SCOTTISH HOSPITALS INQUIRY

Bundle of documents for Oral hearings commencing from 16 September 2025 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow

Witness Statements – Volume 2

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Scottish Hospitals Inquiry
Witness Statement of
Professor John Brown CBE

1. This statement has been given in support of the Scottish Hospitals Inquiry. The issues addressed in this statement include those identified by the Inquiry as relevant to my former role as Chair of NHS Greater Glasgow and Clyde (NHSGGC) and my comments and insights include my response to specific questions set by the Inquiry team.

2. I have been unable to answer all of the questions sent by the Inquiry team as in some cases I do not possess the technical or clinical knowledge to give an informed view on the subject, or the matter being highlighted is outside of my role as the NHS Board Chair and was dealt with as an operational management issue by the Corporate Management Team.

3. Any deficiency in the technical and clinical knowledge of individual NHS Board Members is rectified by an integrated governance system that NHS Boards are required to have in place. The governance arrangements that provide the NHS Board with oversight of the service delivery are outlined in paragraphs 9 to 27 of this statement. These arrangements are expected to include providing Board members with information and assurance on the safety of the operating environment.

4. As some of the questions asked by the Inquiry team refer to a situation that existed from 2015, it has not always been possible to give exact dates when actions were taken but I have relied on my memory, or documents made available by NHSGGC or the Inquiry team to at least narrow the timeframe down to the year the issued occurred. I am assuming that where required, the Inquiry team will have details of the exact dates from the evidence of other participants.

5. When answering the Inquiry team's questions I have used 'NHSGGC' when referring the healthcare organisation and 'the NHS Board' when referring to the 30 Non-Executive, Executive, and Stakeholder members appointed by the Cabinet Secretary for Health & Sport to direct and oversee the governance of the organisation.

6. It should also be noted that the planning and design stage of the Queen Elizabeth Hospital (QEUH) and the Royal Hospital for Children (RHC) had been completed prior to my joining the Board of NHSGGC. The construction stage was completed, and the new hospitals were handed over by the construction company to NHSGGC shortly after I joined the NHS Board as a Non-Executive Member, eight months before I was appointed Board Chair.

7. Therefore, I was not involved in or had knowledge of the processes or governance involved in the planning and design of the new hospitals. I was not involved with the NHSGGC Project Team and had no part in the handover or commissioning of the hospitals. As a result, I am not able to comment on the extent to which the design or handover of the hospitals considered the specific requirements and risks to different cohorts of patients.

8. The previous NHS Board Chair, Andrew Robertson CBE would be best placed to answer questions on the planning, design, construction and handover of the hospitals, including the provision of appropriate ventilation and water supply to patients who are immune-supressed. Mr Robertson would also be able to provide details of the governance arrangements that the NHS Board put in place to oversee the planning design, construction and handover of the hospitals.

Personal Details and Professional Background

9. The CV included as Appendix B to this statement outlines my professional background, my current employment and the previous roles held by me since 2002. This includes a description of my role as Chair of NHS Greater Glasgow and Clyde.

NHSGGC Board and Governance

10. Descriptions of the role and responsibilities of NHS Boards and Standing Committees are included in the Scottish Government's policy document, the NHS Scotland Blueprint for Good Governance **(Bundle 52, Volume 1, Document 14, Page 194)**.

11. The Blueprint for Good Governance was commissioned by the Director General for Health and Social Care to support an independent governance review of NHS Highland. The review team developed the Blueprint to provide a baseline against which the governance of health boards could be assessed. The review team consisted of myself and Mrs Susan Walsh, a Non-Executive Member of the Healthcare Improvement Scotland Board. The development of the Blueprint reflected research into the best practice in both the private and public sector in the UK and abroad, interviews with a wide range of stakeholders, and the review team's personal experience of corporate governance in the public sector. This included my experience as a Director in the tax system, a company secretary in the education system, and a Chair in the National Health Service.

12. More detailed descriptions of the NHSGGC Board's governance arrangements and the guidance on implementing these arrangements are contained in a portfolio of documents that is developed, maintained, and communicated by the Board Secretary. This includes Standing Orders, Standing Financial Instructions, Schemes of Delegation, and Risk Management Instructions that provide the senior leadership and management of the NHS with their principal operating guidance. These documents are reviewed, revised as necessary, and approved by the NHS Board on an annual basis. Copies of the operating guidance documents are available from NHSGGC.

13. The NHS GGC Board and the Standing Committees request, receive and consider information from the Corporate Management Team and other sources in writing or verbally at meetings. This information supports effective decision making and constructive debate and provides assurance to Board Members on the delivery of the organisation's purpose, aims and objectives.

14. The corporate governance system is designed to ensure that decisions by Board members are well informed, evidence based, and risk assessed. This not only includes the efficiency and effectiveness of the services delivered to patients and service users but also the safety and quality of the healthcare provided by NHSGGC. This would include the identification, management, mitigation, and reporting of risks to patient safety from the hospital environment, including the water and ventilation systems.

15. The Scheme of Delegation and the Terms of Reference of the Standing Committees describe the decision making responsibilities within the NHSGGC governance system and from this it can be determined who would be required to confirm the need for and authorise works to improve or remedy deficiencies in the hospital environment, including the water and ventilation systems.

16. The NHS Board formally meets six times a year. The meetings are conducted in public, and Agendas, Minutes and Board Papers are available on the NHSGGC website. The NHS Board can also meet on an ad-hoc basis between the scheduled meetings, should the need arise to discuss any urgent issues before the next meeting.

17. Board members are also invited to seminars three times a year to receive training and information on any new initiatives or changes to legislation that affect the NHS. These informal meetings are not open to the public and the information received is usually in the form of PowerPoint presentations. This is not a decision-making forum and any actions proposed at these meetings would have to be approved at an NHS Board or Standing Committee meeting.

18. The Standing Committees either meet three or four times a year, on dates prior to the formal Board meetings. These meetings are held in private, but a report of the items discussed, and decisions made is presented at the public NHS Board meetings. This report and the Minutes of the meeting are included in the Board papers that are available on the NHSGGC website.

19. In addition to agreeing the information required for the standing agenda items, the standard assurance information pack, and the mandatory reports expected by the NHS Board, the Chief Executive, Board Chair and Vice Chair meet to agree what other issues or concerns should be escalated to the NHS Board. The same system is in place for the Standing Committees and at each of their meetings a decision is made on what needs to be escalated for decision or decisions at the next meeting of the NHS Board.

20. The Corporate Management Team are also required to identify any issues, decisions and reports that should be escalated to the NHS Board or the Standing Committees. These would then be discussed with the Chair and Vice Chair of the NHS Board, or the Standing Committee and a decision made to include the item on the agenda for the next meeting.

21. The concerns around the potential risks to patient safety from the hospital environment, including the water and ventilation systems, would have been included in the discussions the NHS Board and Committee Chairs/ Vice Chairs held with the Corporate Management Team concerning the information required by Board Members. This process was designed to provide assurance that all significant questions about the safety and quality of healthcare services were being addressed, and to ensure the monitoring, progress, and resolution of the management of issues and risks, including those identified in relation to the safety of the hospital environment.

22. Throughout my time as NHS Board Chair, the NHS Board adopted an active and collaborative approach to governance. This included adopting a continuous improvement approach to the corporate governance arrangements in NHSGGC. The changes in the governance structure introduced during my term as Board Chair, including the establishment of new committees and the

requirement for the Chairs of Standing Committees to update on discussions and decisions made at their respective committees reflect that approach being delivered. The Scottish Government and the NHS Board are satisfied that the implementation of this approach has enhanced and strengthened the governance of NHSGGC at Board level.

23. The NHS Board's role can be clearly differentiated from that of the Corporate Management Team. The Corporate Management Team is the principal decision-making body for operational management within NHSGGC. To support the effective management of operational issues, the Corporate Management Team have put in place a hierarchy of management teams and advisory groups across the organisation. These teams and groups meet formally and informally to deliver the services delegated to their sector or business unit of NHSGGC. These teams and groups form part of the decision-making framework that reports to the Corporate Management Team who hold them accountable for the delivery of services to patients and service users. This includes the identification, management, mitigation, and reporting of risks to patient safety from the hospital environment and compliance with the Scottish Government's guidance on infection prevention and control.

24. It is important to note that there is a separation of the corporate governance and operational management functions from the decisions made by clinicians on the care and treatment of patients. Therefore, both clinical decision-making and the medical treatment of specific patients do not fall within the ambit of the NHS Board, the Standing Committees, or the Corporate Management Team and its subordinate teams or groups.

25. The governance arrangements described in paragraphs 9 to 27 of this statement provide the NHS Board with the opportunity to scrutinize and challenge the outcomes of the decisions made by operational managers on the quality of care delivered by NHSGGC, including the impact of their decisions on patient safety.

26. Any concerns expressed by staff that there is evidence of wrongdoing, failures in performance or inadequacies of systems are investigated and reported in compliance with the Whistleblowing policy introduced by the Scottish Government to respond to this type of situation in the healthcare system. This policy requires that Board Members be aware of whistleblowers' concerns and the opportunity is provided for them to review and challenge the senior management team's response.

27. The specific concerns about the safety of the hospital environment raised by staff were taken very seriously by the NHS Board and were considered by Board Members in accordance with the NHSGGC policy on Whistleblowing. The application of the NHSGGC Whistleblowing policy in this instance was reviewed at senior management and at Non-Executive Board Member level and found to be compliant.

28. Following the appointment of Mr Charles Vincent as Whistleblowing Champion by the Cabinet Secretary, the NHS Board commissioned a review of the effectiveness of the NHSGGC Whistleblowing policy. The NHS Board was assured by the outcome of the review that the Whistleblowing policy remained fit for purpose. A copy of Mr Vincent's report is available from NHSGGC.

29. As the NHS Board Chair, I was in regular contact with both the Cabinet Secretary and the Director General for Health and Social Care concerning the safety of the hospital environment, including the concerns raised by whistleblowers around the water and ventilation systems. In addition to face-to-face meetings, these exchanges were by email, text, and phone calls. At these informal discussions, we not only discussed the possible cause of these concerns but also the actions being taken by NHSGGC to address these challenges and restore public confidence in the safety of the hospital environment. The Cabinet Secretary and the Director General also received regular and detailed briefings from the NHSGGC Chief Executive and the government officials who were advising and supporting the Corporate Management Team.

Handover

30. As I was a new Non-Executive Board Member and not personally involved in any aspect of the handover of the hospitals to NHSGGC, I do not consider myself well enough informed to comment on the extent to which the actions taken or not taken at that time may have affected the safety of the hospital environment, including the ventilation and water systems.

31. My role as NHS Board Chair from December 2015 included oversight of the steps being taken by the Corporate Management to resolve the concerns and issues around the hospital environment from that date and while this has given me some insight into some of actions taken before then, I suggest that the Inquiry team's questions around what happened in February 2015 would be more appropriate to being answered by the previous NHS Board Chair.

32. Following the handover, the issues that the Corporate Management were investigating were primarily around infection prevention and control. The possible links between the environment and the quality of the construction of the new hospitals and the safety of the hospital environment were being actively considered. These issues were unresolved when the Chief Executive, Mr. Robert Calderwood retired, and Mrs. Jane Grant became Chief Executive on 1 April 2017.

33. Although unable to confirm an exact date when I first became aware of the concerns and issues around the hospital environment, it would have been in 2016. I was advised of the situation that was developing at the QEUH Campus during my regular informal discussions with the Chief Executive and then more formally through the governance arrangements that were in place to provide information and assurance on infection prevention and control in the healthcare system.

DMA Canyon Report

34. In 2018, Dr Jennifer Armstrong made Board members aware of a Legionella Risk Assessment Pre-Occupancy Report and a Pseudomonas Report on Water Delivery System that had been completed by DMA Canyon Water Treatment Ltd in 2015 and 2017.

35. These reports highlighted concerns around the management of risks to the quality of the water system at the hospitals and identified the actions required to address these risks. I had been advised by the Chief Executive of the existence of the DMA Canyon L8 Risk Assessments prior to the presentation made by Dr Armstrong to the NHS Board in 2018 and the Board Members had no reason to doubt that Dr Armstrong had provided all the relevant information concerning this issue. Copies of the reports and Dr Armstrong's presentation can be provided by NHSGGC.

36. The reviews commissioned by the Director of Estates and Facilities from Health Facilities Scotland and Health Protection Scotland in 2018 identified delays in bringing the DMA Canyon risk assessment reports and the failure to complete all actions required to mitigate them to the attention of the Corporate Management Team, the appropriate Standing Committees, and the NHS Board.

37. In 2018 Board Members were also advised that there was no record of a risk assessment of the water system having been undertaken by the construction company or the NHS Board's advisors prior to the handover and the opening of the hospitals in June 2015. Until that point, I was also unaware of the NHS GGC decisions taken following the meeting with HPS, HFS and others in 2014 concerning the use of Home Optitherm Taps and the actions required to manage the risk they presented to water safety.

38. Following the discovery of the 2015 and 2017 risk assessments, the appropriate Standing Committees and the NHS Board received assurances from the newly appointed Director of Estates and Facilities, Mr Thomas Steele, that a review of the governance processes within the Estates and Facilities Directorate had been undertaken and control mechanisms and processes had been refreshed

to ensure this did not happen again. Mr Steele also confirmed to the appropriate Standing Committee and the NHS Board that that all the technical actions from the 2015 and 2017 Legionella Risk Assessment Pre-Occupancy Report and Pseudomonas Report on Water Delivery System reports had now been delivered.

39. While the time it took for the DMA Canyon reports to be discovered was of concern to the Board members, Mr Steele was not working in NHSGGC prior to 2018 and therefore unable to provide the NHS Board with the reasons why the recommendations in the 2015 and 2017 risk assessment reports were not actioned, or why the failure to do so was not escalated to the Corporate Management Team.

40. The failure to escalate the issues raised in the DMA Canyon reports was referred to in a letter to Ms Monica Lennon MSP concerning the death of a patient in 2017. The response given to Ms Lennon reflected the information known to the NHS Board and the Chief Executive at that time but recognised that in respecting individual patient confidentiality, it was not possible to comment on the circumstances surrounding the death of the patient specifically referred to by Ms Lennon.

Beatson Adult BMT Unit and Ward 4B

41. The transfer of Bone Marrow Transplant patients from Ward 4B in the QEUH to the Beatson West of Scotland Cancer Centre was completed in July 2015. As this also predates my appointment as NHS Board Chair, I was not involved in the decision to return the Adult Bone Marrow Transplant Unit to its previous location.

42. Therefore, the previous NHS Board Chair, would be best placed to answer questions on the governance around the decision to relocate the Adult Bone Marrow Transplant Unit, including why the ventilation system of Ward 4B had not been completed to a specification that would have enabled the Adult BMT service to remain at the QEUH, and why that did not prompt a wider investigation into the ventilation of the whole hospital.

43. As far as the relocation of the Adult BMT Unit back to the QEUH is concerned, my recollection is that the Acute Services Committee received a detailed option appraisal and risk assessment from the Director responsible for this service. The option appraisal complied with the governance arrangements at that time with a range of options having been identified, considered, and assessed against a previously agreed criteria by a group consisting of senior clinicians, managers, and estates staff. Therefore, the recommendation to return to the QEUH was accepted.

Ventilation Concerns/ Review of Ventilation

44. I was first advised about concerns having been raised around the rate of air changes at the hospitals by the Chief Executive, Mr Robert Calderwood, in 2016 when I was briefed on the reasons why the Adult BMT Unit had been relocated back to the Beatson. Mr Calderwood also referred to the situation in other parts of the hospitals where the standards included in the NHS Scotland guidance on the air change rate were not being met.

45. The NHS Board was aware of this situation and was satisfied that any risks to patient safety had been identified and were being effectively managed. NHSGGC would be able to provide details of the specific actions taken to identify, mitigate and report any risks to patient safety from the risk management framework. This framework is an integrated system that provides details of risk at various operational and management levels across NHSGGC. It includes escalation routes that bring changes to the level of risk to the attention of the NHS Board and the Standing Committees.

46. The risk management framework is a key component of the governance system and plays an important part in resolving conflicting opinions and arriving at a consensus view by the various management groups and governance committees that are responsible for patient safety, including infection prevention and control.

47. A review of the ventilation at the hospitals was undertaken in 2018 by Mr Jim Leiper. I was not involved in the commissioning of this work and have no recollection of seeing this report or it being discussed by the NHS Board or a Standing Committee and therefore I cannot comment on any specific actions taken by NHSGGC because of Mr Leiper's report. NHSGGC would be able to provide details of who received Mr Leiper's report and what actions were taken as a result of his findings.

Ventilation of Ward 2A – The Schiehallion Unit

48. I first became aware of concerns around the effectiveness of the ventilation system in Ward 2A of the Royal Hospital for Children in 2016. This was initially reported to me by the Chief Executive, and we agreed updates on the situation would be provided to the NHS Board through the formal governance arrangements in place at that time.

49. The Board Members understanding at that time was that any risk to patient safety was being prioritised and managed in accordance with the NHS Scotland infection prevention and control process. Infection prevention and control is one of the NHS functions that is governed by policies and procedures set by NHS Scotland and scrutinised by Healthcare Improvement Scotland on an ongoing basis. Reports on the level of compliance with the policy and procedures for infection prevention and control were standing agenda items at meetings of the Clinical Governance Committee and the NHS Board. Details of these discussions would be recorded in the minutes of the meetings, and these are available from NHSGGC.

50. My recollection is that the standard of ventilation was only considered an issue for patients with compromised immune systems and not one that had to be addressed for all the hospital wards. Therefore, the focus remained on resolving the situation with Ward 2A in the RHC and Ward 4B in the QEUH.

51. My recollection is that the Board members were surprised and disappointed that this situation had arisen, and the ventilation system did not meet the standards required for air change rate, pressure differentials and HEPA filtration. As time progressed this reaction was one that became common as we were made aware of the other defects in the design and construction quality of the new hospitals.

52. The recognition that the design of the isolation rooms in Ward 2A were not built to SHTM 03-01 standard was also mentioned in a draft options appraisal document in respect of the Adult BMT unit in March 2017. I do not recollect the discussion at the Acute Services Committee including mention of Ward 2A but would assume that as the paper stated that the rooms have a positive pressure of 10 PA hepafiltration, have anterooms, and it had been agreed to upgrade four of these rooms to meet the full standards, then the Board Members would have been assured that appropriate measures were in place or being taken to mitigate the risk to patient safety.

Ventilation of Ward 4C

53. In 2019 the NHS Board was advised of the Health & Safety Executive's investigation into the ventilation within Ward 4C. Updates on this issue would have been given to the Standing Committees as part of the regular reports on the management of health and safety risks within NHSGGC.

54. As the NHS Board Chair, I did not have the necessary technical expertise to contribute to the development of the HAI-Scribe risk assessment, nor would I have been expected to be involved. Responsibility for the completion and oversight of this work rests within the Corporate Management Team. The same would apply to the completion of any SBAR document by the infection prevention and control team that was addressing this issue. Therefore, I did not receive copies of the HAI-Scribe assessment or Dr Inkster's SBAR document.

55. My recollection is that although Ward 4C was not classified as a 'Neutropenic Ward' and HEPA filtration was not a legal requirement, the decision was made to introduce this facility to further reduce risk. This approach, i.e. where all possible action was taken to reduce the level of risk to the lowest possible level, was common at that time and reflects the extremely low level of risk appetite applied to patient safety in the hospitals.

56. This extremely cautious approach report to risk management at NHS Board level reflected a situation where different clinical opinions were being given to the Board Members on the potential causes of infections in different cohorts of patients. This was a recurring feature of discussions on this issue and while some NHSGGC clinicians argued that the ventilation system was a possible source of infection, others including Dr Peter Hoffman (an external expert from Public Health England) held the view that the number of air changes is not relevant to infection prevention and control. Details of the meetings where these discussions took place, and any reports of Dr Hoffman's contribution to the debate, can be obtained from NHSGGC.

57. Therefore, in the absence of a consensus clinical view on the extent or existence of the risk, the NHS Board encouraged and supported the introduction of all reasonable measures to mitigate risk to patients at that time.

'Water Incident' and Events in 2018

58. In 2018 I was advised by the Chief Executive that concerns had arisen around infections in the Schiehallion Unit and the hypothesis being considered by the Infection Management Team was that the water system might be a contributing factor to the situation. The Board Members were also advised of the concerns and of the decision to close the Ward as a precaution until the Infection Management Team identified cause of the infections and an appropriate response had been determined by them.

59. While the Board Members did not receive (or expect to receive) the minutes of the Infection Management Team or the other management groups meetings concerning the concerns around water safety, we were briefed at the Standing Committees and the NHS Board meetings about the situation. This provided

assurance to Board Members that the actions taken by the Corporate Management Team were consistent to the NHS Board's risk appetite where patient safety was concerned. This included taking the significant step of relocating the patients to Ward 6A in the QEUH until it could be determined that patient safety was not being compromised by the water system in the Schiehallion Unit.

60. The NHS Board and the Standing Committees were provided regular updates on the situation concerning the actions being taken to ensure the safety of the water supply through the formal governance arrangements and at Board Development Sessions.

Ward 6A and Events in 2019

61. Following the decant of the Schiehallion Unit, I visited Ward 6A on several occasions and discussed the situation with parents, staff, and managers. The staff were concerned about the length of time they were required to remain in the QEUH and suggested some improvements to the ward environment. This included a playroom for patients and better facilities for families spending considerable time on the Ward. Following discussions with the Corporate Management Team these issues were resolved and at my next visit I received positive feedback on the improvements made.

62. Concerns were also raised with me about delays in communications and the way the situation was being described in the Scottish Parliament and the media. I made the Cabinet Secretary, the NHS Board, and the Director of Communications aware of these issues.

63. The Chief Executive advised me of Dr Inkster's resignation as Lead Infection Control Doctor in 2019. I was advised that she had resigned for personal reasons and the Medical Director was supporting Dr Inkster and addressing the issues raised by her in her resignation letter. Dr Inkster's letter has been copied to me by the Scottish Hospitals Inquiry and now that I am aware of the issues identified by Dr Inkster as the reason for her resignation, it is clear that "personal reasons" do not accurately describe the situation.

64. In 2019 I was also advised by the Chief Executive of the concerns expressed by Professor Gibson and her colleagues concerning the hospital environment. In a letter to the Chief Executive and the Medical Director, Dr Gibson requested a meeting to discuss the situation. I was advised that the Chief Operating Officer, the Deputy Medical Director and the Director of Women & Children Services would take this forward, meet with Professor Gibson and her colleagues and ensure that the clinicians at the Royal Hospital for Children were fully engaged with the actions being taken to provide a safe environment for the treatment of their patients.

65. Following discussions with Scottish Government in 2019, the Chief Executive advised the NHS Board that Professor Fiona McQueen had approved the reopening of Ward 6A to new patients. Board Members were also advised that the NHSGGC Infection Management Team agreed with this decision.

Cryptococcus

66. As I do not have the necessary clinical or technical expertise or knowledge, I am not qualified to comment on the situation where two patients who died after contracting Cryptococcus neoformans were accommodated in rooms without HEPA filtration, whilst unable to be prescribed prophylactic anti-fungal medication. In particular, I am not qualified to give an opinion on what part if any that played in them contracting the Cryptococcus infection.

67. The NHS Board and the Standing Committees relied on updates on the investigations into the care of patients with Cryptococcus neoformans through the existing arrangements for clinical governance. These arrangements provided Board Members with reports that summarised the discussions and findings of the various clinical and managerial groups responsible for the oversight and management of infection prevention and control, including the Infection Management Teams.

68. The NHS Board had no influence or input to the work of either the Cryptococcus Infection Management Team or the Cryptococcus Subgroup. This includes their decisions on which hypotheses should be investigated or reported. This is true of all Infection Management Teams within NHSGGC.

Communication with Parents

69. In 2019 I was advised by the NHS Board Vice Chair, Mr Ross Finnie, that he had been asked by a third party to speak to Professor John Cuddihy concerning his daughter's treatement at the RHC. Molly Cuddihy was a patient of the paediatric haemato-oncology unit. I agreed with Mr Finnie that I would contact Professor Cuddihy and determine what action should be taken by NHSGGC to address his concerns.

70. I contacted Professor Cuddihy by phone and he described his daughter's illness, her treatment and his concerns about the safety of the hospital environment. Professor Cuddihy was concerned that his daughter's health had been damaged and her recovery from cancer was significantly at risk due to a healthcare associated infection that he felt could have been avoided. I advised Professor Cuddihy I would look into his concerns and identify the best course of action.

71. Following discussions with the Chief Executive and Medical Director concerning Molly Cuddihy's clinical condition and treatment, it was decided to invite Professor Cuddihy to meet with the Medical Director and Chief Executive. Given the seriousness of the issues raised by Professor Cuddihy and my previous offer to meet with any patients or families with concerns about the safety of the paediatric haemato- oncology unit, I decided to attend the meeting.

72. At the meeting with Professor Cuddihy, we discussed in detail his daughter's treatment and his family's concerns around the investigation into another patient who had the same type of infection while in the paediatric haemato-oncology unit. Professor Cuddihy's view was that had the source of the earlier infection been identified and eradicated, Molly would not have been infected by this bacteria.

73. The Medical Director explained the Scottish Government's policy on the investigation of single cases of infection and the guidance on linking cases for the purposes of infection prevention and control. She also confirmed that the policy and guidance had been properly applied in Molly's case.

74. While Professor Cuddihy acknowledged the time given by the NHSGGC senior leadership to reviewing his daughter's case, he was not convinced that the Scottish Government's policy was an effective or acceptable approach to the management of healthcare acquired infections. He clearly felt that Molly had been let down by NHSGGC, and had suffered as a consequence of what he considers the mis-management of infection prevention and control at the hospitals.

75. My engagement with Professor Cuddihy was informed by the briefings I received from the Chief Executive and Medical Director and I shared all the information I had with him at that time. I advised the NHS Board of my interaction with Professor Cuddihy as part of the Chairman's report at the NHS Board meeting and updates on any actions arising from the investigation into his daughter's case would have been provided to Board Members as part of the ongoing reporting on the overall situation.

76. As far as the quality of the communication by the Royal Hospital for Children is concerned, I believe that NHSGGC could have done better, and I am confident that lessons have been learned that will improve engagement with the families of patients in the future.

77. The Communications Director and her team have a key role in ensuring that any concerns about the safety of the hospital environment are quickly and effectively shared with the patients and families affected, the NHS staff involved in their care, and the general population who use the hospitals. In most cases, the input of the NHSGGC Communications team has ensured that the right information was received by the right people at the right time, including media statements and regular updates to front-line managers and staff across the QEUH campus.

78. However, communications on the issues around the hospital environment could have been more effective on some occasions, particularly when the cause of infections was still being determined by the clinicians. As each case was individually investigated, the cause of infection and the time taken to establish this varied from patient to patient.

79. Some patients, their families and staff should have been more frequently contacted to reassure them that, although no new information was available on the concerns around the hospital environment, this risk was being actively managed and mitigated while the cause for the concern was being investigated by suitably qualified clinicians.

80. Media statements were also issued with as much information as was available at the time. These statements were by necessity brief but did include background notes for editors. The need to provide updates on the situation in a short format did prove challenging on occassions when describing a complex situation and chain of events. It is possible that could have resulted in misunderstanding of the situation or the sequence of events but this risk was managed by scrutiney of the output from the communications team by members of the Corporate Leadership Team and from October 2019 by the Scottish Government.

