SCOTTISH HOSPITALS INQUIRY

Hearing Commencing
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Scott Davidson
Jann Gardner

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10:00

THE CHAIR: Good morning. Now, Mr Mackintosh, our first witness is Dr Davidson.

MR MACKINTOSH: Dr Davidson, my Lord, yes.

THE CHAIR: Good morning, Dr Davidson. Please sit down. Now, as you appreciate, you're about to be asked questions by Mr Mackintosh, who's sitting opposite, but, first, I understand you're prepared to take the oath.

DR DAVIDSON: Yes.

Dr Scott Mitchell Davidson
Sworn

THE CHAIR: Thank you, Dr Davidson. Now, I don't know how long your evidence will take. I anticipate it will certainly not take the morning and may take a little less. We will take a coffee break at half past eleven, but if at any stage you want to take a break, just give me an indication and we will take a break. So feel that you're in control of the situation. Now, Mr Mackintosh.

MR MACKINTOSH: Thank you, my Lord.

THE WITNESS: Thank you.

Questioned by Mr Mackintosh

Q Dr Davidson, I wonder if I can take your full name.

A Scott Mitchell Davidson.

Q Thank you. Now, you produced a statement in response to a questionnaire we produced and, before I ask you whether you adopt it as your evidence, I think you want to make a minor correction, which appears in response to Question 23, which is on page 162 of the statement bundle.

A Yes. It's simply I put in, "I didn't attend", and it should say that I did.

Q Thank you. So, that's page 162. You did attend BICC and you did so as the chair of the Acute----

A Yes.

Q -- Infection Control Committee. Thank you, but we'll go back to that because we are going to touch on that committee later on. With that correction, are you willing to adopt your statement as part of your evidence?

A Yes.

Q Thank you. Now, conscious that you are currently-- well, what's your current job title?

A I'm the executive medical director and responsible officer for NHS Greater Glasgow and Clyde.

Q Is there only one medical director in the Health Board?

A You have one executive medical director and I have a number of

deputies, and you have one responsible officer.

Q Thank you. Now, what I want to do, because we're dealing with events that largely happened before you took up that post, is to walk through – not directly following the structure of the statement – the various jobs you've held and ask you a series of questions as we go, which will be more questions as we get to the later jobs.

If I might start looking at your statement on page 132, you helpfully provided the years you held various posts, and so I want to look at the period from 2015 to 2017 when you were clinical director of medical services. Now, before we look at that, as a consultant respiratory physician, which wards would that be normally?

A So, when we moved into the-- So, prior to moving into Queen Elizabeth, at the Southern General Hospital I had one ward----

Q Yes.

A -- and in the Queen Elizabeth University Hospital we moved into a unit that had four wards, 112 beds, and also a front door receiving unit of 16 patients.

Q Are those wards mainly on the seventh floor?

A We had the whole of the seventh floor, or we do have seventh floor.

Q Now, I have a memory – which you may want to correct me – that one of the four wards on the seventh floor at one point contain the Cystic Fibrosis Ward. Am I right in that?

A Yes.

Q Is that part of your unit, in essence?

A So, I'm not a specialist in cystic fibrosis----

Q I appreciate that.

A -- but, yes, we have cystic fibrosis----

Q And that sits within the respiratory community, as it were?

A Yes, they're part of the team.

Q Thank you. Now, if we think of the period '15 to '17, how many of your-- I'm assuming you were full time, 10 sessions, at this point?

A So, I was a 12-session consultant----

Q Right.

A -- specialising in-- I specialise in home ventilation of neuromuscular patients, and I had two sessions a week for clinical director role----

Q And 10 sessions for practice?

A Yes, plus on call for weekends and overnight.

Q Yes. Now, we've been hearing evidence about various different bits of the hospital that may or may not have had, at various times, issues with their

ventilation systems. I'm assuming that your responsibility at this point didn't cover any part of the Children's Hospital?

A No.

Q No, or indeed the regional Bone Marrow Treatment Unit that was occasionally on Ward 4B. That wouldn't have been part of your responsibility?

A No.

Q No. Would infectious diseases have come within your remit as clinical director of medical services?

A Yes.

Q Yes. So, I suppose the question is simply this: what knowledge did you have in this period when you were clinical director of medical services about questions of whether the general wards in the adult hospital had an air change rate somewhat half of what was recommended in national guidance?

A I don't recall having any awareness.

Q Thank you. Now, I want to move on to the next period on your CV, so go back to your statement, the final paragraph, 2017 to 2019, chief of medicine, South Sector. Now, of course, you remained a consultant respiratory physician, but how many sessions were you, as it were, still doing of clinical practice at this point?

A To begin with, I was employed on a five-session managerial contract. I had a 12-session contract because I still did my on-call and still practised clinically. Latterly, I think I was up to about 7 sessions in terms of managerial, perhaps 8.

Q So it started as 5 out of 12 and moved towards 7 or 8?

A Yeah, yes.

Q Right. Again, would this only have included adult patients?

A Yes, South Sector.

Q Would it have included the Adult BMT Ward?

A No.

Q No, right. So, again, to ask the same question again, when did you cease to be chief of medicine? What month was that?

A So, it's quite hard to answer because there was a bit of a changeover in terms of getting someone in and moving, so I kind of did probably a bit of both. I went on holiday-- I think it was June or July in 2019, and when I came back from holiday I felt that I was totally into my new role.

Q Right, and Dr Stewart explained he retired in June of '19.

A Yes.

Q Yes. So, if we think of the period between your arrival as chief of medicine and that soft changeover, as it were, what knowledge did you have about the question of whether the general

wards of the adult hospital had an air change rate of half or so of the national guidance?

A Again, I don't recall an awareness of that.

Q Right. It's probably worth, before we go on any further, asking when did you become aware of that issue?

A I'd need to refer to my statement again, if I will, because I want to get it absolutely right but----

Q Of course, yes.

A Sorry. It was certainly-- I was aware, obviously, of the need to decant children but, in terms of air changes, it would have been in my role as deputy medical director.

Q Right, so you actually mention that on page 149.

A Yes.

Q So, if you look at 149 of your statement.

A Yes.

Q So, you became aware of this issue. You say the decant-- You were aware of the issue when you were chief of medicine, South Sector. In terms of ventilation, you think it was when you were deputy medical director that you learned about the ventilation issue?

A Yes.

Q Thank you. Let's go back to your statement now and go to page 137, because you mention a group called the South Sector Management Team, and that's in answer to Question 6. What just might help us to connect you to other people in the story, when you sat on the South Sector Management Team as chief of medicine, South Sector, who was the general manager? I understand there was three you in management for the sector. Was it you, a nurse, and a manager?

A So, as the chief of medicine, I sat with the director, Anne Harkness.

Q Who was the chief nurse for this particular sector, can you remember?

A Sorry, I can't remember.

Q I understand. Now, you actually provided a copy of the South Sector Clinical Governance Annual Report with your statement, which we'll put on the screen, for 2017 to 2018. That's bundle 52, volume 2, document 32, page 426. If we go to page-- Can you explain what the purpose of this report was and who was the audience it was to be read by?

A So, we would always take the-- So, we would pull together a Clinical Governance Annual Report for the team within the South Sector. We were still a very early team, having come together in 2015, and so we tried to pull together these reports that demonstrated the work that was being done within the team across the sector, and then obviously you

would share that within the team in the South Sector.

Q So it would go to people in the team.

A Yeah.

Q Would it go up the system as well?

A I can't actually recall if it did.

Q The reason I put it on the screen is because there's nothing in this report-- no reference to this issue of ventilation, and so presumably that would be consistent with what you've just said, but '17/'18, there's no mention of it in there. Right.

Now, I want to pick up your membership of AICC, and I'll put it to you in short and see if you'll accept it and, if not, we can go and look at the document. There's a minute from 19 June 2018 describing you being appointed to AICC. For background, that's bundle 13 – I don't need you to put it on screen – document 16, page 121. But you don't actually attend meetings of the AICC until you become deputy medical director. Is that what you recollect to be the case?

A Yeah. So, I've read through them, and there's certainly, I think, four or five where I was unable to attend. My apologies----

Q Can you help us about why that might have been?

A It will almost undoubtedly have been clinical commitments.

Q And the pressures of the clinical practice.

A And the pressures of clinical practice.

Q Now, we went and looked at your statement, and I took you to a paragraph slightly out of sequence. It's page 149 of the statement bundle, and this is about the decant. Now, if we look at page 149, we asked you a series of questions and you've put them into the form of a table. So, you seem to be saying that as chief of medicine, South Sector, you were aware of the need to decant 2A from the Children's Hospital to 6A in the tower.

A Yes.

Q Can you help me about why you would have learnt that, what your involvement in the decant process would have been as chief of medicine, South Sector?

A Mainly that the move was going into one of our adult wards.

Q I understand it was a care of the elderly ward. Might that be the case?

A I'm not sure it was care of the elderly. I think it was split, and I think some of the Renal team worked in it as well. I can't recall. but it was a general medical ward.

Q Did you have any particular involvement in this process or was it just

something you were aware of and had sort of been handed to you: “You’re losing the ward”? Or were you involved in the debate in any significant way?

A I don’t remember any significant debate.

Q However, you become deputy medical director, Acute Services, and we understand-- of Dr Stewart’s retirement in June ‘19 and you’ve just explained about going on holiday, coming back in the autumn, you’re in the role. Can I just understand, from your perspective, how does your role relate to that, then, of Dr Deighan as deputy medical director, Corporate? What’s the sort of split between the two of you?

A So, I was-- The acute role was, I think, much more operational in terms of what was happening on the ground, and Dr Deighan’s role was more corporate and probably looking at policies and such like. So, we were quite different roles, and the acute medical director – or the acute deputy medical director, sorry – I think was a new role when Dr Stewart retired, so they were split. So----

Q Because previously he’d done both, effectively?

A Yes.

Q Is the general manager at this point, who you’re working with, Mr Best as chief operating officer for Acute Services?

A Yes.

Q Right. Now, I want to just deal with your attendance at BICC and AICC. The reason I’m just going to do this is I’m going to come back to some questions about it later. You first attend 29 July 2019. That’s bundle 13, document 58, page 4 to 5. Now, by this point, I think you might have attended one meeting of the Schiehallion Unit IMTs earlier in the year. Does that roughly accord with your recollection?

A Yes.

Q Yes. So, this is your first meeting, and if we step through onto the next page and the next page, we will eventually see – keep going, next page, next page – Item G on page 430, a short note of a report on “Water/ Ventilation Issues” at the Queen Elizabeth.

A Yes.

Q Now, the reason I’m putting that up on the screen is just to ask you: at this point, can you sort of summarise what you understood the issues around water and ventilation issues were? This is July ’19 in the Queen Elizabeth in the Children’s Hospital.

A As I recall, we were seeing some children with gram-negative infections and, therefore, beginning to work through that.

Q Do you have a recollection of knowing at the time, in a sense, when this

story had started? I mean, you might not have known about it at the start, but you might have been told about when the issue of gram-negative infections might be said to have begun, in some sense, in the Children's Hospital.

A I couldn't put a month on it, but it would have been through 2019.

Q Right. If we go to the next meeting, 7 October – that's the same bundle, 13, document 59, page 433 – we see Dr Armstrong's in the chair and you're present. Again, if we step forward to find the equivalent item – it's on page 453, it's the fifth bullet point – there's a long record of a discussion. Now, the question I have for you at this point is: various sort of events have occurred in the period since 29 July, and I wondered if you could help me with the extent to which you had been told about any of these things by the time we get to October.

So, the first one would be the-- Well, you obviously knew about the involvement of the Scottish Government because it's mentioned in the minute here, so I don't need to ask you about that. The second one would be the resignation of the lead infection control doctor. Do you remember when you were told about that?

A It would have been after my leave, in 2019.

Q Right. So, you went away on this leave in the summer.

A Yes.

Q I mean, at risk of asking how long your holiday was, can you remember roughly when you came back?

A I was away for two weeks, but I can't----

Q Because the date of the resignation is early in September, and I'm wondering-- It's only a few weeks before this October BICC, and I just wondered if you learned about it before the meeting.

A I don't recall when I knew about it.

Q Did you learn about it at some point?

A Yes.

Q Yes. Can you recollect what you were told about the resignation of the lead ICD in that autumn?

A No.

Q One of the ways that some people have described the period between July and October, I suppose-- There were various bits of evidence over the last year, but it includes from some people, from many people, an accession of tension within the IPC/microbiological community. What awareness did you have, by the time we get to October – so it's, what, two or three months after your holiday – of such a tension?

A I was aware of tensions.

Q What would have been your source of briefing on that?

A So I think, having attended-- I'd been at IMTs and just general discussion.

Q There was no formal briefing to you of what was going on?

A I don't recall having a formal briefing.

Q Now, I've already asked you about when you learned about the issues around the ventilation in the general wards. I wonder if I can now press you on a couple of other issues that we're aware of. So, the first one is whether there were any standard operating procedures or ways of operating in the Infectious Diseases Unit which address the absence of isolation rooms in Wards 5C and 5D at this point.

A I wasn't aware of any particular SOPs.

Q Did you ever become aware of an issue around-- Sometimes patients were to be sent to other hospitals if they had certain conditions; were you aware of anything around that?

A I was aware there was the rebalancing of the rooms in the fifth floor, and obviously there was then work done within the critical care floor of the Queen Elizabeth with regards negative pressure rooms. So I was aware of that.

Q When it was done?

A I was aware of it at the time, yes.

Q Yes, and that's picked up one of the other issues. The final issue relates to the ventilation system in Ward 2A. Now, obviously, Ward 2A has been closed, and there have been reports prepared by, amongst others, Innovative Design Solutions about the ventilation in 2A in the latter part of '18. I wonder when you became aware of the programme to upgrade the ventilation in Ward 2A?

A I couldn't recall when I was aware of it, but I was certainly aware of the work and being planned.

Q Is this around the time of being deputy medical director?

A Yes.

Q So, if I put to you that, effectively, prior to becoming deputy medical director you would have had no knowledge about any issues with the ventilation systems in the Queen Elizabeth, would you accept that?

A Yes, I don't recall any other detail.

Q Thank you. Now, given that you were both the respiratory consultant and then chief of medicine, South Sector, do you think you ought to have been told about the fact that the general wards had a low air change rate compared to Scottish Government Technical Memorandum Guidance before you

became medical director?

A I don't know the answer to that. I mean, I think I moved from working in hospitals with Nightingale wards and I was moving into a hospital with single rooms and ensuites for every patient, so that was seen to me as a real bonus. So I have to say I had no concept of what a low air change rate would even mean.

Q I suppose one of the differences between a Nightingale ward, in addition to that----

THE CHAIR: Sorry, just for my note, "no concept of"?

A The low air change and what that would mean.

THE CHAIR: Right. No concept of what a low air change rate would mean?

A Yes.

THE CHAIR: Thank you.

MR MACKINTOSH: I suppose the Nightingale ward, not only would it not have single rooms, but it would also have opening windows. I'm assuming in the Southern General you opened the windows if it was a bit stuffy?

A In the main.

Q In the main, yes. If you think about the seventh floor and your time in clinical practice as opposed to a manager, presumably you can open the windows on the seventh floor?

A No.

Q No. Was there any other discussion amongst you and your colleagues, and indeed with patients, about, in a sense, the air environment? We're sitting in a room here in our hearing centre which has 10 air changes, and you go into a room that has a low air change rate, you might – I don't know – perceive it to be different. Was there any discussion amongst your teams about the air quality on the seventh floor?

A I certainly don't recall any. I mean, certainly you would sometimes be warm in the wards, but I don't recall any specific conversation.

Q Thank you. Now, I want to move on to your statement, to the same page, actually, 149, where you touch on the risk assessment for Ward 4C. This is the bottom of the page. Now, this is partly-- I'm asking you about this because I neglected to mention this in putting a question to a witness last week. So, there was a risk assessment done on Ward 4C?

A Yes.

Q Now, firstly, let's work out when it was done, because we should look at the document, which is bundle 20, document 62, page 1428. Now, was this produced when you were deputy medical director?

A Yes, I think this is-- I can't recall the date at the end of it, but I----

Q If we can step on, we can go and look at the end.

A Yes. I think it was 2020.

Q One more page. It goes on a bit. There's some tables. Keep going. There we are.

A Yeah.

Q February 2020.

A Yeah.

Q Now, am I right in thinking that the people in the box were the people who actually did the work?

A Yes.

Q Right. Can you help me understand, in a sense, why they were each involved, what they bring to the process?

A Yes, of course.

Q Please. Just start with the top and take your way down the list and explain, from your perspective as medical director, why they were involved in this risk assessment.

A So, the patients within the unit, the haematology patients, so we had Mike Leach who was the clinical director at that time.

Q And he's the clinical director for regional services or for South Sector? This is 4B after all-- 4C, so it would be South Sector.

A Haematology. So, we had haematology patients within the Beatson as well as within the South Sector, but he would be regional, yes.

Q He's regional, right. Okay, and then we have Dr Hart.

A We had Alistair, consultant haematologist, again, as a consultant within 4C. Brian Jones as head of microbiology. We had Melanie McColgan, who was the general manager of Regional Services.

Q Effectively, is she the managerial equivalent of Dr Leach?

A Yes.

Q Yes.

A We had Myra Campbell, who would be the clinical services manager. Darryl, who was there in terms of ventilation. Tom----

Q Would "AP" mean authorised person?

A Pass.

Q Right, okay.

A Tom Steele is director of Estates and John Green is our interim health and safety lead, and they will have undertaken the work related to the risk assessment.

Q Now, if we go back to the start of the risk assessment, page 1428, I'm going to ask you a series of questions, and it may be you don't know the answer, but I'd be interested to see what you do. Now, obviously, one of the issues that we have discussed in this Inquiry at considerable length is the Scottish Health

Technical Memorandum. Now, it's 03-01 that deals with the ventilation systems. Is that a document you've now become aware of that you weren't previously aware of?

A I now know of this SHTM 03-01.

Q Yes. Is there anything that we should take from the fact that it's not mentioned in the bottom right-hand corner as guidance to be referred to? If you look in the box, "Specific risk assessments or guidance to be referred to", it mentions the NICE Guidelines, IDSA, ESCMID, and Infection Rates reports – over the page – and then there's nothing else in that column. So, it's not listed as a background document to this risk assessment. Is there any reason for that?

A I would be surmising.

Q Now, if we go back to the list of people on the last page, it occurs to me-- Well, let me ask you the next question and then we'll work out who I should ask if I really need to press this. In your reading of SHTM 03-01, did you come across the concept in one of the tables of a neutropenic ward?

A So, I have not read SHTM 03-1 in detail.

Q But is it a phrase you've heard of?

A Yes.

Q Yes. So, I'm taking it that you're probably not the right person to ask why there's no discussion of this ward being a neutropenic ward in the risk assessment?

A No.

Q No, but if I want to know because I failed to ask before, who on that list do you think would be the best person to ask – I'm suggesting probably Mr Conner – about why there's no reference to SHTM 03-01 or whether this is a neutropenic ward in terms of that guidance? Can you help me about who are other candidates I might pick if I was going to send a brief questionnaire to?

A I think Alastair as well, as the clinical lead.

Q In that case, we'll do that. So, we'll contact Dr Hart and Mr Conner. Thank you. Take that off the screen, please. Now, this is a question that arose from the evidence of both our Inquiry expert, Mr Poplett, and Mr Calderwood, the former Chief Executive up until 2015. It relates to the cleaning of chilled beams. Now, can I take it you're familiar with what a chilled beam is?

A Yes.

Q When you arrived in the hospital, did you know there were chilled beams or what a chilled beam was?

A No.

Q Because presumably you

didn't have them in the Southern General?

A No.

Q No. Can you remember when you first became aware that there was such a thing as a chilled beam and there was one in each room?

A I couldn't tell you when I first became aware of chilled beams.

Q So, Mr Poplett, who is an authorising engineer-- ventilation and Inquiry expert, carried out an audit of the management of the ventilation system. Is that something you're aware of?

A Yeah.

Q Yes. In evidence, he explained something he put in his report that I didn't understand. He described that there's a challenging aspect of chilled beams. This is column 118 of his transcript for my colleagues. They're challenging to clean because it requires patients to be moved out of a room whilst the chilled beam is serviced or cleaned, and you have to deploy something called a HEPA cart, which provides a-- providing a HEPA filtered airflow in an enclosure underneath the chilled beam, and you put a cleaning member of staff, engineer, and a ladder inside the HEPA cart's enclosure. You clean the chilled beam, and then you remove the whole thing from the room.

Mr Calderwood described in his evidence, albeit this will be before 2017, how he recollected that the cleaning of chilled beams caused an issue in that it delayed the transition from one patient to the next because often you had to have a full clean of the chilled beam when one patient had left the room before the next one went in. I just wondered, as executive medical director, whether this is an issue that you've come across in terms of delivering-- well, effectively, bed occupancy and capacity in the hospital?

A We have many issues with bed occupancy in our hospitals, particularly at the moment. I'm not aware of any issue coming to me because of chilled beam cleaning.

Q Thank you. Now, the next topic I want to turn to is your interaction with the Oversight Board. So, you arrived as deputy medical director in July/August/September period of 2019, and the Oversight Board arrived two months after you. I'm assuming it's been quite a high level of work since then. As deputy medical director, having the Oversight Board around.

A Yes, although I think we went into escalation on 22 November. Shortly after that, we had COVID and the majority of my time was----

Q Because you went back to a lot of respiratory work, presumably?

A I did a lot of work around the

response to COVID. Probably one of the biggest things that I struggle with is the fact that I was not able to be as clinical as I would have wanted to have been during COVID, and during that time I went in in evenings and weekends to help.

Q And indeed all doctors, hospital----

A Yeah.

Q -- doctors, worked exceptionally hard. We have a particular question that I've been asked to ask you about an interaction you had with a member of the Oversight Board, and that's Dr Andrew Murray.

A Yeah.

Q Now, he provided a statement, which is from the Glasgow II statement bundles, and the section I want to turn to is page 525 of that statement bundle. Sorry, 529, my mistake. So, earlier in his statement, Dr Murray has explained that he was asked to look at the issue around the prescription of prophylaxis and whether it was being done consistently. I understand that was his task. Do you recollect that?

A Yes.

Q Thank you. But he explains in paragraph 25, "Following my appointment I spoke to [Dr] Armstrong…" and a meeting was set up with you. You can see in the second half of paragraph 25, and you had a conversation. He then goes to meet the hospital staff, and he gets various minutes and documents. At paragraph 27, he describes how you helped him to understand the clinical context.

A Yeah.

Q

"He explained the [infection control position, explained the microbiology position, different specialties, also infectious diseases]."

Please, go back to the previous page:

"There were the different players within those clinicians involved, and I was informed that there had been some tensions within those different clinical perspectives. I was also made aware there was whistleblowing going on from within that group. That meant there might be different agendas..."

