Scottish Hospitals Inquiry
Witness Statement of Questions and Responses
Dr Linda de Caestecker

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. Full name
A. Linda de Caestecker

2. Occupation
A. Doctor (retired)

3. Qualification(s)
A. MBChB, MRCOG, FFPH, D.Univ

Professional Background

4. Professional role(s) and experience
A. I was the Director of Public Health at NHS Greater Glasgow and Clyde from 2006 until March 2022

5. Professional role(s) and experience within NHS
A. I qualified in medicine in 1979 from the University of Glasgow and I was a junior doctor in Obstetrics and Gynaecology in Glasgow, Edinburgh and Leicester and a specialist in Obstetrics and Gynaecology in Ghana until 1987. I then trained in public health in London and Glasgow and was appointed as a consultant in public health at Greater Glasgow Health Board (GGHB) in 1993. I was seconded to the Scottish Executive in 2003 as Head of the Women and

Children's Unit. I returned to GGHB as interim Director of Public Health (DPH) in 2005 and was appointed to the substantive post in NHS Greater Glasgow and Clyde (NHSGGC) in 2006. I remained in that post until I retired in 2022 apart from a year's leave of absence in 2015-2016 to work as Director of Projects at the International Federation of Gynecology and Obstetrics.

6. Professional role(s) and experience within GGC

A. Consultant in Public Health 1993-2003; interim DPH 2005-06, DPH 2006-2022

7. Professional role(s) and experience within QEUH/RHC

A. None directly but I provided public health leadership and support to all services in GGC. This mainly related to prevention, equality and improvement in health.

8. Area(s) of the hospital/GGC in which you worked

A. Apart from as a junior doctor in 1979 – 1981, I have always worked in the corporate HQ team and not in individual hospitals.

9. Role and responsibilities within the above area(s)

A. I led the public activities of the Board. I managed the Public Health team which included sections in health services, health protection and health improvement. I undertook strategic planning for public health and led the Board's emergency planning response. I did not have responsibility for infection control which was led by the Medical Director and then the Director of Nursing.

10. If you had more than one role, how was it split?

A. I only had the one role of Director of Public Health (DPH).

11. How many hours per week did you spend in your role at GGC?

A. Full-time of 10 sessions per week

12. Who did you report to?

A. The Chief Executive (CEO) of NHS GGC

13. Who reported to you?

A. Heads of services for the 3 domains of public health, i.e. Health Services, Health Protection and Health Improvement.

14. Describe an average working day in your role.

A. I provided leadership to improving health and addressing health inequalities for the Board. I led a team of over 80 staff through the section heads providing health improvement services, health services planning and evaluation and health protection including the pandemic response and vaccination coordination, management of outbreaks in the community, development of strategy on blood-borne viruses and emergency planning. I led the planning and implementation for specific public health topics including the physical activity strategy, implementation of healthy weight interventions, tobacco control, anticipatory care, parenting initiatives and staff health. I advised on performance management of health improvement and organisational development to support the organisation's corporate effort in addressing health inequalities. I also contributed to national public health policy through the national group of Scottish Directors of Public Health and membership of national groups on child health and child poverty. In public health it is difficult to describe an average day as they are so varied. Regular commitments included team meetings, the corporate management team meetings (CMT), national meetings with DPH colleagues and preparing public health reports for the CMT and for the Board. I produced a biennial report on the health of the GGC population (except during the pandemic years) and I would edit others' contributions as well as produce my own chapters. I was frequently asked to present to conferences or groups on public health topics.

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

A. My direct reports, the heads of service described above, the Chief Officers of Health and Social Care Partnerships (HSCPs), the Corporate Directors of NHSGGC, the Head of Emergency Planning.

Issues of Concern – QEUH/RHC

16. When did you first become aware of concerns in respect of the built environment of the QEUH/RHC?

A. I was made aware of the concerns in 2018 through my role in whistleblowing. I was one of the non-clinical Board Directors who would hear and investigate Stage 2 whistleblowing concerns. Prior to this I was aware of some concerns as a Board Director via our informal Directors' weekly meeting but did not know the details or the specificity of any concerns until I was involved in the whistleblowing Stage 2 investigation.

a) What were these concerns?

A. The concerns raised at Stage 2 whistleblowing were a) the standard rooms at the QEUH and RHC should have 6 air changes per hour (ACH/hr) and the rooms did not meet this standard with 3 ACH/hr.; b) Positively Pressurised Ventilated Lobby (PPVL) rooms were not suitable for the isolation of patients with air borne infections (c) there were not sufficient rooms for the isolation of immunocompromised / Bone Marrow Transplant (BMT) patients at RHC. d) there were concerns about the current management of immunocompromised adult patients e) there was a query on whether issues around ventilation are on the NHSGGC Risk Register.

b) Are you aware of when concerns in respect of the built environment were first raised by colleagues within QEUH/RHC? What were their concerns?

A. I became aware of concerns by reviewing documentation as part of the whistleblowing investigation at a later date but I did not have any direct involvement at the time. Dr Redding had raised some concerns during the commissioning process in 2009. These concerns were about negative pressure rooms which she thought should be available on every floor of the new hospital. In 2015 Dr Peters raised concerns about air quality in the BMT unit resulting in a move of patients from the unit. This process has been described in information previously sent to the inquiry.

c) Were GGC aware of these concerns? If not, when did they become aware of these concerns? What actions were taken?

A. It is not clear what is meant by “GGC”. If it means the Board of GGC, I am not sure when the Board was made aware of these concerns. The Lead Infection Control Doctor (ICD) and the team leading the new build were aware of the initial concerns in 2009 when Dr Redding raised them in her advice on the new build. In relation to the concerns raised at the whistleblowing in 2018, the Infection Control Manager, the lead ICD, the Director of Estates and Facilities and the Medical Director who led on Infection Control were aware of the concerns.

d) Do you consider these issues to be fully resolved? If so, please provide details including actions and dates.

A. Within the Stage 2 Whistleblowing investigation, I was reassured that the concerns that Dr Redding and Dr Peters raised in their whistleblowing complaints had been taken very seriously by the appropriate directors and remedial actions were put in place to resolve the concerns. From reviewing documentation, I am aware that the Action Plan to address the issues was signed off as being complete by the Clinical and Care Governance Committee in June 2021 except for one action which was considered technically impossible and was not part of whistleblowing concerns. As my role was to investigate whistleblowing complaints and not to lead on infection prevention and control, I am unable to give precise updates of the actions with dates.

17. When did you first become aware of concerns in respect of infection control in the QEUH/RHC?

During the stage 2 whistleblowing investigation in 2018.

a) What were these concerns?

A. The concerns raised at Stage 2 whistleblowing were a) the standard rooms at the QEUH and RHC should have 6 air changes per hour ACH/hr and the rooms did not meet this standard with 3 ACH/hr. b) Positively Pressurised Ventilated Lobby (PPVL) rooms were not suitable for the isolation of patients with air borne infections: c) there were not sufficient rooms for the isolation of immunocompromised / Bone Marrow Transplant (BMT) patients at RHC. d)

there were concerns about the current management of immunocompromised adult patients; e) there was a query on whether issues around ventilation are on the NHSGGC Risk Register.

b) Are you aware of when concerns in respect of infection control were first raised by colleagues within QEUH/RHC? What were their concerns?

A. In 2009 Dr Penelope Redding made recommendations about having negative pressure rooms in every floor in the new hospital to the project team. Her recommendations were discussed and later rejected by the new build team following minuted meetings with clinicians.

c) Were GGC aware of these concerns? If not, when did they become aware of these concerns? What actions were taken?

A. I am unsure who is meant by GGC. In relation to the concerns raised at the whistleblowing in 2018, the Infection Control Manager, the lead ICD, the Director of Estates and Facilities and the Medical Director who led on Infection Control were aware of the concerns.

d) Do you consider these issues to be fully resolved? If so, please provide details including actions and dates.

A. The issues that Dr Redding and Dr Peters raised in the Stage 2 whistleblowing were investigated and I identified that the issues had already been raised with appropriate Directors and that actions had already been identified to address them. Progress on the 27 Point Action Plan that was developed to address each of the issues was presented to the Board Infection Control Committee; the Clinical and Care Governance Committee; Acute Infection Control Committee; Board Clinical Governance Forum; and Partnership Infection Control Support Group. I am aware that the Action Plan was signed off as being complete by the Clinical and Care Governance Committee in June 2021 except for one action which was considered technically impossible and was not part of whistleblowing concerns.

Role of Infection Control Doctor (ICD)

18. What is an ICD?

A. An Infection Control Doctor is involved in preventing and managing healthcare-associated infections (HAIs) within healthcare settings. The job includes developing and implementing infection control policies, developing and implementing surveillance systems, involvement in management of infections and outbreaks and advice to clinicians.

19. What is your understanding of the role of an ICD?

A. I did not manage or work closely with the ICDs but I understood their role as part of my investigation of the whistleblowing concerns and involvement of my health protection team in Incident Management Teams. The role of an ICD is to provide advice and support to clinicians and 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, monitor infection rates, support compliance with national targets and national standards and guidance, assist the lead ICD in reviewing and updating IPC policies, attending various groups and committees overseeing IPC, escalate concerns to the lead ICD and contribute teaching, training and audit. The role of the lead ICD is to act as the lead medical clinician for Infection Control within NHSGGC, provide leadership to medical staff within Infection Control on clinical issues, act as a key member of the Senior Infection Control Team, support the Infection Control Manager (ICM), work closely with the ICM and the other members of the Senior Infection Control Team to develop the service and implement change, co-ordinate the available Infection Control Doctor sessions across NHSGGC.

20. Is an ICD a full-time role?

A. No. An ICD has dedicated sessions in their job plan for the role. The lead ICD has additional clinical sessions in their job plan for the leadership role but it is not a full-time role.

