Scottish Hospitals Inquiry
Witness Statement of Questions and Responses
Jennifer Armstrong

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

Personal Details

1. Name, qualifications, chronological professional history, specialism etc – please provide an up-to-date CV to assist with answering this question.

A I have attached a word document with an updated career summary which addresses the questions above. This is attached in the reference document which accompanies this questionnaire (Please see Appendix D).

Professional Background

2. Professional roles within academia.

A I have no formal professional roles within academia. However, within my Medical Director job, I have 2 roles which are linked to academia. These are the lead director for under and post graduate medical and dental education and the lead director for Research and Innovation for NHS GGC. I have highlighted and described these roles in detail on the updated document provided for question 1.

3. Professional Roles within the NHS.

A I have set out all professional roles in the career summary document in chronological order from qualification in 1988 to the present day in 2024. I have worked in public sector for over 36 years; this comprises 31 years in the NHS with 5 years as a senior medical officer in the Scottish Government.

4. Professional roles including dates when roles occupied.

A I have set this out in the career summary document in section A.

5. Professional roles within NHS GGC.

A I have set these out in section A.

6. Professional roles within QEUH/RHC.

A I do not have a professional role specifically within the QEUH/RHC. My job spans across the whole of GGC from acute services to mental health and primary care. GGC is one of the largest healthcare organisations in the UK and as Board Medical Director, I have a cross system post which spans the whole organisation.

7. Roles and responsibilities within the above areas.

A I have set out in the career summary in section A, my current and previous roles and responsibilities for NHS GGC.

8. If had more than one job, how was work split?

A I do not have more than one job.

9. How many hours a week did you spend in your role at QEUH/RHC?

A This is not applicable given my answers above.

10. Who did you report to?

A I have always directly reported to the Chief Executive of NHS GGC: from 2012-2017 this was Robert Calderwood and from 2017 to present day, this is Jane Grant. I am part of the board executive team for GGC.

11. Who reported to you?

A I refer to the current structure diagram for the Board Medical Director as I have both direct reports (hard line) and professional reports (dotted line). This is set out in the career summary in section A.

12. Describe an average working day in your role.

A I have certain fixed points which involve meetings and other activities to fulfil the responsibilities of my role both internally and externally to GGC. However, there is a very wide range of other activities in which I am involved, given the breadth and depth of my role right across the organisation.

13. Which of your colleagues did you work with most closely on a daily basis?

A The executive team based in JB Russell House at Gartnavel Hospital (the Board Headquarters), the Board medical directorate team and senior clinical leaders across GGC.

14. Refer to Estates Team bundle, document 29 – Organograms showing the organisational structure within the QEUH.

a) Does the organogram match the organisational structures of the QEUH?

A The bundle I have reviewed sets out the acute sector organisational structure which, in 2015, comprised 6 divisions. The acute sector was led by the Chief Operating Officer (COO), who was part of the Corporate Management Team (CMT) and reported directly to the Board Chief Executive (BCE). I note that estates and facilities are also included but, as the diagram indicates, the Director of Estates now reports to the Board Chief Executive.

b) If not, why not?

A The chart is mainly setting out the divisional structure of acute. However, the organisational structures at the QEUH included both site-based management teams as well as cross system management teams. This has been described in GGC's submission to RFI 5 which includes a high-level organogram showing acute, partnerships and directors, and detailed organograms for specific areas which do indicate sectoral working.

c) How does the structure and hierarchy operate across the different sectors?

A For the QEUH/ /RHC, there are 2 main teams highlighted in the diagram: this is the South Sector team and Women and Childrens team who managed the QEUH and RHC respectively. Both these teams also managed other services across GGC. However, there are other teams, set out in the diagram, who managed services across GGC and at the QEUH/RHC. This would include Diagnostics and Regional services. For example, adult haemato-oncology services in ward 4B are based at the QEUH but linked managerially to the Regional Directorate.

SMT (pre 2015) (questions 15 – 32)

Infection Prevention & Control (IPC) Senior Management Team (SMT)

There are a number of teams to which this could refer. However, I am interpreting the question as the Senior Infection and Prevention Control Team IPC SMT). Pre 2015, this team was led by the Infection Control Manager (ICM), Tom Walsh and his direct reports including the Lead Infection Control Doctor (LICD), Professor Craig Williams, and the Associate Nurse Director for Infection Prevention and Control Sandra MacNamee (Devine).

The IPC SMT led and coordinated the IPC sector based teams and the surveillance team. The structure is designed to ensure a consistent approach is taken across all sites and services and to ensure national/local guidance is followed.

The sector IPC teams are based on all main sites in GGC and each team had responsibility for a geographical area. A separate IPC team provides a service to mental health inpatient areas and health and social care partnerships. Each team comprised an Infection Control Doctor (ICD) and Infection Prevention & Control nurses (ICNs). A separate surveillance team (nurses and data managers) lead on the monitoring and prevention of surgical site infections and monitoring of all Healthcare Associated Infection referred to or identified by the IPC team. The SMT was made up of these teams and chaired by Infection Control Manager, Tom Walsh.

Tom Walsh reported to me. I met with Professor Williams, Tom Walsh and Sandra Devine to discuss infection related matters, either formally through board committees, or informally, through catch ups/phone calls etc.

However, I was not a member of the SMT and I did not attend the meetings. I therefore would suggest that questions 15-32 maybe better addressed by Tom Walsh.

AICC (pre 2015) (questions 33 to 44)

This refers to the Acute Infection Control Committee (AICC). I understand that the inquiry has AICC minutes and papers. I was not a member of this group, nor did I attend the meetings. This committee reported to the Board Infection Control Committee, which I chaired. I note the AICC chair was Dr David Stewart, deputy medical director of acute services with Tom Walsh deputising. The LICD and the AND were members at this time.

I am not a member of the AICC and I did not attend the meetings. It may be more appropriate if the questions in section D from questions 33 to 44 are addressed by either the chair of the committee or members of the SMT who attended to the Acute Infection Control Committee (AICC) on a regular basis.

BICC (pre-2015)

45. What is the BICC?

A The Board Infection Control Committee (BICC) is a standing committee within NHS GGC, with a range of multi-disciplinary members, with specific areas of expertise within infection control, pharmacy, Board nurse director, senior medical clinicians, public health experts, estates, health and safety and both public and trade union representatives. I was the HAI executive lead for GGC from April 2012 to January 2020. One of the responsibilities of this post was to chair the BICC. I rarely missed a meeting and organised any annual leave to ensure I was able to chair the meeting. There were rare events whereby a deputy stepped in for me.

46. What was the purpose of the BICC?

A The committee's Terms of Reference (TOR, updated from March 2017) are included in the Governance and Quality Assurance Framework for Infection Prevention and Control 2019. This was an amalgamation of previous papers and sets out clearly the governance framework within which Infection Control operated in GGC. **(Please see A49401488 – Bundle 27, Volume 8, Page 9)**. The history of the Framework's development up to 2021 was covered in our response to the Oversight Board draft report which the inquiry have under RFI 1 6.

The committee's purpose was to provide a single corporate function for policy approval and strategic monitoring of infection control across GGC; facilitate collaboration between GGC and other agencies; liaise with appropriate committees within GGC; and monitor performance and ensure consistent application of IC policies based on national manual and local Standard Operating Procedures (SOPs). It reports directly to the NHS Board and other board governance sub committees including the board clinical governance group, as well as nonexecutive chaired groups which have changed over the years (quality and performance committee; acute services committee; and care and clinical governance committee).

47. What was escalated to the BICC?

48. Who was in the BICC?

49. How often did the BICC meet

50. What issues were discussed at the BICC?

53. To what extent, if any, were there issues with record-keeping of BICC minutes etc?

A The answers to each of these questions is set out below:

The Public Inquiry have access to minutes and papers of the BICC and these were submitted by GGC in the summer of 2020 prior to the development of formal RFIs with additional minutes and papers for 2020 submitted under RFI 1 2.4 and it sets out clearly that the committee met 6 times per year. It had the support of a secretariat with the agenda, papers and minutes and considered standing items on the agenda which included:

- Healthcare Associated Infection Reporting Template (HAIRT), implementation plan; policies for review and endorsement; educational issues.
- New Build project from late 2014 onwards (at my request).
- Exception reports and updates including the variant Creutzfeldt–Jakob Disease (vCJD) group; Antimicrobial Committee; Acute and Partnership infection control committees and recent outbreaks/incidents.
- Any new business, which was a range of issues from reports to new guidance and action plans on a broad range of issues.
- Update from Public Health Protection Unit.

Section C (the exception reports) detail the issues escalated to the BICC: Mainly red and amber outbreaks and a whole range of other issues e.g. antimicrobial reports. There are clear lines of reporting from ‘bed to board’ and these are set out in appendix 1 of the accountability framework. The HAIRT is a Scottish government template which is in use for all boards across NHS Scotland. This was made up of reports from across the board area.

54. What if any input did the BICC have in the specification of the QEUH/RHC before handover in January 2015?

A From the time I started chairing the BICC in 2012, The BICC had no input to the specification of the QEUH/RHC before handover in January 2015. However, it did have a role in *seeking assurances* from the project team about the specification, and I have detailed this role below in chronological order:

BICC seeking assurances from the project director and team:

There was some discussion about the new hospital which started in July 2014 at the BICC. This spanned over 3 meetings and included meetings between the Infection Control Team (ICT) and the project team as well as subsequent emails including general management and others. Discussion of the new hospital is set out in the paragraph below:

28/07/2014: BICC (28th July 2014)

In relation to the new hospital, Dr Armstrong asked if infection control were involved in the commissioning group. Tom Walsh confirmed that Fiona McCluskey is liaising with Sandra on this and Sandra advised that she has nurses sitting on the groups that they have been asked to be involved in. Rosslyn Crockett (then Board Nurse Director) asked Tom and Sandra to ensure that they are part of the commissioning group. Dr Armstrong asked for an update to be provided at the next BICC and for this to be an agenda item at future meetings. Tom asked what the procedure is for migration of departments and was informed that Grant Archibald (then chief operating officer) is the chair of the on the move programme board and David Loudon is in charge if the commissioning group. Tom agreed to email David Loudon.

29/07/2014

Tom Walsh emailed David Loudon, Project Director and Director of Estates for GGC on 29th of July 2014 offering further support and saying BICC were keen that Infection Prevention and Control Team (IPCT) are appropriately involved in the on-going and future commissioning of the new facilities and offered support.

David Loudon responded on 30th July noting good engagement with the project team and IPCT and to ensure that IPCT were aware of any future or emerging issues, Fiona McCluskey (Consultant IC nurse with the project team) has asked all project team members to alert her to any infection issues, which she would pass to Sandra Devine. He also noted that IPCT was consulted during the design stage. **(Please see A49401487 – Bundle 27, Volume 8, Page 37)**.

06/10/2014: BICC – Senior Nurse Advisor

There were subsequent discussions on 6/10/14 at the BICC, when the Senior Nurse Advisor for the project attended the meeting. She provided a detailed overview along with

a paper setting out who had been involved and in what capacity from Infection Control in the design and at all the stages of work. **(Please see A49401486 – Bundle 27, Volume 8, Page 39)**. There were technical questions from both Professor Williams about ventilation/multi-drug resistant TB (MDRTB) regulations and transplant patients and from the Dr Andrew Seaton, a consultant in infectious diseases, concerning the relocation of the adult unit. Fiona McCluskey agreed to contact Brookfield and get back to ICT.

01/12/2014

At the subsequent BICC meeting on 1/12/14, the Professor Williams reported that he has not heard back regarding issue with transplant patients, and if a contingency plan was in place for MDRTB patients and the emergency flow of paediatric patients. I suggested a formal letter to David Louden asking for an update on these issues and Professor Williams agreed to do this. I also stated that all these issues should be addressed prior to opening.

22/12/2014 – 14/01/2015

There were then a series of emails including the Professor Williams, David Loudon, Wallace Whittle, Currie Brown as well as others, which sets out the position and their opinion that this has been designed to the standards. However, there are further queries from the Professor Williams on the guidance and David Loudon suggests a meeting, which I asked Professor Williams to attend. **(Please see A49401485 – Bundle 27, Volume 8, Page 43)**.

27/01/2015 – 09/02/2015

There are a series of emails from clinicians, managers and Professor Williams seeking clarity from David Loudon. On the 5/02/15, there is an email from Professor Williams together with annotation from David Loudon to Jamie Redfern, General Manager, Paediatrics (later Director for Women and Children), concerning both the MDRTB rooms and the Bone Marrow Transplant (BMT) rooms in paediatrics. The conclusion is that lobbied rooms can be used for MDRTB and the BMT rooms are a similar specification to the rooms in Yorkhill and could be used. There is finally an email from me seeking follow up. **(Please see A49401484 – Bundle 27, Volume 8, Page 47)**.The inquiry has, under RFI 7 2.24, the SBAR dated 26.4.2016 which summarises multiple emails concerning the Infectious Diseases Unit (IDU) including the view of the LICD late January/early February 2015 that the lobbied rooms were acceptable for MDRTB and other infections of high consequence.

29/01/2015

There is an email from me to the Chief Executive, Robert Calderwood outlining issues with rooms and indicating awaiting further guidance from David Loudon. **(Please see A49401483 – Bundle 27, Volume 8, Page 50).**

55. What, if any input did the BICC have into changes in the contract for the QEUH/RHC handover in January 2015?

A The BICC did not have any input into changes in the contract, nor did it have any input into the specification of the new hospital.

I will describe below the only area of involvement I had, which led to an additional service, the adult Bone Marrow Transplant (BMT) Unit, being added to the QEUH in 2013. My role was to assess the clinical case and present to a subcommittee of the board to gain funding. I was not involved in the specification or contract variation for the unit thereafter.

I put forward the proposal to the Quality and Performance (Q&P) committee in July 2013, along with the Chief Operating Officer, Jane Grant (JG), to ask the committee to approve the transfer of the Bone Marrow Transplant Unit at the Beatson Oncology Centre (BOC),

together with haemato-oncology beds at the Southern General Hospital, to the new hospital at an additional cost of £840,000. This had been put through the Board's change process and costed with the project team. The clinical team expressed the view that the services should be co-located with an on-site Intensive Therapy Unit (ITU), which would enable future proofing of services.

This was agreed by the Q&P committee, with an action for the project director to progress. The design and planning of the unit was taken forward by the project team with input from the LICD and external expert advice. The Q&P approval and BMTU design were covered in a timeline submitted under RFI 1 6 and referenced in later timelines submitted under RFI 7.
I did not have any input into this and did not see the specification or the plans for the unit.

Summary of Section E

- The BICC had a clear role and remit, and the governance document sets this out together with terms of reference and membership.

- I, along with the Chief Operating Officer, put forward a proposal in July 2013 to move the Adult BMT unit at the BOC along with the Southern General Hospital haemato-oncology beds to the new hospital. This had clinical support and had been through the Board's change process. The Q&P Committee agreed the proposal and the funding of £840K. Thereafter, the project team, with input from LICD and other experts, took forward the planning and specification of the unit and the contract change.

- I had asked for assurance and ensured that the new build was put formally on the agenda for BICC from July 2014 onwards. The BICC received assurances from the project team that there had been and was ongoing involvement of IC in the design and commissioning stage.

- Between October and December 2014, Professor Williams raised issues with the project team regarding BMT rooms and rooms for patients with infectious diseases. This led to a

formal email to David Loudon, Project Director seeking assurances. He, in turn, asked the contractors. Professor Williams looked for further guidance and assurance as well as sought advice from Health Facilities Scotland (HFS).

- I have **no** expertise in the areas of ventilation, nor the questions being posed regarding BMT and Infectious Diseases. However, I sought to ensure that the project team director engage directly with members of the IPCT as well as senior managers and clinicians to resolve the questions in advance of the hospital opening. Professor Williams along with David Loudon provided assurance to the BICC, me and others that these areas had been resolved in February of 2015. The outcome was the rooms were safe to use with some further work on reviewing specification of BMT.

Involvement in specification of the new hospital prior to January 2015

I cannot answer any of the questions in this section as I was not involved in the specification of the new hospital prior to January 2015. These questions would be best answered by the project director of the QEUH or the team.

In terms of the questions 56 - 79:

A I can summarise that I was not involved in the specification, nor consulted, nor offered advice in the specification for the new hospital. I did not give information or advice on the various NHS guidance, I had no access to plans, manuals or designs. I did not have knowledge, give advice, or receive documentation on the specification and design of the ventilation or water systems, and I did not discuss any of this subject matter with the project team.

I was not involved in and nor do I have any specialist expertise in design, specification and planning for the ventilation or water system for the new hospital. I have not seen any plans, manuals and specification for any of the rooms in the new hospital. I have described the events of late 2014 which involved seeking to address issues raised at the BICC under the previous section.

For questions 80 - 90:

A I know that there are NHS guidance notes (Scottish Health Technology memorandum), but I am not familiar with them and don't have an in depth knowledge of this area. It is only in recent times, I have become aware of these notes and derogations. I am not sure what the impact of non-compliance is and I am not sure which are mandatory or voluntary. I was not involved with the specification of the new QEUH/RHC and did not take part in the clinical output specification and I am not familiar with the RDD.

For questions 91 - 134:

A I had no involvement in the commissioning or validation of the new hospital and this was led by the project team. I don't recall receiving, and I did not ask for, any information from them concerning the outcome of the commissioning and validation.

I do not have specialist expertise or knowledge to be able to address issues regarding the **questions 103 - 113**. I did visit the hospital prior to opening, but I don't have any expertise in reviewing ventilation or HEPA filters and I did not discuss these with any colleagues or any external partners. I did not liaise with the project team over ventilation or water. None of these areas were within my remit or role.

I have described the information sought in **question 54** by the BICC and LICD from the project director and in **question 55**, the request to include the adult BMT Unit and haemato-oncology beds in the new hospital. I understand there was external advice sought but I passed this to the project team to enact. I can't recall a meeting in the RHC in 2013, and I don't know who made the decision on the RHC rooms specification.

For questions 114 - 116, and 126: I have detailed the BICC involvement on gaining assurance from the project director on both BMT and ID facilities in answer to question 54.

Summary of Section F

- I had no expertise nor involvement in the specification of the new hospital prior to January 2015. I joined the board in 2012 after the design and planning stages of the project.

- I have set out in answer to the questions 54 and 55, my only involvement prior to 2015.

Risk assessment at Occupation.

In relation to questions 135 to 139:

A I have no knowledge nor involvement of the risk assessment at the QEUH/RHC and I have not seen any documentation in relation to risk assessment.

140: DMA Canyon Reports

a) Have you seen these reports before?

A I have seen them briefly and, as I am not an expert nor is this my area of responsibility, I have not read them in detail.

b) Was this the DMA Canyon 2015 report (document 29)

A I note document 29 is the DMA Canyon report though I am not familiar with it.

c) In her statement, Dr Inkster has advised the Inquiry that you called her when you were told HFS had found the DMA risk assessment reports, and that you were' *really worried about patient safety implications'* When did you first become aware of this report?

A I first became aware in or around late June/early July 2018.

d) Who made you aware of this report?

A The Chief Executive called me into her office and showed me a hard copy of these reports and drew my attention to some of the issues highlighted.

e) What actions did you take upon becoming aware of this report?

A As the reports were highly technical, I was keen that they were shared with Dr Inkster who had been managing water incidents and for her to make an assessment of them. I can't recall the phone call with Dr Inkster. I did not have a copy of the 2 reports, and I asked Tom Walsh, who did have access to them, to share immediately with Dr Inkster. **(Please see A49401482 – Bundle 27, Volume 8, Page 56)**.

In addition, there is also an email with a briefing note and presentation which was given at a board seminar on 3/7/18. This sets out the 2 reports and describes how the Board will take forward an internal review, and support an external review, of the water systems at the request of Scottish Government (SG). This was to be led by the Chief Operating Officer with support from the Infection Control Manager. A Water Systems Review SBAR dated 8.8.2018 was submitted to the SHI under RFI 7 2.24; **(see also A49401481 – Bundle 27, Volume 8, Page 61 and Bundle 13, page 921)**

For questions 140 f) to r): (p is answered below)

A I cannot answer these questions as these were estates reports and I don't have the knowledge or expertise to address these questions. Following the discovery of these reports, the Chief Executive ensured that all the actions were completed along with the new Director of Estates. I do not know why Infection control only advised in 2018.

For questions 141 and 142:

A These questions maybe better addressed by estates colleagues.

p) What was the impact, if any, of the failure to implement in 2015 recommendations on patient safety or bring its conclusions to the attention of the IPC team within the hospital?

A. I cannot comment on the technical issues within the DMA Canyon report and how this impacted on the management of the water supply within the QEUH/RHC as this is perhaps best addressed by estates and infection control colleagues. The Board's internal investigations suggested that there was no clear link between the hospital, including its water supply and the environment with the exception of 2 individual cases in 2016 and 2019. The Board has also commissioned external reports to consider this matter. Ultimately my understanding of the available evidence is that there is no increased risk of infection over and above that of other comparable hospitals.

Summary of Section G

I was not involved in the risk assessment prior to or at occupation. I became aware of the DMA Canyon report in summer of 2018 when the chief executive asked me to review them in her office. I asked Tom Walsh to send the reports urgently to Dr Teresa Inkster, the LICD to determine if there were any implications. I presented a briefing note and presentation to board members in July 2018 about the reports. The COO led the review of the water issues to send a full report to SG.

The available reports, including in relation to epidemiology, review of evidence and WGS do not indicate that the environment at the QEUH/RHC presented any additional risk of infection to patients over and above the normal risk. The summary of evidence presented also highlights more likely causes. I am not an expert in these areas but many of my colleagues who are due to give evidence, are experts in these areas.

Infection Control in General

I have set out in question C (SMT pre 2015), the structure of the SMT and how it related to the different sectoral teams. A detailed organogram covering the IPCT from 2014 to 2022 was submitted under RFI 5 and sets out in detail the structure and the numbers/names of staff who comprised the infection control team. There was a team for the QEUH and one for the RHC with the structure described.

The Assurance and Accountability Framework document 2019 has already been submitted to the inquiry, which sets out how the surveillance and monitoring works from point of care to the board and the various reports which set this out (appendix 1). The response to outbreaks is also set out in appendix 7. All PAG and IMT minutes for the entire QEUH site since April 2015 have been submitted to the inquiry under Section 21 notice 2 [RFI 11], unless previously submitted under RFI 7 2, or within timelines submitted under RFI 1 6 (the timelines covered the 2018 water IMT and 2019 cryptococcus IMT).

Many of the questions relating to the QEUH team specifically, maybe best addressed by Tom Walsh, the infection control manager. **(questions 143-156).**

Many of the specific issues in **questions 157-177** may be best addressed by the LICD/Sandra Devine for Infections control. Questions relating to HAI/Risks of infections etc are perhaps best addressed by the IC clinicians.

Water supply in General

This section requests information about the water safety group: I was not a member of this group and did not attend any of their meetings. I note the Board Water Safety Group minutes were submitted to the inquiry under RFI 7 2.13.

Questions 178 - 186:

A I would suggest that Mary-Anne Kane, Interim Director of Estates, or Tom Walsh may be better placed than me to address the questions in this section. The remaining questions from **187-196** may be better addressed by estates colleagues and LICD.

Horne taps and filters (questions 197- 202)

Question 197a) b) and c): Understanding of the use of Horne taps

A I note that I am recorded as being present in the IMT of 19/03/18. I have little recollection of the meeting. I have read the paragraph regarding decontaminated taps and issues about autoclave Horne components. However, I don't recall this. I don't have the expertise and I cannot answer the question **197 a) b) or c)**. This maybe better addressed to the LICD/ICM.

Question 198 a) to g) to 201– Meeting Friday 6/04/2019

A I have reviewed bundle 10, document 1 and it is the minutes of a water review meeting held on Friday 6th of April 2019. I was not at this meeting and have not any specific knowledge of it and I cannot answer the questions set out in 198 to 201.

Question 202 – Point of Use Filters

A I have a basic understanding of Point of Use (POU) Filters only and these questions would be better addressed to LICD and Estates.

The Water Incident

203. What concerns did you have about the water supply at QEUH/RHC?

A I had no concerns about the water supply in QEUH/RHC prior to March 2018. No one had raised any concerns with me concerning the water supply. Water testing and results were raised in October 2017.

204. When did these concerns emerge?

A Date concerns emerged: 01/03/2018.

205. Please provide details of the concerns as they emerged in 2017 into 2018 in respect of water issues?

a) When did the concerns arise?

A **2017:** The concerns raised in 2017 had been about water *testing* and the *receipt of results*, which are set out in the minutes for the 4th of October 2017 (this was the meeting which led to the 27-point action plan). At that meeting, David Loudon advised that GGC were compliant with testing and the estates manager undertook to ensure results were timeously provided. I was not made aware of any positive samples, which would indicate that water supply was an issue.

In addition, a retrospective review of the Microbiology Senior Management Team minutes for 2017 did not suggest any concerns raised there; A retrospective report showed appropriate reactive water testing in relation to infections with no positive results as far as I am aware. A report, "Management of infection control incidents in ward 2A/RHC during 2017' was submitted under RFI 7 5.4." **(Please see A40615542 – Bundle 14, Volume 2 page 75 to 78)**.

2018: On the 1st of March 2018, Dr Inkster emailed me and others to alert us to 'a significant issue' with the water supply in ward 2A. **(Please see A39240389 – Bundle 27, Volume 9, Page 377)**. Due to the weather situation, (beast from the east), it was not possible to hold an IMT and Dr Inkster was updating by email.

b) Nature of the concerns:

A Dr Inkster's email set out there had been cupriavidus isolated from a patient's blood culture in January 2018. There had only been 2 previous isolates before in RHC: 1 in September 2017 and one in February 2016 which was linked by typing to a contaminated water supply in the aseptic unit. The patient responded to treatment. Another case of a patient with pseudomonas was raised in Feb 2018, with an outlet positive, but patient had not been in that room.

c) Possible causes of concerns:

A a number of outlets were tested positive for cupriavidus. The source was unclear and awaiting results from main tanks with swabs from taps which included flow straighteners implicated in incidents elsewhere.

d) What Actions were taken in response to these concerns:

A Control measures were put in place, not using showers, washing patients with bottled water or wipes with hand hygiene using sinks with alcohol gel. It was HIATT red and reported to Health Protection Scotland and a draft statement at present. These actions were the advice of the lead ICD for the Board, Dr Inkster. The IMT minutes of the 2018 water incidents have been provided to the inquiry and were submitted in a timeline under RFI 1 6. I was not present at the IMT on the 02/03/18 nor 09/03/18. There were control measures in place and no new patient cases reported.

206. Refer to IMT Bundle 1, Document 16, page 63 (IMT 12/03/18)

a) What is your recollection of this meeting?

A I cannot specifically recall this meeting: I have identified emails which may provide context.

11/03/18: On evening of Sunday 11/03/18, Dr Inkster emailed me, and she asked me to call the next day. I note an email from Dr Brenda Gibson, the lead clinician for haemato-oncology on Sunday 11th of March highlighting that despite sanitisation to the water supply on ward 2A, bacteria were still present. She suggested an emergency meeting the next day (Monday 12th) and asked that Dr Inkster contact me. Dr Inkster also highlighted the SBAR of the taps to me on 12/03/18. **(Please see A49401480 – Bundle 27, Volume 8, Page 62)**.

b) Dr Gibson raised concerns that the pathogens found from the samples taken were potentially lethal organisms to immune suppressed patients within ward 2A. What was your reaction to this?

A My (and indeed everyone's) focus at the meeting was on the very vulnerable group of young patients and it was really concerning when the pathogens were described. The focus was to do all we could to ensure the safety of patients and that trumped everything. One patient was described as being colonised with steno and no patients giving cause for concern. Dr Gibson expressed concerns which we all shared. The response given by Dr Inkster was that we could deliver a safe source of water and she also confirmed that the patients should not be moved to other wards as the water outlets had not been tested.

The hypothesis at that meeting was that the organisms were being transmitted by human touch and not the water supply.

c) Do you think the action plan from this meeting was adequate?

A The action plan was extensive, with further actions added including all showers put out of use; sterile water for drinking; bottled water for washing and bathing; and wipes for younger patients. In addition, all shower heads were replaced with disposable ones; taps sanitised; 22 mobile hand wash basins to be delivered at 10pm and fitted the following

day. I note I have been minuted as trying to accelerate the showers fitting. The IMT agreed the action plan and no-one suggested further actions.

d) Do you think these significant and very serious concerns were being given the appropriate amount of gravitas?