Now, do you recollect his conversation with Dr Murray?

A I remember meeting Andrew, yes.

Q In broad terms, is he talking about the same conversation you remember happening?

A I assume it will be. I have to say I only remembered the conversation when this came in.

Q Well, I'll ask you the question. It's suggested in this statement that Dr Murray recollects you discussing the

whistleblowing with him. Why were you discussing the whistleblowing with him?

A I suspect what I was doing was describing the tensions within the team and the situation. I don't believe I'll have gone into any specific detail. I certainly, for example, don't recognise the use of the word, "tribal". It's not a word I would use.

Q I suppose the only follow-up question is: what would have been the sources of the information you were passing to him about the views in and around the whistleblowing? Where would you have got the information from, because you weren't involved in the events as they happened? So where would you have got the information from?

A So, I had been at IMTs, as we----

Q Right.

A -- discussed.

Q So it would have been from that?

A Yeah.

Q But you weren't at the IMTs in August '19 at the time of the removal of Dr Inkster as lead?

A No.

Q So it's perhaps an earlier IMT you're thinking of. Now, you're nodding. There's a transcript----

A I don't-- Sorry. I can't recall.

Q You can't recall?

A Yeah.

Q Now, in your statement, if we go back to your statement, page 144, we asked you some questions about infection prevention and control, and of course you are not, unlike your predecessor was originally, the HAI infection lead for the Health Board.

A No.

Q No, but you are here and so it may be you can help me pick up a couple of things. If you can't, let me know. You mention, however, in paragraph (g) on page 144, the production of a "'Governance and Quality Assurance Framework for the Infection Prevention and Control Service' which was developed in 2019." Now, I want to check that we have the right document in mind when you say that. I wonder if I can show you what I think might be it, which is a draft from August '19, bundle 27, volume 8, document 1. Just to help your memory, we'll just step forward a few pages just to see the structure of the document. Do you recognise this document?

A Yes.

Q Right, if we go back to page 9. Now, I think we've been provided with the actual first operational version only in the last day or so, because this is just a draft. Were you involved in sending us in the actual working document?

A Yes, because I understand obviously from 2019 it was a draft, and then obviously that-- full disclosure, and this didn't get approved through various committees because of the escalation ,and then there's subsequent versions.

Q So when was it actually approved? After the Oversight Board or before?

A So, it was certainly into-- Again, I think it was after.

Q Because the reason I put it that way is that we had evidence earlier in the week from Ms Ward, who was the civil service support lead for the ARG Committee that reviewed implementation of recommendations. You've heard of the ARG, I take it? Now, when you nod, you make life harder for the person doing the transcript----

A Sorry, yes.

Q Yes. One of the matters that is mentioned in the corporate statement from the Scottish Government at paragraph 31 is a suggestion that they had some role in causing this framework or part of what it says around hot debriefs and things in IMTs to come into place. Could it be that the draft of this might have been started in '19, but it wasn't until '21 or later that the actual Board approval was finally given for the framework?

A Yes, looking at the date.

Q All right, thank you. Now, if we take that off the screen, the main issue I want to ask you about, IPC process, related to the role of AICC and BICC. I'll set out the sort of broad proposition, and if we need to look at something, we can.

A No problem.

Q So, there's been some criticism from some witnesses, and I have to say that I and my colleagues have observed in reading AICC minutes, that to a great degree, when events are happening, possible outbreaks or in fact data exceedances in infection terms, are happening in the Queen Elizabeth – I don't know about the other hospitals – what you see in an AICC minute is a report that is noted. You don't ever see action being decided upon in an AICC. I wondered if you thought that was fair, or would you phrase it in a different way?

A So, I think the minutes do reflect-- there is a lot of detail, and they are often descriptive, as you say. I think there are-- often a richness of discussion within a committee. Certainly when I'm chairing a committee, I like to try and bring out conversation through the committee. So I do think they're documentation of very factual evidence. They perhaps don't always pick up the richness of conversation within the committee, would probably be my reflection on committees.

Q Because, I mean, thinking about one of the sequence of issues that occurs, almost entirely before your time as deputy medical director, is the sequence of decants and partial decants in the Children's Hospital. So, we have the September decant, we have the transfer of patients to CDU in early '19, and then we have the closure of 6A to new admissions in the summer, August of '19. None of those-- the decision-makers, to the extent there are any, appear to be senior directors and managers on advice of the IMT chair.

So, how would you respond to the suggestion that it does appear the AICC is not actually making even strategic decisions about the management of potential outbreaks or data exceedances in the Acute Services? It is discussing them, informing people, but, in terms of management, it's not actually controlling what goes on. Would that be a fair description, or would you put it some other way?

A I think-- I'm just trying to think my way through that because, obviously, you may then go and talk to people but, within making those decisions, I think you're right. Those people are not on that committee.

Q I just wondered whether there was a tension between-- and it may be just us as lawyers coming in and looking at this from the outside, that the Acute Services is to some extent run by three people – it is run by the general manager, the clinical lead, and the lead nurse director – but the Acute Services Infection Control Committee is a greater number of people, and therefore if a difficult decision needs to be made, it's not made by the AICC; it's made by those three people. Have I understood that correctly?

A Yeah, but I think it would be with a-- a discussion and a conversation. I don't think these groups work in isolation. It's certainly not how I would try and practise.

Q Are you trying to suggest there's sort of a collegiate approach to these issues?

A So, that's certainly the way that I always aspire to work, and I guess you're talking about AICC and I've chaired AICC.

Q So if, for example, we look at the AICC meeting of 2 September 2019 – that's bundle 13, document 23, page 177 – we see you in the chair, and if we go to the report and we think about what's happened since the previous meeting in July – there's been the closure of 6A to new admissions and the removal of the chair of the IMT – and then if we go and look at the report on page 181, Item 11, we see quite a series of reports in here. We do see, "The ward is currently closed"

being reported, but we don't see the change to the IMT chair in here. Now, I'm not going to ask you a question yet because I want to draw a contrast with-- I want to look at another item on the next meeting and sort of set this up, because I think there's a wider point that you may or may not accept.

If we then look at the meeting of 12 November, so that's the same bundle-- Well, it's not. It's bundle 52, volume 2, document 29 – for some reason this one didn't make it to us earlier – at page 401. Again, you're in the chair, and if we go to the report on Ward 6A at page 405, we have no report of all the Estates actions that are happening at that time, because we know this is the point when the ward is about to be reopened to patients.

What I'm suggesting to you at this point is that-- It may be a consequence of the minuting system and not the reality, so that's what I'm trying to find out. Does an AICC attempt to capture all the major events in a major incident like this and discuss them all – in a sense, a resume of what has happened, and discuss them and work out what to do – or does it just draw out the things that are live at the time of the meeting? What's the approach to what you discuss at the AICC?

A I think a lot of it is what's live at the time. I think minutes are minutes, and I don't think minutes always reflect the entire conversation. I think, going forward, the benefit of having new tools such as Copilot will also help us in terms of transcribing our meetings, which we tend to do now as well. So I think there's learning.

Q Because the thing that occurs to me is that – and I recognise this might be an over prescriptive question, so you should tell me if you think I'm applying too much structure to something – if it's the case that AICC is really only looking at the things that are live when it meets, then it should either meet more often or, actually, it's too big and it doesn't need to exist. Do you think it's worth having?

A Yes.

Q What would you say is its value?

A So, I think it is the discussion; it is sharing; the hot debriefs; you get learning. We looked, for example, around-- I think over time – I'm just trying to pull things – we looked at chlorhexidine dressings, for example, around cannulas. So there are things that it has achieved, and I think it's also important that we've got a record of areas as well. Is it perfect? Clearly not, but I think, on balance, I've enjoyed AICC.

Q Might, in a sense, the problem here be that I'm seeing the word "committee" and seeing some sort of

executive function, decision-making body, and that might be my error, or its name is misunderstood?

A I think potentially.

Q Right. Now, what I wanted to do was to look at BICC just briefly and sort of slightly replicate the same conversation, but I'm conscious this is a period when you weren't the chair, and I haven't got the sequences when you're the chair. It may have changed in style, so you can tell me, but if we look at the equivalent BICC minutes, so 7 October 2019 – that's bundle 13, document 59, page 433 – when you are present but you're not, of course, the chair at this point, and we go to page 435 and you see at the fifth bullet point, as we've looked before, there is quite a more detailed note of what is going on, and I'll show you the next one before I ask the question. 25 November----

THE CHAIR: My fault, Mr Mackintosh, which year are we----?

MR MACKINTOSH: 2019, my Lord, so this is 7 October '19. So, I'm trying to show Dr Davidson two AICCs and two BICCs from approximately the same period in order to ask this question.

THE CHAIR: Yes.

MR MACKINTOSH: Then 25 November, 2019, bundle 42, volume 1, document 70, page 360. It also didn't get caught up in the original bundle for some reason. You're being welcomed to this-- Dr Armstrong is welcoming people to the meeting, and then, if we go onto page 361, we see a briefing about Ward 6A, and it goes on in quite some depth. Now, what I wanted just to do is to ask you: is there something there in the difference of the nature of discussion between the two committees, or are they really the same thing, just at different level? Are they different committees or the same in terms of style?

A I think they're slightly different, from the minutes. I haven't-- I haven't attended BICC on many occasions.

Q Yes. Do you attend it now?

A No.

Q No, and that's partly because you're no longer the HAI lead?

A Yes.

Q Right. From when you did attend BICC, did you see it as the same sort of committee as AICC but just a higher level, or as something more executive?

A No, I think it was a similar committee, just at a-- that higher level.

Q Thank you. Right. What I want to do now is to ask you almost final questions around – take that off the screen, please – the reporting of HAIs by the Health Board. Now, I'm conscious that you're not the lead for this, but have you followed the various pieces of

correspondence between Ms Lamb, the director general, the Chief Executive, and people from NSS ARHAI over the past few months?

A Yes.

Q Yes, and we ended up looking at a document that was-- I think is the current live version of the Incident Management Process Framework, which is bundle 52, volume 7, document 61, at page 486. Now, I understand this is the live policy at the moment, although Version 4 is in creation.

A Yes.

Q Yes. Now, you may not be able to help us, but it would just help me a little bit. Version 2, which was in place from ’23, is, I think, the version that ARHAI had some difficulties with. Is that your understanding as well?

A I believe so.

Q Yes. The fact that Version 3 had been produced didn’t emerge until a meeting between GGC staff and NSS staff a matter of weeks ago, and yet this policy has been in place since April ’25. Can you explain why GGC haven’t supplied these documents to ARHAI once they knew there was a controversy around them, because Version 3 isn’t-- We have correspondence between Professor Gardner, which I’m presuming not writing herself entirely, and Ms Lamb and Ms Morgan around, “Is there something wrong with Version 2 to some degree?” and yet Version 2 had been superseded months before, and no one in GGC appears to have told ARHAI or the Scottish Government of Version 3’s existence. It slightly mystifies me, and I wonder if you can help me about how that might have happened.

A I don’t know, sorry.

Q Okay. You were also involved in a correspondence around the production of information requested by ARHAI in respect of Cryptococcus infections.

A Yes.

Q Yes. How did you become involved since you’re not the HAI infection lead?

A So, the medical director from NSS dropped me an email to have a conversation about information release.

Q Is that when you first were involved?

A Yes. I knew that information had gone to ARHAI, a vague-- and then, as I say, Sharon got in touch with me, medical director, and---

Q Just help me. What’s her surname?

A Hilton-Christie.

Q Thank you. So, Dr Hilton-Christie gets in touch----

A Mm-hmm.

Q -- and that’s when we see you

in the thread of events.

A Yes.

Q Yes. Would it be fair to say that that call might well have been to slightly break a logjam or to prompt some action?

A Yes.

Q Right. I suppose this is the part-- You're obviously not the HAI infection lead, but you are the executive medical director, and so to what extent do you think the public, and equally ARHAI as well, and I suppose also the Scottish Government HAI unit, can have confidence that GGC is and will continue to report HAIs in accordance with Chapter 3 of the National Infection Prevention and Control Manual?

A So, certainly I've worked with my infection control colleagues. I've met with my infection control doctor colleagues. I know that they come to work to do the absolute best that they can, and I'm assured that they report in line with Chapter 3 of the manual. And, as I say, during these last meetings, I've met with colleagues. I've supported some of my colleagues over the last few years because it has been difficult. I believe they are highly qualified, very good colleagues, and I think-- I have confidence that they are reporting in line with the manual.

Q I've been asked to ask this question: what awareness do you have of the previous times that NHSGGC has not reported in accordance the manual, including back in November 2015 when they were subject to the CNO's algorithm for that reason and a couple of occasions since then when reports haven't gone in?

A I'm not aware of non-reporting.

Q Okay. Now, you obviously have some knowledge about what you didn't describe in your words as "tribal" but what Dr Murray reported as "tribal", the relationships amongst IPC, microbiologists and management in the hospital. I'm not going to ask you for your understanding because it's, to some degree, secondary, but do you think that NHS Greater Glasgow and Clyde has done everything it can do to ensure that its culture encourages the disclosure of patient safety issues, if required, through the whistleblowing procedure?

A I have no reason to believe not, and I do believe we are doing everything that we can, yes.

Q Did you have some involvement in the decision by the chair and the Chief Executive to make a public acknowledgement and apology in response to the HIS report into issues amongst the A&E consultants that was published earlier in the year?

A Yes.

Q So, how would you respond to

the suggestion that one feature of that response is a public acknowledgement that those consultants should not have had to whistleblow in order for their issues to be addressed? Would that be something-- you accept as part of that response?

A Yes.

Q Do you feel such a response is required by the Health Board in respect of these whistleblowers?

A So, I think we're sitting in a public inquiry. I think, even on a personal note, I feel an acknowledgement is an apology for every patient, family member, staff, both internal and external, that required to be acknowledged, and we need to learn from the Inquiry and we need to move on and ensure that we have that culture and environment going forward.

Q Just a moment. Dr Davidson, my Lord, I think that's all the questions I have, but of course we need to see if any questions in the room arise. I wonder if we might take an early coffee break, because that will enable us to both have questions ready for Dr Davidson, but also I'm not expecting Professor Gardner in the building until half past 11, though she may of course come earlier, so I need to find out whether she's here.

THE CHAIR: I think she may have come early.

MR MACKINTOSH: But if we take the coffee break now, I can sort of do both things.

THE CHAIR: Right. Do you want to take a slightly longer coffee break, or----?

MR MACKINTOSH: Yes, maybe until 25-- Well, we need to ask the questions, if there are any of course. Maybe until 25 past. That might help.

THE CHAIR: Right. Doctor, as Mr Mackintosh has explained, he has asked you the questions he wishes to ask you, but he wants to check with colleagues whether there are other questions out there. So, what we'll do is we'll take 25 minutes, which is longer than he requires for that, but during that period of time I hope you're at least offered a cup of coffee. Can I invite you to return to the witness room?

THE WITNESS: Thank you.

THE CHAIR: Right, we'll sit again at 25 past.

(<u>Short break</u>)

THE CHAIR: Mr Mackintosh.

MR MACKINTOSH: My Lord, I have three questions.

THE CHAIR: Perhaps three questions, Dr Davidson. Now, Mr Mackintosh.

MR MACKINTOSH: My Lord, three questions. The first question is I was

reminded that we've had quite a lot of evidence about cystic fibrosis patients, various IMTs that took place in the events we're interested in around infections in that cohort. I wondered if you knew whether there'd been a risk assessment of the ventilation system in the Cystic Fibrosis Ward, given that it does operate at less than half the levels of air change rates set out in the Scottish Health Technical Memorandum.

A I'm not aware of a formal risk assessment.

Q Do you think one would be a good idea, given the vulnerabilities of cystic fibrosis patients?

A I can't see any reason why not.

Q What's the disadvantage of not doing a risk assessment?

A I don't think there are any.

Q So there's no particular reason to do one then? If there's no disadvantages of not doing it, then there's no reason to do it.

A Sorry, I'm just picking up two negatives----

Q Sorry, my fault.

THE CHAIR: I think I was confused by the number of----

MR MACKINTOSH: Is there any disadvantage that flows from not doing a risk assessment?

A Any disadvantage from not doing one? Sorry. Sorry, I'm just trying to get my head round----

Q So, if one hasn't been done----

A Yes.

Q -- does the fact that one hasn't been done cause a disadvantage, cause any harm or risk or question of safety or anything like that?

A I'm not aware of any significant issues, so I don't-- I don't think so.

Q I asked you a question about HAI reporting in compliance with the manual, and you expressed confidence in the work of your colleagues in IPC to report.

A Yes.

Q I'm asked what have you done to check that they are actually reporting in compliance with the manual?

A So, what I've done to check is simply to talk to my colleagues, work with my colleagues, and have confidence in my colleagues.

Q Now, in the last question before the coffee break, I asked you – and I have a note here – and this is in the context of acknowledgement of whistleblowers: "Do you feel such acknowledgement is required by the Health Board in respect of these whistleblowers?" What I have noted, or my learned junior has noted, is you said something like this:

"So, I think we're sitting in a public inquiry. I think, even on a personal note,

I feel an acknowledgement is an apology for every patient, family member, staff, both internal and external, that require to be acknowledged and we need to learn from the Inquiry and we need to move on and ensure that we have that culture and environment going forward."

Now, what does that mean? Because what you said was, after mentioning that we're a public inquiry and making the remark a personal note, you then said:

"I feel an acknowledgement is an apology for [a list of people] that require to be acknowledged."

I wonder what that means.

A So, I think-- Try and put it another way. I think we-- So, as a clinician who's worked in the Queen Elizabeth for-- since it's opened, I think it's been a complex hospital to work in. The media around it in terms of lots of issues has been challenging, the issues that we've seen. We've talked about the relationships that we've talked about ,and I think, moving forward, I would like to see the Public Inquiry, if you like, as a process that will come up with recommendations and findings that allows us all, I think, to get into a place where we can start to talk about the huge amount of good that is done.

As someone who's practised in there 10 years and in my role, the good things that I see being done across Greater Glasgow and Clyde are immense. Some of that, and a lot of that, come from the Queen Elizabeth University Hospital and the Royal Hospital for Children, and I think I would like us to be in a position where we can celebrate that so much more than we can at the moment, and I think the Public Inquiry is an important step in that.

Q The question I asked you originally was, "Given that you've been involved to some degree in the decision of the chair and the Chief Executive to make a public acknowledgement and apology and respond to the HIS report"----

A Yes.

Q -- "amongst the A&E consultants that was published earlier in the year, how do you respond to the suggestion that one feature of that response is a public acknowledgement those consultants should not have had to whistleblow?" And you accepted that was part of the response. I asked you, "Do you feel that such an acknowledgement is required by the Health Board in respect of these whistleblowers?" and I'm not sure you actually answered that question. So, what----

A Sorry, I thought I had.

Q Do you feel that such an

acknowledgement – equivalent to the HIS one – is required by the Health Board in respect of the whistleblowers that this Inquiry has heard from?

A So, I think in terms of-- Again, I think it's important to acknowledge everyone involved and affected. That includes whistleblowers; it includes colleagues; it includes patients; it includes families.

Q Now, we can read the words of the Chief Executive and the chair at the Board meeting earlier this year. Are you suggesting that a broad acknowledgement of everybody and everyone's role is what they said about the HIS case? Are you describing the same thing or something different?

A I haven't got that in front of me. I think I'm expressing my thoughts.

Q Okay. So, I'll make the question more precise then, because it may be I didn't make it precise enough. Do you feel that the Health Board requires to make an acknowledgement to these whistleblowers that they should not have had to whistleblow in order for the issues they raised to be raised?

A So, I would like to be in an environment where whistleblowing is really important that it's there so that people have that, but I would like to be in a situation where whistleblowing is almost a never event. So, yes.

Q So there should be an acknowledgement?

A Do I think there's an acknowledgement to a colleague? Yes.

Q No. I'm sorry to do this----

A Okay.

Q -- but I'm going to have to press you. You've acknowledged that there was some form of acknowledgement to the A&E consultants----

A Yes.

Q -- in the Board's response to the HIS report. I'm asking you whether the Board needs to make an equivalent acknowledgement to these whistleblowers. Whilst I may have misunderstood your answer – I'll have to read the transcript with care when it's been produced – I'm not getting a definitive yes or no from you. I'm getting a discussion of the need to move on, to learn to have an environment that is positive for whistleblowers. Those things may all well be true, but they're not actually an answer to the question I asked you, which is: do you think the Board needs to make a specific acknowledgement to these whistleblowers as it did to the A&E ones? It might well just be a yes or no answer. I can ask you for your reasons once you've given it.

A So, I'm obviously one member

of the Board and I feel that, yes, there should be an acknowledgement to those colleagues-- whistleblowers.

Q Mm-hmm.

A Yes.

Q Thank you. My Lord, I have no more questions for Dr Davidson.

THE CHAIR: You don't want to say anything further?

MR MACKINTOSH: No, I was just reading, my Lord.

THE CHAIR: Dr Davidson, that means that's an end to your evidence, and you're free to go but, before you do that, can I thank you for your attendance here this morning, but also the preparation of your written statement and the background work that will inevitably have been involved in that, in the context of your many other duties. So, you're free to go, but with my thanks.

THE WITNESS: Thank you. Thank you.

(The witness withdrew)

MR MACKINTOSH: My Lord, I'm pleased to report that Professor Gardner has, at our request, arrived early, and she's now available to start her evidence now, my Lord.

THE CHAIR: (After a pause) Perhaps just two minutes.

MR MACKINTOSH: I'm happy to wait.

THE CHAIR: (After a pause) Please sit down, Professor Gardner.

PROFESSOR GARDNER: Thank you. Good morning.

THE CHAIR: Good morning. Now, as you appreciate, you're about to be asked questions by Mr Mackintosh, who's sitting opposite, but, before you do that, I understand you're prepared to take the oath.

PROFESSOR GARDNER: Yes, thank you.

Professor Jann Catherine Susan Gardner

Sworn

THE CHAIR: Thank you very much, Professor. Now, we will sit until one o'clock and take a lunch break of about an hour and resume in the afternoon. If, on the other hand, you wish to take a break at any stage, just give me an indication and we can take a break.

THE WITNESS: Thank you.

THE CHAIR: Now, Mr Mackintosh.

Questioned by Mr Mackintosh

Q Thank you, my Lord. Professor, firstly, thank you for agreeing to come early to accommodate what I anticipated to be a shorter piece of

evidence from Dr Davidson. Can I take your full name?

A Jann Catherine Susan Gardner.

Q Thank you. Did you produce a statement for the Inquiry?

A I did, yes.

Q Are you willing to adopt that as part of your evidence?

A I am, yes. Thank you.

Q Thank you. Did the Health Board also produce a paper setting out the Board's approach to governance, which has been attached to bundle 50 – it is the last document in that bundle at page 73 – which I think was produced as part of a response to one of our position papers on governance?

