Scottish Hospitals Inquiry
Witness Statement of
Fiona McCluskey

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

Personal Details and Professional Background

1. Name, qualifications, chronological professional history, specialism etc – please provide an up-to-date CV to assist with answering this question. Please include professional background and role within NHS GGC, including dates occupied, responsibilities and persons worked with/ reporting lines.

A. My name is Fiona Jane McCluskey. I am a retired Registered Nurse.
I started my general nurse training in July 1978 at Glasgow Royal Infirmary and qualified in August 1981 as a Registered General Nurse.
I worked for 39 years within NHSGGC in a variety of clinical and senior nursing management roles. I retired from NHSGGC on 31st March 2017. On 31st August 2017 my Nursing Registration lapsed with the NMC and since then I have not practiced as a Registered Nurse.

I have attached my CV which details my chronological professional history **(See Appendix C)**

<u>Qualifications:</u>
BSc Health Studies (Hons 1st Class) 1998
Diploma in professional Studies in Nursing (Distinction) 1995
Scottish National Board Certificate in Operating Department Nursing 1982
Registered General Nurse 1981
SQA Certificate in Patient and Public Involvement 2008

Role as Senior Nurse Adviser – New South Hospitals Project

I was appointed as Senior Nurse Adviser for the New South Glasgow Hospitals Project team on 1st April 2009 following a competitive interview process in December 2008. This was initially advertised as a secondment opportunity for 2 years. In 2011 the post was made substantive due to the value of the project. My post with the project ended on 30th June 2015. I have attached the Job Description for my post as Senior Nurse Adviser.

On the 1st July 2015 I was redeployed through the NHSGGC Organisational Change Policy to the post of Assistant Chief Nurse Governance and Regulation in the Nursing, Midwifery & Allied Health Professionals Directorate based at NHSGGC Health Board HQ.

The main purpose of my role as Senior Nurse Adviser was:

- to provide expert nursing professional advice in relation to all service redesign, planning and implementation aspects associated with the New South Glasgow Hospital and New Children's Hospital Project.
- To develop training programmes with clinical services to ensure that staff were well prepared to facilitate new models of care.

My responsibilities as Senior Nurse Adviser were to:

- build key internal and external stakeholder networks to achieve key project objectives
- be responsible for ensuring there is user involvement in the Project
- challenge and lead the drive for modernisation of clinical services by encouraging innovation, identifying new ideas and practices and use of new technology
- work with the Acute Nurse Director in providing expert Nursing advice and significantly contributing to the identification of a nursing workforce for the new hospitals
- identify changes in roles and skill mix and identify training requirements in taking forward the new ways of working

Persons worked with during the New South Glasgow Hospital Project

The core project NHSGGC team members I worked with were the Project Medical Director's for both adult (Dr Stephen Gallacher) and children's hospitals (Mr Morgan Jamieson in 2009 until his retirement. When Mr Jamieson retired, Dr Jane Peutrell took over as the children's Project Medical Director. I worked with the adult and children's Project Managers (Heather Griffin and Mairi Macleod) the Facilities Management Lead (Karen Connelly), Project Technical Manager (Frances Wrath) and Project Deputy Medical Director (Peter Moir).

I reported to the Project Director Mr Alan Seabourne from 2009 until his retirement then I reported to Mr David Loudon. My professional reporting line was to the Acute Director of Nursing Mr Rory Farrelly from 2009 -2014. After Mr Farrelly left NHSGGC, I reported to the Board Director of Nursing Mrs Roslyn Crocket.

I also worked with other NHSGGC project managers including Technical Managers, Community engagement, Health Information & Technology, Telephony, Clinical Physics, Procurement and equipping. I also worked with the Laboratory Project Manager, Lorraine Peebles, on a project 'enhancing the environment for the bereaved'. We obtained Charity funding to enhance the bereavement areas and the mortuary viewing rooms in the paediatric mortuary based in the Laboratory building. I also worked with David Hall (Currie and Brown).

Design and Specifications

2. When did you first become involved in the design of QEUH/RHC. Please describe your role and responsibilities.

A. I commenced in post as Senior Nurse Adviser with the New South Glasgow Hospital Project Team on 1st April 2009. I first became involved in the design of the hospital during the competitive dialogue process which began May/ June 2009. I cannot remember the exact dates. I was assigned to the adult and children's clinical group meetings which were held with the bidder teams' architects. I attended these meetings along with Dr Stephen Gallacher, adult hospital Medical Director, Dr Morgan Jamieson, Children's Hospital Project

Medical Director, Heather Griffin, Project Manager - adult hospital meetings and Mairi Macleod, Project Manager - children's hospital meetings and Annette Rankin Consultant Infection Control Nurse. My main role was to provide expert nursing advice to the clinical meetings. These meetings were led by the bidder teams' architects and started with the 1:500 block plans of their design, working through some departmental 1:200s, then specific 1:50 rooms. These meetings largely concentrated on clinical adjacencies, clinical flows and 1:50 room layouts. This was a 2 -way process where we would review the design presented by the architect and give feedback at the meeting. The adult and children's meetings were held concurrently in a large room to facilitate access from Annette Rankin and myself to both groups. I had no input to technical or commercial meetings during competitive dialogue.

I was a member of the clinical evaluation group during bidder evaluation with Dr Stephen Gallacher, Dr Morgan Jamieson, Heather Griffin and Mairi Macleod and Annette Rankin the Consultant Infection Control Nurse. My main role was to provide expert nursing advice to the clinical evaluation process.
I had no input to any technical meetings or any commercial meetings during the bidder evaluation stage. The next stage of the design process was when the user group meetings were set up. My main role was to provide expert nursing advice to the clinical user group meetings.

a) Can you please explain what you mean by providing, "expert nursing advice" and provide some examples to provide context.

A. The Job description for the Senior Nurse Advisor post (attached) states that the post holder is required to provide the project team with expert nursing advice. The post holder was also required to have 'substantial professional nursing experience with additionally several years working in senior management posts'.

Providing expert nursing advice in the context of the Senior Nurse Advisor post required me to use knowledge gained through my nursing education and experiential learning from previous clinical and nursing leadership roles. This fits with the 'expert nurse 'as described by Patricia Benner in her book 'From novice to expert, excellence and power in clinical nursing practice' Benner P (1984). Addison -Wesley Publishing Company.

I provided nursing advice on many occasions. Five examples to provide context are detailed below. These examples influenced changes to the design to support the delivery of safe patient - centred care. I did not provide nursing advice in isolation. I collaborated with other nurses and specialist advisory groups through a 'hub and spoke model'. This included nurses within NHSGGC and other external organisations.

Examples to provide context

In April 2009, when I commenced in post, the majority of the hospital estate was built in the late 19th & early 20th century. The design of ward areas in the demitting hospitals consisted of a variety of multi-bedded wards, ranging from nightingale wards to four bedded rooms. It was recognised that the move from multi-bed accommodation to 100% single rooms was going to mean a significant change in practice for nursing staff.

A number of UK sites were visited by me with other nursing staff in support of design development. This included the Bevan Ward at the Hillingdon Hospital NHS Trust which was a Royal College of Nursing research pilot site for different layouts of 100% single rooms. One of the key learning points to maximise patient safety was good visibility into the bedrooms.

