Scottish Hospitals Inquiry
Witness Statement of
Sandra Bustillo

Introduction

1. My name is Sandra Bustillo. I am employed by NHS Greater Glasgow and Clyde ('NHS GGC') and I am currently the Director of Communications and Public Engagement.

2. I am a member of the Executive Leadership Team and provide strategic advice to the Executive Team and the NHS Board on corporate communications and engagement. I am responsible for the delivery of corporate communications and public engagement with our staff, patients, the general public, the media and other stakeholders. This includes developing stakeholder communications and engagement approaches for a wide range of, often complex, issues affecting NHS GGC. I lead a Directorate comprised of the corporate communications team and the Patient Experience Public Involvement Team. I have held this position since May 2019, initially as Interim Director, before being appointed to the substantive role in February 2020.

3. I began my career in the NHS in March 1992 as a graduate management trainee with Greater Glasgow Health Board. Following a two-year training programme, I specialised in corporate communications and have held various roles managing this function in the period since, including Head of Communications for North Glasgow University Hospitals NHS Trust (2001-2004), Head of Communications for NHS GGC's Acute Services (2004-2008) and Associate Director of Communications, NHS GGC (2008-2019).

4. I have a Master of Arts degree in Politics and History, obtained from the University of Glasgow, and a post-graduate diploma in Management Studies, obtained at Glasgow Caledonian University.

5. The Scottish Hospitals Inquiry, the 'Inquiry', has asked me to provide a written statement relating to the concerns summarised in paragraph 7, sub paras (xvii) to (xxiii) of Counsel to the Inquiry's closing submissions to Glasgow I and paragraphs 365-455 and questions in paragraph 456 of Counsel to the Inquiry's closing submissions to Glasgow II.

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

Functions of a Communication Team

7. Firstly, I have been asked to summarise what the functions of a Communication Team in an organisation like NHSGGC are. The Corporate Communications Team for NHSGGC provides a range of communication functions within the Communications and Engagement Directorate to support the organisation deliver its objectives. My post reports to the Chief Executive and the communication priorities are delivered through 3-year Stakeholder Communications and Engagement Strategies and Internal Communications and Employee Engagement Strategies.

8. I am responsible for a team of 11 corporate communications staff and eight staff who deliver the patient experience and public involvement function. The team are based in JB Russell House, NHSGGC's headquarters. We cover services provided throughout NHSGGC, including all acute services and corporate functions, mental health, sexual health and primary care.

9. The key functions of the Communications and Engagement Directorate are:
    - Publication of proactive press releases and reactive media handling (responding to media enquiries) including a 24 hour on-call service, media monitoring, liaison with Scottish Government communications and other local partners and other stakeholders.
    - Delivery of corporate-level communications for 41,000 staff
    - Public information

- Digital communications, including full technical support and information population of the NHSGGC website, and corporate social media and YouTube accounts
- Creating and delivering campaigns for staff and the public, including service advice, social marketing and public health information campaigns
- Preparation for emergency comms handling
- Event management, including Ministerial visits, Royal visits, Celebrating Success Event, Annual Review
- Graphic design
- The design and delivery of the Board's corporate public engagement programme (including major service change).
- Management of corporate feedback systems, including Care Opinion, to support the organisation to listen and learn from the experiences of people
- Providing training, support and expert advice to staff on local engagement and involvement activities along with best practice advice on ensuring they are reaching as wide a range of their service users as possible
- Monitor and report on what patients and carers are telling us about their experiences including key themes and trends to the NHS Board and clinical teams to identify and learn from positive practice and highlight areas for improvement
- Evaluating engagement to identify good practice and areas for improvement.

The range of activities of the function are demonstrated in the attached public Board paper which was a summary of the previous three years' activity.

Communication with Patient and Families

10. I was heavily involved in the preparation of documents in response to the Inquiry's Request for Information No. 6 which cover communications by NHS GGC and its senior officials to patients, their families and other stakeholders. In the interests of efficiency, I will not replicate the full detail of the responses to Request for Information No. 6 but will summarise the relevant aspects which

respond to evidence heard at the Glasgow I and II hearings in relation to communication with patients and families.

Issue 1: Overall communications strategy/Requirements of the National Infection Prevention and Control Manual in relation to communications

11. One of the comments to have been made by parents at Glasgow I hearing was that NHS GGC lacked any communications strategy for dealing with the infection incidents and the ongoing questions over safety concerns.

12. At all times in the management of infection outbreaks and incidents, NHS GGC follow national guidance in determining the communications response to the incident. The key guidance is as follows:

(a) National Infection Prevention and Control Manual (NIPCM) which is the national framework for managing infections and outbreaks. This includes guidance on how such incidents should be communicated.

(b) Healthcare Improvement Scotland standards on Healthcare Associated Infections (HAI), which includes a communications standard. When this set of standards was first published in 2015, NHS GGC became the first Health Board to develop a Healthcare Associated Infection Communications Strategy [submitted under RFI 1 22.1] to bring together key processes to ensure compliance with the national HAI communications standard. This process has been followed since its commencement in 2015, and with the exception of a short period between 2019 and 2021 (due to the focus on managing infection incidents and the response to the pandemic), the strategy has been subject to a two-yearly review and update, including in 2021, learning from the experiences of families in the QEUH/RHC incidents of 2018-19 [the current version is on the NHSGGC website at HAI Communications Strategy and Guidance for IMTs - NHSGGC].

(c) Associate Chief Nursing Officer letter on behalf of the Chief Nursing Officer to HAI Executive Leads, copied to Chief Executive Officers and Infection Control Managers, dated 11 February 2019, which stated:

"It is a requirement for all infection incidents/outbreaks that the Incident Management Team (IMT):

- Communicate with all patients affected and where appropriate their families.
- Communicate with all other patients and where appropriate families who may be affected or concerned e.g. those in the same ward/unit as patient(s) affected.
- Prepare a press statement (holding or release) for all HIIAT amber or red assessed outbreaks/incidents. If a proactive media communication is planned then this should be undertaken in consultation with HPS and Scottish Government communication team colleagues."

13. NHS GGC communications complied with relevant guidance throughout 2018 and 2019 in relation to infection outbreaks and incidents at QEUH/RHC. In addition, as the situation continued into the second half of 2019 and parents outwith those in the unit were becoming anxious, we went beyond the requirements of the national guidance.

14. On 9 September 2019, the Cabinet Secretary for Health and Sport, Jeane Freeman, MSP, asked the then Chair of NHS GGC, Professor John Brown CBE, for a briefing on the Ward 6A Incident, including NHS GGC's communications approach. This briefing noted a plan to extend communications with parents to include those whose child or young person was not a current inpatient, amongst whom a number had expressed concern about the Board's communications. The following is an extract from the briefing [submitted as part of Ward 6A narrative under RFI 6]:

"We have established and continue to provide regular communication to staff and family/carers with patients on Ward 6A. We are committed to resolving concerns

and issues raised by patients/ families and press briefing statements are agreed after each IMT to facilitate communication with patients and families.

1. Face to face communication with all inpatient families. Our experience with patients and their families suggests that this method is very effective and it is well received from patients/ families as well as staff. We will also provide patients with a written briefing in the form of a question-and-answer information leaflet.

2. There continues to be an open offer to patient/ families on the ward who wish to have a discussion with senior charge nurse/ infection control advisor/ senior manager (RHC) on a one-to-one basis.

3. We will draft a letter to all other patients (day cases, shared care and outpatient clinic patients) offering a point of contact to address any issues and concerns with an offer to contact a senior manager to arrange a meeting with clinicians.

4. We will share any patient/ family patient briefings with other in-patients in other locations (e.g. NHS Lothian).

5. The GM (General Manager) has a regular call with the other centres who care for our patients and to provide an update on any relevant issues.

6. Staff Communications. We currently facilitate face to face briefings with all staff following each IMT and we will continue to deliver this. Our aim is to ensure all staff are updated with relevant information to multi-disciplinary teams.

7. The patient population is geographically dispersed, and we will consider additional forms of communication including Facebook, Twitter and are being informed in our communications by SNIFFER risk communication in managing large scale group meeting (Though aimed at contaminated land

incidents, SNIFFER contains information to support communication on environmental risks).

I have been asked what SNIFFER is, to explain its significance and why it was used under these circumstances. Scotland and Northern Ireland Forum for Environmental Research (SNIFFER) was suggested for inclusion in the briefing to the Cabinet Secretary by Dr Iain Kennedy, Consultant in Public Health. This document describes a framework for a good communications strategy. Its only connection to 'environmental risks' was that it was devised in relation to the management of land contamination risks, but otherwise it offers general advice and a framework for communications including information on the following "Hallmarks of an effective communication strategy; Recommendations on how to develop an effective, robust communication strategy; and Practical advice on how to deliver your message effectively."
Risk_communication_booklet_Sniffer.pdf

8. Wider communication - we continue to communicate with the Board, HPS, and Scottish Government through our national guide protocols of infection control reporting. The communications for staff, patients, and media is regularly discussed and is a standing item on the IMT agenda."

15. The Cabinet Secretary agreed to this communications approach. From this time forward, NHS GGC widened out its communications from those parents directly affected to include a wider cohort of parents, including parents of outpatients and day cases. Also, from September 2019, with the establishment of the closed Facebook account for Ward 6A parents and patients, statements were also posted and shared with parents who had joined the page. In addition, the Chair, Chief Executive and other senior executives also personally met parents in Ward 6A and also wrote to all other parents and offered to meet them, including a meeting with families on 2 November 2019.

16. In November 2019, the Cabinet Secretary for Health and Sport advised that she wanted to see and clear all NHS GGC communications relating to infection,

prevention and control at the QEUH and RHC, to include 'enquiries where there is a claim of a contention even if it is not the case'. This was conveyed to me in an email from Suzanne Hart, Senior Media Manager, Scottish Government [submitted with Narrative 7 under RFI 6 in an email dated 28.11.2019].

17. The process of Scottish Government oversight and Cabinet Secretary clearance was not routine and not consistent with NHS GGC strategy or internal governance procedures and this is covered in greater detail in paragraphs 135 - 191 within this statement.

Reflections on the use of the National Infection Prevention and Control Manual (NIPCM) framework and strategy:

18. From early 2019, comments began to be made by third parties that NHS GGC was not following the NIPCM in how it reported incidents, for instance, the Cryptococcus incident. As a result, suggestions were being made that NHS GGC was withholding information, lacking transparency and that our communications were not timely. My witness statement will cover the Cryptococcus incident elsewhere, but these criticisms I believe, in part, stem from a degree of ambiguity in the national guidance and a lack of awareness amongst some public commentators on what the guidance advises in relation to communications.

19. All incidents and outbreaks are assessed by the Incident Management Team for their severity of illness, impact on service, risk of transmission and potential to cause public anxiety. Any incidents which are assessed as 'Amber' require the NHS Board to prepare a holding statement, a statement which can be used to react quickly and respond to news of an incident emerging in the public domain. Any 'red' incidents require the NHS Board **either** to prepare a holding press statement or issue a press release proactively. The NIPCM states that the '*Incident Management Team will determine which course of action is in the best interest of the patient(s) directly involved and the public*'. This current guidance was changed in 2017. Prior to that, the guidance stated that 'all incidents rated as 'red' **must** have a press statement proactively released in the public domain'.

20. I am aware from conversations with journalists and politicians that there was a misunderstanding about the manual and what a Board should do in the case of a 'red' rated incident. One journalist for instance had been given the pre-2017 version of the guidance by an unknown source which may have led to an incorrect assessment of how NHS GGC should be managing communications. The absence of an automatic release of information into the public domain, whilst sensible and proportionate, can also result in an inconsistency in approaches, which in our case, resulted in unwarranted criticisms of a lack of openness and transparency. I would add that, regardless of the assessment of the incident as either 'green, amber or red', it is open to the IMT Chair to decide that a proactive statement is in the public interest.

21. As we continued to investigate a series of incidents and outbreaks in NHS GGC throughout 2018 and 2019, IMTs were sensitive to the heightened level of public anxiety generally on healthcare associated infections being investigated by NHS GGC. This made the IMTs more inclined to take a proactive approach, which in turn, further heightened levels of anxiety. The ambiguous nature of the national guidance, and the lack of a definitive framework, added a level of challenge in how communications were managed and how this was perceived by patients, the public and other stakeholders. However, at no time were I or my team involved, or aware of, any deliberate concealment or misrepresentation of information on the part of NHS GGC in our public communications.