A Yes, I did.

Q Yes. Now, what I asked to be done is to see if you would adopt this as part of your statement----

A Yes, happy to do so.

Q -- because it simply came in a bit late for the process, and therefore I didn't want to be in a position where we couldn't think about it. So, thank you for that. We'll come back to that. In your statement, at paragraph 1, you explain that you were appointed as Chief Executive of NHS Greater Glasgow and Clyde on 1 February 2025. When did you learn that you were going to be the new Chief Executive?

A The process took place through September, and that was confirmed by the end of September, and I then came into post, as you've said, on 1 February 2025.

Q Might there have been a public announcement on the last day of October?

A Yes, indeed.

Q Now, we've heard from Professor Brown, who was the previous Chair, that before Ms Grant was appointed he had a discussion with her about the issues facing the Board. I didn't ask Ms Grant that question – it didn't occur to me – but that's what he explained. I wondered if you'd had a similar conversation with the current chair before you accepted the appointment.

A Yes. I was aware of the issues in Glasgow. Those were raised to me by the current chair, and I also had brief discussions with the outgoing Chief Executive prior to taking up post.

Q So, if we, as it were, place you back at around about that time, what did you consider to be the principal challenges that you would need to address or face as the new Chief Executive of NHS Greater Glasgow and Clyde?

A So, coming into the role in relation to the issues of the Scottish Hospital Inquiry----

Q No, just in general, because we're very conscious that, when we were talking about procurement of the hospital, we were interested in the ventilation system and there were lots of other issues. So it's always useful, I think, to check context. So, in terms of what was on your to-do list – and if it's not the reference for the Inquiry, you don't have to mention confidential matters – did you have a list of things that were on your to-do list for your start?

A Yes. So, obviously, NHS Greater Glasgow and Clyde is the largest NHS organisation in Scotland, serving over a million and a half people. It also provides regional and national services – the national, obviously, to people across Scotland. So I was very thoughtful coming in. I was conscious of the issues within the Scottish Hospitals Inquiry and-- and the journey from the build of the Queen Elizabeth. I was also very thoughtful about the need for the organisation, at a time and place, to be able to transform in a way that would allow us to go forward into the future in a more resilient manner.

Demand and population demographics are changing, and that means that healthcare cannot stand still. Financial challenges, etc., in the landscape mean that we need to do things differently. So, as I was coming in, my priority was, first of all, to really assess the organisation I was coming into. I was looking across the four quadrants of good governance, which would be workforce, finance, performance and clinical safety, and my assessment really is built around those elements, coming in, to understand better the organisation and to take my time to understand what was needed. In high terms, in high-level----

Q Before you go on, whilst we have a highly efficient transcriber working behind the scenes, his Lordship is about to tell you that he's trying to take an approximate, note as is my learned junior, Mr Maciver.

THE CHAIR: Yes, I mean----

A Apologies.

THE CHAIR: Professor, there's a question of pace. There's maybe a question of purpose of what you're saying.

A I hear.

THE CHAIR: You might bear these things in mind. I mean, I came to the conclusion that this was not part of your evidence that I was going to be able to note, and perhaps it wasn't intended to be noted but, yes, bear in mind that I can only write so fast.

MR MACKINTOSH: Would it be fair to say that the issues around the Queen Elizabeth were just one of the issues?

A Yes. If I may reframe that piece, then. So, strategically, I was looking to understand the issues in the organisation and to set a new direction harnessed with technology and a modernised healthcare system, but I was also looking specifically at the areas that I thought were of concern within the organisation. I needed to develop a better understanding, and to do that I was looking at data. I was getting out and about to understand from people directly what was happening. And then, quickly into my tenure – although that is moving on – we had the issue with Health Improvement Scotland, which is referenced later on. But, as I came in, strategically setting the direction, understanding better the issues from my own perspective.

Q So, in a sense, you're saying that you have a series of aspirations around developing the service in the financial demographic environment that you're in----

A Indeed.

Q -- but you also need to look back at a certain number of issues, of which the topic of this Inquiry is one.

A Of course.

Q I mean, there may be others.

A Yes, and I think primarily my role is to be able to give public confidence, to provide a service to the people that we are here to serve, where they can come to receive that care safely, and that they can be confident in doing so, and they can do so with their families without anxiety.

The second part linked to that that's really important is that our staff can come to work-- people come to work in healthcare because they want to make a difference, and that they can come to work knowing that the landscape has created the right conditions for their success clinically, and also where they will feel valued and empowered. So those are the critical elements.

Q Thinking about the issues around this, that we're interested in at this Inquiry – so that's the procurement of the hospital, the management of issues as they arose, the question of whether GGC encourages the raising of patient safety issues through the whistleblowing process, the question of whether GGC has learned from any issues around HAI reporting – when you were about to take the job, how much understanding did you have of the scale of these issues?

A I had some understanding. I had done work prior to coming in to try to understand better, but it would absolutely be fair to say that now, eight months into the role, I have a much greater understanding of those issues, and actually much more of the landscape and

the challenges during that journey.

Clearly, in 2025, we're a very different organisation from 2015, and that has been a significant journey. It's not a moment in time here and there. So, I have learned.

Q Just thinking about your career before you arrived at NHSGGC, have you previously had experience of dealing with organisations that, to some degree, have had issues of controversy, public-note problems – I mean, those are all euphemisms, I realise – in their past that have required, to some degree, to be learned from or moved on? Is that something you've come across before in your previous career?

A I've had a significant career. I began as a clinician, and I've moved through increasingly more senior management roles. At a senior level, I've been deputy Chief Executive of NHS Fife, Chief Executive at NHS Golden Jubilee, Chief Executive of NHS Lanarkshire, and then coming to NHS Greater Glasgow and Clyde. So it would be fair to say that, during that journey, you will meet challenges in a complex healthcare system. I have been involved, whilst I was in Forth Valley, with the capital build of Forth Valley Royal Infirmary.

Q So that's the new hospital at Larbert?

A Indeed, and I was part of the

team that developed the journey towards going into that hospital. At NHS Golden Jubilee, I was involved, again, with the development of Phase 1 and Phase 2 of that capital build. I'm speaking specifically about building matters here---

Q Yes, of course.

A -- but of course, on a day-to-day basis, on a week-to-week basis, when you work in an area where you are giving public assurance, you will be tested both politically and, indeed, by the public directly. So there are very often matters of issue being raised. They may be with staff; they may be in HR processes; they may be issues of incidents that families are querying. So, many, many issues across that level of experience of role.

Q Thank you. Now, what I want to do is just pick up an issue I've been asked to raise with you, which is whether there is a body within the Board now created called the "Rectification Board" which, it's been suggested to me, might report to Capital Planning and be chaired by Ms McIntyre and be in charge of fixing the defects that are subject to the legal action against Multiplex and others. Is that something that exists?

A So, in terms of the delegation, of course, the Inquiry has heard before that I delegate the responsibility to my

director of Estates and Facilities who gives me assurance. He, in turn, will deputise to different elements within his team, and there are also authorised individuals and authorised engineers reporting, etc. There is an entire structure that's set out within the governance paper that describes the different elements of flow up and through into our committee structure. I wouldn't attend those meetings, but should any issue----

Q But does such a thing exist is the question?

THE CHAIR: I don't think we have an answer to the question----

MR MACKINTOSH: Yes, the question is----

THE CHAIR: -- which I think was, "Does such a body exist?"

MR MACKINTOSH: Yes.

A I don't know.

Q Right.

THE CHAIR: Right.

MR MACKINTOSH: Now, this is a good point to raise another issue that has been raised quite a lot in evidence. We've had a lot of evidence about the management structure of the Health Board, which doesn't seem unusual for Scotland, in that you have-- in sectors or parts of service, you'll have a general manager, you'll have a clinical director, and you'll have a lead clinical-- a lead nurse director. They will operate in a number of different layers within the organisation up to, and ultimately, the Chief Executive level because there'll be the medical director and there'll be the nursing director, amongst others, at top level.

Now, we've also had a lot of evidence about assurance, and you just said that your director of Estates will give you assurance. Now, one of the features that seems to have come out in evidence is there seems to have been a system where a general manager at any of these levels would work on the basis that if matters weren't reported to them by their reporting lines, then nothing was wrong, and it's only by exception reporting that you would learn there was a problem.

A No. So, assurance works in two different-- in two different approaches. One is proactive and one is reactive. In a proactive basis flowing up to the Board level, there will be reports. As set out in a paper earlier this year to the Board in terms of coming in as a new accountable officer, the different elements of being assured that plan maintenance was being undertaken. So, there are schedules of plan maintenance, and if-- and there are reports to note on a monthly basis that that plan maintenance is taking-- is taking place proactively. At times in a healthcare setting something

may need to be rearranged, but that is in-- it's only escalated if they cannot be rearranged, for example.

Q So your understanding of receiving assurance is a regular cycle of reports that should effectively, if everything is going well, say, "We've done it. We're up to speed, and here's some evidence"?

A Proactive/reactive. So, Level 1 is proactive. The reports are coming from building-- from Estates and Facilities, from the monitoring, so I know that things are being effectively monitored. Then I know that the data is being assessed, and then I know the assessment of that data, and that comes up through flow. And the second point, if I may, is that there is reactive. So, if at any point there are points of concerns, those would be raised if they couldn't be rectified.

Q So, I understand the split. I just want to translate this into something that I've been thinking about, so I may not use the terms you use. So, is it your position that now, whatever happened in the past, but now those reporting to you are required to report proactively that they are meeting whatever standard is set for their service, but also to report when those standards can't be met, whenever that happens?

A They can't be met and they can't be resolved.

Q Yes.

A So, in the first instance, it would be their responsibility to resolve that matter and bring it to the fore, either if it was a complex resolution that required the executive and indeed potentially the Board to be aware of it if it was required.

Q But if the news is, "We have continued to meet the standard that is set for us," you would receive a report effectively saying that on a monthly basis?

A I would know that the proactive work was happening and then the reactive work would be-- the reactive elements, yes.

Q How would you know? Would you be told or would you presume?

A In the proactive or the reactive, sorry?

Q The one that happens regularly-- So----

A So, regular----

Q So, I don't understand the proactive/reactive difference, so let me explore it with you.

A So----

THE CHAIR: As I'm understanding at the moment, you're distinguishing, and you give the example of plant maintenance, a proactive approach, which is to ensure that there is no difficulty or failure of delivery of service.

In the course of that proactive, really, discharge of the obligation of----

A Yes.

THE CHAIR: -- the responsible manager, if he or she detects something which he or she can't resolve----

A Yes.

THE CHAIR: -- there would then be reactive reporting?

A Yes.

THE CHAIR: Now, I think what counsel is exploring with you at this particular moment is that, accepting your terminology, how do you get routine assurance that the proactive discharge of responsibility is actually happening?

MR MACKINTOSH: Yes. So, if we take Estates as an example, and let's use an example that a particular piece of equipment of significant importance to the Board is being successfully maintained and validated whenever it has to be done. Presumably there's somewhere down the organisation a person whose job that is. The fact that they have done it successfully and all as well, is that reported by them as a matter of routine to the layer above? Even if----

A Yes.

Q -- the layer above doesn't notice, they still get told it.

A Yes, and so that is through those individuals, and so there's formal elements----

Q So, are you looking at the document that I've asked you to adopt as part of your statement?

A Yes. Yes, in terms----

Q Brilliant. So, it starts on page 73. Let's look on the screen because we can actually-- because the version that we have is incorporated into a bundle.

A Yes.

Q So, if you look on the screen, tell me what number you're looking at, paragraph number.

A It says-- It's page 73, and I'm just looking at the general-- the hierarchical----

Q Yes.

A So, if we can move forward?

Q To page 74.

A I'll bring up it. Sorry, if you just----

Q If you tell me the paragraph number, then we can jump straight to it, you see.

A So, in terms of the-- If we go to page 7 in that document?

Q That will be 78, I think.

A So, that's just-- that's describing at a very high level----

Q So, which section is this?

A Apologies, page 7----

THE CHAIR: Yes----

A -- which is----

MR MACKINTOSH: Page 79, right.

A Yes. So, if-- if we look to the

flow up into our Corporate Management team. So, in terms of what happens on a regular basis, to give you that sense, on a weekly basis, the directors will meet each week. If there is an informal issue, a director may raise it for discussion with the directors, the executive directors. They'll either raise it informally or formally in that space. If it has to be raised for either an assurance point or if it's raised for decision, it goes up to the Corporate Management team where decisions are made, and then you can see onward the flow into the Board.

Q So, let's continue to use a vital piece of equipment as an example.

A Yes.

Q So, let us place that vital piece of equipment in a particular-- In Figure 2----

A Yes.

Q -- we would place it-- and zoom in to make that chart bigger. I imagine it would sit----

A So, it depends. So, it will come up through-- potentially through capital planning. It may come up through health and safety forum if it was for example a ligature issue. It may come up through the Board Clinical Governance Committee.

Q Let's imagine it's the Board computer system. So, it will appear in Digital Healthcare and Strategy Board?

A Indeed.

Q Right. So----

A But the ramifications of it, if for example, and that's----

Q Yes, but I just want to focus----

A Yes, of course.

Q It's a very tight question. Just check----

A Yes.

Q -- I've understood correctly. So, let's imagine a big computer system the Board owns. Every year it needs to go through a process where someone externally comes in and checks it's working.

A Yes.

Q Every year that happens because people do their job.

A Yes.

Q Does the fact that it has happened and there's nothing untoward get actively reported to the layer above the person who does the actual work?

A Yes, it does, and, in relation to Estates and Facilities, there are accredited competent, authorised persons, and then there is an authorised engineer who will put in an annual report. But these elements, the authorised person, on a daily basis, weekly basis, they are giving reports up to the layer above, and they have a series of checks and balances of what should be done. If they're being done, that's accepted. If it's

not being done, it's escalated and so on. If it can't be resolved, it would be-- it would continue in its escalation up.

Q And if it's important in terms of risk to the Board, it goes higher up the structure?

A Yes, and, for example, if there was then a need for capital to be assigned to that because there is a rectification required, it would come up through potentially one of these groups depending on what the issue were (sic).

Q So, let's pick an issue from the past: the non-escalation of the 2015 DMA Canyon L8 risk assessment. So, are you familiar with Mr Leiper's investigations----

A I am, but I would-- I think to comment on the structure that was in place at that time----

Q I'm not going to ask you to comment----

A Okay, thank you.

Q -- on the structure. I'm going to ask you to comment on what happens now. Of course, there's not a new hospital being built now but, just for the sake of humouring me, imagine a new hospital is being built now and we know that one of the things that has to happen is an assessment being done before occupation. If it's done, would it be reported as part of the management rules for that service up in the structure? And if it's not done, how can we be sure that the people higher up the organisation know to look for it to be done?

A So, I think there's two points I think we need to differentiate from here. One is: is this a new capital plan?

Q Yes.

A So, if this is a new build, you would have a new infrastructure. The way that we build today is very different from 2015----

Q I know.

A -- because of NHS Assure being in place, and I've had that proactive experience of having been part of Forth Valley Royal and then being part of NHS Golden Jubilee. As Golden Jubilee moved to Phase 2, NHS Assure came into being. So it's a very different structure. So the structures in place----

THE CHAIR: Can I----

A Sorry.

THE CHAIR: I apologise for the interruption.

A No.

THE CHAIR: The example we're looking at, just to explore this point, is the pre-occupation risk assessment, which is a requirement of----

A Yes.

THE CHAIR: -- as you have already demonstrated you're aware, of L8 taken with SHTM 04-01. Now, that requirement is still current----

A Yes.

THE CHAIR: -- and it's at the point of when the hospital is about to be occupied.

A Yes.

THE CHAIR: Now, as I understand the KSAR process, that will all have been in the past. So, taking this example, allowing for the fact that things have changed----

A Yes.

THE CHAIR: -- have things changed in relation to this? In other words, it's still a requirement and it's a requirement which may have to be discharged at a stage after NHS Assure has completed the KSAR----

MR MACKINTOSH: So, the question I'm asking is: one of the concerns that has emerged around the L8 risk assessment 2015 was that it was not escalated to the next layer up in the structure and ultimately appears not to have reached the knowledge of the Board Water Safety Group----

A Yes.

Q -- the two chairs of that and so on up the structure towards the duty holder, the Chief Executive. There are a number of reasons that have emerged in evidence around that to do with resource levels, possibly to do with knowledge of technical issues, to do with whether people have been appointed to various jobs, and to do with the state of knowledge of the Chief Executive of their duties.

But what I'm trying to get – and I appreciate that this system is a modern system developed now, not 10 years ago – is how can you be sure that events that arise out of the maintenance and operation of buildings that have the potential to have significant risks to the whole Board's services will always be reported up through the structure if they're not actually going to plan? How can you be sure of that?

A So, in terms of the structures that we have now and the learning of the last 10 years, it's really significant. We're describing almost a fictitious structure right now but, if we assume that structure, I would absolutely expect, given the way that buildings are built now, that the Programme team would escalate that, and the reason I'm confident of that is how you commission the report to be done in the first place.

So, the person who committed to commission that DMA Canyon water report, they should have-- there should have been knowledge at a senior enough level of the commission of that. So, today, if something of that ilk was being commissioned, I would know about it, or one of my executives would know there is a commission in place. Therefore, there is a requirement, one, to act----

Q So, that's a sort of financial check independence of the----

A It's a check and balance, really that, one, it should come back up, but you have to have the safety element of, "You will check to close that loop."

Q So, does this amount to this: that when something needs to be done that involves commissioning an external service, not only should you know about it through the normal structure, but the very fact that you've commissioned an external service will also result in the system knowing about it?

A Indeed.

Q That's really helpful, thank you. What I want to do now is think about the question of reporting of healthcare-acquired infections to ARHAI.

A Yes.

Q Now, I do appreciate that you're not an expert in infection prevention and control, and I think you mentioned that in your statement on page 57 when we asked you some preliminary questions about this in Question 3, and of course, since you wrote the statement, lots of things have happened.

So, what I want to do is to, slightly laboriously, because it's just easier for our understanding, walk you through the process. Along the way, there are questions, and indeed you may have things you wish to say, but the reason I'm going to do it slowly is it certainly helps me understand. So let's ground ourselves to this questionnaire. So, the incident management process framework that's referred to here is 27, volume 17, document 28, page 315, and this is the Version 2 from December '23 with a review date of December '25. If we go to page 317, we find the bit that if, I understand correctly, ARHAI doesn't like, which is at 2.1.

A Indeed.

Q Now, I'm not going to ask you to explain why they don't like it because you're not an IPC expert. What I want to just understand is when do you first become aware that there is a challenge from ARHAI to this Version 2 of the framework?

A So, it takes time to understand that it is a direct challenge from ARHAI----

Q I understand that.

A What I first became aware of was that we had-- we believed-- It was being raised with me that we believe that we should improve our procedure and, in April-- sorry, April 2025----

Q So this year?

A -- of this year, so I had been in post for a couple of months by that point, it was raised with me that we were reviewing the procedure to improve its alignment with the national standards, and I didn't, at that point in time, dig any

further into why and who and how, and-- and that's a learning journey in this piece, but at that point it was being raised with me that we intended to improve our procedure to give greater alignment to NIPCA.

Q So, just to clarify this, if we look at-- I wasn't intending to show you this version it but, since we've got here, we might do that. (After a pause) Now, I'm going to come back to that because I think it probably should be-- but there is a Version 3.

A Version 3.

Q Yes.

A So, what was in existence was Version 2, and that makes reference, as you've said here, in terms of the two elements of how we're approaching-- how we're approaching our management.

Q So, at that point, and of course you've only been in post two- and a-bit months----

A Yes.

Q -- at this point, someone comes to you and says, "We need to improve our alignment with our processes with the manual"----

A Yes.

Q -- "and here's a new Version 3. Let's put it through the government structures."

A Yes.

Q That's done.

A And that's done.

Q And it goes on the website.

A Yes.

Q Who comes to you?

A Director of nursing-- executive director of nursing----

Q And that is?

A Angela Wallace.

Q Right. No one mentions to you at the time-- and it may be just that you're new in the job and there's lots going on, but no one actually mentions to you that ARHAI have challenged Version 2?

A So, I'm aware in the background, through the coming into post, that there has been concerns around Glasgow's management, but it's not specific into, "This is being done in response." We don't really have that protracted discussion around that at that time, not to my recollection.

Q Okay, right----

A And something may have been said and I haven't-- I haven't placed----

Q No, I understand that.

A -- it with a level of importance at that time.

Q However, in August, 20 August, you get a letter----

A Yes.

Q -- from Caroline Lamb. Now, before-- Director General of Health and Social Care. Before we go and look at the letter, between April – and that process

that approved Version 3 – and 20 August, has the question of IPC and HAI reporting crossed your radar at all in that intervening four months----?

A Yes. So, there have been discussions around the fact that there's a request for information. I remember----

Q This is about Cryptococcus case.

A This is about Cryptococcus, yes, and that has been raised by both Angela Wallace, executive director of nursing, and Scott Davidson, our medical director, in terms of aiming to resolve and get the information back.

Q Because Dr Davidson has just given evidence that he was contacted by the clinical lead-- medical director, sorry, for ARHAI, whose name now temporarily escapes me, in order to, to some extent, prompt action.

A Expedite, yes.

Q "Expedite", that's the word he used.

A Yes.

Q So----

A And I'm made aware of that.

Q Right.

A I'm made aware of that in July, and I then query why it has taken so long, "It's taken far too long for us to respond, and so I therefore am asking to expedite. Can we please ensure that this information is returned?"

Q Thank you. We're going to go to the document if I can remember the reference. So, Version 3, it's bundle 52, volume 7, document 61, page 486.

A And, actually, as you're bringing this up for me, I'm asking, "Does this comply in the way"----

Q You're asking, "Does this comply?"

A "Does this comply?" and I'm being assured that it does, Version 3.

Q Right, and if we go on to page 489, yes, we have a new version at paragraph 2.1.

A Yes.

Q We're actually told by ARHAI that this paragraph does comply.

A Yes.

Q We just heard that----

A Yes.

Q Take that off the screen. Let's go back. So, back to July, you're asking questions around this Cryptococcus data set and, indeed, it is then supplied to ARHAI, I get the impression relatively quickly after your intervention.

A Yes.

Q Can you help us about why it took an intervention from both the executive medical director and you to produce material for ARHAI that-- some of which have been requested some months before?

A Yes. I don't think there is a

clear, good explanation for why it did. There was concerns being raised within the team. I do not think that they are reasonable concerns, and I think-- going forward, I don't think-- I am confident, going forward, we will not be that position again. I'm being very clear that when we are asked to provide information – and, of course, that begins to unpack in what we will presumably move into in August and September – that we respond in a very timely manner. The issues that were being raised I don't think are unreasonable, that people should have some concerns. They're asking about patient information governance, and what we should----

Q So "they" in this context is ARHAI?