81. While the appointment of Professor Craig White as an advisor to NHSSGC in October 2019 assisted the Communications Director in improving communications with the patients and their families, some delays in communications being issued could have been avoided had the Cabinet Secretary not also insisted on Professor White or herself personally approving communications with the patients, their families and the media.

82. It was not always possible to receive approval from the Cabinet Secretary or Professor White in time to meet deadlines from the media for publication of the NHSGGC response to concerns around the safety of the hospital environment with the result that families would on occasion obtain information about the hospital in which their child was being treated from the media, prior to the Health Board being permitted to issue any communication to them directly.

83. The communications around the safety of the hospital environment were also affected by media reports that expressed the views of some clinicians and Members of the Scottish Parliament who were critical of how the situation was being managed and reported by NHSGGC. This situation was made worse by an unnaceptable and widely reported comment by the NHSGGC Communications Director that Professor Cuddihy "may have won the battle, but he won't win the war."

84. The lack of information, the manner of some communications, the delays in communicating, the criticism of the management response to the situation, the accusations of a “cover up” or a “criminal conspiracty” all contributed to a lack of trust in the communications from NHSGGC. In some cases, this caused family members to decline to meet with senior management and clinicians to discuss their concerns.

85. One of the steps taken by NHSGGC to overcome the lack of trust in the organisation was to publish a detailed response to a list of issues raised by the families of children in the Schiehallion Unit. I was not personally involved in writing this document, but I was asked by the Chief Executive to review it before it was issued and give an opinion on whether the language used would be easily understood by people from a wide range of backgrounds. I believe the document that was issued made a positive contribution to the situation.

86. The NHSGGC Communications & Engagement Strategy describes the other actions and initiatives that have been taken to improve how the organisation communicates both its stakeholders. This approach has been scrutinised and approved by the NHS Board who receive regular updates on the effectiveness of both external and internal communications. Copies of these reports are available from NHSGGC.

Whistleblowing / Reporting of Patient Safety Issues by Infection Control Doctors and Microbiologists

87. I was advised by the Chief Executive in 2015 that the leadership team at the QEUH were experiencing difficulties in integrating some of the clinical teams at consultant level. This was despite the involvement of clinicians in the design of the QEUH Campus and although it had gone well across the hospitals, it remained a problem in a few areas, including the Emergency Department and the Infection Prevention and Control Team. I was advised the Medical Director was addressing these issues and it was not until the Infection Control Doctors raised their concerns formally through the whistleblowing process that the Board became aware of the specific concerns they had raised around the hospital environment. At that time, the Medical Director confirmed that although senior infection control doctors and microbiologists had been part of the team of clinicians involved in designing the QEUH and RHC, the whistleblowers remained concerned regarding the specialised ventilated areas within QEUH and RHC and the impact on patient safety. The date when the whistleblowing process was initiated, and the detail of the investigation is available from NHSGGC.

88. The concerns expressed by the Whistleblowers that environmental factors may be responsible for healthcare associated infections were investigated and reported in compliance with the Whistleblowing policy introduced by the Scottish Government to respond to this type of situation in NHS Scotland. This policy requires that Board Members be aware of the staff's concerns and the opportunity is provided for them to review and challenge the senior management team's response.

89. To protect the confidentiality of those involved, other than those Non-Executive Board members directly involved in specific case reviews, Board members do not have sight of the detailed whistleblowing reports produced following the investigations. The NHS Board and Standing Committees receive a summary of the investigations, including progress reports on any recommendations from the investigations.

90. The ongoing concerns about the safety of the hospital environment that were raised by the Whistleblowers, including those raised by Dr Penelope Redding in 2017 were taken very seriously by the NHS Board and were considered by Board Members in accordance with the NHSGGC policy on Whistleblowing. The application of the NHSGGC Whistleblowing policy was reviewed at senior management and at Non-Executive Board Member level and found to be compliant. Therefore, I had no reason to doubt the outcome of the investigation or to personally access any of the papers concerning the investigation.

91. The implementation of any recommendations from the Whistleblowing investigation and reviews were the responsibility of the Corporate management Team and progress against timescales was reported through the clinical governance arrangements in place at the time, including reference to the relevant Standing Committees and the NHS Board.

92. Updates on the implemention of the action plan that was introduced to address the issues raised by the whistleblowing investigation was provided to the Clinical and Care Governance Committee by the Infection Prevention and Control Team. The NHS Board would have received details of this work as part of the feedback from the Standing Committtes that the NHS Board receive at their meetings. This provided the opportunity to escalate any concerns to the full Board.

93. The Medical Director was responsible for ensuring feedback on the outcomes of the Whistleblowing investigation was provided to the Whistleblowers. Other than the exchange of emails with Dr Redding in 2022 where I shared my opinion on the NHS Board's confidence in the assurances received from the Corporate Management Team concerning the effectiveness of the infection prevention and control systems at NHSGGC, I have had no contact with the Whistleblowers. I have no recolection of receiving a letter or email from Dr Redding concerning her disatisfaction with the outcome of her Stage Three whistleblow and have been unable to find her correspondence or a reply. The Inquiry team may wish to ask NHSGGC to examine the files held by them and confirm the position.

94. Following the appointment of Mr Charles Vincent as Whistleblowing Champion by the Cabinet Secretary, the NHS Board commissioned a review of the effectiveness of the NHSGGC Whistleblowing policy. This review was led by Mr Vincent with support from an independent subject matter expert. A copy of this report is available from NHSGGC.

95. The NHS Board was assured by the outcome of Mr Vincent's review that the Whistleblowing policy remained fit for purpose. It should be noted that Mr Vincent is the son of one of the Whistleblowers and the Cabinet Secretary considered this to have added credibility to Mr Vincent's report.

96. The Whistleblowing policy and procedures were regularly reviewed and widely promoted throughout NHSGGC during my period as NHS Board Chair. This included discussions at the Area Clinical Forum and team meetings across the organisation. Articles on the role and importance of Whistleblowing were included in the Core Brief issued to all staff. Details of how to engage with the Whistleblowing process is also included on the NHSGGC website. I believe that it would be incorrect to suggest that Whistleblowing was not encouraged or supported in NHSGGC and have seen no evidence to support that suggestion.

Duty of Candour Policy

97. The NHSGGC Duty of Candour policy was approved by the Board in April 2018 and the Clinical & Care Governance Committee were assured in December 2018 that the policy had been effectively implemented. In 2020 the internal auditors provided further assurance to the Audit & Risk Committee that policies and procedures had been developed and implemented to fulfil the Board's obligations under the applicable legislation and regulations.

98. The NHS Board approved the Duty of Candour Policy (2018-2021). In December 2018, an update was provided to the CCGC who noted "In summary, the committee was content to note the report and update on the implementation of the Duty of Candour Policy. The Committee noted and were satisfied that this was being managed in line with policy requirements."

99. While the independent review undertaken by Dr Fraser and Dr Montgomery describes the NHSGGC Duty of Candour policy as adequate, they also advised that the Scottish Government should undertake further work on this matter.

100. My understanding is that Professor Craig White was asked to take this forward by the Scottish Government in 2020 and his work identified the need to provide further guidance to NHS Scotland on the definitions in the legislation, including what constitutes an incident and the meaning of unintended and unexpected in relation to healthcare incidents. This lack of consistency in the interpretation of the legislation by the health boards across Scotland lies at the root of the disagreement between Professor White and NHSGGC on whether the NHSGGC policy fully reflected the statutory requirements. The Duty of Candour policy was reviewed, updated, and approved by the NHS Board in 2021.

101. As the sponsor of the NHS Boards, the Director General for Health and Social Care has put in place a performance management framework to assist the Scottish Government in ensuring that NHS Scotland are delivering services and targets to the required standards, within budgets and with the appropriate governance.

102. The NHS Scotland Performance Management Framework provides five stages of a Ladder of Escalation that provides a model for intervention by the Scottish Government when there are concerns about a health board's ability to deliver the expected standards, targets, and governance. The model not only describes the stages of performance but also the level of support that would be provided by the Scottish Government at each stage.

103. In November 2019, the Director General for Health and Social Care escalated NHSGGC to Stage Four of the Performance Management Framework in relation to the systems, processes and governance surrounding infection prevention, management and control at the Queen Elizabeth University Hospital and the Royal Hospital for Children and the associated communication and engagement issues.

104. The intention of the escalation to Stage Four was to ensure appropriate governance was in place to increase public confidence and strengthen current approaches that were in place to mitigate avoidable harms.

105. The NHS Board was advised of the Director General's decision to escalate NHSGGC to Stage Four and the appointment of a Transformation team to support the organisation in resolving the issues identified by the Scottish Government Directorates for Health and Social Care.

106. At the same time, the Director General asked Professor Marion Bain, the former Medical Director of NHS National Services Scotland, to take over responsibility for infection prevention and control within NHS Greater Glasgow and Clyde. Professor Angela Wallace, the Executive Director of Nursing at NHS Forth Valley, was given this role in 2020, when Professor Bain was appointed to a different role in the Scottish Government. This decision meant that the Scottish Government were directly responsible for the management of infection prevention and control in NHSGGC and accountable to the Cabinet Secretary for Health and Social Care through the Oversight Board. This arrangement remained in place until 2022, when the Director General made the decision to return NHSGGC to Stage Two of the Performance Management Framework.

107. The Performance Management Framework has been used on several occasions across NHS Scotland in recent years and, in addition to NHSGGC, I have personal experience of its use in three other three health boards, NHS24, NHS Tayside and NHS Forth Valley.

108. My first experience of the escalation process was in NHS 24, where I was a member of the Advice and Assurance Group that was appointed by the Scottish Government to support the NHS Board, following their escalation to Stage Three of the Performance Management Framework. In NHS Tayside I was appointed interim Chair of the NHS Board after the resignation of the previous Chair in response to the escalation of the health board to Stage Five of the Performance Management Framework. In 2022, Susan Wallace and I were commissioned to undertake a review of corporate governance in NHS Forth Valley as part of the NHS Board's response to being escalated to Stage Four of the Framework. Therefore, I understand the Performance Management Framework from several different perspectives.

109. In principle, the deliberate lack of detail around the approach to be adopted to interventions by the Scottish Government is designed to provide a flexible approach to the level of support provided to health boards by the Directorates for Health and Social Care. This means that the Scottish Government's response is tailored to meet the specific circumstances faced by the health board at the time the decision to escalate is made. As a result, the individuals appointed to support this process changes on each occasion the escalation process is used by the Scottish Government to ensure services and targets are being delivered within budgets and with the appropriate governance.

110. Therefore, the effectiveness of the escalation process is influenced by the skills, experience, and behaviours of those involved in the Transformation team appointed by the Scottish Government and the approach adopted by the Oversight Board in managing the situation.

111. In the case of NHSGGC, the role of the Oversight Board and the Transformation team was decided by the Scottish Government who can provide the terms of reference of the Oversight Board. The specific responsibilities of the Transformation team members should also be available from the NHS Scotland Health & Social Care Management Board.

112. As far as the effectiveness of the Transformation team is concerned, the complexity of the situation meant that some of the issues being addressed were outside the experience of some of the individuals involved. As a result, it proved difficult at times to reach a consensus view on what had occurred or the underlying cause of some of the serious concerns being considered by the Transformation team. Consequently, there were delays in resolving issues and this had an impact on the overall effectiveness of the escalation process and the time taken to reach a position where the decision was made to return NHSGGC to Stage Two of the Performance Management Framework. This lack of consensus was evident in the exchanges between the Transformation and NHSGGC concerning the completion of the report of the Case Note Review and the Interim and Final Reports of the Oversight Board.

113. Throughout my term as NHS Board Chair, the Board and the Standing Committees continued to operate in line with the principles of good governance described in the NHS Scotland Blueprint for Good Governance.

114. The NHS Board was not represented on the Oversight Board, but I did have the opportunity to comment on the terms of reference of the Oversight Board. Although not invited to join the Oversight Board, I was invited to attend their first meeting and I had access to the minutes of subsequent meetings.

115. I also had several one-to-one meetings with the chair of the Oversight Board, Professor Fiona McQueen. These were at my request as I required assurance on behalf of the NHS Board that the Oversight Board and the Transformation team were receiving the appropriate level of support and information from NHSGGC for them to function effectively. Professor McQueen gave that assurance on every occasion we met.

116. During my two terms as NHS Board Chair, I reported directly to four Scottish Government Ministers: Ms Shona Robison, Ms Jeanne Freeman, Mr Humza Yusaf, and Mr Michael Matheson. I had regular informal discussions with all four Cabinet Secretaries on the progress being made to address the issues and concerns that had arisen around the hospital environment and the NHSGGC's management of this situation, including the approach adopted to supporting and communicating with the patients and their families.

117. During the period that the health board was escalated to Stage Four of the Performance Management Framework, Ms Freeman often raised her concerns about the level of trust placed in the organisation concerning the safety of the hospital environment and questioned the effectiveness of the NHSGGC approach to communications.

118. The organisation's culture and leadership were also raised as a concern on several occasions by Ms Freeman. Although she did reassure me during these conversations that she had faith and confidence in the Chair and Chief Executive's ability and commitment to resolving the situation and this is reflected in her request that I accept her offer of a second term as NHS Board Chair in 2019. Mr Yusaf and Mr Mathieson also expressed their ongoing support for the Chair and Chief Executive during their terms as Cabinet Secretary for Health and Social Care.

119. In response to the escalation of NHSGGC to Stage Four of the Performance Framework the NHS Board commissioned an independent review of the Board Member's effectiveness from the Quality Governance Collaborative of the Royal College of Physicians of Edinburgh. The review was conducted by Professor Michael Deighan, a highly regarded expert in governance in healthcare. The review report was shared with the Scottish Government and is available from NHSGGC. The recommendations and the recommendations in the report and the findings of the Board Members self-assessment of Board effectiveness were brought together in a continuous improvement programme that was reviewed and updated on a regular basis by the NHS Board. A copy of the Board Development Programme is also available from NHSGGC.

The Case Note Review

120. The Case Note Review was established by the Scottish Government in 2020. The terms of reference for the review and the methodology employed for the review team were decided by the Oversight Board. NHSGGC clinicians were involved in discussions on how the Review team would be supported, including what evidence would be appropriate for consideration by them.

121. In its final report to the Oversight Board the Review team described the difficulties they experienced in identifying specific sources of infection and presented a range of scenarios in respect of the role of the hospital environment as a possible or probable source of infection. The Review team made several recommendations that were relevant to either NHSGGC and/or NHS Scotland.

122. Although the NHSGGC Medical Director expressed some reservations concerns around the methodology employed by the Case Note Review, the Oversight Board were content that all the relevant evidence had been taken into account by Review Team. The Oversight Board's response was accepted by the Medical Director and on that basis, the NHS Board accepted the recommendations for NHSGGC. Details of the specific areas of concern raised by the Medical Director and the Oversight Board's response can be obtained from NHSGGC and the Oversight Board.

123. A media statement reflecting the Board's position at that time was issued following the publication of the Case Note Review report. This statement apologised for the distress caused to patients, their families, and our staff, described the remedial action already taken, and emphasised the organisation's commitment to implementing the recommendations from the Review.

124. The recommendations from the Case Note Review were integrated into the action plan that included all the recommendations from the previous external reviews and the Oversight Board Interim and Final Reports. The delivery of this plan was overseen by the Scottish Government as part of the work of the Oversight Board. It was as a result of the Oversight Board being assured that all the recommendations had been implemented and the action plan completed,

that NHSGGC was de-escalated to Stage Two of the NHS Scotland Performance Management Framework.

125. As my second term as NHS Board Chair ended in November 2023, I was not involved in any discussions that resulted in the NHS Board's decision in 2024 to revisit NHSGGC's acceptance of the findings and conclusions of the Case Note Review. Therefore, I cannot comment on the Board's most recent submissions to the Scottish Hospitals Inquiry that NHSGGC does not accept that anything contained in the Case Note Review can properly justify any adverse inference about the safety of the water, drainage or ventilation systems at the new hospitals. The current NHS Board Chair, Lesley Thomson KC would be best placed to answer questions on this matter.

Remediation Works

126. A significant programme of remediation works has been undertaken by NHSGGC since the point of handover of the new hospitals in 2015. This includes work on the water system and the ventilation system. Full details of this work have been provided to the Inquiry team by NHSGGC.

Summary

127. The information provided in this statement refers to my role as Chair of NHS Greater Glasgow and Clyde from December 2015 to November 2023.

128. Following the opening of the QEUH and the RHC in 2015, it became obvious that the construction of the QEUH and the RHC had failed to deliver what had been expected by the Scottish Government in relation to the quality of the hospital buildings when they agreed to invest in the new hospitals.

129. The full details of all aspects of what was an extraordinarily complex situation, including the Board Members involvement in resolving the issues that required to be addressed, have been made available to the Inquiry team and include Minutes of meetings, internal reports, and external reviews of the QEUH Campus.

130. As I am not aware of the information available to the NHS Board at the planning, design, commissioning, or handover stages of the construction of the QEUH and the RHC, it would not be appropriate for me to comment on decisions or actions taken by NHSGGC prior to December 2015. This includes whether the built environment was safe and fit for purpose at the time of handover in January 2015 or whether a phased handover would have been more beneficial than handing the buildings over all at once.

131. I also do not consider myself qualified to provide an opinion with regards to whether any specific infection or outbreak of infection can be linked to the hospital environment. As set out in the NHS Scotland Blueprint for Good Governance, the active approach to corporate governance requires Non-Executive Board Members to take assurance from several sources, including the professional advice of the senior clinicians in the organisation and any other experts who have had access to all the evidence. This was the approach adopted by the NHS Board in relation to whether the risks around infection prevention and control were being identified, recorded, and mitigated. Details of role played by Non-Executive Board Members play in challenging and scrutinising management decisions related to hospital environment safety are contained in the minutes of the NHS Board and the Standing Committees.

132. Throughout my time as Board Chair, the NHS Board followed an approach to governance consistent with the model described in the NHS Scotland Blueprint for Good Governance. This included adopting a continuous improvement approach to the corporate governance arrangements in NHSGGC that provided the Board Members with assurance that the concerns around the safety of the hospitals were actively investigated and addressed by the Corporate Management Team.

133. However, it should be recognised that the complex nature of the situation and the difficulty in reaching a consensus about the possible cause of the risk of healthcare acquired infections resulted in delays in identifying the remedial action required. Once these difficulties had been overcome, often by seeking external expert advice, action was taken to improve the quality of the hospital environment and mitigate the risk of infections.

134. The Scottish Government provided additional financial support to NHS GGC to remedy the situation and as most of these costs relate to failures in the quality of the construction of the new hospitals, legal action has been taken against the construction company and the NHSGGC professional advisors to recover these costs. This reflects the extent to which the NHS Board considers the construction company and the NHS Board's professional advisors accountable for the challenges that NHSGGC faced following the opening of the QEUH and the RHC.

135. Although I have found no evidence of any deliberate attempt to withhold relevant information from any of the key stakeholders in the quality of healthcare provided by the QEUH and RHC, I accept that while the cause of infections was still being determined, communications with patients and their families could have been more effective. I regret the distress this caused and have apologised to the families affected on behalf of NHSGGC. In hindsight, this is an area where the NHS Board and I could have been more engaged.

136. I also accept that the failure to either implement the recommendations made in the DMA Canyon risk assessment reports could have had the potential to increase the likelihood of risks to patient safety. However, the failure to detect this operational failure or escalate the issue to senior management does not reflect a 'cover up' by NHSGGC. This is a case of a failure by certain individuals to effectively perform their duties, rather than a deliberate attempt by the organisation to ignore a potential risk to patient safety.

137. I have no concerns around the effectiveness of the NHSGGC approach to whistleblowing during my time as Board Chair. Both the review of the response to the specific concerns raised about the safety of the hospital environment and the review of the policy and procedures that underpinned the handling of those concerns confirmed that the system was fit for purpose and applied appropriately to the cases concerning the hospital environment.

Declaration

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

Professor John Brown CBE

August 2025

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

Appendix A

A43255563 - Bundle 1 - Incident Management Team Meeting Minutes (IMT Minutes)

A43273121 - Bundle 3 - NHS National Services Scotland: SBAR Documentation

A43299519 - Bundle 4 - NHS Greater Glasgow and Clyde: SBAR Documentation

A43296834 - Bundle 5 - Communications Documents

A43293438 - Bundle 6 - Miscellaneous documents

A43955371 - Bundle 8 - Supplementary Documents

A47390519 - Bundle 11 - Water Safety Group

A48890718 - Bundle 13 - Additional Minutes Bundle (AICC/BICC etc)

A49525252 – Bundle 14, Volume 1 – Further Communications

A49541141 – Bundle 14, Volume 2 – Further Communications

A47664054 - Bundle 15 - Water PPP

A48245730 - Bundle 18, Volume 2 - Documents referred to in the expert report of Dr J.T. Walker

A48946859 – Bundle 20 - Documents referred to in the Expert Reports by Andrew Poplett and Allan Bennett

A49618520 – Bundle 23 - Queen Elizabeth University Hospital and Royal Hospital for Children, Isolation Rooms PPP

A49799834 – Bundle 27, Volume 4 - Miscellaneous Documents

A49847958 - Bundle 27, Volume 5 - Miscellaneous Documents

A50002331 - Bundle 27, Volume 7 - Miscellaneous Documents

A50976013 – Bundle 29 - NHS Greater Glasgow and Clyde Audit Reports

A50976005 – Bundle 29 - NHS Greater Glasgow and Clyde Audit Reports

A50976001 - Bundle 29 - NHS Greater Glasgow and Clyde Audit Reports

A33474856 –Bundle 52, Volume 1 – Miscellaneous Documents

A52378408 – Bundle 52, Volume 1 – Miscellaneous Documents

A39495998 – Bundle 52, Volume 1 – Miscellaneous Documents

A39495969 – Bundle 52, Volume 1 – Miscellaneous Documents

A33474856 –Bundle 52, Volume 1 – Miscellaneous Documents

A44777296 – Bundle 52, Volume 2 – Miscellaneous Documents

A49847577 - Hearing Commencing 19 August 2024 - Witness Bundle - Week Commencing 2 September 2024 - Volume 3

A50766285 - Hearing Commencing 19 August 2024 - Day 35 - 24 October 2024 - Transcript - Professor Craig White

Appendix B

Professor John Brown CBE

MBA, ACMA, GCMA, FRCP Edin, FInstLM, FCICM

PROFILE

An accomplished executive director with over 40 years' experience of driving up performance and leading public facing organisations through transformational change. A chartered management accountant and former finance director with extensive operational management experience, using quality management systems and programme management techniques to improve service delivery, achieve targets and drive down costs.

An influential chair and governance advisor having successfully pursued a portfolio career at Board level, using experience and understanding of operational management, leadership of change and corporate governance to

create a shared vision of the future and realise the organisation's potential to deliver successful outcomes for the community it serves.

An inclusive and collaborative leader with experience of the UK healthcare, education, tax and welfare systems and an extensive network of professional contacts across the public sector, including Ministers, national and local politicians, and government officials.

CURRENT ROLES

Executive Director of Corporate Services,
St Margaret of Scotland Hospice
May 2024 to date

The St Margaret of Scotland Hospice is the largest hospice in Scotland and is widely regarded as a centre of excellence for the delivery, research, and teaching of specialist palliative and hospital-based complex clinical care. Patients come from the Greater Glasgow and Clyde area and in addition to inpatient care, the Hospice offers day care, community specialist palliative care and counselling services. Founded in 1950 by the Religious Sisters of Charity, the Hospice continues to uphold the principles of the Catholic faith, providing care that is holistic and considers the spiritual, physical, psychological, and social needs of its patients and their families. The Hospice cares for patients and employs staff from all communities, irrespective of their religion or belief.

The Executive Director of Corporate Services has overall responsibility for the day-to-day management of all non-clinical operational and administrative functions of the Hospice. This includes responsibility and accountability for leading, directing, planning, and managing the finance, fundraising, human resources, governance, administration, facilities, building maintenance, IT services, information systems and cyber security functions of the Hospice. The Executive Director for Corporate Services also has responsibility for the development and maintenance of the corporate risk system and business continuity plans.

The Hospice is a Company with charitable status, limited by guarantee, and in addition to functioning as an Executive Director, the postholder has been a Company Member and a Trustees of the Charity since January 2024.

Advisory Board Member,
University of Strathclyde Centre for Health Policy
Dec 2023 to date

The University of Strathclyde Health Policy Unit was established in 2014 as an academic hub for fresh perspectives on healthcare and public health policy. The Unit's current cross-disciplinary activities cover reducing health inequalities, mental health and understanding long-term changes in health and wellbeing and their relationship to economic, social and health policies.

The Advisory Board works to support health policy research, strengthen and broaden connections with external organisations, increase research impact via public and policy engagement, and develop health policy teaching and training.

Advisory Board Member,
University of Dundee School of Business
Dec 2019 to date

The University of Dundee's School of Business is the UK's newest and fasted-growing business school. Its primary aim is to contribute and add value to its communities through excellence in teaching, research, and community engagement.

The Advisory Board provides critical advice to the University Principal and School Executive on the direction of the School of Business, advising on stakeholder engagement and collaboration and promoting the University of Dundee and its School of Business locally, regionally, and internationally.

Senior Faculty Member,
Royal College of Physicians of Edinburgh
Oct 2017 to date

The Royal College of Physicians works in collaboration with the World Health Organisation, governments, universities, and health and social care providers to determine appropriate responses to the challenges faced in the governance of health and social care systems across the globe.

The College's Quality Governance Collaborative brings together multi-professional groups to shape international corporate governance practice,

ensuring that integrated health and social care systems continue to deliver the best possible outcomes for the population and communities they serve.

CAREER HISTORY

Chair, Hub East Central Scotland Ltd
Oct 2023 to Feb 2025

Hub East Central Scotland Ltd is a public and private sector partnership delivering new community infrastructure across Falkirk, Clackmannanshire, Stirling, Perth & Kinross, Dundee, Angus, and Fife.

The Company offers expertise in strategic development, value driven procurement and project management and provides Local Authorities, NHS Boards, the Scottish Ambulance Service, Police Scotland and the Scottish Fire and Rescue Service with a platform and mechanism to deliver and manage buildings more effectively. Working collaboratively with central and local government partners, Hub East Central Scotland has delivered over 60 major construction projects with a combined value exceeding [redacted].

Chair, NHS Greater Glasgow and Clyde
Dec 2015 to Nov 2023

NHS Greater Glasgow and Clyde is the largest healthcare system in the UK with an annual budget of [redacted], employing over 40,000 staff to deliver local, regional, and national healthcare services to a population of over 2.1 million people. The Board Chair is directly accountable to the Cabinet Secretary for Health and Social Care for improving health at population level and creating an integrated health and social care system that meets the present and future needs of the people of Greater Glasgow and Clyde.

