SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
19 August 2024

Day 36
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THE CHAIR: Now, Mr Connal, we have Professor Wallace. What's your information on the timing on that?

MR CONNAL: My information earlier in the day, my Lord, was that she had been asked to be available to give evidence from 12 but had indicated a likely intention to be here around 11.30. I haven't heard any update on that, but it's easily checked, so perhaps it might be appropriate to take a short break just now and anticipate we might be resuming somewhere around 11.30.

THE CHAIR: Right, we'll do that. I would ask legal representatives not to go too far. Whether coffee will be immediately available, I'm not sure, but I'm sure efforts will be made in that direction. So, we'll see if we can begin about half past 11, but obviously we would want to give Professor Wallace a moment to draw breath before beginning, so if legal representatives just keep in touch with the Inquiry staff.

(Short break)

MR CONNAL: Apologies for the slight delay, my Lord.

THE CHAIR: Now, Professor Wallace.

MR CONNAL: Professor Wallace, indeed.

THE CHAIR: Good morning, Professor Wallace, and thank you for bringing forward your attendance. That's very helpful. Now, as you understand, you're about to be asked questions by Mr Connal, who's sitting opposite you, but, first of all, I understand you're prepared to take the oath.

A Absolutely.

Professor Angela Wallace

Sworn

THE CHAIR: Thank you very much, Professor Wallace. Now, I anticipate that your evidence will go into the afternoon, perhaps, maybe as-- Well, we'll just see how long it takes. We'll take a break for lunch at one, but if at any other time in your evidence you want to take a break, just give me an indication, and we'll take a break. Now, Mr Connal.

Questioned by Mr Connal KC

Q (Inaudible) my Lord. Good morning. Yes, it's still good morning.

A Morning.

Q Good morning, Professor Wallace. As His Lordship has said, thank you for moving forward your appearance. That's of great assistance to the Inquiry. I start by asking you the same question I ask all the witnesses, which is: you have produced a witness statement; are you content to adopt that as your evidence?

A Absolutely.

Q You understand that that then means that the whole of the witness statement and everything referred to it becomes part of your evidence even if we don't deal with it today?

A Understood.

Q Now, your original profession is as a nurse. Is that right?

A I am.

Q You set out the journey that you've had within that original title in your CV, and you very fairly say on the first page of your statement-- and what we'll do is we'll use the witness statement as a sort of guide to where we've got to and what topics we're covering. So, if we could bring up the witness statement, that would be helpful. We're at page 431. You'll see we have electronic page numbers, and I'll probably also refer to paragraph numbers, which will probably help you in following where we've got to.

You say there in answer to question two that you don't have any specialist qualifications in Infection Prevention and Control. Does that pose challenges when you're having to manage people who have a lifetime's experience in IPC?

A I think, across NHS Scotland, mainly the nurse directors have the lead for Infection Prevention and Control as an executive lead. So, I guess it represents a lifelong nursing career where Infection Control is at the heart of things that we do. You will see from my CV that, as an Executive Director, we have a range of executive lead roles, and Infection Control is one of them. For example, I'd also have the lead for healthcare scientists; I've got the lead for quality within Greater Glasgow and Clyde.

So, what we have is a broad knowledge, and then you use your leadership experience, your challenge, and your support to drive forward an agenda. So, I don't think that managing Infection Control colleagues-- you know, they're pretty feisty, they're really passionate, but all colleagues are. So what you add to that is an executive leadership role to that, and you accept the accountability and responsibility for those areas in your portfolio, and I feel my accountability and responsibility pretty strongly.

Q You're somebody who had no original involvement, if I can call it that, with the new Queen Elizabeth Hospital, and then you were – I think I used the phrase for someone else the other day – parachuted in, as it were, to a position. You explain that on page 433 in the answer to question six on this document. I'm just wondering how you dealt with being pulled in two different directions, because what you say in the middle of the answer to question six is that you were asked to take this "post in support of

Prof Bain and the Scottish Government Oversight arrangements," which is sort of one hat.

A Yeah.

Q But we know from elsewhere in your statement that you were reporting to the Chief Executive of the Board who, in one view, was right at the heart of a lot of the issues that the Board was facing. Did that thought cause you to be pulled in two different directions?

A I think the role was extremely challenging. I said, further in my statement, that I hadn't any knowledge of the detail of what the system was facing, and therefore I think having that ability to come in fresh I think added strength to what I was trying to do. I didn't know any of the colleagues involved in Infection Control and Microbiology, and therefore I felt that I would be able to come in and stay in that operational sense of a role.

As I said in my statement, the CNO – Fiona McQueen – had already had Professor Bain there, and therefore she was having that executive lead role, and therefore I would be supporting at that operational level. I felt, with my director experience, that I would be able to come in and listen carefully to all colleagues, and therefore take that forward.

The reporting arrangements-- I can see why you would ask that question in terms of how long was I able to keep my independence, but I guess for the other-- the corollary of that would be if I wasn't-- had access to the Chief Executive, I could quite easily be trying to work and listen to my colleagues and take things forward but be quite disconnected from the organisation. So, what I tried to do was retain that independence as long as I could, really focus on working with my Microbiology colleagues and Infection Control colleagues, but I was also really keen to make sure that Infection Prevention and Control had a priority within the organisation.

The one thing I would say that, you know-- I have been-- I'm really really experienced. I'm used to working at that level. So, it was quite difficult for me to be in the operational space when I was so used to being in a very strategic space. I think I used that strategic experience to give me the levers to make sure that the work that I wanted to do with the Microbiologists and the Infection Control team-- that I could do that and it could also be central in the organisation.

So I think it was difficult. I think I had to be incredibly thoughtful about how I maintained that independence and supported colleagues, but I also needed to make sure that I had the ability – if there was anything that I needed – either to, you know, go to the Chief Nursing Officer and go directly to the Chief

Executive, and that was the path that I absolutely tread for this role.

Q Did you say-- I'm not sure whether it's Teresa Inkster or Christine Peters at one point that you intended to be Switzerland, neutrality?

A So, yes, I did say that, and hopefully colleagues will see that in the spirit of the intention of being new to the organisation, trying to build that trust whilst listening very carefully to colleagues. So, I was trying my best to maintain that, and it was quite an isolated position but, in the same time, whether it was Teresa and Christine or whether it was the Infection Control team, they needed to see someone that keen to support them but also had the ability to work on a strategic level if that was required because this was about safety and this was about concerns. I needed to make sure that I could do both things, and I certainly did that to the absolute best of my ability. You're quite right, it wasn't an easy thing to keep managing---

Q I'm jumping ahead in your statement a bit but, elsewhere, you say that you were trying to look at things from an independent perspective, but you immediately recognise that, as you put it, that may not have longevity.

A Absolutely.

Q So that any intention to stay in Switzerland might have disappeared fairly soon. Is that really what you're pointing out?

A Well, I think it was a risk, and I really think that that would depend on whether I could gain people's trust, whether the assessments that I was making-- and the direction of travel in terms of moving colleagues and the service forward. I think being able to have trust but people seeing that I was listening and that the act-- and what the concerns that they were telling me or the wishes that they wished to have in terms of moving the service forward, I was doing that too. I think people needed to see change if that was what mattered to them.

So, I think I was trying to do those three things. I was trying to be as independent as possible. I was trying to listen to everyone and be equally challenging to everyone. I was trying to take what people were telling me to create a way of moving forward, and I was also, you know-- there's a personal and a leadership perspective where the people were people trusting me and trusting the way that I was trying to take things forward.

Q Can I just ask you a point of information at the moment? At various points in your evidence, you refer to the Board's positioning paper, did you

participate in the drafting of that paper?

A No.

Q If we could move on in your witness statement now to page 434, and I'm going now to paragraph 9. I think you report-- it's perhaps where the challenge of your position starts to emerge in the wording because a minute or two ago, you said you needed access to the Chief Executive, and one immediately understands that.

A Yeah.

THE CHAIR: Here, you say, "I was reporting to the Chief Executive," which is perhaps a reflection of a management link there. You see the point I'm making?

A Yeah, absolutely, and I-- that was the arrangement that my Scottish Government colleagues made. I think, as I said previously, that they had some additional support coming into Greater Glasgow and Clyde. There was Professor Bain, and then I was asked to come in, and there was also suggestion that some other colleagues may come in to add capacity. Professor Bain demitted her role after a few months, and no other colleagues came in. So I'm in this central place, and you will see from later on in my statement that some of the work that I initially did was commissioned by the Chief Executive in terms of the organisational development or bringing people together.

So, the arrangement to report to Jane was-- Jane Grant was made by the Scottish Government and Ms Grant obviously accepted that, but going back to the-- that position that I was trying to achieve, I was absolutely clear-- and in the brief that the Chief Executive had given me was that I needed to make sure that I was supporting people, that patient safety was front and centre and that, obviously, as a Chief Executive, she would want to know if I was finding things that were concerning, and I did that, as I've said in my statement, through kind of informal arrangements, and I also kept in touch with the Chief Nursing Officer.

Q The point about being promised extra bodies and them not arriving, I think, for the record, appears in your answer to Question 8 on the same page, but we needn't go back to that.

A Yeah. Sorry.

Q Then the question is, "Well, what were you told about what had been going on?", and what you say in answer to that, at the foot of that page, is that the Chief Nursing Officer:

> "…shared that there were some microbiology colleagues within NHSGGC who had, and continued to, raise concerns regarding infections which they believed were connected to the ...

building and the environment."

Just pausing at that point, is there anything inappropriate if a professional thinks there's a concern in them making that note?

A Sorry, could you repeat that, Mr Connal? Sorry.

Q Yes. What you said in Answer 10 was that the Chief Nursing Officer:

> "… shared that there were some microbiology colleagues within NHSGGC who had, and continued to, raise concerns regarding infections which they believed were connected to the [maybe we'll call it just 'to the building' for the moment]."

And I'm just saying, well, let's stop the sentence there for a moment and say, "If a microbiology colleague has a concern, which professionally they believe is connected, is there anything inappropriate with them raising it?"