A key aesthetic feature in the new hospital design was that each patient would have his or her own en-suite toilet & shower room. This required an uncomplicated route from bed to en-suite in the design to maximise patient safety and give patients direct access to toilet and shower facilities.

1. **Visibility into the bedrooms**

A key design principle was to maximise visibility from the corridor into the bedrooms. This was achieved by incorporating large observation panels to enable nursing staff to have a direct line of sight into the bedroom. Privacy issues were addressed by the incorporation of interstitial blinds into the observation windows.

1.1 **Observation windows**

The initial design presented by the Multiplex design team was an observation window with interstitial blinds (blinds in the double glazed panel). The initial design of the blinds reduced visibility into the bedrooms which was unacceptable for nursing observation. After several iterations the Multiplex design team produced a blind design which increased the space between the blind slats and maximised the visibility into the bedrooms to enable easier nursing observation of patients.

1.2 **Door panels**

The initial design presented by Multiplex was a narrow visibility panel on the upper part of the bedroom door which gave little visibility into the room and was unacceptable for nursing observation. Multiplex changed the design to full 'Vistamatic' panels thus increasing the visibility into the bedrooms

2. **Direct access to toilet and shower facilities**

2.1 **En-Suite Doors**

The initial design of the en-suite doors was a bifold arrangement which I felt was unacceptable for patient safety. I had seen the door with other nursing colleagues at another hospital site and based on our opinion and that of a Health and Safety assessment we felt that there was a high risk of finger trapping. In addition, we felt that many older people and wheelchair users would find the door difficult to use and reduce accessibility into the en-suite.

The Multiplex design team changed the design to twin doors opening outwards set on piano hinges. This enabled the doors to swing outwards and be set flat against the wall, an innovative design at the time. This in turn gave patients easier access to the en-suite and increased the area around the toilet to enable nurses to carry out moving and handling of patients from both sides of the toilet. This also assisted in wheelchair bound patients independent accessibility on and off the toilet.

2.2 **Ensuite Floor**

The initial design of the en-suite wet room floor included a 'lip' around the shower area to reduce egress of water. From a nursing perspective this design was felt to be unacceptable for patient safety as the lip had the potential to be a trip hazard for patients. The lip was also too high for wheelchair users to access the shower unaided, thereby reducing their independence. The lip also had the potential to be a moving and handling hazard for nurses who would be required to assist a patient into the shower area on a mobile shower chair. After a number of iterations, the Multiplex design team re-designed the floor and removed the lip replacing it with a shallow slope towards the drain.

2.3 **Vinyl Flooring**

The initial floor vinyl design presented by the contractor was a heavily spotted design which was unacceptable for patients with dementia or cognitive problems who can experience visual-perceptual difficulties, leading to misperceptions and distortions of reality e.g. dark patches on a floor can be mistaken for a hole. The contractor supplied a different design which was acceptable for patients with dementia.

3. **Hoist Strategy**

In conjunction with the NHSGGC Moving and Handling Lead, I developed a hoist strategy for the whole hospital. Overhead hoists were fitted to specific rooms in the wards and included some rooms fitted with bariatric hoists. This reduced the need for the use of mobile hoists which can take up a lot of space in a ward area.

4. **Nurse Call Handset**

The initial patient handset presented to the project team by the contractor had the potential to operate the lighting system and the entertainment system as well as connecting the patient to the nurses via the 'call bell' system. Following a review with nursing colleagues it was felt that the handset may be confusing for some patient groups so a simpler handset suitable for patients in both paediatric and adult settings was chosen. An additional feature of a torch was included in the handset and proved to be popular with patients when using the handset at night.

5. **Supporting the delivery of patient centred care**

I also utilised best practice nursing standards to support the delivery of safe patient care and to create patient-centred environments within the new hospital.

Examples of these in the hospital are the locations of the 'Care Assurance Standard Boards' in the entrance to every ward, the 'What Matters to Me' Boards in every bedroom and the 'Patient Status at a Glance' Smart Boards located at staff bases in every ward, in the Acute Assessment Unit and in the Emergency Department where clinical huddles are carried out.

I liaised and fed back output from the clinical user group meetings to the Director of Nursing / Heads of Nursing meeting which were held on a monthly basis and in 1:1 meetings with the Director of Nursing. I also gave feedback to the Project Director and at Project Team meetings. There were circa 70 user groups involved in the design of the hospitals, these were clinical and non clinical. I attended most clinical meetings. I cannot recall all the meetings that I did attend as it was 15 years ago. I did not attend any non clinical meetings regarding the design of facilities or estates rooms e.g. Regen kitchens, plant rooms, mechanical or electrical systems, ventilation or water systems, IT hub rooms, basement areas & AGV's or the helipad.

The main purpose of my role as Senior Nurse Adviser was:

- to provide expert nursing professional advice in relation to all service redesign, planning and implementation aspects associated with the New South Glasgow Hospital and New Children's Hospital Project.
- To develop training programmes with clinical services to ensure that staff were well prepared to facilitate new models of care.

My responsibilities as Senior Nurse Adviser were to:

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Further detail on my role and responsibilities are detailed in the Senior Nurse Adviser Job Description which is attached with my statement.

3. The Inquiry understands that you were Senior Nurse Advisor for the QEUH/ RHC Project Team from around 2010 to 2012. Describe in detail this role, including when you started and left this role. Including your role, if any, in the User Groups.

A. As detailed earlier in my statement, I was appointed as Senior Nurse Adviser for the New South Glasgow Hospitals Project team on 1st April 2009 following a competitive interview process in December 2008 which I held until my role on the project ended on 30th June 2015.

I have attached the Job Description for my post as Senior Nurse Adviser.

The main purpose of my role as Senior Nurse Adviser was:

- to provide expert nursing professional advice in relation to all service redesign, planning and implementation aspects associated with the New South Glasgow Hospital and New Children's Hospital Project.
- To develop training programmes with clinical services to ensure that staff were well prepared to facilitate new models of care.

My responsibilities as Senior Nurse Adviser were to:

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My role also included the following

- Competitive dialogue - member of the clinical group - nursing input
- Bidder evaluation - member of the clinical evaluation team - nursing input
- Clinical User groups meetings - nursing input
- Clinical Migration Project Planning Lead 2013 -2015 – with Dr Stephen Gallacher, Adult Hospital Medical Director
- Hoist Strategy - with Cameron Raeburn Moving and Handling Lead NHSGGC
- Resuscitation Strategy - with NHSGGC Resuscitation Training Officers
- Nurse call system – nursing input
- Chair of the Generic Ward Operational Policy Group
- Patient Focus / Public Involvement Group
- Scrub sink and clinical wash hand basin assemblies - with J Barmanroy
- Dispenser locations - with J Barmanroy
- Art Strategy - enhancing the healing environment led by Jackie Sands Arts Lead
- Wayfinding strategy
- Patient entertainment system
- Dementia Signage
- Bereavement Strategy - Chair of the short life working group
- Improving the Environment for the bereaved - successful bid for charity funding to enhance the paediatric mortuary rooms situated within the laboratory building
- Bedroom and critical care bedhead and ceiling lighting workshops & demonstrations for clinical staff - with the lighting contractor Whitecroft
- Mock rooms - 2011
- Mock Ward - 2014
- Chair of scenario planning Working Group -2014
- Horne Taps briefing paper 2012 - in conjunction with J Barmanroy
- Bedpan washers vs Macerators- in conjunction with J Barmanroy
- Patient and public Events - in conjunction with Community Engagement
- Staff events - with H Griffin/ M Macleod
- Meetings with local GP's - with Dr Stephen Gallacher Adult Hospital Medical Director
- New Hospital Staff tours – with other Project Team members
- New Hospital Staff induction Programme - with other Project Team members