A The minutes don't convey the gravity with which the senior team was treating this situation. At 7.26am when I read Dr Inkster's email from Sunday evening, I immediately cancelled my meetings and alerted the senior team at the RHC together with the chief officer, Jonathan Best. I set up an early teleconference with Dr Inkster followed by one with the senior divisional team. In addition, Jonathan Best also sets up teleconference for later in the day after IMT which, I believe to be about this topic. **(Please see A49401477 – Bundle 27, Volume 8, Page 67)**. I also went to the RHC for a meeting with the team and then onto the IMT. I can't recall all the details, but there were a lot of discussions about this issue.

The meeting was organised for that day at the request of Dr Brenda Gibson with a multidisciplinary group of experts, all focussed on taking actions at pace. The current actions were designed to prevent children coming into contact with taps/showers and water with actions put in place to resume safe water use. Many preventative actions had already been implemented on Friday evening as soon as the results from the taps were known. At this point, there were no new cases, HPS (Health Protection Scotland) was briefed, and the HIATT was red.

An urgent briefing note was also jointly agreed with Mary Anne Kane/Dr Inkster and sent to me/Jane Grant on the 15/03/2018 setting out all the actions. **(Please see A49401478 – Bundle 27, Volume 8, Page 68 and A49401475 – Bundle 27, Volume 8, Page 69)**.

207. IMT of the 16/03/2018

a) What were the concerns raised at this meeting?

A I remember Dr Inkster phoned me to say that there were three new HAIs in the haemato-oncology patients. I immediately went to RHC and attended the IMT for 16/03/2018 as this was a concern. I don't specifically recall this meeting, but I note the minutes and the discussion as set out.

b) What discussions took place relating to the source of infection?

A I cannot specifically recall this meeting and I can only note what is set out in the IMT minutes. I do, however, note that HPS are in attendance and Health Facilities Scotland (HFS) were asked for advice.

c) Did the increase cases cause concern?

A As I have set out in a), I recall being concerned when Dr Inkster phoned me and heading straight over to the RHC to attend the IMT.

d) What concerns did you have following the meeting?

A I was **not** content to leave this over the weekend and I felt we needed urgent advice from external agencies to determine if there were any advice/actions we needed to take to ensure we did all we could for our patients.

e) What actions did you take?

A I set up urgent teleconferences over the weekend (17/03/18 and 18/03/18) as I was keen that we get urgent advice from NHS England, Health Facilities Scotland (HFS) and HPS. The Chief Executive, Jane Grant, joined, along with GGC team of LICD, General Manager and Public Health team, together with external experts. There was a further teleconference on Saturday at 4pm with NHS GGC, HPS, HFS, and Public Health England (PHE). There are notes highlighting what the group agreed. On the Sunday, Point of Use (POU) filters were discussed and recognised as an effective mechanism for preventing passage of bacteria, and the need to ensure proper fitting. It was emphasised this was a short-term measure. There was also discussion on longer term measures. There was a further teleconference with PHE, HFS, HPS and GGC setting out measures as well as communication. These are in the 'water incident' narrative submitted under RFI 6. **(Please see Bundle 14, Volume 1, Page 105 and Bundle 5 page 116).**

f) Action plan from meeting notes you are going to speak to Jane Grant to see if a proactive press statement should be actioned. What happened?

A It was agreed that we should issue a proactive press release given the public interest in this issue. This was agreed with Dr Inkster, the chair of IMT and a full statement was proactively issued by GGC later that evening to all media and this is included within the 'water incident' narrative submitted to the inquiry under RFI 6, and submitted under RFI 1 22.6

208. Bundle 1, Document 18, page 70, IMT 19/03/18

a) What measures were being taken to manage the situation?

A I cannot specifically recall this meeting, but I note that I was there, so would refer to the IMT minutes, wherein I note reference to the weekend calls. There was a focus on ensuring measures were implemented at pace e.g. extra staff to ensure installation of POU filters. The details of all the measures are set out in the minutes with the full support of HPS/HFS. The hypothesis at this stage was perhaps a batch of contaminated domestic product to explain how ward 4B had cupriavidus in the water.

b) What was your involvement?

A The response was being overseen and led by the lead ICD with advice from HPS/HFS and the IMT. I was keen to ensure board support for all actions and was there to support the LICD.

c) What information were patients/parents given regarding this situation?

A For patient information, this is set out in the 'water incident' narrative submitted to the inquiry under RFI 6 which contains family and staff briefings with narrative context. This was led by the LICD/Directorate management team, and they may be better placed to answer this question.

d) What information were staff given regarding the situation with water?

A This information has been submitted to the inquiry under 'water incident' narrative under RFI 1 6. This was led by directorate team and Jamie Redfern/Jennifer Rodgers maybe better placed to address this question.

e) Who was responsible for overseeing the response?

A IMT guidance sets out the roles and responsibilities, and the IMT has an independent role to ensure effective response. The chair of the IMT leads the response. To co-ordinate the requirements of resources, then the directorate team, in conjunction with the acute SMT, will oversee and co-ordinate the response. The Executive team will be kept appraised or may support with significant issues/decisions as well as ensure board kept updated.

f) What is your view of the control measures put in place?

A The POU filters were confirmed, and quality checked in many areas throughout the RHC/QEUH on morning of 22/03/18. Further specialist advice was sought from Suzanne Lee, an expert in water recommended by Dr Inkster. HPS/HFS were asked to join the response before formal escalation took place on 19/03/2018. There was a range of control measures which were already in place. Please see **A49259264 – Bundle 27, Volume 9, Page 401** and **A40562758 - Bundle 14, Volume 2, Page 105.**

209. In the IMT of the 4th of June 2018, Jamie Redfern advises that a weekly report of actions and investigations is being issued to you. What did these reports contain? Did you follow them up for further information?

A There is a note of a conference call on 24/05/2018 and a draft action plan. I was keen to ensure all possible actions were taken to ensure patient safety. My recollection is that I asked to meet with the team to ensure we were clear on key actions and progress. I also included the COO, Jonathan Best. There is an action plan which sets out a series of 10 actions with responsible people named. (**Please see A49401474 - Bundle 27, Volume 8, Page 73; A32249275 – Bundle 13, Page 379; A49401472 – Bundle 27, Volume 8, Page 83; and A49401471 – Bundle 27, Volume 8, Page 84).** From my recollection, the agreement was for a weekly report with a weekly teleconference to follow up which I did. Events were overtaken as can be seen on 4/06/2018 meeting.

210. What is your understanding of how the rest of the water incident unfolded?

A I have taken this question to mean the 2 incidents from 1/03/2018 to 27/03/2018 then the second one from 04/06/2018.

March 2018: The incident started on the 01/03/2018 to the last IMT held on 27/03/2018. The IMT was stepped down and a separate group was set up with IPCT, facilities, HPS and HFS to investigate filters; new taps and chlorine dioxide, to ensure a long-term response was in place. There was a full report in April 2018 which has been submitted in the water timeline submitted under RFI 1 6.

May 2018: There had been a series of PAGs in May 2018 reviewing some infections which were not thought to be related to water. The May 2018 PAG minutes which consider a possible link to drains are included within the RFI 1 6 water timeline. In the HOIRT 20th May 2018, it is noted that there was to be a review of antibiotic prescribing, specifically meropenom but this does not appear to have been completed. Please see **A36412022 – Bundle 27, Volume 9, Page 402**.

June 2018: The second part of this incident started on the 04/06/2018 at the request of the Dr Gibson and the consultants: Jamie Redfern's email sets out the actions which were advised by the IMT and HPS were also in attendance. There were 8 further IMTs and all have been submitted to the inquiry in the water timeline under RFI 1 6. The focus was more on the general environment and drains. Admissions were initially restricted to the ward then re-opened fully on 21/06/2018. Triggers were agreed and if no new cases for 6 weeks, normal triggers would be resumed. HPS were updating SG daily and the first teleconference between senior staff in GGC, HPS and senior SG officials took place on the 15/06/18 and they were appraised of all the information. This is included in the water incident narrative under RFI 6. The IMTs were stepped down in 21/06/2018 with the ward opened to admissions. (Please see **A38662372 - Bundle 27 Volume 9, Document 18, page 405)**.

211. Was this incident resolved successfully? Explain your answer.

A At the time, it was felt the incident had been resolved. The POU filters essentially ensured patients were protected, and there was a long-term plan in place for the water supply. Patients were back being treated by staff in the appropriate environment albeit with infection control restrictions. We had engaged with SG, HPS, external experts, patients, parents, staff and the media. In the external review by Drs Montgomery and Fraser, they commented that the organisation had performed well. In the teleconference with SG/HPS and GGC, SG officials commented that they were reassured and did not identify any further actions GGC should take. Please see documents for question 210.

212. Refer to IMT Bundle 1, document 35, page 149, (5/09/18)

a) What were the issues with the drains?

A I have reviewed the minutes and the action plan. These areas are not within my remit nor my expertise to answer and I would suggest either LICD or senior estates colleagues maybe better placed to address these questions.

b) Refer to Action Plan at page 153 – what actions were taken to remedy these issues? Were the issues resolved?

A These areas are not within my remit nor my expertise to answer and I would suggest either LICD or senior estates colleagues maybe better placed to address these questions.

213. The inquiry is aware that chemical dosing of the drain alongside the water system was instigated. Please explain how that process came about and, in your view, whether it was/is effective:

A I don’t have the technical expertise to answer this nor was it within my remit. Either the LICD or a senior estates expert maybe better placed to answer this question.

Summary of section K

There was a full and focused response to the first phase in March 2018 with both immediate short- and long-term actions agreed. Support and advice were sought from across the UK. Reporting to both external agencies and internal GGC governance. There was a range of hypotheses, which were put forward by the LICD and IMT. The Point of Use filters were fitted at pace on 22/03/2018. This was an effective measure to prevent bacteria coming into contact with children and enabled long term solutions to be pursued.

In April/May 2018 there were PAGs set up to explore some infections in ward 2A. These were reported to HPS. There were some areas which were raised, but not concluded e.g. meropenom prescribing. However, the focus moved to drains as the POU filters had been fitted.

In June 2018, the clinical team were concerned and further IMTs were held with full involvement with HPS/HFS and teleconferences started with senior officials at the SG and GGC. The issues of drains were raised and became the main hypothesis.
The safety of patients was paramount with a full range of investigations and actions with the sole purpose of protecting vulnerable patients. There was a proactive press release and continuous reporting both internally to the Board and externally to SG through proactive teleconferences and a whole range of other reporting routes. The RFI 1 -6 water timeline submitted to the inquiry covers the reporting of the incident as does the ‘water incident’ RFI 6 narrative

Other Water Incidents

214. What other specific events to you recall in relation to water? Do you have any recollection of debris in the water tanks? Refer to IMT Bundle, document 45 as starting point:

A I note that this relates to document 45 which is a minute of an IMT on the 5/10/18. I cannot answer the questions set out and, as far as I can recollect, I was not aware of debris in the tanks. These questions are better addressed by LICD or estates colleagues who were present at the meeting and who were tasked with taking these actions.

215. What are the NHS procedures for raising concerns about water or water infections?

a) How were these dealt with by you?

A I have set out in other questions the governance around Infection Control and the reporting from 'bed to board' under section E, as well as the 27-point action plan in section DD and detailed in this section and other sections about how concerns were dealt with.

b) How is it confirmed they are dealt with?

A Please refer to the Infection Control governance structure of the board with the various reporting levels through the board to HPS and SG with requirements to review the national manual and ensure compliance and formally report on all incidents to ensure they are appropriately managed. In addition, other measures such as whistleblowing policy set out how these concerns are addressed.

c) Do you recall specific incidents and in particular any that gave you concern?

A I would refer to the answers given in section K, section S, section W and section DD.

The Ventilation System (questions 216-229)

I do not have the specialist expertise to answer these questions and indeed, these matters mainly relate to estates colleagues, the project team or those with specialist infection control expertise. As I noted before, I was not involved in the design, building, commissioning or maintenance of these systems. I do not have responsibility for these matters.

Wards and Hospital Occupation from January 2015 (230-237)

These questions maybe best addressed by the project team or those from external contractors. I do not have the knowledge; expertise nor was I responsible for this area.

March 2015 – 2A/B (238-247) and P

238. In March 2015 – in her evidence to the inquiry Dr Brenda Gibson raised concerns regarding the safety of ward 2A prior to patient migration:

a) What was the intended use and purpose of Ward 2A?

A Please refer to answer set out in question 54.

b) Were you aware of the intended use and purpose at the handover of QEUH/RHC in January 2015?

A Please see my full answer set out in question 54.

c) What were the ventilation requirements specific to ward 2A?

A This was not within my remit/expertise to set out the ventilation requirements of 2A and as I have indicated. I was not involved with the specification, planning, construction or commissioning of ward 2A.

239. There were concerns in March 2015 regarding ward 2A/B – refer to Estates team bundle: documents 35 and 37

a) What were the concerns at the time?

A I have read this bundle, and I was not aware of any of these issues, and I don't have the remit, knowledge nor expertise to answers these questions.

b) Why was ward 2A handover accepted by NHS GGC in January 2015 without the HEPA filtration being in place?

A As I have already set out, I was not involved in the handover, or commissioning of this site. I cannot answer this question as it is not within my role or remit.

240. Dr Gibson in her statement refers to HEPA filters not being in place at point of handover in wards 2A/B;

a) Explain your understanding of the situation.

A I was first alerted to this issue on Friday, 5th of June 2015 by Professor Williams. He described that he had initially visited the unit on 29th of May 2015 and had identified work which needed to be addressed. On further inspection, Mary Anne Kane had discovered that HEPA filters had not been fitted. **(Please see A49401464 – Bundle 27, Volume 8, Page 88).**

b) What was the impact of HEPA filters not being installed?

A This would mean that it would be potentially unsafe to move children to the unit and that the unit could not move into the RHC without filters.

c) What was the potential impact on patients of the absence of HEPA filters?

A I am not an expert, so if further details are required, an ICD or clinician may be able to describe the issues better.

d) What was done to resolve any HEPA filter issues?

A In a subsequent email that day, he advised that facilities had sourced filters and Professor Williams asked that adult facilities be double checked. **(Please see A49401521 – Bundle 27, Volume 8, Page 89).** The COO (Grant Archibald) then led the process and the email reports delivery of the filters with validation. He sets this out in an email and was taking this forward. **(Please see A49401523 - Bundle 27, Volume 8, Page 90).**

e) Should HEPA filters have been installed at handover:

A Yes.

f) Who was responsible for providing HEPA filters and ensuring they were installed in the build?

A I am not able to answer the questions regarding the build, handover and commissioning as I was not involved in any of those areas. This is best addressed by the project director/team.

g) Who signed off the handover without HEPA filters being installed?

A As in answer f) above, I don't know as not involved in this process.

h) Which infection control doctors and nurses were consulted?

A I don't know as not involved in this process.

i) Why was handover signed off without HEPA filters?

A I don't know as not involved in this process.

241. What other wards were missing HEPA filters following handover? Please provide details:

A I cannot answer this. It may be best answered by senior estates senior manager or project team colleagues.

242. Describe how the lack of HEPA filtration in ward 2A was managed, what was your responsibility/involvement, what was the outcome?

A Please see answer to question 240d) This sets out that Professor Williams raised the issue, which was escalated to me as well as Grant Archibald. The Chief Operating Officer was responsible for the acute division and took the lead in ensuring that these filters were sourced and delivered.

243. To what extent were you satisfied that the relevant work had been carried out to secure the ward for patients?

A It is not part of my remit to assure the relevant work. This was reviewed and led by the Grant Archibald together with estates colleagues and Professor Williams.

244. Bundle 8, documents 25-31(page 125-133) Please provide a summary of the events discussed in these emails.
Please provide a summary of the events discussed in these emails.

Please include.

a) What was the issue with ward 2A

A **Pre move**: I have set out in question 240, my knowledge on the HEPA filters which were fitted in June 2015.

Post move: the inquiry had shown me a series of emails during July 2015 where there is discussion concerning the particle counts, the ward suitability to carry out transplants and the advice which was being sought from clinical and engineering experts. To the best of my knowledge, I became directly involved in early August 2015 when Sandra Devine forwarded an email to me concerning this issue on 07/08/2015 which I sent to Grant Archibald and David Stewart (attached)

b) Why were the transplants not proceeding?
The email from the ICD sets out that additional advice was being sought from a UK Public Health specialist as well as internal clinical and estates specialists to assess if the rooms could be used for transplantation.

c) What steps were being taken to resolve this?

A As the chief operating officer (COO) is the most senior manager of the acute division, the responsibility for managing the situation lies with the COO and the local senior managers of the unit. However, the process of doing this requires input from experts in infection control, the clinical team and the estates team together with the management team so that a clear position is reached. To this end, Grant Archibald organised a meeting on Monday 10th of August to gather input from multiple disciplines to seek to resolve this.

d) Who was involved in this and what were their roles?

A There is an action plan of the meeting on the 10th of August which was chaired by Grant Archibald. The action notes sets out who attended the meeting and this included me, Executive Medical Director, Dr Gibson, lead clinician for haemato-oncology unit, Dr Hood, consultant in Microbiology, Professor Jones, consultant in Microbiology, David Loudon, Director of Estates and Project Director, Dr Mathers, Chief of medicine Women and Children, Sandra McNamee, Associate Nurse Director Infection control, Peter Moir, estates and project team, Jamie Redfern, General Manager Women and Children, Dr Stewart , Deputy Medical Director and Tom Walsh, Infection Control General Manager.

e) Who was responsible for decision making/managing this situation?

A The Chief Officer was leading the group but was seeking clear advice and an agreed position from the multidisciplinary group. He allocated tasks to the attendees at the meeting and asked that they all be forwarded to him..

I note that I was copied into an email trail on the 24/08/15. This was an email from David Loudon with a response from Grant Archibald. In the 24/08/15 email, Grant Archibald sets out that he wishes David Loudon, as the director of estates, together with Professor Williams, the LICD, to answer questions that he has set out.
(Ref: A49661442 – Bundle 27, Volume 4, Page 327).

245. Refer to Bundle 8, Document 31, page 133

a) Dr Gibson stated that the clinical team has 'lost faith', outcomes have been 'compromised' and that matters are not being addressed with the 'appropriate sense of urgency'; what is your view on this?

A **24/08/2015**: I understood completely Dr Gibson's frustration as there was a child who urgently required a BMT. From the emails and my recall, I became aware of the work to address concerns in ward 2A in early august 2015. I noted that the Chief Operating Officer was handling this issue with urgency along with the Director of Estates and with advice from the LICD. **(Please see**
A49401522 – Bundle 27, Volume 8, Page 92).

- There had been meetings and actions to move this forward as set out in the meeting organised by the chief officer on the 10th of August, 2015.

b) What was the outcome to Dr Gibson's email?

A I received the email dated Friday 4th of Sept 2015 at 5.30pm. I forwarded it to both Grant Archibald and Robert Calderwood, Chief Executive at 6.25pm and indicated that I would speak to Professor Williams later regarding the issues. On Monday the 7th of September, I sent an email at 08.15am seeking a meeting at 4.45pm that day to discuss the issues. **(Please see A49401520 – Bundle 27, Volume 8, Page 94).**

I set out that there had been daily calls to drive this forward suggesting there was a lot of effort to progress this issue. I provided a structured approach to the issue and asked people to prepare information for the meeting so it could be considered. I also forwarded

this to the Robert Calderwood and asked to meet with him that day. **(Please see A49401519 – Bundle 27, Volume 8, Page 95).**

246. Refer to bundle 6, document 4. (this is the minutes of the 7th of September meeting referred to in b) above.

a) Do you recall this meeting?

A Yes.

b) What was the purpose of this meeting?

A I wished to address the issues raised by Dr Gibson and as set out in the notes of the meeting, to 'identify the progress made in resolving the Bone Marrow Transplant (BMT) room, estates issues in RHC and determine position for the paediatric haematology oncology service in being able to start new cases… and the need to plan for patients currently awaiting transplant'.

c) What were the circumstances which led to this meeting?

A It was to address Dr Gibson's concerns highlighted above in b) and to move this forward with all the key facts to get the best outcome for the patient.

d) The minutes state that the sealed rooms are providing the appropriate level of 10 Pa positive pressure. How was that conclusion reached? Do you still agree with this conclusion?

A I don't have the estates nor IC background to answer this question, so I don't know how that conclusion was reached, and I am not an expert in current pressures within the unit.

e) What actions were taken following this meeting?

A **Wednesday 9th of Sept**:

the minute of the meeting sets out clearly the issues and findings from each of the 3 areas: estates, infection control and clinical issues. Jamie Redfern had undertaken to follow up on all the actions to ensure completion and set out a document which brought together the clinical issues, the infection control issues and the estates issues to enable a 3 director sign off. I forwarded the email and minutes to David Loudon and Grant Archibald and copied in Robert Calderwood. **(Please see A49401515 – Bundle 27, Volume 8, Page 101)**.

247 Refer to Bundle 6, Document 5, page 22

a) Do you recall this email?

A I am copied into the email dated 11/09/2015, but I don't specifically remember it.

b) Do you recall speaking to Sandra McNamee regarding the safety of ward 2A?

A I don't specifically recall this conversation.

c) The balance between proceeding with a child's treatment and the safety of the environment is discussed. What is your view on this?

A What is set out are several issues, which needed to be taken into account when considering the options available. The well-being and safety of the patient is paramount. What Sandra Devine is doing is setting out different aspects of the issue which need to be clearly understood before a decision is made.

d) In his email of 11th Sept 2015, Grant Archibald states that the ICT doctors say they have not had a handover from the senior ICT and lack information to inform their decision making regarding the safety of ward 2A. Were ICT doctors provided with all the information required to make an informed decision on this?

A I cannot answer this question and it may be better address by the ICM/LICD as I don't know the facts here. However, what I can say is that we did ask the directorate team with estates, Professor Williams and Dr Gibson to review all the parameters and provide advice to me, Grant Archibald, David Loudon and David Stewart, the deputy Medical Director on this issue, so there was clear advice based on facts. This process is set out in question 248 below.

Summary of 0

A In the answer to question 54, I described the process and issues which were considered by the BICC between November 2014 and February 2015 regarding the BMT rooms in 2A. The advice from the LICD, estates and external contractors was the rooms were appropriate for BMT treatments. This was documented in emails and at the BICC in 2014 and 2015. Further work was to be undertaken by Professor Williams and David Loudon to review other UK units as, I understood, there was no national specification for the design of these facilities.

I was not involved with the design, specification, planning, building or handover of the unit. This was the remit of the project team and contractors.

The HEPA filters were not in place, this was rapidly escalated, and Grant Archibald led the process to ensure they were installed. This was required as the clinical and Infection Control advice was children could not be moved to the unit without the filters in place. This hepafilters were subsequently fitted. To the best of my recall, in early August 2015, I was advised of the situation in ward 2A directly by Sandra Devine. I advised the Chief Operating Officer for acute services. He convened a multi-disciplinary meeting to discuss the issue on the 10/08/2015. This resulted in a series of actions. If there is a need to review the technical details of the document, this could be addressed by others with specific expertise in these areas.

In September 2015, I was directly emailed by Dr Gibson, setting out the need to resolve the estates and infection control issues for the BMT rooms in 2A as there were patients awaiting transplant. I immediately convened a multidisciplinary group to ensure that there was a thorough assessment of all the options. The decision advised that following infection control review and further estates work, that the rooms should be used. This was signed off by clinical, infection control, management and estates colleagues. Thereafter by a 3 way sign off at executive level with the final decision by Robert Calderwood.

Ward 2A – Paediatric BMT – Specifications

248. Dr Mathers states that 'the facilities are at least as good as the RHSC and are believed to be built to a higher spec. They are NOT identical. They are not as high spec as the Beatson Adult System. This does not mean that they are suboptimal standard. What is your interpretation of this? Do you or did you believe that the RHSC was of the necessary standard to treat patients? Please provide an explanation. (Bundle 4, Document 4, page 13)

A **Tuesday 15th of September 2015**: This email from Dr Mathers to Jamie Redfern, copied to me, describes his assessment of the situation. This sets out his conclusion that he would support treatment at the RHC. However, it was important that we receive expert advice which comprises the management team, the infection control advice and the clinical advice. On the 15th of Sept, 2015 I responded to an email from Jamie Redfern and asked him to set out the whole picture with Professor Williams and the treating clinician, Dr Gibson, setting out the pros and cons then a recommendation. **(Please see A49401514 – Bundle 27, Volume 8, Page 102)**.

Therefore, I understood the argument Dr Mathers set out but I thought there required to be a 'whole picture' set out with estates, the clinical team and the management team with a properly constituted paper and the agreed sign off with estates, with the clinical team and the management team before a definitive decision was made.

a) Who was the document shared with?

A I don't know who else Dr Mathers shared it with apart from the people mentioned in the email.

b) What action was taken:

A On the 16th of September, Grant Archibald confirmed Dr Gibson and Professor Williams were in agreement with Dr Mather's conclusions**.** On Thursday 17th of September, there is an email from Me, Grant Archibald, David Loudon and David Stewart setting out the recommendations and signalling our agreement. This was sent to the Chief Executive, who responded that day with *'thank you for the very comprehensive email, setting out all the issues and background to this complex situation. I believe you and colleagues have taken all reasonable steps to review and rectify problems and the decision to proceed with the treatment of this BMT patient is arrived at after due consideration of all the risks and benefits and I agree with your recommendation'*

(Please see A49401516 – Bundle 27, Volume 8, Page 109 and A49401518 – Bundle 27, Volume 8, Page 114).

249. Please refer to Estates Bundle, Document 109
This email details a meeting which took place to discuss Ward 2A BMT isolation rooms. Ian Powrie states that the meeting was arranged at your behest. The email states that the rooms were all built to SHPN 04-01 standard however this design is not suitable for neutropenic patients and the rooms should have been built to SHPN 03-01 standard and this was agreed by clinical representatives at the meeting.

a) Were you aware of this before this meeting?

A I cannot recall this meeting. I am not familiar with the SHPN guidance, and this is not within my remit nor expertise. However, I have provided the SHI with the emails from David Loudon to me concerning a specification for ward 2A which had been set out by Professor Williams prior to his departure and now approved by Dr Inkster in May 2016. I have also provided the email which I forwarded to the directorate team as I was keen that they and the clinical team review the proposal with estates and infection control. For details of the meeting or the specification, it would be better to ask Dr Inkster or David Loudon directly as I don't have expertise to address this. I am not sure if this was the prelude to the meeting referred to in document 109. My recollection as to the origins of this work on specification was that I emailed the chief executive on 30/12/2015 highlighting an email sent by Dr Peters to Dr David Stewart which he had forwarded to me. I set out to the chief executive that I had sought external input into the Ward 4B issues but not the other issues highlighted and was looking for a way to address the concerns. I recall that this led the chief executive (as far as I can remember) to set up a meeting on the 21/01/2016 with members of the GGC project team, external contractors, Infection control, me and the chief officer to review concerns. The Director of Estates developed an action plan following this meeting. I do not have the expertise to address the areas in the action plan and other witnesses may be better placed to do this. I have provided the SHI with the emails on the need to address the concerns highlighted and the action plan which resulted from the meeting on the 21st of January to review concerns.

b) What actions were taken?

A I understand that the funding was approved, and cubicles upgraded but it may be better to ask estates colleagues for further details if required. I have also identified an update from David Loudon to myself and the chief executive setting out the tender for this work which was sent in May 2017 and I have provided this email to the SHI. This perhaps links back to the meeting set out in document 109. If there is a need to review the technical details and implementation, this is perhaps something which Dr Inkster or David Loudon could address.

Ref Documents:

A49661443 - Bundle 27, Volume 8, Page 215
A49661444 – Bundle 27, Volume 8, Page 230
A49661445 – Bundle 27, Volume 8, Page 213
A49661446 – Bundle 27, Volume 8, Page 234
A49661447 - Bundle 27, Volume 8, Page 243
A49661448 - Bundle 27, Volume 8, Page 267
A49661450 - Bundle 27, Volume 8, Page 283
A49661451 - Bundle 27, Volume 8, Page 288
A49661453 - Bundle 27, Volume 8, Page 289
A49661454 - Bundle 27, Volume 8, Page 291
A49661456 - Bundle 27, Volume 8, Page 269
A49661457 - Bundle 27, Volume 8, Page 300
A49661458 - Bundle 27, Volume 8, Page 298
A49661459 - Bundle 27, Volume 8, Page 301

Summary of Section P

A A risk assessment was undertaken for ward 2A by the directorate team and the LICD. This took account of clinical, environmental, infection control and management issues. The advice given was to enable to BMT to take place at the RHC. This was agreed by the senior executive team and chief executive.

