SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
16 September 2025

Day 16
10 October 2025
Jeane Freeman

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10:00

THE CHAIR: Good morning, Ms Freeman.

MS FREEMAN: Good morning.

THE CHAIR: Now, as you're aware, and of course you've given evidence to the Inquiry before, you're about to be asked questions by Mr Mackintosh, but first I understand you're prepared to take the oath.

MS FREEMAN: I am.

Ms Jeane Tennent Freeman

Sworn

THE CHAIR: Thank you very much, Ms Freeman.

THE WITNESS: Thank you.

THE CHAIR: Now, your evidence is scheduled for the day. Whether it takes the full day or not, I'm not sure. We will take a coffee break at about half past eleven and take lunch at one o'clock for about an hour, but if at any stage you want to take a break, just tell me and we can take a break.

THE WITNESS: Thank you.

THE CHAIR: Mr Mackintosh.

Questioned by Mr Mackintosh

Q Thank you, my Lord. Ms Freeman, before I ask you any questions, I should just say there was a technical issue with the YouTube feed last night, in case any of those watching online were wondering why they couldn't see yesterday's evidence. We've resolved that now. I was going to say that before you came in. Can I ask your full name?

A Jeane Tennent Freeman.

Q What's your current occupation?

A So I am part time at the University of Glasgow as Dean of Strategic Community Engagement and Economic Development.

Q Thank you. You previously gave evidence to this Inquiry on 12 March last year.

A I did.

Q Thank you for returning on this final day of evidence in the Glasgow leg of the hearing. We obviously have two statements from you from the Edinburgh leg, a principal statement and a supplementary statement. Are you willing to adopt this third additional statement as part of your evidence?

A With one correction, if I may.

Q Yes. Could you tell me which paragraph it relates to?

A It relates to paragraph 15.

Q Which is on page 99 of the hearing bundle. This relates to the responsibility of chief executives?

A Yes, it's-- it's simply to clarify

what I meant. It's a little misreading-- misleading as you read it just now where I say that:

> "Health Board Chief Executives are accountable to the DGHSC/ Chief Executive of NHSS."

The actual fact is that a health board chief executive is accountable to their employing authority, which will be their health board, but they are appointed as accountable officer by the Chief Executive of NHS Scotland and are accountable to that person for that role.

Q As accountable officer?

A As accountable officer.

Q With that clarification, are you willing to adopt----?

A I am.

Q Thank you. Now, actually, my first question was about that, from a slightly different perspective. If we stay with paragraph 15, you mention the role of the Director General as Chief Executive NHS Scotland; it appears on headed paper. There's also a chief operating officer of NHS Scotland within the directorate. I wondered whether these titles might to some degree overstate the amount of day-to-day control that both of those office holders can exert over the operations of the parts of the health service that are run by local health boards. I wonder what do you think of that?

A I-- Excuse me. I don't think they overstate the degree of control. I think, for example, the Chief Operating Officer, as perhaps we will see subsequently in relation to NHS Greater Glasgow and Clyde, has a-- a direct responsibility for ensuring that the operation of individual health boards is designed and delivered in such a way that it meets the objectives of the Scottish Government, who has set out what objectives the NHS in Scotland need to meet in any particular given period.

And the combination of the role of Director General for Health and Social Care with NHS Scotland Chief Executive is, I think, designed to ensure that the two are complementary. So we don't have a separation between the head, if you like, of the policy area of health in Scottish government and the day-to-day challenges and operation of the NHS in Scotland. Now, there is a debate-- there's always been a debate inside Scottish government as to whether those roles should be separated or should remain combined, and I think that remains a live debate, but, as of now, they are combined.

Q I suppose the reason I was asking the question is not because of any thought that they should be separated, but simply because, in the sample of one,

i.e. one health board, that this leg of the Inquiry has dealt with, one sometimes gets the impression from chief executives – not all of them we've spoken to, but two of them anyway – that there's a level of autonomy in the operations of NHS Greater Glasgow and Clyde, which is not only justified in policy terms, but is right and proper in the way the world is set up.

A Mm-hmm.

Q Obviously we'll discuss situations and hypothetical future situations where a Scottish government might wish things be done a certain way. In this sample of one, one doesn't always get the impression that what the Scottish Government wants necessarily happens in a health board, and so what I'm suggesting is there's a lack of transparency in the job title.

A So, I completely understand your question and I understand what has led you to ask that, and it is true that there is a tension where some of our health boards do believe that they are autonomous of Scottish Government, and I think that in part arises from the 1978 Act and the statutory basis on which our health boards are formed and their role as the employing authority.

However, my view is and always has been, and when I was the health secretary our boards were very clear on this, that health boards were not autonomous of Scottish Government; their funding came from the Scottish Government in order to meet the objective set. Where there is, if you like, autonomy and discretion, quite rightly, in individual health boards, is how they apply the requirement to meet those objectives to local circumstances.

So, for example, I would expect that the delivery routes in NHS Greater Glasgow and Clyde will differ in some important ways from NHS Highland to take account of the geography, perhaps the different demographics between different health boards, so that the services are tailored to meet the needs of a local population. But I don't accept that a cohort of patients, for example, who have cancer of any particular type between Aberdeen and Glasgow is sufficiently distinct for there to be distinct approaches to how they are treated.

Q Thank you. I wonder if we can, within this conversation, focus down on capital procurement. You discuss that in the previous paragraph on page 99, and you refer back to evidence you've previously given on the role of the Scottish Government in the procurement of large-scale hospital building projects. I think that's in columns 708 or thereabouts in your transcript from last year.

Then you sort of summarise your position here in the rest of this paragraph.

We've obviously had a different scenario in Glasgow from that faced by Lothian Health and you in 2019 in respect of the Edinburgh hospital, and we've heard about the creation of NHS Assure and I'll come back to that in detail later on.

I'm keen to explore with you the extent to which the government, in the form of either the Cabinet Secretary or the Director General, should take responsibility for ensuring that these large, multi hundreds of million pound procurement projects – and this, I suppose, is the biggest – comply with things like HAI-SCRIBE, Scottish Health Technical Memorandums, and also don't end up signing contracts that don't actually deliver their stated employer's requirements. Effectively, what level should the Scottish Government take a direct interest to ensure that the public interest as the funder is protected in the really big projects?

A So, I think the Scottish Government should do that. I do not agree with the "arm's length" approach that has been taken on procurement. So, you see it in this particular instance; to a degree, we saw something similar with the hospital in NHS Lothian. Because, at the end of the day, the public is perfectly entitled to hold the government to account when building projects go wrong; either they're delayed, or they're-- they don't-- they go over their budget, or there are other more-- or equally substantive mistakes in their design and construction.

That is not the position that I was in as Cabinet Secretary and, to a large extent, that view that I'm now expressing to you underpinned both my experience with both those hospitals, but also my desire to see the creation of something which has now become NHS Assure.

Q Thank you. What I was proposing to do now is to start at beginning and go through and, as it were, pick up NHS Assure when we get to it in the natural order of events.

A Sure.

Q I want to start with your awareness of issues with the Queen Elizabeth, and you start that at paragraph 18 of your statement, but actually that's on page 101. I think your position is relatively clear, but, effectively, does it amount to this? That when you became Cabinet Secretary, you had no real engagement with the Queen Elizabeth New Southern General Hospital at all?

A No, I hadn't had-- I had had some engagement with NHS Greater Glasgow and Clyde in a-- pre my period of being an elected politician, when I was chair of NHS Golden Jubilee. But I-- I had no direct involvement in anything-- or any direct knowledge of any of the issues around the Queen Elizabeth.

Q Well, the reason I've been asked-- Well, let's look at the briefing note that you received on 27 July 2018, so that's bundle 52, volume 4, document 4, page 18-- in fact, it starts at page 19. Do you remember receiving this briefing note?

A I do.

Q Yes. Having read that briefing note for that first time – that's July '18 – what was your initial reaction to what was going on at the Queen Elizabeth?

A So, my initial reaction, as I recall it, was to begin to understand some of the detail of the infection incidences that were challenging Greater Glasgow and Clyde, and to look for a conversation with Professor McQueen to get behind some of that, and to have a concern about the cumulative impact of those infections and her assessment of the Board's response.

Q To what extent is your focus at this point on infections as opposed to infrastructure?

A It's on the infections.

Q It's on infections. So do we see, for example, within this briefing, the explanation that what was previously the CNO's algorithm and then the framework for the CNO has been engaged by this point?

A Yes.

Q Yes. Now, in the statement, if we go on to paragraph 19, we asked you – and, to be fair, we kept asking you throughout the questionnaire that we sent you – when you knew certain things about the ventilation. I was thinking about a way of helping you to find out when you might have learned things, because I think there's an element of a lack of certainty in your statement, which may be the passage of time.

So, if we just recap where we are at this point in the hospital, so this is July '18, Ward 4B, the adult BMT unit, has returned to the hospital; it returned before you took office. Ward 2A remains in use, and I'm not going to ask you about the somewhat diffuse issue of isolation rooms; I figure that's-- And the other issue is general ventilation across the general wards. Now, if we try and put an end to this period, when you then authorise the Independent Review----

A Yes.

Q -- at the moment you authorise the Independent Review, do you then know that there are issues with the ventilation system?

A Can you remind me of the date when I authorised----

Q That would be 22 January.

THE CHAIR: 2019.

MR MACKINTOSH: 2019.

A 2019. So, yes, at that point, I do know about ventilation issues.

Q Right. So, with that end point in mind, what I want to do is to sort of step through the events. In your evidence on 12 March last year, and it's column 42, you explained that you thought you knew by the end of 2018.

A Mm-hmm.

Q And there's an HPS SBAR about ventilation in Ward 2A that precedes your appointment, so that is bundle 3, document 8, page 62. I'm assuming that you wouldn't have seen this?

A No.

Q No, because, at one level-- it's sort of below the level that is briefed to ministers.

A Yes.

Q So, if we then step forward to the moment of the decant decision in September of 2018, can I take it that you were being briefed-- I think we've had evidence that you were being briefed about this decant as it was being made?

A Yes, I was.

Q Would you have known about the ventilation standards in Ward 2A by the time of the decant?

A I don't believe I did. From memory, my recollection is that I understood the decant to be about water.

Q Because one of the questions that has been suggested I ask you is, given that the patients from Ward 2A moved to Ward 6A in the adult hospital, which had, for the Queen Elizabeth, its standard ventilation, which isn't compliant with SHTM 03-01, were you aware at the time of decant that this was a move from a ward that, to some extent, was trying to provide specialist ventilation to one that wasn't?

A No, I wasn't, and I think-- I think it is fair to say, with hindsight, I wish I had been. I assumed – and the assumption was wrong on my part, assumptions that I learned, through the experience with Greater Glasgow and Clyde and with the Lothian hospital, that were mistaken and should be challenged by me – that boards were meeting the necessary standards. So, I assumed that matters to do with ventilation and infection prevention and control were standard practice and being met by boards. That clearly was not the case.

Q So, again, in an effort to help you try and nail this down a bit, it occurs to me, I might put to you a number of different ways you could have found out before the Independent Review was instructed: you could have been briefed directly by your civil service team; you could have received something from the health board that told you of this, maybe from Professor Steele who was the director of Estates at this point; you could have heard from a constituency member

of parliament; you could have heard from the media; and it occurs to me you could have heard from a whistleblower who isn't the ones we know about, because they don't contact you until January. Does that help you in any way recollect how it was that you learned, in the run up to 22 January, that there was an issue with the general ventilation across the hospital?

A It doesn't particularly, I'm afraid, but what I do recall is I don't believe that my officials knew that the ventilation standards were not met, and I think it is-- is a number of other events that drew that to their attention; possibly the DMA Canyon report when that was revealed, and certainly the whistleblowers raised it with me.

Q So, the whistleblowers don't contact you until after the Independent Review is announced, and therefore maybe we have to look in the HFS work that's going on and how they might have fed to you, and we can continue to look at written material with that in mind.

A Yes.

Q I want to move on to a series of questions that I've been asked to put to you. Clearly, from the Independent Review onwards, you begin to take direct steps, and we'll come back to what they are. But I've been asked to put to you that, prior to the end of 2019, were there mechanisms in place for the Scottish Government to assure itself that commissioning and validation and processes like HAI-SCRIBE were being carried out in connection with the NHS Scotland building project?

A I'm sorry, could you repeat that?

Q So, prior to the end of '18, so i.e.----

A Prior to the end of '18?

Q Yes, so before the Independent Review has been instructed. Were there systems in place by which the Scottish Government could satisfy itself that individual health boards were properly commissioning new facilities in compliance with HAI-SCRIBE and the relevant technical memorandums, or was it, as you seem to have just implied, somewhat a system of trust?

A I think it was a system of trust, yeah, to a significant extent. There was, I think, an assumption that board chief executives would take responsibility in leading those projects, any build project, to ensure that the design required the build to meet the relevant standards, and I think there was a-- an assumption that, anything that was going wrong, that the information would come from a health board to Scottish Government officials and that that would then trigger, for example, the example of the chief nursing

officer's office, if it was about infection prevention and control, or any of the other agencies with their support.

Q At the beginning of your evidence today, we discussed the role of the Chief Executive and chief operating officer of NHS Scotland, and you talked about your belief that the public would expect that the government does take responsibility for the spending on the larger projects, in paraphrase.

A Mm-hmm

Q Had I asked you that question, assuming you would have not been surprised if I'd done that, at the end of 2018, how would you have answered it back then?

A I think I would have answered it exactly the same way.

Q Right. I've been asked to put this to you. How would you respond to this suggestion, that it might be seen as a failure of oversight and scrutiny at the end of 2018 by the Scottish Government to have a system that, to some degree, or to great degree, relies on trust in this area?

A I'm not sure that I think it would be fair to say it is a failure of oversight and scrutiny. I think it is naive of government not to have that situation-- to maintain that situation. But I'm also conscious that there has been, on occasion, criticism of my approach, which is to suggest that it is overly centralist, but I do strongly hold the view that, if government is to be held accountable as it rightly is for such matters, then government should exercise more oversight and scrutiny than it has done in the past.

Q I mean, this is probably an impossible question to answer, but where do you think the public thinks the accountability lies for a £100 million project? What institutions does it look to, really, to make sure the money is spent wisely?

A I think it looks to both the individual institution that is overseeing whatever that build is, but I think it also looks to government, and I think the public in Scotland is much more sophisticated in its understanding than we often give it credit for. So, it looks to, in this instance, Greater Glasgow and Clyde, but it also looks to government to say, "Why did you not stop that? Why did you not intervene to improve that?"

Q How do you feel the role of those elected to public office who are outwith the government and individual institutions-- What role does the parliament play in this accountability conversation we've just been having?

A So, Parliament's role is to hold government to account, and I think-- in this particular situation and indeed in the

Lothian one, I think it is possible to see how individual MSPs from all parties sought to question me and demand from me what I was doing and to express a view as to whether or not they thought that was good enough.

Q Given that the MSPs were holding you to account, can you help us about where the people are who would be holding NHS Greater Glasgow and Clyde to account are?

A Well, that was my role.

Q So you feel there's a sort of a step through? So the parliament is holding you to account, you hold the health board to account?

A Yes.

Q What about the role of the non-executive board members? Because there's an awful lot of them.

A So, I think, in the normal operation of a health board, it is the role of the board to hold the Chief Executive and its executive members, i.e. the various directors, to account for the work that they are doing in a way that is both supportive and challenging. I think the role of non-exec members on a board is to look for evidence, to question, and to pursue issues if they are not satisfied. That is what I believe their job to be. That is what I took to be my job when I was a non-executive member of a health board.

I think it is entirely possible to undertake that role in a way that is supportive and challenging, and that's what I expect from non-executive members of boards. I don't accept a position which says, "I was assured that..." if you did not ask questions and seek the evidence to back the assurance. That's not a criticism of the individual assuring you, that is making sure that you can be assured because you have seen the evidence that they are working from.

Q You open that question with a reference to day-to-day matters. Were you seeking to draw some sort of contrast between day-to-day matters and exceptional matters like large procurement or----

A No, not at all. Not at all.

Q No. What I wanted to do now was to move to your decision to appoint the Independent Review. Now, the Independent Review, we have it in bundle 27, volume 9, document 11, at page 160. Because we have your terms of reference at the foot of the page quoted by the authors:

> "To establish whether the design, build, commissioning and maintenance the Queen Elizabeth University Hospital and Royal Hospital for Children has had an adverse impact on the risk of

Healthcare Associated Infection and whether there is wider learning for NHS Scotland."

Now, you covered this in some considerable detail last March, and we find that in your previous statement at paragraph 72. I wanted just to take one particular question and expand it. So, if we look at the Review and go to page 169, at paragraph 1.6.6, this is a discussion of documents. Now, one of the things that this Inquiry has noticed is that we had access to more documents than the Independent Review.

A Mm-hmm.

Q And that has included the material that has enabled us to drill down and find out when the decision, if not why the decision, was made to accept ventilation at 40 litres a second for each of the 1,300 rooms rather than six air changes an hour. Now, it doesn't appear that information was available to the Independent Review, and it may be that paragraph 1.6.6 is where we see why, because they state:

"A significant number of these documents are not in the public domain, and now deemed to be commercially confidential and sensitive due to ongoing legal action between NHS GG&C and their former Design and Build (D&B) Contractors and other consultants. Several of these documents emerged, or were completed, at later stages of the Review. We continue to correspond with, and gather evidence from, individuals and organisations until a late stage of our Review to ensure that we could present as fair, accurate and complete an account as possible for all concerned."