A I beg your pardon?

Q "They" in this context is ARHAI.

A Apologies, "they" are the Infection Control team in NHS Greater Glasgow and Clyde----

Q Yes.

A I'm saying, "Why have we not provided this information? Why are we not"-- and I'm given a series of explanations which, whilst not in-- in themselves are unreasonable, they are points that should have been resolved in a timely way. So I don't think we responded in a timely manner----

Q I understand.

A -- and I've-- I've been clear with my colleagues and onward that we need to respond, in any future requests, in a timely manner, and raise points and resolve points in a timely manner.

Q However----

THE CHAIR: It's probably sufficient that I have your view that the explanations coming from the Infection Prevention and Control team were, in your view, not reasonable. Did they include reference to patient confidentiality?

A They did, yes, in terms of information governance, and Dr Davidson explores that and speaks to colleagues to reassure them, and ensures the Caldicott Guardian has been involved in that discussion to resolve that matter.

THE CHAIR: This is in the context of routine reporting from a health board to ARHAI?

A Indeed, but I don't think-- I don't think we should be concerned about these matters. There is a methodology that we can use to assure ourselves in terms of the process, so I don't think-- I understand why people were saying they were concerned. I don't think it should have caused the delay that it did.

THE CHAIR: Thank you.

MR MACKINTOSH: Let's look at the letter and move the story forward.

So, this is in-- the letter 20 August is bundle 52, volume 5, document 31, page 144. Now, what we might just do is just check we've got the whole letter. So, this is the first page on 144, and 145 is the second page, and it's been copied to the interim chief nursing officer, Ms Critchley, at NSS and Professor Wallace. Now, if we go back to the front of the letter-- So, firstly, we've all read this, but just from your point of view, what did you take from this letter?

A So, what I-- the net-- the net message from this was we had provided information, but it still had not satisfied ARHAI in terms of we had not provided the information that they were requiring in order to be assured, and that we needed to progress forward.

Q Is there anything that we should draw as significant or relevant by the fact that the author of this letter is not Ms Morgan at ARHAI but the director general herself?

A I think that's of concern. I-- I also think it's of concern that, from July, no one had come back to say we would-- to my knowledge, to say, "We need further information," but I think what we can see throughout this, and we'll continue to come back to that, is there is clearly a tension in the relationship between the NHSGGC Infection Control team and ARHAI, and we go on to explore that further in-- presumably, in the letters that will come----

Q Yes, I'm sure we will, and we're probably better to do it then.

A Yes.

Q What do you do when you receive this letter?

A I am concerned, because it-- it raises to me that there is something wrong in this flow of information and that, somehow, Scottish Government are now not content that the information flowing back and forward between NHS Glasgow and Clyde and ARHAI is right, and that they feel they need to intervene.

I think what is clear is I had thought in the 20 July, when the response had been given, it was responding to the questions in the way that was required. This says to me that there is concern that that is not the case, and of course that-- that goes on to become the case and becomes clearer. And in totality, again, it raises with me the work that is needing to be done in this space and, again, we will begin to unpack that----

Q Yes, because one of the things that occurs to me is that the request was for sufficient information for ARHAI to carry out its own assessment of whether there was an issue here.

A Yes.

Q This letter explains at the end of the third substantive paragraph, just

the four lines at the bottom of the page, the information received on 20 July----

A Yes.

Q -- so that's exactly a month before. Then there is a----

A Yes.

Q -- statement of what the assessment is. Now, we have evidence from Ms Imrie there might be a small error here, that, actually, the letter should have said that the assessment identified an area in the new hospital and the retained estate, but the point is an assessment is set out there anyway.

A Indeed, yes.

Q Then, over the page-- No, they say at the bottom of it:

"ARHAI observe that it would be prudent for NHSGGC to undertake further investigations to these cases in order [over the page] to determine whether they should be defined (and reported nationally) as a cluster and [then, of course] that a further root cause analysis should be undertaken to explore the possibility..."

A Yes.

Q Now, who did you anticipate, from this sentence, is being proposed to carry out the root cause analysis?

A I think what this letter intends is that Glasgow should have considered itself but, also, it should have had discussion with ARHAI, and ARHAI should have been involved in discussing and considering the criteria by which Glasgow was making its decision for onward reporting, given-- given the set of circumstances.

Q Can I just take a moment to step out and just, as it were-- At the risk of being told, "Of course," can I check your level of comfort at this point with the general topic of how one manages infection prevention and control? Have you come across the content of a root cause analysis at this point before?

A Yes, I have. Yes.

Q And are you familiar with IMTs and PAGs?

A Yes, I am.

Q From a managerial----

A From a managerial perspective, yes, I am.

Q Right. So, are you aware that following the oversight board, there will be a recommendation that root cause analysis should have been normally used in IMT processes?

A Yes, I am, and I am asking now more questions of my colleagues to understand better the circumstance and be briefed on what has taken place in order to assure ourselves that the root cause has been considered and the process that we have gone through.

Q And then you've got three requests that Ms Lamb makes.

A Yes.

Q She wants immediate confirmation they've been escalated through the appropriate channels.

A Yes.

Q That the Board-- Do you think she means "the Board" as in the people who are on the Board, or "the Board" corporately in a more diffuse sense?

A So, in this regard, I've taken it that the Executive are aware of this and are looking at this with the potential that we need to then onward escalate this to clinical governance and note to clinical governance as a committee of the Board that there are concerns.

Q So, you're reading this as a check that clinical governance are fully aware.

A Yes.

Q Right. And then some confirmation that reporting is handled as required in the manuals because DL (2024) 24 makes reference to the manual.

A To the manual.

Q Right. And she gives you a rather tight deadline.

A She does.

Q And then requests further information around these cases.

A And she's requesting further information which I'm reading to be then a breakdown case by case, which has to be returned to ARHAI no later than 8 September.

Q Yes. Now, you send a holding reply, which I won't put on the screen, but you do however send your letter on 26 August, I think with everyone's consent.

A Yes.

Q Bundle 52, volume 5, document 32, page 146. Now, I've got a lot of questions about this letter.

A Yes.

Q Before I ask you them, it might be worth just exploring with you what you thought your objective was-- what you were trying to achieve by sending this letter.

A I was trying to give, first of all-- setting a context of how we had approached looking at the information; I was trying to give an assurance that we wanted to make sure clinicians were involved in decisions around it so when there is an issue-- I was trying to make a point in paragraph 4 around the fact that you would want your microbiology, your infection control and those people involved in looking after patients involved.

Q Can I just explore that with you, because it's quite interesting in the context? So, "We are keen to ensure," you say in the fourth paragraph, "that the patient's clinical teams"-- By that I assume you mean the clinicians responsible for treating that patient.

A Yes.

Q Yes. "…have the opportunity to contribute the collection of this information." Now, that means the information that's being requested for ARHAI.

A Yes.

Q Right. And then you wouldn't apologise for delay, but you explain your reason. Now, normally when a report is being made to ARHAI through the online reporting tool, clinicians wouldn't be involved in collecting the other information at a normal level, would they?

A No, but they would be involved, as I understand it, in that initial assessment of whether a case should be escalated. I guess what you're looking at the full circumstances-- So, for example, what has been the reporting from a microbiology perspective, what are Infection Control team looking at and what is happening in the patient's clinical condition?

So, what's happening in their blood results, what they're seeing in that patient. Are they becoming more unwell, less unwell? What have they seen in that patient population or sub-population that they're looking at? That's what I mean by that.

Q Because one of the pieces of evidence, if I've understood it correctly, from Ms Imrie, is that initial assessment of whether the various categories of outbreaks, data exceedance, etc., in Chapter 3 of the manual can be done by a single IPC clinician. It doesn't require a PAG.

A It does not.

Q No, so----

A It does not. However, it does help build up a clearer picture.

Q Right, so you're doing this in order to build collegiate----

A It's collegiate, but it also does help understanding, particularly when it's often within a subpopulation of the patient cohort who will have specific issues. So, for example, in renal patients, for example, in bone marrow transplant, etc. So that's often why it can aid the discussion.

Q Now, if we go to the previous few paragraphs, there's some sentences I want to explore with you. So, it's the second paragraph:

"It is recognised that the QEUH, Scotland's largest hospital, hosts some highly specialised units, including renal inpatient transplant units; adult and pediatric bone marrow transplant; haematology-oncology; and infectious diseases, which includes patients with HIV. The occurrence of sporadic Cryptococcus spp. cases within the specific patient cohorts this campus are expected, although occur infrequently."

Now, what I'm putting to you is that occurrence of cases might be higher in some of those groups that you've listed than others.

A Indeed, and also the different types of Cryptococcus, as I understand-- Again, I'm not going into that expert opinion in this space, but of course there are the different types, and I don't seek to unpack that there.

Q So, one of the documents that we have, and I don't know whether you saw it on the document list, was a report prepared in early 2019 by Dr Kennedy. I think he's still working for the Board. Have you come across him?

A No.

Q No. But Dr Kennedy was asked by Dr Armstrong in 2018 to assist the IMT, and he attended most of the IMTs from almost the start of the water incident, and he provided a number of reports. This one is bundle 24, volume 3, document 3, page 19. Now, if we go back one page, it starts-- It's a short document. It's reviewing the Cryptococcus species in GGC, so it's the whole GDC, not just the Queen Elizabeth.

A Yes.

Q And then there are 19 cases-- you can see it says, "Summary (n=19)"-- and then over the page we have a very bright, colourful chart which reports no cases of Cryptococcus in the renal population of GGC over a nine-year period.

A "Reported".

Q Yes, I appreciate that. But what I want to do is go back to the letter in 52, volume 5. You wrote this on advice. I'm not expecting you to have done the research yourself. This question I've been asked to ask you is that reference at the end of that first paragraph, "The occurrences of spread of Cryptococcus in specific patient cohorts on this campus are expected, although occur infrequently"-- It's not really expected for renal patients, is it?

A No, and it should have been clarified, and of course, in hindsight, I would rewrite this letter in many different ways now. But to be very specific in terms of what is expected, I think it could have been much clearer.

Q I mean, given what I'm about to turn to and given how these cases came to the attention of ARHAI, this conversation was going to happen, wasn't it? I was always going to ask you about this letter at some point in the----

A Yes, but I suppose what I would say is even through this period, I'm learning quite rapidly of the significant level of issue and I'm learning more about what the specific issues have been, why they have been reported, why they have not been reported, how we would

consider these different patient cohorts, the level of incidence, etc., etc.

Q Right. To go back to your paragraph we looked at before, "We are keen to ensure...", the fourth paragraph.

A Yes.

Q This delay is the delay since 20 August, not the earlier delays.

A I'm sorry?

Q So, in the fourth paragraph, we discussed how you wanted to involve the patient's clinical teams. This is about any delay since 20 July, not the earlier delay we're talking about.

A So, this isn't-- No, that's not what I meant by this.

Q Right, okay. What did you mean by it?

A What I meant by that was we were keen and historically that was a delay. So actually, I think more correctly I could have said, "I'm sorry for the lack of timely response."

Q Is that the earlier one in the year?

A Yes.

Q Right.

A So the information that was sent in July, and we had wanted to ensure that X, Y and Z. So it's not looking for-- Because actually, as we will come on to in due course, within nine working days of this, you can see-- and we'll come to that-- the number of actions that take place in order to expedite this. So I'm not actually saying here there's going to be another delay----

Q No, no, I think you misunderstood me.

A I'm sorry.

Q This paragraph I read as an apology for a delay.

A Yes.

Q And I wanted to understand whether it's an apology for any delay that occurred between November '24 and July or any delay that occurred between 20 July and now----

A So, no, I didn't mean the second part because I didn't----

Q You meant the first part.

A I meant the first part, and I'm also trying to say, "We will now expedite, and I'm sorry for any delay now, but we will expedite the information now." I actually hadn't expected-- When I was told on the 20 July, I thought we had-- I thought the information had been sent. So I wasn't expecting another----

Q So you weren't expecting ARHAI to look at it and then have more questions?

A Or I was expecting to have been told, "There are more questions, and we need to respond to this in a timely way." When this letter, when the letter of the 20th arrives, I'm surprised because I thought we had responded to it after Dr

Davidson's intervention on 20 July. Sorry, am I answering your question?

Q No, you are. I'm just trying to make sure I ask my questions. One of the things that arises is the question of Caldicott approval. Now, it appears in an email exchange, bundle 52, volume 4, pages 80 to 81, I hope. Yes. And if we step onwards-- Yes. So, one of the ICDs writes internally, I think, to the Board, referencing the need for Caldicott approval. So, is it your understanding that these concerns, the ones expressed in this email, arise as part of a process that also includes discussion with the clinicians who are treating the patients?

A This is part of the-- Yes.

Q We have the whole exchange. The historical exchange is taking part as part of a discussion with clinicians who treated the patients and microbiologists who examined the samples.

A Yes. And the reason specifically, and I'm sure that's clear in the evidence, but what was shared with me is because of the nature of the condition of these patients, it was very sensitive because some of the patients may have had, for example, HIV, or have had another disorder. So that's what I'm being told is some of the concerns about the sensitive nature. I don't know what the sensitive nature is, but it's been explained to me as such now.

Q Okay. Let's go back to the letter.

A This is a historical piece, but I don't think it's-- Can I just reiterate again I think they should have been resolved quickly?

Q The one thing that occurs to me is that at one level, that's an obvious point. It will be sensitive because these are unusual cases, because we in the Inquiry have had to deal with evidence around other Cryptococcus cases and find a way of discussing them in public, which has been hard.

A Indeed.

Q So I understand that, but equally----

A We should have found a way to respond to this.

Q Exactly.

A We should have. No, there's no question.

Q If we go back to the letter of the next page, you mention:

"In May 2025 the GGC infection prevention and control doctors reviewed in depth each of the cases of suspected or confirmed Cryptococcus 2024. They identified a cluster and respectfully ask the information provided to the Scottish Government by ARHAI colleagues be shared with the IPCT in GGC to ensure that any relevant information can be included in the review of these cases."

Now, we later discover that all the information ARHAI had came from GGC.

A Yes.

Q What were you being told about what information they might have had? Because you're obviously asking for information here, and presumably someone has said to you, "You really need to ask the information."

A So at this point-- Sorry, I'm not sure I'm understanding your question. At which point you're speaking----

Q So you're writing this letter on 26 August----

A Yes.

Q -- and I read the second half this paragraph as containing within it a request to get from ARHAI information that they have given to the Scottish Government.

A Yes.

Q I want to just understand why someone asked you to make that request, given that we later learn that all the information ARHAI had came in July from GGC.

A Yes, I understand. So, the first point around that is in response to Caroline Lamb's third point in her first----

Q Yes. Well, we can jump back to that just to make sure we're looking at the right thing. So, bundle 52, volume 5, document 31, page 144, I think. Yes, 145.

A So, in the first three-- it's the next page.

Q There we are.

A In those first, she's asking for immediate confirmation that they're aligned. So, I am saying in this space that it has been confirmed to me that the local team have looked in May again to make sure there's not a cluster. So, that's what I'm responding to.

Q I get that bit, yes.

A The second part that you're raising around is that the Infection Control team are basically saying if ARHAI now looking at this information and they have a different opinion and they have concerns that we should have reported something that we didn't, Glasgow is asking to understand that information.

Q Right. Let's go back to the other letter. Here we are. So again, just thinking about the chronology here. So the four cases that I put to Dr Mumford and Ms Dempster on I think 14th, it might have been 13th, 14 November last year, were confirmed by a Section 21 request to the Board some weeks before. We asked a series of questions, we received a series of answers, we then constructed a document which we put into the Inquiry papers, which removed a lot of information. It didn't, for example, include the fact they were renal patients because we felt we couldn't reveal too much

information about individual cases, and we only asked the question of our experts around the question of reporting. We didn't ask them, "is this a cluster?"

So, that was November. The Health Board provided an explanation about why it hadn't reported to this Inquiry in November, which is in a bundle. So, I'm wondering why it took from November to May for an in-depth review to take place of these cases.

A So, there wasn't-- it's not that it took until May. My understanding is that an in-depth review took place in November, and then there's a refreshed look at it in May again to make sure that there isn't something that has been missed. We consider each of the different elements in terms of criteria for onward reporting.

But I think we would now say there's much debate within all of this and we need to discuss this as we go forward, but that's what that is saying is in November we look at it, the SBAR that we will come back to in the previous paragraphs that is produced in November does look at that, and then they're looking at it again in May.

Q So, if we just go back to the previous page, 146. So, at the second last paragraph of page 146----

A Yes.

Q -- there's a reassurance was sought by your predecessor and the chair, and that's when the SBAR is produced.

A Yes.

Q Then in May, there's a fresh exercise, or review.

A They review it again.

Q Right.

A They refresh and look again.

Q Let's think about the SBAR.

A Yes.

Q So, it's on page 148. Now, you're obviously not the author, and it was produced before you arrived.

A Yes.

Q It was sent to your predecessor.

A Yes.

Q Now, my first question, would you accept it's a little bit-- its phraseology is not necessarily diplomatic?

A No, and its tone isn't right.

Q So, why did you send it to the DG?

A So, if we look back to the letter, if I may, I do note----

Q Go back the letter to 1446.

A -- I note that it is historical information. One of the issues that's raised is that Glasgow isn't transparent in sharing information. I wanted to be fully transparent. I didn't want to redact a document that had been produced for a chief executive back in November. It was

a clearly-timestamped piece, it was written for a purpose, the purpose was clear and it was sent at that time.

What I regret, in hindsight, is I should have put an additional sentence into this piece to say, "I do not support the tone or the content of this and we're exploring this as part of our internal work." So, there is a piece that could have added to that element but it's not me endorsing it.

Q Yes, because when this document came to the (inaudible) the Inquiry, simply because of the----

A Indeed.

Q -- multiple organisations it went to, given who it's copied to, we didn't see the context and perhaps that sentence might have been helpful.

A Indeed, and I absolutely-- and that's why I put it forward to you now. However, what I would say is that there are also, there were conversations going on around these letters at that same time. I could have made that clearer for sure in this letter. But I did want to-- the purpose of sharing in that regard was to show a historical document factually without-- or with complete transparency.

Q So, the next question is – and you may not know the answer to this but I suspect from your investigation that you hopefully might – I get the impression from the way this is written, but I may be wrong, that the raising of these issues in the Inquiry was, to some extent, news to your predecessor and the chair, which is why they asked for the SBAR to be prepared. Have I misinterpreted or can you not help me?

A I couldn't comment specifically on that. I can understand the assumption, but I can't specifically comment.

Q Understood, okay. Let's go back to the SBAR. So, let's just check a few things. Until we led evidence about the four of the cases, we actually-- there are seven, I think, in total.

A There's seven, yes.

Q The first one, 2020, we had led evidence on early in the Inquiry, and it had been considered by Mr Bennett, our expert on ventilation, in his attempt to understand the Cryptococcus cases----

A Yes.

Q -- because it happened during the period of the expert subgroup work, but wasn't mentioned in it and so we explored that. The later four we mentioned-- we didn't pick up the other three, but when those four were mentioned, they hadn't been reported to ARHAI, had they, at the point we mentioned them in November?

A No.

Q No, and they hadn't been brought to attention of the Board at the

corporate clinical care and governance either?

A No, because the local process is saying that they believe that they have assessed it not to be, and our local experts are saying that they do not believe this is an issue.

Q Which is my third question, right. Do you have any concerns about that fact, that the local processes didn't draw them detention of the Board's governance structures until the Inquiry brought them in a governance sense?

A I mean, I think you'll see from the actions that I've taken that I clearly, first of all, have to be concerned with this matter. We need to find a resolution. They are our experts and the people who work in our organisation today are considered highly-experienced experts. Their decision making is being challenged and they are being asked numerous times to re-evaluate this information.

But I think, as a high-level point rather than a specific response to your specific question, the tension in the relationship between NHS, GGC, Infection Control Team and ARHAI definitely leads me to a place of concern and a place that we need to action in order to resolve. It has been raised before, how would you know-- ARHAI have said the points on a number of occasions, I understand, in this Inquiry, "we don't know what we don't know."

So, you would hope that how they know comes about from a number of different opportunities. It's been addressed that actually potentially, a recommendation out of this Inquiry might be the strengthening of national surveillance through all information electronically flowing up. I think we would all endorse that as an excellent way forward. That would let them do that high-level surveillance.

The second element then is having informal, trusted conversations locally between local teams and ARHAI when there are questions of dispute-- or not dispute, when there are issues where people are not sure.

THE CHAIR: Professor----

A Sorry?

THE CHAIR: This is very fluent. I'm finding it a little bit difficult to-- certainly to note, and I just feel I may be losing some of the content of what you're saying by its very fluency, if I might put that point or, to be maybe a little bit more blunt, if you could maybe give evidence a little more slowly, I'll find it easier to follow.

MR MACKINTOSH: Yes, I think what I might suggest is: we're coming up to the lunch break and I think there's another point I need to put to you. Then I

think I might revisit what you think about this whole experience at the end of this letter after lunch but just ask you a couple of preliminary questions now, because otherwise there's a risk we run that we keep going around in a circle where, for the reasons you've explained, you express some misgivings and concerns, you talk about what might happen in the future. I'm going to come back to that. So, what I might suggest to you is let's move on to a couple of questions----

A Yes.

Q -- and then we'll return to it. I have been asked to put some content to the SBAR to you. Given what you said, I may already know your answer. Go to page 150, in the assessment section, the second paragraph. I take it you've read this.

A Yes.

Q Do you accept that the allegations made here are rather serious?

A Yes, and I don't think the tone or, indeed, the nature of them should have been articulated, certainly not in a formal SBAR. I think they raise a number of concerning points, yes.

Q Did you make any attempt to investigate whether there's any merit in these?

A Yes, and I think what is helpful, and hopefully trying to be succinct with Lord Brodie's comments, it would be

helpful if I also have the opportunity to step forward into what we have done to try to address these points----

Q I'm going to do that.

A -- and then we may be able to step back.

Q But just looking at this document----

A Yes.

Q -- it makes reference to statements by the whistleblowers, ARHAI colleagues and experts. Now, I know what the statements made by experts are because they were here.

A Yes.

Q I've asked ARHAI, in the form of Ms Imrie, what she thinks about that. What I want to put to you is that there has been no evidence in this Inquiry by any of the whistleblowers or Dr Inkster – who is not a whistleblower in this context – in the form of statements or evidence about the four Cryptococcus cases for the very simple reason I haven't permitted it to happen.

A Yes.

Q So, why is that there?

A So, that's written in November and I can't comment on why someone put it in the statement. I think what it underlines, though, is that there is a loss of trust in the relationship between NHS, GGC, Infection Control Team and ARHAI. Whether it is founded or not I think is

most definitely questionable and I would not endorse these statements. However, there is a loss of trust. I'm sure the Inquiry has explored these elements but it is a very complex landscape and I'm trying to be very sensitive in what I say because I recognise we have experts in different parts of our system who are experts, and they have had different professional opinions expressed through this period of time.

