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 5

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Scottish Hospitals Inquiry
Witness Statement of
Kevin Hill

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

Personal Details and Professional Background

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

A. The details of my qualifications and job roles are as described in my application form and CV. Copies of these documents should be retained in my Personal File held by NHSGGC. I understand that the Inquiry has requested these documents from NHS GGC however due to their document retention policy they no longer hold these.

Role as Director for Women and Children's Services

2. The Inquiry understands that you were Director of Women and Children's Services within NHS GGC from 2010 until 2022. What were the circumstances surrounding your appointment?

A. I was appointed following advert for the vacant post and completed an application form and interview.

a) What was the remit of your role?

A. Refer to Job Description. I understand that the Inquiry has requested this document from NHS GGC however due to their document retention policy they no longer hold these.

b) To whom did you report in your role?

A. Refer to Organisation Chart at **Bundle 52, Volume 2, Document 25, Page 282.**

c) Who reported to you?

A. Refer to Organisation Chart at **Bundle 52, Volume 2, Document 25, Page 282.**

d) Please describe the procedures and governance in place within Women and Children's Services during your tenure.

A. I designated the Chief of Medicine to take the lead role, as a practising clinician, for all matters regarding Clinical Governance. I retained overall responsibility for Clinical Governance through this direct report. I was responsible for leading Directorate Governance; Human Resources, Financial Governance and reporting any issues of concern to Corporate Governance. This responsibility was enabled with professional qualified designated reporting support managers.

e) Please describe your oversight role regarding maintenance and water safety in clinical areas of the RHC, including how you ensured compliance with maintenance schedules, documentation (such as HAISCRIBE), and water quality testing at source (e.g., taps)?

A. The maintenance and water safety in clinical areas is undertaken by Director of Estates and Facilities in conjunction with Infection Control, who will request testing if infection arises at variance with the normal pattern for patient care. The General Manager and Chief Nurse receive update reports and verbal updates from Estates colleagues who are in regular contact with ward/nurse managers and clinical support managers.

The routine maintenance and water safety testing in a clinical area will be discussed and agreed with the relevant nurse manager to ensure minimum interruption to process of patient care. Timings and frequencies will be communicated in advance and can be altered accordingly should the need arise. Documentation would be received by the General Manager and Chief Nurse to monitor compliance and to examine any areas of concern or omission. Any exceptions would be highlighted through Clinical Governance meetings chaired by Chief of Medicine. Any risks highlighted would be immediately dealt with to ensure risks were managed and continuity of care for the patients was not affected.

f) How did you verify that maintenance of the water system of the RHC was being carried out every three months and that relevant paperwork was A. properly completed and submitted?

A. I do not recall ever having sight of paperwork confirming a three month testing and results outcomes regarding RHC water system were properly completed and submitted. The results of water testing I understand was reported as described in my response to question 2 e) above.

g) Can you explain your role in ensuring compliance with these maintenance and testing protocols to protect patients from contamination?

A. My role would be to address and raise issues of outstanding concern with the Director of Facilities and Estates and Chief Operating Officer.

Governance Reporting Structures within NHS GGC

3. During your time at NHS GGC please explain how the governance structure and reporting lines to the NHS GGC Board and its first line of subordinate committees received information and made and authorised decisions in respect of:

a) the procurement of the new Southern General Hospital (that became the QEUH/RHC)

A. The procurement of the new SGH (QEUH/RHC) was lead by the Chief Executive through the appointment of a Commissioning Team (CT) directly responsible to Chief Executive. My involvement with the CT was in regard to ensuring ward and department plans were signed off as being an accurate specification of the users (Staff and Patients) requirements based upon the purpose and functionality of the patient groups identified. This process of sign-off and approval for each specified area was the designated responsibility of the General Manager (Mr Jamie Redfern) as the senior hospital manager.

b) the safe and efficient operation of the water and ventilation systems of the QEUH/RHC

A. I would have anticipated and expected the new building (QEUH/RHC) to have met the current hospital building standards and that specific requirements for patient clinical conditions would be compliant. This includes water and ventilation systems. Any exceptions or omissions should have been communicated and discussed at the Board Water Safety Group and at Acute Infection Control Committee and reported to the Board Infection Control Committee. Documentation submitted to each Group/Committee highlighting potential clinical risks and cost benefit analysis of the implications of each exception and/or omission. The impact on the build schedule from adjustments to the technical specification and cost and time implications would always have to be assessed.

c) the management and reduction of risks to patient safety from infections that had the potential to be connected to the environment (particularly the water and ventilation systems) of the QEUH/RHC.

A. All new NHS buildings, wards and departments should comply with the current approved national building standards especially, where specified, for specific patient conditions and to ensure safe treatment. This is particularly essential when dealing with immuno-compromised patients who are at higher risk and vulnerable to infections at certain times in their clinical treatment. All patients need to be protected from potentially known sources of infections.

d) the need for and authorisation of works to improve or remedy deficiencies in the water and ventilation systems of the QEUH/RHC

A. The Board overall is responsible for the standard and safety of NHS buildings and premises and as such through the Chief Executive and the Director of Estates & Facilities, who is the professionally qualified individual reporting to the Chief Executive. Any design omissions, upon discovery, should be reported and highlighted along with remedial works to correct any deficiencies in the hospital environment and therefore reduce risks to vulnerable patient groups.

e) the processes put in place to ensure that disclosure by staff of evidence of wrongdoing, failures in performance or inadequacies of systems was encouraged and reacted to by the Board to ensure that the safety of patients and the best value use of public funds were protected.

You should be aware that Hearing Bundle 13 contains minutes of the Board Infection Control Committee and the Acute Infection Control Committee, and that Hearing Bundle 11 contains minutes of the Board Water Safety Group.

A. Any issues and concerns were able to be reported directly to Line Managers and this approach was encouraged where staff have any concerns and this was supported by involvement from professional associations and trade unions. This approach was the main route for raising individual and staff concerns. The Board would and should receive reports raising any issues through Executive Reporting at Board meetings and by the submission of papers including where relevant attendance by specialist qualified "expert" individuals at the Board meeting to answer questions and explain technical matters, assess risk to patient groups and their potential impact upon patient care. This can be by "expert" verbal statement as well as documented and preferably both. The Board has a "Whistleblower" policy in place to encourage and ensure any concerns by individuals are able to be raised confidentially and for an "independent" investigation to be undertaken.

4. Please explain what informal and formal meetings or groups met outside the structures you have described in the previous question that made decisions about the issues listed in Question 2.

A. I am unaware of any formal or informal meetings that made decisions about the issues listed in Question 2. (Or and related to Question 3).