Now, I'm sure they're trying to present as complete an account as possible, but did you expect that issues of confidentiality associated with the legal action to prevent the Independent Review having access to these logs and email exchanges around the final days before contract close in 2009?

A No, I didn't. I would have expected-- I did expect those documents to be made available to the co-chairs of the Independent Review because I had every confidence that they were perfectly able to maintain confidentiality and understand sensitivity. But, from memory, Greater Glasgow and Clyde's view was, because there was legal action underway, that it was not possible to disclose those documents to the Review.

Q How would you respond to the suggestion that, whilst there will be much in the Independent Review that is of value, because it wasn't just looking at

this issue, a failure to understand how it was, if not why it was, that this decision was made rather causes a gap at the heart of the conclusions of the review.

A I think that's fair, and I think the co-chairs would agree with you.

Q I've also been asked to put to you something in your statement. So, if you go to paragraph-- I think it's 73 of your statement, because at one point we decided not to ask the questions in chronological order, for which I apologise. Paragraph 73. It's page 124. We asked you-- and I'm conscious that you've already given evidence about this. We asked you to consider if the Independent Review had sufficient authority to carry out its work, and you say, in the third sentence:

> "It dealt with the concerns it was asked to address: design, procurement and build."

I need to put it to you that it was also asked to consider the possibility of adverse impact on infections, and that might just be an oversight in your part of the statement.

A Yeah.

Q At the point you instructed the Independent Review, you of course hadn't heard from Dr Redding and Dr Peters, if I understand correctly. Is that as I understand it?

A Mm-hmm, yeah.

Q So let's look at your interactions with those. Again, you've covered those in your Edinburgh supplementary statement in some detail, but let's go to page 102 of the current statement. In fact, it starts at page-- well, it's 102 and it's paragraph 21. You describe the detail of the interactions there. You've covered them in considerably more detail in Edinburgh III statement and indeed in evidence, but I want just to clarify for absolute certainty when you deal with each of them, as it were. So, you have no contact with Dr Inkster before December-- or was it September of 2009 when you first meet her?

A Sorry?

Q You have no contact with Dr Inkster until December of 2019?

A That's correct.

Q Yes, but your first contact with Dr Peters is the day after the Independent Review has been announced. She contacts your office or thereabouts?

A I'm not quite sure that's right. The first contact with Dr Peters and Dr Redding comes at the request of Anas Sarwar to me.

Q Would that have been before the Independent Review was announced?

A It would be at the time of the Independent Review. Whether it was immediately before it was announced or after it was announced, I can't recall.

Q Presumably it took a few weeks to get the Independent Review set up and chairs found?

A It did. I think the-- from memory, I announced that there will be one and then, at that point, we don't have who the chair is going to be, and there-- subsequently it becomes co-chairs. But Anas had contacted me informally and asked me to meet Dr Peters and Dr Redding, and as I say in my statement, I did do that. It was an entirely informal meeting. No officials----

Q Yes, and this is the one you describe in '22 and '23?

A Yes.

Q To what extent did-- I mean, you may not be able to be sure about this, the extent to which that conversation, that first conversation, inform the decision to set up the Independent Review, or was it, in effect, already something you decided to do?

A No, it was already in train. The setting up of the Independent Review was already in my mind and in train because we were seeing a number of instances of infection higher than would be expected in a hospital of that type, treating patient cohorts of that type, and we did not seem to be getting to the bottom of, "Why is this happening?" That was the point of the Independent Review.

It was set up not on a statutory basis. It then encountered at least one of the major problems you've highlighted, not being able to access documents, and in part that experience is what led to my decision to set up this Public Inquiry on a statutory basis, so we can't get into arguments about whether documents can be released or not released.

Q If we think back to decision to set up the Independent Review, just to keep the story, as it were, flowing in a sort of narrative way, because we always look back at your previous evidence, that awareness of infections is both the water incident that had started before you arrived and what you were briefed about in April in that briefing note we just looked at, but would that also have included the Cryptococcus cases over that December/January of '18/'19, or had the idea actually come to you before the first Cryptococcus cases are drawn to your attention?

A There was also-- There were also, from memory, bloodborne infections as well before that, so we had the issues around water, we had bloodborne infections, and it was in my mind that we needed to find out what was wrong here, because we were also seeing high-- high

levels of compliance in practice by clinical and nursing staff. So it seemed that there would-- there may be something wrong with the building, and then we have the Cryptococcus incident.

Q Now, you obviously meet Dr Redding and Dr Peters with Mr Sarwar. You then have the Independent Review announced; Dr Peters gets in touch, we have emails, we can read those. Before I move on to-- Well, I'll park that question and come back to it, it's probably better to do it later. I want to think about the HIS inspection.

A Mm-hmm.

Q Now, if we go to your statement, over the page on page 103, you explain your recollection of the issues raised by Dr Peters and Dr Inkster, including in respect of water testing results and the sign-off of HAI-SCRIBEs. We've heard their evidence about that. Then there's discussion about the issue of the ventilation systems in 2A, 4B, 4C, and infectious diseases.

Now, I appreciate that a lot of time has passed, but it would be quite interesting, in a way that couldn't be asked last year, to understand from you how much of what you were being told by the whistleblowers was actually news to you in its entirety. Because I'm sure they were giving you extra detail and stuff you'd already heard about, but was there anything they were telling you that was genuinely totally new to you?

A So, the most substantive thing they were telling me that was genuinely new was how persistently and for how long they had been raising concerns, which they felt very strongly had been ignored, not listened to, and that they had felt in some way penalised and dismissed for persistently raising those concerns within the Board. That-- The extent of that and the degree of that was new to me.

It resonated with other issues in other boards around the whole culture of openness and transparency and people being able to raise concerns and have them treated seriously and not feel that they would in some way be punished for having done so, but of course there is always more than one perspective to any particular situation, and that is why, although I undoubtedly took the issues that they raised with me seriously, I then asked the CNO to take matters on and see, in her view, how much of the concerns that were being raised could be corroborated and evidenced, if you like.

Because both the doctors were, perfectly understandably, very engaged and very concerned both professionally and personally in this situation, and individually impacted by what they-- the experience they'd had. So you have to

then take step back and say, “I take all of that absolutely seriously and I don’t doubt what you are telling me or that you are telling me this sincerely, but we need to now look and see how much of this is actually the case.”

Q Thank you. I want to just try and explore that in a number of different ways. So, you mentioned different perspectives. So if we take that-- you’ve explained that at some point in January is when you’re hearing this, and that you’re not really being told about new things that are live at that point, but are being told about the length of time things have been raised. If you think back to the----

THE CHAIR: Could I just confirm? I’m sure counsel is absolutely right. What I’ve taken from your answer so far, Ms Freeman, that you were not necessarily being given information about the-- if I can describe it as the history of the building, the state of the building, that you had previously been unaware of?

A That’s true. I wasn’t. I understood that there were-- Obviously I understood that there were concerns around the water supply and its safety and its-- whether or not it had a link to infection, bloodborne infections, so, “Was there something wrong with this building?” But what I was being told that was new was that these concerns had been raised for a number of years prior to

them being raised with me. And of course Drs Peters and Redding were also explaining what they perceived as their inability to get information and data that they believed was necessary for them to do their job.

THE CHAIR: Thank you.

MR MACKINTOSH: So, prior to the appointment the Independent Review, had you had meetings yourself with personnel from NHS Greater Glasgow?

A I think I certainly had a board meeting, I attended a board meeting. I’d also had in January, and I think I referred to it in my statement, the meeting with the Chief Executive, the chair, the medical director, the head of Estates. That was around-- In particular, it was triggered by the pigeon dropping incident, but it covered more than that. It covers the other areas of infection as well.

Q In that meeting or indeed any other interactions that you personally had with GGC officials, had you been given by them any indication that these issues had been raised internally within the Health Board over the previous three and a half/four years?

A No.

Q No. Secondly, just to connect this, you mentioned your awareness about issues of culture in the Health Board. I noticed that the Sturrock Review was instructed in November 2018; it’s a

different health board, I appreciate that. You've obviously instructed the Sturrock Review for NHS Highland.

A Yes.

Q Did you intend the Independent Review to get into the same territory as Mr Sturrock had done or to stay firmly on procurement and infection link, as it seems to have to greater degree done?

A Yeah. So, no, I didn't intend it to get into the territory that Mr Sturrock had done, although it was in my mind over-- over the coming period, from kind of January onwards, that we might need another version of the Sturrock Review. The Sturrock Review was triggered because we had a group of whistleblowers, as you know, in NHS Highland who had been consistently raising issues of concern from their professional backgrounds and consistently being ignored and dismissed by senior members of the executive team and the Board to the point where they went public on that matter.

And I have a really strong view that people who work in our health service do so because they want to provide the best possible service that they can to the public they serve, whatever their job is, whether they are housekeepers or porters or senior clinicians. And so, when they raise concerns, they deserve the respect of being heard and those concerns treated properly. When they get to a point where they blow the whistle, then they have been pushed to that point by not being heard and not being listened to, and they absolutely should be. I don't think any organisation is beyond criticism, and indeed can learn a great deal from concerns and criticisms. So, of course, the NHS Highland situation was in my mind as I then hear from Drs Peters and Redding.

Q So, might it well be that the act you took was to instruct or ask the chief nursing officer to instruct, at her recommendation, the HIS inspection that then took place?

A Yes.

Q Now, let us just connect things together, because it's somewhat useful to us in the Inquiry so we make sure we're looking at the right report. So, it's bundle 18, volume 2, document 128, page 1490. So, as far as you can recollect, would this be the result of the unannounced inspection that you'd ordered?

A Yes.

Q I'm assuming you would've read this report at the time?

A Yes.

Q If we go to page 1494, there's a list of things that are the inspection focus, and, if we go to the next page-- Sorry, go back two pages, I'm just on the

wrong page. There we are. One of the issues that we have evidence from Dr Inkster, and she in her statement, paragraph 739, says the inspection team told her they were going to ask about culture.

A Mm.

Q And that that was a novelty, I think, to them. Did any extent of your instructions through the CNO encourage HIS to look at culture?

A Yes, it did.

Q Did you give HIS instructions of anybody to speak to?

A No, no. I wanted them to carry out the inspection in the manner in which they chose, so not particularly, "Go and speak to this person or that person," because that potentially skews the work they do. They are professional in what they do, and they should be free to get on and do that job.

Q So the fact that it happened to be Dr Inkster who was in the offices that day is pure serendipity?

A It certainly was not something that I asked for or arranged.

Q To what extent was the issues that you gave to the chief nursing officer, or discussed with her and developed with her for the inspection, effectively an attempt to check to some degree that there is a third-party verification of what you're being told by Dr Peters and Dr Redding?

A To a degree. I think in-- From memory, although I can't be certain of this, in speaking to Professor McQueen, one of the areas that she-- about what Dr Peters and Dr Redding had raised with me in-- in the cumulative sense of all the other issues that we were dealing with in Queen Elizabeth, and with the background of NHS Highland, a clear understanding that NHS Highland are not necessarily unique in their cultural challenges-- It would be likely-- Although it would not be definite, it would be likely that Professor McQueen would say, "One of the things we can do is ask HIS to conduct an unannounced inspection."

Q If we look back at your statement on page 103 of the statement bundle, in the middle of paragraph 24, it's about 10 lines down, you see it says-- "Work to investigate this" starts the line, and then:

> "I would defer to the CNO in relation to the detail of this but would observe that the results produced by HIS were quite shocking."

What was it that was shocking about the report's conclusions?

A So, I think it was primarily that, on the one hand, what the inspectors were seeing was a high standard of

infection prevention and control practice on the part of staff in the areas that they were inspecting; in terms of hand hygiene, appropriate use of PPE, appropriate use and disposal of blood samples, fluids, etc. But they were also finding serious problems and issues around the fabric of the building.

Q Were those issues of fabric things that had been mentioned by Dr Peters and Dr Redding?

A I don't believe in particular, no.

Q No. So, in effect, they're finding more than, to some degree-- obviously you will take whatever they say as their results, but you wouldn't have been surprised if they'd reported what Dr Peters and Dr Redding had told you, and now they're telling you other stuff?

A Yes.

Q Right. I think we find that on page 1498 of the results of the report of things that the Health Board could do better. So that's bundle 18, volume 2, page 1498, paragraph 33. We also see paragraph 31, which is the bottom of the previous page:

> "We were shown a clinicians' report from 2017 that detailed 27 issues within the Queen Elizabeth University Hospital and the Institute of Neurosciences. We raised this with NHS Greater Glasgow and Clyde's senior management. We were provided with an action plan for these issues, however we were not assured actions had been taken to resolve some of the issues."

Now, we're about to talk about the Cryptococcus meeting that you've already mentioned. When this report arrived in your office, were you at that point aware of the 27-point action plan?

A No.

Q If we go to page 1502, so that's five pages further on-- the next page, please, we also see detail about the absence of functioning negative pressure isolation rooms at paragraph 63. Again, is that something that's been drawn to your attention by those GGC officials who you've met?

A Why-- Sorry?

Q So, if we look at paragraph 63:

> "Senior management told us there were no functioning negative pressure isolation rooms in the hospital."

Is that something that had been mentioned in the meeting about ventilation and Cryptococcus and the pigeons?

A No. No, it had not. No.

Q So, to what extent did you see this report, amongst other things, as a confirmation of what the whistleblowers

had told you?

A To a significant extent. I mean, it did not-- it did not touch on the issues they'd raised about the problems they had had or they believed they had had in doing the job that they were there to do with access to data and their concerns being actioned, but, in other ways, it did validate other concerns that they had raised.

Q Clearly there are recommendations in here. We just looked at three of them, but there are a lot more than that. Did you take an interest in whether the Health Board ultimately complied with these recommendations?

A Yes.

Q And are you able to tell us if there was a point after this report got to you when you were satisfied they had implemented everything on the list?

A No, there wasn't a point where I was satisfied. The work was underway, of course, but the-- the pace was not sufficiently speedy enough for me, and of course, as you know, as we progress through that year, we move to a situation where the Board is escalated in the NHS escalation framework.

Q So would I be right in inferring that, by the time escalation happens, they still haven't done everything on this list? They have done some of it?

A Yes.

Q Right. Now, I want to move on to the Cryptococcus meeting you mentioned before. So this is paragraph 35 of your statement, 804 of the statement bundle. Paragraph 26, actually, sorry. It's also covered in your Edinburgh statement, to some degree, paragraph 34, the main one. You recall a meeting, and you list in paragraph 26 some of the people who were there. So that's the Chief Executive, Ms Grant, the chair, Professor Brown, the medical director, Dr Armstrong, and Professor Steele, the new head of Estates. Now, at whose initiative did this meeting take place?

A At mine.

Q Did you tell them, in that sense, what you wanted it to address?

A Yes, I want-- I wanted to-- So this was, if you like, the latest in a line of a series of infections/incidents at this hospital, so I wanted to understand if-- what they were doing to identify how had this happened, how had apparently pigeon droppings found their way into the hospital in a way that then impacted on patients, but I also wanted to understand how well they were seeing the current cumulative situation in the round and were acting to address that.

Q I think it's probably fair to note that, as of the day before yesterday, it

was certainly the position of the Health Board that pigeon droppings did not get into-- didn't cause any impact to patients. Was that a view that was expressed to you at this meeting?

A No, it wasn't. Remember-- And, in fairness to them, this meeting was fairly early on after the infections had been identified, and it was at that point considered possible that this had come from a gap in the plant room at the top of the building where pigeons had got in, and that that had then found its way through. It was subsequent work that suggested that that was not the case.

Q And would that be the results of the Cryptococcus expert subgroups that we've heard about?

A Yes.

Q That took some years to be produced?

A Yes.

Q In fact, they may not even have been produced before you left office.

A I'm not sure if it was.

Q Right. This meeting takes place in January before the Independent Review is set up?

A Yes.

Q Did you tell them the Independent Review was coming at this meeting?

A No.

Q No. Did you receive any assurances from them?

A I did not feel assured when I left.

Q Right. So, thinking about your definition of "assurance" from earlier on, did you ask questions?

A Yes, I did.

Q What sort of questions were you asking?

A So, I was asking in-- in detail what their view overall was of the infection that they had been dealing with up to till point – the water, the bloodborne, now this – what was their thinking about why this was happening, and my impression was that they were dealing with each in a discrete manner and not seeing a cumulative impact, nor were they particularly aware in a serious manner of what the impact of all of this might be on public confidence in the safety of the hospital.

Q If we just break that down a bit, thinking about these discrete events as they were presenting them to you-- Clearly they haven't expressed to you a view on causation in respect of the latest cases as you've just said that, but if we think back to the water incident that was underway when you took office, and then the decant in September, did they express any view as to how it was those infections had come about?