A No, not at all. Not at all, and in terms of my understanding, when I was approached by the CNO, it really was in response to having someone in that space that could, you know, be fresh in the space, you know, to be neutral, as my colleagues have said, and so, no, and, you know, I think that was the reason in terms of the Chief Nurse speaking to me. I'm was more concerned----

Q The additional point that you then go on to make at the foot of that page and going on to the top of 435 is that you thought you were going to be the liaison with Scottish Government, but you discovered that these colleagues-- and I'm assuming you're talking about Christine Peters and Teresa Inkster there. Is that right?

A So at that point, she just had said "colleagues". I didn't-- I-- My understanding from the conversation, and just from recall, that it wasn't just Teresa and Christine. She'd said "a small group of colleagues", so that would have been my understanding.

Q But you make a point, I think, of criticism there that they were in communication direct with colleagues in Scottish Government, and you thought you were going to be the contact, and this was being supported by people in government as opposed to discouraged.

A Yeah.

Q And that wasn't something you were very pleased with.

A I don't know that I would say "pleased with", and I was really thoughtful about putting this so early in my statement but, as explained, I've been asked to come into a situation, and it was probably much more complex than I could have imagined. What I'm showing here-- and this was not about my

microbiologist colleagues, but one of the things that I was trying to do-- and you will see in my statement, there was so much trauma experienced by staff. That's what they were conveying to me in terms of how they were feeling, and what I was trying to say here is that everyone was trying to support my microbiologist colleagues – and I think it was more than just Teresa and Christine – but I was here trying to help people, support people and move forward, if I possibly could, with my colleagues, and at the same time, when people were still having concerns, that was sitting outside the process.

So, I'm trying to support the Infection Control team. There was lots of other colleagues, and also, within this space, Teresa and Christine were part of the work that I was doing, and there was other conversations, so I was really just trying to-- It's no criticism on my Microbiology colleagues, but I was trying to show the context in which I was trying to help support colleagues in Greater Glasgow and Clyde.

Q I just wanted to ask you about that, because I'm conscious that people produce answers to questions, they produce a witness statement, and then sometimes you need to look back at it again.

A Sure.

Q You said you didn't intend any criticism, but the end of that paragraph says, "this continual questioning of processes hindered the process and undermined the position I was asked to fulfil," which sounds, perhaps, to the outside reader as a criticism.

A Yeah, and that was not intended, and I can see why you would think that. I think I was-- Having the responsibility where people are sharing their concerns and how that has made them feel, what I was trying to do was to wrap around the support, and people were taking part in that, and therefore, if-- Whether it was the Infection Control Team or whether it was my colleagues with concerns, if there's other avenues opening when I'm trying to help people move forward-- You could see that there may be colleagues having to consistently tell their information here, when I'm here thinking that we've captured that and we're trying to move forward. So, it's-- and I can see the criticism. I genuinely was trying to show the Inquiry, the complexity of the environment in which-- and colleagues were supporting me, and in which I was trying to support them.

THE CHAIR: I wonder if you can help me.

A Of course.

THE CHAIR: Professor, the way this witness statement came to be is that we provided you with a list of questions,

and you provided us with the answers. Therefore, the words are your words.

A Yes, they absolutely are.

THE CHAIR: Now, going back to what the Chief Nursing Officer told you at the beginning-- I'm looking at page 434:

> "Fiona McQueen shared that there were some microbiology colleagues within NHSGGC who had, and continued to, raise concerns."

Now, what's the significance of the word continued?

A I think the Chief Nursing Officer was alerting me in that statement to the fact that-- that it-- you know, there required to be more work done. I think, your Lordship, she was simply, in that, trying to understand that there were concerns and that they were continuing to raise concerns.

And in answering Mr-- I think, then, what I was understanding is that everyone was still trying to support my colleagues who were raising concerns. They'd set up a new process in which I would come in to support, and what I was seeing here was that, in trying to move things forward, there was still lots of other conversations happening around that, and I was just recognising that that could pose a risk to both the trust that people had in me in this space and also my ability to take actions that may support colleagues in terms of moving forward. So I think it was a context piece, your Lordship.

THE CHAIR: Going over to the next page, you say, "despite reaching out to those with concerns". I take it that these would include Dr Peters and Dr Inkster? "Outwith," I think, probably should be one word? Is that right?

A Yes, sir.

THE CHAIR: "Process continued". So, what's this a reference to?

A So, everyone's concerns I had gathered through listening and gathering information as part of the organisational development process. So, my colleagues Teresa and Christine were sharing what was concerning them, and I was also listening to a range of other stakeholders, and including the Infection Prevention and Control team.

So, the concerns of how infection control felt to people in Greater Glasgow and Clyde are the processes that I'm sharing here, and the other process is that I'm trying to help move colleagues forward, based on their experience, and those two things were constantly-- It was quite a dynamic situation. So, the continual question of processes is people's concerns, which wasn't just Teresa and Christine. The Infection Control team were raising concerns of process, and then I am trying to, having heard all of that-- thinking about what we

might need to do to create the system to work as best as we can and build the relationships. So, they're the two processes that I refer to there, your Lordship.

THE CHAIR: "This pattern of behaviours was supported by colleagues in SG". Now, tell me if I'm wrong; "patterns of behaviours" has a sort of critical flavour to it. So, what was wrong with the behaviours, if I'm right in interpreting that as critical.

A Yeah and, again, I can see why that would feel critical, and I was simply observing that, across the system that I was working with – my microbiology colleagues, some of my senior manager colleagues and the Infection Control Team – people were quite rooted in their beliefs and views, and they're absolutely their truth, and I understood that, but the patterns of challenging processes, which was across the system-- This is not just-- I'm not just speaking about my two colleagues in particular, Teresa and Christine here. What I was seeing is just patterns of behaviours that had been happening over what I think would have been the kind of recent history.

So they were-- Kind of-- Probably just speaking in more organisational development terms, it's just what I'm witnessing, and when I'm listening to people and what I'm seeing, it's just a

constant way of behaving, if you will.

THE CHAIR: "Was supported by colleagues in Scottish Government?" Again, is that a criticism?

A So, I think it refers to my earlier point where Scottish Government colleagues had asked me to come in, and I'm working with everyone equally in my-- as neutral a position as I can and, I think, if I'm being fair to my Scottish Government colleagues, if colleagues have got concerns, they're still going to my Scottish Government colleagues. And I did have conversations to say, "I understand that, but at least if I can have that information, it then allows me to make sure that I can continue." Otherwise, as I've said, you know-- and whether people intended it or not, it did undermine the position I was trying to fulfil.

And, as I said, your Lordship, you know, having the neutrality to look at the system as fresh as I could because I had never been in the system – well, I trained in the Victoria when I was pretty young, but I hadn't been in the system for a very long time – I was trying to make sure that Teresa and Christine and other colleagues with concerns could feel supported, and I was also trying to create a way where the Infection and Prevention Control team really felt that their position was pretty impossible.

Apologies if I'm not being clear. And it's a very human dynamic that I was managing. I think my Scottish Government colleagues-- If colleagues were wanting to raise concerns, of course they must be able to do that, but the risk of that is the process that Scottish Government colleagues had set up could be undermined, and that was simply trying to show the Inquiry the range of complexity that was in the system.

THE CHAIR: Thank you. Sorry, Mr Connal.

MR CONNAL: I'll see if I can take a general question now, because it crops up at various places. At various points in your questionnaire-cum-witness statement you were asked about things that happened prior to 2020, when you became involved, and you say, "Well, I really wasn't there, so it's not for me to comment." In terms of the challenges that you faced in this new role, I wonder what you think of this proposition. We've heard quite a lot of evidence about the challenges, the issues, just to use neutral phrases that arose in the hospital, probably from 2015----

A Yes.

Q -- right through until not long before you arrive, and some of the colleagues you were dealing with had lived through all of that?

A Absolutely.

Q And did that not make it more challenging for you to come in and try to impose your position on anyone?

A Absolutely, absolutely, and I think lots of times I really considered of did I-- Should I know all the history? Would that help, or should I come in and be and not have the information so that I could be in the moment and try and support colleagues moving forward. I think that – and I mention it in my statement – that listening to colleagues and their concerns and their ways of working over a long period of time was really hard to hear, and that was from a range of colleagues.

So, I think, in some ways, not having history and not having the deep knowledge, I think, allowed me to really hear and listen and try and understand, and also try at a human level of understand what might take-- what I might do with the support of colleagues that are skilled in organisational development to create a way that we might be able to help colleagues move forward.

So I think it was really difficult. I found it, just as colleagues-- and I've said here today, as colleagues having to constantly relive their truth. I think it was really hard for me to do that, and then the responsibility that I have to make sure that, in hearing that, that I took care of

people, as well as care of the information and try and find a way that perhaps would support colleagues in the future.

And that's absolutely what I did to the best of my ability despite the complexities, and I didn't know any colleagues-- and I've said it elsewhere that colleagues were open. They shared with me. They were looking to find a way forward, and I felt the responsibility of that.

Q I think one way that's sometimes used to express this kind of challenge – and I want to see whether you agree with it or not – is that you can't look to the future until you understand the past?

A Yep.

Q Do you agree?

A Absolutely.

Q Just moving on, the point that we picked up earlier about you realising your independence might not have longevity appears for the notes in paragraph 13 on page 437. One of the issues that's been raised by others is that initially, you were regarded, it would appear, as a new neutral person?

A Yes.

Q And then one of the criticisms is then we discovered that Professor Wallace uses "management speak" to answer questions. Have you heard that criticism before?

A No, I haven't heard that particular-- but I think working with my organisational development colleagues we were using some terms, if you will, to try and find that way forward. So-- and I guess that, you know, as I've said to you, I'm a senior leader. We do have a particular way of speaking. I do try and speak plainly.

But also, I think, in relation to one of my earlier points, I think the benefit of me being in this neutral position when I was a really senior colleague in another Health Board and coming into Greater Glasgow and Clyde, I was able to use the experience that I have in this space. So colleagues need to forgive me for speaking in management speak, but what I was really trying to do was to use the skills and experience I have with the organisational development colleagues to create a different way forward.