5. How is it decided which issues, decisions and reports would be escalated to the full Board or one of the first line of subordinate committees?

A. The escalation of issues, reports and decisions were subject to consideration and deliberation by the Chief Executive, Executive Officers, First Line Subordinate Committees, for example, Acute Infection Control Committee, Acute Directors Meeting, and/or Board Meeting. The decision making level was at the discretion of the Chief Executive.

6. What procedures were put in to ensure all significant questions about the issues listed in Question 2 were being taken to the Board or one of first line of subordinate committees, discussed and actioned?

A. The Board would be updated through verbal and documented reports at its meetings, through receipt of the Board Infection Control Committee minutes and papers and Board Infection Control Committee and separately Acute Infection Control Committee minutes and papers. Details from the Women & Children's Directorate Clinical Governance meetings were distributed and shared with Chief Executive and Executive Officers and any concerns and issues raised were highlighted monthly to Acute Clinical Governance Committee. The same reporting arrangements, as above, were replicated from Women & Children's Directorate Infection Control Committee for Acute Infection Control Committee to ensure issues were raised and actions to remedy and ameliorate and/or eliminate potential source(s) of infection impact were taken in a timely way.

7. What procedures were put in place by the Board to ensure monitoring, progress and resolution of issues related to the list in Question 2 that had been reported to the Board or one of first line of subordinate committees?

A. Once a decision was taken to address any and/or all issues arising in relation to Question 2 (and Question 3) the required actions were highlighted at the Infection Control Committee for Children's Hospital along with a description of the remedial works required, the interruption to the ward and the arrangements

for safe patient care and treatment to continue during this period. The decision for the detailed works was the responsibility of the Director of Estates & Facilities with approval from the Chief Executive and Executive Officers, for example, Director of Finance to ensure funding to complete programme of works. The responsibility, during any works in a clinical area, for the safety of patients, parents and staff and visitors was the responsibility of Director of Women & Children's Services (myself). The Board would receive a report on progress via Chief Executive and Director of Estates and Facilities.

The New South Glasgow Hospital Project

8. Please detail your involvement if any in the following matters in respect of the QEUH/RHC. Where applicable please note where you expressed views and what they were:

a) Site Selection

A. I had no involvement or responsibility for site selection.

b) Procurement

A. I had no involvement or responsibility for site and general hospital procurement.

c) Finance model

A. I had no involvement or responsibility for the Finance model.

d) Value for money in respect of the build

A. I had no involvement or responsibility for Value for Money in respect of the build.

e) Construction/design

A. I had no involvement or responsibility for Construction/Design of the build. The General Manager Children's Hospital and Lead Nurse along with clinical leaders and clinical staff had involvement in the interior layout of wards, theatres and clinical departments, for example, siting of electrical sockets.

f) Commissioning and validation

A. I had no involvement or responsibility for Commissioning and Validation of the build.

g) Derogations

A. I had no involvement in decisions regarding Derogations to the build.

h) With reference to your answer to Question 8(e) of your statement of May 2025 you state that you had no involvement or responsibility for Construction/Design of the new RHC. Mr Calderwood who was Chief Executive at the time has suggested in his draft statement that the design of the RHC was initially led by Dr Morgan Jamieson with your involvement. Can you explain why Mr Calderwood might think you were involved in the Construction/Design of the new RHC after your appointment as Director of Women and Children's Services within NHS GGC in 2010?

A. I was not involved in any discussions regarding the construction/design of the new RHC as my predecessor, Mrs Rosslyn Crockett, I understand would have engaged with Dr Morgan Jamieson in this regard. Upon my appointment the plans for clinical areas and adjacencies within the new RHC were concluded. Specific ward layouts and number of bed spaces and supporting facilities were already detailed in the plans I recall seeing after my appointment.

i) In its most recent its Glasgow 4, Part 1 hearing in May 2025 in the Inquiry heard evidence about the absence of formal Validation of the ventilation systems of the new SGH prior to occupation of the hospital by patients. It appears that members of the NHS GGC Project Team may not have understood the difference between 'commissioning' a ventilation system to confirm it has been fitted in compliance with the contract and 'Validation' of a ventilation system to confirm that it operates as its users expect it to. Do you have an understanding of the difference between 'commissioning' a ventilation system and 'Validation' of a ventilation system and can you assist the Inquiry in understanding why the ventilation system of the RHC including specialist ventilation areas such as isolation rooms and haemato-oncology wards were not validated before patient occupation?

A. Yes I do have an understanding of the difference between commissioning a ventilation system and validation of a ventilation system. My previous experience of refurbishment of existing and new NHS buildings and facilities, including paediatric intensive care unit, operating theatres and catheter laboratories. My understanding of commissioning is that the construction firm and supplier provide the match to the specification of the ventilation system and initially builds and fits the system and confirms when it is fully installed and operational. The validation process is when the system is tested to ensure it delivers the ventilation requirements for the area being used to meet the specification for example number of air changes, negative or positive pressure.

It is disturbing to learn that the ventilation system was not validated to ensure compliance with the requirements of the patients who would occupy the ward. The responsibility for validation and ongoing monitoring rests with the Director of Estates and Facilities.

j) With reference to your answer to Question 3 of your statement of May 2025 how did you ensure that on the arrival of patients in Ward 2A on 10 June 2025 that ventilation system for both the ward as a whole and the BMT isolation rooms in particular was operating on accordance with the standards then set down in SHTM 03-01 or that there was a derogation in place if it was not?

A. I did not personally check or ensure that the ventilation system was functional and operational. My expectation was that the specification describing additional ventilation system requirements should have been tested and proven “fit for purpose” prior to occupation and certainly during the commissioning period before acceptance of the building. I cannot recall whether a derogation was in place.

k) In his draft statement Mr Calderwood has explained that you took the decision that the new RHC was safe to move the children into the new hospital in June 2015.

(i) Is that correct?

A. The new RHC building was physically completed and ready for patient occupation and therefore my decision to move was a foregone conclusion

given the readiness of the new facilities. Prior to patient occupation and transfer from RHSC Yorkhill environmental “snagging” had been completed by the clinical and operational teams to ensure the facilities enabled highest standards of patient care. This did not include from a hospital operational and clinical team perspective any testing of water, electrical, drains, air handling and ventilation systems as these were within the remit of the Director of Estates and Facilities. My decision to move was based on the physical finish of ward areas I was responsible for and therefore I could form a view on readiness to occupy. At this time the building and wards appeared to be satisfactorily completed and functional.

(ii) Can you describe the process and documentation that constituted the validation of the ventilation system of Ward 2A RHC before occupation by patients? Did this include formal testing, certification or independent audit of the ventilation.