A No. What they told me was what they were doing about them, so what they were doing to secure an improved water supply, what they were doing by way of in-ward maintenance-- I remember Mr Steele, who was new in post, was clear about his concerns around the overall maintenance schedule and how jobs were being prioritised and so on, and his intention to improve on that. And, for someone who was very new in post, he had a number of very specific actions he intended to take about which I was assured, but what I was being otherwise told was what was being done to fix the problem, not, "What are we doing to understand why there is a problem?"

Q Now, before I ask you the next question, I want to just attempt to ground again in documents we have. We have a HPS summary of the incident produced in December 2018, which is bundle 7, document 2, page 32. Now, there are a number of these, and you probably haven't seen this for some time, but I wondered if, by the time you went to the meeting-- If we look at this report, and I'll just jump to the conclusions in order to set the question up, which are-- not conclusions, the hypotheses, which is a much better way of putting it. They are-- Sorry, page 45.

This HPS report discusses, at the bottom of the page, a number of different possibilities, one of which is "Ingress contamination", one of which is "Regressional contamination", over the page, and one of which is "Contamination at installation/commissioning". It actually reaches the view, on the previous page, that it's B and C. I just wondered if-- before this meeting, whether you'd had or had the opportunity of reading this or received briefings that HPS felt this was possibly down to regressional contamination of the water system or contamination at installation? Whether you had that level of knowledge at the point you met----

A I don't recall having that level of knowledge. What I do recall is a feeling – which may have been based on this knowledge, but a feeling – that there was something wrong with this building. You can't have this number of incidents and not feel something is wrong underneath all of this that we don't know and we don't understand.

Q We can take that off the screen. Did you feel that your interlocutors from the Health Board were acknowledging a similar concern, or were they not thinking about that?

A My feeling was that they weren't acknowledging that. They were dealing with the actions that they had taken, intended to take, in order to deal

with the problems discretely as they arose – the water problems, bloodborne, etc.

Q I suppose, to sort of wrap up this sequence of questions, I'll put this to you. Did they tell you that the conclusion of the water incident team was that the cause of the infections in the first half of the year was contaminated water?

A I believe they did.

Q They did, right. You describe on the same page in your statement bundle, page 104-- Well, actually, let's look at the broader concerns so we just stay grounded in all the detail. Paragraph 27, you recall from the meeting being surprised that the medical director-- Would that have been Dr Armstrong?

A Yes.

Q "... asked me why I was there and what this matter had to do with me."

A Yes.

Q Are you sure that's what she said?

A Yes.

Q Did you respond?

A I believe I did. I am very sure that is what she said – some things do stick with you – and I explained that I was the Cabinet Secretary for health and I was responsible for and accountable to the public in Scotland on how our health service operated and delivered safe care, and that was why I was there.

Q Do you have any observation on whether it's a little bit unusual that you had to say that?

A I think it's very unusual that I have to say it. I think-- By that I mean-- I'm not saying that every time I meet senior-- senior members of an executive team in different health boards that they may not have thought that, but they never said it. And I think I was taken aback not least because I was sitting with the chief medical officer for Scotland and the DG for Health and Chief Executive of the NHS in Scotland, and I would've thought that that in and of itself would be a strong indicator to those present that we were taking these matters very seriously indeed.

Q Now, I'm not asking you to speak for all your predecessors, but if we think of the people who have held office of Cabinet Secretary for health and social care, and before that in minister of social care, and before that parliamentary undersecretary-- before parliament. Was there anything unusual about, as it were, the three of you going to visit a health board like this, or is that something that happens relatively frequently, as far as you understood?

A I don't believe it is a frequent or even relatively infrequent occurrence.

Q It's just one of these things that happens?

A It's not-- It's not one of those things that happens.

Q Right.

A Because-- Cabinet secretaries go and visit health boards, of course they do, and they go and visit hospitals and healthcare facilities, but you rarely have-- and sometimes they are accompanied by the Director General as well, but you very rarely also have the chief medical officer there.

Q Yes.

A So you have now brought the three most senior people from government to a board. I can only reflect that, when I was the chair of a health board myself, I would have seen that as very serious indeed.

Q Is there anything that would have been more serious in terms of a bunch of visitors turning up?

A I think possibly only if you had the First Minister involved.

Q Right. Now, I don't know whether you're being diplomatic or summarising, but I wonder if you can expand on the next sentence. You say:

> "I came away from that meeting with a general impression of surprise and concern about NHSGGC's guardedness and down-playing of the importance of the situation."

Now, is that an impression gained from everything that was said, just thinking back on it? Sometimes you come out of a meeting and you think, "Well, if I look at the whole thing, that's the impression I might gain," or is it actually that specific things were said like, "It's really not as serious as you think"? Can you help me about which it is, or is it a mixture of the two?

A So, it-- it's probably a mixture of the two. I think I went to-- I called that meeting and I went to that meeting expecting the Board to have a series of actions to put before me, to have-- in their tone of what they said to be clear how serious they this, to raise asks of me about what they might need to help them, and I certainly expected them to understand the overall impact on the wider public.

I did not see or hear any of that, and I did, as I say, came-- came away additionally concerned on top of all the issues that we were dealing with as to whether or not this Board and its senior team really understood the seriousness of what they were confronting.

Q Because this isn't the spring of 2018, this is January 2019.

A Yes.

Q Do you want a moment here?

A Yeah, I'm fine. Thank you.

Q So, from your perspective as a

Cabinet Secretary and a politician and, before that, a special advisor and a chair of a health board, when something goes wrong or is perceived to go wrong in the institution, how would you expect an institution that's on the ball to think about responding when they're challenged about their actions? What sort of processes would be going on in their collective minds about how to react in that sense of responding to a crisis?

A Yeah. So, I would expect them to seek to take the-- to be on the front foot here, and before-- once you get past the pleasantries of good mornings and what-have-you, to state clearly that they understand the seriousness of the situation, what they have done to try and initiate actions to identify what might have been going wrong in that particular instance, that they understand this then comes on the back of a series of incidents, and these are the actions that they intend to take, and to second guess what a Cabinet Secretary might additionally be concerned about, which would be, "And how do the public see this?"

Q Now, I'm going to suggest a couple of thoughts that might have occurred to you, but please, there may be others. It occurs to me one might think in such a situation that they don't have the skills. Equally, one might think they do have the skills, but they haven't realised it's significant enough that they need to use them. One might think they do have the skills, they've realised it's significant enough, but they don't want to act. There may be others in that territory. Can you break down your feeling of confidence or absence thereof or level of assurance that you had when you left that meeting about the collective leadership that you'd just met?

A As I said to you earlier, I was not assured when I left that meeting. I was additionally concerned, so I-- so I left with all the concerns that I had on the way in with an additional one, which was, "I'm not sure they really understand how serious this is, and I'm not sure why that's the case. Why do they not understand this?"

Q I take it you probably said why you thought it was serious in the meeting.

A Yes.

Q But you still had that concern at the end?

A Yes.

Q At the end of the meeting, did you have a concern that they weren't capable of addressing the issue?

A So "capable" is an-- is an interesting word. I did not have the concern that they were not capable in terms of having the necessary skills, intellectual capacity, or access to

resources, but capable is also about attitude, and my impression was that there was a view that-- there wasn't a degree of fuss about nothing and that public confidence was not an overly important area to be concerned about, because they were doing A, B, and C, X, Y, and Z, to address each of the discrete areas of difficulty and not seeing the cumulative impact of that on their own staff, on patients, and on the wider public.

Q Can you help us by putting into context-- I mean, you've described how you've had a meeting, confidentially, with Mr Sarwar--

A Yes.

Q -- who's not the same political party as you.

A No.

Q At the time, was he an opposition spokesperson?

A I think he was the opposition spokesperson on health, but he was also a Glasgow MSP.

Q I understand that, but what I wanted to do is see if you could help us understand how significant these events were from the perspective of not only you as Cabinet Secretary, in terms of public confidence, but Glasgow MSPs, the wider Parliament, professionals who take an interest in these things. We've obviously been through the whole pandemic since, and we've been used to, well, you

appearing on the media regularly, and that daily briefing, and it changes the way you think about things. If we go back to that point in early '19, can you help us understand, was there anything else in your portfolio, sort of that six-month period, that was as significant?

A At that point, obviously NHS Highland was bubbling away. There were issues around-- No, there isn't anything that was as significant as this, actually, because the other pressing issues-- There had been the whole situation with respect to the use of mesh for women, and that had been-- we were moving to resolve that. There were issues of course around waiting times, particularly for elective care, but the plan in place was beginning to show results. So there are always issues in the Health Portfolio, but it's less about whether there are issues and more about: are we beginning to see progress in any particular area? So this was at that point, I think, fairly-- it's fair to say, the most significant, because there was-- it did not feel to me at that point that we had a total grip of this.

Q One of the things you've explained, more than once now in your evidence, is that the issue around the meeting was to some extent related to the possibility of pigeon ingress into plant rooms. I wanted to look at paragraph 29,

on the next page, where we asked you specifically whether you had any recollection of having been informed in late ’18 or early ’19 – and it would have been very late ’18, early ’19 – whether the rooms of the two patients who contacted Cryptococcus had benefited from HEPA filtration. Now, I suppose the follow-up question is, at that meeting, was there any acknowledgement that there was no HEPA filtration for the rooms those patients were accommodated in? If you can’t remember, then you can’t remember.

A I can’t recall. I would expect that to be the kind of question the CNO would ask, because she would be very well aware of the importance of these, but I can’t recall whether she did or what might have been discussed on that.

Q Okay. In paragraph 30 – I think you touched on this already – you discuss Professor Steele discussing the maintenance rota, and the things he wanted to do with maintenance, and you came away assured, to some degree. If we think back to the HIS report – which you haven’t yet got; which you’re about to get – did that assurance remain in place once you read the content of the Assure report about maintenance?

A To an extent it did because, for example, from memory, I think that the HIS report talks about 300 outstanding maintenance issues. One of the things that Professor Steele spoke briefly about at the meeting that we’re discussing was the importance of triaging maintenance requests in terms of level of importance, and I had-- I had a view that he understood the importance of the building fabric and infrastructure to infection prevention and control, and that some maintenance requests and requirements were more important for patient safety than others.

Q Thank you. I want to look at now the letter that was sent to the Chief Executive by the DG Health on 25 January. So that’s at bundle 4, document 3, at page 8. At least I hope it’s at page 8. (After a pause) Excuse me. Yes. So, if we get our timings right, this has been sent two days, three days, after the Independent Review has been announced, a week or so-- a bit longer after you’ve met at the meeting in Glasgow?

A Not much longer.

Q Not much longer? We can read it and we understand it amounts to a request to seek information on maintenance. This pre-dates the HIS report, doesn’t it?

A Yes.

Q Yes. Is there any particular reason why the focus is only on maintenance and not on asking health

boards to confirm whether facilities, perhaps specialist facilities, are built in compliance with standards in SHTM 03-01?

A So I think-- I think the question in terms of, "Was there a thought to extend the nature of the letter beyond what it covers?" is probably best addressed to Mr Gray. I do recall a discussion with him, though, that says, "So, some of the maintenance that clearly is not getting done at the Queen Elizabeth is maintenance I would assume is being done, so can you double-check that they're all doing it?" And this letter comes from that.

Q Because at this point, you and your team do know that there are parts of the hospital that weren't built with ventilation in compliance with the standards.

A Yes.

Q And what we might explore after the coffee break is what happens next. Let's focus on the Schiehallion Unit. It decanted 26 September. We have the Innovated Design Solutions report about the ventilation in 2A in October. Can I take it that at the meeting with GGC, they're telling you about their plans for 2A to some degree?

A Yes.

Q Presumably they're asking you for money.

A I don't recall that they specifically asked for money, but----

Q But you at least know that they've got to think about upgrading that ward, and they've upgraded 4B already, we know that. Is there any talk – is the best way of putting it – about upgrading any other parts of the hospital, in ventilation terms, at this stage?

A No.

Q No. My Lord, this might be a good place to break for our coffee break. There is a document I need to check before moving on to the next section.

THE CHAIR: Very well. We'll just do that. Ms Freeman, can I ask you to be back for quarter to twelve?

A Yes, of course. Thank you.

(<u>Short break</u>)

THE CHAIR: Mr Mackintosh.

MR MACKINTOSH: Thank you, my Lord. Ms Freeman, I just thought I'd go back to something you said earlier on. We were talking about accountability and you, I think, accepted that you're accountable to the Parliament. Obviously it's a very real, public accountability, and then you explained that you thought that the Board is accountable to the Cabinet Secretary. Now, obviously, it's a sample of one, but when you go to that meeting in January, would it be fair to say that

they don't necessarily see themselves as accountable to you?

A Yeah, I think that's entirely fair.

Q I just wondered whether those senior officers see themselves as accountable to their board, primarily, and not the Cabinet Secretary.

A Yes, I think that would be true.

Q Now, if that's the case, that executive members of health boards think they're accountable to their board, and those board members are all appointed by-- well, not all of them, but most of them are appointed by, to some degree, the Cabinet Secretary or by local government, could it be the case that, if not in reality but in the heads of the members of health boards, they don't see themselves as really directly accountable to the Cabinet Secretary?

A Yes, I think that is a fair proposition. I think-- So I don't think we should be too narrow here. There is accountability in terms of I don't know your employment status, or, in the case of a politician, your elected status. There's also accountability-- So that's quite a formal thing. There's also accountability more widely defined for your behaviour and your actions and your decisions.

So, I am not directly accountable to the Scottish public in a formal sense. I am accountable as Cabinet Secretary through the Parliament to them. I'm accountable to my constituents, and they exercise their judgment on that at election time. But there is a wider view of accountability, which is a sense of responsibility, regardless of employment status or any other formal situation, for what you do and the decisions that you take.

Q I suppose that, being at the risk of being overly legalistic about this, I wonder whether, if we stick with the formal accountability for a moment, there's a risk with a health board as a class of organisations that one confuses them with a local authority, where the members are accountable through the means of election. A health board, that's not the case, whatever it seems to imply in various parts of the act. So, can a health board provide a proper level of scrutiny and accountability for their executive teams, given that they're not directly elected in the way that councils and the Parliament are?

A I think we can, because I think-- whether or not you're a member of a health board appointed by a cabinet secretary or put forward by the relevant local authority, I think you have a responsibility to hold the executive members of that board accountable for the job that they are doing and whether or not the actions that they take meet the

overall direction for your board that has been set by Scottish Government.

Q Thank you. I'd like to go back to February 2019 and the arrival of Mr Wright as your new DG.

A Yes.

Q Now, he has explained in his statement-- It's paragraph 9 of his statement. We don't necessarily need to put it on the screen, because it's a very short paragraph. He simply says:

> "Upon coming into post, I had a number of initial conversations with [you] who spoke of the concerns at the QEUH and RHC and the high-priority being given to addressing them."

Then he has a number of meetings, he gets a briefing from his predecessor, and he tells us that, of course, at that point, Greater Glasgow and Clyde was in Stage 2 of the National Framework. Is that your understanding?

A That's right.

Q Do you put them there, or have they been there since when you arrived?

A I think they were there when I arrived.

Q I realise it's not your decision at that level of the framework; it's a lower-down decision within the framework. So, if we recap to where we are now, the Independent Review has been set up, you've done the HIS inspection, you've been to your meeting, the letter's gone out about maintenance from the DG, Mr Wright's arrived, and we know they're at Stage 2.

What I've been asked to raise with you is the possibility that at that stage you should have acted and taken them either to Stage 3 or Stage 4, but up within the Framework, as to do so might well have prevented things that happened later in that year, particularly the breakdown of communications within the IPC team, but also would have resulted in oversight of the decisions around the closure of Ward 6A to new admissions to start earlier and might have helped public confidence. So how do you respond to that suggestion that you could or should have acted in the way that you did later in the year in February/March?

A So, first of all, I think it's fair to say that that is an entirely fair question and I have reflected on that. As a caveat, it is not actually the Cabinet Secretary's decision whether or not a board is escalated or not, as you know, I think, from Mr Wright's evidence, but also from all the information you will have-- that it is in fact the decision of the Director General as to whether or not-- what level of escalation a board sits at.

Undoubtedly the Cabinet Secretary has a role in that decision. I think at that

point it was my view that we needed-- we needed to continue to see how the Board performed, having had that meeting in January, having had a follow-up discussion with Professor Brown and Ms Grant – where I think my position was clear – and having instructed the Independent Review that it was at that point too early to move fairly to escalate them further.

Q You effectively wanted to see what happened now, now that various steps had been taken?

A Yes.

Q Now, one of the things the Inquiry has done is constructed a narrative of what happens. So, in March, we are not yet in the summer gram-negative infections in Ward 6A. That doesn't start, I think, until June. When do you become aware that there are new concerns – or renewed concerns, depending on your point of view – about gram-negative infections in the Schiehallion Unit in its new home in Ward 6A?

A I can't recall exactly when. I know that there was another HIS report looking at data, but I don't recall the date of that or when I might have been informed.

Q I just wondered whether, if we can think of events on that journey, the closure of the ward to new admissions at

1 August might have been something you'd have been briefed on.

A I would have been briefed on that.

Q All right. Then the next event after that is 23 August, when the new chair of the IMT, Dr Crighton, takes over from Dr Inkster, who's been removed as the chair. I wondered if-- Well, ARHAI didn't know in advance, so I'm therefore assuming you didn't know in advance.