I cannot recall the meeting set out in 249 and it is not within my remit nor expertise. For details on the upgrade, estates colleagues may be better able to address the details. However, I have identified emails which may be associated. In May 2016, I have forwarded a proposed tender from David Loudon to the senior management team to ensure clinicians are fully sighted on this and given the opportunity to review this. This

maybe related to the subsequent meeting in September 2016 but I cannot be certain. I have attached 2 further emails from David Loudon which may be related to the meeting and are a summary of the tenders in 2017. In addition, I have set out a summary of events which, as far as I can recall, led to the development of the specification and tenders. This was led by the chief executive and Director of Estates in 2016.

June – July – Ward 4B (250.- 268.)

250. In June 2015 patients migrated to ward 4B – at the point of migration NHS GGC had accepted handover of the ward from Multiplex – save for defects – did you consider the ward to be compliant with guidance and suitable to meet the needs of BMT patients? If so why, if not why?

A I cannot answer this question. As I have outlined in question 54, I did not have the expertise to assess the ward for compliance with guidance and suitability for BMT patients. I was not involved in the design, planning, building, handover or commissioning of the unit and was not an expert in what changes to the specification were required.

251. What was the intended purpose of Ward 4B?

A I was not involved with the specification, planning or design of the original purpose of 4B as this took place before I joined GGC.

252. Did the purpose change prior to January 2015? And if so, what changes were made?

A I have outlined in question 54, the process in 2013 when the Chief Operating Officer, Jane Grant and I put forward a paper to the Quality &Performance committee to secure resource and agreement that the adult BMT service move to the QEUH from its current home in the Beatson, together with the haemato-oncology beds at the Southern General Hospital There was clinical support and clinical reasons for this proposal. It cost circa £840K. The proposal was approved along with the funding. Thereafter, this was passed to the project team to work with the LICD to ensure design, specification and building of this. They then took forward the change for ward 4B with the builder.

253. Were there changes required to the ventilation system prior to January 2015? If so, why?

A I cannot answer this question as this was taken forward by the project team and was/is not part of my remit.

254. What was your involvement in these changes?

A I was not involved in these changes.

255. There were issues with ward 4B almost straight away, with an SBAR being prepared around the 7th of June 2015;

a) Discuss the concerns about ward 4B. Refer to estates document 30- what was the purpose of the SBAR?

A I note the concerns set out in Anne Parker's SBAR, which was sent to me and others on 6th July 2015. It sets out the environmental issues and the need to move high risk patients back to the Beatson Oncology Centre (BOC) and to ensure access to the critical care transfer teams if required. There are several other recommendations which set out the need to remedy the faults to enable the service to move back.

I became aware of this issue on 1st of July 2015 when the Tom Walsh emailed me to alert me that there were several actions being taken at the unit to address high particle counts. On the 3rd of July 2015 a further email from Tom Walsh indicated that the changes were not adequate and he attached an email from Professor Williams. I asked for an update that same evening and Tom Walsh responded to say that the clinical view was that transfer plans should be worked up for the unit to return to the BOC and they would have further discussion on Monday 6th of July 2015 regarding this and all issues are covered in detail in timelines submitted to the inquiry under RFI 7.

I forwarded this immediately to the Robert Calderwood, Chief Executive and the Chief Operating Officer, Grant Archibald, to say this was urgent. I received two BMT briefing documents: one from Gary Jenkins, the Director of Regional Services which is in the main BMTU timeline submitted to the inquiry under RFI 7 (and in Section 21 notice 1/RFI 10) and the SBAR from Anne Parker on the 6th of July 2015.

There was agreement, with the advice of the clinicians and the ICT, to transfer the patients back to the Beatson Oncology Centre on the 8th of July 2015. There is an email from Gary Jenkins, which details this on the 7th of July 2015 for the information for Scottish Ministers, who wished an urgent briefing. It also highlights the work to take forward rectification with the Brookfield, Multiplex, Estates and Facilities and ICT. I forwarded the press release to the CMO. **(Please see A49073362 – Bundle 14, Volume 1, Page 413)**.

b) Less than one month after migration to ward 4B patients were decanted back to the Beatson. Is this correct?

A Yes.

c) The issues raised in the in the SBAR from June 2015 were present at the point of NHS GGC taking occupation in January 2015, and when Ward 4B was handed over to NHS GGC. Is that correct?

A As I have stated before, I was not involved in the occupation or handover and I don't have a detailed knowledge of the estates issues within 4B. This is better addressed by the project team.

256. How was the ward signed off and handover accepted given the issues which arose immediately following handover prior to patient migration?

A I don't know given I was not involved in this process.

257. Refer to Estates team bundle, document 39

A With specific reference to question 257a, b,c,d , estates bundle, document 36, As far as I can recall, I had no awareness or knowledge of this early testing and cannot answer these questions.

258. At the BICC meeting on the 27th of July 2015 Professor Craig Williams states that in respect of ward 4B 'the *unit was not built to the correct specification and Brookfield have agreed to rebuild this area and the timeframe for this is 12 weeks'*

a) Did you agree with Professor Williams statement at the time?

A I can't recall this statement, but I note it is in the minutes. I did pass his paper, setting out what was asked for and what was built, to Robert Calderwood as set out in question 260. However, I can't address what is the correct specification, nor if Brookfield Multiplex agreed to rebuild this area within a timeframe of 12 weeks.

b) Do you agree now?

A I think this is best answered by the estates/IC colleagues who may have looked at the specification and perhaps members of the project team who were in touch with Brookfield at that time.

c) If the ward was built to specification, why were patients decanted to the Beatson less than a month after migration?

A I am not party to the estates and specification documentation. However, patients were moved back to the BOC on the advice of the clinical and infection control team.

259. Works were carried out to ward 4B – do you recall the nature of these works and why they were carried out?

A There has been a detailed timeline of ward 4B submitted by GGC to the inquiry and it sets out all the detail and works to 4B prior to the return of the patients. Technical details are in Section 21 notice 1/RFI 10 - background and discussions/decision making in timelines submitted under RFI 1 6 and RFI 7. It maybe that estates and IC colleagues are best placed to address this detail.

Refer to Document **A43502680 – Bundle 20, Page 13.**

260. What is this document?

A It is a document which considers the specification of the adult BMT unit and also considers the commissioning of the unit.

261. Why did Craig Williams send it to you?

A I have no recollection of the reason why Professor Williams sent it to me. However, I did forward it to Robert Calderwood and Grant Archibald on receipt and let Professor Williams know I had done this. **(Please see A49401512 – Bundle 27, Volume 8, Page 118 and A40241788 – Bundle 27, Volume 9, Page 411)**.

262. What was your response on seeing the document?

A I don't remember.

263. Did you share it with anyone?

A Yes, I sent it directly to Robert Calderwood, the Chief Executive and Grant Archibald, the Chief Operating Officer.

264. Why did you request the report?

A See answer to 261 and email in references.

265. What actions were taken following this report?

A I don't know, as the estates and contracting issues were not my remit.

266. What is your understanding of the ward specification?

A These questions are better addressed by estates/IC as I have never specified a ward, and am not sure how it is done, and not in my remit.

267. What is the importance of ward having certain specifications?

A These questions are better addressed by estates/IC as I have never specified a ward, and am not sure how it is done, and not in my remit.

268. If a ward did not have a required specification relevant to its purpose, would this be putting patients at risk?

A These questions are better addressed by estates/IC as I have never specified a ward, and am not sure how it is done, and not in my remit.

Summary of Section Q

I have highlighted that I cannot address the technical issues concerning specification, planning, building and I outlined in question 54, the process in 2013 to approve the relocation of the BMT unit from the Beatson to the new QEUH.

There were rapid actions taken to transfer the patients back to the Beatson in July 2015 on the advice of clinicians and infection control. A report by Professor Williams on Ward 4B specification and commissioning was sent to me and thereafter Robert Calderwood. It indicated the specification did not match the actual delivery. However, this is an area is best responded to by estates/project colleagues.

Ward 2A – Invasive Fungal Infections (269)

I note this relates to an SBAR dated 30/10/2017 and is to all ICDs at the QEUH. I have not received this or seen this as far as I can recall and to my recollection, I was not aware of it at the time. I think that the LICD or Director of Infection, Prevention and Control may be best placed to address these questions.

Decision to close wards 2A/B and move to 6A and 4B (270-271)

270. Discuss the issues surrounding and leading up to the decant of patients from ward 2A in 2018

a) What was the lead up and background to this refer to IMT bundles?

A I have read all the bundles and note the context. However, I did not attend the IMTs and I have set out the emails and papers which I and others at the corporate level considered.

04/09/2018: I got an email from Dr Inkster advising that she was reconvening the water IMT due to 3 patient bacteraemias and issues with the drains. The patients were not giving cause for concern. **(Please see A49401510 – Bundle 27, Volume 8, Page 119)**.

05/09/2018: This email was sent by Tom Walsh and highlights the HPS email from Annette Rankin with Chief Nursing Officer's instructions to review every case being discussed by the IMT with an SBAR to HPS. The email from Sandra Devine sets out the triggers of 2 cases within 14 days and this IMT was set up following 2 cases within 11 days. She explains '*they were different organisms but Teresa's opinion is that they are associated with the water, so the IMT process has commenced as normal*'. **(Please see A49401509 – Bundle 27, Volume 8, Page 120)**.

13/09/2018: This email from Kevin Hill reports on Infection Control advice following the IMT meeting on the 13/09/2018. IC advised that it is 'unsafe' to continue to treat BMT and haemato-oncology patients in their current environment (ward 2A) at the RHC. The meeting also discussed options, ruling some out, while agreeing transfer of 3 BMT patients to ward 4B and asking Anne Harkness to scope out an option in QEUH. **(Please see A49401508 – Bundle 27, Volume 8, Page 122)**.

14/09/2018: A full executive meeting was held with some members of the IMT to discuss the options and advice. **(Please see A49401511 – Bundle 27, Volume 8, Page 124)**.

20/09/2018: This email from Kevin Hill sets out a response to a clinical question, the reasons and rationale for the decant and the process taking place to prepare the adult ward. This was sent to SG in response to their questions. **(Please see A49401504 – Bundle 27, Volume 8, Page 126 and A49401507 – Bundle 27, Volume 8, Page 129).**

26/09/2018: This email, from Grant Archibald, sets out that the process of transferring all the patients to the adult ward was complete with OP the next day. **(Please see A43171441 – Bundle 27, Volume 9, Page 533)**.

b) What was your involvement?

A My role in this process was at a corporate level rather than an operational level. The executive team, of which I am a member. was taking advice from the IMT and the operational team. I was also updating the internal board committees and linking with senior colleagues at the SG. In addition, I was also receiving updates from the ICM/SMT.

c) What risk assessments were carried out in respect of the decision to decant the Schiehallion Unit to ward 6A and 4B?

A On the 14/09/2018, a water meeting exec team. This was held at the QEUH and I have provided a note of the meeting to the SHI. It sets out the advice of the IMT and the agreed actions for a full risk assessment to be led by KH. The divisional team working with the IMT and directorate team carried this out.

d/e) The advantages and disadvantages of the move are set out in a paper on 17/09/2018.

A The detail of this was discussed by the IMT and the directorate team. The IMT considered papers on this issue. It may be better for the directorate team to address all the advantages and disadvantages.

f) What additional measures were put in place to ensure patient safety as part of the decant

A This was taken forward by the divisional team. Kevin Hill sent the full action log which sets out all the actions.

g) What concerns, if any, did you have about where the patient cohort was being moved to? If so, why did you have those concerns?

A Many of these concerns are highlighted in the disadvantages of being disarticulated from the childrens hospital with easy access to all the services for patients and for parents. There was also the issue about an adult ward as opposed to purpose built childrens ward. There were concerns for the elderly patients who were being moved to Gartnavel for them and family visiting and the impact on winter capacity beds for the QEUH.

h) What was your understanding of the suitability of wards 6A and 4B for the treatment of immunocompromised children?

A This was not optimal for the reasons set out in g). There would also be a curtailment of the adult BMT timetable to enable them to provide beds for children in ward 4B. However, the ICT and the IMT signed off both wards once some work had been completed.

i) Please comment on the facilities within ward 6A, the access to the ward and the distance from key facilities such as PICU and the crash team:

A This question may be better addressed by the operational teams. However, I note the development of SOPs in the action log.

j) Please comment on the facilities within ward 4B, the access to the ward and the distance from key facilities such as PICU and the crash team:

A This question may be better addressed by the operational teams. However, I note the development of SOPs in the action log.

k) Did you have any environmental concerns relating to either ward 6A or 4B? If so, what were they?

A Please see my answer to h). The IMT and LICD, ICN reviewed the wards and advised that they were fit for purpose.

l) What impact did this decant have on patients and their families?

A There was a significant impact on parents and children, which was so movingly described by parents in Glasgow 1 hearings. The impact of learning your child has a cancer is catastrophic and then compounded by worry about the facilities. These concerns were very prevalent in our minds. The focus of the corporate team, and indeed all the teams, was to do the best we possibly could for the children and families under our care. I also felt for the staff. It is a stressful job working in oncology services. Staff are highly trained and skilled at what they do. They now had to deal with uncertainties in the environment and it was clear they were losing confidence in the environment. So, both factors were huge in the decision making to move the ward, and indeed, embark on a total transformation of ward 2A/2B. The communication process and the response to the families has been submitted to the inquiry and it may be better addressed by GGC's Director of Communications (Sandra Bustillo) and the Director of Nursing at the time (Margaret McGuire).

m) Discuss and detail the works done to ward 2A/B, which was required to be done and why, what had been done and when the work was completed. Please include details of your involvement.

A I am not the correct person to address this question as I don't have the knowledge or expertise to describe this and it is the remit of senior estates colleagues to address.

n) Any other relevant information.

271. Discuss the issues surrounding the ward 2A patients when in occupation of ward 6A, in particular, views you may have in respect of:

a) Chill beams:

A I don't have the expertise to address this. It may be better to seek view of IC experts/ Director of estates.

b) Gram negative bacteraemia:

A I don't have the expertise to address this. It may be better to seek view of IC experts.

c) Water filters:

A I don't have the expertise to address this. It may be better to seek view of IC experts/ Director of estates.

d) Ventilation:

A I don't have the expertise to address this. It may be better to seek view of IC experts/ Director of estates.

e) Issues/testing/escalation/response/IMTs/SBARs:

A I am not this most appropriate person to address this. It may be better to seek view of IC experts/ Director of estates/operational teams.

f) Patient experience and patient communication:

A Jennifer Rodgers or Mags McGuire or the Director of communications maybe better placed to address this issue.

g) Internal Escalation

A HIATT scoring: this should be addressed to the LICD.

h) External Escalation:

A I have set out the external process of escalation for the areas I have been involved with e.g. SG, teleconferences, Board papers, board subcommittees etc. However, there will be other processes, e.g. IC to HPS to SG, obtaining expert advice which ICT is best to describe.

Summary of Section S

On the 4th of September 2019: There were 2 patients with gram negative bacteraemia within 11days. They were different but it was Dr Inkster's opinion that they were both associated with water and hence the IMT process was triggered.

Following the IMT on the 13/09/2019, there was a meeting of the operational management team, IC, clinicians, HPS and Public health. The IC advice was that it was unsafe to continue to treat BMT patients. Some options were discussed with some taken forward, whereas others were dismissed.

On the 14/09/2018, the corporate team then met with IC, Women and Children Senior Management Team, HPS, Public Health and Estates colleagues to discuss this and agreed the actions, including to risk assess the options for decant.

The IC team were providing advice to the operational team and ensuring that ward 6A and 4B had the appropriate arrangements in place to ensure that both wards could accept the children.

The advice from the IC team was that ward 6A environment was better than ward 2A and the children should move there and that there was no increased rate of infections in the adult site. Ward 4B already housed the adult BMT patients and there had been no increased infections.

All these issues were reported through the corporate governance structure of the board. HPS was involved in all the decisions and Annette Rankin, HPS, sat on the IMT. SG questions were addressed and there were 3 teleconferences during this period between senior GGC staff and senior policy/CNO officials in SG.

Ward 4C (272)

A I do not have the knowledge, background or expertise to answer this section. I was also not involved with the HSE actions. These areas may be best addressed by estates colleagues, HSE GGC leads or clinicians running the ward.

IMT attendance (273-309)

A The IMTs are organised and led by IC colleagues with input from a range of specialists with expertise. The policy based on national guidance is developed by Public Health colleagues and approved through committees. The output of the IMT reports to the AICC.

In my role as Medical Director and HAI exec lead, it would not be expected for me to attend the IMT. However, I have attended some IMTs and this can be at the request of the members or the chair or indeed if there is a significant organisational issue which required executive support.

I would suggest that these detailed questions of the IMT are best addressed by the ICT or a senior Public Health specialist as they will ensure the policy is updated and they will be routinely leading and attending them. I do not have the detailed expert knowledge to address them.

The minutes have all been submitted to the inquiry. All PAG and IMT minutes for the entire QEUH site since April 2015 have been submitted under Section 21 notice 2 [RFI 11], unless previously submitted under RFI 7 2, or within timelines submitted under RFI 1 6 (the timelines covered the 2018 water IMT and 2019 cryptococcus IMT).

HIATT process (310-314)

A Outbreak reporting was covered in submissions under RFI 7 2 and I am aware of this process and reported the HIATT in the report to the board. However, it was not something I was routinely involved in at an operational level and therefore it may be better to ask the ICT/ICD to describe the process.

Gram Negative Bacteria (315-340)

315. Describe the gram negative bacteraemia outbreak and your involvement in it? Bundle, document 72-88 are the IMT minutes (June 2019 onwards)

A At the time, I would receive along with other senior exec members, updates by email with a summary of the IMT from Dr Inkster and Sandra Devine, which reported on the outcomes of the IMTs**. (Please see A49401503 – Bundle 27, Volume 8, Page 135; A49401505 – Bundle 27, Volume 8, Page 138; and A49401502 – Bundle 27, Volume 8, Page 141).**

I would also refer to the page 33 of the response to the oversight board. This is incorrectly under the decision to decant but in fact is a timeline of the August to November 2019).

19/06/2019: IMT held to discuss cases of gram negative bacteraemias and 2 cases of M Chelonae.

The issues which were debated include:

1. Were the numbers of infections higher than the usual background rate?
2. Were there unusual infections occurring?
3. Was there evidence from the environmental sampling, which could be linked with these infections

There were water samples sent to a research lab, which confirmed a close link to case of cutaneous M Chelonae in 2019, but no link to the case in 2018. This was closed after many actions in August 2019. This was fully reported in the HAIRT in August 2019.

01/08/2019: Ward 6A was closed to new admissions and newly diagnosed children were diverted to either Edinburgh or Aberdeen causing great distress and increasing risk to other units and children. Children were also started on prophylaxis, which the lead clinician later described as causing vomiting and diarrhoea.

There was significant environmental testing being carried out with the hypothesis of chill beams being explored.

The epidemiology by Dr Iain Kennedy, consultant in public health and subsequently by HPS suggested that there was no increase in background levels of gram negative bacteria.

All the environmental tests failed to show any link with the children, and there was nothing to link them to the ward environment or to infection control practices in the ward.

23/08/2019: There was a change in chair as set out in section EE. The new chair emailed me on Friday 23rd of August 2019 with a report indicating the possibility of opening the ward on the 2nd of Sept, 2019 if a number of actions were concluded. She also escalated to me that an additional 2 beds were required on the transplant ward, which I forwarded that night to the Chief Operating Officer. **(Please see A49401470 – Bundle 27, Volume 8, Page 143 and A49401466 – Bundle 27, Volume 8, Page 147).**

14/09/2019: email from Dr Emilia Crighton outlining that ward 6A is microbiologically safe for patients and recommended opening to admissions. The IMT heard about risks of

sending patients to other units and furthermore, epidemiological and microbiological data did not support the decision to close the ward on 2/08/2019. **(Please see A49401469 – Bundle 27, Volume 8, Page 149).**

18/09/2019: I was on touch with Medical Director of NSS to be clear what the recommendations were from HPS to GGC. One of the key ones is the MDT approach to all new cases, which led to the development of a more robust process. **(Please see A37849990 – Bundle 27, Volume 9, Page 415).**

All the following are in the response to the oversight board from GGC which has been submitted to the inquiry.

26/09/2019: A meeting took place with Chief Nursing Officer (CNO), NHS GGC and HPS. It was agreed HPS would do a full review of the epidemiology. The chair of the IMT, Dr Crighton set out clearly the epidemiology of the infections as well as reviewing each hypothesis. **(Please see A49401467 – Bundle 27, Volume 8, Page 151).**

17/10/2019: In response to a request from HPS, a full response was sent to NSS Chief Executive from the NHS GGC Chief Executive outlining in over 11 areas key actions for NHS GGC and a full review of all water incidents from 2018 onwards. **(Please see A49401468 – Bundle 27, Volume 9, Page 417).**

05/11/2019: IMT minutes (bundle) Prof Craig White informs IMT that decision to open the ward will be taken by CNO.

18/11/2019: CNO advises that the ward can be opened once GGC confirms actions completed with further email on 20/11/2019 from CNO setting out the need for cabinet secretary to be assured of actions.
21/11/2019: A response is provided to the cabinet secretary from NHS GGC Chief Executive. The emails include the SBAR dated 7/10/19 from Dr Inkster and Dr Peters with annotated comments from Dr Kennedy and Jane Grant sets out the intention to undertake a review of all cases. (email attached)

26/11/2019: HPS publish epidemiology review and advise the ward is safe.

External reporting: One of my roles was to ensure reporting at a corporate level and there is a full timeline available for this. This include BICC (29/07/2019); email to board members alerting them to this issue (02/08/2019); HAIRT with full report on 20/08/2019); Clinical and Care Governance committee (03/09/2019); Finance and Planning Committee (01/10/2019); with further HAIRT at Board (October 2019). In addition, there were teleconferences between senior team in GGC and senior officials in SG. (minutes available) These have been submitted to the Inquiry.

316. The inquiry understands there was an increased number of line infections in ward 2A in 2016 and 2017. Please provide details of your recollection of these infections including suspected causes of these infections, the outcomes for patients and whether/how this increased rate of infections were resolved.

A My role was at a corporate level and GGC, in common with other boards, has a well-defined escalation plan which I have set out under section E. Many of the infections would have been investigated by the ICT and they may be able to furnish more of the detail. I will set out my recollection of this time from the information which is provided at a corporate level and the requests for further detail.

2016: I have reviewed the reports from 2016 for 2A and as far as I can recall, I did not receive any reports to the BICC regarding gram negative infections in ward 2A. There was one report concerning 2 infections, which was discussed at BICC and reported to the NHS Board in 18/10/2016, but these were not gram negative infections. I cannot recall gram negative infections in ward 2A being raised with me in 2016. However, it may be helpful to ask the LICD/ICT for further details.

2017: In April 2017, there was a rotavirus outbreak in ward 2A, which led to a hot debrief and discussion at the BICC and report to the Board. Due to the issues raised about IC practices, cleaning and staffing, I asked that the directorate team to put in place a process bringing together estates, senior clinical staff, senior management and IC to ensure a weekly oversight to improve this situation. The weekly reports were reviewed by me (or my deputy when I was on annual leave) and continued from June to August 2017.

October 2017: At the BICC, there was a discussion about a patient who had sadly died of a gram negative infection together with another case. Both cases had been fully investigated with direct involvement from HPS and no linkage had been found. I had requested a full update about ward 2A at the next BICC meeting.

November 2017: A paper was presented at the BICC setting out service, infection control, domestic and estates actions in ward 2A. This indicated that all the actions were working to bring down the number of infections. **(Please see A32261049 – Bundle 13, Page 343)**.

There was a retrospective report which was done to look back at all the infections in 2017 in ward 2A: This has been sent to the inquiry (report attached question 205). It documents all the infections and how they were investigated. This has been reviewed though the governance committees of the Board. Some of the key conclusions are set out below.

The work of Quality Improvement Group to reduce line infection in Ward 2A has been instrumental in helping to reduce the line infection rate from a median rate of 3.5 in 2016 to 1.26 in January 2020.

There has been ongoing involvement of external agencies during this time period to seek advice and guidance to help manage incidents and provide independent assurance to improve the ward environment in Ward 2A.

The IPC Team have followed a set of national mandatory definitions requirement for IC reporting and have complied with the National Infection Prevention and Control Manual including the reporting of incidents to HPS.
Infection Control incidents in RHC, Ward 2A appear to have been acted upon quickly and the IMT has functioned well to facilitate a multi-disciplinary approach to the management of infection control incidents.

151 water samples were taken in Ward 2A/2B from March 2017 to November 2017. All samples have been negative.

Inpatient families and carers of patients within Ward 2A have been kept fully informed of incidents and education sessions have been delivered to encourage good infection control practice.

The Stenotrophomonas maltophilia isolates that were identified from the patients affected were sent for typing. Results show that these were not linked and there has been no single source of infection found from the environment.

Questions 317-326 (IMT 25/06/2019)

317. What is mycobacterium chelonae

318. What was your involvement in the m. chelonae outbreak:

A I was not directly involved in the investigation or management of this incident; my role was to report one case to the board via the HAIRT in August 2019.

I was not directly involved in the issues which are highlighted in **questions 317 - 326**. I reported on one case to the board via the HAIRT in August 2019. It may be worth noting that this was not an 'outbreak' as described in the question above and indeed this is one of the 2 cases which we have linked to the water.
The inquiry has all HAIRTs under RFI 11

319. Three hypotheses are discussed as potential sources of contamination causing infections during this meeting. What is your view on each hypothesis?

A I was not present at the meeting.

320. The minutes mention a requirement to refer unusual episodes to HPS? Did this happen?

A I was not directly involved, but there was a review of this for the oversight board response. This extensive response from GGC to the Oversight Board clearly describes many of these issues. The Inquiry has been sent this full Oversight Board response under RFI 1 6. Perhaps if detailed evidence on this is required, then IC experts can address this.

321. Who made the referral?

A I don't know.

322. What was the outcome of this?

A I don't know what the conversations were.

323. What actions were taken?

A These are set out in the IMT minutes of which HPS a member; the LICD of HPS representative would be better placed to address this.

Question 324- 326:

A This relates to HPS involvement, extent of involvement and actions taken by HIS: this relates to IMT/operational issues, which is set out on pages 38-40 and may be better addressed by LICD or HPS representative.

Question 327 - 331

A This relates to SBAR incident, data and epidemiology, dated 07/10/19. I was not present during the discussions on this SBAR, nor was the classification discussed with me. These questions may be best addressed by Dr Crighton, Prof Leanord or Dr Kennedy.

This report was sent directly to the cabinet secretary on 21/11/2019 with annotations from Dr Kennedy setting out GGC's position. The cabinet secretary approved the ward to open shortly thereafter. **(Please see A36591647 – Bundle 27, Volume 9, Page 426; A36591643 – Bundle 1, Page 373; A38694850 – Bundle 27, Volume 4, Page 180; and A36591614 – Bundle 27, Volume 9, Page 535).**

332-338 (document 72 relates to the meeting of 19th of June)

332. What was your understanding of the cases of m.chelonae and Stenotrophomonas which were emerging?

A I was not present at these meetings. I note that they are described in the questions as 'outbreaks'. I have noted in my response to question 315 that I was kept updated by Dr Inkster and her email to me is attached on the 19th of June 2019. (see question 315 email) This indicates that there is uncertainty whether the GNB may represent normal background rates with further investigations ongoing. For the M. Chelonae, there was water sampling with the filters off for M.Chelonae and further actions detailed. Both HPS/SG informed with further IMT organised.

333. Who was updating you on the situation?

A This was mainly Dr Inkster and Sandra Devine

334. Did you have any concerns? What were they?

A At this stage, it was the beginning of the investigation and results had not yet emerged. The concerns are always for the safety of the patients, and how this would impact on both patients and staff.

335. What actions did you take?

A There are email/IMT minutes, but there was also a lot of discussion and debate about the actions and any issues we needed to address.

336. What concerns were emerging regarding the source of the outbreak?

A This is set out in the HAIRT: for the m. chelonae case, it was about the link to the water and keeping patients safe. For the other cases, it was about whether this was really an 'outbreak' and whether there were 'unusual' organisms or not.

337. What were the concerns regarding drains?

A I am not sure as this seemed to be only discussed briefly. So perhaps the LICD best to answer this.