So I'll need to take that criticism, but I'd hope that colleagues would see that they had a very senior colleague working alongside them, and I think that's the bit that I was bringing to working across Greater Glasgow and Clyde.

Q I just wanted to see if I could find an example.

A Yes.

Q One of the things you deal with in your evidence is an action plan for the Paediatric Intensive Care Unit, and I don't

think we need to read through the evidence about that, but if we go to page 440, you've explained what's in the action plan, you explain the various items, you say it was fully implemented. You're asked, was it completed? "Yes". And then you're asked a question halfway down page 440. “How effective have the plans been?” which, on one view, is a relatively short and simple question, to which your answer is:

"PICU is and continues to be a challenging environment due to the vulnerability and complexity of the patient cohort. Therefore, PICU continues to be a focus and robustly managed, supported and monitored."

Now, that might be regarded by some as answering a simple question with a series of management speak without actually dealing with the question. Do you see where I'm coming from?

A Yes.

Q Because the answer might have been "very effective," "not at all effective," "we don't know yet," but you answered it by telling us a lot of other things.

A Yes, and I accept that. I was probably trying to be helpful, and also in relation to the PICU action plan, that was something that I had taken over from Professor Bain, and so I was coming into the work halfway through, and I guess, for me, the reason I've maybe added the extra words is because the Pediatric Intensive Care Unit does continue to be a focus, and that's simply what I meant by that, but I accept your version of the points.

Q Let me ask you some more really information points because this may be helpful to the Inquiry more generally. Obviously there were a series of investigations. Somebody said it's the most investigated hospital.

A Yes.

Q There was the independent review. There was the Oversight Board interim report and final report. There was the case note review.

A Yes.

Q And one of the things that happened in your witness statement was you were asked, “Well, what happened to the recommendations from these various communications?” And am I right in thinking two things? Firstly, that the way a record was kept, or at least latterly, of what was happening about these recommendations was to create a spreadsheet with the recommendation, who was in charge of it, what they were supposed to do, and what was then done. Is that correct?

A Yes.

Q And I think I'm right in saying that there's a 2024 version of that

spreadsheet, which you have, but for various technical reasons due to a SharePoint problem we've been advised we don't have yet, but it's coming our way, but that should have all of that information on it, I take it?

A Yes, absolutely. If I may, so, that process of the spreadsheet was an organisational control system and to make sure that the actions were completed, but also that they were being tested to make sure that they had been implemented, or that they were working, how the actions from all of these reports were ensured that they were being delivered. We all had individual areas, and you'll see that from the report, but also there was a Gold command structure set up, and those structures were being talked about because during the pandemic, the Gold and Silver, and Bronze commands were in the fore, and that was set up.

And the work of all of these requirements or actions were challenged and tested in the organisation to make sure they were being delivered, and then the spreadsheet and the SharePoint that you refer will show the documentary evidence of that. So there was a process in the organisation to make sure that the actions were being taken forward, that they were being taken forward timeously, and there was an additional process to make sure that if an action was put in place that it indeed had been implemented. So there is two things in there, if that's helpful?

THE CHAIR: Did I hear you use the expression "Gold and Silver"?

A Yes, Gold, Silver and Bronze.

THE CHAIR: Right. It's quite important that those of us who don't necessarily have access to more technical language understand what you're saying. Now, am I right in thinking that the expression "Gold" in this context means strategic level, Silver means "tactical level"----

A Absolutely.

THE CHAIR: -- and if we get to Bronze, which i don't think we do in your statement, that would mean "operational"?

A Absolutely----

THE CHAIR: Thank you.

A -- and it came to the fore, your Lordship, during the pandemic, so that was used in Greater Glasgow and Clyde to show the focus on these actions.

THE CHAIR: Thank you.

MR CONNAL: And, in effect, what happened in your witness statement-- but you were asked, "Have all these recommendations been done?" And you said, "Yes, they have," I think as of August of 2024, and then you're asked, "Is there anywhere we can see that

documented?" and I think my understanding is that the best place to find that documented is in the 2024 version of the document we've just discussed. Is that correct?

A Yes, I think that's the most up-to-date one, absolutely.

Q And we're told that that's coming. There's said to be some difficulty in accessing SharePoint, but in any event, this, again-- this is quite important from a technical perspective. In your witness statement at page 444, just bring that up, you confirm that "all the recommendations of the Oversight Board have now been completed as of August 2024." That's your position?

A Yes, well, certainly that's the document that I reviewed in relation to all of my actions.

Q And then you're asked a similar question about the case note review and on 445 you say as far as you're concerned that had all been implemented?

A As far as the information that I have, and obviously and I would be looking at the actions that were assigned to myself as a lead but, yes, that's my understanding.

Q I wonder if we can just look at a couple of these because they are said to be of particular interest. Can we look at the ARGG that's referred to on page 445, bundle 27, volume 14, page 25? We'll just bring that up, and I'm looking for para 31. I think it should be something like page 39. Can we just scroll through this? I'm looking for what's described as "para 31." It's a reference to NHSGGC reviewing the ICNET alert organism list. Actually, I'll not be able to find it now.

Oh, yes, it's down at the foot of the page that we're looking at at the moment in 7.1. Was that one of the ones that was for you to deal with?

A Yes, well, it would say-- it says Int--- yes, yes, yes, it would be, yes.

Q So Int Director of IC is----

A I think so, I think so, it doesn't have my initials, which it normally does, but I think they would have been for me, that would be the "Interim Director of Infection Control," yes.

Q I think the initials against it are probably Sandra Devine's, it would appear?

A Yes, so the-- yes-- I mean, I think either way we had worked on these together because, again, I was fairly new in post and also, as I've said in my statement, supporting the Infection Control Team and so I would have been close to all of these, and, again, going back to the the role which you described earlier in terms of that, you know, I was supporting and also making sure that my colleagues had the support to do their

roles. So you would have saw me supporting both-- both having the lead for something and then working closely with the colleagues and the Board.

Q So your understanding is that is an action that is complete?

A Yes, my understanding is that that's complete, yes.

Q And the next one, the-- no, back to-- I need to move down, I think, another one. I'm looking for one that says "revisiting concerns about outbreaks of gram-negative environmental infections", which, for some reason, doesn't appear here. Can we just scroll on? I apologise, I've been given a sightly different document. Do you remember having to look at a recommendation that you had to review "trigger concerns about future outbreaks" and "reliance on SPC charts should be reevaluated"? That does seem to be one that you were dealing with. Do you remember dealing with that?

A Yes. Yes, I would-- I mean, yes.

Q Is your recollection that the recommendation was complied with?

A Yes, that is my recollection.

Q Thank you. Just again for completeness – we can leave that document now – you were also asked about the independent review and what came out of the independent review, and your evidence in page 447 of your witness statement, if we just go there, about two-thirds of the way down is that, so far as you're aware, there are no outstanding actions arising from that independent review.

A That is my understanding, and, yes, I-- yes, in terms of-- I was pretty new in the Board at that time, and I did have specific-- in relation-- specific actions which I then took into the Silver command, but I was in a supportive role in there, but-- I'm not sure about the whole document, but my understanding is the actions that I had were complete for these, yes.

Q I've been asked to raise another question with you about the incident management process framework, and you deal with this on page 451 of your witness statement. You use an interesting word there, which we've seen used elsewhere. You say you've got an incident management process framework, etc, and you say, "This framework is informed by the following documents," and then you mention a number of documents, and you go on to deal with essentially the reporting tool that arises from that. Now, the question that I've been asked to raise with you is is it the case that GGC has its own structures about HIIAT assessments which is not precisely the same as the

NIPCM, Chapter 3 details? Because NSS, I think, are suggesting that you should be doing the same as everybody else here.

A Yes.

Q I just wondered if I could have your comment on that.

A As far as I'm aware that we follow the correct process, the word "informed"-- I don't know whether that suggests that we do not comply. I think everyone has worked really hard to make sure that we're fully compliant, and I think any board would do, and certainly in the board that I was also in at that time we would do that, so I'm not aware that we're following-- we're not following that to the absolute letter, but the word and form, I don't know whether that's the issue, but I'm not aware of a variance from that.

Q I'm advised and the information I've been given is that:

> "The Board has developed its own governance structures around carrying out HIIAT assessment and criteria for reporting infected-related incidents…"

That came from the evidence of someone called Laura Imrie to this Inquiry.

> "…including its own criteria for deciding when a HIIAT will be carried out, if a PAG or IMT is set up and when incidents are required to be reported."

Also coming from the same source, and I've been asked by NSS to say, "Well, why are you doing your own thing here?"

A I'm not aware that there's a variance, and I think the other guidance documents that have been developed have been developed to really support staff being-- following the guidance routinely and easily, for them to follow the guidance. I'm not aware that we are not following the guidance, I'm not.

Q The reason obviously I've been asked to ask this is that----

A Yes, understood.

Q -- NSS would say, "Well, if we are trying to keep tabs on what's going on across Scotland, we need all the boards to follow the same system for reporting, otherwise we can't make a comparison." Is that a fair point for them to make?

A Well, it would absolutely be correct if there's national guidance and there is an omission or change on our part. I am not aware that there's anything within the guidance that we are not following, and I'd need to check that for the Inquiry, and I would be obviously concerned about that because, again, from the journey you've taken me on through my statement today and I continue to work every single day,

everyone is absolutely trying to get this right.

In some ways, I think Greater Glasgow and Clyde in its journey has probably been trying even more than-- or trying to do even more to make sure that they-- and me now that I'm working there, but they-- what we're talking about here, we're absolutely following things to the letter and-- So, I'd need to check that, but I'm not aware that we're following anything that I have seen. Whether it's our communication strategy to support Infection Prevention and Control, whether it's the framework that you mentioned, absolutely, it reads across to the guidance and I would be happy to check that for the Inquiry.

Q Well, I think probably all I need to do, given that evidence, is ask you this: do you accept that it's unhelpful to the national oversight of infection-related issues if different boards use different criteria?