A No.

Q No, but I wonder when you first learned of, as it were, a change of personnel in the IPC team in late August 2019? Because you do meet Dr Inkster early-- Sorry, you don't. Ms McQueen meets Dr Inkster early in September, and I wonder when you first learned about these developments?

A It would be at the point where the CNO was advised of it. She would have told me.

Q Right. Now, given all this had happened – so the Independent Review's been set up with a remit that covers HAIs and infection link, the meeting in January, Cryptococcus – would you have expected GGC to have sought the advice of anyone else, whether that's ARHAI, the CNO, or anyone else in the centre, as it were, about the decision to remove the chair of an IMT whilst at Stage 2, given the high level of government interest, the

scrutiny they're under at the time?

A I wouldn't necessarily have expected the Board or GGC to ask the advice of, but I would have expected them to have informed the CNO.

Q You ultimately met Dr Inkser in December--

A Mm-hmm.

Q -- and you just explained that you thought you would have been told about her removal by the chief nursing officer at least once they met. What impact, if any, did the news that the lead ICD had been removed and then resigned have on your views or concerns about the events in Glasgow?

A Well, they added to them. I wasn't obviously in a position to comment on, at that point, or indeed at any point, on the rights and wrongs of someone being removed from their position, but I was concerned that that had happened, and of course heard Dr Inkster's view as to why that happened, and there seemed to me to be a repeat of a pattern which whistleblowers had expressed, which was, if you keep raising concerns and challenging, you're considered to be a problem and so you need to be moved on.

Q Thank you. I wanted to look at an update that you receive in the form of a timeline which-- I want to make sure I go to the page that's Glasgow, not Edinburgh, at this point. So if you allow me just a moment to do that. (After a pause) This is the one that's referred to at the end of paragraph 32 of your statement on page 106. Let's go to it. Let's check that it's the right document, because it may be we've added the wrong document here. So it's bundle 52, volume 1, document 5, page 29, and it's an email from Mr Wright to you. I'm wondering whether this might be actually a briefing about Edinburgh. So, if we go to page 30, it's from January 2020, it looks to be largely a briefing about events in Edinburgh.

A Yes, it does.

Q Yes. So what I might just do is just double check-- there was something I thought I'd noticed, but it may have been-- Yes, page 32, paragraph 19. So, obviously we're discussing in this context the Edinburgh hospitals' Haematology-Oncology service, but you'll see at 19:

> "The service at RHSC supported the GG&C Paediatric service from August to December 2019 by taking patients while they were closed to new admissions. GG&C were able to resume taking new patients in December 2019. The additional workload was challenging at times, particularly for Pharmacy colleagues but was well

managed overall by the RHSC clinical team."

So, can I take from that that, whilst this closure to new admissions was going on in Glasgow, given that it affects two health boards, your team, if not you, would have been monitoring the closure?

A Yes, yes.

Q Thank you. The next section in your statement, back on the same page, 106, is headed in our structure "Retrofit at Queen Elizabeth and the Royal Hospital for Children". Now, I think what I need to do is attempt to, well, firstly check your understanding. So you've set out your understanding of what the retrofits are. So (i), line 1, is Ward 2A and 2B, and then (ii) appears to suggest:

"... individual room areas including changes to sinks and, where necessary, showers in order to improve the water filtration system."

I wonder if you can expand on what you understand by that?

A At (ii)?

Q (ii), yes, please.

A So, from memory, what that refers to is where, in individual rooms, there needed to be changes to the taps or the showerheads or the sealing-- the sealants around shower areas in terms of water ingress and also the quality of water coming through the system.

Q To some extent, might that be connected to work that was done in Ward 6A in January that required a decant to CDU?

A Yes, it may have been. Yes.

Q Right. So I want to ask you about a couple of other issues which aren't on this list, which is the Adult Haematology Ward. So this is not Ward 4B, the Bone Marrow Treatment Ward, but the other haematology ward, where, once we get into 2019, there is discussion involving the Health and Safety Executive around that ward, but I'm wondering when and how the issues in 4C first came to your attention. Perhaps most importantly, who told you? Whether it's GGC or your own team.

A It would be my team that told me. Now, whether or not they had that information from GGC, I can't say, but it would be my own team who told me. Exactly when, I'm afraid I can't recall.

Q Now, there's another issue that's a bit related to it, and it's been quite low on our radar, so it's possible you weren't aware of it, which is issues around the ventilation in Paediatric ICU on the first floor.

A Mm-hmm.

Q Now, just for reference – which I'm not going to put on the screen – there is a correspondence in bundle 12,

documents 149 to 157, which is a correspondence between the Health Board and the Health and Safety Executive, but it seems to involve changes to that ventilation system and how it is operating. Were you aware of that issue on the first floor in the Children's Hospital?

A Yes, I was.

Q Can you help us understand when that would have been?

A I'm afraid I can't.

Q But it wouldn't have been in the first few months of 2019, it would have been--

A No, no.

Q Right. Then you've already told us that you think you're aware of the general ward ventilation question in December/January, turn of the year '18/'19.

A Yes.

Q Right. You discuss in your statement from this page the issue of retrofit, and you discuss it in evidence – and I'm just not going to go there – in columns 45 to 47 of your previous transcript. What I want to do is look at paragraph 34 on the next page. You say:

> "I did not receive, at that time, any explanation from NHSGGC as to why it had taken the length of time it did from the hospital opening to identify and put in hand changes to the patient environment in the Schiehallion Unit in general and specifically to its ventilation system."

Are you sure about that?

A I am.

Q Because we have had evidence that the issue was firstly on agendas of the Acute Services Committee in 2017, and it does look as if Health Protection Scotland were involved in writing an SBAR for January '18. So the Health Board had been in discussion with HPS. So could it be that, in a sense, it had gotten to the knowledge of the Scottish Government even before you arrived that there were issues around ventilation?

A It may well have done.

Q And how would a health board find money to do a retrofit on something like Ward 2A? I mean, it was very expensive in the end, but how would they fund that?

A They would either-- I'd imagine they would either look to see how they could use their existing capital allocation and re-prioritise its use, or, if they wished additional funds, they would come to the finance section of the Health Portfolio. I'd also imagine, if they wanted to re-prioritise the use of the capital funds, they would at least need to inform the finance section of the Health

Portfolio----

Q Well, that was my question, is that, if you're going to restructure your capital programme as a health board, you do need to tell the Scottish Health Department?

A Yes.

Q All right. So would you be effectively saying that in order for them to do anything, whether it's to use the money they haven't got or reallocate money they have got, they've got to engage with the Scottish Government?

A Yes, I believe so.

Q And did you ever-- You say you didn't receive an explanation. Did you ever seek an explanation?

A Yes, yes, I did.

Q And when might that have been?

A I can't be specific on when that would have been, but I think as I became increasingly aware of the situation around the ventilation in various parts of the hospitals, I would be asking, "Why has none of this been fixed up until now?"

Q Because in at least your meeting in January, that is three months after they've issued a statement which is of some controversy in which they note they're going to take action on the ventilation system of the ward. There is a question about whether that is entirely frank, but the statement is issued. So when that statement was issued, presumably, would you not have seen the statement, or been briefed about the fact they were issuing statements saying----

A I would have been briefed about the statement.

Q So, in a sense, the issue of, "Why haven't you done this before?" would have come to be important possibly as early as October '18, suddenly, around the time they're making statements, "We're going to do the work."

A Yes.

Q And does that help you understand when you might have raised the issue with them?

A It may well do but, as I say, I may well have raised the issue. I did not at any time receive an explanation as to why it had taken the length of time it did.

Q You mention in paragraph 35, where you are discussing retrofit-- and you explain that you're concerned about the fact the changes were needed in the first place, nervous about whether retrofitting would meet the standards, given that these standards were not met initially. Can you expand on what you mean by that? It's a little gnomic.

A About being nervous?

Q Yes, that sentence.

A I think it's about confidence. It is about, if these standards weren't met in the first place, can we be absolutely sure

they're going to meet them now?

Q I understand, and that's in the context of the Health Board doing it?

A Yes.

Q Is that a sort of concern about capacity, interest? We've had a conversation about where you got assurance when you met them in January. To apply the same question here, are you concerned about their ability or something else?

A II think it was incomprehensible to me how the standard required was not met in the first place when the hospital was built. Why was that not-- I think I said before in a previous appearance, I don't see-- I don't see the point of having a standard which is about patient safety, and then blithely ignoring it. So I couldn't understand, why was this not right first time round? In the absence of an explanation as to why it was not right first time round, I am, I think, reasonably nervous about whether or not-- albeit, might be different personnel-- you're going to get it right this time round.

Q But you let them go on and do it, because 2A was done under GGC's supervision. They'd started, in a sense, in 2018.

A Yes, yes. Yes, of course, because it needed to be done.

Q Did you put in any forms of additional scrutiny or assurance around the 2A project at that stage? I mean, I recognise Assure comes down the track towards the end, after you've retired, but in terms of trying to check them, did you put any structures in in '19 to check they're doing the 2A project properly?

A Well, in 2019, at this point, we're getting pretty close to the escalation, and that brings all sorts of oversight and scrutiny to what is happening.

Q So you see the escalation as the scrutiny, in a sense?

A Yes, escalation-- escalation to Level 4 is certainly about scrutiny and oversight.

Q Now, one of the questions we've been asking – and getting different answers for different wards – is whether there were risk assessments done around different wards' ventilation systems, and we learned that there's never been a risk assessment done for the general wards----

A Mm-hmm.

Q -- although there has been a risk assessment done for Ward 4C, for example. Was the question of whether there had been risk assessments something that was on your mind or your team's mind in that summer of '19 as something that needed to be done?

A It would not particularly be on

my mind. It's a level-- It's not unimportant, but it's a level of detail I would expect my team to be dealing with.

Q So it's not something that, as a matter of reality, crossed your agenda, as it were, at that time?

A Not that I recall.

Q So given what you were saying about what you knew about ventilation when the decant happened, can you be looking back on it satisfied that the patients were moved to a suitable alternative environment when they were moved to a ward which might well have had-- in fact, it had the same ventilation, but it's two different problems. So 2A, outside the Bone Marrow Treatment rooms, has the same ventilation as 6A, but you and your team weren't aware of that at the time the decision was being made.

A I don't believe so, no.

Q Does any issue arise about the level of scrutiny GGC put into the various different options they considered for decant?

A I think it's possible, with hindsight, that that does arise. I think it is likely that my team assumed that there was work undertaken to consider each of the options in terms of suitability for that patient cohort, but whether or not assurance was given on that, I can't comment.

Q So the next issue I want to raise with you is the question of-- Well, it's something that arises in paragraph 37, so that's on the next page. You're discussing here the possibility-- you "made inquiries", as you describe, of the possibility of carrying out works to the ventilation of the Queen Elizabeth/RHC "to bring them up to this required standards for a new build hospital". You're obviously reliant on your advisors, and you remind us you're not personally an engineer. You spoke frequently – in the middle of the paragraph – to the CNO and sought advice from HIS and NSS. Then the Oversight Board gave you advice. There's a question of priority discussed at the bottom, and you say:

> "... air change rates not meeting the standard across the hospital is not unimportant, but the priority had to be the wards and rooms housing the most vulnerable patients, whether adults or children. Consideration had to be given to the order of that and is reflected within the TOR of the OB."

Now, we ask in the next question-- Well:

> "I am asked [you say] why, before leaving office as Cabinet Secretary, did I not order retrofit or remedial work to the ventilation

system or an investigation into how such a step could be taken ..."

Over the page, you explain why you felt a retrofit couldn't be done: because it's an active hospital and it's different from the Edinburgh experience. I'm not going to press you further on that, but it's about the investigation. Why didn't you order, or indeed suggest to the Oversight Board or the Health Board, that they carry out an investigation of what it would take to retrofit, or a risk assessment of whether it was needed? Because one of the issues we're in is a slight information vacuum. The Inquiry will have to make its own decisions. But there wasn't a systematic consideration of what it would take and whether it was necessary to retrofit the general wards, even as an investigation. I wonder why you didn't press for an investigation.

A It's a very good question and I really don't have a satisfactory answer to that, from my point of view, far less yours. I do not know why I did not ask that. It is an obvious ask to have made.

Q Could it, to some extent, be grounded in the sheer scale of such an investigation? Because it's 1,300 rooms, largest hospital in Scotland. One gets the impression that, not only would it not be easy, it would not be cheap. Is there any possibility that you simply didn't really want to ask, for fear of getting the answer?

A No, I don't think so. I don't think-- I don't think I've ever been held back from asking because I'm afraid of the answer. I think it is-- And I think your offer of an explanation is kind, but I think it is simply that I have no explanation as to why I did not ask, and I think that was a mistake.

Q Now, equally, we know that when Ward 2A was being refitted after you had left, there was some form of process by which the ARG group, led by the chief nursing officers, and other parts of Scottish Government and NSS, attempted to have some assurance over whether that was built to the correct standards. There's a debate about whether they did well enough, but there is at least some process.

Given that 4B had been redone and had opened before you arrived, why not check back to make sure 4B has been done properly? Given all the concerns you've expressed about the Health Board's-- I don't quite mean reliability, but the lack of assurance you had, why not look back at 4B and check it's been done right? Because it doesn't have 4 air changes. It doesn't have HEPA filtration in the corridor – and there's a debate about whether that matters – but from your perspective as the government coming in and asking all these questions,

why not challenge about 4B as well?

A Again, I don't have a definite answer to that question. It could be that I assumed that my team would be asking that, and if there was a problem that they would bring that to my attention, but I'm conscious that's not-- if I was listening to myself, that is not a particularly satisfactory answer.

Q Yes, because you've just told me that that's not assurance.

A Yes, that's right.

Q We've done this with other people, so we ought to do it with you at this point: how much of your time as Cabinet Secretary is being taken up with NHS Greater Glasgow by the time we get into September, October, November of 2019?

A A significant amount.

Q Is it causing any difficulties with capacity for you and your team at that point? I'm conscious COVID is coming down the track, which will dwarf everything, but is it dominating to the extent it's excluding other things?

A I don't believe it did, no.

Q What I want to do now is to move on to NHS Scotland Assure. Now, you've covered that in some detail in your earlier statement for Edinburgh, the longer one, paragraphs 151 to 158, and of course that evidence was focused on, in simple terms, the problems that existed with the Edinburgh procurement. I don't want to revisit that. Paragraph 39 onwards of this statement, you discuss it here and you remind us that you didn't actually set it up, you just suggested it, in simple terms. I want to perhaps remind you of a couple of things you said, and then put some things to you. So, in your transcript, I have noted that you saw it as:

> "... my attempt to walk [this is column 34] the tightrope between the position of health boards in terms of their legal standing and statute and what I consider to be the responsibilities of Scottish Government and a Cabinet Secretary."

Is that reference back to this discussion about accountability we previously had?

A To a degree, yes.

Q But also to do it "without throwing up in the air the legislation that underpins health boards..." Is that the act that creates them, an independent body?

A Yes.

Q Right. You talked at column 78 about the idea of having a clerk of work, someone walking around with a clipboard.

A Yes.

Q Can you expand? I mean, Edinburgh, it would have been looking at

spreadsheets, but in this context what would you imagine this clerk of work is doing in the context of the Glasgow hospital?

A So, if we-- The phrase “clerk of works” comes from the situation in the Edinburgh hospital, where the difficulty with the ventilation system in the particular areas that were critical came to the attention of the Health Board and therefore-- from there to the Scottish Government and to me, at last minute, when someone went to physically check the air change rate-- up until that point, it had been a paper exercise, and that’s-- from that is when I said, “We can’t do this on the basis of a paper exercise, we actually need--” and my phrase was, “I want a clerk of works. I want the equivalent of the guy that wanders around with a clipboard switching things on and off to check that they actually do work and they’re working in the way in which we require them to work.”

From that came the proposition of what is now NHS Assure. In other words, that you don’t satisfy yourself that standards-- the required standards that link directly to patient safety, on whatever aspect of the build you’re talking about, have been met on the basis that you have the relevant bits of paper to say they have been met. At some point, somebody has to go and physically check

that that’s the case.

Q The reason I mentioned that example is because, whilst in the Glasgow Hospital there wasn’t the clerk of works, well, what there was was an NEC3 supervisor role performed by Capita. One of their staff gave evidence, and we looked at their contract, and they going around physically checking that things were built in accordance with the drawings.

A Mm.

Q Therefore, they weren’t looking at whether they were built in accordance with the contract, but even if they had been looking at whether things were built in accordance with the contract, they wouldn’t have found the problem because it was embedded in the contract. I suppose what I’m asking is, to what extent did you imagine, when you were thinking the thoughts that became NHS Assure, that the problem wouldn’t be someone making a mistake in the process of turning contract into building, it might be actually embedded into the contract itself?

A Both.

Q Right.

A Both. I think that we cannot continue with an assumption that the commissioning and the design that then follows that and construction that then follows that will-- will without question and

without checking cover all relevant standards that pertain to patient safety. You need to be sure of that, because if you don't get-- It's like anything else, if you don't get the commissioning right, then at some point down the line you're going to have to retrofit and fix that, and that inevitably-- it costs more money, but more importantly, in a situation like a healthcare facility, you have increased risk in the exercise.