338. What actions did you or others take?

A These are highlighted in the IMT minutes for operational actions. In addition, there is further discussion under question 315 and 416 on actions taken.

339. At page 326c, it states that there have only been 4 cases of m.chelonae reported in the adult population in the last decade and no paediatric cases and now there has been two within 12 months. Did this concern you? Was this escalated? The HIATT score is only listed as amber, do you think this appropriately reflects the severity of the situation? 25th of June

A I reference the email from the ICM setting out the findings and the actions. The questions regarding chelona cases and the HIATT scoring are best put to those who scored the HIATT at the time with the information available. It would also be for the public health team to review the epidemiology, reporting and a detailed Root Cause Analysis (RCA) of the cases.

I received an email from Dr Inkster on the 28th of June, 2019 highlighting that one of the chelona cases was linked to the pre filtered water in ward 6A while the case in 2018 was not linked.

Please see the full report with the HAIRT which was taken to the board meeting in August 2019.

Refer to IMT Bundle, Document 74,

340. The water reports from this meeting state that a water outlet come back as positive for mycobacterium even with a point of use filter on it. It was suspected the filter may be defective. What was the outcome of this? Was the filter found to be defective? Are point of use filters 100% effective?

A I don't know the response, and this would be best addressed by estates colleagues.

Chill Beams (341-345):

I do not have any expertise in chill beams and this may be better addressed to specialists within estates and IC who are better able to answer these points.

346: The issue of patient placement is also discussed to avoid putting patients from 6A into wards where there are chilled beams. The minutes state that Dr Scott Davidson will discuss this with you. Did you have this discussion? What was the outcome?

A I don't recall any meeting/emails about this issue.

IMT – 14th of August 2019 (347 – 358)

Please refer to IMT Bundle Document 77

347. Do you recall this meeting?

A No, I did not attend it.

348. What was the purpose of this meeting? Describe the circumstances leading up to this meeting.

A I have set this out in my response to question 315**.**

349. At this meeting Dr Deighan disagrees with Dr Inkster that the numbers of bacteraemia have increased. What is your view on this? Please provide reasons for your conclusion.

A I agree with Dr Deighan. The epidemiology reports from Dr Kennedy and the HPS report show the same pattern and indeed in 2018, when the ward was decanted, rates were within expected numbers as shown in Dr Kennedy's charts. There was no clear case definition and not a consistent RCA.

350. Did you agree with Dr Inkster and Dr Peters that the nature of the bacteria was a concern in that it was environmental and associated with water/soil? If not, why not? Please provide details for your answer.

A This was the same argument used in the September 2018 IMT by Dr Inkster: the issue is that numbers are small, these environmental bacteria are widespread, and they were seen in Yorkhill.

Dr Iain Kennedy's reports

351-358

I have seen these reports while reviewing documents for various investigations over the past 4 or 5 years. I was working at a corporate level, so these reports would probably have been presented at the IMT to form part of the decision making of the IMT. I am not an expert in the various methodologies or data used to construct the reports. I think these questions may be better addressed by the Public Health consultants and/or IC. I have not seen the rationale for Dr Inkster, Dr Peters and Dr Harvey Woods which led them to disagree with the conclusions.

The advice from the chair of the IMT on the 27/09/2019) and the discussion at the Atlantic Quay (26/09/2019) are (attached to question 315) and set out the advice given by the chair of the IMT. The HPS report published in 27/11/2019 seemed to be in accord with this advice.

Summary of W, X, Y, Z

The IMT started in June 2019 and there were 2 issues: 2 cases of M.Chelonae and a discussion of gram negative cases in the unit.

For M.Chelonae, one case was DNA linked to the water while the other case was not linked. This was closed in August 2019 and the response from GGC to the oversight board sets out in detail that it was fully reported and investigated at the time.

For the gram-negative cases, there was debate around whether this was actually a background rate, whether they were unusual and whether they could be linked to the environment. The detailed epidemiological review suggested that the numbers of cases were equivalent to the expected number and that these bacteria had been seen before in Yorkhill. The environmental tests were negative.

The unit was closed to new admissions at the beginning of August with newly diagnosed children sent to other units. There were considerable risks in the closure of the unit together with a further erosion of confidence in the environment.

Following concerns which were raised by IMT members, a new chair was appointed. The evidence was reviewed, a new multidisciplinary review of cases was introduced to a (rather than one person) with a RCA. A further detailed review by HPS and the University of Strathclyde concluded that the ward was safe. All the information sent to NSS and SG. The cabinet secretary announced that the ward could reopen in November 2019.

Prophylactic Medication (359-370)

It would be more appropriate for a clinician/ICD to address the detail of the questions set out in this section. This is not an area in which I have any expertise.

The prescribing of prophylactic medication is a matter for the clinical team together with support from ICD/microbiologists. It can also involve antimicrobial pharmacist and infectious diseases consultants.

There was also a review done by Dr Andrew Murray which sets out some of these issues. **(Please see A42208416 – Bundle 6, Page 10).**

In the Bundle 12, document 137 refers to an email of 8/01/2019. In the initial management meeting to discuss the issues raised by Dr Gibson (09/01/2019) Jamie Redfern mentions a review of prophylaxis in point 3. This was also discussed with consultants 2 days later on 11/01/2019. See the response to question 393.

Cryptococcus (371-395)

371. Recall your understanding of the cryptococcus infections in 2018

a) What was your impression/reaction upon learning of the presence of cryptococcus in 2018 in the QEUH?

A I will set out in chronological order when I first heard of the patients with cryptococcus infections and the events thereafter.

20/12/2018: I received following email from Dr Inkster. **(Please see A40562747 – Bundle 14, Volume 2, Page 266).**

- Jennifer - we had an IMT today re two cases of Cryptococcus neoformans in blood cultures, hospital acquired in haematology patients. I need some urgent advice re duty of candour as the paediatric patient has sadly passed away with positive post mortem samples. Can you call me at some point….

- From memory, I asked Dr Stewart, deputy medical director to call Dr Inkster back as I was at the GJH then on my way to Yorkhill hospital. Dr Stewart called me and alerted me to the situation: a child had sadly died on the [redacted] and another patient had tested positive. Both patients had cryptococcus neoformans in their blood cultures which is rare. In the case of the paediatric patient a postmortem was carried out to establish the cause of death: it found cryptococcus neoformans had spread [redacted] while the adult patient was positive 3 weeks after transfer to the QEUH from a hospital in [redacted].

- The query was should they tell the child's parents. I responded to Dr Stewart and Dr Inkster that we should absolutely tell the child's parents, and indeed I also suggested that we should tell the adult patient. I was keen that this was done by the clinical teams in a sensitive manner and indeed, there was a question about before or after the child's funeral. I felt that this should be a judgement call by the clinician who knew the family and done with the utmost sensitivity but that we still needed to do it.

b) What is cryptococcus?

A I have reproduced the definition in John Hood's report;

C. neoformans is a fungus that lives in the environment (including soil, some trees including decaying wood) throughout the world. It has a known, although complex, association with the guts of pigeons and other birds. Although most people who are exposed to the fungus do not get sick from it, a small number of people can become infected after breathing in the spores. Only one outbreak associated with a hospital has ever been previously reported in the literature Vallabhaneni, S et al (2015)2.

C. neoformans infections are very rare in people who are otherwise healthy; most people affected are immunocompromised (weakened immune system).

c) Have you seen/heard of Cryptococcus in a healthcare setting prior to QEUH?

A As set out above, there is only one outbreak worldwide ever reported in the literature.

d) What were the issues with Cryptococcus at the QEUH? When did you first become aware of these issues? What happened in response to these issues?

A As highlighted in a), the 20th of December 2018 was the first time I was aware of any issues with Cryptococcus at the QEUH/RHC and the issue was set out in the email sent to me by Dr Inkster. In response to these issues, an IMT was set up on the 20/12/2018 and led by Dr Inkster.

372. What steps were taken in response/precautions put in place?

A The advice was agreed by the IMT on a range of actions, which are documented in the IMT. HPS and SG were informed on the 20/12/2018 by Sandra Devine in the HIORT. The weekly director's report on 27/12/2018 and 03/01/2018 summarised the IMT findings. **(Please see A36690608 – Bundle 27, Volume 9, Page 427).**

a) What were the hypotheses put forward for cases of cryptococcus? Who put these forward?

A The main hypothesis put forward by Dr Inkster in the IMT and is set out in John Hood's report:

At this time the main hypothesis was, that cryptococcal spores (from pigeon guano) were being aerosolised into the Plant room air, then getting into the Air Handling Units (AHUs) during routine maintenance, i.e. during shut down, opening and final filter change, then onwards to the patients down the duct.

b) Did you agree with these?

A At the time, the hypothesis seemed plausible, and it was the main one advocated by Dr Inkster.

c) What was your hypothesis regarding the cryptococcus cases?

A At that point, I did not have one as I was focussed on the advice from the LICD. Although I was aware of latency in crypotococcal infections.

d) What was the rationale behind your hypothesis?

A I was taking the considered advice of the IMT and acting on a precautionary approach.

373. Bundle 1, IMT document 58 (IMT 16/01/2019).

A I was at the IMT as I note I am minuted as attending. I cannot recall the meeting and cannot really add any more than is set out in the minute. I was not assigned any actions.

374. Discuss your involvement, if any, at the Cryptococcus sub- group meetings:

A I did not attend the sub-group meetings.

375. What, if any, external reporting occurred?

A The media communications were extensive around this time as well as communications to patients and families. However, Sandra Bustillo, or the directorate team may be able to address these issues. In terms of external board meetings, this issue was described in the Board meetings of 19/02/19, 16/04/19 and 25/09/2019 with full description in an accompany report (HAIRT) for each board meeting.

376. PAGs/IMTs/AICC/BICC.

A I will address the Board level committees, while others may address the other areas and I understand the inquiry have all these minutes. There was a weekly report and this incident was included as a weekly update. For the BICC, this issue was discussed on 28/01/2019, 25/03/2019 and update in 03/06/2019 minutes. It was discussed at the non-executive chaired clinical and care governance meeting on 05/03/2019 with a full paper presented by Dr Inkster In addition, it was discussed at the Board Clinical Governance forum on 8/04/19.

377. What steps were taken in response/precautions put in place?

A This may be better addressed by the LICD and is detailed in the HOIRT of Feb 2019.

378. Did you read John Hood's report?

A Yes.

379. When did you read John Hood's report?

A From my recollection, I first read Dr Hood's report in 2020. He also presented it to the executive team circa 2020. I have subsequently read the unredacted report, which was the final report in 2022.

380. What observations, if any, did you make after reading John Hood's report?

A For the report, my observations included:

- The report is a thorough investigation into each of the hypotheses concerning the origin of Cryptococcus, which was found in an adult patient and a paediatric patient in the QEUH. This was investigated by the IMT.
- I am not an expert in the issue, and it may be better to seek evidence from an ICD/specialist. However, on reading the report, on the balance of probability for a whole range of reasons from environmental factors to clinical factors, it is highly likely that this represented a reactivation of previous infection which is much commoner and more likely than a hospital acquired cryptococcus.

381. What else could have been done? How could matters have been handled differently? What concerns, if any, did you have about how matters were dealt with?

- It is perhaps helpful to outline where the origin of John Hood's report. It was not the IMT which suggested the review, although the subgroup was set up to report to the IMT. At the BICC on 28th of January 2019 the cryptococcus cases were discussed. Dr Andrew Seaton, who is a consultant in infectious diseases at the QEUH, inquired whether the 2 cases could be sporadic cases with previous cryptococcal infection, which was reactivated due to severe immunosuppression. It was agreed that there would be a subgroup set up and would look at all hypotheses. On the 30th of January,2019, I discussed this with the executive team to ensure that there was support for this and then

asked Tom Walsh, Dr Inkster and others to set out TOR. **(Please see A39235402 – Bundle 27, Volume 9, Page 430).**

- It was important for GGC to be clear what the most likely scenario was, not least for all the other patients and staff in the QEUH. The initial hypothesis did not include the most likely scenario.
- It is important to consider the evidence and what happens commonly as opposed to alighting on a cause without evidence then not considering other causes when the evidence does not fit.

Question 382-386.

A These questions relate to specific issues concerning the plant room. This is not within my remit nor knowledge and would be better addressed by LICD or estates colleagues.

387.

A I note that this relates to IMT on the 16th of January 2019, but I don't recall these discussions in detail and cannot answer the questions. It may be better if LICD or estates colleagues address these issues.

388.

A I note this relates to the IMT on 17th of January 2019 but I don't recall this detail and it may be better if the LICD or estates colleagues address these issues.

389. Three incidents are discussed including a paediatric patient who died following testing positive for cryptococcus:

A I have set out my understanding of the situation, who kept me informed and actions taken in 371a and 372.

390. Discuss this case. What was the outcome (Question 390 (Bundle 1, document 94) 02/07/20):

A I was not involved with this case and cannot comment.

391. How many cases of cryptococcus have there been in the QEUH/RHC between 2015 to date? Please provide details of each case.

A I cannot answer this question. I understand that this Data has been provided under RFI 26 to the inquiry.

392. Dr Gibson emailed you following the death of a child, she states, ‘as a consultant body we are now very concerned about the safety of our environment… we are concerned we may have moved to an even less safe environment. ‘What is your view on Dr Gibson’s concerns? (Bundle 12, Document 137)

A I was also concerned when I read the minutes from the IMT on the 07/01/2019 and I will set out a timeline below for that evening as I had already escalated these issues to the senior team before I received Dr Gibson’s email. I could absolutely appreciate her concerns as there had now been a series of IMTs from March 2018 to June 2018 then from Sept 2018 to December 2018, which included a relocation of the children and their families with staff to the adult hospital and now this incident. The GGC teams had tried to do everything in their power to address all the issues and patients and families along with staff were at the heart of all the decisions with the only aim to keep patients safe and enable staff to provide good care to patients and their families.

The timeline for 07-09/01/2019 is as follows:

A further IMT on the 07/01/2019 highlighted issues with communication and prophylaxis. This was briefly mentioned in the Acute Infection Control Committee which Dr Inkster attended and gave an update. The hypothesis was at that point focussed on a plant room.

On the 08/01/2019: I received the IMT minutes of the 07/01/2019 at 17.35pm. I read them later that evening and sent an email to Jane Grant, Jonathan Best, Margaret McGuire and Tom Steele highlighting the debate concerning issues of prophylaxis, communication and ward 6A at 9.27pm. I attached the minutes and said it would be helpful to discuss. Around 10.15pm, I received an email from Dr Gibson setting out very clearly concerns about the safety of the environment and setting out her concerns. I escalated the email to the senior team at 10.23pm. **(Please see A49401465 – Bundle 27, Volume 8, Page 152; A36690566 – Bundle 1, Page 255; and A49401501 – Bundle 27, Volume 8, Page 164).**

At 06.35am on 09/01/2019: I emailed several people and suggested a meeting with Chief Operating Officer, Jonathon Best, Tom Steele, Kevin Hill, Senior IC and Dr Kennedy. From memory, I also contacted Tom Steele about how to access hepafilters urgently; he advised that there were spare filters on the site as back up for ward 4B. **(Please see A49401500 – Bundle 27, Volume 8, Page 166)**.

On 09/01/2019: I urgently convened a meeting with senior clinical and managerial leaders, the Director of Estates, the ICM, 2 ICDs, Iain Kennedy and the Director of Nursing for GGC. Dr Inkster was invited but was on annual leave. A minute of the meeting is available and has been submitted to the inquiry under RFI 6 cryptococcus narrative.

This sets out clearly all the key issues and actions to address these issues. It was noted that the IMT on Monday 7th of January 2019 had discussed HEPA filter units and there was a comment that they were noisy and indeed there were some on the ward but not in use. Jen Rodgers and Dr Mathers said that they were no louder than a fan heater. It was agreed by me and all at the meeting that the HEPA filters should be deployed without delay. We had 30 HEPA filter units in the QEUH, which could be sourced immediately, and the ICD would visit the ward to advise where they should go. We discussed the best way to alert parents and staff and it was felt there was a need for discussion directly with parents.

On 10/01/2019: The HEPA filters were deployed with communication to staff and patients. This is the first time that these filters were deployed on this scale.

393. Dr Gibson described having to give prophylaxis to vulnerable patients and describes two serious anaphylactic reactions, which required adrenaline. What actions were taken following these concerns:

A There was agreement on the 08/01/2019 meeting to address each point in Dr Gibson's email and to meet the consultants directly on Friday 11th of January 2019 to hear their views and set out issues which require further work.

Friday, 11th of January 2019: I organised a meeting with specialist teams and the consultants, including Dr Gibson, to discuss the points raised in her email. This included Jamie Redfern reporting that there had been a review of prophylaxis requested with a microbiologist, a clinical pharmacist and a clinical oncologist to review the guidance which they took forward (there was also discussion of this issue on 07/01/2019 IMT) and the deployment of the HEPA filter units. It was confirmed the work would go ahead on the 2 rooms situated in 6A and an ICD agreed to sign off the scribe. **(Please see A44099044 – Bundle 27, Volume 9, Page 431).**

394. Dr Gibson describes two rooms with water damage and mould which had not been attended to by Estates. Were you aware of delays in addressing these issues by Estates? Whose responsibility would addressing such issues have been?

A I was not aware of this, and the response was detailed in the meeting on the 11/01/2019 detailed in the paragraph above. I am not aware what happened in this case. So, I suggest that estates/directorate team are best to provide a response.

395. Who was responsible for managing the concerns outlined by Dr Gibson?

A The directorate team would manage the concerns in partnership with clinicians and colleagues from other directorates depending on the issues raised.

Summary of Section BB: Cryptococcus

Dr Inkster set up an IMT in the 20/12/2018 as 2 patients had been diagnosed with cryptococcus neoformans in blood cultures with one patient sadly dying. There were a series of measures taken including prophylaxis for the children and investigations carried out. The hypothesis put forward was that cryptococcal spores were being aerosolised into the plant room then onwards to patients via the ducts. There was a significant amount of external and internal reporting of the incident over the months which followed. The second patient also sadly died.

I alerted the senior team to the IMT minutes of 8th of January as significant issues had been raised. Shortly after, I received an email from Dr Gibson setting out her concerns. I set up an urgent meeting the next day on the 9th of January and ensured that HEPA filters were deployed to the ward at scale on the 10th of January. I met with Dr Gibson and her colleagues as well as the senior team and IC on the 11th of January to ensure all actions discussed and agreed.

Over the course of the next few weeks, all the tests were negative for Cryptococcus neoformans and the patients were moved out of ward 6A to enable some works to be progressed. At the BICC on the 28th of January, an infectious disease specialist asked if these patients could be sporadic cases with reactivation: the committee agreed that an independent expert group should be established. This was agreed by the executive team and it was also agreed it should report to the IMT.

The report was available in draft in 2020 and sets out why the reactivation of a latent infection is the most likely cause.

Whistleblowing and Communication

396. Can you explain the key aspects of the duty to communicate effectively with patients generally?

A The key aspects of the duty to communicate with patients is set out by the GMC in guidance to doctors on Good Medical Practice and the expectations around communication with patients and their carers.

To summarise, we should communicate sensitively and considerately, recognising their knowledge and experience of health and acknowledge their concerns. We should not make assumptions about what a patient will consider significant and be willing to explain the reasons for our recommendations for treatment. We should recognise that patients may be vulnerable and be alert to signs of distress.

We should involve patients in decisions about their care and be aware of our legal and ethical duties relating to consent.

We must ensure that any information we give is clear, accurate and up to date and can be understood by those with different language or communication needs.

We must be open with patients when things go wrong and seek to:

1. put matters right, if possible
2. apologise (apologising does not, of itself, mean that you are admitting legal liability for what's happened)
3. explain fully and promptly what has happened and the likely short-term and long-term effects
4. report the incident in line with your organisation's policy so it can be reviewed or investigated as appropriate – and lessons can be learnt, and patients protected from harm in the future.

397. Can you explain how the duty to communicate should be approached when it comes to telling patients about an infection: the possible causes of the infection; and about the impact upon health; and upon future treatment?

A Infections occur during hospital admissions for many reasons. Sometimes as a consequence of the underlying illness and sometimes as a consequence of treatment. There is a duty to ensure patients are fully informed of the risk of infection, which may be increased by treatment (e.g. chemotherapy) during the consent process. It is our duty to communicate and would always involve telling a patient that they have an infection and the plan for treatment. Where this has an impact on future treatment, we would of course explain this. It might help to consider the example of a patient who has pancreatic cancer, but who develops cholecystitis (an infected gallbladder) as a consequence of placement of a bile duct stent. While this is unavoidable and is a recognised complication of the condition, it may delay further cancer treatment and this would need to be fully explained. Where an infection is a consequence of an unexpected incident (for example an outbreak of linked infections on a ward or where there has been a breach of infection control policy) this would necessitate an apology and would trigger an investigation to identify the cause and prevent further infections form happening.

398. Can you explain how the duty to communicate should be approached where something has gone wrong during care or treatment?

A When something has gone wrong during treatment, the GMC set out in their guidance how we should approach this as described in my response to question 396 above. This is professional duty of candour.

399. Are you aware of the duty of candour and how would you explain that?

A Professional duty of candour is as set out in my response to question 396 above and is a requirement of the medical regulator on all doctors at all times.

Organisational Duty of Candour is a specific legislative requirement which sets out additional responsibilities of the organisation in the event of an unintended or unexpected incident that has resulted in harm or potential harm.

The key <u>additional</u> requirements are:

1. To notify the responsible person of the incident, explain what has happened and what actions we will take and also to explain the reasons if there is a delay of more than one month since the incident date.

2. To offer a written apology.
3. An invitation to a meeting and the opportunity to ask questions in advance and to provide a note of this meeting.
4. To give contact details for a member of staff.
5. To conduct a review of the circumstances that led to the incident.
6. To provide a written report including any defined actions recommended.
7. To share the report with the responsible person.

In NHSGGC, these requirements are met by conducting a Serious Adverse Event Review (SAER).

400. If staff had concerns about wrongdoing, failure or inadequacy within the hospital.

a) were there procedures to facilitate disclosure of this either to other GGC staff or to individuals external to GGC? What were these?

A There are a range of ways which the organisation is keen to encourage staff to speak up

- Through the line management structure.
- Through the professional line management structure.
- Utilising the governance procedures e.g. through datix or governance processes.
- Through HR process.
- Whistleblowing procedures.
- Induction for junior doctors goes through who to raise concerns with as well as regular surveys.
- Through the clinical structures e.g. Morbidity and Mortality meetings.
- Occupational health.
- Trade Unions.
- More recent examples include peer support and confidential contacts.
- Through external organisations e.g. GMC, Health Improvement Scotland, HSE.

b) Were these procedures and details of how to use them easily available to staff?

A There was a lot of effort put in to ensure that staff are aware of the policies and procedures which enable them to raise concerns: either through on-line resources, or through training and induction. For example, junior doctors, through site based induction, are made aware of how and with whom to raise concerns. Many of the policies on the HR

connect site can help staff know where to go and recent campaigns such as Speak up are aimed at encouraging staff to do so.

c) Is disclosure in this manner something that has always been encouraged within GGC?

A Yes, it is detailed on all the available resources and avenues set out above.

401. Are you familiar with the whistle blowing policy for GGC in 2018?

A I am not a whistle blowing champion/designated expert and I have a basic knowledge of it. However, Dr de Caestecker maybe better placed to answer these questions.

402. Was the policy easily accessible to staff? Are you aware that this policy was out of date and had not been updated appropriately?

A I am not familiar with the policy nor was I aware it was out of date. However, the HR team have a speaking up campaign which brings together all the ways of raising concerns and this is very accessible and easy to reach.

403. In your view was the whistleblowing policy in place in 2018 effective?

A I am not sure if it was effective or not as I did not deal with the whistleblowing cases and did not see complaints about it from any of my dealings within the Board. This question may be best addressed by whistleblowing champions/support at GGC.

404. Has the whistleblowing policy been updated?

A I have accessed the speak up campaign site within GGC and I note from there that NHS Scotland have updated the policy and I understand from board papers, that the GGC policy has been updated.

405. What updates have been made?

A I am not sure, and this question maybe best addressed by whistleblowing champion. I understand from colleagues, one of the updates is to make stage 1 clearer.

406. Do you think the current policy is adequate?

A From Board papers, I have no reason to suggest it is inadequate, but one of the Whistleblowing champions may be able to address this question.

Whistleblowing – QEUH/RHC

407. What was your involvement in the whistleblowing process? Please provide details:

A I did not have any involvement in the whistleblowing process at the board as I was not and am not one of the whistleblowing champions and I don't investigate cases. I have referred issues to the whistleblowing champions to review, I have answered a question from whistleblowing processes, and I have received a recommendation from a whistleblowing process. (see Question 444)

408. What is your understanding of the concerns that led to the stage 1 whistleblow in 2017? Did you agree with those concerns?

A I will take this as referring to the issues raised by Dr Redding and others in September of 2017. It was not understood by me that this was a whistleblowing process. I should note that there is a full timeline been submitted to the Inquiry concerning all these emails and all the actions taken. (RFI 7 4.1).

In my email of the 28/09/2017, I invited Dr Redding and her colleagues to a meeting with many of the senior representatives which she had suggested in her email to me on the 27/09/2017. My intention was to **fully** explore and document all her concerns with the senior colleagues who had knowledge of and responsibility for the areas of concern. However, her emails to me mentioned a series of issues ranging from infection control incidents to planning and design of the QEUH which she had been involved in, but it was unclear to me what the specific issues were. I have pasted the paragraph of my email of the 28/09/2017 to Dr Redding below.

I was, however, a little unclear from your e-mails what the specific areas of concern are; and therefore, in order to ensure the meeting is as productive as possible, it would be helpful if you and Dr Peters could set out in writing clearly the areas of concern in advance of the meeting. The SBAR format is particularly useful, and if possible, I would be grateful if this format could be used.

409. Refer to emails between 5th September 2017 and 3rd of October 2017: Email chain between Penelope Redding, Tom Walsh and Jennifer Armstrong dated between 5th September 2017 and 3 October 2017

a) Do you recall receiving these emails from Dr Redding?

A Yes.

b) Dr Redding raises issues concerning patient safety and infection control: were you aware of these concerns in advance of Dr Redding's emails? If so, please provide details:

A Dr Redding raised a wide range of issues from current ongoing IMT investigations into incidents, to the roles within ICT, the design and planning of the hospital as well as ventilation issues. She also advised that she is no longer an ICD, but her colleagues can

provide more information. My answers throughout this questionnaire have demonstrated that when I have been aware of concerns, I have worked with colleagues to investigate as well as address them. Her emails lacked clarity as I set out in my response to her outlined in my response to question 408. I was keen to ensure we captured her concerns so we could understand and investigate them and engender a collective responsibility to work together to address these concerns in a constructive way.

c) What was your view on Dr Redding's concerns?

A In her email to me on the 28/09/2019, she said '*There are many contradictory versions of the information relating to the issues of recent and historical events. It is very complex to fully grasp all the facts. I feel a meeting needs to be arranged so that a record, in one document, of all the evidenced issues can be made. This will ensure that the issues are openly understood and addressed with appropriate action plans*.' I did agree with that for 2 reasons: the most important one was to ensure that patient safety was paramount and therefore to understand any patient safety issues and take clear actions. Secondly, I know colleagues in IC were often distressed by some microbiology colleagues whom they felt were always questioning/being critical of them as opposed to trying to collectively solve problems. I did want to explore the concerns, agree collectively what needs to be done and engender a collective response and ownership of the actions.

d) It would appear that Dr Redding sent emails on the 5th, 15th, 21st and 27th September 2017 before receiving a response; how would you account for this delay in responding?

A This relates to an email to Tom Walsh on the 5th of September, and emails to me and Dr Stewart on the 15/09/2017, 21/09/17 and the 27/09/17.

- My office acknowledged receipt of the email on the 15th when it came in and I responded fully on the 28/09/17 as described in the previous questions in this section. In her email of the 15/09/2017, Dr Redding says she is due to take annual leave until the 5th of October. This is later clarified in Dr Redding's email of 27/09/2017 as we arranged the date of the meeting to suit her availability.
- I note that Tom Walsh was on annual leave from Monday 4th of Sept to Monday 18th of Sept. Dr Redding emailed him on the 5th of September, the day after his annual leave began.
- I did want to discuss the concerns with Tom Walsh and Professor Brian Jones, (Consultant Medical Microbiologist, Head of Service, Microbiology & Virology, NHS GGC, Professor of Clinical Microbiology & Infection, University of Glasgow and lead ICD covering Dr Inkster's sick leave) in the first instance. I cannot recall when we discussed the concerns, but it would be after Tom Walsh's return from annual leave on the 18/09/17.