Whistleblowing now has standards but actually, we need to be very thoughtful about when whistleblowing is raised, that we listen to people, and I'm sure we'll come back to that, that we listen to people. It makes their statements neither wrong nor right that they are whistleblowers, but it is-- it's within a context. Some of those individuals who have raised issues previously worked in NHSGGC, now work in ARHAI, these are complex relationships. I'm not saying-- I'm not saying that this is the exact reason why people wrote this. I can't confirm. I wasn't the author; I do not condone it.

However, I do think we need to recognise both the current state of the loss of trust in their working relationships, whether they are real or perceived, and I think what we need to be demonstrating as a system is as we go forward that we have systems, processes and we have

methodology that helps to rebuild those relationships.

Q I think in the few minutes before the lunch break, I should ask you this question. So, I'll put something to you because obviously this Inquiry has been investigating, to some extent, and has noticed some tensions between ARHAI and the GGC IPCT, not least around the removal of Dr Inkster as chair of the IMT on 23 August 2019 and that meeting and the subsequent doubling up of ARHAI nurses at IMTs. I'm assuming you know or you've found out about that.

A I know high level about all of these----

Q Yes.

A -- elements although obviously, I wasn't involved.

Q I just wondered this question. If we accept as an assumption, for the purposes of this question, that there was a point in August, September, maybe October 2019 when relations between ARHAI teams and some of GGC's IPC professionals deteriorated. Now, that may not be the word you want to use but, in broad terms, is that broadly what your understanding is to some degree, that there's a moment of----

A I think there's tension and anxiety.

Q So, tension and inflexion.

A There is anxiety. I think it's

worth us noting, it's anxiety. It's anxiety about people's professional opinion and standing.

Q Yes, and so, this is on both sides?

A In my perception, yes.

Q Yes, but the point I'm trying to put to you is that that period of time, August/September, from the point of view of ARHAI and in some of the IPC professionals in GGC, that deterioration, it's a point of inflexion: the deterioration gets worse, the anxiety gets worse at that moment in time. To some extent, do you accept that as your understanding, as well?

A That is my understanding, yes.

Q Yes. Right.

A And I think it goes beyond. I think there is also looking beyond the teams directly to look for help to resolve.

Q Yes. I'm going to put to you something that's occurred to me. Of course, it's not a concluded view; I have to write submissions by 21 November and I'm thinking about it all the time. Could it be that some of the reasons for this inflexion point firstly might include the difficult issues that were being discussed in 2019? Was that possible? It's a much tenser period; there's lots going on.

A I think that's a hypothesis. I couldn't-- I can't say yes or no. I can-- I can understand the rationale.

Q No problem. But the other one might be that, could it be that, actually, part of the reason, from ARHAI's perspective, for this concern, is an observation of what they see as the response to Dr Inkster from within GGC, so that, for better or worse, she is removed, and ARHAI staff see that and take it as a less-than-positive step, and that's part of the instigation of that inflexion point.

A I think, not being there at the time, I wouldn't want to comment to that specific. I think I've seen a number of very complex issues of people, and I don't-- I think this is far, far deeper and wider spread than one or two individuals, because these are about-- this is about professional opinion and professional standing.

So I think, within the team, people are constantly-- And I would say that, from all of the difficult elements that I have read and heard, I do think, at all points, people are maintaining their-- their commitment and indeed their responsibility to do the best for the people that we serve. I think that is their motivation at all points.

I don't think this is about a breakdown in relationships which is around getting at one person or another. I think people are trying, in a difficult, very complex, landscape, to hold to what they

think is the right thing for patient care and to report in what they believe is an honest and balanced way. I'm not an expert to be able to comment, and I know many other experts have.

Q Before the lunch break, what's your understanding of how long – in time – there has been a perception of less-than-positive relationships within the IPC/Microbiology community in GGC? Just in very broad terms, is this something that starts then or goes a long way back in the past?

A I don't think it's just about GGC Infection Control Team and ARHAI; I think this is about a complex landscape. If you think about it in career-positive terms and the fact-- I bring us back-- People-- We all come to serve people, to do the best we can for people. A new building is coming, and there is much hope, and then, as this new building comes to fruition, there are issues, one after another, and infection control is raised in there. We know that there were building design and construction issues, so people are constantly concerned about this, to make sure they are discharging their duty.

So, I don't think it is as simplistic as just GGC/ARHAI. I think this is a period of time, from 2015 onward, where people within their professional sphere of responsibility are in a heightened state of anxiety in terms of wanting to be assured and to give assurance that things are okay. And I think that starts to create a different landscape where you need to make sure people feel that they're being listened to, that they're empowered to raise things within their team, between colleagues and, indeed, with more senior colleagues.

It's a very, very complex issue, so I don't think it's as black and white as there is a point at which ARHAI and GGC-- And I can't comment on that specific date, having not been part of that journey, but I do think-- I do think the complexities are there.

Q You see it as a complex thing that goes back in time to the new hospital?

A Yes, and as differences of opinion begin to form within the teams, there is challenge between individuals. Whistleblowing is part of that, but there are-- on a regular basis there are differences of opinions beginning, and I know some statements have been put into the Inquiry, but that is what I'm seeing. It's a difficult space to work in.

Q Let's pick that up again after the lunch break.

A Yes.

Q I think you've answered some of my questions, or that I haven't asked yet. So, I'll need to reflect on that. My

Lord, this might be an appropriate time to break for lunch.

THE CHAIR: Yes. We'll take an hour for lunch, Professor. So could you be back for two o'clock?

THE WITNESS: Yes. Thank you.

THE CHAIR: Thank you.

(Adjourned for a short time)

THE CHAIR: Good afternoon, Professor.

THE WITNESS: Good afternoon.

THE CHAIR: Now, Mr Mackintosh.

MR MACKINTOSH: Thank you, my Lord. Professor Gardner, I need to correct something I said in a question this morning. We were talking about the SBAR, and the reason that I didn't recollect this is it came in a piece of evidence that my colleague dealt with, but Dr Peters was asked questions about Cryptococcus cases, and she'd mentioned the existence of these cases and the fact they were in the new hospital on 12 September last year. So, whilst the other whistleblowers didn't, she did mention that.

I've got a couple of questions just before we leave the SBAR, as it were, and your letter-- sending it to the director general. You mentioned that you don't support the tone or content of the SBAR. What are you doing to address or correct the behaviour and attitudes that led it to be written in the form it was?

A So, I have to take time to understand what led people to get to a place where they felt in a position that they believed that was the correct way to write that piece. But there are a number of different elements within this, and that links on to my final letter and the work that we're doing now.

So, there are systems and processes that need to be addressed. So, as you are aware, we have now, with ARHAI-- between GGC and ARHAI, we have sat down together with my Deputy Chief Exec William Edwards representing me in that space with Julie Critchley, Sandra Devine and Laura Imrie to look at developing Version 4 of our procedure, which-- now there is agreement, and that's a much, much better-- and that's a-- that's a reasonable way forward. That's how it should have been done together.

The second element is to have a system by which we can sit down together. So, we have instigated weekly meetings but this time with Julie Critchley and William Edwards present and, at those, Mary Morgan and myself have made a commitment that should any issue be raised in there that cannot be resolved-- that we will then set out to aim to resolve it, and indeed it can be resolved with us.

Q So, just to focus on that particular action point, we'd understood from Ms Imrie that these meetings would be between her and Ms Devine, but you're saying that actually it's a group of four----

A There's four, and I think it's really important because we want to try to set ourselves on a different path forward; a path where we are not only just aiming to resolve the issues but to set ourselves in a way where we can openly discuss some of these elements, understand from some of the flash points that have happened, and begin to work forward. But there's-- there's different component parts of that.

So, as I say, first of all, there is Version 4. We need to be compliant with the manual, and we also need to be assured that what we are doing, ARHAI would also recognise as the right thing to do, and I think with Version 4, we have arrived at that place.

Q Would you accept that by attaching the SBAR to your letter, albeit you now explain that you wish----

A Yes.

Q -- you'd explained it more at the time, to some extent, you were contributing towards the loss of trust between ARHAI and GGC?

A I don't-- That was never the intention, and there was dialogue

happening, as I said to you already, in the nine days that go from that letter-- nine working days from that letter to 5 September, by the time I'm writing back to Director General, I've met with Mary Morgan, that group has met, we have established V4----

Q No, I understand that but if at the time you sent it-- I mean, appreciate you've explained what you'd have wished you'd done at the time but do you accept that it might, to some degree, have been inflammatory to send it without the explanation that you now wish you would have----

A I can absolutely understand that, and I've noted myself that, in hindsight, it would have been much better to clarify that. However, there were conversations and there were actions going on around that to try to put it into the right context and framing. But I absolutely understand and acknowledge, as I have already, that a better framing would have been-- would have been an improvement on the letter as it was written. Absolutely.

Q Now, you've addressed what steps you're taking to----

A If I may----

Q Yes, please.

A If I may.

Q Sure.

A There are-- There are more

steps and there are not many----

Q No----

A -- so I would appreciate the opportunity to just set them out.

Q Yes, please.

A So, there is Version 4, there is then the weekly meeting, and the weekly meeting will be Laura Imrie and Sandra Devine, William Edwards on my behalf, and Julie Critchley on behalf of Mary Morgan, and that allows opportunity. So, through them, there's been discussion about Version 4. That also means that if anything is of concern on a weekly basis, there's an opportunity to discuss it at Infection Control level but there's also an issue-- so, there's also a way where Mary Morgan and myself can be assured that actually we are walking forward and there is nothing in the room that's being left unspoken and----

Q I understand.

A -- and not addressed.

Q And there are other steps beyond that?

A Yes, and so then the other element is that we have also agreed that we will co-commission a piece of work between Mary Morgan and myself to bring together the Infection Control teams in each of the organisations to begin to do some development work.

Now, that will need a skilled external support to be able to unpick this. This is not-- This is not a superficial organisational development type of piece. This is really looking and exploring roles and responsibilities, reflecting back on some of the flash points that have caused concerns, and setting out together a new methodology by which we can step forward.

So, we intend now-- we've touched on – and I believe in that group we've touched on – should there potentially, for example, be a Version 5 that we agree to together that says, "If there is an escalation where there is not agreement, what do we do next".

So, how do we come together with perhaps the help of Ms Critchley and Mr Edwards, and then if it's not resolving and it's a complex clinical issue which is actually at the heart of many of these elements, how do we bring in, then, an independent expert to help facilitate that conversation, because I come back to the points-- these are all individual expert professionals in their own right but what we need to be able to do is have a methodology that gets us to a mutually respectful acceptance of a position that-- we can go forward with a shared narrative whilst it might accept the elements in both.

Q Right. So----

A Thank you.

THE CHAIR: If I may, can I take

advantage of you being here really to help my education? You contrast what you've just spoken to by way of "organisational development" with "superficial organisational development". Now, "organisational development" is an expression we've heard from more than one witness, and I've let it go past me on the assumption that it is often assessed a good thing. But you're identifying superficial organisational development. What do you have in mind by that?

A So, sorry-- no, so I'm trying to say the opposite. So, I think this will need to be quite sophisticated. I think we'll need to bring in----

THE CHAIR: No, I understand that point but what I was taking, and if I'm wrong in taking this-- is that organisational development is a thing which, from time to time, organisations just—they pay lip-service to-- or they have a day's conference and everyone goes away and just behaves as they've been behaving before, and I was wondering if you have any insight to follow on that or simply to correct me in my misunderstanding of what you were saying?

A I will clarify, then, and I'm doing a great disservice to Organisational Development colleagues in this but where there are colleagues coming together into-- for example, if we bring colleagues together into a conference day to be able to do work on a particular project but there isn't tension, there isn't significant tension there at the point that you bring them, you may be doing it in team building, you may be talking about positive ways of interacting, you might be exploring ways that you can be more successful and high-performing.

In this instance, we're going to have to do some very sensitive, very skillful work in addition to that. A first step that really explores respectfully, with dignity, some of the issues that are there that are grittier issues but, through those honest conversations and through that commitment to that work, I think we will get to a different place. So, I'm sorry, I shouldn't have used such flippant language as "superficial" but what I really mean is----

THE CHAIR: No, I thought you were----

A -- it will take----

THE CHAIR: I thought that you were quite considerate.

A It will take expert support to do this. I think it will be a number of sessions, and I think we will need to look for evidence that actually it is working for people and indeed it is bringing about the type of change. We need to be very clear in the objectives. We don't want to be in this position again. We don't want people

to feel that they have an opinion and then feel that they are then alienated from their colleagues and there is no way to bring that consensus position back.

So, it's a clear methodology that we can use, and actually we have been discussing in GGC-- and of course as part of my statement you've referenced other issues that I have dealt with since I came into the role. There are other issues. When you take highly skilled professionals-- I'm sure across many other professions but with expert opinion at points, you will have a clear disagreement on the best way forward is. Also, when you put in management into that space, again, it can add to that.

I think Glasgow wants to move forward with a strong culture where we are genuinely listening to our staff. We're hearing our views of our patients and their families. We're being honest and transparent, and we are giving feedback to people, and we are sharing information more honestly, and to get to that place, I think we need to be intentional.

I suspect we may even develop some resource internally where we can deploy the types of resources in a protracted period of time because I don't think this is one session and it will all be fine but where you can; for example, give psychological support to individuals, you can allow them to explore on an individual coaching basis, on a team coaching basis, you can use restorative practice, you can use expert opinion. This is a multifactorial approach that we will explore. That's----

Q Before I can ask you some questions about that, I want to just make sure we connect the evidence to the documents.

A Okay.

Q I'm just going to show you the joint letter, so you just confirm that's the one you're talking about. So, that's the joint letter, 9 September 2025, bundle 52, volume 7, document 51, page 453. This is a letter----

A Yes.

Q -- that you both sent jointly to Ms Lamb. Again, just to connect it to the rest of the evidence, what followed out from this was a series of meetings of the four people you've just identified which produce an SBAR, which has produced a version of-- Version 4 of the framework, and that has informed these actions that you've just discussed.

A Yes, and in addition to that, the point that I should have also made is the fact that-- with a deadline of 8 September, to return all information requested to ARHAI by 5 September----

Q That was done.

A -- showing a real confidence and a real commitment to working in a

different manner, we have returned all information, and through that weekly meeting, we're exploring to see is there anything else that's required. So, hopefully a very different tone and a very open committed approach.

Q Okay. So, let's-- I'd like to go back to the SBAR. So, that's bundle 52, volume 5, page 150. The reason I'm doing this is to simply focus on the fact that you have just discussed in considerable detail the steps that you are taking with NSS to address the difficulties in the relationship between GGC's IPC team and ARHAI. I'm grateful for that, and we have that, and that's very helpful. I don't think there's any need for actions to take between the GGC IPC team and the Public Inquiry's experts. I'm sure they'll cope fine. So, I don't think we need to mention them at all but there's a third group in this list, which is the whistleblowers.

I asked you about whether attaching the SBAR contributed to the loss of trust between ARHAI and GGC's IPC team, and you gave me an answer for that, and I'm grateful for that. But the other half of that question is, given the length of the story around the whistleblowers – that, as far as this Inquiry is concerned, goes back to an attempt by Dr Peters and Dr Inkster to demit their IPC sessions in July 2015 – could it be that attaching this SBAR to a letter to Ms Lamb actually creates more distrust between GGC and the whistleblowers?

A So, I can absolutely understand the point that you're raising but the actions that follow suggest something different, (1), and (2) I would also put it that perhaps if the Scottish Hospitals Inquiry had put this SBAR to me today and I hadn't raised it transparently with Ms Lamb as an accurate reflection of a piece that was written in November, then that was being less transparent. I accept the points you're making – I absolutely do – and I-- again, I come back to the point-- with hindsight, I think there could have been a much better framing from me that original letter to clarify that point but to hide a document that was written----

Q That wasn't the reason I was asking the question.

A No, but that's, I guess, the point that I was taking and sharing in that regard to the Director General was: I didn't-- I wasn't sending it to the whistleblowers. I meant no disrespect to anyone within it but it was a factual piece that was constructed for a purpose to report to the Chief Exec at a point in time.

Q So, I suspect there will be a debate later in the submissions about whether the steps being taken by ARHAI and GGC, in respect to the relationships

between ARHAI and GGC, are the right steps sufficient-- other people will express opinions on that because we have Term of Reference 9 and many CPs will have views but let's put ARHAI to one side and focus on the whistleblowers. In your statement, which-- If we go to page 53, we asked you a series of questions about the HIS report.

A Yes.

Q Particularly question two, if you go to page 55, we set out, in quite a long question, a series documents which I'm not going to go to but they include the press release issued on a day of publication, a paper to the Board by you, a press release issued when it went to the Board, and a minute which records apologies by you and the Chair. We asked you a question-- a series of questions, and you've answered them.

Now, I get the impression that you had to investigate, or at least form a view, on whether the conclusions HIS reached were ones that required you to act. Would that be a fair assumption of a part of the process that you were going in? You had to read the report and decide what to do next?

A Yes.

Q Right. Now, in your discussion this morning about the-- I asked you about the length of time the whistleblower had been going on, and you discussed it going back to the procurement of the hospital and issues emerging and it being very tense. That seemed to be the context I got from you. Was I right to take that?

A Not necessarily whistleblowing. I think just the tension within infection control. I'm not saying whistleblowing from that point in time but there is tension, and you can see that in the story, yes.

Q So, I'm going to put to you a few things that could well be facts that this Inquiry might decide to reach findings on but there's certainly material that supports them. There's material that doesn't support them as well but, I mean, just taking these as potential findings. As we go through them, it occurs to me you could say, "Yes, in broad terms, I recognise that" or, "I have no knowledge" or, "I just don't know" but you could-- or, "I reject it".

You could take a broad response to each of them, and I do appreciate that my phrasing of each of them might not be entirely what you think, and I'm not asking to accept whether what I say is true but just-- that you're aware that that is a view that is held and keep it soft in that sense because I want to ask a question that flows from this.

So, we'll try one and we'll see how we get on. If we think about that summer

after the hospital opened, July 2015, it might well be a fact this Inquiry reaches that Dr Inkster and Dr Peters decision to seek to deem it their sessions was motivated in part by concerns about both the management of IPC and the safety of the building, and they didn't feel that the safety of the building was properly investigated at that point. Now, the question is: is that something you've heard as a view expressed or is it completely news to you?

A It's something I would recognise from points of reading the Inquiry.

Q But not necessarily from anywhere else?

A I think that it's very difficult to extract one from the other----

Q I understand.

A -- and so I think I would-- I think I would prefer to note it in terms of my points that I have already raised. I think also we should note factually, as I understand it, again, only from reading elements, that I was not there at that time----

Q No, that is a given. That is-- We should run that through as a stick of rock through the next five minutes----

A But, actually, I'm not sure that they actually did-- they chose to demit their responsibilities, but I believe that they continue to do----

Q Well, they were told they couldn't, but that's the evidence, but anyway, so----

A I just didn't want it to be a point in time that just stopped.

Q Right. Next one is 2017. Now, at this point, Dr Inkster is not at work. She's off sick. She's happy to discuss that. So, the three microbiologists – Dr Redding is perhaps the leading light of this – send in an SBAR, and there is a meeting on 4 October 2017 which results in a 27-point action plan. Now, is that something you've heard of?

A Yes, but I'm thoughtful about going back into elements where I can't give an accurate reflection----

Q No, I understand that but----

A I hear you acknowledging that point, but I do think the relevance in terms of the quality of what I can share-- I recognise that at the highest level from the issues raised within----

Q That's all I ask you to do at this stage.

A Indeed.

Q We then have a point which, from memory, is in February 2018, where Dr Redding forms the view that there is inadequate action on five points in that SBAR, and goes to Stage 2 in the whistleblowing process. Is that something you're aware of in broad high level terms?

A Indeed.

Q Yes. The water incident happens to start at the beginning of March that year. In May, Dr de Caestecker produces a Stage 2 whistleblowing report into Dr Redding's whistleblower, and that happens in May of that year. Again, is that something you are, in broad terms, aware of as something that might have happened?

A Broad terms.

Q Broad terms. When they-- Dr Redding and Dr Peters, who has helped her to some degree and attended the meeting, see that document, they discover – and this is some years later – that there's criticism of Dr Peters' professional practice in the document. Is that something you're broadly, at a high level, aware is in the Stage 2 whistleblower report?

A I hadn't specifically understood that element----

Q I understand that.

A -- but I've understood high level tensions and issues that people have been concerned about, but I wouldn't have been able to name that specific element.

Q We then get to the winter of 2018/2019. There is at some point a point where the working relationship between perhaps Dr Inkster, Professor Steele-- to some extent, begins to deteriorate. It's quite hard to pin down when for the two of them but at some point, it deteriorates and we end up in the summer 2018, August, when doctor-- there is a meeting of the IMT when Dr Armstrong forms the view that action needs to be taken and Dr Inkster is removed as Chair of the IMT. That is, again, at a very high level and that is a very quick summary. You're aware roughly of that story?

A Yes.

Q Yes, and then Dr Inkster resigns as the lead ICD. There's then a discussion about reopening Ward 6A to new admissions. An SBAR is produced by Professor Leanord, and I think Professor Jones, and another one by Dr Peters and Dr Inkster. They take very different positions, and there is a disagreement between those clinicians and others about this issue, which is ultimately resolved by the Chief Nursing Officer a few weeks later opening the ward. Again, at a high level, is that something you're aware of?

A Yes, high level through the Inquiry.

Q Yes. We then get to lockdown, the stress of the whole system is under the huge pressure of lockdown, and ultimately Ward 2A re-opens. There is then a question, which I'm not putting higher than a question, about the extent to which that process of validating the

reopened Ward 2A has been good enough. I don't know the answer to that question but it's certainly a question that is floated around, again, at a very high level. Are you aware that there are people asking that question?

A I heard your question among others.

Q Right, okay. Now, we then get to the Inquiry and a lot of the views of all these people within your IPC team come out in evidence, and it's clear there's not a lot of agreement between many of these people. Again, happy with that as a----

A Yes.

Q -- broad high-level conclusion? In fact, Dr Inkster and Dr Peters and Dr Redding makes some criticism of some people, and Dr Armstrong and others make criticism of them, and there is a cross-criticism in their evidence. Again, were you familiar with that as a broad thing?

A I think to agree to these points, my level of knowledge of each-- you're specifying specific----

Q I want to give the impression that when I ask the question-- that at least you understand where I'm coming from in terms of setting the frame here. The reason say all this is that – and this is what I want to ask you – whether you accept this-- that, from the perspective of the whistleblowers, they have raised issues about the ventilation and water systems of this building, and the way IPC and water testing is done over the best part of, well, nearly five years before lockdown, and they don't feel that either they're being listened to or that their-- how can I put it? That it is considered to be valid for them to raise the issues. Now, you might not agree with that perspective on their part but would you recognise that may well be a perspective they hold?

