Scottish Hospitals Inquiry
Witness Statement of
Jennifer Haynes

Introduction

1. My name is Jennifer Lynne Haynes. I am currently employed by NHS Golden Jubilee University National Hospital as Service Manager for Theatres and Decontamination. I was previously employed by NHS Greater Glasgow and Clyde ('NHS GGC').

2. I joined NHS GGC in 2007 and left in 2022. During my time I held a number of different posts:
   - 2007 to 2008 – Administration Assistant for Paediatric Managed Clinical Networks (Yorkhill Hospital);
   - 2008 to 2010 – National Graduate Management Trainee – employed by NHS National Services Scotland, but placed in NHS GGC;
   - 2010 to 2012 – Operational Support Manager for Neurosciences (Institute of Neurosciences, Southern General Hospital);
   - 2013 to 2014 – Business Manager for Chief Executive Office (JB Russell House, Gartnavel Royal Hospital);
   - 2014 to 2016 – Clinical Service Manager for Care of the Elderly and Stroke – (Gartnavel General Hospital);
   - 2016 to 2022 – Board Complaints Manager, which then transitioned into Corporate Services Manager (JB Russell House, Gartnavel Royal Hospital).

3. I left NHS GGC in February 2022 to take up my current role as Service Manager for Theatres and Decontamination at NHS Golden Jubilee Hospital.

4. I have an M.A. Honours Degree in Public Policy from the University of Glasgow and an MSc in Health and Public Leadership from the University of Birmingham.

5. The Scottish Hospitals Inquiry (the 'Inquiry') has asked me to provide a written statement in preparation for the Glasgow III hearings commencing later this year in relation to my experiences during my time at NHS GGC.

6. This statement seeks to provide that information to the best of my recollection.

NHS GGC Role

7. When I was Corporate Services Manager for Complaints from March 2016 until February 2022, my responsibility was for the strategic direction, leadership and specialist expertise in the management of complaints and monitoring of performance of complaints across the whole of NHS GGC. I was also operationally responsible for the management of the Board's complaint function, and therefore required to take senior decisions on a wide variety of complaints related issues.

8. Duty of Candour legislation was not part of my direct responsibility in any posts I held in NHS GGC, however, I do have a working knowledge of it, because of the type of work that I undertook. My understanding is that Duty of Candour means that if an adverse event happens to a patient, the organisation is required to be honest and transparent about what happened, by explaining to the patient what went wrong. The organisation should also apologise to the patient for any such incidents, and communicate effectively with them about any investigations, learning and actions.

9. I have been asked if I am aware of the duty of candour held by clinical staff towards their patients, separate to that of NHS GGC as an organisation. I am aware that there is a professional duty of candour for clinical staff towards their patients, which means clinicians should always be open and honest with patients when something has gone wrong with their care or treatment. I realise this is different to legislative Duty of Candour, which organisations require to adhere to. I am not an expert on Duty of Candour, so my knowledge of it is not detailed.

Whistleblowing Process

10. As part of my role as Corporate Service Manager for Complaints, I took over responsibility for the whistleblowing function for NHS GGC in early 2018 up until I left NHS GGC in 2022. Similar to complaints, I was responsible for the strategic direction, leadership and specialist expertise in the management of whistleblowing and monitoring of performance across the whole of NHSGGC. I was also operationally responsible for the management of the Board's whistleblowing function.

11. There was an NHS GGC whistleblowing policy in place and at that time, which was an internal, local policy. Sometime later, National Whistleblowing Standards were published, which all Boards in Scotland have to adhere to. I think this was in 2021.

12. The NHS GGC whistleblowing policy at that time consisted of:

- Stage 1 – local investigation, undertaken by line manager
- Stage 2 – more formal investigation, undertaken by a nominated Director, from a different service and with support from the NHSGGC whistleblowing function
- Stage 3 – formal investigation undertaken by a Non-Executive Board Member

13. Whistleblowers received the findings via a formal report, however, this was not possible if concerns were raised anonymously.

14. I attended a number of meetings related to whistleblowing, including meetings with whistle-blowers themselves, meetings with witnesses as part of an investigation, and meetings with investigators (nominated Directors). I also went to operational meetings regarding whistleblowing – for example, to give updates on performance, as well as national meetings regarding whistleblowing.