To deliver this ambition the Chair must ensure that the NHS Board engages with key stakeholders to develop strategies and plans that focus on improving population health and addressing health inequalities, while delivering high quality, sustainable, person centred and effective health and social care services. At the same time the Board needs to hold the executive leadership

team to account for the delivery of services and the deployment of resources, including staff. The Board must also influence the leadership approach within the organisation to ensure an appropriate organisational culture is in place. Considerable progress towards the achievement of these goals in NHS Greater Glasgow and Clyde was delivered by the Chair taking the following actions:

- Encouraging and facilitating strategic partnerships with the extensive range of public and private sector organisations who influence the health and wellbeing of individuals and communities across Greater Glasgow and Clyde
- Engaging with the executive leadership team to identify areas for improvement across the full range of local, regional, and national health and social care services, including the development and implementation of post pandemic remobilisation and recovery plans for urgent and elective care
- Prioritising activities to increase the organisation's capability and capacity for transformational change, in order to improve performance, reduce costs and ensure sustainability and resilience
- Introducing an active governance approach and assurance framework that integrates and improves strategic planning, risk management and assurance information flows at Board level
- Recruiting a well-balanced and diverse NHS Board capable of addressing equality, diversity and inclusion issues in their deliberations and decision making
- Developing and promoting a collaborative and compassionate leadership approach to shape the organisational culture and improve relationships at national and local government level
- Leading the Board's response to the failures in the design and construction of the Queen Elizabeth University Hospital campus, prioritising the restoration of public confidence in the safety and quality of care provided in the hospitals
- Promoting initiatives to ensure the health and wellbeing of staff at all levels during the Coronavirus pandemic

In addition, the NHS Board Chair also functioned as Chair of the Glasgow Centre of Population Health and the NHS Greater Glasgow and Clyde Endowment Fund.

The Glasgow Centre for Population Health exists to generate insights and evidence, support novel approaches, and inform and influence action to improve population health and wellbeing and tackle inequality. Working with a wide range of stakeholders, the Centre conducts research of direct relevance to policy and practice, facilitates and stimulates the exchange of ideas, fresh thinking, and debate to support development and change, not only in Scotland but worldwide.

The NHS Endowment Fund is a registered charity with the primary objective of the advancement of health for the population of Greater Glasgow and Clyde. The charity has an annual income of around [redacted] and holds funds of [redacted] in trust. A sizeable proportion of the Endowment Fund is allocated each year to support research and innovation in healthcare.

Prior to being appointed Chair, served as a non-executive member of the NHS Greater Glasgow & Clyde Board from January 2015. This included membership of the management boards of the Glasgow City Health & Social Care Partnership and the Renfrewshire Health & Social Care Partnership.

Co- Chair, Glasgow Health Sciences Partnership
Dec 2015 to Nov 2023

The partnership with the University of Glasgow aims to integrate world-leading research, top quality education and expertise in clinical practice across the University and NHS Greater Glasgow and Clyde. This approach is built on enabling a culture where clinicians are encouraged to be aware and active in research activities as part of their daily work.

The Health Sciences Partnership's annual work programme includes over 300 research projects and initiatives to support innovation in healthcare. The clinical trials associated with this research include around 8,000 patients each year. The following list gives examples where research and innovation have contributed to the improvement of healthcare:

- Research into the impact and treatment of the Covid-19 virus, both in the short and longer term

- Research into the causes and treatment of cancer with significant funding and activities channelled through the Beatson West of Scotland Cancer Centre
- Development of a public/private partnership and funding of [redacted] to promote Precision Medicine through innovation and capability building in data analytics, diagnostics and genomics
- Establishment of an Innovation Zone to provide space and facilities for industry partners to focus on major disruptive innovation and change

These programmes and numerous other research projects have resulted in Glasgow being considered among the world leaders in healthcare research, development, and innovation.

Chair, NHS Scotland Global Citizenship Advisory Board

Oct 2017 to Mar 2024

The NHS Scotland Global Citizenship Advisory Board supports Scotland's international development commitments as set out in the Scottish Governments' International Development Strategy, in particular the commitment to support capacity strengthening in population health and wellbeing.

The Advisory Board provides advice to Ministers, officials, and NHS Boards on how NHS Scotland can support population health and wellbeing in low and middle income countries at a strategic and organisational level. This work has included expanding the NHS approach to global citizenship beyond international volunteering to encompass broader issues such as planetary health, climate change and health inequalities. Projects and initiatives that have contributed to developing the NHS Scotland approach to global citizenship include:

- Developing and delivering a comprehensive programme of activities to address the recommendations of the Royal College of Physicians and Surgeons of Glasgow's 2017 report titled 'Global Citizenship in the Scottish Health Service'
- Establishing a Global Health Co-ordination Unit to provide a central point for advice and support to NHS Boards and their staff

- Introducing a tripartite health partnership between Malawi, Zambia, and Scotland, facilitated by the World Health Organisation, which aims to achieve sustainable improvements in the quality of healthcare through the mutual exchange of knowledge and skills and co-development of solutions to deliver the ambitions of each partner country
- Revising national HR policies to recognise global health volunteering as part of Continuing Professional Development across all NHS staff groups
- Publishing guidance on the 'Once for Scotland' approach required for donations of medical equipment by NHS Boards to low and middle income countries

As Advisory Board Chair also initiated projects to identify new options for improving the flow of charitable funds to NHS staff participating in global citizenship activities and introduce an 'Investors in Global Citizenship' scheme that describes best practice and supports NHS Boards on their journey towards achieving the 'Gold Standard' in supporting global citizenship in the NHS.

Chair, NHS Scotland Corporate Governance Steering Group

Oct 2017 to Nov 2022

The Corporate Governance Steering Group had responsibility for setting the standards for corporate governance in NHS Scotland. This involved developing and maintaining a 'Once for Scotland' blueprint to define the functions, enablers and support required of an effective governance system across the 22 NHS Boards.

As the Chair of the Steering Group and the author of the NHS Scotland Blueprint for Good Governance, the role primarily involved providing advice to Scottish Government Ministers, government officials and NHS Boards on best practice in health and social care governance and ensuring that the agreed way forward was rolled out across NHS Scotland. This not only required awareness of the latest research into good governance but also ongoing engagement with the key players in the governance of NHS Scotland, including the Scottish Government, Local Authorities, the NHS Board Chairs, Chief Executives and NHS Education for Scotland.

The activities undertaken to improve the governance arrangements for health and social care across NHS Scotland include:

- Recommending changes to the governance systems in NHS Forth Valley, NHS Highland and NHS Tayside following delivery of external reviews based on the Blueprint for Good Governance
- Providing assurance to the Cabinet Secretary on the rollout of a new IT system for NHS 24
- Commissioning and approving new induction and skills training for Board Members
- Developing an original approach to reviewing Board effectiveness
- Promoting a culture of active governance and supporting the rollout of this across NHS Boards
- Partnering with NHS Education for Scotland to develop on-line support for Board development

This work on improving the governance of health and social care across NHS Scotland culminated in the publication of a second edition of the Blueprint for Good Governance in October 2022. This places more emphasis on the delivery mechanisms and the need to apply a continuous improvement approach to health and social care governance arrangements. The governance of change now features more prominently in the description of best practice and the updated guidance on implementing the Blueprint also highlights the need for NHS Boards to adopt both active and collaborative approaches to governance.

Independent Director, Culture & Sport Glasgow

February 2020 to Mar 2021

Culture & Sport Glasgow (trading as Glasgow Life) is a charity that delivers cultural, sporting and learning activities on behalf of Glasgow City Council, for the benefit of citizens and visitors. It aims to make a positive impact on individuals, the communities in which they live and the city as a whole by delivering a range of services including arts, music, sports, events and festivals, libraries, community development and learning programmes. Over 19 million people attend Glasgow Life's facilities and events each year.

Glasgow Life manages 171 venues and sites across every part of the city, is responsible for a budget of [redacted], employs around 2,660 staff and is supported by more than 850 regular volunteers.

Interim Chair, NHS Tayside

Apr 2018 to Dec 2019

NHS Tayside provides a comprehensive range of acute, primary, and community-based health services for the 415,000 people living in Dundee City, Perth & Kinross, Angus and North East Fife. The Board employs around 14,000 staff and is responsible for a budget of [redacted].

Following the resignation of the previous Chair and Chief Executive, the interim Chair was appointed by the Cabinet Secretary with the remit of working with the executive leadership team to stabilise the organisation, introduce more effective governance arrangements and develop a transformation programme that would deliver financial balance and sustainable improvements in service delivery.

During the time at NHS Tayside the interim Chair worked closely with the interim Chief Executive and the executive leadership team to stabilise the situation and restore public confidence in the leadership of the organisation by:

- Implementing the recommendations of the external review of governance arrangements commissioned by the interim Chair
- Recruiting new Board Members with experience of transformational change in the public sector
- Leading the refresh of the NHS Tayside change programme, known as ‘Transforming Tayside’
- Supporting the Finance Director in developing a credible three-year financial strategy that was agreed by the Scottish Government
- Recruiting a permanent Chief Executive and supporting the transition from an interim to a permanent leadership team at Board level
- Engaging with Ministers and national and local politicians to manage their expectations and gain their support for the changes required

- Handling media enquiries and giving interviews on TV and radio to ensure the public were aware of the progress being made by the organisation

During this period the NHS Board Chair also acted as Co-Chair of the Dundee Academic Health Sciences Partnership, a collaboration with the University of Dundee to promote education, lifelong learning, research and quality improvement in health and social care across Tayside.

Company Secretary, Student Loans Company

Oct 2013 to Dec 2015

The Student Loans Company is a non-profit making Government owned organisation, providing [redacted] per annum in loans and grants to students at universities and colleges across the UK. The Company plays a vital role in supporting the Higher Education and Further Education sectors by delivering assessment, payment and repayment services and managing a [redacted] loan book.

In addition to the usual Company Secretary remit for corporate governance, the role also included responsibility for legal advice, regulatory compliance, and internal audit services. Achievements in this role included:

- Redesigning the end-to-end corporate governance system following in-depth reviews of Board effectiveness, risk management, information security governance and internal audit arrangements
- Negotiating the Company's sponsorship agreement and performance management framework with the Department for Business Industry and Skills
- Securing exemption from regulation by the Financial Conduct Authority

As Senior Information Risk Owner, also advised the executive leadership team on the effectiveness of information risk management across the organisation and provided assurance to the Board and the UK Cabinet Office on the effectiveness of the governance arrangements for the digital transformation being delivered in partnership with the Government Digital Service.

Civil Servant, HM Revenue & Customs

Apr 2002 to Mar 2013

As a senior civil servant held a variety of challenging leadership roles following the integration of the Inland Revenue and HM Customs and Excise. During this period gained extensive experience of collaborating with key stakeholders to create a shared vision of the future and develop the organisation's potential. Roles involved leadership of up to 18,000 people in a network of 164 offices across the UK, managing budgets up to £580 million and collecting £240 billion in tax and excise duties. Posts included:

- Director Central Compliance Operations (2011 to 2013)
- Director Cross Cutting Group (2008 to 2011)
- Compliance Director, Wales, Scotland, and Northern Ireland (2007 to 2008)
- Finance Director, Debt Management and Banking (2006 to 2007)
- Director, Debt Management Operations (2005 to 2006)
- Director, Accounting and Payments Service (2002 to 2005)

These roles required working as both an Operations Director and as a Change Programme Director to deliver business as usual and transformational change at the same time. All these roles involved building management capability and capacity to better understand customer behaviour and promote a culture of continuous improvement built around quality management, employee engagement and teamwork. This introduction of modern management techniques created a learning organisation that ensured delivery of key operational targets, within budget and to the quality standards set by Government Ministers.

QUALIFICATIONS & MEMBERSHIPS

- Master of Business Administration, University of Glasgow (1997)
- Chartered Management Accountant, Chartered Institute of Management Accountants (2013)
- Fellow, The Royal College of Physicians of Edinburgh (2021)

- Fellow, The Institute of Leadership and Management (2011)
- Fellow, The Chartered Institute of Credit Management (2006)

HONOURS

- Appointed CBE for significant contribution to improving leadership in the Public Sector
- Appointed Honorary Professor at University of Dundee, School of Business for work with the Business School on the governance and the leadership of transformational change

  Appointed Honorary Professor and Senior Research Fellow at University of Glasgow, College of Medical, Veterinary and Life Sciences for contribution to research and innovation in health sciences.

Scottish Hospitals Inquiry
Witness Statement
Professor Jann Gardner

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

Whether disclosures of evidence relating to patient care and safety are encouraged in NHS GGC

1. You were appointed as Chief Executive of NHS GGC on 1st February 2025. On 27 March 2025 Health Improvement Scotland (HIS) published a review of the emergency departments at the Queen Elizabeth University Hospital, Glasgow Royal Infirmary and the Royal Alexandra Hospital (**Bundle 51, Document 7, Page 904**) ("the HIS Review") which included consideration of issues raised between 2021 and 2023 in a series of written and in-person exchanges between the emergency medicine consultants and NHS GGC senior management which ultimately led to the escalation to HIS of concerns over "Leadership and Culture".

   Do you consider that there any similarities between the events that led to the HIS Review and the raising of concerns by Dr Redding, Dr Peters, Dr Inkster and others about the impact of the water and ventilation systems at the QEUH from 2015 to date?

A. As noted, I joined NHS GGC as Chief executive on 1st February 2025 therefore I can provide a detailed account of actions and assurances undertaken from that date, however, can make only limited comment on events taken prior to my time in post.

To assist the Inquiry, I can explain the following:

1. The HIS Review and the issues which led to concerns being raised with HIS.
2. Whether there are any parallels to be drawn with the issues raised previously.
3. In relation to the water and ventilation systems at the QEUH, the response of the Chief Executive, Chair and Board to the 'HIS ED Review' and ongoing concerns including the development of the GGC Way Forward Improvement Programme.

THE 'HIS REVIEW' AND RELATED ISSUES

The issues raised in the HIS report result from a number of very complex issues as set out below:

Significant system challenges with resultant impact on staff and patients. Whole System flow issues (as seen across NHS Emergency Systems in Scotland and the UK) led to tensions in relationship within teams, between teams but predominately between clinical teams and site and system management reflected in the review as leadership and cultural issues. The complex issues were set out in the following themes:

a) Medical and Nurse Staffing
b) Facilities
c) Flow and Escalation
d) Incidents/Reporting and Organisational Learning
e) Culture
f) Communication

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

PARALLELS

There are significant differences both in relation to firstly, the actual issues raised by the ED Consultants and those raised by Drs Redding, Peters and Inkster and secondly, the Executive leadership in post at the point of the publication of the HIS Review (including a new Chief Executive, Medical Director, HR Director).

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

RESPONSE/ACTIONS-

The GGC Way Forward Improvement Plan 2025. In response to both the HIS review the following actions were taken:

Significant staff engagement including circa 40 hours of meetings with myself plus my senior Executive colleagues. A clear narrative expressing importance of values and culture with a personal commitment from me to staff about what they should expect from me, my executive team and from one another. In addition, an outline of how to raise issues to managers, via process, through the GGC Way Forward and a direct offer to email exec colleagues or myself directly.

Apology to Staff – in meetings, through media and at Board by both the Chair and myself.

Development of a comprehensive improvement Programme based on the themes from the meetings and HIS Review – The GGC Way Forward which was approved by the Board in April 2025)

This is a co-produced programme with co-Chairs from the ED departments – medical – nursing and site management.

The Programme is split into 3 layers – sector, whole system and executive oversight. To ensure transparency and challenge non-executive Board members, CfSD (Centre for Sustainable Delivery) and HIS (Healthcare Improvement Scotland) are members of the latter two layers.

Human Factors/People/HR – a range of actions to support people and resolve issues. An essential component of the programme is the commissioning of external expertise to help us improve culture, trust, professional relationships and leadership culture. This includes psychological support and/or occupational health referral where appropriate as well as facilitation, mediation and career conversations.

The GGC Way Forward reflects a collective commitment to learning, improvement, and building a stronger, more compassionate NHS Greater Glasgow and Clyde.

2. The Inquiry Team notes that you have made a number of responses to the HIS Review including in a press release on the day of its publication (**Bundle 52, Volume 2, Document 40, Page 572**), in a paper to the NHS GGC Board on 23 April 2025 (**Bundle 52, Volume 2, Document 36, Page 549**) and a "new strategic improvement programme – The GGC Way Forward Programme". A press release was also issued (**Bundle 52, Volume 2, Document 38, Page 566**). The Inquiry Team also notes that the draft minutes of the Additional Board Meeting of 23 April 2025 (**Bundle 32, Volume 2, Document 37, Page 559**) record an apology from the Chair, Dr Lesley Thomson KC that it was "wholly unacceptable" that emergency medicine consultants were required to raise issues externally in May 2023 and an apology from you that "the organisation did not respond more effectively when concerns were raised and staff had to escalate concerns". With these matters in mind:

a) Did NHS GGC respond effectively to the patient safety concerns raised by Dr Peters and Dr Inkster in July 2015 (**Bundle 14, Volume 1, Pages 414-415 and 416-42**)?

A. I have set out the approach I think is necessary to listen to staff, provide pathways for escalation, establish an improvement programme, where required, with full staff involvement to ensure a shared commitment and satisfaction.

I cannot comment on how effectively actions were undertaken previously as I was not in post at that time.

b) Did NHS GGC respond effectively to the patient safety concerns raised in the SBAR of 3 October 2017 (**Bundle 4, Document 20, Page 104**).

A. As I was not in post at the time, I do not have any detail about these matters. However, I understand that significant evidence has already been heard in respect of the Board's response to the concerns raised by the microbiologists in the SBAR dated 3 October 2017, which should be considered here.

c) Is it acceptable that Dr Redding had to escalate the concerns she had to a Stage 2 and the Stage 3 whistleblowing?

A. I have set out the approach I think is necessary to listen to staff, provide pathways for escalation, establish an improvement programme where required with full staff involvement to ensure a shared commitment and satisfaction.

I cannot comment on the detail in relation to the whistleblowing process relating to Dr Redding or on how effectively actions were undertaken previously as I was not in post at that time.

d) Is there any inconsistency between the approach NHS GGC has taken since the publication of the HIS Review in respect of the emergency medicine consultants to raise concerns about patient safety and the approach taken by NHS GGC to the actions taken by Dr Redding, Dr Peters and Dr Inkster to raise concerns about patient safety? If, not, why not?

A. I refer back to the approach I have taken in the GGC Way Forward.

Learning Lessons from the process and practices of reporting healthcare associated infections

3. Please refer to NHS GGC IPCT Incident Management Process Framework SOP (**Bundle 27, Volume 17, Document No. 28, Page 315**). It is the position of Laura Imrie, Lead Consultant, ARHAI Scotland and Clinical Lead NHS Scotland Assure that this local SOP appears to advise that a separate assessment is carried out locally prior to deciding if an assessment using the NIPCM HIIAT is required. This may account for the variation in reporting against the NIPCM.

a) Might this NHS GGC SOP result in incidents not being reported to ARHAI Scotland following initial review by the IPCT in NHS GGC?

A. As Chief Executive and Accountable Officer I seek advice from my Professional Advisors.

In respect of the SOP, we are now working with colleagues from NHS Lothian to ensure complete alignment and consistency with their approach moving forward.

As I am not an expert in this field I would not be in a position to comment further.

b) Is this NHS GGC SOP consistent with the letter and spirit of the National Infection Control Manual?

A. As advised, in respect of the SOP, we are now working with colleagues from NHS Lothian to ensure complete alignment and consistency with their approach moving forward.

As I am not an expert in this field I would not be in a position to comment further.

c) Should the Inquiry be concerned by the terms of this NHS GGC SOP when considering its Term of Reference 9 in respect of learning Lessons from the process and practices of reporting healthcare associated infections?

A. Term of Reference 9 – 'To examine the processes and practices of reporting healthcare associated infections within QEUH and determine what lessons have been or should be learned.

As advised, In respect of the SOP, we are now working with colleagues from NHS Lothian to ensure complete alignment and consistency with their approach moving forward.

As I noted previously, The GGC Way Forward reflects a collective commitment to learning and improvement.

Declaration

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

Appendix A

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

A52454817 – Bundle 51 – Sir Robert Francis Whistle-blowing Expert Report

A53376430 – Bundle 52 Volume 2 – Miscellaneous Documents

A53376428 - Bundle 52 Volume 2 – Miscellaneous Documents

A53376429 - Bundle 52 Volume 2 – Miscellaneous Documents

A53376427 - Bundle 52 Volume 2 – Miscellaneous Documents

A38176264 – Bundle 14 Volume 1 – Further Communications

A32310963 – Bundle 14 Volume 1 – Further Communications

A38694873 - Bundle 4 – SBAR Documentation

A50811313 – Bundle 27, Volume 17 – Miscellaneous Documents

Scottish Hospitals Inquiry

Witness Statement of

Shona Robison MSP

Introduction

1. My name is Shona Robison. I am a Member of the Scottish Parliament. I have been a Member of the Scottish Parliament since its inception in 1999. I have served in government and in opposition. During that time, I have held a number of ministerial posts. I am currently the Cabinet Secretary for Finance and Local Government.

2. In this statement I address:-

    - My professional background and qualifications;
    - The role of the Minister for Public Health and Sport;
    - The decision to build a new hospital in Glasgow; and
    - The opening of the Queen Elizabeth University Hospital ("QEUH" and the Royal Hospital for Children ("RHC") and ancillary matters.

Professional Background and Qualifications

3. As I explain above, I have been a Member of the Scottish Parliament since its inception. During that time I have served in government and opposition and have, accordingly, held a number of ministerial posts. I list those posts below. Prior to being elected to the Scottish Parliament I worked for Glasgow City Council as a Senior Community Worker then as a Home Care Organiser. I have an MA in Social Science from Glasgow University.

4. Ministerial and other positions as an MSP:-

    - June 2001 – March 2003 – Deputy Party Spokesperson on Health

- June 2001 – March 2003 – Deputy Party Spokesperson on Community Care
- May 2003 – April 2007 – Party Spokesperson on Health
- May 2007 – February 2009 – Minister for Public Health
- Feb 2009 – May 2011 – Minister for Public Health and Sport
- May 2011 – April 2014 – Minister for Commonwealth Games and Sport
- April 2014 – November 2014 – Cabinet Secretary for Commonwealth Games, Sport, Equalities and Pensioners' Rights
- November 2014 – May 2016 – Cabinet Secretary for Health, Wellbeing and Sport
- May 2016 – June 2018 – Cabinet Secretary for Health and Sport;
- May 2021 – March 2023 – Cabinet Secretary for Social Justice, Housing and Local Government
- March 2023 – May 2024 – Deputy First Minister and Cabinet Secretary for Finance
- May 2024 – present – Cabinet Secretary for Finance and Local Government.

5. During my time as a Member of the Scottish Parliament I have sat on, and convened, a number of Parliamentary Committees.

The role of the Minister for Public Health and Sport

6. The Cabinet is the main decision-making body of the Scottish Government. It is made up of the First Minister and all Cabinet Secretaries. Each of Government's "policy" areas is headed by a senior member of Government called a Cabinet Secretary. Cabinet Secretaries are supported in their role by (junior) Ministers. For example, the current secretary for Health and Social Care, Neil Gray MSP, is supported in his work by, amongst other people, the Minister for Public Health and Women's Health, Jenni Minto MSP.

7. Between February 2009 and May 2011 I was the Minister for Public Health and Sport. Throughout this period, Nicola Sturgeon MSP, was the Cabinet Secretary for Health and Wellbeing.

8. As Minister for Public Health and Sport it was my responsibility to, in general, support the work of the Cabinet Secretary for Health and Wellbeing. My specific policy responsibilities were:-

    - adult support and protection;
    - the Care Inspectorate;
    - care, support and rights;
    - child and adolescent mental health;
    - dementia;
    - forensic mental health services and reform;
    - mental health wellbeing;
    - the Mental Welfare Commission;
    - the National Care Service;
    - self-directed support;
    - social care and integration;
    - social prescribing;
    - social service workforce;
    - sport and physical activity;
    - suicide prevention; and
    - overseeing preparations for the 2014 Glasgow Commonwealth Games.

9. I am asked by the Inquiry to what extent I would agree or disagree that the Cabinet Secretary for Health and Sport is, in the eyes of the public of Scotland and the Scottish Parliament, responsible for the safe and effective delivery of hospital services within Scotland. The Scottish Ministers have a collective responsibility to ensure the safe and effective delivery of healthcare in Scotland in accordance with the National Health Service (Scotland) Act 1978. The actual provision of health care is delivered by Health Boards. The Cabinet Secretary for Health has the overall “portfolio responsibility” for matters connected with

the delivery of health care in Scotland. Accordingly, I do not disagree with the statement put to me.

10. I have had the opportunity of considering Ms Freeman's description of the Role of Cabinet Secretary for Health and Sport as set out in paragraphs 9 to 26 of her witness statement **(Hearing Commencing 26 February 2024 – Witness Bundle, Volume 1, Document 8, Page 160)**. I agree with what Ms Freeman says in these paragraphs of her statement.

11. I am asked whether the Scottish Government was responsible, at the time the QEUH and RHC was being procured for ensuring that the hospital was built in compliance with relevant guidance as regards its ventilation and water systems. The responsibility for building a hospital that provided a safe environment for the provision of patient care rested with NHSGCC.

12. I am asked a similar question in relation to building hospitals in a way that is compliant with HAI-SCRIBE procedures. The responsibility for constructing the hospital in accordance with relevant guidance and procedures rests with NHSGGC.

13. I understand that the Inquiry has already heard evidence and legal submissions in relation to the separate and distinct functions of Government and territorial health boards (see chapter 10 of the Inquiry's Interim Report). I am not sure that I can assist the Inquiry further than any other witness from whom it has already taken evidence in this regard without simply repeating their evidence.

A New Hospital for Glasgow

14. Between 1998 and 2002 NHSGGC undertook a review of its acute services provision. The findings of the "Acute Services Review" were approved by the then Cabinet Secretary for Health, Malcolm Chisolm. That review concluded, amongst other things, that a new Southern Hospital should be built. As I am sure the Inquiry is aware, the Scottish Nationalist Party, of whom I am a member

and elected representative, did not come into government until May 2007. Accordingly, I was not involved in the Acute Services Review or approval of its findings.

15. However, in due course, NHSGGC submitted an outline business case for a new Southern Hospital (later to be known as the QEUH) to the Scottish Government's Capital Investment Group ("CIG") for consideration and approval. That business case was considered by CIG on 14 March 2008 and considered by Cabinet for approval on 8 April 2008.

16. It would normally be the responsibility for the Cabinet Secretary for Health to present a paper to Cabinet (if appropriate) that related to the business case for the construction of major healthcare infrastructure project. The site for the new Southern General Hospital was within the constituency area of the then Cabinet Secretary for Health. In order to avoid any conflict of interest between the Cabinet Secretary for Health and Wellbeing's role as a government minister and an elected representative of her constituency, it was considered appropriate that the Minister for Public Health (as a Junior Minister working under the Cabinet Secretary) present the paper recommending approval of funding for the New Southern General Hospital at a meeting of Cabinet on 8 April 2008, which I duly did. A copy of the paper presented to Cabinet is produced at **Bundle 52, Volume 2, Document 1, Page 7.**

17. The paper I presented to Cabinet was prepared by colleagues in the Health Finance Directorate. I believe that Mike Baxter would have led on its production. I was not consulted on the proposed design or method of construction of the new Southern Hospital. I would not have expected to have been consulted on these matters. NHSGGC were responsible for the design and construction of the hospital. If it was thought appropriate by NHSGGC to consult with the Scottish Government then such consultation would have been between NHSGGC and civil servants, not elected representatives. I do not recall being briefed on the design or construction of the new Southern Hospital by civil servants prior to presenting the paper to Cabinet.

