SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
23 September 2025

Laura Imrie
Malcolm Wright
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CONTENTS

THE CHAIR: Good morning. Now, Mr Mackintosh, our witness this morning is Ms Imrie.

MR MACKINTOSH: Yes, my Lord.

THE CHAIR: Good morning, Ms Imrie.

THE WITNESS: Good morning.

THE CHAIR: I think you're familiar with our procedure. As you understand, you're about to be asked questions by Mr Mackintosh, but, first, you've agreed to take the oath.

THE WITNESS: Yes.

Ms Laura Jane Imrie

Sworn

THE CHAIR: Thank you, Ms Imrie. Now, again, you'll be familiar with this. You're scheduled for this morning. We will take a coffee break at about half past eleven, and, if at any stage you want to take a break, just give me an indication and we'll take a break.

THE WITNESS: Thank you.

THE CHAIR: Now----

MR MACKINTOSH: Thank you, my Lord.

Questioned by Mr Mackintosh

Q Ms Imrie, I wonder if you can give us your full name.

A Laura Jane Imrie.

Q And you're currently clinical lead of NHS Scotland Assure?

A That's right.

Q You gave evidence last year on 6 September. Are you willing to adopt your second supplementary statement as a further part of your evidence?

A I am.

Q Thank you. What I wanted to do first was to start with something that you touch on in your statement. It's about the National Infection Prevention Control Manual.

A Yeah.

Q I discussed this with Ms Dodd last year and I felt it was probably important to revisit some of the aspects. We have a relatively recent addition, and I appreciate it's an evolving document, in bundle 27, volume 4, document 16, page 165. You mention it in your statement, just for context, at paragraph 5, page 188. What I wanted to do was just be clear, which organisation drafts the National Infection Prevention Control Manual?

A NSS ARHAI Scotland.

Q Under what authority do you do that? And why you? Why not somebody else?

A Because we-- ARHAI Scotland are the national body that are given the

remit of putting the National Infection Prevention Control guidance together.

Q Who is the editor, in day-to-day terms, of the manual?

A So, within ARHAI Scotland, we have six priority programmes, one of which is the guidance and evidence, and we have two leads, Susan Dodd and Sofia French, who are both nurse consultants in IPC who oversee the programme, but the manual is done in collaboration with other experts: the boards; Public Health Scotland; anybody-- other national stakeholders.

Q So there's a consultation process?

A It's-- There's a-- Yeah, a very robust consultation process.

Q Does it go through formal editions or is there a regular timetable of updates?

A Yes. It's a real live document, so we have a group of scientists that are running reviews all the time to make sure that there's no emerging evidence that's coming up that contradicts what we have in our guidance, but there's also three-year programme that we do a formal systematic literature review to check each of the chapters.

Q Do you formally consult the other health boards in Scotland as part of that three-year cycle?

A Yes, we have representation

from the boards on our working groups and our oversight group. We have an oversight group that's chaired by Professor Evans, so he's an external chair that reviews the-- the work that's been done within MPGE(?) and it's agreed through those groups how the manuals develop.

Q Does that oversight group have representation from every health board in Scotland?

A It has representation from the networks. So, the way, in Scotland-- because we have so many groups, I mean, we've got six priority programmes and, within them, there might be other groups, we have an Infection Control doctors' network, an Infection Control managers' network, and Infection Control nurses' network. So, the way they set it up is they send representatives for those networks who will then----

Q So, there's one, effectively, manager, one----

A One or two, and then they'll feed back to their networks and bring back any-- any issues or anything they want to discuss, but, at the stage where you get to a final draft or a new chapter or an update of a chapter, the consultation would go out to all boards.

Q And that's a formal consultation?

A That's a formal consultation.

Q So you send out the draft and say, “Comments?”

A And comments, yes.

Q Thank you. If we think about Chapter 3, which I seem to remember is on page 178, what’s the purpose of the reporting system described in Chapter 3?

A So, there’s the commercial purpose, there’s the purpose of supporting the boards, putting all the guidance from the literature reviews around how to do early recognition, investigations and reporting of incidents, and there’s also laying out the expectations within NHS Scotland of what the Scottish Government expect to be reported and clearly defining what we expect to be reported.

Q Now, if you go back to your statement, page 188 of the statement bundle, paragraph 5, you refer halfway down the document, starting on the sixth line:

> “The purpose of this list is to support NHS Board IPC teams to establish and maintain local surveillance/reporting systems, including the development of triggers for clinical areas.”

What do you mean by “triggers”?

A So, Appendix 13, the Alert Organism Conditions, gives a list, but I think it also says there that it’s not exhaustive.

Q So an organisation can create its own triggers?

A The-- Yes, and-- and-- That’s a kind of minimum list, if you like, but I think you need to recognise, within each health board, you have very highly-qualified, skilled and experienced Infection Control people who will know their patient population and the kind of pathogens that they are looking for. I think one of the examples that gives is, you know, cystic fibrosis. That might be unique to a hospital, not even a health board, so they might want to set up triggers that would alert them for that-- that population.

Q So, a hospital that has a major burns unit might have a different trigger list from a district general hospital?

A They-- They might have triggers for wooden swabs for Staph aureus, you know, but you wouldn’t expect that in another surgical ward, or you wouldn’t-- So, it’s-- Triggers-- I think there’s been a lot of discussion about the difference between triggers and criteria for reporting. Triggers are what should alert you to start an investigation. It doesn’t necessarily mean that you have an incident because you have a trigger.

Q So, if we go back to the manual and we to page 178, we see-- so that’s bundle 27, volume 4, page 178.

Yes, we see definitions of “Healthcare Infection Incidents”, “Outbreak”, and “Data Exceedance”. Just to help me and stop me making a category error, whether there is a trigger precedes the question of whether there is a healthcare infection, incident, outbreak, or a data exceedance? You would see “trigger”, then you look at this definition?

A Yes. So, you might set up your triggers and you have-- it comes up as a trigger that you have got two MRSA patients, for instance. Then your local team would go and they would review and say, “Oh, actually, this patient was admitted and positive on admission, and there’s historic records there that they’ve been previously”-- So they’ve got one other patient. That’s not going to be a criteria for reporting into us.

Q Right.

A They would then record on the patient’s notes the investigations they’ve done and the actions they’ve taken. They wouldn’t come----

Q So you might have a infection or infections that trigger the triggers, but they don’t meet any of the definitions in 3.1 and so they don’t get into the reporting process?

A Yeah.

Q Right. Let’s go to section 3.2 on page 178, and something slightly gone distressing-- That’s much better. Now, you mentioned the alert list in Appendix 13, which is mentioned in the first paragraph of 3.2, but it’s 3.2.1 that they wanted to draw out. We discussed it in evidence before, so I won’t revisit it. Once you’ve decided that there is a incident or outbreak or data exceedance in 3.1, do you have to do an assessment under 3.2.1?

A If you’ve-- If you’ve looked at the-- your trigger and you either suspect or are able to confirm that you have an incident----

Q Or an exceedance or an outbreak.

A -- or an exceedance or a criteria, then we would expect you to do a HIIAT assessment that then gives you a green, amber, or red outcome.

Q And since, I think, a date in 2018, a green has to be reported?

A 2016, I think.

Q 2016, my mistake.

A Yeah.

Q Was there a formal letter sent around the 2016 change, or was it just an updated version of Appendix 14, the HIIAT tool?

A From memory, I think there was an HDL that went out to say that all assessment had been----

Q But it’s a long time ago now.

A Yeah.

Q Right. So, Ms Rankin, in her

evidence-- and I'm just going to give the column reference for other people, but I'll put it to you without taking to it: on 3 September, column 66. My recollection is that she said that the manual does not require every infection to be reported. Is that correct?

A That's right.

Q So, just to be clear, how would an infection not get reported through the HIIAT system?

A There's hundreds of infections happening every day in hospital, and it's part of your assessment, as an experienced, skilled Infection Control person, to know whether or not they would meet the criteria and if there's an ongoing risk through the healthcare-- either environment or procedure. Many infections that occur in hospital are from patients' own intrinsic factors. I mean, you've heard about gut translocation and-- and other issues. You wouldn't report an infection that you didn't feel needed-- controlled or managed, that was a kind of individual patient infection.

Q So, just to begin-- This about checking I understand this correctly, because I have learned over the last two years that I didn't at various points. You might identify an infection because of a trigger, or you might just identify it because you identify it. Am I right in thinking the only way it gets into the Appendix 14 process is if it meets the definitions in 3.1, either provisionally or definitely?

A For----

Q So, go back to 3.1, at the middle of this page. So, the only way you have to do a HIIAT is if, provisionally or definitely, you think there is an infection incident, outbreak or data exceedance?

A Yeah, you-- you suspect or you-- you confirm that it is----

Q Now, if you suspect that there is a-- Well, in fact, let's look at something you said last year. This is terribly cruel to quote back at what you said before, but, if we look at your evidence from last year on 6 September, because I'm hoping your transcript is available, looks nervously at my colleague-- and it's column 48. Up a bit-- There we are. One more, thank you. So, I asked you, bottom right-hand corner:

> "The board might make that decision, right. Now-- So, in essence, if a board doesn't think-- doesn't notice a decision, it won't carry out a HIIAT and therefore you won't know?"

And you said:

> "Yeah, there's two ways that we might not know. The board might know about it and they might assess that they don't report it up for

whatever reason that they've assessed or, if their local surveillance systems don't pick it up, then they might not know about it either."

Over the page, and I asked you:

"Because, since April 2016, if a board decides to apply the HIIAT system to the infection, you're going to know about it because, even if it's a green, you're going to know."

And you said:

"That's right."

But I want to go back to the answer that you gave, bottom right-hand corner of the previous page. You seem to be implying that it might be possible to carry out a HIIAT assessment and not report. Is that possible?

A I'm not sure. I mean, we really only know about the ones that are reported to us. I don't know if it's possible that a board have done the assessment and deemed not to require a HIIAT assessment, so they've-- they've done a----

Q So it doesn't meet 3.1, effectively?

A Yeah.

Q I'm sorry to be pedantic about this, but it seems to be a matter of contention, so-- A board might decide that it suspects an outbreak, exceedance, or incident, and it starts a HIIAT assessment. Can it realise during that HIIAT assessment that there isn't an outbreak, incident, or exceedance, and just stop and not report?

A Well, if they realise when they're doing it that there isn't an incident, then it wouldn't meet the criteria for them to report.

Q Right. But if it remains a suspected outbreak, incident, or data exceedance, then the running of the HIIAT assessment in Appendix 14 inevitably results in a report, because the only three options are red, amber, and green?

A Yeah.

Q Are you saying yes?

A Yes. The HIIAT assessment is an ongoing process, so-- I think what's really important is, when you're doing an investigation into a suspected or confirmed outbreak, that you set all your definitions out, because that then allows you to determine if you do have two cases, and it also might mean that you report something in with information that you're still carrying out investigations.

So, for instance, you might report in that you have one confirmed case and two suspected cases and those suspected cases are "probable" or "possible", whatever definition you want to use-- won't be confirmed until you get

laboratory results or until the clinicians looked at a chest X-ray or-- So you can still report things in. The next report you might put in would say, "Actually, we're standing down. The two possible cases have now been excluded" or----

Q So, "We've just got one case, so we don't need"----

A "We've only got one case. We're not reporting that in."

Q I understand. Right. I'm going to move on to the GGC SOP on HAI reporting which emerged out of evidence that Professor Wallace gave. It's in bundle 27, volume 17, document 28, page 315. Yes, and if we go to the top of it, it's called "Infection Prevention & Control Team (IPCT) Incident Management Process Framework". It's described as having an effective-from date of December '23. When did you and your colleagues at ARHAI first learn about this document?

A I think I'd seen reference to it but I didn't understand that it was a document. I think, in response to an enquiry that I'd put to Glasgow, Sandra Devine responded to say, "This is within our governance framework," but I didn't understand at the time that there was, like, a SOP.

Q When was that?

A I think that was maybe in 2023----

Q So, you had some information?

A I had a vague recollection that there was a reference made.

Q Right.

A The first I really-- I've seen the document, I think, was after Professor Wallace gave evidence, if I remember correctly.

Q And then we recovered it from the health board and provided it to NSS. Let's go to your statement, paragraph 9, page 189, where you said in your oral evidence:

> "NHSGGC has developed its own governance structures around carrying out HIIAT assessment and criteria for reporting infection related incidents, which appear not to align with NIPCM reporting."

And you discuss that. Now, what I wanted to understand was-- I know you've taken some comments here, but I'd like to look at it in the document. So we go back to the document, 27, 4-- No, so that's-- We're going back to 27, 17, sorry. Thank you. I think it's paragraph 2.1 that causes you concern. Should we go there? Next page.

A Mm-hmm.

Q Next page. No, one back. So-- Another one back. Here we are, page 317. So, what's the concern that you

have about this part of the framework?

A I think it's the part that says:

"There are normally two potential outcomes to a PAG: ... "

And the first one being:

"No significant risk to public health and/or patients; the PAG stood down, but surveillance continues ..."

Q Can we look at the second one before you explain what's wrong with that? Over the page.

A And then:

"There are some concerns and the situation is assessed using the National Healthcare Infection Incident Assessment Tool (HIIAT) ..."

Q Right. So, if we go back to the first one, what's concerning about that first bullet point at the bottom of page 317?

A So, I think it's very subjective. So, "No significant risk"-- I don't know that there's an assessment that's been done there to say what the significant risk is, and-- I-- I was concerned that extra step that's not within the National Infection Control Manual allows boards to make a decision that there's no significant risk, but there's-- there's no definition or criteria for how that risk has been assessed.

Q What would be the consequence if a board decided there was no significant risk of a particular infection or infections that met the definition of 3.1 of the National Infection Prevention Control Manual and didn't report it to you? What might be the consequences of that?

A From a national point of view, things that might seem insignificant to one board when they're reported in by several boards become significant. So, you might have small numbers or something happening in a board that doesn't look terribly significant, but, if we're seeing the same thing being reported in by several boards-- for instance, a couple of years ago, we seen an ITU, a number of-- small numbers, again, but over three boards, and we spoke to our colleagues in England and it turned out to be a product contamination that they were also seeing. So, by joining up national data, you can put controls in place quite quickly. You're missing some of that intelligence.

Q Might you also have the same thing if clinicians change a treatment practice across multiple boards?

A Yeah. So, in some hospitals, you might have a speciality that's only-- the service might only be delivered in one or two boards. Again, small numbers-- When you've got small numbers in the

patient population, small numbers of infection coming from, you know, two centres or whatever can be significant that might not be significant within one board. I also think, when you introduce separate assessments within boards, then we in ARHAI are not confident that we're measuring the same thing across all the boards.

Q Does that affect the quality of your data?

A Yes.

THE CHAIR: So, when you say "separate assessments", separate criteria for assessment?

A Yes.

THE CHAIR: Right, yes.

MR MACKINTOSH: And worth just checking-- Where does your data go? You mentioned it going to the other boards, but does it go, as it were, up within the system as well?

A So, following the Vale of Leven Inquiry, there was some work done to surveillance, and then, following the Oversight Board for Glasgow, I think one of the recommendations was around people in boards being able to see their data. So, when HIIATs are reported in using our outbreak reporting template, they are all stored on a data set that the boards can then go in and run queries on their own data.

Q So they can look at their own reports?

A Anybody in the board that has been given permissions to can go in, and the theory behind that was, in some big boards, or even in other boards, you might have different chairs of IMTs, and, if you're chairing something with only two cases and they might think that's insignificant, if you can run a query and say, "Well, we've actually had an incident in the same ward," you know, "last year"----

Q Or even in a different hospital than that.

A They will not see anybody outwith their board, it's protected that way that you can only see your own board's data, but it allows people within the board to know if this is a recurrent theme that they might not have been aware of, but the data is all there for them to use.

Q Right.

A They can also run off for every incident an SBAR that they can use for reporting. So we've tried to design it in a way that you put the data in and you can use the data locally as well as nationally.

Q Do you, as ARHAI, also report to the Chief Nursing Officer's Office?

A So, we report all amber and reds that come in to the Chief Nursing Officer's Directorate. We also report any greens that we are providing support to the boards. So, some boards, even if

they've assessed it as green, they will ask for ARHAI to come to the IMTs or might ask for ARHAI to look at their data, and, on occasion, we will report up to the Chief Nursing Officer's Directorate greens where we feel that there's a significant-- if it's a vulnerable population or we feel that the CNOD should-- should know about it.

Q Right. Before we look at the GGC response to your concerns, I want to look at another document. Now, this would appear to be Version 3, or it might be Version 3, of the same document, which the Inquiry downloaded from the GGC website last week. It will be in, I think, either volume 9 of bundle 52, or it may be in a reissued volume 8, but we'll let CPs know. I can put it on the screen. This document has the same title and is described as Version 3 and has an effective date of April '25. Now, can I take it that, when you wrote your statement, you didn't know about this document?

A No, I didn't.

Q When did you learn about this document?

A There was some correspondence between Scottish Government and the chief execs of NSS and GGC----

Q And that's quite recently?

A Quite recently around Cryptococcus, and then the chief execs of NSS and GGC had a meeting to talk through how they could support best working through the issues that Director General had wrote to Glasgow about. And, following on from that, I think Mary Morgan, the chief executive, and NSS shared with me that Glasgow had another document and----

Q So, you weren't told about this by the IPC team in Glasgow?

A No, no. No, I didn't know about it until they've asked to review it.

Q Does it address your concern that you've just described about the first-stage process in the previous Version 2?

A Yes, the-- the section that was from Public Health Scotland's guidance has been removed----

Q Well, let's just look at this version, Version 3.

A -- from Version 3.

Q Because I haven't got Version 4 yet. We might come to it in the moment, but let's concentrate on this version. If we go to this version, on page four of the document-- Let's not contact GGC's website at this point. If we go to page 4, we see a new version of 2.1. Does this version of 2.1 insert anything like an early stage before the operation of the HIIAT assessment?

A No, they're-- they're talking about the investigations you would do if you had a trigger and an alert first, and then moving on to----

Q And, at the bottom of the page, where it says:

> "A Problem Assessment Group might be called if the situation requires further discussion, or an opinion of other teams as required."

Have I misunderstood if previously I've thought that having a PAG means you've already decided that there's a potential----

A Not necessarily. I mean, you might have, like, a PAG, and a PAG can sometimes be a very small group of people that----

Q So, a PAG might not involve a recognition of an outbreak, incident, or exceedance at the stage it's called?