The detail of this has already been submitted to the Inquiry (RF 7 4.1) with relevant emails and details. I have detailed the executive summary below which if linked with the RFI, can perhaps address the points raised in this section.

I was keen to ensure all areas were addressed and that there was full visibility within the Board about these issues as well as monitoring to ensure actions completed. This was in some instances, complex engineering issues which took time to address. All actions, except one, were completed and signed off by October 2021.

e) The inquiry understands you did not treat Dr Redding's emails/concerns as a stage 1 Whistleblow, that is despite Dr Redding stating in her email of the 27th of September 2017, ' *I would like to avoid going to a Stage 2 of the GGC Whistle blowing policy'* Can you explain the rationale for this decision?

A The simple reason is that I had not understood from this sentence, that I was the stage 1. I had thought that whistleblowing issues at stage 1 were dealt with by a line manager and I therefore thought she had previously raised this within the line management structure of the diagnostics division where she was based. This would either be at the general manager/clinical director or chief of medicine/director of division or indeed the deputy medical director acute or the chief operating officer.

In addition, Dr Redding had not alluded to whistleblowing in her emails of 15/09 or 21/09 to me: she talked of escalating her concerns to me. I took this as a professional complaint and was keen to address the concerns she was raising.

410. Refer to SBAR of the 3rd October 2017 – Re Infection Control and Patient Safety at the QEUH

a) Do you recall receiving the SBAR on 3rd of October 2017?

A Yes, as I set out in my response to question 408, I asked Dr Redding to send me this.

b) Going through it, please provide your views on each of the following:

A As I have detailed in responses to questions 408 and 409, I was clear that my role was to ensure that those with specialist knowledge or responsibility in this wide ranging SBAR met with the microbiologists directly to discuss the issues raised. This was why I was keen that a multi-disciplinary group met to look at the concerns, identify what had been done already to address these concerns (as many actions had already been taken), explore areas of misunderstanding and seek a common agreement of the challenges. Thereafter agree actions to address remaining concerns. As suggested by Dr Redding, we would capture the concerns and the actions in one document and ensure actions were followed through.

Therefore, I cannot answer the questions set out in 410 b). For the areas of patient placement, cleaning and estates there was a need for those with specialist knowledge and responsibility to discuss the areas, determine what has already been done to address the issues and identify any gaps or areas to take forward. For the Infection Control Structure, this seemed to work well in all the teams except the QEUH team and

there was a need to understand if there was common agreement on these issues with the Infection Control Senior Management Team. For the recommendations, I do agree that there needs to be a full understanding of the concerns but also a collective willingness to address them.

411. The SBAR states that some of the issues raised, for example patient placement and cleaning were first raised in June 2015. Why were these issues not being addressed in a timeous manner?

A I cannot answer this question as many of these issues were being raised at an operational level, so I don't know what was raised, what the actions were and the response. However, what I can say is that the minutes of the meeting on the 4th of October 2017 and the subsequent emails and action plan sets out that a lot of areas had been addressed or that there was work on going to address them. In some instances, this involved quite complex engineering issues which required access to clinical rooms which had to be timetabled in. One of the reasons I was keen to get an action plan and monitor it was to raise these issues, ensure transparency and visibility not just in operational teams, but also at Board level to support progress on these areas.

412. In your view did the SBAR of 3rd of October 2017 raise valid concerns?

A Yes

413. If yes, what was the response to these concerns?

A The response to these concerns was thorough and wide ranging. There has been a very detailed timeline of events submitted to the public inquiry which shows each concern was minuted, then mapped to an action plan (27-point action plan). This was then highlighted through a range of governance groups to ensure progress and completion of all the tasks which occurred in 26/27 points. The following summary sets out the very extensive information already provided to the Inquiry:

Summary of actions to address concerns and full timeline

- In September 2017 Dr Penelope Redding raised concerns with Dr Jennifer Armstrong about infection control in the QEUH/RHC.

- Dr Jennifer Armstrong requested that their concerns be formally documented in an SBAR (Subject, Background, Assessment and Recommendation) tool, detailing specific areas of concern, so that appropriate actions could be taken. She also agreed to convene a meeting of key staff to discuss concerns and next steps. (*See Item 1 below)*.
- In response, Doctors Christine Peters, Penelope Redding and [redacted] (and not Dr Teresa Inkster) (the "Consultant Microbiologists") drafted an SBAR re Infection Control and Patient Safety at QEUH/RHC dated 3 October 2017 (the "October 2017 SBAR"). (*See Item 2 below*.)
- A meeting was convened as a matter of urgency on 4 October 2017 with the Consultant Microbiologists, Senior Directors and Senior Clinicians of GGC. (S*ee Item 3 below*.)
- Many of the various issues raised within the October 2017 SBAR and discussed at this meeting had already been identified and were in progress prior to the submission of this SBAR. (*See minutes of meetings below*. *Further information is available on request*.)
- A 27 Point Action Plan (the "Action Plan") was developed to address each of the separate issues raised.
- Regular meetings of the following committees were convened to discuss and progress the Action Plan:
  - Board Infection Control Committee (BICC);
  - Clinical and Care Governance Committee (CCGC);
  - Acute Infection Control Committee (AICC);
  - Board Clinical Governance Forum; and
  - Partnership Infection Control Support Group.
- The concerns raised in the October 2017 SBAR were thoroughly investigated and actions taken in respect of each separate issue.
- The October 2017 SBAR and Action Plan were signed off as being complete on 1 September 2021. (See email at Item 17 below.)

Refer to the minute of the meeting dates 4/10/2017

a) Do you recall attending this meeting, please provide details of your recollections:

A Yes, I chaired the meeting with senior colleagues. Dr Redding with Dr Peters went through the SBAR, which had been circulated. They were listened to, and each area was discussed with an agreed action plan at the end of the meeting.

b) There is some discussion surrounding PPVL rooms not being built to SHTM standards and that they did not provide appropriate protection for patients, something which David Loudon disagreed with. Were PPVL rooms built to SHTM standards?

A I don't know as I don't have remit nor knowledge. I suggest ask estates colleagues or David Loudon.

c) There is a discussion surrounding the Infectious Disease Unit, its relocation to QEUH and HPS agreeing to provide details of the room standards required to accommodate patients. A meeting took place with HPS on 2nd October 2017. Can you elaborate on the circumstances surrounding this, as well as the reasons for the delay in HPS providing the details required?

A I don't know as I did not attend this meeting.

d) There is discussion surrounding HEPA filters not being fitted in PICU and in prep rooms in Ward 2A. Can you explain this decision? Who was responsible for managing the installation of HEPA filters?

A I cannot answer this question and may be best addressed by estates colleagues and ICT

e) Do you agree there was an issue with cleaning practices within the QEUH/RHC? Who was responsible for the management of cleaning practices?

A I can't answer this question as it is not within my remit.

f) Water quality and testing concerns were discussed: What is your view on these? Who was responsible for the cleaning and maintenance policy of taps?

A I can't answer this question as I don't have specialist knowledge, and this may be better addressed by estates colleagues/LICD.

g) Do you agree that there was a delay in providing test results to ICD?

A I don't know as I had not seen evidence of this.

h) Dr Peters raised concerns regarding ICD requesting and receiving the water sampling results in a timely manner where a water source of infection needed to be investigated: Do you agree with this? Was there an issue with ICDs receiving test results?

A I had not seen evidence of any instances where this had occurred. This maybe something which the ICT can advise.

i) What was the extent of the issues of sewage in the neuro surgical theatres? Who was responsible for dealing with this?

A This maybe better addressed by estates colleagues or the operational management team.

J) Looking at the 'Agreement of Further Actions/Next Steps', where possible, please provide details as to what actions were taken and the outcomes of these.

A I would refer you to the summary detailed above in response to question 413 and to RF 7.4 1 as there was a huge range of actions taken with 26 out of 27 actions done. One was not technically feasible.

414. 27 point action plan – refer to Action plan arising in response to SBAR dated 03/10/2017 details. Please discuss this plan including:

a) Who was responsible for the management of the plan and updating it?

A The Infection Control Manager

b) What actions were taken in terms of each issue?

A I would refer you to RFI 7.4 1. These actions were logged and each one is documented throughout the period from 2017 to 2021. There as also extensive scrutiny from operational to Board level review. The final paper which documents all the actions is at the clinical and care governance committee in June 2021.

c) Which actions have been fully resolved?

A All actions except the one which is not technically feasible.

d) Which actions are outstanding?

A None

415. In this paper from June 2021, the Clinical and Care Governance Committee comment that many actions from the plan were still marked "in progress" in 2019 and therefore request a further update, a review and closure of the plan. Can you please comment on the final positions relating to each issue and whether, in your view, they have been satisfactorily resolved:

A All issues have been fully resolved

The updated action plan was presented by Sandra Devine and discussed at Clinical and Care Governance Committee on 8th June 2021. The committee were asked to note that 26/27 actions were now completed, and one action was technically impossible. The committee requested update to actions, 3, 17 and 24. This was done and an email sent to Chair and Vice Chair of C&CG with update of 3, 17 and 24 from secretariat and from Director of Clinical and Care Governance. The SBAR was signed off on 01/09/2021. **(Please see A38759130 – Bundle 27, Volume 9, Page 435; and A49401499 – Bundle 27, Volume 8, Page 167).**

The RFI 7.4 1 has the detail of all of the actions. If there are technical questions, they may be better addressed by the relevant director with the detailed knowledge as I cannot address these issues in detail.

416. Note of meeting about IMT on Tuesday 20/08/19

a) Do you recall this meeting?

A Yes

b) What is your understanding why this meeting was called?

A After the IMT of the 13/08/19, there were reports from clinical and managerial staff that the meeting had been very unsatisfactory and difficult: I recall that there were reports that the IMT was not working, they were not getting anywhere and there were behavioural issues. I recall having a conversation with Kevin Hill, the director for W & C who reported his concerns in JB Russell house (the Board headquarters) where he was attending a meeting.

Prior to this, there was some disquiet about the lack of direction and the focus on proving a hypothesis even when the evidence did not support it. I recall one of the senior team saying they were like ‘meercats’ and taking a lot of environmental swabs at the request of the IMT and not finding anything. Even if the results were negative, this was not accepted.

There were very significant risks with West of Scotland patients being sent to units in Aberdeen and Edinburgh that these units would become overstretched, and the risk of

errors increases as well as the impact on patients and their families from the West of Scotland and potentially impacting on their local patients. In addition, the confidence of staff, patients and families was severely impacted as this was now the 4th infection investigation in little over a year. These risks needed to be balanced against a proper assessment of the environmental risks in ward 6A which was currently closed to new admissions.

After discussion with colleagues, it was decided that we were now in a serious situation with the IMT and there was a clear and urgent need to explore the issues which had been raised. It is critical that an IMT functions well, takes account of all the evidence and makes the right, risk based decisions based on the needs of patients.
It was therefore decided that we needed to explore the issues raised with senior clinicians and managers who had attended the meeting, and this included the role of the chair.

c) What was your understanding of why Dr de Caestecker was involved?

A I asked Dr de Caestecker to chair a meeting to review the functioning of the IMT. There is a role for the Director of Public Health to do this if there are concerns raised and Dr de Caestecker agreed.
The NIPCM guidance on IMT chairing states '*Where there are implications for the wider community e.g., TB or measles, or rare events such as CJD or a Hepatitis B/HIV look back, or where there is an actual or potential conflict of interest with the hospital service, the CPHM may chair the IMT.'*

d) What was your understanding of the issues raised surrounding the IMTs? In particular, what do you understand the issues raised with the role of the chair and behavioural issues?

A I have set out in response to 416 b) many of the issues with the IMT. However, with role of the chair, this individual needs to consider all the evidence to determine what is the most likely hypothesis rather than determining the hypothesis and looking for evidence to support it. There seemed to be no clear definition of which cases were included in the IMT with no clear analysis of the reasons for inclusion. In addition, there was an anxiety that when challenged, this was taken as a personal insult as opposed to the need for constructive dialogue to get to the best outcome. There is a need to look at all the evidence, including epidemiology, to determine if this was an outbreak or not. The IMT was, by all accounts, chaotic as results were tabled, cases were added and hypotheses were not pursued that did not fit with the environment. The behavioural issues related to Dr Peters who had apparently been very intimidating at the meeting on 13/08/2018. There was a view, and this is set out in the external review, that it had become more about proving themselves right rather than a focus on the children. This is well described in the external review and is set out below.

Reference: The Queen Elizabeth University Hospital Review Report: June 2020 (Bundle 27 Volume 9, Document 11, page 145)

8.17.7. There is no excuse for the 'extreme behaviour' as reported by one witness and expressed by a large number of others in several ways, or the resultant intimidatory atmosphere that built around the IMT process during 2019. Amongst the accounts were reports of intolerance and lack of respect, for expertise and the integrity of the views of others.

8.17.9. IMTs have to remain an open-minded and constructive business-like experience where participants act as a team, and where patient wellbeing prevails over notions of the moral high-ground and uniqueness and correctness of one view to the exclusion of others.

e) Please provide details as to the discussions for re-setting the IMT process and having an independent chair

A I cannot add much more than is set out in the minutes. There was to be an independent chair either another ICD or a consultant in public health. In addition, there was discussion about ensuring the guidance was developed to reflect the lessons learned from this process and there was a range of practical suggestions to improve the effectiveness of the IMT to ensure that all information and actions are appropriately identified and that an escalation process established.

f) Please explain the actions taken and how they were taken forward:

A The deputy Director of Public Health, Dr Crighton was asked to chair the IMT and she assumed that role. Sandra Devine may be best placed to address the operational issues suggested and how they were taken forward and I understand the Dr Kennedy did revise the IMT guidance for GGC ensuring that it fit with national guidance. They may be best placed to speak to this.

g) Dr Inkster was removed as chair of the IMT following this meeting without her having the opportunity to discuss this. Do you think this was a fair approach to take?

A On the day of the meeting (Tuesday, 20th of August,2019), an email was received from Dr Peters, setting out that Dr Inkster was off sick for the next 3 days and she would

appreciate it if she was not contacted. This was sent by Dr Peters to Dr Inkster's line manager, Sandra Devine, who would normally be the person whom Dr Inkster would be expected to contact. **(Please see A49401496 – Bundle 27, Volume 8, Page 185; and A36591680 – Bundle 6, Page 70).**

There was an urgent need to ensure that the IMT, which had been set for Friday, the 23rd of August, went ahead for the following reasons:

- New admissions were still paused to the unit; Scotland's only national bone marrow transplant service was no longer functioning.
- Children and their parents were now going to other units with the consequent impact on these units' ability to cope with the west of Scotland patients as well as their own patients.
- For current patients/families and staff, the confidence in the unit was by now, very low and children were on prophylaxis, which was making them unwell in some instances.
- The IMT required support and stability with a safe space to really debate the issues and come to a risk-based assessment of the way forward.

Sandra Devine, who was Dr Inkster's line manager, had intended to discuss this fully with Dr Inkster to ensure she was fully appraised of the situation and indeed had already discussed some of the issues with her the evening before the meeting on 20/08/2019. However, Dr Inkster had now, through a colleague, advised that she was off sick for at least the next 3 days, and she was not to be contacted.

The minutes set out well the reasons why it was felt that a chair should be appointed who did not have a role with considerable input and that *independence would facilitate challenge and consideration of all views expressed*. This is crucial for good risk-based decision making, ultimately for patients and their families.

On the Thursday 22nd of August,2019, Sandra Devine had not been able to identify a chair and asked me for help. I emailed Dr de Caestecker who asked Dr Crighton, and this enabled the IMT to go ahead.

h) Dr Inkster is of the view she was forced to demit as chair of the IMT with various different reasons cited for this decision, all of which are untrue: what is your understanding of this? What reasons were given to Dr Inkster?

A I did not discuss this with Dr Inkster and I don't know what reasons she has been given. I cannot answer this question.

417. What was your involvement, if any, with the stage 2 whistleblow:

A I assume this relates to 2018 WB Stage 2: I had no involvement in that process and indeed I am not aware of what was raised. However, on the 8/10/18, I was copied into an email to Tom Walsh from Dr de Caestecker which detailed a recommendation from her recent report on whistleblowing concerns from Dr Penelope Redding and Dr Christine Peters and is set out in italics below:

The infection control team should be supported to deal with multiple emails from Dr Peters about the issues in which she has no direct role with a standard response.

Tom responded that this recommendation was very 'helpful and very timely as we discussed a recent increase in email traffic again just this morning at our SMT meeting. Teresa, Sandra and I will agree a standard response and implement the recommendation. **(Please see A40450754 – Bundle 27, Volume 9, Page 439).**

418: What was the stage 2 whistleblow process within GGC in 2018?

A This was not my area of responsibility and best answered by whistleblowing champions.

419. What do you understand to be the issues raised through stage 3 whistleblow to have been?

A I don't know.

420. With whom were these issues raised and how were they addressed?

A I don't know.

421: Do you have a view on whether these issues were resolved satisfactorily?

A I don't know.

422. What was your involvement, if any, with the stage 3 whistleblow?

A I was not involved.

423. What was the stage 3 whistleblow process within GGC in 2019?

A I don't know.

424. What do you understand to be the issues raised through stage 3 whistleblow?

A I don't know.

425. With whom were these issues raised and how were they addressed?

A I don't know.

426. Do you have a view on whether these issues were resolved satisfactorily?

A I don't know.

427. What was your involvement, if any, with the stage 3 whistleblow in April 2020?

A I received an email from Jennifer Haynes, which was about the 2017 whistleblowing issue. I had responded around the line management issue as this was where I thought stage 1 whistleblowing were raised.

428. What do you understand the issues raised though whistleblow have been?

A I don't understand what they have been and only input is the detailed in my response to question 427.

429. Dr Redding was of the view that GGC had attempted to ‘cover up’ the Whistleblow of September 2017 by not recording it as a Whistleblow. What is your view on this?

A I don't know what the process is for recording it but as set out in my response to question 409e), I did not appreciate I was the stage 1, and I would absolutely reject this assertion. I ensured full visibility of the meeting and the issues raised with non-executives within GGC.

430. With whom were these issues raised and how were they addressed?

A I don't know.

431. Do you have a view on whether these issues were resolved satisfactorily?

A I don't know.

432 – 434. Are you aware of the whistleblow to HPS in August 2019?

A Yes.

I can provide a full email trail for this issue but broadly, on the 21/08/19, I had a call and follow up email from the medical director for National Services Scotland (Dr Lorna Ramsay) which houses HPS. She set out that they had been alerted by a whistleblower to concerns which Dr Ramsay sets out in the email of 21/08/2019. I told Dr Ramsay about the meeting the night before at the GRI, which is described in my response to question 416. Other key points were around alerting Scottish Government which I was comfortable with, and I advised her we had a whistleblowing process in GGC.

I responded to Dr Ramsay on 26th August setting out that the Board's designated directors had offered to meet with the chair of IMT and I also asked Dr Ramsay to seek permission from the whistleblower to share their details. This was declined in an email response next day.

I then wondered with Dr de Caestecker if we could still investigate their concerns and she thought we could, and she had asked to meet Dr Inkster to take this forward as a whistleblowing process. (Please see A49401497).
My further engagement with this whistleblowing process is then through Dr Inkster's resignation letter which is set out in my response to EE when I suggested some of the issues raised by her in the letter could be added to the whistleblowing process already underway. Apart from this issue which I will describe below, I had no further involvement.

435. Do you consider these issues to be fully resolved?

A I don't know as no further involvement.

436. Dr Inkster and Dr Peters raised their concerns with the Scottish Government, which resulted in several meetings throughout 2019 and 2020. Are you aware of these meetings?

A No.

437. What is your understanding of why these meetings took place and the concerns raised?

A I don't know as not aware of them.

438. Were you contacted by the Scottish Government regarding these meeting? Were the concerns raised conveyed to you?

A As far as I can recall, I was not contacted and no concerns conveyed to me.

439. What actions were taken?

A I don't know.

Summary of Section DD

I am not one of the Board's experts in whistleblowing. I set out my experience with whistleblowing issues which includes responding to recommendations, requests for information and ensuring whistleblowing emails are reviewed by the Board experts to ensure all issues rigorously examined.

I described in detail my response to Dr Redding and absolutely reject that GGC concealed the stage 1 whistleblowing. It was not clear in her emails to me that I was the stage one. I took her concerns to me as a professional complaint. She emailed Tom Walsh the day after his annual leave started and I have detailed the timeline of response to her.

I undertook a very thorough review of [redacted], Dr Peters and Dr Redding's issues which they raised with me. I set up a joint meeting with them and senior GGC managers and clinicians; each concern was discussed, documented and it formed the basis of a detailed 27 point action plan which set out a clear plan to address the areas of concern. In 2021, 26 out of 27 actions were completed with one physically impossible.

I alluded to the concerns about the IMT process in August 2019 under section W. It was incumbent on the Board to step in to investigate and deal with these concerns. A new IMT chair together with IMT members, were able to take a balanced view of all the facts by careful analysis of the data and the hypothesis which had been put forward. The new chair, Dr Crighton advised in September that the ward was safe to re-open. However, the CNO advisor made it clear this was a decision for the Chief Nursing officer. The opening of the ward was approved by the cabinet secretary on 22/11/2019. The HPS report was also published, and it was agreed the ward was safe to open. I was unaware that Dr Inkster and Dr Peters were meeting with SG officials.

Resignation of Dr Inkster and other ICDs

Refer to Dr Inkster resignation letter Sept 2019 details - Objective ECM (scotland.gov.uk) (Bundle 14, Volume 2, page 572)

440. What is your understanding of why Dr Inkster resigned from her role as ICD in September 2019?

A On the 2nd of September, Dr Inkster sent an email with an attached letter to me, Dr de Caestecker and Dr Peters. There were a number of issues highlighted in Dr Inkster's letter which may have led to her resignation, and I summarised these in my response to her on the 5th of September 2019. In my letter, I set out 5 areas including workload and immediate environment, involvement and discussions within the wider IC team; lack of involvement in a forthcoming Gt Ormond Street visit; issues relating to the leadership role; the recent issues surrounding the chair of the IMT (described above); and the HR/Payroll issues. I also note issues surrounding Dr Inkster's health were mentioned in her letter to me dated 02/09/2019.

441. In her resignation letter, Dr Inkster states a colleague referred to her, "doing the work of 4 people", what is your view on this? Were there resource issues with ICDs? Please provide details.

- There was a recognition of the need to improve support towards the end of 2018/ spring of 2019. A lot of efforts were made to do this while balancing the needs of microbiology service as there was a shortage of this skill set. The areas of support to the QEUH IC service are set out below.
- In December 2018, following an SBAR from the ICM, a request was made for 2 additional ICD sessions costing circa £30K for the built environment; this was agreed by estates colleagues and funded. (Please see A38694852).
- In February 2019, there was further support from the diagnostics services which was organised by Dr Green and Tom Walsh to increase the number of infection control sessions to the QE site.
- Tom Walsh/Sandra Devine may be able to advise further on additional resources provided as well as personal arrangements put in to support Dr Inkster.

- If Dr Inkster felt that she required additional resources or to review her workload, this should be escalated to her line manager, Sandra Devine and the head of service for microbiology. I am not aware that she sought a job plan review.
- There was some surprise from the Chief of Medicine for Diagnostics, when it appeared that Dr Inkster had applied for an additional role as Training Programme Director with a proposed SLA with NSS for this role in March 2019. This had not been discussed with Dr Green. It is unclear who it was agreed by as it is usual practice for the line manager to approve these additional roles based on the needs of the service.

442. In her resignation letter, Dr Inkster refers to being undermined, being shown a lack of respect, being unsupported and undervalued during IMTs and despite discussing this with senior management these issues persisted. Were you aware of these issues mentioned by Dr Inkster before she raises them in her resignation letter? If so, were these being addressed? What are your views on her concerns?

A It may be helpful if I set out my awareness of the issues raised by Dr Inkster in the terms set out in the question and detail how these were addressed prior to her resignation letter.

Lack of respect/behavioural

- On the 31st of January 2019, Ann Gow (Director of Nursing, HIS) phoned me to alert me to a serious concern that Dr Teresa Inkster had accused another member of staff of telling her to not put anything in writing. Dr Inkster had qualified this by saying she was well supported by me and the ICT. This has been submitted to the inquiry as part of RFI 7 7.4
- I visited Dr Inkster on 4th of February 2019 and explored those concerns. Dr Inkster raised issues around staffing in ICD, support from ICT and her interactions with colleagues during IMTs. We talked about possible solutions. We also talked about a mediated meeting with the staff member she had complained about directly to the HSE inspectors. This has been submitted to the inquiry as part of RFI 7 7.4.
- On the 20th of Feb 2019, I had a follow up meeting whereby we discussed that Tom Walsh had decided to step down and Sandra Devine was temporarily taking on the role of ICM; I also had asked Dr Stewart to provide additional mentoring support to Dr Inkster. Dr Inkster raised an issue of duty of candour, which I asked her to discuss, in the first

instance, with the Dr Mathers. We discussed the need for Dr Inkster to address concerns and raise them through appropriate channels. We talked about the need to work within a team and build trust. This has been submitted to the inquiry as part of RFI 7 7.4

- 14th of March 2019, a meeting took place at the Teaching & Learning Centre at the QEUH and included Dr Inkster, Dr de Caestecker, me and Tom Steele; the notes indicate a good exchange of views and an agreed set of actions. Notes of this meeting have been included under RFI 7 7.4.
- Over the course of the following months, there were several meetings which Dr Inkster did not attend including the BICC without explanation. I was keen to meet with her and Sandra Devine on 7th of August 2019, but she asked to dial in. I sent her an email which is attached to check if things were ok. **(Please see A49401495 – Bundle 27, Volume 8, Page 192).**
- In summary, throughout 2019, there were significant efforts made to support Dr Inkster and investigate/mediate and resolve various issues.

443. The Inquiry has been told that Dr Inkster previously attempted to resign in January 2018 but was persuaded to remain in post by you. Can you provide details of this?

A On 24/01/2018, Dr Inkster copied me into an email to Professor Jones and Tom Walsh setting out her resignation. (This has been submitted to the inquiry). There were several reasons cited, but the key reason seemed to be a new structure, which the team had been working on to address the concerns set out in the 2017 SBAR of the 03/10/2017.

I understood from earlier emails from Dr Green that this had been discussed with Dr Inkster in December 2017. Dr Inkster emailed me separately to set out that it had nothing to do with me but related to her role. I note I have asked for these emails to be printed for a discussion with Jane Grant and Jonathan Best.

I recall that I discussed this with the SMT (Tom Walsh, Sandra Devine and Professor Jones). They were not in agreement with the areas set out and were surprised and upset by the resignation email. I also spoke to Dr Inkster and recall we talked about the reasons for her email, the fact that the team had worked extremely hard on many of the areas set out in her email and indeed Professor Jones had sought to cover her lead responsibilities as well as his own. I recall Dr Green also spoke to Dr Inkster and we

agreed with the SMT and Dr Inkster that we would send an email out rescinding her resignation and setting out the structure. Shortly after this, Dr Inkster sent an email to Professor Jones apologising for her email. This has been provided to inquiry under RFI 7 6.20.

Refer to: Dr Armstrong response to Dr Inkster resignation letter Sept 2019 details - Objective ECM (scotland.gov.uk) (Bundle 14, Volume 2, page581)

444. In your response to Dr Inkster's resignation letter, you state that you are keen for the issues which she raised to be fully considered and properly investigated and that a full investigation under the Boards' Whistleblowing Policy will be carried out. The issues which Dr Inkster raises are not new issues, why are they only being fully/appropriately addressed now?

A I have set out in my response to question 442 and 443 above, the resources, discussions and processes to support and resolve some of the issues raised by Dr Inkster. As set out in the note of 20/02/19, as far as I am aware, Dr Inkster did not evoke any board processes to address her concerns, and this made it more difficult to carry out formal investigations. This led to 2 issues:

1) The personal comments made by her about colleagues were made directly to HEI inspectors without any evidence to substantiate them.
2) There was no due process evoked to investigate them and enable Dr Inkster to provide evidence and colleagues to put forward their side of the events.

445. You identify 6 key issues which Dr Inkster raises in her resignation letter; do you have a view on each issue? What steps were taken to address each issue, and do you know if they have now been fully resolved?