18. I am asked whether I was briefed on the financial aspects of the project. While the overall responsibility for managing the healthcare budget sits with the Scottish Parliament, the day-to-day management of that budget rests with Health Finance Directorate. The paper I presented to cabinet includes the financial implications (as then known) for approving the project. These financial implications were prepared by the Health Finance Directorate and I had no reason to doubt their accuracy.

19. I am asked about my consideration of the "funding model" to be used in respect of the new Southern Hospital. The paper I presented to cabinet discusses revenue (NPD) and capital funding as potential funding models for the project. As the paper sets out, a capital funding model was thought to present significantly better value for money. In particular, the paper provides:

> *In affordability terms however, given the impact of resource accounting and budgeting, the impact of the two routes is markedly different with the additional revenue costs of the public capital option £53.8m per annum against the impact of £76m per annum for the NPD route. In other words use of the NPD route would require an additional £22m of service savings to be achieved with no additional value for money benefit.*

20. Cabinet duly approved the recommendations set out in the paper when it met on 8 April 2008.

21. On 22 April 2008 I announced that the Scottish Government had approved funding for construction of the new Southern Hospital. I am asked what my expectations were in relation to that hospital. Put simply, I expected NHSGGC to deliver on the commitments set out in its outline business case. A copy of that business case is produced at **Bundle 17, Document 28, Page 1077** and was before cabinet on 8 April 2008. I had no reason to suspect that NHSGGC would fail to do so.

22. I had no involvement in the commissioning or validation of the QEUH and RHC.

The opening of the Queen Elizabeth University Hospital

23. I attended the official opening of the QEUH and RHC on 3 July 2015. I was impressed by what had been constructed. It appeared to me that NHSGGC had constructed a "world-leading" "state of the art" facility and I said so at the time. I had no reason to believe this was not the case.

24. I am asked if I still hold these views today. This Inquiry was established, by the Scottish Ministers, to amongst other things, establish how deficiencies in the design, construction and commissioning of the QEUH impacted on patients and families. I do not wish to usurp the function of the Inquiry in this regard. Suffice to observe, however, that the Scottish Government has spent significant sums remedying defects in the design and construction of the hospital and there is evidence in the form of the Independent Case Note Review that links the built environment at the QEUH with patient infection. Against that background, and while the Scottish Government is assured that healthcare is currently delivered in a safe environment at the QEUH and RHC, it seems as though there is a strong possibility that the facilities delivered by NHSGGC in 2015 were not the "world leading" "state of the art" facilities I thought they were.

25. I am asked about when I became aware of concerns related to the built environment at the QEUH. I am also asked about when I was first made aware of concerns being raised by microbiologists at NHSGGC about incidences of infections related to the ventilation and water systems at QEUH.

26. As I understand the Inquiry is aware, health boards are required to report certain infections to Health Protection Scotland ("HPS") in accordance with the National Infection Prevention and Control Manual. Upon receipt of a report from a health board HPS may, depending on the nature of the report, update the Scottish Government. Such updates/reports from HPS are received by the Chief Nursing Officer Directorate. I understand that the first report received by the Scottish Government relevant to the questions posed by the Inquiry was received in March 2017 and concerned the presence of Aspergillus on Ward

2A at the RHC. A timeline (prepared in response to s21 Notices dated 3 and 17 May 2023) that narrates a record, at a high level, of infections (and other relevant incidents) reported to the Scottish Ministers during the time period under investigation by the Inquiry is produced at **Bundle 52, Volume 1, Document 37, Page 609.** The Inquiry should note that I demitted office as Cabinet Secretary for Health and Sport in June 2018.

27. I am asked whether, during the period I held the offices of Cabinet Secretary for Health, Wellbeing and Sport and then Cabinet Secretary for Health and Sport from April 2014 to June 2018, I consider that NHSGGC kept the Scottish Government fully informed of issues relating to the adequacy of the ventilation system of the QEUH/RHC and the risk of water contamination in the domestic water system of the QEUH/RHC. The responsibility for the provision of frontline healthcare, including managing the estate within which that healthcare is provided, rests with NHSGGC as health board. Communication between the Scottish Government and NHSGGC related to discharge of NHSGGC's responsibility will, in the vast majority of cases, take place between NHSGGC's employees and members of the Scottish Government Health and Social Care Directorates ("SGHSCD"). As Cabinet Secretary, I was regularly briefed by relevant leads within SGHSD on a vast range of matters. I cannot recall being briefed on the adequacy, or lack thereof, of information received from NHSGGC relating to the ventilation and water systems at QEUH/RHC. Fiona McQueen, as former Chief Nursing Officer, and head of the Chief Nursing Officer's Directorate, may be able to assist the Inquiry as regards any impressions she formed concerning the information provided to her directorate by NHSGGC, noting that the Chief Nursing Officer's Directorate is the principal recipient of data from health boards concerning patient infection.

28. I have been asked about a meeting I attended with NHSGGC and HPS on 21 March 2018 as referenced in internal Scottish Government email correspondence of the same date **(Bundle 52, Volume 2, Document 2, Page 29)**. Unfortunately, I do not have notes of this meeting and cannot recollect what was discussed or who attended, accordingly, I have sought to rely on contemporaneous material that references the meeting to help answer the

Inquiry's question. I note that in a briefing prepared for the First Minister in advance of the meeting it is recorded that Professor Jacqui Reilly, Lead Consultant at HPS, Annette Rankin, Nurse Consultant, Infection Control, Built Environment and Decontamination Programme, HPS, and Dr Teresa Inkster, Lead Infection Control Doctor NHSGGC were due to attend this meeting and that the purpose of the meeting was to discuss incidence of infection related to the water contamination on Ward 2A QEUH. The purpose of the meeting would have been to obtain an update from those who attended the meeting as to the current situation in relation to Ward 2A as well as seeking assurance that appropriate steps were being taken to address the concerns being reported to Government.

29. I was asked a Topical Question by Anas Sarwar MSP during a meeting of the Scottish Parliament on 20 March 2018 concerning contamination of water at RHC. A copy of the relevant report of Parliament is produced at **Bundle 52, Volume 4, Document 26, Page 155.** Having answered Mr Sarwar's question, I was asked a supplementary question by Ms Annie Wells MSP (column 11 of the Parliamentary Report). In response to Ms Wells' question I stated, amongst other things, that "*…the hospitals [QEUH and RHC] are state of the art facilities.*" I am asked whether, at the time I made that statement in Parliament, I was aware that in December 2009 a decision had been made by NHSGGC to build the single rooms of the QEUH/RHC with a ventilation system that supplied air at half the rate than that called for by Scottish Government Guidance. I understand the Inquiry's question relates to the Scottish Health Technical Memorandum 03-01. As a minor point of detail, this is guidance issued by NHS NSS not the Scottish Government. Nonetheless, in answer to the Inquiry's question, I cannot recall being made aware of NHSGGC's decision of December 2009 prior to addressing Parliament in March 2018. I have asked my officials to check relevant briefings to confirm my recollection. I understand NHSGGC's decision is not mentioned in those briefings.

Declaration

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

Appendix A

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

A43255563 – Bundle 1 – Incident Management Team (IMT) Minutes

A35289380 – Bundle 48 – Governance PPP

A48892261 – Bundle 52, Volume 2 – Miscellaneous Documents

A35289393 – Bundle 52, Volume 2 – Miscellaneous Documents

A46622450 - Hearing Commencing 26 February 2024 – Witness Bundle, Volume 1

Appendix B

The witness provided or referred to the following documents when they completed their questionnaire statement.

A35289377 – Bundle 17 – Procurement History and Building Contract PPP

A53109064 - Bundle 52, Volume 1 – Miscellaneous Documents

A35289393 – Bundle 52, Volume 2 – Miscellaneous Documents

A48892261 - Bundle 52, Volume 2 – Miscellaneous Documents

A53858279 – Bundle 52, Volume 4 – Miscellaneous Documents

Scottish Hospitals Inquiry

Witness Statement of

Fiona McQueen

Introduction

1. My name is Fiona McQueen. I am now semi-retired. I was formerly the Chief Nursing Officer ("CNO") for Scotland.

2. This statement addresses:

2.1 My professional qualifications and background;

2.2 My role as CNO and the CNO Directorate as part of the Scottish Government;

2.3 The Scottish Government's HAI and AMR Policy Unit, HAI Reporting and the National Support Framework;

2.4 My Involvement with the Queen Elizabeth University Hospital ("QEUH") and Royal Hospital for Children ("RHC") during its procurement, design, construction and commissioning;

2.5 Interactions with the QEUH Infection Prevention and Control ("IPC") team in 2015;

2.6 A water incident and Cryptococcus at QEUH and RHC in 2018;

2.7 Commonly Recognised Information Pictures;

2.8 The escalation of NHS Greater Glasgow and Clyde ("NHSGGC") to level 4 of the NHS Board Performance Escalation Framework;

2.9 The NHSGGC QEUH Oversight Board ("the Oversight Board");

2.10 The Independent Case Note Review; and

2.11 My engagement with Drs Inkster, Peters and Redding.

Professional Qualifications and Background

3. I am a registered nurse with a Diploma in Management Studies, a Masters Degree in Business Administration and a Degree in Nursing Studies.

4. I am semi-retired. A copy of my CV is produced as an appendix to this witness statement (Appendix C).

5. Between November 2014 and April 2021, I was the CNO for Scotland.

6. As I explain later in this statement, between 27 November 2019 and March 2021 I was Chair of the Oversight Board.

My Role as CNO and the CNO Directorate within the Scottish Government

7. As CNO I was responsible for overseeing the work of the Chief Nursing Officer Directorate; a Scottish Government Healthcare Directorate responsible for achieving the best health and care outcomes for the people of Scotland by working on patient, public and health professions policy, and supporting Ministers and the NHS in delivering a safe, effective and person-centred health and social care system.

8. The CNO Directorate is one of a number of Scottish Government Health and Social Care Directorates. Each Health and Social Care Directorate has responsibility for a different function relative to NHS Scotland's delivery of health and social care in Scotland. The number of directorates changes from time to time depending on the requirements of Government. The current list of directorates is:

- Chief Medical Officer Directorate
- Chief Nursing Officer Directorate
- Chief Operating Officer, NHS Scotland, Directorate
- Health and Social Care Finance Directorate
- Health Workforce Directorate
- Mental Health Directorate
- Population Health Directorate
- Primary Care Directorate; and
- Social Care and National Care Service Development
- Children and Families Directorate

9. The CNO Directorate has a wide remit including responsibility for:

- student nurse and midwife intake;
- leading on nursing, midwifery, allied health professions and health-care science;
- modernising and improving NMAHP (Nursing, midwifery and allied health professionals) and HCS (healthcare support) services and standards of practice;
- leading on all aspects of healthcare-associated infection policy and antimicrobial resistance; and
- leading on health professionals and workforce regulation.

The CNO Directorate is responsible for providing Ministers with policy advice in relation to all of the aforementioned “policy” areas.

10. The Chief Executive of NHS Scotland and Director-General Health and Social Care has overall responsibility for the Scottish Government Health and Social Care Directorates, including the CNO Directorate.

11. At paragraphs 9 to 26 of Jeane Freeman's witness statement related to the Royal Hospital for Children and Young People **(Hearing Commencing 26 February 2024 - Witness statements - Volume 1, Document 8, Page 160)**, Ms Freeman sets out the duties of Ministers, the Scottish Government and Health Boards in relation to the delivery of healthcare in Scotland. While Ms Freeman's evidence is presented in the context of her former appointment as Cabinet Secretary, I agree that Ms Freeman's evidence accurately represents the responsibilities of the various bodies responsible for the delivery of healthcare in Scotland during my time as CNO.

12. I have been asked about my understanding of IPC issues at QEUH and RHC at the time I assumed my role as CNO. I became the CNO for Scotland in November 2014 and the hospital opened in 2015. As far as I can recall, I was not made aware of any IPC issues during the construction phases of the hospital when I took up my post and I had no awareness of any such issues from my previous employment with NHS Ayrshire and Arran.

The Scottish Government's HAI and AMR Policy Unit, HAI Reporting and the National Support Framework

13. The Scottish Government Healthcare Associated Infections and Antimicrobial Resistance Unit ("the HAI Unit") sits within the CNO Directorate. It is staffed by members of the CNO Directorate and reports to the CNO who, in turn, reports to the Director General of Health and Social Care. The HAI Unit is constituted by, principally, the Scottish Antimicrobial Resistance Healthcare Associated Infection ("SARHAI") Strategy Group which, as I explain below, is an evolution of the Scottish HAI Task Force ("the Task Force") and the Healthcare Associated Infections Policy and Strategy Team.

14. The HAI Unit is responsible for the development of strategies, policies, frameworks and action plans targeted at HAI in Scotland. The HAI Unit also receives reports of relevant HAI from the Antimicrobial Resistance and Healthcare Associated Infection Scotland ("ARHAI"), a division of NHS NSS, and briefs Ministers in relation thereto. Examples of the "policy" work of the HAI Unit includes:

a. Provision of funding to national organisations to support infection surveillance, education, guidance development, incident support and reporting mechanisms in relation to healthcare associated infection, safety in the healthcare-built environment and infection prevention and control.

b. Publication of Better Health, Better Care Action Plan in 2007, which included Health, Efficiency, Access and Treatment (HEAT) targets for reduction of key pathogens. To reduce all staphylococcus aureus bacteraemia (including MRSA) by 30 per cent by 2010.

c. Provided funding for hand hygiene coordinator with the aim to achieve a sustainable change in culture in relation to hand hygiene practice between 2005 and 2008.

d. Publication of the Healthcare Quality Strategy for NHS Scotland (2010), which includes as a priority, focus on a safe and clean environment in which to deliver care.

e. Supported the development and implementation of reduction targets for key pathogens.

f. Supported the development and implementation of the National Infection Prevention and Control Manual and the Care Home National Infection Prevention and Control Manual. These manuals include guidance on how to manage HAI

incidents and when Scottish Government should be informed.

g. The development and updating of Healthcare Improvement Scotland Infection Prevention and Control Standards (most recent version published in 2022).

h. Requested and supported the development of the Scottish Urinary Tract Infection Network (SUTIN) to reduce the risk of urinary tract infection (UTI). SUTIN developed the national catheter passport in 2014. The national catheter passport continues to be a key tool in reducing catheter associated infection.

i. Supported the establishment of a Scottish Surveillance Programme for HAI in Intensive Care Units in 2015.

15. In December 2001 concerns were raised with the then Scottish Executive following an outbreak of Salmonella at the Victoria Infirmary Hospital in Glasgow. In January 2002 the then Minister for Health and Community Care, Malcolm Chisolm, publicly committed to reducing the burden of disease and avoidable illness caused by HAI. Mr Chisolm requested that a review was undertaken into the Salmonella outbreak noted above to highlight any lessons that could be learned for the NHS in Scotland as a whole. A review group, chaired by Dr Brian Watt (a consultant microbiologist) was established. A copy of the "Watt Group's" report is produced at **Bundle 52 Volume 1, Document 32, page 352**. The Watt Group made a number of recommendations for health boards and the Scottish Executive.

16. Mr Chisholm also convened a convention of relevant HAI experts on 28 June 2002. The intention of the convention was to use the event as the basis for developing an action plan covering measures to tackle HAI in Scotland.

17. In November 2002 the Scottish Executive published the first "preventing infections acquired while receiving health care" action plan. The plan

accompanied HDL (2002) 82, a copy of this letter is produced at **Bundle 52, Volume 1, Document 33, page 397.** The action plan included a number of matters to be implemented by health boards and the Scottish Executive, including the formation of a HAI "Task Force" to be led by the Chief Medical Officer (CMO). The remit of the task force was to:

- *co-ordinate the development and implementation of the HAI Action Plan;*
- *review progress across Scotland;*
- *monitor the levels of HAI and assess the impact of control measures;*
- *take forward amendments to the action plan and its component initiatives; and*
- *report on progress to the Minister of Health and Community Care and annually through the CMO's report, to the public at large.*

18. At the same time as the Task Force was established, NHS NSS was commissioned to establish national surveillance of HAI and a national IPC programme. The Task Force, the Chief Medical Officer and the CNO had oversight of this commission.

19. The HAI "Task Force" led on the significant increase in work undertaken by the Scottish Government and Executive from 2002 until 2015. In June 2015 the Task Force was replaced by the Scottish Antimicrobial Resistance Healthcare Associated Infection ("SARHAI") Strategy Group. This group is chaired by the CNO. The purpose of the SARHAI Strategy Group is to provide strategic leadership across both AMR and HAI policy agendas. This work complements the work undertaken by HAI Policy Strategy team to reduce avoidable infections and support the NHS in Scotland to provide quality and safe care to patients in Scotland.

20. The Scottish Government, and previously the Scottish Executive, has had formal procedures requiring health boards and others to report potential HAI to a central

authority since 2002. The purpose of this reporting is to allow the Government and Ministers to be advised, in a timely manner, of any potential incidence of HAI that may require intervention by, for example, arranging for a health board to be provided with operational advice, support or expertise. It also informs the CNO as to whether it is appropriate to implement the National Support Framework, discussed at paras 24-29 below. Reporting does not transfer responsibility for dealing with a potential HAI from a health board to the Government. To properly advise Ministers, those in the Unit require expert input from professional advisors. In this regard, the principal professional adviser is ARHAI.

21. The current procedure for reporting HAI is set out in the National Infection Prevention and Control Manual for Scotland ("NIPCM"). Health Boards are required to report certain potential HAI to ARHAI. In turn, ARHAI will review the reports they receive and, where appropriate, make onward reports to the government. As well as making reports in respect of specific incidents of infection, ARHAI provides the Unit with a weekly report containing a summary of incidents/outbreaks from the key respiratory pathogens, across NHS Scotland.

22. Incidence of potential HAI are assessed by health boards using the Healthcare Infection Incident Assessment Tool ("HIIAT") and graded as either green, amber or red. The grading correlates with the seriousness of the risk to patient safety, red being the most serious and green the least. The grading dictates the frequency with which the health board is required to report to ARHAI (ranging from daily to weekly). ARHAI reviews the reports it receives and provides the HAI Unit with the details of the report. ARHAI advises the Scottish Government of amber and red reports and, in some cases where ARHAI considers appropriate, green reports. It is important that Health Boards follow these reporting processes. Failure to do so inhibits ARHAI's and the Scottish Government/Ministers' ability to monitor, and thus be assured, that a Health Board is responding to an incidence of potential HAI in an appropriate manner. If it became known to either ARHAI or

the HAI Unit that the processes were not being followed then either Health Protection Scotland and/or the CNO Directorate would intervene and work with the Board to ensure that the processes were being followed in an appropriate manner. An example of such an intervention is discussed at paragraph 35 of this statement.

23. Officials within the HAI Unit use their own professional experience and judgement, informed by expert advice where appropriate, as to when it is necessary to brief a Minister following a report from ARHAI. A range of factors are considered when the decision to brief is made including: the nature and sensitivity of the incident, the type of pathogen, the effect on patients, their families/ visitors, healthcare staff and/ or services, any risk of further transmission and other contextual factors the HAI Unit may be aware of in relation to the particular Health Board. Decisions as to whether or not the Minister is briefed are taken on an ad hoc basis. As a minimum, relevant members of the HAI Unit meet weekly to discuss whether a briefing is required. Although this post dates my time in office, I understand that since Spring 2023, the HAI Unit has invited IPC professional advisers to attend this meeting to help inform their decisions.

24. HAI reports and information received from ARHAI may cause the CNO to implement the National Support Framework (previously known as the CNO Algorithm). A copy of the National Support Framework is produced at **Bundle 27, Volume 4, Document 15, Page 161**. As is explained in this document:

The National Support Framework ('the Framework') is a structure that sets out the roles and responsibilities of organisations in the event that a healthcare infection outbreak/incident, data exceedance or Healthcare Environment Inspectorate (HEI) report deems additional support to a NHS Board is required. This framework supersedes CNO algorithm (2015).

25. The predecessor to the National Support Framework, the CNO Algorithm, was first implemented in 2010.

26. The National Support Framework contains the criteria for invocation as well as the action that requires to be taken by the health board, Health Protection Scotland and the Scottish Government.

27. There is no set criteria/ expected performance set by the framework. In the event of the framework being invoked, Health Boards are supported by Health Protection Scotland/ARHAI to develop an action plan relevant to the Board and their situation.

28. ARHAI engage regularly with the Board as they work through the action plan and the Scottish Government is provided with performance updates. A decision on whether a Board remains on the framework or whether the framework is stood down is based on the health board's performance against the action plan. The CNO is guided in this decision by the recommendations of Health Protection Scotland/ARHAI.

29. During my time as CNO, performance of a health board under the National Support Framework was overseen by the HAI Unit who would, in turn, brief the Cabinet Secretary and me. The briefing would be based on the HAI Unit's assessment of the situation under review. That briefing would be informed by the advice provided to the HAI Unit by Health Protection Scotland in relation to whether or not they considered that appropriate action was being taken by the health board. I would then take a view as to whether further intervention was required.

30. I have been asked about paragraph 139 of Dr Peters' witness statement where she says, among other things, "*Prof Leanord was still part of our rota at that point. I remember handing over to him a very high prevalence of infection amongst*

paediatric haematology/oncology patients. He was definitely aware of the infections we were seeing and he sat as advisor to Fiona McQueen at the HAI policy unit so my assumption was that he would be keeping an eye and communicating with the policy unit, especially as we are the only BMT unit for paediatrics in Scotland." I am asked if I received any data related to the "high prevalence of infection" from Professor Leonard as referenced by Dr Peters.

31. At the relevant time Professor Leonard acted as a professional adviser to the HAI Unit in performance of its functions in relation to the whole of Scotland, rather than issues related to NHSGGC. I do not recall Professor Leonard providing me with data in relation to the matters referenced by Dr Peters or in relation to any other potential incidence of HAI. It would not be appropriate for, or expected of, an individual clinician to provide the CNO with data in this way. Instead, the processes described earlier in this statement should be followed. In particular, reports should be made to ARHAI not the Scottish Government if such reporting was appropriate.

My Involvement with QEUH and RHC during Procurement, Design, Construction and Commissioning

32. The Inquiry has asked that I provide the detail of my involvement, if any, in relation to the following matters concerning the QEUH [and RHC]:-

- Construction/design;
- Commissioning and validation;
- Finance;
- Site selection;
- Value for money in respect of the build;
- Derogations; and

- Procurement model

33. I confirm that I did not have any involvement with these matters. The procurement, design, construction and commissioning of the hospital occurred (for the most part) before I took office in November 2014. In any event, the delivery of major healthcare facilities is, in so far as the Scottish Government is involved, the principal responsibility of the Scottish Health Finance Directorate not the CNO Directorate. Mike Baxter may be better placed to address the Inquiry's questions in relation to these matters.

Interactions with QEUH IPC Team in 2015

34. I have been referred to an SBAR report prepared by Health Protection Scotland in relation to the neonatal intensive care unit ("NICU") at RHC **(Bundle 3, Document 3, Page 15.)** The report is dated November 2015 and relates to the recorded incidence of a bacteria called Serratia Marcescens. Serratia Marcescens is a type of gram negative bacteria found in soil, plants, water and animals. It can cause serious infections in immunocompromised patients. The SBAR report was provided following the Scottish Government's invocation of the National Support Framework. The National Support Framework is discussed earlier in this statement.

35. The SBAR report records the incidence of Serratia Marcescens infections and colonisations, the potential source of those infections and colonisations and the IPC measures taken by NHSGGC in relation thereto. The SBAR report concludes with Health Protection Scotland's IPC recommendations and notes the ongoing support that will be provided to NHSGGC.

36. I have been asked by the Inquiry about my impressions of the NHSGGC IPC team in 2015. In particular, was I aware of tensions, a lack of clarity related to roles and decision making, relationship difficulties between team members, issues with record keeping, a culture of bullying and the attitude of senior management at NHSGGC to IPC issues. I was not aware of such tensions etc. in 2015. I recall, however, that my directorate asked that I convene a meeting with NHSGGC IPC leads to discuss reporting of HAI to Health Protection Scotland. At that time, Health Protection Scotland and the HAI Unit had a concern that NHSGGC had not been adhering to the reporting arrangements for HAI as outlined in NIPCM. At the meeting, we clarified how incidents and outbreaks should be reported. Dr Jennifer Armstrong attended the meeting supported by her colleagues who at that time acted as the IPC leads for NHSGGC. I cannot recollect the names of everyone who attended the meeting due to the passage of time. However, the main issue appeared to be that NHSGGC had not been reporting incidents that they believed to have been under control. At no time, however, was there any suggestion that NHSGGC were deliberately withholding information.

37. Failure to follow the HAI reporting procedures set out in NIPCM was highly unusual during my time as CNO. The only time I required to address such a failure was in relation to NHSGGC and the incident described in the above paragraph. Occasionally, NHSGGC reported an infection as green that should have been recorded as amber. This was addressed by Health Protection Scotland without formal intervention from me or the HAI Unit.

A "Water Incident" and Cryptococcus at QEUH and RHC in 2018

38. In 2018 NHSGGC were required to report potential healthcare associated infections to ARHAI who would, in turn, make colleagues in the CNO Directorate aware (all in accordance with NIPCM). Identifying the source of a potential HAI

can be complex. I have been asked by the Inquiry when I first became aware that there were concerns about a potential link between the water system at the QEUH and RHC and a number of infections in patients in the Schiehallion Unit (wards 2A and 2B).

39. A table is provided with this statement that includes a timeline (prepared in response to s21 Notices dated 3 and 17 May 2023) that narrates a record, at a high level, of infections (and other relevant incidents) reported to the Scottish Ministers during the time period under investigation by the Inquiry **(Bundle 52, Volume 1, Document 37, Page 609.)** I have not duplicated the contents of the timeline in this statement but draw out key dates in the hope that is of assistance to the Inquiry

40. On 1 March 2018 Health Protection Scotland notified the Scottish Government in relation to the presence of Cupriavidus in water samples taken from Ward 2A, QEUH. At this time, further support was not requested of Health Protection Scotland by NHSGGC. Health Protection Scotland provided further updates in relation to this incident on 7, 12, 13 and 16 March 2018. On 20 March 2018, I invoked the National Support Framework. The National Support Framework is discussed at paras 24-29 above.

41. On 18 May 2018 a report was received from Health Protection Scotland regarding stenotrophomonas blood stream infections in Wards 2A/2B. At that time, I was advised that there was an understanding amongst some at NHSGGC that the source of certain gram-negative infections in patients in the Schiehallion Unit was the water systems in the hospital. That understanding was not, however, universally accepted. Nonetheless, because “water” was one hypothesis for the source of infection, control measures were put in place by NHSGGC. It is important to note that the fact that water was considered to be a source of infection does not necessarily mean that the water system, as constructed and commissioned, was itself defective. Water contamination can

occur in healthcare settings for a variety of different reasons such as inadequate treatment, damaged pipes (albeit usually connected with older buildings), improper storage, microbial growth or disruption of the water supply (amongst other reasons).

42. In December 2018 I received a report from Health Protection Scotland entitled *Summary of Incident and Findings of the NHS Greater Glasgow and Clyde: Queen Elizabeth University Hospital/Royal Hospital for Children water contamination incident and recommendations for NHSScotland* **(Bundle 7, Document 2, Page 32.)** The report indicates, amongst other things, that there may have been contamination in the water supply in QEUH since commissioning. The report makes a number of recommendations to support NHSGCC (as well as health boards and Health Protection Scotland generally).