- Senior Charge Nurse generic ward training programme
- Medical Directorate 'On the Move' operational planning groups
- Clinical Migration Logistics Group
- Patient Flows Event - testing patient flows to the new adult outpatients with members of the public prior to the hospital opening
- BBC filming – 'Our New Super- Hospital'.
- Risk assessment tool for nursing patients in single room ward accommodation -2015
- nursing workforce plan for clinical migration/ double running

Role in User Groups

My main role was to provide expert nursing advice to the clinical user group meetings. I liaised and fed back output from the meetings to the Generic Ward Users Group, the Director of Nursing / Heads of Nursing meeting which was held on a monthly basis and in 1:1 meetings with the Director of Nursing and the Project Director and at Project Team meetings.

My recollection is that there were circa 70 user groups involved in the design of the hospitals, these were clinical and non clinical. I attended adult and children's meetings relating to wards and clinical departments. I did not attend any meetings regarding the design of facilities or estates rooms e.g. Regen kitchens, plant rooms, mechanical or electrical systems, ventilation or water systems, IT hub rooms, basement areas & AGV's or the helipad.

a) Confirm who attended the user groups meetings from IPC, Estates, Clinical and the GGC Project Team for the following areas: Ward 4B – QEUH; Ward 4C – QEUH; Level 5 – QEUH; Renal – QEUH; Critical Care – QEUH; Ward 2A & 2B – RHC; PICU RHC – RHC; All Isolation rooms

A. My recollection was there were circa 70 user groups. For the areas specified above in the question it is impossible for me to be able to detail everyone from the specialties who attended these meetings because I no longer have access to my NHS emails or project folders kept during my time with the project. A register of attendance at meetings was taken at the user group meetings by the Project Managers.

User groups were represented by subject matter experts, usually senior clinicians / nurses/ AHP's who were experts within their specialty. The representatives were nominated by their Director. The Project team had no involvement in nominating clinical users. The user group lead was either a Clinical Director (a senior doctor), a Senior Nurse, a General Manager or a Lead Allied Health Professional.

My recollection of Project Team members at the above user group meetings were as follows:

Project Manager:

Heather Griffin for the adult Hospital meetings

Mairi Macleod for the children's hospital meetings

Infection Control

Pamela Joannidis and Sandra MacNamee (Devine) attended meetings until Jackie Barmanroy came into post in 2010, then Jackie Barmanroy attended the meetings

Project Medical Directors:

Dr Stephen Gallacher (Adult hospital)

Dr Jane Peutrell (Children's Hospital)

Senior Nurse Advisor

Fiona McCluskey

Project Technical Manager

Frances Wrath

Technical Adviser

David Hall (Currie and Brown) or a deputy in his absence

Architects

The architects from Nightingale Associates were responsible for the design of the hospital including all wards and departments and led the users through the meetings.

b) How often were user group meetings scheduled to review design proposals and agree the design with the user groups.

A. My recollection was that there were approximately 3 rounds of User group meetings. I cannot recollect how often each of the user group meetings were held. Some smaller/less complex departments or specialties with individual rooms perhaps only required a couple of meetings whereas other more complex departments had more meetings scheduled.

c) Describe your involvement in the design of the Schiehallion unit, PPVL and BMT rooms. Who signed off these areas from Infection Control?

A. The Schiehallion Unit wasn't given its name until after the hospital opened so my recollection is that the name Ward 2a was used during user group meetings. My recollection was that I attended most if not all of the ward 2a user group meetings although it is hard to remember. The meetings were held on the Yorkhill site at the request of the users to ensure maximum attendance from clinical users at meetings.

My recollection is that the ward 2a meetings followed a standard format used in all user group meetings.

In the first meeting the group were introduced to the project team and the architect. The architect had the responsibility for the design of the ward. The architect took the group through the 1:500 block plans, clinical adjacencies and artists impressions of the hospital site. The purpose of this was to give the group a high level understanding of the whole hospital.

My recollection is that the architect then showed the group the proposed plan for ward 2a on the 1:200 departmental layout. This included the ward bedrooms and the support rooms within the Ward, the Teenage Cancer Trust (TCT) area, the MIBG (meta-iodobenzylguanidine) suite and the seminar room. The user group was told that they could change round the layout of the ward if they wished, providing they remained within the 1:200 envelope.

At subsequent meetings the architect worked with the user group on the detail of all rooms within the entire Ward area using 1:50 graphical room layouts.

Separate meetings were held with TCT, although I do not recall attending these meetings.

I attended the MIBG suite meetings which were held separately from the 2a meetings. These were also attended by the architect, the Project Manager Mairi Macleod, Technical Advisor Frances Wrath, Jackie Barmanroy ICN and David Hall Currie and Brown. Clinical Physicist Dr Michael Bradnam was the lead user. Other users attended but I cannot recall their names.

PPVL / BMT rooms were discussed at the 2a meetings . My recollection of this is that the discussion focused more on the 1:50 floor layout, nursing staff/ and patient flows within the rooms, the practicalities of how nurses would work in the PPVL rooms, how the lobby would be used, donning gowns and masks, visibility into the rooms from the corridor, wall and floor finishes, clean and dirty flows and patient flows throughout the ward. I cannot recall any technical discussion or discussion about ventilation.

At a very early 2a user group meeting, Dr Brenda Gibson, who was the nominated User Group Lead, with other clinicians present at the meeting raised concerns regarding the lack of accommodation / office space for medical staff within the ward. They were extremely unhappy about a previous executive decision made by NHSGGC Health Board to build an office block adjacent to the hospital which meant that all medical secretaries and administrative support

teams would be based within the office block. Dr Gibson stopped attending user group meetings at this stage.

I cannot recall who then became the User Group lead although I recall some medical staff attended some further meetings. The Senior Charge nurse, charge nurse, nurse specialists, pharmacists and play specialists continued to attend all the meetings.

I recall Mairi Macleod raising Dr Gibson's concerns regarding medical staff accommodation with Mr Alan Seabourne the Project Director and also at a Project Team meeting although I cannot remember the dates. I think she also contacted Jamie Redfern the General Manager at Yorkhill to discuss.

As part of the generic ward design all wards including Ward 2a were designed with an office for the Senior Charge Nurse and an interview room designed as a quiet space for 'difficult conversations' with patient's relatives. There were also small meeting rooms and quiet rooms out-with the ward. These were dotted throughout both hospitals and could be accessed on a bookable basis.

My recollection is that Multiplex was responsible for the design of the PPVL/BMT rooms. I do not recall attending any technical meetings regarding PPVL/BMT rooms

d) In your view, would there have been a requirement for infection control input into these technical meetings?

A. I don't know if there would have been a requirement for infection control input to these technical meetings as I was not involved in any aspect of these technical meetings.

e) From your recollection of those involved at the time, who would have been most appropriate to provide this input to Multiplex?