A Absolutely. I would add, if I may, that as part of the work that I described earlier on, I did look at other boards, and it was an action for me from the Oversight and looking at other boards, and as I think I've said, Greater Glasgow and Clyde compared extremely well and often were exceeding what was being asked. Again, I was constantly testing what I was seeing because I was

a nurse director in a board at the same time with an Infection Control lead, and I was also comparing the two systems to my own system, although it was much-- a smaller system, so-- But we must-- I mean, the reason for these is to make sure that we're doing the right thing, and I absolutely understood that we were.

Q If we can move on to the next page, please, I have another question for you. In the middle of answer 48, you say that:

> "Performance against the national infection targets were strong and improving across NHS GGC and sitting well against other Health Boards..."

So I can give you some context to the question, you'll understand that much of the material the Inquiry has been hearing is not about the routinely monitored infections but about issues of possible connection between infections and the environment. Whether it's air or water, it doesn't matter.

A Yes.

Q The question that I need to put to you is how helpful are these national targets as giving any indication of the risks from the built environment?

A I mean, I think I would have to agree that-- I'd probably answer, maybe, this in two parts, but the targets in terms

of the infections that we're looking at across Scotland is important in the fact that we are comparing systems across NHS Scotland, so I think it is an important benchmark in terms of Greater Glasgow and Clyde as compared to other boards as it would have been for the board that I was in. I think these infections-- Although you're right they're not connected particularly to the concerns perhaps around the built environment, but it shows a whole system that's caring for patients and trying to keep patients safe, and a high degree of compliance with infection control processes across not just the Queen Elizabeth and the children's hospital, all of the hospitals. So, it gives an oversight for us for improvement in terms of Greater Glasgow and Clyde. It compares us against other boards and looks to see if we are at all out of kilter.

One of the things you'll have seen me reporting in the HIIAT and one of the things that-- coming to Greater Glasgow and Clyde was, "How do we make sure"-- as your Lordship had mentioned earlier, in that Bronze command or that very, very fundamental level is how we supported people every single day to take care of patients in terms of Infection Prevention and Control, and we developed a whole system improvement collaborative. So, what this does allow us

to see is a system that's behaving extremely well around Infection Prevention and Control, but you're right, it doesn't deal with-- particularly with the areas in relation to the environment.

However, within the HIIAT report-- and that was something that-- coming to Greater Glasgow and Clyde and as part of that new approach and listening to colleagues, we did refresh the HIIAT, and then you'll see in the HIIAT making sure that we are reporting incidents and outbreaks, and narrative in terms of what we were seeing and how we were managing them. So, I agree with you that-- in relation-- but it also does show a system that's continuing to improve around the fundamentals of infection control, albeit not particularly linked to the environment, as you've said.

Q Thank you. I'm going to pick up with you, at various points in your witness statement, issues where you appear to be-- I'll perhaps avoid the word "criticising", given our conversation earlier, but making comment on what a number of the microbiologists have or have not done. Let me just pick one up here that I can probably do fairly quickly – page 453. What happens here, as I understand it, is that, at number 51, Dr Peters contacts you and says, "Look, there's talk here of two patients, but, in fact, three have died and one's very

unwell." Now, I just pause there because you give a very long narrative explaining who did what and when and so on. The facts raised by Dr Peters are correct, are they not?

A Yes, that was in relation to the outbreak in intensive care, which was just a few weeks after me coming to the board and, absolutely, what I tried to do was also show the information in relation to how we were caring for people. I think that it was a timing--

I was pretty disappointed and devastated when I saw that, because everything I was trying to do through the HIIAT and through colleagues was to make sure that we were as open as we can be, and actually I was trying to do even more than that, given the context, and this was because the outbreak ran over the reporting period. What I do now at the Board is that I normally-- I'll have data-- I'll have the data that's in the HIIAT, and I'll have probably almost nearly a month and a half or almost two months of data, although the second month wouldn't be verified yet, so what I always try and do is then say, "Add if there's anything changing in that period," and that was something that I learned from the concerns that Christine had raised. It was a genuine-- just timing of reporting, but I can see the concern that it created, and what I wanted to do here in

my statement was show the processes in which people were following to understand the outbreak, make sure that we could contain the outbreak, and care for people. I genuinely, when I saw that, was disappointed that in some way the information hadn't been complete. That was not my intention at all.

Q The reason I put that to you is that there are comments about your Microbiology colleagues scattered throughout your statement, and I'm keen to understand exactly what it is that you're saying that they are doing that is inappropriate because I think you told me earlier on that if they have a concern, they're probably obliged to raise it.

A Mm-hmm.

Q If we take that one as an example, yes, you explained very carefully how that was a reporting date overlap, but she was right to point out that one thing had said two and, in fact, there were four.

A Yeah.

Q So, she wasn't making it up or alleging something that was untrue or anything of that kind. Is that not a fair point?

A Yeah, and, I mean, as I said in relation to all colleagues, I absolutely did my utmost to listen and hear and to try and make changes. I absolutely did. I think, when you look at my statement,

there's about 14 or 16 incidents where my colleagues have written to me, and, again, coming to Greater Glasgow and Clyde, I wanted to hear that. Therefore, you're seeing me responding, seeing that I'm hearing them, that I'm listening, and that I'm taking-- and I usually work with-- because it tended to be Teresa and Christine-- to see what they would be comfortable with me linking with the Infection Control team or others because I was trying to bring people together. In that space in the middle, or that neutral space, I was also trying to be fair to Teresa and Christine and also the Infection Control team.

So, in my statement, I was just conscious when there were so many of the incidents. I think it was about 14 incidents where colleagues had raised with me, and then you're asking how I've responded to that. What we're seeing is me then responding or trying to give the information to show that we were listening and that the concerns that Teresa or Christine had in this case were being dealt with as part of a normal process.

What you're not seeing is the constant challenge and the responses from the Infection Control team because I was trying to be fair to both, and because of these incidents it looks as if I'm constantly mentioning Teresa and

Christine. I think if the Infection Control team were here, they would feel that I was equally challenging to them, trying to understand-- and also, I had a-- I'm a different individual, new in the organisation, and I had a way that I wanted to help colleagues move forward for the benefit of patients and all those with concerns, including colleagues.

So, again, as I've said earlier, I accept that these are my words, and I absolutely accept that. Every single thing that Teresa and Christine raised with me, I paid attention to. I tried to make sure that they had the information that they had, and also-- I had to also support the Infection Control team, who were who were doing a really difficult job every day.

That's why the organisational development work or the team building work was-- I was trying to understand everyone's perspective and then find the common ground that we could move forward because in some ways-- and I know earlier in the statement colleagues talked about a fractured system that I was coming to work with. What I saw was – and I mentioned it – that everyone was trying to look after patients and take care of patients, and make sure that people felt safe to come into the hospital.

I think that everybody's compass was pointing in that one direction but, in some ways, that compass seemed to

have been disconnected, and in some ways what I was trying to do-- and I was only one individual, but was trying to, with the support of the organisation, help colleagues make that connection again.

I mean, you mentioned colleagues talking about me saying I was neutral or Switzerland or whatever. I also said all of the time, "I needed everyone in Greater Glasgow and Clyde to help me support them in terms of the way forward," and I think perhaps that that feels as if I'm mentioning Teresa and Christine more, but I think if you spoke to the Infection Control team, I think they would have found me extremely challenging.

Q Well, I think the point I have to put to you, given you acknowledge that what's in the statement is your words, you comment on – criticise, whatever phrase one likes to pick – Peters, Inkster, that group of microbiologists, if that's not always just the two of them----

A No.

Q -- on quite a few occasions in your statement, and I didn't find any criticism of anyone else anywhere else in the statement at all, which-- Now, I'm open to be corrected about that, but I certainly didn't find it, so I just wonder how you square that with your proposition that you've just given us that you were equally challenging to one group as you were to another.

A Yeah, and I guess I, you know-- that's maybe an omission on my part in terms of-- As you said at the beginning, it's been a question and answer, and therefore I have been answering the questions. I think, in reflecting, you have an incident here as well, and quite a lot of the questions and answers in my statement are in relation to concerns that my colleagues raised, and therefore you see me responding to them, so you are seeing-- you're not seeing a 360 degree vision on that, and I should have perhaps, in my statement, really broadened that out, but I was answering, in particular with these questions where colleagues have got concerns about patient safety and about patient care and about Infection Control processes. I should perhaps made it much broader in terms of the challenge that that I was making.

As well as supporting Teresa and Christine – I used to meet with them every couple of weeks to listen to them and to try and make the connections – I think the Infection Control team would have felt supported, but I was asking them to work differently. I was also trying to change the narrative that external people had around Greater Glasgow and Clyde, which-- I thought Greater Glasgow and Clyde could tell a different story or a different kind of narrative, and I haven't included that here, but I think colleagues

would have found-- and I had lots of incidences where my challenge and my way of working was very difficult for the Infection Prevention and Control team but, as you said at the beginning, I am now in a role where there's not Professor Bain. I'm Director of Infection Prevention Control. I'm having to lead that system, and therefore responding to anybody with concerns is in the context where I am trying to support and manage the system.

So, I can see why that would feel imbalanced, and I absolutely tried everything I could to treat everybody the same. As I say, everybody did want a different way forward, and I took that opportunity.

Q Well, let me just move on. There was another example of technical reasons I won't go in to – I'm not going to put the document on screen – where I think there was a complaint that a particular piece of microbiology hadn't been mentioned in a minute, and you say, well----

A Yeah.

Q "Yes, it wasn't mentioned, but we don't always mention everything." So, there was obviously a difference of view over that. That's dealt with, just for the record, at page 455, so I'll move past that one.

Let me ask you about another piece of question answering. 457, you were

making the point, no doubt very fairly, in answer to question 60 that more stuff was put in place in GGC than there was anywhere else in these particular areas.

Then you were asked in question 61, "Well, did these measures achieve what it was they achieve," to which your answer is, "The aim of the measures is always reduction", which, it might be suggested to you, doesn't answer the question. I can see why it's a nice answer to give, but I'm not sure it answers whether these have achieved what they're meant to achieve.

A In relation to 58, 59 and 60, I guess the learnings in terms of these very particular cases in these high-risk areas, in terms of children-- I think that ARHAI had-- we're now saying the reporting was robust and there was learning for all Scotland. So, the work that ARHAI had done and looking at the infections around a particular area then Greater Glasgow and Clyde extended them to other areas, I think the report was about challenging the rest of Scotland.