Issue 2: Communications regarding water issues relating to Wards 2A, 2B, and 6A, particularly whether facts as they were known were withheld/ concealed/ misrepresented by the Board.
Plus
Issue 3: Communications regarding closure of Wards 2A and 2B and the decant to Ward 6A and the reasons given for this, particularly whether facts as they were known were withheld/ concealed/ misrepresented by the Board:

Communications Regarding Water Incident (2018)

22. An Incident Management Team was established on 1 March 2018 to investigate and manage infections on Ward 2A/B of the RHC. I personally did not attend the Incident Management Team meetings. As is normal practice for IMTs, these would be attended by one of the press officers who directly reported to me in my role (as Associate Director of Communications) at the time ['water incident' IMT minutes were submitted as part of a timeline under RFI 1 6].

23. In line with national guidance, underpinned by NHS GGC's Healthcare Associated Infection Communications Strategy, IMT meetings were the principal means by which decisions were made on communication in relation to outbreaks and incidents. Communications with patients, public, staff and media were an item on the agenda of every meeting, in accordance with the NIPCM. Actions around communications flowed from every meeting.

24. In accordance with the NIPCM and communications standards specified by Healthcare Improvement Scotland, the IMT Chair was personally involved in decisions regarding communications with parents, staff, the media and the public. The role of the press officer was to support the IMT in the delivery of their communications actions.

25. A patient's interface with a Health Board is routinely and primarily through their relationship with the clinical team. It is normal practice during an IMT for communications with patients therefore to be led by the clinical team providing their care. This is standard practice and, in my experience, it would be highly unusual in the management of incidents for senior Executives or members of the corporate communications team to communicate directly with patients and their families.

26. Throughout the water incident IMT, the bulk of communications with parents/carers was carried out by senior ward staff, and notes from the water incident Debrief Meeting on 15 May 2018 show that an additional nurse was put on the rota with the specific purpose of 'water incident communication' to liaise

with parents/carers and staff [submitted with 'water incident' narrative under RFI 6]. Recollections of Jennifer Rodgers, who was Chief Nurse within Women and Children's Directorate at the time of the incident, are that the additional nurse was in place as early as 5 March 2018.

27. I have been asked who the additional nurse is that I refer to, whether liaising with parents and carers was specific to them and their role, who they reported to, where they received instructions on what to communicate and when and were there records of these communication. A ward nurse was rostered on duty for that role each day as a communication conduit providing information that had been agreed by the IMT. This would be a senior Band 5 or Band 6 nurse who played a supporting role to the Senior Charge Nurse in liaising with staff and families around the activity linked to the IMT actions. The nurse reported to the Senior Charge Nurse. The hot debrief also describes this process. I have no further information on whether their conversations would be recorded.

28. IMT minutes show that senior infection control, clinical and managerial staff, including IMT Chair and Lead Infection Control Doctor, Dr Teresa Inkster, Chief Nurse, Jen Rodgers, and Women and Children's Directorate General Manager Jamie Redfern, regularly visited the ward to support Emma Somerville, Senior Charge Nurse, Ward 2A with staff and family/carer communications, personally handing out letters/briefings, answering questions and addressing concerns. These actions were not routine practice in NHS GGC and were put in place to offer an additional level of support to families/carers.

29. Relevant clinical disciplines responsible for the care of patients were represented on the IMT, and communications actions flowed from these representatives to clinical staff through team briefings and staff huddles.

30. We provided support to the clinical staff by arranging for management representatives to speak regularly to parents. Jen Rodgers and Jamie Redfern were senior managers within the Royal Hospital for Children and during the water incident IMTs, the decant and the later Ward 6A IMT they attended the unit to speak to parents after every Incident Management Team meeting to brief them.

In addition, as the Ward 6A incident continued in the second half of 2019, a senior Estates and Facilities management representative also attended the ward to speak to any parents who wished information. The Chief Executive and Chair also attended the unit in 2019 and separately offered to meet families of any patient who had been in the unit since it opened.

31. I have been asked whether there are records available of communications which took place with patients and families other than those which are noted in the IMT minutes. There may potentially be a record of discussions with patients and families in a patient's medical records but this would be a question for clinical staff to answer. There were also written communications between individual families and the organisation, which was recorded and managed by Jennifer Haynes, Corporate Services Manager – Governance. An action plan was also developed responding to the key issues raised by the families who met the Chair and Chief Executive on 2 November 2019.

32. The IMT also communicated significant developments with the wider staff across NHSGGC through Core Brief – a system of briefings and corporate messages shared with all NHSGGC staff in real-time by email. My team are responsible for the preparation and publication of messages via the Core Brief system, and this would be co-ordinated between the IMT, my press team and the internal comms desk. My then Communications Director, Ally McLaws, and I would have oversight of these actions.

33. It has been suggested to me that Core Briefs were not a suitable source for the information about the issues with the hospital environment for a variety of reasons including the extent to which everyone had time to access them was mixed, some did not have ready access at all, and they also carried a wide range of other information.

34. There were a variety of methods for communicating these issues with staff.

35. Those directly impacted were represented on the Incident Management Team meetings by Senior Charge Nurses, Consultants and senior members of the

hospital management team. As part of their role on the IMT, these individuals would communicate with clinicians and ward staff both verbally and also using the written briefs that were prepared for staff and families.

36. The Core Brief supplemented this activity but also provided an opportunity for the wider NHSGGC staff to be kept updated on key developments. Core Brief is issued by email to every email account holder within NHSGGC (approximately 49,500 mailboxes). It is also published on the organisation's intranet, Staffnet (accessed via the IT network), and on the public website, enabling anyone to read Core Brief at any time. We also ask for printed copies to be shared with staff who do not have access to a PC in the workplace.

37. From time to time, we conduct audits of our internal communications channels. The last audit, carried out in 2020, found that of a survey response of more than 2500 staff members, Core Brief was rated higher than all other forms of internal communication, with 89% rating it average, very good or excellent and 1.69% not having used it.

38. My team were also responsible for the issue of media releases and media statements in response to specific media enquiries. These communications were agreed with the Chair of the IMT in line with the NIPCM. Depending on the issue or significance of the content of the release, media statements could also be agreed with other colleagues, including senior NHS GGC officials. The press officer responsible for drafting releases and statements would also take advice from the Communications Director and me and copy us to the email communications that took place with the IMT Chair and other colleagues to draft and agree a media release or media statement for issue. As per the NHS GGC Standard Operating Procedure for issuing press statements [submitted under RFI 1 22.1], all statements would require approval from a senior officer, in this case, from the IMT Chair, and where relevant, other senior officers, before being issued. My press team would not issue information that had not received this approval. There was a very low risk threshold for managing the release of information to the media.

39. As such, the process to agree a media statement was an inclusive one, intended to ensure that it reflected accurately the current situation, with the result that the approval process could be lengthy involving a number of people. This at times impacted on the organisation's ability to communicate responsively and at pace.

40. It was also routine for NHS GGC to update the Scottish Government on developments and decisions of IMTs, with proactive and key reactive statements regularly shared for information. The then Director of Communications or I would email the lead for the press desk within Scottish Government, Suzanne Hart, and her team, to share statements and alert them to developing issues.

41. From the outset of the water incident, as evidenced by IMT minutes, parent/ patient communications with those on the ward at the time was prioritised, along with staff communications. The minute of the IMT of 6 March 2018 reported that communications with families were ongoing [submitted in a timeline under RFI 1 6]. A proactive media release was first issued 10 days later, on 16 March 2018, by my team following approval by the Chief Executive, Jane Grant, Medical Director, Dr Jennifer Armstrong, and IMT Chair, Dr Teresa Inkster. The media release was shared with the Scottish Government for information and published on the NHSGGC website. We also informed the NHS GGC Board. The information contained in the media release was consistent with a written briefing prepared for families and issued on the same day [submitted within 'water incident' narrative under RFI 6].

42. The media release made clear that NHSGGC were investigating the presence of bacteria in the water supply to wards in the Royal Hospital for Children in Glasgow and that three children were receiving treatment for infections potentially linked to these bacteria found in the water supply. We also confirmed that a number of mitigations were in place and set these out in detail, including "alternatives to tap water supplies to paediatric patients in wards 2A, 2B, 3C and the hospital's intensive care unit". A Core Brief containing the proactive media statement was also issued to all staff [submitted within 'water incident' narrative within RFI 6, dated 16.3.2018]. This statement, agreed with the IMT Chair, was open and transparent in setting out the detail on our understanding of the issue.

43. Following the publication of this information in the public domain, the IMT managed the release of further information proactively as their investigations continued and also responded to all requests for information from the media. Throughout, the IMT, working with my team, sought in good faith to co-ordinate the release of accurate information proactively to the media with updates for parents and families, and where appropriate, with other stakeholders, including the NHS GGC Board, wider staff and the Scottish Government.

44. The water incident IMT was closed on 27 March 2018, upon completion of mitigation measures and since no new cases had been reported since 16 March 2018. When the water incident IMT was reconvened on 29 May 2018, it continued to take the same approach, with information provided to patients and families being prioritised and co-ordinated with any proactive media statements. This included the proactive release of information about a chemical disinfectant treatment of the drains in Ward 2A/B, with the first information on this measure being published on 4 June 2018 [submitted within 'water incident' narrative under RFI 6]. This statement made clear that treatment was being carried out on the drains in the unit because traces of bacteria had been found during testing. It further confirmed that there was a potential for patients to be moved temporarily to another ward within the hospital, if required, to allow the work to be completed and that our infection control experts believed the bacteria to be linked to an earlier issue with taps which had since been fitted with filters. This was an accurate, open and honest account of the potential hypothesis, potential for harm and the actions being taken to remedy the situation.

45. This media statement, which was approved by the IMT Chair, Dr Teresa Inkster, was shared with Jamie Redfern and senior ward staff to brief parents/carers. It was also shared with Scottish Government for information.

46. The minutes of the IMT show that parents continued to be updated on the hydrogen peroxide vapour (HPV) decontamination process after this by staff, including a further update on 13 June 2018 which also confirmed that prophylaxis was being prescribed as a precaution for some patients [submitted in a timeline under RFI 1 6]. This information was made public in a proactive media release

issued by my team on 13 June 2018 [submitted within the 'water incident' narrative under RFI 6].

47. I have been asked for clarification about communication with parents regarding the HPV decontamination process and prophylaxis being described as a precaution for some patients.

48. My team was not responsible for the provision of information to parents on HPV cleaning but did co-ordinate media statements with information provided to parents.

49. As is noted in IMT minutes, HPV cleaning commenced on 5 June 2018 until 17 June 2018.

50. In the minute of the IMT held on 4 June 2018 (A36690448), there is reference to a patient information leaflet specific to HPV cleaning. I do not have a copy of that leaflet and my team were not involved in the production of the leaflet.

51. On 6 June and 8 June IMT minutes (A36690461, A37989601 and A36690464), it is noted that parents were updated on the HPV clean process. This was not carried out by my team, but by Jen Rodgers, Chief Nurse, and nursing staff. I cannot say whether this was a verbal update and whether the patient information leaflet was given to parents at this time.

52. The minute of the meeting of 8 June noted that "parents continue to be updated on the HPV process, and that TI (the Lead Infection Control Doctor) has spoken to 3 sets of concerned parents".

53. The further minute of 11 June (A36690462) notes: "TI to draft a statement for families who have children already in ward 2A explaining what works will be going on."
[TI in this context means Dr Teresa Inkster]

54. A copy of a patient information sheet dated 13 June 2018 **(A38662234 Bundle 5)** has been previously provided to the Inquiry under RFI 6. It states:

> "Information for parents about cleaning in ward 2a
> The week beginning 12th June we will be using a new cleaning method in ward 2A. Your child's room will be cleaned as normal by the ward domestic. After this we will be using a mist to spray each room - this is called Hydrogen peroxide vapour (HPV).
>
> This is a fairly new cleaning technology which we have used elsewhere in the children's hospital and also in the adult hospital. It works by coating every surface evenly with HPV and is therefore more reliable and effective than the human eye for cleaning.
>
> To clean your child's room you will need to move into another room whilst the process is undertaken for approximately three hours. Most things can stay in your child's room but any item made of fabric or paper such as bedding, soft toys and books will need to be removed. Nursing and domestic staff will remove these items for you.
>
> You will notice a technician and two machines on the ward for the whole week. The technology is very safe. The hydrogen peroxide quickly dissolves into oxygen and water. Your child can go back into the room once it is finished.
>
> We will also be taking the opportunity to clean ceiling areas and sink drains which ordinarily can be difficult to access, so you may notice this also.
>
> Because this technology is very effective it may be used as a cleaning method 2-3 times a year in ward 2A."