A No. You might ask for a PAG so you-- An Infection Control team might have had a trigger, went and seen, and then wanted more input from either the patient's clinician or others just to do that full assessment.

Q So, the second paragraph on page 5:

> "If a PAG is held the IPCT ag is held, the IPC team will complete an NHS GGC IPC Situation Assessment Summary Document (Appendix 1). If an incident is suspected or declared, the situation will be assessed using the National Healthcare Infection Incident Assessment Tool (HIIAT)."

So, is that effectively a change on the previous Version 2?

A Yes.

Q And if we look at 2.2, what's this concern you were about to tell me about reference to Public Health Scotland publications?

A No, I'm saying the difference between Version 3, which you've got on the screen, and Version 2 that I had commented in my statement, is that-- that part from the Public Scotland guidance has been removed where----

Q Oh, that pre stage?

A Yes, where you would do your assessment.

Q Right. So, conscious that this Inquiry has been taking an interest in this topic, let's look at Ms Devine's responses. If we go to her supplementary witness statement of 19 August, page 13, she states-- So, it should be in the statement bundle for Ms Devine, and it should be on page 13-- Paragraph 1. It's not page 13. Go back-- No, that's Jane Grant. We need Ms Devine's statement in that week. So that's not in here, it's in a different bundle. I'll check which one it is. (After a pause) I don't think it's 3. No. (After a pause) I'll come back to that.

What I wanted to do was to-- Do you understand that there's been a

suggestion that, in Version 2, the Public Health Scotland guidance on the management of public health incident-- guidance on the roles and responsibilities of NHS Incident Management teams has some relevance to this work on the reporting of HIIAT?

A So, the ARHAI Guidance team and the Public Health Scotland Guidance team work very closely together; we both sit in each other's guidance groups. Both documents lay out the general principles for investigating infection incidents, but they both clearly point to the relevant parts, depending on where the incident is.

So, the Public Health Scotland document is a supporting reference, if you like, in the Chapter 3 of the National Infection Control Manual, but Chapter 3 of the National Infection Control Manual has its own systematic literature review that informs what's in Chapter 3, including the assessment, and the literature review has been done to answer questions around effective management of healthcare incidents, not wider population health incidents.

Q If we now have Ms Devine's statement, we'll put it on the screen.

THE CHAIR: Mr Mackintosh, just so that I'm keeping up-- It's my fault, Ms Imrie----

MR MACKINTOSH: So, that's the-- --

THE CHAIR: When you're talking about the PHS, the Public Health Scotland document, remind me of which document we're talking about?

A It is the-- I'm looking for the name. It is the Public Health Scotland "Management of public health incidents: guidance on the roles and responsibilities".

THE CHAIR: Right. Thank you.

MR MACKINTOSH: My Lord, it's bundle 27, volume 14, document 18 – I'm not going to go there – page 113.

THE CHAIR: Thank you.

MR MACKINTOSH: We have Ms Devine's statement now, so, for completeness, it's in volume 3 of the Glasgow IV Part 2 hearing bundle, which is the week of 19 August, and it's Statement 2, and we're going to page 13. Taking this slightly in the wrong order, I take it you've read this statement?

A Yes.

Q And you've responded to the suggestion within this statement that, to some degree, the Public Health Scotland guidance should be used to interpret Chapter 3 of the manual?

A No.

Q No?

A I-- I think they're-- they're supporting documents, and the-- the Public Health Scotland guidance refers throughout to Chapter 3 of the National

Infection Control Manual. What I was saying is they have both got the general principles for good incident management, but Chapter 3 is supported by a systematic literature review that-- that examines healthcare.

Q Because the Public Health one is for wider public----

A It's for-- It's for, you know, population health, it's-- Normally, it's your Health Protection teams that will be looking into Legionella, foodborne illness, in the general population. So, in Public Health, you don't always have the links to a place, whereas, when you're looking at incidents in a hospital, then you have a link to a place.

Q Now, there's also, in paragraph 2 of this statement by Ms Devine, a reference to the environmental pathogens surveillance pilot that ARHAI Scotland ran, which we have in bundle 44, volume 2, document 47, page 79. I won't go to it. In this section, Ms Devine appears to have noted that, in the pilot, 60 triggers were identified between January and August 2024, but there are only 14 outbreak tool reporting submissions. Why might there be fewer submissions and triggers in this pilot?

A I think Ms Devine has misinterpreted the report. I think, later in the paragraph, it does go on to describe that the triggers were not mutually exclusive. So, it was a pilot, and the main objective of the pilot is to explore if the triggers that are being suggested work in practice or if they're oversensitive, but you might have-- and two of the centres, I think, looked at NICU. You might have a Serratia case in NICU that-- that could end up triggering three or four times depending on the time period you've put on for your trigger, if your triggers include just Serratia or if you've got a trigger for wider gram-negative bacteraemia. So they're not mutually exclusive, the case and the trigger.

Q So a case could trigger multiple triggers?

A Yes.

Q But, also, a trigger could be triggered and it still wouldn't meet the definition of 3.1 of----

A Yes.

Q Okay, right. In any event, however, in this new document-- well, it's not new, the new-to-us document, the Version 3, which is not yet in a bundle-- In April '25, GGC changed their policy.

A Yes.

Q Now, had you known about this, Version 3, would you have been content with what it said back in April?

A Yes. I've now, through a small group that's meeting, we-- I've reviewed the document for Glasgow and I've sent--

sent back comments and said that this now is aligned with Chapter 3.

Q So there's a proposal for a Version 4?

A Yes, I think it'll be a Version 4, yes. I think they've-- they've taken on board the comments and it'll be going back through their governance sign-off.

Q Are they of the same order of significance as your concern that you had about the first initial assessment level in the Version 2?

A No. To be honest, my comments were really about the hierarchy of the-- the documents that they're referencing, given that it's a healthcare incident management process framework, that-- it was just really some feedback around how-- how----

Q It's that sort of area?

A -- how they position it.

Q But the fundamental process that the Board were using, or policy was, since April '25 was incompliant with NIPCM?

A Yes.

Q You just didn't-- ARHAI didn't know?

A I-- We-- I didn't know they had changed to Version 3.

Q Are boards under any obligation to provide-- I mean, there are not many boards boards-- I mean, holding a meeting of them must be

difficult because there's enough to make a meeting full, but are boards are required to provide these sort of policies to ARHAI so that, for example, when your nurse consultants go to assist, they can metaphorically take off the shelf the folder of the policies for the board they're going to help and understand the context?

A They're not under any obligation to share. I don't think there's many boards that have separate guidance. Prior to 2012, each board had their own Infection Control manual which was seen as being problematic because they were all doing something different.

Q From your awareness, how many other boards have their own SOP or something similar in the broad territory of this document?

A It's never come up before. I've never, you know----

Q Right. But, if they do, they don't have to tell you?

A They don't have to tell us, and a lot of the-- a lot of the guidance is maybe to support some of their internal communications as well. Like, Glasgow obviously keep a record through an incident summary form, and they're wanting to put that in an SOP so that staff can find it and know where it is. But a lot of them are on intranets and things like that that you-- you wouldn't find even if you looked for them----

Q A lot of them contain email addresses of the relevant people and who to invite and those sort of rules.

A Yeah, yeah. Yeah.

Q Obviously, we've discussed with ARHAI nurse consultants them attending a large number of IMTs in Glasgow, and presumably you must attend large amount of IMTs across the country in a year. To what extent would it assist your nurse consultants to be more effective and more helpful if they had access to this sort of documentation, if it exists?

A When we're supporting IMTs, we're working on the national guidance and the principles around the national guidance. I think, if something came out through an IMT that we thought was misaligned, then we might ask to see documents. I would say boards in general are quite open about sharing, do you know, the-- what the framework is, if they're making decisions. But all information is helpful when you're supporting the board.

Q Well, if we go back to Ms Devine's statement, I want to put one more thing to you, which is paragraph 4 of it. Ms Devine says:

> "While reporting all triggers may benefit national intelligence ..."

Do you want people to report all triggers?

A No.

Q No:

> "... it risks undermining the clinical judgment of board IPCTs, whose key role is to investigate and escalate issues that need further local action. Reporting all triggers would place an additional reporting burden on teams, without any benefit to patients."

But you're not suggesting that you report all triggers?

A No, no.

Q "Additionally, conducting a HIIAT assessment for all triggers ..."

Is that what you're suggesting?

A No.

Q "... would require a multidisciplinary team meeting to review patient and clinical confirmation, temporarily removing frontline clinical staff from their duties. "

Does carrying out a HIIAT assessment require, in the manual, a multidisciplinary team meeting?

A No.

Q Can it be done by one ICD?

A Yes.

Q Can it be done by one ICN?

A Yes.

Q Right. I mean, I'm not sure,

given we now know what you're saying, the next sentence really stands up, but we should put it to you: to what extent does causing work to health boards by making them report things have the potential to compromise patient safety?

A Well, I think if you were asking health boards to report every trigger, then they would spend much of the day reporting triggers. If you're asking them to report through criteria that's set, I-- I don't believe that it's without any benefit to patients. I mean, it's part of your monitoring and surveillance which is a fundamental of infection prevention and control. Unless you understand and can measure, you can't improve.

Q Thank you. If we go back to your statement, page 191, you discuss, at paragraph 13 at the bottom of the page-- If we can zoom down, it'd be great:

> "The Scottish government has been leading on the development of an outline business case for a national IPC e-surveillance solution. This was completed in April 2025. It is intended that this system will have local and national functionality."

Now, will this e-surveillance solution fundamentally change the way that Chapter 3 of the manual and the HIIAT tool works, or would it just be a system under which it operates?

A So, I'm very clear that it's just at the developing in business stage, and I don't know that there's a commitment from funds, so-- But if I'm to be optimist, then we have the national functionality being considered as well, so, if you were developing it-- a new system for the boards, then, if you like, there could be national triggers built into that system as well.

Q So this would be a system that the boards would use for their own business and you would use as well, and there would effectively be multiple ports of entry to the data?

A Yes.

Q But would it change fundamentally – and I know we're lawyers and you're not – the rules in Chapter 3 of the manual about when you have to carry out a HIIAT assessment and when you report? Would that change under this process?

A I-- I wouldn't like to commit to saying yes or no. I-- I think it'd be a discussion that they would have to have once they knew what the functionality of the system was.

Q But, at the very least, it would involve boards inputting data into that system before they had decided it was necessary to report?

A Yes, yes. If you're talking about incidents and outbreaks, you would

still need a local to do an assessment because all the electronic system would do is give you a trigger.

Q So, effectively, you would-- There's a stage in Appendix 14 HIIAT where you effectively fill in a form and then you decide to use the online reporting tool.

A Yes.

Q And this would just bring the online system forward into the point before the board has decided to report?

A Yes. They would-- They would need to make that full assessment, if you like, before they-- they completed that report in any template.

Q Okay. Can I put this issue to one side and turn to concerns about Cryptococcus reporting? So, if we can go back to your statement again, page 193, you discuss-- Well, it starts at page 192, actually. No, actually it is 193, sorry. Paragraph 20. The Inquiry asked you on 9 May:

> "Are you able to assist the inquiry about whether an issue has arisen this year about NHS GGC failing to respond promptly to a request from the ARHAI to produce material about suspected Cryptococcus cases. Did you have to raise an issue about such a request with anyone at NHS GGC? Please set out the background to the request, the material sought and any issues that arose in obtaining the material from NHS GGC?"

So, the next paragraph makes a reference to an email from Mr Urquhart, policy lead, Scottish Government. Would he be in the CNO's HAI unit?

A Yes.

Q Right:

> "... inquiring whether the ARHAI Scotland team was aware of [over the page] NHSGGC reporting additional Cryptococcus cases. "

And he makes reference to evidence in the Inquiry. Now, what I wanted to do was check we have seen something, which is the explanation given to the Inquiry for not reporting. That is in an email which I think we've redacted to remove the name of the relevant solicitor, or I certainly hope so; bundle 52, volume 5, document 24, page 111. We have. So, this was the document, Ms Imrie, that I read extracts of to Dr Mumford and Ms Dempster. Had you seen it until it got put in your document list?

A I don't think I'd seen it before it was put in the list.

Q Right, but you'd read the transcript of the evidence?

A Yes.

Q Right. Did you obtain an

explanation directly from GGC on 21 November? Bundle 52, volume 4, document 9, page 77.

A Yes. So, following Mr Urquhart inquiring whether we had received any reports for the four cases that were referred to by Dr Mumford, we confirmed we hadn't. I emailed Glasgow and they came back to tell us they had seven cases within the time period that we'd asked them about.

Q Seven cases?

A Yeah.

Q And that runs back to 2020?

A It was-- Yeah, 2020 was when I----

Q At that point, how many of those cases were you aware of?

A One.

Q One. After that, was there a request for a national investigation or decision to carry out a national investigation?

A I think, after Glasgow confirmed that they had seven cases from 2020 to 2025, I had another meeting with the-- the Policy unit where I advised that we should look across Scotland, because Glasgow had seven, it might just be that other boards had similar numbers that weren't being reported in and we had a national, kind of, issue. So, it was agreed that we would look firstly at the Electronic Reporting Laboratory System, and then, once we realised we didn't have robust data in there for Cryptococcus, we went out to the Scottish Microbiology and Biology network to ask them to confirm the cases that had been isolated in their laboratories over that period.

Q When did you obtain sufficient information from NHSGGC in order to answer that question?

A There was-- Some emails went back and forward. I think we go to December, 10 December.

Q What information did you get in December? Well, let's look at your statement. So, we go on page 195, page 25, you make reference to a pro forma being issued on 27 November.

A That's right.

Q And a response to GGC, which is bundle 52, volume 4, document 10, page 80, on the 28th. So, if we go on to the next page, we have an email from Dr Bal asking whether ARHAI has obtained Caldicott approval. What's "Caldicott approval"?

A So, Fiona Mackenzie, who was our contact in SMBN, agreed to send it out to all the board leads. Dr Bal was in GGC, and I think he was putting the email back to Fiona to say, "Does this need Caldicott approval? Please can you ask the other boards?" So, I'm not sure what Dr Bal-- I think what Dr Bal was saying

was that there was patient identifiable information and that it did need Caldicott approval, but that would be done at board level.

Q But eventually you did get information back from the Board that contained patient identifying information?

A Yes.

Q If you go back to your statement, paragraph 27, you mention receiving anonymous and de-duplicated data by 10 December.

A I think we got that on 6 December, and then I contacted----

Q But what's wrong with the data you received in December? Was it good enough to carry out the work?

A No, because we had already received quite a lot of the other boards' data and we'd started doing analysis, and, when you give anonymised data, we are unable then to de-dupe, to do our national-- And what we found in some of the boards was that two boards were reporting the same patient.

Q Because they might be transferred across----

A Yeah, because of the way, you know, networks work across NHS Scotland, you might have a patient that was attending another hospital and they've also taken a sample. So, with anonymised data, we wouldn't know that then what we were reporting was correct.

Q So, did you then request non-anonymised data?

A Yes. I think I went through the NSS medical director.

Q We might see that in paragraph 29 of your statement, you-- there was correspondence between both medical directors out of ARHAI and GGC.

A So, that's relating to the second request that we went back to.

Q Oh, right. Okay.

A So, we'd done-- we'd done a national request that had come back at the end of November where we done a-- an assessment of what all the boards gave us back, and then, following on from that, there was two boards that were followed up for more in-depth----

Q And one of those is GGC?

A And one of them is GGC.

And that follow up, did that produce data?

That gave us more data----

Q Was it sufficient data to carry out the exercise?

A We looked at patient risk factors-- So, once we had done the national analysis, what we were looking for there was a link to time and place.

Q So you need to know which ward they were in, their background, their treatments, those sorts of things?

A Yes. Well, we didn't know that in the first national one. We-- We'd done

a screening, if you like. So, most of the boards reported single cases, or there were cases that were spread out for years and we didn't follow them up, but, once these two boards-- we asked for more information about the clinical-- like, the risk factors and where they'd been----

Q So, just to make sure I understand, the first response that comes in December is anonymised, so it's not usable, you can't deduplicate it?

A From Glasgow.

Q From Glasgow. Is that right?

A Yeah.

Q Yes. Then a second response comes----

A On 10 December they give us the----

Q And that comes with-- it's no longer anonymised?

A Yes.

Q Right. I wasn't clear from your statement. You then carry out the national exercise, and that prompts you, then, to look in greater detail at two of the boards?

A Yes.

Q One of which is Glasgow?

A Correct.

Q And then you need to recover more data for the Glasgow and the other board, because you now need where they were, when they were admitted, what treatment they were on, that sort of

stuff?

A That's right.

Q Yes. Underlying health conditions, presumably?

A Yes.

Q Yes. Whether they have a connection to any of the traditional Cryptococcus risk groups, that sort of thing?

A Yes.

Q Yes. Right. When did you get that information? Because, I mean, I'm reading these two paragraphs as you hadn't had it by the time you finished this statement.

A No, I-- I think, actually, my statement went in on 17 April----

Q Well, let's look at the email that you refer to in paragraph 30. So, it's bundle 52, volume 4, document 21, page 127. So, it's an email from Dr Davidson, who was then medical director for Glasgow, which explains what about when the information will finally arrive in April?

A So, as-- as I said earlier, the NSS medical director is also a Caldicott guardian, Sharon Hilton-Christie, and we had involved there-- and she started communicating back with Scott Davidson, the medical----

Q Let's go to the previous page, 126. It might have what you need. No, go 128. So, effectively, when you finish

your statement, the matter is with Dr Davidson?

A Yes.

Q Because Dr Hilton-Christie has been in touch with him directly?

A Yes.

Q And that's what these email threads are?

A Yeah.

Q So, at that point, you haven't got the data you need, but then-- Now, could it be that, eventually, you get it on 20 July this year? And I see that from a letter that we're going to look at in a moment. I'll take you to that letter. So, we have a letter from the DG Health and Social Care to Professor Gardner of 20 August, which is bundle 52, volume 5, document 31, page 144. So, have you seen this letter before, is the first question.

A Yes.

Q Right. There's a narrative paragraph, the large paragraph second from the bottom, "In order to gain a national picture..." That one?

A Yes.

Q Do you see at the bottom, last three lines:

> "Following a letter prompting a response to ARHAI's request from the CNO to Angela Wallace on 15 April 2025, all of the information was received from NHSGGC on 20 July 2025."