A. I am not aware and was never involved in the process or documentation of validation of the ventilation system prior to occupation by patients.

(iii) With reference to your answer to Question 3 of your statement of May 2025 how did you ensure that on the arrival of patients in Ward 2A on 10 June 2025 that ventilation system for both the ward as a whole and the BMT isolation rooms in particular was operating on accordance with the standards then set down in SHTM 03-01 or that there was a derogation in place if it was not?

A. This question is the same as 8 j) above. Please refer to my answer to 8 j).

<u>Infection Control</u>

9. What is your understanding of how infection within the QEUH/RHC was and is monitored, investigated, reacted to and reported both internally and externally. Please provide full details.

A. Daily and weekly and monthly inspections undertaken internally by ward leader and Lead Nurse and Infection Control Nurse designated for Children's Hospital as well as Estates & Facilities Directorate Manager for domestic and cleaning

would participate in walk-rounds and produce monitoring audit reports highlighting any issues and concerns. Any issue requiring immediate attention would be escalated to Children's Hospital Management and actions required agreed and corrected. Any issues for reporting to Senior Management would be highlighted via verbal, written (email) and formally reported at Children's Hospital Infection Control Meeting and Chief Nurse meetings with Lead Nurses. At all times the senior nurse-in-charge could escalate any concerns and Lead Nurse would consider the urgency in conjunction with the Hospital's Clinical Services Manager(s) and General Manager. The internal formal reporting process was to the Children's Hospital Infection Control Committee and to the Women & Children's Infection Control Committee and separately, as appropriate, to the Women & Children's Clinical Governance Committee and then externally to Acute Infection Control Committee and/or Acute Clinical Governance Committee.

10. When did you first become aware of concerns raised by infection prevention control colleagues in respect of the built environment, water and ventilation systems within the QEUH/RHC? What actions were taken in respect of these concerns? Do you think the concerns raised were taken seriously?

A. I do not recall the specific month or year. At some future date, following the opening of the QEUH/RHC buildings I was aware through, I believe, the Acute Directors Meetings of discussions pertaining to Infection Prevention Control clinical staff concerns being raised during, I think, the design and planning stages of the build and post-opening of both hospital buildings. I do not know what actions were taken. I am unable to comment on whether the concerns were taken seriously.

Ventilation in Ward 2A/B

11. To what extent (before handover) did you anticipate that the ventilation system in Ward 2A RHC would be of equivalent standard or better than that installed in the Schiehallion Unit at Yorkhill?

A. I anticipated and expected that the ventilation system in Ward 2A/B would be at a minimum equivalent standard of that installed in Schiehallion Unit at Royal Hospital for Sick Children Glasgow (Yorkhill). I expected that, where appropriate, any upgrades to standards for such units throughout the UK would be incorporated into Scottish Health Technical Memorandum – Technical Building Notes and Design Specifications; to ensure the latest and proven ventilation systems were incorporated into any new build or refurbished units and wards.

a) When was the proposed ventilation system in Ward 2A RHC first drawn to your attention?

A. I am unaware that the proposed ventilation system in Ward 2A RHC was ever drawn to my attention prior to the completion of the build.

b) When did you learn that the ventilation system in Ward 2A RHC did not meet the standards anticipated by the treating clinicians in the Schiehallion Unit?

A. Following the opening of the RHC, I am unable to recall a date, month and year, when the issue that the ventilation system did not meet the standards of ventilation of previous Schiehallion Unit at RHSC Yorkhill was raised with me.

c) To what extent was this a surprise to you and why?

A. The information that the new RHC did not as a minimum have the previous standard of ventilation system installed to ensure safest standards of ventilation to one of the most vulnerable group of child patients' was extremely serious and of great concern.

12. Which members of NHS GGC staff had approved the design if the ventilation system for Ward 2A before handover, when and how had they done that and did they ever give you a reason for doing so?

A. I do not know who approved the ventilation system installed in Ward 2A as part of the QEUH/RHC build.

13. Dr Brenda Gibson gave evidence to the Inquiry that in March 2015 she raised concerns regarding the safety of Ward 2A prior to patient migration and that on

a visit to Ward 2A shortly before the move, it was discovered that HEPA filters were not in fact installed in the BMT rooms on Ward 2A. Were you aware of Dr Gibson's concerns? Who told you and when?

A. I was made aware following Dr Gibson's visit to Ward 2A in March 2015, prior to the transfer of RHSC Yorkhill two months later. I am unsure who told me initially and can only speculate that my General Manager Children's Hospital and/or Chief Nurse/Lead Nurse and/or Clinical Services Manager briefed me on the discovery of this omission. I would certainly have held a discussion/meeting with Children's Hospital Commissioning Manager (Mhairi McLeod) to seek an explanation for the omission.

14. Once you became aware of issues with the ventilation system in Ward 2A RHC what steps did you take to find out why it did not meet the standards anticipated by the treating clinicians in the Schiehallion Unit and what was the result of that investigation? Was any consideration was given by the Board to undertake a review to understand why this had happened?

A. I would have contacted Children's Hospital Commissioning Manager to seek clarification and to understand whether the requirement for HEPA Filters had been incorporated into modern fitments that had been installed? Thereby omitting the need for a separate fitment. I would have also raised this personally with the Director with responsibility for New Build and Commissioning of the new hospitals (David Loudon). The outcome was to retrospectively install HEPA filters throughout clinical departments at New RHC. I am unaware of whether the Board undertook a review to understand why this had happened.

15. Why was Ward 2A handover accepted by NHS GGC in January 2015 without HEPA filtration being in place?

A. I am unaware why Ward 2A handover was accepted by NHSGGC in January 2015 without HEPA filtration being in place.

16. Who signed off handover without HEPA filters being in place?

A. I am unaware of who signed off the handover without HEPA filters being in place.

17. The Inquiry understands that the isolation rooms in Ward 2A were Positive Pressure Ventilated Lobby rooms built to SHPN 04-01 standard however this design was not suitable for neutropenic patients and the rooms should have been built to SHPN 03-01 standard. Were you aware of this? What information were you provided about this? Why did this happen?

A. I was made aware of this information regarding the Scottish Health Planning Note at the time this was discovered and the resulting Positive Pressure Ventilated Lobby Rooms. These Lobby Rooms were unsuitable for Neutropenic Patients' and therefore a non-compliance in ventilation requirements in the overall treatment environment for such highly vulnerable patients. Following the discovery of this issue then discussions and meetings took place between Hospital Management, Ward 2A Clinicians and Clinical Teams, Ward Nursing Leader, Lead Infection Control Doctor, Infection Prevention and Control Lead Nurse and with Director/Senior Managers and Estates & Facilities. The aim and purpose was to ensure alterations to the ventilation system to meet the standards required. I do not know the reason(s) why this occurred and how erroneous air pressure happened.

a) When concerns about ventilation system of Ward 2A RHC were raised for the first time in 2015, did you take these concerns seriously at the time? What specific actions did you take to address them in line with your responsibility for safety?