A. If there had been a requirement for infection control input to these technical meetings, Doctor Craig Williams NHSGGC Lead Infection Control Doctor would have been the most appropriate to provide input. Mr David Hall (Currie and

Brown) would be most appropriate to provide technical advice with Wallace Whittle, the mechanical and engineering consultants.

Jackie Barmanroy signed off the 1:50 layout drawings at the user group meeting from an Infection Control perspective and if any issues arose, she would discuss these with her professional lead, Sandra McNamee and Dr Craig Williams, Lead Infection Control Doctor. My recollection is that the 1:50 drawings at the Ward 2a meetings only showed the placement of equipment and furniture within the rooms and used ADB component codes on the drawings. I cannot recall any technical sheets being used at user group meetings.

f) In respect of PPVL rooms, Dr Peters raised concerns with you in late 2014. What is your recollection of these concerns? Do you agree with Dr Peters oral evidence that the PPVL rooms didn't look like they were negative pressure? What action, if any, did you take following Dr Peters concerns? Who signed off the PPVL rooms?

A. I have no recollection of Dr Peters raising any concerns with me.

g) When did you first see the PPVL rooms?

A. I cannot recall seeing the PPVL rooms. I would not have expected to visit these rooms with regard to the technical requirements as I had no involvement in the technical specifications of these rooms or had any involvement in the technical meetings.

h) Did you have any concerns when you first viewed these rooms?

A. I cannot recall viewing the PPVL rooms.

i) How were designs approved for construction and who signed off on the agreed design?

A. My understanding was that contractor was responsible for the design of the hospital.

My understanding is that designs were signed on behalf of NHSGGC by Frances Wrath to allow the contractor to proceed to the next stage

4. Explain the purpose of the guidance relied upon by the design team and why this was important.

A. I don't know which guidance the Multiplex design team relied upon. I can only assume it would be Scottish Health Planning Memorandums.

5. Explain how the output for the design of the Wards was confirmed and signed off. In doing so describe the purpose of the clinical output specification, and your involvement.

A. The generic ward design principles were agreed prior to my taking up post on the project. My understanding is that the principles of the generic ward design, the development of the clinical output specification and schedule of accommodation for a generic ward was developed with health planners and agreed by a multidisciplinary group, the Generic Ward User Group, chaired by the Director of Nursing, Mr Rory Farrelly. This group had representation from medical staff, nursing staff, Allied Health Professionals and Facilities Management staff with input from Health & Information Technology. The meetings also had significant patient and public involvement, both from an adult and a children's perspective.

The purpose of a clinical output specification is to detail the current service, the patient group and how the service will work in the future. These are developed and signed off by clinical users. All clinical output specifications were signed off before I took up post.

6. Describe the role and involvement of Infection Control in the design process, in particular, describe your role in the design process. Who from infection control signed off the design?

A. During my time with the Project, I recall that Infection Control were actively involved in the clinical design process.

During Competitive Dialogue meetings I recall Annette Rankin being actively involved and she was also present during the Bids evaluation phase.

In early-stage user group meetings I recall Dr Redding, Pamela Joannidis and Sandra McNamee being involved until a Project Consultant Infection Control Nurse was appointed to replace Annette Rankin.

From 2010 Jackie Barmanroy was the full time Consultant Infection Control (IC) Nurse on the Project Team. She was present at both adult and children's meetings during the user group process. This was agreed with the IC Senior Management team in order to maintain consistency of IC advice across both the adult and children's hospitals meetings.

My understanding is that Jackie Barmanroy sought nursing Infection Control advice at the weekly NHSGGC IC Lead Nurse meetings on a range of practical infection control issues. Jackie Barmanroy sought technical advice from the Infection Control Senior Management Team, namely Assistant Director of Nursing Sandra McNamee(Devine), who was Ms Barmanroy's professional lead and the NHSGGC Lead infection Control Doctor Dr Craig Williams.

My role was distinct from Infection Control, in that I was responsible for giving nursing advice to the Project Team. My main role was to provide expert nursing advice to the clinical design meetings. I have no qualifications in Infection Control.

Jackie Barmanroy signed off the 1:50 graphical room layouts on behalf of Infection Control at the user group meetings.

7. Describe the intended use and purpose of the following wards in QEUH/RHC: Ward 4B – QEUH; Ward 4C – QEUH; Renal – QEUH; Level 5 – QEUH; Critical Care – QEUH; Ward 2A & 2B – RHC; PICU RHC – RHC; all Isolation rooms. What guidance was considered in the design of these wards, what processes were in place to ensure guidance compliance? Were there any changes to the design during the design and build, if so, please describe any such changes, describe the impact, if any, on guidance compliance, and described the sign off process for any such changes, your involvement and how any changes were communicated to the Board. Was external advance ever sought in respect of design changes?

A. Ward 4B QEUH - initially haemato-oncology until the change request to move the Beatson wards in 2013. The ward was then split between haemato-oncology / BMT

Ward 4C QEUH - Renal

Level 5 QEUH - Wards A/B/D General Medicine; Ward C Infectious Diseases (initially this was assigned to General Medicine until the change request in 2014)

Critical Care QEUH - Intensive Care / High Dependency/ Coronary Care.

Ward 2A RHC - Haematology/ Haemato-oncology/ BMT

Ward 2B RHC - outpatients haematology/ haemato-oncology

PICU RHC - paediatric intensive care unit

Isolation rooms - I cannot recall all the isolation room locations and purpose.

Guidance used in the design of these wards would have been the relevant SHPN and SHTM in use at that time. I cannot recall the versions used.

I cannot recall any changes to the design and build. I cannot recall if external advice was sought in respect of design changes.

a) What do you recall in respect of a) the change request for ward 4B

A. I was aware of the change order request for 4B from Jonathon Best in 2013 as I have also stated in my answer to Question 17, but I was not involved in any aspect of this.

b) And Ward 5C?

A. I do not recall being made aware of a change request for Ward 5C.

c) What actions were taken upon agreement of the change request?

A. I was not involved in any aspect of this.

d) How was this change communicated to teams?

A. I was not involved in any aspect of this.

e) How was this change communicated to Multiplex?

A. I was not involved in any aspect of this.

f) Are you aware if any risk assessments took place following the change request?

A. I was not involved in any aspect of this.

g) Are you aware of the input, if any, infection control had before and after the change request was agreed?

A. I was not involved in any aspect of this.

8. The Inquiry has heard evidence from Pamela Joannidis that Jackie Barmanroy confirmed that SHTMs were being followed in respect of all ventilation systems in the hospital. Describe your role relative to Jackie Barmanroy. Were you aware that SHTMs were being followed in respect of ventilation systems? What information, if any, had you seen that allowed you to confirm this?

A. I was Jackie Barmanroy's operational line manager on the Project Team**.** I signed off her annual leave and carried out appraisals. I have no qualifications or expertise in Infection Control. Jackie Barmanroy's professional line management was to Sandra McNamee the Assistant Director of Nursing for any issues, support or advice regarding Infection Control.

Jackie Barmanroy also sought nursing Infection Control advice at the weekly NHSGGC IC Lead Nurse meeting on a range of practical infection control issues. She sought technical advice from the Infection Control Senior Management Team, namely Assistant Director of Nursing Sandra McNamee (Devine) who was her professional lead and the Lead infection Control Doctor Dr Craig Williams.