So, do you eventually receive all the information you receive on 20 July 2025?

A Yes.

Q Now, at this stage – nice, easy question – is that an acceptable period of time for it to take?

A I-- I was quite surprised at the length of time it took.

Q For what reason?

A Well, Glasgow had intimated that they had done an assessment and they weren't required to report in, so, having done an assessment, as they responded in November, I thought that, when we asked for the information, it would be quite quickly provided.

Q Have you ever seen their assessment that they say they did?

A So, the latest request for information came from Scottish Government to Glasgow to provide ARHAI with further information, and they have provided a case-by-case if they felt that it met the criteria for reporting.

Q But was that one done in May or one done in November?

A No, I think it was done just in the last month.

Q Right. Have you ever seen a written assessment document from November/December 2024?

A No.

Q No. Can I just, because I'm-- Although I think it probably deserves to be clarified, do you see, at the foot of this letter from Ms Lamb, the DG----

A Yes.

Q It says:

> "ARHAI's assessment has identified an area of the QEUH retained estate with Cryptococcus cases potentially linked in time and place."

Is that accurate?

A So, there was an error in the word "retained estate". There were cases across the retained estate and the-- the new build. The assessment that we highlighted was----

Q That's ARHAI's assessment?

A -- ARHAI's assessment, was actually a potential cluster in the new build, so we've-- we've clarified that with Scottish Government and----

Q Can you help us? Because----

A Sorry?

Q -- we're to some degree interested. Which floor?

A It-- It was within the renal specialty. So, renal patients have journeys through-- there might be different wards or dialysis units, so----

Q So you can't be precise about which----

A I couldn't say definitely.

Q Right. Now, following this letter, there's a reply, and the reply is volume 5, bundle 52, document 32-- I think it's page 146. Yes. Now, before we look at the substance of the reply, can I ask you to look at the attached SBAR to-- not the next page, to page 150. It starts at 148, actually. So, my Lord, this is an----

THE CHAIR: My fault, Mr Mackintosh. Could you give me the bundle reference for the letter?

MR MACKINTOSH: So, there's a letter of 26 August 2025 from Professor Gardner to the DG Health and Social Care, bundle 52, volume 5, document 32, page 146. Attached to it is this SBAR, Appendix 1, which is at page 148 of the same bundle. (To the witness) Now, when did you see this SBAR, Ms Imrie?

A Julie Critchley, my director, was copied into that letter and she shared it with me.

Q But it appears to be dated 20 November 2024.

A I've never seen the-- the SBAR. I've only seen it when it came as an attachment to----

Q No, I appreciate that, but we're just trying to place it in time. Do you see that it has a date produced in November?

A Yes, yes.

Q If we go on to page 150 in the "Assessment" section-- Have you had

the opportunity of reading the "Assessment" section?

A Yes.

Q How do you respond to the suggestion that you and your colleagues in ARHAI are trying to sensationalise the fact that there are cases of Cryptococcus?

A I-- I don't believe that anybody in ARHAI has ever tried to sensationalise anything to do with Cryptococcus or another infection.

Q Why do you say that?

A Well, it says that-- you know, that it's biased by our personal beliefs and interests. ARHAI act on the behalf of the CNO Directorate responding to evidence that came up from an expert witness, and our role and remit is to investigate where we think there could be increased incidents of infection and explore what controls have been put in place for patient safety.

Q Now, if we go back to the letter on page 146, do we see, second paragraph:

> "It is recognised that the QEUH, Scotland's largest hospital, hosts many specialised units, including renal inpatient and transplant units, adult and paediatric bone marrow transplant, haematology/oncology and infectious diseases, which includes patients with HIV. The occurrences of sporadic Cryptococcus sp. cases within the specific patient cohorts on this campus are expected although occur infrequently."

What view do you have of that final sentence of whether it's relevant or indeed accurate or valid? I'm not sure which you would want to comment on.

A So, I-- I think that's correct, that occurrences of sporadic cases within some patient populations are expected, but expected infrequently, is correct.

Q If we think about renal patients, what's your knowledge of whether anyone's done any work in the past about the frequency of Cryptococcus cases in renal patients from 2009 to 2018? Have you seen Dr Kennedy's report? Which is bundle 24, volume 3, page 19. (After a pause) So, we go back three pages-- two pages forward. Yes. We have review of Cryptococcus cases produced by Dr Kennedy, although, to be fair, I don't think he spoke to this because it emerged after he gave evidence. Then, since it's a review, the chart on page 19 might be of assistance. Does this report how many renal patients there were in the Glasgow area who had a Cryptococcus diagnosis.

A So, there's no renal patients.

Q And so, if we go back to the letter from Professor Gardner, if you have a infection like Cryptococcus, can it ever be said that an infection in an individual patient is expected? Because, "There will be lots of patients, very few infections, but eventually you'll get one," is a reason not to be concerned to report?

A So, an individual patient would be a trigger that you might, you know----

Q And you don't have to report all triggers?

A You don't have to report all triggers-- that you would go and investigate, and part of your investigation would be a look-back exercise to see if you'd had any other cases, if there's-- if they have known risk factors, you might want to do a rapid review of the literature to understand better. You would be looking at if the patient spent a lot of time in hospital, if they're immunosuppressed. You might have a conversation with the-- the consultant looking after their care, maybe consider the patient group they're in. That would be a trigger, although you could report it in, and, in fact, of the seven cases that Glasgow reported, there was a single case that they reported in. That was, I think, later then felt to be a false positive.

Q Could that have been a case in 2020?

A Yes. So, I think, when you have that single case, that's fine. If you have another case in the same specialty within a year, and you've not seen any in the previous decade, then you might then want to do a wee bit more investigation.

Q Without wishing to sensationalise matters, if you do have more than one Cryptococcus case in a renal specialty in a year, for example, for what reasons might you think that was worth reporting?

A So, this-- this goes back to the point of the role and remit of a national service as well. You-- You might have one or two that you might do your own investigations and think that they have their own risk factors and you don't want to report it in, but, if two other boards have reported one or two in in the same specialty, that-- that might trigger something nationally that we might want to have a conversation with the renal physicians – and I'm using renal as an example – to find out if there is new treatments, new immunosuppressants that might be making these patients more vulnerable, they might want to consider prophylaxis in certain groups-- So, it's-- You're not reporting in all the time to say, "We have an issue in this site." A lot of the time you're reporting an-- an unusual pattern of infections that you feel should be investigated further.

Q Given that it's the ARHAI

assessment that there is a potential cluster in the new building that might be associated with renal, what would you expect GGC IPCT to have done with that information when it originally had it?

THE CHAIR: Sorry, when they-- they had----

MR MACKINTOSH: To have done with the knowledge of the infections when they originally had them?

A So, I must say, you know, our final kind of report is in draft form, and-- and we will have a final report that will go-- go out. I think it's very difficult----

Q When you say "go out", where will it go to?

A Well, it will go to the Scottish Government and to Glasgow.

Q Right.

A I think it's very difficult for me to understand because I-- I don't know what investigations were done. I think what's come back is that they didn't meet the criteria for reporting, but I don't know how that conclusion was reached.

Q Because you haven't seen the document from November/December that you assume would exist?

A Yes, I haven't seen any of that.

Q Just to be-- I think we can do this. Thinking about the reporting steps-- So, you've explained to me that a Cryptococcus case in this group of patients or this hospital, or, in fact, anywhere really would be a trigger. Have I got that right?

A Yeah.

Q So any Cryptococcus is a trigger.

A Yes.

Q You don't have to report a trigger?

A No.

Q No. There clearly is a disagreement between yourselves and the GGC IPC team about whether there's a cluster.

A Yes.

Q Yes. From your perspective, how confident are you that one of the definitions in Chapter 3.1 of the NIPCM is met?

A I could-- In this instance, I think it meets more than one criteria.

Q Right. Which ones does it meet? If we go back to it, just to help us, put it on the screen-- So, that's bundle 27, volume 4, page 178. Can we zoom into that part of the page, please, 3.1? So, which ones does it meet now?

A So, we have, firstly, an exceptional episode which talks about severe outcomes. Invasive Cryptococcus in transplant patients has a mortality rate of over 50 per cent according to the published literature, so, in this patient group, that-- it might be an exceptional infection episode where you want to

report something and that might have severe outcome for the patient.

Q Even if it's just one case?

A Even if it's one. Depending, again, on the-- the assessment you've done of the patient and their condition, it might not be invasive. A healthcare infection exposure-- by the time you have two in twelve months, I think you would be considering, as a hypothesis-- one of your hypotheses, that you've had a healthcare exposure, especially in a patient population that require a lot of healthcare. So, I think it's important to say as well, when you're investigating, you can have many hypotheses; because you put one down as a hypothesis, doesn't mean that, you know-- until you investigate properly.

Q No, we're familiar from reading Professor Hood's report that he investigated a wide range of hypotheses, and indeed Mr Bennett has suggested other ones.

A Yes. Yes. a healthcare infection data exceedance-- well, I think that was helpful, to see Dr Kennedy's report again. Three cases in one specialty within 15 months is a greater than expected rate of infection, and a healthcare infection incidence should be suspected of a single case of an infection to which there's previously no cases in the facility seen. So, I could fit it into a few of the criteria.

Q All four, okay. What I wanted to do, just before the coffee break, was to think forward, because one of those things the Inquiry has to do is to think about recommendations, and I've already, for example, asked you about the value of ARHAI knowing local policies as a sort of formal reporting mechanism, and you've told me about the possible electronic national system that you're pursuing as an idea.

A Yeah.

Q What's your view on mandatory reporting being extended to those organisms that may – and I emphasise "may" – have a ventilation-related environmental source, such as Aspergillus and Cryptococcus?

A So, both are alert organisms already. I think the key point there is "mandatory". So, the National Infection Prevention Control Manual has guidance. There is the HDLs that support that guidance from Scottish----

Q Well, I'll rewind my question then. In Appendix 13, you have a list of reports that you must make.

A Yes.

Q So, by "mandatory", I mean adding to the list in Appendix 13. So, perhaps if you could start again based on me rewording my question.

A So, in 2024, we actually

published Chapter 4 in the National Infection Control Manual, which is dedicated to the built environment, which is added to the list of alert organisms. There's a section on water at the moment, and we're currently in-- the systematic literature review for ventilation in healthcare in relation to IPC is currently being carried out in collaboration with the boards. So we are actively looking to expand the National Infection Control Manual to take account of water and ventilation.

Q So, if we stay with ventilation, does it already include Aspergillus?

A Yes.

Q Right, and does it already include Cryptococcus?

A Yes.

Q Right, and, when it comes to water, since we're here, does it include Cupriavidus?

A Yes, I think so. I-- I can confirm that for you. It's added in more pathogens, but also more guidance about how you would investigate something that you suspect----

Q "Has an environmental source"? Is that where you're going?

A Yes.

Q Because you sort of piece it out there.

A Sorry, yes. For-- For water, as I've said, we've completed that

literature review and the guidance is there, and the ventilation is in progress.

Q Right. Do you think ARHAI should have the ability to require to be given board-level data on things like numbers of infections, water sampling of water systems in hospitals, to-- not individual patient records, but aggregate data sets of how many out-of-specification water samples they've recovered, or how many infections of a particular sort across the whole health board in a particular period of time? Do you think ARHAI should be able to require health boards to produce that sort of material?

A I think there should be systems within boards that they have governance around that and they-- they can produce it if asked.

Q But do you think they should be able to say no?

A I don't think I've-- We-- We support many IMTs where we ask for water results and-- and we support the boards. I-- I don't think a board has ever said no.

Q Whilst I'm sure you know that, the reality that it took an issue arising in a public inquiry and then six months of correspondence to produce the data that you ultimately required on Cryptococcus, does that not raise the question of whether ARHAI needs greater power to

say, “We want it, you must give it”? Or is that an attack on the sort of principles of ARHAI and how it works?

A Yeah. ARHAI functions very well as a support to boards, and I think we have very senior Infection Control doctors, nurses, managers in all our boards that-- I like to think that ARHAI works collaboration with to provide Scotland with an Infection Control service. I think, if we had to turn ARHAI into a scrutiny organisation, you would lose that support. I don’t-- I don’t know that boards would be so keen to maybe phone and ask for you to sit in their-- the IMT where they’re working through issues, or-- or phone for advice. So, I think you might gain one thing on one hand and lose something on the other hand.

Q Right. Do you think ARHAI should be able to run national surveillance on environmental bloodstream infections? I suppose that’s the same question. Should you be able to run a surveillance programme where boards have to report all bloodstream infections-- samples of a particular organism?

A So-- So, that’s part of the pilot that we’ve been running in some of the high-risk units.

Q Is that the pilot that Ms Devine was referring to?

A Yes. So, looking at the-- the highest risk patient population, we’re concentrated on NICU and ITU units to gain an understanding of the kind of background, what the pathogens are, and-- So, those-- those pilots have been running, and that might lead to a national surveillance programme.

Q What advantages would that have?

A I think, if you have a national surveillance programme within these, you can set your definitions and your criteria and your methods and everything, and you maybe wouldn’t get into the situation that-- that we were in with Ward 2A and 2B where many different people have taken the data and ran it slightly different ways and came up with different figures when they’ve compared units against units, and you would have a better understanding if you’re comparing similar patient populations, and it-- it would give you an overall burden on the-- the high-risk patient population.

Q So, just to help me understand, might that involve, for example, “We’re going to look at all adult patients who might, in their patient journey, be neutropenic, in all hospitals, all units that do that sort of thing, and we’re going to look at a particular range of organisms and we’re going to just measure that continuously”? Is that

roughly what you have in mind as a broad concept? That's one example, but----

A As a concept, yeah. ARHAI run the kind of-- the national surveillance for Staph aureus bacteraemia and E. coli and things like that, and, because there is a definition set, we're quite confident that we can monitor over time and-- and look trends in five years and-- and I've been able to put improvements plans in there as we discussed, I think, the last time, about, "Your gram-positives need different improvements from your gram-negatives," I think.

The high-risk areas, you're concentrating on them, they might be slightly different from a NICU department to an adult intensive care, and that's part of what the pilot's looking at. I think that some of the difficulty is, when boards are maybe investigating an outbreak in a NICU and they want to compare their data against another NICU, they then find that they have a different patient population, they have different screening programmes. So, if you're looking more for pathogens, then you might find more, but that doesn't necessarily mean that you're worse in the performance than another unit.

And it's why we try and encourage boards that, if they're comparing themselves, compare yourself against yourself because, over time, if you've got

enough data points, you will see if there's an improvement or not. You're taking away all the variables from patient populations, therapeutics, things like that, and, if you have a surveillance-- It's not necessarily around nationally putting together league tables comparing one high-risk unit with another. It's about giving them the support that they can monitor robustly what's happening in their unit and then they're able to spot if there's something that they need to put interventions in.

Q One of the things that I think there was some evidence about in Glasgow III is that the current national surveillance ones, such as E. coli, have been running for a long time and, in a sense, (a) they're not controversial and (b) sadly, they're not that rare. But if you're running a surveillance programme for gram-negative bacteria, I presume you'd have to have a list----

A Mm-hmm.

Q -- and that list might be controversial, and also one would hope that, a lot of the time, the number of cases is quite low. So, is there a risk that you're actually creating a bureaucracy that imposes a cost, perhaps in the way that Ms Devine has mentioned in her statement, that takes clinicians away from actually doing their job?

A So, I think that's what the

pilot's intended, you know, it's designed to look at, "When are your triggers too sensitive? Are you going to set off more reports and IMTs that are not required?" But all the national programmes are based on evidence, so evidence that it is something that's causing harm, it's something that we can put improvements in. We don't carry out surveillance on pathogens that are community-acquired or aren't related to healthcare or don't have an impact for the patient or the system. So, that would all be built in to implement in any surveillance, so we're quite far away from that at the moment.

Q Thank you. My Lord, we're about to have the coffee break, but I thought I should mention, mainly for the benefit of CPs, that I'm going to put to Ms Imrie a document that I know she's being given notice of, because I mentioned it to counsel for NSS, but of course the rest of the room doesn't know that they need to have it. So, it's the November 2024 SBAR on environmental testing, and I've been asked to put this to you. Bundle 44, volume 3, page 214. We don't need to go to it on the screen, but it may be that colleagues want to look at it. Bundle 44, volume 3, page 214. It might, at this point, be an appropriate time to have a brief coffee break, my Lord.

THE CHAIR: Right, we'll do that. Might it be an idea to take a slightly longer coffee break?

MR MACKINTOSH: It's not the most complicated document in the world, but I'll be guided by how anxious people look when I stand up, my Lord. Shall we say quarter to or five/ten to?

THE CHAIR: No, I think I would say ten to. Right, we'll try and be back for ten to.

(<u>Short break</u>)

THE CHAIR: Mr Mackintosh.

MR MACKINTOSH: Thank you. Mr Imrie, I've been asked to put to you an SBAR produced, I think, by your organisation, which is at bundle-- or within your organisation anyway, which is bundle 44, volume 3, at page 214. So, is this an ARHAI document, or was it just produced in ARHAI style?

A No, it was done on behalf of ARHAI.

Q Behalf of ARHAI, okay. I mean, obviously, you're not an author. The authors are Dr Inkster and Ms Cairns, but are you familiar with this document?

A Yes.

MR MACKINTOSH: What do you understand to be its principal recommendation?

A It----

Q We can go to them if it would help. They're on page 220.

A So, the recommendations are really about setting out the infrastructure that's required to----

Q So what's it required to do? What's the issue that's being addressed by this proposal?

A So, there's limited laboratories across Scotland. The diagnostic laboratories-- clinical diagnostic laboratories, some of them feel that they can't do some of the tests or they can't interpret some of the tests, accreditation, the capacity within the the regional labs.

Q So some labs in Scotland don't have the capacity to do certain environmental tests.

A Yes.

Q Is that driven by resource, or scale, or what?

A So, I-- I think, like most things in the NHS, they-- they're working to full capacity and-- and they'll have their programs of work. If-- I think what this is setting out is if we're looking for a national approach to environmental testing, then we need to acknowledge that the laboratory infrastructure needs to be built around that.

Q So that either here would be to, effectively, turn the GGC GRI lab into a national reference laboratory for environmental testing and typing and whole genome sequencing, or to create four regional labs?