A. I was absent from work from July 2015 until December 2015 due to an infectious eye condition therefore I am unable to respond. The General Manager would be temporarily covering my areas of responsibility

b) Given your role, should you not have initiated a formal investigation into the omission of HEPA filters from the ventilation system? If not, why?

A. Please see response to Question 17 a) above.

c) Following disclosure of the HEPA filter omission, were you concerned about the overall integrity of the ventilation system? What steps did you take in response?

A. Please see response to Question 17 a) above.

The Water Incident

18. Before NHS GGC took responsibility for the QEUH/RHC building in January 2015 were you aware of the requirement for a L8 Preoccupation Risk Assessment? Are you aware of what steps were taken to ensure that one was carried out? What steps did you take to ensure that the water system of the RHC was safe and not subject to widespread contamination before patients moved in?

A. Not aware and not my responsibility. No. Not my responsibility.

19. When did you first become aware of the recommendations of the DMA Canyon Report 2015 L8 Risk Assessment (**Bundle 6, Document 29, Page 122**) and why? What steps, if any, did you take to ensure sufficient steps were being taken to address the issues identified within the reports?

A. I was not aware during 2015/16 of the publication of this report or its contents. I later became aware of reference to a DMA report during 2018 but was still unaware of its contents. I am unsure whether I ever received a copy of the 2015 DMA report. My understanding is this report highlighted issues related to hospital QEUH/RHC water system and identified the build up and presence of legionella. My understanding is the hospital water system should be tested every two years as part of conformance with regular water testing regime for the presence of legionella and other water-borne organisms. The responsible director of Estates and Facilities would be expected to action the issues arising from this report.

20. The QEUH/RHC uses large numbers of Horne Optitherm Taps. Following neonate deaths at hospitals in Northern Ireland and Western Australia a meeting was held with representatives of HPS, HFS and others on 5th June 2014 (Refer to **Bundle 15, Document 9, Page 692** and the HPS SBAR of 2014 **Bundle 3, Document 1, Page 5**). What is your understanding of the decision that then faced NHS GGC in respect of the use of Horne taps within the new SGH? Given these Horne taps were used in the new Children's hospital what was reported to you, as Director of Women and Children's services, about this

issue and specifically what steps were being taken after handover to ensure that these taps were being used safely and without build-up of biofilm?

A. I do not recall being directly involved during 2014 in the discussions or meetings regarding the use of Horne Optitherm Taps in QEUH/RHC. My recollection is that discussions regarding model and types of taps within clinical areas were part of general issues, including fitments and shape and style of sinks, formed part of ongoing discussions between the New Hospital Commissioning Team and General Manager and Chief Nurse for Children's Hospital along with their direct reports responsible for operational management. The advice of Infection Prevention and Control would have been sought to determine the safest outcome for patients. I understand that the solution reached was to test the taps for build up of biofilm and presence of contaminants. I think there may have also been discussion about replacement of such taps in phased way commencing with the highest risk patient group ward areas as a priority.

21. What is your involvement in or understanding of any water contamination issues in the QEUH/RHC and the extent to which infections suffered by patients in the Schiehallion unit cohort may be linked to contamination of the domestic water system?

A. My involvement in potential water contamination issues as a direct source of infections in patients in Schiehallion unit; was a member of an Infection Management Team (IMT) either through attendance or briefed following attendance of Chief Nurse and/or General Manager or Lead Nurse or Clinical Services Manager with responsibility for Children's Hospital Services. The presence of professional experts lead by the Lead Infection Control Doctor (Dr T Inkster) would outline the issues and the types of bacterium found infected in patient(s) and scenarios would be described as to the possible source(s) of infection by organism type. This was a dynamic picture and weekly IMT meetings would highlight potential sources of infections and remedial actions to be taken to reduce risk of further patient contamination. It is always regrettable and a failure in hospital systems management whenever a patient is infected by a bacterium from internal (ward environment) and/or external source wider hospital environment and/or from out with the hospital itself. It is always a serious concern and resultant anxiety for the impact on patients and

families when such infections occur especially in an immune compromised patient group.

a) With reference to your answer to Question 19 in your May 2025 statement:

(i) Having been made aware of the DMA Canyon reports and the high-level risks identified, what concrete steps did you take as Director to ensure the water system was safe for patients in the RHC?

A. Testing of water systems is the responsibility of the Director of Estates and Facilities and the safety of the water system for patients in the RHC would be considered as part of the role of Infection Control. Any variances and highlighted risks would be considered in conjunction with the Clinical and Operational teams in the RHC. If required, an IMT would be established to highlight issues of concern and address actions to alleviate risks to patients.

(ii) Was testing for biofilm and contaminants in taps ever carried out? How did you ensure this testing was performed and results acted upon?

A. The evidence to answer this question will be held by Director of Estates and Facilities and Infection Control colleagues. My understanding from IMT meetings was that testing was discussed and therefore where applicable undertaken although I am uncertain as to the results of such testing due to the design of the taps and whether the issue was more to do with the design and efficiency of this type of tap in the clinical area concerned. I do not recall whether testing for biofilm and contaminants in taps was carried out. I think the debate may have considered that there would be the presence of such contaminants in all taps. Testing and acting upon results were reported through Infection Control at IMT and on daily briefings/updates to Operational and Clinical teams in RHC.

(iii) With reference to your answer to Question 20 in your May 2025 statement you state that you “understand that the solution reached was to test the taps for build-up of biofilm and presence of contaminants”. When did testing and maintenance of the Horne Optitherm taps commence?

A. The details of the testing of taps and results will be found through Director of Estates and Facilities along with Infection Control colleagues with the Laboratory function who will have processed the samples

Decision to Close Wards 2A/B and Move to 6A and 4B

22. Discuss the issues surrounding and leading up to the decant of patients from Ward 2A/B in 2018.

a) What was the lead up to and background to this?

b) What was your involvement?

c) What risk assessment and additional measures were put in place to ensure patient safety?

d) What concerns, if any, did you have about where the patient cohort was being moved to? If so, why did you have these concerns

e) Discuss and detail the works done to Ward 2A/B what was required to be done and why, what has been done and when the work was completed. Please include details of your involvement. **Please note IMT minutes are contained within Bundle 1.**

f) Any other relevant information.