21. What is an Infection Prevention and Control Team (IPCT)?

A. I did not manage the IPCT and was not directly involved with the team other than asking for advice on public health issues. The IPCT is a multi-disciplinary team that operates across all the sites in the Board area. The team develops and implements infection control policies and plans, reviews positive microbiology results and advises ward staff on the implications of those results. The team also supports the management of outbreaks of infection. The team develops and delivers training and supports staff to prevent and control infection. They will also advise estates and clinical staff on cleaning, decontamination and design of the environment. In summary their role is patient management, surveillance, outbreak management, advice on the built environment, audit, development and implementation of local and national policy and standard operating procedures, education and training, advice on decontamination, and governance and reporting.

22. Where does an ICD fit within the IPCT structure?

A. I did not manage the IPCT or the ICDs and I was not directly involved with them other than for public health issues. I understood that an ICD is part of the IPCT which in NHS GGC is led by the Infection Control Manager (now the Director of Infection Prevention and Control) who is a senior experienced nurse with a full time role. The lead ICD reports to the IPC Manager (now Director of IPC) and manages the ICDs. There is joint reporting of the ICDs to the head of service for microbiology as they still have roles in that service.

23. What was the IPCT structure at the QEUH/RHC from 2015 onwards?

A. I was not directly involved in the management and operation of the IPCT. The Infection Prevention and Control Manager reported to the Medical Director who was the Board lead for IPC. The manager managed the other roles in the team including the Lead ICD and the Associate Director of Nursing for Infection Control who in turn managed the lead IPC nurses for each hospital site in the Board. There are IPCTs based on all main sites in NHSGGC and each team has the responsibility for a geographical area. A separate IPCT provides a service to mental health Inpatient areas and Health and Social Care Partnerships. Each team comprises an Infection Control Doctor and Infection Prevention and Control Nurses. A separate surveillance

team (nurses and data managers) lead on the monitoring and prevention of surgical site infections and the monitoring of all Healthcare Associated Infections referred to or identified by the IPCT. The teams were coordinated by the Infection Control Manger and direct reports, which include the Lead Infection Control Doctor and the Associate Nurse Director for IPC.

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

A. There was a clear job description for the lead ICD. The role was to act as the Lead Doctor For Infection Control within NHSGGC, provide leadership to medical staff within Infection Control on clinical issues, act as a key member of the Senior Infection Control Team, support the Infection Control Manager, work closely with the Infection Control Manager and the other members of the Senior Infection Control Team to develop the service and implement change and to co-ordinate the available Infection Control Doctor sessions across NHSGGC. For the ICDs, the role was within their duties as microbiologists and included in their job plans. Their role was to advise on and support activities of infection prevention and control in the hospital sites for which they had responsibility.

25. Both Dr Inkster and Dr Peters has told the Inquiry they sought clarification on their remit as ICD on several occasions but were unsuccessful in obtaining this. What is your view on this?

A. I was not directly involved in managing these staff but my view from reading emails and interviewing staff as part of the whistleblowing processes is that their query about their roles related to management and leadership. However they did not discuss this issue directly with me. My impression from emails and interviews was that they did not agree that the IPCT should be nurse led and they felt that the medical staff should be the leads, whereas the strength of the IPCT is the multi-disciplinary team working. A range of actions was put in place over years to assist the team-working and clarification of roles within the IPCT. In 2015, the ICM Tom Walsh met with Dr Peters at her request to discuss her role. There are no notes of this discussion that included the lead ICD Craig Williams. Tom Walsh recalls that Dr Peters asked for clarity on her remit in relation to the new hospital and Dr Williams confirmed that, at that

time, others were leading on this and she should focus on her ICD support to the existing Southern General Hospital site. In 2015 following David Stewart's report, Anne Cruikshank was appointed as an overarching CD for IPC and microbiology as part of the process to improve joint working. In 2016 the IC manager Tom Walsh worked with the Director of Facilities, David Loudon, to produce a document on the role of the IPCT on new builds and refurbishments. In 2017 there was a review of the ICD role by Tom Walsh, the ICM, informed by a review of ICD roles in Scotland by Dr Keith Morris of NHS Fife, in 2017. This review aimed to clarify the reporting and management arrangements in IPC and in microbiology. The Chief of Medicine in Diagnostics, Dr Rachel Green was asked to clarify the job descriptions and the roles of the IPCT and she organised a meeting in December 2017 which Dr Peters reported had been a helpful meeting. The meeting identified that other ICDs were content with the structure of the IPCT and ways of working and it was found that the uncertainty of roles was only felt in the south sector (QEUH/RHC). Rachel Green proposed a deputy lead ICD and also asked that Dr Christine Peters and Dr Brian Jones meet with Dr Inkster on her return from sick leave to discuss this. In February 2018, Dr Green organised a programme of Organisational Development to help the microbiology and IPC teams work more constructively together. When Dr Inkster returned from sick leave in January 2018 she resigned from her role as lead ICD, citing a number of issues including that she would now report to the Head of Microbiology. This arrangement had been proposed to clarify that the lead ICD still had sessions in microbiology. Dr Inkster was also not happy to be managed by Sandra Devine, the Infection Control Manager. However Dr Armstrong persuaded Dr Inkster to continue in her lead ICD role. Both Marion Bain and Angela Wallace, when they were interim Director of Infection Control from 2019 onwards, put in place regular meetings with Dr Peters and Dr Inkster in part to improve the working with the IPCT.

26. The Inquiry understands there were several resignations from the role of ICD from 2015 onwards. What, in your opinion, caused these resignations?

A. I cannot be sure what caused these resignations but in investigating the whistleblowing complaints, I became aware of tensions between some ICDs

and the rest of the IPCT as well as with the (then) lead ICD Craig Williams. When both Christine Peters and Teresa Inkster resigned in 2015, they complained about the lead ICD, Craig Williams, in particular about his management style and the culture that he had created. They also complained about the lack of clarity about their ICD role. In September 2017, the ICDs in the south sector resigned complaining that Brian Jones the Head of Microbiology had dealt with an upgrade to the Bone Marrow Transplant unit without reference to Dr Peters. In my investigations into the whistleblowing complaints, it was reported by members of the IPCT that they felt that this step of multiple resignations was taken to destabilise/undermine the IPC service. At this challenging and difficult time for the IPCT, four of the senior nurses in the IPCT approached the Royal College of Nursing to complain that they were being emailed frequently with queries and complaints by Dr Peters and they felt that this was an active campaign to undermine the entire team. The RCN was reassured by Dr Armstrong that this would be dealt with so they did not raise a formal grievance. Members of the IPCT and also Dr Jones, the lead for microbiology, reported that they received frequent emails from Dr Peters about matters relating to IPC even when she was no longer an ICD. Dr Armstrong asked Dr Green to work with Dr Peters and address this issue. In January 2018 Dr Inkster resigned as lead ICD in 2018 as she disagreed with her management arrangements. She then took up the role again.

David Stewart undertook a review into the resignation of ICDs

27. Refer to Summary of Infection Control Issues details (**A47739010– Bundle 14 Volume 1, Document 41, page 464**):

a) Have you seen this report before?

A. Yes

b) Who instructed this review?

A. The Medical Director, Jennifer Armstrong

c) What was the purpose of the review?

A. To try to understand the reasons behind the resignations of the ICDs and to

develop solutions to address any problems

d) Do you know what actions, if any, were informed by the findings of this review?

A. I was not involved in this review but the report which I have read contains remedial actions for each theme identified. These included Dignity at Work Awareness Workshop, mentorship, clarifying roles and responsibilities, development of job descriptions, review of reporting arrangements for lead ICD and ICD, having an escalation route and process for reconciling conflicting advice and opinions, review of operational structures, review of standard operating procedures, OD interventions, team development review of recruitment arrangements and review of out of hours arrangements. The ICM was supported by the Medical Director in implementing the actions from the review. It was agreed that there should be an overarching clinical director appointed for both Infection Control and Microbiology and she was appointed in November 2015. There was also mentorship support for the lead ICD put in place.

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

A. My views are informed by reading the report in retrospect. I was not involved with the team at the time.

a) Cultures and behaviours

A. The review found little evidence to support concerns of ongoing bullying and harassing behaviours. The report stated that events described centred around particular issues of high focus.

b) Leadership style/management skills

A. The report described ongoing tension in the relationship between the Infection Control and Microbiology Leads. Leadership style/management skills were reported as an ongoing theme. ICDs reported concerns around lack of communication and governance arrangements. The report stated that the ICM had put in place actions to address this in the previous 4-6 months.

c) Team functioning/structure

A. The medical management was not clear due to joint roles in the IPCT and in microbiology. The line management arrangements for the lead ICD are complicated by the fact that the role is managerially accountable to the ICM but the job plan is agreed with the CD for microbiology. The report stated that there needed to be more formal joint working between the General Manager for Microbiology and the ICM to address this. The report also stated that there was a need for greater clarity on levels of accountability in the decision-making where there were conflicting views or opinions.

d) Service/patient concerns

A. The report stated that Infection Control did not have the same degree of senior managerial oversight as applies to other acute service directorates. It was stated that current appointment arrangements mean that the ICM has little influence on the appointment and organisation of ICDs.

29. Did David Stewart discuss this report with you? If so, what was discussed?

A. No

30. Do you know who this report was shared with?

A. No

31. Do you know if the issues set out in this report were resolved? If not, why not?

It did not appear that the issues were fully resolved from what was reported to me as part of whistleblowing investigations.

A. I am unable to comment on why they were not resolved.

32. This report focuses on behaviours and cultures within the ICD team rather than focussing on the concerns raised in respect of the building: what is your view on this? Were the issues raised in respect of the building being treated with the appropriate seriousness?

A. The aim of the report was not to investigate issues with the building but to respond to concerns about roles and responsibilities as well as the working of

the IPCT. Given this, it does not comment on the issues raised in respect of the building.

Refer to Bundle 4 – SBAR – Document 33, page 136

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) Do you know what happened as a result of this?

A. I was not directly involved but it was reported to me by the Medical Director that additional sessions were allocated.

b) Do you know if additional ICD sessions were put in place?

A. I understand that the sessions were put in place.

c) Was there an issue with resources within ICD?