43. I am asked when I became aware of water risk assessment reports prepared by DMA Canyon Ltd for NHSGGC. I cannot recall the exact date I was first made aware of these reports but believe I was made aware of their existence in Autumn of 2018. By that point, and as I set out above, NHSGGC were already working on the hypothesis that water contamination may have been the source of patient infection at the QEUH and RHC and were taking steps to mitigate the risk of patient harm as a consequence, with the support of Health Facilities Scotland and Health Protection Scotland. Health Facilities Scotland and Health Protection Scotland kept the HAI Policy Unit updated in relation to NHSGGC's response to the potential that the water systems at the QEUH and RHC were the source of patient infection.

44. I am asked about my awareness of Cryptococcus infections at the QEUH in 2018. Health Protection Scotland advised the Scottish Government of the presence of Cryptococcus neoformans in wards 6A/4C (Haematology units) at the QEUH on 21 December 2018. Health Protection Scotland advised that a patient had died on [redacted] 2018 and another patient was affected in

connection thereto. I understood that NHSGGC were responding to the situation with the assistance of Health Protection Scotland. A further update was received from Health Protection Scotland on 21 January 2019.

45. I am asked whether I had any involvement in the work of the cryptococcus sub-group established by NHSGGC. I had no involvement with this group. Likewise, I had no involvement in statements made to the media in relation to Cryptococcus by NHSGGC.

46. I have been asked about previous evidence I provided to this Inquiry in respect of the Royal Hospital for Children and Young People ("RHCYP") and the Department of Clinical Neurosciences ("DCN") in Edinburgh. In particular, I have been asked about lessons learned in respect of the QEUH that were applied in respect of my involvement with the RHCYP/DCN and what those lessons were. My previous evidence is noted at pages 196-200 of the transcript of my evidence and relates, principally, to ventilation systems. More generally, however, the evidence relates to the need to provide healthcare services, particularly to vulnerable patient cohorts, in a safe environment and that involved the provision of appropriate services in that environment, including water and ventilation (amongst others). We had learned from our experience at QEUH and RHC about the dangers that may arise from failure to ensure a safe patient care environment and that simply because the provision was new that was not an assurance that all systems were of an appropriate standard or commissioned in an appropriate way. I recall in particular, stressing to NHS Lothian that the water systems at RHCYP/DCN required to be commissioned in a safe manner before the hospital could be opened (albeit there was no suggestion that NHS Lothian would have failed to commission the water systems at RHCYP/DCN in an appropriate manner). This vigilance was a direct lesson learned from my experience at QEUH and RHC.

Commonly Recognised Information Picture ("CRIP")

47. A CRIP is a process by which information is shared in a concise way to raise awareness in relation to a specific matter (or matters). In the NHS in Scotland, CRIPs are used by Scottish Government Directorates and/or units within those Directorates to share information in relation to important matters that occur across NHS Scotland. This allows for all relevant parties within government to maintain a level of oversight in relation to, for example, matters of concern.

48. In relation to the QEUH and RHC, the CRIP process was used to share information, amongst SG colleagues, about suspected HAI. The process was initiated at the request of the Director General and supported by those in the resilience room. The Scottish Government Resilience Room is a dedicated facility with the Government that coordinates responses to urgent matters involving the Government. It serves as a central hub for decision making and information sharing and is used as an additional resource by whatever policy area requires its assistance. The information contained in a CRIP in relation to HAI is informed by what Health Protection Scotland report to the HAI Policy Unit.

49. The use of the CRIP process was not unique to events that happened at the QEUH. It is a commonly used information sharing tool, used across the Scottish Government.

The Escalation of NHSGGC to Level 4 of NHS Board Performance Escalation Framework

50. I have been asked about the function and purpose of the NHS Board Performance Escalation Framework ("the Framework").

51. I previously provided the Inquiry with a witness statement concerning the RHCYP and DCN in Edinburgh **(Hearing Commencing 26 February 2024 – Witness Statements – Volume 1, Document 6, Page 129)**. As the Inquiry is aware, NHS Lothian ("NHSL") were escalated to levels 3 and 4 of the Framework in July and September 2019 respectively. As a consequence of NHSL's escalation to level 3 of the Framework an oversight board was put in place to oversee delivery of the RHCYP/DCN project. At paragraphs 8 and 9 of my earlier statement I explain the function and purpose of the Framework. In that earlier statement I refer to the Framework as the Scottish Government's NHS Scotland: support and intervention framework. That is simply the current name for what was previously known as the NHS Board Performance Escalation Framework.

52. I have also considered paragraphs 81 and 82 of Malcolm Wright's statement dated 18 December 2023 **(Hearing Commencing 26 February 2024 – Witness Statements – Volume 1, Document 11, Page 278)**, where he explains the purpose and function of the Framework. I agree with Mr Wright's comments and have nothing to add to my earlier evidence and that of Mr Wright.

53. The Inquiry has asked what the legal basis of the Framework is and the role of the CNO in relation thereto. The Scottish Ministers are responsible for NHS Scotland in accordance with the National Health Service (Scotland) Act 1978 ("the 1978 Act"). The Framework is a performance management tool used by the Ministers to meet their statutory duties under the 1978 Act.

54. For stages 1 and 2 of the Framework, the relevant policy lead within the Health and Social Care Directorates decides whether a health board should be escalated. It is not uncommon for health boards to be designated stage 2 for at least one part of its operation. For stages 3 and 4, the decision is taken by the Director General of Health and Social Care. For stage 5, the decision is made by the Cabinet Secretary for Health. Decisions in relation to the Framework are not made in isolation. Rather, the decision maker is guided by their advisers. In

relation to stages 3, 4 and 5, the decision maker's principal adviser is the Health and Social Care Management Board ("HSCMB"). Malcolm Wright explains the purpose and function of the HSCMB in paragraphs 15 and 16 of his statement dated 18 December 2023. I agree with Mr Wright's evidence in relation thereto.

55. Depending on the reason(s) for escalation, different Health and Social Care Directorates will play a more or less prominent role in advising the decision maker through the HSCMB. The CNO Directorate, with the CNO as its head, provides advice in relation to the "policy" areas discussed at paragraph 8 above.

56. NHSGGC were escalated to stage 2 of the Framework in 2018. The purpose of the escalation was to provide NHSGGC with support to improve its performance in the delivery of scheduled and unscheduled care. However, I cannot recall exactly what the reasons were for the escalation. Stage 2 is an informal support stage, where the Scottish Government provides support and guidance, but does not intervene with the board.

57. On 22 November 2019 Malcolm Wright, the then Director General for Health and Social Care, escalated NHSGGC to level 4 of the Framework. A copy of Mr Wright's letter to the Chair and Chief Executive of NHSGGC is produced at **Bundle 52, Volume 1, Document 23, Page 310.** The letter explains:

In light of the on-going issues around the systems, processes and governance in relation to infection prevention, management and control at the QEUH and the RHC and the associated communication and public engagement issues, I have concluded that further action is necessary to support the Board to ensure appropriate governance is in place to increase public confidence in these matters and therefore that for this specific issue the Board will be escalated to Stage 4 of our performance framework.

58. Mr Wright's decision to escalate NHSGGC was informed by the HSCMB which met to discuss the potential for escalation on 22 November 2019. At that meeting the HSCMB considered a paper I prepared entitled "Consideration of Escalation", dated 21 November 2019. A copy of that paper is produced at **Bundle 52, Volume 1, Document 6, Page 34.** The paper sets out my concerns in relation to HAI and IPC at QEUH and my recommendation for escalation. I authored the paper as the concerns it contains fell within the "policy" areas of the CNO Directorate.

59. I am asked whether I had concerns about IPC at the QEUH and RHC prior to September 2019. Beyond those I have already referenced in this statement (reporting of infections – paragraph 35 – and invocation of the National Support Framework – paragraph 38, I did not).

60. I am asked whether I had concerns about NHSGGC's communication and engagement with patients and families before October 2019. In general, I was not aware of any systematic problems related to NHSGGC's communication and engagement with patients and families before October 2019. The responsibility for person centred policy (including patient communications by health boards) lay with another Scottish Government Director, Jason Leitch. I would only have been involved in patient correspondence concerning NHSGGC by providing the Cabinet Secretary with support when she was corresponding with members of the public who were unhappy with their care. This, by its very nature, means one only really deals with areas that are problematic. Accordingly, I couldn't reach any view from that experience as to how NHSGGC's communications were with patients generally. My sense had been that NHSGGC's clinicians and staff worked very hard to provide a high standard of care that included communication and engagement.

61. I am asked whether the decision to reopen Ward 6A in November 2019 was inconsistent with my recommendation to escalate NHSGGC. I do not think it was. Ward 6A was reopened following assurance provided by Health Protection Scotland that it was safe to do so. That was a single issue. The reasons why, in

respect of IPC and communication, I recommended escalation of NHSGGC were systemic, relating, in particular, to NHSGGC's reporting and handling of incidents of potential (and actual) HAI. Those reasons are set out in full in my paper discussed at paragraph 55 of this statement.

The Oversight Board

62. The paper considered by the Health and Social Care Management Board on 22 November 2019 included the following recommendation:

Based on the most recent discussion at the National Performance Oversight Board there is no evidence to suggest a systemic issue at NHSGGC which would require whole system escalation beyond stage 2. However given the concerns about the delivery of a safe and effective service for paediatric haemato/oncology in-patients, and the significant risks to public confidence in the delivery of the wider service, the recommendation is that NHSGGC is escalated to level 4 for IPC issues, and as such, external, expert support is sought (IPC, as well as communications and engagement) and an oversight board is established, chaired by the CNO.

63. This recommendation was accepted and an oversight board (chaired by the CNO) was established as a consequence of NHSGGC's escalation to level 4 of the Framework. This was communicated to NHSGGC in a letter from Mr Wright dated 22 November 2019.

64. The recommendation that the CNO Chair the Oversight Board was made following feedback from Mr Wright and Ms Freeman. The reasons for escalation fell within the "policy remit" of the CNO Directorate. Therefore, it was considered appropriate (by Mr Wright and Ms Freeman) that, as the head of that Directorate, with oversight of the HAI Unit, that the CNO should act as Chair of the Oversight

Board.

65. The purpose of an oversight board is to provide additional governance support to a health board. In relation to the QEUH, that additional governance support was targeted towards NHSGGC's systems, processes and governance in relation to IPC and associated issues relating to communications and public engagement.

66. In my role as Chair of the Oversight Board I reported to the Director General for Health and Social Care and, ultimately, to the then Cabinet Secretary for Health and Sport, Jeane Freeman.

67. The Oversight Board was provided with secretariat support by the Scottish Government. That support was led by Philip Raines who was part of the CNO Directorate.

68. The Oversight Board first met on 27 November 2019. A copy of the minute from that meeting is produced at **Bundle 49, Document 1, Page 4**. At that meeting, draft terms of reference were finalised and agreed. Those terms were subsequently approved by Malcolm Wright. A copy of the Oversight Board's terms of reference are produced at **Bundle 52, Volume 1, Document 4.1, Page 2.**

69. The purpose and role of the Oversight Board is set out in its terms of reference as follows:
To support NHS GGC in determining what steps are necessary to ensure the delivery of and increase public confidence in safe, accessible, high-quality, person-centred care at the QEUH and RHC, and to advise the Director General that such steps have been taken. In particular, the OB will seek to:

- *ensure appropriate governance is in place in relation to infection prevention, management and control;*
- *strengthen practice to mitigate avoidable harms, particularly with respect to*

infection prevention, management and control;

- *improve how families with children being cared for or monitored by the haemato-oncology service have received relevant information and been engaged with;*
- *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, including cases of infection;*
- *provide oversight on connected issues that emerge;*
- *consider the lessons learned that could be shared across NHS Scotland; and*
- *provide advice to the Director General about potential de-escalation of the NHS GGC Board from Stage 4*

70. The Inquiry has asked to what extent the Oversight Board was independent of NHSGGC and the Scottish Government. The purpose of the Oversight Board was to provide support to NHSGGC in accordance with NHSGGC's escalation to level 4 of the Framework. In order to deliver that support, the Oversight Board required to work collaboratively with NHSGGC. For example, the Oversight Board required support from NHSGGC to understand the issues the Oversight Board had been established to address and, likewise, NHSGGC required to implement the decisions made by the Oversight Board. In that sense, the two bodies were not truly independent of one another. However, the Oversight Board was not subject to the direction or control of NHSGGC and nor were the decisions I took, independently, as its Chair.

71. Although NHSGGC staff attended the Oversight Board meetings they were not members of the Oversight Board and attended for purposes of providing clarity and listening to learn. I had no particular engagement with the non-executive directors of NHSGGC other than with the Chair. For completeness, I note that NHSGGC's Employee Director and the Chair of the Area Clinical Forum attended meetings of the Oversight Board when they were available. I attended one

NHSGGC Board meeting to explain the process of escalation, attended another NHSGGC board meeting in support of the Cabinet Secretary and met with the clinicians who were members of the clinical governance committee. Otherwise, I did not engage with the board of NHSGCC as a whole in my role as Chair of the Oversight Board (or as CNO). I am asked whether I formed the view that NHSGGC adopted, in relation to the work of the Oversight Board a "nothing to see here" attitude, complying with its recommendations in a "begrudging" manner by paying "lip service" to its recommendations. I demitted office after publication of the Oversight Board's final report so cannot comment on NHSGGC's attitude or approach to the Oversight Board's recommendations. However, during my time as Oversight Board Chair, and as discussed further below, I can advise that NHSGGC complied with any requests made of it, albeit at times there were administrative delays or errors in doing so I can also confirm that when I engaged with NHSGGC's Chair and Chief Executive they were both clear that NHSGGC would work to implement the recommendations made by the Oversight Board. Both the Chair and Chief Executive saw doing so as a key objective to be met to achieve de-escalation on the Framework.

72. As Chair of the Oversight Board, I reported directly to the Director General of Health and Social Care. Further, as CNO I was a senior office bearer of the Scottish Government. Having regard to these factors, I don't think that it would be correct to characterise the Oversight Board as independent of the Scottish Government. However, nor would it be correct to view the Oversight Board and the Scottish Government as being one and of the same. The appropriate way to view the "independence" of the Oversight Board, in my opinion, is to set it in its proper context as additional governance support provided to NHSGGC in consequence of its escalation to level 4 of the Framework. NHSGGC had not been escalated to Level 5 of the Framework and, as such, retained primary responsibility for the delivery of healthcare at the QEUH and RHC, albeit, with very significant support and oversight from the Scottish Ministers.

73. The Oversight Board worked collaboratively with NHSGGC. I am asked whether, as Chair of the Oversight Board, I had the power to issue directions to NHSGGC. As can be seen from the minutes of the Oversight Board I made many requests of NHSGGC during my time as Chair. Those requests were, without exception, complied with. Accordingly, it was not necessary for me to consider whether I had the "power" to issue formal directions. The question as to whether or not I had the power to issue formal directions perhaps misunderstands the role of the Oversight Board. The Oversight Board was in place to support, not direct, NHSGGC. The responsibility for the provision of health care rests with NHSGGC and escalation to level 4 of the Framework did not alter that. However, the Inquiry may ask what I would have done had NHSGGC not done what I asked? Depending on the nature of the failure, I would have required to report that to the Director General of Health and Social Care. Consideration may then have been given to escalating NHSGGC further on the framework. As the Inquiry is aware, stage 5 of the Framework, which would be invoked only in the most serious of circumstances, results in the responsibility for the provision of healthcare being removed from a territorial health board and assumed by the Scottish Ministers.

74. I have been asked whether NHSGGC's Directors of Estates and IPCT reported to the Oversight Board. They did not.

75. An agenda was circulated in advance of each meeting of the Oversight Board. Thereafter, the matters on the agenda would be discussed by those attending the meetings. The agenda included matters to be addressed by the full Oversight Board as well as the progress being made by the Oversight Board's sub-groups. Progress was measured on an ongoing basis rather than having targets and outcomes that were date and time limited.

76. I am asked about the first meeting of the Oversight Board on 3 December 2019. A copy of the minute of that meeting is produced at **Bundle 49, Document 2, Page 8**. In particular, I am asked about the discussion of the "Sturrock Review" that

took place at the meeting. The Sturrock Review considered cultural issues related to allegations of bullying and harassment in NHS Highland. It was authored by John Sturrock (then QC, now KC) and the report was published on 9 May 2019. A copy of the report is produced at **Bundle 52, Volume 1, Document 34, Page 425**.

77. The Sturrock Review was raised by Dorothy McErlean, NHSGGC's employee director, during the course of a discussion relating to the Oversight Board's terms of reference. The minute of the meeting records:

DM referenced the recommendations from the Sturrock Review and noted this could be an opportunity to change ways of working at board level to enable the NHS to become more open and transparent, so it was essential the OB takes people with them.

78. Having refreshed my memory from the minute, I believe Ms McErlean's comment was said with a view to encouraging the Oversight Board to work in a way that was in accordance with the recommendations of the Sturrock review. Ms McErlean was encouraging the Oversight Board to work in an open and transparent way as a means of engaging all those at NHSGGC who would be impacted by the work of the Oversight Board. Working in this way was one of the key recommendations of the Sturrock Review. In any event, I considered that it was important for the Oversight Board to have regard to the recommendations of the Sturrock Review and, in particular, to the recommendations relevant to the link between poor organisational culture and detrimental impact on staff. Ultimately, this required the Oversight Board to foster good working relationships with all those with whom it interacted (both directly and indirectly). The Sturrock review contained important observations about culture. The lessons to be learned from the review were relevant to all health boards, including NHSGGC. Improving "culture" at NHSGGC formed part of the "organisational development" work undertaken by Jenny Copeland (discussed at paragraphs 102 and 105 of

this statement).

79. The Oversight Board did not meet between 19 February 2020 and 4 September 2020. By February 2020 Covid-19 had spread to mainland Europe with Covid-19 related deaths reported in, amongst other places, Italy and France. It was clear, therefore, that the NHS in Scotland would require to adapt to meet the demands of what would later be declared a pandemic. To a very significant extent, those responsible for the safe delivery of IPC across Scotland (a number of whom sat on, or attended, the Oversight Board) required to dedicate their time to the Covid-19 response. As the Inquiry will appreciate, the work required to respond to Covid-19 was for those professionals, and me as CNO, very demanding. As such, it was not possible for the Oversight Board to meet for a short period while adjustments were made to working practices.

80. The Oversight Board met on 19 February 2020. A minute of that meeting is produced at **Bundle 49, Document 8, Page 34**. A further meeting was scheduled for 5 March 2020 but did not take place. On 19 March 2020 meetings of the Oversight Board were suspended. An update was provided to the Cabinet Secretary detailing how the work of the Oversight Board would continue remotely. A copy of that update is produced at **Bundle 52, Volume 1, Document 35, Page 601.** The Peer Review was established and the findings were compiled into a report. A copy of that report is produced at **Bundle 52, Volume1, Document 7, Page 45.** On 13 May 2020 officials provided an update to the Cabinet Secretary on the progress of the Oversight Board being undertaken remotely. A copy of that update is produced at **Bundle 52, Volume 1, Document 8, Page 75**. On 4 September 2020 the Oversight Board held its first meeting since February 2020. A copy of the minute of that meeting is produced at **Bundle 52, Volume 1, Document 9, Page 90**.

81. I have been asked about my recollection of a meeting that is described at paragraph 268 of Professor Cuddihy's witness statement (**Hearing**

Commencing 20 September 2021 – Bundle 6 – Witness Statements for Week commencing 25 October 2021, Page 56). The meeting took place at Atlantic Quay, Glasgow on 23 October 2019 (prior to the establishment of the Oversight Board) and involved Professor Cuddihy, the then Cabinet Secretary Jeane Freeman and myself. At the meeting Professor Cuddihy explained his concerns and how they had impacted his family. In particular, Professor Cuddihy explained, amongst other things, the distress he and his family had experienced by what he considered to be a lack of open and honest communication by the corporate leg of NHSGGC. It was clear to me that Professor Cuddihy was raising his concerns with Ms Freeman and me not just on behalf of his own family but because he thought the difficulties he and his family faced, if not remedied, were potentially harmful to others. It appeared to me that Professor Cuddihy was genuinely motivated to effect change as a result. This meeting with Professor Cuddihy furthered my understanding of the issues faced by patients and families at QEUH and RHC and, in particular, helped shape the role Professor Craig White would play in improving communications at NHSGCC.

82. I am asked by the Inquiry what steps were taken by the Oversight Board to ensure that the water and ventilation systems of the QEUH were in compliance with relevant statutory regulation and other applicable recommendations, guidance and good practice. This task did not form part of the terms of reference of the Oversight Board. However, as Chair of the Oversight Board, I was assisted by the Oversight Board's Technical Issues Subgroup. The purpose and objectives and membership of the Technical Issues Subgroup are set out at pp 105-106 of the Final Report. It is explained that one of the functions of the subgroup is to:
Confirm that relevant environments at the QEUH and the RHC are and continue to be safe

83. The Technical Issues Subgroup, chaired by Alan Morrison, reported to the Oversight Board on the "mechanical" and other works that were being

undertaken by NHSGGC as part of its response to the incidences of infections with the QEUH and RHC (in so far as that work interacted with the Oversight Board). This allowed the Oversight Board to monitor these works and to ensure that appropriate progress was being made. In this regard, Alan Morrison's advice to the Oversight Board was informed by advice he received from Health Protection Scotland and Health Facilities Scotland.

84. I am asked to what extent I would accept that by December 2019 the Scottish Government and the Oversight Board knew that at that time (a) the question of whether the PPVL isolation rooms in the QEUH/RHC were suitable for immunocompromised patients remained a live issue, (b) that it remained unclear the extent to which the ventilation systems of the QEUH/RHC had been validated, (c) that the ventilation of the general wards of the QEUH/RHC did not provide 6 ACH as stated in SHTM 03-01, (d) no risk assessment had been carried out in respect of the air change rate for the general wards of the QEUH/RHC, (e) no HAI-Scribe had been completed for the construction of the QEUH/RHC and (f) the ventilation system Ward 4C did not meet the air change rate, pressure differentials and requirement for HEPA filtration set out for a 'Neutropenic Ward' in SHTM 03-01? I cannot recall, as Chair of the Oversight Board, being briefed on the technical questions set out in this question. Others who attended the Oversight Board, such as the members of the technical issues subgroup, may have had knowledge of these matters and that collective knowledge may have formed part of any assurance I was provided as regards the safety of the QEUH and RHC. The function of the Oversight Board was, primarily, to provide governance support in relation to the delivery of IPC at the QEUH and RHC. Good IPC process, practice and governance is one of, it not the most, important factors in delivering healthcare in a safe environment. It was not within the remit of the Oversight Board to undertake the type of investigations/technical review as is suggested in this question. In so far as the question relates to the Scottish Government's state of knowledge, I can only speak to my knowledge as CNO. In that regard, by 2019, I was aware of a number of concerns related to the

construction and maintenance of the hospital. The Final Report of the Oversight Board contains a very detailed timeline detailing “incidents” of infection, what was done to investigate those incidents and the measures taken to mitigate harmful consequences. The timeline describes the actions of the different organisations involved in responding to those incidents.

85. The final piece of work undertaken by the Oversight Board was the publication of a report addressing its terms of reference and making a number of recommendations. The QEUH Advice, Assurance and Review Group (“AARG”) was established to monitor NHSGCC’s compliance with the recommendations. The group was established after I had demitted office so I cannot assist the Inquiry in relation to any conclusions reached by the group in relation to NHSGGC’s compliance with the Oversight Board’s recommendations.

86. I am asked whether I consider the Oversight Board’s recommendations in relation to governance and communication sufficiently addressed the issues that caused the Oversight Board to be established. I am satisfied that, if fully implemented by NHSGGC, then the relevant recommendations would address the issues related to governance and communication that were known to me as the Chair of the Oversight Board at the time when they were made.

The Independent Case Note Review

87. The Independent Case Note Review “the Case Note Review” was commissioned by the then Cabinet Secretary for Health and Sport, Jeane Freeman. The purpose of the Case Note Review was to investigate how many children and young people with cancer, leukemia and other serious conditions were affected by infection caused by Gram-negative environmental bacteria at the QEUH and RHC between 2015 and 2019. In relation to those children found to have been affected, the Case Note Review was to determine, as far as is possible, whether

those incidences of infection were linked to the hospital environment. The Case Note Review was also tasked with characterising the impact of the infections on the care and outcome of the patients concerned. I understand that the principal driver for the Cabinet Secretary when commissioning the Case Note Review was to provide patients and families with a professional and independent view as to the cause of the infections they or their family member had experienced.

88. The panel of experts who were commissioned to undertake the Case Note Review was selected following discussions between the Chief Medical Officer and members of the HAI Unit. I was not directly involved in these discussions but supported the recommendations. Once established, the Case Note Review was supported in its work by a secretariat provided by the Scottish Government. That secretariat sat within the CNO Directorate. In that regard, my responsibility, as CNO was to oversee, at a general level, the work of the secretariate in so far as it supported the establishment of the Case Note Review and supported the expert panel as they undertook their work. Further, the Case Note Review's principal "sponsor", responsible for ensuring it delivered on its terms of reference, was Professor Marion Bain. Professor Bain reported to me as Chair of the Oversight Board in performance of this role and I ensured that she was provided with sufficient and appropriate support and resource to achieve her objectives.

89. I have been asked whether I accept the findings of the Case Note Review as contained within its Overview Report. I accept the findings of the Case Note Review as representing the opinions of the expert panel having regard to the methodology adopted by the panel. I accept that the findings reached by the Case Note Review deliver upon its terms of reference. I do not have concerns about the methodology adopted in the Case Note Review. That methodology was considered to be appropriate by the expert panel and I do not have a basis to conclude that their assessment in that regard, or any other, was inappropriate. Recognising that the panel, rather than me, are the experts within the field upon which they have reported.

90. I understand that NHSGGC were provided with a draft of the Overview Report for comment before it was finalised. I have not considered NHSGGC's response to the draft report so cannot assist the Inquiry in relation thereto.

91. I have been asked about whether the recommendations contained in the Overview Report have been implemented by NHSGGC. Any implementation of the recommendations would have taken place after I demitted office. As such, I cannot comment on whether NHSGGC has implemented the recommendations.

92. As the Inquiry is aware, the Case Note Review produced individual reports as well as the Overview Report. The individual reports were shared with the patients and families concerned. They were not shared with NHSGGC, the Scottish Government or me as the Chair of the Oversight Board. I have not had sight of any individual report; however, I understand the reports summarise the expert panel's findings in respect of individual patients and, in respect of patients who experienced more than one incidence of infection, each incidence.

93. I have been asked by the Inquiry to what extent I accept that the decision to ensure that individual reports were confidential to the patients and their families and were not made available to NHSGGC has now made it possible NHSGGC to reject the conclusion of the Case Notes Review and attempt to persuade the Inquiry, the patients and the families that there was no link between all but two of the infections in the Schiehallion patient cohort and the hospital environment?

94. The approach and methodology adopted by the Case Note Review expert panel is set out in the Overview Report. The data upon which the expert panel formed its views was provided by NHSGGC. Throughout the panel's work there was ongoing dialogue between the expert panel (and the team supporting them) and NHSGGC clinicians. Against that background, I am therefore unsure why failure to provide NHSGGC with individual case reports would permit NHSGGC to reject the report's findings. The conclusions reached, and the reasons, therefore, are set

out in the Overview Report. Any individual reports, I understand, simply contextualise those conclusions as regards individual patients and/or incidences of infection.