A. It became apparent throughout the IMT meetings that the types and varied number of infections impacting upon this vulnerable patient group and the anxiety of parents, who often reside on the ward during inpatient duration or periods when their child receiving critical and intense treatment, was unsustainable. The impact of the situation on clinical and ward staff members was stressful and unbearable. The ward 2A/B and whole children's hospital was attempting to maintain safe clinical care during this unprecedented time. The ward was basically subject to incremental works disruption as each scenario arising from the decisions of the IMT were quite correctly investigated in order to try to identify the source(s) of infection(s) and consequently resulting in higher risk environment for patients. The relentless and ongoing situation whereby potential sources of infection were potentially widespread within the ward environment could not continue. Therefore following an options appraisal to consider ward decant options it was correctly decided to decant the entirety

of patients treated in Wards 2A/2B to the adult hospital QEUH. The decision would also impact upon adult patients and their respective clinical teams and management. The most appropriate adult wards were Ward 4B and Ward 6A. This was not an easy decision as it involved the transfer of the most vulnerable children patients as well as the entirety of the functioning ward staff and provision of equivalent space for parents. However despite concerns the main reason the move was supported enabled the entire Ward 2A/B to be emptied and 'stripped back' to expose pipework, shower cubicles, sinks and drains. It also allowed for all wall partitions and facings to be completely removed to investigate the source of damp/mould/water ingress and any other build/material defects that may have caused source/incidence of patient infections. The decant freed up the entire ward environment to facilitate a 'root and branch' forensic assessment of the environment overseen by Director of Estates and Facilities to address all of the areas requiring examination as per the recommendations from IMT meetings and including the review of chilled beams, ventilation system, drains, sinks and shower cubicles, taps and water filters, positive and negative pressure rooms, as appropriate.

g) Discuss the issues surrounding the ward 2A patients when in occupation of ward 6A and your views in respect of:

(a) Chilled beams
(b) Gram Negative Bacteraemia
(c) Water filters
(d) Ventilation
(e) Issues/ testing/ escalation/ response/ IMTs/SBARs impact on patients
(f) Patient communication
(g) Internal escalation - HAIIT scoring
(h) External escalation

A. The questions arising from the occupancy of Ward 6A QEUH were highlighted, discussed and actions agreed as part of IMT meetings. The discovery of potential sources of infection in this vulnerable children patient group created a situation of extreme anguish and concern for both patients and parents as well as management and staff. The daily situation of increased concern from clinical staff, parents and patients and further interruption to their planned care and

treatment consequently resulted in the “temporary” relocation of the Ward 6A group of child patients, inpatients and outpatients and day care, to the clinical decisions unit of the Royal Hospital for Children. This move was to enable a review of the technical and ventilation facilities within Ward 6A that may be causing concern and consternation that the location chosen as part of the decant of Ward 2A and 2B required to be vacated to enable works to be undertaken to reduce further harm to inpatients. This action was taken to safeguard patients and to facilitate a ward environment supportive to provide the highest standards of care and treatment by paediatric clinical staff. All decisions taken were considered at IMT meetings and risk assessment concluded the need for such actions.

h) The Inquiry is aware of Mr Redfern’s Options Appraisal for the decant of 17 September 2018 (**Bundle 6, Document 13, Page 38**) and that based on the evidence of Ms Rodgers, Ms Dodds and Mr Redfern steps were taken to prepare Ward 6A to receive Ward 2A/2B patients, but prior to the decant on 28 September 2018 did you ensure a comprehensive review of the technical and ventilation facilities in Ward 6A to confirm the environment was safe for patients?

A. No I did not request a comprehensive review of the technical and ventilation facilities in Ward 6A. The existing BMT adult patients were already receiving treatments on Ward 6A and the children who required this facility would also be treated in this area utilising single rooms designated for such purposes. This area therefore for the patient cohort appeared safe to use.

i) With reference to your answer to Question 28 in your May 2025 statement you explain when referring to the decision to decant patients from Ward 6A to the CDU to how “A multidisciplinary team needs to reach a consensual position that all parties can support even with reservations on the part of some participants”.

(i) In this context why was not the relevant multidisciplinary team not the IMT itself?

A. The decision to decant patients from 6A to the CDU was taken following a meeting of the IMT where the managerial and operational and clinical

concerns were appreciated by the IMT members and therefore as Director it was my responsibility to review risks of such a move from with colleagues who met separately to the IMT to determine the suitability of the CDU.

(ii) Why was a meeting called with a small number of individuals after the IMT?

A. Please see response to question S14a above.

(iii) Was this meeting truly multidisciplinary with no clinicians present?

A. The decision and the meeting that took place was to identify and manage any foreseeable risks in moving to CDU. The Ward 6A area was already close to being a “building site” with the volume of works underway and the impact from shower areas being designated unusable for patients. The task of the small meeting group was to reach a decision on whether it was suitable to move patients and in doing so was there a higher risk from CDU compared with the current situation in Ward 6A. The decision to move was taken in the best interests of patients, families and staff to maintain a safe clinical environment for children.

(iv) Did you disagree with Dr Inkster regarding the risk to patients from mould in the shower rooms?

A. No I did not disagree with Dr Inkster regarding the risk to patients from mould in the shower rooms. The issue to resolve was how to remedy the situation whilst continuing to treat patients. The only two options were continue to undertake work arounds whilst patients remained in-situ on Ward 6A or move to another ward area. The decision, after considering risk assessment, to move patients, in order to continue treatment and care was the correct decision.

j) With reference to your answer to question 35 of your May 2025 statement:

(i) Did you think it was wrong for the IMT to sample drains and if so why?

A. I understand and appreciate the decisions of the IMT as a participant and will always refer to facts, specialist opinion and discussion to inform my view. I may not support every decision however the specialist opinions inform the meetings on why certain hypothesis need to be ruled out or developed further

to identify the source of infection. I understand the debate regarding testing drains was that you would expect to find biofilm and contaminants in a drain system. Therefore the results would be unsurprising if contaminants were positively identified.

(ii) Were you concerned about the methodology for sampling drains and if so why?

A. Please see my answer to question j) (i) above.

23. What involvement did you have on or about 18 January 2019 in the decision to decant Ward 6A to the CDU? What was your understanding as to why a decant was necessary?

A. A decant was considered necessary to safeguard patients from an unknown source of infection suspected to be arising from somewhere within the ward environment.