A. I am unable to answer this as I did not have management or operational involvement.

34. What do you understand the current and ongoing requirement for expert input and advice into the built the built environment to have been? Please provided details.

A. It is an important role for IPC specialists to advise on the built environment. The importance of a multidisciplinary team in managing and mitigating infection risks in the built environment is described in the CEL 18 (2007). I am unaware of the time commitment or number of sessions this requires.

Whistleblowing and Communication

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

A. Good communication is part of every health professional's responsibilities. Patients require clear information about their health and treatments and they also require empathetic, compassionate communication about their concerns and ongoing management and care. The General Medical Council describes doctors' duties on good communication including how to communicate when things go wrong.

36. 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.

A. The same principles of openness, honesty and compassion would apply in relation to infection as well as other health issues. There are many reasons why infection occurs in a healthcare setting including that it is due to the patient's disease or a risk of the treatment. In other instances such as an outbreak or a breach of an infection control policy, there may be a need to invoke Duty of Candour.

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

A. The GMC describes this in their guidance for doctors. Every health and care professional must be open and honest with patients and people in their care when something goes wrong with their treatment or care that causes, or has the potential to cause, harm or distress. This means that health and care professionals must tell the person (or, where appropriate, their advocate, carer or family) when something has gone wrong, apologise to the person (or, where appropriate, their advocate, carer or family), offer an appropriate remedy or support to put matters right (if possible), explain fully to the person (or, where appropriate, their advocate, carer or family) the short and long term effects of what has happened. Doctors should report the incident in line with their 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. Doctors must respond promptly, fully and honestly to complaints. They must not allow a patient's complaint to adversely affect the care or treatment they provide or arrange.

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

A. Yes. The GMC has produced joint guidance with the NMC on the professional duty of candour with practical advice for individual professionals on when and how to apologise and also about reporting mistakes. I am also aware of the organisational duty of candour as set out in the NHS GGC policy on this. The organisational Duty of Candour procedure is a legal duty to support the implementation of consistent responses across health and social care providers where there has been an unexpected event or incident that has resulted in death or harm, or could result in death or harm, where the outcome relates directly to the incident rather than the natural course of the person's illness or underlying condition. The Board's policy describes the responsibility of all staff to identify and respond when this occurs and also sets out the organisational duties.

39. 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. The Board's whistleblowing policy describes these procedures. A concern would usually be raised with the manager in the first instance, or a more senior manager where this would be more appropriate. If the concern is not resolved at that level then staff can contact one of the designated whistleblowing contacts, who have been given special responsibility and training in dealing with whistleblowing concerns. If the individual is still concerned that the matter is not being dealt with they can contact a designated non-executive director or the Board at Stage 3. This was the policy at the time but the standard policy for Scotland is now that the Independent National Whistleblowing Officer (INWO) is the final stage for whistleblowing concerns about the NHS in Scotland. If an individual remains dissatisfied with an NHS organisation after its process has concluded, they can ask the INWO to look into their concern. For individuals external to GGC there is information on national websites such as NHS Scotland, Public Health Scotland and Citizens Advice Scotland about how to whistleblow and access

advice. The Board's Duty of Candour policy describes the process of identifying and investigating an incident. It states that every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. The policy states that effective communication between staff who recognise an unexpected or unintended incident and their management team is vital in order to ensure that the organisational Duty of Candour process is implemented from the outset.

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

A. They could be accessed via Staffnet or from line managers. The Board's Core Brief which goes to all staff will inform staff of new policies or updates and how to access them. Clinical leads and managers are expected to assess training requirements in Duty of Candour for particular roles. The NES online module on Duty of Candour is added to mandatory training every 3 years for role specific staff. This information is promoted on HR Connect and through the Learning and Education calendars that managers and staff can access. In addition the requirements of the Duty of Candour regulations are embedded in existing relevant policy based programmes for example Root Cause Analysis and People Management programmes.

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

A. The Whistleblowing policy of the time encouraged employees to be open and guaranteed to consider their concerns. The policy was clear that the Board would not tolerate any harassment or victimisation of staff using the policy. The Board recognised its duty to support whistleblowers. When conducting whistleblowing investigations, I made sure that whistleblowers knew that they were supported and should report to me any instances when they felt that this was not the case or if they felt discriminated against or victimised in any way because they were whistleblowers. We would hope that most issues could be resolved by the management team of the service and I always felt disappointed if someone had to whistleblow but I recognised that it is vital that

staff can do this and can be reassured that any concerns will be investigated without any detriment to the whistleblower.

40. Are you familiar with the whistleblowing policy for GGC in 2018?

A. Yes

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

A. It was available on Staffnet and through line managers. There had been staff information about whistleblowing in Core Briefs to all staff. The names and details of directors who led investigations at certain points were out of date but the contact details of the lead for whistleblowing were provided and they could inform staff of how to raise a concern and with whom.

42. How often was the whistleblow policy reviewed? Who was responsible for this?

A. The policy was regularly reviewed with revisions in 2015, 2016, 2017 and 2018. There was a gap from 2019 to 2021 as the new national standards were to be launched which were delayed. The impact of COVID then further delayed the launch which was ultimately on the 1st April 2021. The policy would be reviewed by the corporate services team under the Head of Administration for the Board, working with the Board's Whistleblowing Champion. A member of the Corporate Services team was given a lead role in whistleblowing to support management of the process. The Policy was reviewed and presented to the Audit Committee and the operation of the Policy is monitored by the Area Partnership Forum.

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

A. In general it was effective but the Stage 1 process could have been more effective. It was not always clear when Stage 1 was being or should be invoked. The review in 2021 found that there was a need to increase the use of Stage 1. The current National Whistleblowing Standards promote that cases should be investigated and responded to at Step 1 in the process whenever possible unless there is a specific reason to immediately move to

the Step 2. At the time in NHS GGC, Whistleblowers often sought an immediate Step 2 process. At Stage 2, concerns were taken seriously and fully investigated although the review of 2021 also identified the need for more rigorous performance management of recommendations and more staff training. In my view there was at times confusion on the part of staff about when to use the whistleblowing policy and when to use the Dignity at Work policy.

44. Has the whistleblowing policy since been updated?

A. Yes

45. What updates have been made?

A. The policy is now a national policy based on the national whistleblowing standards and staff can contact the INWO if they feel the Board has not addressed their complaint adequately. It also clarifies when to use the Whistleblowing policy and when to use a Grievance or Dignity at work policy.

46. Do you think the current policy is adequate?

A. It clarifies the process. I am not aware of whether there has been a review of the national policy and whether it is considered to be operating adequately.

Whistleblowing – QEUH/RHC

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

A. I was one of the directors who would investigate stage 2 whistleblowing concerns.

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

A. I was not aware that there had been a formal stage 1 in 2017. When I met with Penelope Redding and Christine Peters in 2018, they did not talk about a stage 1.

Refer to emails between 5th September 2017 and 3rd October 2017
(A38759263 - Bundle 14 Volume 1 – Document 73, page 722)

49. Email chain between Penelope Redding, Tom Walsh and Jennifer Armstrong dated between 5 September 2017 and 3 October 2017:

a) Have you seen these emails before?

A. I saw them when I was asked to write a narrative report on the whistleblowing investigations.

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

A. I was not aware of these concerns as DPH as I did not lead on Infection Control. I am unable to comment on who was aware of these concerns.

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

A. In the emails, she is not very specific about her concerns. She states that there are concerns about ventilation and she also talks about lack of experience amongst the ICDs and that the IPCT should not be a nurse-led service. She says she would like to avoid going to Stage 2 whistleblowing and in retrospect this could be read as a Stage 1. However the outcome would have been similar; that there needed to be clear written description of concerns, a meeting to discuss them and actions put in place to resolve them.

d) It would appear Dr Redding sent emails on 5th, 15th, 21st and 27th September 2017 before receiving a response; are you aware of the circumstances which led to this delay in responding? Do you have any concerns regarding this delay?

A. Tom Walsh was on leave but I understand that Dr Armstrong acknowledged receipt of the emails. I cannot comment on why there was a delay in the fuller response but it is likely she would be waiting for Tom Walsh to return from leave to discuss this issue and also she may have asked for a meeting to be organised with Dr Redding.

e) The Inquiry understands that GGC 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?

A. Her email does not state that this was a Stage 1 whistleblowing complaint. The policy at the time stated that Stage 1 would be to discuss the concerns with the line manager. At that time, there was not a robust process for documenting Stage 1 complaints at Board level. This has now been resolved in the updated policy. In my view the actions taken i.e. meeting to discuss the concerns and to put in place actions to address them, would have been the same even it had been formally set up as a Stage 1 Whistleblowing. However in retrospect it would have been helpful to ask Dr Redding to clarify if this was a Stage 1 complaint.

Refer to SBAR of 3rd October 2017

50. Re Infection Control and Patient Safety at QEUH – Bundle 4, Document 20, page 104:

a) Have you seen this SBAR of 3rd October 2017?

A. I was not aware of it at the time but I reviewed it as part of the whistleblowing investigation.

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

i) Patient Placement

A. I am unable to answer this question as it is not my area of expertise but I was aware that others including the lead ICD of the time Dr Inkster was involved in reviewing this.

ii) Cleaning

A. I am unable to comment on how accurate these assertions are but they merited investigation.

iii) Estates

A. The issues raised about plumbing in the neurosurgical building were already known, some actions had been taken and others were planned.

iv) Infection Control Structure

A. The issues of communication with ICDs needed investigated and resolved. The IPCT reported in the whistleblowing investigations that Dr Peters made frequent email requests for further information that were outwith her role and remit. Responses took time away from their other work and they reported that they felt harassed and undermined. Brian Jones, the lead for microbiology, reported similar multiple communications and reported that he felt harassed by their frequency. The issues therefore were not straightforward and had to be investigated by obtaining views from the team as well as others involved.

v) Recommendations

A. The recommendations are reasonable and fair

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

A. I was not aware of these issues in 2015. My understanding is that the (then) Lead ICD was aware of the issues. I am unable to comment on why they were not addressed but it may have been that the lead ICD at the time did not agree with these issues.