I was not involved in any technical meetings regarding ventilation or have any knowledge or experience regarding ventilation systems so I cannot comment on whether SHTMs were being followed.

9. Describe your involvement and understanding, if any, in the removal of the maximum temperature variant? Why was the decision taken and by whom? What risk assessments, if any, were taken prior to making this decision? What was the impact, if any, in removing the maximum temperature variant?

A. I had no involvement in the removal of the maximum temperature variant.

10. Please describe and name the people who were involved, the sign off process involving RDD, and your knowledge and understanding of the purpose of the scale drawings and designs, how the technical requirements for the rooms were managed, including your role and involvement.

A. I don't know as I had no involvement in technical matters.

11. Describe the IPC involvement in the design of Ward 4B – QEUH; Ward 4C – QEUH; Level 5 – QEUH; Renal – QEUH; Critical Care – QEUH; Ward 2A & 2B – RHC; PICU RHC – RHC; all Isolation rooms, who was involved and who signed off the final design and when.

A. In early-stage user group meetings for the above areas, I recall Dr Redding, Pamela Joannidis and Sandra McNamee (Devine) being actively involved. They also agreed and advised the Project Team on the number of isolation rooms required for both hospitals prior to competitive dialogue.

From 2010 Jackie Barmanroy was the full time Consultant Infection Control (IC) Nurse on the Project Team. She was present at adult and children's meetings during the user group process. The post had been agreed with the IC Senior Management team in order to maintain consistency of IC advice across both the adult and children's hospitals.

My understanding is that Jackie sought nursing Infection Control advice at the weekly NHSGGC Lead Nurse meeting on a range of practical infection control issues and sought technical advice from the Infection Control Senior Management Team, namely Assistant Director of Nursing Sandra McNamee (Devine) who was her professional lead and the Lead infection Control Doctor Dr Craig Williams.

My recollection is that User group meetings focused on the 1:50 scale drawings that the architect supplied. Any changes requested by the users were marked up by the architect on the 1:50 drawings at the meeting. Jackie Barmanroy signed off the 1:50 graphical room layouts on behalf of Infection Control at the user group meetings. My recollection is that the1:50 drawings at user group meetings only showed the placement of equipment and furniture within the rooms and used ADB component codes on the drawings. Discussion focused on the clinical use of the room. I cannot recall technical sheets being used at user group meetings.

12. What concerns, if any, did you have regarding the final design specification of Ward 4B – QEUH; Ward 4C – QEUH; Level 5 – QEUH; Renal – QEUH; Critical Care – QEUH; Ward 2A & 2B – RHC; PICU RHC – RHC; all Isolation rooms, and what action, if any, did you take in respect of these concerns?

A. I cannot recall having any involvement in final design specification.

13. Describe the purpose of the ABD sheets and the relevance of ADB in respect of the intended patient cohorts. Who was responsible for sign-off of the ABD sheets? From the point of signing off the ADB sheets when did it become apparent that the ventilation specification of in parts of Ward 4B – QEUH; Ward 4C – QEUH; Level 5 – QEUH; Renal – QEUH; Critical Care – QEUH; Ward 2A & 2B – RHC; PICU RHC – RHC; all Isolation rooms did not meet the requirements of SHTM/ HTM? What action, if any, did you take in respect of this?

A. ADB sheets were used during the User group meetings so that the clinical users could ensure that the architects had captured their clinical requirements on the 1:50 scale drawings that the architect supplied. The technical ADB sheets were not used at these meetings.

Any changes requested by the users were marked up by the architect at the meeting. Jackie Barmanroy signed off the 1:50 graphical room layouts on behalf of Infection Control at the user group meetings and Frances Wrath signed them off on behalf of the Project to allow the contractor to move to the next stage.

My recollection is that the1:50 drawings at the user group meetings only showed the placement of equipment and furniture within the rooms and used ADB component codes on the drawings. I cannot recall technical sheets being used at user group meetings.

I was not involved in ventilation specifications and I don't have the knowledge or skills to comment.

14. What concerns, if any, did you have regarding isolation rooms and compliance with SHTM/HTM? What action, if any, did you take in respect of any such concerns?

A. I do not recollect being made aware of any compliance problems regarding isolation rooms.

a) The Inquiry has reviewed the RDS in excel format and note there is an entry under 'Design Notes' relating to Ward 2A isolation rooms; the entry states: WARNING NOTICE: This room is based on a theoretical design model; which has not been validated (see paragraph 1.8 of HBN 4 Supplement 1). Specialist advice should be sought on its design. The lamp repeat call from the bedroom is situated over the door outside the room.

(i) Was this note entered on the RDS? If so, why and by whom?

A. I didn't review the RDS. I wasn't involved in the RDS process so I am unable to comment.

(ii) Question for witness: Can you advise who was involved in the RDS process And may be able to assist us with this question?

A. David Hall Technical Advisor from Currie and Browne attended all technical meetings. Wallace Whittle were the engineering consultants.

(iii) What specialist advice was sought relating to the design of these rooms?

A. I wasn't involved in the RDS process so I am unable to comment.

(iv) What was the final agreed design for isolation rooms and who approved this?

A. I wasn't involved in the design for isolation rooms so I am unable to comment.

b) The Inquiry has reviewed the RDS in excel format and note there is an entry under ‘Design Notes’ in the RDS which refers to HBN 4 Supplement 1, paragraph 1.10, and states:

"EXCLUSIONS”

This supplement does not describe the specialist facilities required in infectious disease units or on wards where severely immuno-compromised patients are nursed. Guidance for these facilities will follow in a further supplement to HBN 4."

(i) Were you aware of the exclusion in para 1.10? If so, what action was taken? What was the impact, if any, of the exclusion?

A. I wasn’t involved in the RDS and was not aware of the exclusion.

c) What ceiling types were specified and approved for use in isolation rooms? Who from the GGC Project Team approved this? Describe your involvement, if any? What was the impact, if any, of the choice of ceiling tiles? What concerns, if any did you have regarding the choice of ceiling tiles?

A. I don’t know. I don’t recall having any choice of ceiling tiles.

15. The Inquiry is aware that in respect of a derogation being agreed in respect of the ventilation system and the requirement to achieve ACH in compliance with SHTM. Where you aware of this at the project phase?

A. I recall being asked to attend one meeting regarding Brookfield’s design solution for the ventilation in general ward bedrooms. There were other members of the Project Team also in the room, but I cannot recall all present. I recall Mr Alan Seabourne, Mr Peter Moir and Mr David Hall being present.

I cannot recall the date, but I think it was before the contract was signed.

I cannot recall the detail of the meeting but do remember some discussion about the maximum numbers of people in a general ward bedroom and the air changes required. There was a lot of discussion about who would be present with the patient in the bedroom during ward rounds and how many relatives would be in the room during visiting hours.

I recall being told at the meeting that Dr Hood, a microbiologist at Glasgow Royal Infirmary, had been contacted for advice on air changes. Dr Hood had contacted Mr Peter Hoffman at the Health Protection Agency in England as he was an expert on this matter. My recollection is that Mr Hoffman had advised that air changes in general ward bedrooms were specified for temperature control and were related to patient comfort and not infection control.

After this meeting I had no further involvement in any other meetings regarding ventilation system requirements or the final derogation decision.

a) If not, when did you become aware? In hindsight, should you not have been aware of this at the time?