24. The Inquiry understands that ward 6A was closed to new admissions at the start of August 2019. Patients were diverted to other centres, including Aberdeen and Edinburgh (see Witness statement of James Redfern, para. 118 - **Hearing commencing 12 June 2023 - Bundle of witness statements , Document 7, Page 371**). The Minutes of the IMT of 1 August 2019 (**see Bundle 1, Document 75, Page 334**) imply that a decision was previously to close Ward 6A to new admissions and patients requiring higher risk chemotherapy. What knowdledge did you have of that decision at the time. Why was it made, who made it and who approved it?

A. The decision to close Ward 6A to new paediatric admissions was discussed and considered at length by the IMT and by separate meetings involving the paediatric clinical team. Although this was the stated position, to inform staff, patients and parents, each patient case would be determined in detail by the consultant responsible for the patients care or in the event known patients ongoing care in conjunction with the parents concerned. A small number of patients and parents were offered and referred to Royal Edinburgh Children's Hospital and Aberdeen Children's Hospital and some parents accepted the alternative, however I understand that very few took up the offer and of those

who did they did not consider the alternatives to be as conducive as RHC Glasgow. All decisions regarding patient care were determined with the full involvement of the named consultant, with clinical team input and infection control and senior hospital management. The ultimate decision rested with the patients' consultant in conjunction with the respective parents.

25. What steps were taken to ensure that ward 6A was safe for new admissions before the decision was made to re-open the ward?

A. Once the initial works required, as identified through IMT, and upon closer inspection of the vacated ward and any other changes technically assessed, as required to the ward and replacement fittings were completed. Following satisfactory testing and assessment of ward 6A environment the final stage was for the entire ward area to be treated using HPV process it was deemed "fit for purpose" and a safe clinical area.

26. Please outline the governance procedures and reporting practices which were in place in respect of the decant.

A. There was regular daily contact with the "decanted" ward as occurs on every day to every clinical area through the Lead Nurses and Clinical Services Manager. The children's hospital has for a number of years pre-move held once daily at 8.00 Hospital Huddle to enable hospital wide issues to be raised and for attendees to suggest ways to manage any pressure points in the care system to reduce or eliminate interruption to patient care. This process is continuously monitored and reported at 12.00, 16.00 and 20.00 and midnight to ensure support for hospital coordination and immediate assistance to ward and clinical areas requiring planned assistance. Whenever there is an urgent issue emerging the routine alert system would be to report to the most senior person on duty in the first instance. Escalation beyond this throughout 24 hours 365 days a year is in place to ensure safety and support staff. The normal reporting arrangements for clinical governance were in place; escalation by verbal contact; written SBAR; online Incident Reporting Sytem Datic; formal reports to Hospital Clinical Governance Forum and Acute Directors Meeting. In addition, depending on the nature of the issues arising, discussion and reports would be considered by Directorate Health & Safety Forum including

professional staff representatives. All reporting lines were maintained prior to and during the decant, throughout the decant period and post return to ward 6A.

27. Refer to Dr Inkster's statement at paragraph 710 (**Witness Bundle – Week commencing 30 September 2024 - Volume 7, Document 1, Page 3**). Dr Inkster refers to a meeting with yourself, Tom Steele, Jamie Redfern and Jennifer Rodgers following the IMT of 18 January 2019 where it was agreed to move patients to the CDU. She states that she felt "under pressure" and "bullied". Please detail your recollection of that meeting.

A. I was astonished and shocked to read that Dr Inkster felt "under pressure" and "bullied" during a meeting with myself and colleagues to discuss and consider the adequacy of Clinical Decisions Unit (CDU) RHC as a temporary transfer ward area for the patient cohort being treated in Ward 6A. We are all colleagues from different backgrounds and professions working for the same organisation to ensure the highest quality of patient care and had been required to consider and finalise an alternative to the "decant" Ward 6A; given the incidence of infections affecting patients arising from source(s) suspected from within the Ward 6A area.

I do not believe I personally bullied or Dr Inkster under pressure to reach a decision to move Ward 6A patients to CDU. I suspect I would have asked questions and challenged points and sought suggestions and possible solutions at the meeting as was my 'modus operandi' throughout my 36 years of NHS management positions. A multidisciplinary team needs to reach a consensual position that all parties can support even with reservations on the part of some participants.

a) Did you oppose the decision to move the 6A patients to the CDU? If so, why?

A. I was in full agreement with the temporary move of the ward 6A patients to the CDU.

b) Did you feel that children should remain on the ward whilst the work took place? Please explain your answer.

A. I did not want to increase the risk to patients whilst works were underway in ward 6A. I therefore felt it was clinically, technically and managerially appropriate to temporarily transfer ward 6A patients to CDU.

Cryptococcus

28. What were the issues with Cryptococcus at QEUH? When did you first become aware of these issues? What happened in response to these issues? What was your involvement, if any, with i) the cryptococcus IMTs and ii) the cryptococcus sub-group?

A. I would whenever available attend IMT meetings when the issue of mould in Ward 6A had been raised and during discussion regarding chilled beams leaking/dripping water onto patients/beds. I do not recall the specific dates when I first became aware of Cryptococcus affecting patients in Ward 6A. The ultimate decision was to decant Ward 6A to CDU to facilitate a full and thorough technical investigation into mould, water leaks, materials and fitments used, likelihood of bacteria build up in existing ward water systems. Cryptococcus organism is found in soil and bird droppings particularly pigeons. I do not recall any personal involvement in the Cryptococcus sub-group.

29. What was your role in respect of communicating with i) patients and families in respect of cryptococcus infections

A. My role in communicating with patients and families regarding Cryptococcus was indirect as the persons responsible direct patient care, the consultant with the involvement of Infection Control professionals and the senior hospital management provided support and they as a team performed the direct communication with patients and families. My role was in conjunction with the Boards Communication Team to prepare a general communication following the outcome of each IMT meeting. To ensure that the communication was sensitive to the situation affecting patients and parents and ward staff whilst maintaining factual accuracy. If the source of infection(s) was unknown then the statement could not include speculative or multiple reasons without conclusive

evidence. Truth and honesty is vital to maintain trust with patients, parents, staff and public.

30. and ii) the Scottish Government?

A. The communication with the Scottish Government was direct from HPS as they were present at the IMT meetings. My involvement would also include assisting

31. Refer to the Action Plan from the IMT of 16 January 2019 (**Bundle 1, Document 58, Page 264**). What is this document? What was its purpose? What actions were you responsible for and why? Did you complete your actions? Were all the actions in the plan completed? How did this contribute with the overall management of the cryptococcus incident?

A. This document states the actions arising from the IMT meeting of 16/01/2019 and indicates against point 18 that the communication for adult patients and paediatric patients (and parents) was completed on 17/01/2019 by the colleagues named collaborating to reach an agreed statement(s).