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

A. The concerns were valid ones requiring further investigation.

53. If yes, are you aware of what the response was to these concerns?

A. The Medical Director organised a meeting to discuss the SBAR with relevant Directors and their teams. A 27 point action plan was developed after the meeting in October 2017 to address all of the points raised.

Refer to Minute of Meeting dated 4 October 2017

54. Estates Bundle 12, Document 116

a) Have you seen these minutes before? What is your understanding of the purpose of this meeting? What was discussed?

A. I was not aware of the meeting at the time but I became aware of it and reviewed the minutes as part of the investigation of Whistleblowing concerns. The meeting was to discuss the concerns of Dr Redding and Dr Peters as set out in the SBAR they developed. Each of the issues in the SBAR was discussed and either responded to on accuracy, or actions agreed to investigate them further and actions put in place.

b) There is some discussion surrounding PPVL rooms not being built to SHTM standards and that they did not provide appropriate protection for patients. Do you know if PPVL rooms were built to SHTM standards?

A. I do not have the expertise to answer this question but the minute of the meeting states that the Director of Estates reported that the rooms met 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. Are you aware of the circumstances surrounding the Infectious Disease Unit, as well as the reasons for the delay in HPS providing the details required?

A. I was aware that the inclusion of the Infectious Diseases Unit was a late addition to the QEUH as the clinicians were of the view that it was essential they were co-located with ITU. I am not aware of 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. What is your understanding of the distribution of HEPA filters in both QEUH/RHC? Who was responsible for managing the installation of HEPA filters?

A. I do not have the expertise to answer this question and I was not responsible for HEPA filters. In investigating whistleblowing, I would consult with others with more expertise in particular areas but my role was to ensure that the

issues were known about, were treated seriously and the actions were in place to resolve them.

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. Cleaning practices were not my responsibility and I am unable to answer this as I was not involved in cleaning or monitoring its quality. Responsibility for cleaning lies with the Estates Department but also with individual staff to ensure cleanliness. The IPCT has a role in monitoring the quality of cleaning and training of staff.

f) Water quality and testing concerns were discussed: what is your view on these? Do you know who was responsible for the cleaning and maintenance policy of taps?

A. I do not have the expertise to comment on this and I was not responsible for these issues. Facilities staff would be responsible for this, working with the IPCT if infection control advice was required.

g) Do you know if there was a delay in providing test results to ICD?

A. I note that [redacted] reported this at the meeting but I would not have been aware of this at the time. Ian Powrie from Estates responded this may have been due to staff changes so it would be my understanding that he would address this to ensure any delays did not continue but I am unable to confirm this.

h) Dr Peters raised concerns regarding ICD requesting and receiving the water sampling results in a timely manner where a water source or infection needed to be investigated: do you know if there was an issue with ICDs receiving test results?

A. It was reported at the meeting that there were issues. I cannot comment on whether this was accurate.

i) Do you know what was the extent of the issues of sewage in the neuro surgical theatres? Who was responsible for dealing with this?

A. This was reported as part of the whistleblowing complaints. In my investigation it was reported that this had occurred, remedial action put in place and that new theatres were planned. The Director of Regional Services (Gary Jenkins at the time) and Director of Estates (David Loudon at the time) were responsible for dealing with this.

j) Looking at the 'Agreement of Further Actions/ Next Steps', where possible, please provide details as to what your understanding is regarding actions taken and outcomes of these.

A. The minute could have been clearer about the development of the action plan to address the issues in the SBAR. The action plan makes it clear what actions are required and who was the lead to implement them. Progress on implementation was overseen by the Clinical and Care Governance Committee.

27 Point Action Plan – refer to Action Plan arising in response to SBAR dated 3 October 2017 **(**A38759270 - Bundle 20 – Document 48 page 792**)**:

55. Please discuss this plan including:

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

A. Actions had different teams and directors responsible for the actions but the plan would have been overseen by the Medical Director who at the time led on infection control. Progress was also reported to the Clinical and Care Governance Committee.

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

A. The actions were described under each issue. I was not directly involved in implementing the action plan. My role from the Whistleblowing investigation was to ensure that there was a plan to resolve the issues and that it would be monitored through the appropriate governance processes.

c) Which actions have been fully resolved?

A. All the actions have been completed except for one which was accepted as technically not possible.

d) Which actions are outstanding?

A. The action outstanding was in relation to negative pressure facilities in the Emergency Department but I am unaware of the detail of this.

Refer to Bundle 4 – SBAR – Document 51, page 220

56. 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. As I am now retired, I am unable to give an accurate update on this. However I am aware from documentation prior to my retirement that the Clinical and Care Governance Committee reviewed the progress at its meeting in June 2021 and that the actions were signed off as complete in September 2021.

Whistleblowing Stage 2

57. What was your involvement with the stage 2 whistleblow?

A. I was the director who heard the stage 2 and investigated it and wrote the report

58. What whistleblow policy was in place in GGC in 2018?

A. The whistleblowing policy of 2018 described the process.

59. What was the stage 2 whistleblow process within GGC in 2018?

A. Whistleblowers could contact a nominated director and the concerns would be investigated if a member of staff felt unable to raise the matter with their Line

Manager or did not think that this would effectively address the concern, or where discussion with the Line Manager had been tried but had not led to action within a reasonable period of time for whatever reason. Once a concern had been raised at Stage 2, the designated director confirmed with the individual concerned whether or not the matter was being raised in confidence and they could undertake one of the following investigations: an informal review, an internal inquiry or a formal investigation. The director would then meet with the whistleblower, clarify the concerns and find out more information. The further inquiry could include interviews with others, reviewing documentation and/or follow-up meetings with the whistleblower.

60. What was your experience in dealing with whistleblowing prior to 2018? Had you undertaken any training? If so, please provide details.

A. I had undertaken internal training and refresher training about investigating whistleblowing complaints. I had also investigated a number of stage 2 cases.

61. What did you understand to be the issues raised through the stage 2 whistleblow to have been? Were you aware of any of these issues in advance of receiving the whistleblow?

A. The concerns raised at Stage 2 whistleblowing were a) the standard rooms at the QEUH and RHC should have 6 air changes per hour ACH/hr and the rooms did not meet this standard with 3 ACH/hr. b) Positively Pressurised Ventilated Lobby (PPVL) rooms were not suitable for the isolation of patients with air borne infections: c) there were not sufficient rooms for the isolation of immunocompromised / Bone Marrow Transplant (BMT) patients at RHC. d) there were concerns about the current management of immunocompromised adult patients; e) there was a query on whether issues around ventilation are on the NHSGGC Risk Register. I was not aware of the detail of these issues in advance of the whistleblowing.

Refer to email 8th February 2018 - (A40450652 - FW STEP 2 -Whistleblowing Policy Ventilation at QE and RHC – Bundle 14 Volume 2 – Document 87, page 71**)**

62. From Dr Penelope Redding to Dr Linda de Caestecker - FW STEP 2 - Whistleblowing Policy Ventilation at QE and RHC:

a) What steps did you take when you received this email?

A. I organised a meeting with Dr Penelope Redding to discuss her concerns.

b) What information did you request/receive in respect of the issues raised?

A. In investigating whistleblowing, it is my normal practice to meet first with the whistleblower to understand clearly the complaint and to request other information after the initial meeting.

c) Who did you speak to regarding the issues raised?

A. I interviewed Dr Iain Kennedy, Dr Brian Jones, Mr Tom Walsh, Ms Sandra Devine, Dr Rachel Green, Dr Teresa Inkster and Ms Mary Anne Kane.

d) What actions did you take?

A. I reviewed the Health Building Note 04-01, the minutes of meeting on infection control estates issues at QEUH and RHC on 4/10/17 and the action plan that resulted from this, the Clinical and Care governance committee paper about these concerns, emails and letters on the organisation of infection control, and risk registers.

e) Please describe the investigation process which you undertook and any conclusions which you reached.

A. The investigation process involved interviews with key people and review of documentation and guidance. I concluded that the whistleblowing concerns about ventilation and patient safety were valid but that they were already known and there was an action plan in place. There is now agreed policy that any changes from building regulations or original specifications must be signed off by infection control. The investigation had highlighted that the IPCT found Dr Peter's frequent communication difficult to manage given she was not an infection control doctor at the time and had no role in the day-to-day management of IPC.

63. The Inquiry understands you held a meeting with both Dr Redding and Dr Peters to discuss their concerns. Please provide details of this meeting.

A. We met on 16/3/18 in my office and I asked them to describe their concerns. Although the email stated that their concerns related mainly to ventilation issues, they said they had wider concerns about infection control. They stated that they felt isolated by raising the issues. They then described the history of the issues from the design and building of the QEUH. They talked about the PPVL rooms and Dr Peters said that there is debate amongst experts about PPVL rooms but regardless of this they were of the view that the rooms had not been built to standard. They were aware that negative and positive pressure rooms were now being built but they did not know the timescale for when this work would be completed. They also raised problems of plumbing at the Institute of Neurological Sciences. Dr Peters was aware that HIS had been involved and recommended actions. Both Dr Peters and Dr Redding said that they felt the roles in infection control were not clear and that infection control should be a doctor led service. They said that there was poor teamwork and communication. The meeting mainly involved them speaking and me asking questions for clarification. I let them know I would investigate their concerns by speaking to others in the first instance and I would send them my findings as soon as I could.

Please refer to your letter of 4th May 2018

Email from C Peters to R Bajwe re Letter from Dr Linda de Caestecker - 15 May 2018 and the Stage 2 Whistleblowing Report NHS GGC - Step 2 Whistleblowing Report - dated May 2018 **(A46157941 Bundle 14 Volume 2, document 97, page 222** and **A34427379 - Bundle 27 Volume 3 – Document 24, page 472)**

64.

a) What was your conclusion in terms of points 1, 2 and 3 set out in your letter dated 4th May 2018/your report in terms of the suitability of accommodation within the QEUH:

A. My conclusions did not cover all of these points in detail. I had concluded that the issues had been raised with the appropriate directors responsible for addressing them and that the action plan put in place was appropriate to do

this. I took the view from the reports given to me by the people that I interviewed that the whistleblowers, especially Dr Peters, required additional support in their relationships with the IPCT but I was aware that this was already being put in place.

i) Did standard rooms only have 3ACH/hr?