A Yeah, I think there's a-- a number of options that are put forward. I know Dr Inkster, on behalf of ARHAI, is on the Public Analyst Laboratory Group that are looking to set out kind of a standard operating business case at the moment, and she's also working with the Public Health Scotland microbiology labs, who commission the regional labs, as well to understand better what needs to be put forward, whether it will be supported or not. But the fundamental purpose here is that if we change what we want the laboratories to do, we need to be able to support the laboratories to do it.

Q Is that possibly involving the way they are governed and accredited?

A It could involve both of those things. I think accreditation, for some lab,s may be an issue. They don't want to do tests they're not accredited for.

Q So you'd have to increase accrediting for more tests in some labs?

A To be honest, you're kind of going beyond my expertise in the land----

Q I'll try more----

A -- of accreditation.

Q I'll try one question, and please tell me if it is beyond your expertise. One of the things we've noticed in this Inquiry is that, I think, two things are true, is that

before some point in 2018 and after that point there's a big step up in the quantity of water environmental testing being done in the NHS GGC laboratories.

A Yes.

Q Are you aware of that?

A Yes.

Q Yes. If we look around the other health boards in Scotland, do they-- this report is actually saying they don't have a comparable capacity to what the GGC labs now have.

A Yes.

Q Could it be they have the similar sort of capacities that GGC used to have before the water incident?

A I think it's more about the-- the laboratory. The way it's set up as a-- a national reference laboratory is within GGC, but it's a national service, and I think what this is asking to do is that we look at it as a national service and that there's equity to the service. So----

Q So that, for example, people in Stirling can access it?

Yes, so in-- if Dumfries and Galloway or whatever wanted test done, then they would be sent there and given the same priorities as tests coming from Glasgow would be given.

A Which is presumably not the case at the moment, necessarily.

Q Glasgow maybe have more access because the laboratory's within

their-- their system, or they're more aware of the access that they have.

Q Okay, well, what I want to do now is to go back to the correspondence. So, just to sort of assist me in preventing me getting confused and perhaps help, let's go back to the first letter from the director general on 20 August 2025 to Professor Gardiner. That's bundle 52, volume 5, document 31, page 144. Now, would you have seen this letter in your role in NSS at the time it was sent?

A No.

Q No? When did you first see it?

A Julie Critchley shared it with me.

Q Later on in the correspondence?

A Yeah.

Q Right, but in any event, it says what it says, and it goes to Professor Gardner on 20 August. It receives a reply, which we've already looked at, which is on 26 August, and that's bundle 52, volume 5, document 32, page 146. This is the letter that has the SBAR attached to it and we already discussed the second paragraph, and this is the letter you was shown by Ms Critchley around that time it was received?

A Yes.

Q Right, and then there's now a further set of letters, one of which was sent by the director general to to Mary

Morgan, chief executive of NSS. That's bundle 52, volume 6, document 3, page 48, and we see that's been copied in to Ms Critchley.

A Yes.

Q Did you see that at the time it was received by Ms Critchley?

A Just shortly after.

Q Shortly after. Effectively, is it the director general asking for a meeting to be set up between NSS and GGC?

A Yes.

Q Right, and now there's another parallel letter, which is from the DG to Professor Gardiner, which is 52, volume 6, document 4, page 49. It's a rather longer letter. Next page, we see that was also copied to Ms Critchley, and do you see that within it, it sets out information that GGC should supply to ARHAI Scotland?

A Yes.

Q Did you have any involvement in specifying what the information was to be?

A No.

Q No, right. What was the information they were asked to provide you with? I think it's in the third paragraph. So, there's a reference in the second paragraph on this page to the new version 3 document that we've looked at. Yes?

A Yes.

Q Yes, and then the observation is made in the fourth paragraph that it's different from version 2.

A Yes.

Q There's then a reference in the fifth paragraph:

> "You also ask [this is sent to Ms Gardner] that the information provided to SG by ARHAI Scotland be shared with NHSGGC."

The response is made:

> "ARHAI Scotland was commissioned by SG to review nationally available data of Cryptococcal cases from January 2020 in Scotland."

Is this the review that Mr Urquhart asked you to carry out?

A Yes.

Q Right.

> "ARHAI reviewed NHS Scotland level intelligence from three sources of data: ECOSS, Outbreak Reporting Tool submissions, and a direct request to laboratories. Therefore, this data (for NHS GGC) is already available to NHS GGC."

So, is that effectively saying that the material you ultimately received in July, 20 July, is the material used to produce the conclusion about the potential cluster and the non-reporting that's in the 20

August letter?

A That's right.

Q Right, and then the meeting takes place between Ms Morgan and Professor Gardner on 2 September, and we see that from a letter from Ms Lamb on bundle 52, volume 6, document 5, page 51. Now, did you have any involvement in that meeting on 2 September?

A No, I believe that was just the two chief execs.

Q Right, but then we see on 9 September another document, bundle 52, volume 7 document 48, page 453, which is a letter to the DG from, if you go with the page, Ms Morgan and Jann Gardner, and you're copied into this.

A Yes.

Q So, if we go and look at the substance of it, did you have any involvement in contributing from the ARHAI side to this process to produce this agreement?

A No, that was the-- the three points that the chief execs agreed----

Q Right. Of these three bullet points, is there more information that was provided to you by GGC about Cryptococcus cases on 5 September?

A Yes.

Q So, given we discussed on 20 September you acquired information about time, place, underlying health

conditions, treatments, what sort of information is the additional information that came in on 5 September?

A So, the first letter from the director general outlines the information that they-- to share by ARHAI-- with ARHAI, but I think the date she gives us by 8 September. That was the----

Q So that's the letter back on 20 August?

A Yes, yes. I think there she sets out the that's go back to CNO, then the information that's going to ARHAI.

Q So, if we go back to that, that's bundle 52, volume 5, document 31, page 144, and we go over the page.

A Yes.

Q Is this the three bullet points on the second paragraph?

A That's right.

Q So, they wanted immediate confirmation that all cases-- that these cases have been escalated via appropriate IPC governance channels to the Board?

A Sorry, that-- that's the information that's to go to Scottish Government. It's the second----

Q Ah. Right, sorry.

A -- bullet point.

Q It's under the bold heading. You want information provided to ARHAI, and you want confirmation of a PAG. Did you eventually receive confirmation of

whether a PAG was held?

A Yes.

Q Was a PAG held?

A For one of the cases.

Q Right. "Detail of the environmental and clinical investigation in relation to these cases..." Did you receive that?

A Yes.

Q So, would that have included any documentation about assessment of reporting of these cases in 2024, other than that PAG?

A From memory, excluding the-- the paediatric case that was reported and-- and then reported as false----

Q Oh, that's 2020 case.

A In 2020. I think all other cases, the assessment has said that it's thought to be community-acquired, and no further investigation was done. I think there was one adult case where they said that there was some walk around with the Estates department----

Q Did you receive any contemporary documentation like assessment forms----

A No.

Q -- produced at the time of the assessments?

A No.

Q No. Ignoring the 2020 case, which we're familiar with, did you receive details of what hypotheses were tested in relation to the other six cases?

A I think all the hypotheses were community-acquired.

Q Right That was the only hypothesis being tested?

A Yes.

Q I won't get you to explain what the details of clinical management were, but did you receive sufficient information to understand the clinical management of each of the six cases that were new to you?

A Yes, we-- we received information that allowed us to make an assessment on their kind of clinical picture, and----

Q So, where they'd been in the hospital, what treatments they'd----

A Yes, yeah.

Q -- had, that sort of thing.

A Yeah, what specialty they were under.

Q What control measures were described as being in place?

A So, I think one of the adult cases, it gives some information around a walk-about with the Estates department and the plant room being visited. I think, for the others, it's recorded that there wasn't thought that there was any control measures required as they were most likely to be community.

Q Of course, these patients would have been accommodated in

single rooms, being the Queen Elizabeth?

A Yes.

Q Not necessarily----

A Also, human-to-human transmission is not something-- So, a control for Cryptococcus would be-- you would be looking at environmental factors.

Q Did you find out whether any of these six patients were accommodated in HEPA filtered isolation rooms?

A No, we don't have that detail.

Q You don't have that detail. Okay, if we go back to the letter on 9 September, so that's bundle 52, volume 7, document 48, page 453. So, you receive the information on 5 September. "ARHAI's liaising with CNOD..." is that the Chief Nursing Officer Directorate?

A Yes.

Q "...regarding additional reporting requirements..." Why might that be?

A So the-- letter that went from director general asking Glasgow to share data, we were then going back to CNOD to ask what-- what did they want us to do with the data? What was the end product that we're looking for?

Q Right, and then the second bullet point was this one that would have involved you?

A Yes.

Q Am I right in thinking this relates to, effectively, the continued editing of version 2 and version 3, and now potentially version 4, of the SOP?

A Yes, So, the small group – myself, Julie Critchley, William Edwards, and Sandra Devine – have met a couple of times, and that was one of the-- the first things we looked at, I think.

Q Now, Mr Edwards is not a name we've come across. Who is Mr Edwards?

A He's the deputy chief exec for GGC.

Q Right, and you're going to hold some facilitated development sessions after 10 October?

A Yes.

Q Any particular reason why 10 October was picked?

A I think, given that we're quite small teams, and myself and Julia were both witnesses at the Scottish Hospitals Inquiry, we asked if we could wait till----

Q I understand. Now, the two chief executives say:

> "We hope this provides you the assurance that GGC and NSS are committed to working collaboratively. You have asked that you are kept informed of progress and we will provide you with an update following our first

development session the end of October. ”

Now, since that letter went-- (After a pause) there’s also a reference in the middle, which I didn’t draw out, of the middle bullet point to reinstating weekly operational meetings, in the third line.

A Yes.

Q Now, you previously told us when you gave evidence that you were having weekly meetings with Ms Devine.

A That’s right.

Q These stopped. When did they stop?

A I can’t remember exactly. In November, I want to say, November time 2024.

Q I mean, to what extent would it be self-centred of the Inquiry to note that they stopped just after our Glasgow III hearing session, when you and Ms Devine had given evidence?

A I-- I couldn’t make any comment. Ms Devine stopped the meetings, said that they had served a purpose and they were no longer----

THE CHAIR: Sorry, I just missed that----

A Sorry.

THE CHAIR: You sometimes allow your----

A Voice to drop.

THE CHAIR: -- voice to drop.

A Ms Devine emailed me to say that-- although she found them useful, that they had been going on for some time, longer than anticipated, and that we-- we should stop the meetings, and I think in the email there was some reference to Scottish Government roles and remits of ARHAI being revisited. I-- I can share the email again----

MR MACKINTOSH: Well, it would be helpful if you did, but the thing that occurs to me is my recollection is that you requested the meetings following the IMT meetings in the autumn of 2019 when you and Ms Rankin had started going to meetings together. I’m wondering whether I recollect that correctly, that these----

A No.

Q -- meetings started back then.

A No.

Q When did they start?

A The-- the weekly meetings with myself and Sandra started when there had been a number of emails that had been going direct to Scottish Government from the lead infection control doctor in Glasgow and Clyde to-- the back of HIAT communications to say, “ARHAI are misinterpreting what we’re saying. We should communicate directly to you,” and if I remember correctly, it was Mr Urquhart that contacted myself and Sandra and said, you know, “Please sort this out between the two organisations,”

and that's when we agreed. I think that was in----

Q So when----

A -- maybe the beginning of 2023.

Q Right. So, if Mr Urquhart, to some extent, asked you and Ms Devine to meet to address a particular issue, by the time we got to November last year, had the issue been addressed?

A We-- we'd certainly done some training sessions with the ICNs in Glasgow around the outbreak reporting template and how, you know, to report things in. The issues might have not been there because the ICNs were doing more reporting. The issues were more about maybe requesting information from the infection control doctors when they were-- they were reporting in incidents.

Q So, can you expand that? What information?

A So, if there was incidents being reported in and we were going back asking for questions, or we felt we were maybe not getting the information timely, or the full information, and that was----

Q And then you were asking them to get information from the doctors?

A So, in the boards, it might be an infection control doctor that completes the ORT or files out the information around an----

Q That's the online reporting tool?

A Yes, or we might contact them to say, "You know, we've seen something in the data that suggests there's an issue. Can you explain, or----?" and. as I said before, the-- the ICD had replied to a Scottish Government email, you know, asking that they report direct. So that-- that was more----

Q Asking that they, the ICD, report direct?

A No, the boards report direct----

Q To the Scottish Government?

A Yeah.

Q Missing you out?

A Yeah.

Q Had they stopped doing that while the meetings were going on?

A No, they've always reported to ARHAI. I think that's what----

Q No, no, no, have they stopped sending emails to the Scottish Government?

A Yeah. So, the meetings with Sandra, I think, did help with a lot of that, the issues that we were seeing there, but, again, in ARHAI, we only know what we know, so if things aren't reported in we don't know about them. But I think from the ARHAI nursing team, they felt that there had been the relationship building with the nurses through the training and-- and----

Q So that's the ARHAI nurses and the ICNs in Glasgow?

A Yeah, so some of the nurses and the scientists in ARHAI had done training on the ORT and, you know, definitions and how to report in the incidents just to-- people change-- you know, staff change all the time, a refresher, and I think they felt that was, you know, worthwhile.

Q So when Ms Devine announced she was stopping the meetings, did you at that point form view of whether the reason that Mr Urquhart had requested the meetings take place had been addressed or not?

A Well, it's certainly seen a change in who was reporting in incidents and it was more the nurses, and maybe the ICDs in Glasgow had stepped back and the reporting was done, so we maybe weren't seeing the same incidents when Sandra finished the meetings.

Q When we think about the correspondence, about the attempt to get information about these seven-- or six Cryptococcus cases between November and, well, September, ultimately, of this year, might it be the case-- or what's your view on whether it's the case that there's still an issue that requires to be addressed between ARHAI and GGC IPC?

A I think there is still an issue that needs to be addressed, and I think that's what we're suggesting that the facilitated development sessions are held, so that we both have a-- a common understanding of roles and remits and what's-- what's expected.

Q So, when you say those remits, you mean how you report within Chapter 3 of NIPCM and Appendix 14 HIAT?

A And also, the role of ARHAI when we come back and ask questions, because I think that's when we get a pushback, that if something's reported in, then that should be accepted.

Q That you will go back and ask questions?

A Yes.

Q Given that you said you had joint training between some of your nurse consultants, and of your scientists, and some of the ICNs in Glasgow, and that you had a year or more of weekly meetings with Ms Devine, why do you think that a new set of facilitated development sessions will make any difference?

A I think it's looking at the wider team as well and-- and getting that understanding. Both the-- the chief executives are very open in that they want to support this, and that this should happen with a wider team, not just myself and Sandra.

Q I appreciate the chief executives are now involved, and that presumably might make a difference, but is there anything else that's changed since November '24 that either would give you, as clinical lead at ARHAI, more or less confidence that these development sessions will make, ultimately, the difference that's required?

A Well, I'm always the optimist, and I think, you know, if you can get people in a room and the opportunity to listen to each other's challenges, then you-- you can move forward in how we build those relationships.

Q I'd like to look briefly at the SBAR that was produced at-- I understand that two meetings took place on 10 and 15 September of the four of you, that is you, Ms Critchley, Mr Edwards, and Sandra Devine. So, was an SBAR produced?

A Yes.

Q That's in bundle 52, volume 7. I think it's the final document in a reissued version, so if anybody has downloaded 52, volume 7 and doesn't have this document, if they go back to our website and re-download it, with a bit of luck the SBAR will appear, I say very nervously looking at my colleague working the database. It's the last document. Yes. Go back to it. Yes. Is that the document that was produced at one of the meetings?

A Yes.

Q So, does this SBAR sort of cover, as it were, the agenda for those facilitated workings and any changes that need to take place in the relationship between ARHAI and GGC IPC?

A An agenda?

Q Well, what I'm trying to say is you've obviously discussed-- had set out in the letter between Ms Morgan and Professor Gardner a series of action points, two of which-- one involves joint meeting and this SBAR, and the other involves facilitated development sessions. You've listed them both there, and what I'm trying to understand is, if the Inquiry wants to understand what's now going to be done in respect to those two bullet points, do we find it in this SBAR?

A Can you go to the next page?

Q Certainly, page 484. So, you've got some background----

A Yeah.

Q -- and you have an assessment. What on this page would you draw out of significance to the question of whether GGC are going to operate in future in compliance with NIPCM?

A So, I think the-- the framework was set out there, you know, that I had the opportunity to review.

Q That's the version 3

document?

A The version 3 document, and we agreed as a group that that version-- and Glasgow have updated to say that that's gone through their-- their kind of governance for their framework, so that's----

Q So that's basically saying that the version 3 is broadly in compliance?

A Yes.

Q Right, over the page onto 485. It's just that this document doesn't discuss what might need to be done-- If you go back to the first page, 483, the second bullet point – as it were, the scope of the facilitated development sessions – you've not set that out in this document, have you?

A No, and they'll be kind of externally facilitated, so we'd be looking, you know, for somebody to set that out.

Q I suppose one of the difficulties here is that the Inquiry will hold its last, we hope, oral evidence session on 10 October, and we will then hold our final oral submission hearing for discussion on 20 to 23 January, and then his Lordship has the task of writing up his report. If we think about the world as it is now, not as it's hoped to be after 10 October, do you have confidence that, now, NHS Greater Glasgow and Clyde is reporting, now, infections in compliance with Chapter 3 of the National Infection Prevention and

Control Manual?

A I think if they're following version 3, then they should be reporting in against the manual. However, the assessment of the Cryptococcus cases has kind of made me more aware that there's maybe more subjective views around how we fit that into criterion----

THE CHAIR: Sorry. Again, I kind of lost the end of that sentence.

A I'm saying the assessment of the Cryptococcus cases that-- given that I gave where I would fit them into the criteria and that the report that we got back from Glasgow is sitting in-- fitted the criteria, there's maybe some work that will need to be done in development sessions around that.

THE CHAIR: In order to achieve a common understanding?

A Yes.

MR MACKINTOSH: So, one of the things that I've been doing this week is preparing my questions for the former chief nursing officer, Professor McQueen, and in her statement at paragraph 36-- Now, I'm going to have to press her on the date, but I think she might be saying there were concerns about HAI reporting by GGC as far back as 2015. The Inquiry's experts, Dr Mumford and Ms Dempster, in their report identified a Mycobacterium chelonae case from 2016 which didn't-- we think in the early

months of the year, didn't result in a PAG or a report, and a Cupriavidus case in 2017 which didn't prompt a PAG or a report to HPS. Now, I mean, there may be more. Then we have the Cryptococcus cases we've just discussed, including the 2020 case. Should the Inquiry have any concern about a pattern of non-reporting over a number of years, and what information does ARHAI hold about, as it were, the history of concerns it has raised, and have been raised with it, about non-reporting?