Q This Inquiry of course has not reached conclusions, but we've issued various preliminary position papers. One of them, PPP 13, sets out this position, which is that – and I think it's been confirmed in evidence, just to a great degree – a matter of days before contract close on 18 December 2009, the final issue of an inconsistency between the proposal by the tenderer, Brookfield Europe, and the Employer's Requirements set out by the Health Board was resolved, and that inconsistency was that the requirements required compliance with the guidance in draft of that form, SHTM 03-01, but they also required a maximum temperature in the building of 26 degrees, when the guidance requires 28.

Brookfield Europe's bid did that by the use of chilled beams and a low air change rate, and that was resolved a matter of days before in the negotiations. Now, would your vision of NHS Assure have spotted something like that in the last few days of choosing a tenderer? Not the building of it, the Full Business Case, or even the Outline Business Case, but that final moment when it's all getting quite busy?

A That is where I would want NHS Assure to be. I think that requires different expertise than perhaps NHS Assure currently has. Because at that point, as I would understand it-- and I am no expert at all in this regard, but I would think at that point, as in any contract, then you require a degree of legal advice as to whether or not what you're negotiating is up to what you want.

Q I think it's fair to say that NHS Greater Glasgow did have legal advice.

A Right.

Q I'm wondering about-- Well, firstly, let's talk about NHS Assure as it is now. Did you have the opportunity of watching or at least reading a summary of Ms Critchley's evidence?

A I did read-- I read a summary.

Q Just before we came in, you mentioned you had some thoughts about the way she had described the organisation that she now leads.

A Yes.

Q Can you help me what those might be?

A So-- And this is only from

reading the transcription. As you know, I stood down in ’21, so I am not able to comment on how NHS Assure has been set up and-- and what it is doing, but in her evidence, I understood her to say that the organisation was there to work in collaboration with health boards and to provide support, to be supportive. I wouldn’t disagree with either of those two propositions, but I have a concern that organisations can be overly supportive when what we need them to do is to set out clear red lines that the organisations they’re working with are required to meet.

So, that’s my, if you like, niggle, that you can take support too far. It’s like when people fear that you can’t be challenging in holding a board, or whoever, to account if you’ve also to be supportive. I think it is entirely possible to be both. So, my only concern from that transcript, which may be unfounded in truth, and I’d accept that, is that NHS Assure is not being as firm in what it requires from boards as I had envisaged it might be.

Q How would you respond to the suggestion that rather in the way that, in a large development project, the funder, a bank or investment fund, would put its own lawyers into the negotiations to make sure the contract met its requirements in addition to the landlord or the tenant, the Scottish Government in

the biggest – and I don’t just mean in an important GP practice, but a large tens, hundreds of millions of pound project – in the biggest projects should put it’s own, and presumably would have to get these in from outside, team of construction lawyers into the negotiations to make sure that slip-ups, or mistakes, or errors, that might have big impacts on the long-term viability of the building don’t happen? However, it might be rather expensive. These lawyers are not cheap.

A I think that is a perfectly valid proposition that should be given consideration. I can see full well why that is reasonable to do, and the point about cost: you have to balance the cost of providing that degree of assurance at the very early stage with the potential cost of having to fix problems down the line, not just financial cost, but cost to patients, their families, and the wider public.

Q Thank you. So, I’ve been asked to ask you a couple of questions. The first one is: who should patient or group of patients go to to escalate matters in the event of a failure by an NHS board to comply with Scottish Government guidance? In this case, it is the air change rates in Ward 4B, but there may be others. What should someone do when they learn this, whether they’re a patient or patient-- because clinicians can raise it internally

and hopefully through whistleblowing, but how would a patient act? What should they do?

A I think, in the first instance, the patient or their families would raise that directly with the chair of the Board. If they were dissatisfied, felt they hadn't been given a full answer or that they were dissatisfied with the answer or believe they didn't get one, they have three options, I think. One is a public service ombudsman who will hear those kind of concerns. I believe we now have a patient safety commissioner for Scotland, so that would appear to be a direct route, and the third option – and they're not necessarily mutually exclusive – is whoever is in post as the Cabinet Secretary.

Q Thank you. The other one is, Ms Critchley, I think, gave evidence that she and her organisation see HIS as a regulator for health boards. Now, maybe she just-- that was a quick answer, but is that correct? And if it isn't, do you need a regulator for the NHS in Scotland, rather like Monitor down south?

A I don't believe that HIS is a regulator. Now, do we need one for the NHS? Possibly, I think, and I only say possibly because I don't think it is wise to rule it out. I think it is wise to give it proper due consideration and see how such a regulator might operate alongside other regulators that are part of the health landscape – for example, the GMC, other regulators in terms of the professions inside the NHS – but I think it is worthy of proper consideration.

Q I'm just going to check-- Can we move on, I think, to the topic of duty of candour, which you covered from paragraph 43? You explain on page 111 that families had no criticism for the staff because the staff had no knowledge of what was going on. Can I just check, in this context, this is families largely for the Schiehallion Unit?

A Yes.

Q Yes, and therefore the families were doubly cross about not being told what was happening, but also that their clinicians were not being able to answer questions. Now, you make a reference-- you then say:

> "The meetings highlighted to me the Board was failing in their organisational duty of candour; and the individual clinicians were hampered in the exercise of their individual duty of candour as a result of not being provided with relevant information."

Now, what I wanted to do was to sort of break this down because we've obviously heard about the organisational duty of candour under the 2016 Act, and

we've heard about the individual duty of candour which exists within the medical professional regulatory system. I don't think anything arises about your reference to the individual duty of candour but, with the organisational duty of candour, are you thinking about individual patients not having appropriate organisational duty of candour carried out for them? Is that what you're trying to point at?

A It is individual patients and it's also a number of individual patients. So it is the wider group. So, I met that group of families, and families of young patients, but also including some young patients, as I explained, I think, earlier. I met them with the chief nursing officer and heard from them their concerns, their attempts at finding out what was happening, why there was a decant, why things were being done to sinks and showers, all of that, and that they were getting nowhere. They were not getting any answers, and their upset that the staff that they were receiving or their relatives were receiving care from were themselves upset because they could not provide them with those answers too.

And they were very, very clear that they had no criticism whatsoever of any of the clinicians, nursing staff, housekeepers, porters, anyone that they were in contact with and were providing care and support to them. That was not where their criticism lay. I then, as I say, also met individual families who did not want to be part of that bigger group meeting and heard the same thing from them. So it was clear to me that those individuals I was hearing from, that the statutory duty of candour was not being met, but it was also not being met to that group-- as a group.

Q Well, that's what I wanted to just try and break down the two parts of it. So, we stay with the statutory duty of candour for a moment. We know from Professor White's participants, and the meetings of his subgroup of the Oversight Board, that he had some concerns about the GGC policy on statutory duty of candour and whether it was compliant. You're familiar with that?

A Yes.

Q Yes, and it was subsequently changed. Now, when asked about what she thought about the fact that the Board was operating a non-compliant duty of candour policy, Ms Grant's position was that, to some extent, that should be seen in the light of the fact that the legislation was new and that their policy had been looked at by other health boards, indeed might have been used by others to some degree, she felt, and therefore it wasn't really a breach of the statutory policy to follow their policy as it was set out at the

time because they'd effectively done their best to do it right. How do you feel about that?

A I think that is an inadequate explanation of not having a policy that is compliant with your statutory duty.

Q Could more have been done to explain these policies to health boards?

A I think-- I don't know. I've not seen the transcript of his evidence or his witness statement, but I think Professor White would rightly argue that a great deal was done to explain exactly what the statutory duty meant to health boards on more than one occasion, including in the bringing together of the legislation, the passage of the legislation through the Scottish Parliament, and then the final Act and how was to be implemented.

Q So, the other thing you talked about was a duty of candour to a group and, when I read the legislation, I see it triggered by a concern expressed about an outcome on an individual patient by a registered medical practitioner. Is that roughly your understanding?

Yes.

A So, would it be fair to say, therefore, that there is no statutory duty candour to group? So that if there are a group of parents with a group of patients in a unit, if one patient has an outcome that triggers the policy, they should receive a duty of candour declaration and the appropriate steps as per the Act, but the duty of candor legislation, does it really provide any requirement to provide information to the rest of the community?

A No, and when I used the phrase "group", I simply meant there was a lot of individuals.

Q Right.

A There was a large number of them, and they were described to me as a situation-- they were described to me by the Board as a situation where the majority of patients and their families did not have concerns; this was a particular Facebook group that was troublesome.

Q From where in the Board did that come?

A It was actually said to me at one of the Board meetings I attended.

Q The actual formal meetings?

A Yes. It was also reported to me by the chief nursing officer and was something that was said to her by one of the executive Board members. So that was-- it's all part of this view that, "There isn't really a huge problem here and people are being difficult." I have rarely had-- in all the time that I have been Cabinet Secretary, I do not think I have had another meeting that had quite the impact that meeting with families had on me because they were asking questions for which they were perfectly entitled to the answers and were not being given

those answers.

THE CHAIR: Can I just take a step back because it's quite striking? At a Board meeting, which would be attended by the 30 or so members of the Health Board, somebody described the family group with whom you had met as a particular Facebook group which was troublesome?

A Yes.

THE CHAIR: So, whoever made that mistake, it was heard by every other Board member. Did you pick up any challenge from anybody in the room to that proposition?

A The only challenge I recall is from me.

THE CHAIR: All right. Thank you.

MR MACKINTOSH: And approximately when would this meeting have taken place?

A I think it would-- well, it would be in 2019, and it may have been at the point prior to the escalation.

Q So it happened in the late summer/early autumn?

A Yes.

Q After the meeting in January around the Cryptococcus cases with the executive members?

A Yes.

Q After the Independent Review?

A Yes, and there was a Facebook group.

Q Well, indeed, we've got copies of its communications. I'm just trying to understand-- I'm not going to use you as an expert witness, because I think the idea of being an expert politician is a dangerous concept, but----

A I would agree.

Q Did you attempt to rationalism or understand in your mind and think about how someone could have got themselves into that position after more than a year since the water incident started to see that Facebook as a few troublesome people?

A I think, for me, it was part of a pattern, which I think earlier you said it was diplomatic, I described as guarded and defensive. I think that was a general pattern of attitude from which flowed behaviour that came from the Board and the senior team at Greater Glasgow and Clyde.

Q And you do see this as wider than just the corporate management team and the executive Board members at the top, to include the non-executives as well?

A Yes, I think so, yes.

Q We haven't taken statements from non-executives-- We've spoken to two, and we have statements from Mr Lee and Mr Winter, and we haven't covered this issue with them, so we haven't heard in their perspective. Apart

from going to Stage 5, do you have any steps you can take, I suppose with a small "p", politically, to react to when a board has the attitude you're describing? What else can you do other than go to Stage 5?

A So, the chair and some of the non-executives are appointed by the Cabinet Secretary, so it is possible to consider the continuation of that appointment. That is something a cabinet secretary can do. In addition, though, as you know, in this instance, Professor White was tasked with the role of being the direct point of contact with those families and providing the information so that they could get the answers to the questions that they were legitimately asking, and, in doing so, it was hoped that the Board and the teams working to the Board would improve their communication and the transparency of the information they were providing.

Q So, in a sense, you took practical steps. Rather than dealing with the Board members, it was about dealing with the issue?

A Yes.

Q Would you accept that the adding of Professor White, to some extent, as the middleman in the process may actually have had the effect of slowing down effective communication?

A No, not at all. Not at all. I think what he did by his actions, by his understanding and by his behaviour, is he began the process of regaining trust from those families concerned and providing the information necessary to a wider group of relatives and patients who may not have been present when I met them on 28 September.

Q Ah, that gives you the date. Right. Now, let's turn to the process of escalation. We know when you escalated.

THE CHAIR: Sorry, just so that I can pick up on that. The 25 September date----

MR MACKINTOSH: 28 September----

A 28 September is the date.

Q When you met the families?

A Yes.

THE CHAIR: Sorry, 28th.

A 28 September is when I met the group of families, including some young patients. I think 1 October is when I met two families separately.

THE CHAIR: Thank you.

MR MACKINTOSH: And would the meeting with the Board have occurred after those meetings?

A I can't recall.

Q What I'm going to do is I'm going to ask one of my colleagues, before the lunch break, to just walk through our Board meetings, and no doubt there'll be

a minute saying you were there. So we'll find out which one it is and I'll put it to you just after lunch.

A Okay.

Q However, at the stage you're heading towards escalation-- (After a pause) I want to understand what you felt, before the lunch break, were the main barriers that you felt existed to effective resolution of the issues that you are now aware of by the time we get to September/October 2019. So, can you help us with what you think the main barriers to resolving these issues were?

A So, I think-- I was still not seeing from the senior team an understanding of the issues as a whole, as opposed to discrete elements. I was not seeing from the senior team a significant willingness to look for additional support and external support from Scottish Government or elsewhere, and we had, as I expressed, a pattern that continued of what I perceived to be guardedness and defensiveness from that senior team and the Board overall, and a lack of appreciation as to how all of this was impacting on confidence – public confidence, but also how a lowering of public confidence in a hospital impacts itself on the staff in that hospital.

Q Now, I want to just check we've got some chronology right. So, the next page, paragraph 45, you start with-- and actually this is in a section entitled "Whistleblowing" and you've moved into duty of candour.

> "Around this point in time I also appointed Professor Marion Bain as a new Medical Director to deal with IPC."

That would have been after Stage 4 was escalated.

A Yes.

Q Yes, so that's fine, and so it's worth, I think, just bringing in some names and characters that we'll deal with after lunch, as it were. So, we'll come back to Ms Bain's appointment later, but then you appointed Calum Campbell to assist as turnaround director. Now, is he ultimately going to be a player in the Programme Oversight Group as opposed to the Oversight Board, the sort of second oversight board?

A Yes. So, Mr Campbell-- and, my apologies, it's not as clear as it could have been in my statement. Mr Campbell is appointed following the escalation of the Board in full to Level 4.

Q So he is, to some extent, and we'll discuss the differences, the equivalent of Professor McQueen for the whole escalation, or have I got that wrong?

A Yes-- Yes. No, he's not. So, the first escalation of the Board to Level 4

is around infection prevention and control.

Q Yes.

A And that is then the creation of the Oversight Board chaired by Professor McQueen, the appointment of Professor Bain as the medical director who will deal with infection prevention and control. Subsequent to that, as a result of the Board's performance in other areas-- and I think you have sight of the position paper from John Connaghan, who was the chief operating officer for NHS Scotland-- so performance in other areas, not least waiting times and other matters, the Board is escalated in total to Level 4.

Q But with a different structure?

A Yes, and that carries its own oversight board on performance.

Q Which is the Performance Oversight Group?

A Yes. That is chaired by Mr Connaghan, and Mr Campbell is appointed as what's called the turnaround director. In other words, he is responsible for making sure that the plan to improve performance in areas of, for example, elective care is delivered.

Q So, to some extent, and I appreciate this is a very loose analogy, he is the Professor Bain of the other oversight board?

A Yes, yes.

Q I think it would be a good idea if we look at these two letters from Mr Wright escalating and we talk about those after lunch, my Lord.

THE CHAIR: All right. Well, we'll take our lunch break now and could I ask you to be back at two o'clock?

THE WITNESS: Yes.

THE CHAIR: Thank you.

THE WITNESS: Thank you.

(Adjourned for a short time)

THE CHAIR: Good afternoon, Ms Freeman.

THE WITNESS: Good afternoon.

THE CHAIR: Mr Mackintosh.

MR MACKINTOSH: Thank you, my Lord. Ms Freeman, one of the consequences of a lunch break is it enables counsel for the various core participants to propose extra questions for me and me to go and look at extra documents, and so what I might do is spend a few minutes jumping back what we've already looked at.

A Okay.

Q The first question relates to-- I think, you've described in some detail how you learnt of events and the particular impact the meeting in January 2019 had on your understanding of what were the issues and concerns about the Health Board.

A Mm-hm.

Q It's been put to me that Professor Cuddihy wrote to the then chief medical officer in-- well, actually, before you were appointed in June 2018, and wrote a long letter which hasn't made it into a bundle in which he sets out, for various reasons associated with his daughter's care, the belief that no one in the Health Board has a grip of the situation. I think it's fair to say that's a widely-held view amongst parents at that time. What awareness did you have before decant that there was a view that the Health Board didn't have a grip of the situation in Schiehallion?

A I don't think I had much of any awareness that that was a widely-held view external to Scottish Government. What I think I did have was an awareness that there was a growing concern on the part of my senior advisors that perhaps the Health Board didn't have a grip.

Q What I've been asked to put to you is that it should have been obvious to the Scottish Government in the summer of 2018, not January 2019, that the Health Board may well not have had a grip on the situation, and that actions should have therefore happened even earlier than they did. How do you respond to that?

A I think if I was either a young patient or a family member of a young patient, that may well be a view that I would share. I think, from the point of view of senior officials in Scottish Government, I'm hesitant to speak on their behalf, but also my own behalf in the Summer of 2018. From my point of view, I was still getting to grips with what the situation actually was, what had gone before, where were we, and conscious that I was relatively new in the role and that views that I had entered the role with – for example, that health boards are not autonomous bodies – needed to be tempered with the reality of being the Cabinet Secretary and taking responsibility. And I think there is a style, an approach in health, certainly at that time in the health directorate, which is to provide support, advice, but encourage boards to act on their own behalf.