95. I have been asked whether NHSGGC' public statement, issued on 22 March 2021 in response to the Case Note Review and Oversight Board reports (**Bundle 25, Document 61, Page 1260**) was discussed with me or at the Oversight Board. The public statement would not have been discussed at the Oversight Board. The last meeting of the Oversight Board was 19 January 2021 and the report had not, at that stage, been finalised. I can confirm through copy correspondence that I have considered when preparing this statement that I was familiar with the GGC public statement prior to its publication, as was the Cabinet Secretary.

96. I am asked if, while I was Chair of the Oversight Board, I received any indication from NHSGGC that the NHSGGC Board corporately did not accept the principal conclusion of the CNR that 30% of the infection episodes they reviewed were probably related to the hospital environment. I did not.

97. I am asked, at the time of the reduction of NHSGGC from Level 4 to Level 2 of the Framework on 13 June 2022 what was my understanding of whether NHS GGC accepted the principal conclusion of the CNR that 30% of the infection episodes they reviewed were probably related to the hospital environment. I had demitted office by this point so cannot assist the Inquiry as regards NHSGGC's view of the CNR at this point.

98. I am asked when I first became aware that it is the current position of NHS GGC in its most recent submissions to the Inquiry that NHS GGC does not accept that anything contained in the CNR can properly justify any adverse inference about the safety of the water, drainage or ventilation systems at the QEUH. I cannot recall when I became aware of this position. It would have been after I had

demitted office and most likely as part of my engagement with this Inquiry.

My Engagement with Drs Inkster, Peters and Redding

99. The Inquiry has asked me a number of questions about my engagement with Drs Inkster, Peters and Redding and "whistleblowing" at NHSGGC. I have attempted to answer those questions as best I can in this section of my statement, noting that some of the questions relate to conversations for which there is no written record and which took place a number of years ago.

100. At the outset it is important for me to outline the context within which I engaged with Drs Inkster, Peters and Redding. It is important for me to engage authentically with the people I meet (particularly those who may be distressed). I adopt a personalised and conversational approach. Further, I had an existing relationship with Dr Peters, having worked with her previously. Consequently, the language I used in conversations with Drs Inkster, Peter and Redding may not have been as "formal" as some may have expected. However, that lack of formality is not, and should not be taken as, an indication that I did not treat what I was told by Drs Inkster, Peters and Redding seriously.

101. I respect and appreciate that the prior experiences of Drs Inkster, Peter and Redding, as articulated to the Inquiry, demonstrate that the matters upon which they have given evidence are associated with very significant personal impact on them.

102. I have not had any involvement with the NHSGGC whistleblowing policy so cannot assist the Inquiry in relation thereto. I note, however that the policy ought to conform, as a minimum, to the relevant NHS Scotland Partnership Information Network policy ("PIN"). PIN policies are national policies developed between NHS Scotland employers and trade unions and set out the minimum standards

which health boards must either meet or exceed.

103. I am asked about a meeting I had with Drs Peters and Inkster on 4 September 2019 **(Witness Bundle – Week Commencing 30 September 2024 – Volume 7 – Page 189, paras 556-557 and Page 298, paras 949-952; Witness Bundle – Week Commencing 9 September 2024 – Volume 4, Page 171, paragraph 223; Bundle 14, Volume 2, Document 171, Page 637**). I do not recollect every detail of this meeting. However, I recall at a high level, that Drs Inkster and Peters explained to me the concerns they had, as explained in Dr Inkster's statement at para 949. I took those concerns seriously and I am sorry that Dr Inkster did not think I did. As I discuss at paragraphs 50- 61 I recommended that NHSGGC was escalated to stage 4 of the Framework as I felt it required additional support in relation to IPC. What I was told by Drs Peter and Inkster informed my view of the recommendation I made to the HSCMB.

104. I am asked whether Dr Inkster raised concerns about a failure by NHSGGC to initiate a review of three Stenotrophomonas bacteraemia infection from 2017. I cannot, at this time, remember if this was something that Dr Inkster did or did not raise. Had she raised it, I would have passed the concern to my team within the CNO Directorate to action as appropriate.

105. I am asked whether I told Dr Inkster that Dr Armstrong was being mean to her. I cannot recollect using these words. However, I recall that Drs Inkster and Peters described their interactions with colleagues in NHSGGC. If they described an interaction that I believed was inappropriate, then I may well have indicated that one explanation was that Dr Armstrong's reported actions did not reflect kindness. Adopting the conversational style of communication discussed at para 100 above, I may have used the words in the way Dr Inkster recollects. Of course, while I listened and engaged with Drs Inkster and Peters, I was not able to form a view as to whether their concerns were reasonably held because I was not a party to the events and actions they described. That being the case, the

comments attributed to me by Dr Inkster should not be taken as my acceptance that Dr Armstrong was, as a matter of fact, being unkind to Dr Inkster (or otherwise acting inappropriately).

106. I am asked whether I told Dr Peters that the Scottish Government shared her concerns that the culture in the NHSGGC Board was toxic and, as a result, I was not surprised by what I was told. I was not authorised to communicate any such position to Dr Peters on behalf of the Scottish Government so I do not accept that I said that the Scottish Government believed the culture of the Board to be toxic. However, my meeting with Drs Inkster and Peters did not take place in isolation. I was aware from information provided by my team and Health Protection Scotland (as well as Drs Peter and Inkster themselves) that those delivering IPC at QEUH were facing internal challenges. I had concerns about this and it is likely that I shared these concerns about ways of working and culture. I may have indicated that the culture appeared to be toxic given how it had been described to me. IPC governance was one of the reasons for NHSGGC's escalation. Anything I said related to culture would have been from an IPC perspective rather than about the Board in general.

107. Following the meeting with Drs Inkster and Redding I sent information provided to me by the doctors to the Independent Review so that it could be considered in that context. I also used the information to formulate a view of what further action required to be taken in relation to NHSGGC. I began to formulate my thinking around requirements to improve IPC governance, culture, and openness and transparency, relying upon a range of sources of information, my own observations and experiences – including the valuable discussions with Drs Inkster and Peters. Ultimately, this resulted in my recommendation that NHSGGC should be escalated to level 4 of the Framework.

108. I am asked about a meeting involving Drs Peters and Redding, the then Cabinet Secretary, Jeane Freeman and myself that took place on 5 December 2019. By December 2019 I had a very good understanding of the issues impacting IPC at QEUH. Drs Peters and Redding explained their concerns in relation thereto but I cannot remember exactly what was said. The concerns raised by Drs Peters and Redding were not, however, "new to me" and I am not sure why the doctors thought they were. I would have been "actively listening" to what I was being told which would involve me asking questions to demonstrate that I was interested in what the doctors had to say or summarise what I had heard to affirm my understanding. It may be that this was misinterpreted by the doctors as demonstrating an apparent lack of awareness in relation to the matters being discussed.

109. I am asked whether, during this meeting, I said that I "*couldn't understand "why GGC had not just offered the families 50 grand which is a trip to Disneyland, rather than deny that there had been harm caused"* (**Witness Bundle – Week Commencing 9 September 2024 – Volume 4 – Page 174, Paragraph 236**). I do not recall using these words. I recall, however, discussing Dr Peters' concerns about the way patient complaints had been handled. I would have offered, from my own experience, examples of how patient complaints (and civil claims) might be resolved. In no way would I have sought to downplay the seriousness of the concerns conveyed by Dr Peters. I should also make clear, for completeness, that in responding to all of the concerns raised by Drs Peters, Redding and Inkster, my primary motivating factor was always patient safety.

110. I am asked what action was taken to address the concerns raised by Drs Peters and Redding. By this point, the work of the Oversight Board was underway. As discussed above, the concerns were not new to me and were already in the process of being addressed.

111. I am asked about a meeting with Drs Inkster and Peters referred to in para 951 of Dr Inkster's witness statement (**Witness Bundle – Week Commencing 30 September 2024 – Volume 7 – Page 289, para 951, 317 and 1025**). In particular, I am asked about the comment "*it depends on who you think the troublemakers are*" I am said to have made. I do not recall making this comment nor the context within which I am said to have made it. If I did use the words attributed to me then it is likely that I would have been trying to convey my view that behaviours and relationships at NHSGGC IPC needed to improve rather than focusing on whether anyone was making trouble for others. I should make clear that I did not consider that anyone involved in the delivery of IPC at QEUH was acting in a malevolent way. There were, however, strongly held differences of opinion in relation to a range of matters amongst those responsible for delivering IPC. These differences of opinion, appeared to me to be fueling relationship difficulties. I do not consider that Drs Inkster and Peters were troublemakers. At all times I accepted what they were saying in good faith and my actions to meet with, listen to and ensure that their views informed my decision-making and advice to Ministers reflected the importance of discussions with them.

112. I am asked if I accept Dr Inkster's criticism at paras 972 and 973 of her witness statement, that she felt she was being "*passed between different people and each time we had to…explain ourselves*" (**Witness Bundle – Week Commencing 30 September 2024 – Volume 7 – Page 304**). I understand why Dr Inkster might feel this way. However, it was important that those who were put in place to address the concerns related to IPC at QEUH (Professor Bain, Jenny Copeland and Professor Angela Wallace) met with Dr Inkster so they could obtain a first hand understanding of her concerns without the risk of messages being confused or lost if relayed by others. I do not accept that Dr Inkster explaining her concerns to more than one person meant there was a lack of action to address those concerns. As is clear from the minutes of the Oversight Board, very significant action was taken to address those concerns.

113. I am asked if I indicated to Drs Inkster and Peters that they would be part of the Oversight Board process. I cannot recall, standing the passage of time, whether I indicated to Drs Inkster and Peters that they would be part of the Oversight Board Process. It is more likely than not that I did. While Drs Inkster and Peters were not members of the Oversight Board they both made significant contributions to the work of the Oversight Board. The matters raised with me by Drs Inkster and Peters helped inform the Oversight Board's Terms of Reference. Likewise, prior to the establishment of the Oversight Board, the information provided to me helped inform my recommendation for escalation of NHSGGC. Their views and concerns (both historical and current) were shared with the Oversight Board by Professor Marion Bain (Director of IPC at NHSGGC) and Phil Raines. The doctors' views shaped both mine and Professor Bain's views that organisational development work should be initiated to improve workplace practice and behaviour amongst the NHSGGC IPC team. This led to the urgent appointment of Jenny Copeland. The doctors also provided their views on the accuracy of documentation produced by the Oversight Board, including the timeline produced as an appendix to the Final Report. Likewise, the doctors helped inform the work of the Case Note Review by meeting with Professor Stevens (whose work fed into the work of the Oversight Board).

114. The purpose of the Oversight Board, as I discuss at para 59, was to provide NHSGGC with governance support relevant to IPC. As Drs Inkster and Peters were part of the IPC/microbiology team at NHSGGC it would not have been appropriate for them to be members of the Oversight Board. Their roles were part of the "operational delivery" of the IPC. The Oversight Board was established to provide governance in relation to that delivery.

115. I also received regular updates from my Deputy CNO in respect of the organisational development work being undertaken by Jenny Copeland and was assured that Drs Inkster and Peter were engaged in this process which formed a part of the overall range of processes overseen by the Oversight Board and by me as its Chair.

116. I am asked whether the concerns raised by Drs Inkster, Peters and Redding were adequately addressed by NHSGGC and the Oversight Board. The Oversight Board made a number of recommendations which required to be implemented by NHSGGC to improve IPC at QEUH. I am satisfied that if implemented, those recommendations would have addressed the reasons why the Oversight Board was established and as I have noted above, the concerns of Drs Inkster, Peters and Redding contributed to that. The AARG monitored NHSGGC's implementation of the Oversight Board's recommendations. I had demitted office by the time the AARG was established so cannot comment on the extent to which it was satisfied that NHSGGC had complied with the Oversight Board's recommendations.

Declaration

117. I believe the statement attached is true and accurate and may now form part of the evidence before the Scottish Hospitals Inquiry and be published on the Inquiries website.

Name: Professor Fiona McQueen

The witness was provided access to the following Scottish Hospital Inquiry bundles/documents for reference when they completed their statement.

Appendix A

A47231435 - Hearing Commencing 26 February 2024 - Witness statements - Volume 1
A43273121 – Hearing Commencing 12 June 2023 – Bundle 3 – NHS National Services Scotland: SBAR Documentation
A48541141 - Bundle 14 – Further Communications - Volume 2
A49799834 - Bundle 27, Volume 4 – Miscellaneous Documents
A50091087 - Bundle 27 - Miscellaneous Documents - Volume 5
A43955371 – Hearing Commencing 12 June 2023 - Bundle 8 – Supplementary Documents
A49882926 - Witness Bundle - Week Commencing 9 September 2024 - Volume 4
A50152363 - Witness Bundle - Week commencing 30 September 2024 - Volume 7
A43299519 – Hearing Commencing 12 June 2023 - Bundle 4 – NHS Greater Glasgow and Clyde: SBAR Documentation
A49529391 - Bundle 14 – Further Communications - Volume 3
A53425732 – Bundle 49 – Documents related to the Oversight Board, Advice and Assurance Review Group (AARG) and Healthcare Improvement Scotland (HIS)
A35000166 - Hearing commencing 20 September 2021 - Bundle 6 - Witness statements for Week commencing 25 October 2021
A50611329 - Bundle 27 – Miscellaneous Documents – Volume 14
A43293438 – Hearing Commencing 12 June 2023 - Bundle 6 – Miscellaneous documents
A43940545 - Bundle 7 – Reports prepared by HPS, HFS and ARHAI

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

Appendix B

A53244263 – The Watt Group Report – Bundle 52, Volume 1

A53282851 –Ministerial Action Plan on Healthcare Associated Infection – HDL (2002) 82 – 22 November 2022 – Bundle 52, Volume 1

A53284845 – Report to the Cabinet Secretary for Health and Sport into Cultural Issues related to allegations of Bullying and Harassment in NHS Highland – April 2009 – Bundle 52, Volume 1

A53109064 – Scottish Ministers' Response to Part 1 and 3 of Annex A of S21s dated 02 May (as amended) and 17 May 2023 – Bundle 52, Volume 1

Appendix C

Fiona C McQueen CBE BA DMS MBA RGN

Career History

I have recently retired from my full time nursing career and am currently creating a portfolio career that gives me the opportunity to utilise my leadership skills across the wider public sector.

Chair Ayrshire College Board April 2022 –30 June 2025

The College Sector has a key role to play in improving lives of individuals as well as broader communities. I provide leadership for the Board of Ayrshire College to ensure, through effective governance and leadership there is an appropriate skills provision to support local, regional and national economic development and growth and local citizens have access to a skills-based education that will support them into employment and prosperity.

Vice Chair of Drug Deaths Taskforce January – July 2022 (fixed term).

The Minister for Drugs invited me to be Vice Chair of the taskforce. This was a challenging piece of work however working in partnership with the Chair the report was produced within the timescale required by the Minister (that had triggered the resignation of the previous Chair and Vice Chair of the Taskforce). In particular, I took a leadership role in ensuring the voice of people with Lived and

Living experience was heard and was woven into the report, by ***working collaboratively and collectively*** across sectors. I have also identified the opportunity to support people who use drugs into education/ skills-based training and subsequently into employment.

Scottish Police Authority Member April 2021- 31 January 2025

Scottish Police Authority – Interim Chair February 2025 – 7 April 2025

Chair from 7 April 2025 - Present

Chief Nursing Officer Scottish Government (November 2014-April 2021)

Provided advice to Ministers on Nursing & Midwifery, Hospital Acquired Infections and latterly on matters related to the COVID pandemic. ***Through my strategic leadership***, I created a framework for widening access to nursing by opening up a number of routes, including access via Scottish Colleges which contributes to stabilising the workforce as well as improving opportunities for social care staff and reducing inequalities; created a ***strategic*** and systematic approach to new roles for nurses and midwives improving performance of the NHS and maintaining service delivery by providing an appropriately educated and trained workforce.

Executive Nurse Director (NHS Ayrshire & Arran 2002 – November 2014).

In this role I provided ***strategic leadership*** to improve patient care and reduce mortality and morbidity by:

- Providing clinical leadership to ensure safe, effective, person-centred care was delivered for every person, every time based on ***collective and collaborative working.***

- Ensuring appropriate levels of education and training was provided for the professions, as well as ensuring a safe and effective learning environment for undergraduates through close links with UWS at all levels, both strategic and operational as well as Ayrshire College.
- Providing leadership for clinical and care ***governance and assurance*** which improved outcomes for the people of Ayrshire, including a root and branch review of mental health services.

Previous Positions

- Executive Nurse Director - NHS Ayrshire & Arran Acute Hospitals Trust - 1998-2002
- Executive Nurse Director - Hairmyres and Stonehouse Hospitals NHS Trust - 1993-1998
- Assistant Chief Area Nursing Officer – Lanarkshire Health Board – 1989-1993
- Various Clinical Posts in Glasgow and Lanarkshire – 1982-1989

Education

- BA Degree in Nursing Studies & Registered Nurse - Glasgow College of Technology 1982
- Diploma in Management Studies (Distinction) – Glasgow College 1989
- Masters Degree in Business Administration – Glasgow Caledonian University 1996

Scottish Hospitals Inquiry
Witness Statement of
Professor Marion Bain

Introduction

1. I am Professor Marion Bain. I am Interim Deputy Chief Medical Officer for Scotland. I have held this role since May 2020. As Interim Deputy Chief Medical Officer I work with the Chief Medical Officer to: provide the Scottish Ministers and Scottish Government policy colleagues with clinical, healthcare and public health advice to inform decision making; and provide leadership to medical and public health professionals across NHS Scotland. My current role has no responsibilities related to Infection Prevention and Control ("IPC") or NHS Greater Glasgow and Clyde ("NHSGGC").

2. Between 6 January 2020 and 10 May 2020, at the request of Scottish Government within the Stage 4 Escalation of NHSGGC, I was appointed to the role of Director IPC at NHSGGC. In terms of my formal contractual employment arrangements, I remained an employee of NHS National Services Scotland ("NSS") throughout this post.

3. Between January 2020 and 2 July 2021 I acted as the principal "sponsor" of the Case Note Review with overall responsibility for delivering a report on its findings to Professor Fiona McQueen as chair of the Queen Elizabeth University Hospital Oversight Board ("the Oversight Board").

4. I address the following in this statement:

a. My Professional Background and Education;
b. Appointment to NHSGGC as Director of IPC;
c. IPC Governance at NHSGGC;
d. IPC concerns raised by NHSGGC staff;
e. Escalation of NHSGGC on the NHS Scotland Performance Escalation Framework;
f. The work of the Oversight Board;
g. My response to questions posed by the Inquiry in relation to:
i. The presence of Cryptococcus at QEUH;
ii. The "culture" within the NHSGGC IPC team; and
h. The Case Note Review.

Professional Background and Education

5. A copy of my CV is appended to this statement. However, by way of short summary, I qualified in medicine from Edinburgh University in 1988, then worked across a range of clinical areas (including in Microbiology) and hospitals in Scotland before specialising in Public Health Medicine. My career developed increasingly over time into senior clinical leadership roles and medical management.

6. I have held a range of senior medical leadership roles at strategic and national levels in Scotland including:

- Medical Director of Information Services Division of NHS National Services Scotland (2003-09);
- Board Executive Medical Director, NHS National Services Scotland (2009-17);
- Delivery Director and Senior Medical Adviser for Public Health Reform in Scottish Government (2017-19); and

- Interim Deputy Chief Medical Officer for Scotland (since May 2020).

7. Between 2014 and 2017 I was the elected Chair of the Scottish Association of Medical Directors ("SAMD"). SAMD comprises all the NHS Scotland Board Executive Medical Directors and is also open to Deputy and Associate Medical Directors with the agreement of their Executive Medical Director. Advice and formal representation from the group is routinely sought when senior medical management expertise and advice is required by the Scottish Government and for cross NHS Scotland work.

8. I held the role of Director of IPC at NHSGGC from 6 January 2020 to 10 May 2020. I discuss my appointment to that role and my responsibilities below.

Appointment to NHSGGC as Director of IPC

9. On 22 November 2019 NHSGGC were escalated by the Scottish Government to Stage 4 of what was then known as the NHS Scotland National Performance Framework. The NHS Scotland National Performance Framework is now known as the NHS Scotland: support and intervention framework. Despite the name change, the "framework" is substantially similar now to that which was in place in November 2019. The framework provides a model by which the Scottish Government can provide Scottish health boards with support and interventions designed to improve performance. My appointment as Director of IPC was a direct consequence of NHSGGC's escalation to Stage 4. I was not involved in the Scottish Government's decision to escalate NHSGGC, or any of the events leading up to that decision. Accordingly, I am not a position to assist the Inquiry in relation to whether the Scottish Government should have made its escalation decision sooner than it did.

10. In late December 2019 I was contacted by Professor Fiona McQueen who was, at that point, the Chief Nursing Officer for Scotland. Professor McQueen explained that the Scottish Government wished to make an external appointment to the Director of IPC role at NHSGGC (within the Stage 4 Escalation) and asked whether I would be willing to take on that role. Professor McQueen's approach followed an initial conversation I had with the then Chief Medical Officer for Scotland, Dr Catherine Calderwood. During this conversation with Professor McQueen I was advised of the background to the proposed role and asked if I would consider taking it on. Having taken time to think about matters, I advised Professor McQueen that I was willing to take on the role and would deliver it to the best of my abilities. By letter dated 23 December 2019 I was appointed as Director of IPC at NHSGGC. A copy of that letter is produced at **Bundle 52, Volume 2, Document 34.1, Page 446.** I took up post on 6 January 2020.

11. I was asked by Professor McQueen to undertake the role to provide senior clinical leadership and to set the strategic direction for IPC improvement. As set out in the letter of appointment, the role of Director of IPC had the following responsibilities:

- Responsibility for leadership of Healthcare Associated Infection at NHS GGC.
- Lead on any transformation work required in NHS GGC to ensure improvements to the systems, processes and governance in relation to infection prevention and control (IPC) within NHS GGC, with a particular focus on QEUH and RHC.
- Where required, to put in place relevant staffing support in NHS GGC to take forward this work in agreement with the NHS GGC Board.
- Work with the IPC sub-group of the Oversight Board to ensure timely provision of information (and, where required, to the Oversight Board).
- Work with the Scottish Government programme management team and others in their assurance roles in supporting the work of the Oversight Board.

- Work with the Chair of the Incident Management Team (IMT) to ensure actions arising have been acted on and ongoing assurance from the IMT members regarding outbreak investigation and applied rigour.
- Support the development of an improvement culture with robust IPC risk management among clinical and IPC staff, including any necessary steps to improve relevant joint working between different Directorates within NHS GGC.
- Oversee the development and conduct of a case review of relevant cases for the Oversight Board.
- Provide advice to CNO as Chair of the Oversight Board and Jane Grant as CEO of NHS GGC.

12. I reported jointly to Ms Grant, Chief Executive of NHSGGC and Professor McQueen as Chair of the Oversight Board. I reported in terms of my employment accountability to Ms Grant at NHSGGC; and I had briefing and advisory reporting obligations to Professor McQueen as Chair of the Oversight Board. I had no direct line management responsibilities, but I worked on a regular basis with Sandra Devine as Interim Infection Control Manager and Professor Alastair Leanord as acting Lead Infection Control Doctor. There was a collaborative and professional approach from all those with whom I engaged at NHSGGC and I do not consider that an absence of direct line management responsibilities inhibited the effective performance of my role.

13. I have been asked by the Inquiry whether, in consequence of my reporting requirements to Ms Grant, I considered myself to be independent in my decision making when undertaking the role of Director of IPC. The role I was asked to undertake was not an independent one. I was appointed by the Scottish Government within a Stage 4 Escalation context specifically in response to the concerns that resulted in the escalation. I was appointed to the role of Director of IPC within the then existing NHSGGC system. Within that context, in delivering my responsibilities, I made independent decisions based on my professional judgement. I appreciate that some may have the perception that, as part of the NHSGGC executive structure, I was inhibited from making independent decisions, however, that was not my experience.

14. My priorities were: ensuring a strong focus on practical delivery of high-quality IPC, both at the time and to advise on requirements going forward; and contributing and providing insights to the Oversight Board and its IPC Sub-Group set up as part of the Stage 4 Escalation in ensuring IPC systems and processes were fit for purpose. Separately, and as discussed further below, I had responsibility for overseeing the Case Note Review.

15. I focused on: ensuring the day to day delivery of effective IPC was being delivered; identifying and addressing needs in terms of additional capacity and resources for IPC delivery; putting in place organisational development to improve the joint working that is needed for effective IPC; hearing the concerns raised by the microbiologists Dr Teresa Inkster and Dr Christine Peters; meeting with them regularly (generally weekly) to ensure I understood those issues; working with other NHSGGC colleagues to discuss these concerns and agreeing where action was needed; feeding back to Drs Inkster and Peters; keeping both the Chief Executive of NHSGGC and the Chair of the Oversight Board updated, including with more general views, based on my experience of working in the board, of how to improve the effectiveness of the IPC system in NHSGGC.

16. From 17 February 2020 Professor Angela Wallace, Director of Nursing at NHS Forth Valley, was seconded three days per week to NHSGGC as the Operational Director of Infection Prevention and Control following my recommendation to the Chief Executive of NHSGGC and the Chair of the Oversight Board that such an Operational Director be put in place. Professor Wallace took responsibility for the practical delivery of IPC at that time, working with me. Following our joint work, and discussions with the Chief Executive of NHSGGC on the best ways to support work going forward, Professor Wallace subsequently took on full executive lead responsibilities for IPC from 14 April 2020.

17. My role was intended to be time limited and the provisional time agreed with Ms Grant and Professor McQueen following me starting in the role was for six months. I demitted my direct role in NHSGGC on 10 May 2020 as I was asked at that point to take on the Interim Deputy Chief Medical Officer role in Scottish Government in response to the Covid pandemic. I continued to oversee the Case Note Review work until July 2021 following publication of the Case Note Review report on 22 March 2021 and the final meeting of the Case Note Review Core Project Team which I chaired on 2 July 2021.

18. I discuss my involvement in the Case Note Review later in this statement. For clarity, although my formal letter of appointment to Director of IPC at NHSGGC indicated “Oversee the development and conduct of a case review of relevant cases for the Oversight Board”, as one of my responsibilities, the work I undertook in overseeing the Case Note Review was separate to my role as Director of IPC at NHSGGC. My reporting responsibilities on the Case Note Review were directly to the Oversight Board and Professor McQueen. As indicated above I continued to oversee the Case Note Review until its completion beyond the time I demitted the role of Director of IPC.

19. Professor McQueen advised me of the issues with IPC and the built environment at NHSGGC that had led to their escalation prior to my taking up post as Director of IPC. Those issues are summarised at paragraph 11 of the Oversight Board's Final Report **(Bundle 6, Document 36, Page 795)**. For ease, I have copied para 11 of the report below. I had not had any prior involvement with IPC and the built environment at QEUH and RHC prior to my appointment as Director of IPC.

20. Escalation came against a background of a series of infection issues affecting children and young people in the paediatric haemato-oncology service at the QEUH and the RHC over a number of years, combined with rising concerns about the source(s) of those infections and how they were being handled.