A Yes, I understand the points that you're making in terms of that they feel that they raised issues that they were listened to but not sufficiently. I think that's-- I'm paraphrasing what you're saying----

Q Mm-hmm.

A -- and because-- and I think I can-- I can draw that conclusion because we never really got consensus but I think, alongside that, I would note-- and I know we haven't touched on that here and it's not for me to give that-- that specific evidence but efforts have been made in parallel, and I suppose what I would want to just note is that I don't think issues were being raised-- from what I'm observing-- I wasn't there and I'm not either defending or condoning because it's a complex picture that-- I think there's much to be told from within that picture.

However, there was scientific experts being brought in to try to help understand the picture through a range and a series of different elements. There was exploration, both internally and externally, in terms of looking at this evidence. So, I recognise the point that you're saying. From what I understand, it's that people felt they these issues, they were listened to but not sufficiently, but I also would want to just acknowledge the fact that I think it would be erroneous to not also acknowledge that there was much work going on in parallel to seek-- to seek answers.

Q Sorry, I just want to check because I may have misunderstood what you said. I'm conscious that there may well have been reports produced by persons out with that whole debate in 22 and 23. I'm not aware of any external experts being brought in between 2015 and 2023.

A No, so I understand your point in terms of that----

Q The reason I'm-- I'm grateful for your summary, then, because it enables me to focus the question this way.

A But if I may----

Q Yes.

A In terms of the role of of colleagues as we move through that time period in terms of NHS Assure and ARHAI, there is debate with the CNO office, etc. about, "What is right? What is the different elements?" So that's really what I'm referring to. There are discussions going on, there's also reports being done, there's air sampling checks being done, there's water sampling. That's really what I'm meaning-- is-- in terms of making sure that there is work going on alongside and parallel to this. That's-- That was----

Q We've had a lot of reports done. We have the reports done by Mr Poplett talking about the management of the water ventilation system, and his reports about his views on the management.

A That's what I'm referring to.

Q Yes. The reason I set out that, which I recognise is a slanted perspective, is this. If we go back to the SBAR and, conscious that you have explained the reason you produced it and what you wish you'd said in the letter when you did so, and conscious of all the work that you're planning to do and have started doing in respect of ARHAI, how do you propose to address the relationships issues, the potentially somewhat embedded disagreements, between those whistleblowers who still work for your organisation and other people within your organisation because you haven't yet discussed how you're

going do that?

A And that will need to be part of our plan as we go forward in terms of work. With ARHAI, they'll need to be work between GGC and with ARHAI, and they'll need to also be work within GGC itself, and there may be work between-- within ARHAI.

I can't comment on that relative part, but there will need to be work within NHSGGC itself, and that's really what I was trying to reference in terms of internal discussions, and I think without going into the specifics because I wasn't there and I wasn't part them-- but you do see flash points in these discussions over a protracted period of time both internal and indeed between GGC and ARHAI, and that's really what I was trying to reference. So, I think there is remedial work that will need to be done to explore different roles, responsibilities, and different perspectives to get to a better space in place.

Q So, I suppose there's a quick question to this and then there's a longer one. The quick question is, since you took up in post, have you attempted to speak to any of the whistleblowers?

A No, I have not because of the Scottish Hospitals Inquiry, and it's one of those elements-- actually, it's very delicate in terms of knowing what is the right thing to do. I've been trying to understand the different component parts of this. We're working through what is right today in terms of making sure our system is safe, but I think that is a piece that will absolutely have to be addressed as part of this, and I would intend to do so as part of this as we go forward.

Q I'm conscious that you've described a future set of steps that you intend to take, and I'm conscious that we, as the Inquiry, to some level cause an inconvenience or an impedance to any such process because we're here asking questions, requesting documents, and demanding statements but, from the outsider looking in, it doesn't look like it required much time to decide to issue the acknowledgement and apology in the HIS A&E events. So, why is it taking so long to address this one?

A I think there's two elements to that. (1) The Health Improvement Scotland issues related to Emergency department were-- were of a much simpler nature than this. This is a protracted very, very complex situation involving particular patient care issues, and indeed the matter of a public inquiry. So, rightly or wrongly, I've been more thoughtful about how to address that without in any way perversing-- being perversive to the course of this Inquiry.

I didn't want anyone to feel that in any way I was asking something of them

in a way that in any way put any discomfort. We will have to consider all the different elements, and we've looked to the Inquiry to test much of this and to help GGC to move forward in this respect as well. Whereas, the Health Improvement Scotland element, they had considered and they had come up with their recommendations, and so therefore, respectfully, I didn't approach until after the recommendations came out from Health Improvement Scotland, and then I began a journey to be clear on what and how-- to go forward, and that may be right or may be wrong but it was done with genuine good intent.

Q What that prompts me to do is to ask a couple of technical questions and then pick up and end this section. So, the two technical questions are: if we look back at the-- well, not at the SBAR actually but your letter. I won't go to it. You mentioned there was a consideration of the Cryptococcus cases in November 2024.

A Indeed.

Q Will you undertake to produce that to ARHAI and the Inquiry?

A So, this SBAR related to that, and I've asked if there's further documentation, and if there is further documentation, I've not yet seen it, but I have asked----

Q So, when you talked about an assessment being done in November, this is it? The SBAR is it?

A Is the product of that. Now, there may be further documents, and I have-- I have recently asked, "Should there be further documents". I think they should go into that weekly discussion to start to unpack the Cryptococcus----

Q Well, when you were talking and I asked you about the May review, the November one is this SBAR?

A Yes.

Q It is. Right, okay. Now, this is a question that I've been asked specifically to ask you. In Dr Inkster's consequential statement – I don't think I need to go to it – which in volume 2 of the part 2 papers is at page 107, 109, she talks at some length about a concern from ARHAI about the grading at HIIAT Green of two cases of Cupriavidus in Ward 2A in November '24, and ARHAI's disagreement about the grading. Have you learnt about this issue?

A I have heard about this issue more recently, yes.

Q What, if anything, have you or are you intending to do about it?

A Again, through the weekly discussions, I want us to begin to unpack these issues. I also want to explore with ARHAI whether there's other issues that we think, but it's back to the point that I've touched on earlier, and Ms Imrie spoke

about in her statement: they won't know necessarily what they don't know. I want to explore that to understand how better we have proactive conversations, and we feel confident and we have the trust in place that we can explore.

I think the ideal situation that we're wanting to get to is where, for example, Glasgow is considering these cases. So if I look to how-- as far as I can hear from colleagues, the explored elements in November last year, and there may well be other documents at a clinical level that were explored at that time. I would have thought if you were coming to a point where you're really discussing these, it would be valuable to then sit down with ARHAI and have a conversation about it and that's where we're trying to get to, so much more proactive.

Q Now, I've been asked to put it this way. Obviously you've explained today in some great detail steps you are taking and intend to take in this area. We've had concerns expressed by patients and families and through their legal representatives that they do not yet have confidence that GGC fully reports HAI. So it's not just ARHAI; there's a sort of audience out there as well. Whilst I obviously get the impression from what you're saying that you think these steps will hopefully begin to address the issue with ARHAI, what do you need to do, if anything, to address concern from particularly those patients and families who have experience in the hospital in earlier days where maybe things weren't as they are now?

A So, I think there are two elements. Element 1 is again about how we monitor so that I can show and demonstrate assurance in a more public space, and currently we're looking at how, at Board level, we can provide a report on a monthly basis. That will show all maintenance elements being shown.

We already have the flow up of any testing that's being done through clinical governance, but I want, again, to bring that into a more succinct report so that people can see publicly at the Board level that we are-- we are monitoring everything that we should. In terms of the data that's coming from that, again, that flows up through clinical governance, but I want to bring it into one easy place through an integrated performance report that then can be seen publicly at Board on a regular basis.

And then the final element is the assessment of what we have found, and that then allows scope for further external additional comments to be added within that, should we believe that there is any question of-- I guess of-- of uncertainty or further discussion required.

So in terms of our hospital today, I

have got to go on the basis that I see the reports that show that we are maintaining our estate, that we are monitoring our estate – that includes ventilation and water; including any further mitigations that we have put in place – that we then look at our data on a regular basis, and that we then benchmark that data to be assured that we do not have a problem.

And that in itself is a very robust process that you would expect to be within any organisation and I do think we fulfil that, but I think we could be-- and, again, I think out of this Inquiry, I think it would be a really positive element if we could have a standardised way of every board reporting in that way to Board level so that, again, you knew that you were compliant, so that if we were, God forbid, sitting in a situation-- again, maybe not an Inquiry but you're sitting somewhere, I would be able to say, "We are fully compliant with a standard set in terms of reporting against maintenance, reporting, assessment and indeed where there is any potential challenge."

Q It's very interesting you mention that because you'd appreciate that amongst the counsel team, we often discuss potential recommendations and there's often a tension in the conversation-- or not tension, there's two perspectives, that we sort of bounce ideas back and forward and sometimes we need a new process. We need a new form. We need a new system. That's one perspective, and there are many ideas around to address many different aspects of the subject of this Inquiry that broadly form into that group of steps, but the response to that is often, "Well, that's fine, but actually you want an organisation which its culture is about that sense of internal challenge of questioning."

A Indeed.

Q But then of course, if you push that too far, it boils down to a recommendation of, "Everyone should behave and not make foolish decisions," which is of course not a very helpful recommendation. So do you see the issue that having a new system, and all the systems you've described, does ultimately turn on the culture of the organisation?

A I-- I hear the point that you're making, but actually whether the Scottish Hospitals Inquiry suggest that this is then put in place for every organisation across Scotland in a standardised way, NHS Greater Glasgow and Clyde will continue to report, as we are doing today, and indeed we will enhance our reporting so that it is clearly all in one place.

The reason I was making the point nationally-- and we will be raising this with ARHAI-- is a potential positive that

could come out of not just the work with Glasgow but actually more broadly, is it then lets members of the public look at Glasgow's data versus "Board X" or "Board Y." It is a way of reading across, because when you go into data sources, we know that it can be very confusing and to give people assurance, "I'm going to be treated in this hospital." And I think-- I've said it already, but 2015 to 2025 is hugely different as an organisation. The landscape has changed. NHS Assure has come into play. Whistleblowing standards, duty of candour and indeed the very, very, very significant learning from this Inquiry----

Q Just a moment. Duty of candour was in place when this incident happened and you had a whistleblowing policy in place. These aren't new things, Professor Gardner.

A Yes, but I think the standards that are there now and how organisations--

Q So there's a change. I understand that.

A Yes, yes.

Q Right, right. Yes, yes.

A What I'm saying is it's not a static piece, I think we have continued, but actually the learning from all of this. We have changed our systems and our processes. We've been more diligent. We have increased the number of times we both maintain or we test different elements within our system, again, to provide more robust assurance.

So, what I was trying to say is Glasgow takes the culture of internal scrutiny very seriously. Internal scrutiny and assurance is absolutely at the very top of my own responsibility and I think the Board is doing that. It doesn't need the Inquiry to see that. I was trying to put forward that I think being able to look across a landscape could enrichen in that but, actually, out of this, we will continue to step back and take all of the recommendations and again move forward further.

Q So, I appreciate that you have these steps in mind and these changes of the way governance work and assurance works. Can you help us about the extent to which-- putting aside issues within the IPC team and the issues in the ward and the water system, all the technical sides, just thinking about Board level governance, to what extent has Board level governance scrutiny, challenge, questioning changed in GGC since 2020 and how can the public be sure that it has changed?

A Yes, so in this regard I would-- I would make reference to the paper that was attached--

Q Yes, of course.

A -- to my-- to my statement.

And I would like----

Q So that's bundle 50, page 73.

A And if I may, I would like to speak particularly about what I have recognised within 2025 and the work in terms of now. If I may, I also would like to just clarify the point, whilst I'm making further recommendations for the steps that we will take, I want to be really clear that the governance that is in place today and the scrutiny that is in place today test and assures us of these issues that I've already set out. I'm just-- I just didn't want to leave an ambiguity.

Q No, I understand that. But how has it changed since 2020 to today?

A Yeah. So, what I'm saying is in this paper we are describing different elements. So if I can go to the page again with the governance structure, which is page 7 of that document.

Q So that's page 79.

THE CHAIR: 9.

A Yeah, so we can see that we have-- at Board level there has been the establishment of the People Committee that is looking very much at the cultural issues and is challenging and digging into different elements around all aspects to do with our patients. That is around feedback from patients; it's around feedback from staff; it's around whistleblowing. The Audit and Risk Committee is looking at all reports on our whistleblowing. We now have a Speak Up campaign in place. Again, any elements linked to the Speak Up campaign where staff can come and raise issue will-- again will be heard through the People Committee.

Through our-- through our reporting back from patients in terms of any incidents and closing out of complaints, and so on, again, I think there is a more robust challenge in and around that, but the People Committee wasn't in existence at that time.

And if we look down in terms of then the-- the-- the next layer down we have the Inquiry Oversight Sub Committee, which is looking at all elements of the Inquiry to make sure that we are being--

Q But we'll be gone, so that doesn't solve the long-term problems.

A No, but it-- excuse me, but it-- it does allow us to-- it does allow us right now, while this is a piece in motion, to be addressing the points and making sure that we're placing them into our core governance. I think we've taken a much more agile approach to governance.

If you go down a layer further, again, we have-- if we just look to even the cluster, which is around the Executive Oversight Group.

Q So if we zoom in on Figure 2, please.

A Yes, thank you. That's down

into the pink areas on the left-hand side of the screen. So we've established the Executive Oversight Group for Transforming Together and the GGC Way Forward, which includes the work that we've done in and around the A&E department. We now have a non-exec who sits on that group. That wouldn't be-- that wouldn't be normal practice. This is an executive group, but we've brought further scrutiny. Health Improvement Scotland is also sitting on that group, again, to help continue to be an external challenge to us and the Centre for Sustainable Delivery.

If we go down in terms of the Portfolio Group and that Oversight Group, again, another non-exec and it's not just sitting on that group-- sorry, that's, if we go down to the GGC Way Forward, the Whole System Oversight Group and this is--

Q So that's on the next page, is it, now?

A Same diagram, in the pink.

Q Same diagram.

A One layer down.

Q Oh, yes, Transforming. Right, yes.

A So, this was looking specifically at the Health Improvement Scotland elements and really unpacking those, but that means that non-execs of the Board are also out and about, they're meeting staff and at that group. And then at the following group that sits above it, are hearing and seeing from staff the issues that they are raising and indeed challenging us in terms of whether we are closing out.

So, in totality, we have walkabouts from our non-execs. Our non-execs are engaging much more on a proactive basis in our Board setting and in our committee setting, the Chair is encouraging, again, more stimulated discussion and challenge of the executives in that space. And so we are looking to explore different elements, but it also means that they are doing so in our strategic elements from a very informed position, where they've actually been sitting in the meeting live and can give feedback to colleagues on their experience of sitting within that new pink area.

So, from this, this is into the executive, going up to Corporate Management and in Figure 1, the element that-- where I started, we then have enhanced focus in and around our scrutiny of-- in and around people, meaning patients and staff.

Q So, perhaps I suppose the thing to-- Before I move on to your statement and a couple of other issues-- take that off the screen-- this paper was produced last week to the Inquiry. I

mean, I'm sure it----

A For the Inquiry, yes.

Q To the Inquiry, yes.

A Not to the Board.

Q Not to the Board. We issued our PPP 15 which dealt with governance issues up to and including October 2010, a full business case. A little bit more after that, but it basically stops then in June-- or was it in May, now that I think about it? Am I right in thinking – and please tell me if I'm wrong – that this structure, these evolutions that you're describing, are very much the product of this calendar year?

A Yes.

Q Right.

A But prior to that, and I can only comment as an observation, the alignment was with the NHS Scotland blueprint for good governance and the committee's-- the standing committees----

Q We've looked at that.

A -- whereas as per other Boards in that regard, but I can't speak to the active nature of governance. Governance is a piece that we can look at in structures but, actually, when you are embedded within it, you can get a very clear sense of whether there is very active, agile governance within that space, where people are being openly challenged, they feel able to speak up and you're providing the Board with the relevant information on a timely basis, in a simple way of-- of describing but with enough detail that they can scrutinise to be really effective and that's an area that we're strengthening this year. And I think it right that I speak to this phase of governance. It is difficult for me to comment on how actively as I wasn't part of that Board at that time.

Q Well, I appreciate that but, I mean, I suppose the problem with the question that's forming in my mind is that we've heard a lot of evidence about 2009, 2008 to 2015, the procurement of the hospital, then after that the DMA Canyon Report and there seems to be, as we discussed at the very beginning of this discussion, some issues then around reporting up through the system, decisions not being reported to the Board committees, not appearing in minutes, and no real hint that non-executive members have any awareness of what's going on.

For example, there's a statement by Mr Lee, who's just one non-executive director, who very helpfully provided a statement. I don't think it's unfair to say that he was aware of the problems that were going on around the specification of the ventilation system in the hospital-- as indeed when Professor Steele came, he couldn't work it out.

So, in the past there's been a lack of challenge and reporting. And so,

effectively, is it your position that this this paper summarises the actions that you're taking in this last, what is it now, eight months, nine months to bring about a real change in these things?

A With the Chair of the Board. The Chair of the Board's obviously responsible for these elements, but I am-- I'm responsible to provide proactive information in a way and to be transparent and to encourage and work closely with the non-execs to ensure that they have transparent access. But I do believe that what I see from my own experience and indeed working with my executives, I have developed—

I can only comment on those elements, but the structure that I put in place around my-- my weekly executive around the Corporate Management team using data an analysis each week, using a tighter set of papers in terms of decision-making, etc., all of that is in my tenure and I can't comment on that. However, what I can comment on is I believe that there was areas that are required to be strengthened.

Q To what extent does your inability to comment on previous events place you in the position where because you can't know if something went wrong, or you can't acknowledge if something went wrong because you don't know, that it makes it hard for the organisation to

then move forward, if it doesn't understand what it's moving forward from?

A I think if I don't have full understanding in terms of being able to represent accurately what happened at that moment in time, I don't think that stops me from taking a strategic overview of circumstances. I have diligently tried my best to understand what is a very, very complex journey. I understand the pertinent points and I have to trust my executive. I challenge and I ask them questions so that I can build up a picture. I've worked with the Chair of the Board and non-execs, again, to build up a picture of knowledge, and I've looked at expert advice. So I've got to use all of those elements to try to get a position today based on that journey.

So I don't think it precludes me, but it does make-- it gives a responsibility to me to go back at points and either query the data or indeed to look at the recommendations, for example, from this Inquiry, or indeed to seek, for example, the work that we're going to do with ARHI as a way of resolving in areas that I don't have that expertise.

But I think the commitment that I am showing is to try to understand the best I can, to be respectful to those who have endured stress and distress during this period and that is-- that is notable –

nobody wants to be in this place – and to do all that I can to make people-- to give people assurance that our hospital is safe today because of the data and standards and the information that we have and indeed the commitment by the organisation to deal with issues in a timely manner as we go forward.

Q Thank you. I want to look at a particular answer in your question there. So, if we go to the page 53 of the statement bundle. This is back to the HIS review, but do you see how you've summarised the bottom half of the page, the HIS review and related issue? And it's a very brief statement, but at the bottom of the page you said:

"External escalation of these issues by staff who were frustrated by the ongoing issues which they felt were not being adequately addressed."

Now, I think you explained a few minutes ago, they were relatively short time periods, but you've said this here. Over the page, we'd asked you whether there were any parallels between their experience and the whistleblowers involved in this Inquiry, and you've responded:

"There are significant differences both in relation to firstly, the actual issues raised by the ED Consultants and those raised by Drs Redding, Peters and Inkster and secondly, the Executive leadership in post at the point of the publication of the HIS Review ..."

Now, if I misunderstood (sic) correctly, the HIS review is covering events that took place under the same executive leadership as these events.

A Yes. Sorry, I'm not-- I'm not--

Q The review comes in afterwards?

A Indeed, the review comes in. And at the point that we are beginning to do this work, there are a number of key changes. That's what I was noting.

Q Okay, right. And then you say:

"While I am unable to comment on the decisions and actions at that time, on the basis of the information I have seen on these matters, there would appear to be some parallels in relation to leadership and culture."

I think it's only fair to ask you, what are these parallels?

A Yeah, so I think, first of all-- Apologies.

THE CHAIR: With apologies for interrupting again, can I encourage you perhaps just to speak a little more slowly? I have----

A Sorry.

THE CHAIR: -- a challenge with noting, but as ideas come very, very quickly, I have a problem with sort of absorbing the information. So can I encourage you to speak just a little

slower?

A Apologies. So, in relation to the parallels, I think, first of all, we've got to-- or I see the parallel between whistleblowing and the issues being raised external to the organisation. I think any organisation has got to look to itself when issues are being raised by its workforce where they may have been listening to them, and I think in both instances you can see actions or attempts to do things, but they are not sufficient to satisfy the people who have concerns.

And I think that's the first concern, is that there are people within the issues that we've been discussing over the past few hours and there are also issues within the Emergency department, where they believe that they have been raising things to executive level and they are not being sufficiently addressed to their satisfaction, and they have to go external to the organisation.

I think that in itself, the fact that people can't be heard in their own organisation and have to either whistleblow or indeed go to Health Improvement Scotland, or any other, shows some level of failing of us as an organisation, that we have not been able to adequately support our staff to raise points and to be heard to a level that is satisfactory. I think acknowledging the point that we may not always come to a consensus, but there has to be a process and a methodology by which-- by which people can feel they have exhausted the issues that they needed to have fully considered.

Q Thank you. I'm hesitating to ask this question because it feels like pulling at a thread that we've already discussed, but I was thinking about, as you were talking about, the failure to come to a consensus. Now, I know there are times in this saga that we have investigated where there is no consensus.

A Mm-hmm.

Q I suppose in many ways they happened in 2019, but in 2018 there was a consensus. And when we asked Dr Armstrong and other of her colleagues whether the issues raised in that 2017 SBAR were wrong, we didn't hear, "Yes, they're wrong and for these reasons." My impression was we received an acknowledgement-- albeit not particularly loudly stated-- that the issues raised were broadly accurate around the ventilation and water testing and things.

So, does it make a difference to the impact on a whistleblower if they're raising an issue and no one's actually telling them they're wrong, they feel they're not being listened to?

A Yeah, so I-- I'm not suggesting

that by reaching consensus, I'm saying, "You're right" or, "You're wrong," that is only Part 1. Part 2 must be that you're feeling that you are part of an action, that you have a voice and that you are empowered to be able to see it to a fruition, an end point that is acceptable to all, and that's really where I'm meaning on the consensus point as well.

