SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
19 August 2024

Day 28
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Sandra Devine

CONTENTS

10:02

THE CHAIR: Good morning. Now, Mr Connal.

MR CONNAL: We have one witness today, my Lord, Sandra Devine, sometimes referred to in emails as McNamee----

THE CHAIR: Right.

MR CONNAL: -- in the early days.

THE CHAIR: Good morning, Ms Devine. As you understand, you're about to be asked questions by Mr Connal sitting opposite you, but, first, I understand you're willing to affirm. Sitting where you are, would you repeat these words after me?

Ms Sandra Devine

Affirmed

THE CHAIR: Thank you. Now, your evidence is scheduled for both this morning and this afternoon. We will take a break at about half past eleven, for coffee, but if, for whatever reason, you wish to take a break at some other time, just give me an indication of that and we'll take a break. Something I say to most witnesses, partly because my hearing is not absolutely great, is that I need to hear you and the room needs to hear you. So could I encourage you-- it's not necessarily straightforward, but could I encourage you to speak maybe a little louder than you would in normal conversation, maybe a little slower than you might speak in a normal conversation, because I and others in the room are keen to hear what you have to say and note what you have to say. The microphones should help, but I would much appreciate that if you were able to do that. Now, Mr Connal.

Questioned by Mr Connal

Q Thank you, my Lord. Ms Devine, you've provided a statement to the Inquiry following a questionnaire and answers to that. Are you content to adopt your statement as evidence at this Inquiry?

A I am.

Q Thank you.

UNKNOWN SPEAKER: (Inaudible). The screens are not engaged.

THE CHAIR: Ah, Once again, Ms Laurie, thank you for the contribution. I didn't hear it, but others will have done so.

MR CONNAL: The screens are not visible.

THE CHAIR: Right, is it-- is the screen now-- the screen is now visible.

MR CONNAL: At least that one

is, yes.

THE CHAIR: Right.

MR CONNAL: That's fine.

THE CHAIR: Okay. We're not immune from technical problems. Mr Connal.

MR CONNAL: Thank you. Your background, as you fully set out in your statement, is originally as a nurse, from which you've progressed into various posts and, in 2009, you became the Associate Nurse Director for Infection Prevention and Control. And then, in 2019, on an interim basis, the Infection Control Manager. Is that correct?

A That is correct, yes.

Q And you're currently in the position of Director of Infection Prevention and Control for the Board.

A That's correct, yes.

Q Now, you very helpfully set out in your statement quite a lot of information about structures and governance and so on. Now, I'm not necessarily going to ask you orally to go through all of that because it becomes a little tricky, I think, to take orally, but before we go to your witness statement, which I'm going to use essentially as a guide to take us through today's evidence, and I'll be referring to passages as we go, I wonder if I could just take one or two general things from you.

At various points in your evidence, you're very careful to point out the restrictions on your ability to offer comment on various matters. For instance, you say, "Well, I'm not a microbiologist."

A Correct.

Q **"**I'm not qualified to comment on ventilation systems."

A Correct.

Q You didn't have particular knowledge of water microbiology.

A Correct.

Q And you use these to restrict your comments in answer to questions that you're asked. I suppose I just wanted to ask you a general question before we go into the detail. That being so, why is it that we find at various points of the-- let me just call it a "saga" for the moment, that you seem to be challenging people who do have these qualifications, who are microbiologists, in fact, consultant microbiologists who are familiar with ventilation in a built environment and who do have knowledge of water microbiology, why do you find yourself, as it were, challenging the views that they are expressing?

A I mean, I don't really consider asking questions and trying to clarify for my own learning and

knowledge a challenge. I mean, I work with Infection Control doctors and nurses, as you know, at the moment, and it's always been a collaborative process where we learn from each other. So I know others may have pitched that as a challenge, but I think in order-- and sometimes I will ask, essentially, the daft lassie question in order to clarify maybe a point for a room or-- and also for my own knowledge.

So I think I'd probably say that it is my role to be enquiring, and I-- you know, I learn from the microbiologists, and I hope that they take some learning from the Infection Control nursing service as well. So I know it may seem like that, but I have always had that relationship with microbiologists and Infection Control doctors, where I ask a question and-- you know, for my own clarity.

Q Yes. So, they sometimes may have been perceived as you challenging them.

A Yes. I don't-- I don't believe that's the case with the vast majority of my clinical colleagues.

Q Another general question, we'll come back to this a little later about how things are meant to work, but the phrase "nurse-led" crops up on occasion, and I'm just wondering whether you can help me on this point. If the Infection Control doctors don't think that things should be nurse-led, and you do think that it should be nurse-led and you encourage your team of nurses to follow that line, could that be behind a number of the areas where there appears, at least, to be conflict?

A I don't believe it's a nurse-led service. I don't know who first spoke about it being a nurse-led service. It has never been a nurse-led service. We are a team. I've always worked in a team. I've worked in many areas with microbiologists and Infection Control doctors, and it can't be nurse-led because the two things have to complement each other in order to take action. So I'm not clear where that came from but I have never considered it to be a nurse-led service.

It's nurse-- I-- No. It's mainly nurses. So my team is about 50-strong and probably about 35 to 40 of them are nurses, and we have a team of Infection Control doctors, but we also have clinical scientists and healthcare scientists, surveillance staff. So I have never considered it to be nurse-led, so I'm not sure where that has come from.

Q No. So, if an Infection Control doctor didn't think it was a

nurse-led service, that wouldn't be a criticism of them, because you would say, "No, it isn't"?

A I don't believe it is, no.

Q The other point of a general nature – I'm trying to pick up one or two points that recur – is that at various points when issues or suggestions as to, "What do we do now", or whatever it is are being discussed, you say things like, "Well, the clinicians were concerned." And then, you say you would never ignore the concerns of clinicians, so, in many cases, you say, "So we didn't do whatever it was, because they were concerned".

At some points of this exercise, there sometimes seems at least to be a situation where the Infection Control doctors feel they have the support of the clinicians, yet are being challenged by people like yourself. Now, that doesn't kind of square with the idea of supporting the concerns of clinicians, does it?

A I think I always support the concerns of clinicians. I suppose for context, because I believe I can understand where you're going, there is an Infection Control service, but-- So, just for context, so we take across into our systems about 40,000 referrals a year, right? So 40,000 patients are referred into our systems, and these patients are assessed and advice is given to clinical teams in order to try and look after these patients.

I have a responsibility to make sure that all patients across Glasgow and Clyde, with 6,000 beds, have the same access to the Infection Control team and Infection Control services and, you know, there are times when I would like to do everything for every patient, but that is not possible to do. I mean, we work with the resources that we have and we are a very well-resourced team in terms of comparators across the UK, but there are times when it would be nice to do something, and I would absolutely do everything I can in order to make that happen, but sometimes everything we do in healthcare has an alternate effect, right? So if you do one thing, you're not doing another and so it's my responsibility to make sure that that's evened-out across the patch.

So, sometimes I would-- I would love to do line surveillance everywhere, but it's intensely resource-- well, it's resource-intensive and you do where you think the greatest impact is going to have for your services. So I understand that there might have been asks of the

Infection Control team that we haven't been able to fulfil properly or as much as we would like, but that is-- that's a judgment that we're making all the time in terms of where we put our-- where we put our service.

Q Thank you. I think I will now have a look at the witness statement, so we can work our way through. You'll find that not every question you've been asked is in strict chronological order, so we'll just need to cope with that as we go.

If we go to 396, and you'll find that there's electronic numbers at the head of the page which will come up on the screen in front of you. I'm not sure whether you're working from a paper copy or an electronic copy. I'm on 396 in paragraph 11, near the foot of that page.

I just wanted to ask you very briefly about that.

What you're describing there, as I understand it, is what's called the senior management team. Now, that's you, the Infection Control manager when you weren't the Infection Control manager, and then the lead Infection Control doctor. Is that right?

A Correct, yes.

Q And they're described as a senior management team. Does that mean they're responsible for managing the process of Infection Control?

A Well, as I say, it's my responsibility to make sure there's an Infection Control service across the board. It's also my responsibility at the moment to direct and directly manage that service. So, in this context, at this time, I would have been the lead for the nursing and the surveillance service, so I would have managed all of the nurses, surveillance service, and everything they were doing at the time. The lead---

Q Is this not a team that's supposed to manage between them the whole thing?

A But we do. So, at that point, I would do the nursing part of it. I think it would have been Professor Williams in the first instance and then Dr Inkster. They would have managed the function of the ICDs, and Tom would have been the Infection Control manager. So he would have had oversight of the entire service.

Q Mr Walsh is the one that wasn't an Infection Control practitioner.

A Correct.

Q But do you not manage it together? Do you just manage your own little bit? Is that how you're saying it works?

A No, no, we come together and-- we come together to

manage the service in its entirety. I mean, it's a service where the nurses will do a lot of the kind of frontline liaison with clinical staff, but, for example, if there is an incident or an outbreak, obviously the Infection Control doctor, perhaps at the site, or the lead and I would come together and any actions that were taken would either be part of the doctor's role or part of the nurse's role. So it was a collaboration.

So, we did-- So, Tom was manager of the service, but, I mean, we did things together. I mean, we didn't do it in silos apart, and we had an SMT meeting where we all met together. We do that now every week and we bring to the table shared learning and issues that we're trying to resolve, and we come together and try and take a collaborative approach to any issues that are being raised.

Q I want to ask you about a couple of other organisations just very briefly, to see if you can assist us at all. If you go to electronic page 402, paragraph 22, of your witness statement, there's a reference at the top of the page to the AICC, the Acute Infection Control Committee, and we know there's also a BICC, a Board Infection Control Committee.

A Yes.

Q Now, we've had a lot of evidence from a lot of people since this Inquiry started, and the fault may be mine, but, at the moment, I can't think of any example of either the AICC or the BICC actually doing anything. You hear of them having reports or having meetings or noting events, but all of the actions seem to be taken elsewhere. Can you help us about that? Is that not something they do?

A Well, they have oversight. So, every year, I prepared an Infection Control programme and a work plan. So the programme and the work plan are based on our responsibilities in relation to standards and policies that come from the government.

So, in that work plan it will say what the issue is, who is the lead for that issue, and what we plan to do about it. So these-- although there are reports that go to AICC and BICC, these detail the work that is being done across the piece. So the work plan is there and is visible and and we're asked to tell when the work plan is slipping or when we've achieved things, so they're complete. So there are pieces of documentation that go to AICC and BICC, describing the work that the teams do. We also-- I mean, it is quite a big agenda, because there

is a lot----

Q I can understand-- Sorry to interrupt. I can understand you make a number of reports to them and you put material to them. Can you tell us any example-- You lived through the "issues" – and I'm just using as a neutral term – at the new hospitals from 2015 right through the progress of matters 2019, 2020 and so on. Can you give us any example of the AICC or the BICC actually instructing or ordering or intervening in any of the events that happened?

A I mean, I don't think that's the function of AICC. I think the function is oversight and for us to give assurance that we're doing things. So, if there is an incident or an outbreak, we complete the hot debrief tool, and, within that, there's lessons learned and we-- AICC has clinicians from each of the sectors on it. So we're trying to share learning around those lessons, and it's entirely possible that someone might say, "Well, that happened at the Royal and we've done that," and we share lessons across the piece.

So it is a forum where there is a lot of papers and the intention is that people look at papers, "What are you doing about this?" and ask questions about it. So although you might think that the group doesn't do anything, I think the governance groups are about oversight and us giving assurance that we're taking things forward.

Q Can I ask you about another governance group which appears on the same page of the witness statement, in paragraph 24, the Clinical and Care Governance Committee? Because to an outsider, having explained what the AICC and the BICC are, here's another committee which seems to be not dissimilarly named. How does the one committee relate to the other?

A I mean, it's an escalation process. So, the Clinical and Care Governance Committee will consider clinical issues right across the board. So it could be how the pathology service is delivering a service, perhaps a new initiative. It will have a look at the-- It will review the output from the Acute Clinical Governance Group, which will detail any issues that might be within acute care that has been raised.

So the governance is almost a filter. So the governance systems within GGC is-- by the time it gets to Clinical and Care Governance, that will be looking at governance and care in its broadest sense, including partnership areas and primary care. So it's-- that group has a quite-- you

know, a large remit.

Q Thank you. Just a couple of things I want to pick up briefly in passing through your witness statement. Can we go to 405, to paragraph 33? Just so I'm getting this correctly, the point you're making there is that you've changed your standard operating procedure for outbreaks following the recommendations from the Oversight Board. Is that correct?

A That is correct, yes.

Q If we then go on to page 406, in paragraph 36, where you note that when you were first in the role of associate nurse director, Professor Williams was the lead doctor. This is why I asked you about how the SMT worked, because we've had quite a lot of evidence about very significant issues encountered by Infection Control doctors and those who were asked to become Infection Control doctors and were basically saying no, universally. You, I think, say in your witness statement that you sort of knew nothing about any of this-- any of these problems. How can that be if you're working as a team?

A You know, I understand-- I suppose "not aware" is not probably the right term. I mean, within professional groups, you will get a bit of competition and challenge. When I was associate nurse director, which I was up until 2019, my primary focus was in making sure that the nursing team were working well together, were working with the ICDs. I don't think I had a full awareness, perhaps, of the issues that were present, I think specifically within the South Sector.

So, again, obviously, I'm covering the entire Board area. There was never anything that was brought to my attention from any of the microbiologist ICDs in the Clyde Sector or in the North Sector. So it did seem to be an issue with the South.

Now, when you put labs together-- So, when I first was an Infection Control nurse, there was a lab in the Royal, a lab in the Western, a lab in Stobhill. So when you're putting these labs together and you have these kind of quite big personalities and clinicians, you will get a degree where they may not agree, but I can honestly say it wasn't until I was asked to attend the meeting with Dave Stewart that I really had any sense that perhaps Professor Williams wasn't getting on as well as he would have liked to with the other Infection Control doctors.

I'd probably like to say as well, if I may, that the current team have been working together since 2019 and all work collaboratively together. We all

work well together, and there are no issues with that team-- with our team.

Q Can I just move on, then, from that point? Because we'll pick up the Dr Stewart meeting a little later on. First of all, just for identification, I just want to pick up one reference you made. I asked you a short time ago about the Clinical and Care Governance Committee, and you helpfully tried to assist us with an explanation of what things might come to it.

If we go to page 414 of your statement, in paragraph 63, we find that committee mentioned. Now, I'm not sure we need to dig that document out, but am I right in thinking that what's being referred to there is the action plan following concerns raised by microbiologists, and that ended up at that particular committee?

A I believe so, yes.

Q Thank you. Again, this is probably just in terms of picking up a few details. If we go to 419, I'd quite like you to help me with a phrase that you use in paragraph 81. We've been talking in this section of your evidence about standard operating procedures, and you note in paragraph 81 that:

> "The recommendation from the Oversight Board is to phase out all local guidance ... and refer to the manual."

And then you say you've been "gently migrating" towards it. Perhaps you could just help his Lordship with what you mean by "gently migrating".

A So, I was a nurse consultant for a while, and we used to come together as a nursing team and put together local policies and procedures. We were actually advised that they probably weren't policies, they weren't SOPs, so we changed it to SOPs over time, but we had a manual before there was a National Manual, and people were very proud of the work and the effort that went into producing that manual.

So, there was a subgroup of the BICC which specifically drew up these types of protocols and SOPs and, like I say, they were very proud and we thought they were more locally relevant.

I was very aware that we had a National Manual but, you know, people liked their local SOPs. So, when I say "gently", I was kind of persuading specifically some of the senior nurses to perhaps go towards the reference to a National Manual rather than of our local bits and pieces. So, that's why I meant "gently", sorry.

THE CHAIR: Can I just check

that I've got things right? There has been the National Infection Control Manual available since I think 2014.

A Yes.

Q And it was updated, I think, in 2022.

A It's updated all the time, yes.

Q Right, and you're contrasting that with local standard operating procedures?

A Correct.

Q And what we're talking about are things of a very practical nature, such as hand washing regimes and the like. Right, thank you.

A Yes. The National Manual is a great resource and it has literature reviews that back it up, but the sections are in slightly different places. So if I'm a nurse in a ward and I have a patient who comes in who has, perhaps, salmonella, you would have to go into different sections of the National Manual to have a look at SIPs, isolation procedures, incubation periods.

So what, basically, the Infection Control nurses in Glasgow and Clyde did was they put all of that information into a single SOP, so that you didn't have to kind of navigate your way through the National Manual and we felt that, especially out of hours, if you had everything that you needed within a couple of pages, it might be easier for frontline clinical teams to refer to it rather than using the National Manual.

Q Thank you.

MR CONNAL: I think it might be then appropriate just to pick up the same reference in page 422 of your witness statement at paragraph 89 where, again, you refer to the National Manual and SOPs and, in fact, we see the dates of the National Manual quoted in bold there. So that's an easy reference.

The one point I did want to ask you about this, just so we understand on the Inquiry what you're saying, is that further-- near the at the bottom of the page, you say:

> "Well, we define what a problem assessment group is, what is an IMT," and then you say, "It asks members of the IMT to consider that if there are risks that cannot be addressed in the IMT process, these should be considered for inclusion in the IPC or services risk registers."

Now, can you help us understand what kind of things might not be capable of being dealt with in the IMT, so we know what you're referring to here?

A Well, as an example, yes, we recently had an outbreak of MRSA in the burns unit in the Royal Infirmary and there was an IMT process, put controls in place, screen patients. There's a whole list of things we might do for that type of outbreak, but one of the recommendations in the hot debriefing from the IMT was that the ventilation system within the burns unit should possibly be reviewed and upgraded, just because these patients are not nursed in what you would imagine a specially ventilated area for a burns unit would be.

So, one of the things that we have asked them to do is to put that on the risk register and escalate it through governance, in order that that area might be able to be prioritized for an upgrade in ventilation system going forward. So, it would be fairly large things that an IMT isn't able to address.

Q Well, maybe my fault, let me try and unpick that answer if I can. I can understand that you have the outbreak, you take steps to deal with it.

A Yes.

Q One of the conclusions is, there's at least a question mark over the ventilation. Could it be better?

A Yes.

Q Should we do something about that? And I can understand that the recommendation needs to go somewhere else for that to be done – presumably Estates have to be involved and so on. Where does the risk register fit into that process?

A Well, so if I was a director of the Royal Infirmary-- What happens is the services have their own risk register, so you might find that the burns unit in itself will have its own risk register and, on that, we'd go with that ventilation recommendation and then it's scored. So they would do that as a service and say, "We think this is quite a high risk." So the scoring system would be-- you know, say, it was 20 as an example. All the risk registers for the service within that sector would be reviewed and any that scored high risk would go on to a sector risk register, and then it can go all the way up to the Board. So it's a process where services have risks, and then they're escalated so that they're within the context of maybe a sector risk register and then it goes all the way up to the Board risk register. So it's a way of identifying an issue and then trying to place it within the context of different risks.

Q So it's not simply a question of the people concerned with

the burns unit saying, “We need better ventilation,” and going to somebody and saying, “Give us it”?

A No, I mean, it’s a way of highlighting that this is something that we would like to do, but it gives the context of what might be possible. So the burns unit might like ventilation, or an upgrade to ventilation, but say the ITU didn’t have the right ventilation. So somebody would have to make the decision about what is the greater risk there, and then it would be prioritised in terms of actions and, absolutely, Estates would have to be involved in something like that.

Q Which might be a slightly frustrating process if you were the person who had made the recommendation that the IMT-- because you would think it was disappearing somewhere into a sort of process driven world.