A For ease of reference, I have set out these areas from my response on 05/09/2019 to Dr Inkster's resignation letter.

Synopsis of Key Issues

1. Workload and immediate work environment.
2. Involvement and discussions within wider IC team
3. Lack of involvement in the forthcoming visit to Great Ormond Street.
4. Issues relating to Leadership Role and chair of IMT
5. HR/Payroll related issues

6. Issues reported to HPS including: (see question 432)
a. Support from Management
b. Information flow within IMT and to Chair
c. Microbiology and Clinical Judgements
d. Issues relating to communication.

For the HR/Payroll issues, I advised that the Diagnostic Directorate would take this forward with her. For the other issues, I agreed with Dr de Caestecker that they would be incorporated into the whistleblowing review which was in the process of being set up with external HR input. I am not aware of the output of this review. I cannot answer whether they were fully resolved.

Dr Inkster, on her return from annual leave, sent me 3 further areas she wished investigated. **(Please see A49401494 – Bundle 27, Volume 8, Page 193 and A49401493 – Bundle 27, Volume 8, Page 196).**
Essentially Dr Inkster wished for the SCI process, Duty of Candour and Governance relating to specialist groups reporting to IMTs to also be investigated. This investigation was taken forward by Dr Chris Deighan and the report was finalised in May 2021 and submitted with NHSGGC's first Positioning Paper in December 2022. The delay was due to covid intervening. In summary: these concerns have been explored in detail and this review is unable to corroborate the specific concerns that were raised in her initial correspondence.

446. In July 2015, Dr Inkster, Dr Peters and Dr Wright all resigned from their roles as ICD. Dr Inkster and Dr Peters were persuaded to remain in their roles but made several future attempts to resign before finally giving up their posts. There appears to have been an ongoing problem with ICDs resigning from their role; what in your opinion caused this?

A In July 2015, there were 2 ICDs – Dr Inkster and Dr Peters who resigned their roles. This was Dr Inkster's first resignation. I was unaware of any problems prior to their resignations and as far as I am aware, they were not raised through any management process. I understood that Dr Wright's resignation was not linked to the complaints of Dr Inkster and Dr Peters.

There were allegations against Professor Williams, who was the LICD at that time. Dr Inkster rescinded her resignation, although I was not involved with this conversation at the time. Dr Peters, as far as I am aware, did not rescind her resignation and shortly afterwards was made the lead microbiologist for the QEUH site.

Dr Inkster resigned another 2 times – once in 2018 on her return from sick leave detailed in my response to question 443 above, and finally in September 2019 (which was documented in her letter), as detailed in 445. I also know that [redacted], another ICD, resigned on 2017 and this was reviewed by Professor Jones, the acting LICD at the time, covering Dr Inkster's sick leave.

Therefore, there were 2 doctors (Dr Inkster and Dr Peters) who accounted for 4 of these resignations and 1 doctor [redacted] who resigned. It may be worth commenting that these issues, as far as I am aware, were not present in the other IC teams in the North, Clyde, mental health or partnership teams who were also led by the SMT. Therefore, it seems to me that this was confined to the QEUH team and specifically Dr Peters, Dr Inkster and [redacted]

In the case of Dr Inkster's 1st resignation and that of Dr Peters, the issues raised in her first resignation were fully investigated in Dr Stewart's report and for [redacted] it may be better to discuss this with Professor Jones. For Dr Inkster's second resignation, she rescinded that and apologised to Professor Jones who had been covering her workload during her sick leave. Her 3rd one is described above. In each case, there seemed to be little attempt to utilise well recognised channels to raise issues and indeed be part of resolving the issues.

447. Was there a clear remit for the role of ICD?

A The ICD role is to provide advice and support to the local IPC nurses; to be involved in the planning upgrading and commissioning of facilities; to contribute to the 24 hour infection control medical on call service; to chair PAGs and IMTs; to attend the monthly ICD and SMT meetings as well as regular attendance at the AICC; monitor local SSI rates and investigation of data exceedance; support compliance with national targets and national standards and guidance; assist the lead ICD in reviewing and updating IPCT policies; attendance at specialist groups such as decontamination and theatre ventilation;

escalate concerns to the lead ICD; advise and support the lab manager on IPC as well as contributing to teaching, training, audit and research.

The IPC accountability framework sets out the role of the LICD and the remit of local ICT teams. There was also a joint agreement set out between the LICD and the Director of Estates – first set out in 2016 – about the role of ICD in new builds. This builds on a previous HDL (2007). As Dr Redding set out in her email to me, Infection Control is a team working together to ensure the tasks of the IC service are fulfilled. In all the sectors, and indeed within QEUH/RHC sector, except for Dr Peters, there was no ICD who raised issues with the role and their understanding of it. IC does depend on good team working and the team supporting each other.

There is a national context to the role of the ICD which has been evolving. In the minutes of the meeting with the CNO and HPS and GGC (2015), the CNO described work to review the role of the ICD after the Vale of Leven Inquiry. There was also some discussion regarding recent issues raised by ICDs on workload and role. In 2024, SG has published guidance which sets out roles of team and specialists. **(Please see A49401492- Bundle 27, Volume 8, Page 198; and A48699683 – Bundle 13, Page 197).**
There may be a requirement, as set out in the external review, to review the training programme for microbiology and infection control doctors and their role which is evolving. However I have not been directly involved in this national process and infection control/ SG colleagues maybe better placed to address these issues.

448. Dr Peters has told the Inquiry she sought clarification on her remit as ICD on several occasions but was unsuccessful in obtaining this. What is your view on this?

A My understanding was that Dr Peters demitted her role as an ICD in July 2015. However, I understand that microbiologists are required to cover IC issues when on call and this has been the case for many years. I don't know what clarification Dr Peters has sought and from whom, so I cannot comment on this issue. She has raised issues with me in 2017: this led to Dr Green convening a meeting to discuss these issues directly in December 2017. I did not attend this meeting. However I understand from Dr Green that the meeting discussed structure, roles and responsibilities and team dynamic with proposals to take this forward.

449. David Stewart undertook a review into the resignation of ICDs – Refer to Summary of Infection Control Issues details - Objective ECM (scotland.gov.uk) (Bundle 14, volume 1,page 464) – who instructed this review? What was the purpose of the review? What actions, if any, were informed by the findings of this review?

A I instructed the review following the resignations in July 2015 of Dr Peters and Dr Inkster. The purpose of the review was to determine the main issues surrounding the resignation of the 2 doctors and determine if any actions required to address these issues. There were a series of actions following the review: these included the temporary appointment of Dr Cruickshank which is set out in a letter from Isobel Neil, director of diagnostics and Tom Walsh on the 12/11/2015. The aim of this was to bring together the ICT and the diagnostic directorate to address many of the issues raised within the report. Many of the ICDs had a dual role as a microbiologist and infection control which required them to report into 2 directorates. The appointment of Dr Cruickshank as the Clinical Director for both was to support work to ensure issues addressed. There was also an Organisational Development process and a workplan set out based on organisational objectives to take forward the service. This is set out in 2015 and 2016. Some of the work was interrupted due to sickness in one of the senior managers. In 2016, Professor Williams resigned, and Dr Inkster was appointed as the lead infection control doctor for GGC. Dr Cruickshank continued with her oversight role until the 1st of August 2016 and reported that the role maybe largely redundant by then and in addition, Tom Walsh felt Dr Inkster was fitting in well. **(Please see A49401491 – Bundle 27, Volume 8, Page 200 and A49401490 – Bundle 27, Volume 8, Page 202).**

450. What is your view on each of the following issues within his report and proposed remedial actions?

a) Culture and behaviours:

A The issues set out around culture at the time indicated a mix of historical and current issues. I had not appreciated the degree of historical issues, which were driving some of the fractured relationships in the present. Some of the issues, e.g. undermining colleagues, did endure through different time periods despite interventions, either through Organisational Development (OD) or personal reflection at appraisal and with personal intervention e.g. coaching/mentoring. This may suggest a lack of awareness/insight. The

remedial actions depended on individual self-awareness and the organisational ones on all the individuals being prepared to work together.

b) Leadership style and management:

A Much of the leadership style seemed to be focussed on the LICD with some historical and current issues.

c) Team functioning and structure:

A There is a range of issues from better administration, e.g. meetings with recording of outcomes, with some of the issues concerning the organisational structures with diagnostics and IC. There are other issues which proved more qualitative and did recur in the years to come, which was the ability to reconcile different opinions and the need for risk-based assessments.

d) Service/patient concerns:

A This seemed to reflect the opinion from the 2 doctors who resigned. I do think the teams were all focussed on safety and doing the best for patients taking the whole risks into account. This was not acknowledged by individuals who felt they were the custodians of safety.

Looking back at this review, there were many findings which were predictive of what continued throughout the years. There were interventions and structural changes throughout this time and OD workshops. There were periods of stability followed by unstable periods, which often seemed to be about who was in the LICD post. There are some areas which are amenable to management actions, e.g. appointing Dr Cruickshank as clinical director for a while. There are other intrinsic individual traits, which can disrupt whole services as well as the local team, which are far less amenable to intervention. It is also worth noting that all the other ICT teams who were led by the same SMT did not experience these issues as far as I am aware. The 2015 report was at a point in time and the SMT tried to address the issues. However, as time moved on, it became clear that there were patterns which repeated themselves, which were compounded by some very complex issues, both internal and external, which made this a difficult situation to manage.

451. Did David Stewart discuss the report with you? If so, what was discussed?

A Yes, Dr Stewart did discuss the report with me. I can't recall exactly, but I was in full agreement with him that there should be a workshop sharing the findings of the report with the teams in a sensitive way. This was cancelled by other members of diagnostics and ICT who wished to let new management arrangement bed in.

452. Who was the report shared with?

A The senior teams from IC and diagnostics and the LICD in November 2015. I am not sure who else.

453. Were the issues with ICDs resolved? If not, why not?

A I think it is important to sort out what is meant by ICD. From around April 2016 to around June 2017, there was relatively calmness in the IC service. Indeed, from 2012-2017 (bar the period of the resignations in 2015), the IC team worked well. There were issues which recurred with some microbiology colleagues, and they were managed. Indeed, throughout this whole period, there has been a good IC service in the QEUH/RHC. However, there were significant pressures which, as the external review mentioned, meant that the team became more fractured as opinions differed in the reasons for infections. This came to a head in August/September 2019 and November 2019.

454. Email from C Peters to J Armstrong - 21 September 2017 details - Objective ECM (scotland.gov.uk) – (Bundle 14, Volume 1, page 696) Re.4B, [redacted] – HAI SCRIBE

a) Do you recall receiving this email?

A Yes

b) Dr Peters sets out a number of outstanding concerns, including [redacted] not having required information to allow [redacted] to sign off an HAISCRIBE and Dr Inkster being quoted as having approved the document when this was not the case. What is your understanding of this situation? Were these concerns investigated further?

A I responded on the 3rd of Sep 2017 to Dr Peters' earlier email on the 23/08/2017 setting out the process to date and explained that Professor Jones would take over the HAISCRIBE for this area. I am not party to the earlier issues about Dr Inkster being quoted as approving the document and I cannot answer this question. I understand that there is a full RFI submitted to the inquiry on this matter. The full BMTU timeline

submitted to the inquiry under RFI 7 has a detailed entry on this issue and the reasons for this.

455. Refer to Bundle 4 – SBAR – Document 33
This SBAR from 6th December 2018 recommends additional ICD sessions to support the current and ongoing requirement for expert input and advice into the built environment at QEUH/RHC.

a) What happened as a result of this?

A I took this forward with the Director of Estates and the ICM.

b) Were the additional sessions funded?

A Yes, they were funded at a cost of £30K and I understand an ICD was appointed.

c) Was there an issue with resources within ICD?

A I have set out in question 441 the response to this.

456. In your opinion were there issues with the role of ICD and what were they?

A Please see my response to question 447; there are local and national issues.

Summary of section EE

I have set out the sequence of events before Dr Inkster resigned. There had been significant efforts to enhance resources at the QEUH and these were documented by Dr Green. In addition, Dr Inkster took on an additional job in April 2019 which was not discussed with Dr Green or Sandra Devine. Dr Inkster raised concerns directly to the HIS inspector about an individual and, as far as I am aware, had not raised them using recognised processes internally nor provided any evidence to substantiate them. A mediated meeting was organised between her and the individual, At the end of this meeting, she indicated that she did not wish to take this further.

All the complaints set out in her resignation letter were thoroughly investigated through a whistleblowing review. She added a further 3 issues in an email to me after her resignation letter and they were also investigated: the report was delayed due to covid and was completed in May 2021.

She had resigned in 2018 and she rescinded it a few days later and apologised to the lead clinician who had covered the workload.

The resignations of Dr Peters and Dr Inkster in 2015 are described: there was a full investigation and the appointment of a clinical director to oversee the service until August 2016 when it appeared stable. However, many of the findings of that would apply to behaviours which recurred over the years.

The role of the ICD is under review currently by the SG team.

National Performance Framework

457. When did the escalation of the QEUH to Stage 4 of the National Performance Framework take place?

A 22/11/2019

458. What was your understanding of why NHS GGC was escalated to stage 4?

A The letter from Malcolm Wright dated 22/11/2019 sets out

In light of the on-going issues around the systems, processes and governance in relation to infection prevention, management and control at the QEUH and the RHC and the associated communication and public engagement issues, I have concluded that further action is necessary to support the Board to ensure appropriate governance is in place to increase public confidence in these matters and therefore that for this specific issue the Board will be escalated to Stage 4 of our performance framework. This stage is defined as 'significant risks to delivery, quality, financial performance or safety; senior level external transformational support required.'

459. What were the events preceding this?

A I will take the time from Sept to November 2019 as the time period before escalation. However, in order to give a little more background to the 'doctor led' review, I will describe how this review came about, in that I asked for it to be done but, from my recollection, I was not alerted to any concerns/issues before it was reported in the media in November 2019.

February 2019: Dr Inkster mentioned a duty of candour issue with an MSP and Dr Gibson during my conversation with her on 20th February 2019. I asked her to discuss this with Dr Gibson and Dr Mathers in the first instance. (see my response in question 442).

March 2019: Following an email from Dr Mathers, I had asked Dr Mathers to undertake a review of 2017 cases and other issues. Full details have been sent to the inquiry about this review with timeline- See RFI 7 7.5, and timeline at Section 21 no.5 (RFI 15)

September to November 2019: I have set out my response to question 315, the issues surrounding the re-opening of ward 6A; the IMT issues with the change in chair; the engagement with SG and HPS which led to announcement that the ward would open on 22/11/2019. In my responses to questions 440 - 443, I described events surrounding Dr Inkster's resignation.

In November 2019, the Director of Communication may be best placed to describe the media events which took place around the 14th of November 2019. Full details of the events surrounding this have been submitted to the inquiry on both the communications and the clinical review. RFI 6 Question 7 narrative (submitted to the inquiry) covers the media and political responses in November 2019.

An email from Dr Gibson sets out some of the issues. I had **not** been aware of the review outcome nor been alerted to any concerns until the case was discussed in the media. I had also not been alerted that the Cabinet Secretary had been aware of the case as set out in Dr Gibson's email. **(Please see A49402737 – Bundle 27, Volume 8, Page 203).**

460. Describe the process of escalation and the consequences of this:

A Sandra Bustillo can perhaps describe the process of escalation from media and communication point of view. The process of escalation involved Board papers being scrutinized and amended by SG; the oversight board subgroup for IC was set up and this involved a lot of information and presentations together with peer reviews; a review of all paperwork by auditor; and a new post of Director of Infection and Prevention was established with the HAI exec responsibilities incorporated into the post.

461. What actions were taken?

A The actions are set out in my response to question 460 above and the oversight board and case note review were established and published their reports with recommendations.

Case Note Review and Oversight Board

462. Please describe the process involved for the Case Note Review. Please include how this was established, who was involved, what work was done and any relevant outcomes.

A This question may be better addressed by SG colleagues as I was not directly involved with this process. In terms of the draft report, GGC clinicians and managers set out a range of concerns with supporting evidence regarding the methodology, processes and conclusions of the report together with a covering letter from the chief executive. As part of the GGC response, Dr Emilia Crighton submitted the public health commentary regarding the concerns on the methodology employed by the case note review and this has been submitted to the SHI. The senior team met with the casenote review authors to discuss the draft final report and our concerns. These responses to the casenote draft report were submitted to the SHI (RFI 1 part 6).

463. Please describe the process involved for the Oversight Board. Please include how this was established, who was involved, what work was done and any relevant outcomes.

A This question may be better addressed by SG colleagues as I was not directly involved with this process. I, along with a team from GGC, engaged with the Infection control subgroup and provided evidence to them on any areas they requested. GGC also provided a comprehensive response with evidence to the Oversight board draft reports and these have been submitted to the SHI (RFI 1 part 6)

464. Have you read the Overall Report of the Case Notes Review and noted its recommendations?

A Yes.

465. Have you read the Interim Report and/or Final Report of the Oversight Board and noted its local recommendations in respect of Governance and Risk Management?

A Yes.

466. Have you read the Interim Report and/or Final Report of the Oversight Board and noted its local recommendations in respect of Communications and Engagement?

A Yes.

467. What steps have been taken by GGC to implement each of the separate recommendations of the Case Notes Review, when they were taken and to what extent do you consider the implementation to have been effective? Please provide evidence to support each effective implementation.

A In response to RFI 4 submitted to the inquiry details the status of the recommendations as of 2022

468. What steps have been taken by GGC to implement each of separate recommendations of the ‘Local Recommendations’ of the Oversight Board, when were they taken and to what extent do you consider the implementation to have been effective? Please provide evidence to support each effective implementation.

A The response to RFI 4 submitted to the inquiry details the recommendations and actions as of 2022.

Communication- Staff information sharing

Questions 469 to 470:

A The Director of Communications would be better able to address these questions along with the directorate team.

Communication with parents;

Questions 471-473:

A The Director of Communications and the Director of Nursing for GGC at the time would be better able to address these questions.

Staff/culture within the QEUH

474. What was the working environment like within the QEUH – work life balance/ workplace culture? What issues, if any, are you aware of? What was your experience of this?

A The Director of the QEUH, Anne Harkness and the Director of HR for GGC maybe best placed to answer this question.

475. In your view, were the concerns raised by infection control colleagues regarding the general build of QEUH/RHC taken seriously? What action was taken in response to these concerns, if not already mentioned in your answers?

A Yes, the concerns were investigated, I have set out a lot of examples within my responses to the questions and no doubt there are many more from others as well.

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

Declaration

I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

The witness was provided the following Scottish Hospital Inquiry documents for reference when they completed their questionnaire statement.

Appendix A

A37805538 - Dr Armstrong response to Dr Inkster resignation letter Sept 2019 – Bundle 14, Volume 2, Page 581

A43502680 - BMT Document" - from Craig Williams to Jennifer Armstrong that considers the specification and identifies deficiencies with the BMT Unit Bundle 20, Page 13

A43955371 - Scottish Hospitals Inquiry - Hearing Commencing 12 June 2023 - Bundle 8 - supplementary documents for the Oral hearing commencing on 12 June

A38759270 - Action Plan arising in response to SBAR dated 3 October 2017
Bundle 20, Page 792

A37805537 - Dr Inkster resignation letter Sept 2019
Bundle 14, Volume 2, Page 579

A47739010 - Summary of Infection Control Issues
Bundle 14, Volume 1, Page 464

A38825069 - Email from C Peters to J Armstrong - 21 September 2017
Bundle 14, Volume 1, Page 696

A47069198 - Scottish Hospitals Inquiry - Hearing Commencing 19 August 2024 - Bundle 12 - Estates Communications

A47395429 - Scottish Hospitals Inquiry - Hearing Commencing 19 August 2024 - Bundle 10 - Water Technical Group / Water Review Group Minutes

A47175206 - Scottish Hospitals Inquiry - Hearing Commencing 19 August 2024 - Bundle 9 - QEUH Cryptococcus Sub-Group Minutes

A43293438 - Scottish Hospitals Inquiry - Hearing Commencing 12 June 2023 - Bundle 6 - Miscellaneous documents

A43299519 - Scottish Hospitals Inquiry - Hearing Commencing 12 June 2023 - Bundle 4 - NHS Greater Glasgow and Clyde: SBAR Documentation

A43255563 - Scottish Hospitals Inquiry - Hearing Commencing 12 June 2023 - Bundle 1 - Incident Management Team Meeting Minutes (IMT Minutes)

The witness provided the following documents to the Scottish Hospital Inquiry for reference when they completed their questionnaire statement.

Appendix B

A49661442 – 07082015question244 – Bundle 27, Volume 4, Page 327

A49661443 - FW FW Pediatric BMT Ward 2A Neutorpenic ventilation – Bundle 27, Volume 8, Page 215

A49661444 - Wd 2A Ventilation spec 17032016 – Bundle 27, Volume 8, Page 230

A49661445 - RHSC BMT Meeting Monday 10th August 2015 – Bundle 27, Volume 8, Page 213

A49661446 - AHU 23 SUPPLY (2ND FLOOR ISOLATION) REPORT – Bundle 27, Volume 8, Page 234

A49661447 - FW Ward 2A isolation room Tender approvals – Bundle 27, Volume 8, Page 243

A49661448 - Fw RHC Ward 2a Draft Tender Document – Bundle 27, Volume 8, Page 267

A49661450 - RE Ward 2A isolation room modification meeting – Bundle 27, Volume 8, Page 283

A49661451 - Ward2a Tender – Bundle 27, Volume 8, Page 288

A49661453 - Fw RHC Ward 2a Draft Tender Document – Bundle 27, Volume 8, Page 289

A49661454 - RE Ward 2A isolation room modification meeting – Bundle 27, Volume 8, Page 291

A49661456 - RHC Wa69d 2a Isolation Rooms Tender – Bundle 27, Volume 8, Page 269

A49661457 - QEUH RHC - BMT Theatres Action Plan t for catch up with IC team and also david stewart – Bundle 27, Volume 8, Page 300

A49661458 - FW Infection control concerns – Bundle 27, Volume 8, Page 298

A49661459 - QUEH - BMT Action Plan ar 21 January 2016 – Bundle 27, Volume 8, Page 301

The witness was provided with a questionnaire by the Scottish Hospitals Inquiry from which some of the questions were combined and answered collectively to achieve an overall detailed response.
The details of all questions within the questionnaire are:

Appendix C

Questionnaire for Statement

A. Personal Details

1. Name, qualifications, chronological professional history, specialism etc – please provide an up-to-date CV to assist with answering this question.

B. Professional Background

2. Professional roles within academia

3. Professional roles within the NHS

4. Professional roles, including dates when roles occupied.

5. Professional roles within NHS GGC

6. Professional roles within QUEH/RHC

7. Roles and responsibilities within the above areas.

8. If had more than one role, how was the work split?

9. How many hours per week did you spend in your role at QEUH/RHC?

10. Who did you report to?

11. Who reported to you?

12. Describe an average working day in your role.

13. Which of your colleagues did you work with most closely on a daily basis?

14. Refer to the Estates Team Bundle, document 29 - Organograms showing the organisational structures within QUEH.

a) Does the organogram match the organisational structures of QEUH?

b) If not, why not?

c) How does the structure and hierarchy operate across the different sectors?

C. SMT (Pre-2015)

15. What is the SMT?

16. Who was part of the SMT?

17. How many colleagues were in the SMT?

18. What were the roles and backgrounds of members of the SMT?

19. What was the structure of the SMT?

20. How often would the SMT meet?

21. Were members of the SMT were also members of the IMT?

22. To what extent, if any, were there issues with record-keeping of SMT minutes etc?

23. What was the purpose of the SMT meetings?

24. What was the escalation process for the SMT?

25. What, if any, documentation would the SMT monitor?

26. To what extent, if any, would the SMT be involved in making policy?

27. Who did the SMT report to?

28. Who reported to the SMT?

29. How many hours per week was spent on SMT meetings and related activities?

30. What parts of the QEUH/RHC specification were considered at any meetings?

31. What, if any input, did the SMT have in the specification of the QEUH/RHC before handover in January 2015?

32. What, if any input did the SMT have in changes to the contract for the QEUH/RHC before handover in January 2015?

D. AICC (Pre-2015)

33. What is the AICC?

34. What was the purpose of the AICC?

35. Were you a member of the AICC?

36. What was escalated to the AICC?

37. Who was in the AICC?

38. How often did the AICC meet?

39. What types of issues were discussed at the AICC?

40. What documentation was considered at these meetings?

41. What parts of the QEUH/RHC specification were considered at any meetings?

42. To what extent, if any, were there issues with record-keeping of AICC minutes etc?

43. What, if any input, did the AICC have in the specification of the QEUH/RHC before handover in January 2015?

44. What, if any input did the AICC have in changes to the contract for the QEUH/RHC before handover in January 2015?

E. BICC (Pre-2015)

The Inquiry understands you were chair of the BICC:

45. What is the BICC?

46. What was the purpose of the BICC?

47. What was escalated to the BICC?

48. Who was in the BICC?

49. How often did the BICC meet?

50. What types of issues were discussed at the BICC?

51. What parts of the QEUH/RHC specification were considered at any meetings?

52. What documentation was considered at these meetings?

53. To what extent, if any, were there issues with record-keeping of BICC minutes etc?

54. What, if any input, did the BICC have in the specification of the QEUH/RHC before handover in January 2015?

55. What, if any input did the BICC have in changes to the contract for the QEUH/RHC before handover in January 2015?

F. Involvement in specification of new hospital prior to January 2015

56. Can you recall when you were first consulted about the specification of the new hospital, the QEUH/RHC?

57. Who consulted you?

58. What information or advice were they seeking from you?

59. What, if any, information or advice did you give in relation to the various NHS guidance notes (SHTMs etc)?

60. To what extent did you have access to plans, manuals and specifications for all the rooms and systems for the QEUH/RHC?

61. Can you recall if there was any information or advice sought from you in relation to vulnerable patients (such as immuno-compromised patients)?

62. If so, what was the information or advice that was sought?

63. If so, what information or advice did you provide?

64. Can you recall what was in the ventilation specification?

65. Did you request information on the designs of the ventilation system?

66. If so, who did you request it from?

67. What design documentation was provided to you?

68. Did you request information on the designs of the water system?

69. If so, who did you request it from?

70. What design documentation was provided to you?

71. Did you discuss the ventilation system with the estates/project team?

72. If so, with whom?

73. Did you discuss the water system with the estates/project team?

74. If so, with whom?

75. What did you discuss with them?

76. Who, if anyone, outside the NHS was asked to review the specification for the QEUH/RHC?

77. What meetings, if any, were you invited to review the design plans for the RCH in or around June 2013?

78. If so, what was discussed at the meeting?

79. Who ultimately made the decision on the specification of the rooms in the RHC?

80. What do you understand the purpose of the NHS guidance notes (SHTMs etc) to be? Why are they important?

81. Do you understand the NHS guidance notes (SHTMs etc) to be just guidance or are they mandatory?

82. What do you understand the potential patient impact to be from non-compliance with the SHTM guidance to be?

83. To what extent did you have communications with the Project Team for the QEUH/RHC?

84. Which other colleagues were being consulted about the specification of the new hospital?

85. What is a Clinical Output Specification?

86. Were you consulted to provide input for the Clinical Output Specification ("COS") for Haemato-oncology?

87. If not, who was consulted to provide input for the COS for Haemato-oncology?

88. Why were you not consulted to provide input for the COS Haemato-oncology?

89. What, if any, reviewable design data ("RDD") did you see?

90. What involvement did you have with RDD in the QEUH/RHC?

91. Can you explain the difference between the process of 'commissioning' a new hospital and 'validation' of a new hospital?

92. What commissioning documentation did you see?

93. If not, did you request commissioning documentation from the Project Team?

94. What validation documentation did you see?

95. If not, did you request validation documentation from the Project Team?

96. How far did you escalate, if any, the issue of the lack of validation documentation?

97. Were the BMT isolation rooms built using the specification for a multi-drug resistant tuberculosis ("MDR-TB") isolation room?