A. Yes as far as I understand.

ii) Were PPVL rooms suitable for the isolation of patients with airborne infections?

A. I do not have the expertise to comment on this but I was aware that this issue was identified and was part of the action plan.

iii) Were there sufficient rooms for isolation of immunocompromised/BMT patients in RHC?

A. I do not have the expertise to comment on this but I was aware that this issue was discussed and was part of the action plan.

b) With whom did you speak to/what documentation did you see which allowed you to conclude that the issues raised in the SBAR of 3rd October were being satisfactorily addressed? Do you still hold this view? Please provide an explanation for your answer.

A. I spoke to those I interviewed for the whistleblowing investigation (see above) and also to Dr Jennifer Armstrong the Medical Director. I reviewed the minutes of the meeting of 4/10/17 and the report to the clinical and care governance committee that included the action plan to address the issues. I still hold the view that the concerns raised at the Whistleblowing investigation were taken seriously and addressed.

c) Following this letter/report what were the responses from

i) Dr Peters

A. Dr Peters responded that she was encouraged that there was now a clear policy and plan being followed and was reassured that the issues in the SBAR were being taken seriously. She was satisfied with the outcome.

ii) Dr Redding

A. I have been unable to locate Dr Redding's response.

iii) Dr Redding requested updates on the progress being made on the actions agreed. Was she provided with these? If not, why not?

A. Dr Redding asked for an update in July 2018 and I responded to her request in September 2018 with an update. I realise this was a delay in responding but it took time to get responses from the relevant staff for the appropriate information.

65. Who was your final report shared with?

A. The Board's administrative lead for Whistleblowing and the Non-Executive Director who was the Whistleblowing Champion. I shared the recommendations with those responsible for implementation. A summary was also provided in the Whistleblowing Annual report that went to the Audit committee. I wrote to the whistleblowers with a summary of my findings and conclusions.

66. Following your involvement with the stage 2 whistleblow in 2018, did you seek any updates regarding the plan in place and progress of actions? If not, why not? Please provide details.

A. I was provided with updates by the Board lead for whistleblowing who follows up actions from whistleblowing reports. Progress on actions were reported to the Non-Executive Director with responsibility for Whistleblowing (now the Board Whistleblowing Champion). The concerns were being dealt with at a senior level and the Action Plan had been produced and reported to the Clinical and Care Governance Committee. Dr Inkster the lead ICD reported that she was reassured that all actions were in train. I was therefore of the view that appropriate updates would be provided through the infection control and clinical governance structures.

67. Do you have a view on whether the issues raised in the stage 2 whistleblow were resolved satisfactorily? Were the recommendations put into place? Please provide rationale for your answer.

A. I was reassured that the action plan included all of the issues within the Whistleblowing complaint and that actions were being taken forward. Whistleblowing investigations are required if the concerns are not being adequately recognised through existing management structures and processes. On this occasion, I was of the opinion that the issues had been reported to the Director leading on Infection Control and the Estates team and actions were in place to try to resolve them. These are described in the 27 point action plan already shared with the Inquiry.

Whistleblowing Stage 3

68. What was your involvement, if any, with the stage 3 whistleblow in November 2019?

A. I did not have direct involvement although I was asked about the stage 2 investigation.

69. What was the stage 3 whistleblow process within GGC in 2019? What policy was in place?

A. The policy (2018) stated that a whistleblower could contact a designated non-executive board member to investigate concerns at Stage 3. The policy states that if Steps One and Two have been followed and the member of staff still has concerns, or if they feel that the matter is so serious that they cannot discuss it with any of the above, they should contact the nominated Non Executive Member (or deputy) of the NHS Board. The nominated Non Executive Member of the NHS Board will receive appropriate professional support where relevant from the Medical Director, Nurse Director or any relevant Corporate Director.

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

A. The issues were: factual inaccuracies in media statements regarding water testing; issues with the new QEUH/RHC similar to the Stage 2 investigation

but also including issues about chilled beams; testing of the plant room for Cryptococcus; data on infection rates; culture and bullying.

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

A. Ian Ritchie a non-Executive Director and previous president of the Royal College of Surgeons of Edinburgh, supported by William Edwards (eHealth director who hears whistleblowing cases at Stage 2). They undertook a Stage 3 investigation which I understood involved a meeting with Dr Redding, getting information from other relevant staff and review of previous documentation and emails.

72. Were you consulted as part of the process?

A. Yes, Ian Ritchie asked me about the stage 2 investigation.

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

A. I was not directly involved but my view was that the conclusions seemed clear and reasonable. The investigation noted that it was regrettable that the media lines implied that NHSGGC did not test the water for Stenotrophomonas at the time in question. The timeline for water testing was shared with Dr Redding. There was a full response to Dr Redding on the actions and conclusions about the building, the chilled beams and the plant room as well as the validity of the data. It was decided not to investigate the issues of culture and bullying as part of whistleblowing but to work with the department through Dr Marion Bain who was then in post and had been appointed by Scottish Government as part of the escalation process to oversee Infection Control. Dr Redding also raised concerns at this time about her Stage 1 whistleblowing complaint which she said had been raised in 2017. She was asked for the records that these concerns had been formally raised as a Stage 1 but she was unable to access all her emails as she was now retired. She was reassured that the process and end result would have been the same whether or not the concerns were raised with Dr Armstrong as formal whistleblowing or as concerns in her professional role. A thorough review of communication and emails was undertaken and is included in the report of the whistleblowing. It was acknowledged that the new Whistleblowing standards

would make the Stage 1 process clearer and that there is learning for NHSGGC on use of Stage 1 of the policy. The overall conclusions of the Stage 3 investigation were that the issues raised were vitally important and detail was provided on actions which had already been put in place to address many areas of concern. It was concluded that there were also lessons to be learnt in relation to communication and that the concerning issues of bullying and poor culture needed dealt with in another process including the work by Marion Bain with the teams concerned. It was noted that much of the clarification and information that Dr Redding was seeking had been covered in the 27 point action plan referred to above and that feedback from the external review on the action plan in responding to the concerns raised in 2017 would provide an independent review. Ian Ritchie also asked that any individual accusations of bullying be taken forward through the appropriate HR processes but none came forward.

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

A. I did not have direct involvement but I have read the communication.

75. What do you understand the issues raised through this whistleblow to have been?

A. In April 2020, Dr Redding requested a subsequent Stage 3 whistleblowing investigation. At the time the previous Stage 2 was still underway and nearing completion. This complaint was that there had been a “cover-up” regarding the initial Stage 1 complaint. This complaint arose because of questions by the Independent Review and the other Stage 3 interview above, leading Dr Redding to believe that the process had not been followed correctly and that there had not been a formal acknowledgement by NHSGGC that the Stage 1 process had been started. There was no doubt that Dr Redding and colleagues had raised concerns in 2017 but there was no explicit written evidence which would show that these were raised as a Stage 1 whistleblowing concern. Dr Redding asked for access to her work emails but due to the passage of time since her retirement, her account had been disabled. Mr Allan Macleod non-Executive Director was appointed to investigate this case. Dr Redding acknowledged that the actions taken to deal

with the concerns were not in question but that her concerns should have been recorded as Stage 1 of whistleblowing. The investigation concluded that in retrospect when Dr Redding said she was escalating her concerns to Stage 2, there should have been an explicit examination of whether Stage 1 had been followed. However at that time, many Stage 2 concerns were raised without an explicit Stage 1 having taken place even when the line manager had tried to resolve the issues. It was not possible to give a definitive conclusion as to whether the initial concerns were submitted as a Stage 1 case due to lack of written evidence one way or the other. There was however no evidence that there was any deliberate attempt to cover up Stage 1. The conclusions acknowledged that NHSGGC's preparations for the new whistleblowing standards should take account of the learning from this case. In July 2020, Dr Redding wrote to John Brown, chairman of NHSGGC with concerns about the accuracy of the report of the investigation into the whistleblowing concerns she had raised at Stage 3. The chair's response was that these matters of accuracy did not materially affect the conclusions and recommendations of the report. Dr Redding had also received further communication from Elaine Vanhegan in August 2020 responding to each of her points about accuracy. Dr. Redding raised concerns that her Stage 1 Whistleblowing complaint had not been formally documented as such. She remained concerned that her concerns should have been recorded as Stage 1 of whistleblowing.

76. Were you consulted as part of this process?

A. No

77. Dr Redding was of the view that GGC had attempted to 'cover up' the stage 1 whistleblow of September 2017 by not recording it as a whistleblow. What is your view on this? Please explain the rationale behind your conclusion.

A. I do not agree that there had been a "cover up" in any way although I acknowledge that the Stage 1 process required to be clarified, which it now has been. The Stage 3 investigation concluded that when she said she was escalating her concerns to Stage 2 there should have been an explicit

examination of whether stage 1 had been followed. However there was no evidence that there was any deliberate attempt to cover up Stage 1.

78. With whom were the issues in this whistleblow raised and how were they addressed?

A. Allan McLeod a non-Executive Director was appointed to investigate the case. Dr Redding also contacted the Chair of the Board, John Brown, who responded that Dr Redding's concerns about the accuracy of the stage 3 report did not materially affect the conclusions. Elaine Vanhegan the Head of Administration also responded to all of Dr Redding's concerns in a letter to her.

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

A. They were investigated and all the concerns were responded to. The need to increase the use of Stage 1 whistleblowing was addressed in the review of the whistleblowing policy in 2021 and in the revised policy based on the national standards.

Communication with Scottish Government

80. 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. I was made aware of them when I reviewed some correspondence in a narrative about whistleblowing, previously submitted to the Inquiry, that showed there had been emails and meetings between Dr Inkster, Dr Peters and the Scottish Government. I was not aware of them at the time they occurred. The emails did not describe any detail about the content of the meeting.