So I think, in terms of these infection outbreaks-- in terms of-- the action plan was, as I say, created by ARHAI and, again, the action plan that, again, is in the evidence, you'll see that Greater Glasgow and Clyde-- and I was just in the organisation at that point. I was completing them. I guess in terms of the

aim for measures , there's always reduction, and maybe I should have been more specific in that, but I understand that not all infections can be prevented, but I get up every single day to try and see if we can.

Certainly, within some of these contexts – and as I explained earlier about what we were trying to do in improvement across the system – we're always going to aim for zero, even if the patient cohort or the treatments that they're on make them much more susceptible to infection. Again, I should have maybe have elaborated, but for me-- and I remember coming to Glasgow and Clyde and being absolutely clear about, "We're aiming for no harm and zero despite in some areas we may not be able to do that," and I should have perhaps elaborated on that but, for me, all of these-- and all of these every time is about being better. Even if we get into a best in class, I would still be looking for us to set the bar higher, so that's what I meant by that.

Q So, we had a little bit of a discussion-- I think it was yesterday was Professor White, because somebody had wanted to say, "Well, these were an acceptable level of infections," but you, from what you've just said, wouldn't regard saying, "There's an acceptable level of infection" as an appropriate thing to say.

A Well, I can't comment on that, but certainly for me and what gets me up every single day is caring for people and supporting staff, and I-- unless we aim for something really quite huge or almost seems out of reach-- if we don't do that, then we'll get small incremental changes.

Therefore, aiming for zero infections or no pressure injuries or no person falling and harming themselves under our care-- then I want to aim for something much greater, and hope that the system and that the staff can use improvement to think about the possible-- So I understand the likely rates of people who will get an infection in hospitals. I understand that, but it will not stop me from designing a system that's aiming for something much greater, despite knowing the likely evidence in relation to that. So, that's certainly where I would come from and what gets me up every single day.

Q Thank you. Can I move to another page and another topic? 464. One of the issues that obviously cropped up is that, from time to time, there are differences of opinion, and let's not get into what these were for the moment. No doubt, there is a process whereby if somebody is not happy, they can complain. The question you then asked in 74 is:

> "What about where there's a significant difference of opinion perhaps getting an external element into the system either [I think it's suggested] by a peer review [so somebody in specific] or possibly a conversation led by someone else."

You didn't think that was a good idea.

A So, it maybe touches on the answer earlier. So, one of the suggestions when-- in dealing with so many differences of opinion, as we've touched upon, I did think about setting up a kind of space in which we could-- where there was a difference in opinion, and we could have that discussion because that's how I would expect colleagues to have-- and conflict-- perhaps with a small "c", but conflict is really important in getting improvement.

However, when I did suggest that perhaps we would you know have a separate process, I couldn't garner support for that. I think, in the process that I was with the two organisational development colleagues in terms of trying to find the common themes and trying to find answers to them to make the system and colleagues within it feel better, this just felt like the time wasn't right. I think I had support from some colleagues, and other colleagues felt that they wouldn't be safe in that space in terms of-- their relationships weren't strong enough yet.

Also, I was being challenged about doing things outwith the system, and what I'm trying to do, in terms of supporting colleagues, is to make sure that they can be supported and that the system works. Similar to the conversation that you'd had earlier with me around the CNO, if we've got a system and we're trying to make it work and we're trying to build confidence, if you create things outside the system, we could be in a risk of missing things or not following the process and not making sure things are sitting within the organisation's governance and risk management.

So I think the timing-- I did suggest it. I did think it would be a helpful thing. I think it was a suggestion from-- I think it was conversations I'd had with Teresa, who was really supportive of me in showing some of the ways that they worked before. It was out of that conversation with Teresa that we thought of maybe having this space and-- the timing-- my assessment was that that would not-- it just wouldn't work, and I did revisit it, and I had a really-- Again, in terms of maybe perhaps me not showing the 360 degree, I had a really difficult conversation with colleagues in relation to, "Could we make this work," and it wasn't felt that that was safe to do, so--

and I risked sitting outside of the system. In terms of that additionality, we would sit outside the management arrangements. It just could be quite destabilising, and for those reasons, I didn't pursue it, although I did consider it.

MR CONNAL: My Lord, this might be an appropriate time to break.

THE CHAIR: Yes. As I said, we usually take our lunch break between one and two, so if I could ask you to be back for two o'clock. Thank you.

A Thank you very much.

(Adjoruned for a short time)

THE CHAIR: Mr Connal.

MR CONNAL: My Lord.

Professor Wallace, despite my best endeavours, I have to go backwards rather than forwards. Can I go back to the discussion about the reporting process and the issue you said you were going to go and look into----

A Of course.

Q -- as to whether your Board was diverging from the national guidance.

A Yeah.

Q I'm told – or probably reminded, since I was there – that Sandra Devine had said that there was an SOP for assessment and reporting of infections, and I'm told, and I'm afraid I haven't had time to check personally, that this may not necessarily be readily available among the documents that we have. So, the ask is that, assuming there is such a thing, that you arrange for it to be provided to the Inquiry.

A Yeah, absolutely, and the-- If I may, the SOPs that were referred to-- and I think colleagues have answered that-- It was one of the first actions that colleagues were asked to not use SOPs and just to use the national guidance where-- I think colleagues had shared that they had developed SOPs so that a staff nurse in the middle of the night would have a very easy-read access. So, I think that action was taken literally before I came into post, or certainly just not that long after.

Q Well, if there is such a thing----

A Of course.

Q -- it would be helpful if you would make it available, and then, of course, we'll make it available to all of the participants.

I've suggested I could ask you a sort of quasi-hypothetical question to understand the kind of reporting process. If there was a water leak in the NICU, given the potential risks to that particular cohort – I mean, the water may not have been clean, and so on – would that be reported to ARHAI, as far as you know?

A So, every single incident we look at it on its merit, and we also look at it with a range of colleagues. Water leak

infection control would be really close to that. A water leak could potentially be an organisational incident rather than an Infection Control incident. I think what we would do, and certainly what I would do with the Infection Control team, is look at that incident and see if that requires a HIIAT scoring or a reporting scoring or not.

I do think it's one of the things in terms of, you know-- There was one of the things when I was listening to stakeholders when I came to Greater Glasgow and Clyde-- was people's perceptions of Greater Glasgow and Clyde and how they shared their information. So, that kind of dynamic way of making sure that we are doing the right thing, as I said earlier, that we're considering the stakeholders in the widest sense, and that, of course, patients and families are front and centre; and then just how we develop formal and informal relationships with colleagues to make sure that we are reporting things in the way that others would.

There was some challenge to me, if I'm honest, when I came around that and about the tone of reporting, and that's something that we've been working really closely with and we're developing over time. So, we would treat each incident as we've seen it, and a water leak-- and, certainly, water leaks have been reported before, and not every water leak has.

Q Thank you. Can we now go back to your witness statement? We'll make an endeavour to move forward now, instead of back, at least in relation to the witness statement. We go to 472, please. It's just, really, a point of information. At the foot of that page, let me just scroll it up, you make the point that-- We're talking about Neonatal Unit here:

> "This is the only unit in Scotland that does this extensive screening which can lead to an increased number of isolates from babies which triggers scrutiny of ... environmental issues."

Were you aware who instituted that screening and why?

A So, I don't think I am aware of who instituted it, and I can, in terms of-- I think I tried to share some of the-- I listened to the colleagues in this particular area, and I think the going above and beyond was because these are our smallest and sickest babies, and also everyone's working really hard. This is a case where we would absolutely be working really hard to prevent any infection. So, my understanding – and I don't have the correct history but, again, I would be able to find that – is that colleagues did this over and above

screening to try and be ahead of the curve, so try and avoid any infections, where they can, in this group of tiny babies.

Q I'm sure that's a very good idea. The information I have is that it was introduced by Dr Inkster following an outbreak in 2015, but you wouldn't know that one way or the other?

A No, I didn't know that, although I have to say that, you know, Teresa's interest in NICU has always been considerable and, again, I would absolutely see that this was something that she would do, but I wasn't aware of that, no.

Q Another point of, perhaps, detail, if we go to 477, where we know there was this Cryptococcal Advisory Group, and I'm not going to ask you about the operation of that group, but the question at the bottom of 477 was:

"Was this... Group Report made available to the IMT [that had been] dealing with the Cryptococcus incident?"

And you say you don't know, and then you're asked another question about, "Was there a debrief?", and you say, "Well, that's for the Chair", but if the report doesn't go to the Chair, they can't do a debrief on it. Is that not the challenge here?

A Yeah. No, I would see that, and-- yeah, and obviously-- It's by no

way an excuse, but obviously that was prior to me coming to Great Glasgow and Clyde, and so I do have some aspects of history, but you're absolutely right: that would be expected in terms of the Chair.

Q Can I ask you about another issue that we've already touched on now more than once in evidence with other witnesses. On 484-- I need to get your view about this. Particularly, we asked the witness that immediately preceded you about this.

You were asked about why did you ask Mrs Slorance to go to the complaints system, and there has been some evidence suggesting that relatives who are looking for meetings, answers, questions to be responded to in a patient-focused way, and all these other things that we're being told about, don't see themselves as making a complaint at that stage and might be-- So, they might think that the use of the complaint service is in effect a means of diverting them, shutting them up even.

A No. Gosh, no.

Q Is that not a fair comment?

A Well-- and the intention is absolutely the opposite of that, and I'm really, really sorry that anyone would think that. I think, from my perspective, there had been lots of discussions with Mrs Slorance and with colleagues in terms of setting up a meeting where they

could have a conversation with clinicians, and that wasn't possible, just because of the kind of-- the amount of people and types of individuals within that meeting. I remember that taking quite some time in trying to find the right way of doing that.

I think the complaints handling procedure-- and I appreciate the word "complaints" can have that negative impact, but what I was thinking-- If that meeting wasn't going to happen-- Often with families, they will tell us their versions of their concerns or their versions of what matters to them, and then, using the complaints handling procedure, we can systematically-- I can seek the answers from colleagues, and often families will, you know-- They value that. They may then decide to take a formal complaint on or they may decide to to say, "You've given us the information."