Decant of Ward 2A/B – Timescales

55. As the water incident IMT continued to investigate a number of infections in Ward 2A/B, it was decided to move the patients out of these wards to allow

investigations to continue into the build-up of biofilm in the drains. These wards treated children with cancer who have very low immunity to infections so to let technical staff in and put cameras down the drains it was decided to decant the ward to another ward.

56. Whilst collectively, the IMT, myself and my team and fellow senior managers, endeavoured throughout to ensure that patients were briefed at the same time or ahead of information being released to the media, this regrettably did not happen when the decision was made to decant patients from Ward 2A/B to Ward 6A. A number of parents reported at the Glasgow I hearing that they found out about the decision to decant patients from Ward 2A/B through a report on STV news rather than from NHS GGC, and that this indicated a culture of secrecy and poor communications with parents.

57. This arose as my team was ultimately unable to control how news of the decant decision was managed because of a premature release of information to the media from an unknown source whilst the decision was still being made.

58. I was on leave during the period of 16-18 September 2018, but I am aware from communications subsequently shared with me by the then Director of Communications, and through emails which I have subsequently seen, of the timeline for communicating the news of the decant which I understand to be as follows [email summaries, media statements and briefings supplied as part of 'water incident' narrative under RFI 6]:

    1. The press office received a media enquiry on the late afternoon of 17 September 2018 from an STV journalist enquiring about an issue with bacteria in the drains at the Royal Hospital for Children. The journalist had been informed that chemotherapy for at least one child was delayed for a few days and that children may be transferred elsewhere for cancer treatment and that the affected ward was at one point not taking new patients. The journalist was content to receive a comment the following day given the late hour of the enquiry.

2. A detailed statement was drafted by the Director of Communications and one of the press officers and shared with Dr Inkster, Chair of the IMT, and senior managers on the morning of 18 September 2018. The IMT agreed that written statements for parents/patients, staff and the press would have common content.

3. As this detailed statement was being finalised, STV made a further inquiry, having interviewed the family of a patient on Ward 2A. At this stage a draft written statement was still in circulation for approval by Dr Inkster and senior officials of RHC and the Executive Team. With STV now able to report a first-hand account of the information that had been shared with families, this effectively removed the ability to for us to control the timings of how we could inform parents of the decant decision.

4. Throughout the remainder of the afternoon, the NHS GGC statement was finalised, including comments from Dr Inkster at 4.30pm, and at around 5pm it was shared with senior staff and ward staff to be used as the basis for conversations with parents on Ward 2A/B.

5. At 5.16pm the media statement was shared with STV in order to provide comment for their evening bulletin, before being issued to the wider media at 5.24pm. At 5.28pm, the statement was issued to all staff via Core Brief, and at 5.39pm a communication was issued on NHS GGC's Involving People Network. The statement was also published on the NHS GGC website.

6. Unfortunately, colleagues were detained in meetings discussing the decant arrangements and there was a delay in confirming to Jen Rodgers and a senior medical colleague who were in the Ward that they should go ahead to speak to families face-to-face with the written brief. This delay was due to Jen Rodgers awaiting confirmation from Keven Hill, Director, Women and Children's Services who himself was delayed as he was in a meeting with other Directors discussing the decant. At 6pm, STV news aired and reported on the decant decision. The responsibility to manage communications with staff and pass on details of the decant arrangements were with the IMT

representatives from the service, Jamie Redfern, General Manager, Jen Rodgers, Chief Nurse, Professor Brenda Gibson, Clinical Lead and Emma Sommerville, Senior Charge Nurse.

59. Former Counsel to the Inquiry, Alastair Duncan KC, asked Jamie Redfern about a press release on the proposed decant issued on 17 September 2018 in Glasgow hearing II. I am able to clarify that no press release was issued. I believe that the document being asked about was a draft press statement, which was in circulation, but not issued until 18 September 2018.

Decant of Ward – Accuracy of Statement

60. The full proactive written statement provided to patients, families, media and the public on the decant has been provided to the Inquiry. This was a full statement on the history of the water issues in the hospital, how they had impacted on patients and what steps were now being taken to remediate further the perceived problems. This had been approved by Dr Inkster, as Chair of the IMT, and I therefore believe this to be an accurate account of the assessment of the IMT on the decant.

61. There were detailed written communications prepared to explain the decant and these have previously been provided to the Inquiry. For ease these are reproduced here.

The following briefing was prepared for families:

'WARD 2A AND 2B UPDATE
We appreciate that you have been experiencing disruption whilst we have introduced an enhanced cleaning programme.

As you may be aware we initially experienced a build-up of material (known as biofilm) in the sink drains in Ward 2A and 2B. This is the same sort of biofilm we get in domestic sink drains but as the patients in these wards are being

treated for cancer their immune system is compromised and they are more susceptible to infection.

Today we have introduced a new cleaning product called Hysan to clean the drains. Hysan is a hard surface disinfectant effective against bacteria.

Whilst this will work in the short term; longer term we require a permanent solution. This will require us to temporarily transfer ward 2A and 2B to another ward in QEUH adult hospital.

This will provide opportunity for drainage and technical experts to undertake a comprehensive investigation and complete any remedial works required. We are working to make this happen as soon as possible and will keep everyone in the two wards fully updated on our plans as they develop.

As this only affects immuno-compromised patients and no other patients at the Royal Hospital for Children are affected.

Thank you for your cooperation and assistance to ensure the highest standards of care and treatment continue to be provided for your child.

The following media release was issued and was also shared with all NHSGGC staff.

NHS Greater Glasgow and Clyde statement on drains at the Royal Hospital for Children

From January until June this year we experienced issues with the water supply in wards 2A and 2B of the Royal Hospital for Children when a number of patients were affected by bacteraemia.

Our technical experts advised the metal parts inside taps were replaced with plastic ones, filters attached to the taps and the drains cleaned with a chlorine

based detergent. In addition the ward environment was cleaned with Hydrogen Peroxide Vapour (HPV).

After this work was completed there had been no new cases of bacteraemia for several weeks.

But more recently there have been six new cases and although all the children have recovered and been discharged or are continuing with their normal treatments we instigated an Incident Management Team to further investigate and manage the situation.

What we are seeing is a build-up of biofilm in the drains which is the same sort of biofilm we get in domestic sink drains. This build up has happened only seven weeks after they were cleaned by HPV.

We have worked with national experts in Scotland and sought advice from UK experts on the issue as we seek to find a permanent solution and understand why this has happened.

These wards treat children with cancer who have very low immunity to infections so to let our experts in and put cameras down the drains we need to move the patients.

Ward 2A has a combination of haemato-oncology patients and other cancer patients. Four bone marrow patients will move to the bone marrow adult ward (4b) in the adjoining Queen Elizabeth University Hospital (QEUH).

The remainder of the 22 patients from ward 2A and the outpatients who attend ward 2B (this is a day care ward with no inpatients) will move to another ward in the QEUH.

Patient safety is the one key overriding issue and this temporary move will enable our technical experts to make thorough investigations.

No other services at the Royal Hospital for Children are affected.'

Reflections on Communications Handling of Water Incident

62. Throughout the period of the management of the water incident which extended over two periods from March 2018 to December 2018, there was significant proactive parent/carer communications activity by clinical staff, members of the IMT and senior managers, supported by me and my team, which were focused principally on those patients and families present in the unit directly impacted by events. As public, media and political interest in issues affecting the unit grew and became more sustained into 2019, it became increasingly evident that we needed to communicate with families beyond those whose child or young person was in hospital and so we developed approaches to facilitate this. I appreciate that, for some parents who were not in regular contact with the unit, until the launch of the Facebook page in September 2019, their main source of information may have been through the media coverage which was not at all times accurate.

63. Furthermore, I believe that the information that parents were being given from different sources may have caused confusion and mistrust of the information and updates we were providing. For instance, once the measures had been taken on the water supply, our statements – as agreed with the IMT Chair and the Director of Estates and Facilities - reported that the water was safe to use. However, the continued use of bottled water to 'build up the confidence' of parents in the water supply, combined with posters asking patients only to use the clinical sinks for handwashing, could understandably give a different, conflicting impression; the experience of patients and carers in this regard was at odds with our statements.

64. I have been asked who was responsible for making decisions such as continuing to use bottled water when the water had been cleared as safe to use. I was informed by Jamie Redfern, who was the then General Manager, Hospital Paediatrics, that it had been agreed within the Royal Hospital for Children to

continue to supply bottled water. I am not aware whether that was an active decision or who was involved.

65. I have been asked could this have been handled differently. On 4 June 2018 IMT, the minute notes that: ""TI responded that the filtered water remains safe to use and she is comfortable that patient's [sic] continue to use showers." It was also noted that bottled water continued to be issued at that time as the kitchen was closed, meaning that parents were unable to refill water jugs.

66. Had the use of bottled water ceased when the kitchen was re-opened, then this may have reduced confusion or conflicting messages.

67. Any mistrust may have been compounded by an error on the part of my press team when, in October 2019, in response to an enquiry from the Herald on Sunday, it was mistakenly stated that we had not given advice to stop drinking water. Whilst this was accurate in the case of the Ward 6A IMT underway at the time, there had been a period in the early stages of the water incident IMT in March 2018 when such advice had been given at the Royal Hospital for Children. The detailed narrative and associated documents provided to the Inquiry in RFI No. 6 explains the events which led to this inaccurate statement being issued. This mistake was regrettable and undoubtedly impacted trust [the narrative is the 'water advice' narrative provided under RFI 6].

Issue 4: Knowledge of the Board of issues with the water supply since 2015 and "suppression" of the DMA Canyon report. The Inquiry has heard evidence, in particular from [redacted], of an allegation that the Board failed to act upon the issues raised in the DMA Canyon report regarding the water supply and failed to communicate with patients and families as to the issues raised in the report in terms of how these issues may impact upon patient safety.

68. I have only limited knowledge of the DMA Canyon reports.

69. I was not a member of the NHS GGC Executive team when the DMA Canyon Reports were first brought to the attention of the Chief Executive, Mrs Jane Grant, in early summer 2018. The then Director of Communications, Ally McLaws, may have been party to discussions about the reports, but did not share this with me.

70. I first became aware of the reports when the Leader of the Scottish Labour Party, Anas Sarwar MSP, referred to them in the Scottish Parliament on 28 November 2019.

71. In my role, I was responsible for working with colleagues to respond to media questions about the DMA reports, including enquiries that followed comments by Mr Sarwar in November 2019 [see the media statement issued 28.11.2019 and submitted under RFI 1 22.6], a question from the BBC Disclosure programme makers in 2020 [as included in the Disclosure narrative submitted under RFI 6 in an email thread dated 18.6.2020], and an enquiry from Hannah Rodgers at the Herald on Sunday [see response made 24.5.2019 submitted under RFI 1 22.6]. These media statements were all prepared during the period of Scottish Government oversight of NHS GGC communications (as per paragraphs 135 - 191 of my statement) so would all have Cabinet Secretary clearance and have been provided to the Inquiry.

72. When the DMA Canyon water risk assessments were raised with the Chief Executive, the potential issues with the water supply were already being investigated, about which we had been open and transparent with patients, their families and the public, as I describe elsewhere in my witness statement.

Issue 5: Communications ventilation issues relating to Wards 2A, 2B, and 6A, particularly whether facts as they were known were withheld/ concealed/ misrepresented by the Board; [December 2018 to March 2022]

73. The decision to remain in Ward 6A to enable work to take place to upgrade the ventilation system was communicated to parents, staff, the NHS GGC Board, the public and media in December 2018. The water incident IMT was continuing to meet at this time, and it is noted in the minute of the meeting on 30 November

2018 that “Dr Inkster wishes Comms to be released informing parents and staff that the ward will not be moving back on 14 December due to ventilation issues” [as included in a timeline submitted under RFI 1 6].

74. The then Director of Communications, Ally McLaws, prepared a core message on the work to be undertaken on the ventilation system which he shared with Dr Inkster, Grant Archibald, the then Chief Operating Officer, Kevin Hill, Director, Woman and Children’s Services, Tom Steele, Director of Estates and Facilities, Tom Walsh, Infection Control Manager and Jonathan Best, who was to take over the role of Chief Operating Officer from Grant Archibald.

75. The content of this message was to be used proactively as the basis for a patient and parent briefing, a media release, staff communication, NHS GGC Board Member briefing and to be published on the Involving People Network for the general public.

76. Given the significance of the issue, Ally McLaws also shared the draft with Jane Grant, Chief Executive and Dr Jennifer Armstrong, Medical Director.