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

A. As I don't know the content of the meetings, I am unable to answer this question.

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

A. No

83. What actions were taken?

A. I am not aware of what actions were taken.

84. What was your communication with the Scottish Government in respect of the QEUH/RHC and the respective whistleblows?

A. I did not communicate with Scottish Government about these matters.

85. Did you provide them updates? If so, who did you provide the updates to? Please provide details.

A. No

Whistleblow to HPS

86. Are you aware of the whistleblow to HPS in August 2019?

A. Yes. I investigated this.

87. What do you understand the issues raised through this whistleblow to have been?

A. The whistleblower contacted HPS to raise concerns about the Incident Management Team (IMT) in NHS GGC for ward 6A and infection control. The whistleblower complained that the Chair was unable to do her job in protecting patients from infections due to the culture and organisational failings, citing lack of support from management and that critical information has been denied to the Chair, or false accounts given by high level managers. The complaint was also that Microbiology/Clinical judgement regarding the fact that there was a real issue with unusual environmental pathogens in

Haematology paediatric patients was being continuously questioned and that there was lack of transparency re communication. Shortly after this, on 2 September 2019, Dr Inkster wrote to Dr Armstrong copied to me and to Dr Peters resigning from her role as lead ICD and sector ICD. She asked that the contents be confidential. In Dr Armstrong's response to Dr Inkster, she asked that some of the issues could be shared as they needed to be fully considered and properly investigated where appropriate in line with the Board's governance processes and policies. She summarised the key issues as: workload and immediate work environment, involvement and discussions within wider IC team, lack of involvement in the forthcoming visit to Great Ormond Street, issues relating to leadership role and Chair of the IMT and HR/Payroll related issues. Dr Inkster followed up with additional issues she would like to raise that were: the Significant Clinical Incident process, Duty of Candour regarding infection control incidents and Governance of IMT sub-groups. The latter issues were not included in the whistleblowing investigation but investigated separately.

88. Who from HPS did you discuss this whistleblow with?

A. The Medical Director of NSS Lorna Ramsay contacted the NHS GGC Medical Director Jennifer Armstrong and asked NHSGGC to investigate this.

89. Who from NHSGGC/QEUH/RHC did you discuss this with?

A. I initially discussed this with Jennifer Armstrong and Anne McPherson, Director of HR, about the investigation. The investigation was conducted with Barbara Anne Nelson, director of Workforce in NHS Fife. We interviewed Iain Kennedy, Tom Steele, Chris Deighan, Sandra Devine, Dermot Murphy, Scott Davidson, Teresa Inkster, Christine Peters, Brian Jones, Jamie Redfern and Jen Rodgers.

90. This whistleblow has been escalated to the Scottish Government: please provide details of who this was escalated to, what their response was and what actions/follow up were taken?

A. I am unable to answer this other than Lorna Ramsay reported that she had let Scottish Government know about the complaint and that she had passed it to NHS GGC.

91. Why did you contact Dr Inkster? What was her response?

A. Dr Inkster had been the chair of the IMT and given the complaints we wished to find out her views. Her resignation letter to Dr Armstrong referred to above had described similar concerns and we included these in our investigation. She agreed to have a discussion with us. In our interview with her she described the stress of such a prolonged IMT and she talked about a "division" between managers and clinicians. She complained that the minutes were not sufficiently detailed and that too much of the meeting was spent having to amend the minutes. She had not raised this previously with the IPCT to find a solution. She also complained that she had no control over who attended the meeting. She found it difficult to manage the meeting if the IPC manager had different opinions from her own. Although she had weekly meetings with the IPC manager she did not raise these issues with her. It appeared that she did not acknowledge the 20 years' experience of the IPC manager who could form different views. She interpreted this as not acknowledging there was a problem.

92. What steps were taken as part of this investigation?

A. I worked with a senior HR manager from another board, Barbara Anne Nelson, on this investigation to ensure I received HR support but also to have external advice.

93. Who did you speak to?

A. We interviewed Dr Iain Kennedy, Mr Tom Steele, Dr Chris Keighan, Ms Sandra Devine, Dr Dermot Murphy, Dr Scott Davidson, Dr Christine Peter, Dr Brian Jones, Mr Jamie Redfern, Ms Jen Rogers and Dr Teresa Inkster.

94. What actions were taken?

A. We interviewed the above people confidentially and produced a report on the findings from the interviews.

95. What was your conclusion?

A. The situation was complex, emotive and at times tense but there were also examples of good collaborative working. We concluded that there were additional supports that could be put in place when an IMT is as complex and long-running as this one. Some concerning behaviours were reported within the IMT and outwith the IMT.

96. What recommendations, if any, did you make?

A. We made recommendations about the practical arrangements for IMTs. It was understood that the Standard Operating Procedures for IMTs were being reviewed. From the learning from this whistleblowing investigation, this would be a welcome and essential undertaking, and we recommended that the following areas should be covered within it: (i.) An IMT should have a defined attendees list, and only those on it should attend meetings. The only exception to that should be if a nominated colleague attends on behalf of an IMT member during a period of absence. (ii.) There should be ground rules for the IMT – for example, attendance, minutes, circulation of papers and so on. (iii.) An appropriate meeting room should be taken out of circulation during the lifespan of an IMT to be at their full disposal. (iv) If there are to be pre-meetings before an IMT, it must be made very clear to the wider group what the purpose of them is. The purpose would be to help/facilitate a well organised IMT, not for decision-making purposes. (v) An experienced minute taker should support the IMT. Recommendations were also made about supporting the IMTs and the Chair of the IMT. The report discussed the high pressure, emotive nature of the subject matter, and that this has taken its toll on staff. Support to both the Chair of the IMT and IMT members is therefore essential. It was recommended that IMT situations should be categorised on severity /risk. For those ranked at the higher end of the scale, it should be considered whether some key colleagues should come out of their substantive posts temporarily, in order to give full attention to the IMT. It was recommended that the chair of such IMTs should not be expected to be a full expert participant and that the Chair should be a separate role. If an expert of the same role / specialty as the Chair is needed, this should be in addition to

the Chair. It was recommended that Chairs should receive specialist training on how to fulfil this role and discussions should be held with HPS about training courses. High profile IMTs should have a Vice Chair for added support, and this support should include constructive feedback, reflection and a chance to de-brief. The organisation should ensure that all participants of a high profile and/or long-running IMT have access to support via a Vice Chair. We also made recommendations about behaviours given what we heard in the interview i.e. (i.) As well as the ground rules noted above, there should be rules of engagement for the IMT which aim to create an atmosphere that supports respectful and respected debate done in a kind and helpful way. (ii.) The Director of the Diagnostic Directorate should take senior OD advice on the most appropriate bespoke Organisational Development programme which would assist the microbiology team at QEUH. (iii.) Staff who raise concerns about individuals should be signposted to the relevant HR policies and advised to utilise these when appropriate. (iv.) Discussions should take place with the Chief of Medicine for the Diagnostic Directorate and HR to consider how best to support Dr Peters to enable a more productive way of working with colleagues at times of stress and when opposing views are held.

97. Do you consider the issues raised to be fully resolved?

A. There was a great deal of effort to resolving the issues made by Marion Bain and byAngela Wallace. Many of the issues remained unresolved, in particular how Christine Peters and Teresa Inkster related to the IPCT. There have been changes in personnel and my understanding is that relationships and communication are now much improved. However, I have not been directly involved since my retirement.

98. What actions were taken?

A. We interviewed relevant stakeholders and members of the IMT. A set of recommendations was made, as described above and the lead for each recommendation was documented. Progress on implementation was then overseen by the Lead for Whistleblowing liaising with the leads for each recommendation.

99. Do you consider this to be fully resolved?

A. I cannot fully comment as I am now retired. I am aware that relationships between Dr Peters and the IPCT were not fully resolved at the time of my retirement.

Meeting re. IMTs

100. 20th August 2019 - Refer to Bundle 6, Document 22:

a) Do you recall attending this meeting?

A. Yes. I was asked to chair this meeting by the Medical Director.

b) Why was this meeting called?

A. At the most recent IMT, a number of members had raised concerns about the behaviours at the meeting. They had reported to their managers that they felt personally criticised and intimidated if they disagreed with the Chair or with Christine Peters who had attended that meeting. They also complained about documents being tabled at the meeting rather than being pre-circulated. Members also felt that although it was meant to be a confidential discussion that some members leaked issues to the media. Jennifer Armstrong, the Medical Director, asked that I chair a meeting to discuss these complaints.

c) How did you become involved?

A. I was asked to chair a meeting to discuss these concerns and agree ways to improve the working of the IMT.

101. What was your understanding of the issues surrounding the haemato-oncology unit at the QEUH/RHC? What was discussed at this meeting?

A. The meeting was to discuss the concerns of members of the IMT about its functioning and behaviours at the recent meeting. The meeting was not held to discuss the infections that were being investigated by the IMT.

102. 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?

A. Some of the issues raised were practical ones about changing membership, the number of people attending, the appropriateness of venues. The group highlighted the need for an IMT to work within a safe and confidential environment in order to manage the situation and protect patient confidentiality. However it was reported by staff that recent press leaks had led to a climate of fear and intimidation as staff are concerned that if they disagreed with others at the meeting, they might be criticised in the press. This had resulted in a lack of openness at the meeting which could affect decision making. It was also felt unhelpful when information is tabled at the meeting, thus not enabling everyone to review it properly to inform decision making. Other issues that were raised were about behavioural issues Concerns were raised about the nature of communication within the IMT ('confrontational', 'uncomfortable dialogue', 'off-the-scale bad', 'totally disrespectful', 'inappropriate language'), and feelings of defensiveness and vulnerability experienced during the meeting, noting particularly a 'toxicity' and lack of identification as a team, as well as feelings of blame being attributed. It had been reported that some people felt unable to speak up at the IMT because of this culture, concerns about confidentiality and the tone of discussions because members felt there was a lack of respect for them if they held differing views.

a) Please provide details as to the discussions for re-setting the IMT process and having an independent Chair.