- While cases were reported in 2016 and 2017, concerns significantly mounted between January and September 2018 when the number and diversity of type of infections substantially increased. According to Health Protection Scotland (HPS), there were at least 23 cases, involving 11 different organisms.

- From Spring 2018, there was a succession of outbreaks, including one in September in the RHC which led to the de-canting of patients into the QEUH and extensive (and continuing) refurbishment of Wards 2A and 2B. In 2019, there was a further major outbreak in Ward 6A in the QEUH, into where the children and young people had been moved after de-canting.

- The organisms associated with these outbreaks were unusual and often linked to environmental bacteria. In 2018, water testing results suggested that there was systemic water contamination in the QEUH, prompting the introduction of a site-wide chemical dosing solution later that year.

- Concerns had been raised about the fitness of the new hospitals by several clinicians and microbiologists with respect to environmental infections at various points over the period, dating back to the completion and handover of

the building. Some QEUH/RHC clinicians and microbiologists did not feel that their concerns – particularly about water and ventilation safety – were being effectively addressed, and in some cases, formal whistleblowing procedures were triggered.

- Concerns were also raised by families of the patients involved about how the Health Board was communicating and engaging with them in light of their increasing anxieties about the safety of the hospitals. (These issues have been discussed in the Oversight Board's Interim Report.)

- It was not until summer 2018 that senior management were made aware of the existence of external reports highlighting the risks of water contamination as early as 2015, but which had not been acted upon at the time. These reports were discussed publicly for the first time in November 2019.

21. Prior to taking up my post Professor McQueen had explained to me that some clinicians and microbiologists in NHSGGC did not feel that their concerns, particularly about water and ventilation safety, had been previously, or were currently, being listened to or effectively addressed. Two microbiologists, Dr Teresa Inkster and Dr Christine Peters, had been in touch with the then Cabinet Secretary for Health and Sport, Jeane Freeman, to raise their concerns, and this had been followed up by discussions between Professor McQueen and Drs Inkster and Peters.

22. When I commenced my role it was evident that there were significant issues in terms of working relationships between Drs Inkster and Peters and NHSGGC senior management. There were also issues in the working relationships between Drs Inkster and Peters and the core IPC Team. I discuss these issues further below. I had no prior knowledge of the IPC teams at QEUH and RHC preceding my appointment so cannot comment on its culture before that time. My task, once appointed, was forward facing. My responsibility was to ensure effective delivery of IPC and to inform future plans, not to review past actions.

23. I am asked if I can assist the Inquiry in relation to what action was taken by NHSGGC once senior management were made aware of the DMA Canyon water reports (referenced as external reports highlighting the risks of water contamination at paragraph 19 above). In particular, I am asked whether disciplinary action was taken or whether an investigation was instigated to understand how recommendations of these reports had not been actioned. The delayed disclosure of these reports was not within my remit as Director of IPC. Therefore, I cannot assist the Inquiry with this question. As I discuss in the preceding paragraph, my role was "forward facing" and did not cover the matters suggested in the Inquiry's question. I am asked whether any work was undertaken by NHSGGC to identify whether any other similar reports/concerns about the hospital environment had been "hidden/ignored". For completeness, I confirm that as far as I am aware, no such work was undertaken during my time as Director of IPC.

IPC Governance – NHSGGC

24. When I took up my post as Director of IPC, there was a central IPC team, which included the interim Infection Control Manager, the acting Lead Infection Control Doctor and the Acting Associate Nurse Director for IPC. There were also local IPC teams covering the different NHSGGC sectors such as South, Clyde and North. There were IPC Groups covering the acute and community sectors and a Board Infection Control Committee.

25. In my opinion, at the time of, and throughout, my appointment, NHSGGC undertook its IPC functions in line with the guidance provided in the National Infection Prevention and Control Policy Manual **(Bundle 4, Document 7, Page 50)**. The overall governance and structures in place at the time were as set out in the draft NHSGGC Infection Prevention and Control Assurance and Accountability Framework document 2019 **(Bundle 27, Volume 8, Document 1, Page 9)**, however within the Stage 4 Escalation process I undertook the Executive Lead for Infection Prevention Control role from 9 January 2020 and subsequently this transferred to Professor Wallace on 14 April 2020.

26. More generally in relation to IPC delivery and governance, my views, as shared with Ms Grant and the Oversight Board in 2020, were that:-

- IPC services were under considerable pressure to respond to the ongoing IPC challenges (even ahead of Covid-19) within NHSGGC. IPC services were continuing to deal with outbreaks and unusual organisms. They were also dealing with and monitoring the changes that had been made in response to the water issues, and dealing with the increased concern and focus around IPC, including ongoing media focus;

- That pressure was felt more acutely in relation to the QEUH and RHC than other areas of the NHSGGC estate. The majority of the complex IPC work related to QEUH and RHC and the issues that arose following migration to the new building;

- The complex and evolving IPC environment within QEUH and RHC presented challenges which required broader approaches to problem solving beyond what was sometimes adopted. There were agreed approaches to IPC which were being followed by NHSGGC, but the particular challenges being faced also required consideration and thinking beyond the routine guidance available to fully consider the potential broader picture around infections and outbreaks that were occurring; and

- There was a need to strengthen effective linkages and joint working for IPC, with clarity about respective roles and responsibilities. I refer to the breakdown in relationships between IPC staff later in this statement.

These views were based on my direct observations and assessment as Director of IPC in NHSGGC, and are also reflected in the Final Report of the Oversight Board, to which I contributed my views.

27. A Healthcare Associated Infection Report which included a summary of the Healthcare Associated Infection Reporting Template ("HAIRT") and was informed by the work of the groups in para 23 above was presented by the Executive Lead for IPC at Board meetings. The HAIRT report routinely included details on key Healthcare Associated Infection ("HAI") performance indicators along with details of any incidents and outbreaks. It would be the responsibility of the IPC Executive Lead to decide what additional matters should be reported. I attended one Board meeting on 25 February 2020 during my time as Director of IPC and included an additional (i.e. beyond what would routinely appear in the HAIRT) update on an increased incidence of gram negative cultures in patients in the Paediatric Intensive Care Unit and the work underway to further investigate and address this. The minutes of the board meeting are found at **Bundle 42, Volume 4, Document 73, Page 1461.** The HAIRT presented at that meeting is found at **Bundle 52, Volume 2, Document 35.3, Page 459**.

28. The presentation of a HAIRT occurs at every NHS Scotland Board meeting as a standing agenda item and, as far as I am aware, NHSGGC adhered to this practice. The report also went to the NHSGGC Board Clinical Governance Forum.

29. I have been asked by the Inquiry why any matter of relevance to IPC would not be reported to the NHSGGC Board. As I discuss above, it is the responsibility of the IPC Executive Lead to bring matters of relevance to IPC to the Board's attention. I do not know, and am not able to speculate as to, why a matter relevant to IPC would not be reported to the NHSGGC Board. From my own experience, I attended a single board meeting during my time as Director of IPC and ensured that all matters of relevance related to IPC were reported to the Board at that meeting.

IPC Concerns Raised by NHSGGC Staff

30. As I discuss above, I was aware from discussions with Professor McQueen prior to taking up my post that concerns had been raised in relation to QEUH and RHC. I was aware that some of those concerns originated from NHSGGC staff and dated back to completion and hand over of the building.

31. Shortly after taking up my post, I met with Drs Inkster and Peters, who provided me with comprehensive details of their concerns. Their main concerns were that: issues they had previously and consistently raised around patient safety relating to environmental infections, in particular relating to water and ventilation, had not been adequately addressed; issues they had raised around lack of clarity of the Infection Control Doctor ("ICD") role, alongside the structures to support effective ICD input, and concerns around the cultural environment had not been resolved; and, there were inaccuracies in public media statements that they had historical and ongoing concerns around. I found this initial meeting helpful in understanding more of the background to the IPC issues in NHSGGC and the specific areas where Drs Inkster and Peters had particular concerns. I also met with other NHSGGC colleagues in the core IPC team and members of senior management soon after I started, who also provided me with helpful details from their perspectives of the IPC issues and how they had been addressed. At the initial meeting I asked Drs Inkster and

Peters to email me with any IPC concerns they had moving forward. Thereafter, I met with the doctors on a regular (usually weekly) basis to discuss any concerns raised. These meetings covered Drs Inkster and Peters' historical concerns as well as any novel (current) issues. Such novel issues included; when a new infection/ organism of IPC concern had been identified; when they were aware of a potential environmental risk; and concerns about accuracy of public statements. As expanded on below, I followed these up with other relevant NHSGGC colleagues. I discuss how I responded to concerns raised by Drs Inkster and Peters later in this statement.

32. I have been asked by the Inquiry to provide my views on the adequacy of communication and information sharing between staff within the QEUH and RHC. In this regard, I can only assist the Inquiry from my own observations during my appointment as Director of IPC.

33. From my perspective, there was clear evidence of a breakdown in positive working relationships between Drs Inkster and Peters with both senior management and the core IPC Team. There was a lack of trust from Drs Inkster and Peters. The doctors did not feel that their concerns were being addressed. In return, the core IPC Team and senior managers in NHSGGC had a feeling of constant challenge and criticism from Drs Inkster and Peters. As a result, open and constructive communication was not evident. In my role as Director of IPC I was concerned to ensure that any and all issues of concern were adequately considered and addressed. As a short-term solution I met regularly with Drs Inkster and Peters to hear their concerns and follow them up as required with other colleagues in NHSGGC. The longer-term aim was to resolve the underlying issues as described below.

34. I am asked to respond to the suggestion that if there was a lack of trust of senior management and the core IPC Team from Drs Inkster and Peters that this might, to some extent, have its roots in their perception that those senior management and the core IPC Team had failed to respond to their concerns about culture within the IPC team and the safety of the water and ventilation systems of the building raised by them as far back as their attempts to resign a sector ICDs in July 2015. I agree, based on my conversations with Drs Inkster and Peters that this is very likely. I am not in a position though to comment on to what extent this perception of failure to respond to concerns was justified as it relates to a time prior to my appointment as Director of IPC at NHSGGC.

35. I am told by the Inquiry that both Dr Inkster and Dr Peters sought clarification on their role as ICD on several occasions. During the period of my appointment as Director of IPC neither Dr Inkster nor Dr Peters had formal roles as ICDs. However, as I explained above, I had regular meetings with Drs Inkster and Peters. During these meetings the doctors raised a range of historical IPC concerns. These included the doctors' concerns around how the IPC team had been working, the place and authority of the ICD within this working construct and the general culture around IPC.

36. As Director of IPC I considered all the concerns that were raised with me by Drs Inkster and Peters. The steps taken to deal with them depended on the specific issue. For example, if an issue which was raised related to a current IPC concern, then I ensured that the core IPC team were aware and were dealing with it and that it was appropriately followed up. If an issue was raised regarding a policy or lack of policy, I took forward development and agreement of the policy. If an issue related to communications, I discussed that with the Director of Communications and Public Engagement to ensure messages were clinically accurate. If a concern around facilities was raised, I discussed with the Director of Facilities to ensure that it was being addressed. In the midst of this, there were, sometimes strongly held, differences of opinion between the views of Drs Inkster and Peters and others involved in both direct IPC roles,

other microbiology roles, and associated roles such as communications and facilities. For some of Drs Inkster and Peters' concerns there was a straightforward route to address it (e.g. by ensuring the IPC team were aware and addressing a specific identification of an organism/organisms or progressing delivery of a specific policy). For others, there was a need to improve the working relationships to facilitate sharing and constructive discussions to come to agreement. I used my professional judgement to assess what needed to be, and could be, addressed as a matter of urgency in the short term, while also putting in place the organisational development work intended to develop constructive joint working that is required for effective IPC.

37. In delivery of the Director of IPC role I was focused primarily on current IPC issues and improvements for the future. As a member of the Governance Subgroup and as an attendee at the Oversight Board I was also able to bring my direct reflections, including those gathered from my meetings with Drs Inkster and Peters to the discussions.

38. Differences of opinion in complex clinical matters require open and constructive discussion between experts to inform the best advice in caring for patients and their families. In my view, this open and constructive discussion was not happening. Therefore, through my direct discussions with others, I ensured that concerns being raised were being considered and addressed. This was intended as a short-term solution to ensure effective IPC was delivered. There was a need to create and strengthen positive working relationships across the wider IPC function. This was discussed and agreed throughout January 2020 with Ms Grant and Professor McQueen. Specialist external Organisational Development support was agreed and was commenced during my time with NHSGGC. I discuss this support more fully at paragraph 40 below.

39. I am asked to explain what should happen when a Lead ICD and/or Consultant Microbiologist is of the view that there is a real risk that a particular building system may be the source of infections being suffered by highly immunocompromised patients and they are challenged at an IMT by managers with no experience in microbiology and consultants from other medical specialisms as to whether there is any merit in that hypothesis?

40. I would always expect the views of clinical experts to be listened to and fully considered when assessing infection incidents. Overall, patient safety should be the primary consideration when making IPC decisions. Membership of an IMT will vary depending on the specific circumstances of the incident but the value comes from having a range of relevant specialists and experts, including those with different backgrounds. For example if there are concerns about the risks relating to the built environment, I would expect facilities managers to be involved and contribute their understanding and expertise. IMTs should provide an opportunity for views to be put forward by all present as well as constructive discussion to agree the required actions. I am not in a position to comment on the IMTs prior to my appointment as Director of IPC in NHSGGC. During my time with NHSGGC my expectation and my experience was that IMTs fully took into account the views of the Lead ICD.

41. **Bundle 13, Volume 10, Document 16, Page 99** is email correspondence between myself and Drs Inkster and Peters dated 20 January 2020. This email correspondence (and those in the email chain that preceded it) followed from my first meeting with Drs Inkster and Peters on 10 January 2020. In the last paragraph of my email of 20 January I express a desire to "…get GGC back into a positive and collaborative place for the benefit of patients." As described above, the breakdown in positive working arrangements amongst those involved in delivering IPC within NHSGGC meant that the usual processes of open and constructive discussion were not taking place. My email is clear that work was needed to get 'positive and collaborative' approaches to IPC in place, and that I was intending to work with Drs Inkster and Peters (and others) on this.

42. In order to improve working relationships to support effective IPC I agreed with Ms Grant as Chief Executive of NHSGGC and Professor McQueen as Chair of the Oversight Board that a programme of Organisational Development ("OD"), involving external expertise, would be put in place. I developed this further with Professor Wallace when she took up her role as Operational Director for IPC and the work started in February 2020. A very experienced OD practitioner, Jenny Copeland, was identified to lead the work. The 'discovery phase' of this work was undertaken during my time with NHSGGC. This involved interviews with a wide range of NHSGGC staff involved with roles relevant to IPC and was intended to shape the next stages of a detailed OD plan. This phase of the work was just coming to an end when I left the Director of IPC role however, the work continued to be taken forward under the leadership of Professor Angela Wallace.

43. At paragraph 200 of her witness statement **(Witness Bundle – Week Commencing 2 September 2024 – Volume 3, Document 2, Page 63)** Dr Redding states:

"Mr Ian Ritchie began looking at the bullying culture within GGC and said he was keen to address this. He spoke with Professor Marion Bain who planned to get some external advice on the cultural issues within the IPC and Microbiology teams within GGC."

44. Dr Redding is referring to the "discovery phase" of the agreed external Organisational Development work described above. Jenny Copeland was appointed in February 2020 to take forward the work. Jenny Copeland worked with Professor Wallace and me to develop a tailored programme of OD. I had left NHSGGC by the time the initial review was completed and I have not had sight of the final report. It was not part of my remit or role to consider issues of bullying.

45. The Inquiry has asked me about my involvement in whistleblowing processes at NHSGGC. I had no involvement in any whistleblowing process at NHSGGC and cannot assist the Inquiry in relation to this. It was not part of my role as Director of IPC to consider the whistleblowing procedures in place at NHSGGC.

Escalation of NHSGGC on the NHS Scotland Performance Escalation Framework

46. I was not involved in the decision of the Scottish Government to escalate NHSGGC to Stage 4 of the NHS Scotland Performance Escalation Framework. I describe my understanding of the reasons for the Scottish Government's decision at paragraph 19 above. I was not involved in setting up the governance structures that accompanied escalation but was made aware of them as my appointment was discussed. The Oversight Board and three subgroups were established as set out in Chapter 1 of the Oversight Board Final Report **(Bundle 6, Document 36, Pages 795-921)**.

The Work of the Oversight Board

47. The Final Report of the Oversight Board (**Bundle 6, Document 36, Pages 795-921**) describes how the Oversight Board was established and constituted. I was not involved in those arrangements.

48. During the time that I was Director of IPC at NHSGGC, I attended the Oversight Board. I was a member of the Infection Prevention and Control and Governance Sub-Group. Between January and May 2020, I contributed to the discussions by providing, amongst other things, direct insights from my role as Director of IPC within NHSGGC. I also provided the Oversight Board with regular updates on progress with the Independent Case Note Review (discussed further below). When I left NHSGGC in May 2020 I continued to attend meetings until the Case Note Review work was completed, subject to the demands of my role as Interim Deputy Chief Medical Officer during the Covid pandemic.

49. As I discuss above, in my role as Director of IPC I reported jointly to Ms Grant Chief Executive of NHSGGC and Professor McQueen, Chair of the Oversight Board. I had no specific or different reporting arrangements in relation to my attendance at the Oversight Board. I had a specific, and separate, task from the Scottish Government related to the delivery of the Case Note Review and I reported regularly on progress on this to the Oversight Board.

50. I contributed to the reports (interim and final) of the Oversight Board as a member of the IPC and Governance Sub-group and during my attendance at meetings of the Oversight Board. I agree with the Oversight Board's recommendations. I was no longer in post at the time the recommendations were made so cannot comment on the steps taken by NHSGGC to implement the Oversight Board's recommendations.

51. I am asked whether, during my time as Director of IPC, I formed the view that NHSGGC took a "nothing to see here" approach to the work of the Oversight Board/their escalation to level 4 of the NHS Scotland Performance Escalation Framework.

52. During my time as Director of IPC, the Oversight Board made regular requests for information from NHSGGC related to its IPC systems. Those requests were responded to fully and comprehensively by NHSGGC. Responding to some of these requests was a very time consuming exercise for NHSGGC. I found all of those with whom I interacted at NHSGGC to be fully committed to delivering and supporting patient care, including by responding appropriately to any demands placed upon them by the work of the Oversight Board.

53. I would not describe NHSGGC's attitude as being "nothing to see here" in so far as it might be implied that they were dismissive of, or obstructive towards, the work of the Oversight Board or my appointment as Director of IPC. However, the IPC core team and senior management in NHSGGC expressed to me that they felt that they and NHSGGC had done, and continued to do, all that could be done to deliver best patient care, including by following all processes required of them prior to their escalation. My reflection on that was that NHSGGC did not generally accept that further support was required for them to help address the underlying causes of their escalation.

Cryptococcus at QEUH and RHC

54. Cryptococcus is a fungus that is found in the environment. It is usually harmless to humans but can cause infections in people with weakened immune systems. Concerns about Cryptococcus infections and NHSGGC's response to those concerns were raised by Drs Inkster and Peters in the first discussions I had with them in January 2020. These concerns (at that point) related to what had happened prior to my involvement with NHSGGC and I considered this as useful background as I took on my role which was, as I discuss above, "forward facing".

55. Dr Inkster emailed me on 15 January 2020 raising concerns about governance in relation to the IMT Expert Advisory Sub-Group (referred to as the "Cryptococcal advisory group") **(Bundle 13, Volume 10, Document 16, Page 101)**. In particular, Dr Inkster raised concerns about discussion of the group's report at Board meetings and the partial dissemination of the report to the Health and Safety Executive. The matters raised by Dr Inkster on 15 January 2020 related to a time before I took up post as Director of IPC. Nonetheless, I agree with Dr Inkster's position that any reports that are discussed at board meetings or released to external agencies must be fully accurate and that appropriate governance arrangements should be adopted to ensure that

happens. I cannot comment on whether such governance procedures were adopted in relation to the points raised in Dr Inkster's email of 15 January 2020 because the relevant events pre-date my appointment.

56. When I took up post as Director of IPC in NHSGGC in January 2020 there had been work underway by the Cryptococcus IMT Expert Advisory Sub-Group since February 2019. I had no direct involvement with the Cryptococcus IMT Expert Advisory Sub-Group. I understood it had been set up to explore hypotheses around the Cryptococcal infections at QEUH and RHC and I was content to let it do its work. My more direct involvement with Cryptococcal infections occurred when Professor John Hood alerted me, on 24 February 2020, to his concerns about inaccurate information in Board papers. Those concerns were raised in an email dated 24 February 2020 **(Bundle 14, Volume 2, Document 125, page 455)**. Professor Hood emailed me to express concern that the wording used in papers to be discussed at the board meeting of 25 February 2020 was inconsistent with the views/hypotheses of the Cryptococcus IMT Expert Advisory Sub-Group. As discussed above, I had no direct involvement with the sub-group so no reason to doubt the accuracy of the papers prior to receiving Professor Hood's email. I was grateful to Professor Hood for raising his concerns with me. I was concerned that the Board receive fully accurate information. Given that the Chair of the group had indicated that he did not agree with part of the update report, I was keen to ensure that the Board received information that accurately reflected the view of the Chair of the group.

57. I understood Professor Hood's specific concerns about the report to the Board, to be as stated in the letter attached to his email to me, relevant excerpts of which are copied below:

"…the Final Report of this Group has yet to be completed (let alone discussed and agreed by the Group) and may take many more weeks yet…"

(Regarding the statement in the Board paper) " 'The hypothesis that the air from the plant rooms, via the AHUs, was the likely source of the cryptococcal spores, specifically those of C, neoformans, which were then breathed in by the case patients, has subsequently been categorically ruled out as it is not technically possible''

I would certainly not use the words 'categorically ruled out', my words would be 'very unlikely'. I also feel that this statement is misleading. The insertion of 'via the AHUs' is the key. The nuance being that those reading this statement may believe that we have 'categorically ruled out' the plant rooms as the source of cryptococcal spores. This is not correct."

58. Following receipt of Professor Hood's email, I alerted Ms Grant to the concerns raised by Professor Hood by telephone. I did so ahead of the Board meeting to ensure that she could provide an accurate report and correct the statement that had been made in the papers circulated to the Board. At the Board meeting, Ms Grant highlighted the previously provided statement that 'the hypothesis that patient acquisition could have resulted from spores of Cryptococcus neoformans (derived from the pigeon guano) likely to be present in the plant room air, which then 'gained access' in some way into the Air Handling Units which provided the ventilation to the wards in which the patients were treated was categorically not the case'. She advised the Board that it was not yet possible to state this categorically, however, reported that this hypothesis was very unlikely and also noted that the final report was awaited. This was recorded in the minutes of the Board meeting of 25 February 2020 **(Bundle 42, Volume 4, Document 73, Page 1461).** It was Ms Grant's decision how to advise the Board but in my view this addressed the specific concerns raised by Professor Hood as stated in his letter to me.

59. I have been asked by the Inquiry whether the Board of NHSGCC were seeking to rule out hypotheses and force a conclusion on the likely cause [of infection] being reactivation before full investigations had taken place? I understand the Inquiry to be asking whether, in my view, the Board of NHSGGC sought to force conclusions that the source of patient infection was not the hospital environment but an alternative hypothesis that this was reactivation of a latent infection from the patient themselves. I have no evidence that this was the case. As I describe above, Ms Grant was clear to correct the inaccuracy highlighted by Professor Hood.

60. I have been asked by the Inquiry whether I considered the governance structure of the Cryptococcus IMT Expert Advisory Sub-Group to be effective. The governance had been established prior to my time with NHSGGC. When I joined NHSGGC as Director of IPC in January 2020 the Sub-Group appeared to be thoroughly assessing the situation and progressing satisfactorily with its work but with more to do before completion. I was content for it to continue to undertake its work with the expectation was that it would report back to the IMT once its work was completed.

61. I have been asked if I have read the final report of the Cryptococcus IMT Expert Advisory Sub-Group **(Bundle 6, Document 39, Page 1115)**. I have not. I understand that the final report of Cryptococcus IMT Expert Advisory Sub-Group was published in 2022 which was after I demitted office as Director of IPC. The purpose of the group was to provide advice and evidence to the NHSGGC Incident Management Team on the hypotheses relating to a Cryptococcus incident within QEUH. This is not a matter that falls within my current remit as Interim Deputy Chief Medical Officer. HAI is an area of policy responsibility for the Chief Nursing Officer's Directorate. I was not aware that NSS do not accept its findings and do not know the reasons why that view has been reached.

62. I had no involvement in the media and press statements released in respect of the Cryptococcus incidents at QEUH and RHC in 2018 and 2019. I took up my position as Director of IPC in January 2020.

63. I had no involvement with a Cryptococcus case at QEUH and RHC in around June or July 2020. I was no longer in post as Director of IPC at this time. Likewise, I cannot comment on the Board of NHSGGC's awareness of "future cases" of Cryptococcus at QEUH and RHC.

Culture within the NHSGGC IPC Team

64. The Inquiry has asked for my view on the culture within the IPC Team at NHSGGC, particularly in the QEUH and RHC? I have been asked if I have any concerns in respect of the culture within the IPC Team at the QEUH? In particular, do I consider that the IPC Team at NHSGGC, particularly in the QEUH and RHC, created an environment where ICNs, ICDs and microbiologists were actively encouraged to bring forward concerns about potential links between infections and the hospital environment and where systems existed to ensure that unusual microorganisms not included on national lists of mandatorily reported infections and infections caused by them were reliably identified, investigated and reported to HPS/ARHAI in compliance with the National Infection and Prevention Manual?

65. I cannot comment on culture prior to taking up my role as Director of IPC in January 2020. As described above, the culture when I arrived was not conducive to open and constructive discussion. In my role I actively encouraged highlighting and reporting of unusual organisms and, in particular and as described above, put in place short term measures to ensure that Drs Inkster and Peters were able to raise any concerns with me directly.

66. The Inquiry has asked me whether the removal of then lead ICD, Dr Inkster, as chair of the Gram Negative Bacteraemia IMT was done in accordance with acceptable standards of good governance and good clinical practice?

67. This occurred prior to my appointment to NHSGGC and I am not able therefore to give an informed view on this.

68. By reference to the report of the Vale of Leven Inquiry I am asked, from what I learned as Director of IPC at NHSGGC, was there sufficient connection "from Board to Ward" in respect of IPC at NHSGGC in 2017, 2018 and 2019. I cannot comment on what occurred prior to my appointment. However, part of the role of the Director of IPC is to ensure connection from Board to Ward and from Ward to Board. I ensured this connection was in place during my time in that role. As well as my meetings with the IPC team and receiving routine IPC updates, I regularly visited the wards in QEUH/RHC. At the Board meeting that took place during my time as Director of IPC I provided the Board with a written and verbal update. As Director of IPC I regularly met with Ms Grant as Chief Executive of NHSGGC and Professor John Brown as Chair of NHSGGC to discuss IPC matters.

The Case Note Review

69. On 28 January 2020 the then Cabinet Secretary for Health and Sport, Jeane Freeman, announced in the Scottish Parliament that the Scottish Government had commissioned a Case Note Review, to be undertaken by independent experts, to consider concerns related to certain infections in the paediatric haematology oncology service at QEUH and RHC.