But what we try and do all of the time is to meet with families, to listen to them, even from the moment anyone is raising concerns, and the intention was, absolutely, if a meeting wasn't going to take place, my feeling was that at least if I understood the issues and concerns I could start to investigate them, and then furthermore that the Ombudsman-- If people are not happy with our responses or they still have more questions that we've not answered, they nationally can

instruct external reviews, which-- Often families find that really powerful in terms of comparing with the answers that we have given.

But my absolute intention here – and I'm sorry it's not been taken like that – was the opposite of fobbing off. It was to try and get answers where a meeting wasn't going to happen and therefore my concern was that Mrs Slorance wasn't getting the answers to the questions.

Q Okay. Just so you have had an opportunity of dealing with the points that have been made, I think one of the points made about that is that if you don't know what happened and you're trying to find out what happened----

A Yes.

Q -- you don't see yourself as having the information to complain about anything, because you're still trying to get the facts, and therefore if somebody comes in saying, "Oh, here's a complaints process," you may feel you're being pushed in a direction you don't want.

A Yes, no, absolutely, and again I can't state any more than that was the opposite of that. I have to say that often with, I mean, families we can have those meetings with them, we can be clear about the answers that they seek, and in the absence of the meeting, which wasn't going to be arranged or couldn't be arranged for other reasons-- I just had

reached out to think if at least then I could hear the concerns or the organisation could hear the concerns, then I could investigate that.

A family at that point, when we provide the answers, often they then say to us, "Actually, that's fine and I don't need to use a complaints process," or they would say, "Actually, I've got further questions since I've saw the information you've given." So although the complaints handling procedure sounds as if it's perhaps taking it in a different path. The idea is that we get the answers to what people are seeking, and that was the absolute intention to that.

My concern was that Mrs Slorance had questions, and because the meeting wasn't happening, therefore she had not had the information, and I was just really trying to find some way of doing that, and also the complaints handling procedure ensures that there's a timescale as well, and I think, for loved ones, having the organisation respond at an appropriate time helps them, and it also makes sure that the organisation is able to process that as quickly as we can. But families will always be in control of the next steps, or whether they wish to make a formal complaint.

Q If something is submitted with the head of “complaint”, it does mean it's not going to be a meeting at that point, doesn't it? Because everything stops while that complaint is then progressed?

A Well, not necessarily. I think, as I've said, with every family is different and every situation is unique, and we do try and take a person-centred approach to complaints handling, or people raise concerns that are not part of the complaints process. People tell us their stories, which I gather and use at Board meetings. So every family is different and also, as I've said, families may say to us-- many families will say "I've got these concerns and can you respond?" and we give information, and then they'll decide whether they want to proceed or not.

There's lots of times when we're looking at complaints we'll see complaints that have not been moved forward, because families have decided we've answered the questions. So families are in charge of all of that, and meetings can happen during that complaints process. We have a complaints relations team who do a patient case management, so they stay close to the family, check in with the family, and families often change what they seek, and we will respond to that. So it isn't a binary process like that at all. The families are in control of that.

But the opportunity is that the organisation takes the issues, finds the answers and gives them to the families, and then they decide if they need more

information or less. So it's not-- if you make a complaint, the world doesn't change like that at all, and it shouldn't do.

Q Can I just move on to another issue about communication, just so we can touch briefly on it? On 489, in answer to 157, you've been asked what-- and one view might be a relatively obvious question: why is communication between Estates and Infection Control important? And you've said it's "vital."

A Absolutely.

Q Would you then agree that, in any building project, close involvement of Infection Prevention Control is very important?

A Oh, absolutely. Absolutely.

Q And I suspect you're probably also aware that, historically, there were issues about matters in the knowledge of Estates being not communicated to Infections Prevention Control, which you would regard as unsatisfactory?

A Yes, absolutely. That is just, it's absolutely vital.

Q Can we move to-- back a bit? I'm conscious that you've told us earlier today that although you may appear to have made criticisms of only one group, you do feel you were challenging other groups, even though it's not mentioned in your witness statement?

A Yes.

Q Can we go to 492? Now, at the foot of that page, you're talking about developing ways of working, and you say:

"This challenge from a small number of microbiology colleagues can cause significant system disruption, increased and additional anxiety for IPC as the narrative is that their concerns not being explored and responded to..."

Can we then look at the example that you've produced? That's bundle 27, volume 10, page 335. So, we can see the example that you've selected.

Now, Teresa Inkster appears to be raising an issue about the fact that she's already done work on duty of candour. She doesn't know what's happened to that, and that it doesn't cover the issue about post-mortem results. Now, I suppose the question is, is there something inappropriate in the communications that are on that email?

A No, not at all. As I mentioned earlier, Teresa was being incredibly helpful. I-- Christine was much closer to the organisational development work, and I was seeking to have other ways of working closely with Teresa. She had worked really closely with colleagues before and had shared a range of work to help me in terms of resetting the system, and this is an email just offering work and, as I said, I was literally just in Greater Glasgow a few weeks at this point.

And the work on duty of candour was happening across the whole of Scotland, including Greater Glasgow and Clyde and I did-- so this, I thought, was absolutely helpful, and there was no sense that this was a concern for me at all, that she was helping me.

Q You appear to have selected it as an example of a problem rather than something that was helpful?

A No, no, not at all, I didn't, I mean-- I think-- I mean, I think that the conversation you see with Teresa and Christine and myself was around, you know, they were actively sharing their experience. So, I'd heard everyone's stories in terms of the organisational development work and then we were thinking, there's quite a lot in the organisational development work about systems and processes and how communication could better work given that, you know, there was the tension in the relationship.

So, again-- and I've maybe not been choosing my examples properly, but this was something I was really positive about, and then making sure that if there was a gap around post-mortem results, because, in particular, this-- and, again, further in the email Teresa was helping around that, because obviously there's-- you know, there's sadly children and adults having post-mortems in Greater

Glasgow and Clyde that come from a different system, so what she was trying to help me was to make sure that we were aware of the results, and so this was a positive thing.

THE CHAIR: You do see the disconnect between what you've just said and the text we see at the bottom of 492?

A Again, yes, I can see that, and I've maybe not chosen my examples in a way that's been helpful. That was not my intention. But, as I said, because Christine was closer to the work and the Buzz meeting that I was setting up, Christine would be part of that, because she was a clinical lead. So she would be in that space, and Teresa wouldn't be in that space just because of the organisational role.

So Teresa was sharing things around that she'd worked on duty of candour, and I had recognised that, and also that she had shared some examples of how things worked well in the past, which I had taken onboard in terms of resetting the system. So forgive me if I've in some way suggested otherwise. That's not my intention.

THE CHAIR: Well, as I think Mr Connal has probably made clear, at least on one reading, you make a number of quite strong criticisms of-- they may be referred to as "microbiology colleagues," but we understand it as Dr Inkster and Dr

Peters. We point to this email chain, and we've only just looked at one email.

A Yes.

THE CHAIR: But if there's anything else in the chain you want to draw attention to, your narrative and evidence would not seem to support, thus far, any criticism of either Dr Inkster or Dr Peters in this specific context.

A No, that was not-- yes, that's not-- this was a-- I think this was-- I think this shows that we were working together and I was also trying to make sure that things that colleagues were raising can be played into the wider work. That's my----

THE CHAIR: Sorry, Mr Connal.

MR CONNAL: Just if we could leave that email, please, and return to the witness statement at 493? You mentioned Buzz meetings a moment or two ago. Am I right in thinking that Teresa Inkster helped you set up the Buzz meetings?

A So, Teresa wasn't-- just as I've mentioned to his Lordship, Teresa wasn't involved in the Buzz meeting, because we were bringing together across the whole of Greater Glasgow and Clyde, because I was trying to look at the system in the round, because there was so much focus on the south, and the relationships in the south not being the same as other as in the north and in

Clyde.

And this idea-- we were now in-- the pandemic was now in pretty early stages and causing great concern, but actually colleagues wanted to come together, and because Christine was clinical lead, therefore she would be involved in that. Teresa wasn't involved in this just because of an organisational role, but Teresa had given me-- both in terms of telling me how things worked previously, she'd given me lots of examples of how things had worked well in the past for me to replicate. But the Buzz was-- or this meeting of bringing people together for the first time-- I don't think people had been in the room together, and I widened the range of colleagues that were here. So it wasn't just about Microbiology and Infection control. I was looking at it in the kind of wider sense.

And I was initially supported by the organisational development colleagues to try and help create a positive space but, no, Teresa wasn't involved in this, but she did give me lots of examples of where things had worked well, which I took onboard.

Q Can I ask you about another topic? Duty of candour. Now, you've been around long enough to know there are technically two. There's the duty of candour imposed on each-- let me call them "medical professionals" for the

moment, on a professional basis, but also something now called the "organisational duty of candour."

A Yes, yes.

Q I'm not quite sure how the timing works. Were you involved in the preparation or development of the organisational duty of candor at NHSGGC?

A No, and I thought I had covered this in my statement. So, the organisational duty of candour was being supported across NHS Scotland. I had been involved closely in my own Board, but not within Greater Glasgow and Clyde. So, no, but because of the learnings and the feedback from some of the reviews, duty of candour was a key topic. In terms of the policy happening in real terms and how that-- staff can be supported to share when things have gone wrong with patients and their families. So, I was aware of that and I was aware of that in the Infection Control context that I was supporting.

Q If we go to page 497 of your witness statement where you're asked about that and you're asked to explain it:

> "... unintended or unexpected incidents that result in death or harm or additional treatment required to prevent injury that would result in death or harm."

Are you aware that the wording of the Board's policy was challenged by Professor White and then had to be revisited?

A Yes, I think I was aware of that at the time. As I say, initially, I was involved in some of the subgroup work, and I was aware of that, and I was also aware that Greater Glasgow and Clyde made amends following Professor White's feedback.

Q In particular, if you look at the last part of your answer there where you say "would result". Do you know now that it should be "could result"?

A Yes.