15. I was asked by the Inquiry if I attended ant IMT's, which I did not. IMTs are not part of whistleblowing processes.

16. In 2018, a new whistleblowing concern was raised by Dr Penelope Redding, Consultant Microbiologist, regarding ventilation in the QEUH and RHC. Dr Redding made a further whistleblowing concern after she retired. I also had some contact with Dr Christine Peters, Consultant Microbiologist, as part of whistleblowing processes, but I cannot recall the detail of that.

17. An anonymous whistleblowing concern was also submitted regarding the Initial Assessment Team (IAT) who were considering the issues in the QEUH / RHC.

18. In relation to the specific whistleblowing cases detailed above:

- Dr Redding's Stage 2 whistleblowing was investigated by Linda de Caestecker. Dr Redding asked on 21 November 2019 to progress her whistleblowing process to Stage 3, which was investigated by Ian Ritchie, supported by William Edwards. After the Stage 3 level investigation was completed and Dr Redding received the final report, she asked for a number of changes, but was advised in a detailed response why that was not possible. This was because the final report was the outcome reached by the investigators. I was Dr Redding's main point of contact for whistleblowing.

- For the anonymous whistleblowing concern raised in August 2019, this was investigated by Linda de Caestecker, supported by Barbara Anne Nelson, who was an HR Director in another Health Board at the time. This was to help give assurance of impartiality. I was involved in that case the same as I was for all other cases, in that I worked with the Directors, attended interviews and wrote the draft final report.

19. My responsibility for the whistleblowing function in NHS GGC included ensuring that all concerns were investigated via the policy, supporting whistleblowers, witnesses and investigating Directors, reporting on whistleblowing performance and representing NHS GGC at national whistleblowing meetings. On a day-to-day basis, this involved being the point of contact for all those who had raised whistleblowing concerns, supporting them, linking with departments / individuals

who had been named in whistleblowing concerns, attending interviews, reviewing evidence and writing final whistleblowing case reports.

20. Prior to the introduction of the national whistleblowing standards in 2021, there were no further options available after Stage 3. As described previously, Dr Redding wished for a range of changes to be made to the Stage 3 final report, and the Board Chair and Director of Corporate Governance both wrote to her regarding that at the time.

21. I have been referred to the whistleblow policy **(A38225430 - NHS GGC Whistleblow policy as at 2013 - Bundle 27, Volume 4, page 45)**. It has been stated to me that when Dr Redding made the Stage One Whistleblow in 2017, the policy was out of date. I have been asked given my responsibilities for whistleblowing can I explain why this was the case and who was responsible for reviewing and updating the whistleblow policy. I was not involved in whistleblowing in 2017, so I cannot explain why it was out of date. John Hamilton, the previous Head of Administration, was responsible for whistleblowing at that time. He retired in 2018.

22. I have been referred to three documents: **(A38759263 – Email chain between Penelope Redding, Tom Walsh and Jennifer Armstrong – 05 September 2017 to 03 October 2017 – Bundle 14, Volume 1, page 722); (A32452188 – SBAR RE Infection Control and Patient Safety at QEUH – Bundle 14, Volume 1, page 732); (A32353240 - NHS GGC - Infection Control Issues Meeting Minutes dated 4th October 2017 – Bundle 12, page 883); (A38759270 – Action Plan arising in response to SBAR – 3 December 2017 – Bundle 27, Volume 4, page 338).** I have been asked if I recall the Stage One Whistleblow, if I recall what actions were taken and what is my view on the adequacy of the actions taken. I was not involved in this whistleblowing; it took place before I was involved in the whistleblowing process. I was, however, involved in a subsequent Stage 3 whistleblowing which considered the handling of this Stage 1 whistleblowing. There is a detailed report from the Stage 3 whistleblowing which details the findings and outcomes.

23. I have been referred to an email chain: **(A40450652 – Email chain from R. Bajwe to J. Haynes – FW: STEP 2 – Whistleblowing Policy Ventilation at QE and RHC – 08 February 2018 to 13 April 2018 – Bundle 14, Volume 2, page 71).** I have been asked if I recall this whistleblow, what was my involvement and can I recall the outcome. Yes, I was involved in this case. I supported Linda de Caestecker, who led the investigation, by arranging and attending interviews to gain views on the concerns raised, reviewing documents and drafting the report. I cannot recall the outcome, but it will be detailed in the final report.