A Yes, no, I mean, I understand that. It’s just trying to balance the relative risks. I mean, in health, risk is a dynamic process. So, the burns, unit that might be a risk today. They might have another large outbreak of MRSA where patients have been significantly affected and they might feel then that that risk is increased and, you know, that risk assessment will have changed.

So, everything in health is about balancing risks and also the consequences perhaps of things that you might do. So almost everything that we do has a consequence that we might not have thought of. So, I mean, if I give a patient-- or if a patient is – I’m trying to think of an example – prescribed an antibiotic, that will alter their natural flora. It might make them more susceptible to something else, or if your patient has-- that needs a proton pump inhibitor, which takes down your gastric acid, you need that because, say, you have heartburn but actually by doing that makes you more likely to have C. diff, for example.

So it’s almost like everything we do usually has some kind of counter to it. I’m sorry if that’s not clear, but I’m just trying to say there is things----

Q I’m just wondering, to stick to your example, what is the risk of the burns unit getting better ventilation being balanced against? You instance the example of, well, if ITU needed ventilation and there was no money, presumably, they would need to get it first but not immediately obvious what you’re balancing this risk against. The risk has been identified. Do you not just fix it?

A Yes. That would be wonderful, you know, I mean, it would,

but it's just not like that in the NHS. So it's scored in order to try and describe that level of risk and, I mean, I probably can't explain it much more than that. I mean, I have risks in my risk register that we score and then the highest risks go forward for consideration with other services risks, and then another group of senior staff will have a look at that and then-- I mean, it's just the way-- it's just how it operates in practice.

Q The net result of that process, if I'm picking it up correctly, is that risks that have been identified, perhaps by clinicians, are not actually actioned because they don't score high enough in comparison to other people's risks.

A I mean, I don't agree with that.

Q No?

A I mean, everything-- we're actioning things all of the time. We're upgrading ventilation all of the time. There might be a new service that comes in, like a surgical service, maybe some kind of innovation, like-- I don't know, maybe, you know, we might get a government-- in fact, I think there was a letter come in just the other day about vaccines and RSV vaccines for elderly patients. So that might come in and that will require resource and not doing that will have a risk.

So, it's dynamic and it's complicated, I understand, but health is a complicated system and there has to be some way of everybody's voice being heard in terms of risk, in order for decisions to be made about how they're going to address those risks and what risks might be more than others.

Q Yes, so if I just take the very end of your answer there, some risks might be more "highly scored" than others, or whatever the right phrase is?

A Absolutely, yes.

Q And, therefore, they will get priority. Is that right?

A Yes.

Q And the others will not, at that stage?

A Yes, so what happens is, you're reviewing your risks all of the time. So I do it every quarter and things might change and the risk might-- the score might go higher or you might have a risk that's been addressed, in which case the risks that are underneath that might become more prominent. So it is-- I'm really sorry I'm not a risk manager. I couldn't completely describe the entire process to you, but that is the process that we

work within in the NHS and I think you'll find that in every board.

Q Thank you. Let me ask you an entirely different question. You referred to Dr Teresa Inkster at various points in your statement and certainly in the earlier parts of your statement, you're really quite positive about her. You say you respected her, you say you had no problems with her becoming LICD, and so on and so forth. Is that correct?

A Absolutely.

Q And you felt you worked quite well with her.

A Yes, I worked with Teresa in the Western when she was a-- I was the lead nurse for West Glasgow hospitals and Teresa was-- I think she was a senior registrar in West Glasgow at that time as well. So I had worked with Teresa on and off for quite a long time.

Q We'll come back to that, no doubt, later. Just for completeness, on page 428, paragraph 108 of your witness statement, we see there, you say you were aware that Dr Inkster had been off in a period of sick leave. She was unhappy about certain conversations and she resigned and then, I think, we may have heard that she was persuaded to come back. So that would be something that would be bothering you, presumably, if your much respected colleague was unhappy enough to step down. Is that right?

A Absolutely, yes.

Q Now, in the next section of your witness statement, you're dealing with issues such as reporting structures and I just wanted to make sure I'm not misunderstanding one of your points. In paragraph 109, you explain circumstances under which you and Mr Walsh, or you and Mr Walsh and Dr Inkster, or Mr Walsh and Dr Inkster would go off and see Dr Armstrong.

A Yes.

Q I'm paraphrasing what you've said. Then you appear to be making some kind of criticism in paragraph 110, where you say, "I think Dr Inkster thought that because we went together, she had a direct line to Dr Armstrong." Is that a criticism of her you're making there?

A No, that's just my understanding.

Q Because if you go onto the next page, on 429, you say in paragraph 113:

> "I found when working with Dr Inkster she would often quite informally go to Jennifer directly

as would I ... It could be any of us and we normally did this collaboratively. I considered it an effective way of working."

So there'd be no criticism of Dr Inkster for going to Dr Armstrong, would there?

A No, none.

Q At least not from you?

A No.

Q Thank you.

A We had different skillsets. So I could probably do an update in something like an MRSA outbreak, but, absolutely, if it was something like, you know, the water incident, it's better-- Teresa would have had much more of an analysis of what was going on and what actions was taken. So it was almost like a process-- like, if it was more kind of nursing-type actions, I would probably do the update, or sometimes I would just speak to Teresa or she would speak to me and we would collaboratively do a briefing for Jennifer. It wasn't a, "I'll do that, and you do that," kind of thing. It was a process where we worked together in order to get the right information to Dr Armstrong, should it be needed.

I mean, it wasn't a demarcation of anything. It was simply a-- I would meet Teresa and say, you know, "Dr Armstrong's looking for a briefing on that. Do you want me to draft it up and I'll send it to you?" So it kind of worked in a kind of harmony like that.

Q Now, in your witness statement at 432, at paragraph 124 onwards, we're touching on this thing called "triggers", which are part of the process of triggering either a PAG or an IMT. Is that correct?

A Yes, that's correct.

Q Did you have differences from Teresa Inkster on what the triggers should be?

A Right. So, the triggers were put in place by Dr Inkster, and that's just a thing that happened. I mean, that-- I didn't have any problems with the triggers we had, these environmental organisms that had been added into the manual and, really, there wasn't any guidance in how we would carry out surveillance round about these particular organisms. So, to a certain extent, we were in the dark.

Now, normally, in some of the areas where they were bigger, we would have used the SPC charts in order just to monitor trends over time, but, actually, looking at retrospective data with SPCs can be quite difficult. You're better to do these in real time, but it takes two years-- over two years

before you can get all that information in. So----

Q Can I just ask you to pause just for a second, so that his Lordship gets what an SPC is, please?

A Sorry, a statistical process control chart.

Q And just tell us what that is, and then I'll take you back to where you were.

A So, it's literally a graph. It's only numerical, so it's only numbers that are counted, and it gives you a trend over time. So as long as the trend is within the control limits, it looks like natural variation. So, you might get three cases of C. diff one month and two the next, and that would be natural variation. The SPCs are set up so that if you breach the upper control limit, it tells you that something unusual is going on. It doesn't tell you what it is, it just says-- it's a trigger for action. It says, "Go and have a look at this. Something has changed. Your numbers are higher than you might expect." So, we used these types of charts for C. diff and MRSA over many years. So that's----

THE CHAIR: Am I right in thinking you need a minimum number of data points in order to----

A Yes, (inaudible).

Q -- set up your graph?

A Yes.

Q And when you use the word "unusual," there's a certain circularity in that, because your graph defines what is unusual.

A Yes, uh-huh. It's usually three standard deviations from the mean. So, statistically, they'll say, if your numbers fall within a higher than expected level, then you should go and action. Sorry, I'm not an epidemiologist, but it's about a natural variation, so something that you wouldn't expect based on your historical data.

Q And of its nature, it's a way of looking at things which you expect will happen. Am I right about that?

A Yes, uh-huh. So, it will give you a background rate. I mean, you don't want any patient to get infections, but, unfortunately, patients do have infections, so it will give you, perhaps, what you might expect to be a normal background rate.

Q Not so useful in relation to events that you don't expect?

A No.

Q Right. Thank you.

MR CONNAL: Well, just so we deal with this question of triggers while we're there, could we look at bundle

27, volume 8, page 120, please? If we just look at the email in the middle of that page, this is an email from you to Tom Walsh about triggers, and it appears there that you're saying:

> "Teresa's opinion is that these are associated with water [these are the gram-negatives] so the IMT process is commenced as normal."

Are you disagreeing-- Is this part of you disagreeing with Teresa Inkser or not?

A No, absolutely not. I think I did see this email, it might just have been yesterday. It's not, it's just me simply reporting that the IMT process is starting, why it's starting. I think in particular with this one, it was-- if I read down that email properly, it was-- CNO had instructed that we had a different process. So, the only reason I would have emailed that and said that perhaps we should share it with Jennifer and Mags was that we were getting instruction from the Scottish Government to change a process back again.

So, no, I didn't disagree. I mean, Teresa was the lead ICD, she was running the IMT. If Teresa thought that two organisms in a two-day period was-- or a-- you know, whatever

period, was a concern, then, that, I wouldn't have disagreed with it.

Q Thank you. If we go back to your witness statement, if we go back to page 433, again, I'm using you as a means of making sure we understand certain things and one of them is something called the Point Prevalence Survey. Now, a couple of things about that. First of all, in principle, this is something done every four years.

A Correct, yes.

Q So, it no doubt provides useful information – this is logic – but it may be not very good at dealing with unusual things that happen in the meantime. Is that right?

A Absolutely, that's correct, yes.

Q Am I also right in thinking that what you say in paragraph 128 is that the focus of these surveys is traditionally on patient-to-patient infections? That's really what they're traditionally looking for?

A I think I say traditionally our focus is infections that have the potential to go patient-to-patient. So, the Point Prevalence Study, it really is a study that informs government policy, so-- but it would look at patients-- all of the patients in all of our wards, once every four years, but it

includes things like respiratory tract infections, urinary tract infections. What I'm saying is the focus of Infection Prevention and Control over years has traditionally been the types of infections that would go patient-to-patient, so things like Clostridium difficile – C. diff – salmonella, E. coli.

So, the Point Prevalence Study is the only time when we actually have a sense of the burden of healthcare associated infections. So, at any point in time, based on previous Point Prevalence Studies, about between 4 per cent and 5 per cent of all patients will have some kind of hospital-acquired infection. We don't know that as a team, because that kind of information is only done every four years because it's so resource intensive to do it. So, the focus traditionally of Infection Control teams is to prevent infections between patients of the same organism generally.

Q I think I'm right in saying that, so far as the period that this Inquiry is primarily concerned with, there was a Point Prevalence survey done in 2016, but then for other reasons it wasn't done in the next section, presumably, at least in part due to COVID. Is that right?

A That's correct, yes.

Q And all it identified is how many infections you've got, but not how. Is that right?

A Correct, yes.

Q Yes, because that's not what it's-- it can't do that----

A It's just a measurement. It is to drive policy. So I think the last Point Prevalence Study, there was a high-- if I remember correctly, I think the most common infection was catheter-associated urinary tract infection. So there was workstreams that came from the Scottish Government about how we can try and drive down the rate of catheter-associated urinary tract infection, for an example.

My understanding, if I remember correctly, is they collect quite a lot of information about antimicrobial prescribing, and, again, that's used to develop policy in terms of antimicrobial governance or stewardship.

Q Thank you. You've very properly told us another thing you're not is you're not an epidemiologist.

A That's correct.

Q Therefore, I restrict my questions to you on this point, but in your witness statement 435, in paragraph 135, and this is unfortunately where the witness statement is not all-- and it's our fault

as much as anybody's, it's not all in chronological order to events that we'll otherwise come to, but you describe there wanting some baseline data to see how you were performing for key indicators. Now, the key indicators that you mentioned there, that's, what, C. diff, and Staph aureus, and the other one is----

A E. coli bacteraemia.

Q E. coli, yes, and apologies if I'm using shorthand for the full name. So, not the infections that----

A No.

Q -- are the ones that we've been talking about on other areas, and that was all you could get. You could find out how the hospitals were performing, you were told, on these indicators.

A It was just to, I think, give a sense of whether or not the hospitals were outliers with any available indicators. So, in the absence of having anything specific, was there anything that would draw your eye to the hospital being some way out of kilter with the indicators that we had? So, I mean, that's why we asked for-- So, we get Board information, and, obviously, if you're on smaller boards, it might be more meaningful. So, we asked ARHAI if they could do the indicator-- the indicator specifically for QE and RHC, just to see if, for some reason, because we're getting Board data, perhaps they were outliers in any way.

Q And you understand that the hospitals used for comparison were older hospitals?

A Yes.

Q Then, on page 436, you're asked whether comparing the still, I suppose, brand new Queen Elizabeth Hospital with-- and excuse me, if I say Queen Elizabeth Hospital, I'm including the children's section, just to save us using the full title every time. You say, "Is it fair to compare a new hospital with an older hospital?" and your answer is, "Well, not in relation to C. diff, but the others are a bit more complicated." Is that right?

A That's correct, yes.

Q In the next paragraph, you say, "Well, shouldn't a new hospital be doing better?" and I think in part you agree with that, because you say, "Well, given how it's set up, particularly with the single rooms, we should be reducing infections from patient to patient." I think that's what you say in paragraph 138.

A Yes.

Q Can I just ask you this, then? That's dealing with the patient-

to-patient transmission, but if you have a hospital that's supposed to be state of the art, picking up all the lessons from the past, best design, etc., etc., should they not be producing better results across the board?

A I mean, the hospital is only one factor in terms of preventing infection. So, I think that I try and say-- So, the environment is important, but as long as you have to put lines into patients, so plastic into people's bloodstream, as long as you have to perform surgical procedures, it's not as binary as that kind of direct link.

You would, absolutely, in terms of person-to-person type infections, expect a single room accommodation to make a great impact in these types of infections, but in terms of things like E. coli bacteraemia, that's about how we manage patients' lines, for example. So that should be the same regardless of your environment. So it's not as-- it's not as connected as-- I'm trying to-- I'm not explaining that very well, but it's one factor in amongst probably a complex number of factors.

Q But at least the environment should be giving the teams working there the best possible chance of reducing the infections?

A Yes, absolutely.

Q You quite properly say it's unlikely you'll ever get them down to nil, but you should be trying to reduce them?

A No, I mean, absolutely. I mean, during COVID, I approached ARHAI for some data round about hospital-acquired COVID cases, and it was for the three big hospitals across the board, so the Royal, REH and QE, and, not unexpectedly, the QE did quite well in that analysis compared to some of our older facilities. So, in terms of things like respiratory infections, then, yes, you would expect that, and that's-- that's what was reported.

Q Thank you. Now, can we go on, and we probably only need to deal with this briefly, to 440, where we're coming back to the point that I've probably asked you in part already about culture, because you're, in effect, saying in paragraph 150 that you weren't aware of a lot of the issues until you met with, among others, Dr Stewart, and you said you hadn't seen any problem. I mean, were you and Mr Walsh contributors to the problems that the ICDs had?

A I don't believe so.

Q Because you say, at paragraph 151, on page 441, that you consider the Infection Control team have always interacted well with

Microbiology.

A That's correct.

Q Not exactly the picture that you paint later in your statement, is it?

A So, I have been working within Infection Control for, as I say in my statement-- for 30 years. I've worked with microbiologists in the Royal, in the Western, in Stobhill. I worked with microbiologists and Infection Control all over the Board now and have what I consider to be a really positive and collaborative relationship with all of the team, including the ICDs that currently work in the QE. There was certainly a point in time when that didn't work as well.

Q The reason I'm asking about it is that you say, on page 442, that you, and I think by that you mean you and the nurses, felt that your actions were being questioned and you weren't being supported, and that's in effect the complaint that the ICDs were making, that they felt they were being questioned and not supported. So, somewhere in there, your impression of collaborative working might not be correct.

A Again, for the vast majority of the time and the vast majority of people, I still say that we work well together. We work collaboratively together. There was a point in time when it didn't work so well, so, I mean, Dr Peters was appointed in 2014 and was, you know, a really good ICD, actually. I mean, really knowledgeable, very focused and hardworking, but the issues arose in that it was difficult to work in that kind of team dynamic there.

So, when Tom and I first came into post in, I think it was 2007/'08, the Board-- right across the teams across the Board had been in separate hospitals for a long time and had come together and had very different practices in how they managed their systems and processes. So, for example, I worked out of the Western, and we had-- we used an AP Info. It was a freely available database that, I think came from the CDC in the States, in order to manage our patient load and try and do some analysis of our data.

In the Vale of Leven, there was cards up against a wall with patient names and some notes. So, there were very different systems and processes across the piece. So we spent, I think, probably the first three, maybe five years ensuring that the systems and things were the same across the piece, so that no matter where you were on the Board, if you

were a patient, the same types of advice and support were given to you. So we spent a lot of time doing that, and that was a collaborative process.

Dr Peters was used, I think, to being a single-handed ICD in Ayrshire and Arran, so, you know, had quite fixed ideas about how she wanted things done and didn't really understand why, if she said something, it wasn't done. Now, there's no reason why it couldn't have been done, and there's no reason why whatever Dr Peters wanted done, it couldn't have been done quite quickly, but the way that we operated at that time was we came together as a team, and the team in its entirety might have taken something forward, so-- and that way-- that everybody-- and there was the governance round about that. So, you could do things quite quickly if you had to, but if it was a significant change in policy, we would write it up and we would-- not just Infection Control teams. So we would collaborate with people like ID physicians or occupational health physicians, or people who normally sit around AICC, Public Health consultants, to give a kind of team-wide, multidisciplinary perspective, and then we could change things or not, but, you know, that wasn't the case. Dr Peters just

would like things done her way, and it just--

I could have worked around it. It was absolutely fine. We often have people who have got very great ideas, fixed opinions, but we work in a collaborative way, so that everybody's doing the same thing. If you don't do that, then, quite quickly, people start to do very different things across the piece and then the patients don't get the same care.

Q There's obviously a range of views that have been offered on this and, obviously, it depends on your perspective because I think that the criticism that both Dr Peters and Dr Redding in fact make is that it was the nursing people who were not open to collaborating with them, whereas you're saying that it's the doctors that are not collaborating with the nurses?

A I mean, I don't like to think of it as a them and us because it's not. It's not something I recognised currently or before. It is just everybody comes together and we hopefully do the right thing going forward. I was fairly thoughtful about Dr Redding's statement, because I always felt as if it had gone really well with Penelope. We'd worked together on a piece of work after there was an outbreak of salmonella at the Victoria Infirmary,

and the government had put a piece of a guidance document together, called the Code of Practice, and we worked together quite strongly on that. So I was disappointed-- I was disappointed to hear that. I don't believe that's how we operated then, and certainly not now.

Q I think one of the criticisms that Dr Redding makes is that she felt some of the senior nurses were really just wanting to use the doctor as a kind of rubber stamp for something that they'd already worked out.

A Absolutely not.

Q No.

A I mean there would have been a time when some of the Infection Control doctors had what I would-- I think I've referred to as a light touch. So when I worked with Dr Edwards in Stobhill, he-- you know, he just sort of let me go on with the Infection Control stuff and I would tap his door if there was an issue, and we would approach solving that issue or incident or outbreak together. So-- I've lost my train of thought, sorry. So, I've always felt that it was a collaborative process.

Q Well, the-- one of the reasons that I asked you about this is that earlier in your evidence, which we touched on this nurse-led idea, and you explained your view on that, but in your witness statement, at paragraph 155, you've actually selected as relevant a criticism of Dr Peters for not accepting that the Infection Control is a nurse-led service, which appears in a whistleblowing report. So if you don't think that's right, why would you select it as a criticism of her? You can see that about half a dozen lines from the bottom.