A I think that's quite difficult to answer, and I know I've said on a number of occasions that ARHAI only know what we know. There might be other boards that have, you know, infections that have not been reported in either. It is quite a trust relationship that, you know, you provide the guidance, you work in collaboration with the boards to make the guidance both evidence-based but pragmatic as well, so the boards give us a lot of feedback, you know, when we're developing guidance, and I think the Scottish Government, ARHAI then expect that that's the guidance that we're all following and that we all understand what we're reporting. So, I'm not trying to avoid giving an answer. I just-- I'm not really sure what evidence I would base my answer on other than what-- what we've provided.

Q I suppose you've given me a question. Thinking about the whole GGC Infection Prevention and Control team as a collective group and not any one individual, do you trust that team to report in compliance with the manual?

A I don't know that I can answer that without an evidence base to say-- I think I have questions when it's difficult to get information, or when there's been an assessment made that they don't need to report and then we maybe see it in a different way. I think there's times where they have maybe not reported in as I would expect, and I don't know if that was, as I said in my statement, part of version 2 of the framework that had actually built internal guidance that allowed them to do that within their governance structure that wasn't shared with us. I mean, I think going forward to version 3 does align, and I would hope that there is more (inaudible 03.00.17) against the manual and what we see coming in.

Q My Lord, I think that's probably all the questions I have, but it might be a good moment to see if any of the other core participants have any further questions they would like me to ask.

THE CHAIR: Ms Imrie, as you probably recall, our procedure is to give

counsel the opportunity to check with other legal representatives whether there are additional questions that should be asked. So if I could ask you to return to the witness room, and we would hope to be able to call you back in about 10 minutes.

A Thank you.

THE CHAIR: Yes.

(Short break)

MR MACKINTOSH: We have four questions, my Lord.

THE CHAIR: (After a pause) Perhaps four questions, Ms Imrie.

A Thank you.

MR MACKINTOSH: First question is – it depends whether you know this – are you aware of an issue around a reporting of Cupriavidus in January 2025 by GGC?

A I am aware that there was Cupriavidus reported in that-- I would need to look back to get the full detail. I think it was reported in as a green. I think ARHAI went back with some questions.

Q So it's more about the grading, rather than when it's reported at all?

A I'm sure it was reported in, but I think we had a question. I would need to revisit the incident.

Q Okay. So, this is back to this idea that I think you hinted, that renal patients in the Queen Elizabeth might move around the hospital as part of their treatment. So where might they go?

A So, renal patients, when they get to the stage where they've either had a transplant or they're awaiting a transplant, there's renal medicine. They might have been to outpatients dialysis, outpatient clinics. Depending on other comorbidities they have, they might have visited, you know, surgical wards, medical wards, so they're quite complex at that kind of state in their renal disease.

Q Can you help me about whether the wards and spaces you've just listed in Queen Elizabeth-- whether those are spaces covered by the general ventilation of three, or just under, air changes per hour rather than six in the SHTM 03-01?

A Some of them they'll be.

Q Yes. To what extent would you have any concern about the impact-- the risk that lower air change ventilation might pose if there is Cryptococcus, environmental source, effectively, in the hospital. Does that cause any concern to you?

A I think it's more complex than just the air changes. You need to understand the whole kind of ventilation system, the air entry. I think some of the-- the pests infestation, plant rooms, but

there's also been in corridors and-- and other places as well, so----

Q When we say pests, we mean pigeons?

A Pigeons, yeah.

Q So you don't feel you can draw that out as a particular concern?

A No, I think I'd need more kind of information and-- on the ventilation system and where the-- any of the issues had arose.

Q In a sense, that information would have to wait until you have more information on whether or not there is actually a cluster here, rather than the suspicion at this stage, because you need to have all the patient pathways and think about the ventilation and almost do a root cause analysis.

A So, yes, that might be something that we would ask if the Board have done, if they're able to share anything like that with us.

Q One of these-- possibly a simple question is: you work at ARHAI, Dr Inkster works at ARHAI, what's your experience of working with Dr Inkster?

A I first met Dr Inkster around 15 years ago. She was appointed to the ICD position at the-- the West Sector in Glasgow, where I was the lead infection control nurse, and I'd say in the 15 years that I've known Dr Inkster, either working directly with her or as kind of senior

infection control people in NHS Scotland, I've always admired her. I feel very privileged that she chose to come to ARHAI and work with us. She's a very good team player within ARHAI to work across multidisciplinary teams, both within NHS Assure, engineering, scientists.

But, also, my experience, being her line manager, is I always get good feedback. I get requests for Dr Inkster to support boards. NHS England have asked for Dr Inkster to support some of their work in environmental. So, all in all, I feel privileged to be Dr Inkster's line manager and to work with her, and she's always integrated well into all-- She's ran many national projects now in ARHAI as well.

Q Thank you. One final question, and I emphasise I don't want names in answer to this question. You described in your statement, and we've discussed today, issues or difficulties or challenges in the question of HAI reporting between GGC, IPC, and ARHAI. Have you come across equivalent or similar difficulties with any other health board in since, say, 2019?

A No. I think I-- in that time I've escalated maybe one IMT to Julie as my line manager, and that-- that was another environmental, quite complex, and we were waiting for data, but that was

resolved quite quickly. If I remember right, Julie spoke to the director of Estates for that board and the information-- It was just-- one of the nurse consultants and one of the engineers that was supporting the IMT. I think that was resolved quite quickly. So, no, definitely not experienced anything.

You-- when you ask a board questions, if they're dealing with an incident or an outbreak, generally, they give you the answers. They might ask you why you're asking that question, or if there's something-- But, no, I don't-- I've never, even myself. I don't think any of the nurse consultants have either. The sort of things that the nurse consultants from other boards have escalated to me is where they're concerned that there is maybe a-- a growing number of patients, or a growing number of incidents, within a unit, but, generally, that's recognised by the board as well. It's not that they're raising a concern with me to say they're not acknowledging it.

Q Thank you, and thank you for coming back. My Lord, that's all the questions I have for Ms Imrie.

THE CHAIR: Right. Can I just repeat that thanks, Ms Imrie, for your evidence today and your evidence when you previously came before the Inquiry, and the work that goes behind that, but you're now free to go.

A Thank you.

THE CHAIR: Thank you.

MR MACKINTOSH: (After a pause) My Lord, we have Mr Wright this afternoon. It's Mr Connal who's taking it.

THE CHAIR: All right. We'll reconvene at two o'clock.

(Adjourned for a short time)

THE CHAIR: Good afternoon, Mr Wright, thank you for coming back to give evidence again. You're about to be asked questions by Mr Connal, but first of all, you're agreeable to take the oath?

MR WRIGHT: I am.

Mr Malcolm Wright

Sworn

THE CHAIR: Thank you very much, Mr Wright. You may recollect from your previous attendance here that while we plan to have up to four o'clock available to us this afternoon, if at any stage you want to take a break for any reason, we will take a break. Please feel that you're in control of the situation. Now, Mr Connal.

Questioned by Mr Connal

Q Thank you, my Lord. Good afternoon, Mr Wright. Let me start with a formal question, which as you will know from your previous evidence, everybody gets asked. You've produced a witness statement for the purposes of this Inquiry. Are you content to adopt that statement as part of your oral evidence?

A Yes, I am.

Q Thank you. Now, I'll probably use that statement as a kind of guide to where we've got to in the narrative, so if we just bring that one up on the screen, please, it's at page 214 of the witness statement bundle. You indicate the positions that you held, with particular reference to this Inquiry, but the one that we're interested in was as Director General for Health and Social Care and Chief Executive of the NHS in Scotland for a period between February 2019 and July 2020. Now, I think I'm right in saying, and we obviously have your CV from the previous appearance, that you've also spent time as a chief executive of a health board, is that right?

A Yes, I'd spent quite a bit of time in my career being the chief executive of different health boards in Scotland, so Dumfries and Galloway. I was asked by the government to go into the Western Isles when it was in some trouble. I was Chief Executive of NHS Education for Scotland, which is the

national body that looks after all the postgraduate education. I went into Grampian Health Board and then Tayside Health Board and Grampian and Tayside together, so I'd-- I've worked in different parts of the country as a chief executive.

Q Thank you. Now, in the next few paragraphs, we touch on what this job as chief executive actually means, so we go on to page 215. You talk about the job being incorporating the role of chief executive and accountable officer, and you refer to individual board chief executives also being accountable officers. Now, just very briefly, what does an accountable officer mean in this context?

A Right. An accountable officer is defined by the Public Finance Manual for Scotland, and it involves a personal responsibility for the proper use of public funds, and it's a personal accountability to Parliament for the proper use of public funds, and as an accountable officer, both in a health board and in the Scottish government, I had to personally sign off the accounts every year that were audited, and if there was any issues with the accounts, then I had to account to Parliament for that, so-- and the principal accountable officer in Scottish Government is the Permanent Secretary.

Q I see. Now, the first point I just wanted to ask you about so we can

understand it is a point you make on that page, which is that notwithstanding the title of Chief Executive of the NHS, you don't line-manage health board chief executives. Now, that, to an outsider not familiar with the system, might sound a little odd. They might assume that you're the Chief Executive of the NHS so you control them, but that's not the case.

A I am Chief Executive of the NHS. I'm also the Director-General in Scottish Government, so the post of Director-General in the Scottish Government is directly reporting to the Permanent Secretary, one of six directors-general and I have personal accountability for the use of the £14 plus billion of money that was there when-- when I was in the role. Health boards are established in primary legislation. We pass the monies to the health boards together with a very clear set of outcomes we want those boards to achieve with those resources within the frameworks of national policies and so forth, and we performance-manage the National Health Service.

So, one of the big roles of the Director-General is to ensure the performance management of the National Health Service. That is done through the board chief executive, so while the board chief executive is the employee of the health board, and I can talk more about

that if you wish me to, is the employee of the health board and is line-managed for employment purposes by the chair, there is an accountability whereby the board chief executive reports to me on the performance of the board over a whole range of parameters, and I think I say in the statement that the director-general had nine directors in post and one of those is the Chief Performance Officer for the NHS in Scotland who played a major role in this.

Q The reason I ask is that we've obviously been hearing various things about the events that we're concerned with in this Inquiry, and some of them indicate that material information and the like tends to come up through the pyramid and end up in the hands of the Chief Executive and that the role seems to be quite important, and therefore, you say chief executives report to Health Board chairs, and it's the chairs that are then held responsible. I just wonder, does that not create an issue if you're reliant, as it were, on the relationship between an individual chief executive and individual chairmen?

A Well, maybe there's two ways to help answer that question. First of all, the boards, which are the statutory authority, so when I was a board chief executive, it was always my view that anything that moved within the board was

my personal responsibility, that I was appointed by the board. I met with my chair two, three times a week, so a chair is in and around the board and is paid to be in and around the board three, four days a week, and the board has a whole set of governance committees where reports go through the board. So, the day-to-day management and governance of the board is done by the board.

However, given the huge sums of public money and ministerial accountabilities of Parliament, the service is performance-managed by me through my directors to the chief executive of the board. So, the formal accountability process is one of, we'd have an annual review of a board's performance and which the chief executive would be at and I would be at. We'd have a mid-year review of board performances and that could come into some of the evidence here today, and the different directors of the Scottish government would be constantly talking to the board chief executive and the executives within the board about different parameters of performance, and that would be brought together, and I would hold the board accountable on behalf of the Cabinet Secretary for the overall performance of the board.

Q I think I could probably move on a little. You've listed on page 216 the

various reports that were in place at the time you held the post of DGHSC. One of the challenges we face is trying to remember all the acronyms. So, can I just ask you about an acronym that appears about halfway down paragraph 6 which is HSCMB----

A Yes.

Q Now, that's the Health and Social Care Management Board.

A Yep.

Q Now, does that comprise those direct reports or are there other people on that board?

A Yes, it comprises those direct reports. It was a formal business meeting which was agendered and minuted, met every week, same day of the week. There were other attendees, so the people who are not under my direct line management within government, so the Chief Social Worker Officer, for example, or the Director for Children's Services that was in another part of the Scottish Government, they would come along and we would look at the strategic policy development of the National Health Service. We would look at the overall performance of the National Health Service.

We would look at particular issues within the National Health Service, and one of the subcommittees of that was the National Performance Oversight Group.

That was chaired by John Connaghan and his team would be bringing together all of the performance parameters so that was the kind of-- From my point of view that was the key point in the week where all the Scottish directors got together and we looked at issues. We took decisions, and as I say here, the Cabinet Secretary would regularly attend and we'd have an opportunity to talk to the Cabinet Secretary about current issues and she would say what her priorities were and that, of course was supplemented by all of the directors of the Health and Social Care Management Board.

We would meet the Cabinet Secretary as a team every single week, immediately after Cabinet, so the Cabinet Secretary would give us a readout from what happened at Cabinet, and we would say to the Cabinet Secretary, "Look, you know, we would like to make you aware of this going on in Board X, that's happening in Board Y, and this is what we're doing about it" or to lead a discussion about, you know, how we handled particular issues. So, it's quite a connected system within government, I think, in that I met with my team as a team every single week. I had one-to-one meetings with them, one-to-one meetings with the Permanent Secretary.

I met with the Cabinet Secretary one-to-one every single week. The team

met with the Cabinet Secretary, and of course the Cabinet Secretary would ask directors to come and see her, or groups of people to talk about particular topics, so it was pretty, I thought, pretty connected.

Q Now, just a couple of points of information before we leave that page. A little further down, you say:

> "These meetings were in keeping with the objectives within the Scottish Government to remove organisational boundaries..."

Now, that's perhaps a phrase the explanation of which doesn't immediately spring to mind. Very briefly, what does that mean?

A Right, and I'll try not to get into management-speak here, but given the size of the Health and Social Care portfolio, it was by far the biggest portfolio within government, and there was a-- and there was a number of things, and given the Scottish government had set up what's called the National Performance Framework, so it's very much looking at outcomes we want to see for people in the Scottish population, and that needs different agents to be-- to be working together. So, an example of that would be that I co-chaired the Health and Justice Collaborative Board, which was bringing different justice agencies

together with Health, with local authorities, to think through what do we need to do to work together in communities to identify and support some of the most vulnerable people in society? So it was that sort of cross-cutting work that needs a lot of people to come together to say, “how do we get those outcomes?” So, that’s one example of that.

A Thank you, and the only other point, I think probably-- I don’t need to get you to explain it, but near the foot of that page, you talk about meeting NHS board chief executives on a monthly basis, but in fact, you explain later in your witness statement that this was a collective group----

A Yes.

Q -- rather than the notion that you were meeting individual board chief executives on that basis.

A Yes, that’s absolutely right and this was a-- this was a formal, minuted meeting between the Scottish government and the of board chief executives and we’d have a lead medical director, a lead director of Public Health and others in attendance. So, it was a pretty big room of, you know, 30, 35 people and I would chair that with all of my directors in place, and all of the board chief executives and we-- They would meet before and talk about things they wanted to raise with me. I would have a list of things I wanted to talk to them about, so it was a collective monthly formal point of contact between the government and the boards and it also gave a really good informal opportunity to talk to colleagues about particularly hot topics.

Q Well, if we could move on to page 217, so we start to turn to look at the issues relating to what I’ll just call the new hospital. You said, basically, as soon as you arrive, your predecessor makes you aware that----

A Yes.

Q -- the new hospital is an issue.

A Yes.

Q And you get a briefing of what is going down.

A Yes, and I was aware of that from my time as a health board chief executive, and I was fortunate to have some time as a-- with a-- as a handover with Paul Gray. So, Paul briefed me on this, and I-- and I read various briefings that had gone to the Cabinet Secretary, that had gone to the First Minister, and I was aware, I mean there’s a whole panoply of, you know, challenges facing the National Health Service, but I was aware that this was pretty acute, pretty important, and in my conversations with both Fiona McQueen and Jeane Freeman, I was-- you know, I very clear

that this was a high priority for us in government.

Q Thank you, and you point out that one of the issues that was drawn to your attention was that there had been what they called a executive's letter gone out to other health boards----

A Yes.

Q -- touching on some of the points emerging from the new hospital issues, such as ventilation systems, and you set out the details of that in paragraph 8, and I don't think I need to get you to read through that.

A No, but we were keen to make sure that issues arising from the Queen Elizabeth were actively brought to the attention of other boards so when the unannounced inspection from HIS in March came out, for example, we made sure that all of the boards were aware of that, and I think I wrote a letter to the board chief executives, and I'm sure we will have discussed that at our monthly meetings to say, "Look, this is what's happening here. You need to assure yourselves and your boards that you've got this stuff covered."

Q So, as I say, you set out in paragraphs 7, 8, 9, 10, essentially your initial steps, who you were chatting to. I'm sorry, I'll take that one away, I don't mean chatting in a casual sense, but who you were engaged in conversations with

on what the issues were, and I won't ask you to read through all of that, but if we can come to something it did land on your plate, which was escalation. Now, we can pick up, perhaps just shortly, a document which has the escalation levels laid out in it, but initially, at the time you arrived, Greater Glasgow and Clyde was at Stage 2.

A Yeah.

Q Now, we will see the details later, but it seemed to me that Stage 2 perhaps could be described as, "better keep an eye on this" rather than taking a stage requiring specific direct action. Is that a fair summary?

A No, I don't-- I don't think it is and the reality was that by the-- You know, as I came in post and certainly what I can attest to since I was in post, there was a very considerable amount of time, energy, support going into this issue. So, I was aware that Fiona McQueen who was CNO and also the policy lead for HAI and Infection Prevention and Control she was in regular contact with the board with the chief executive of the board, that as issues were arising, as infections were-- were being reported, she was mobilising Health Protection Scotland, Health Facilities Scotland. So, actually there was a lot of support going in and just thinking about that in advance of this

hearing, the level of support probably wasn't quite at Level 3, but it was-- it was certainly moving in that direction.

Q Thank you. So we'll just deal with the-- We'll deal with the formal step and then we'll come to how that was achieved. You say in paragraph 12 that NHSGGC was at Stage 2 or perhaps lurching in the direction of being described as Stage 3, and you took the decision to escalate to Stage 4.

A Yeah.

