we're now in version X." So that would have been the nature of briefing.

**Q** I'm told that there was some

evidence from Sandra Bustillo, generally along the lines that she'd had some feedback that patients didn't really want to hear from the organisation. Does that match with your experience?

**A** No. Any families that I was in touch with, it wasn't that they didn't want to hear from the organization. There's clearly a variation, a range of views, but they very much did want to hear, but perhaps from different people in the organisation or at different levels in the organisation, but they did very much want to hear.

**Q** The only other question I have is, throughout this exercise, there were obviously some communications coming from areas in Scottish Government, as well as simply from, say, GGC and so on. Was it any part of your role to look at Scottish Government communications to see if they were matching up to what you would expect?

**A** That would form part of my role. I mentioned earlier about being copied in, for example, in a range of communications, although I don't recall specific examples, probably because it's such a frequent occurrence.

But, yes, I would have anticipated that if a policy team were submitting a proposal to Scottish Government Communications as part of the process of it being reviewed by them, being



reviewed by special advisors and then passed to ministers for clearance, I would have been copied into relevant proposals for Scottish Government Communications, and would likely and often do comment on when I would support or not support what it's being proposed that the government communications' response is.

**Q** Thank you. I have nothing further, my Lord.

**THE CHAIR:** Can I just clarify that last answer?

**A** Mm-hmm.

**THE CHAIR:** As I understood the question, was it part of your role to consider Scottish Government communications? When I heard the question, I wondered if it was communications that have been made prior to your appointment, but in considering your answer, I could see that it might go further than that. Did I pick up correctly that it would be part of what you would do, just as part of your approach, to comment on any proposals that came to your attention?

**A** If, by proposals, you mean proposed responses to media enquiries----

**THE CHAIR:** That's not what I understood you to be talking about.

**A** Okay, that's what I understood Mr Connal to have asked, but apologies.

**THE CHAIR:** Well, I suspect the fault is entirely mine. Mr Connal, perhaps ask the question again so I can better understand the answer.

**MR CONNAL:** Yes, I think the question was probably framed more generally than that because, although there were clearly responses to the media, there may well have been responses to other parties involved in this overall exercise.

**A** Yes, I understand. Yes, okay.

**Q** But nevertheless, communications, which have, shall we say, a Scottish Government label, I had understood you to say that, quite often, if there was something to be communicated to someone, whether it was the media or otherwise, it would be copied in to a large range of people, including you.

**A** Yes, apologies.

**Q** Is that right?

**A** Yes, apologies, and thank you for clarifying. That is an important distinction. So your question is, would I have been involved in any of the processes around communication more widely?

**Q** Yes.

**A** Yes, so yes. Examples of that would be, as is the common business of government, ministerial correspondence is often drafted by officials. So if there was a letter to be drafted by the cabinet secretary in relation to the issues that we've been discussing, that might be drafted by policy officials and I might, as part of that process, be asked to for a comment or view, as would several others involved in the process.

Those communications might be to other elected officials, it may be to citizens affected-- or people affected by it, and then, finally, there would also be an involvement in statements to Parliament, responses to parliamentary questions. But I would be one of a number of senior officials who would give a view and it would then go into the relevant processes through the ministerial private office.

**Q** Thank you.

**THE CHAIR:** Thank you, Professor. That's the end of your evidence and you're now free to go, but before you do, thank you for your attendance today and answering Mr Connal's questions and my questions, and thank you for the preparation of the written statement, which obviously indicates a great deal of care. You've made an important contribution to the Inquiry and I'm grateful for that, so thank you, but you're now free to go.

**A** Thank you, Lord Brodie, and thank you to everyone today for showing me where to be at the right time and all the support. It made it a much easier experience, and I'm grateful. Thank you.

**(The witness withdrew)**

**THE CHAIR:** We begin tomorrow with Ms Haynes, is it?

**MR CONNAL:** Ms Haynes, yes.

**THE CHAIR:** And Professor Wallace thereafter.

**MR CONNAL:** Yes, that's right. I think I've indicated, or someone has indicated on my behalf, that, on reviewing the evidence, it struck me that Ms Haynes might not take the whole of the morning and, therefore, we might get to starting Professor Wallace slightly earlier than 2 p.m. at some point during tomorrow.

**THE CHAIR:** Right, very well. Well, we'll see each other tomorrow morning, but until then, have a very good afternoon.

**(Session ends)**

**15:19**