77. It was through this iterative process that the final version of the statement was agreed, and this was given to parents and issued to other stakeholders on 6 December 2018 [media statement submitted under RFI 1 22.6]. This statement advised of the decision to upgrade the ventilation, the anticipated cost of doing so and the consequences of this for patients. I understand this to be accurate at the time of writing and do not believe this was misleading.

78. It has been stated to me that there is evidence that patients (and not only patients) were told that ‘the opportunity was being taken to upgrade the ventilation’ during the decant of Ward 2A. I have been asked if this is a full and transparent explanation of why works were done and if ‘upgrade’ was a fair description of what was done.

79. This communication was drafted by the then Director of Communications, Ally McLaws, and shared with the Incident Management Team, the Lead Infection Control Doctor, Teresa Inkster, other Directors and the Chief Executive. The version of the statement that confirmed the ventilation was to be upgraded was approved by the Chair of the IMT, Directors and the Chief Executive. The statement included the anticipated cost of £1.25m, confirming it would take an anticipated "12 month programme to design and install the upgraded system'.

In addition, a background note was provided which explained the timeline:

'Background note
In March of this year bacteria was found inside the taps of patient rooms in ward 2A of the Royal Hospital for Children. The water supply from the main tanks to the hospital tested clear and we identified the taps and shower heads as potential sources - all have been replaced.

The drains were also tested and in September we took the decision to move the patients out of wards 2A, 2B and the adjoining Bone Marrow Transplant unit into wards in the adult hospital next door. This allowed our technical staff to carry out remedial works and to make investigations into the whole ward environment. It was during this period that our teams identified the opportunity to upgrade the ventilation system and this work is now being progressed."

80. Whilst the programme did take considerably longer, and cost considerably more, not least due to the impact of the pandemic, I believe the statement to be accurate at the time of writing.

Issue 6: Communication as regards the Cryptococcus incident, including leak to media; [November 2018 to May 2019]

81. An adult patient being treated in Queen Elizabeth University Hospital had a positive blood culture for Cryptococcus neoformans on [redacted] November 2018. A paediatric patient had a positive blood culture for Cryptococcus neoformans

reported on [redacted] December 2018. Both patients sadly died. The two cases were reported by a microbiology colleague to the Lead Doctor for Infection Control, Dr Teresa Inkster, on [redacted] December 2018. A Problem Assessment Group met the following day, and the first meeting of the Cryptococcus Incident Management Team took place on 20 December 2018 [IMT minutes were submitted within a timeline under RFI 1 6 and are discussed within the cryptococcus narrative submitted under RFI 6].

82. Communications was a standing item on the agenda of the Cryptococcus Incident Management Team (IMT) meetings in line with the National Infection Prevention and Control Manual (NIPCM).

83. Using the Healthcare Infection Incident Assessment Tool (HIIAT), the incident was assessed as red on 20 December 2018 and, in line with the NIPCM, the IMT considered whether to issue a proactive release.

84. In this instance, the IMT noted that the funeral of the paediatric patient who tested positive for Cryptococcus was due to [redacted], and the parents would not know the outcome of the Fiscal instructed Postmortem until after [redacted]. The IMT also noted that there were no wider public health implications and that the cause of the incident remained unknown. The press officer advised that a press statement should not be released before the parents of the paediatric patient were informed, to prevent them finding out via the press.

85. Within this context, the IMT decided against a proactive release and agreed that a holding line should be prepared in the event of any media enquiries. Relevant clinical disciplines responsible for the care of patients were represented on the IMT, and communications actions flowed from these representatives to clinical staff through team briefings and staff huddles.

86. When the IMT next met on 27 December 2018, the Chair of the IMT, Dr Inkster, fed back that she had discussed the incident with the NHS GGC Medical Director who agreed that, in line with Duty of Candour, patients must be told of the concerns of the IMT. The adult patient who tested positive for Cryptococcus had

been spoken to by the Lead Doctor for Infection Control about the blood culture results. The parents of the deceased child did not yet know the outcome of the Fiscal instructed Postmortem and the current hypothesis. The patient's funeral had been held on [redacted] and the parents were to take a break for a few days. Discussion took place as to the content of what the parents would be told and when. The IMT agreed that the final Fiscal report would be helpful, prior to speaking to the parents, however, if this were to take a considerable amount of time, it was important to tell the parents before the report was available. It was agreed that the Procurator Fiscal should be contacted to find out when the report would be available.

87. As was subsequently noted by the IMT, a meeting with the parents of the paediatric patient took place on 4 January 2019. I was not present at that meeting.

88. On 7 January 2019, there was a further Incident Management Team when the incident was rated as green, as there had been no further cases. There was agreement by the IMT that no proactive communications were required at this time.

89. Following this meeting, and in response to a letter from the Lead Clinician for Haemato-oncology on the ongoing situation, the Medical Director convened a meeting with a number of colleagues involved in the IMT, at which it was agreed that HEPA filters should be deployed to Ward 6A and that there was a need to supply rapid information to staff and parents to explain this [the meeting minutes of 9.1.2019 are contained within the cryptococcus narrative submitted under RFI 6].

90. A written note was initially planned and then an aide memoir was instead agreed and distributed to ensure staff were fully briefed and messaging was consistent for parents and families [copies are included in the cryptococcus narrative submitted under RFI 6, dated 9.1.2019].

91. Parents on Ward 6A were briefed verbally on 10 January 2019.

92. This was followed up on 13 January 2019 by a written communication, following concerns from four families being raised directly with the Cabinet Secretary for Health and Sport. The written briefing was drafted by a press officer and agreed with IMT representatives, senior officials and the then Director of Communications, Ally McLaws.

93. The written briefing was given to parents on Ward 6A individually, face to face, with a verbal update and an opportunity for discussion by Jen Rodgers, Chief Nurse, and members of the clinical team [included in the cryptococcus narrative submitted under RFI 6].

94. As the IMT continued to meet to review and manage the situation, including the results of a second round of air sampling, one of my press officers reported to the IMT that the Sun newspaper had made an enquiry about the situation. The newspaper subsequently confirmed that they were speaking with parents. A reactive media statement was agreed and issued to the Sun on 17 January 2019.

95. The Sun journalist confirmed that the paper was not planning to run their story until the weekend. The IMT agreed that if, NHS GGC was going to release a press statement, then information would also be needed to distribute to patients/parents and staff and a further written communication for parents and patients in the unit was issued on 17January 2019 [included in the cryptococcus narrative submitted under RFI 6].

96. A number of IMTs were organised over 17 and 18 January to review the results of the air sampling obtained on 16 January 2019.

97. On 18 January 2019, the decision was taken by the IMT, and senior officials within NHS GGC, to issue a proactive press release and a briefing for all staff. I agreed the draft release with the Chair of the IMT, Dr Teresa Inkster, and other colleagues. There was agreement that the release should only be issued once the families of the two patients who had tested positive for Cryptococcus were

notified that a release would be issued, and that media coverage was expected. This delayed the issuing of the release until 8pm on the evening of the 18 January [included in the cryptococcus narrative submitted under RFI 6].

98. I updated Scottish Government and Health Protection Scotland communications officials on our plans to issue a proactive release and shared this with them ahead of issue. I also alerted NHS GGC Board members [included in the cryptococcus narrative submitted under RFI 6, at 18.1.2019].

99. There was significant resulting media coverage over the weekend, with further requests for details of the cases. An all-staff briefing was issued on the QEUH site on 20 January 2019 and verbal briefings were given by the then QEUH Director, Anne Harkness, to all receiving consultants/Emergency Department/ ICU team at the 12.00 noon huddle (communications and safety meeting representing all parts of the adult hospital) [correspondence and written briefing included in the cryptococcus narrative submitted under RFI 6].

100. In the aftermath of the initial proactive statement from NHS GGC, there was intensive and sustained media and political scrutiny of the Cryptococcus incident which continued for a number of weeks. This was compounded by further unrelated infection incidents in NHS GGC hospitals, all of which contributed to a heightened public anxiety and media and political scrutiny of infections.

101. Throughout the period that the IMT continued to meet to consider the incident, communications were a core agenda item in line with the NIPCM. At no time were I, or my press team, asked to withhold any aspect of the incident, unless to protect patient confidentiality. We were proactive in our communications throughout.

Reflections on the Cryptococcus IMT Communications

102. There were a number of key issues in the communications handling on this incident which I would highlight.

(a) Challenge in balancing the public interests with the need to respect patient confidentiality

103. Central to the considerations and planning of communications about the incident, were the two patients and their families. At all times, the IMT, senior officials, my team and I endeavoured to respect and protect patient confidentiality. The risk of deductive disclosure was a key concern, particularly in the case of the paediatric patient, and this restricted the level of detail that, collectively, we were prepared to confirm on the cases. When the IMT agreed to a proactive release confirming the investigation of two cases, we agreed with the IMT Chair and other senior officials to the release of information, without providing details of the deaths of both patients. Given the small number of paediatric patients within this cohort and the very small number of deaths over this period, to have disclosed this might have revealed the identity of the patient and thus breach professional codes respecting patient confidentiality. This position was agreed in good faith but unfortunately had negative consequences:

(i) Release of information on deaths was uncontrolled

Comments began to appear on social media within a few hours of our press release on 18 January that two patients had died. This included misinformation that both of the patients were children. Both STV and BBC contacted the press office to enquire about this and I worked with a number of officials to agree a statement that would confirm the deaths, and clarify that this did not involve two children, whilst still seeking to protect the identity of the paediatric patient by not confirming that a child had died.

Despite a number of enquiries from media, we maintained this stance on not confirming further details of the patients due to patient confidentiality. This was not consistent with other authorities, including the Crown Office and the Cabinet Secretary for Health and Sport who did release details of the patients in the public.

(ii) Complaint by the family of the adult patient

In seeking to protect the identity of the paediatric patient, we inadvertently caused distress to the family of the adult patient by the use of language in the public statement issued on Saturday 20 January, for which we subsequently apologised. We referred to the patient as 'elderly', a term that gave offence to the family of the adult patient. The use of this term, to distinguish between the two patients, had been carefully considered in the drafting of the statement and was felt to be respectful. Unfortunately, it caused distress to the patient's family, which I very much regret.

(iii) Criticism from politicians on 'failure of Board to answer legitimate media questions'

The decision not to share patient specific details was a factor in subsequent claims by politicians that we were seeking to 'cover up' the incident. NHS GGC was criticised in the Scottish Parliament by Cabinet Secretary for Health and Sport, Monica Lennon MSP, for a failure to answer legitimate questions over the weekend. These questions related specifically to the deaths as well as the timeline for the incidents (see below).

(b) Misunderstanding of the NIPCM

104. There were comments made by third parties that NHS GGC was not following the NIPCM in how it reported this incident, with a suggestion that the infection should have been reported publicly within 24 hours of it being confirmed. As is explained in Paragraph 111 below, this is incorrect.

105. Questions about the timeline for the incident began to be asked by media on 20 January to which NHS GGC responded, [included in the cryptococcus narrative submitted under RFI 6 at 20.1.2019 as 'third proactive statement'] confirming the following:

"These two cases of infection were identified in December and an Incident Management Team was formed. A likely source was identified and dealt with

immediately. The small number of paediatric and adult patients who are vulnerable to this infection are receiving medication to prevent potential infection and this has proved effective."

"Air sampling was carried out and HEPA filters were brought in on 10 January to specific areas before conclusive results were available. Results identifying the organism were obtained on 16 January."

106. The Scottish Labour Party began to ask questions about the timeline for the announcement about the infections on 21 January 2019 in a general news release issued that day: "It has already been confirmed that the government knew about fungal infections at the hospital last December." Scottish Labour Shadow Cabinet Secretary for Health and Sport, Monica Lennon, was quoted.

107. Again, we confirmed the timescales for managing the incident [media statement dated 21.1.2019 , included in cryptococcus narrative submitted under RFI 6].

108. On 22 January, Alex Neil MSP stated:

"..a great deal of anxiety has been created unnecessarily as a result of the way in which external communications have been handled by NHS Greater Glasgow and Clyde. If the information had been made available more timeously, I am sure that much of the anxiety that has been created in recent days could have been avoided. Will the cabinet secretary make sure that the health board learns lessons on the need, in such circumstances, for effective and timeous communications and transparency as part and parcel of the strategy for handling such outbreaks?"

109. On 26 January 2019, Hannah Rodgers, journalist with Herald on Sunday, enquired about the timescales for informing the public about the Cryptococcus situation, suggesting incorrectly that our guidelines stated that given the seriousness of the situation we should have shared this rapidly [included in cryptococcus narrative submitted under RFI 6].