A. It was recognised that chairing such a long-running, important, high profile IMT is very difficult. It can be particularly difficult if the Chair is also the subject expert. This can make chairing more difficult if the Chair has to manage behaviours, let all views be heard and valued and also provide the expert input to the team. It was therefore felt that it would be preferable to have a Chair who understood the issue but was not the expert, freeing up Teresa Inkster as the lead ICD to provide the expert input.

b) Please explain the actions taken and how they were taken forward.

A. My actions were to chair the meeting and then to ask Dr Emilia Crighton in my public health team to take over the chair of the IMT. It was Jennifer Armstrong's or Sandra Devine's responsibility to speak to Teresa Inkster and explain why it was felt that she should be on the IMT as the expert in IPCT but that it would be easier for her to provide that expertise if not also chairing the group.

c) 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?

A. Dr Inkster was invited to the meeting and I, as chair, only found out at the last minute that she was unable to attend. It would have been preferable if she had been able to attend so that she could have been part of the discussion and recommendations. We changed the time of the meeting to make sure Dr Inkster was able to attend and then before the meeting, we were informed that Dr Inkster unfortunately had had to go off sick.

d) 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?

A. I did not speak to Dr Inkster after the meeting as it was agreed that the Infection Control Manager, her line manager, would do this. The ICM tried to contact Dr Inkster to meet with her and discuss the chair role. She thought that Dr Inkster was still off sick and had to ask someone else to chair the IMT. She approached the ICDs but they were unable to chair and she then asked Dr Emilia Crighton, consultant in public health to chair the IMT. Dr Inkster returned from sick leave and attended the IMT before there had been the opportunity to speak to her about the chair role. It would have been preferable if there had been time to explain to Dr Inkster that she was not being forced to demit as chair but that the decision to have a new chair was to support her and enable her to have the role of expert so that the IMT could function more effectively. It is unfortunate that this is the way things happened

and that the ICM did not have the opportunity to explain properly the rationale behind changing the chair before Dr Inkster attended the IMT.

Resignation of Dr Inkster

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

A. She stated her reasons in her resignation letter. Her reasons related to workload, feeling she was undermined, being asked to demit the chair ofthe IMT and being unclear of the reasons, concerns relating to duty of candour and her contributions to a recent SCI report. She also cited HR and payroll issues.

104. 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.

A. I am unable to accurately comment on this as she did not raise this particular issue when we interviewed her. I would agree that at the time there would have been many demands on her time as Lead ICD but I am also aware that both Dr Armstrong and Dr Green put in place measures to reduce her workload. I am not aware that there were resource issues with ICDs but I was not involved in the operational management of them.

105. 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 raised them in her resignation letter? If so, were these being addressed? What are your views on her concerns?

A. I was not aware of these before they were raised in the resignation letter and in the whistleblowing complaint to HPS. There is no doubt that the IMT was a difficult one to lead as it continued for such a long time and it was very high profile with different views about the situation. That must have been difficult

for her. I am sorry that she did not view the appointment of a new Chair as helpful to her as it was intended to be. I am aware that I personally tried to make sure she knew how valued she was as an expert and the lead ICD. The recommendations in the whistleblowing report of 2019 described below were intended to address the issues.

106. In Dr Armstrong's response to Dr Inkster's resignation letter, she states that she is 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. The issues in her resignation letter were similar to the issues raised in the Whistleblowing complaint to HPS so it was thought appropriate that they be investigated together. The Medical Director did not agree with Dr Inkster that she had been unsupported as she and the IPC Manager had regular meetings with her to ensure she was supported. In March 2019, the Medical Director and I had a joint meeting with Dr Inkster and the Director of Estates Tom Steele to try to ensure that they supported each other including in IMTs. We asked that they continue to meet every week to make sure any problems were quickly resolved.

Refer to email 24th Sept re whistleblowing concerns :
(A41745739 - Bundle 14 Volume 2 – Document 156 page 603)

107. In your email of 24 September 2019 to Dr Inkster, you suggest that the concerns raised, 'may be better dealt with through normal processes … rather than a whistleblowing concern': please provide your reasons for this decision.

A. The whistleblowing concerns reported to HPS were from an anonymous whistleblower and Dr Inkster was not asking to be anonymous so I could raise the issues with her line manager or as she suggests in her email with the Medical Director directly. Stage 2 Whistleblowing is meant to be for complaints that cannot be resolved directly with line managers or senior managers. There are also occasions when people use the Whistleblowing

policy when they should use Dignity at Work or other policies. I was planning that Dr Inkster and I explore the best way to report and resolve her issues when we met. I was not pre-judging the outcome of these discussions. I am aware that the issues such as the SCI report, governance of sub-groups and duty of candour were fully investigated by Dr Chris Deighan at the request of Dr Jennifer Armstrong.

108. What steps were taken as part of this investigation?

A. These are described under the section on the HPS Whistleblowing. I worked with a senior HR manager from another board on this investigation to ensure I received HR support but also to have external advice. We interviewed key staff and produced a report based on our findings.

109. Who did you speak to?

A. We interviewed Dr Iain Kennedy, Mr Tom Steele, Dr Chris Deighan, Ms Sandra Devine, Dr Dermot Murphy, Dr Scott Davidson, Dr Christine Peters, Dr Brian Jones, Mr Jamie Redfern, Ms Jen Rodgers and Dr Teresa Inkster.

110. What actions were taken?

A. We interviewed the above people confidentially and produced a report on the findings from the interviews. A set of recommendations were made that included responsibility for implementation.

111. What was your conclusion?

A. The conclusion of the Whistleblowing investigation was that the situation was complex, emotive and at times tense. Some concerning behaviours were reported within the IMT and outwith the IMT that had made the work of the IMT more difficult. It was recognised that the need for difficult and complex judgements and decisions that impact on patients can cause tension and that discussions can be heated but it is expected that all staff behave with respect and care for colleagues. The recommendations made were intended to support good collaborative working.

112. What recommendations, if any, did you make?

A. The recommendations were about firstly the practical arrangements for IMTs and that in the review of the Standard Operating Procedures for IMTs, the following areas should be covered within it: (i.) An IMT should have a defined attendees list, and only those on it should attend meetings. The only exception to that should be if a nominated colleague attends on behalf of an IMT member during a period of absence. (ii.) There should be ground rules for the IMT – for example, attendance, minutes, circulation of papers and so on. (iii.) An appropriate meeting room should be taken out of circulation during the lifespan of an IMT to be at their full disposal. (iv) If there are to be pre-meetings before an IMT, it must be made very clear to the wider group what the purpose of these are, and this should be to help/facilitate a well organised IMT, not for decision-making purposes. (v) An experienced minute taker should support the IMT. Recommendations were also made about supporting the IMTs and the Chair. The report discussed the high-pressure, emotive nature of the subject matter, and that this has taken its toll on staff. Support to both the Chair and IMT members is therefore essential. (i.) IMT situations should be categorised on severity /risk. For those ranked at the higher end of the scale, it should be considered whether some key colleagues should come out of their substantive posts temporarily, in order to give full attention to the IMT. (ii.) The Chair should not carry out this role and also be expected to be a full expert participant. If an expert of the same role / specialty as the Chair is needed, this should be in addition to the Chair. (iii.) Chairs should receive specialist training on how to fulfil this role. Discussions should be held with HPS about training courses. (iv.) High profile IMTs should have a Vice-Chair for added support, and this support should include constructive feedback, reflection and a chance to de-brief. (v.) The organisation should ensure that all participants of a high profile IMT have access to support via the Vice-Chair. We also made recommendations about behaviours given what we heard in the interviews. (i.) As well as the ground rules noted above, there should be rules of engagement for the IMT which aim to create an atmosphere that supports respectful and respected debate, done in a kind and helpful way. (ii.) The Director of the Diagnostic Directorate should take senior OD advice on the most appropriate bespoke Organisational Development programme which would assist the microbiology

team at QEUH. (iii.) Staff who raise concerns about individuals should be signposted to the relevant HR policies and advised to utilise these when appropriate. (iv.) Discussions should take place with the Chief of Medicine for the Diagnostic Directorate and HR to consider how best to support Dr Peters to enable a more productive way of working with colleagues at times of stress and when opposing views are held.

113. Do you consider the issues raised to be fully resolved?

A. There was a great deal of effort to resolving the issues by Marion Bain and by Angela Wallace. Many of the issues remained for some time, in particular how Christine Peters and Teresa Inkster related to the IPCT. There have been changes in personnel and my understanding is that relationships and communication are now much improved. However I have not been directly involved since my retirement.

Cryptococcus

114. What is your understanding of the cryptococcus outbreak at the QEUH?

A. I was not directly involved in the outbreak and did not have a role in investigating it or managing it. I do not therefore have the expertise to answer this section.

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

A. N/A

116. What is Cryptococcus?

A. N/A

117. Had you seen/ heard of Cryptococcus in a healthcare setting prior to QEUH?

A. N/A

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

A. N/A

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

A. N/A

120. What were the hypotheses put forward for the cases of cryptococcus? Who put these forward? What were the conclusions on each hypothesis?

A. N/A

121. What was your view on the pigeon infestation on the QEUH/RHC site?

A. N/A

122. Did you read John Hood's report? bundle 6, document 39

A. N/A

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

A. N/A

124. What observations, if any, did you make after reading John Hood's report? What actions were taken following the John Hood report?

A. N/A

125. 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?

A. N/A

126. What is your view on the pigeon contamination in the plant rooms?

A. N/A

127. Who was responsible for clean up regarding this?

A. N/A

128. What actions were taken?

A. N/A

129. Was air sampling of plant rooms undertaken?

A. N/A

Please refer to IMT Bundle 1, Document 58

130. A discussion of plant rooms and sampling for fungi and cryptococcus takes place.

a) What do you understand to have been discussed?

A. N/A

b) Do you know what control measures were implemented?

A. N/A

Please refer to IMT Bundle 1, Document 59

131. 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.

A. N/A

b) When did you first become aware of an infestation of the plant rooms?