Q Do you think, in a sense, there was a reticence about stepping in too fast?

A There would be a reticence about stepping in too fast, and that is partly a reasonable reticence because evidence is needed to justify doing that.

Q Thank you. Another question I've been asked to raise relates to your discussion about the importance of asking questions when obtaining assurance that things have happened when you sit on a board or hold a job like the Cabinet Secretary. If you make assumptions that things are being done

without asking questions, what do you see as the likely impact or risks of doing that in the health sector?

A So, I think the risks will range from relatively minor to severe, depending on the situation. I don't think it is good enough to accept an assurance at face value, and I don't think it is good enough to operate on the basis that, "Well, nobody raised a problem with me, so there can't have been one." If you're the Cabinet Secretary, your job is to gather information from as wide a range of sources as you can – hence meeting the families, hence meeting the whistleblowers. There are good reasons for doing that in and of themselves, but there's also the reason of gathering as much information and different perspectives on a situation as you possibly can to help you form a view about the situation and about what you should do about that, and I think that applies to others in situations where their role carries significant responsibility.

Q Such as chairs and chief executive.

A Indeed.

Q Right. The next issue is attempting to work out this Board meeting that you've attended. Now, there was a moment of excitement when I thought I thought it was 24 October 2019, but I don't think it is, but I'll just set out some more information I've learnt.

It's not in a bundle; it will get into a bundle. We found the document, which is a mid-year review meeting at Atlantic Quay on 24 October, attended by the Chief Executive and chair of the Board, you, Mr Wright, Mr Connaghan, Mr McCallum and, for note-taking purposes, Dan House. It's quite a substantial bundle of papers. It covers a huge range of issues, not just Schiehallion, but it's not a Board meeting.

A Yes.

Q We will, I think, produce it because in it there's a report from both the CNO and from the Board on the issues in Schiehallion as they then stood, so that's quite handy. We will produce that. We also looked through all the Board minutes which we have across various bundles, and at no point in a formal meeting are you minuted as being present. I'm just wondering whether it might have been a Board seminar that you attended.

A No, it wasn't. It was a Board meeting and it was in the HQ of Greater Glasgow and Clyde, which is in the grounds of the Royal Hospital at Gartnavel.

Q Thank you. Would it be possible, after this hearing, for you to-- Would your old diaries still be available to you?

A Yes, they should be.

Q I wonder if someone might look at that for you and perhaps ask Scottish Government's solicitors to write to us with that date to just help to bring the chronology together.

A Yes.

Q Now, the next thing is that we were talking about the escalation, that we haven't yet reached, to Stage 4. In paragraph 47 of your statement, you address escalation, and we've obviously had evidence from both Mr Wright and Professor McQueen, as she then was, and I'm not going to go through this in a huge amount of detail, but I want to ask you some questions about the nature of the escalation and why particular steps were there.

So, the letter sent to the Board is bundle 52, volume 1, document 23, page 310, and we see that Mr Wright has set out the-- I think over the page there might be further information. No, that's the report. Back onto page 310. Am I right in thinking that the escalation was effectively in respect of IPC issue?

A Yes.

Q Yes. So, at the point you make this escalation-- or you don't, but would you accept that you would have had input into the decision?

A That I would have had?

Q Had input into the decision.

A Yes, I did, yes.

Q Is there a sort of political reality that a director general is probably not going to escalate without taking the Cabinet Secretary with them?

A That's probably fair but, equally, the Director General is not going to escalate beyond what they believe the correct----

Q Yes.

A -- level, regardless of what the Cabinet Secretary says.

Q So that, in a sense, the Cabinet Secretary can escalate to Stage 5 if they want to, but the Director General goes where they want to go, having had conversations and discussions.

A Yes.

Q Right. At this point – so this is 22 November – to what extent did you have confidence in the governance of the Board at board level around the issues involving the Queen Elizabeth and the RHC?

A So, I don't have a great deal of confidence, but I have confidence in the escalation to Level 4 because it will bring into play the Oversight Board, and allow the appointment of Professor Bain, and effectively remove the actions necessary on infection prevention and control to the oversight of that board and those individuals, but the Board does remain responsible for infection prevention and

control.

Q Can you explain why the remit of this Oversight Board and this Stage 4 doesn't extend to explicit supervision or oversight over the rectification of issues in the water system as a whole?

A No, I can't.

Q Or the ventilation in wards outwith Schiehallion?

A No.

Q Or indeed, actually, explicit reference to the rectification of Ward 2A and 2B? It's not explicitly within the scope of the Oversight Board.

A It's not in the terms of reference?

Q Well, it is to some degree. Let us just go and look at those, which is-- We'll find it in the Oversight Board itself. So, that's bundle 6, document 35, page 700-- I'm just going to check on that because I've just missed a note out of my notes. While someone reminds me of that bundle reference, we'll talk about the water system as a whole, and we'll come back to that one. There'd obviously been a water incident that had started before you arrived and there had been the DMA Canyon reports.

A Yes.

Q Can you help us with whether there was any thought about putting the supervision-- the support of the Oversight Board over the whole recovery of the water system for the whole hospital?

A I can't recall whether there was or not.

Q Do you think that might have been a good idea, given that it's a single system?

A At this length of time since that discussion, I don't think I can reasonably answer that question yes or no.

Q Similarly, you, by this point, knew the extent to which there were issues with ventilation across the whole hospital, and indeed you'd appointed the Independent Review. Now, I appreciate we asked you whether you should have looked at identifying what needed to be done to rectify the ventilation systems. There doesn't even seem to be, for example, the management of the ventilation system across the whole hospital and risk assessments within the remit of the Oversight Board. Is there a reason why that step wasn't taken?

A Again, I'm afraid I can't answer you. The terms of reference of the Oversight Board would have been-- would have come to me following discussion between Mr Wright and Professor McQueen, and I can't recall a discussion with them about what else may have been in those terms of reference that weren't.

Q Because, when we pressed Ms McQueen about it, I gained the

impression that the Oversight Board idea comes out of her work as chief nursing officer with the responsibility for healthcare acquired infections and whether they were being properly handled, and, in a sense, that's why it does what it does because it comes from that place. Does that can accord with your sort of understanding of what it was for?

A So, the chief nursing officer is the lead advisor policy official on infection prevention and control, and so the escalation to Level 4 was primarily around those issues, which would make it logical that she would then be the chair of the Oversight Board, and the Oversight Board would be addressing those matters.

There may be, notwithstanding that the independent inquiry-- or Independent Review had been set up, there may still have been an inadequate appreciation of the role of the built environment with infection prevention and control to the extent that you would then include that. Now, I'm surmising. I cannot say if that is definitely the case.

Q Because when one looks at-- Well, we can look, for example – I think I put it in the document list – at your statement to the Parliament. It was in the official report, which I think might have gone in the documents list. So, while I

find that reference, were you presenting the Oversight Board as simply dealing with infection prevention and control or something wider?

A When?

Q When you were announcing it and setting it out for the benefit of those who were listening to your decision to introduce it.

A So, we'd need to go back to the statement I made to Parliament. I don't know if that would be 20 November statement.

Q I think it is. I'll just find it on the document list.

A No, I think it is February.

Q You made a statement to Parliament when the Oversight Board was originally established, did you?

A Yes.

Q I know we have the draft of your statement in a bundle, and somebody will pass to me, I hope, the----

A It's the ministerial statement on 10 December 2019 where I advise Parliament that the Board has been escalated to Stage 4 for infection prevention and control and engagement and information with patient and families.

Q Yes. So, if we look at the terms of reference, that's bundle 52, volume 1, document 4, page 24, and go to page 25, we see the terms of reference focusing on:

"... the OB will seek to:

- ensure appropriate governance is in place for [IPC] management and control;
- strengthen practice ...
- improve how families … monitored by the ... service;
- confirm that relevant environments at the QEUH and RHC are and continue to be safe;
- oversee and consider recommendations for action further to the review of relevant cases ...
- provide oversight on connected issues ..."

Now, what I'm pressing you on here is that, whilst the fourth bullet point there:

"... confirm that relevant environs at the RHC are safe and continue to be safe ..."

That reads as if it's focusing really just on 2A and 2B and not the wider system. Do you accept that?

A No, I don't think I do. I think you can read it as focusing on the areas of the hospital where infections have emerged that cause concerns, at least those areas, so that is wider than 2A and 2B. It potentially does include, as you've asked earlier, water, but it could include the wider hospital, but I don't recall specifically if it did include the wider hospital.

Q Okay. The other issue is it doesn't explicitly include the concept of the whistleblowers and how they were being treated and whether there was an issue of culture in the organisation. Now, would you accept that, given the meetings-- the conversation-- the email exchanges you had with Dr Peters, Dr Redding and the meeting you have with them, and then with Dr Inkster and Dr Peters in the autumn, you would have been well aware that there was a viewpoint that the Health Board was not welcoming internal criticism?

A Yes.

Q Yes. So, when I pressed Professor McQueen on this, she accepted that the Oversight Board didn't, as it were, completely resolve this issue, but it isn't actually jumping out within its remit either.

A No, but I think you have correspondence from either myself, or between myself and those doctors, and/or with Professor McQueen----

Q No, we do. You're right, yes.

A -- that indicates that I had sought for the Oversight Board to hear their concerns and involve them.

Q And there is a debate about

the extent that took place.

A Yes, there is.

Q But the point, I suppose, that occurs to me to put to you is that, whilst things were done by the Oversight Board, the Oversight Board doesn't appear to have managed to resolve the issue of the culture within the Board. Would you accept that?

A I would, and I think, in fairness to the Oversight Board, arguably there were-- Two points: arguably there were more pressing matters in terms of patient safety for them to oversee and resolve; and, secondly, they barely had their feet under the table when we faced a global pandemic----

Q I do appreciate that.

A -- which inevitably delayed, skewed their practice and the numbers of people they could pull into a system.

Q But a possible alternative, I put to you, is given that you had awareness and your team had awareness of culture issues dating back to the-- starting at the Sturrock report in the previous year, as an issue in the health service, and you described it in quite some detail, might it have been an oversight to miss out from this reference of the Oversight Board a particular requirement to look into culture within GGC?

A No, I don't think it was a mistake to omit that from the role of this

Oversight Board. What I had in mind is that we would run a repeat exercise of the Sturrock Review in Greater Glasgow and Clyde in parallel – separately, but in parallel – recognising that this is a much larger board, and so to do that properly would take time, but should be begun, but we never got to that point.

Q Partly because of the pandemic?

A Yes.

Q Right. So, when you come to make the escalation decision, or rather Mr Wright comes to make the escalation decision, that is a few days after Ward 2A has been reopened to new admissions. You're aware of that?

A Yes.

Q Yes. So, if we think about the factors that are playing around, to what extent does the fact that Ward 2A has been reopened render some of these issues moot and, actually, you didn't need to go to Stage 4 because you've managed to reopen the ward, things are improving, actions were being taken on the water system, Professor Steele's management list was being worked through? In a sense, could it be that your escalation was unnecessary?

A No, I don't believe so at all. I think there is an argument that the escalation could have happened earlier, but not a reasonable argument that it

wasn't necessary at all. And if you look at the terms of reference of the Oversight Board, regardless of whether a ward has reopened or dosing is now happening to the water system, that I think was recommended in 2017, in fact, by DMA Canyon-- regardless of that, all of these things still need addressed because they go to the heart of some of the challenges that we are dealing with in Greater Glasgow and Clyde.

Q So, what I want to understand is what of the various threads of information that you and Mr Wright and the chief nursing officer are receiving play a role in this decision. So, we've heard from Ms McQueen that her concerns about non-compliance with reporting requirements dating back 2015 played a role. Were you aware of those?

A Yes, I was.

Q To what extent-- what role did the views of patients and their parents have in the decision to escalate?

A A significant role.

Q And that's following the meetings that took place?

A Following the meetings that took place, following the other information that came to me from both MSPs but also, in some instances, directly from families themselves, or from Professor White.

Q And is that as a result of his involvement with communications with the family?

A Yes.

Q So he's reading their communications, effectively, because he's in the Facebook group.

A He is, but he's dealing directly with families, asking them what questions they want answered, then trying to get the answers, getting that through to the families, dealing with the communications team in the Health Board itself. So he's doing a great deal of work that is direct contact with families.

Q What role did the epidemiology and the HPS review – that's bundle 7, document 6, page 214 – have in----

A So, all of these reports all have a cumulative role, if you like, in taking us to a position where escalation to Level 4, for the reasons set out at that time, is, I believe, the right decision to have made.

Q Right. Now, again, to revisit the question of whether it's the right time, I know you've already to some extent addressed this, but if we think about a lot of these information sources, they actually existed from some time before. So the families' concerns existed before; HPS's reports about the environmental systems existed before; your concerns about the way that the Board was approaching matters existed before; the whistleblowers had been in touch before.

To what extent is this potentially-- was a lag in escalating because of this continued desire to let the Board have its autonomy and to give them a chance to resolve things?

A So, I think I'd say two things. I mean, first of all, from my perspective as the Cabinet Secretary, the families' concerns were crystallised for me at that meeting in September and then in October, which is not that long before the escalation decision is actually made. The whistleblowers, as we've gone through before, in the detail that they had to offer, came to my attention around about the time of the Independent Review being announced – so again, not that long. There is a cumulative sense of the Board not having a grip – we've discussed this already – about why that might be the case, whether it is capacity or attitude. My own view is that it is more attitude than capacity.

So, as all of that gathers, you then get to a point of saying, "We have to escalate now in order to more directly intervene because everything that has been tried up till now, the Board is not responding to this in the way that we need them to respond."

Q So, the Oversight Board is set up. We've heard evidence from Professor McQueen and other members. We've looked at the minutes and we've looked at her recommendations. I want to look at the second escalation. Now, there is a document which we'll put on the screen now, which is a letter from Mr Wright dated 24 January 2020. It's not yet in a bundle but it will be soon, I hope. So, what is this escalation?

A So, you'll recall from the paper that Professor McQueen put to the directorate's management body----

Q Yes.

A -- to argue for escalation to Level 4 for infection prevention and control and communication with families. In that paper, she said there is no systemic evidence of this Board not performing well in other areas. So that's why it's discrete.

Q Yes, we've been to that with her.

A So, subsequent to that, from the chief operating officer of NHS and member the directorate, John Connaghan, who is responsible and concerned with performance of all health boards – and that's performance in relation to the targets set for them, be it on finance, be it on waiting times, whatever – he brings forward a paper to that body that says, "The performance of Greater Glasgow and Clyde is not good enough and everything we have tried so far has not improved that sufficiently, so I now want agreement that we escalate the

Board as a whole to Level 4," and this time it's not just about infection prevention and control, it's about performance, and that's what that letter is concerned with.

Q Does that pose any concerns in terms of confusion, in that the main Oversight Board is meeting as an oversight board, it ultimately will produce a report, it's addressing IPC adjacent issues, and of course the pandemic will come along and disturb everything, but at this point you're probably just getting into your weekly briefing. What is it, third week of January you're beginning to get the worrying signs? So, is there any risk that having two oversight boards at the same time, where one is almost within the scope of the other – in a sense, one's the whole board and one's a subset of it – might have caused confusion?

A I don't believe so because the areas are-- they're obviously, in practice, connected. How well you do on infection prevention and control does have an impact on how well you meet your performance targets, clearly, but they are equally discrete, in a sense, and the letter and the escalation was clear that, on the question of the plan to improve performance, that would be overseen by a group chaired by Mr Connaghan and would have, operating to it, Calum Campbell as the turnaround director, and

so he would take over responsibility for the delivery of the improvement plan on performance, which would allow Ms Grant to focus on what needed to be done by way of leadership on infection prevention and control and communication with families.

Q And----

A So I don't think-- I mean, I accept that----

Q Do you think Ms Grant----

A -- from the outside, it may appear confused, but I don't believe for one minute the Board was confused.

Q Do you think Ms Grant saw her role was shrinking and effectively handing over most of the Board's operations to Mr Connaghan?

A I don't know whether she saw it in that way or not.

Q Let's just-- we want to be clear on one particular issue. Obviously, we know there's a programme. It's reported regularly to Board meetings to address some of the physical defects in the building, a lot of work on water, sequentially through wards, there's litigation, all these things are running on. Do they fall under the remit of this Oversight Board, or the first one, or neither?

A In a sense, litigation doesn't fall under the remit of either of the boards. The Health and Safety

Executive's intervention and engagement is also a separate but parallel issue, that it is important for government, but also the Board chaired by Professor McQueen, to be aware of, insofar as it is possible to be aware of how that is progressing, but the maintenance programme is, where relevant, for the Board overseen by Professor McQueen because it relates to the fabric of the building, the maintenance of that fabric, and, as we've seen and discussed, that has a direct connection with effective infection prevention and control.

Q So, before the pandemic intervenes, we should see the intention as all the work being done by Professor Steele to address, in the broadest sense, deficiencies in the building falling, to some extent, within Professor McQueen's Oversight Board's remit, to the extent it impacts on risk to patients.