24. It has been stated to me that Dr Redding's Stage One whistleblow became subject to a Stage Three whistleblow due it not being recorded by NHS GGC as a whistleblow at the time. I have been asked what my view on this, should it have been treated as a whistleblow and can I recall the outcome. My recollection is that this issue was raised in a Stage 3 whistleblowing, along with a range of other issues. From memory, although the original Stage 1 submission was not labelled as a whistleblowing concern, Dr Redding later referred to escalation to Stage 2, which would suggest she considered her original submission a Stage 1. I think the Stage 1 was submitted to Dr Armstrong, the Medical Director, who had not realised that Dr Redding had intended her concerns to be considered under the whistleblowing policy, and therefore did not treat it as such.

25. With the benefit of hindsight, I think it should have been treated as a Stage 1 whistleblowing, or clarity sought if that was the intention, but I do not believe there was any ill intent in not doing so; my impression was that Dr Armstrong simply did not realise that was Dr Redding's intention. Dr Armstrong did take the concerns seriously, by convening a meeting, from which an action plan was produced and worked through.

26. From memory, I think the outcome of the Stage 3 whistleblowing, which will be detailed in the final report, was similar to what I have described above.

Communications with Patients and Families

27. I cannot recall when and how I became aware of the issues at QEUH. It was an issue that began to emerge over time, but I cannot pinpoint an exact time when I became aware.

28. I was the point of contact for all families with queries related to the QEUH/RHC issues. I think I was asked to assist with this work due to my role (and therefore skill set) with complaints, and my position within the organisation in Corporate Services, reporting to Elaine Vanhegan. For all families that required a written response to questions, I would liaise with the relevant colleagues to find out the information and draft the response letters. These would be reviewed and signed by a senior colleague, usually the Chief Executive Officer, Chief Operating Officer or Deputy Medical Director. I kept a log of all communication, and the stage we were at with it, to ensure that it was all documented, and that all enquiries received a response. This was shared regularly with colleagues such as Jonathan Best (Chief Operating Officer) and Scott Davidson (Deputy Medical Director), to ensure there was awareness and updates to senior officers.

29. My role was to be the main point of contact into NHS GGC for affected families, so they had a route into the organisation, and a named person they could go to. A large part of the role was therefore email and telephone correspondence with families, as well as investigating individual concerns and preparing response letters, liaising with the Scottish Government, and assisting with draft communications that went out to all families. There was no job description or defined role, as it was something that developed over time, and was responsive to what was required. *I did not have a role in liaising with the media.*

30. Although there was no job description or written expectations of what I would cover with this work, I very much saw my role as supporting patients / families and advocating for them. For example, investigating and getting answers to questions they had for NHS GGC was one of the biggest parts of my role, and I took my responsibility to review the information and use it to draft thorough,

honest, clear and kind response letters very seriously. Similarly, whenever I was emailing patients / families, or speaking to them on the phone, I tried very hard to ensure that I was empathetic, approachable, kind and supportive in my contact. I was always hugely conscious of how upset and worried families were, and wanted to do whatever I could to help them.

31. I did have a role with the case note review, but due to the passage of time, I cannot recall what that was.

32. Also due to the amount of time that has passed since I was involved with this work, I cannot remember details and specifics for all of the work. I do, however, recall there were concerns about approach and wording. For example, I was aware that the Scottish Government put pressure on NHS GGC to send a specific communication out to all families potentially affected by what was being reported. I cannot recall the details, but I do remember thinking that the approach was wrong, and that families (some of whom had lost children) would receive a letter out of the blue. I was worried this was insensitive, and another approach, or choice of wording, would be better. I believe NHS GGC did raise concerns about this. My name was on the letters as the contact point, and afterwards, a bereaved mother phoned me, absolutely devastated to have received the letter. She was crying and described the distress it had caused her. I remember being really upset that we had caused that distress, and it had been avoidable if a different approach had been taken.

33. In my view, it is absolutely right that public bodies, especially Health Boards, are held accountable. For this particular situation, that is even more important, given the ramifications. Working in the NHS GGC Board Headquarters and doing the type of role that I was doing, I was acutely aware of the pressure that was being put on the NHS GGC senior leadership team by the Scottish Government. I was sometimes thoughtful of whether the interactions were conducive to an effective working relationship and getting answers to the extremely important questions.

34. From a personal perspective, I found this a particularly hard chapter of my career. The subject matter was hugely emotive, and my heart went out to the patients

and families involved whom I was in regular communication with. I cannot begin to imagine how distressing it must be to have a child diagnosed with cancer, and all that happened in the QE/RHC brought even more worry to them, at an already incredibly difficult time. This was coupled with a significant amount of media stories, which seemed often to add fuel the fire, and cause more distress.