32. Describe your understanding and involvement, if any, in the media and press statements released in respect of the Cryptococcus incidents at QEUH/RHC in and around 2018/2019? Were you satisfied with how this was managed? If so, why and if not, why not?

A. The outcomes agreed at the IMT meetings would form the basis of patient, parent and staff briefing meetings. I would be fully involved in the preparation and drafting versions of such statements usually including the General Manager and Chief Nurse for the Children's Hospital. This involvement could be a long process given the need for iterations to be approved before a final 'agreed' version was produced. With regards to preparing media and press statements I would usually be contacted to review a draft version and if appropriate, I may suggest amendments to the content however the final approved version would be the responsibility of the Chief Executive along with the Director of Communications and following extensive engagement with the Scottish Government. Satisfaction with the content and timing of media and press releases is not something I can conclude one way or the other as it depends on the amino of facts available to inform the briefing and the accuracy to be able

to define and conclude what caused “x”. This unfortunately is very rarely clear and unambiguous especially when dealing with cases of infection and therefore unless it is categorically established then possible multiple sources and speculation only cause greater degrees of anxiety and worry and stress at the time when we are trying to maintain hospital services and confidence in the expertise and skills of our medical and clinical teams. We have a duty of candour to communicate clearly and precisely what we know to patients, parents, staff and the wider public.

33. Please refer to IMT minute of 17 September 2018 (**Bundle 1, Document 39, Page 171**). At this meeting you advised that the executive group had not approved the decant of Ward 2A/B. Please explain why this was not approved. What other options were considered? Who do you understand to have made the final decision to decant the ward?

A. The decision of the Executive Control Group not to approve the decant at that time of Ward 2A/B to the preferred ward was to allow the initial assessment by a drainage expert to take place and to be in receipt of a preliminary scope report on their methodology and where appropriate, any findings at this stage that may inform IMT decision making. I did confirm to the IMT that a decant option was actively under consideration, reflecting the current recommendations of the IMT.

34. Please refer to IMT minute of 25 June 2019 (**Bundle 1, Document 73, Page 325**). The minutes note an action point in that you and Chris Deighan will establish whether other hospitals sample their drains. Did you complete this action? Why were you seeking to understand other hospitals’ practices? What do you understand the reasons behind drain sampling to be?

A. The action to try and obtain a picture throughout the NHS England of frequency of drain sampling and incidence of potential linked infection(s) was undertaken by Dr Deighan and myself following the IMT meeting. My recall is that we discussed how we could obtain this information and concluded that national meetings of Health Protection Services in England and cross country meetings involving Scotland, Wales, Northern Ireland and England may be a potential source to obtain the information we required. Ultimately I think this action was

completed through HPS Scotland in collaboration with the Department of Health England. I think the outcome of the enquiry was incomplete as the testing regimes were different across and throughout the UK.

Communication

35. Refer to the Core Brief of 6 December 2018 in respect of the decant of Wards 2A/B **(Bundle 52, volume 2, Document 3, Page 66).** Here you state "As our patients and staff had already relocated to another ward, this provided a good opportunity to carry out this upgrading of the system", why did you not address the issue of the ventilation not meeting the required standards? Do you feel this statement is open and transparent?

A. Please see my answer to 42 a) (ii) and 42 a) (iii)

36. Refer to Dr Inkster's statement at paragraph 322 **(Witness Bundle – Week commencing 30 September 2024 - Volume 7, Document 1, Page 3).** Dr Inkster notes that she had concerns with your communication in relation to the decant. Do you feel that communication with staff and patients' families was accurate, honest and transparent? Please explain your answer.

A. My statement at the IMT of the 03/07/19 was an accurate 'repeat' of what I had been told directly by Mr Brown, Chairman and perhaps also, although I do not recall clearly, in the presence of Jane Grant, Chief Executive. I was not party to the content of the conversation(s) that occurred between Mr Brown and Professor Cuddihy.

37. Refer to Dr Inkster's statement at paragraph 826 (**Witness Bundle – Week commencing 30 September 2024 - Volume 7, Document 1, Page 3).** Dr Inkster notes that she was made aware of a telephone conversation between yourself and Jamie Redfern, during which you instructed that they were not to contact Professor Cuddihy in relation to his daughter having contracted M. Chelonae. Please detail your recollection of this. Did you instruct Jamie Redfern not to contact Professor Cuddihy? Please explain your answer.

A. The content of a private telephone conversation between Mr Redfern and myself was made known to Dr Inkster by the recipient of the conversation. This was a breach of confidentiality. I had suspected Mr Redfern was briefing and possibly speculating with Dr Inkster and Professor Cuddihy throughout this period. Mr Redfern in my opinion and from direct observation did not like confrontation and disagreement (I do not think anyone is a supporter of it especially being at the receiving end of it) however this would result in him conceding and sharing information and who was requesting the action. This is undermining of the position of Senior Management and causes barriers to communication of facts. The instruction from myself to Mr Redfern was a direct result of the Chief Executive and Chairman informing me that they had received a letter from Professor Cuddihy and they would be responding to it. My concern when speaking on the telephone with Mr Redfern was that the details of a second child who had caught the same infection was going to be discussed with Professor Cuddihy therefore a "breach of confidentiality" would arise without prior consent from the parent of the second child concerned. A failure of "duty of candour" to the parents of the second child. I would have sought Mr Redfern's view on the appropriateness of such a conversation and the rationale for the meeting. I do not recall whether Mr Redfern provided a response to my points. At this stage I had no idea of the content of the letter from Professor Cuddihy to the Chairman.

a) Dr Inkster further notes that at the IMT of 3rd July 2019 (**Bundle 1, Document 74, Page 330**) you reported that John Brown was in contact with Professor Cuddihy. She followed up on this at the next IMT where you reported that John Brown had spoken to Professor Cuddihy but that she subsequently became clear that John Brown had not informed Professor Cuddihy. Why did you report that this had been the case if it had not?

A. My statement at the IMT of the 03/07/2019 was an accurate 'repeat' of what I had been told directly by Mr Brown, Chairman and perhaps also, although I do not recall clearly, in the presence of Jane Grant, Chief Executive. I was not party to the content of the conversation(s) that occurred between Mr Brown and Professor Cuddihy.

38. What is your view of the quality of the communication with parents of patients in relation to increased infections and the decants? Do you consider updates were provided in a timely and transparent manner? In your opinion could GGC have done better and if so, how?