So, at the end of it, if I go to the Emergency department, for example, we set up the NHSGGC Way Forward programme to let them be part of it. They are the co-chairs of each of the groups. They sit. Those who raise points sit as part of that process and they are actively working with us to resolve. Today we haven't resolved all the issues because they are an issue of demand in our system and-- and complex set of circumstances, but they actively have a voice, and we are actively supporting them in the issues they are raising. So that is a thing.

And then to the side there is a separate part, which is that there is the human factors element, supporting people and how they're feeling, giving them the ability-- In the Emergency department, for example, we have brought in an external facilitator who's taking the time to listen to how they're feeling. Some of them have asked for external psychological support.

So, it's two things-- two component parts. One is about the things that will fix it, that they will get to a place where they feel we are satisfied. They may not get to the point that is everything they want, but over here there's also the human factor. So, coming back to your point that you are raising, it's not just about acceptance of, "Yes or no." It is then that we are saying to someone, "And I'm now empowering you. I'm giving you the ability to be part of the journey now to get us to the best place possible."

Q Can you give me a moment?

THE CHAIR: So, at the risk of just saying back to you, Professor, what you've just said to us, you would see as part of a proper reaction on the part of the organisation, specifically GGC, two whistleblowing criticisms/concerns, to be involvement of the whistleblower in the action which the organisation decides to take--

A Yes.

THE CHAIR: -- assuming that the organisation--

A Yes.

THE CHAIR: -- decides to take an action.

A Yes. And I think it's not just the whistleblowers. I think it's the point was trying to make earlier as well, is that it's both the whistleblowers and others in that landscape to try to help everyone

move forward together because the real risk I think in whistleblowing, or indeed in colleagues coming forward even in another space, is that they end up almost dislocated from part of the service. I'm not saying necessarily individuals here, but the-- then you lose some of that professional group harmony because we're not working through things together. There is a-- a view here and there is a view there and then that never leads to a positive working environment for anyone.

You want people to come into work feeling fully supported and feeling that, actually-- because, actually, whistleblowing or indeed opinion is very rarely a static point. It comes, "I may have something to say today, but actually next week I've maybe got a point on something else that I want to raise." And we need to create the conditions whereby, "I feel safe and I feel supported to be able to speak up next week about this other issue," rather than being, in any way, held back by the fact that, "I raised something and people didn't listen to me properly and didn't let me be part of a solution. So, therefore, can I raise another thing?" And that's a more generic point I'm raising, but it is part of-- of what-- the approach I think you need to take to resolve.

THE CHAIR: Now, what I would

take from that is that it would not be a satisfactory response for the organisation faced with specific concerns to say, "We know about that. We're in the process of doing something." That would not be satisfactory.

A I don't think that's how you should go forward. I think you've got to engage people and allow-- Because, also, when people have raised thing through, for example, whistleblowing or going externally, they feel-- they must feel very passionately because they've had the courage to come forward and raise a point that is difficult, and it takes a great deal of courage to do so and I've reflected that to colleagues in the Emergency department.

So it's not going to dissipate quickly by somebody just giving a quick-- a-- a brief, "It's fine." You've got to help people have the opportunity to genuinely work through what they feel passionate about to help them work through with the organization, how we resolve those matters, so that they feel assured and they feel listened to and they feel that actually the points have been addressed. It may-- they may have been influenced during that journey to get to a different end point, but they have had proper opportunity to be part of that resolution.

THE CHAIR: Thank you.

MR MACKINTOSH: So, Professor,

I've got one final map document to put to you before we move to the final topic. So this is Dr Redding's statement to the Inquiry, which is in the bundle of evidence for the week commencing 2 September. Her statement is document 2, but we're going to page 135. Dr Redding gave evidence last year. This statement, I think, is dated from earlier that year. So that's Dr Redding statement, witness bundle, week commencing 2 September '24, and it's volume 3, and it's page 135. It might take a moment.

A It's not on my screen.

Q No, it's not. I'm watching my colleague's furrowed brow behind you. So it's the Glasgow III, volume 3 statement bundle. It's the first document on the document list. (After a pause) While that's coming up, I'll read it to you. Paragraph 212:

"During the whole process, there was no recognition or understanding of the stress experienced by the Whistleblowers. We were treated as troublemakers throughout. I thought of giving up on several occasions. I promised my family that I would give up after stress resulted in my admission to coronary care in April 2019. This is a promise I later broke because I found it more stressful to stand back and do nothing, given the harm I believed had been and was being caused. I took a Hippocratic oath which includes 'Taking prompt action if you think patient safety is being compromised'. This is what I believe I was doing."

Do you accept on behalf of the Board that in the past it has not recognised or understood the stress experienced by, in this case, Dr Redding, who I think might have been your first female microbiologist ever?

A So, I can recognise the stress and distress that must have been-- must have been felt by Dr Redding coming forward, raising a piece and linked very much without regurgitating the piece that I've just noted, without having that opportunity to channel through to a point of completion the issues I'm sure that caused. And I've read that statement and again I would draw parallels to comments that have been made by the Emergency department colleagues as well, where they have felt enormous stress and distress by raising something and not feeling that they were part of it.

So what I would say today is as-- as a board we are being very clear that that is not what we're trying to do today because—because-- and that's the important bit - because we recognise that it's not good enough for our staff, that we need to be able to do the two elements that I described: to support staff, to listen to them and to make them part of the

resolution of a problem so that they have that opportunity. Because, as Dr Redding noted about taking-- having taken the Hippocratic oath, it's linked very much to the comments that came from the Emergency department colleagues. They felt that absolutely compelling responsibility to patients to be able to resolve an issue that was troubling them to a level that they felt compelled to raise it.

Again, I repeat the piece that I think it takes great courage to do so and the Board, I think, has today been very, very clear that this is not the way this organisation wants to go forward and Glasgow 2025 is being very, very clear in noting those points in terms of a way forward.

Q Having had to say that, it prompts me to ask this question: do you consider that in any way Dr Redding is owed an apology by NHS Greater Glasgow and Clyde?

A I think, exactly as I said around the Emergency department colleagues – and again I note those parallels – absolutely, for-- for those involved in this, acknowledging that they were very different circumstances. Again, I think it is-- I-- I am sorry that-- that individuals did not feel listened to by the organisation, were not treated in a way that allowed them to feel empowered and to be able to

be harnessed onto a solution and were not afforded that opportunity.

I think it's a complex landscape where it is our responsibility to understand different perspectives and to take time to really unpack, but also to help colleagues come together to find the best way forward, and I don't think-- I don't think from my observation that, while some efforts were made, that that was fully afforded to those individuals.

So on that basis, I am sorry that they were not-- that she and others were not afforded that opportunity and today I think through my actions in 2025, I have demonstrated genuine commitment and humility in that space to say, "We need to do better for the people who come to work every day to do amazing things for our patients," because our patients deserve our staff to be in the best place and we have amazing experts in our system and we need to look after them, we need to look after our patients and we need to look after the families.

So on that basis, I'm not trying to protract my-- my point but it is really important to-- that is our big why, and if we care about our patient safety and we care about our staff, then I am sorry that they didn't have that opportunity.

Q Would you extend that to all three authors of the 2017 SBAR and Dr Inkster?

A I think to anyone who has felt within this process, and it may well go beyond. I think the people who would say they felt stress and distress will probably go beyond those who have raised these points.

Q Obviously, I put Dr Redding to you.

A Yes. Yes.

Q You said "people" in a collective. Would you include those four----

A Yes, absolutely. Absolutely.

Q Okay. Right. Okay. Thank you. I'd like to----

A In that regard, but-- but if I may, it does extend beyond that because I do think if I look to the Emergency department and not-- and not providing opportunity for those who had the courage to speak up, there were many others on that landscape that we had to address their issues, and we're beginning to unpack a more complex picture. So you have to take time and we obviously, despite all the efforts that people believe they took, we needed to do more or we wouldn't be where we are today.

THE CHAIR: Really a point about the use of language. What counsel put to you is whether GGC should or in fact does apologise to Dr Redding. Now, you replied using the expression "I am sorry." Were you distinguishing "I am sorry" from "I, on behalf of the Board, apologise" or were you not?

A On behalf of the Board I would need to reference to the chair and to the Board. It would be wrong for me to speak on that behalf today but I think if I can reference to the Board and to the chair has clearly made these points in and around the Emergency department elements and when the chair, Lesley Thomson KC and myself made those points in public. We made the generic points as well as the specific points to those individuals. So in terms of people having to go outside the organisation, I think those points stand, but I think as a point of correct-- of-- of absolute correctness, that is required to be clarified.

But I say today, on behalf of the organisation, as chief executive and current accountable officer, I can speak to say I think it-- we can do better for our staff and I'm sorry that they didn't have the resolution from this, but I do also want to acknowledge, because it would be erroneous of me not to, that there are many, many other people in this landscape who have been through this journey, and I think we owe it to them to begin to work forward and have resolution in how we go forward. That doesn't mean-- If I may, though, it doesn't mean that today we are not taking all

steps to ensure our organisation is safe and effective and we're treating people with dignity and respect, but I do think we have something to do to restore some of the hurt and anxiety that has been created.

Q Thank you. I want to move on to a final topic which is the topic of the Case Notes Review. Now, obviously when the Case Notes Review came out, presumably you would have been in NHS Fife in the middle of the pandemic and so you wouldn't have read it at the time.

A Yeah, so-- so the Case Note Review-- Sorry. I----

Q What I'm asking is have you read the Case Notes Review overview report?

A Yes. Yes, I have.

Q Yes, you have? Right.

A Yes, I have.

Q Now, I want to emphasise that what I'm about to ask you is not set out in order to suggest the Inquiry does not have to consider all evidence it has heard about the question of whether there is not or is a connection between infections and the environment. We will consider all the evidence. It's more to do with, well, in a sense, governance. So, we asked a series of questions of Ms Grant and Mr Calderwood and she explained that she'd had a handover from her predecessor and you mentioned that at the beginning of your evidence.

When you had your handover from your predecessor, did she give you any handover on the question of whether GGC accepted the conclusions of the Case Notes Review on the question of whether there was a connection between the hospital environment and any of the 118 infections suffered by 84 children in the Schiehallion unit?

A That was never part of the specific handover. However, I have read the Board paper associated with it from 2021.

Q Yes. So that's the Board paper of 27 April '21.

A Yes.

Q Which is bundle 37, document 58, page 1068. Now, I want to check. Did you read this before we put it in a documents list?

A Yes.

Q Right, and it's associated minutes we'll come to in a moment. Now, this is a paper produced by Ms Grant. You've read it. Would you accept that it doesn't explicitly state whether the Board accepts or rejects the conclusion on the infection link? Or do you think there's a way of interpreting this differently? In which case, I'm very happy for you to take me to the right page and we can look at it. Should we look at the section? Let's go to page-- Sorry, carry on.

A I would say that my-- my understanding of it from, as I have read it, it is, and again I go back to the Case Note Review perhaps just for a moment if I may, to note that what I think about of that was both a set of recommendations and indeed conclusions based on a level of probability. I have read Professor Mike Stevens' comments around it in terms of in the absence of definitive sources and the strong possibility of a link is undeniable. I think what the Board has got to accept in this space – and I think that is what it is doing here – is noting and accepting both the-- and I acknowledge-- I-- I heard the-- I heard your interviewing of-- of my predecessor-- --

Q Yes.

A -- and so putting her points to the side, my reading of this is that there is an acceptance of both the recommendations and the conclusions which are based on probability.

Q Okay. Now, it's interesting you say that because we can read her evidence and no doubt kind of think about what she was trying to say. We've also the evidence of Professor Brown.

A Yes, indeed.

Q And he was----

A Definitive.

Q Definitive----

A Yes.

Q -- that the Board accepted the conclusions. Now, if we think about a slight timeline here, this is April '21. We now know from a document produced by Professor Stevens, which we put to Ms Grant, that for the next few weeks after this, Professor Stevens and his colleagues were still meeting with the parents of some of the families who wanted meetings, and it wasn't finally wound up for a few more days yet after 27 April. Then in September, this Inquiry held what I think for some is known as the perceptions hearing, or Glasgow I, in which we heard from families, parents and patients about their experience.

I wasn't here. I wasn't the Counsel to the Inquiry, but reviewing these statements, I noticed that of the 32 witnesses, at least 13 parents, and of course, some of those share a child, as it were, they'd been told by the Case Notes Review that their child's infection was either probably or possibly connected to the environment, and I suppose that would make a certain amount of sense if you think of the cohort.

But then, last year, those parents began to learn through questions being asked and documents being produced through this Inquiry that the GGC did not accept the conclusion that there was a link between the environment and the infections, for some of them. In fact, they

had it down as two. Now, has the Board ever formally told these parents of the change of position?

A So I don't-- I think for absolute clarity, for my time as accountable officer chief executive, I-- I have not heard that point. What I hear is a point which is around a Case Note Review that there was full acceptance of the recommendations and full acceptance of the conclusions based on the categorisation of the "possible/probably" or "more likely".

There is no – I'm noting those points – definitive source. However, the strong possibility of a link is undeniable. I think there's full acceptance of those elements and I think as proof of the full acceptance, we go on to look at the 15 themes, the 43 recommendations and the 108 action plan that followed as a result and we have fully-- we have fully implemented or-- for those elements, for example, things like an electronic record that are still ongoing, we are still in the process of implementing. But there was full acceptance.

I think that it was-- I presume you're referring then to the HAD report. You may-- You may not, but I think it was----

Q I wasn't going to.

A Apologies.

Q I wasn't going to, but please continue.

A I think it was reasonable and prudent, given the fact that we had not come to a definitive answer on everything, not to-- I don't think it is an either/or. I think there is full acceptance of the clinical note review. I think what the HAD report-- my own opinion on this is what the HAD report or what Glasgow sought to understand by the commission via CLO was to understand in more detail the-- the risk that-- that potentially existed or not. We did not know the outcome of enquiry-- that-- that piece of work and I think it's really important to note that until obviously it had concluded and Glasgow was not involved in that. So I think it was reasonable----

Q Just a moment. Glasgow, the Health Board?

A The Health Board.

Q Instructed the HAD report?

A So, via CLO.

Q You're the client.

A Yes.

Q You instructed the HAD report.

A Yes.

Q To some degree, it would seem possible – I only say "possible" – that encouragement was given to Dr Professor Leanord and Dr Brown and Professor Evans to review the whole genome sequencing information. A positioning paper was lodged with this Inquiry setting out that:

"…with the exception of two discrete cases of paediatric infection, there is no evidence before the Inquiry to properly suggest a link between infection suffered and anything arising from the built environment."

That's not the CLO's position. That's the health board's position and we'll investigate it. My question is this, did the health board tell the parents?

A So, to my knowledge, no, but also as coming in as chief executive that was not the inference that was given to me. My-- The-- The piece that I understood as I arrived was that the Case Note Review, the recommendations and conclusions were fully accepted and as a result, and as a-- as a prudent measure and for safety, we-- we have adopted all recommendations to ensure patient safety as if all of these are fully accepted.

So, I think our actions in terms of the HAD report, I think it was reasonable and prudent commission as preparation for onward proceedings. I think it was asking the Inquiry to test but it was meant to be around technical assurance of that relative risk. I don't think it was to undermine. That's my own interpretation. I don't think it was in any way to undermine the points around possibility or probability set out in the Case Note Review. If I am wrong in that, and that was of my-- of previous individuals, if that was their intent that was not ever conveyed to me.

Q So one of the issues that arises is of course those 13 parents who gave evidence and spoke about the Case Notes Review did so in September, October and November of 2021, and they've moved on with their lives, presumably – and I don't know – on the assumption that they'd been told something of weight. There was a possible or probable connection to the environment in their child's case. Now, one of them has produced a supplementary statement – and it will be published I think tomorrow – and when one reads Professor Cuddhiy's supplementary statement, there is a reference to a certain amount of disquiet.

He chose his own adjectives. You can read it when we put it in the bundle this week, but do you see how it might be somewhat distressing to the parents of children who were treated at Schiehallion to think the issue was, for their child, resolved to then discover nearly two years later that the health board's position being presented in this Inquiry was "That's wrong"?

A So, I think in any-- and-- and forgive me because I think in any healthcare setting you're continuously seeking the best information possible in order to take whatever steps required to

be taken to understand the past and to keep the future and the current as safe as possible. Therefore, we use science, and-- and in this particular instance science never came to a definitive consensus across a range of experts. However, in good faith we fully accepted, as my understanding, the Case Note Review.

I hear the point that you're raising but I do not believe-- but I was not there to instruct at the time, so I cannot make comment on-- but-- but I do not believe that the HAD report was commissioned in order to cause distress to families, to undermine a level of possibility or probability, but to more be clear on the relevant risks associated with water and ventilation and ensure that we were taking all adequate steps today and in the future to ensure full safety and to understand where and if and how we had gone wrong.

So that is the way in which I have read it and if families have been upset by that piece, I-- I do understand your point. It must be absolutely horrendous to lose a child or to go through the stress and distress that they have gone through and that is absolutely awful and also for all of the staff who have been involved with all of these cases, again I go back to the point that people come to do a good job and so it is awful if despite all of those

efforts a child is lost. It's felt of course by the family, but our staff also feel a huge responsibility, and that goes to every level within a healthcare organisation. So, we take this very seriously, and there is-- there would be no intent, I don't believe, to upset. But I was not there to be able to say what the intent was of the commission.

Q I appreciate that, and so the next few questions are quite-- I do appreciate that you're slightly at a disadvantage in answering them, but I feel I have to press them.

Firstly, you've mentioned at least twice the idea there's no definitive conclusion. Now, I think the word used in the case review is "definite", but there is no definite case in the Case Notes Reviews. You're absolutely right and the Case Notes Reviews-- 30 per cent is, more likely than not, the balance of probability, which is of course the same standard that this Inquiry has indicated it's going to apply.

So, the fact that there's no definitive conclusion, is that a problem? Does that cause it to be necessary to produce something like the HAD report?

A I think in terms of being assured that there is no further steps that we should be taking to provide assurance of safety on a day-to-day basis, I want to be able give public confidence, and I-- I

also sincerely hope out the back end of this that the hospitals Inquiry has held people publicly to account and has tested that, that lets people and patients and families come forward and know that we are providing information that we have taken and exhausted all steps possible to ensure a safe environment and can demonstrate that through our monitoring. So I think it is within that framing I still make those points.

I think to suggest and certainly for me and as I say I cannot-- I cannot speak to the motivation but for me to think that we would commission a piece of work to be done to understand further, to ensure that we were taking all steps possible as a way of harming or undermining, that feels horrendous to me because I would-- I would hate to have caused further distress to the families who have already suffered a great deal.

I don't think for a moment we are challenging "possible or probable", but I think you could take it from the other-- the other end of the telescope and say it's "possible" or "probable" enough for you to be assured that you're taking all the steps that are relevant and do you need to go further? This was based on 84 children and 118 episodes.

The HAD approach came at it, and other scientific approaches may continue to come at this approach. We do it on a daily, weekly basis to be assured.

Q Can I just check something? Have you read the HAD report?

A Yes.

Q Do you recollect that it doesn't at any stage discuss any design features of the water or ventilation system?

A Yes, and that's a limitation for sure, and so I'm not suggesting-- I want to be clear. I'm not suggesting that the HAD report replaces the Clinical Note Review. It's quite the opposite. I think these are all different elements. We can go through in this story from the-- Fraser, Montgomery to the-- DMA Canyon, right through the different elements including the issues that have been looked at internally as well.

There is a whole range of different ways of looking at this but all of them collectively and individually are trying to create a story. So there are limitations with-- with each of them that we could pick apart, but I think it has been-- and today from my perspective certainly we are looking to try to use the learning from each of these elements in a way to give assurance today.

Q Thank you. I was proposing in a moment to just to wrap up for the 10-minute check, but it did occur to me that-- I hope you won't take this the wrong way, but you have explained in considerable depth and detail in the first two-thirds of

your evidence, the steps that you have taken and intend to take to address what might be found in very, very shorthand relationships, understanding trust issues between your own IPC team and ARHAI and wider out into the whistle-- and then you've made commitments in respect to the whistleblowers in the future, and I hear that.

Now, could it, would you accept that it might make it hard for patients and families to trust the Board to do these steps----

A Yes.

Q -- that the has produced the HAD report and taken the position it did take last year and the year before on infection link? Do you see how the two things might----

A I do hear the point that you're leading towards----

Q Yes.

A -- but I'm trying to be really as open, as honest and as transparent I can about the culture and the standards that we're trying to set for NHSGGC in 2025. I'm trying to demonstrate through this today, which is a tiny snapshot of all of the steps that we're taking to give assurance to the public today and going forward. I do hear your point, but I don't know that I can do any more in giving assurance around the steps that we're doing today. I'm acknowledging your points. I hear your points.

Q One final question, which is obviously you're a new chief executive. Your chair is also relatively new. To what extent do you feel confident that you have the support of your non-executive Board colleagues and your executive Board colleagues to deliver this programme of change you've just described?

A I feel very confident in that regard because we've taken a great deal of time. We've-- we've done board development sessions with our staff. We've run what we call "hackathons", but that's basically sessions to bring people together to look at problems, to work through problems in a different way, to listen to our staff. We're dealing with specific issues in the GGC way forward, and through our board-- board sessions, informal and formal, we are taking active steps to unpack more information and to be able to provide better ways of reporting so that scrutiny is clearer.

We are out and about. I am out and about on a regular basis listening to staff and there are active visits by the Board to the staff and there-- and you hear and see under the hood directly from people. I also raise on a regular basis, as does the chair, as do the other non-execs, again, that break-glass, that people can escalate and people have escalated within the organisation to raise points.

It's always an effort, especially in an organisation the size of NHSGGC – 42,000 staff members – to change a culture, to set an improved trajectory but I am trying with the Board to be very clear and I'm doing work with my executive to set out very clear objectives, to set clear standards, to have KPIs that can be measured and to have assurance statements and assurance and scrutiny opportunities on a more frequent basis.

Q Thank you.

A I'm not sure if that was addressing your point.

Q No, I think it does. My Lord, I've got no more questions at this moment for Professor Gardner. Might I take the 10-minute moment to see if there are any further questions in the room? I have one I've already been given, but I will answer it in the block as it comes.

THE CHAIR: We'll do that. Professor, the procedure we adopt is to give the legal representatives the opportunity to suggest to counsel questions which he might have asked but didn't. So, that takes about 10 minutes. So can I invite you to return to the witness room and we'll be back with you I hope within about 10 minutes.

THE WITNESS: Absolutely. My Lord, may-- may I have an opportunity at the end just to make a few comments? Is that possible?

THE CHAIR: It is possible.

MR MACKINTOSH: Yes.

THE WITNESS: Thank you very much. Thank you.

(<u>Short break</u>)

THE CHAIR: Mr Mackintosh, do we have more questions?