98. Why was it built to an MDR TB specification?

99. What input, if any, did you provide on the Schiehallion Ward (2A and 2B) at the RHC?

100. Were you consulted to provide input on Schiehallion Ward at the RHC (2A and 2B)?

101. What steps did you take in relation to specification of the Schiehallion Ward (2A and 2B) at the RHC?

102. What did you understand the specification to be for Schiehallion Ward (2A and 2B) at the RHC?

103. What is a PPVL?

104. How comfortable were you about PPVL being installed at the QEUH/RHC?

105. What specifically did you understand was being provided by Multiplex in relation to PPVL?

106. What air was being HEPA filtered? The air supply into the lobby or elsewhere?

107. What are positive pressure isolation rooms ("PPIR")?

108. Did you expect to find PPIR in the QEUH/RHC when the hospital opened?

109. What is the difference between PPVL and PPIR?

110. What changes were made to the contract between 2009 and 2015?

111. What involvement did you have in any changes to the contract?

112. If so, why were these changes to the contract made?

113. Who ultimately approved the changes to the contract?

114. What concerns did you have about the specification before handover of the QEUH/RHC on 26th January 2015?

115. Why were you concerned about these specification issues?

116. Which other colleagues shared these specification concerns?

117. What was your understanding of the decision-making process between NHS GGC and Multiplex in relation to the specification?

118. Can you recall any of your observations from your visit to the QUEH/RHC?

119. What observations did you specifically have in relation to HEPA filters in wards?

120. Did you raise any of your observations with colleagues?

121. If so, to whom did you raise your observations?

122. Can you recall if you had any meetings to discuss your observations?

123. If so, can you recall any of the discussion from these meetings?

124. What assurances, if any, did you receive from the Project Team that the ventilation commissioning had been done successfully?

125. If so, who, in the Project Team, gave these assurances?

126. What assurances, if any, did you receive from Currie and Brown before handover on 26 January 2015?

127. Did Multiplex seek advice or information from you or any of your colleagues?

128. If so, what advice or information was sought by Multiplex?

129. What was the response from you or your colleagues to Multiplex?

130. Did you request commissioning and validation results for any of the wards?

131. Who did you request the results from?

132. Did you receive the results?

133. How often, if any, were you liaising with the Project Team on ventilation?

134. How often, if any, were you liaising with the Project Team on water?

G. Risk Assessments at Occupation

135. Are you aware that there is a legal requirement to carry out a water risk assessment at the point of occupation?

136. Where is this legal requirement set out?

137. Are you aware if such a risk assessment was carried out at the QEUH/RHC?

138. If so, when did you become aware of this risk assessment?

139. What documentation have you seen in relation to this risk assessment?

140. DMA Canyon Reports: Refer to Bundle 6 – Miscellaneous documents – documents 29 and 30.

a) Have you seen these reports before?

b) Was this the DMA Canyon 2015 report (document 29)?

c) In her statement Dr Inkster has advised the Inquiry that you called her when you were told HFS had found the DMA risk assessment reports, and you were “really worried about patient safety implications”. When did you first become aware of this report?

d) Who made you aware of this report?

e) What actions did you take upon becoming aware of this report?

f) Who would have instructed these reports?

g) What would the cost of such reports be?

h) Who would have signed off on these reports? What would this process look like?

i) Are you aware of why the risk assessment was not undertaken prior to handover in 2015?

j) Do you have a view on why this might have happened?

k) The report makes several recommendations, do you know what was done to follow up on these recommendations between 2015 and 2017?

l) Do you know if/when the works suggested in the 2015 report were actioned?

m) What is your own view of the findings of the 2015 report? Do you agree with it or not? Explain your rationale.

n) The 2015 report highlights a number of actions required to be taken, are you aware how these actions were managed by estates? If so, please provide details of the management of the recommended actions.

o) DMA Canyon prepared another report in 2017 (document 30). Do you know what works, if any, recommended in the 2015 were carried out prior to the 2017 report?

p) What was the impact, if any, of the failure to implement the 2015 recommendations on patient safety or to bring its conclusions to the attention of the IPC team within the hospital?

q) We understand that Infection Control were only advised about the 2015 DMA Canyon Report in 2018. Do you know why they were not told sooner? What happened?

r) Do you have any concerns about the way in which the water system was managed?

141. What risk assessments have been undertaken in respect of the water system since the DMA Canyon Reports? Please provide details.

142. Following the DMA Canyon Reports, what water maintenance strategies have since been put in place? When were these actions taken? Who is/was responsible for these? Please provide details of any applicable strategies which were put in place.

H. Infection Control in General

143. How was infection control managed when the QEUH opened in 2015?

144. How large was the infection control site at the QEUH/RHC in 2015 and onwards?

145. How many colleagues were in the infection control team in 2015 and onwards?

146. How involved were you in the governance of the infection control team when the hospital opened?

147. Which colleagues were in the infection control team when the hospital opened?

148. What was their experience and expertise?

149. How often would the team meet?

150. Were there minutes of these meetings?

151. How would issues be escalated within the infection control team?

152. What was the structure of the infection control team in 2015 and onwards?

153. Who did the infection control team report to?

154. How many hours per week did you spend working with colleagues in the infection control team when the hospital opened in 2015? Did this change over time?

155. What, if any, infection control plans were prepared by the infection control team?

156. If an outbreak occurred, how would the infection control team respond to it?

157. What is HAI?

158. What, if any, distinction is there between Hospital Acquired Infection and Healthcare Associated Infection?

159. To what extent, if any, is infection (whether endogenous or arising from the environment) always a risk for certain sorts of patients?

160. To what extent is it possible to prevent infection?

161. What, if any, sorts of infection can be expected to arise no matter the level of care taken in relation to IPC/hygiene?

162. How is infection control monitored in the QEUH/RHC?

163. What infection control investigations are carried out in the QEUH/RHC?

164. Would you have expected infection control to be involved in the design of the water system?

165. Who was involved from infection control in the design of the water system?

166. To what extent did you have any involvement in the ventilation system design?

167. Would you have expected infection control to be involved in the design of the ventilation system?

168. Who was involved from infection control in the design of the ventilation system?

169. To what extent did you have any involvement in the ventilation system design?

170. How is infection control reacted to and reported internally?

171. How is infection control reacted to and reported externally?

172. How many colleagues were covering infection control for the QEUH/RHC site on 2015 and onwards?

173. Who would the infection control team go to for expert advice?

174. How often would expert advice be sought?

175. What relationships did the infection control team have with other teams (e.g. domestic team)?

176. How were these relationships?

177. How often would teams communicate?

I. The Water supply in General

178. What were the functions of the Water Safety Group?

179. How did this Water Safety Group at the QEUH/RHC come about?

180. Who was in the Water Safety Group?

181. Were you provided with updates from the water safety group?

182. Who did the Water Safety Group report to?

183. How often did the Water Safety Group have to report to another agency within the NHS?

184. To what extent, if any, were there issues with record keeping of Water Safety Group minutes?

185. What documentation did the Water Safety Group review?

186. What testing was carried out on the water supply before handover on 26 January 2015?

187. Which colleagues were involved in testing the water supply?

188. What was the outcome of the testing?

189. What remedial steps, if any, were taken after the testing?

190. When was the chlorine dioxide dosing of the water supply carried out?

191. What are biofilms?

192. What sort of organisms can be found in biofilm?

193. What discussion, if any, can you recall about bio films and taps?

194. What risk assessments, if any, were carried out in relation to taps?

195. If so, who prepared the risk assessments?

196. What, if any, communication was there with Health Protection Scotland concerning taps?

J. Horne Taps/POU Filters

197. The use of Horne Taps was discussed in the IMTs relative to the water incident. Refer to IMT Bundle 1, document 18

Please confirm:

a) Your understanding of the use of Horne taps.

b) Who authorised the use of Horne taps?

c) Why were Horne taps selected?

198. Refer to Bundle 10, document 1:

a) Are you aware of this meeting?

b)

c) What was the purpose of this meeting?

d) How did this meeting come about?

e) Did you have any concerns in terms of the discussions which took place and the use of Horne taps?

f) Do you know what actions were taken following this meeting? Were these completed?

g) Do you know if the follow-up meeting with the Horne representatives occurred? If so, what was the outcome of that meeting?

199. When the decision was made in 2014 to use Horne taps were any risk assessment carried out by NHS GGC, its suppliers or its contractors about how the taps should be used and maintained? What steps did those risk assessments recommend and were they thereafter carried out?

200. Flow straighteners: when did you become aware that they were non-compliant with SHTM 03-01 guidance? Do you know if they were non-compliant at handover?

201. Were new taps replaced in January 2019? If so, why were they replaced? Was the replacement related to the use of chlorine dioxide?

202. The use of Point of Use Filters was discussed in IMTs. Refer to the IMT Bundle
Please confirm:

a) Your understanding of the purpose of point of use filters

b) Who authorised the use of point of use filters?

c) Why were point of use filters required at the QEUH/RHC?

d) Who was responsible for the management of point of use filters and how often they were cleaned/changed?

e) How effective are point of use filters and are they still in place?

f) If they are still in place, why are they still in place?

K. The Water Incident – 2018

203. What concerns did you have about the water supply at the QEUH/RHC?

204. When did these concerns first emerge?

205. Please provide details of the concerns as they emerged in 2017 into 2018 in respect of the water issues. Initially focus on your recollection of events as they happened. In relation to the concerns:

a) When did the concern arise?

b) Nature of concerns?

c) Possible cause of concerns?

d) What actions were taken in response to the concerns?

e) In your view, how sufficient were these actions?

The following IMTs have been highlighted to assist with this: IMT Bundle Documents 16-18, 21,24, 26-29, 31-32. If you are also able to respond to the questions raised in respect of the IMTs below when considering your recollection of events.

206. Refer to IMT Bundle, Document 16

Multiple positives for cupriavidus and stenotrophomonas have been found from the taps and a showerhead in Ward 2A.

a) What is your recollection of this meeting?

b) Dr Gibson raised concerns that the pathogens found from the samples taken are potentially lethal organisms to immune suppressed patients within ward 2A.

What was your reaction to this and the potential that patients' lives were at risk?

c) Do you think the action plan from this meeting was adequate?

d) Do you think these significant and very serious concerns were being given the appropriate amount of gravitas?

207. Refer to IMT Bundle Document 17

This meeting discusses the increase in hospital acquired bacteraemia cases including Stenotrophomonas, pseudomonas and cupriavidus.

a) What were the concerns raised in this meeting?

b) What discussions took place relating to source of infection?

c) Did these increased cases cause concern?

d) What concerns did you have following this meeting?

e) What actions did you take?

f) The action plan from the meeting notes you are going to speak to Jane Grant to see if a proactive press statement should be actioned. What happened?

208. Refer to IMT Bundle Document 18.

a) What measures were being taken to manage the situation?

b) What was your involvement in this?

c) What information were patients/parents given regarding the situation with the water?

d) What information were staff given regarding the situation with the water?

e) Who was responsible for overseeing the response?

f)

g) What is your view on the adequacy of the control measures put in place?

209. In the IMT of 4th June 2018, (Bundle 1, document 23) Jamie Redfern advises that a weekly report of actions and investigations is being issued to you. What did these reports contain? Did you follow them up for further information?

210. What is your understanding of how the rest of the water incident unfolded?

211. Was this incident resolved successfully? Explain your answer.

212. Refer to IMT Bundle, Document 35:

a) What were the issues with the drains?

b) Refer to Action Plan at page 153 - What actions were taken to remedy these issues? Was the issue resolved?

213. The Inquiry is aware that chemical dosing of the drains alongside the water system was instigated. Please explain how that process came about and, in your view, whether it was/is effective.

L. Other water incidents

214. What other specific events do you recall in relation to water? Do you have any recollection of debris in the water tanks? Refer to IMT Bundle, Document 45 as starting point.

If so, please explain:

a) What the issue was
b) The impact on the hospital (include wards/areas) and its patients (if applicable)
c) Who was involved
d) What was escalation process
e) What was the result of any escalation
f) Were any external organisations approached to support and advise
g) Detail the role and function of HPS and HFS, advise if they were involved and any reports prepared by them
h) Detail advice given from external organisations; what was the advice, did you agree with it, how was any advice managed/ communicated with others in your team and your superiors?
i) Was there opposing advice and by whom
j) What remedial action was decided on and who made the decision
k) Was the issue resolved – consider any ongoing aftercare/support/monitoring
l) Detail any ongoing concerns you had, or which you were made aware of
m) Was there any documentation referenced during or created after the event? i.e. an SBAR/ minutes from a meeting – use the bundle provided to assist.
n) Did anyone sign off to say the work had been completed and issue resolved/area safe? If so, who signed off on the work?

215. What were the NHS procedures for raising concerns about water or water infections?

a) How were these dealt with by you?

b) How was it confirmed that they had been dealt with?

c) Do you recall specific incidents, and in particular any that gave you concern.

M. The Ventilation System

216. What is neutropenia?

217. What ventilation standards are required for neutropenic patients?

218. What guidance (SHTMs/HTMs/HBMs etc) did you understand applied to the following at (i) the planning, (ii) the construction and (iii) the handover of the QEUH/RHC:

(a) HEPA filtration of wards

(b) Room air change rates

(c) Room air pressure

(d) Chilled Beam Units

(e) Sealed bedrooms/ensuites

(f) Air-lock entrances to wards

(g) Back-up air handling units

(h) Pressure monitoring systems

219. What was your understanding of compliance of the above systems within the QEUH/RHC with the SHTMs/HTMs/HBMs guidance at the point of handover?

220. If anything was not compliant why did handover take place? Who would have authorised this?

221. What remedial actions were taken to deal with those systems which were not compliant?

222. What is your understanding of the process for taking air samples? Who was responsible for this?

223. Were you concerned by any air samples?

224. Why were you concerned by these air samples?

225. How confident were you in the Project Team and/or Estates Team?

226. How confident were you that they knew what they were supposed to deliver?

227. How confident were you that what was delivered would meet the needs of patients?

228. What is HFS?

229. To what extent did you have any involvement with HFS during the build phase of the QEUH/RHC?

N. Wards and Hospital Occupation from January 2015

230. At the point of taking occupation of QEUH/RHC on 26th January 2015 please confirm whether the following wards were completed, commissioned, and validated to the expected specification from Multiplex to NHS GGC:

Ward 2A/2B
Ward 4B
Ward 4C
Ward 6A
Ward 6C

231. Please also confirm your understanding of the ward specification and patient cohort to be located in each ward on the date the ward opened?

232. If a ward or wards were not handed over on 26th January 2015, or were partially handed over, please confirm:

a) Why they were held back?

b) Any financial consequence to both Multiplex and NHS GGC of the ward(s) being held back?

c) What works were carried out in order to allow this ward(s) to be handed over the NHS GGC?

233. Were any other wards, aside from those referred to above, retained? Answer as above?

234. We know that the energy centre was retained by Multiplex

a) Why was the energy centre retained?

b) What financial consequences, if any, arose for either Multiplex or NHS GGC if the energy centre was retained?

c) What works were carried out to allow hand over of the energy centre to NHS GGC?

235. Were any other parts of the hospital retained by Multiplex pending works being carried out? Why? What works required to be carried out prior to them being handed over?

236. At the point of handover on 26th January 2015 how satisfied were you that all areas accepted by NHS GGC were designed to the intended specification and suitable for the intended patient cohort, meeting all the relevant guidance requirements?

237. If not, why were the wards handed over? Were any issues escalated to more senior management/ Board level? Please confirm.

O. March 2015 – Ward 2A/B

238. March 2015 – in her evidence to the Inquiry Dr Brenda Gibson raised concerns regarding the safety of Ward 2A prior to patient migration:

a) What was the intended use and purpose of Ward 2A?

b) Were you aware of the intended use and purpose at handover of QEUH/RHC in January 2015?

c) What were the ventilation requirements specific to Ward 2A?

239. There were concerns in March 2015 regarding Ward 2A/B - refer to Estates Team Bundle, documents 35 and 37:

a) What were the concerns at the time?

b) Why was Ward 2A handover accepted by NHS GGC in January 2015 without HEPA filtration being in place?

240. Dr Gibson in her statement refers to HEPA filters not being in place at the point of handover in wards 2A/B:

a) Explain your understanding of the situation.

b) What was the impact of HEPA filters not being installed?

c) What was the potential impact on patients of the absence of HEPA filters?

d) What was done to resolve any HEPA filter issues?

e) Should HEPA filters have been installed at handover?

f) Who was responsible for providing HEPA filters and ensuring that they were installed during the build?

g) Who signed off handover without HEPA filters being installed?

h) Which infection control doctors and nurses were consulted?

i) Why was handover signed off without HEPA filters?

241. What other wards were missing HEPA filters following handover? Please provide details.

242. Describe how the lack of HEPA filtration in Ward 2A was managed, what was your responsibility/involvement, what was the outcome?

243. To what extent were you satisfied that the relevant work had been carried out to secure the ward for patients?

244. Refer to Bundle 8, Documents 25-31

Please provide a summary of the events discussed in these emails.

Please include:

a) what was the issue with ward 2A

b) Why were transplants not proceeding

c) What steps were being taken to resolve this

d) Who was involved in this and what were their roles

e) Who was responsible for decision making/managing this situation

245. Refer to Bundle 8, Document 31

a) Dr Gibson states that the clinical team has “lost faith”, outcomes have been “compromised” and that matters are not being dealt with with the “appropriate sense of urgency”; what is your view on this?

b) What was the outcome/response to Dr Gibson’s email?

246. Refer to Bundle 6, Document 4

a) Do you recall this meeting?

b) What was the purpose of this meeting?

c) What were the circumstances which led to this meeting?

d) The minutes state that the sealed rooms are providing the appropriate level of 10 Pa positive pressure. How was this conclusion reached? Do you still agree with this conclusion?

e) What actions were taken following this meeting?

247. Refer to Bundle 6, Document 5

a) Do you recall this email?

b) Do you recall speaking to Sandra McNamee regarding the safety of ward 2A?

c) The balance between proceeding with a child’s treatment and the safety of the environment is discussed. What is your view on this?

d) In his email of 11 September 2015, Grant Archibald states that ICT doctors say they have not had a handover from senior ICT and lack information to inform their decision making regarding the safety of Ward 2A. Were ICT doctors provided with all the information required to make an informed decision on this?

P. Ward 2A - Paediatric BMT – Specifications

248. Refer to Bundle 4, Document 4

a) What is this document?

b) Dr Mathers states that, "the facilities are at **least** as good as the RHSC and are **believed to be** built to a higher spec. They are NOT identical. They are **not as high spec as the Beatson Adult System.** This does **not mean that they are a suboptimal standard".** What is your interpretation of this? Do you or did you believe that the RHC BMT was of the necessary standard to treat patients? Please provide an explanation.

c) Who was this document shared with?

d) What actions were taken?

249. Please refer to Estates Bundle, Document 109

This email details a meeting which took place to discuss Ward 2A BMT isolation rooms. Ian Powrie states that the meeting was arranged at your behest. The email states that the rooms were all built to SHPN 04-01 standard however this design is not suitable for neutropenic patients and the rooms should have been built to SHPN 03-01 standard and this was agreed by clinical representatives at the meeting.

a) Were you aware of this before this meeting?

b) What information were you provided following this meeting from Jamie Redfern?

c) What actions were taken?

Q. June – July 2015 - Ward 4B

250. In June 2015 patients migrated to Ward 4B – at the point of migration NHS GGC had accepted handover of the ward from Multiplex – save for defects – did you consider the

ward to be compliant with the guidance and suitable to meet the needs of BMT patients? If so why, if not why?

251. . What was the intended purpose of Ward 4B?

252. Did this purpose change prior to January 2015? If so, what changes were made?

253. Were there changes required to the ventilation system prior to January 2015? If so, why?

254. What was your involvement with the changes?

255. There were issues with Ward 4B almost straight away, with an SBAR being prepared on around 7th June 2015:

a) Discuss the concerns about Ward 4B. Refer Estate Team Bundle, document 30 - What was the purpose of the SBAR?

b) Less than one month after migration to ward 4B patients were decanted back to the Beatson, is this correct?

c) The issues raised in the SBAR from June 2015 were present at the point of NHS GGC taking occupation in January 2015, and when Ward 4B was handed over to NHSGCC, is that correct?

256. How was the Ward signed off and handover accepted given the issues which arose immediately following handover prior to patient migration?

257. Refer to Estates Team Bundle, document 36:

a) Were you aware of the early testing being carried out?

b) Why were tests being carried out? Was it in response to the SBAR from June 2015?

c) Please provide information about your involvement.

d) Did the test result provide assurance regarding Ward 4Bs suitability for the intended patient cohort? If so, how?

258. At a BICC meeting on 27th July 2015 Professor Craig Williams states that in respect of ward 4B '*the unit was not built to the correct specification and Brookefield have agreed to fund the rebuild for this area and the timeframe for this is 12 weeks*'

a) Did you agree with Professor Williams' statement at the time?

b) Do you agree now?

g) If the ward was built to specification why were patients decanted to the Beatson less than a month after migration?

259. Works were carried out to Ward 4B – do you recall the nature of these works and why they were carried out?

Refer to Document A43502680 - "BMT Document" - from Craig Williams to Jennifer Armstrong that considers the specification and identifies deficiencies with the BMT Unit details - Objective ECM (scotland.gov.uk)

260. What is this document?

261. Why did Craig Williams send this to you?

262. What was your response to seeing this document?

263. Did you share this with anyone?

264. Why did you request this report?

265. What actions were taken following this report?

266. What is your understanding of ward specification?

267. What is the importance of ward having certain specifications?

268. If a ward did not have a required specification relevant to its purpose, would this be putting patients at risk?

R. Ward 2A – Invasive Fungal Infections

Please refer to Bundle 4, Document 23

269. This SBAR of 3rd October 2017 was produced highlighting concerns following a patient contracting an Invasive fungal infection.

a) Do you recall this incident? Please provide details of your recollections.

b) What was the outcome for this particular child?

c) Were any more invasive fungal infections detected? Please provide details.

d) In your view, did this SBAR raise valid concerns?

e) What response was taken and additional measures implemented, if any, as a result of the SBAR?

f) Was the situation fully resolved? Please provide details.

S. Decision to close wards 2A/B and move to 6A and 4B

270. Discuss the issues surrounding and leading up to the decant of patients from Ward 2A in 2018.

a) What was the lead up and background to this refer to IMT Bundle, documents 16, 23,29, 37- 48, 50, 51 53, 54, 55, 57,59, 60, 62, 76,

b) What was your involvement?

c) What risk assessments were carried out in respect of the decision to decant the Schiehallion Unit to Wards 6A and 4B?

d) To your mind what were the principal disadvantages of a decant?

e) To your mind what were the principal advantages of a decant?

f) What additional measures were put in place to ensure patient safety as part of the decant?

g) What concerns, if any, did you have about where the patient cohort was being moved to? If so, why did you have these concerns?

h) What was your understanding of the suitability of Wards 6A and 4B for the treatment of immuno-compromised children?

i) Please comment on the facilities within ward 6A, the access to the ward and the distance from key facilities, such as PICU and the crash team.

j) Please comment on the facilities within ward 4B, the access to the ward and the distance from key facilities such as PICU and the crash team.

k) Did you have any environmental concerns relating to either ward 6A or 4B? If so, what were they?

l) What impact did this decant have on patients and their families?

m) Discuss and detail the works done to Ward 2A/B, what was required to be done and why, what has been done and when the work was completed. Please include details of your involvement. Reference IMT Bundle to assist.

n) Any other relevant information.

271. Discuss the issues surrounding the ward 2A patients when in occupation of ward 6A. In particular, views you may have in respect of:

a) Chilled beams

b) Gram Negative Bacteraemia

c) Water filters

d) Ventilation

e) issues/ testing/ escalation/ response/ IMTs/SBARs impact on patients

f) Patient communication

g) Internal escalation - HIIAT scoring

h) External escalation

[Type your answer here

T. Ward 4C

272. To what extent were you aware that the ventilation system of Ward 4C does not meet the Scottish Health Technical Memorandum (SHTM 03-01) Ventilation for Healthcare Premises?

When did they first become aware of this?

What changes (if any) are you aware of the hospital management/NHS GGC making to the ward by bringing in additional equipment, when that took place and specifically what equipment was brought in?

What changes (if any) are you aware of the clinicians running the ward taking to mitigate any risk that would arise from noncompliance with SHTM 03-01?

Do you consider that the fact that ventilation system of Ward 4C does not comply with SHTM 03-01 gives rise to any increased risk of infections in patients and why they have reached that conclusion?

Are you aware of any attempt by the Health and Safety Executive to take enforcement action against NHS GGC in respect of the ventilation system of Ward 4C, what was the basis of

that action, what was the response made by NHS GGC and what was the result of any such action by HSE?

U. IMT Attendance

273. What is an IMT?

274. When is it appropriate for you as Medical Director to attend an IMT?

275. In the event of an outbreak, describe what steps are taken by an IMT.

276. How often would an IMT meet?

277. Who would make up an IMT?

278. How many colleagues would be in an IMT?

279. What are the roles and backgrounds of members of an IMT?

280. What is the purpose of IMT meetings?

281. Who was the ICD at the time of your involvement in the IMT?

282. What is the function of the ICD?

283. Is this a full-time role?

284. Who was the ICN at the time?

285. What is the function of the ICN?

286. Is this a full-time role?

287. How often would an IMT seek expert advice during an outbreak?

288. Who would an IMT seek expert advice from?

289. What other teams would an IMT communicate with?

290. To what extent would the make up of an IMT differ depending on the circumstances of an outbreak?

291. To what extent, if any, were there issues with record-keeping of IMT minutes etc?

292. How does an IMT process end?

293. What steps are taken at the end of an IMT process?

294. How do you decide that an incident is over?

295. How do you assess there is no longer a significant threat to public health?

296. What circumstances would merit a statement to the general public or other interested parties when an incident is over?

297. What, if any documentation, is prepared as a result of an IMT process?

298. What was the escalation process for an IMT?

299. What if any, report is prepared as a result of an IMT process?

300. If so, who would prepare the report?

301. What process is used to summarise the conclusions, results, and lessons learned of each IMT?

302. What, if any, de-brief meetings take place at the end of an IMT process?

303. If so, how soon after an incident is over should a de-brief meeting take place?

304. How do you evaluate how effective an IMT has been for a specific incident?

305. Who is the report shared with? How is the report communicated within the NHS?

306. Who else within the organisation is responsible for endorsing the conclusions of an IMT report?

307. What, if any steps, are taken by the NHS following the report prepared by an IMT?

308. Who is responsible for preparing any action plan based on an IMT report?

309. What parts of the QEUH/RHC specification were considered at any meetings?

V. HIIAT Process

310. What is the HIIAT?

311. Describe the HIIAT process?

312. To what extent are Health Protection Scotland (HPS) involved when there is an outbreak?

313. What documentation is during and after the HIIAT process?

314. How clear and comprehensible is the HIIAT process?

W. Gram Negative Bacteraemia

315. Describe the Gram Negative Bacteraemia Outbreak and your involvement in it

Refer to IMT Bundle, including Documents 72-88

316. The Inquiry understands there was an increased number of line infections in Ward 2A in 2016 and 2017. Please provide details of your recollection of these infections, including the suspected cause of these infections, the outcomes for patients and whether/how this increased rate of infections was resolved.

Refer to IMT Bundle, Document 73

317. What is mycobacterium chelonae?

318. What was your involvement with the m.chelonoae outbreak?

319. Three hypotheses are discussed as potential sources of contamination causing the infections during this meeting. What is your view on each hypothesis?

320. The minutes mention a requirement to refer unusual episodes to HPS? Did this happen?

321. Who made this referral?

322. What was the outcome of this?

323. What actions were required to be taken?

324. Under what circumstances would HPS normally become involved?

325. What was the extent of HPS involvement?

326. What is your view on the adequacy of the actions taken by HPS?

327. Refer to IMT Bundle, Document 83

Dr Peters and Dr Inkster produced an SBAR for this meeting (Refer to Bundle 4, document 44) which suggests broadening the classification of HAI, do you recall being advised

regarding the discussions around this SBAR? Please provide details. What was your view on the recommendations regarding broadening the outbreak definitions?

328. In your view was the case definition adopted by the IMT adequate? Please explain.

329. Refer to IMT Bundle, Document 84

A detailed discussion is noted in the minutes to have taken place regarding the definition/classification of HAI and HCAI. What is your understanding of this discussion?

330. Was the classification of HAIs and HCAIs discussed with you? What view did you take on this?

331. What was the final decision taken on the classification/definition of an HAI and an HCAI? Please provide details.

Refer to IMT Bundle, Document 72

332. What is your understanding of the cases of m.chelonae and stenotrophomonas which were emerging?

333. Who was updating you on the situation?

334. Did you have any concerns? What were they?

335. What actions did you take?

336. What concerns were emerging regarding the source of the outbreak?

337. What were the concerns regarding the drains?

338. What actions did you/others take?

Refer to IMT Bundle, Document 73

339. At page 326, it states that there have only been 4 cases of m.chelonae reported in the adult population in the last decade and no paediatric cases and now there have been two

within 12 months. Did this cause you concern? Was this escalated? The HIIAT score is only listed as amber, do you think this appropriately reflects the severity of the situation?