A Yeah, I mean, I think I'm just quoting from the-- I think I'm quoting from-- I mean, that nurse-led service thing, I mean, I know I've said that to you, but it's just not how it operates. It really isn't a nurse-led service and I certainly never said that, but I think that was from the whistleblowing report that I had been sent. So I pulled that out to say, perhaps, that she doesn't accept it's a nurse-led service, but actually neither do I. I'm not sure where that came from. It certainly----

Q No. I just wondered why you'd picked it, because the report, we know from other material, was created after interviewing a number of people in various roles, but not either clinicians or microbiologists. It was really more the management side that were interviewed, and Dr Inkster from

Infection Control, so-- but you didn't particularly pick that as a criticism for Dr Peters. It's the bit before that about not listening to the views of others. Is that, in your view, a fair criticism?

A I'm sorry, I'm going to have to ask you if you could say that again.

Q Sorry. I'll reframe the question. In paragraph 155, under the part in bold, you say:

> "The points summarised which were relevant to IPCT were that she (Dr Peters) does not accept being part of team and listening to the views of others..."

Now, I think we know that Dr Peters wouldn't accept that that was a fair criticism, but do you think it's a fair criticism?

A I think I have put that in, and I wish I hadn't, because I know that that implies that I think it should be a nurse-led service, but I have just literally pulled that from that report. I can absolutely assure you that at no point in my career have I considered the Infection Control service to be a nurse-led service.

Q Very well. And you finished that section by making the point that you were happy to work with Dr Inkster. Can I ask you about a slightly different point? In paragraph 156 on page 443 of your statement, at the top of that page there, you say, "During meetings of the IMT no-one ever flagged to me that there was an issue with the quality of minutes." You see that?

A Yes.

Q Now, is that statement not in fact incorrect, because you're well aware of a number of occasions when people complained about the quality of the minutes?

A I don't recall that. I mean, the minutes were complicated, and they were being turned around really quickly, and there was a number of amendments to them, but, I mean, that is a process. You know, there's a minute taken, it's sent out, any comments are received, the minutes are updated. I don't recall a specific time when someone said to me, "You need to find someone else to take minutes because they're such a poor quality." I mean, it's a-- it's a fast-paced type of situation, but I honestly don't recall a time when someone said to me, really, "I have significant concerns about these minutes".

Q Could we look at bundle 1 page, page 343? It's the IMT minutes bundle. This is a set of minutes of a meeting you attended on

14 August 2019, which has been suggested as an example of this. Is that not a meeting at which there was a lot of discussion on the previous minutes of a meeting on 8 August?

A Yes, but that would be a-- that would be a normal process. As I was saying, these meetings were happening quite quickly.

Q Can we just then scroll through the rest of it to see if there's any other reference to it? And again, and there may be nothing at the end. Next page. The suggestion that's being made, I think, is that at that meeting, which you were present at, there was a lot of discussion about the minutes and, in fact, it got to the stage of Dr Inkster suggesting that it might be a good idea to record them so that we got an accurate reflection of what had been discussed.

A Yes.

Q You remember that?

A Yes.

Q Now, if somebody is accustomed to these groups coming together, having a meeting, you know, in the normal way, and then you're producing a minute, does it not suggest considerable concern about the accuracy of minutes if someone's saying, well, "We'll need to start recording them"?

A Or it could suggest that they're happening quite frequently and the pressure on the minute-taker in order to turn them around and amend them was significant, and perhaps they weren't-- you know, perhaps she felt they weren't as good as they could have been. So it was a highly-- it was a time of intense pressure and these minutes were being turned round really quickly, and they may not have been perfect, but, you know, that is how we do things now.

Q Well, we can leave the minutes for the moment. Thank you, and we'll go back to your witness statement at paragraph 158. You record there the role of the Infection Control doctor, and you're pointing out that you'd had experience of working with somebody with a light touch, and now you're finding that ICDs are getting involved in a lot more issues about the environment, ventilation and so on, and you're actually supportive of that notion. Is that right?

A That was the chain of thought that I lost before. There was a time when the ICDs would have had – sorry if that's a poor expression – light touch, but, laterally, the ICDs are much more interested in the service and it's actually starting to become almost like a subspecialty of microbiology, and all

our Infection Control doctors are really pushing the boundaries of how we actually practice Infection Prevention and Control and bring a wealth of different perspectives and experience.

I'm very grateful to be in the team that I'm in at the moment, because they are continually, let's say, pushing the boundaries of what we do and how we do it.

Q And it's not a criticism of an ICD if they're not light touch and if they do want to get involved?

A Absolutely not, no. I mean, they only bring benefits to patients having the ICDs, because at the moment, for example, our lead Infection Control doctor is trying to do a piece of work about an early warning system for neonatal units where she's trying to triangulate different types of data. So we have a lot of data ourselves, but we're not so good at bringing in other types of data like patient acuity, so how sick the patients are, or staffing levels and things like that. So she's working with our healthcare scientists in order to try and work out a system for that at the moment.

Our Infection Control doctor in the Royal is looking at the effects of chlorine systems and water, for example. So, all of that brings more intelligence into the service and, like I say, only benefits patients.

Q Can I just ask you about one other thing there? We know from other evidence that there were a lot of unhappy people on the ICD side. In fact, it was actually very difficult to get anybody to take the job on because of what they perceived, at least, as a bad culture impacting on them. Did this impact on nurses at all? Were nurses leaving because there was a bad culture?

A There was a natural turnover of nurses. Like I say, we have quite a big team. Nearly all of the nurses I can recall that I have worked with over the last 20 years have gone on to promoted posts. I think I've only had two Infection Control nurses that have actually gone back into wards because it wasn't for them, but all of the nurses that I have worked with and helped to train over the years, we have an natural turnaround, but that's expected.

I mean, one of the key priorities for me is develop Infection Control nurses – and doctors, now that my remit has expanded – so that they can go on to promoted posts or different types of posts.

Q Let me ask you about another incident that you record here,

starts in paragraph 159. There seems to have been a patient in the high dependency unit with-- Is that quite a serious thing, this virus that you mention there, the metapneumovirus?

A Cold.

Q Cold?

A Mm-hmm.

Q But whatever it was, Dr Peters thought that people should wear masks.

A Yes.

Q And is there anything wrong with her saying, "Why don't you wear masks?"

A Well, there was unintended consequences. I mean, sometimes more is not more. So, if you take that to conclusion, there are a lot of patients-- Wearing FFP3 masks can be quite difficult. I mean, I think if you see any of the information round about nurses in ITU having to wear FFP3 masks during COVID-- I know that the position is, surely more is better? It's not always better and it's not all-- I mean, we work on the evidence base in the National Manual, and that evidence is there for a reason, so----

Q But if, on a particular instance, an experienced Infection Control doctor says, "I think in this instance you should wear a mask", I mean, presumably she's not doing that just to annoy somebody. She's doing that because she's formed a view----

A Yes.

Q -- in the interests of the patient.

A And, as I said, we would take that back to the team and we would get the opinions of all the other Infection Control doctors about whether or not that was-- So, there are consequences with FFP3 masks as well in terms of communication with patients. So, a lot of people during COVID said that-- So, you can have errors in terms of information passing between patients and staff because of masks.

So, it's not that anything additional is-- just said, "No, we can't do that." It's about following the evidence and the evidence base and then trying to do the right thing and not-- and some of these things do have-- like, you know, there are sometimes knock-on effects for things.

Q I can understand all of that in terms of process, but if you followed that line of thought, the Infection Control doctor comes on the scene, forms an assessment, says, "I think, in this instance, now, you should wear a mask." If the answer from the nurse is, "No, because we have to go

through some process," the net result is the mask isn't worn. So, does that not then create the kind of issue that the Infection Control doctor has complained about, that they're being undermined by people not following what they asked them to do?

A I mean, I think "undermined" is-- I don't know that that's the right-- Most of the time, if an Infection Control doctor says to us, "We need to do X," then X is what is done. It's just sometimes, when it is something-- So, if we put FFP3 masks on in that high dependency unit, the staff within that unit might think that that's the right thing to do, but if you go into the high dependency unit in the Royal, the Infection Control doctor in there might not think that's a proportionate response. So they're doing something different, and then you start to get a drift in terms of what people are doing.

I know that sounds like I'm a control freak, but I'm afraid when it comes to the practice of IPC, I do like to revert back to the science and the evidence base, and I think quite a lot of my colleagues would say the same thing. So, we-- I mean, we do-- all of our practice is based on the evidence and the science, and obviously some of this is emerging and then we change things, but, I mean, that is just the way the system operates.

Q You want processes followed as opposed to the advice of the Infection Control doctor?

A Science. Oh no, just the science and just for the same thing to be done everywhere so that staff, if they're moving from intensive care to intensive care, know what's expected of them, what PPP to wear and why.

Q But the effect in a case like this would be that, at least from the perspective of the Infection Control doctor, they'd asked for something to be done and they were getting resistance to that.

A Absolutely, I understand that.

Q Yes. I think you probably pick up on a similar point in paragraph 161, where you were saying, "Well, there was an expectation that teams would prioritise anything that Dr Peters felt was important."

Well, you said she was a very good Infection Control doctor, very hardworking, concerned, presumably, for her patients, for the patients that came across her gaze, because obviously she's not the clinician. So, what's wrong with Dr Peters assessing something and saying, "Well, come on, we need to do X and we need to do it

now rather than after a long process"?

A And generally speaking, that's the response that she would get, was, "Yes, this is an issue. Let's see what we can do about it," but, again, balancing things. The local teams have a responsibility for, you know, a large number of patients across a diverse area. We are not limitless in terms of resource and we do prioritise, you know, what we are required to provide in terms of advice to clinical teams for all patients that come across as referrals onto the system.

So, that's the primary function, is to make sure that everybody who is coming across on to us as referrals is nursed appropriately with the right kind of advice and that the nursing and medical teams have the right information and support.

So sometimes, as I said before, I would like to do much more. I mean, I would like to do, you know, lots. I'd like to survey every single type of surgical infection, but that isn't possible. So it was just more about a balance of making sure that every patient had the access to the right amount of staffing resource, in order to meet our responsibilities.

Q I understand the perspective that you have laid out for us, but from the perspective of an Infection Control doctor keen to get something done, that might be perceived as people resisting from their end.

A So, the normal process would be that Dr Peters would say, "I'd really love to do," I don't know, "surgical site infection in," I'm trying to think of somewhere we don't do, "vascular surgery," at that point in time. So I would have a conversation with Dr Peters and probably other Infection Control doctors and nurses and say, you know, "Is there any chance that we can put this together and try and achieve this?" So, we'd make every effort to meet the needs of ICDs-- not meet the needs. If they think that's an issue or clinical teams think it an issue, we all work really hard in order to address whatever it is that's being requested of us. But, I mean, sometimes-- and if I had a conversation with an ICD and said, you know, "I think that's a great idea. We're doing this piece of work at the minute. As soon as that's finished, we'll go on and try and have a system and have a look and see what we can do in terms of support for that thing," that would be a process where you'd have a conversation and you'd come to some kind of plan in order to take that forward.

So it's a process whereby you have that conversation and it's a collaborative process. It was just much more difficult with Dr Peters in terms of having that conversation about perhaps other types of priorities and what was possible.

Q Do you accept that when Dr Peters asked for something to be done or suggested something should be done, she would be doing that because she felt that was appropriate for the patients?

A Absolutely. Mm-hmm, yes. Then, again, you're balancing that relative risk. If you do that, you're not doing something else. So that risk is dynamic and you do have to consider everything in the round. There is almost nothing that we can do that we don't have to-- that something else won't get done. So, it was about having that conversation about, "I understand that's a thing. Over here we've got another thing. Let me turn this off so that I can do that for you," but sometimes the risk is greater with the other thing.

Q Let me ask you something else, 445, paragraph 163. This is a specific point that's been raised and has been put to you. The suggestion is that you told the nurses in Infection Control not to discuss issues with doctors Inkster and Peters. Now, the way you reply to that is you don't say it specifically, but it might have been appropriate to direct them somewhere else. Is it possible that you did say to the nurses, "Don't refer things to doctors Inkster and Peters"?

A I just wouldn't-- It's just-- That wouldn't be my normal thing to do. I think that it's entirely possible that I would have said, "Dr Inkster and Peters aren't doing an Infection Control doctor-type roles anymore. If you do have issues in terms of, you're worried about something, there's a trigger, we need to do something a bit more, can you direct your comments to Infection Control doctors rather than microbiologists?" which is what they would have been at that point in time.

Q Although you would know at that time that both of them had very extensive knowledge and experience----

A Absolutely, yes.

Q -- that might have helped.

A Absolutely. I mean, a normal process would have been, generally speaking, that-- and this happened in the past, that, say, the Infection Control doctor wasn't available, you would know who you could go to in Microbiology and ask the

question. So that's always available.

So I used to work in the Royal and it was Dr Hood who was the Infection Control doctor, but if Dr Hood wasn't available, I would have gone to Professor Jones, for example, or other microbiologists within the system, and that would have been a normal process then.

It has drifted away a bit in recent years just because, as I said, Infection Control is becoming more of a subspecialty of microbiology. So it has changed over time, but I think it's entirely appropriate that the first point of contact for the ICNs would have been the ICDs, but that wouldn't have been to the exclusion of asking someone else for help should they have needed that. In fact, in some of the other boards you would have to do that because we are in the fortunate position where we have ICDs that are dotted across the sectors, so there is more scope for that. So if I'm in Ayrshire and Arran and there's one ICD, I have to go to microbiology and that's entirely appropriate.

Q Now, we see in 164, you're narrating there that Dr Peters demitted her sessions as ICD, was then appointed as lead consultant, microbiology. So, here was a very experienced person, you said a very good ICD, got a lot of knowledge about microbiology and the complaint then is that when she finds something she's concerned about, she sends information about it to you and you basically say, "Don't do this." Is she not obliged to do it if she sees something that's of concern because that's a professional obligation on you all?

A I mean-- So, if I think about microbiology in the North or the South-- the North or Clyde, they would normally speak to the Infection Control doctor for the service and say, "I have a concern about this and I'd like you to have a look at that." We had systems where we were pulling over all of the information from the lab all the time. So the nurses were getting all of the referrals that they were supposed to get, but Dr Peters wasn't an Infection Control doctor but continued to ask for updates on things that-- I mean, I wouldn't expect an ICD to go into the lab and say to Dr Peters, "I see you prescribed X antibiotic for that patient in that ward. Why did you do that?"

Q Why not, if that was something that concerned the ICD? If they had a concern about it, they'd go and ask.

A Because it's still-- That's your-- You're talking about

undermining. That's their professional judgment. You know, they have decided that that patient has been prescribed that antibiotic for their reasons. So it's not an inquiry for learning. It's an inquiry, "Why did you do that?"

And to be fair, Dr Peters, really, when she decided that she didn't want to be an ICD, there were things that were going on and processes that had changed and matured and she didn't have access to all of the information about perhaps what we were doing, but any other microbiologist wouldn't have asked for all of that information either. It was almost like-- it was almost like a parallel surveillance process and it did--

So, the way we felt as Infection Control nurses, that whatever we were doing, it was never good enough. So everybody in my team works hard all of the time and how that made everybody feel was like-- And the narrative that comes across is that we don't care about patients. I don't have a person in my team-- I don't know anybody that comes into work and doesn't have the patients as a priority in their practice. So, this continual question about what we were doing was difficult to deal with.

Q She not suggesting, is

she, that you don't care. She's saying there's something that concerns her and she'd like to know what's happening.

A No, but----

Q And she doesn't know what's happening unless you tell her.

A Yes. No, I mean, it is-- I'm just telling you how we felt. It was implied-- I mean, we were doing everything that we were supposed to do. We were doing more than that. We were doing-- You know, there's other things in terms of patient management. We have responsibility for education, for monitoring how standards and policies are implemented, talking to patients. So there's a huge big remit. It's like a specialty in its own and microbiology is in a specialty in its own and that, generally speaking, they work independently but collaboratively, but this wasn't that kind of system. This was Dr Peters continually challenging really what we were doing all of the time and I just-- it was just--

I know where you're coming from. Surely, all of it's to the good. It is, but I considered that what we were doing was good and that-- I honestly think although Dr Peters wasn't an ICD, she probably did still want to be an ICD.

Q I suppose that it might

come down to the point you make at the top of page 446, that people didn't feel they could ignore it----

A Absolutely not.

Q -- in case there was something that they didn't know about.

A Absolutely.

Q Now, is that not the same, if you look at it from the other end, from Dr Peters' end? She can't ignore it in case there's something you guys don't know about.

A No, absolutely. I mean, that's why I said we didn't ignore it. I mean, if you look at the-- I think it was the first whistleblowing report, it was clear after people had been interviewed that it was issues that perhaps weren't in Dr Peters' remit anymore, and she didn't have all the information, so she didn't really know what we were doing. I don't-- You know, it was-- I'm trying to think. It was just more that-- I'm trying to-- Really sorry, I can't think of a way to put that.

Everything that was coming across was what supposed to come across. We've worked off the manual and I know that that's been criticised as well and that we stuck too rigidly to policy. Everything in the manual we were having referred to us. There were unusual things that came across and we embraced those when they did come across and we had IMTs, or we developed policies in order to address the issues that were being raised, but it was just a continual ongoing challenge in everything that we were doing and, to be absolutely honest with you, that continues today.

THE CHAIR: Sorry, "to be absolutely honest"----

A That continues today.

MR CONNAL: My Lord, I'm conscious of time slipped slightly past the scheduled possible break.

THE CHAIR: Coffee break's approximate, Mr Connal. I don't think you have to hit half past, square on the button.

MR CONNAL: This is as good a point as any to pause.

THE CHAIR: So we'll take our coffee break now, Ms Devine, and could I ask you to be back at, let's say, five to twelve? Thank you.

THE WITNESS: Thank you.

(<u>Short break</u>)

THE CHAIR: Mr Connal.

MR CONNAL: Can I just take you back to something that we touched on briefly earlier about risk registers? One of the questions that some people have is, "Well, so what?

Let's put something on the risk register, tick. We've got it on the risk register." So if, for instance, water was on the risk register, who owns that risk? Whose responsibility is to ensure that something happens with it? Can you help us at all on that?

A I think water is a difficult one, to be honest. I mean, intuitively, you would say that the management of water should be in the risk register for Estates and Facilities, because, generally speaking, the risk is owned by people who have the ability to influence and action round about that risk.

So I would say that that's probably logically the place for it, but water affects every patient in every area, so you could also, I suppose, think that, in terms of-- you know, if I was the director of the North, that it might be my risk register as well, because it's impacting on my patient group. So it's not-- absolutely, it's not a perfect system, but, generally speaking, if I'm considering what we are putting on our risk register, it's usually something that I can have an influence in terms of an action to sort.

Q I suppose that the question someone might ask is-- you know, this is clearly a very well-intentioned system, it flags it up, it puts it on a record somewhere, but unless someone, in sense of a person, is then directly responsible for making sure something happens about it, it's simply a paper exercise. Would that be a fair comment?

A Well, no, I don't think that is, to be honest. So, for instance-- sorry, for example, our risk register, we present that at each of the governance-- our governance committees. So we will say, "We have updated the risk register. This is the scores, this is what we think is the risk," and in the risk register, it describes the risk, and you describe your current controls, and then you describe things that you might do to mitigate that risk, to make it lower. So that's over-- So there's an oversight of that at our committees and things like that.

Q But who actually does it? I mean, it's fine you're reporting on it and you're saying, "Here's a risk, here's something we can do."

A Yes.

Q Who is responsible for making sure that is done?