A. I was in attendance at one meeting (as explained above) but had no further involvement.

b) What concerns, if any, at the project phase did you have in respect of the ventilation system?

A. I cannot recall having any concerns as I was not part of the discussions on ventilation other than described above.

16. Describe your involvement, if any, in respect of the decision to use Horne taps.

A. I attended a meeting in 2012 along with several members of the Project Team; this included Alan Seabourne, Peter Moir, Heather Griffin, Mairi Macleod and David Hall (Currie and Brown). I cannot recall the date of the meeting.

The group were advised that Multiplex proposed to install the Horne Optitherm thermostatic tap for clinical use within both the adult and children's hospitals at all clinical wash hand basins and scrub sinks.

The purpose of the meeting was for the Project Team to view a demonstration of the Horne Optitherm tap, followed by a questions and answer session. There was a follow-on technical meeting which I did not attend. The Horne tap representative demonstrated the dual lever arrangement which allowed the tap to be operated by using the thumb then turned off using the elbow or upper forearm. There appeared to be no issues in relation to performing a clinical hand wash or full surgical scrub.

We were told that the Horne tap differed from the standard design of other hospital taps as there was no requirement to remove IPS panels for maintenance purposes which interrupts clinical activity. This seemed very attractive from a clinical point of view as it meant less disruption in the clinical area, less downtime for the ward bedrooms and less interruptions to the patient flows through the hospital.

We were also told that testing and sampling for micro-biological analysis could be carried out in situ with the use of the manufacturers 'Flushing kit'. The manufacturer recommended the use of 'Thermal Disinfection' of the tap instead of chemical disinfection, commonly used for other taps within NHSGG&C, as they believed chemical disinfection would degrade the components inside the Opthitherm tap.

I do recall a discussion between the estates representative and others in attendance at the meeting that the best way to facilitate thermal disinfection would be to have a stock of spare taps already disinfected within the estates workshop to facilitate a 'swap over' process to replace the taps in situ therefore preventing a bedroom being closed down for disinfection.

Following on from the meeting Mr Seabourne asked me to carry out a 'fact finding' exercise to find out if there were any hospitals locally that had installed the taps. The Horne Optitherm tap was installed in Monklands Hospital Lanarkshire and in the Vale of Leven Hospital Theatre Suite.

Mr Seabourne and I visited Monklands Hospital and met with the Senior Infection Control Nurse (ICN). He advised that thermal disinfection had not been an issue in practice and advised us to accept the training sessions offered by the company to train staff on the use of the taps.

Jackie Barmanroy and I met with the ICN at the Vale of Leven. She provided us with the information she had been given from the company. We were also advised that the internal mechanism was seen to be 'nurse proof' and over tightening of the tap was not a problem, which had proved to be an issue causing leaking taps in other tap designs within NHSGGC. Both infection control nurses gave us positive feedback in terms of clinical usability, infection control and domestic cleaning. They reported that maintenance was straightforward and removing the IPS panel is unnecessary therefore disruption in the clinical area is minimal.

Jackie Barmanroy also attended a national Infection Control conference and gave Mr Seabourne and I an update on this. Horne had a stand at the conference and attendees gave her very positive feedback. Jackie Barmanroy and I co-wrote a paper to update Mr Seabourne in July 2012 and this was circulated to the full Project Team including Facilities Management and David Hall.

a) What concerns, if any, did you have regarding the use of Horne taps?

A. Following the demonstration by the Horne team and benchmarking with other sites, there appeared to be no clinical issues in relation to performing a clinical hand wash or full surgical scrub.

There also appeared to be no infection control issues provided the correct disinfection process and maintenance regimes were followed.

We did take up the offer of the Horne training and this was incorporated into the training provided to Senior Charge Nurses and departmental managers during the 12-week operational commissioning process.

b) What risk assessments were carried out in respect of the use of Horne Answer

A. I don't know.

c) Who was involved in, and who signed off the use of Horne taps?

A. The whole Project team were involved in the meeting (as described above) with Horne, including Facilities Management, Infection Control, Project Managers, myself, the Project Director and David Hall from Currie and Brown. As far as I can recall the paper that Jackie Barmanroy and I co-wrote was circulated to all members of the Project Team. As I do not have access to the Project Team folders or my emails, I cannot confirm this. I don't know who signed off the use of the Horne taps.

d) Did you attend the meeting regarding the use of Horne taps in 2014? If so, why was the decision made to proceed with Horne taps?

A. No.

e) Question for the witness: Please refer to Bundle 3, Document 1, page 5 (A33680955). Have you seen this SBAR before?

A. I have been asked to refer to Bundle 3, Document 1, page 5 (A33680955). **I** have not seen this SBAR before.

f) Having read it, do you now have concerns about the decision to proceed to use Horne taps?

A. Having read the SBAR I would follow the advice given in the recommendation.

g) The Inquiry understands that despite the decision to proceed to use Horne taps no management or maintenance of the taps or water sampling schedule was put in place? What is your view on this?

A. I don't have the technical knowledge to comment on management and maintenance of taps or water sampling schedule. I was not involved in any management or maintenance of the taps or water sampling schedule.

Bone Marrow Transplant Unit and Ward 4C

17. The Inquiry understands that the BMT service was to transfer from the Beatson following a change order request, issued by Jonathan Best in July 2013.

a) Following the Change order request, what actions did the GGC Project Team take to confirm the technical and environment requirements (in particular air change rates, pressure regimes and HEPA and air permeability requirements) for the BMT Unit?

A. I was aware of the change order request from Jonathon Best but was not involved in any aspect of this.

b) What design review meetings were held to confirm with the user groups to confirm the requirements for the BMT Unit.

A. I cannot recall

c) Was the design for the BMT Unit subject to the RDD process

A. I don't know

d) If so, who was involved in the RDD process for the BMT Unit

A. I don't know

e) What feedback regarding Air Change Rates and pressure differentials was received from Multiplex regarding the Change Order?

A. I don't know

f) Prior to handover did the BMT unit at QEUH/ RHC meet the requirements and specifications of the intended patient cohort and comply with SHTM guidance? If not, why not, and if not, how was this area of the hospital accepted at handover? Who from infection control was responsible for singing off on handover?

A. I don't know.

g) In his oral evidence during the hearings commencing 20 August 2024 Professor Craig Williams told the Inquiry that Jackie Barmanroy was the infection control nurse leading on the projects and that she was saying that the hospital had been built and was compliant with the appropriate legislation. Do you agree with this statement? If so, how did you satisfy yourself that compliance had been achieved? With the benefit of hindsight do you now agree this this to be the case?

A. My understanding at the time was that the contractor was responsible.
I had no involvement in compliance. I don't have the technical knowledge or qualifications to comment.

18. In respect of the BMT unit describe your involvement, in the decision to return the BMT unit to the Beatson in July 2015? Please include details of the escalation process and whether any external advice and support was sought and why the decision was taken.

A. I was not involved.

19. The Inquiry is aware that the change order not only confirmed that the Bone Marrow Transplant (BMT) service would transfer to Ward 4B in the QEUH but also that the haematology patients that were originally planned to accommodate Ward 4B would move to Ward 4C.

a) Describe how this change was communicated to the project team and Multiplex and how this change was captured in the design and specification documentation.