Refer to IMT Bundle, Document 74

340. The water reports from this meeting state that a water outlet come back as positive for mycobacterium even with a point of use filter on it. It was suspected the filter may be defective. What was the outcome of this? Was the filter found to be defective? Are point of use filters 100% effective?

X. Chilled Beams

341. What are chilled beams?

342. Are you aware of any circumstances where chilled beams should not be used?

343. Can you recall the events relating to the chilled beams at the QEUH/RHC?

344. At Page 166 of Bundle 4, Dr Peters lists reasons why chilled beams should not be used in neutropenic settings due to the infection risks associated with them, including the build-up of dust and them being a water source from condensation, leaks, and dripping water: Do you agree with this? If so, can you explain why? If not, can you explain why?

345. Refer to IMT Bundle, Document 76

a) What is the action plan referred to for chilled beams?

b) Were patients being put at risk remaining in rooms where chilled beams were located?

c) Who was responsible for the management of the swabbing/testing results taken from the chilled beams?

d) Who was responsible for addressing the leaking chilled beams?

346. The issue of patient placement is also discussed to avoid putting patients from 6A into wards where there are chilled beams. The minutes state that Dr Scott Davidson will discuss this with you. Did you have this discussion? What was the outcome?

Y. IMT - 14th August 2019

Please refer to IMT Bundle Document 77

347. Do you recall this meeting?

348. What was the purpose of this meeting? Describe the circumstances leading up to this meeting.

349. At this meeting Dr Deighan disagrees with Dr Inkster that the numbers of bacteraemia have increased. What is your view on this? Please provide reasons for your conclusion.

350. Did you agree with Dr Inkster and Dr Peters that the nature of the bacteria was a concern in that it was environmental and associated with water/soil? If not, why not? Please provide details for your answer.

Z. Dr Iain Kennedy's Reports

Please refer to Bundle 6 Documents 27 and 28

351. Have you seen these reports before?

352. Who shared these with you?

353. What do you understand was the purpose behind Dr Kennedy's reports?

354. What were the circumstances leading up to the instruction of these reports?

355. Who would have instructed these reports?

356. What was the methodology used to complete these reports? What is your view on the adequacy of the methodology used?

357. What are the conclusions of these reports? Do you agree with these conclusions, if so, please explain your reasoning.

358. Dr Inkster, Dr Peters and Dr Harvey-Wood disagreed with the conclusions of Dr Kennedy's reports. What is your view on this?

AA. Prophylactic Medication

359. To what extent if at all were there patients in QEUH and in RHC prescribed prophylactic medication as a result of concerns about increased HAIs, the water system (including drainage) and/or the ventilation system?

Please identify/describe:

a) The medications in question

b) In particular, is it the case that in contrast to the general position across UK and Scotland the following were prescribed in QEUH/RHC as a matter of course: Ciprofloxacin, Posaconazole, Ambisome, Caspofungin, Septrin?

c) What was the reason for the prescription of these medicines?

d) In particular, was the prescription of any of these linked to concerns about the environment and if so what concerns?

360. Which group of clinicians would be responsible in an individual case for the prescription of this medication to patients: i.e. would it be treating haematologists/oncologists or would it be somebody else?

361. Are you aware of any general decision being taken regarding whether this additional/different medication ought to be made available to patients; if so which bodies/individuals were involved in that?

362. In what way, if at all, did the way in which these treatments were used differ from the standard use of prophylactic medications (i.e. duration of use; dosage etc)

363. What risks did patients face if they did not receive this medication?

364. Were staff given any guidance or was there any discussion about the use of prophylactic medication?

365. Were staff given any guidance or was there discussion about how this matter was to be communicated with patients?

366. What approach was taken to discussing with patients?

367. Are you aware of any withholding of information about the prescription of prophylactic medication or any suggestion or instruction that matters to do with the use of prophylactic medication ought not to be shared with patients?

Please refer to Bundle 12, Document 137

368. In this email Dr Gibson outlines her concerns regarding the use of prophylactic medication. What is your view on her concerns raised?

369. Who was authorising the use of prophylactic medication?

370. Was there guidance in place for this?

BB. Cryptococcus

Refer to the Cryptococcus Bundle to assist.

371. Recall your understanding of the Cryptococcus infections in 2018:

a) What was your impression/reaction upon learning of the presence of cryptococcus in 2018 in the QEUH?

b) What is Cryptococcus?

c) Had you seen/ heard of Cryptococcus in a healthcare setting prior to QEUH?

d) What were the issues with Cryptococcus at QEUH? When did you first become aware of these issues? What happened in response to these issues?

372. What steps were taken in response/ precautions put in place?

a) What were the hypotheses put forward for the cases of cryptococcus? Who put these forward? Refer to the cryptococcus bundle

b) Did you agree with these?

c) What was your own hypothesis regarding the cryptococcus cases?

d) What is the rationale behind your hypothesis?

e) Discuss your knowledge of/involvement at the Cryptococcus IMTs: Refer to IMT Bundle

373. Refer to the Action Plan Bundle 1 IMT, Document 58:

a) What is this document?

b) What was its purpose?

c) What actions were you responsible for and why?

d) Did you complete your actions?

e) Were all the actions in the plan completed?

f) How did this contribute overall to the management of the cryptococcus incident?

374. Discuss your involvement, if any, at the Cryptococcus Sub-Group Meetings - actions taken, internal escalation: HPS involvement.

375. What, if any, external reporting occurred?

376. PAGs/ IMTs/ AICC and BICC involvement.

377. What steps were taken in response/ precautions put in place?

378. Did you read John Hood's report?

379. When did you read John Hood's report?

380. What observations, if any, did you make after reading John Hood's report? What actions were taken following the John Hood report?

381. What else could have been done? How could matters have been handled differently? What concerns, if any, did you have about how matters were dealt with?

382. What was your view on the pigeon infestation on the QEUH/RHC site?

383. What is your view on the pigeon contamination in the plant rooms?

384. Who was responsible for clean up regarding this?

385. What actions were taken?

386. Was air sampling of plant rooms undertaken?

Please refer to IMT Bundle 1, Document 58

387. A discussion of plant rooms and sampling for fungi and cryptococcus takes place.

a) What is your recollection of these discussions?

b) What view did you take on what was being discussed?

c) What control measures were implemented?

Please refer to IMT Bundle 1, Document 59

388. Cryptococcus and other organisms were found that are carried by pigeons giving evidence of an infestation of the plant room.

a) Discuss this meeting, including incident updates, hypothesis, risk management and control measures, further investigations, recommendations, and actions.

b) When did you first become aware of an infestation of the plant rooms?

c) What was your understanding of the extent of the infestation and how the pigeons were accessing the plant room?

d) What was your understanding of how the infected air was reaching the wards?

e) What steps were taken and by whom?

f) Was this issue fully resolved?

Please refer to IMT Bundle 1, Document 55

389. Three incidents are discussed including a paediatric patient who has died following testing positive for cryptococcus.

a) What was your understanding of this situation?

b) Who kept you informed of the situation?

c) What actions did you take?

Please refer to Bundle 1, Document 94

390. Discuss this case. What was the outcome?

391. How many cases of cryptococcus have there been in the QEUH/RHC between 2015 to date? Please provide details of each case.

Please refer to Bundle 12, Document 137

392. Dr Gibson emailed you following the death of a child, she states, “as a consultant body we are now very concerned about the safety of our environment … we are concerned we may have moved to an even less safe environment.” What is your view on Dr Gibson’s concerns?

393. Dr Gibson describes having to prophylax vulnerable patients and describes two serious anaphylactic reactions which required adrenaline. What actions were taken following these concerns?

394. Dr Gibson describes two rooms with water damage and mould which have not been attended to by Estates. Were you aware of delays in addressing these issues by Estates? Whose responsibility would addressing these issues have been?

395. Who was responsible overall for managing the concerns outlined by Dr Gibson?

CC. Whistleblowing and Communication

396. Can you explain the key aspects of the duty to communicate effectively with patients generally.

397. Can you explain how the duty to communicate should be approached when it comes to telling patients about an infection; about the possible causes of the infection; and about the impact upon health; and upon future treatment.

398. Can you explain how the duty to communicate should be approached where something has gone wrong during care or treatment.

399. Are you aware of the duty of candour and how would you explain that?

400. If staff had concerns about wrongdoing, failure, or inadequacy within the hospital:

a) were there procedures to facilitate disclosure of this either to other GGC staff or to individuals external to GGC? What were these?

b) Were these procedures and details of how to use them easily available to staff?

c) is disclosure in this manner something that has always been encouraged within GGC?

401. Are you familiar with the whistleblowing policy for GGC in 2018?

402. Was this policy easily accessible to staff? Are you aware that this policy was out of date and had not been updated appropriately?

403. In your view was the whistleblowing policy in place in 2018 effective?

404. Has the whistleblowing policy since been updated?

405. What updates have been made?

406. Do you think the current policy is adequate?

DD. Whistleblowing – QEUH/RHC

407. What was your involvement in the whistleblowing process? Please provide details.

408. What is your understanding of the concerns that led to the stage 1 whistleblow in 2017? Did you agree with these concerns?

409. Refer to emails between 5th September 2017 and 3rd October 2017:

Email chain between Penelope Redding, Tom Walsh and Jennifer Armstrong dated between 5 September 2017 and 3 October 2017 details - Objective ECM (scotland.gov.uk)

a) Do you recall receiving these emails from Dr Redding?

b) Dr Redding raises issues concerning patient safety and infection control: were you aware of these concerns in advance of Dr Redding's emails? If so, please provide details.

c) What was your view on Dr Redding's concerns?

d) It would appear Dr Redding sent emails on 5th, 15th, 21st and 27th September 2017 before receiving a response; how would you account for this delay in responding?

e) The Inquiry understands you did not treat Dr Redding's emails/concerns as a stage 1 whistleblow, that is despite Dr Redding stating in her email of 27th September 2017, "I would like to avoid going to Stage 2 of the GG+C Whistle Blowing Policy": Can you explain the rationale behind this decision?

410. Refer to SBAR of 3th October 2017 – Re Infection Control and Patient Safety at QEUH – Bundle 4, Document 20

a) Do you recall receiving the SBAR of 3rd October 2017?

b) Going through it, please provide your views on each of the following:

i. Patient Placement

ii. Cleaning

iii. Estates

iv. Infection Control Structure

v. Recommendations

411. The SBAR states that some of the issues raised, for example patient placement and cleaning, were first raised in June 2015. Why were these issues not being addressed in a timeous manner?

412. In your view did the SBAR of 3rd October 2017 raise valid concerns?

413. If yes, what was the response to these concerns?

Refer to Minute of Meeting dated 4 October 2017 – Estates Bundle 12, Document 116

a) Do you recall attending this meeting? Please provide details of your recollections.

b) There is some discussion surrounding PPVL rooms not being built to SHTM standards and that they did not provide appropriate protection for patients, something which David Loudon disagreed with. Were PPVL rooms built to SHTM standards?

c) There is a discussion surrounding the Infectious Disease Unit, its relocation to QEUH and HPS agreeing to provide details of the room standards required to accommodate patients. A meeting took place with HPS on 2nd October 2017. Can you elaborate on the circumstances surrounding this, as well as the reasons for the delay in HPS providing the details required?

d) There is discussion surrounding HEPA filters not being fitted in PICU and in prep rooms in Ward 2A. Can you explain this decision? Who was responsible for managing the installation of HEPA filters?

e) Do you agree there was an issue with cleaning practices within the QEUH/RHC? Who was responsible for the management of cleaning practices?

f) Water quality and testing concerns were discussed: what is your view on these? Who was responsible for the cleaning and maintenance policy of taps?

g) Do you agree that there was a delay in providing test results to ICD?

h) Dr Peters raised concerns regarding ICD requesting and receiving the water sampling results in a timely manner where a water source of infection needed to be investigated: do you agree with this? Was there an issue with ICDs receiving test results?

i) What was the extent of the issues of sewage in the neuro surgical theatres? Who was responsible for dealing with this?

j) Looking at the ‘Agreement of Further Actions/ Next Steps’, where possible, please provide details as to what actions were taken and the outcomes of these.

414. 27 point action plan – refer to Action Plan arising in response to SBAR dated 3 October 2017 details - Objective ECM (scotland.gov.uk)

Please discuss this plan including:

a) Who was responsible for the management of the plan and updating it

b) What actions were taken in terms of each issue

c) Which actions have been fully resolved

d) Which actions are outstanding

415. Refer to Bundle 4 – SBAR – Document 51 -

In this paper from June 2021, the Clinical and Care Governance Committee comment that many actions from the plan were still marked “in progress” in 2019 and therefore request a further update, a review and closure of the plan. Can you please comment on the final positions relating to each issue and whether, in your view, they have been satisfactorily resolved.

416. Refer to Bundle 6, Document 22

a) Do you recall attending this meeting?

b) What is your understanding of why this meeting was called?

c) What was your understanding of why Dr de Caestecker was involved?

d) What was your understanding of the issues raised surrounding IMTs? In particular, what do you understand the issues raised with the role of the chair and behavioural issues related to?

e) Please provide details as to the discussions for re-setting the IMT process and having an independent Chair.

f) Please explain the actions taken and how they were taken forward.

g) Dr Inkster was removed as Chair of the IMT following this meeting without her having an opportunity to discuss this. Do you think this was a fair approach to take?

h) Dr Inkster is of the view she was forced to demit as chair of the IMT with various different reasons cited to her for this decision, all of which were untrue; what is your understanding of this? What reasons were given to Dr Inkster?

417. What was your involvement, if any, with the stage 2 whistleblow?

418. What was the stage 2 whistleblow process within GGC in 2018?

419. What do you understand to be the issues raised through the stage 2 whistleblow to have been?

420. With whom were these issues raised and how were they addressed?

421. Do you have a view on whether these issues were resolved satisfactorily?

422. What was your involvement, if any, with the stage 3 whistleblow?

423. What was the stage 3 whistleblow process within GGC in 2019?

424. What do you understand to be the issues raised through the stage 3 whistleblow?

425. With whom were these issues raised and how were they addressed?

426. Do you have a view on whether these issues were resolved satisfactorily?

427. What was your involvement, if any, with the stage 3 whistleblow in April 2020?

428. What do you understand the issues raised through this whistleblow to have been?

429. Dr Redding was of the view that GGC had attempted to 'cover up' the whistleblow of September 2017 by not recording it as a whistleblow. What is your view on this?

430. With whom were these issues raised and how were they addressed?

431. Do you have a view on whether these issues were resolved satisfactorily?

432. Are you aware of the whistleblow to HPS in August 2019?

433. What do you understand the issues raised through this whistleblow to have been?

434. What actions were taken?

435. Do you consider this to be fully resolved?

436. Dr Inkster and Dr Peters raised their concerns with the Scottish Government which resulted in several meetings throughout 2019 and 2020. Are you aware of these meetings?

437. What is your understanding of why these meetings took place and the concerns raised?

438. Were you contacted by the Scottish Government regarding these meeting? Were the concerns raised conveyed to you?

439. What actions were taken?

EE. Resignation of Dr Inkster and other ICDs

Refer to Dr Inkster resignation letter Sept 2019 details - Objective ECM (scotland.gov.uk)

440. What is your understanding of why Dr Inkster resigned from her role as ICD in September 2019?

441. In her resignation letter, Dr Inkster states a colleague referred to her, “doing the work of 4 people”, what is your view on this? Were there resource issues with ICDs? Please provide details.

442. In her resignation letter, Dr Inkster refers to being undermined, being shown a lack of respect, being unsupported and undervalued during IMTs and despite discussing this with senior management these issues persisted. Were you aware of these issues mentioned by Dr Inkster before she raises them in her resignation letter? If so, were these being addressed? What are your views on her concerns?

443. The Inquiry has been told that Dr Inkster previously attempted to resign in January 2018 but was persuaded to remain in post by you. Can you provide details of this?

Refer to: Dr Armstrong response to Dr Inkster resignation letter Sept 2019 details - Objective ECM (scotland.gov.uk)

444. In your response to Dr Inkster’s resignation letter, you state that you are keen for the issues which she raised to be fully considered and properly investigated and that a full investigation under the Boards’ Whistleblowing Policy will be carried out. The issues which Dr Inkster raises are not new issues, why are they only being fully/appropriately addressed now?

445. You identify 6 key issues which Dr Inkster raises in her resignation letter; do you have a view on each issue? What steps were taken to address each issue, and do you know if they have now been fully resolved?

446. In July 2015, Dr Inkster, Dr Peters and Dr Wright all resigned from their roles as ICD. Dr Inkster and Dr Peters were persuaded to remain in their roles but made several future attempts to resign before finally giving up their posts. There appears to have been an ongoing problem with ICDs resigning from their role; what in your opinion caused this?

447. Was there a clear remit for the role of ICD?

448. Dr Peters has told the Inquiry she sought clarification on her remit as ICD on several occasions but was unsuccessful in obtaining this. What is your view on this?

449. David Stewart undertook a review into the resignation of ICDs – Refer to Summary of Infection Control Issues details - Objective ECM (scotland.gov.uk) – who instructed this review? What was the purpose of the review? What actions, if any, were informed by the findings of this review?

450. What is your view on each of the following issues within his report and proposed remedial actions:

a) Cultures and behaviours

b) Leadership style/management skills

c) Team functioning/structure

d) Service/patient concerns

451. Did David Stewart discuss this report with you? If so, what was discussed?

452. Who was this report shared with?

453. Were the issues with ICDs resolved? If not, why not?

454. Email from C Peters to J Armstrong - 21 September 2017 details - Objective ECM (scotland.gov.uk) – Re.4B, [redacted] – HAI SCRIBE

a) Do you recall receiving this email?

b) Dr Peters sets out a number of outstanding concerns, including [redacted] not having required information to allow [redacted] to sign off an HAISCRIBE and Dr Inkster being quoted as having approved the document when this was not the case. What is your understanding of this situation? Were these concerns investigated further?

455. Refer to Bundle 4 – SBAR – Document 33
This SBAR from 6th December 2018 recommends additional ICD sessions to support the current and ongoing requirement for expert input and advice into the built environment at QEUH/RHC.

a) What happened as a result of this?

b) Were additional ICD sessions put in place?

c) Was there an issue with resources within ICD?

456. In your opinion were there issues with the role of ICD and what were they?

FF. National Performance Framework

457. When did the escalation of the QEUH to Stage 4 of the National Performance Framework take place?

458. What is your understanding of why NHS GGC was escalated to Stage 4?

459. What were the events preceding this?

460. Describe the process of escalation and the consequences of this?

461. What actions were taken?

GG. Case Note Review and Oversight Board

462. Please describe the process involved for the Case Note Review. Please include how this was established, who was involved, what work was done and any relevant outcomes.

463. Please describe the process involved for the Oversight Board. Please include how this was established, who was involved, what work was done and any relevant outcomes.

464. Have you read the Overall Report of the Case Notes Review and noted its recommendations?

465. Have you read the Interim Report and/or Final Report of the Oversight Board and noted its local recommendations in respect of Governance and Risk Management?

466. Have you read the Interim Report and/or Final Report of the Oversight Board and noted its local recommendations in respect of Communications and Engagement?

467. What steps have been taken by GGC to implement each of the separate recommendations of the Case Notes Review, when they were taken and to what extent do you consider the implementation to have been effective? Please provide evidence to support each effective implementation.

468. What steps have been taken by GGC to implement each of separate recommendations of the 'Local Recommendations' of the Oversight Board, when were they taken and to what extent do you consider the implementation to have been effective? Please provide evidence to support each effective implementation.

HH. Communication – Staff/Information Sharing

469. What is your view on the adequacy of communication between staff and information sharing between staff within the QEUH/RHC? Please provide details.

470. What is your understanding of the following:
All communication from management to clinical staff regarding infection risk where there had been or was a concern about links to the hospital environment; and as regards such concerns:

a) All instruction from management to clinical staff regarding what and how to communicate with patients

b) All communication from management to patients

c) All communication from management to the media

d) The pre-broadcast advice to staff regarding the BBC programme

e) All communication between management and external bodies such as SG, HPS and HFS

II. Communication with parents

471. What is your view on the adequacy of communication and information sharing between staff and patients and families?

472. Do you believe that there were circumstances where this could have been improved? If yes, please provide details/examples.

473. What steps have been taken to improve communication failures.

JJ. Staff/culture within QEUH

474. What was the working environment like within the QEUH – work life balance/ workplace culture? What issues, if any, are you aware of? What was your experience of this?

475. In your view, were the concerns raised by infection control colleagues regarding the general build of QEUH/RHC taken seriously? What action was taken in response to these concerns, if not already mentioned in your answers?

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

Appendix D

Dr Jennifer L Armstrong

Education and qualifications

M.B.Ch.B (University of Glasgow)	1988
Master of Public Health (University of Glasgow)	1995
Diploma in Management, Caledonian University (**prize for best student**)	1999

Professional qualifications

General Medical Council [redacted]	1988
Membership of the Royal College of Physicians (Glasgow)	1993
Membership of the Faculty of Public Health (London)	1998
Public Health Medicine Higher Specialty training CCST	2000
Elected Fellow of Faculty of Public Health (London)	2007
Elected Fellow of Royal College of Physicians (Glasgow)	2015

Career summary

01/08/88 – 31/01/89: Junior House Officer in General Medicine
University Department of Medicine, Glasgow Royal Infirmary
01/02/89 – 31/07/89: Junior House Officer in General Surgery
Royal Alexandra Hospital, Paisley
01/08/89 – 31/01/90: Senior House Officer in Geriatric Medicine
The Victoria Geriatric Unit, Glasgow
01/02/90 – 31/07/90: Senior House Officer in Accident and Emergency
Glasgow Royal Infirmary
01/08/90 – 31/01/91: Senior House Officer in Obstetrics and Gynaecology
Royal Alexandra Hospital, Paisley
01/02/91 – 31/07/91: Senior House Officer in General Medicine
Inverclyde Royal Hospital, Greenock
01/08/91 – 31/01/94: Registrar in General Medicine
Royal Alexandra Hospital, Paisley
01/02/94 – 30/09/94: Registrar in Resource Management (part time)
Law Hospital NHS Trust, Carluke
01/02/94 – 30/09/94: Registrar in Occupational Health (part time)
Glasgow Occupational Health, Stobhill NHS Trust, Glasgow
01/10/94 – 31/01/00: Registrar in Public Health Medicine
West of Scotland Specialty Training, Greater Glasgow Health Board
2000-2004: Senior Manager North Glasgow Trust
2004-2007: Senior Medical Advisor National Services Division in Edinburgh
2007-2012: Senior Medical Advisor, Scottish Government

2012-current: I am currently the Medical Director of NHS GGC. This includes: developing GGC clinical strategy; ensuring patient safety and driving forward quality improvement; financial, staff and professional governance; and ensuring that there is a robust clinical governance system in place.

NHS Greater Glasgow and Clyde is the largest healthcare system in the UK with an annual revenue budget of £4.4 billion, employing around 41,000 staff. The board serves a population of around 1.15 million (24% of the Scottish population). We have 35 hospitals of differing types providing a comprehensive range of Acute Hospital, Maternity, Mental Health and Community Care facilities. We work with our six Health and Social Care Partnerships covering Glasgow City, Renfrewshire, East Renfrewshire, Inverclyde, East Dunbartonshire and West Dunbartonshire.

We deliver local services to a population of over 1.2 million and a wider regional population of 2.2 million and a national population to the whole of Scotland when our regional and national clinical services are included.

My current responsibilities are described below.

- I am an Executive Director and member of the NHSGGC Board and I am a member of the Corporate Management Team. I am responsible for providing professional advice to the Board and leadership to medical professionals, across NHSGGC.

- I am the Responsible Officer for the GMC in NHSGGC and provide recommendations to support the revalidation of around 4,000 doctors with a connection to the Board. It is my responsibility to ensure that all career and other grade doctors in NHSGGC are appraised annually and through this demonstrate their fitness to practice. I will put forward a recommendation for revalidation for over 700 doctors per year to the GMC.

- I provide professional leadership to medical, dental and pharmacy staff to ensure they are effectively developed, organised, integrated, and managed. I also link with senior staff across NHSGGC on matters relating to conduct, capability and ill health for medical staff and link with regulatory and advisory bodies, including the General Medical Council (GMC), Royal Colleges and NHS Education for Scotland. I ensure there is application of national policy and guidance relating to doctors, including Good Medical Practice, and other professional bodies such as Medical Royal Colleges.

- I work with the Director of Medical Education to ensure the delivery of high-quality medical education in partnership with Glasgow University Medical School, NHS Education Scotland, and the General Medical Council. NHS GGC employs around 2,000 doctors in training every year and support the education of over 800 medical students. I also work closely with the chief of dentistry in relation to undergraduate and post graduate training of dentists.

  I am the lead director for Research and Innovation in the Board and I work with the Director of Research and Innovation to deliver a range of research and innovation activity in both commercial and non-commercial environments and ensure that there is a robust research governance system in place. This includes delivery of 1040 current studies, 394 (38%) commercial; 126 (12%) sponsored and 458 (44%) eligibly funded. The West of Scotland Innovation team manage £43 million of active projects as of 23/24.

I am the lead director for the Board's approach to Prescribing Quality and Efficiency through working with the Director of Pharmacy and the sponsorship of the Area Drugs & Therapeutics Committee together with the application strong governance to support prescribing at all levels. This includes systems to coordinate over 24 million prescriptions per year, ensuring both clinical quality and efficiency for the budget of over £800m per annum, implementation of HEPMA and the strategic transformation and redesign of service and pharmacy workforce to support MFT clinical model and organisational operational priorities.

- I am the Lead director for the Corporate Planning Team (from 2017) and provide executive leadership for strategic planning for the Board, ensuring the delivery of key programmes of work including the Moving Forward Together (MFT) Implementation Strategy, Annual Delivery Plan and Clinical Infrastructure Strategy. This means that I work with the director of planning to set out both 1 and 3 years plans for the whole of NHS GGC and ensure monitoring of delivery of the plans.

- I lead the development of the clinical vision for NHS GGC setting out how services will develop and transform over the next 10-20 years across all clinical services as well as developing person centred preventative services and care closer to home. I work closely with the Director of Digital Health to drive forward the development of the digital NHS. I also chair the MFT programme board with responsibility for the implementation of large programmes of work e.g. Major Trauma, thrombectomy and stroke services, Primary Care and Mental health strategy.

- I work in partnership to improve unscheduled care pathways across the system including primary, secondary, and social care and I lead the development of the annual board's winter plan. This includes the implementation of the flow navigation centre virtual services, the development of the mental health assessment unit and the delivery of new digital ways of working.

- I contribute to the Board and Directorate's Sustainability and Value Programmes and lead on specific programmes of workstreams to support cross system financial efficiency and savings.

- I am the lead director for clinical governance, working with the Director of Clinical governance to support clear cross system governance processes to support high quality of care; this includes developing system wide national or local policies to support effective clinical governance, commissioning reports and investigations and providing regular updates and reports to various board. I also work in partnership with the Director of Nursing to ensure that there is a system of corporate accountability and assurance is effective in the provision of high-quality patient centred care.

- I was the Health Associated Infection (HAI) Executive Lead for the Board from April 2012 to January 2020 providing leadership to develop appropriate strategies to reduce levels of infection, promote continuous improvement and report to Board committees on our performance in this area.

- Externally, I link with a whole range of organisations including Scottish Government, Scottish Association of Medical Directors, national and regional NHS groups, University sectors, post graduate deans and NES, local and national staff side organisations, professional regulators, local authorities, voluntary and independent sectors, MSP/MPs and media organisations.

- I take part in an on-call rota (1 week in every 12) as well as direct access for urgent advice. I was the NHS Gold Commander during the Glasgow Commonwealth games in August 2014 and I have led the NHS response to Major incidents (for example Glasgow helicopter crash: Clutha Incident).

- I have had media training with experience in all forms of media interviews from written press to BBC/TV interviews on camera.

- I lead the Board Medical Directorate which consists of medical education, pharmacy, the clinical governance support unit, planning and research and innovation. The BMD has a budget of £51 million and staffing of 1.239 WTE. The organogram below sets out the organisational structure and key programmes of work.

Appendix 1- Structure Diagram – Board Medical Direct

Board Medical Directorate Management Structure and Professional Reporting Lines