Q Now, I think we can see from your witness statement that when I say, "you took" that's because the decision-maker for that purpose was the person holding your post.

Q Yes, that is correct. A Level 4 escalation is a decision for the Director-General. I took that decision and I take responsibility for that decision, and I took that decision on the advice of the Health and Social Care Management Board. A movement to Level 4 is a serious step. It has a whole set of ramifications. It carries some risk with it, and it is a balanced judgment, and it is normal or it was normal practice within government that the initiation of recommendations to escalate and de-escalate would come from different directors around the Health and Social Care Management Board table, quite often the Chief Performance Officer, but in this case it was the Chief Nursing Officer because she was the policy lead on it. She talked to me about it in advance. I talked to the Cabinet Secretary about it and on the basis of that advice, and on the basis of Fiona's paper, I took that decision and I take responsibility for it.

Q Well, I don't think we need to put up on the screen the formal letter that you then wrote to the Chief Executive of the board, but can I just ask this? I mean, this was November, the letter was 22 November. One of the questions that inevitably arises is, with the benefit of hindsight, could it have been escalated sooner? Have you any view on that?

A Yes, I do and I've given that a lot of thought in preparation for this hearing. One part of me thinks, you know, if we'd-- if that team had been in six months ago, we would have, you know, got to some of the granularity of this more quickly. Another part of me thinks, what was the information coming out of the Board that was pertinent here? So, if we look at the Board's annual review, which was carried out in March, 11th March, where the Cabinet Secretary and I, and directors from Scottish Government, we have the best part of the day with the Health Board.

We have a private session with the Chair and the Chief Executive, we have a public session. We meet the area clinical

forum, we meet the area partnership forum. We meet patients groups and the outcomes of that review are confirmed in writing, and the Cabinet Secretary's letter, I think fully reflects that we had a robust discussion with the Board because we'd had the water reports. We'd had the unannounced-- his inspection coming forward, and we were not content, and we really held the Board to account and said to the Board, "we need you to get on top of this and to manage this situation." And the Cabinet Secretary says in her letter that she was assured by the Board, and that is my recollection, that strong assurances were given by the Board that they were fully committed to seeing these issues through, and that we could be assured by that.

I think the other thing that happened around about that time was that the Chief Executive, Jane Grant had announced her own set of reviews. That's-- that's mentioned in the letter, and I think they were-- She was going to chair an overall programme board, and I think there was three reviews going on about patient flow, about clinical outcomes, and about the environment in which patients were being treated, and that all of that work was to-- was go ahead. So, that was a pretty important point because that was the government publicly holding the Board to account and receiving the assurances from the Board that we know that this is a serious situation, we need to get to the bottom of it.

And I guess from my point of view, just thinking back and thinking, well, what were the-- what were the points along the way that moved us into a position of escalation to Level 4, and I think there's probably three. I think-- I believe Fiona McQueen is giving evidence, but I think her meeting with Dr Peters and Dr Inkster and her telling us about that and the challenges of team working within the Infection Prevention and Control team, I thought that was significant. I think the Cabinet Secretary and the CNO meeting families at the end of September, and while I wasn't at those meetings, I talked to the Cabinet Secretary, I talked to Fiona McQueen, and really, some of the feedback that we were getting from families was really very, very, very concerning indeed.

And on the back of that, the Cabinet Secretary appointed Craig White to go in and my interactions with Craig White-- he was very much reinforcing that families were feeling that they were not being communicated with well. They were not being engaged with well, and they didn't feel a sense of confidence that what they were being told was actually the full story. And I know that in October, the Cabinet Secretary and CNO met with Professor

Cuddihy, and again, that feedback, I think-- So, the meetings with clinicians, the meetings with families, and I think the third thing that really struck me was, I think, around about 15 October, we received the AECOM report, which I know the Inquiry has seen, and my reading of the AECOM---

THE CHAIR: Sorry, I just didn't-- on 15 October?

A 15 October, we got the AECOM report, A-E-C-O-M report, and that was the report that had been commissioned, I think, by Greater Glasgow and Clyde, looking at the-- at the building and the deficiencies of the building, and I read that, and I thought, you know, that a combination of the-- what the clinicians were saying, what the families were saying, and what we, you know, what we were getting in writing pulled together about the building and what that was going to take to get that to a better place. I think those were the kind of three main sort of turning points in-- in my mind.

So, I think there's a period of about four weeks from that all happening to actually escalation taking place, and then I think we had the whistle-blowers going to their elected representatives and really highlighting cases going back to 2017 that we didn't know about, I'm not sure

that the Board knew about. And I think as a combination of all of those things, linked to a loss of public confidence, that certainly led me to the conclusion, and I know it led the Cabinet Secretary to the conclusion, and Fiona McQueen to the conclusion that we have to sort of cross the threshold and get in there and put a very senior team in there really very quickly indeed. So, in a nutshell, those were the main things that got me to that point and why I got to that point.

THE CHAIR: I probably should know about this, Mr Wright. Towards the beginning of your answer to Mr Connal, you mentioned the GGC annual review.

A Yes.

THE CHAIR: Now, it's just that I don't recognise that. Perhaps I should, so, what is it?

A Okay, this is part of the process of the government holding boards to account. So, every health board has an annual review with the Cabinet Secretary, with the Director-General, with some of the directors from government, the chair, the chief executive, and it's a big set piece event, and it's organised in advance. The whole of the performance of the board is brought together for that, and the board is challenged by the Cabinet Secretary about, you know, you haven't done that, or that's not good enough, but you have

done that, and that is really good, and you are to be commended on that. So, that is a formal set piece event every year where boards are held to account. One of the things the Cabinet Secretary and I did together was to put in place a series of mid-year reviews which were less formal, but involved the Director-General and the Cabinet Secretary getting the chair and chief executive of board in a room, and having a conversation about various performance issues, and that mid-year review for Greater Glasgow and Clyde happened on 24 October.

And I know the Inquiry has got a copy of that letter, but I think it's interesting to note that that letter from the Cabinet Secretary confirming 24 November-- of October was written in January, because we then very quickly escalated the board and we met with the whole of the board after that. So---

THE CHAIR: Right.

A -- I hope that answers---

THE CHAIR: So, the reference to the GGC annual review is reference to a process as opposed to a document?

A There is a document in the Inquiry's papers, I think, that contains the letter, the formal letter from the Cabinet Secretary to the chairman of the board, saying, "You had your annual review. We met the area clinical forum, the area partnership forum. We had a private meeting..." and there's a-- there's a substantial section in there about Infection Prevention and Control, and it-- it lays out the Cabinet Secretary's expectations. And the Cabinet Secretary says, you know, "You assured me that..." So, that's maybe worth----

THE CHAIR: Thank you, Mr Connal.

MR CONNAL: Just so we're clear about the timing of these events, did I understand one of your earlier answers to indicate that the annual review with the Board, the one in which various assurances were given and so on, took place in March---

A Yes.

Q -- of that year and then the half-year review, the smaller gathering took place in October, is that right?

A That is correct.

Q Now, in your witness statement, obviously, you set out a lot of the things that, in fact, you've touched on: discussions with the Cabinet Secretary, the Chief Nursing Officer, probably being the sort of driver behind a lot of these issues because her responsibility included Infection Prevention and Control, and that matter then came before the group that we discussed earlier, this board on which they all sat, is that right, and they reached a conclusion with which ultimately you agreed to take

that step, is that so?

A Yes, and I'm the decision-maker for Levels 3 and 4, and I do that on advice of the Health and Social Care Management Board, and of course I will speak to the Cabinet Secretary before coming to that decision.

Q Just so we have it, I think if we could just have Bundle 52, Volume 1, page 34? Now, I think you said you had a paper from Fiona McQueen. Is this what we're talking about here?

A Yes, it is.

Q I don't think we need, openly, in a sense, to read through all of it, but does it set out the kind of points that you've indicated?

A Absolutely, and I think she succinctly stated what the issues were and the reason for escalation being around the systems of Infection Prevention and Control at Greater Glasgow Health Board, and how patients-- how patients were engaged and communicated with, and I think she explicitly says that at that point, there was no evidence of a wider systemic issue at Greater Glasgow and Clyde and the recommendation was that it should be escalated to Level 4 for this very defined purpose.

I think later on in January, we escalated the Board more widely to Level 4 because of other performance issues,

but this was a very concise and precise intervention that we were going to make in the Health Board on those two major issues.

Q Yes. Well, let's just see how this document is set up so we can see what's in it. The front page, of course, is the one at which it is suggested that a particular step be taken. The Board is asked to consider escalation to level 4, the Board being that committee, if one likes and if we just go on to 35, that's just the end of that section. 36, and one then sees, I think, a fuller narrative.

A Yeah.

Q That essentially makes up the remainder of the paper that was placed in front of you. Is that correct?

A Yeah.

Q Thank you very much. When you were having these discussions before, during, and immediately after that meeting, was there any degree of dispute about what you should do, or was there a consensus?

A There was no dispute about what to do. I'd talked to the Cabinet Secretary about, and she talked to me about, should we go to Level 5 and---

Q We'll come back to that later, I think.

A Sorry?

Q We will come back to the question of Level 5 later, but yes, so you-

--

A But in terms of this recommendation, it was unanimous from the Health and Social Care Management Board that that was the course of action to be taken, and of course, I had had that conversation with the Cabinet Secretary before we took that decision, and I would never not do that, because as soon as that happens, the Cabinet Secretary has to go and give evidence in parliament, has to make a statement, and it becomes a very, very public thing. So, while it is my decision, you know, clearly I would have that conversation with the Cabinet Secretary before doing it.

Q I was interested in a phrase that appeared in your witness statement, so if we just take that document off screen at the moment and we go to page 220, in the course of narrating the different considerations, some of which you've already mentioned in evidence, the information coming back from Professor White and so on, in paragraph 17 you say:

> "which was leading to rising levels of concern about the extent to which NHSGGC had a proper grasp of the issues at the QEUH/RHC..."

Is that a summary of where you thought you were?

A Yes, yes it is and that's not to say we were not being regularly assured, reassured by Greater Glasgow Health Board that they were working on this, and there was a lot of activity, a lot of work taking place, but I think there was a pattern of-- So, I think if you step back from it, I think there's a pattern of, there's an infection problem arisen there, we'll, you know, we'll put in the appropriate-- appropriate Infection Prevention and Control mechanisms. We'd have Health Protection Scotland over it. Action would be taken, that would be closed off, then something else would happen over here, and something else would happen over there and as-- as time elapsed, there were-- there were many of these coming forward and a sense of, "Have we really got to the bottom of this? Have we really understood what the underlying issues were?" And in my conversations with Jane Grant and John Brown, and I can't remember the date exactly, my Lord, but I visited Greater Glasgow and Clyde Health Board and spent some time with the Chair, the Chief Executive, with the executive team.

I saw aspects, you know, physically went and saw aspects of the Queen Elizabeth Hospital. I got a strong sense from them about their commitment to seeing these things through, but I think there was a pattern of things happening and things that had happened quite a

long time ago suddenly coming to light and thinking we hadn't to the bottom of this yet and we need to get to the bottom of this. So, you know, and I think when the AECOM report came through and to get that sense of, this is the building that we've got and these are the deficiencies in the design, commissioning, and-- of that building, there was a sense of, actually, a lot more work is going to have to be done and a lot more public money is going to have to be spent getting the building to the place that we-- that we need it.

So, it's not, and I think Fiona McQueen's feedback to me was that the Board-- It's not that the Board weren't doing anything. They were working extremely hard, they were responding to issues as they arose, but the issues just kept on coming and I felt that a point-- a threshold had been reached whereby we needed to take action and actually cross the threshold at the Board, if you like, and go in with a transformation team.

Q What I wanted to ask as a follow-on to that, because if we go onto page 221, we see you referring to the fact that the Cabinet Secretary has to make a statement to Parliament and then she writes to the relevant committee and so on. You then go on to say, well, we created an Oversight Board. Now, again, looking from outside, one might

immediately think that the Oversight Board are running things, not NHSGGC, and that might, on one view, coincide with the sort of public perception of, "the government has stepped in" or words to that effect. Just help me understand how it was thought that an Oversight Board which didn't directly take over was intended to work.

A Yeah. The Oversight Board carries very significant authority from the Director-General and the Cabinet Secretary, and the Chair and Chief Executive knew this and they recognised it. Level 5 is the stage where the government comes in and says, "We're running this and we're taking accountability for it" and I think it's really important to be clear on boundaries because where does legal accountability lie at any point in time? So, level 4, the legal accountability for the delivery of safe, effective patient care services lies with the Board as a statutory body, and what the Oversight Board is doing is it's going in with a very senior respected person, and on the back of that, further people are going in who are senior and respected, but also people who've got a skill set that allow them to work collaboratively with both the Board's management and senior clinicians along the lines of, we need to get to the bottom of this.

And I don't think that the Chair and Chief Executive of the Health Board were in any doubt that if they chose to be obstructive, if they chose not to give information when it was sought, there would be a series of consequences for that, and I-- Fiona McQueen's feedback to me was that she got the cooperation she needed. She was able to do her work, she got the information that she needed, and we never needed to do that, but the Chair and Chief Executive would be in no doubt that if Fiona McQueen came to me and said, "Look, Malcolm, I've asked for this 10 times, I'm not getting it. I need you to phone the Chief Executive" I would phone the Chief Executive and say, "This is what I need you to do" and I know from my time as a Board Chief Executive that you don't get calls from the director general very often, but when you do get them, actually, it's about something very significant and it's coming from the Director-General and the Cabinet Secretary.

So, the Chair and Chief Executive recognised that. They're both experienced people, so it didn't-- I don't think it arose in practice. So, I think it's really important because I don't think-- the government coming in and saying, "we're running this bit of it, but we're not running that bit of it" I think that is a recipe for chaos and for-- and for things falling through the cracks. So, you know, the Board is either in statutory charge of its business or it's not and Level 4 is somewhere in-- you know, they're still in charge, but they're being directed, and I use that in a-- not a legal direction way, but they are being-- really, with the authority of the Cabinet Secretary and myself, we are going to get to the bottom of this.

Q Well, I was going to ask you about that because on page 222, a phrase jumped out at me on my most recent reading. Near the end of paragraph 22:

> "Both the OB and its sub-groups were intended to be a vehicle to rigorously manage the emerging situation at the QEUH/RHC."

Now, at least on the face of it, an oversight board that doesn't have any power, technically at least, to instruct anybody to do anything, might struggle to rigorously manage the process at first glance.

A Yes, and perhaps I could have worded that differently, but I think they were rigorously managing the business that they were set out to do under their terms of reference, and they were having challenging conversations with colleagues on the Board about what was

emerging, what needed to be done, but there was no point in which the statutory authority for doing those things did not lie with the Board.

Q That, as I understand from your statement, is in part because you were focused on particular area of Board functions centred around the new hospital, as opposed to all the other things that the Board was doing, which at that point were not the main focus.

A That's right. I mean, the Board, I think, had something like 35 hospitals. It had mental health facilities, primary care, and, you know that wasn't the focus. The focus was Infection Prevention and Control systems and engagement with families. That was the precise focus of what we wanted to see improvement in.

Q Can I just then pick up and make sure we're understanding another thing that you mentioned, which is mentioned on page 223. Now, I think you did mention it in the context of an earlier answer, the National Planning and Performance Oversight Group.

A Yeah.

Q Now, how does that fit into the picture we've been discussing?

A Well, the National Performance Oversight Group is a group within Scottish Government that is chaired by the Chief Performance Officer

who at that time was John Connaghan, and it was his job and his performance colleagues' job to pull together all of the performance parameters of the Board and to present that to myself and to the Cabinet Secretary to say the-- you know, say, take Dumfries and Galloway, "The Board's doing really well on here, they're on track here, here and here. They're really under some pressure here; we need to help them with that particular aspect." so to give it an overview of a board's performance so that we could say to the Cabinet Secretary, "Look, this is where we are with this board and, you know, do we need to escalate them? Do we need to de-escalate them?" John and his performance colleagues, working with all of the other-- well, you know, directors across government, so the Public Health portfolio would play in, the Integration portfolio would play in, to give that overview of a board's performance, and that reported to HSCMB and to me.

Q Now, you may have in part answered this question. If you look at page 224, you set out the terms of reference, the things that the Oversight Board was intended to do, ensuring appropriate governance was in place strengthening practice to mitigate avoidable harms etc., so if they encountered difficulties, challenges in getting done what they wanted to do, did

they have any power of enforcement to ensure the thing was done?

A Well, as I was-- I think there's one set of powers in terms of ministerial directions, and actually, we don't want to get to that stage unless we absolutely have to get to that stage. I think what I was trying to convey was that this Oversight Board carried the authority of the Cabinet Secretary and the Director-General. So, if the Oversight Board wanted a piece of information, wanted to go and speak to particular clinicians or particular staff, I would not expect them to encounter resistance from the Board, and if the Board was saying, you know, "Back off, this is none of your business" then actually there would have been follow-up action with the Chair and the Chief Executive of the Board.

I think in this instance, the Chair and Chief Executive are very, very keen to get the board de-escalated in time and certainly from the Chair's point of view, very keen to assist the Oversight Board and I know he met with Fiona McQueen on a-- on a regular basis. So, there's a-- there's a sort of important technical point there: did the Board have the power to direct? My answer to that would be, we absolutely made sure it never needed to get to that and that the Board understood that the performance framework is a dynamic system and it can go up and

down, and just because we've escalated the Board for that, doesn't mean that if there is evidence arising over here for that, we can't widen the escalation, and in an extreme event, I could make a recommendation to the Cabinet Secretary for a Level 5 escalation.

And in an extreme event, a cabinet secretary would get a chairman of a health board in, and if she was not content with the chair's performance, she would hold him to account, and there were examples in other parts of Scotland where, you know, chairs resigned on-- on the back of those sorts of conversations. Now, you try not to get to that position, but, you know, there are things that would be done to make sure that the Board did cooperate with the Oversight Board.

THE CHAIR: I think that's very clear. Could you just help me with, you used the expression, "widening the escalation." Now, what I understood from that answer was you were looking at a situation where the Board has been escalated to Stage 4. There remains the option for restating the basis of a Stage 4 escalation. Was that what you're referring to by widening?

A That's a very good way of putting it, my Lord and I-- which I hadn't considered, but yes, it's changing the basis of the escalation. So, in January of the following year, John Connaghan

came forward with a paper saying that a number of performance parameters in relation to waiting times, access targets, and other pressures, and there is a letter in the papers, in the Inquiry papers, outlining that, so the basis of the escalation was widened appropriately.