110. In fact, this line of enquiry misunderstood and misrepresented the NIPCM. Firstly, the guidance no longer states that all HIIATs that are assessed as red must have a press statement proactively released in the public domain. The NIPCM makes clear that the decision on whether to make a proactive statement on an incident is at the discretion of the Chair of the IMT. The guidance changed from the former to the latter position in 2017. NHS GGC is aware that Ms Rodgers had been given the pre-2017 version of the guidance by an unknown source.

111. Secondly, the timing in the guidance also does not relate to the date when an infection was confirmed, but the date of an IMT meeting. The guidance states that the IMT should complete a Healthcare Infection Incident and Outbreak Reporting Template (HIIORT) within 24 hours and prepare a press statement and send to Health Protection Scotland (now ARHAI Scotland) but it does not state that it has to be released publicly within 24 hours. The statement can be issued proactively, at the discretion of the Chair of the IMT, but the guidance does not state that this must be within 24 hours.

112. In this case, there were a number of factors which influenced the media handling of the incident and the decision not to issue a proactive statement including the personal circumstances of the family of the paediatric patient, together with the timescales for the post-mortem and also, critically, the timescales for the air sampling and the confirmation on 16 January of the presence of the organism within the hospital environment as detailed in paragraphs 81-107 of this statement.

113. Finally, the NIPCM states that, in the case of a red HIIAT, the Board should complete a report using the Healthcare Infection Incident and Outbreak Reporting Template (HIIORT) and share this with HPS within 24 hours – again this was carried out. It is the responsibility of HPS to share the report with Scottish Government.

114. In a statement to the Scottish Parliament on 22 January 2019, the Cabinet Secretary for Health and Sport confirmed:

"The Government was first informed of the Cryptococcus infection in two patients on 21 December. That was the right time for the Government to be informed, because it was the post-mortem following the child's death that identified the second case. As I said, a second case is the trigger for additional infection control action. We were rightly informed and kept up to date." [correspondence and briefings around this statement and the visit of the same day included in the cryptococcus narrative under RFI 6].

(c) Source of the infection

115. The decision was taken to release information on the potential source of the Cryptococcus organism – the plant room - which was being considered as the hypothesis at the time. This action was taken in order to address potential public anxiety about the safety of the wider hospital environment. However, as has since been concluded by the technical Incident Management Team established under the chairmanship of Dr John Hood, this hypothesis has been shown to be technically infeasible. The speed at which we reported on the hypothesis was made with good intentions but was ultimately confirmed too quickly – and once in the public domain was difficult to undo.

116. At the NHS GGC Board meeting on 19 February 2019, the Medical Director gave a report on the incident to Board members. She advised that an Expert Advisory Group had been set up to report to the Incident Management Team to help establish whether a definitive source of the Cryptococcus could be found, "although it was noted that an American study has reported that the organism can lie dormant in a healthy human and only become harmful when a person becomes extremely unwell with suppressed immunity". The then Director of Communications, Ally McLaws, recorded this in the Core Brief issued as a summary of the meeting. The Core Brief has been submitted within Request for Information No.6 [included within the cryptococcus narrative submitted under RFI 6, dated 19.2.2019]. This was published after the meeting. Later that evening, I received a call from the Medical Director asking me to phone to apologise to Dr Inkster for this point having been highlighted in the Core Brief as Dr Inkster would

be upset by this. I did so; it was my impression that Dr Inkster was unhappy that this possible alternative hypothesis was put into the public domain as this questioned her hypothesis and her personal judgement.

(d) The pace of reporting of the incident

117. In the days and weeks following the announcement of the Cryptococcus incident, intense media scrutiny continued, and this made it more difficult to manage the release of information into the public domain. Establishing the facts takes time and the investigation of an incident does not necessarily align with the media cycle, a point that was recognised by the Cabinet Secretary for Health and Sport in a statement to Scottish Parliament on 22 January 2019. She said: “However, we must understand that, in order to be sure of one’s facts, one cannot always work exactly to the timetable of the news cycle. There will be times when I or a health board cannot answer questions from our friends in the media at the precise point at which they are asked.”

118. The fast pace of the development of the narrative around the incident was exacerbated by comments running on social media. This was difficult to respond to and undermined our ability to manage and control the release of information to the public.

Issue 7: Operation of the IMTs

119. I don’t personally attend Incident Management Team (IMT) meetings, but corporate communications are represented by a member of the press team. Their role is to support the IMT in its communications handling. They draft and prepare written communications as agreed with the Chair of the IMT and other colleagues.

Issue 8: Effect of third-party leaks to media and politicians upon communications, including by those identified as whistleblowers

(a) Leaking of documents

120. Beginning in February 2019 and continuing throughout that year, a series of internal documents, including those containing information about individual patient cases, was shared by unknown sources with journalists and politicians from opposition parties. This impacted significantly on the organisation and on our ability to engage proactively with patients, their families and the public; it eroded trust, caused significant harm and distress to parents and carers, as well as staff, unfairly and unjustly resulted in accusations of cover up and ultimately contributed to NHS GGC being escalated to Level 4 on the performance framework for issues relating to communications and engagement with patients and families.

121. It also impacted personally on me and my team, as it led to a significant, intensive and pressurised workload for the press team, responding to a large volume of complex enquiries, including many media enquiries and Freedom of Information requests.

122. The journalist, Hannah Rodgers of the Herald on Sunday, was a regular recipient of internal documents from unknown sources, initially between February and May 2019 and then again from September to November 2019, when information leaks were also shared with politicians and political journalists. She confirmed to my team that there were three unnamed individuals providing her with information, which included physical copies being left at the offices of the paper.

123. Information leaked to Hannah Rodgers, other journalists and politicians included:
    - Patient details including information relating to the deaths of three children at RHC Paediatric ICU, one with Serratia and two with Pseudomonas infections, information on an individual patient who was treated for Stenotrophomonas, and information that ‘one patient was taken to Edinburgh for treatment’ when Ward 6A was closed temporarily.

- Numerous internal documents including SBARs, ‘documents relating the Queen Elizabeth University Hospital and Royal Hospital for Children which show evident problems in the hospital’s ventilation system’, an Innovated Design Solutions Feasibility study regarding increasing ventilation air change rates in Ward 2A – October 2018, minutes of meeting to discuss BMT Unit RHC, Health Protection Scotland and NSS situational report on the SBAR raised about QEUH Bone Marrow Transplant Unit.

- Internal staff information relating to the Infection Prevention and Control team and relationships with Estates and Facilities, as well as information seeking to discredit colleagues.

- Details of ‘a clinician-led probe’ into infections linked to the water supply at the flagship Queen Elizabeth University Hospital in ten cases in 2016 and twenty-six cases uncovered in 2017. [media enquiries were submitted under RFI 1 22.6, and some are also discussed in narratives submitted under RFI 6].

124. The leaks were investigated by the Head of Information Governance, Isobel Brown, and a report was submitted to the NHS GGC Information Governance Committee and the UK Information Commissioner. This investigation found that, whilst it was not possible to obtain any definite evidence that personal identifiable information had been released to external bodies, the documented timelines “would imply that individuals with knowledge and access to information have been operating out with the Board’s formal communication channels or recognised whistleblowing process”. It was confirmed by the Head of Information Governance that the NHS Whistleblower referred to by the MSP, Anas Sarwar, when he spoke of the ‘clinician-led probe’ did not report this through NHS GGC’s whistleblowing policy. [Timeline and Report submitted 14.6.2024 with this statement]

125. There is evidence that the information released by these unknown sources, when put in the public domain, caused considerable distress to family members who had no prior knowledge that their child’s case would be made public. For

instance, when the details of [redacted] case were put into the public domain, neither we nor, importantly, [redacted] family, knew that their [redacted] was the case raised in Parliament. In a letter from [redacted] to NHS GGC dated 14 November 2019 [redacted] said that [redacted] found it very upsetting that [redacted] was being discussed. In response, NHS GGC agreed that a letter should go to families in Ward 6A from Kevin Hill, Director, Women and Children's Directorate to apologise for any anxiety caused by the media coverage that followed the debate in Parliament [letters included in Narrative 7 submitted under RFI 6, in email dated 15.11.2019]. This was also the case for other families whose children were discussed without their knowledge in Scottish Parliament and who spoke to NHS GGC colleagues of their anger at that.

126. The leaking of information by unknown sources also caused considerable anxiety amongst other families and staff and had the potential to cause anxiety amongst the thousands of patients who were cared for in the QEUH/RHC every week. These actions and the criticism that resulted from opposition politicians ultimately led to 23 clinicians writing a letter to the First Minister to outline their immense disappointment and frustration at the way the QEUH and RHC were being portrayed unjustifiably in the Scottish Parliament and in the media undermining public confidence in the hospital. In the letter, the clinicians also outlined their grave concerns about the erosion of trust between clinical staff and their patients and families. [submitted 14.6.2024 with this statement]

(b) Impact of whistle-blowers on communications

127. Three staff members have been identified in Scottish Government documents provided to the Inquiry at Bundle 13 – Miscellaneous Volume 10 as whistleblowers. These were Dr Christine Peters, Dr Teresa Inkster and Dr Penelope Redding.

128. On the whistleblowers, the Cabinet Secretary for Health and Sport, Jeane Freeman, MSP, said in an update to Scottish Parliament on 10 December 2019:

"I have also met recently with a number of NHS Greater Glasgow and Clyde clinicians who have raised concerns. I have found their insights to be incredibly helpful in shaping the actions we are now taking. I want to thank them not only for making their concerns known, for persisting in following their professional responsibilities and to thank them for accepting my invitation to continue to work with us to consider the evidence we have, the decisions taken and the steps needed to resolve the outstanding issues."

129. Dr Peters and Dr Redding have also identified themselves as whistleblowers in the BBC Disclosure programme, 'Secrets of Scotland's Super hospital' which aired on 24 June 2020. As well as speaking to the media, the clinicians were also in contact with the Leader of the Scottish Labour Party, Anas Sarwar MSP. He confirmed in a radio interview to Good Morning Scotland on 25 June 2020 that he had been closely communicating with them 'for almost a year, if not longer than a year'. Dr Inkster has also spoken publicly to the Herald on Sunday.

130. Drs Inkster and Peters raised the accuracy of various media statements issued by NHS GGC with Dr Marion Bain, who was the Scottish Government appointed Director of Infection Prevention and Control at NHS GGC following escalation to Level 4 of the performance framework. Dr Bain held this position from January to May 2020. Dr Bain gave me details of these complaints and asked me to respond. A full review of the comments and challenges from Drs Inkster and Peters to the media statements was carried out, with independent oversight by Professor Angela Wallace, NHS Forth Valley Nurse Director and NHS GGC HAI Executive Lead appointed by Scottish Government and Mr Mark White, Finance Director, NHS GGC, who was not personally involved in the issues being investigated [correspondence concerning the review is included within Narrative 7 submitted under RFI 6, at 26.3.2020]. A full report into each of their claims was provided to Dr Bain before she stood down from her role with NHSGGC (18 May 2020). This review accepted only one point made by the two microbiologists; all others were not upheld. [see 2 emails submitted 14.6.2024 with this statement]

131. All statements produced by me and my team and agreed with the relevant senior director(s), were made in good faith and reflected the corporate understanding

and position on a range of complex issues. The statements were not inaccurate. The challenges to them, rather, reflected the difficulties we faced in handling and responding to two sets of opposing views about matters.

Issue 9: Communication on use of prophylaxis medication and whether any necessity for its use due to concerns about the hospital building:

132. Elsewhere in my witness statement, I refer to public, media statements issued on the use of prophylaxis. Communication with parents on the use of prophylaxis was the responsibility of clinicians. I can offer no further information on this.

Issue 10: Effect of escalation of Board, including prior requirement to clear communications with Scottish Government:

133. It is routine for me and my team to alert the Scottish Government press team for awareness to contentious and sensitive media issues that we are handling ahead of sharing them with media. This was the case before the formal clearance processes were established in November 2019 (following escalation to Level 4) and remains the case today.

134. Prior to establishment of formal clearance processes, NHS GGC informed the Scottish Government of emerging issues in relation to issues relevant to the Inquiry including handling of the adult Bone Marrow Transplant transfer (2015), the water incident (2018), Ward 2A/B decant (2018), the Cryptococcus Incident (2019), Mucor investigation (2019) and cladding issues (2017/18).