A. N/A

c) What was your understanding of the extent of the infestation and how the pigeons were accessing the plant room?

A. N/A

d) What was your understanding of how the infected air was reaching the wards?

A. N/A

e) What steps were taken and by whom?

A. N/A

f) Was this issue fully resolved?

A. N/A

Please refer to IMT Bundle 1, Document 55

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

a) What was your understanding of this situation?

A. N/A

b) When did you become aware of this situation? Who kept you informed of the situation?

A. N/A

c) What actions were taken?

A. N/A

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

A. N/A

National Performance Framework

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

A. I was not directly involved in this process although it was reported to the Board. As I am now retired I do not have access to all the files I would need to check the dates and process for this.

135. What is your understanding of why NHS GGC was escalated to Stage 4?

A. My understanding was it related to the infections at the QEUH which were widely reported in the media causing concern from the public about the safety of the hospital. The Scottish Government felt that the Board required support to restore confidence in our infection control procedures and also in the hospital itself.

136. What were the events preceding this?

A. The Oversight Board was established to focus on three broad areas of infection, prevention and control; governance; and communication and engagement. The events preceding this had been infection issues affecting children and young people in the paediatric haemato-oncology service at the QEUH and the RHC over a number of years, combined with rising concerns about the source(s) of those infections and how they were being handled.

137. Describe the process of escalation and the consequences of this?

A. The Oversight Board conducted its work through a review of key documents and direct inquiry with NHS GGC involving experts who took part in the Oversight Board and its Subgroups. The Oversight Board reviewed minutes of the Board and sub-committees, IMTs, SBARs and papers from external experts and statements on specific issues, as well as information from clinicians in the Board. The Oversight Board also reviewed national and local guidelines and data. The Oversight Board held discussions with representatives of the affected children, young people and families, some NHS GGC clinicians and microbiologists that had raised concerns about the Health Board, and NHS GGC representatives.

138. What actions were taken?

A. The Oversight Board made a number of recommendations for improvement some for NHS GGC and others for national bodies.

139. Were you in communication with the Scottish Government throughout this period? If so, please explain the extent of your communication and what it related to.

A. I was not directly in communication with the Scottish Government about this.

Case Note Review and Oversight Board

140. 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. I was not involved in the Case Note Review process. The only involvement I had was reviewing the draft report and contributed to comments and responses from NHS GGC.

141. 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. I am unable to answer this as I was not involved in its establishment of the Oversight Board or its work.

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

A. Yes

143. 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

144. 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

145. 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. The implementation of the recommendations were led by other Directors in NHS GGC and not by me so I am unable to answer this in any detail.

146. 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. I was not directly involved in this but was aware that the CEO led a process to implement and review progress on each of the recommendations.

Communication – Staff/Information Sharing

147. What is your view on the adequacy of communication between staff and information sharing between staff within the QEUH/RHC? Please provide details.

A. I am not directly involved in this so I cannot comment on the communication between staff within the QEUH/RHC. The communication within my own Public Health team working in the QEUH was good.

148. 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. I was not involved in this process so I am unable to comment. The same applies to the questions below.

a) All instruction from management to clinical staff regarding what and how to communicate with patients

A. I was not involved in this so I am unable to comment

b) All communication from management to patients

A. I was not involved in this so I am unable to comment

c) All communication from management to the media

A. I was not involved in this directly so I am unable to comment

d) The pre-broadcast advice to staff regarding the BBC programme

A. I was not involved in this directly so I am unable to comment.

e) All communication between management and external bodies such as SG, HPS and HFS

A. In relation to the events in question, I was not involved so I am unable to comment.

Communication With Parents

149. What is your view on the adequacy of communication and information sharing between staff and patients and families?

A. I did not have direct involvement in this but I am aware that clinicians and managers tried very hard to ensure the communication was good. However I can also understand that parents, worried about their child's illness, may at times feel it should be improved.

150. Do you believe that there were circumstances where this could have been improved? If yes, please provide details/examples.

A. There was one particular episode in which communication could have been improved and it displayed how important it is to communicate clearly with both colleagues and patients and that busy staff can sometimes use shorthand with colleagues that can be mis-interpreted, causing distress to parents/patients. I

reviewed the documentation about some communication with [redacted], one of the [redacted] being treated in haematology/oncology. In August 2019, there was a meeting with Dr Inkster, Mr Jamie Redfern and [redacted]. There had been a previous meeting with [redacted] some months earlier about [redacted] rare infection and [redacted] concern that this should have been counted in the IMT cases. It was explained that with only one case, it would not be defined as an outbreak although Dr Inkster agreed to look into the case. Months later there was a second case reported to the IMT and Mr Redfern and Dr Inkster planned to meet with [redacted] to explain this but first had to speak to the second case's family. In the intervening time, Kevin Hill, the then Director of the Women and Children's Directorate told Mr Redfern and Dr Inkster that they should not speak to [redacted] because [redacted] was in communication with the Board's Chair about a range of issues in relation to the hospital and [redacted] and they should let that process continue. Both Dr Inkster and Mr Redfern then went on leave. On return from leave, Mr Redfern received an email from [redacted] which he described to me as containing inflammatory language, complaining that communication was very poor. Mr Redfern and Dr Inkster agreed to meet with [redacted]. The meeting was arranged at a time when an IMT was over-running so Mr Redfern met with [redacted] and Dr Inkster joined later. Mr Redfern tried to explain why they had not met [redacted] earlier but was interrupted by Dr Inkster who had then joined the meeting. Dr Inkster stated that they had been told by senior management not to meet with [redacted], at which point [redacted] left the meeting. [redacted] subsequently complained about this statement in a letter of complaint and was responded to by Jane Grant CEO. In [redacted] complaint letter, it is presented as if Teresa Inkster was explicitly told to withhold relevant information as part of a "cover-up". Whilst it was not meant in this way, the way it was expressed by Dr Inkster was unfortunate as it could be implied that she was asked to with-hold information whereas the request from Mr Hill had been made to prevent confusion when communication was on-going with the Chair of the Boards.

151. What steps have been taken to improve communication failures.

A. I was not directly involved in this but I am aware that the Board was supported by Prof Craig Whyte who had been asked by Scottish Government to support communication. Prof Mags Maguire the (then) Director of Nursing led the endeavour to ensure that communication was as clear, understanding and sympathetic as possible, working closely with management from the hospital. An important element of this was regular meetings with staff and parents to provide information and reassurance as well as written communications.

Staff/Culture Within QEUH/RHC

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

A. I can comment on my experience of being part of the team at Board HQ. There was a positive, supportive culture although this included robust challenge at times. My experience was that I was well supported by fellow Directors and my own team. The Heads of Service in the Public Health Directorate had regular team and one-to-one meetings with their teams to make sure there was good communication and team-working. All the directors and their teams worked very hard and there were times especially during the pandemic when most were working very long hours. During that time, the Directors, led by the CEO, tried to make sure that their teams and fellow directors were getting sufficient rest and support.

153. 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. I cannot comment if they were taken seriously at the commissioning and build stage as I was not involved. When I was involved from 2018, the issues were taken very seriously. There was not always agreement with the Whistleblowers about all the issues but they were taken seriously, investigated and remedial actions implemented.

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

A. There were on-going attempts to work constructively with both Dr Peters and Dr Inkster and ensure constructive working within the IPCT from 2020. In February 2020, Angela Wallace replaced Marion Bain as Interim Infection Control Director and she started meeting with Dr Inkster and Dr Peters accompanied by external Organisational Development (OD) support. OD expertise was secured with Terri Hunter in the GGC OD team and Jenny Copland from Scottish Government OD team. An OD plan was developed. Despite the pandemic the OD plan continued to be implemented. Jenny Copland offered 1-2-1 coaching support to all the Senior Team. Angela Wallace had a weekly meeting with the Infection Control Community including microbiology, IPCT, Laboratories and Virology doctors to rebuild the IPC Team. Angela Wallace met every 2 weeks with Drs Peters and Inkster and OD staff for 10 months and made herself available to support colleagues in the IPC team and wider community to build new ways of working. Angela Wallace reported that she was made aware by IPCT members and microbiologists that Dr Peters continued to send challenging and frequent emails often late at night to the Infection Control Manager, the Infection Control nurses and the lead IC doctor which caused them to feel under pressure, fearful and anxious. As Angela Wallace tried to resolve the tensions and disputes created by the constant challenging of the IPCT, the OD experts concluded although mediation or similar interventions might have been available, their advice was that in this set of circumstances they would not improve the situation. Angela Wallace continued try to build day to day relationships and ways of working for two years. There were still very frequent emails to the IPC nursing team giving random sample results and CHI numbers causing duplication of referrals despite Dr Peters being informed that all isolates come across automatically to the team. In one week the team received 10 emails from Dr Peters and when reviewed they were already aware of all the information they contained via their own systems and processes but they still required work to cross-check this. The Infection Control Manager has suggested that the psychological health of

several members of nursing and medical staff has been impacted by this behaviour which has been in place for a number of years.

Declaration

155. 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.

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

Appendix A

A43255563 – Bundle 1 – IMT

A43299519 – Bundle 4 – SBAR

A43293438 – Bundle – Miscellaneous

A47069198 – Bundle 12 – Estates

A47739010 - Summary of Infection Control Issues details – Volume 14 Volume 1

A38759263 - Email chain between Penelope Redding, Tom Walsh and Jennifer Armstrong dated between 5 September 2017 and 3 October 2017 – Bundle 14 Volume 1

A38759270 - Action Plan arising in response to SBAR dated 3 October 2017 – Volume 20

A40450652 - FW STEP 2 -Whistleblowing Policy Ventilation at QE and RHC – Volume 14 Volume 2

A46157941 - Email from C Peters to R Bajwe re Letter from Dr Linda de Caestecker - 15 May 2018 – Volume 14 Volume 2

A34427379 - NHS GGC - Step 2 Whistleblowing Report - dated May 2018 – Volume 27 Volume 3

A41745739 - Email 24th sept re whistleblowing concerns details – Volume 14 Volume 2