And I think we saw some of this happening in Lothian, that when you've got something of the order of what was happening in the Queen Elizabeth, it is clear that senior management time and energy and attention is going to be focused on sorting that out and, therefore, the time and energy and focus they can give to other aspects of the Board's performance, like waiting times in A&E or waiting times for operations and for outpatient appointments, they're not going to have-- they can't have the same amount of focus on that, so they need more support in another area of the Board. Does that help, my Lord?

THE CHAIR: It does.

MR CONNAL: Well, let me just ask you then about the possibility of a next stage or consideration of a next stage. If we go to 225, you were essentially asked, "Well, did you think about going to Stage 5?" What about going to Stage 5? Would that have been better or worse? And you described that as the most exceptional circumstances only to go to Stage 5, is that right?

A Yes, and it's laid out in the guidance about what are the parameters for a Stage 5 escalation, and those parameters – allow me just a moment – those parameters talk about the most exceptional circumstances, and they talk about a level of dysfunction across the Board's activities that requires ministerial intervention. And it also says that Stage 5 shouldn't be seen as a, and these are my words, shouldn't be seen as a logical next step from Stage 4, because we always wanted to get Boards down the ladder of escalation rather than up the ladder of escalation. But it really was a-- would have been a very, very serious move to make and one we would have made if the circumstances warranted it.

Q Was it an option you looked at when you did the Stage 4 decision?

A Yes, it was, and it was an option that the Cabinet Secretary discussed with me. And I think, by that stage, the Cabinet Secretary was hugely concerned and exercised, rightly so, about what had emerged, what had emerged in the AECOM Report, but I think her involvement of going and meeting the families face-to-face and hearing firsthand what those families were describing to her about how they felt they had been treated, and I think Fiona McQueen's engagement with the clinicians, and I think with the

whistleblowers going to their MSP and highlighting cases in November and highlighting cases that I think went back to 2017, the Cabinet Secretary was hugely exercised by all of this.

And my observation of working with this Cabinet Secretary was she took her responsibilities to parliament and her accountability to parliament extremely seriously. And she said to me, you know, "Should we not go for Level 5?" and we talked about that. My advice to her, my best advice, and I can only give my best advice, but my best advice was that I think we need to get in and around the Infection Prevention Control System and the engagement with the families, we need to move quickly and we need a team in place, you know, within a matter of days to get that. Because one of the things that really exercised me during this time was that as all of this was emerging, and as those whistleblowers came forward in November, public confidence in the Queen Elizabeth Hospital was being severely eroded.

And if you put yourself in the position of a patient or a family about to go into that hospital, reading all of that in the press, all of this that has come out, and you think, "Am I going to be safe here?" And it's really important that the public of Scotland correctly believe that the hospitals that they're going into are safe. So, for all of those reasons, I think having that very targeted approach on Level 4, in my advice, was the best thing to do. If the cabinet secretary had said to me, "Look, Malcolm, hear all of that, but I still want to go to Level 5," we would have done it. No question at all. But Level 4 does not-- Level 4 is the maximum the Director General can do. Level 5 is a ministerial decision, and Level 4 does not preclude, as you've said, my Lord, a redefinition of the basis of the Level 4 escalation, and it doesn't preclude moving to Level 5.

And I have found, because I've been personally utilised by government on a number of occasions to go into Boards that have been escalated on a Level 4 where a chief executive has moved on, you cannot avoid understanding the culture of the Board because, to me, it's human behaviours, it's human interactions, it's teamwork that are often at the root of these problems. So, it's quite possible when you go in on a Level 4, you go in to look at that and that-- and you see something else and you think, "My goodness, you know, we need to take further action here." So, Level 4, in my advice to the Minister, was the very focused, immediate thing that we could do, but it did not preclude the Minister from moving to Level 5, if she wished to do that.

Q Let me just ask you now then while we're on this theme about some of the possibilities. As you say, Level 5 is the drastic one. Essentially, as I understand it, it's regarded as taking over the Health Board on the part of the government. Is there any scope for suggesting that something less than that might be a useful tool? Because clearly, as you say, some areas might be quite happily going along, others might not. You've got this Level 4, which is intervening but not controlling, and then you've got Level 5, which is taking over everything.

A Yeah.

Q I just wonder whether you have any views on whether that's too inflexible, whether options in between ought to be available to the Cabinet Secretary?

A Or options in between that are kind of quicker. I suppose it is always within the gift of the Minister to ask the chair to move on, and then I think comes the question of the Chief Executive. And the Inquiry heard, on the Edinburgh leg of this Inquiry, advice we sought about the removal of accountable officer status for chief executives. So, if I do my best to explain to the Inquiry, if you're a board chief executive, there are three appointments you've got. One, your contract of employment is with the Board.

So, the employing authority is the Board. Your terms and conditions, your annual performance review, your personal development plan, your challenge is done between the chairman and the Chief Executive.

The second appointment is from me as the Accountable Officer. So, I have to have confidence that the Accountable Officer is qualified and capable of fulfilling those responsibilities, and that is why the Director General is usually on the appointments panel of chief executive of a board because they have to be appointed as accountable officer. And if-- And I think Stephen Lee Ross's advice that we saw in the Edinburgh part of the Inquiry was the processes that would need to be gone through to remove accountable officer status, and that is quite significant, and I think it's laid out in Annex 3 of the Public Finance Manual. So-- But that's not a straightforward thing to do, and it's quite narrowly focused on financial responsibility for financial resources.

Then the third appointment one has is that the Cabinet Secretary writes to the Chief Executive and appoint you as a member of the Board. That's a voting member of the Board. So, those are the three appointments. And I conclude from your question, because I've thought about this-- And if the question is

directed towards removing executive members of the Board, all of those executive members of the Board are employed by the Board. So, that includes the Medical Director, Director of Public Health, the Director of Finance and so forth. And I think government powers to remove that are intrinsically linked to where these folks are employed. So, you could say----

THE CHAIR: Sorry, I just missed that last sentence. Entirely my fault, sorry.

A I was saying it's intrinsically linked to who employs these folks. So, the Board employs them. The Board is the statutory accountable authority. And you could say, "Right, somebody else is going to employ the chief executives," that changes the whole dynamic of the Board because the point of having a statutory authority with a range of governance in place is that the Board holds them to account. So, if they're thinking that they actually report into the government, that's a different dynamic, and I'm not sure that Scottish ministers would wish to directly employ chief executives. So, there are pros and cons to different----

MR CONNAL: I'm just trying to explore possibilities with you, none of which are probably fully formed, but I suppose what I'm trying to suggest is there might be circumstances in which the government thought that part of the problem or whatever----

A Sorry, could you just----

Q Part of the problem might have been the chairman. Now, the way you dealt with that was to say, "Well, the Cabinet Secretary could ask the chair to go."

A Yeah.

Q And the Cabinet Secretary-- Well, one possibility is the Cabinet Secretary should have power to remove the chair. Ask them to go. Another possibility might be if it was thought that the Chief Executive was part or all of the problem, a mechanism could be put in place by which the Chief Executive could be removed and a new Chief Executive appointed by the Board, not to be appointed direct by government. These are possibilities, perhaps intermediate possibilities, I wonder whether you'd had any thoughts on?

A Yes, I think government determining that an executive director of the Board is the problem is pretty problematical from employment law perspective because I think all employees of the National Health Service have got contracts of employment. They've got, you know-- we have an obligation to honour those contracts of employment, and taking precipative action to try and

get a chief executive moved on, somebody could well say, “Well, this is not fair,” and an employment tribunal could result from all of that. So, I think one needs to be quite careful about it. I think in those circumstances, all chief executives have their performance reviewed by their chair every year.

All of those performance reviews in terms of where they’re placed on the scale come to government. So, government takes an overview about who’s performing well, who’s performing less well, and I would certainly have no difficulties in having a conversation with a chairman of a board to say, “Look, we have some concerns here, and can we have a conversation about it, please?” But that falls short of, I think, what you’re maybe hinting towards.

Q Well, I suppose what I’m trying to think about are the possibilities. If Stage 5 is a fairly drastic one under which a government, in effect, takes over. Anything short of that, removal of a chair, removal of a chief executive, removal of all the executives----

A Yeah.

Q -- leaving in place perhaps the non-executives, or indeed removal of the Board and making new appointments might be options short of that ultimate step. I don’t know whether you’ve given any thought to that.

A Well, I have and I think my best advice is that I think it is linked to who employs the Chief Executive. Is it the government or is it a statutory body? And I don’t have a legal training, and if that was to be explored, I would want to take legal advice on that, but that is my best sense of it. Yeah, I think it is linked to where these folks are employed, and I think it’s linked to their employment rights. And I think somebody from an external body saying, you know, “Time’s up, move on,” I think that raises all sorts of legal challenges to the Board who are the employer about is that-- was that conclusion arrived at reasonably and fairly. I think it’s problematical.

THE CHAIR: Mr Wright, remind me, and again I should know this, the members of the Health Board. Now, as I understand it, some of these are appointed directly by the Cabinet Secretary. Am I right in thinking others are nominated by, for example, the local authority?

A Yes.

THE CHAIR: Yes.

A And still appointed by the Cabinet Secretary----

THE CHAIR: Right.

A -- but nominated by the local authority. And the same applies to the employee director who will be nominated by the trade unions and will be then

appointed by the Cabinet Secretary. So, all of the Board members are appointed as Board members by the Cabinet Secretary.

THE CHAIR: But the local authority has the nomination role and might have views about their nominee being removed?

A Exactly. Exactly so.

THE CHAIR: Sorry, Mr Connal.

MR CONNAL: No, that perhaps illustrates the issue. I suppose I'm envisaging a situation in which an issue arises, it's thought to focus in perhaps one or two areas of responsibility and a Cabinet Secretary says, "Well, I don't want to remove all these people who've been nominated or appointed by me. I just need to appoint another group, and it can cause all kinds of problems, but I really don't think A, B, or C should remain in post given what I've had reported to me." At the moment, you see that as being problematic because of their employment rights? Is that where we've got to?

A Yeah, because they're employed by a different authority. However, if I or the Cabinet Secretary had concerns about the performance of a particular Chief Executive colleague, I wouldn't want to leave the Inquiry in any doubt that I would have conversations with the chairs. So, for example, one of

the things I did every year on behalf of the Cabinet Secretary was to do the performance appraisal of the chair. And, you know, part of that would be, "How's your Chief Executive? What are the challenges, what we need to do." So, there are ways into this that I would have no hesitation to take if that was what was necessary.

Q Can I just ask you another point, sort of, along the same theme? One of the issues that has been mentioned by some witnesses was that when the Oversight Board was in place, there was a lot more reporting having to be done by people in NHS GGC, and this was budensome for various reasons, however understandable. If you have a-- I suppose the question, if I can formulate it correctly, is if you have a very large organisation, could a situation arise in which more reporting would actually be helpful, as opposed to-- It might not be helpful to those having to do it, but might be helpful to the recipients. Can you see that as being a possible decision?

A It may well be, but I would give that fairly short shrift. I think if you're running a multi-billion pound organisation and you're saying, "This is too much work," I would say that's the least of your problems. Really, really that's the least of your problems. And secondly, I had and have full competence in Fiona McQueen

that she would go about her role in a way that was sensitive to to the way in which the Board operated. She would be very clear in what she wanted. She would work collaboratively and we would try and minimise the reporting requirements. But, you know, when you send a Level 4 team in, of course there's going to be reporting requirements. And, you know, Fiona, I think, very helpfully set up a number of subgroups to look at different things. So, of course that is gonna generate work.

But if it didn't generate work, it wouldn't be doing what we wanted it to do. So, that is a risk. There are a number of risks sending in an Oversight Board, confusion about who's in charge and who's making decisions, and I think, given the skills of Fiona McQueen, I was never in any doubt that she would be able to manage those through and she would command the confidence of not only the management but the clinical staff of that Board, and I believe she did.

Q Let me ask you another question. Again, we're staying broadly with a theme. Culture might be something that's influenced by those near the top of an organisation----

A Yes.

Q -- in these circumstances. Approach, general method of that kind, attitudes, and so on.

Q Now, in your witness statement at 236, we may come back to some other things, but if we just go there for the moment, you were asked a specific question, which I suspect may have come from one of the participants, is there a risk that, because day-to-day running of the Board remains at the hands of the Board, issues of institutional culture can't be addressed and then the phrase is "without the full cooperation of the Health Board and its senior officers"? Let's leave aside for the moment people being actively obstructive, how do you deal with an unsatisfactory culture in a situation of that kind?

A Yeah. And to answer your question, I think I would fall back on my experience as a Board Chief Executive when I was asked by government to go into the West Isles, to Grampian and to Tayside. And in each of those boards-- So, you know, you take the Western Isles, the presenting problem was a massive financial overspend. Actually, beyond that, you very quickly got to the point about how does this organisation run? What's the culture like? What's the leadership like? And it was the same in Grampian, and it was certainly the same in Tayside where the presenting problem was financial overspend, lack of financial control, charitable funds being allegedly used for revenue expenditure and so

forth.

And you very quickly, because going into a board, you talk to people, you interview people, and you very quickly get a sense of what's the culture here. And I've always had in my mind the phrase that, "Culture trumps strategy every single time." And I've always felt that one of the most important parts of a chief executive role is to lead and manage the culture of the organisation, and you do that by example. You do that by how you chair your management team meetings, how you walk about, how you interact with clinicians, the things that you value and the things that you don't value.

So, in the Glasgow situation, I would value clinicians, I would value clinical voices, I would value clinicians who were whistleblowing, who were not happy. And just because people are whistleblowing and that is a threat to the organisation, my sense has always been to surround myself with people who are very bright and who will tell me things sometimes I don't want to hear. So, I think it's about having a culture that encourages people coming to you and saying, "Look, Malcolm, that's not right, and while you're at it, you need to understand that, that, that, and that." And having a culture that doesn't punish people for giving you bad news, I think that is absolutely essential.

And I look back to what happened in Lothian Health Board many, many years ago, where there was a huge scandal about their waiting list. Culture was at the heart of that. And you had people, different layers of the organisation, not being prepared to report of bad news because they were afraid of the consequences upon them. Now, my sense is if you're going to get the best out of an organisation, you need a culture where you report that coming through. So, I was shocked when I read the DMA Report, and I was shocked for two reasons. One, the content of it, but I was shocked because it said something about what was going on in that part of the Board, that colleagues felt able not to report it up, not to follow it through.

And it said something to me about, how's the Estates department working with Infection Control people? How is bad news getting reported up the line? And what's that culture of kind of openness and a sense of, you know, you're not going to be hung out to dry if you give me bad news, you know. You're going to be-- You'll feel my critique of you if you don't give me the bad news, but if you bring me bad news and say, "Look, find this out, not happening," then I will respect that. And I always find as a board chief executive, that if something was going wrong in my board, one of the

first things I'd do would be to phone somebody in government and say, "Look, you just need to know that that's happening, this is about to hit the press, and this is what we're doing about it." And you don't have people's blind sided. And I suppose what I saw coming through here was regular things coming out of the woodwork that had not come out of the woodwork before.

So, I think when a team goes in, culture is one of the first things they come across. They can't avoid it, and that has to be a part of the diagnosis of whatever problem the Board is facing. That would be my perspective as a board chief executive.

Q That's very helpful as it touches on a range of issues that this Inquiry has heard about. I just want to ask another question in the same connection. I mean, you said, what was it, "Culture trumps strategy every time"? Another phrase sometimes crops up which is that, "People don't learn unless they accept they were wrong in the first place." Now, one of the witnesses we've heard from recently was Professor Bain who was obviously inserted into the Board to deal with a particular aspect, and one of the things that perhaps jumped out of her witness statement to us was that she said that she got the very clear impression, having talked to senior people in the Board, that they didn't think there was any need for any of this?

A Yes.

Q So, in other words, they were doing what they're required to do because they didn't have any choice perhaps, but they didn't think there was any necessity for the interventions, they didn't need the help. Would you regard that as an obstacle to making progress?

A I'd regard that as a clear symptom of the culture of an organisation. So, while it might be perceived as a problem, it would just double the determination of myself and the Cabinet Secretary that we're going to work through this. I mean, you know, I've gone into boards in the past. You know, I remember going into one particular board I won't mention where the first reaction was, "This is unfair. We're really being badly dealt with here. The government's being really unfair to us. They don't understand all the work that we're doing." And actually you get them to open up about that and you understand that there are huge problems of the grappling, we're not trying to blame them but our focus is on getting things right for patients. That is the only focus.

And if the culture is one of defensiveness, then that's a red flag for me. And if I may be allowed, my Lord, when I worked at Great Ormond Street

Hospital, my boss was an ex-Third Sea Lord of the Admiralty. He trained as a barrister, and he taught me that if there's something wrong under your command, you report it, you own up to it and you get it out quickly and, you know, you then respond to it. And that lesson has always been with me. So, if that is being encountered, that's a big red flag to me about the culture of a board.

Q Well, let me ask you an associated question. In your witness statement, you were asked one or two questions about the Case Note Review, which was part of the process that was being put in place. I'm calling it through the Oversight Board because the Case Note Review, I think reported technically to the Oversight Board. Now, I appreciate that you weren't necessarily in post by the time all of this came out, but the Case Note Review-- Sorry, my Lord.

THE CHAIR: When you say, "When it all came out," you mean the publication date of the----

MR CONNAL: The publication date of the findings for the Case Note Review.

THE CHAIR: Right, in March 2021?

MR CONNAL: March 2021.

THE CHAIR: Yes.

MR CONNAL: Yes, my Lord. I apologise. This is dealt with in-- So, we have it, for ease of reference, paragraphs 51 to 54 in your witness statement on page 231 and 232.

A Yeah.

Q I'm not actually going to ask you the direct questions that are here to which you've given answers, but-- When we asked Professor Bain, "Who was the sponsor of the Case Note Review?" about aspects of it, she described its principal conclusion as the one that said that 30 per cent or thereby of patients had received, most probably received, probably received their infections as a result of the environment. And why was that the principal conclusion? Because that was the ask. That's what they'd been asked to go in and do.