A Well, we probably are, in terms of our risk register. So if I've got a risk in my risk register, then it's my responsibility to make sure that there are actions in place and then also

mitigations in place. It's my responsibility with the team to score that risk, and then that risk register goes forward to the next layer of the organisation, and then they'll review it in amongst other risk registers, and then-- you know, that's----

Q And do what?

A And collate the ones that are the highest risk.

Q And then do what?

A And then the organisation will make decisions about where they're going to allocate resources.

Q Right.

A I mean, sometimes it's something that I can-- Sometimes it's a risk that occurs and I'm aware of it, and then I try and, within my own budget, allocate resources to try and fix that risk. It just depends-- it just depends where the risk lands eventually.

Q The reason I ask is----

A It's difficult in a bigger organisation, I would say.

Q Yes. We've had some evidence about something called the Board Water Safety Group, which we had described as, essentially, having to take collective responsibility for, oddly enough, water safety, but there wasn't a great deal of evidence of the Board Water Safety Group doing anything during any of the events that we've been considering in this Inquiry. So the suggestion perhaps was that this business of reporting to a committee who noted the report and so on wasn't actually generating any positive action. So, we're just, sort of, asking an open question about whether this is a working system or not.

A I believe that the system works. It's not perfect, and, I think, in the bigger boards, it's harder to see some of the local risk. So, for example, the ventilation in the burns unit, which I gave as an example, that would probably be a decision that would be made at a, kind of, Glasgow Royal level. It probably would never make its way up to the very top of the organisation. So, in that terms, I think it's not perfect system. I think it does work. I think in the bigger organisation, it's quite difficult in terms of filtering the right information to the right level, and I mean, that-- that does happen.

Q If you're the person that's reported whatever the point is, it must be quite frustrating while it works its way through processes, because that, to you, is the immediate issue because you're closest to it.

A Yes, I mean, I-- Mm-hmm.

Q I did want to ask you one question, which I think we've probably sort of touched on in a way already, which is this question of systems and processes, because you would say, "Well, you need to have systems and processes, and you should have them the same everywhere." The other argument is, if you stick to systems and processes, you're not flexible enough to cope with the unusual or the difficult or the challenging which crops up, or not fast enough. Is that a fair criticism?

A No.

Q Why not?

A Because we learn all of the time, we change things all of the time, we modify, we add on, we re-assess priorities and resources and take things forward. So, I think, although we work within systems and processes in order to make sure that the standard is the same across the board, we respond appropriately if new things occur, or-- You know, I mean, it's changed so much, even just in the last 10 years. Like I said to you, I've been in Infection Control for 30 years, but it's changed so much in the last 10 years, but really, all to the better.

I mean, every time-- It's unusual for us to make a change and to revisit it, but we do respond to what's coming, different things, emerging organisms, COVID, you know, nobody really expected that. So, I think that we are learning, changing, improving all of the time, and I think you'll find that most healthcare systems would say that.

I mean, you have to. It's so rapidly changing, even in terms of treatments for patients, and treatments, vulnerabilities, different services, you're having to respond to that all of the time and adjust whatever it is that you're doing. So, it's-- No, I don't accept that we're rigid and we don't move. I don't, sorry.

Q So, am I right in thinking then that, if something unusual crops up that suggests a step which is not in accordance with whatever the process is at the time, nevertheless you would just take that step if thought appropriate?

A We would go back to the team, collaborate, decide what we're doing and take the actions forward. That can be done quite quickly. I meet my own team every Friday. If it was something that somebody said to us, "We really need to do something about that now," then you communicate that through the system if it had any implications for the rest of the system,

but things can be done quickly. It's better to do them in a, kind of, measured and a considered way and make sure that you have the infrastructure to support that, but I don't accept that we had a rigidity that meant that we couldn't respond to anything.

Q Now, going back to your witness statement at 446, we see, in 167, we're coming back to this problem, and it was a problem that people didn't want to do the ICD role for reasons that they were complaining about their treatment, and people weren't prepared to step up and do it because they didn't want to do it either. I think I suggested to you earlier there was pretty much consensus that nobody, at that point, wanted to do the role because they were unhappy about how they were being treated.

One of the consequences was that Dr Peters suggested that they should have a generic mailbox. Now, clearly that had deficiencies, because it didn't give you a direct contact to an appointed ICD. Was it not just a well-intentioned attempt to help in a difficult situation?

A So, just to go back, the ICDs in the other sectors were reluctant to step in because I think they felt that they knew their own area and they knew their own team, and obviously, the ICDs in the North in Clyde knew about the issues in the South, and there was a professional-- maybe an anxiety about going into an area which they wouldn't normally cover, but also with the issues within the South cohort.

It might have been-- Absolutely, it was a solution, but it wasn't-- I didn't consider it to be a great solution to the situation at that time, because we didn't know, if we were emailing in, whether or not emails were being picked up. If we did have an incident or an outbreak, it might have been somebody different each day that would take that incident forward, and in terms of continuity of information and knowledge, that was quite difficult.

So, it was a solution-- I mean, it was-- In my head, I was hoping that Dr Inkster would have been back, so if it had been a long-term solution, then I think I would have had to flag it in terms, and it would have been to Tom and others, about the issues around about it.

Q I'm going to ask you some questions now about a microbiologist called Ms Harvey-Wood, and I suspect we're going to come back over similar ground again. She

was a microbiologist with, we've heard from her, a huge amount of experience in paediatrics.

A Yes.

Q I think, by the time she retired, she had about 40 years of it. We also heard evidence from her that she, at the request of and with the support of the clinicians, presented material to them about her views on unusual organisms and so on that she was seeing, but it appears that you weren't happy to get material from her from wearing your hat. Is that right? And you told her not to do it?

A I asked her respectfully if she could route some of these issues through the Infection Control doctors on the site. We were pulling across all the referrals into the ICNs. Dr Harvey-Wood did have lots of experience. I actually don't know her particularly well, but she would send lists of patients without any kind context in terms of-- you know, some intelligence around about what she thought this might mean or what the issues might be, and all I asked was that she had a discussion with the local Infection Control doctor, and then we would pick up anything that they felt was appropriate.

Q Should you not have been welcoming the assistance of somebody of that level of experience and knowledge?

A Quite often-- quite often it doubled the work for the nurses on the sites, because it would be things that we already knew about, we'd already looked at, we'd-- and then, by the time we'd come through with CHI numbers and things like that, they'd have to look all that back up again, make sure that the right actions had been taken. So, all I said was quite a lot of the things that she was flagging was already on our system, we can add to the system, and that's-- that's my position.

Q Again, as I think we've highlighted in relation to a number of issues, if you're Ms Harvey-Wood, that might have been perceived as being received with open arms by the clinicians, but Sandra Devine saying negative things all the time.

A I mean, I just-- I just don't agree with that position. We have really good relationships with clinical teams throughout Glasgow and Clyde. Quite often, they would come to us if they had any concerns as well. I mean----

Q Yes, but we're not talking about relationships with clinical teams, because the clinical teams had-- seemed to have a good relationship with Ms Harvey-Wood. It's the

relationship between Harvey-Wood and you.

A Yes, but we would have had the same type of relationship with clinical teams, so they could have flagged it to us directly.

Q All right. Let's move on. 448, please. This is starting to build to a question, which I'll need to come to you later, but, again, you're saying positive things in paragraph 173 about Dr Inkster, and I asked you earlier about her resignation, and that must have bothered you. But then, I mean, why did you think, if you had such a good working relationship, she didn't value your opinion? How did that come about?

A I don't-- So, during that time, I just-- I mean, Teresa was just different and in a good way, actually. Different is good. So, Professor Williams had a way of working and Teresa had a way of working, and it was an impression that I had at that point in time, but when Teresa came back and took up her appointment again she came to see me and just say-- I think we were just different, and I had a lot of experience, perhaps, you know, it just-- I don't know. I got a sense of that, but that doesn't stop you from working well and, I mean, I've worked with lots of people over times and all are different, and all have different ways of working, and I like to think that whatever happens, I can work with, you know, whoever it is. I can't remember why I had a sense of that, but I think at one point in time I did have that.

I mean, we worked through it. Teresa was our lead Infection Control doctor. I had the greatest respect for her, and, yes.

Q And it would appear from your witness statement that other ICDs also looked to Teresa Inkster in light of her experience and knowledge.

A Yes.

Q 450, you're asked about points being raised by Dr Redding, and is this another example of where the ICDs want things done, but you're saying they can't be done, just that simply?

A Yes, it is, sorry, yes.

Q Because I suppose that this is back to process, isn't it, that you're a great fan of processes? That would be fair to say, isn't it?

A Yes, it would.

Q And so, in 183, you say, well, Dr Redding sees a problem, she says, "Fix it", and the answer comes not, "Yes, we will", or, "Yes, we will, but not till next week". It's, "Well, no, we have to work through the following

processes". So, that would be perceived, at least, as people not being responsive to what an Infection Control doctor felt should be done.

A There were things that were going to take time. So, the Institute of Neurological Sciences is an old building. It was actually due to be replaced, but that's been put on hold, is my understanding. It is an old building, it has problems with the plumbing and the pipework. It still has issues that we work through all of the time. A lot of the buildings in Glasgow and Clyde are older buildings now.

So what you do, in a proportionate way, is you say, "This is a thing. What is the plan to fix that thing?" But that-- some things can't just be done immediately. I mean, they just-- they just can't be done immediately, but what you have to do is appreciate that teams within the Health Board are aware. They know there's an issue, and they're coming together in order to sort that issue, and that's my experience of some of these, kind of, bigger things that I okayed, that, you know, there was issues in the building and-- but that people were coming together in order to sort these issues. Because, I mean, the alternative was not to use the building. So from my-- from my point of view, all I see is teams working collaboratively with the best of intentions to make sure that patients are cared for in the right kind of environments, but some things cannot be done really quickly, and that's just unfortunately how that is.

Q There's not actually any assurance they'll ever be done, because it depends what the subsequent groups think of them, presumably.

A Well, the INS was due to be replaced.

Q Now, In the next paragraph, 184, you're touching on something that we've heard a little about elsewhere. There was an action plan following issues raised by microbiologists and heard a whole series of actions on it. Now, all I really want to ask you is, do you agree that the fact that there were 27 points of action arising from the raising of these issues suggested-- suggests that a number of things needed to be done?

A Yes, but lots of those were in chain, so they were being actioned. They might not have been completed. Some were not started, but a lot of the points in the action plan-- It's really-- It would have been really difficult for, like, Dr Redding and Peters to really know what everybody

was doing, everywhere. So they may not have been aware, like, that there was a plan for the Institute or that Jennifer Rodgers had been doing the CLABSI work in the thing. So it's impossible to share all the information about everything that's going on, all of the time, with everyone, and that's-- So I think there was-- there was things in the action plan that absolutely 100 per cent had to be addressed.

There were pockets of people, or bits-- quite a lot of it, I think, if I recall properly, that things had started to be done about it. It was just that they might not have had an awareness of all the things that were already being done.

Q Okay. Let me take you to an entirely different issue at paragraph 188, which is in 451. This is an issue that arose over the signing off of a HAI-SCRIBE for 4B.

A Yes.

Q And the-- Let's see if we can get some consensus on what the issue was. At the time that we're talking about here, Dr Inkster was off.

A Yes.

Q Dr Inkster's name nevertheless appeared on the documentation when it shouldn't have done.

A Absolutely, yes.

Q And the inference, at least, of it being there, if you're an outsider to the process, is that that infers that she's agreed it, when she hadn't.

A Yes.

Q And then an approach was made to another colleague, that we're not mentioning by name, to sign this off, who was doing an ICD role at the time, and that person felt that they didn't have the knowledge or experience to do something of that significance.

A Yes.

Q Do you agree with all of that? Now, we know that they went to Dr Peters, who was their line manager, for help in this situation, and that would be an appropriate thing to do. Correct?

A Yes.

Q So, all of the supposed problem was that that individual felt under pressure to sign off something that they didn't have the experience to do. Dr Peters hadn't been involved and therefore wasn't in a position just to sign it off. So there was nothing wrong with what either her or her colleague had done, was there?

A Well, her colleague had already signed off the SCRIBE.

Q I thought that they

declined to sign it off because they didn't have the experience----

A No.

Q -- and went to Dr Peters.

A No. It-- The-- My understanding is that-- and I'm pretty sure this is what happened. So it was a piece of work in order to bring 4B back into-- I think it was to do with the ceiling-- the ceiling tiles. So it was a piece of work, almost like a block piece of work to do. My understanding is that that person, with Lynn Pritchard, had reviewed the SCRIBE and had responded that, provided Lynn's comments were taken on board, that [redacted] was happy to sign that off, and I think that was probably a number of weeks before the contractors came on to site. And then when the contractors came on to site, Dr Peters wasn't happy about the controls in relation to that and she stopped the contractors working. Then, we-- then the person who had initially reviewed the SCRIBE thought that [redacted] wasn't any longer-- [redacted] was no longer happy to have done that, but my understanding was that that SCRIBE had been signed off.

Q I thought you agreed with me that the individual who had been asked to sign it off was not happy that they had the experience to do so, and had gone to Dr Peters for help.

A Yes, but that-- that was after.

Q Because the SCRIBE hadn't-- wasn't signed off until Professor Jones signed it off, according to your statement.

A I'm sorry if that's what I put in my statement, but my understanding is that the SCRIBE was signed off and then was rescinded, for want of a better word.

Q Oh. I mean, you say in your statement, "Dr Peters advised Dr Inkster was not happy to sign it off." Well, okay, she hadn't signed it off. Dr Peters wasn't happy to sign it off because she hadn't been involved and therefore didn't have the information, and you say here in paragraph 188, "Professor Jones eventually signed off the process with me."

A Yes.

Q So----

A So----

Q It must-- You must be wrong about that then, surely.

A No. So, what happened was Dr Inkster had been involved in the entire process about upgrading and the work in 4B. So there had been a long process that had gone on over-- I'm trying to remember how long, but it would be maybe the two years. So there was quite an involved

process where plans were made for 4B, and assessments were made about whether or not, like, a HEPA filter could be put in the corridor or it was just going in the rooms. So there was a massive-- there was an options appraisal.

So, the plan for 4B when Dr Inkster went off had been set. So Dr Inkster knew what the plan was in terms of the refurbishment and the works that were required in 4B. So I guess the implication that we took from that was that when the SCRIBE work came online, which is something that's much more closer to when the work would require to be done, that Dr Inkster would have signed off that SCRIBE, because she had been involved in the whole process up until that point.

So I think the implication was that she would have been happy to sign that off.

So when it wasn't signed off and we were getting some information back about why there was a problem with this particular SCRIBE, what had happened was that we were told, at that point in time, that Teresa wasn't happy or wouldn't have been happy to sign that SCRIBE off. But my understanding was that because she'd been involved in the process, I couldn't

really understand why that would be the case, but it was, I think-- I don't know what the conversation was, but I was told that that was Teresa's position. It wasn't that-- That was her decision.

Q In any event, she was-- she wasn't there to do it, was she? She wasn't there to sign it off.

A She wasn't there to do it, no.

Q So whatever you were told about her position, she wasn't physically present to sign off this-- this document.

A Yes, but I-- my understanding was that she was going to supervise this piece of work, and because she'd been involved, so she knew what the planning was, I couldn't think why there would be a reason that Teresa wouldn't have signed off the SCRIBE, and I'm sorry that her signature was on that, but I honestly believe that that was an error. Before I came, just a few days ago, I had a look at the number of projects that we've got in play at the moment, and we have sort of roughly between 60 and 70 projects. So there's 60 and 70 SCRIBEs being generated, you know, all of the time. It is-- it is a large process, but I honestly believe that that was-- it was a clerical error for-- I

don't think there was any intention for that to have been the work carried forward without Teresa being there, or we wouldn't have had to involve her colleague.

THE CHAIR: Just so that I'm following, this is work that was completed in 2017?

A No. It was planned work to upgrade 4B, which was the adult Bone Marrow Transplant Unit.

Q Right, so when was that work completed?

A I think the patients eventually went back in-- in '19. I could be wrong.

Q Right. So, it's the regime which is – I think if I've got my dates right– in force from 2014, which has four stages in respect of new construction, but this was refurbishment work?

A Yes.

Q So, in relation to this, as I understand it, three of these stages would be relevant: design, construction and completion. Am I right?

A Yes.

Q Now, presumably, you've been talking about Dr Inkster being involved at the design stage.

A Mm-hmm, yes.

Q Stage 2?

A Yes.

Q Just listening to you, if I'm following, Dr Peters was concerned about the provisions in relation to the construction stage. Am I right about that?

A Well, it was the control stage round about-- I don't want to say-- Yes, it is construction. I would have considered it more an upgrade rather than an actual-- You know, they were doing a lot of work in 4B in order to bring the air-- sorry, not ventilation, make sure the right air changes were in to make sure there was HEPA filtration in the unit. So it was other patients that were in that unit at that time.

So it was a-- I don't mean-- None of the work round about 4B was small, but this was a smallish piece of work in order to seal the tiles. I think it was in the en-suite room.

So, there were stages of it. So, the SCRIBE-- If you're doing any work in an area where you have patients, then you're required to assess the patient cohort and then put the correct controls in place in order to protect the patients who are already there. So this is a kind of SCRIBE that is done all of the time when we're doing what I consider to be smaller pieces of work. So that's----

Q And the colleague who

was asked to-- it's a problem with using terms like "sign off the SCRIBE"-- was being asked to confirm that the work had been completed.

A No.

Q No? Right.

A It was the controls in order to implement the work.

Q Right. So, what was in issue were the building-- the controls during the construction phase,

A Yes.

Q Thank you.

A It's just "construction" sounds like it's an empty area. Sorry.

Q Right, okay. Refurbishment stage. Right. Thank you.

MR CONNAL: At least in your witness statement, you tell us that it was Professor Jones that eventually signed this off----

A Correct.

Q -- with you. So whatever had been said previously, the arrangements for the controls had not been signed off by anyone up to that stage. Could we just move on? I suspect we don't need to go to it. I take it that when that individual and Dr Pepe Valyraki stood down as ICDs, you were told why that was happening?

A Yes.

Q At the time he was-- presumably would be party to at least seeing the emails.

A Yes.

Q Yes. So, that would be a stage at which you were certainly aware of some of the unhappiness on the part of ICDs.

A Absolutely, yes.

Q Now, I won't ask you about the generic mailbox again, because I think we've probably dealt with that. Let's move on to an entirely different topic in completely illogical order. If we go to 459 of your witness statement, we come to the opening of the hospital, and you, I think, had very little involvement in the sort of early planning. Is that right?

A Correct.

Q There were others who were involved. Can we just see bundle 27, volume 7, page 9, please? Let's check what this is. Yes, this is why I wanted to ask you about it, because you've narrated in your witness statement a discussion with Dr Redding about isolation rooms.

A Yes.

Q But this is a section of a minute in which:

"... Dr Armstrong asked if Infection Control were involved in

the commissioning group. Tom Walsh confirmed that Fiona McCluskey is liaising with Sandra on this..."

That would presumably be you.

A Yes.

Q

"...and Sandra advised she has nurses sitting on the groups that they have been asked to be involved in."

A Yes.

Q Which is a kind of reactive position rather than direct-- You know, you wait to be asked and then you get involved yourself.

A I think there is a confusion with the wording in this. It wasn't commissioning group, as such. The nurses, all throughout the process, had been involved in different subgroups in terms of the functioning of the hospital and what they might be used for. So, I think commissioning is not the correct term in this context.

Q The reason I'm asking you is that there's obviously-- an issue has arisen as to the extent to which Infection Control were involved in the early stages of the planning----

A Yes.