Q I want to come back, I'm afraid, to this business of the criticisms. Can we go to 499? Sorry, it's 498, my apologies. Now, you say in-- Remembering the evidence you've given us now is that if you've criticised this group, you challenged other groups as well, and if you haven't mentioned that, that's perhaps an omission on your part.

A Yes.

Q Do we see, in 498, you say this:

> "The behaviours of colleagues who have raised concerns, Dr Peters and Dr Inkster, were however something I had not experienced before despite almost

40 years continuous NHS experience. The overarching desire of all colleagues appeared to be in the service of patient care and provision of quality services."

That's a pretty hefty criticism, if I may put it that way, of Drs Peters and Inkster, which we certainly don't see replicated anywhere else in relation to anyone else. What's the basis for that criticism?

A I mean, I guess in the context of this, I think the word "behaviours"-- Again, I probably can't add anything more than I added earlier. I think I did absolutely everything I could to support Teresa and Christine, and I haven't shown all of the challenges that I was facing, and for that, I've obviously understood that that then doesn't look complete. I think in probably two parts-- In terms of listening to Teresa and Christine and everything they were facing, I think you will see that I tried to get an issues log. I tried to look at the past to help colleagues move forward. I think that people's positions were really rooted-- and that's not just Teresa and Christine, and "behaviours" are not always bad behaviours. I've used the words "patterns" and "behaviours". I think, as I've said, everyone believed that they were absolutely trying to get patient care safe and trying to move people forward. So, even if people have got concerns, I wanted to try and get those concerns into a space where it felt that it wasn't such a conflict, so-- and I just-- Although in my statement there's about 14 or 16 incidents, there was considerable and constant challenges, and what I was trying to do was to respond to them to try and bring colleagues closer together.

I would say, and I have said, that the behaviours/that experience were across a range of colleagues, and I couldn't-- despite everything that I was doing, I couldn't get the answers to the colleagues that they sought, and I was trying to do that and also to try and create a different kind of future for colleagues where they did feel respected, they did feel they could speak up, they did feel-- and that was for all colleagues, and that is absolutely my intention in that, although I accept that that's not what-- the challenge that you're giving to me, and I accept that.

Q You say immediately after that comment that "the overarching desire of all colleagues appeared to be in the service of patient care".

A Yes.

Q Do you accept that Drs Inkster and Peters were always operating in that regard as well?

A I said it at the beginning of my

statement and I've said it in my reflections. When I came to Greater Glasgow and Clyde, I think the level of complexity and challenge, I think, wasn't-- I wasn't aware, but in some ways I'm glad that I didn't know that because I still would have gone and tried to support colleagues. I think that having concerns and how we treat one another is really important, and I was trying to make sure that, in colleagues having to raise concerns, there was still kindness afforded to people, there was still respect.

The only way to get true patient safety is to have non-negotiable respect for one another and to put patients first. That's not about who's right and who's wrong, regardless of who have concerns. It's about how we bring these together. It's the talent in Greater Glasgow and Clyde that I believed, if I could harness, that our system could come even better than it was.

So, it's in that context, and you will see some of the work that I've presented for the Inquiry to consider, the deep organisational development process that we went through, listening to people, discovering what mattered to them, looking for ways to practically make the organisation feel safer for all colleagues, including Teresa and Christine, but also try and move through because, actually, it's not okay that people are not pulling together. That's not about not raising concerns, but actually we are all here for only one thing, and that's to look after the patients and support the staff who care for patients.

If you look at the organisational development work, hopefully you will see much broader than the-- if I've misstepped in terms of the focus in my statements, but actually, you know, the consideration that we have given to everyone was crucial. I know I've used a "clean slate", but I genuinely came in there and had an open mind and tried to treat everybody the same. But I'm now directing in infection control or supporting the system, and I'm trying also to make sure that it's stable for everyone, and not being able to answer colleagues' questions, that was not-- that was a really difficult situation, and that, for me, was the focus of the work and hopefully you'll consider that in terms of the breadth and the depth of that, the work we did to support individuals, and in that, as I've said, and I mean it absolutely honestly, that the challenge I gave to the system was considerable. Personally – and I think I've put that in my reflections as well – I've taken on lots of challenge as well in trying to create a different way forward. So, if I've not reflected that in balance in this, then that's quite difficult to hear, and I accept that, however hopefully you'll

refer to a wide range of work in which I tried to take care of everybody.

Q I wonder if I can ask a follow-up question to that, which may save us a little time in terms of looking at individual emails, for instance.

A Yes, sure.

Q You've, I think, accepted that the desire of Drs Peters and Inkster was in the service of patient care. Can you tell us of any occasion in which the concerns they raised were false or spurious or anything of that kind, or are all the matters that they've raised genuine points of concern?

A In my statement, I had said before the lunch break that there's about 14 incidents where Teresa or Christine have written to me, and I think I said – and I would like to underline it – that every single time that Teresa or Christine raised anything with me, I listened, I heard and I took action. In my statement, I've then tried to respond in a way that shows what Teresa and Christine were concerned about and what was happening in the organisation because they were not either in the IMT or part of that group looking after that patient, and therefore what I wanted to do was to get their views into that mix so that they could be considered and feed back to them when I could. I've also tried to show in my statement that often things were in

hand. There were differences of opinion, of course, and if we can harness that power, then that makes care even safer for patients, and it was often in the manner in which that was being done, and therefore if I take-- and I don't want to take sides because actually I didn't, but on the other-- in terms of the Infection Control team, I often felt that I was constantly challenging them, perhaps not listening to them as closely as I was listening to other colleagues because I also felt if I could support Teresa and Christine, then my other colleagues would be supported.

I think in the way I've answered my questionnaire, perhaps I've not shown the depth and range. I was trying to have a 360-degree view. I was trying to treat everybody the same, and there were times where-- when-- I wouldn't say anything was spurious, but if-- when I've looked at something or when we've looked at something and I've responded back and that answer didn't-- Teresa or Christine didn't feel that that answer was what they wanted to hear, then it didn't feel to them that I had been taking that seriously.

So, I was in a constant state of trying to make sure that I could connect colleagues, raise the questions that they sought, and I was also getting these questions from Scottish Government

colleagues from ARHAI. So, what I was trying to do was to try and create a system where it didn't feel like sides and, at the same time, trying to work in a way that people could perhaps reconnect in a way that they had lost.

THE CHAIR: At risk of just repeating the question Mr Connal has put to you, you are familiar with, or at least I take it you're familiar with GGC's positioning paper, which you were asked about earlier in your evidence. You didn't contribute to that paper, but you know of its existence and I take it you've read it.

A The positioning paper that was in my evidence?

THE CHAIR: It is referred to in your witness statement.

A Okay.

THE CHAIR: The question you were asked by Mr Connal was whether you had any part in drafting it, and you said no.

A Yes. Yes, no, the one that's in my statement is-- I think it's the April '24, and I had no part in drafting that, no.

THE CHAIR: Well, maybe I can approach my question from a slightly different angle.

A Of course, yes.

THE CHAIR: It may be that, once we've heard all the evidence, I will be invited to come to a view on the accuracy of what Dr Inkster and Dr Peters have said and brought to the attention of GGC.

A Understood.

THE CHAIR: I may be asked to come to a view on their good faith. Now, what I think Mr Connal was looking for was your position in relation to your interactions and your knowledge, whether you found any instance of inaccuracy in something in relation to the state of the building or the incidence of infection, any instance of inaccuracy or circumstances where you thought something was being brought to your attention other than in good faith.

A Thank you. I have said consistently today that I believe that everyone was trying to improve care and safety, I absolutely do. In relation to everything that colleagues brought to me, inaccuracy, I would say that's not what I was seeing, but what I was seeing was a difference of opinion between-- and some of the incidents between colleagues raising this, and the response from the Infection Prevention Control team or from what I could find through my curiosity and questioning. So, I believe that everyone was absolutely trying to do the right thing. I understood that these colleagues had terrible concerns about the building. In addition to some of the incidents, colleagues are challenging of whether Infection Prevention Control in Glasgow was a good service, and I heard lots of

things from colleagues to say they didn't believe it was.

What I-- How I approached this was to take them on board, to try and find the answers, to add my own challenge to that, and to feed back to Teresa and Christine, and where there were things that were really helpful, I made sure that they were implemented, and I think it was a difference of opinion, your Lordship, in my experience and the issues that I dealt with, and I was there for a shorter period of time.

So, people in good faith. The views were completely different, and that's why I've used the term about that broken compass. Everyone was trying to find the right direction, but they had lost the connection. I was trying to bring the connection back, and each time – and some examples in my statement – I've gone to the processes in which a range of clinicians, so not just Dr Inkster and Dr Peters-- Infection Control colleagues and the clinicians caring for the patients were making assessments of the infections, our responses, and what we needed to do next. I've tried to do that, hopefully, in a balanced way where we not have been balanced another way.

THE CHAIR: Thank you.

MR CONNAL: Well, I think that probably does help me move through because I won't now ask you to look at every communication and say, "Was that a concern raised in good faith," because you've confirmed that you're not challenging that, but I do have to ask you to go to the closing part of your witness statement where-- generally speaking, whether it's like a questionnaire or whether it's a self-penned statement, each witness has tended to have a section at the end where they're given the opportunity to say, "Well, what do I want to finish with?" When we come to yours at 510, you say-- Question, "What are your reflections?" You say, first of all, "a situation at a level of complexity" that you've never encountered.

A Yeah.

Q You've told us that, and then you say, on the top of page 511, "The safety and care of patients and their loved ones was at the core of this unique" system. So, this is your point; everybody was trying to achieve the same objective, yes?

A Yeah.

Q And then you say in the next paragraph:

> "The approach and impact of the external environment on a system that was focused on acting in response to concerns and often extremely deepseated views added considerable adverse pressure

which did not serve the process well."

You say:

"I could not understand some of the motivations I witnessed which seemed to be at odds with seeking the truth and being accountable to the public we served."

Now, somewhere in there, there seems to be a criticism of somebody behaving in a way that was at odds with seeking the truth. So, I'm keen to understand what you're saying there.