35. I have been asked my view on why patients and their families were not satisfied with the communications approach/strategy. My view was that there was a perception of NHS GGC not being open and honest with families, and that NHS GGC were covering up the truth. I recall a number of media stories at the time being negative about the NHS GGC senior leadership team. I think this must have influenced families' perceptions, and some individuals came across to me in their communications as wary, suspicious and untrusting of NHS GGC managers.

36. There were also times where it took a while to respond to concerns, whilst an investigation was underway into the issues patients and families had raised, and the various checks and approvals were taking place on draft responses, including with the Scottish Government. This sometimes meant delays in responding to families, which I think may have added to poor perception, as it may have been seen as NHS GGC taking time to try to 'cover up' the truth.

37. At the time, NHS GGC was also on special measures with the Scottish Government, which was widely publicised in the media, and I think this also added to the perception that the NHS GGC senior leadership team was dishonest.

38. I was not a senior manager in NHS GGC (in comparison to the Directors I was working with), but I have a strong moral compass, and work in the NHS because I want to make services better for patients. I would never have told patients untruths or been anything other than open, honest and kind. I recall at the time a friend telling me she was scared to take her baby to the RHC, because of all the issues being reported in the media. It made me really sad and worried that

because of media stories, the perception the public had of NHS GGC was that the QEUH and RHC were unsafe for patients. I therefore could understand why families involved in the issues had the perception they did, and I had a huge amount of empathy for them, considering how ill their children were.

39. I have been asked my view on whether patients and families were sufficiently informed and involved in respect of the issues within the QEUH and how these had/would have an impact on them. I think that every effort was made to try and do the right thing and keep patients/families informed and involved in a clear, timely, honest and transparent way. I am sure with the benefit of hindsight some things could have been done differently, but I think that the intent was right and that those involved did their best.

40. I have been asked my view on whether the approach taken by NHS GGC when communicating with patients and their families was adequate. I think NHS GGC did their best to communicate well with families. The circumstances were very difficult, due to NHS GGC's primary concern for patients/families, against a backdrop of regular negative media stories, input from the Scottish Government, staff concerns and a myriad of other factors and complexities. My impression was that the senior leadership team in NHS GGC were under a huge amount of pressure, but that they did want to do the right thing by patients / families.

41. I have been referred to the following document: **(A34259839 – List of issues raised by the families of children treated on the haemato-oncology wards at Queen Elizabeth University Hospital and Royal Hospital for Children with the Cabinet Secretary for Health and Sport, and responses by NHS GGC published 30 October 2019 – Bundle 6 (Hearing Commencing 12 June 2023), page 77).** I have been asked what is this document and what was my role in preparing this document. This is an information sheet, that was sent out to all affected patients/ families. I cannot recall the detail now, but I think I was involved in drafting and finessing it, then sending it out to all the affected patients / families. This would have been done in conjunction with numerous colleagues, and possibly with Scottish Government input too, from Professor Craig White.

42. It has been stated to me in respect of the same document that I am the noted as the point of contact for families in respect of questions relating to their child's care and treatment. I been asked how I became involved in this process and why I was allocated this role. I have been asked whether I recall receiving questions from parents or carers as a result of this document and whether this document was helpful in alleviating concerns. I became involved in this work organically; my direct line manager was Elaine Vanhegan, I worked in the Board Headquarters and with the senior leadership team for NHS GGC on a daily basis. I also had a skill set in investigations and writing letters to patients / families / staff, due to leading on Complaints and Whistleblowing for the Health Board. I do not recall a specific occasion where I was formally asked to become involved or told that my job remit would change. At the time, I was aware of a huge amount of pressure and concern within the Board Headquarters, and it was an 'all hands on deck' type of situation.

43. I do not know if the document was helpful in alleviating concerns, but I certainly hope that it was. I cannot recall if this document specifically instigated further contact from families.

Declaration

44. I believe that the facts stated in this witness statement are true to the best of my knowledge, information, and belief. I understand that this statement may form part of the evidence before the Inquiry and be published on the Inquiry's website.

Appendix A

A43293438 - Bundle 6 - Miscellaneous Documents

A47069198 - Bundle 12 - Estates Communications

A49525252 - Bundle 14, Volume 1 - Further Communications

A49541141 - Bundle 14, Volume 2 - Further Communications

A49799834 - Bundle 27, Volume 4 - Miscellaneous Documents