Q -- of the building. So, you say there were some nurses who were involved at different points on different topics. Is that right?

A Yes. So, obviously, we had Annette initially, Annette Rankin, and then Jackie Barmanroy. So, Jackie, at certain stages, would come back to us as a-- for the nurse group and ask questions about things that might have come up, and then we would collectively say, "Jackie, in our experience, perhaps you should do this or that," or whatever the issue was, but, throughout the process, when they started putting together groups of people to look at specific issues, then we would put the right nurse into that group.

So, I think I attended the intensive care group a couple of times. I know that Pamela was heavily involved in some of the groups round about the Royal Hospital for Children.

Q That's Pamela Joannidis?

A Sorry, yes. Beg your pardon. And the lead nurse, who would have been Claire Mitchell, would have been attending groups. I think I was in the group about domestic service provision, for example. So, there were lots and lots of clinical functioning groups set up, and whenever we were asked to get someone to attend that group, we

would put someone on it, and we shared that about quite a bit, in order that the Infection Control nurses would get some experience in this kind of process, because obviously none of us had been that involved in such a big project before.

Q I think Professor Williams told us that his memory is that most of the questions that he remembered coming back were about things like sinks and taps and stuff like that. Would that be fair?

A Sinks, taps, storage.

Q Sinks, taps, storage?

A Probably bed spacing-- I mean, there was hundreds of things. I mean, you could be asked about mops or you could be asked about, you know, a CT scanner. It was just-- It was lots and lots of different things.

Q Your involvement, you set out in your witness statement – we can leave that minute, thank you – at 460, you recall a discussion about negative pressure isolation rooms, paragraph 233, where you and Dr Redding thought there should be two on each floor, and that's what you fed in, but you never heard any more about it. It turned out that that wasn't what was done.

A Yes, we didn't-- We literally did not hear about that until the building was opened. So, I did go to a meeting with Dr Redding. I can't remember who else was there, but, in 2008, I think, there a global pandemic of influenza. So we had experienced that and the challenges around patients-- Even with COVID patients who required specific specialist care were nursed in hubs, and that's not the right place for them-- or cared for in hubs, because if you require the input from a gastroenterologist, you should really be in a gastroenterology ward.

So, when I went-- with the meeting with Penelope, we thought, in case something like that should happen again, that if we had negative pressure isolation rooms on each floor, then if you were a patient in gastroenterology but you were unfortunate enough to have influenza or, I suppose, COVID, then you could be nursed within gastroenterology but in the right type of room. So that seemed like a really-- you know, a good plan. I think I remember almost at the hospital opening that we were told that that wasn't the case.

Q Again, the reason I'm asking these questions is that an issue has been raised about how central Infection Control was to planning, and it sounds as if you've got lots of people doing little things but maybe not

anyone doing big stuff. Would that be fair?

A Yes. I mean, I think there was-- wasn't a lot of experience, like I say, of a build that size. I was involved with the Beatson. I was probably one of the few Infection Control nurses that had been involved in an actual building going up. I don't think there was anything-- I think the two ACHs had gone up, and Dr Redding had been involved in that with the nurses in the South, but I absolutely accept we had a lack of experience in terms of contributing to that process, but I would also say that, where we were asked to contribute, that I made sure that there was an Infection Control resource in order to do that.

Q This was mainly one of your nurse colleagues?

A Yes.

Q That was a resource you were allocating?

A Jackie Barmanroy would come back. Like I say, she attended the lead nurse meeting every sort of couple of weeks, maybe every month, and she would come with an update but, generally speaking, the nursing part of the planning is about things like sinks and, you know, all sorts of stuff, shower curtains. I mean, I'm just trying to think of something off the top of my head, but it was more about the actual physical, the ward-type layouts and environment, that type of thing.

Q Thank you. If we just move forward a little bit. So, this is the pre-planning stage. Now we're talking about the point after the building has been handed over, and you narrate on page 462 of your statement that Professor Williams had done a walk round and certain things were identified. Do you recollect going round with Teresa Inkster, perhaps in March 2015, who queried certain things?

A I don't, no.

Q It's suggested she may have made some comment about en-suites in ICU.

A I don't recall that.

Q Did you ever tell anybody during any of these early discussions that the building was going to be naturally ventilated?

A I don't recall that either.

Q While we're on 462, we're now starting to turn to the things that were discovered after people were in the building, 2A and 4B in particular. I wanted to ask you about the first paragraph you've put there, because I'm puzzled but it may simply be because I'm not understanding your

narrative here. You say:

> "I was aware that 4B was not as good as it would have been if it had been designed from scratch".

When were you aware of that?

A I think when the proposal was to move 4B-- or to move the adult bone marrow transplant into the building, because I was involved with John Hood with the Beatson, and even something-- I mean I-- As I said, ventilation and water is not something that the ICNs-- but I was aware when the Beatson was going up that John wanted the Bone Marrow Transplant Unit on the top floor, so that the plant work in order to do the ventilation was in the right place. You know?

So, if you put the Bone Marrow Transplant Unit on the top floor, then you were able to get the infrastructure in order to do so. Putting the Bone Marrow Transplant Unit from the Beatson into the new build was never going to be something that you would be able to think about and design from scratch and, you know-- So, it was never-- My understanding was, it was never going to be what you would have built if you'd had a blank piece of paper.

Q The reason I asked the question is that your insight on this seems to be perhaps better than or certainly different from others, because we know what happened with the Beatson, that people turned up, moved the patients in, then very early decided it just wasn't up to what they had been expecting and went away again. So your insight didn't seem to have been shared by certainly the clinicians who were bringing their cohort across.

A As I say, it might have been influenced by the fact that I knew about the meticulous planning that went into the Beatson with John, you know, and I'd had conversations.

When the Beatson went up, I did things like the ward type things and sinks and all that kind of thing as an ICN, but I had had conversations with John at that time. So I knew that-- and I knew that he had been in contact with colleagues in the USA about the design of the Bone Marrow Transplant Unit. So I was just aware that there was an awful lot of work had gone into the top floor of the Beatson and I couldn't think why you would be able to replicate that by putting it into a building that'd already been built, but that's possibly just my take on that.

Q Because it might be suggested that at least the objective was to try to replicate the collection of

protections that were available to patients in the Beatson BMT unit in the new building.

A Yes.

Q That was what people were hoping to do.

In terms of Ward 2A, you tell us that you first heard that there were issues with ventilation in 2015. Now, I have two questions for you about that. Can you help us at all as to how it comes to be that significant issues with ventilation were discovered as early as 2015 and go on to 2016 and, yet, we know that nothing significant was done of the nature that was ultimately done until way on 2018 and onwards? Can you help us why that didn't happen, or maybe you can't?

A It's difficult. At this time, I'm focussing on delivering the nursing service and, to be absolutely honest with you, the issues with ventilation was the remit and being progressed by Professor Williams. My understanding is that when he did his initial walk round with Clare Mitchell, that he did identify issues but that these issues were rectified quite quickly and that he did air sampling things after that because the kids' BMT wasn't the same as the adults'. That was always planned to be in there. So I don't think you could compare the two things. So, my impression was that the children's BMT was built and, yes, he had identified some issues, but these issues, to a certain extent, were more easily rectified than the adults'.

Q The reason I ask, obviously, is you're aware – and you've praised the new unit elsewhere in your statement – that very significant steps were taken to rejig the ventilation and various other things in the new-- in the 2A, presumably on the basis that these were thought to be necessary things to do and, yet, patients were in between 2015 and 2018 being nursed in that environment, well, before they were decanted to 6A.

A I mean-- Yes, I mean, the environment-- sorry, this is-- ventilation's not my area, the environment was what it was, and Craig had done some work in order to make it good. When Dr Inkster come into post, I think her clinical opinion-- and I'm sorry, hopefully I'm not putting words into her mouth, but I seem to recall that her clinical opinion is that she felt that the positive pressure isolation rooms were a better option for this group of children, and then what happened was that she communicated that to the service and that the service put together a business case to

convert four of the rooms that had been put in place to positive pressure isolation rooms, and I do remember there had been a progression of improvements into the area.

Q So, you were focussed on looking after the nursing service and you weren't particularly focussed on any impacts of the ventilation on the safety of patients?

A No, I'm always concerned about the safety of patients. I would think that's fair.

Q No, I'm saying you weren't focussing on that issue.

A Yes, but the ventilation was the remit of the Infection Control doctors and, you know, my awareness is that if anything had occurred and there was problems, that they would be the ones that would analyse that in terms of risk and would take forward any actions that needed, in order to fix them.

Q And I think you go on in your witness statement to explain that you were involved in the process of people eventually moving back into 4B after some work had been done on it and analysis had been done on the sort of pros and cons of where that had got to. Is that right?

A Yes.

Q But these were decisions

taken by others, not by you?

A Yes, I mean, the options appraisal thing, I remember that I think Dr Inkster had been initially asked to go into that group and she actually asked myself and Tom Walsh to accompany her, just to sort of go as a team and to try and present the views both of the nursing service and of the Infection Control doctor service in relation to the options for this group. So I did attend a meeting about the different options for BMT.

Q Okay. Let me ask you a completely random question, which you are asked in your witness statement, but it's one that crops up. We've heard a lot about the smell at certain times of year in the Queen Elizabeth Hospital.

A Yes.

Q And you say at page 466 of your witness statement that people were commenting on it. Were they right to comment on it? Was it as unpleasant as we've heard from some witnesses?

A I think it was unpleasant at different points. So maybe if it was warm. I'm not aware I've ever been on the site and thinking, "Oh, gosh that smells." I actually don't ever recall being on and really thinking that and I'm on that site quite a lot, but I think

that there would have been-- again, not an expert, but I think depending on what way the wind might be going or the temperature outside that there-- or perhaps if the unit-- the sewage works was busy, that there might have been peaks and troughs in terms of the odour.

Q At the top of page 467, you say that these issues don't cause infection. Is that a conclusion you're in a position to make?

A Well, based on my reading of-- I mean, although we're Infection Control nurses, we obviously do quite a bit of microbiology when we're completing our courses and, over the years, microbiology is part of our expertise in a context. So I'm happy to say that I'm aware that smells don't cause infection.

THE CHAIR: Well, smells might not cause infection, but smells might or might not indicate a situation which may cause infection.

A Totally, yes.

Q So, maybe just at risk of repetition, the question is-- I mean, we see in your statement that smells from these types of facilities in themselves do not cause infection. I mean, do you feel qualified to express a view as to whether the Shieldhall water treatment site is, is not, may, may not be a source of infection?

A I would say it isn't.

Q Sorry?

A I would say that it wouldn't be.

Q You would say from your expertise that it wouldn't?

A Expertise that it wouldn't.

Q Right, okay.

A You can get occasions when-- don't want to be too graphic. There are certain patients that you might know have an infection. For example, nurses would tell us that a patient had Clostridium difficile before the lab sample. So it's not as kind of black and white as that, but I don't believe that the Shieldhall was an infection risk as such, but I'm not saying that smells don't tell you something in a certain context.

Q Thank you.

A That's graphic.

MR CONNAL: Let me move on to a couple of things, hopefully reasonably quickly. On 468 of your witness statement, we come back to the question of triggers and, to some extent, we've already covered this. I'd just like for reference to ask you to look at the one email instance there, so in bundle 27, volume 4, 322, once it appears.

Now, I suppose my only question

here is, is this an example of a respectful exchange about this topic, triggers, where you're raising some questions about it and Teresa Inkster says, "Yes, let's discuss," and she says she doesn't think it's oversensitive, triggers, and you're going to discuss it. Again, is this the kind of thing you're talking about?

A Well, yes. I mean, the triggers were a trial-- I don't mean a trial. That was a recommendation and that happens to us quite a lot when we put something in place, and then we test it and then we kind of try and evaluate whether or not that this is working. So, every patient comes across on the systems and then the trigger is supposed to be an escalation where you do a bit more and then IMTs when you do a bit more again. So we really didn't have-- I think there was only one clinical review article that was available to Teresa that suggested triggers. So we tried them and we put them in place, but they seemed to be happening quite a lot, but then when Teresa-- We just left them as they were because we were trialing them to try and review them. So when Teresa came back, I said, "Can we have a wee discussion about these triggers?" and she came back and said, "Yes, let's have a look at them."

So I would say that is an example of a kind of respectful exchange between both of us. You know, we've put this in place. Is it working? Is it not working? Can we change it, modify it, learn? I'd suggest that's what this is.

Q Thank you. I'll just ask you one more question, perhaps before we break, and that's this, and it probably will help us move a little more quickly through some of your statement. You're asked a number of questions about IMTs and, in relation to quite a few of these, your answer is the same. In other words, you say-- well, you're asked, "What do you know about this?" and you say:

> "Well, the IMTs are discussed-- process of discussion. You'll see the outputs in the IMT minutes and I've really nothing to add to what's there."

Is that fair?

A I mean, that was fair and hopefully-- So, I was working on the statement over the summer and obviously there was quite a time pressure to get to, and I asked the team here if it would be okay if rather than go through each the IMTs, that I

referred the Inquiry to the contents of the minutes, just for the sake of trying to get the statement completed in time.

Q Well, I won't ask you any more about these IMTs because obviously we have the IMT minutes, and I think for practical purposes, My Lord, that might be an appropriate point to stop for lunch.

THE CHAIR: We'll take our lunch break now, Ms Devine, and could I ask you to be back for two o'clock?

THE WITNESS: Absolutely, thank you.

(Adjourned for a short time)

THE CHAIR: Good afternoon, Ms Devine. Mr Connal?

MR CONNAL: Thank you, my Lord. Can we go back to the witness statement, please, at 471? I'll try and do two bits of the statement in one by linking passages. This section on that page is about the-- what we've heard other witnesses call, the Horne taps and you say in the statement that you were aware of the outbreak in Northern Ireland because, I think, babies died, from what we were told.

A From what I can recall, yes.

Q One possible implication was that something called flow straighteners, in taps, had been implicated as part of the risk.

A Yes

Q Now, you say that you were aware of guidance by HPS, e.g. the requirement for a Board Water Safety Group and a water checklist. Were you aware that HPS had advised that taps with flow straighteners should not be used?

A I don't think I was aware at the time. I did see the SBAR after, but I think Dr Inkster shared it with me, actually.

Q The reason I'm asking is that this has become an area of some controversy in the Inquiry because, as you note a little further up the page, there's a record. There's no need to apply additional flow control facilities or remove flow straighteners because, in fact, the Horne tap had something like a flow straightener built into it rather than added to it and any residual perceived or potential risk would form part of the routine management process. Were you aware of that going on at the time?

A No.

Q Because one of the issues, I think, is that we've heard from other witnesses that the so-called routine management process involved

thermal disinfection, which wasn't in fact done for quite a long time.

A Yes. I understand that now. Yes.

Q Yes. The way that it's been portrayed by some with an interest in the Inquiry is there was a choice at the time. You had these taps which had, let's call them, flow straighters, just for ease, in them. The choice was change the taps which was going to incur a cost or carry on and try and cope with it in another way, and that's been portrayed by some as money or risk. Is that a fair comment?

A Yes.

Q The other place that you mention this is at page 480 of your witness statement. I just want to see if I can understand that. Now, in paragraph 311, you say that you had a report that, in October '17, that the files were being maintained in all high-risk areas, which may not turn out to be correct. Anyway, you said you didn't think Dr Inkster was aware of the agreement reached, so you shared the information she had and she said:

> "So, basically, HPS and AFS supported leaving these taps in. I have to say I disagree with them."

Now, are you criticising Dr Inkster for forming that view?

A Not at all. No.

Q Thank you very much. Now, I'm going to move on to another issue that's not actually covered directly in your witness statement, but it relates to circumstances in which Dr Valyraki was concerned with something she was being asked to sign off on and engaged, again, the assistance of Dr Peters as a more senior colleague. So, do you remember that incident, generally speaking?

A Not particularly.

Q Not particularly well. Well, can we look at bundle 12, 895, please? Now, I'm starting on 895 because as in the annoying way of email change, you end up starting at the end. If you look at the top of that page, you find Jackie Barmanroy saying:

> "Please find attached a SCRIBE. These rooms are non-patient rooms [and so on]."

Then, if you go on to 894, you find that that's actually addressed to "IC Dr South". So, presumably, at the time, that was a way to do it. Pepe Valyraki comes back, I think she sends it to Brian Jones saying, "Do you know about it?" Brian Jones saying, "No, but

on you go. Is there a problem?"

So, if we just scroll up a little bit so I can see the top of that page. Yes. Pepe Valyraki says:

> "Thanks for your reply. High-level piece of work to convert into BMT accommodation under the oversight of SMT. Is this part of the SCRIBE?"

because she's, obviously, not sure what exactly it is.

Then, she says:

> "Happy to proceed but for me to do it properly I need to walk around the site."

Now, just pausing there, that's presumably a perfectly reasonable thing for her to suggest she does.

A Yes.

Q So, if we go on to 893, Brian Jones says, "Jackie will be able to update/assist you." Then, we find Pepe Valyraki reporting that she's been up with:

> "Jackie and Christine, who's on for ICD tomorrow ... number of concerns ... even a corridor that's very dusty ... there are acute leukaemic patients in rooms in 4B..."

So dusty, in fact, I think Dr Valyraki reported, sort of, coughing and so on.

> "This screen is meant to screen off the work areas, they are flapping open ... there's currently work going on which is [involving] leak testing..."

So, not happy to sign off the SCRIBEs given the situation "as we find it and we suggest" the work stops.

Now, just pausing there, if that's what Dr Valyraki and Dr Peters found, is there anything wrong with what they're suggesting in the email?

A No.

Q So, we go on then to 892. So, this is where you come in, at the foot of the page, saying to a group of people, "Can we meet and sort out the issues ... ensure control measures are in place." You were in the ward and "was happy with the sealing," but perhaps be more throughput. There's a reply, then, from Jackie Barmanroy.

Now, this seems to be controversial for two reasons, one, because there seems to be some inferred criticism of doctors Peters and Valyraki for stopping the work when they found what they thought was an unsatisfactory situation. Now, do you associate yourself with any such criticism?

A I mean, the ICDs or the microbiologists, you know, that-- if they stop the work if they're concerned then

that's what happens. Especially some of these visiscreens because they can flap. I think we use solid hoarding now, rather than the screening for some of the areas. So, I mean, that's fine.

Q Well, the reason this is being put to you is it's said to be an example of you being deliberately uncooperative because there are other emails, which I understand we can display, although they're not yet in a bundle. Can we just have those up on the screen if they're available? Right. So, can we go to the next page?

So, we start with an email from Jackie Barmanroy to Christine Peters saying, "I've listened to your concerns," so she's the senior nurse:

> "…discussed with Sandra. IPCD are happy to attend any meeting and walk around at the request of the haemato-oncology service."

So, the implication seems to be that you will attend but only if the clinicians say so, not if Dr Peters says so.

A I would have gone if Dr Peters had said so as well. I mean----

Q Why do you think, having discussed the matter with you, Jackie Barmanroy says, "We'll walk around at the request of the oncology service"?

A I think we just wanted to ensure that the local team were sighted on the requirement in terms of letting us know if the-- You know, if the screening had come away, we wanted to make sure that they were aware because sometimes clinical teams aren't always as aware of the importance of actually screening off some of these areas as we might be.

Q You can see, perhaps, that the recipient of that communication might think that you're saying, "Well, we'll do a walk around, but only if the clinicians say so"?

A No. That wouldn't have been the position I would have liked to have involved the clinical team. From what I can remember of this, and it was a long time ago, there was a notion that-- it was like a through route to a store and people were taking the screen away and then putting it back on again. So I can't remember if it was Jackie that said that to me, that she'd gone up as well and the screen was away from where it should have been affixed to the-- I don't know if it was a wall or a door.