A Yeah. Absolutely. I think where I was coming from there was that, you know-- when I first came into Greater Glasgow and Clyde-- and I was only there just a few weeks, and then the pandemic started, and I saw the external environment. I refer you to some of my evidence around the sort of-- the analysis that I took when I came to Greater Glasgow and Clyde. I did a strengths, opportunities, threats, weakness, and I did a small tool that looked at the environment. What I could see, if I was sort of-- the patients were in the middle of this. What we had was so much concern in the media, so much concern across a range of, sort of, political positions. There was the setting up of the Oversight Board. There was the announcement of this Scottish Hospitals Inquiry, and it was

that, and I was really concerned about the patients and the families voices in all of that.

I did think that people had really really deep seated views. I think it goes back to the point where I said where absolutely everyone that I met believed their version of the truth and what they thought they needed to do. I paid attention to that internally and externally, and I've said that.

I think that constant pressure and coming into Greater Glasgow and Clyde and watching the colleagues in Greater Glasgow and Clyde from the top of the organisation all the way down, responding to all of these concerns whilst we were dealing with the pandemic-- and I, in my role, was trying to see how the teams were working and how Infection Control was, and that is what I have meant in this, and I couldn't understand—

I appreciate people have challenges, and we must accept them. I feel very accountable, which I've said, but that heat and light, I felt, was-- moving away from actually how did we provide safe services today, how did we learn, if learning is appropriate, and how did we make sure that we could respond in good faith. I mean "respond"-- I mean at every level, whether that was me to the government or Greater Glasgow. Just the external environment, I felt, was a

huge risk. In all of that, I was worried that patients' voices were not being heard the way they needed to, nor could we, as accountable people, respond to people whilst this-- obviously required oversight, and it was required.

So that was my overarching-- was-- and I was thinking about all aspects of that, and how could we find something that brought people together. If this was about patients and families and safe care, how could we, whilst all of this scrutiny was happening, make sure that we weren't adding further stress and distress to a system or taking resources away from some teams or people who needed to be focused together, and if we can't all come together during a pandemic, I'm not sure when we could.

So that's what I meant by the "external environment," and that was somebody who-- lots of experience coming into a situation, and I was aghast at how we managed that whilst-- if everyone believes that caring for patients and keeping them safe and loved ones getting the answers they need was at the center of that, it didn't feel to me in my observations – and they are mine – that that was serving us well.

Q One question I think I need to put to you, because I think it may be important to a number of people, is: when you use the phrase "not seeking the truth" or "at odds with seeking the truth," are you suggesting any of the medical professionals involved in your time was not seeking the truth?

A In this paragraph that-- I was literally speaking about the external environment. I was not speaking about whether the Infection Control team or whether my colleagues with concerns or the staff at the front line every single day caring for patients-- while this concern around their system was happening. So this for me was an external environment. The questions I was asking myself was how could we, as a Scottish system, perhaps have created a different environment where people could be held to account. We sought, you know, whatever the concerns were. We addressed them, but we also held people together. That's not to take challenge, but I just-- my concern was that this was not serving perhaps, in my view, patients and families and just the whole system.

I watched clinicians being fearful. I watched clinicians being unsure because we're getting differing views of advice around patient care. I've said – whether that's my colleagues, Teresa and Christine, or the Infection Control team in a range of things – I watched people who had a significant trauma as they tried to understand if something was wrong in their system or, in this case, defects in

the building, which I know has been covered already. That paragraph for me was, "I think we needed to have done better as a Scottish system." That is a very strong personal view of mine, and I offer it in that vein.

Q Before I leave your witness statement, you have one or two other paragraphs before you come to the very end there. I won't ask you to read your way through all of them, because some of them deal with the impact on you. Any other particular points that you want to make about what you've put in these closing paragraphs, because I think I should allow you the opportunity to finish by explaining where you would like to finish in this narrative?

A I mean, I think I've covered it in my reflections. I think I've been incredibly thoughtful just about-- perhaps my statement should have a bit broader, and I will reflect on that. I absolutely did my absolute best. One person-- and supported by two organisational development colleagues who were fantastic, and even during a pandemic, Greater Glasgow and Clyde, including my colleagues with concerns, all responded, and I'm really grateful for that.

I think we did achieve a lot although, as I've said in my statement, the tensions remain today, and that also includes externally. So I absolutely, you know, did my best to try and care for everybody and keep patients and the families at the centre of everything-- and I'm absolutely convinced that I did my best around that. I would encourage you to look at the wider work that we did, and not just the patterns of behaviours which I saw across a range of colleagues. Hopefully, I've addressed the balance.

Otherwise, it's in my reflections. I'm a nurse of 40-odd years. I've only ever put the patients at the heart of everything we've done. I've done brave things in order to step myself away from others to make sure that we could do the right thing, and I certainly have approached this-- I tried to be calm. I tried to be professional at all times, and I tried to really understand where everyone was coming from. Hopefully, you'll see that in my reflections. It was really tough on my family and other things. External environment can be extremely unkind, and all of this-- I don't think-- I think people not being kind is just not okay, and that was really difficult throughout this period. I appreciate people act differently when they're under pressure, but that was very difficult but, otherwise, my reflections are there for you to consider.

Q I have no further questions, my Lord.

THE CHAIR: Professor Wallace, as

you probably are aware, I need to find out if there's any other questions in the room. So we'll rise, and I'd hope to come back to you in about-- or rather, invite you back to confirm what the position is. Maybe 10 minutes----

A That's okay.

THE CHAIR: If I could ask you to----

A Thank you.

THE CHAIR: -- go to the witness room. Thank you.

(Short break)

MR CONNAL: I have two shortish questions.

THE CHAIR: (To the witness) Perhaps two more questions. Mr Connal.

MR CONNAL: I'm obliged. At the end of your evidence, Professor, when you were reflecting and elaborating on your reflections on the things that you thought, you made the point that you felt there was a kind of "We could have done better in Scotland" than what had actually happened. The system was under stress. Things weren't really working in the way that, ideally, they should have been. Having reflected on it, do you consider that NHSGGC played a part in that system not working in the way it should?

A My feeling was that I was watching the whole system and, therefore, all of us, every single day, need to do better, and I thought that what I saw, before I started to look closely, in Greater Glasgow and Clyde was a system that was trying to respond. I think at every turn, certainly, I was really struck-- working with colleagues-- and I described at the beginning of my evidence the way that I was able to be in that place in the middle-- or as my colleagues describe me-- is-- be in that neutral place, and I watched everyone at every level trying to do the best and learn, and also being quite reflective and thoughtful about how they learned or how they got to that situation, and I would include Greater Glasgow and Clyde in that.

By the time I started, there was a range of-- as you said, a range of reviews ongoing, and I was watching colleagues managing to day whilst responding to that. So, I was literally talking about the external environment and, again, they were only my views, and in terms of if we've got patients and families at the centre, how did we create a response strategically, nationally that got to where we needed to be and no question around the challenge, but try and keep people with us.

I think when I was answering the question around complaints, one of the great strengths that we have is to speak

to families, whether that's duty of candour or not and what we think is happening now, but it may not be so. And I guess I was thinking, just as an individual coming into that leadership role, was "Was that really serving us well?"

So, I saw Greater Glasgow and Clyde challenge themselves, look relentlessly back in time, as well as, now, to understand what was happening in their system, and I was privy to that in that I wasn't in the team but I was in this individual role. So, I really saw everyone responding and, again, just in terms of the organisational development work-- to try and bring colleagues to make that connection again. All colleagues supported that during a pandemic. It would have been easy for a system under so much pressure – and Greater Glasgow and Clyde was under a huge amount of pressure given the challenge of the size and the scale and the population needs – to not pay attention to something that needed to change, and I was absolutely supported to take that forward, and people turned up.

I mean, I mentioned the Gold Command, where the organisation were responding to each and every challenge, learning point, and they would respond robustly back, in terms of-- to make sure that that was accurate. So, I was talking about the external environment, but my reflections were that Greater Glasgow and Clyde-- This was so difficult for them. I saw them with the same emotions that I've experienced with my Infection Control team colleagues, and my colleagues, Teresa and Christine, and I saw the organisation the same.

Q The other question I have, I'm afraid, is a little more directed at you as an individual.

A Okay.

Q We know from many witnesses the time and effort that goes into not just turning up here, but also preparing the witness statement.

A Yeah.

Q As you will have noticed at various points during your evidence today, it's been pointed out to you that there were what we'll call a disconnect between what you were telling us today and what was in the witness statement. Now, are you able to help us as to why it is that you signed off on a witness statement that apparently had all these disconnects in it?

A Well, I think I've really reflected on that, and it was not my intention. I guess, as you've described, it's a questionnaire, it's a-- and therefore I've answered the question. I think the-- and I obviously take personal responsibility around that. I've never had to do a statement before, and I guess what I was

doing was answering the questions.

What I've missed the opportunity to do-- and I've reflected on that and I've accepted that, and I did-- It was no intention to be disconnected, but what I was doing was responding to the questions, and I should have perhaps had a much broader view. I also guess that within the bundles and within the evidence I've provided-- or there is lots of evidence that the Inquiry has that they can consider around the approach that I'd taken, the rationale for that, the way that I conducted myself, and every effort I tried to take care of colleagues.

And hopefully you'll see that, and it'll add some balance. I guess because that was already in the evidence, I haven't elaborated on that, and I would have to accept that I could have been much more rounded, but the intention was to answer the questions that posed of me in my statement.

MR CONNAL: I have nothing further, my Lord.

THE CHAIR: That, Professor Wallace, is the end of your evidence, and you're therefore free to go, but before you do, can I thank you for your attendance today, and as Mr Connall has recognised, there's a lot of work that goes into a witness statement, so thank you for that, but you're now free to go. Thank you.

THE WITNESS: Thank you very much. Thank you.

THE CHAIR: I think that's us for the day.

MR CONNAL: It is indeed.

THE CHAIR: We will be sitting again on Tuesday, I think, with Mr. Mackintosh.

MR CONNAL: We are, yes, I understand so.

THE CHAIR: Right. Well, we'll now rise, but can I wish everyone a good weekend.

(Session ends)