Background to Level 4 Escalation and Scottish Government Oversight of Communications – Ward 6A Incident and Communications [June 2019 to November 2019]

135. An NHS GGC Problem Assessment Group was held on 3 June 2019 to discuss four cases of gram-negative bacteraemia (GNB) in patients being treated within Ward 6A of the Royal Hospital for Children haemato-oncology unit. Following

this meeting, an Incident Management Team (IMT) was set up and met for the first time on 19 June 2019. This IMT updated the incident to five cases of GNB, together with a patient who had an atypical mycobacterium [PAG and IMT minutes were submitted under RFI 7 2.18, with a few IMT minutes also previously submitted in timelines under RFI 1 6].

136. From the outset of the investigation, there was full consideration of an appropriate communications response to the cases being investigated. Decisions on communications were made in line with NIPCM, the NHSGGC's Healthcare Associated Infection Communications Strategy, and the Associate Chief Nursing Officer letter of 11 February 2019, which is explained elsewhere in my witness statement.

137. The Scottish Government, via Health Protection Scotland, were notified of the Problem Assessment Group and the cases being investigated. In an email dated 7 June 2019, responding to an email from the Senior Media Manager within Scottish Government Health Directorates, I explained the initial communications response: [included in the 6A narrative submitted under RFI 6].

> "A full multi-disciplinary team, including infection control doctor, has assessed each individual case and, as you say, the assessment was green. Three of the four cases were considered to be acquired outwith the hospital environment. In addition, it is believed that the HAI case has another source associated with the patient's own gut. In view of the green assessment there was no action to develop a holding line."

138. When the Incident Management Team was subsequently set up on 19 June 2019, 'communications' was a standing item on the agenda in line with the NIPCM. A press officer was in attendance to support the Incident Management Team and the Chair, Dr Teresa Inkster, in delivering the agreed communications actions from each meeting.

139. Using the Healthcare Infection Incident Assessment Tool (HIIAT), the incident was initially assessed as amber. The hypothesis was that the 'atypical

mycobacteria patient has been exposed to unfiltered water source somewhere on site and the GNB cases had possibly been acquired out with the healthcare setting given negative water sampling'. The Incident Management Team agreed that patients/parents would 'not to be informed of GNBs at present as no conclusive evidence that it is due to healthcare environment'.

140. It was noted that Professor Brenda Gibson, Lead Clinician, Haemato-Oncology, would meet the family of the patient with the atypical mycobacterial infection and the IMT agreed that a holding statement should be prepared on the atypical mycobacteria case.

141. It was also agreed that a staff briefing would be prepared by one of the haemato-oncology consultants.

142. In response to the incident, steps were taken to monitor the water and to install point of use filters in the operating theatres. The Lead Infection Control Doctor, Dr Teresa Inkster, wrote to inform surgical and anaesthetic colleagues of these measures on 21 June 2019 [included in 6A narrative submitted under RFI 6].

143. At their next meeting, the Incident Management Team continued to discuss and agree the communications response and noted that parents of the patient with the atypical mycobacteria met Professor Gibson and Dr Inkster on 26 June 2019. A briefing on the case was also to be prepared for other parents on the unit. The information was given to parents that evening by Jamie Redfern, General Manager, Hospital Paediatrics [included in 6A narrative submitted under RFI 6].

144. Following the meeting with Professor Gibson and Dr Inkster, the parent of the mycobacteria patient posted critical comments about the safety of the hospital on a closed Facebook page used by families.

145. At the next meeting of the Incident Management Team, it was noted that Dr Inkster had drafted some lines that 'can be used for a general communication to the patients/parents. Dr Inkster will send this to Kevin Hill for agreement before forwarding it to Angela Howat.' Kevin Hill was the Director of the Women and

Children's Directorate at the time and Angela Howat was a Senior Charge Nurse in Daycare.

146. The Incident Management Team continued to agree to a holding statement being prepared and did not decide to issue a proactive statement.

147. On 25 July 2019, Hannah Rodger of the Herald on Sunday contacted the press office with an enquiry about a new water-based outbreak incident. A statement was issued in response confirming a single case. The following Sunday, in an article in the newspaper, Ms Rodger wrote that a source had informed her that "tests are going on to determine if other children have been affected by the latest bacteria, said to be a mycobacteria linked to the water". A second senior NHS GGC source had also spoken to the paper, according to the article [included in 6A narrative submitted under RFI 6, at 4.8.2019].

148. The focus of subsequent Incident Management Team meetings remained on proactive communications with parents of children in Ward 6A and a further written communication was prepared and delivered in person to parents on 2 August 2019.

149. This communication confirmed the need to create capacity in the ward in order to carry out further investigations and that the IMT had taken the decision to temporarily suspend new admissions to the ward to allow this to take place. The communication also confirmed that as a precaution, prophylactic antibiotics were being prescribed for patients on the ward [included in 6A narrative submitted under RFI 6, at 2.8.2019].

150. On the same day, a follow-up enquiry was received by Hannah Rodger, Herald on Sunday - "Have you identified the source of this infection yet and if so, what is it and what steps are being taken to address that? Was this infection discussed by an incident management group, was there a report to HPS, and was it given a HIIAT score? Just looking at doing a small update for this week. I presume no other patients have tested positive for this infection apart from the one patient?

And no other issues with hospital-acquired infection in this ward at present?" [included in 6A narrative submitted under RFI 6, at 2.8.2019]

151. We confirmed in a statement to Hannah Rodger that investigations were also underway into two cases of rare infections [included in 6A narrative submitted under RFI 6, at 3.8.2019].

152. In the minute of the IMT on 9 August 2019, it was noted: "A press statement was issued on Saturday 3rd of August to the Herald on Sunday newspaper, the day after the letter was shared with families and the two families directly affected were spoken to about the likelihood of media coverage at the weekend. We followed the guidance completely on notifying the patients."

153. On 9 August 2019, Hannah Rodger followed up again asking for details of the specific cases reported the previous week. We issued a further response to the Herald on Sunday, explaining why we were not in a position to provide the newspaper with the specific bacteria being investigated as detailed below: [included in 6A narrative submitted under RFI 6, at 9.8.2019]

"You asked us to also give the reasons why we are unable to name the bacteria/fungi involved in each infection.

"Our primary responsibility is to our patients and their families. When considering what information to put into the public domain there are a number of issues to consider. This includes questions of whether there is a public interest in learning of the specific nature of the infection and whether there is any public health implication for the wider health of the population.

"A further key consideration is clearly whether we would breach patient confidentiality if we shared information about a single case.

"In this case, there is no risk of transmission of these infections from patient to patient and no public health consequence.

"These are three unique cases which mean that we would be releasing confidential information to the media about individual patients.

"The NHS code of practice on confidentiality sets out that key identifiable information includes:

- patient's name, address, full post code, date of birth.
- pictures, photographs, videos, audiotapes or other images of patients.
- NHS number and local patient identifiable codes.
- anything else that may be used to identify a patient directly or indirectly.

"For example, rare diseases, drug treatments or statistical analyses which have very small numbers within a small population may allow individuals to be identified.

"Whilst we have reported on single cases in the past, lessons learned from previous incidents, including criticism from the families concerned, have led us to review this position and in view of the above, we will not in this instance be confirming the specific nature of the infections.

"Scottish Government have also made clear that they will not discuss these specific patients due to the strict rules of patient confidentiality.

"We will of course continue to be open and transparent about any issue of material interest on the management of the infections."

154. As the incident continued, regular updates continued to be provided to parents in the unit after subsequent Incident Management Team meetings. These were all delivered in person, supported by a written briefing, to ensure consistency of message, whilst also providing an opportunity for families to ask questions.

155. On 8 September 2019, as the regular proactive communications to families continued, Hannah Rodger interviewed the parents of the patient with an atypical mycobacterium [included in 6A narrative submitted under RFI 6].

156. The following day, the Cabinet Secretary for Health and Sport asked the Chair, Professor John Brown CBE, for a briefing on Ward 6A, including NHS GGC's communications approach. This briefing noted a plan to extend communications with parents to include those whose child or young person was not a current inpatient, amongst whom a number had expressed concern about NHS GGC's communications [included in 6A narrative submitted under RFI 6, at 9.9.2019].

157. As explained elsewhere in my witness statement, the Cabinet Secretary agreed to this communications approach. From this time forward, NHS GGC widened out its communications from those parents directly affected to include a wider cohort of parents, including parents of outpatients and day cases. From September 2019, with the establishment of the closed Facebook account for parents and patients, statements were also posted and shared with parents who had joined the page. In addition, the Chair, Chief Executive and other senior executives also personally met parents in Ward 6A and also wrote to all other parents whose child or young person had been treated in Ward 2A/B (and/or Ward 6A) since 2015 and offered to meet them.

158. In late September and early October 2019, the Cabinet Secretary met a number of parents, and on 4 October 2019, she appointed Professor Craig White of the Scottish Government as a point of liaison with families. From this time forward, NHS GGC communications were overseen by the Scottish Government.

Escalation and Communications Impact

159. Over two meetings held on 28 September and 1 October 2019, during the period of the Ward 6A Incident Management Team, the Cabinet Secretary for Health and Sport, Jeane Freeman, MSP, met with 14 family members of patients treated by the haemato-oncology unit. From these meetings, her officials compiled a series of 70 questions put to her by the families. These questions covered environmental issues, treatment issues, communications issues and issues that might fall within the scope of the Inquiry; this included issues set out in Request for Information 6 Annex 1 2. (iii) (a, b, c, d, e) and iv (a, j), (v), (vi), (vii) [covered in Narrative 7 submitted under RFI 6, at 28.9.2019].

160. On 4 October 2019, in response to a Government Initiated Question, the Cabinet Secretary announced that she had appointed Professor Craig White as family liaison.

161. This was the first phase of Scottish Government oversight of NHSGGC communications on the issues of infection prevention and control in relation to QEUH/RHC. In this phase, from 4 October 2019 until 28 November 2019, Professor Craig White worked with NHS GGC on communications as follows: [extensive examples are given in Narrative 7 submitted under RFI 6]

- Commenting on, amending and approving the responses to the 70 questions from families (Lesley Shephard, HAI Policy Unit, Scottish Government, also commented on the draft responses and made changes during the drafting stages).
- Commenting on, and approving, the content of letters sent by NHS GGC to parents of haemato-oncology patients about infection issues, including water safety and restrictions on water.
- Commenting on NHS GGC media statements.
- Commenting and offering advice on the NHS GGC's processes for communicating with families.

162. Craig White also joined the Chief Executive, Chair and senior officials when they met nine families on 2 November 2019. He also communicated separately with families.

163. NHS GGC was escalated to Stage 4 of the NHS Scotland performance framework on 22 November 2019 which was attributed to ongoing issues around the systems, processes and governance in relation to infection prevention, management and control at the Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC), and the associated communication and public engagement issues.

164. In the immediate days after, there were no explicit changes to communications approval arrangements, although Craig White continued to contribute to drafting of media statements and parent communications.

165. On 26 November 2019, the Health Protection Scotland review of NHSGGC paediatric haemato-oncology data was published. Our media statement and the Scottish Government statement were inconsistent in their presentations of the findings of the review, leading one journalist to question whether both had read the same report. Our statement, shared in advance with Scottish Government and with their approval, stated: [both included in Narrative 7 submitted under RFI 6, dated 26.11.2019]

"From the Health Protection Scotland review of the data on test results of blood samples over the past six years, their report finds:

- One occasion when the number of infections linked to environmental organisms was greater than expected for this group of patients (Table 5). The period in question was June 2018 which was already being investigated by the infection control team and was identified as being potentially linked to the water supply.

- At no other time between 2013 and 2019 did the rate of infections linked to environmental organisms exceed the upper range of expected levels. This includes 2016 and 2017.

- An increase in Gram negative infections (including both environmental and enteric, i.e. intestinal infections) was noted in 2017, however, this remained within expected levels for the unit. During this time there was an investigation into the possibility that two of these cases may have been linked which was later confirmed not to be the case. This investigation was reported to HPS as per mandatory guidance.

- Since the move to Ward 6A and 4B in September 2018, infection rates have been similar to other Scottish paediatric units."

166. In contrast, the Scottish Government statement on the 2017 data suggested that the levels of infection were an indication of an issue and a reason for Scottish Government escalating NHS GGC; "The report identifies months in which rates of infection exceeded the trigger point requiring further investigation. These data confirm there was a spike in infections in 2018 – this led to the interventions over water contamination and the closure of wards 2A and 2B. These data also confirm higher levels of infections in 2017 and these incidents are part of the reason the Scottish Government announced last week that the board has been elevated to stage 4 of the NHS Board Performance Escalation Framework."