A. I was not involved in the change order regarding the transfer of the BMT Service to ward 4b and 4c. I do not know how this change was communicated to the project team. I do not know who communicated this to Multiplex.
I did not have any involvement in the design and specification documentation

b) Prior to handover did the BMT unit at QEUH/ RHC meet the requirements and specifications of the intended patient cohort and comply with SHTM guidance? If not, why not, and if not, how was this area of the hospital accepted at handover? Who from infection control was responsible for singing off on handover?

A. I was not involved in the handover process.

c) The Inquiry understands that 10 rooms were provided for Haemato-oncology patients (Rooms 66 to 75) in Ward 4C, these rooms had no HEPA filtration, 2.5 – 3 ACH per hour, included chilled beams; rooms were at a balanced or slightly positive pressure to the corridor and had suspended ceilings fitted in patient bedrooms and ensuites.

(i) Who approved and signed off on this specification for the Haemato-oncology patients to be accommodated in Ward 4C?

A. I don't know

d) Describe the IPC involvement in the design of Ward 4C, who was involved and who signed off the final design and when.

A. I don't know

Infectious Disease Unit

20. Describe the impact, if any, of the move of the Brownlee Unit and on the hospital design. What concerns, if any, did you have regarding this, and what action, if any, did you take? Describe the discussions and involvement, if any, you had with Multiplex in respect of this matter? What concerns, if any, did you have regarding the compliance with SHTM. Describe the commissioning and validation process in respect of the infection disease unit and confirm how you were satisfied it complied with SHTM requirements?

A. I was asked to attend a meeting at the Brownlee Centre (Infectious Diseases Unit) based at Gartnavel General on behalf of Mr David Loudon. This was regarding the move of the infectious diseases unit to the new hospital. I cannot recall the date.

I recall the meeting was chaired by Anne Harkness the South Sector Director and included Infectious diseases consultants, the Senior Charge Nurse from the Brownlee Unit and Lead Infection Control Doctor Dr Craig Williams.

I recall telling those present at the meeting that the hospital was built and my understanding was that they would be moving to a general ward in the adult tower. Although I cannot recall a lot of the detail of the meeting as it was around 11 years ago I do recall being asked about technical details regarding the suitability of infectious diseases being cared for in a general ward. I was unable to answer these technical questions but reported that I would relay the request back to Mr David Loudon.

I recall returning to the project office and discussing the output from the meeting with Mr Loudon and other team members. I cannot recall if it was the same day or the next day. I had no further involvement with any technical matters relating to the transfer of the Brownlee Unit. I was not involved with any discussions with Multiplex on this matter. I was not involved in any technical commissioning or validation of the Infectious diseases Ward.

a) Question for Witness: What do you recall in respect of your discussions with David Loudon?

A. I cannot recall the detail of the discussions with David Loudon.

b) Are you aware of what actions Mr Loudon took following this?

A. I don't know. I had no further involvement in any technical matters.

Renal

21. Describe your involvement, if any, in respect of the ventilation in the renal unit. What concerns, if any, did you have regarding this, and what action, if any, did you take in respect of this matter?

A. I cannot recall any involvement with this.

Handover

22. Commissioning and validation:

a) Describe what commissioning of the water and ventilation system took place prior to handover, and your involvement, if any.

A. I don't know. I had no involvement.

b) Who was responsible for ensuring that commissioning of the water and ventilation system was carried out, and who signed off that it had been carried out? What concerns, if any, did you have regarding commissioning and validation being carried out prior to handover?

A. I don't know. I had no involvement.

c) The Inquiry understands that NHS GCC decided to forgo the requirement to have an independent commissioning engineer. Who made this decision? What was the impact, if any, of this decision? In hindsight, do you think that it was the correct decision?

A. I don't know. I had no involvement.

d) The Inquiry understand that no validation was carried out in respect of the ventilation system. When did you become aware of this? How did handover come to be accepted without the ventilation system being validated? Who was responsible for this and who signed off on this?

A. I was not involved in the validation of the ventilation system. I don't know who was responsible and signed off the validation of the ventilation system.

23. Who oversaw contractual compliance? Who was responsible for ensuring that the paperwork was produced to confirm contractual compliance? What action, if any, did you take to ensure that paperwork was in place to ensure contractual compliance? Was validation of the ventilation system a contractual requirement? If so, who signed off on contractual compliance given the lack of validation?

A. I don't know. I was not involved with contractual compliance.

24. **Please see Bundle 12, page 936 and 937.** This is an email from Frances Wrath to you dated 5 May 2015. Frances Wrath states *'All areas have been commissioned in line with contract ER's and all legislative requirements.'*

a) What documentation, if any, did you have sight of in order to accept this statement at the time?

A. I have been asked to comment on **Bundle 12, page 936 and 937 an email from Frances Wrath dated 5th May 2015**

I have read the email. The email title is 'Re: New Children's Hospital.

This is addressed to Jackie Barmanroy cc'd to Lynne Robertson and Pamela Joannidis. I was not copied into this email.

b) At the time, how were you satisfied that all areas had been commissioned in line with contact ER's?

A. I was not involved technical commissioning so am unable to answer this question.

c) Please explain how 'all areas had been commissioned in line with the contract ER's and legislative requirements' give the agreed ventilation derogation which provided for achieving air changes below the required level as provided for in SHTM 03-01 guidance at the time?

A. I was not involved technical commissioning so am unable to answer this question.

d) With the benefit of hindsight do you consider that 'all areas had been commissioned in line with the contract ER's and legislative requirements'? If so, why, and if not, why not?

A. I do not have the technical knowledge to comment.

e) Describe your role in the lead up to accepting handover. What action, if any, did you take to ensure that the wards within QEUH/RHC met the guidance requirements of SHTM.

A. A number of members of the Project team, including myself were asked to carry out a programme of checks of the wards and clinical departments. I cannot recall which wards and departments I was asked to check. This was recorded on paper in a series of folders. The folders contained 1:50 drawings of rooms within departments and wards. The folders contained a checklist related to a general visual check of the room to record if there were any issues e.g. scuffed walls, doors sticking, blinds not working, flooring cracks. This did not include electrical or engineering checks or any checks of lighting, ventilation or water systems.

I was not involved in anything related to the guidance requirements of SHTM for any technical, mechanical or engineering checks up to handover.

f) How were you assured that the wards met the requirements of the specific patient cohorts?

A. I was not involved in anything related to the guidance requirements of SHTM for any technical, mechanical, ventilation or water systems or engineering checks up to handover. Apart from issues regarding snagging I cannot recall being made aware of any technical issues from the Senior Charge Nurses, Infection Control Nurses or technical managers during the operational commissioning period.

g) In her evidence Dr Peters tells us that you gave her a tour of the QEUH/RHC campus in around late 2014. Dr Peters told the Inquiry that she noticed that the sinks had a greenish puddle where the drain was, and that she asked about this, and you assured her that the sinks were compliant. How were you assured that the sinks were compliant? What action, if any, did you take follow Dr Peters comments? In hindsight, what action, if any, should you have taken?

A. I do not recall a tour of the QEUH/RHC campus with Dr Peters in late 2014.

h) Based on Dr Peters' recollection, do you feel you would have been in a position to advise of the compliance of the sinks at the time?