So I fully accept this, perhaps there's not-- I haven't put as much, if I've emailed, information into that as possible, but I honestly think if we're

asked to do something we always do it.

Q In any event, Christine Peters says, "I think we need a meeting including clinicians to discuss what's going on."

A Yes.

Q That's a reasonable response, I would suggest. Is that correct?

A Yes.

Q If we go on to the front page of that email, here we have you again saying:

> "Hi Christine. Melanie's not available today and both Brian and I have spoken to Myra and suggested the clinical service should decide how they would like to take this forward."

So, the implication, again, seems to be that you're not immediately cooperating with what ICD want but you're shovelling it at the clinicians?

A I'm sorry if that's how it seems. It was just my understanding, or my recollection, was that this was to do with a bit of how the clinical team were managing this work going on within a clinical area. So it's not ideal to do any work within a clinical area and I wanted them to be sighted on this.

You know, I accept that might not be as helpful as perhaps I would like to be, but that's my understanding, that we wanted to make sure the clinical team were completely sighted in this.

Q In fact, there was no pushback from Christine Peters about involving the clinicians because she immediately replied saying, "I agree, it's essential to have clinicians there."

A Yes.

Q Very well. Thank you. We can leave that, my Lord. That's a document that only recently was discovered not to be in a bundle but it will appear in a bundle in due course and I'm obliged to the technical staff for arranging it. We could display it on the screen and avoid using hard copies.

Let's just move on to something else. Can we go to 478 of your witness statement? We've discussed the BMT unit, which was a late-ish instruction.

A Yes.

Q There's also the question of the-- what's sometimes called the Brownlee Unit, the Infectious Diseases Unit, and you touch on that on page 478. I wonder whether you can help us about this because, in paragraph 302, you say, "We confirmed that we were waiting." I think, in some ways,

you were probably targeted as the author of that statement:

> "We were waiting for information from HPS regarding the use of designated isolation rooms for patients with high-consequence infections."

The question that's been asked, and I'm not sure we've had a clear answer from anyone else, is this is after-- you know, the Brownlee Unit was moved in before 2015. So why, in 2017, are you looking for advice on isolation rooms?

A I think we had-- Again, this is my recollection of this. I recall and I think there was a discussion at-- I don't know if it was AICC or BICC with regards to whether or not these rooms in critical care were rooms that we'd used for specifically multidrug-resistant tuberculosis and, you know, high consequence respiratory pathogens, and that Professor Williams had contacted-- I don't know if it was the project team or-- I can't remember exactly who, but he had contacted the team to ask them whether or not these rooms were compliant for this type of patient----

Q Is that not the kind information you should have known before the Brownlee Unit moved in?

A I mean, perhaps. I mean----

Q I'm just----

A Yes, no, I mean, perhaps. I mean, I don't know what the ventilation parameters would have been for that unit, so I'm just trying to remember what it was that Professor Williams-- but, I mean, I had worked in Gartnavel, so I knew the configuration of the old Brownlee Unit, and my understanding was that the two rooms in critical care would have been, you know, negative pressure isolation rooms and that they would have been appropriate.

Q Yes.

A I'm just trying to remember this off the top of my head, so I do apologise if any of this is not complete.

Q I think the issue that's been raised on a number of occasions, just so you're absolutely clear why I'm asking the question, is that a decision was taken to move the Brownlee Unit in. Everybody knew what the Brownlee Unit had, as it were----

A Yes.

Q -- and could have easily found out by going there to have a look.

A Mm-hmm.

Q So, on the face of it, you

would think it would be quite easy to work out what they needed in the new hospital, so there's some puzzlement in some quarters as to why people are still scratching their heads in 2017.

A Again, this was not my area at the time, so I do apologise. I'm not trying be deliberately----

Q If you don't feel you can assist us, please just say so.

A I believe that we approached ARHAI in '16. I think this was flagged as an issue, and there was a pathway developed whereby these patients would go to Glasgow Royal Infirmary in the first instance. So, there was a pathway, and from my recollection-- and I think it would have been Professor Williams who had approached HPS regarding those rooms in '16, I think probably with him being away and then Dr Inkster coming in and then Dr Inkster not-- being off, it might have got, sort of, missed in the crossfire, but I actually don't know much more than that about that, I'm sorry.

Q You're aware it became necessary to direct infected patients to other hospitals?

A Yes. Yes.

Q Which obviously wasn't a satisfactory situation.

A Absolutely.

Q I think, just for the notes, that appears at paragraph 338. We needn't go to that at the moment, but it's in your witness statement already. Can I ask you another general question? In a later section, starting on page 481, you start to touch on water issues, and you explain what you were or were not involved in. You, I think, were not on the Water Technical Group.

A No.

Q But am I right in assuming that you were aware that, as a sort of spin-off for the Water Technical Group, a large group of people involving people from GGC, people from HFS, HPS and outside experts, all did a big exercise on working out what was wrong with the water system and why it was wrong?

A Yes.

Q And produced a report dealing with that?

A Yes.

Q Apologies, my Lord. Now, you were involved in some issues about decanting 2A and 2B to 6A and 4B. Is that right?

A Yes.

Q Would I be right in thinking that you were not a lead role in these, you were there to assist with things that needed done as a

consequence? Is that fair?

A That's correct, and to try and support the nurses on the site who were doing quite a of work round about this. So Mrs Dodd was leading that, but Pamela Joannidis had been a paediatric infection control nurse, so we were trying to make sure that the team had all the right kind of resource in order to try and help them carry out the parts of that work that we were required to do.

Q Just in terms of who sorted out what ultimately was to happen – decant, no decant and the like – you deal with this on page 488 of your witness statement, about in the middle of the page, and you say there you recall the COO attending a meeting. You say there was a recommendation of the IMT, but you don't know who formally signed it off. Is that your position?

A Yes, that's correct.

Q But obviously somebody very senior had been present in these discussions?

A Yes.

Q Can we move on then-- and I apologise if we're jumping around a little in topics, but it's the nature of the exercise. Everything in your witness statement becomes part of your evidence of the Inquiry even if we don't touch on it orally. On 489, we move to discuss another topic, Cryptococcus. Now, we've heard a lot about other aspects of that – pigeons and so on – from other witnesses, which is not your particular area, but, at the top of 490, you say-- you've been asked what the issue with Cryptococcus were, uncommon in two cases in a short period of time, which I think is the kind of reaction we've had from a number of witnesses.

I just wanted to ask you about one thing you said on that page again, so we understand exactly what you're saying. 363, after some discussion about hypotheses and sources and so on, you say:

> "I'd been asked whether this was something I would expect to find in a new hospital. [And you say] I would expect to find this in any hospital."

We've heard from a lot of witnesses that Cryptococcus was extremely rare. Many of them had never heard of it in a clinical setting. Is it your position you would expect to find this in a new hospital?

A Perhaps "hospital" was the wrong word. I would expect to find this in humans, in patients, and you-- I hope that you'll reflect on the fact that I

was part of the group that John was the chair of, so I know much more about Cryptococcus now than perhaps I did at the time. So, I'm referring to the findings of John's report-- sorry, Dr Hood's report, when he has-- you know, his conclusion was that you probably won't ever know, but latency is an issue, and he, you know, reviewed the literature and included the literature in his report round about that.

Now, I know that that's not an absolutely definitive conclusion. So, on that basis, what I'm trying to say is, I imagine that that can appear in patients, or anyone, people who are immunocompromised and where this is reactivated in their system. So perhaps "hospital" was the wrong word.

Q I simply asked because we've had evidence from a number of witnesses of very long experience, all of whom said, "We've never come across this in a clinical setting."

A No-- Well-- Yes. So, again, going back, so we did have a patient with Cryptococcus in the REH, and there was also a patient-- I think two patients in Glasgow Royal Infirmary, if my recollection serves me well. So, obviously, I know much more about this topic-- not that I'm an

expert, but I know much more about this topic now than I did at the time.

Q Although you were involved in the Cryptococcus group, you weren't there because you had specialist knowledge of Cryptococcus. You were there to assist if things needed done. Is that again (inaudible)?

A I was there to support John in any way that I could. I was absolutely not an expert in either Cryptococcus or in ventilation, but there were-- I think there was one or two actions that I took away from the group. I think one of them was to check whether or not 4B wanted automatic doors, things like that. So, anything that I could do, I tried to do, and just support John in terms of-- you know, just making sure the papers were out. It's my PA that actually did the admin for this group as well, so I was there to just try and keep the process going and support John where I could.

Q The other thing I need to ask you about there is that a suggestion's been made that you told Dr Inkster not to talk to John Hood about this work, and you deal with this on page 492 of your statement, in paragraph 374. Now, you answer that by saying:

"It's possible I would have perhaps remarked that she should let the process run its course."

Is it possible that you said, you know, "Don't you talk to John about this"?

A Absolutely not.

Q Dr Inkster had a fair amount of knowledge about things like ventilation. Why would you tell her basically to keep out of this discussion?

A It wasn't telling her-- I-- So, there's a process and the process has been put in place. Teresa was already extremely busy, and John was-- you know, he was the chair of the group, and in order just to let the process run its course in terms of basing it on his findings, I mean, I think I was trying to be helpful, to be absolutely honest, and-- you know, just let that run, and it will be what it will be, and we'll deal with it when it comes back, and-- So, it wasn't done with any intent to exclude or to prevent her from talking to John. I mean, they were in the same laboratory. So I don't agree that that was my intent.

Q Thank you. Now, I have a couple of other things I want to ask you, which perhaps don't appear very clearly as things you've dealt with in detail. We'll go, just for convenience, to 495.

I'm asking you to cast your mind back, I suspect, to a meeting around June 2019 when the assertion is that, in effect, you and Jennifer Armstrong are on one side, and Teresa Inkster, HPS and clinicians are on the other, and she doesn't think she can rely on you for support because you're allied with a view that is against hers. Do you remember that?

A I don't have that page in the-- my screen, so I'm not sure which document----

Q Sorry. Well, it's not dealt with directly in your witness statement. I'm asking you whether you remember such an occasion.

A Can I ask what the date was again, please?

Q I think it's probably June 2019.

A And if you don't mind repeating the question, sorry.

Q The suggestion being made is that a point came where, at least from Teresa Inkster's perspective, she was sitting on one side of a fence, which was also occupied by HPS and clinicians, and you and Jennifer Armstrong were on the other side, and she would normally expect to get some support from you

because you were part of Infection Control, but she couldn't because you were allied with a different view about decanting and so on. Do you remember any such event?

A We used to meet with Jennifer Armstrong fairly regularly, so there may have been a meeting in June. I don't particularly remember any specifics about that. What I would say is, though, that at all points, I tried to support Teresa. Now, it might be that, on occasions, and I think this was referenced, that perhaps-- and I would do this with any Infection Control doctor, you know, "Are we happy? How are we going forward? Is there any chance it could be-- Maybe we could look at something else." That kind of thing.

I honestly would say that-- and if you consider, at that point, I'd moved into the ICM's role, so I was trying, actually, to stay away from some of the clinical issues at this point in time and try and be the Infection Control manager for the service with Pamela acting into the role of-- which was my job. I honestly believe that I tried to be as fair and impartial as possible and support Teresa where I was able to do.

I mean, I am a registered nurse, and I do have a professional responsibility to ask those questions,

even if it's just for my own clarity. So, I don't believe that it would be inappropriate for me to say to Teresa, and I would hope-- and I believe that all the ICDs I work with now, if I said to them, "Are we sure about that? Have we had a look at this? Can we revisit that?" all of them, I believe, would say yes.

So, I don't believe that there was a them and us. It was a group of clinical people, both Infection Control, Teresa and everybody in the Board, trying to work together in order to try and help get this service back on again, and so I think that's-- I don't think that's a fair representation of how I supported Teresa.

Q Another suggestion that's been made, that you and Dr Armstrong didn't want something treated as an outbreak because you didn't think that's what was causing it.

A I absolutely disagree with that as well. I mean, I do. Everything that was flagged by any ICD was dealt with. If they thought that that was an incident, an outbreak, or even if they were just exploring the topic, it was done. I would never, ever put anyone in any kind of compromising situation or put any patients at risk by not simply going through a conversation and a process.

Q And you don't recollect a discussion in which, you know, one side of the conversation, represented by yourself and Dr Armstrong were saying, "Well, this isn't an outbreak at all. Some kind of background rate is acceptable. We should be looking at other hospitals"?

A I don't think that looking at other hospitals or trying to determine what a background rate might be is an inappropriate thing to do. I would do that tomorrow if we had an issue in a ward, especially if it was something unusual and something that was perhaps not something we had dealt with before. The first thing you do is go to the scientific literature and other centres to see what that might be. I mean, that's a normal thing to do, to try and explore the topic, to find out, you know, what additional intelligence can we bring to the table?

Q I think the implication is that if you go off to do that, you're not actually treating this as an outbreak at all, you're just stopping and----

A I don't agree with that. I'm sorry, I really don't.

Q Very well. Can I ask you about something else? Just bear with me a moment, find the-- It's a quite different issue that I've been asked to raise with you. The issue here is

apparently about IMTs in respect of something called Mucor.

A Yes.

Q Which is an infection, not the same as Cryptococcus, but in that kind of bracket. Is that right?

A That's correct, yes.

Q Do you remember discussions about that infection arising from IMTs?

A Yes.

Q And the suggestion is that you challenged Dr Peters' assertion about linkage in time, place and person. Is that right?

A Yes.

Q You did?

A Yes. I didn't challenge. This-- The word challenge has been used quite a bit and, honestly, from my point of view, I'm asking questions for clarity and that happens all of the time, and that is a process which hopefully moves things forward, and I don't really accept that challenge is the right word there. I think it's entirely appropriate for anybody who's in an IMT to ask questions and-- for clarity and for queries. So, I know that this word has been used. I'm not challenging their clinical expertise. I would never do that. I wouldn't do that now.

What I'm asking is questions for

clarity, and these two patients were in different parts of the ITU. All I said is, "They're in different parts of the ITU. Is this still considered to be associated with a place?" And I don't think that's inappropriate, and I would-- I would do the same with any of the Infection Control teams.

Q So, your position is you weren't challenging the conclusion, you were simply asking a question.

A I mean, yes.

Q Fair enough. Can I just ask something else about Cryptococcus, just while we're there? 498, please, at paragraph 402. This is still talking about Cryptococcus and the various possibilities, and you say you've been asked what your opinion was, and you say you're not qualified to comment on that. Is that right?

A Yes. I mean, obviously, again, I have read John's report because I've read it a number of times, but I'm still not a microbiologist, so I wouldn't feel comfortable.

Q Thank you. Can we see bundle 14, volume 2, 440, please? Now, I'm just asking you about this because we get a slightly different slant on some of these things. You quite properly told us about, you know, the challenges of dealing with all of the issues that you had to deal with and

the pressures that everybody was under and so on, but if we go down here, we find you reporting that she – that's Jennifer Armstrong – wants "positive statements to try and ensure that public confidence ... is maintained." So the focus here is not so much on, "What's wrong and how do we fix it", but, "Where can we find something positive to say?" Is that an appropriate thing for you to be focusing on?

A If there had been. So-- so, what's happening here is we're trying to pull the science that John is exploring across in order to try and, you know, ensure that the public-- There are people who are sick, ill, that need treatment, who have to go into these buildings and receive care. So if there were-- if there was un-positive things to say, I would say that as well, but we were trying to say, "From the work that's been done at the moment, is there anything that we can say that would provide some assurance that-- you know, that work is ongoing", and if there's any conclusions to date. I mean, that's why I've emailed John.

Q Thank you. I'm not going to go through all of the IMT stuff that you've dealt with in your statement, in which you explain that one of the challenges you faced was that, as

matters proceeded with some of the wards, particularly 2A and so on, clinician confidence was being badly eroded, and that was obviously a challenge for you. Is that fair?

Q Well, I mean, I can completely understand that, yes. I mean, it was-- I mean, like you say, I totally understood where the clinicians were coming from and that their confidence in the building was not great.

Q Well, I now want to ask you about a quite different situation now, and this is a meeting that was held at which there was a discussion, in effect, about Teresa Inkster's performance as chair of the IMTs. You remember that, I take it?

A Yes.

Q Now, that's what was discussed. We know that because we've seen the minutes. Can I ask you to look at bundle 14, volume 2, 568, please? Now, this is the invite to the meeting.

A Yes.

Q And you'll see that it starts by saying,

> "...there are a number of issues regarding the haemato-oncology unit ... and I would like to take this opportunity to invite you to a meeting to discuss these ... to set out the current position and discuss additional support..."

Now, there's not a single mention there of the conduct of the IMT chair, you would accept?

A Yes.

Q Now, let me put this to you, then. Imagine a meeting was called to discuss, I don't know, Infection Control nurse allocation on Ward 6. You couldn't go and it turned out that at the meeting the only topic was Sandra Devine's performance as lead ICN. You would be furious about that, would you not?

A I'm not sure that this-- this was about performance as such. I think that----

Q Oh, be reasonable. You wrote the minutes.

A No, no. I am being reasonable.

Q It ended with her removal.

A I think it was about-- It was bigger than that. It was about the process. It was about, we weren't working together as a team at this point, I don't think, like, the whole-- the whole IMT and, to be fair, it was a long IMT, really. Although it's been broken up into bits, it really was an IMT that almost lasted 18 months. It was

hugely complicated. It was----

Q Well, can I ask you to answer the question again? Because if there was a meeting to discuss----

A Yes, no, I wouldn't be happy if it was about my performance.

Q No, you wouldn't.

A But what-- but what I'm saying to you is----

Q You'd be off to the RCN, wouldn't you?

A I'm not sure that that was about that, specifically.

Q But the consequence was that Teresa Inkster was removed.

A Yes.

Q So, whatever the discussion was that led to it, that's the consequence. Now, if that had happened to you, you would have been off complaining immediately, wouldn't you?

A Absolutely. I would have been.

Q Now, you've told us a lot of positive things about Teresa Inkster in the context of your evidence, both written and oral.

A Yes.

Q Did you not think, when you were at that meeting, that you should have put your hand up and complained and said, "We can't do this when she's not here"?

A So, I thought it might be a positive thing for Teresa as well, and that's-- that's my honest opinion. I did speak to Teresa about it. Like I say, it was a long, prolonged IMT. Her responsibilities in terms of managing the chair and all of the clinical work and speaking to patients was considerable. I mean, there was a lot going on.

What I-- My understanding was that – and I don't know for certain who – a couple of people had raised concerns about the fact that the team as an IMT was not functioning particularly well, and that it is within the scope of the current guidance to have a look at this and review the functioning of the team and perhaps the chair. So, I did speak to Teresa, and I honestly took it as a positive thing. I said, "Teresa, you know, maybe, you know, it would be good for you to get a break. Maybe it would be good, you know, to just refresh the process. Perhaps you can focus on-- you know, with the clinical aspects of this," because that was her passion. That was her thing that she wanted to do and I thought it might help. So I honestly went into this with Teresa and tried to take the positive from it, as-- as I normally do. I totally accept that--

Q If you-- If-- Sorry.

A If Teresa had said to me, when I spoke to her, "That is absolutely-- I'm not happy, that is not going to happen," I would have represented that view at that meeting. I know Dr Inkster was invited to the meeting and, unfortunately, she couldn't go, but if she'd actually said to me that, "That is just inappropriate, I'm not happy with that," I would have said that at the meeting.

Q I mean, are you actually asking us to accept that you sat during that meeting, the consequence of which was she was removed as IMT chair, and you thought that was a positive?