167. Following these statements, two days later, Scottish Government media manager Suzanne Hart informed me and confirmed by email in writing that, given the escalation to Stage 4, the Health Secretary had asked to see and clear all lines relating to infection prevention, management and control at the QEUH and RHC, to include enquiries 'where there is a claim of a connection even if it is not the case' [included in Narrative 7 submitted under RFI 6, at 28.11.2019].

168. In addition to communications with parents, from 28 November 2019 the Cabinet Secretary also cleared proactive and reactive media statements, written communications between NHS GGC and parents, correspondence with an MSP and Board papers. The range of communications to be cleared was confirmed on 2 December 2019 by Professor John Brown, former Chair of NHS GGC to Jane Grant, Chief Executive, and me, when he wrote in relation to a proposed response to an MSP: "As advised by Malcolm Wright yesterday, the SG believes that under Level 4, we must clear all correspondence concerning infection control, clinical governance and patient engagement with the Cabinet Secretary. So once you're happy with what I'm saying can you ask them to ask Jeane Freeman to approve its issue. Can you also suggest that we send Mr Sarwar a similar letter inviting him to meet us too and ask for Cab Sec's permission to take this step." Malcom Wright was the then Director General for Health and Social

Care and Chief Executive, NHS Scotland [included in Narrative 7 submitted under RFI 6].

169. Clearance also extended to letters to individual parents, and responses to a further series of questions from families of parents in the haemato-oncology unit, which were received following the BBC Disclosure programme.

170. Posts by NHS GGC on the Haemato-Oncology Closed Facebook Page were regularly approved by Craig White. The Cabinet Secretary also commented on some social media posts.

171. The clearance process involved initially sharing communications drafted by my team which had been through internal NHS GGC approval processes with Chief Nursing Officer, Professor Fiona McQueen, and Professor Craig White for their feedback and comments. Once that process was complete, the NHS GGC communications team shared the draft lines with the Scottish Government media team, who in turn I understand, shared them with policy colleagues, special advisors and the Cabinet Secretary for Health and Sport, who would either clear, make changes or ask further questions before clearing. Questions would then follow between NHS GGC communications team / senior officials and Scottish Government policy advisors and media team until lines were agreed. Statements were then issued. They were also issued to the senior hospital management team who would discuss with staff and families on the ward.

172. The additional clearance process was not limited to content but also included oversight of timing of release of information to parents and also suggested approaches including exploring individualised preferences to communication methods for engaging with families.

173. In December 2019, for instance, following discussions at the Scottish Government Communications and Engagement Subgroup of the Oversight Board, chaired by Professor Craig White, we developed a new microsite on the NHS GGC website on Wards 6A and 4B, to be used as the basis for improving the flow of information to parents, the public and media on the current situation.

Before going live, the staging site was shared with key stakeholders for comment, including Craig White and [redacted], the parent of a haemato-oncology patient and representative of families/carers on the Communications Subgroup of the Oversight Board.

174. The impact of this process on NHS GGC's communications was significant, not least in removing our ability to respond agilely to emerging issues, both in terms of our engagement with patients and families and with communications with the media. Media statements were often only being cleared late into the evening or the following day and regularly missed media deadlines. In addition, as well as the additional Cabinet Secretary clearance processes leading to changes in tone of response, there were also changes of substance to content, including, at times, relevant points of fact that we were keen to make being blocked. NHS GGC lost all autonomy in managing its public statements for the period from November 2019 to May 2021, when the clearance arrangement ceased.

Issues Relating to Clearance Process

175. A snapshot of some of the issues encountered was prepared by one of my press officers and emailed to me on 10 December 2019. She noted that on media statements which went through the clearance process, a number of issues arose, [included in Narrative 7 submitted under RFI 6] namely.

- Herald on Sunday article on reporting the death of a patient to the Crown Office. On the Friday our line was rejected, and a substituted response was provided by Professor White. The substitute statement was cleared by the Cabinet Secretary and issued to the newspaper. Unfortunately, on Saturday, the reporter came back and was unhappy with the response as it did not answer her question. We contacted Fiona McQueen and Professor White asking if we could issue the original statement that had been objected as this answered the reporter's question. Ms McQueen was happy with this suggestion.

- Mail on Sunday article on issues with the theatres at the QEUH. We provided a statement to Professor White and Professor McQueen. Professor White asked we provide a more prominent response re 'how Board gains assurance re infection prevention and control in theatres, something about processes outside of any annual one to provide assurance that problems are addressed timeously and something about processes to support any staff member to raise concerns re inaction through mechanisms in place for that'. The statement was amended to reflect Professor White's comments and issued to reporter. The subsequent article did not include any of the additional comments suggested by Professor White.

- We had a similar enquiry from both the Daily Mail and the Herald on the prescribing of prophylaxis to patients in ward 6A. This was shared with both Professor McQueen and Professor White. Professor White had a number of suggestions to change the statement. However, Dr Scott Davidson, Deputy Medical Director (Acute), had a conversation with Fiona McQueen on the complexity of prescribing prophylaxis. We agreed a form of words with Fiona as the information Professor White had asked us to include was too detailed and not appropriate.

176. There were also inconsistencies in the position being taken by Scottish Government on our handling of the process. On 18 December 2019, Jenny Clarke, Media Manager, Scottish Government, emailed me to advise: [included in Narrative 7 submitted under RFI 6]

> "For your future reference, I just wanted to flag that Cab Sec wanted this sentence omitted as the phrase "acceptable" levels of infections jarred."

177. We believed this to be inconsistent with previous agreed statements and Board papers as I indicated in my email response to Jenny Clarke on 19 December 2019: [included in Narrative 7 submitted under RFI 6]

> "This line was inserted in response to some initial feedback from the Cabinet Secretary that we should include information on infection control and reflected

the Board paper which was approved by SG and Cabinet Secretary which confirmed that our clinical outcomes showed that in terms of infection control and practice QEUH/RHC were not outliers. Also, on Sunday (15 December 2019), we had a line cleared that confirmed the following:

"The HIS report from March formed part of a wider routine inspection programme to provide assurance that best practice is implemented across health boards in Scotland. The independent report contained a number of positive findings and confirmed our staff have a good awareness of infection control, alongside high levels of hand hygiene compliance. The inspectors further highlighted infection rates were within acceptable levels.

"When we were made aware of the report's findings, immediate action was taken to implement any recommendations to ensure the safety of our patients.

"For additional reassurance, we asked Health Protection Scotland to carry out a detailed review of our infection performance compared to similar large hospitals over the past three years. Findings confirmed that at no time during this period did infection rates at QEUH and RHC exceed expected levels."

178. Scottish Government oversight of handling also caused me to contact Suzanne Hart on 29 November 2019, to flag concerns: [included in Narrative 7 submitted under RFI 6]

"We received approval to issue our lines on the [Anas] Sarwar claims to the BBC at approximately 18:20 but were told not to issue to any other media. We were then not given approval to issue to all other media until 20:46 by which time other outlets were fully aware that the BBC had been given the statement. We received a number of complaints from journalists that we had issued to the BBC but not to others. We also received complaints from journalists about the time it was taking to get a response issued from NHSGGC."

179. A further example of where information was delayed was a proposed briefing to update families on progress with the upgrading of Wards 2A/B which we had

committed to give to them. I shared a draft with Craig White and Fiona McQueen on 1 September 2020. Craig White emailed me on 2 September to advise:

"Further to your text last night and my commitment to update you this morning – this **cannot** be issued to parents and families at present. Further discussions and decisions are required internally." [included in Narrative 7 submitted under RFI 6]

180. Scottish Government only agreed to the release of this update some 20 days later [included in Narrative 7 submitted under RFI 6, dated 22.9.2020].

181. A key issue for us was when we were prevented from making factual statements, notably when the Scottish Government blocked a statement on the outcome of Stenotrophomonas testing in 2017 which confirmed that when the water was tested in September 2017, no Stenotrophomonas was detected. In response to a query from Hannah Rodgers on 6 December 2019, we proposed to say: [included in Narrative 7 submitted under RFI 6, at 6.12.2019]

"The death of any [redacted] is a tragedy and we continue to offer our sympathies to [redacted] family for their loss.

We have written to [redacted] this week to answer a number of [redacted] questions. We have also updated [redacted] on the significant amount of work underway to review [redacted] case and other cases.

These additional reviews have now confirmed that Stenotrophomonas was tested for in 2017 as part of the investigations to look into possible links between [redacted] and a second patient with the same infection. These investigations confirmed no link between the two cases.

Specialist water tests requested by infection control doctors in August 2017 also confirmed that Stenotrophomonas was not present in water samples from the Royal Hospital for Children – including Ward 2A.

More than 100 samples of water from the hospital were tested at the request of infection control doctors.

None of the samples tested positive for Stenotrophomonas.

We have now confirmed this to [redacted] family.

Jane Grant, Chief Executive, said: "I am truly sorry for the distress and pain being caused to [redacted] family by the uncertainty that has surrounded questions about the water supply and whether it was the source of [redacted] infection.

"[redacted] family deserves answers. We owe it them to thoroughly and fully re-examine the investigations that took place.

"We have now done so and we hope that this information will give some re-assurance to [redacted].

"We want to do anything we can to answer [redacted] questions, we have written to [redacted] this week and remain keen to meet [redacted] to discuss these results in more detail with [redacted]."

182. Professor Fiona McQueen would not support this, nor did she support a simpler statement of fact that I suggested instead –

"As part of this we have advised that a review of water tests looking for the presence of Stenotrophomonas has confirmed it was not present in the water samples from Royal Hospital for Children. This was requested by infection control doctors and more than 100 samples were tested in September 2017."

183. Our eventual public statement was issued without any of this detail, despite this having been confirmed to the patient's family.

"The death of any [redacted] is a tragedy and we continue to offer our sympathies to [redacted] family for their loss.

"We have written to [redacted] this week to answer a number of [redacted] questions. We have also updated [redacted] on the significant amount of work underway to review [redacted] case.

Jane Grant, Chief Executive, said: "I am truly sorry for the distress and pain being caused to [redacted] family by the uncertainty that has surrounded questions about the water supply and whether it was the source of [redacted] infection.

"[redacted] family deserves answers. We owe it them to thoroughly and fully re-examine the investigations that took place.

"We want to do anything we can to answer her questions, we have written to [redacted] this week and remain keen to meet [redacted] to discuss these results in more detail with [redacted]."

184. A further example of being prevented from making factual statements is in the preparation of NHS GGC responses to questions from families that we received following the publication of the Independent Review Report and the broadcast of the BBC Disclosure programme in June 2020. All NHS GGC responses to the questions from parents (prompted by the programme and the earlier publication of the Independent Review Report by Dr Andrew Fraser and Dr Brian Montgomery) were cleared by Scottish Government. One of the questions related to the issue of staff having access to all historical documentation and information in order to obtain the full picture and asked 'if 'certain documents and information [were] not within the 'public domain' and therefore not accessible to staff?' [correspondence included in Narrative 7 submitted under RFI 6 – see 29.7.2020, 31.7.2020 and 1.8.2020].

185. Our position on this was as follows:

"Clinical staff were fully involved in all Incident Management Team investigations and reviewed outputs from all independent reports that were available at the time. They had full access to all materials produced through the

IMT process to scrutinise these issues. [Email thread at 24.7.2020 included in Narrative 7 submitted under RFI 6 – quotation is from attachment to email dated 4.7.2020].

186. Phil Raines, Chief Nursing Officer's Directorate, Scottish Government, fed back:

"You'll be aware that Dr Inkster has stated publicly that she requested water-testing results on a number of occasions when ICD and chair of IMTs, especially during 2018, and these did not appear to be forthcoming. I raise this not to say that this should be addressed here, but for you to be aware that [redacted] will know this and might challenge this view. [PR]" referring to [redacted].- [included in Narrative 7 submitted under RFI 6 – comments on attachment to email dated 31.7.2020].

187. We then adapted the statement to include the DMA reports as an additional line but as I was advised that water test results would have been returned by the independent lab or the GRI lab to the microbiology system, we made no further changes in relation to this.

188. Our revised version of proposed response stated:

"Clinical staff were fully involved in all Incident Management Team investigations and reviewed outputs from all independent reports that were available at the time. As highlighted in response to question 17, the DMA reports were only shared with the Senior Executive Team in the middle of 2018." [Email thread at 31.7.2020 included in Narrative 7 submitted under RFI 6 – email dated 31.7.2020, and attachment to another email of the same date].