MR MACKINTOSH: Rather a lot unfortunately, my Lord.

THE CHAIR: We have more questions, Professor, but after these have been asked, I will invite you to say what you wish to say.

THE WITNESS: Thank you.

MR MACKINTOSH: The first question relates to Ward 4B, and that is: is there any plan to bring the ventilation system on Ward 4B into compliance or into concordance with what's in SHTM 03-01 in respect of air change rates and filtration?

A So, not to my knowledge at this point in time, but I would need to take further advice on that. In regard to where we're at today, I believe the derogations that have been put in place, have been considered acceptable, but I can-- I would need to take further advice on that one.

Q Thank you. Now, I need to slightly explain something I said. I talked about the patients and families moving on, and of course, some of those patients

and families moved on to stay in the Schiehallion unit----

A Yes.

Q -- for continued treatment of their children. To what extent does your evidence that, to some extent, you might have said, "we could do better in respect to the whistleblowers" extend to the patients and families as well?

A I think it sits at the very heart of all of this because actually providing the very best service we can to provide that assurance in terms of our tests and balances to make sure that our checks are adequate, and also to make sure that we're looking after our staff so that when they come to work they're in the best place.

All of that is for one purpose, which is to provide the best care for our patients and indeed to help our families to feel supported, and also to help our families feel that when they leave a loved one behind and they have to leave them there in the hospital, that they feel confident that we are going to be doing the right thing. So, I think it is implicit within everything that I've said.

Q Thank you. Now, you mentioned in your evidence, at the very beginning of your evidence, about the tensions between ARHAI and the IPC team. Why does the exchange of staff between GGC and ARHAI cause tensions?

A I don't think it's necessarily a direct tension. I was just trying to explain the landscape of there is-- there is a mix of people who have been in Glasgow who are now in ARHAI and the potential for any relationship complications to continue, but that's not-- That's an observation and that's a perception from me in fairness, and so actually going through this work we will need to unpack what those real issues are. I think today it's at a much more fundamental level of-- I think it often comes from a place of anxiety about sharing and what that will mean and what will happen from a GGC perspective, and also I think--

Also, again, my perception also comes from a place of people feeling that they have the skills and the expertise and the knowledge locally to make the right call. I don't think, genuinely, that there is any intention to hide or to not be clear and open. I think they feel that they have done the right thing, but I think in this regard we need to help people to open up and to share, and hopefully, we'll be able to build trust and build those relationships at a higher level, but today it would be-- it wouldn't be right of me to say specifics because we need to do the work to understand those further.

Q So, the question I was suggested to ask is much longer, but I'll

tighten it down. To what extent and why do you consider a positive working relationship between your IPC team and ARHAI to be a good idea? Why is it a good idea to have that working relationship?

A I think it's a really positive element because you then have the local position. You have the local expertise, of which there is a significant amount. You have the local information from clinicians, but it means that twofold, one, if there are issues that may be of concern or debate, that they can seek external support from others who, again, are very, very skilled.

Colleagues in ARHAI are incredibly skilled, and I think from that skill they bring two different elements: a further external view and that different perspective can often help, and (2) the elements that been spoken about before, from a national perspective it can bring that national surveillance perspective that actually something that is happening, potentially within Glasgow may also be happening somewhere else, and they can bring and enrich the understanding of the issue.

Q Thank you. You've on a number of occasions mentioned that you have expertise and experts within the current IPC team. Do you accept that the three authors of the September 2017 SBAR and Dr Inkster are also experts?

A Oh, absolutely and I'm sorry if I didn't make that clear enough in other points. I thought I had, but absolutely, I most definitely do.

Q Given that the approach of NHS Greater Glasgow in this Inquiry has been to say that some of the whistleblowers are substantially wrong in the science, how do you think those whistleblowers are supposed to trust the process you're now planning to implement?

A I think the opportunity to explore, and we maybe will learn together and develop a more evolved position on these different elements. I think if you don't explore and you don't have the courage to begin to unpack and seek an understanding of different perspectives, you can't really move forward, and we've got to create the conditions, and that won't be easy, in which to give people the conditions to feel they can trust and they feel they can be supported.

I link this back to the point I made earlier. I don't think-- and I think at points this is-- We talk about this almost like it's a moment in time, but these are very extended periods of time. Every single day different types of issues are on the table, and you've got to create the conditions because to move forward, wherever people are, we want them to feel empowered and listened to, and

actually-- because otherwise we know clearly that that damages people as they go forward in their-- in their career, but also that we want them to be able to raise points today, but I'm also, I just want to be clear, in my expert understanding, I'm not making a comment around the views that have either been agreed to or not agreed to. I think that's for experts to unpack together with the expertise to do that.

Q I may have misheard you, so I want to just check this. I got an impression when we were talking about steps to be taken that you're planning action now in respect of the ARHAI relationship, but I got the impression that you were planning to wait until the Inquiry has produced a report before addressing the whistleblowers.

A No, sorry----

Q Oh, did I misunderstand that?

A Apologies. So, I think in an ideal world we would wait until the recommendations. I think it would us more and I think through recommendations it helps people to feel safer in the-- in the route that you're taking. I guess I'm making a connection to any-- to the Emergency department for example. It gave us a substance to begin to speak about, but this Inquiry and indeed the work beyond this has set out very clear issues that we should start to unpack and we need to begin to unpack those issues with colleagues now.

Q I think it's the case that Dr Peters' evidence was that no one's ever offered her-- asked her how she's doing or offered her support other than the support provided briefly in the Oversight Board by Ms Copeland. Do you think that's acceptable?

A I think if that's the case, that's acceptable. I can't make comment. I have been----

Q That that's acceptable or unacceptable?

A Sorry, it's unacceptable for somebody not to be given any support. Again, I couldn't speak to the detail of that right now but I believe that some offers of support were offered at different points to people and I would need to go back to the reference in that regard, but actually me debating whether it was or not is not helpful, and I want to be clear on that piece.

Q Right.

A Going forward though, I think what is really important is I personally will reach out to individuals, and I will also commit to starting a process where we are listening to people and we are working through these elements.

Q So, when the Oversight Board was in place, we had some evidence about attempts at development work

done by Professor Walker, but primarily by Ms Copeland on the Oversight Board. Would you accept that there might be a measure of scepticism from whistleblowers who've been involved in that before if something similar is offered again as to whether the Health Board is genuinely committed to exploring these issues?

A I think you can always absolutely come from that perspective and think it won't get better, but a significant number of things have changed in this landscape and I think we've got a lot of evidence and are able to demonstrate that we are trying in different ways with different groups of staff to move things forward, and I think their reflections-- I hope will help others to be able to see that we are trying different approaches now to be really respectful and to find a way forward.

Q Sorry, I'm actually just getting a document ready to open. I'm going to ask my colleague to find bundle 44, volume 1, but I'll ask you another question while he's doing that. We had evidence from members of staff of the Health Board who might well be the people who appeared to have described, in broad terms, the whistleblowers as giving them misleading or sensationalist evidence. What are you planning to do to create change in that area?

A Sorry, could you repeat your question?

Q So, we've had evidence in the Inquiry from members of staff who are currently still in post, not just in IPC----

A Yes.

Q -- who in very much shorthand have described the whistleblowers as being either misleading, or motivated not by patient care, or exaggerating things. What will you do to address the lack of trust in processes that were probably caused by the whistleblowers?

A So, I think there's a number of steps in that regard. I think from a leadership point of view for me, I've got to set out very clearly that people need to treat one another with dignity and respect, and that actually in speaking about-- that way about colleagues is unacceptable. It's not right that that should have ever been written in that SBAR and it's not right that people should be making these comments.

So I think we need to invite people to do so constructively, but we've got to set out the rules of engagement to begin with and invite people in to that respectful place and to acknowledge how we will look after them as we invite them into the space, and we're going to have to very, very clear about that: be clear about how any conversation would be facilitated, and be clear on what we're asking people

to do with us.

And I think through that clarity we can create, I hope at least, a place where people feel able to speak about the different elements in a different way, but we will also have to ask them. So, in the Emergency department, again, we had to ask people what they needed in terms of the conditions in order for them be able to come forward, in order for them to be able to start to work forward, and it took time and patience to be able to work through that because what I might perceive as being important may not be relevant to them or important to them, so that's the step one.

Q With the Emergency department, is that still a work in progress or is that effectively concluded now, the work?

A No, it's still a work in progress. The GGC way forward have made some significant movements in that regard. In fact we just had-- We've had an external individual in working with the team and we just had a follow-up meeting, so we are making real progress but it takes time to turn around issues that have been of a significant depth of feeling for people to raise these issues, and some of those are the issues of the system, and some of those are the issues of relationships. I do think we have moved on significantly and I think people would reflect that we have

supported them in that journey to do so, but it's still a work in progress.

Q You mentioned the Speak Up campaign.

A Yes.

Q How do you think the way that GGC in its submissions and its staff in evidence have addressed the whistleblowers in this Inquiry has encouraged or discouraged people to whistleblow in your organisation?

A I don't think you would say, if we look to the historical elements, that it would encourage people. I think the conditions that we're trying to set out and indeed the Speak Up campaign giving different levels of-- different levels of people that you can approach, and indeed a really open, robust approach with a whistleblowing champion on the Board, reports up to our Audit and Risk Committee of the Board. We are creating both pathways and governance around it in order to assure people to go forward.

I don't think, historically there has been the ideal conditions either in GGC or sometimes in other organisations. So, I think we need to absolutely acknowledge it has not been right in the past and I think people would say they've come forward and they haven't got to where they had hoped to get to, and so all I can say again is reiterating the evidence of what we're trying to do in the

ED and other areas. I hope begins-- But it--

Building trust takes time and giving people the proof that actually the words that you're saying actually are being converted to meaningful change takes time, and so we're committed to doing that and I've tried to set out on that journey, but I do think it will take time and we'll need to prove ourselves to those who wish to come forward as we go forward.

Q You mentioned in evidence, talking about the HAD report, that the purpose of that was to confirm whether all steps were being done to ensure safety.

A Yes.

Q Have you read the letters of instruction to the authors of the HAD report and what they were actually asked to do?

A I've looked at the high level commission, yes.

Q Well, let's go to bundle 44, volume 1, document 4 which is the letter of instruction to Professor Peter Hawkey on 21 November 2022. Now, if we step through the letter and look at the, "Appendix - Questions" page 242, what I'm effectively putting to you is that in this document, which unless you've read it before, it wasn't on the document list, what I'm asked to put to you is that the report was not instructed on the basis to see whether all steps were being taken to ensure safety because the authors weren't asked to consider what steps were being taken, so they couldn't report on that topic.

A Yes, so perhaps my framing of that point was clumsy. This is really assuring us of, are our systems safe?

Q It doesn't do that either. There's no evidence in this report about systems.

A But it is the questions that are being asked, so I thought that's what you were saying, was around are water systems sterile? Is there evidence of that, etc., so that's how I've taken it.

Q So, I think it's important to explain. No one thinks the water systems are sterile, so the question here is what constitutes a contaminated water system? If there was contamination, how would you see it? That's the question, in essence. There isn't a question, is what we're doing sufficient, adequate, a proper response? That's not the subject of this report.

A No, sorry, but in terms of my point, I wasn't-- I wasn't, as I say, I was perhaps clumsy saying that they were being asked that, but that we were assuring ourselves of what was-- what was a problem in our systems, and then that would allow us to move forward with further action.

Q Okay. Can I show you----

A I get----

Q -- I need to put to you-- or I read to you, but I've been asked to put to you paragraph 3 of the second positioning paper from April 2023, which is bundle 25, document 9, at page 345. This is what I read out to you in a question, but it's been suggested I put this to you directly, so if we zoom into the third paragraph of the executive summary:

"It is the position of NHSGGC that the built environment of the QEUH did not, on a proper reading of the available evidence, expose patients to any increase risk to their health, safety or wellbeing. Further, with the exception of two discrete cases of paediatric infection, there is no evidence before the Inquiry to properly suggest a link between infections suffered and anything arising from the built environment. In particular, there is no evidence to demonstrate any increased rates of infections within the QEUH from micro-organisms related to the built environment. "

Is that still the Board's position.

A So, I think that's an aggregation. I'm not sure that that's the most accurate way to describe those different-- those different elements of expert opinion, but it does align with the elements of the HAD, but it doesn't make reference enough to the Case Note Review and the probability, possibility of the infections as set out in the Case Note Review, which would suggest that there is an issue in relation to infection.

So, I think the clarity of that is to unpack both the elements from the Case Note Review and the elements from the HAD report. I don't think either of them come to a clear-- a clear position and so I think there is a piece around restructuring that because I don't think it's clear enough in the different elements. I don't think anything scientifically has come into a clear end point in a definitive way, and so I think it's much clearer to define the different elements from each of the external pieces that have been put together.

Q All right, I might just ask you a question about communications, quite a long question. I don't know whether you'd accept this premise to it, which is that some of the documented challenges and perceived shortcomings in the relationship with the parents relate to communication strategies, and that's part of an ongoing loss of confidence amongst patients and families, and I wondered what specific steps are you taking to rebuild trust through communication, particularly around transparency, empathy, and responsiveness in engagement with the parents and family

in terms of the way that the communications happen between the Board and its patients and families, particularly in the Schiehallion unit, but also more widely.

A So I think, first of all, there is relearning from the communication, and I think we would be clear that there were opportunities for us to have done better in communicating with the families. I think it's a difficult piece that people tried to communicate in an effective way, but I don't think it was achieved at times. I think information came out before families had been told. Sometimes that is, I think-- sometimes a misfitting of trying to make sure things are fully approved or are fully agreed, but it doesn't really matter what led us to that point.

The communication with the families, there is no argument, was not good enough at that time and there is much learning. We've tried to build in that learning, and that's still part of the People Committee, looking at how our families-- and we've done further work to understand from families and patients how they want us to communicate with them, and we're trying actively at the moment, again, with the new People Committee that's set up through the Board and through the work of the Executive, trying to understand, excuse me, better today what we can do and how

to-- how to change the tone of our communication and the frequency of our communication to let people know what is happening.

Q I suppose the follow-up question would be, given that some of the senior communications, those involved in communications from a senior level in the Board are the same people who were involved in communications in 2018 and 2019 that is the subject of that question. How do you intend to address any learning that's required there?

A So, as an Executive team, we are learning around this. We have done sessions with the Executive and we've had-- and with the Board to talk about our communication approach, so whilst individuals-- there are a number of executives who still are in place. We are a new Executive team formed by the fact that a number of key changes have happened. We've got a different approach, we have a different commitment, and we are together challenging one another in terms of how to go forward in an effective way. We're looking at the different strategies, we've been critical of ourselves to understand and to note where we think we've gone wrong and how we may do better as we go forward.

So, there is live work again, proactively and reactively, and the

Executive having open, honest discussions about this, and for me in direct conversations with my own executives individually, about what I expect of them in this regard.

Q I think my final question is this, it's sort of phrased colloquially to try and sort of get the point across. You've talked a lot about work that's been done this year and what you intend to do and how the Executive and the Board have been learning. It's a big task, 42,000 employees covering probably half the country in some senses. How would you assess the prospects of you succeeding?

A I think we're fully committed and we have a strategy to begin to unpack this. I don't think everything is fixed in a day, but we've set a very clear new route forward. It was quite brave for me even coming straight into an organisation, in honesty and taking on the issues of the HIS review and being out there in a vulnerable space, being open and honest with staff, with absolute humility, listening to their points of view.

So, that is a starting point and that's not ideal in your Month 1, so I've tried though, to be sincere in my approach with my executives. We are absolutely committed and we take time to really understand what it is we're trying to achieve and we're very, very clear on who we're achieving it for, for our patients and for our staff. Our people are absolutely our number one priority. So, I can set the tone.

I think my Executive team are fully supportive of this and they can-- they can amplify that. We are also then aligning with the Board and the Board is very active in this space under the chair of Dr Lesley Thomson KC, and indeed the new non-execs and existing non-execs. They're becoming much more involved in our work and we have, I would suggest, more agile and indeed more challenging discussions around getting it right for people.

So, through all of that, you've got to start somewhere. We've set out a bold pathway. I don't think that it's-- I don't think it's unrealistic, but it will take time to build back from a period that has not been good in the history of NHSGGC, and we want to build back strongly, and we have strong, ambitious plans. I think if we could all just-- sorry.

Q This may be the point where if you want to move into your couple of remarks, that may be something to do now, and I might come back to you, depending on what you say.

A Okay, thank you. So, I think-- I thank you and thank you, my Lord.

THE CHAIR: Please do.

A I want to note the incredibly important role that Scottish Hospitals

Inquiry has in this space in a really difficult landscape, and I'm very grateful for the fact that in that public domain, there is that opportunity for you to be holding in public-- holding us to account; responsible officers and experts, testing the evidence and so on, and letting the public see everything in this-- in this journey. I really appreciate the opportunity to be able to acknowledge the stress and distress for families and for staff, and of course, specifically, the whistleblowers within that staff group.

We are a different organisation in 2025 – I've made that point before; I cannot strongly emphasise that enough – because we are listening, we are learning, and we have the courage to do better, and we are absolutely committed to doing so for the people we serve. We're diligent, we've got humility, and we are not being complacent, and that's why I believe that we will succeed. We provide incredible services for those that we serve.

The things, the clinical things, that are done from GGC are amazing. We provide phenomenal care, and I sincerely hope that this Scottish Hospitals Inquiry can help us as an organisation move forward to help us to build public confidence that we have been scrutinised, and to help our public, our patients and our families to believe that we care – I think more than anything – that we care and that we are attempting to do all we can to build their trust, and that our staff feel that it's a place they want to work and they feel proud and supported to do so. That will take time, and I recognise this isn't all achieved in a moment.

Then finally, in terms of those recommendations that we've touched on before, if it is possible for the Hospital Inquiry to consider, I would absolutely fully echo the points around a national surveillance to ARHAI in an e-system so that they can have that viewpoint across Scotland. Again, potentially noting around the methodology that is required for resolution and restoration, particularly with highly-skilled clinical professionals.

This isn't-- These issues are really deep and significant in Glasgow, but they are not isolated, and we need to do better to resolve and not leave whistleblowers or others without the appropriate support.

And then, finally, I come back to the piece I've said already around, if at all possible, from the Inquiry but if not, then I will try outwith to support then that national standard for reporting from the built environment so that the public can see across the landscape and compare our different organisations but, again, my really sincere thanks for this opportunity.

THE CHAIR: There's a transcript

available, so I will be able to read that text----

A Sorry.

THE CHAIR: -- word for word. Seeking to make a different point, the Inquiry is very interested in every witness who is able to make a suggestion in relation to recommendations, and I'd be quite interested in having your recommendations in a sort of fully articulated form.

A Yes.

THE CHAIR: Now, one mechanism for that is the closing statement which I'm going to invite counsel for Greater Glasgow, together with counsel for all the other core participants, to make. I just wonder if there is another mechanism. I'm quite keen to have your precise recommendations.

MR MACKINTOSH: No, I'm sure that would be-- The way that happens is that we, the Counsel team for the Inquiry, will lodge our submission by the 21st, and then by the Friday before Christmas, as a Christmas present to our colleagues, they will produce their written submissions, and if you could ensure that you have instructed clarity, and I'm sure once you've instructed clarity, clarity will be produced, of clear positions that you think should be taken on board as recommendations, we'll receive those. My Lord, I had one question.

THE CHAIR: Yes.

MR MACKINTOSH: I realised, Professor, that – and now you said what you've just said, it focused it in my mind that I had – in my questions and the questions I received from the room, focused very much on safety and on questions of acknowledgment or apology, but I've realised I've missed something out, and that is the question of patient-centred care.

I think there's a viewpoint, and albeit it's events from '15 to '19, which are well before your time, that perhaps Greater Glasgow and Clyde wasn't sufficiently focused in some respects, not the clinicians, but corporately, in patient-centred care at all times. Is this an area where you're looking at making changes?

A I think patient-centred care is probably every second sentence-- every second sentence in what we're doing today and I've tried, through the description that I've given, to give a greater focus on that piece. We put our people at the very centre and those we serve, that patient-centric element, what they need from us so that we understand that both in clinical and indeed in support terms as they go through their journey.

So, absolutely, it forms part of our strategy and is at the very heart of what we're trying to achieve, to give our people, our patients, a better experience

both in terms of the experience that they have and indeed in terms of the care outcomes that they have. So I'm sorry if I've not been more overt in saying that because actually, it's probably like a stick of rock in me. If you were to open what we are talking about as an organisation today, it sits at the very heart for an executive and indeed at Board level. That is our primary concern.

Q Thank you. My Lord, I might just look at the room because I did merge a number of questions together and I want to just check that my mergers have been broadly successful, and I think I'm being given a grudging acknowledgement by my colleagues, so I have no further questions.

THE CHAIR: Just on this question of patient-centred care so that I fully understand what we're talking about. One might use the expression patient-centred care in an informal way which indicates that it's important to speak to, listen to the patient's view of his or her condition and needs. Am I right in thinking that patient-centred care is also almost a technical matter----

A Yes.

THE CHAIR: -- probably with a history going back to the 1940s in the United States? In other words, it is a formal concept, as no doubt-- as well as it might be an informal concept.

A Yes, and there's been many iterations over the years, but you're trying to consider what the needs holistically of someone are in terms of their direct care needs, in terms of technically, what they are requiring of you to treat them, and then in that-- in that rounded way, that as an organisation, that you're looking after all the components that will hook into their-- into their care to make sure that, again, the conditions for success are there for them as an individual and they are there for those who are caring for them.

So, there's a number of different, almost sort of science and psychological sciences that hook around this, including the Scottish Patient Safety Programme, and indeed the whole concept of psychological safety for both patients and for staff, so-- but at its heart, it's trying to say, "Holistically, what does someone need from this treatment and care episode and how do we best create the environment in order to deliver that?"

And how, importantly, and that's a theme that has come up through this, are we listening to them and to their families to make sure that we are continuing to get it right? Because just like the elements with the staff, these are not static issues and that's the challenge in a human environment. What you need today might not be what you need

tomorrow when your condition has either improved or declined, etc.

THE CHAIR: Thank you. Well, as there are no more questions, that's the end of your evidence and you're free to go, but before you do, can I thank you for your attendance today and the preparation for that attendance, the preparing the witness statement, and the research and reading that has gone behind that? So, you're free to go, but thank you very much.

A My sincere thanks. Thank you.

(<u>The witness withdrew</u>)

THE CHAIR: Now, Mr Mackintosh, tomorrow I think is our final day of oral evidence.

MR MACKINTOSH: And our final witness is Ms Freeman.

THE CHAIR: And the witness will be Ms Freeman.

MR MACKINTOSH: Jeane Freeman, yes.

THE CHAIR: Well, can I wish everyone a pleasant evening, and we'll see each other tomorrow.

(<u>Session ends</u>)

16:43