A Yes.

Q And you never thought, given your respect for her, that you should say it was inappropriate to do it at all when she wasn't there?

A Perhaps, on reflection, I should have done that. It was a very-- It was quite a senior meeting. I was a relatively inexperienced manager in terms of Infection Control, the bigger picture. I honestly believe that if Teresa had said to me, "I'm not happy with that," that I would have said at that meeting.

Q Well, she never got the chance to do that because she wasn't there and the decision was made.

A No, absolutely.

THE CHAIR: When we're talking about that meeting, are we-- I think I'm understanding it as actually the IMT of 23 August, as opposed to the meeting on 20 August.

MR CONNAL: The decision was made at the meeting of the 20th, but the date on which it became effective was the next IMT on the 23rd.

THE CHAIR: Yes. So, which meeting are we talking about?

MR CONNAL: Well, the decision to remove Teresa Inkster was made on-- at the meeting on the 20th.

THE CHAIR: The 20th, yes.

MR CONNAL: Because by the 23rd, there was another chair in place. Is that right?

THE CHAIR: I mean, so we're not at cross-purposes. I mean, when Mr Connal was using the expression "that meeting" to you, you understood that as the meeting on the 20th.

A The 20th, yes.

Q Yes. Thank you.

MR CONNAL: So, what then happens, of course, is that there's a meeting on the 23rd at which you have the rather odd situation of Teresa Inkster having to turn up at a meeting of an IMT, having just been removed without any discussion with her. Is that right?

A It wasn't as straightforward as that, I'm sorry. So, this meeting took place on a Tuesday and Dr Inkster had gone off sick. Dr Peters had let me know that Dr Inkster didn't want to be contacted under any circumstance. I mean, I was anxious that I hadn't spoken to her. I mean, I really was. So, Teresa was off from the Tuesday.

Q So, that's after the meeting of the 20th, so his Lordship understands.

A Uh-huh. So, Teresa was off from the Tuesday and we were asked not to contact her. When I left that meeting, my interpretation was that until we'd spoken to Teresa, that Teresa was still the chair of the IMT, because that was one of the actions, and I thought that was completely appropriate and, you know, respectful of her position.

What happened after that was that over the course of the Wednesday and the Thursday, I tried to get one of her colleagues to step into the IMT on the Friday on her behalf. So, I approached two of the Infection Control doctors at the South who both felt – and I completely understood why – that it was too complicated an IMT for someone to step into, and then I approached Professor Jones on the Thursday as well to see if he would chair it on her behalf on Teresa's behalf.

So, I get to Thursday and I think-- I contact Jennifer Armstrong to say, "I'm really sorry, but we don't seem to have a chair for tomorrow." Now, my instinct at that point would have been to try and move that IMT a wee bit forward, maybe, into the next week. However, at this point in time, we had diverted children to both Edinburgh and Aberdeen, and it was felt that it was too important a meeting for it not to go ahead.

It's my understanding – and I'm sure she would have told me – that Dr Armstrong had approached Linda de Caestecker to ask about a public health consultant to chair that meeting. Again, you know, you can get Infection Control doctors consulting on public health.

So, what happened was, Alison Balfour, sort of late on the Thursday, said to me that Dr Inkster might be back on the Friday. So, I emailed Dr Inkster that night and said, "Just to let you know, Teresa, the IMT is tomorrow and there's a pre-meet at 9.15." Now, I can't prove this, and I don't completely recollect it, but I imagine I would have tried to contact Teresa a couple of times on the Friday morning,

because that would have been a thing that I would have done, because, as I said to you, I was fairly anxious about the fact that I hadn't spoken to her.

I had hoped that Teresa would have attended the pre-meet, but she emailed me to say that she was caught up with some results and that she would be late to the pre-meet. So, I hoped that Teresa would have gone to the pre-meet and then that might have been the opportunity to have a more formal discussion about that, but obviously that opportunity didn't arise, and I'm-- it wouldn't have been something that I would have thought was a great example of a process going forward, but it wasn't intentional, certainly, that she wouldn't have known about it.

Q Well, I can understand why you say that, but by that time the decision had been taken, so a discussion with her effectively amounted to telling her why she was being removed. She didn't have any say in it, did she?

A Well, I don't accept that. If Teresa had come to that meeting-- because I tried to get one of her colleagues. So, in my head, until we'd had that conversation with Teresa, she-- you know, up until that point when events kind of overtook itself in terms of Emelia Crighton being the chair, I was still trying to kind of work the time where I could actually speak to Teresa about it. I didn't think she was completely negative about it.

As I say, I would have represented that on the Tuesday if that had been the case and, honestly, if Teresa had come in on the Friday and said, "I am totally not happy about this," then I think there would have been a conversation that might have changed that in some way, but I didn't get that opportunity and nor did anyone else, and I do regret how that all played out.

Q In your witness statement, you say the decision was made on 20 August '19 to change the chair.

A Yes.

Q So, the decision had been made.

A It was made, but I would still have backed Teresa up if she'd really-- you know, if she'd wanted to go back and revisit that, I would have assisted, supported-- and supported that process.

Q Let's have a look at bundle 27, volume 11, page 101, please. Now, this is an email from NSS in which they are trying to summarise what happened at an IMT.

I don't think we just have the date immediately there, but we'll pick it up in a minute from the previous page.

So, go back to 101. What NSS say, fairly near the bottom of that, maybe three-quarters of the way down that page:

> "NHSGGC have replaced the IMT chair from the lead ICD to NHSGGC deputy director of Public Health."

So that's their take on what's been done. You then challenged that, didn't you?

A I did.

Q So, if we go to 100, you go to them and you say:

> "Chair agreed to be replaced in order for her to have time to review incident results and actions."

That's not correct, is it?

A I could have only said that if that had been the impression that I'd got from the meeting with Teresa on the Monday.

Q You didn't have any information to make that statement. Teresa Inkster didn't agree----

A No, I absolutely agree, I overstated her position and I regret it. It was-- I looked at this, I think it was yesterday, and I thought, "I agree." I overstated what I thought her position would be and I absolutely agree that that was not appropriate.

Q Because what then happens is, at 107, NSS come back to you-- and just carry on down until we see the content, they say, "Well, our reference to the chair was a factual statement made for information." So they're saying, "Well, whatever you're saying, what was said at the meeting was that she'd been replaced," which is correct, isn't it?

A Yes.

Q And, in fact, if we go to 99, we then find the consequence of your having stated what you stated, which is that Teresa Inkster felt it necessary to tell a large number of people that she didn't agree to be replaced to review incident results and actions. In fact, she goes on to say that she was asked to demit due to feedback from everyone as that was put to her that the meeting was difficult, "...however this was not corroborated at the IMT today [being the 23rd] by senior clinicians, HPS, or the microbiologists". So, she doesn't even think everybody was agreed that there was a problem.

A I understand that, yes.

Q And she then got in touch with you to seek an explanation,

did she not?

A She did, yes.

Q Can we have bundle 14, volume 2, 570? Now, you were asked in your witness statement whether Teresa Inkster got in touch with you and you said you had no recollection of it. Do you not remember getting this communication?

A I'm sorry, I didn't at the time. I do apologise.

Q Did you ever reply to it?

A I don't believe I did. What I think that I did was go and see Teresa, because Teresa was still our lead ICD, and for the days preceding this I was in communication with her about trying to ensure that her diary supported the next IMT and trying to make sure that both her and Emilia were available to ensure that obviously she was included in the process.

So, from that point of view, I believe I went over to speak to Teresa directly. I don't remember responding to this email. Perhaps I should have done in writing, but my recollection is that, after that, Teresa was our ICD and I went over and-- I'm sure I went over and spoke to her about it.

Q One of the particular points she's raising there is that, having had the meeting on the 23rd, she felt it was clear that not everyone was saying that the problem was the chair, in effect, that others such as clinicians and microbiology colleagues were not necessarily pointing the finger at her and the need to change the chair as the problem. You see that?

A Yes. As I said, my simplistic interpretation was that the whole IMT wasn't really taking anything forward, we were lacking kind of focus. As I said, it was very complicated. There was lots of things playing into it, there was loads of media attention, the clinicians weren't happy, the kids had been diverted to other hospitals. It was just about trying to make the process function again, so that we could come to a conclusion, whatever that might be, in terms of a way forward. I think that's why there was negative feedback about the IMT.

For me, it's just about-- I'm really sorry, I don't mean to be flippant about this. For me, it's not about personalities and things, it's about trying to find solutions to an issue in order that services are available to patients. Maybe that's-- you know, maybe that's my lack in emotional intelligence, but for me it's just about, "This isn't working. How can we fix it and can we make it better?"

I honestly, honestly thought that

Teresa being the lead clinician for IPC and doing that kind of clinical work would perhaps take some of the pressure off of her and perhaps make this process go forward a wee bit. That is my honest answer.

Q Were you surprised that she was upset about it?

A I was a bit, yes. Like I say, maybe it was my fault. Maybe I just pitched it as a positive thing and that it might be a good thing and, like I say, for me it was just about trying to move things forward, and it just felt like a refresh or maybe just taking a step back. It was really difficult to just sort of say, "Can we take a step back and just have a wee look at this and try and figure out what's going on? Can we refresh this? Can we reset things?"

And it is within the spirit of the existing guidance that if you have a prolonged IMT that perhaps you should think about a chair and a deputy chair, or maybe having another ICD carry this role forward with the ICD with the responsibility for the clinical service perhaps being a part of it. So, it didn't seem like it was out of the ballpark, in terms of a reasonable thing to consider and to do.

I absolutely understand that Teresa wasn't happy about it. I totally take that on board. It was almost like-- It was a bad combination of circumstances. It's not how I would have-- It's not what-- I wasn't happy about the rapidity and the conversations up to that point.

Q Can I ask you then about a totally different issue? In the course of the whistleblowing exercises that went on, you had some involvement in that, did you? Particularly in relation to Dr Redding.

A Yes. Uh-huh.

Q Maybe-- It's been suggested you may be able to help us with this. Please tell me if you can't. Can we have a look at a bundle 27, page 81, please?

THE CHAIR: Sorry, which volume----

MR CONNAL: That's a good question. I thought I had a note of that. I don't. Try volume 1. It's part of the whistleblowing report into Dr Redding. I'll leave the point, my Lord. I can't immediately identify the reference.

I think the question that's been raised is that there's a reference in the whistleblowing exchanges about Dr Redding to air change rates and to an SBAR that had been prepared, I think, by Dr Inkster, and I think the question is, does the discussion in the whistleblowing report accurately reflect

what Dr Inkster said in the SBAR?

A Obviously, I don't----

Q Can we have a look at that, bundle 4, page 52?

A I mean, it is a fact that there should have been six air changes and there were three. I mean, that's all-- that's correct.

Q Yes. I think the question is whether somewhere in this exercise what had been said in this SBAR got diluted or changed by the time it found its way into the report.

A I don't believe I ever saw that during that. I was just interviewed.

Q So you can't really help us about how that was done?

A I don't think so, sorry.

Q Thank you. Right, let's go on to a different topic. I'd like your thoughts on a new insight that we had from another witness. You're asked at page 517 of your witness statement about communications generally and you're not the communications specialist. So we'll have other questions for them in due course, but you'll see in paragraph 478 there's a discussion about what information parents are getting and you agree that it's obviously emotive if it's their child and who could disagree with that statement? In the course of his evidence, Dr Mathers offered the suggestion that you don't ask the person who drafted the communication whether it was effective. You look at it from the perspective of the recipient. In this case, it would be largely parents. Do you think that's a useful insight?

A I think there's a real art to-- The best form of communication is clinician to patient or parent in this thing, because that's the only way that you can gauge how much information that someone might like and it leads you down to have sort of conversations. Drafting information is-- it is a skill because you're trying to balance the information with, you know, does it make sense? Are you using jargon? Does it not-- in terms of trying to gauge a wide scope of different people and communicating well with them. So his point is probably well made. It's whether or not the person that gets that information is happy with it, but there was a lot of that information produced, but it was produced in line with communication with parents and patients at that time as well. I think the best way to communicate with patients is directly, but, in certain circumstances, you do need to draft comms to back up what you're saying or what you're trying to communicate.

Q Yes. Just so I'm clear, that's quite a long answer to what I'd originally intended to be a short question.

A Sorry.

Q I don't criticise you for that, but I'm just keen to understand your response to the point. I think what Dr Mathers was trying to get at was don't ask the comms lady or the doctor, or whatever, whether their communication has been effective, ask the parent because it's the parent who will decide whether that was an effective communication. Did I understand you said that's a point well made?

A Yes, it is a point well made, however, sometimes you do need colleagues-- I mean, we do it when we make patient information leaflets. We send it out to a group who look at it from a patient's perspective, put it into, kind of, I think they call it plain English and things like that. So there is a certain amount of skill in order to do that as well, but, I mean, he is right. I mean, the only people who can really judge how effective it is are the people who receive that type of information, but I'd have to say that one person might say, "Yes, that was great. That was enough," and the next person might say, "No, it wasn't." So,

that's what I'm saying. It's really difficult to draft lines that are going to hit the mark for everybody that receives them.

Q The other question you mentioned in the course of your earlier answer was that the best communication is direct from the clinician. One can readily understand that in the context of discussion about the patient's treatment, prognosis and that kind of stuff. Obviously, the person to have that conversation is the clinician.

The question that's been raised is if the issue is nothing to do with the person's cancer or whatever, nothing to do with which drugs might be most effective, but it's all about whether the environment that the hospital has provided for this to take place in is safe, adequate, whatever phrase you want to use, would that not be the responsibility of other management to communicate that rather than burdening the clinicians?

A I think it's a kind of-- a collaborative process. So, Jamie Redfern was the general manager at that time and Jennifer Rodgers was the chief nurse. So you've got a kind of combination of a manager and a nurse and sometimes that works and sometimes patients would prefer to

speak to a nurse or an Infection Control nurse.

I know that Dr Inkster spent quite a lot of time in that area with clinicians because the best way to do that is probably with both of them, so-- because patients are going to have questions like, “But how does that impact on my treatment?” So it can be quite a complicated situation and is best sort of trying to target the individual patient and their needs in order to get the right things. Now, again, I know that’s a long answer, but it depends on the patient, the situation, the clinician, it depends on lots of things, and it’s a process that I think everybody tries to contribute their best to that, but it isn’t as-- it’s not straightforward.

Q I suppose that the thing I’m trying to get at, perhaps not very well, is that if the clinician is talking about the cancer treatment, say – just keep it simple – and the patient asks a question about the cancer treatment, chances are the clinician knows the answer, or if they don’t, if it’s perhaps a more junior clinician, they know who does, and they can go and get the answer. If the question is about the ventilation or the water system or whatever, that’s not their specialism. So if they’re asked a question, they won’t necessarily know the answer.

A But that’s a very unusual circumstance. So, I’m just going back to it as an example. When we had the outbreak of MRSA in the burns unit, the clinicians, after being at the IMT, were quite happy to communicate to the patients as their primary clinician. They understood, you know, the actions that we were taking around the IMT and what they were telling patients, absolutely accept when it’s water and ventilation, but that wasn’t a normal-- it wasn’t a normal incident.

Q If I take your example, if people had been in the burns unit for a prolonged period, for the sake of argument, and there was an issue as to whether the ventilation needed to be improved in order to improve this patient safety element, the clinicians wouldn’t necessarily be involved, would they, in the whys and wherefores of when that work might or might not be done and therefore wouldn’t be able to deal with that?

A No, but when clinicians feel like that, then they reach out to us and we will send someone to help with that conversation if that’s what they want. So the clinician might have a chat with the patient and they understand and they’re happy and then another patient might say, “I want

more information," and if a clinician feels that he or she is not able to give that information then they would phone and we would come and help that process.

Q Just some pieces of information perhaps in page 518. You're asked about the duty of candour and you're talking about duty of candour in the context of IMTs and then you say in 484, "There's a module regarding duty of candour on learnPro." That's presumably your online learning system. Is that right?

A Yes.

Q And then perhaps, to the surprise of some, you say it's not a mandatory module.

A That's correct.

Q Should it be a mandatory module, duty of candour?

A Well, from my point of view, yes, but it was relatively new in terms of legislation, and so from that point of view, yes. It might be that not everybody needs to do a module on duty of candour. So you wouldn't really expect-- So mandatory training applies to everyone, so you wouldn't really expect domestic staff, reporting staff, or to-- you know, to----

Q You may have to say who it's mandatory for.

A Yes. So, we do Infection Control education and we have a kind of grid at the back of the education strategy and we have groups of staff and there's mandatory education and then we've got suggested modules that we think, in terms of your clinical practice, that we would say that these would be modules that you should complete. So mandatory is-- There's always a thing about mandatory because it's a kind of blanket for everybody and sometimes it's not absolutely appropriate for it to be everyone, but the trick is trying to do these groups of staff, but it would take someone like me to say everybody in the team needs to do the duty of candour module and then that's how that would be managed locally.

Q Thank you. The next section of your report, you're asked briefly about whistleblowing. It's been suggested to the Inquiry by another witness that the real attitude to whistleblowing in many quarters is that it's not really approved of, it's not regarded as something professional to do. Do you have a view on that?

A I mean, it absolutely has its place. I think it's a positive thing, generally. I think what you would expect is for people to try and exhaust every way through their own systems in order to have their voice heard but,

at the end of the day, if they feel that their option is to undertake whistleblowing, then I fully support anybody's right to do that.

Q Again, some further points of detail. At page 525, you pick up on one of the Case Note R eview recommendations, and am I right in understanding that the database that you refer to there, the database of microbiological results, has been developed and is in place?

A Yes.

Q And am I also right in thinking that a form of root cause analysis is now done in certain wards?

A Yes. So, I'm going to be pedantic here. I prefer to call it a clinical review. It was referred to in the IMT minutes as a root cause analysis, but a root cause analysis, if you speak to colleagues in clinical governance, it's a much larger process. What is in place is, what I would say, a clinical review of the cases. We were asked to implement that in Ward 2A, but we have also put that in place for PICU and the NICU. So the NICU and the Queen Elizabeth, we've actually just rolled it out to the NICU and PRM and the RAH as well.

THE CHAIR: Sorry, my fault entirely, I'm not sure if I really absorbed that. Do we have a starting

place in relation to root cause analysis? Do we have a starting point in the statement?

MR CONNAL: If we go to 530, I'm obliged to the witness for the explanation because that was going to be the next question. People talk about root cause analysis. There's been some discussion about root cause analysis, but what you're explaining is that what's actually done is not, to your understanding, strictly root cause analysis. It's a slightly different system. Is that right?

A Yes. It's a clinical review of the patient and, at the end of it, which has been really helpful, is the Infection Control team with the clinician come together and they say, "Looking at all of the information that we collected, where do we think the source of this infection might have originated from?" Sometimes you don't know. Sometimes it's quite clear. A patient has maybe another infection at that time, or-- There are quite interesting things that come through from the clinical review that you perhaps may not have thought about.

Q So, the sort of short version is that having been asked to do root cause analysis, you're doing a clinical review and you find that useful?

A Yes.

Q Earlier in your evidence, I asked you about some attempt you made to look at the rates of the three infections, C. diff, Staph aureus and E. coli in 2019, and I think you've been asked in your witness statement whether you are the author of something called a Summary of Patient Safety Indicators----

A Yes.

Q -- that was attached to a board paper. I think it might be helpful to his Lordship in particular, at least, if we look at this, because you confirmed that you, at least nominally, are the author of it.

A Yes.