A Yes, yes.

Q Now, ultimately, the pandemic did intervene, and we've obviously heard evidence from the Oversight Board of how their meetings stopped for a period, and I asked you about leadership and culture, rather, and you expressed the view that, to some extent, it was the pandemic that intervened to stop some of that work. Now, there's somebody writing a transcript and nodding sagely won't-- it's going to make their life harder, so was that, "Yes"?

A Sorry, I'm very sorry, yes.

Q What I want to turn to now is paragraph 50 of your statement where you touch on the idea of whether there should have been an escalation to Stage 5. So, what would you have understood the escalation to Stage 5 to involve?

A So, escalation to Stage 5 is where Scottish Government intervenes directly and takes over directly the running of a health board.

Q Is that by replacing the board members by new board members or literally taking over and standing in their shoes?

A It can be either. It can be, as was the case with Argyll and Clyde Health Board when Mr Kerr was the health secretary, the closing down of that Board in its entirety----

Q And splitting it to other boards.

A -- and split it. Clyde came to Greater Glasgow. So, it is for the relevant minister to decide how they want to intervene and what they want to do as a consequence of that intervention.

Q So, did you think about Stage 5 as an option at the time?

A I did, yes.

Q And you would-- and I think, from Mr Wright's statement, you spoke to him about it.

A I did.

Q I suppose it's worth thinking of what's the advantages and disadvantages of it. So, thinking without the benefit of hindsight – because of course the pandemic is coming – at the time, what did you think were the benefits of going to Stage 5?

A I think at the time, and I accepted this when Mr Wright put it to me, that I was considering Stage 5 because I'd run out of patience with the Health Board, and I was at a point of, "Could we just get them out the road and let's get on and sort this?" I'm sure I phrased it better at the time. His view was if I really did want to go to Stage 5, then he was not going to stand in my way, but he did not think that that was wise given the size and scale of Greater Glasgow and Clyde, and all the levels of care that it provided, and the demand that would make on Scottish Government to take over all of that in its entirety, that the instability and uncertainty that that would create was not necessarily the most helpful thing to do when you're trying to fix pressing issues of infection prevention and control.

Q What about going to Stage 5 but in such a way that you could then put in people you chose to take responsibility of the day-to-day-- put in a board of your own choosing rather than you becoming responsible for every waiting list-- I suspect the voters probably thought you were anyway, but you're responsible for every waiting list and operation in the entire city?

A Sure, I mean, that is what you would do. If a minister intervenes to escalate to Level 5, which means the government is now taking over the running of that board, it's unlikely to be the actual Cabinet Secretary who's now running that board, and many would argue that's a very good thing indeed. So you would be looking to put in a smaller team, whatever it might be.

I think, even so, Mr Wright's arguments carried a great deal of weight about the level of disruption and uncertainty that you would cause by doing so would detract from the effort and the focus that was needed to actually fix the pressing problems that you were trying to fix.

Q I wonder if we can look at paragraph 51, where we put to you the idea, perhaps naively, that a middle position might exist where you could remove the executive Board members and leave everyone else in place. Now, you've responded:

> "I don't see how that would assist. Executive members of health boards are employed by the Health Board and, even if there were to be

a move to one single NHS employer, that would not be Scottish Ministers."

Now, firstly, what's that's reference to a single NHS employer because----?

A Yeah. So, prior to the pandemic, work was underway with the support of all the relevant trade unions to create a single employer for all NHS employees and overcome-- So, everyone who's employed in the NHS has the same terms and conditions whether they work in Glasgow or Aberdeen or Shetland, wherever, for the role that they are employed to do. So there are national terms and conditions. However, what you have when you have 14 territorial health boards is that you can have disparity in the application of some of that between health boards, and that can cause difficulty.

It is about how people interpret the rules, and we'd had a particular issue where the Royal College of Surgeons had a proposition, which I thought was a very sensible proposition, that would allow us to retain consultant surgeons coming to the end of their career with NHS who no longer wanted to be subject to the demands and pressures of the rota system, but equally didn't necessarily want to give up practice, which would allow them to be seconded, if you like, to some of our more rural and island health boards to undertake surgical procedures in the specialisms that they had that may not be available in those boards.

We hit an obstacle. All of those individuals are necessarily subject to appropriate Disclosure Scotland procedures in the board that employs them, but that disclosure certificate was not being accepted in other boards because they did not employ them.

Q So this was a way of addressing that issue?

A So that was an example of the kind of issue you get when boards stand on their high horse – I can think of no other way of describing it – as the employing authority.

Q Right.

A So there was work that had gone on-- predated my appointment as Cabinet Secretary. There had been work discussions and work ongoing to create a single NHS employer, as I say, with trade union support and I suspect, had we not had the pandemic, we would have seen that work realised.

Q So the question I wanted to put to you beyond that was that, if you had gone to Stage 5 – and it's still part of the framework, I understand, as an option – does the problem that you've identified here still exist? If you take a health board to Stage 5, all those executive directors are still employed by the health board

under their terms and conditions and, whilst you may not want them to be chief executive or whatever, you can't just chuck them out. So, actually, does Stage 5 have a little bit of a problem in it in that it's not quite as clean as it looks at first blush? If you're right and executive members of boards having employment rights would prevent an intermediate stage, it would prevent Stage 5 as well, wouldn't it?

A I'm not sure that it would, to be honest.

Q Right.

A I can't be definite about that because we did not pursue going to Stage 5. I accepted the perfectly reasonable case Mr Wright made to me. But I'm not sure that it would because I don't recall, in the case of Argyll and Clyde, that it prevented the then Cabinet Secretary from putting in place, if you like, a transition team as he dispersed the responsibilities between two other health boards.

Q Right.

A So it would certainly not be a situation without financial cost, as arguably other costs as well, but I don't think it necessarily precludes you from doing that.

Q The other question that arises from this discussion, which is, in local authorities, senior officers of local authorities such as the Chief Executive and the accounting officer are not members of the authority, but they are in a health board. Have these events and the thought processes that you've gone through about escalation perhaps challenge the wisdom of making that corporate management team have, to some extent, the same status as the board who's supposed to be scrutinising them?

A I think that's a very interesting question and I think it certainly has – to some extent, should – initiate a serious review of whether or not that is a wise position to maintain. Part of the reason I say that is that I remember when I chaired the board of Golden Jubilee having a discussion-- and it's not quite the same as you are suggesting, but having a discussion with the then Chief Executive about the size of the board and, in particular, the size of the executive team that attended board meetings. Her position was very clear that she thought that the only two members of the executive team who needed to be at board meetings was the Chief Executive and the medical director, because if the Chief Executive could not answer questions relating to nursing or finance or other matters, then he or she should not be the Chief Executive, which seemed perfectly right to me.

You're suggesting a stage beyond that, which is that the executive team are not members of the board in the way that non-executive members aren't members of the board.

Q Yes, because if you go to a local authority, the Chief Executive is not a member of the council.

A Yeah, and I-- I can see value in that.

Q At paragraph 54 on page 115, you discuss seeing resistance from GGC following escalation to the Stage 4 and a sense they're being unfairly dealt with, and you didn't see their attitude changing when the Oversight Board was in place. Now, you attend a Board meeting – we will in due course work out which one it was – and you presumably had a number of meetings. How did you attempt to address this resistance, because ultimately it's for you to explain your actions and that of the Director General?

A So, I think I attended two Board meetings.

Q How did you put it to them?

A In the sense of why had we gone to Stage 4?

Q Yes, and why they shouldn't have resistance.

A Well, I didn't put to them that they shouldn't have resistance. I put it to them what the arguments were for escalating them to Stage 4 and what that then meant and what would then happen. The resistance I detected was in part from their response – or non-response, I think probably is fair – but also in the many meetings I had with John Brown and Jane Grant.

Q Ms Grant described the decision to escalate as "a bit disappointing". Can you see why she might take that view?

A No, I can't. I think she should not be disappointed by that decision but should-- should have been determined to respond positively to it.

Q The views you describe in paragraph 54 that didn't change when the Oversight Board was in place, did they have any effect as far as you could see on the Oversight Board's effectiveness?

A Directly, no, I don't believe so. I think to a greater or lesser degree it would-- made the Oversight Board's job a bit harder, but the better person to respond to that would be Professor McQueen.

Q Well, what I'm going to do is to move on to the work of the Oversight Board and really to try and work out your assessment of the impact that the Oversight Board had on some issues. I'm conscious you're not a member of the Oversight Board. You set it up, and things happened in the world after it was set up, but if we look at your statement at

paragraph 64, you describe having regular update meetings – page 119 – and at paragraph 65 you describe:

> "… continued reluctance … to act in a way consistent with its organisational duty of candour and co-operate fully with the work of Professor Craig White …"

But taken across the whole period of the Oversight Board's work, not jumping in halfway along, do you think the Oversight Board resolved the issues around duty of candour, and indeed communications that Professor White was dealing with?

A I think the Oversight Board and Professor White and the group-- subgroup of that Board that he chaired, I think, by force of effort and persistence did resolve those issues for that patient cohort. Did that subsequently, when there was no oversight board, change the approach and performance of Greater Glasgow and Clyde to transparent and open communications? I am less confident that it made that change, as in a permanent change.

Q Can you explain why you're less confident?

A Because subsequent to the-- and it is for a short period and I should be clear about that, between the Oversight Board completing its work and me stepping down as an elected politician in May '21, but also from continuing discussions with both the chair and the Chief Executive, I did not believe at any point that they embraced the value of open and transparent communications. "Let's set aside a statutory duty and concentrate on whether or not you see value in doing that and having that approach," and-- and it was not my view that they saw the value of doing that approach in and of itself, other than the fact that if they didn't, they were going to get a row.

Q From Professor McQueen or you?

A Me, probably.

Q Thinking about the whistleblowers, to what extent do you think Greater Glasgow and Clyde engaged with the concerns of the whistleblowers and indeed the encouragement of whistleblowing during the period of the Oversight Board?

A So, that's difficult in terms of Greater Glasgow and Clyde. That's difficult because the bulk of the time the Oversight Board was conducting its work we were in the middle of a pandemic, and that Board, in common with other boards and their staff, were exemplary in terms of NHS staff and how they responded to that pandemic, and that inevitably reduced their capacity to-- to undertake

fully other roles and responsibilities that they might otherwise have been expected to do. So I think it is difficult to say that their approach on whistleblowing could have substantially changed during that period.

Whether or not it has done, it may well do now. I know that there is new leadership at Greater Glasgow and Clyde. The approach may well be very different, but, similar to the statutory duty of candour and everything else that I have said in terms of continued reluctance, I'm not sure that I would be confident that the leadership of Greater Glasgow and Clyde at that time had a similar view to whistleblowing as I did, and that is-- that it is something to be welcomed and acted upon.

Q To what extent would you accept, looking at the whole Oversight Board Stage 4 process-- to some extent, was it a missed opportunity in that it may not, for some reasons you already touched on, really have created a change in the culture of Greater Glasgow in respect of whistleblowing and disclosure, an example being the HIS report into the A&E consultants that's just come out?

A I don't think it is fair, even if you set aside a pandemic-- if we imagine that the pandemic had never happened, I don't think it is fair to put responsibility for changing the culture, the long-standing culture in Greater Glasgow and Clyde from the leadership all the way through – and of course that is how culture works, it follows what is happening at the top – I don't think it is fair to put that responsibility on an Oversight Board set up effectively for a time-limited period to undertake specific pieces of work.

If we had not had a pandemic-- I think shortly before 2020, following NHS Highland-- I think this date is right. This definitely happened. I think the date is roughly right. I had a meeting with health boards, unions, staff associations, and I think some others, to begin to look at, "How do we improve the culture of our NHS?" on the presumption that NHS Highland was not a one-off. To the extent that it existed in NHS Highland, that may be extreme, but generally speaking it could not reasonably be considered to be a one-off.

That work was not progressed by me for obvious reasons, but it was a recognition, and I said that I would want to-- would have wanted to have a re-run of a version of Sturrock for Greater Glasgow and Clyde. That was a recognition by me that cultural change was absolutely essential, but it was a long piece of work. It's not something that you can achieve overnight or even in the course of a few months.

Q I'm conscious that we're

talking about hypotheticals because it didn't happen. That process you had in mind, if it's a form of Sturrock-- John Sturrock conducted an investigation. He spoke to people. He produced a report. Can cultural change come about simply by the production of external reports or does it require change of leadership?

A Yes. It can't come about by the production of reports. It absolutely requires to be led and exemplified by leadership, and by that I mean people need to see from the top of the organisation all the way through, in practice, the values of the organisation being made operational. In other words, they need to see leadership that says "Everyone is valued. All the rules matter. All ideas are welcome, and all complaints are welcome, and we will treat each other with-- consistently with respect."

Q Can I show you a document from one of the Edinburgh III bundles? It's Edinburgh III, bundle 13, volume 10, document 21, page 158. Yes. It's a letter from you to Dr Inkster and Dr Peters on 10 August. Now, the letter follows the launching of the Inquiry, and you explain that they've met Professor McQueen, and you say in the third paragraph:

"I am sorry that you have not been as involved as you would have thought appropriate in the work of the Oversight Board ... and she has assured me that she will ensure all your concerns are acted upon within the overall remit of the Oversight Board. Fiona is also aware of the need to ensure that the concerns about the previously issued responses to questions from parents and assurances on the effective delivery of action plans you mention remain outstanding."

Now, does the issue that prompted this and this reply effectively reflect a relatively limited input, from their point of view, of Dr Peters and Dr Inkster into the Oversight Board? That was their concern. They weren't getting proper input. Do you accept that?

A Their concern, as I understood it, was that their input was not as great as they believed it should be.

Q Did you accept that, or do you think that was mistaken or overstated or-- --?

A I discussed it with Professor McQueen and it seemed to me that the approach that she was taking, which was, as this letter said, to be sending drafts of documents to them in order to secure their comments and feedback, was a good approach, was a way of involving them without them being members of the Oversight Board, which is perhaps what they might have wanted. I don't know that for sure, but I thought that a great deal of effort was genuinely going into making sure that the expert-- (a) that their

concerns were being addressed, but also that the expertise that they had was being harnessed in the most appropriate way to help the work of the Oversight Board.

Q Now, I want to move on to another topic. This is a hypothetical question which I've been asked to put to you. Take that off the screen, please. I appreciate you were not in office or even an MSP in the summer of 2015, and this is a hypothetical question which you may wish to answer. Had you been in office as Cabinet Secretary with all the knowledge that you have now, and perhaps more importantly the knowledge you had at the time of going to Stage 4, would you have allowed the hospital to open? I mean, you didn't allow the Edinburgh one to open, so it seems in one way an appropriate question.

A Yes, I understand that it is. If all the knowledge that I had at Stage 4 includes the DMA Canyon report----

Q It does.

A -- I would not have allowed the hospital to open, no.

Q Again, if you'd discovered all that and had access to the knowledge and the DMA Canyon report, would you have attempted to escalate the Board to Stage 5 or remove the Chief Executive back then?

A In 2015?

Q 2015. If you'd known that, or is that a little bit disproportionate?

A I think that is too hypothetical for me because I would not-- even with the knowledge and the reports and so on, I would not be hearing from the then Chief Executive and chair.

Q Of course. Let's turn to the Case Notes Review, which you established on 20 January 2020. Now, we have the official report of your announcement at bundle 52, volume 7, document 46, page 387, and I think it starts at page 39 of that document, so that will be page 416. I really hope that my maths has done that right. No, it's not. Back 10 pages, please. Stop. 39. There we are. One more page. 109. No, I've got completely lost. I think I'll do this from memory. What do you think was the principal purpose of the Case Notes Review from your point of view?

A So, following the publication of the Independent Review, a number of families still felt that they hadn't had answers to their specific cases. What had happened to their child? Why had that happened? And was there anything about the building that had contributed to or caused harm? And so it seemed to me that in-- in those circumstances, if it's at all possible to provide answers, then individuals should have those and that the best way to do that then was to have an independent Case Note Review--

because we're looking at historical cases, a Case Note Review, and to have that conducted independent of government, of the Health Board, and indeed of NHS Scotland.

Hence the appointment or the ask of Professor Mike Stevens and Gaynor Evans to oversee that review and reach views on the case notes that came to them. Professor Bain, if you like, did the hard work of pulling all the cases and the information and so on together, but the Case Note Review and the conclusions of that review were those of Professor Stevens and Gaynor Evans.

Q And Professor Wilcox.

A And Professor Wilcox, yes.

Q I wonder if we can go to paragraph 77 of your statement on page 126. We asked you about the decision to keep the individual reports confidential, and you've suggested that it was a decision made by Professor Stevens.

A Yes.

Q He thinks it was a decision made by the Scottish Government.

A Okay.

Q Can you help us about-- I mean, it may well have a logical reason to do with trust. I appreciate that, but can you recollect whether you had any involvement making the decision to do it this way?

A No, I didn't. I know I did not have any involvement in that. I remember the-- the conversation with Professor Stevens when we were asking him to undertake this role because I remember saying to him, "What you do and how you go about it is entirely for you to decide. This needs to independent, of me, of the NHS in Scotland, of Mr Wright, of the Board. You need to do it the way that you think is best," and so I then had nothing to do with the approach and the methodology that he-- that was used, and quite rightly so, in my opinion. I understood when I saw the report and so on how he had gone-- they had gone about their work, but the confidentiality aspect, as far as I was concerned at the time and still, was a decision of those leading the Case Note Review.