70. When I was approached by CMO and CNO in late December 2019 I was asked, in addition to taking on the Director of IPC role in NHSGGC, to oversee the work of an independent Case Note Review. This additional role is included in my letter of appointment dated 23 December 2019 as I discuss at paragraph 11 above. I commenced this work in January 2020. I reported directly to Professor McQueen, as Chair of the Oversight Board, in relation my role pertaining to the Case Note Review. I did not report directly to the Scottish Government or Ministers. I did not have any reporting responsibilities to NHSGGC in relation to the Case Note Review as the work was being undertaken on behalf of the Scottish Government. I provided the Board of

NHSGGC with an update on the work of the Case Note Review at the one Board meeting I attended as Director of IPC at NHSGGC.

71. The work of the Case Note Review expert panel and my engagement in relation to this is set out in the Case Note Review Overview Report **(Bundle 6, Document 38, Page 975)**. However, by way of brief overview I worked with Scottish Government colleagues, in particular Philip Raines, to: establish the groups required and identify relevant individuals to contribute. During my time as Director of IPC in NHSGGC I also: identified and facilitated access to relevant data and information held by NHSGGC required by the Review; oversaw communications with the patients included in the review and their families, and also the clinicians involved with their care; and kept NHSGGC colleagues updated on progress. Once the Review was underway my main role was to oversee progress and to keep the Oversight Board updated. I chaired a monthly Core Project Team meeting. This was attended by the three members of the Case Note Review Expert Panel, the leads for the two main clinical and epidemiological data collection groups, members of the Scottish Government QEUH Support Unit and the Programme Manager for the Case Note Review. These meetings considered and agreed the approach to the review, reviewed progress and considered any issues that needed to be resolved. The Core Project Team held its final meeting on 2 July 2021.

72. I am asked why the March 2021 "A Paediatric Trigger Tool Review of Patients at the Royal Hospital for Children in NHS Greater Glasgow and Clyde" ("the PTT Review") **(Bundle 25, Document 9, Page 304)** never published despite a request from Professor Cuddihy? The Paediatric Trigger Tool Review was commissioned by the Chief Nursing Officer to support the work of the Case Note Review, and it provided helpful information that assisted the Case Note Review Expert Panel. Within the Case Note Review work there was not an intention to separately publish a PTT Review report. When I chaired the final meeting of the Case Note Review Core Project Team on 2 July 2021, at which Professor Cuddihy was present as an invited guest, the PTT Review was

discussed. At that point the report had been shared with Professor Cuddihy directly by Dr Patricia O'Connor who had a leadership role in the PTT Review work. Professor Cuddihy highlighted that he felt that the other patients and families should also be able to see the detail of the report. I agreed with this. This was then taken forward through the CNO Directorate at Scottish Government and the QEUH/RHC Advice, Assurance and Review Group (AARG), including consideration of wider publication. My understanding is that the report was subsequently shared by NHSGGC with the families who wished to see it.

73. When I left NHSGGC to take on the Interim Deputy Chief Medical Officer role in May 2020 I continued my oversight of the work of the Case Note Review and chairing the Core Project Team. With my move to the Interim Deputy Chief Medical Officer role and the significant time pressures within that role due to the Covid pandemic, much of the detailed work involved in completing the Case Note Review, dealing with any specific issues around it, and some of the regular reporting to the Oversight Board transferred to Philip Raines from mid-2020 onwards.

74. The conclusions and recommendation of Case Note Review expert panel are contained in chapter 10 of the Overview Report **(Bundle 6, Document 38, Page 975)**. I agree with the conclusions. I am satisfied that those conclusions were reached following a review undertaken by independent and respected experts in paediatric oncology, microbiology and IPC. The approach taken was both thorough and comprehensive. A wide range of relevant data and information was gathered and considered by the panel. I have been asked when I became aware that the NHSGGC Board corporately did not accept the principal conclusion of the Case Note Review that 30% of the infection episodes reviewed were probably related to the hospital environment. I only became aware of this during my preparation for this Inquiry. I had no ongoing involvement with the response to the Case Note Review beyond publication of the report on 22 March 2021 and chairing the final Case Note Review Core

Project Team meeting on 2 July 2021. My remit as Interim Deputy Chief Medical Officer did not include any ongoing involvement with IPC in NHSGGC other than completing the Case Note Review work. I was not involved in the decision to de-escalate NHSGGC in June 2022 so do not know whether the NHS Board's non-acceptance of the principal conclusion of the Case Note Review was considered as part of that decision. All that being said I believe that the Case Note Review was a very thorough, robust and evidence based process which I have confidence in.

75. A draft overview report was shared with NHSGGC prior to finalisation **(Bundle 25, Document 2, Page 45)**. NHSGGC prepared a very detailed response in relation to the draft. The response highlighted areas where NHSGGC considered incorrect findings had been reached. A copy of the NHSGGC response is produced at **(Bundle 25, Document 3, Page 151)**.

76. Professor Mike Stevens provided a response to the points raised by NHSGGC. A copy of Professor Stevens' response is produced at **Bundle 25, Document 5, Page 157**. In my professional opinion, Professor Stevens' response was appropriate and I agree with it. He comprehensively considered all the points raised. In some cases, the points raised by NHSGGC were accepted and amendments were made to the final report. In others Professor Stevens gives additional detail to demonstrate where the NHSGGC point is incorrect. He also fully clarifies the ask of the Case Note Review Expert Panel and describes why the methodology that was used was appropriate.

77. I was no longer in post with NHSGGC when the Case Note Review Overview Report was published. Accordingly, I am unaware as to what extent or how NHSGGC has implemented its recommendations.

78. As part of the work of the Case Note Review, individual reports were prepared in respect of each "infection episode" included within the review for every patient. The reports summarise the panel's findings in respect of each infection episode. The reports were viewed as private reports between the Case Note Review panel and the patient and family concerned. In my oversight/ governance role I did not have access to these confidential reports. I would not have expected to have been provided with access to such documents as it was not necessary for performance of my role. Chapter 7.3 of the Overview Report explains the approach taken by the Case Note Review Panel in relation to the individual reports **(Bundle 6, Document 38, Page 975)**. The individual reports were not shared with NHSGGC other than with the consent of the patient or family in line with Caldicott Principles for sharing of confidential patient information.

79. I have been asked by the Inquiry to what extent I accept that the decision to ensure that individual reports were confidential to the patients and their families and were not made available to NHSGGC has now made it possible NHSGGC to reject the conclusion of the Case Notes Review and attempt to persuade the Inquiry, the patients and the families that there was no link between all but two of the infections in the Schiehallion patient cohort and the hospital environment?

80. As discussed above, the review was undertaken by independent and respected experts in paediatric oncology, microbiology and IPC. The approach taken was both thorough and comprehensive. A wide range of relevant data and information was gathered and considered by the panel. The findings, along with the reasons for them, are described in detail in the Overview Report. The individual reports were intended as specific feedback to patients and their families. In my view not seeing these individual reports is not a valid reason to reject the findings of the report. While I have not seen the individual reports, I have no reason to think that the Overview Report does not fully reflect and report the findings from all the individual reports. My experience of working with Expert Panel was that they delivered what was asked of them, seeking and taking into account all available information, and with their fully independent

views. Professor Stevens and the other members of the Case Note Review Expert Panel may be best placed to address the Inquiry's specific questions in this regard. The members of the panel authored the individual and overview reports.

Declaration

I believe the statement attached is true and accurate and may now form part of the evidence before the Scottish Hospitals Inquiry and be published on the Inquiries website.

The witness was provided access to the following Scottish Hospital Inquiry bundles/documents for reference when they completed their statement.

Appendix A

A37525665 – Bundle 4 – Single Bed Derogation
A50152363 - Witness Bundle - Week commencing 30 September 2024 - Volume 7
A49882926 - Witness Bundle – Week Commencing 9 September 2024 - Volume 4
A47472337 - Bundle 13 – Miscellaneous - Volume 10
A49847577 - Witness Bundle – Week Commencing 2 September 2024 - Volume 3
A43293438 - Bundle 6 – Miscellaneous Documents
A50039563 – Bundle 27 – Miscellaneous Documents – Volume 8
A49541141 - Bundle 14 – Further Communications - Volume 2
A49585984 - Bundle 25 – Case Note Review Expert Panel, Additional Reports and DMA Canyon
A52696861 – Bundle 42, Volume 4 – Previously Omitted Board Minutes and Relevant Papers (2009-2020)

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

Appendix B

A34187609 – Bundle 52 – Volume 2 – Miscellaneous Documents
A37083623 – Bundle 52 – Volume 2 – Miscellaneous Documents

Appendix C

PROFESSOR MARION BAIN CURRICULUM VITAE

QUALIFICATIONS

BSc (Hons) Pharmacology, University of Edinburgh, 1986
MB ChB, University of Edinburgh, 1988
MSc (Community Health), University of Edinburgh, 1993 – awarded the **Brotherston Medal** as the outstanding postgraduate student 1992/93
Fellow of the Faculty of Public Health, 2003
MBA, Henley Management College, 2004
Honorary Fellow of the Royal College of Physicians of Edinburgh, 2015

Full GMC Registration with licence to practice (GMC Number 3288670)

CAREER HISTORY

Current posts

May 2020 – present

- **Interim Deputy Chief Medical Officer** for Scotland, Scottish Government

June 2012 - present

- **Honorary Professor**, College of Medicine & Veterinary Medicine, University of Edinburgh

Previous posts

April 2020 – September 2021

- **Non-Executive Director** on Public Health Scotland Board, and Chair of the Board Public Health and Wellbeing Governance Committee

January 2020 – May 2020

- **Director of Infection Prevention and Control**, NHS Greater Glasgow & Clyde

October 2017 – December 2019

- **Delivery Director for Public Health Reform** and **Senior Medical Adviser**, Scottish Government

July 2009 – October 2017

- **Executive Medical Director**, NHS National Services Scotland

March 2016 – August 2016

- **Interim Chief Executive,** NHS National Services Scotland

October 2003 – June 2009

- **Medical Director**, Information Services Division, NHS National Services Scotland

Concurrently, January 2008 – June 2009

- **eHealth Medical Director**, NHS National Services Scotland

October 1995 – September 2003

- **Consultant in Public Health Medicine**, Information and Statistics Division of NHS National Services Scotland (known as the Common Services Agency at that time)

With half-time secondments:

- **Senior Medical Officer**, Scottish Executive Health Department (2001-2002)
- **National Health Demonstration Projects Co-ordinator**, Scottish Executive Health Department (1999)

September 1992 – September 1995

- **Public Health Medicine Higher Specialist Training,** Edinburgh University, NHS Borders, NHS Lothian

August 1988 – August 1992: **Clinical posts**

- Edinburgh Royal Infirmary, Royal Victoria Hospital Edinburgh, Falkirk and District Royal Infirmary, St John's Hospital Howden, City Hospital Edinburgh.
- Specialties covered: General Medicine, General Surgery, Infectious Diseases, Medicine for the Elderly, Medical Microbiology, Orthopaedic Surgery, Thoracic Surgery, Urology.

OTHER SELECTED POSITIONS

2014 – 2017: Elected **Chair of the Scottish Association of Medical Directors (SAMD**)

Previously **Vice-Chair** (2012 – 2013), and **Secretary** (2008 – 2012)

- Outcomes: support across the Medical Director cohort and sharing of issues for resolution; organisation of three successful Annual Conferences focused on strengthening leadership; increasingly co-ordinated Medical Director leadership in shaping national decisions.

2014 – 2017: **Chair of the NHS Scotland Responsible Officers (RO) Network**

- Outcomes: introduction of a standard appraisal system for ROs to support revalidation; successful revalidation of all NHS Scotland ROs; ongoing support for revalidation across Scotland.

2013 – 2014: Invited **Chair of the Farr Institute (Scotland) Executive Governance Group**

- Outcomes: delivery of the new National Health Informatics Research Institute on time and to budget, and with buy in and support from all partners.

2011: Invited **Chair of the national Technical Advisory Group on Resource Allocation (TAGRA) Morbidity and Life Circumstances Group**

- Outcomes: delivery of what was recorded as a high quality report to TAGRA; implementation of the recommendations which ensures that resource allocation reflects unmet need relating to deprivation and life circumstances.

2009-2012: Invited **Chair** of the NHS Healthcare Improvement Scotland **National Surgical Profiles Group**

- Outcome: evidence of improved outcomes following surgical care.

2004-2010: Invited **Advisor to The Health Foundation 'Engaging with Quality'** award scheme

- Advisor on the design of three major award schemes for improving quality of care in both secondary and primary care; contribution of specific expertise on use of information for quality improvement; member of the core assessment panel.

2003-2009: Member of **National Panel of Specialists for Public Health Medicine**

- Advice on consultant appointments and membership of Appointment Panels.

PUBLICATIONS

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Scottish Hospitals Inquiry
Witness Statement of
Dr Saranaz Jamdar, known as Dr Sarah Jamdar

Background

1. I am a consultant microbiologist in GGC. I began my medical career in 1998 in Glasgow, where I trained as a microbiologist. I then became a consultant microbiologist at NHS Forth Valley in 2009. I returned to Glasgow Royal Infirmary in 2016 and subsequently relocated to the Queen Elizabeth University Hospital (QEUH) in April 2024. I currently report to Dr Abhijit Bal (Head of Service in microbiology) and my Service Manager is Fiona Muir.

2. Between 2016 and 2018, I also worked at the Golden Jubilee National Hospital (GJNH) where I was the Infection Control Doctor (ICD). During this time and for a very short period I provided ad hoc infection control sessions (covering for Dr Inkster) at Queen Elizabeth University Hospital (QEUH).

3. I have made this statement to corroborate elements of Dr Inkster's and Dr Peter's experience involving the Estates department and the IPCT.

4. In 2018 I volunteered to provide ICD sessions at Gartnavel General Hospital (GGH) to cover retirement vacancies and understaffing. This role started on 18th August 2019 and later until 24th October 2019 when I resigned from the ICD role. For the majority of this period, Dr Inkster was my Lead ICD.

5. In response to the whistleblowing process in QEUH and after my resignation, I was contacted by Professor Marion Bain about the issues within IPCT. She was surprised to hear about my experience as an ICD as she had been given the impression that all the issues related to infection control were confined to the QEUH site.

6. I note that Sandra Devine (Director of Infection Control) informed the Inquiry that issues with microbiology, IPCT and Estates were confined to QEUH. This is inaccurate; the issues were widespread and well-known but, clearly, not acknowledged.

Healthcare-Associated Infection System (for) Controlling Risk in the Built Environment (HAI Scribe) Issues

7. During my role as ICD in GGH, I had a challenging relationship with the Estates team and at times with the IPCT based in GGH. I found some of the Estate officers' behaviour in meetings and during routine communication, regarding the Built Environment, water safety and ventilation, difficult and obstructive.
I was not the only ICD who had worked on the site who recognised this.

From the outset, I realised that the signing of the HAI SCRIBEs was carried out by the Infection Control Nurses (ICNs). The related building works ranged from simple maintenance work to complicated and lengthy building works including areas of the hospital populated by clinically more vulnerable patients. I noticed that it was the responsibility of the Estates officers to populate the SCRIBEs including the sections relevant to clinical risk mitigation. This was even though the Estates team would not have had any knowledge about the clinical risks to any given patient group. The Estates team would write the same list of precautions, and sometimes none, on documents which were often the product of cut and pasted sections from previous SCRIBEs with no effort to even change the name of the ward or location of the intended building work. The IPCT had little involvement in the review and scrutiny of the contents and did not challenge the less-than-adequate and often absent risk mitigations. I found the system quite disjointed, dangerous, and difficult to monitor.

8. Following this realisation, I voiced my concern and requested to be involved in populating and signing the SCRIBEs. I felt that this was not welcomed by the Estates team and even some of the IPCT members. Even the introduction of nationally recognised risk mitigation elements into the work was met with resistance.

9. Despite this, I insisted the HAI SCRIBEs should come to me for review and sign-off before any actual work was carried out. The transition from ICN-signed to ICD-signed SCRIBEs was challenging. I thought the ICNs would be happy for me to share the responsibility with them, but I felt that they liked to remain in charge of dealing with the Estates Team, and I was expected to accept this.

10. Even more concerning than the resistance to introducing the risk mitigating features into the intended building work, was the false reassurances that I would receive from the Estates department at the outset. On more than one occasion upon visiting the work site it became clear that despite the SCRIBE, they had not implemented nor had they any intention of applying the safety elements previously agreed on.

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11. On more than one occasion, to deter me from introducing additional safety measures, I was told that Dr Inkster had been happy with the Estate-recommended precautions in the past. This did not sound true to me, so I contacted Dr Inkster, and she confirmed that this had never been the case.

12. With the escalating challenges in GGH, during a senior IPCT meeting, chaired by Sandra Devine, on 24th October 2019, I was told by the lead ICN in GGH that what I was doing (which was essentially asking for proper documentation and requesting appropriate precautions) was “damaging the relationship between the Estates and the IPCT”. During the same meeting, I was advised by one of the other ICNs, that I needed to “learn to compromise”. None of the others present in the meeting challenged these comments. Ironically, it was during the same meeting that Pamela Joannidis, who had been asked to sign

one of the GGH SCRIBEs in my absence, criticised the poor state of a SCRIBE presented to her. She reported to the lead ICN in GGH that the SCRIBE lacked the relevant information related to the task at hand and the information on the required risk-mitigating precautions. She refused to sign the document in its current state.

13. It is important to note that the above challenges were taking place at the time that the concerns about the QEUH were public knowledge.

14. I have been asked by the Inquiry if it is competent for an ICN to sign off on HAI SCRIBEs. For simpler SCRIBES concerning simple work, this is certainly common practice in many health boards. For more complex situations, it entirely depends on the level of training of the ICN in question. If there has been specific training on built environment, and if there is strict application of that knowledge then SCRIBEs can be signed by the ICNs. Having been to different training courses and speaking to the ICNs and ICDs from other health boards though, they all agreed that for complex projects within the healthcare system, an ICD should be involved throughout the process and be in charge of the final sign-off of the relevant paperwork.

15. From my very limited experience at the QEUH, I can confirm that the SCRIBEs generated by the Estates department in collaboration with the external contractors and the ICNs often lacked important and relevant information. On one occasion, I declined to sign a SCRIBE related to the major refurbishment of the MRI suite by an external contractor, presented to me at the last minute. Neither the SCRIBE nor the NHS staff involved in the previous discussions could explain the nature of the work involved and the infection prevention precautions to be put in place.

Resignation as Infection Control Doctor

16. In October 2019 I resigned from my role as ICD. The B7 haematology ward in GGH had had multiple bathrooms with various water leaks, damaging the bathroom structure and often causing damage to the ceiling in the ward below. As part of the initial investigation, we identified black mould in the affected areas in the bathrooms. There was a plan to start refurbishing the affected areas one by one. I had asked for certain measures such as solid hoarding and HEPA filters to protect the patients. Despite several conversations and ward visits, my recommendations were ignored, and the plan for using the Visqueen barrier with a zipper remained in place. Out of concern for the safety of the patients on the ward, I refused to sign the HAI SCRIBE which still lacked my recommendations. On 24th October 2019 I received an angry email from the Lead Estates officer in GGH, copying multiple staff in the health board including the ICNs in GGH and the Estates' Lead in QEUH (Bundle 52, Volume 4, Document 6, Page 45). In it there was a complaint about "condescending behaviour" and I was asked if "I had an understanding of complex hospital ventilation". After weeks of discussions with the Estates and having observed the attitude of the senior IPCT members on the same afternoon as the email, I realised that changing the system for the better was not possible for me. I resigned on the same day.

17. I forwarded the email from the Estates staff member along with my resignation to Professor Alistair Leanord and Sandra Devine. Sandra Devine replied and expressed sorrow for what had happened and offered to speak to the Estates team. I advised that I was leaving because of a lack of support from the IPCT, team amongst other things. I did not hear anything further. Professor Leanord did not reply to that email and has not since discussed this incident with me.

18. In my opinion, the team wanted someone who didn't challenge historical processes and just signed what was required of them. As far as the IPCT members that I worked with, I believe that they were all too eager to defer to the Estates' decisions and plans when it came to the built Environment issues, regardless of how inadequate those plans were.

19. Soon after this incident, I was contacted by Professor Tom Steele's deputy. He arranged for an informal meeting to discuss the reason for my resignation. He was not impressed by what he heard from me about the documentation on the SCIRBEs and the challenges I had faced during my ICD role. He advised that he would try to introduce training in HAI SCRIBE for the Estates team and asked if I would like to do a part of this to which I agreed. I had no further contact regarding this.

20. After my resignation, another ICD took over signing the HAI SCRIBE for B7 and agreed with the Estate team's proposed IPC precautions with a guarantee that they will be adhered to. I was informed that an inspection of the site a few days into the work revealed that the safety precautions in place were not adequate and that this was deemed an unacceptable risk there was a risk to the patients on the ward. As a result, it was decided to close Ward B7 to refurbish the bathrooms- I think this was in early 2020. The patients were transferred to another ward in Beatson. There were discussions about the ward reopening later in 2020, but there was a further delay due to COVID-19. During this time. Given the enormous task facing the existing ICDs during COVIE, I agreed to provide support for the temporary ICD for GGH as this was this doctor had limited. I was also involved in the review of water and ventilation reports and the inspection of B7 before it eventually opened. During this time, we were working with new Estates officers who were very helpful.

Culture in Infection Prevention and Control Team

21. I have been asked by the Inquiry about the culture within Infection Prevention and Control generally. I can comment on sectors in which I worked. I did not find my experience in GGH pleasant. I would not call it hostile, but it was not friendly either. There was a lack of trust and in some cases, respect. I have had a good rapport with the IPCT in GRI, RAH and IRH. I have had very limited contact with the IPCT in QEUH, in particular, the adult hospital. The communication is almost universally one-sided. Microbiology consultants highlight issues/ results to the IPCT. Very little information is communicated by the IPCT to the microbiology team. I am certain that the IPCT holds some overall information which would be of enormous benefit to the working microbiologists at the site for their day-to-day practice and clinical advice.

22. This issue, as well as other communication concerns, have been previously raised with the IPC management, but little has changed. E.g. in 2024, I learned, for the first time, of a major building work by observing workmen on the roof of the building across from my office and not via any email notification from the IPCT. The building work was at the site of the Neonatal Intensive Care Unit (NICU) and required this unit to move to another ward. I was one of the microbiologists providing clinical advice for the unit at the time.

23. Lack of communication breeds a work environment of suspicion where people question what is being concealed from them. In my view, we need honesty and transparency to be able to work together.

The removal of Dr Inkster as chair of the IMT – 2019

24. I was made aware that Dr Inkster was removed as Chair of the IMT in 2019 at a later stage. I was also aware of her resignation as the lead ICD which happened around the time I was working as the ICD for GGH.

25. There was another exclusion episode involving Dr Inkster. At the start of COVID-19 (late March-early April 2020), I was asked by Professor Brian Jones if I would take on the Lead ICD role at the Louisa Jordan Hospital. I later realised that they had replaced Dr Inkster with me. Dr Inkster had first been approached, was already involved and was quite happy to continue with the task. I suggested that given Dr Inkster's limitation for physical presence at the site, I could cover the groundwork and report to her. I was told that not utilising Dr Inkster's input was what the GGC Board had decided. I was not provided any reason for the Board's decision.

Declaration

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

The witness was provided access to the following Scottish Hospital Inquiry bundles/documents for reference when they completed their statement.

Appendix A – N/A

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

Appendix B

A53717342 - Bundle 52 – Volume 4 – Miscellaneous Documents

Scottish Hospitals Inquiry
Statement of
Lisa Mackay

Impact

Essentially, it describes how something significantly alters or changes a person's life. In this instance the life is that of our daughter Eilidh's.

Fundamentally her life has been affected, altered and changed forever and it is she who has had to learn to accept and live with this.

Eilidh's diagnosis of ALL in 2016 at aged 14 was the start of a living nightmare for her and our family and nothing could have prepared us for the long bleak journey ahead filled with pain, uncertainty, worry and darkness. Light came however, in the form of all the wonderful medical professionals whom we have met along the way, and who with their expertise, professionalism, dedication and compassion have made it their life's mission to treat, guide, help and care for patients like Eilidh with the utmost love and respect.

Her ALL diagnosis had brought us to the RHC Glasgow, a state of the art, multi-million-pound hospital of less than a year old, a place of safety and the place where she would be treated and cared for. We felt relief, we felt trust, but above all we felt safe!

After diagnosis her treatment plan was arranged swiftly and efficiently and there was a clear plan moving forward. We all knew the plan, everyone stuck to the plan and the plan was implemented with trust, care and transparency. Eilidh knew she had a fight on her hands but with the love and support of us, her family and the dedicated medical staff she was ready to fight her ALL.

What was certainly not in the plan was that her ALL diagnosis and treatment, the reason we were in the RHC, became secondary to unusual infections and that the treatment of these infections would take precedence and these infections would be what threatened to end her life.

At no time during our 2016/2017 hospital stay of 338 days was Eilidh, or us, her parents, advised that her infections were connected to the hospital environment, ventilation system or water supply. It was not until October 2019 when we received a letter from NHS Greater Glasgow & Clyde advising that they were investigating infections at the hospital, which then led me to find online, a newspaper article dated May 2019. This article spoke of a child (Eilidh) on the cancer ward at the RHC being infected with Aspergillus in 2016 and how it was suspected to have come from mould in a ceiling void, which developed following a leak. That we became aware that the hospital environment was the source and cause of the infections she had contracted, contributing to the ongoing health difficulties she continues to suffer from. The environment we trusted, the hospital where we had felt safe!

It is very difficult to detail the impact on Eilidh. Her life has forever been altered. She has to work harder for everything she wants and will forever face barriers. She has had to learn to accept the far greater changes in her life, becoming a wheelchair user, being diagnosed with epilepsy, to name but a few. Her physical changes are evident but the severe psychological effects caused by these debilitating infections run far deeper than her visible scars. More so than would have been the consequence of her cancer diagnosis. Eilidh chooses not to revisit her dark days as it is a chapter of her life that she finds too traumatic. She prefers to concentrate on her recovery, moving forward with her life and her plans for the future.

Our family life has been impacted and changed forever. The shockwaves permeating from this have reeked devastation on us all and will reverberate for many, many years to come. We have been left in a state of stress, mistrust, disbelief, fear, worry and with an enormous sense of guilt. Guilty, for taking her to the RHC, in the first place, for treatment for her ALL diagnosis. A place that has become the vessel for the countless flaws, failings, consequences and misplaced actions. A place where she should have been made better, a place where she was meant to be safe, a place that has let her, us and countless others down.

I have accepted the baton on her behalf with an aim through the Scottish Hospital Inquiry to seek justice, accountability and clarity. Listening to the evidence of the Inquiry, the missed opportunities, the complete disregard, the countless flaws and failings, the monumental deficiencies, the negative culture, the mistrust and misgivings, the negativity and toxicity, feels like physical blows raining down on me. Our family will never recover from this and in our lifetime, we will never experience anything as traumatic again. But what we must all never lose sight of, is the reason why we are all here and doing what we are doing. The issue that is far bigger than all of us. The victims at the core of it all, the children. Our daughter Eilidh!

In this fight there are no winners, only victims seeking the truth!

Declaration

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

SCOTTISH HOSPITALS INQUIRY

Bundle of documents for Oral hearings commencing from 16 September 2025 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow

Witness Statements – Volume 2