Now, we've had some evidence and we're probably going to get a bit more about what the reaction of the Board was to the report from the CNR that 30 per cent were probable links to the environment and a larger number were possible. And we know what the Board said as a public statement. I suppose what I'm keen to ask you, and you can assist or tell me if you can't assist, is if the Board had responded to that CNR conclusion, that principal conclusion, by saying, "Well, that's your conclusion, we don't agree with it at all. We don't accept that 30 per cent or anything like that is down to the environment," and that had been their response, can you help us as to what the likely consequences of that

would have been, if that had been their position in response to this act of the Oversight Board?

A Well, and given I wasn't in post when the report was published, and I'm not fully conversant with all of the circumstances, but if that was the position and I was advising the Cabinet Secretary, I would say, "Well, why? Why?" So, if we've got a UK expert who I think did the Morecambe Bay review, who I think was sourced by the Chief Medical Officer, you've got three eminent people who are external to Scotland, you've got clear terms of reference, they've been through individual case notes. Now, a case note review is not a novel way of doing things. We've always done case note reviews, and if you really want to understand what has happened in the care of individual people, that is a well-rehearsed way of going about it.

And if you've got three eminent people coming in saying, "We've done this and we've come to that conclusion," I would expect the Board to accept the recommen-- accept the conclusions and recommendations of the Case Note Review, (a) because of the seniority of who is doing it, and I caveat that by saying, "Well, tell us why. Tell us why you're rejecting this," but I'd also expect it because of the perspective of the parents. If your child has been-- you think your child has been the subject of harm, the one thing you want to know is what happened to my child and who's going to accept responsibility for this?

And given that causation is a hugely complex thing, and understanding all of that, I've read the Case Note Review, but I have not been involved in the discussions to date, I would think that if you were really wanting to engage with the parents, you would not say, "Well, we're not accepting any of this." I find that very difficult if the Board-- If I had been there and if the Board said, "We're not accepting any of this," I would find that very difficult, and I think that would prompt advice from me to the Cabinet Secretary about what we need to do.

THE CHAIR: Is it unfair to ask you what the options you might put to the Cabinet Secretary in that state of affairs where the Board has explicitly rejected the conclusions of the Case Note Review?

A Well, I certainly wouldn't put any advice to the Cabinet Secretary until I'd fully understood why, and I would be asking the Chief Medical Officer to speak with the Board, to speak the Medical Director of the Board and to understand why. And to me, it would need to be a pretty high bar as to why the Board wouldn't wish to accept that. So, I'd want to understand it. I think the Cabinet

Secretary would want to understand it. She would want to understand the clinical perspectives and just get a rounded picture of it.

But I think if the Cabinet Secretary came to the view that this was a robust piece of work and that the Board, for which I have accountability in parliament, is refusing to accept this, then I think there would be consequences in terms of conversations that she would have with the chair of the Board, with the non-executives of the Board, and with her overall confidence in how the Board was operating, I would guess. But I'm speculating, and I know you're inviting me to, and I don't want to say things that I don't have knowledge of----

THE CHAIR: Mm-hmm.

A -- because I don't.

THE CHAIR: Well, I can see it's a speculation as to what actually would have occurred. Maybe not a speculation, assuming the facts that we put to you as the hypothesis. It's not a speculation as to what advice you would have given, and I've got your, "want to know why, speak to the Board, Chief Medical Officer of the Board, to understand their thinking" because you would regard rejecting the CNR, which I think you said you'd read----

A Yes, I have.

THE CHAIR: -- yes – would be a high bar.

A I think so. I mean, I'm not medically qualified to----

THE CHAIR: No.

A -- pass a judgment on the quality of the CNR report, but I've read it as a former DG and Chief Executive of the Health Service. I think it is a robust piece of work, but I was not in government when it was proposed. So, yes, I would want to understand that, and I guess if it was the view of the Chief Medical Officer, the Chief Nursing Officer of Marion Bain, it was the view of the chair of the review that this was a credible, robust piece of work that parents are needing to know the answers to, I think there would be a holding to account of the Board by the Cabinet Secretary in those circumstances.

THE CHAIR: Thank you.

MR CONNAL: And I suppose, just to follow up his Lordship's theme, a holding to account sounds very nice, but what does that actually mean? What would happen? Would heads roll or what?

A I really don't want to-- because it would depend on the outcome, but I would be in no doubt that the Cabinet Secretary and Director General would have a robust discussion with the chair and the Chief Executive of the Board. If I was there, I would certainly involve the Chief Medical Officer in that. And we

would see where we got to with that. I don't want to speculate on what a Cabinet Secretary would wish to do in those circumstances, but it doesn't lead to good outcomes.

Q Thank you. I just have a couple more questions. One, NSS Assure, which as you point out, in a sense, emerged in something approaching its current form in part due to the events at the new hospital. Now, this may or may not be in your area of expertise. Knowing what you do about that emergence, do you think it has enough powers to stop things happening in the future?

A I've been retired for five years now and I know that things have moved on considerably since I-- since I retired. And I think I gave evidence at the Edinburgh part of this Inquiry where we had a very clear and immediate case of thinking, "Well, okay, one thing, something else happened," and the need for externality at different stages of the process to assure not only the government but the Board that we are getting what we think we're going to get, and that national standards have been applied, and if there are derogations from national standards, there is a clear audit trail and those derogations have been cleared with an external authority, an external expert authority, because the

Scottish Government, Cabinet Secretary, doesn't have that level of technical expertise, but we need to have an organisation that does, and I think when I read through the history of the Queen Elizabeth and read the AECOM Report, and just the gaps between what we perhaps should have had and what we did get, I would strongly support the need for NHS Assure, but I don't know in detail where that's got to because I'm not involved anymore.

Q Thank you. I think the last question I have for you at the moment at least is probably a fairly open one. We have your witness statement. We can see the way you've dealt with various of the questions there, and I'm not going ask you to go through all of that, and we have perhaps taken advantage of your presence to ask you for your thoughts on a variety of possibilities on which you've offered views. Do you have, in light of your knowledge of the content of this Inquiry, any additional material that you would like to suggest to the Chair that might be helpful in going forward?

A Yes, and I've given this some thought as well, and I want to be helpful to the Inquiry in terms of what I've learned over the years, and if this is low-level management to colleagues on the Boards, I apologise for that, but maybe five quick points I would make and happy

to answer anything on any of them. One is NHS Assure, absolutely, but we've covered that. Secondly is the centrality of Infection Prevention Control, Estates and frontline clinical staff working together. And I want to make a comment later about systems of management and general management models, but I've learned over the years that-- to listen to clinicians very, very carefully.

And in some parts of the NHS in the past, and I think this is a feature of the worst of the NHS trust system, where management was put in charge and authority over a lot of doctors. I've always been of the view, and I've learned this at Great Ormond Street, I've learnt it at NHS education, that actually if you're a consultant in the National Health Service, you will have done five years at medical school, two years of foundation training, and another 8, 9, 10 years of post-graduate education. You are regulated by the General Medical Council. So, your behaviours and your patient-centredness is absolutely in the core of what you've been trained to do.

So, even when clinicians have said to me things I didn't particularly like or they've said them in ways I didn't particularly like, actually they're worth listening to because they've got that level of experience and they know things that I don't know. And I apply the same to nursing staff in terms of their undergraduate and postgraduate education, to pharmacists, physios, and OT. And I undertook a Churchill Fellowship a number of years ago, and I spent some time in New Zealand and I learned the adage of health care systems being clinically led and enabled by management. And the management role was one about making things happen rather than, "This is what you're going to do," which is an old type sort of stereotype.

So, I think the importance of clinicians working with Estates colleagues, and certainly in my time, and we did a lot of work to address this, but Estates have an absolutely central role and them working with Infection Prevention Control, and that's really the heart of it. So, the third point I think leads from that and I think that's about the Board's professional advisory structures. Every single Health Board in the country has got an area medical committee, an area nursing and midwifery committee, an area clinical forum, and these are bodies that are down in regulation that-- every board has to have one. And I've always found them hugely important conduits of clinical opinion within the system.

And I've always met, and I'm sure colleagues at Greater Glasgow and Clyde

do this as well, but I've always made a point of engaging very closely with your area medical committee, your area nursing committee, because you find out stuff about what consultants around the place are seeing and what their views and opinions are, and you can triangulate that with what you're getting through the formal line management structures. So, I think that clinical leadership, I think the professional advisory structure is hugely important.

Fourth point I would make is about when you build a new hospital, and it's easy to focus on the building-- well, it's not easy, but you can focus on the building and what a fantastic £800 million development we're getting here. It's going to be really, really fantastic. But, actually, what you're doing is you are engaging in a huge set of organisational changes because you're bringing teams of people together who work in different parts of the system, and you almost need to put as much work and effort into how these teams-- these new teams in a new environment are going to work together in practice.

And you might have had perceptions from, you know, the same clinical environment but working in one part of the city to another part of the city, they're suddenly brought together and there's all sorts of tensions come out, and you actually have to invest in the organisational development part of all of that, and you need to do it well in advance of the building opening. And I think one of the things that Marion Bain did, from memory, was to institute organisational development within the Infection Prevention Control team and that's absolutely what's needed.

Then the final point, my Lord, I would say that boards need to make sure their systems of management are fit for purpose. Now, a system of management in Greater Glasgow will be different from Tayside, from Grampian, from an island board, and boards are very different. So, there's no one size of management that should fit all boards in Scotland, but I think that board governance systems need to check that their management systems have got clinicians in the middle, we're hearing clinical voices, there's teams of people working together, and what we value more than anything else is not protecting the organisation, but protecting patients, and that if you come forward with something that's bad news, we're going to bring that on. We're not going to punish you for it.

So, all of that. Are our organisational management systems actually fit for purpose? And are they supporting the delivery of healthcare, or do we need to do something about that?

So, that would be four of my things that I would say to the Inquiry that it might be worth thinking about.

THE CHAIR: Two questions from that, Mr Wright. The first, when you talk about the importance of listening to clinicians and the integration of clinicians within the management structure, am I right to understand you mean not simply people who at one stage in their career have qualified as doctors, but people who are currently engaged in providing clinical services?

A Exactly so, my Lord, and having a consultant in specialty X being a clinical leader of that part of the organisation, but also I think there's huge benefit in that-- consultants still doing outpatient clinics, still doing operating theatres, if they can keep their practice up, and that connection with patients, I think is hugely, hugely important.

THE CHAIR: The second question is, although I'm paraphrasing because I don't have the text in front of me, the terms of reference of the Inquiry envisage that the Inquiry will look at the provision of a safe environment for patient-centred care. Now, inevitably, both from the terms of reference and the way the evidence has emerged, in thinking of a safe environment, we've had to think about physical environment, particularly ventilation and water systems. But listening to you, I'm becoming confirmed in a view that a safe hospital environment certainly involves the physical infrastructure, but it also involves the way the services are managed----

A Yes.

THE CHAIR: -- the way there is internal-- or how internal communication among those responsible for the services work, how communication with patients and families work, and how the confidence of both current and potential patients is maintained----

A Yes.

THE CHAIR: -- is all part of providing a safe----

A Yes.

THE CHAIR: -- environment for patients. Am I understanding you correctly?

A I think that's exactly so, my Lord. And I think the two are equally important. So, how clinicians work together, how the team working goes, how they collaborate across different clinical disciplines, how they work together to get the best outcome for patients. And I think where there are problems-- So, you know, one of the questions is, "How do we sort out disputes in this organisation? How do we sort out where there's discord in the organisation?" And it's, you know, is that a sort of top-down, "You're going to do

this because we expect it," or is it how do we bring people together? We explore differences and we look at what the patients want and we create an expectation that we will work together. And it's an absolute organisational expectation that we will work together. We will get these outcomes for patients, and actually, if there are colleagues who don't want to do that, then we will have those conversations separately.

But I think, and I've learned over the years that, you know, the management of performance of a board, your waiting list targets, your A&E targets, you know, that can be reduced to numbers. It's really important. The management of the money, that's really important. The management of the building project, that's really important. But just as important are how these highly trained clinicians coming into an environment that they feel supported, that they can work together, they can have disagreements, they can work things through, and actually, if they want to say something that is not going to be welcomed by management, it's okay to do that. Because if this affects patient safety, I want to know about it, and we're gonna work through it and make things happen.

So, I'd say, you know, the kind of right-hand side is just important as the

left-hand side, and I think the key skill sets that I've always looked for in chief executives are people who could, you know, do the right brain stuff and, you know, your TTG targets and, you know, outcomes and putting numbers down and hold them to account, but you need to be able to do the left-hand side stuff about how do we create the organisational environment where people can flourish. You know, if you've done 15 years of medical training, you don't want to go into a job where you're feeling, you know, you can't express your views, that you can't advance clinical practice. And, you know, these are hugely experienced people we've got in our organisations. They're an incredible resource, and I think if you support them, you can get really good outcomes for patients. Sorry, that's a long answer, my Lord, but I (inaudible 02:14.08).

THE CHAIR: But a useful answer. Mr Connal?

MR CONNAL: Can I just ask you one question, having listened to your points, and see if you can help at all? One or two witnesses when asked about this committee or that committee in the context of what we've been hearing in this Inquiry said, "Oh yes, health Service, lots and lots of committees, arguably too many committees." And I have in mind a piece of evidence in which a witness--

we'd had some evidence about different layers of committees on a particular topic, and we had a particular witness and I said, "You know, we've heard about committee A and committee B and all these events and we haven't had either committee actually do anything. You know they've received reports and they've passed on reports to other committees, but we haven't actually heard of them taking any action." And the answer was, "Well, that's not what they're there for. They're simply to provide oversight." I'm not sure whether you recognise that picture from your time in the health service.

A I believe John Brown is going to be giving evidence next week and I know he's done a lot of work on board governance, and I hope he would agree that the role of the Board committee is not just to seek assurance, but is to ask challenging questions. So, say a board gets an HIS Report and it's got things you're doing well, it's got things you're not doing well, and you need that report brought to you, you need it with a cover paper saying, "We're going to do this, this, this, and this," and that's the sort of-- that's the right brain stuff. The left brain stuff is about, "Okay, how are teams being worked with to make sure that we actually really, really, in practice, put this into place."

So, I think board committees are really important. I think the Board's Infection Prevention Control Committee is absolutely essential and it needs to be asking those hard questions, and it's not for things for noting. Things need to be escalated there. But I think, you know, at the Greater Glasgow Health Board, I think that's something upwards of 30 people sitting around the Board table, and I've looked at the CVs of those colleagues. I mean, there are some pretty senior experienced people. I think how a board chair deploys those non-executive directors, not just to receive papers coming through and saying, "Yeah, that's okay. Go and do that," but actually those non-executive directors to get in and around the system, to do walk-arounds in hospitals, to go into clinical environments, to talk to clinicians so that that soft intelligence can be brought through as well as the hard-edged, "This is in a report. Here's an action plan, and this is what's red, amber, and green."

So, I think-- I've always believed in triangulation of intelligence and, you know, to go back to the Gulf War, not stove piping of intelligence, you know, triangulation of evidence. So, the hard evidence coming through, really important, but I've always wished in my career to triangulate that with, "Well, I'm going to spend a morning in a set of

operating theatres and get gowned up and talk to people," or "I'm going to do a walk around this particular ward," or "I want to meet that group of clinicians." Now, in the Board of Great Glasgow and Clyde, it's a huge thing to do, but it's how, as a chair, you deploy that expertise to make sure you're getting the soft intelligence through, and the things about culture and leadership, where the blockages are, as well as the heart and intelligence.

Q I have no further questions, my Lord.

THE CHAIR: You may wish the opportunity to check with the rest of the room. Mr Wright, if you could bear with us for no more than 10 minutes so that Mr Connal can check whether there's any other questions that should be answered.

A Okay.

THE CHAIR: If I could invite you to return the witness room.

(<u>Short break</u>)

THE CHAIR: Mr Connal?

MR CONNAL: I have what I hope is one question.

THE CHAIR: One question.

(<u>The witness returned</u>)

THE CHAIR: Perhaps one further question.

A Okay.

MR CONNAL: I'm just trying to formulate the correct version of this question. In your witness statement, you spoke of concern over whether NHS GGC had a grasp of what was going on, and you mentioned, I think, in your oral evidence, things were popping up here, things were popping up there, you turned around, something else had popped up. You may remember mentioning that. The point I've been asked to raise with you is this, that the former Chief Executive, Jane Grant, gave evidence and I'm told said that when something cropped up, she focused on what had happened, looking forward, don't look back, don't investigate back, focus on looking forward.

Now, I suppose the question is could that have contributed to the fact that things kept popping up because you're simply looking forward you're not looking back at the root cause?

A If Ms Grant said that, then I understand what she was trying to say in that, you know, if a series of infections has become apparent, you absolutely need to get on top of it quickly with your

Infection Control people, with your medical director, with the help of HPS and, of course you've got to be proactive, and of course you've got to look forward. But I think what I've found of value, and I think what we found in a great value in the Edinburgh leg of the review, was the reports that Ms Freeman commissioned to say, "Let's just understand, go right back to the beginning and understand what we thought we were going to get, what we actually did get. What we thought we were going to get, did that meet extant standards at the time? If not, why not? And what we've got, is that what we thought we were going get?"

And to understand the-- understand the full panoply of issues affecting, my personal practice would always be to try and let's get this stuff out now. Let's-- let's get it out and understand it. Even if that's hard and it's difficult, it's better we get it out now and we understand the breadth and depth of what we've got to deal with. And then we can-- That's not to say we're not going to deal with things as they come up, but it gives us the perspective to say, "Actually, this is the size of the task that we've got here, and we need to go about this in a systematic way." So, I think you've got to do both, would be my----

Q You've got to do both.

A -- best advice.

Q Okay. Thank you. I have nothing further more.

THE CHAIR: Thank you, Mr Connal, and thank you, Mr Wright, for your evidence today. It's the second time you've come to the Inquiry, thank you for that, and thank you for the obvious, careful preparation of the evidence that you've given. It will be helpful to the Inquiry, and I am appreciative of it. However, you are now free to go. Thank you very much.

A Thank you, my Lord. Thank you very much.

THE CHAIR: Thank you.

THE CHAIR: Now, that's the end of our proceedings for today. We will resume again on Tuesday of next week. Again with you, Mr Connal?

MR CONNAL: Yes, I'm returning again with Mr Calderwood.

THE CHAIR: With Mr Calderwood, and that, I think, is scheduled for two days?

MR CONNAL: That is so.

THE CHAIR: All right. Very well. Can I wish everyone a good afternoon, and we will see each other, all being well, on Tuesday.

(Session ends)