Q A disadvantage – or two disadvantages – that occurred to me of that process of having the 84-- 118 reports confidential is, firstly, this Inquiry can't see them, but the other is that the Greater Glasgow and Clyde Health Board never saw them. Did it occur to you at the time that having the work of the Case Notes Review containing confidential conclusions might ultimately, to some extent, inform the Health Board's later actions to decide that one couldn't rely on the Case Notes Review?

A No, because it didn't inform their earlier actions to fully accept the

conclusions and recommendations of the Case Note Review. So, given that that situation with respect to confidentiality pertained at the time when the report was finalised, published-- and published and Greater Glasgow did not see any of that as preventing them from accepting the conclusions and recommendations, I'm puzzled as to why that should suddenly produce an obstacle to them.

Q I don't know whether I need to go to it, but their press statement doesn't accept the conclusions. It just accepts the recommendations and produces an apology.

A Yes.

Q Is that a nuance that you noticed at the time?

A I did.

Q Did you raise it with them?

A No.

Q No. You say in paragraph 81 on page 127:

> "I expect that they accepted them all [by which you mean the conclusions] because they didn't want to have a row with me."

Might it have helped in the long run if you had pressed them on the absence of overt acceptance of the conclusions? It might have resulted in a row that day, but it might have saved some time later on.

A No. What I was concerned about was that they accepted the recommendations. I mean, I think it's really difficult to separate the two. Recommendations come from conclusions. I think you're dancing on the head of a pin if you say, "We accept the recommendations but not the conclusions." That seems to me a rather strange place to put yourself. So, whether or not they said they accepted the conclusions, I think it is reasonable for me to presume that you do if you accept the recommendations. What I am referring to here is if they had at the time taken the position they are reported to have subsequently taken, in that they are questioning the report, that would have been a different situation for me to deal with.

Q Since we're in the game of hypotheticals, what do you think might have happened?

A I think I would have by that stage-- Well, first of all, I'd want to see what was their evidence for not accepting the conclusions and recommendations. What was the basis for that, given-- given the eminence and the track record of Professor Stevens and the others involved with him? And if I did not believe that their position was justified, then we would have had to have a very serious conversation about the chair and

the Chief Executive remaining in post.

Q Well, that enables me to ask a couple of questions because we obviously have their evidence now, and I'd like to find out from you whether at the time either of them expressed the position they've set out in their evidence to you. It may be they didn't, but I'd be interested to know----

A No, they didn't.

Q -- because Ms Grant explained that they accepted the recommendations but did not explicitly accept or reject the conclusions. Did she explain that to you?

A No.

Q No. Professor Brown told us on Friday last week the Board always accepted the conclusions and he seemed surprised that we would ask. Did he express that to you at the time?

A No.

Q The new Chief Executive gave evidence yesterday. Her understanding is that GGC did accept the conclusions and the recommendations together in the actual statement at the time. Did they do that? Did they say that?

A I think their news release talks about the recommendations.

Q But it doesn't talk about the conclusions.

A It doesn't talk about the conclusions.

Q No.

A But I suspect, as I've said, that it is hard for a rational view to separate recommendations that flow from conclusions from conclusions.

Q So, I've got a couple of final questions. The first is, given we've had a discussion about whether you could have gone to Stage 4 earlier and what you said about that, and given we've had a discussion about why the Oversight Board didn't include explicit control over the water system, the mediation of the ventilation system and you gave an answer about that, do you think there's any apology owed by the Scottish Government – I recognise you can't speak for them now, but if you think back to your leadership role at the time – for not taking earlier action to the parents and families?

A From memory – in fact, I am certain of this – I apologised in-- through the Scottish Parliament to patients and families affected by all of this and directly to the families that I met for the situation that they had been put in. I don't think I would expect Scottish Government to apologise for not acting sooner because I think a better position is for government to consider whether or not the role that it directly plays in the procurement, as we've discussed – certainly of major capital builds – is something it should undertake.

I do think that there are arguments to review in our health boards the various schemes of delegation that exist because it does seem to me that schemes of delegation can become proxies for not being accountable, and that we should be ensuring that our boards understand that governance is an active process, not a paper schematic.

Q Well, there's two further questions I have, one of which arises from that, which is: to what extent do you have a concern about information flows in health boards, in that the executive team are the people who control the information and the non-executive members simply receive reports through committees and have relatively limited access to information about events within the board?

A Yeah, I think that is-- that is a problem and I have seen, even in a relatively small board in terms of its size, when I became chair of Golden Jubilee, the bundle of papers for a standard board meeting was at least two thirds of the size of this folder.

Q An inch or so to two inches?

A An inch to two inches of papers. It's much greater for our territorial boards which cover larger areas. The idea that a non-executive is going to plough their way through all of that, understand it and formulate supportive and challenging questions from it is unlikely.

Q Right.

A So I think boards should look at how they conduct their business in a way to make it accessible for non-executive members, who are essentially lay members, to familiarise themselves as far as possible with the operation of the board, the key issues, have all the information they need in a format that is accessible and easily understood, and that the board meetings are conducted in a way that encourages question and challenge, and that includes board committees.

I do have a view that we arguably have too many committees and subcommittees in our health boards, again, a bit like the scheme of delegation. I think, through no ill intent, information and matters can slip down between various committees because there's too many of them and the information flow isn't good enough between them.

So I think there is a need to look at the organisational structure of our health boards – that is different from my view that we have too many of them – assume that we keep all, look at the organisational structure, the number of committees, and determine whether they are all needed or whether they delay decision making and they move it too far

from the front line, and look at what needs to be done to allow non-executive members to actively engage in their role of constructive challenge and scrutiny.

Q Which brings me to my final question. What do you say to patients and families who feel that the Health Board, and to some extent the Scottish Government, failed to protect them and provide timely and honest information about risks in the Queen Elizabeth?

A What I-- what I would say is that I completely understand why they feel like that. I think to a significant extent they are justified in that feeling and that there is no excuse for that having been the case. There may be reasons. There may be legitimate actions subsequently taken to try to redress that, but that doesn't remove the additional burden of anxiety that those patients and family faced at a time when they had enough anxiety and worry to deal with.

Q Thank you. My Lord, those are all the questions I have for Ms Freeman, but I suspect it'd be a good idea if I might have some minutes to check with the rest of the room to see if there are any further questions.

THE CHAIR: Ms Freeman, as you may recollect, our procedure is that at the end of a witness's evidence counsel take the opportunity to check with colleagues as to whether there are further questions. It should take no more than 10 minutes, but can I invite you to return to the witness room?

THE WITNESS: Yes, of course.

(<u>Short break</u>)

THE CHAIR: Mr Mackintosh.

MR MACKINTOSH: I've got about seven questions, I think.

THE CHAIR: (After a pause) Perhaps a further seven questions.

MR MACKINTOSH: So, one of them I think I partially asked but I'm not sure I've asked it quite the way the person who invented it would like me to have asked it, and I think it's worth asking properly. During your tenure as Cabinet Secretary, what steps did you take to satisfy yourself that the ventilation system and the adult BMT ward – that's Ward 4B – at the Queen Elizabeth met the relevant standards in SHTM 03-01 for immunocompromised patients?

A I'm not sure that I can recall detailed steps in that regard. I would, I know, have raised that with both the chief medical officer and the chief nursing officer, and they will have then used the relevant agencies, Health Inspection Scotland being one or Health Facilities Scotland perhaps being the other, to begin to make those checks. But, as best as I can recall, that would be what I would

have done.

Q Do you recollect being told that the retrofitted Ward 4B did not achieve the full standard for a neutropenic ward, in that it had only 6 rather than 10 air changes, it didn't have HEPA filtration in its corridor?

A I don't recollect being told that, no.

Q Thinking about NHS Assure for a moment, I'm not going to put to you what actually happened in terms of its interactions with Greater Glasgow and Clyde at the end of the Ward 2A retrofit project, partly because of time but also you weren't Cabinet Secretary at the time, but, given that the work was underway, or at least in contemplation, when you announced NHS Assure as an idea, what sort of things did you expect that organisation to be doing towards the end of a project to provide assurance that it was built to the right standards?

A I would expect the organisation to undertake a site visit and check.

Q Are you envisaging literally one visit or something more sophisticated than that?

A Well, it depends on the organisation exercising its own expertise whether or not it requires one or more site visits, whether it requires sight of documentation, but I would expect it to actively check whether the relevant

standards had been met.

Q Yes. Do you have confidence that the NHS Assure that has been created will prevent similar failures in water and ventilation systems in future building?

A I'm sorry, I can't answer that because it is now four years since I demitted public office. I have had no involvement with the actual creation of NHS Assure, and so I don't know and can't comment on whether it has been established in the manner that I envisaged. So I can't express confidence or a lack of confidence in that regard.

Q Now, I've been asked to put to you that, despite representations by Professor Cuddihy, there remains on the Scottish Government website inaccurate information in the timelines about Mycobacterium chelonae cases in the Schiehallion Unit. Is that something you were aware of when you were-- It arises out of an Oversight Board timeline. Is that something you were aware of when you were Cabinet Secretary?

A No.

Q Thinking about events in 2009, when of course you were not involved in this project, how would you react to the information that procurement of the new South Glasgow Hospital was not routinely reported to the main GGC Board but to a subcommittee called the Performance

Review Group throughout the 2009/10 period when key decisions were being made? Or would that make any difference?

A Well, I would find that a strange position that I would not understand, and I do think that would make a difference because I'm not sure how the Board could exercise its responsibility of scrutiny and governance if it was not receiving that information directly.

Q My final question relates-- I think we discussed whether the Oversight Board escalation should explicitly referenced culture, and you talked about your idea and contemplation of a larger but equivalent of the Sturrock review in Glasgow, and also wider issues at a national level, and you explained how the pandemic intervened. I've been asked to put to you this: in the world of infection prevention and control, is it actually worth remembering that culture and a willingness to listen to divergent opinions is actually an inherent part of safe infection prevention and control, and therefore it's not possible to divide the two and see them separately as perhaps you might have intended to at the time?

A My answer to that is, yes, it is part of it. I don't think I divided them separately in the sense of not seeing them as unrelated to each other, but in terms of the volume of work or the scale of work necessary to change the longstanding culture of Greater Glasgow and Clyde to improve that culture, I think dealing with those issues separately, albeit in parallel, which was my intent, would have been the right way to deal with it.

Q Thank you. May I just glance at my colleagues who suggested these questions? I think, my Lord, I have no further questions for this witness.

THE CHAIR: Thank you, Mr Mackintosh. Ms Freeman, no further questions, therefore you are free to go, but, before you do go, can I thank you for your second attendance at a hearing of the Inquiry and for the preparation that clearly went behind that in considering documents and providing a number of witness statements in respect of the Edinburgh hospital and the two Glasgow hospitals? But you're now free to go with my thanks. Thank you.

THE WITNESS: Thank you very much, Lord Brodie. That's very kind of you. Thank you.

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

MR MACKINTOSH: My Lord, that concludes the evidence that Mr Connal and I proposed to lead in the hearing sessions in respect of the Queen

Elizabeth University Hospital/Royal Hospital for Children. In respect of the Glasgow part of the Inquiry, my Lord has heard 29 weeks of evidence, 20 weeks of that since 19 August last year, has heard either in person or by statement from 186 witnesses, 131 of them since 19 August last year. The Inquiry team has produced six provisional position papers and 128 bundles of evidence in respect of this hospital.

There remain a number of outstanding witness statements that have been sought following evidence in this hearing. Some have come up in the last few days. The Inquiry team will write to core participants in the coming days to update them on the status of these and when we anticipate to receive them, and we'll probably write again the following week.

The next stage in terms of Direction 12 is for the counsel to the Inquiry team to produce our closing statement by 21 November, and core participants then have until 19 December to lodge their closing statements. Can I reassure my Lord that the counsel team have been working on drafts of key sections for some months now?

I understand that these closing statements should contain all issues that we wish to raise in submission in respect of this hospital, and it's our intention to set out which parts of our former closing statement in respect of Glasgow III remain relevant and where our position has developed.

Now, to some extent, the counsel team's approach has been to investigate events through the medium of asking questions and listening to evidence, rather than, as it were, knowing everything before evidence is led. I'd like to offer my thanks to all the witnesses for their patience when faced with long document lists and questions not raised with them in their original questionnaires or requests for statements.

I'd also like to record my thanks on behalf of the counsel team as a whole to the Inquiry staff who've worked with us to deliver these hearings and to the legal representatives of core participants for their assistance in identifying questions that needed to be asked and for their good humour in the face of early starts and the occasional late document, but that is all the evidence that we intend to lead.

THE CHAIR: Thank you, Mr Mackintosh. In what I have to say, in marking the fact that we've reached a very significant point in the progress of this Inquiry, I'm very conscious that my audience, while including everyone in this room, also includes those who've been following our proceedings on YouTube,

and therefore I perhaps may just say a little more than might otherwise be necessary in respect of the well-informed audience in front of me in Edinburgh.

As it appears from its remit, the purpose of this Inquiry is to determine: how issues relating to adequacy of ventilation, water contamination and other matters adversely impacting on patient safety and care occurred; if these issues could have been prevented; the impact of these issues on parents and families; and whether the buildings provide a suitable environment for the delivery of safe, effective, person-centred care.

Now, looking back to the first of the oral hearings in relation to the Glasgow hospitals, which began on 21 September 2021, I saw it as appropriate to begin by hearing from patients and family members of these patients who had been affected by the issues arising on the Queen Elizabeth campus.

We have ended this hearing by hearing the evidence of present and former senior figures in NHS GGC, NHS NSS and the Scottish Government, but I should make it clear that the need for a focus on the delivery of safe, effective person-centred care means that the experience and interests of patients and their families remains very much at the centre of my consideration of the questions that face the Inquiry.

Now, Mr Mackintosh has explained that we have now heard from all the witnesses who will give oral evidence. We've also taken evidence in the form of witness statements which appear on the website. There are some to be added to that list, and that will happen within the next week or so.

The evidence-gathering stage of the Inquiry has accordingly been completed. This has, as Mr Mackintosh has already acknowledged, involved an enormous amount of work on the part of the Inquiry team and the core participants and their legal representatives. Now, for all that work, I am very grateful. However, the work of the Inquiry is not completed. As, again, Mr Mackintosh reminded us, I have still to hear closing statements, written closing statements from counsel to the Inquiry and core participants, and it is on the basis of these closing statements that I will be offered an assessment and analysis of all the evidence that has been heard.

It is with the assistance of these closing statements that I will be preparing a report for submission to the Cabinet Secretary. I cannot understate the importance of these closing statements. I've heard a lot of evidence, but I need the help of core participants through their legal representatives by setting out in closing statements their perspectives on

that evidence, their analysis of that evidence, and what they consider to be the important issues.

Now, can I turn to Direction 12, which was issued on 1 September of this year? In that, I attempt to set out guidance as to what I would wish to receive – or, strictly speaking, the solicitor to the Inquiry to receive – by the end of business on 19 December of this year.

Can I begin by drawing attention to paragraphs 4.1 and 4.5, where it's set out that, where a core participant which is to adopt, amend or supersede the terms of a previously submitted closing statement, they should do so expressly; and, in 4.5, where a preliminary position paper issued by the Inquiry or expert report or a core participant's previous response to a preliminary position paper or expert report is referred to or relied on, the relevant passage or passages should be identified by bundle, page, and paragraph number.

At the risk of repetition, it is important that core participants who wish to rely on previous submissions that they've made should do so in a precise way so that I can have a clear idea of what the final position of the core participant is. In paragraphs 4.6 and 4.7, there is guidance on circumstances where core participants refer to particular documents, and I would commend what is said there to the attention of those preparing closing written statements.

Finally, on the topic of written closing statements, the evidence has not been all to the same effect. Accordingly, as is set out in section 5 of Direction 12, where a core participant wishes to reach a conclusion on a matter where there is a range of potentially inconsistent evidence, or where they would wish me to reach a conclusion which is different from that proposed by counsel to the Inquiry in their written closing statements, that should be made clear in core participants' closing statements. They should set out there the terms of the conclusions that they submit I should reach and make specific reference to documents, statements, and evidence which they consider support their submission.

As Direction 12 sets out, we will reconvene for an oral hearing, which will be at a date after which I will have had the opportunity to consider the written closing statements, but we will reconvene to hear oral closing statements on 20, 21, 22 and 23 January of next year. After I have heard everything that is said, I shall give it consideration, together with not only the evidence but the written statements discussing that evidence.

Can I end by repeating my thanks to all the witnesses who have given

evidence, to all the core participants who have participated in the Inquiry, to their legal representatives, and to the Inquiry team? As I say, a great deal of work has been necessary to make these hearings happen, and it's only been by dint of the work of a great many people diligently carried out that we've been able to complete these hearings. So can I emphasise my thanks to all those who've been involved?

We'll reconvene on 20 January 2026 in order to hear oral submissions, but, until then, can I wish you a good afternoon? We shall see each other in the new year. Thank you.

(Session ends)

16:01