189. This was factual but Professor McQueen did not approve this version.

190. The final version of the response that was sent after a lengthy email exchange with Professor McQueen, Craig White and Diane Murray of the Scottish Government (the emails having been provided to the Inquiry), was:

"The former Lead Infection Control Doctor for QEUH/RHC has raised an issue about the availability of some reports during IMT investigations and we have confirmed that the DMA reports were only made available to the Senior Executive Team in the middle of 2018 when they were immediately acted on.

"These matters are being examined as part of the current review into NHS GGC's processes for investigating infections by the Infection Control sub-group of the Oversight Board and we anticipate that a report from the Oversight Board will be made publicly available." [included in Narrative 7 submitted under RFI 6, email dated 1.8.2020].

191. This was an example of how, through the Scottish Government clearance processes, we were prevented from making statements reflecting the corporate NHSGGC position.

Issue 11: Comments on communications in relation to Oversight Board:

Background

192. On 22 November 2019, the decision was taken by Malcolm Wright, Director-General of Health and Social Care in the Scottish Government and Chief Executive to NHS Scotland, to escalate NHS GGC to Stage 4 of the NHS Scotland Board Performance Escalation Framework.

193. An Oversight Board, chaired by Scotland's Chief Nursing Officer Professor Fiona McQueen, was established to support NHS GGC, focusing on three broad areas: infection, prevention and control; governance; and communication and engagement.

194. As part of its work, the Oversight Board published an Interim Report and a Final Report, setting out a series of findings and recommendations in relation to the Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC), and the handling of infection incidents affecting children, young people and their families within the paediatric haematology-oncology service between

2015 and 2019 [reports are in the public domain on the Scottish Government website].

The Oversight Board

195. Following its establishment in November 2019, the Oversight Board worked with NHS GGC to provide support with a range of issues, focusing on infection, prevention and control; governance; and communication and engagement.

196. A number of Subgroups of the Oversight Board was established, including a Communications and Engagement Subgroup chaired by Professor Craig White, to review NHSGGC's communications with patients and parents/carers, staff, the public, the media and other external bodies, including the Scottish Government. Craig White had been appointed by the Cabinet Secretary for Health and Sport to act as a point of liaison with patients and families in Ward 6A/B.

197. In this capacity, Professor White communicated directly with patients, and asked for and was given direct access to the Closed Facebook page set up for patients and families.

198. Throughout the period in which support was provided by the Oversight Board, NHS GGC also continued to be proactive in our communications with patients and families/carers, staff, the public and media. We were also in regular communications with Fiona McQueen, Craig White and the Scottish Government to inform them of developments, and to reach agreement over key proactive and reactive statements being shared with the public and the media.

199. As part of its work, the Oversight Board published an Interim Report on 21 December 2020 and a Final Report on 22 March 2021. These reports set out a series of findings and recommendations in relation to areas infection, prevention and control; governance; and communication and engagement.

200. Ahead of each publication date, NHS GGC was given the opportunity to review and comment on each report, suggest factual corrections and request changes to content and meaning [the full responses made by NHSGGC were sent to the Inquiry under RFI 1 6].

201. At the same time, we worked on our own proactive communications in relation to the reports for parents/carers, staff, the public and media, which were approved and cleared by the Cabinet Secretary for Health and Sport and in the days before publication, parents/carers on Ward 6A and 4B were given advance notice about when the reports would be published.

202. On the days of publication, these proactive communications were co-ordinated with communications activities from Scottish Government to ensure information was released appropriately into the public domain. In each case, communication with parents/carers was given priority, and significant effort was put into ensuring all possible parents/carers of patients – both current and those affected by previously infection issues at the RHC and QEUH – were captured with NHS GGC communications.

203. Throughout the period in which NHS GGC received support from the Oversight Board, proactive and reactive communications from NHS GGC made clear its support for the work of the Oversight Board, and its commitment to implementing learnings from and recommendations by the Interim and Final reports.

Issue 12: Comments on communications in relation to Case Note Review:

204. Communications with families involved in the Case Note Review were principally the responsibility of the Case Note Review team and the Scottish Government, although NHS GGC colleagues and I provided support to this process, and we were invited to contribute to the development of the Case Note Review communications plan. NHS GGC did communicate with other stakeholders including staff, the wider patient/parent cohort within the haemato-oncology unit, the general public and media on the review process and the Report. We developed a communications plan to seek to ensure that our activities were co-

ordinated with the Case Note Review communications. Public statements from NHS GGC at this stage required clearance from Scottish Government and the Cabinet Secretary for Health and Social Care.

Issue 13: BBC Disclosure Scotland programme and why the Board was not proactive in communicating with patients and families prior to its broadcast:

205. The first contact from the BBC to NHS GGC on a potential Disclosure programme came in January 2020 when the producers attended the Board meeting, and a number of Freedom of Information requests were made. One of my press team accompanied me to meet the production team at that stage to discuss the programme but we did not hear from them again for a number of months.

206. Following the publication of the Report on the Independent Review by Drs Andrew Fraser and Brian Montgomery, the press team was again approached by Health Correspondent for BBC Scotland, Lisa Summers, regarding a Disclosure Scotland programme on the QEUH/RHC. She outlined the areas the programme expected to cover in an email to me dated 16 June 2020 [included in Disclosure narrative submitted under RFI 6]:

"We will be looking at the stories of a number of families who have questions about treatment.

"In particular [redacted] has questions about the infection that [redacted] contracted. We'd like to address those and what action was taken by the heath board to test for Stenotrophomonas.

"Also the family of a patient who died after contracting Cryptococcus have questions about their care.

"We'd like to ask specifically about the investigation into Cryto and why the plant room has now been ruled out as a source. What is the health boards position on where it came from?

"We also have spoken other families who are worried about infection risk to the care of their children even now in the hospital. We'd like to ask about the care they are receiving.

"We have expert opinion on the water and ventilation systems. They have questions about decision making at the time of opening, and also about the prominence of infection control during the building and design phase and beyond.

"We'd like to ask about efforts to address the issues identified in the water system, whether in addition to the pipe work; taps and shower heads could have contributed to an increase in infections. And we'd like to discuss when issues with the ventilation system were identified and what action was taken as a result.

"We will also be looking into whether a culture of bullying and a lack of transparency impacted on patient safety.

"Not all of these issues were identified in the recent Independent Review and so we would really like to get an on-camera response from the Health Board that will address these concerns."

207. Given the nature of the questions and, in view of NHS GGC's ongoing legal processes in relation to design, build, commissioning and maintenance of the hospitals, we sought legal advice on participating in this programme. Our legal advisors recommended against this.

208. We also discussed the approach from Disclosure Scotland for NHS GGC to provide an on-camera interview for their forthcoming programme on QEUH/RHC with Scottish Government as we remained at that stage in escalation Level 4. Our Chair, Professor John Brown CBE, was also in direct communication with the Cabinet Secretary for Health and Sport about the programme.

209. The Cabinet Secretary indicated that she was content for us to decline to give an on-camera interview as per the explanation that I subsequently gave to the producer of the Disclosure Scotland on 17 June 2020 [included in Disclosure narrative submitted under RFI 6]:

> "Thank you for your helpful email last night and for explaining the decision to air the programme following the publication of the Independent Review findings. "We fully recognise the need for transparency and accountability and have assessed how we could positively contribute to the programme to give our response to the issues you will cover. We have considered the questions you wish to ask and we have concluded that we unfortunately will not be able to contribute to the programme. I wanted to explain our reasons for this.
>
> "As you know, Monday's Independent Review Report was the first of a number of independent investigations put in place by the Cabinet Secretary to examine these issues. The Public Inquiry and the independent case note review, which are still to be concluded, will address a number of the questions you have put to us. It is only right that the answers to your questions are provided following proper consideration through these independent investigations and that we do not pre-empt or anticipate what these investigations will find.
>
> "You specifically highlight a number of individual patients in the programme and ask for us to comment. This again poses difficulties as, at all times, we must respect and protect the right to patient confidentiality and we do not discuss individual patient cases in public.
>
> "Finally, as you know we have launched a legal action against our contractors and advisors and we are restricted in the public comment that we can make in order that we don't prejudice this process.
>
> "As some of the points in your programme have already been covered by the Independent Review and others relate to matters which are the subject of separate legal processes, we will not be providing any comment in response to your questions. We have had the opportunity to discuss this with our legal

advisors and they have agreed that, in view of the above, this is the correct course of action.

"We remain, however, keen to engage with the families participating in the programme. We have offered them meetings previously and continue to extend an invitation for them to meet us."

210. We subsequently received 20 questions from the programme makers and provided a statement and written responses to them. The statements were agreed with a number of NHS GGC colleagues and also reviewed by the NHS Central Legal Office and the legal team representing us in our legal claim. The statement and responses to the questions were also cleared by the Cabinet Secretary.

211. Following the broadcast of the programme, we were asked by families why we hadn't been proactive in sharing with them information that we had given the programme. There were a number of critical comments posted by family members on the private Facebook page on this point.

212. Unfortunately, there was a significant delay to a post being published by NHS GGC in response to this. This was delayed in part as a result of the clearance arrangements in place with Scottish Government. I was on annual leave on the day (26 June 2020) but was copied into correspondence between Dr Margaret McGuire, former Nurse Director, NHS GGC and Executive Lead for patient liaison and Scottish Government colleagues, including Craig White, in which Dr McGuire expressed significant frustration at the length of time it took for Scottish Government colleagues to clear the proposed NHS GGC social media comment in response to the families [emails are included in the Disclosure narrative submitted under RFI 6, dated 26.6.2020].

213. The handling of the communications in relation to the Disclosure programme was subsequently discussed at a special meeting of the Oversight Board Communications and Engagement Subgroup, convened urgently by Scottish Government. In this meeting, attended by members, including family

representative [redacted], I explained why we had not contributed to the programme and Dr McGuire and I also apologised for the delay in sharing information about the programme with families. Following this meeting, we were sighted on the post from [redacted] to other families on the meeting in which [redacted] noted: "The Director of Communications and Public Engagement provided an explanation, defending her decisions whilst reflecting on the complexities involved not least of all what can be said when legal proceedings are ongoing." [included in the Disclosure narrative submitted under RFI 6, in an email chain dated 2.7.2020].

214. In the series of questions put to us by families following the programme, we also explained the delay of the further communication with families:

> "NHS GGC was given no advance sight of the Disclosure Programme and so any advance briefing on the programme to families would have been speculative on our part. We fully acknowledge that, once the programme had aired, we should have put in place arrangements to support families sooner than we did, for which we have apologised to families and have taken steps to improve, including confirmation of the role of Nurse Director as Executive contact for families. As we explained on the Ward 6A Facebook page, this was further delayed as we wished to take advice from the Scottish Government Oversight Board representatives who were considering the questions and concerns posted previously and some of our senior staff were involved in the activation of our Major Incident Procedure following the tragic events in Glasgow city centre. The Chief Nurse for Hospital Paediatrics went on the unit two days after the programme aired to offer support to families." [included in Narrative 7 submitted under RFI 6, as an attachment to an email dated 2.8.2020].

215. We also shared with families the full statement I had given the producers of the programme [included in Narrative 7 submitted under RFI 6, as an attachment to an email dated 2.8.2020].

Issue 14: Any other points which may be relevant to the Board's delivery of communications over the relevant period.

Reflections

216. The period between 2018-2020 was incredibly difficult for patients and families within the Schiehallion Unit and the staff of the unit. It was also a period of sustained stress and pressure for those working to respond to the issues, including me and my team.

217. Throughout this period, I and my colleagues acted in good faith and with honesty to manage and respond to a highly complex and challenging situation. I appreciate that families felt that communications with them should have been better. We have listened and learned from their experiences and used this experience to guide and frame our communication plan for the re-opening of Wards 2A and B in 2022 – which was praised by families who had previous been critical of us.

218. Over a sustained period, the character, integrity and professional reputation of the Chair, Chief Executive and Directors, including me, as well as many others within the organisation, have repeatedly been called into question, unfairly and unjustifiably.

219. Last year, a comment I had previously made in private to one of my team describing the situation in terms of a 'battle' was disclosed and reported in national media. This language, said in a private conversation, was inappropriate and I subsequently apologised for this. Whilst inappropriate, this period often did feel like being under 'siege' as I and my team sought to respond to a prolonged period of significant challenge with sustained media and political scrutiny. We had tremendous difficulty in having our, honestly held, position heard and reported in a balanced way, when others were putting forward counter positions and documents and information were being leaked to the media. This very difficult situation was made even more challenging by the loss of direct control of NHS GGC communications and public statements due to external oversight and

by a lack of a clear, definitive, and agreed position on whether there were, indeed, any links between the hospital and resulting patient harm.

Declaration

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