Q Can I just ask you, when you're described as the author of it, I mean, you're not an epidemiologist. Did you get the material, or did you just find it somewhere else and----

A No, I just sourced it from different places. I was asked just to do, "What data do we have? What information do we have?" So, I used the HPS report. I used the output from Prevalence.

THE CHAIR: Sorry, I could ask you just to go back on that. At dictation speed, what were you asked to do?

A Just to try and gather any information about the entire campus, in terms of an indicator to see if they were in any way unusual.

Q All right.

MR CONNAL: So, just pausing on that, while his Lordship makes that note, you made a point in your witness statement where this is dealt with, at page 529, that this was a summary of available data you had and in no way was it supposed to refer to 2A or 6A, or any particular ward. It's the whole campus.

A Yes, it's the whole campus.

Q Where did you get the information from?

A Well, the Point Prevalence study is published, as was the ARHAI review. I got some information from clinical governance. I'm going to forget what this is. So they have data on expected number of deaths, and I think it's called HMSR data, so they-- we're monitored in all the different hospitals within the Board of what an expected death rate might be, and then they basically say whether or not you're an exception, so back to kind of using charts, or whether or not your expected rate is under the national average. I'm sorry, I'm not explaining that very well, but--

So, there are bits and pieces of

data within the Board that you can-- So I embedded a paper from clinical governance in the main paper. So that was in my work. It was clinical governance work that described this type of data as well. It was just a putting together of what we had in the absence of having sort of more robust data in terms of 2A/B. Really, the only data we had for 2A/B or 6A at that time was the ARHAI report.

Q Well, let's just have a look at it, in particular at the charts, if we go to bundle 25 at page 345. So, we have the positioning paper. So I'm not wanting the positioning paper, but if we scroll through it, we come to the appendix to the positioning paper. Carry on, please. Oh, keep going. It should be at the end, logically. Is this all stuff that you put together, or did you just lift it from somewhere else?

A I think I drafted the paper, but most of it would have been sourced from other-- Whatever available source there was, we had a look at it. So, the national regional services: obviously, that's not in any way controversial. What I think I was trying to demonstrate there is it is an unusual site, I absolutely think that. So, all of our high-risk patients in the west of Scotland probably are on that site, so renal inpatient services, the bone marrow transplant for both adult and children, the ID unit.

So, there is a lot of high risk services within that unit, and that's described in the ARHAI in the National Manual about-- it's actually where you test for pseudomonas, and I think almost everything listed in the National Manual service-wise is on that campus somewhere. I think the one that isn't is cardiac surgery, it's at the Golden Jubilee, but a lot of our most vulnerable patients are on that site.

So, I think I was putting that in to try and balance the risk, in terms of the types of patients that are accessing services, and especially in the Children's Hospital, actually, where, you know, the regional and national services. So, my interpretation is all of our sickest-- There's sick patients everywhere. There's immunocompromised patients everywhere. I don't mean that to sound like-- It's just there is a collection of high risk patients within that site that I think leaves them-- they are more vulnerable.

Q So, if we just scroll on from that page, which is 364 just for aid of reference, then you've touched on social deprivation, and if we go on past that there should be some graphs further on, and you've picked up on

various reports and some figures. Can we just go back one page there, at 372, "Summary," you say:

> "The data presented show that QEUH had lower rates of hospital acquired infection than other hospitals in Scotland..."

A Mm-hmm.

Q Now, what infections were you able to produce material for? Is it not the same three we talked about earlier?

A That is just a Point Prevalence study.

Q Oh, that's a Point Prevalence study.

A Mm-hmm.

Q Right. So, we go on. I think there's-- Did you attach some graphs to this?

A There might've been, yes.

Q Yes. So, what you then have is there's a graph about Staph aureus. Is that right?

A Yes.

Q And perhaps the quirky bit about that graph is that the latter section has changed to look at only cases that are labelled as healthcare associated. Is that right?

A Yes, yes.

Q In fact, that appears to suggest that the hospital is doing not so well in that respect. Is that right? Because this is above the line consistently.

A Right. So, we don't have hospital-specific data. That's why we asked ARHAI to do the analysis of RHC, so this is data for all of Glasgow and Clyde.

Q Of all of Glasgow and Clyde?

A Mm-hmm.

Q Right.

A So, the rates were-- and the definition changed to being only hospital associated. So, they changed the definitions within the national surveillance system and that's what that is demonstrating and, actually, if you look at it, it's starting to sort of cluster around about the sort of central line there, and we have spent many years trying to drive down the rates of Staph aureus bacteraemia. I mean, it's a very serious bloodstream infection, and we continue to do that now.

We have got local reduction groups all over the board but, thankfully, to a certain extent, all of the things that we could do are in place now, and we continue to try and drive this particular infection down but, over time, the big actions that you take start

to-- you know, they're in place, and then you're looking at sort of more subtle ways to try and drive that particular rate down.

Q So, that deals with Staph aureus for the whole Board?

A Mm-hmm. Absolutely, yes, because I don't have hospital-specific data. This is national data. I wanted to use what was available in the national----

Q Do we see graphs for the other two infections as well?

A Yes.

Q C. diff, I think, will come up shortly. Yes, there we are, page 376, where you're being charted against a target. Is that right?

A Yes.

Q The target being, broadly, the dotted line?

A Yes.

Q But there's an aim try and bring this down as well, and you're being tested against that?

A Yes. I mean, our whole-- although we are talking about incidents and outbreaks, the main body of the work, especially probably with the nursing team, is trying to put actions in place to try and reduce-- These are good indicators in general. I hope this demonstrates that, in terms of practice, we've been moving forward and changing things as we go, and these are the results.

So, these are the indicators that the Scottish Government used for boards in order to try and use some matrices for performance. They just happened to pick these three out. Obviously, C.diff was a very serious infection at one point in time, so you can see that the drive was quite clear to try and reduce this, but it's all about trying to reduce infections in lots of different patients over time.

Q This is the infection-- These are the rates for the whole of the Board?

A Yes.

Q This is the particular infection that you said, when asked much earlier in your evidence, you would have expected to be able to bring down in the new hospital because of the way it was set up.

A C. diff? Yes.

Q Just for completeness, is there another one for E. coli, again, for the whole of the Board? Yes.

A E. coli is much more tricky to try and reduce because there's a lot of community cases of E. coli bacteraemia, and with Staph aureus bacteraemia you can kind of focus on line care. With E. coli, the source of the bacteria seeding into the

bloodstream can be a urinary catheter or gallbladder disease, or-- It's much less tangible in terms of actions that you can take to try and bring it down.

So, compared to the other two targets, this is a new target. I say new, it's probably been in place for, I'm guessing, maybe six or seven years, but the C. diff target and the Staph aureus target have been in place since 2006/'07, something like that, but the actions that you can take in order to drive down E. coli bacteraemia are much more tricky and, actually, we're just expecting some communication from the government at the moment about modifying this target to actually make it less challenging, because there isn't a board in Scotland that's actually meeting the E. coli bacteremia target, as far as I remember.

Q These graphs show what are described as healthcare of associated cases.

A Yes. So, that's any contact with any healthcare environment in the previous 30 days. So it can be anything. It could be a dentist, a GP, if you're in a care home, for example. Quite a lot of E. coli bacteraemia are associated with elderly patients as well, so these are in healthcare associated.

Q But, again, these are figures for the whole board.

A The whole board, yes.

Q Not----

A I wanted to use the data that was validated by ARHAI.

Q Yes.

THE CHAIR: For what purpose?

A I think it was just to try and highlight that in terms of performance against the standards, that the Board is a whole-- I wanted to demonstrate that Infection Control as a service strives to try and bring healthcare associated infection down. All I was trying to do with this was just to try and demonstrate that our focus is on healthcare infections generally, and that we were successful to a certain extent in some of these indicators.

Q Right, successful in the sense that----

A Apart from E. coli----

Q -- at least for some of-- is it true for all of the infections that there are a downward trend?

A Well, the E. coli bacteraemia is bobbing about, really, around the mean, so perhaps not for the E. coli bacteraemia, but we actually have workstreams in play at the moment to try and----

Q Sorry, you have a----

A We have workstreams in

place with different groups at the moment to try and reduce this too.

Q All right, so the purpose was to-- or the result was to demonstrate for the whole Board in respect of two infections, Staph aureus and C. difficile----

A Clostridium difficile----

Q -- there's a downward trend over the periods that these infections have been monitored?

A Yes.

MR CONNAL: I don't think I have anything further to ask you about these graphs, thank you very much. I really need to move, I think, to the concluding sections of your witness statement. You've made very positive comments, for instance, about Ward 2A in its newly-refurbished form. Can I just ask you about page 537 of your witness statement in paragraph 546? You mention something called the Key Stage Assurance Review, which is-- I was about to say an NSS process. I'll probably not get the labels correct, but the point I wanted to ask you about in particular was a bit in the middle of that paragraph where you say:

> "There is an expectation that IPC have input at all stages; this is unachievable."

Now, why do you say that?

A The resource in terms of this process is intense. I have an ICD in the North who is the-- working on-- there's a big North East hub. It's a big community type-- dentists, GPs, social work. It's a big centre in the east end of Glasgow, and she has spent weeks and weeks of her time making sure that all of the Key Stage Assurance processes are in place. It has taken up a tremendous amount of clinical time, especially, actually-- no, the ICNs as well, but there's more ICNs, but in terms of the ICDs, it has taken up quite a lot of their time.

And to be fair to the ICDs, some of them are interested in building projects as such, but their passion is clinical care and research and that interaction with clinical teams in patient care. So, to a certain extent, this is, you know, quite interesting. I mean, I find the building work interesting, but it has taken up a significant amount of clinical time, and IPC is a scarce resource. I mean, someone could give me, I don't know, loads of money tomorrow and I couldn't recruit to the posts, because the ICDs literally are so-- they are so skilled now that it takes quite a long time for them to become ICDs. They're all consultant microbiologists, and even the nurses, the pathway from a trainee ICN to a

lead ICN will take four or five years.

So-- In addition to that-- So, we've got this going on. So, during COVID, there was a message that went down to the nurse directors to say that they would take-- I don't think it's responsibility, but they would, sort of, have under their remit nursing and care homes. So, suddenly, we had to put a team together in order to support Infection Control in care and nursing homes, and there's 160 care homes across Glasgow and Clyde.

So there's that remit and then you kind of get into, you know, GPs might have to use FFP3 masks and who's going to, sort of, train on that? So, the scope of the team is getting larger and larger, and the team can't get larger and larger at the pace that the expectation is, round about what they've got to deliver.

Q As a matter of principle, would you agree that it's desirable to have Infection Control at the heart of building projects?

A Absolutely.

Q Given the implications for patient safety.

A Yes, absolutely, but what I would say is, and I-- this is way back in history, I seem to remember a long time, and it was a long time ago that there was a department within-- I think it was the Common Services Agency, and they were the people who consulted on any new hospitals. So, all the expertise were there. There were nurses, doctors, engineers, all sorts of people within this department who, if you had a new build, would come in, in partnership and give advice and tell you how to build this.

So, for me, I mean, our team have quite a lot of experience in this, but I think if I was in a smaller board and perhaps never approached the building project before, it would be quite daunting even just getting up to speed with all of the building notes. I guess our hope was that if you were going to build-- So, to a hospital in Lanarkshire, you learn all the lessons from that and then you take that and you give advice when we were building the same hospital in Glasgow.

You know, it doesn't make sense to me, I don't think, that we have, you know, all of this expertise within NSS, and yet the responsibility for new builds lies with teams who may not have that experience or background. It just doesn't seem a sensible thing to do when that expertise is there, and that's only my opinion.

And I think the anticipation, when NHS Assure came to it, was that they would tell us how to build these

buildings, and we would be partners in that and participate in the process, and especially around about things like the burns unit or, sort of, clinical areas or perhaps-- perhaps a clinical team is anticipating doing some kind of different type of invasive procedure, then you could input into the process. What is happening is that we are the input and the advice, and then that process is assured and, I think, certainly personally, I had hoped that there would be a central place that you could go and say, "We're going to build the North Wast hub. You know, tell us what you think should be in the building." (Inaudible).

THE CHAIR: Now, that was delivered at quite high speed, and I'm interested in your views on this matter. What you're reflecting on is the initiative which is NHS Scotland Assure.

A Yes.

Q Limited number of years of experience, just since 2021, but what I was picking up from what you were saying, there was a sense of disappointment or-- and can I just sort of capture that again, at dictation speed?

A Yes. I think for me it's about the logic of it. If you have that expertise within Scotland and a board is going to build a new hospital, it would seem logical to me that the people who might have done a number of these builds, take that knowledge and bring it to the next board that's going to build a hospital, in order that you're not repeating this process all of the time. So, at the moment, like, for example, our ICDs, if it was an unusual build, we'd have to go away and research the building notes and-- about ventilation or water or, you know, all these kind of things, and then they'd make judgments or give advice to the project team based on that.

It just seems to be illogical, if that expertise-- From my simple point of view, I kind of think that if you're going to build a North East hub, you should be able to lift a manual off the shelf and say, "We built that in Grampian. This is the best way to do that." I mean, absolutely accepting that there is new innovations and technologies and things like that, but it would seem logical to me that if you built it in one board, that you should be able to take that template and do it somewhere else, and that if we have a repository of expertise and lessons learned in a national forum, that it just seems sensible, instead of diverting Infection Control teams in order to do that from scratch up, when, really, you know,

that service-- I think I'd hoped that that's how that service would work.

Q And I take it from what you say, that would involve the central resource, which at the moment is NHS Assure----

A Even if (inaudible)----

Q -- being responsible for the design and supervision of construction.

A Yes.

Q Thank you.

MR CONNAL: I think the consequence of the point his Lordship has just put to you is probably that the-- all of this would be pointless if, you know, a board said, "Well, that's very interesting. We've been told how to build this health centre because Grampian did it so well but, actually, we want a cheap and cheerful one, so we'll not bother putting in A, B and C." There would have to be some kind of mechanism, if you were going to go down that route, of assuring that the best practice was actually applied.

A Absolutely, and that would be the standard.

Q Well, let me just ask you, I think, about one final matter. In your witness statement, in the closing sections, you set out your unhappiness with a lot of things that happened.

A Yes.

Q And as I noted it, and I may have got-- no doubt I'll miss somebody out, you weren't happy with the Oversight Board, you weren't happy with the case note review, you weren't happy with politicians, you weren't happy with Scottish Government officials, you weren't happy with officials in the government agencies. So, in effect, they were all wrong and you were right. Is that really what you're telling us?

A No.

Q Because you're clearly not happy with the fact that what you portray as the Board's position is not-- has not been accepted by a range of bodies.

A It wasn't-- It didn't feel like a fair process. I have spent my entire career trying to do the right thing, trying to support clinical teams in the front line, focus completely on patients. All of my team do the same thing and it felt like, really, it wasn't based on an open assessment of the situation. Now, that's my personal view. I went up to the Oversight Board and we were giving presentations and I felt we were making a really good--

You know, we had a forensic accountant go through all of our systems and processes. We had the independent review. I mean, there

wasn't-- to a certain extent, there was almost a part of me that wanted them to find something so that we could fix it, but we had all of these processes and it just didn't feel like it was an open and fair evaluation of the evidence in front of them. It just didn't feel like that and, honestly, over-- I-- over the last-- I mean, it's five years now, I mean, we've-- it's been a real-- trying to keep everybody together and everybody supported.

We went through COVID as well with everything going on, and then not feeling as if you had, really, a chance to put your side-- And I didn't want them to say, "That's the side," or, "That's the side." All I wanted was an evaluation of the total process and the evidence and, to be honest, it felt as if we were being punished the whole time.

And do you know something, there was points where I felt like they accused, and I don't believe that the team, like, did anything to deserve that kind of-- that kind of position. I'm sorry, but I'm absolutely confident we did everything that we could, everything within the scope. We reported, we used the manual, we audited from the manual. We provided education. We were doing surveillance. I mean, there still isn't gram-negative surveillance now. I mean, there isn't. So we're continuing with the methodology that was given to us, and it did feel like we were found guilty before any kind of process. All we wanted was to be-- have a fair representation of what we were.

In terms of recent assurance, so HIS have come in and have done their inspection of the Queen Elizabeth in 2022. They reviewed our systems, and our processes, and how we were managing patients, how we were reporting infections, and they had a positive view of that. We had the Board, for their assurance, commissioned an external review of our services last year, and they also-- they matched us against six standards. I had no-- no recommendations in terms of patient referrals, education, how we manage the system, how we manage governance, how we managed information.

There was one recommendation, it was how we capture mandatory education and it was a systems thing, but that was six standards and five were green, one was amber. So I feel as if our service has been reviewed, and a number of times, I don't believe anyone stood up and said, "You've done this, you're terrible," and all I was hoping for was a fair evaluation about

what we were doing. I'm sorry, didn't mean to go on.

Q I have nothing further for this witness, my Lord.

THE CHAIR: Ms Devine, what I need to do now is check that there are no further questions in the room. So, we'll break, I'll ask you to go back to the witness room, and I'd hope you could come back within about 10 minutes.

THE WITNESS: Thank you. Thank you, my Lord.

(Short break)

THE CHAIR: Mr Connal?

MR CONNAL: I have been asked to raise two short questions with the witness.

THE CHAIR: Ms Devine, I'm told that there's a few more short questions. Mr Connal?

MR CONNAL: You may or may not be able to help us, but I've been asked to raise them with you in any event while you're here. In paragraph 546 of your witness statement, which is the part we've just been through about how NHS Assure operates, and you've offered us some thoughts on that, you explain the potential value of having, as it were, a core of expertise available. Now, do you know whether NHS Assure offered to come in and, let me use the word inspect, have a look at Ward 2A after it had been refurbished?

A I think they were part of the process. I mean, I remember conversations with Ms Critchley, and I'm sure there was colleagues from HFS and Assure in that process. I mean, yes. I'm sure they were.

Q Well, the question was really focussed about, once you've done the work and it's geared up and you're ready to look at patients, the suggestion is that NHS Assure said, "Well, we'll come and have a look at it now it's all ready," and the Board said no.

A I'm not aware of that.

Q You're not aware of that?

A No.

Q The other question – again, tell me if you don't know – there's an accreditation that you get for bone marrow transplant units, and I'll probably get the initials wrong, but it's JACIE? It's a series of-- Is it J-A-C-I-E?

A I think so. Sorry.

Q Anyway, it's an international-based accreditation focused on these kind of specialist units. Is that right?

A Yes.

Q Did Ward 4B get JACIE accreditation?

A I don't know. I mean, I would imagine so, but I don't know for sure.

Q But you don't know?

A No. I think there was a problem with the JACIE because-- when they were in the Beatson, because I think one of the standards is that they are adjacent to an intensive care unit. I think that was possibly one of the drivers for them being on the QE site, but that is just out of my memory. I'm sorry.

THE CHAIR: Are you familiar with the JACIE standards?

A I'm not familiar with the content of them, no.

Q So you wouldn't know what units are covered?

A I don't know for-- I would be extremely surprised if they weren't covered, but-- because you-- I think it's-- I don't know that they're allowed to operate unless they are. No. But I-- honestly, I don't know. Sorry.

Q Or which countries they apply to.

A I don't know that either. Sorry.

MR CONNAL: I have nothing further, my Lord.

THE CHAIR: All right. Thank you very much, Ms Devine. You've answered all the questions you've been asked, and that means you're now free to go, but before you do, thank you for your attendance today and thank you for the work that's involved in preparing a written statement. I'm very much aware that that's a lot of work. So, thank you for that as well, but you're now free to go.

THE WITNESS: Thank you, my Lord. Thank you.

THE CHAIR: We'll see each other tomorrow morning at ten.

(Session ends)

16:33