A. I don't have the technical knowledge to advise on compliance of sinks.

i) Did you have any concerns about the sinks or anything else?

A. I don't recall having any concerns about the sinks or being made aware of anything else.

j) The Inquiry is aware that the ventilation system in respect of Wards 2A and 2B did not meet the requirements of SHTM knowledge and awareness/ involvement in derogation. Did you have any concerns at the time? If so, please describe. The Inquiry is aware that Ward 2A was handed over without HEPA terminals being in place in wards, how did sign off come to take place without these being in place? Who signed off the RHC as ready for handover, without HEPA being in place?

A. I was not aware that the ventilation system in respect of Wards 2a and 2b did not meet SHTM requirements. I wasn't involved in handover and was not made aware of HEPA terminals not being in place. I don't know who signed off the RHC, without HEPA being in place.

k) The Inquiry understands that there was no validation of the ventilation system prior to handover. Who was responsible for ensuring that this was in place? Why was validation not carried out? When did you become aware that it had not been carried out and what action did you take in respect of validation having not been carried out? What was the consequence of validation not having been carried out? Should the hospital have opened without the ventilation system having been validated?

A. I don't know. I had no involvement in technical matters.

l) Question for the witness: In your view, should the hospital have opened without the ventilation system having been validated?

A. I don't have the technical knowledge to advise on validation of the ventilation system.

m) Describe your knowledge and involvement, if any, in the PMI allowing Multiplex's role as Independent Commissioning Engineer. What was the impact of this?

A. I had no involvement

n) At handover, had a preoccupation L8 risk assessment been carried out? Who was responsible for ensuring that this was in place prior to patient migration? were you aware of a preoccupation L8 assessment having been carried out? Who instructed it? When did you become aware? Why did you not raise it as a concern that you had no seen this prior to patient migration, was this not within your role as Project Manager of RHC?

A. I don't know if a preoccupation L8 risk assessment was carried out. My role was Senior Nurse Adviser so that was not part of my role. I was not the Project Manager of RHC and cannot comment.

o) Who was responsible for providing asset tagging. Why was there no asset tagging who decided to proceed without it?

A. I don't know

p) What, if any, testing and maintenance protocols and regimes were in place at handover? Who was responsible for putting these in place? If they were not in place, why not, and what action was taken and by whom to address this?

A. I don't know

Declaration

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

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

Appendix A

A47069198 - Bundle 12 - Estates Communications

A33680955 – Bundle 3 – NHS NSS: SBAR Documentation

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

Appendix B

A51989087 - Bundle 43, Volume 4, Document 1, Page 14

Appendix C

CURRICULUM VITAE

Fiona McCluskey

PROFILE

I retired from the Health Service in 2017 after 39 years' service. During my career I held a variety of clinical and senior nursing management posts. I was the Senior Nurse Advisor on the New South Glasgow Hospital Project team from 2009-2015. The remit of the post was to provide expert clinical nursing advice for the Project Team.

Following the reorganisation of NHSGGC in 2015 I took up post as Assistant Chief Nurse for the Nursing, Midwifery and Allied Health Professionals Directorate,

providing a leadership role for all aspects of professional governance for nurses and midwives within the board area.
Following my retirement, I was approached by Children's Health Ireland to lead and support the development of a Clinical Migration Plan for the transfer of 3 acute paediatric hospitals in Dublin.

EXPERIENCE

Lead Clinical Migration Manager - Children's Health Ireland (CHI) Dublin 2021-2022

Provided a leadership role in the development of the Clinical Migration Plan for CHI. Provided input to the overall Clinical Commissioning plan for the transfer of the 3 acute paediatric hospitals in Dublin into the new children's hospital.

Assistant Chief Nurse Professional Governance and Regulation NHSGGC —- 2015 - 2017

Provided a leadership role in all aspects of the regulatory requirements for nurses and midwives. Led the implementation of NMC Revalidation for 12,400 Registered nurses and midwives across the health board. Took a lead role in a number of service improvements through the adoption of improvement methodology. Led the implementation of the national programme for Older People's Care within the Board area. Acted as an ambassador for NHSGGC representing the board on a number of national initiatives.

Senior Nurse Advisor New South Glasgow Hospital Project —2009- 2015

Provided expert clinical nursing advice into the design of the new Glasgow adult and children's hospitals working with a wide range of clinical and public stakeholders. Led the redesign of clinical services and systems including the development of the nursing workforce plan. Worked with service users to ensure their views were incorporated into the design of the Hospital. Developed training programmes with clinical services to ensure that staff were well prepared to facilitate new models of care. Led the development and delivery of the Clinical Migration Plan which involved the transfer of 4 hospitals onto the new site.

Lead Nurse Cardiac Rehabilitation NHSGGC — 2003 - 2009

Manager for the Board wide Cardiac Rehabilitation service across six hospital sites. Led the development of the Multicultural Inequalities service for Cardiac rehabilitation patients. Led a number of service redesign initiatives including the development of home rehabilitation and the Ambulatory rehabilitation service. Chaired the MCN Cardiac Rehabilitation sub group which developed the new Cardiac Rehabilitation Strategy. Manager of the secondary care smoking cessation service for all patients across NHSGGC.

Project Manager North Glasgow Hospitals NHS Trust —2003

Project Manager for the redesign of medical services at Glasgow Royal Infirmary. Developed the redesign of clinical pathways for patients with Upper Neck surgery across the West of Scotland. Developed a redesign of Cardiology clinics at Glasgow Royal Infirmary.

Divisional Nurse North Glasgow Hospitals NHS Trust —2002 - 2003

Acting Divisional Nurse (secondment opportunity). Provided a senior management role for the Cardio-Respiratory Directorate on all aspects of the professional regulatory function for nurses. Professional lead for circa 800 nursing staff.

Lead Facilitator RCN Clinical Leadership Programme Glasgow City 2000–2002

Led the implementation of the pan-Glasgow RCN Clinical Leadership Programme. Had overall responsibility for the planning and implementation of the programme in collaboration with the RCN and the four Glasgow Hospital Trusts.

Surgical Assessment Co-ordinator 1997-2000

Manager of a nurse led service to screen patients prior to a general anesthetic. Developed the service from its inception in conjunction with a range of medical stakeholders.Developed clinical pathways for patients from home to admission to hospital. Increased same day admission rate to 93%.

PREVIOUS EXPERIENCE

Theatre/ Anesthetics Team Lead - CEPOD & Trauma Theatres Glasgow Royal Infirmary 1986-1997

Theatre Sister - ENT & Laser Theatre's Glasgow Royal Infirmary 1983 -1986

Theatre Staff Nurse - Glasgow Royal Infirmary 1981- 1983

EDUCATION

Glasgow Caledonian University — BSc Health Studies (Honors 1st Class)1998

Glasgow Caledonian University —Diploma in professional Studies in Nursing (Distinction) 1995

Scottish National Board Certificate in Operating Department Nursing 1982

Registered General Nurse 1981

Certificate in Patient and Public Involvement 2008

VOLUNTARY WORK

Board Trustee 2017 - 2019

The Nurses Memorial Charity to King Edward V11 in Scotland

PUBLICATIONS

Music in the Operating Suite. NATNews September 1983

Does wearing a face mask reduce bacterial wound infection? A literature review. British Journal of Theatre Nursing. August 1996