A. The timing of communication is always a point of potential contention especially when the situation was dynamic and evolving and the headline content of communication was determined by IMT meetings. The involvement of multiple people and layers of organisations as well as Scottish Government before 'approval' to release is granted can be and often is perceived as tardy. I believe despite this content and factual accuracy was relevant and the adjustment of written statement releases dependent upon the audience receiving them was tailored and appropriate. Improvements to communication can always be made especially the verbal updates to allow questions from staff, parents and patients that was successfully managed mainly through Ms Rodgers Chief Nurse and Mr Redfern General Manager, who were the senior management for the operational Children's Hospital. The opportunity in the future to issue statements before the evening of a Friday would be an improvement.

39. Please refer to Annex MB02 of the statement of Mark Bisset **(Hearing commencing 20 September 2021 - Bundle 7 - Statement of Mark Bisset - Annex MB02 for week commencing 1 November 2021).** This screenshot shows a statement posted by you on the private Facebook group for parents and families. Who provided you with advice on the terms of the post?

A. The compilation of this statement would have been the outcome of engagement with Communications Team, Chief Executive and Board Medical Officer and Scottish Government Oversight Board and specifically Professor White along with a review of extracts from all previous statements output from IMT meetings.

a) Had there been no issue with the ventilation in Ward 6a would these enhancements been carried out? Why was there no mention of the water/ventilation issues in the post?

A. I believe that the statement refers to further accessible information in the form of reports and investigations and explains the content subject of such materials are available and readily accessible. This statement does not mention water

issues and refers to technical review undertaken by the Board in 2018 and the Cabinet Secretary's wider external review into design, construction and maintenance of the QEUH/RHC. All papers are accessible for public scrutiny.

40. Please refer to IMT of 14 November 2019 **(Bundle 1, Document 88, Page 402)**. In respect of communications and advice to parents/patients regarding lifting of restrictions to the ward and parents' anxieties in respect of articles in the media. In respect of the Facebook page, you are noted as commenting that, "we have been factual in our account and all controls are in place". What do you mean by this statement? What communication strategies were in place to ease parents' anxieties and to keep them fully informed?

A. Media articles by their very nature can give rise to worry, stress and anxiety especially amongst child patients and parents and in particular when related directly to the ward children are being treated on. I do not recall the specific media headlines or story. My statement at the meeting was to reinforce that all communications affecting patients and parents was discussed and recommended from IMT meetings and any press release would be based upon the factual situation as far as patient care was concerned. Throughout the period following the opening of RHC in 2015 and until the conclusion of works to upgrade Ward 2A and 2B the media headlines could be alarming and draw attention to the claims within any article. NHSGGC attempts to robustly and timely answer all media enquirers and present a factual situation from the Board's perspective. Whether this is reflected in the public media article is out with NHS control. The communication strategies exist firstly at ward level and between the consultant and patient/parent and the wider clinical team. Secondly during times of heightened risk then the presence of Hospital Senior Management assists in supporting staff and interaction to support clinical staff with parents and where age appropriate child patients, in communicating the situation and the cause (if known). This is reinforced by written communication. Thirdly, action plans arising from IMT meetings and recommendations are communicated verbally and in writing as described in previous responses to earlier questions. Fourthly, wider communications usually in the form of proactive press releases and responses to media enquirers will also be shared. All of the above is reinforced daily through management walk rounds by

representatives of the Senior Hospital Management such as the Lead Nurse and Clinical Services Manager and usually weekly Mr Redfern and Ms Rodgers would visit the clinical areas. At any time if parents had concerns then they would be advised to raise them with the Ward Manager and/or named consultant for their child and they would attempt to answer and address any comments and concerns. If this did not resolve the situation then the issues would be raised to the next level of management for progressing. The key issue is open and factual communication and if you do not know something or the cause then say so and refer it to Senior Hospital Management.

41. Please refer to **Bundle 6, Document 25, Page 77**.
What role, if any did you have in the preparation and approval of the NHS GGC response to a list of issues raised by the families of children in the Schiehallion Unit published on 30 October 2019 and do you consider it to be accurate in all respects?

A. I would have had direct involvement in providing answers to some questions and reviewing the final draft answers prior to conclusion of the content along with other colleagues. This would consequently result in a composite response addressing all of the questions raised. I think the responses provided are accurate and factually correct given the “knowns” at the time of preparation.

42. Please refer to the statement of Susan Dodd (**Witness Bundle – Week Commencing 26 August 2024 – Volume 2, Document 5, Page 223**). At paragraph 103 she notes that there was a lot of tension and frustration conveyed at IMTs by Senior Management. She recalls both you and Tom Steele being very frustrated and that she observed this to be directed at Dr Inkster. Please detail your recollection of this.

A. I would need to understand how I was conveying “tension” and “frustration” through my presence at the meeting. I fully supported the work of the IMT and had respect for professional colleagues especially the chair, Dr Inkster, as the dual role she undertook meant her providing the information to the group of the hypothesis and this would often be very scientific as well as chairing gathering of ‘experts’ in their respective professional fields often whom would expect a number of answers to their questions. This was an evolving picture and what

was thought to be a potential source would be addressed to then find the infections continued. As a leader in the organisation I am always conscious of my behaviour, words and actions and certainly would never try to undermine any colleague in a meeting or in private. I will however, when the opportunity arises, ask direct questions and often challenge and may play devils advocate to ensure the discussion considers all points before it reaches a conclusion. That is a key role of a director. To maintain calm whilst debating difficult and awkward questions and encourage others to share their expertise, thoughts, concerns and possible solutions.

a) Refer to the Core Brief of 6 December 2018 in respect of the decant of Wards 2A/B (**Bundle 52, Volume 2, Document 3, Page 66**). Here you state "As our patients and staff had already relocated to another ward, this provided a good opportunity to carry out this upgrading of the system":

(i) Had the need to carry out work to the ventilation system of Ward 2A only been identified by NHS GGC after decant on 28 September 2018?

A. I do not recall the exact date when the need for the ventilation system in Ward 2A to be upgraded was identified. This information will be available from Director of Estates and Facilities following expert and technical assessment report. My statement refers to "carry out this upgrading of the system" therefore I understand the decision to upgrade was already committed however the extent of the works and the scale of upgrade were I understand unknown at this time.

(ii) Why does this Core Brief not address the issue that the ventilation in Ward 2A not meeting the required standards had been recognized in March 2017 options appraisal document from the NHS GGC Acute Service Committee in respect of ventilation systems of Ward 4B **(Bundle 27, Volume 7, Document 6, Page 158 at Page 172**)?

A. The Core Brief was prepared and finalised with NHSGGC Communications Team and approved for issue by the Chief Executive.

(iii) Do you feel this statement is open and transparent?

A. The statement fulfils its purpose to inform what was planned during the time Ward 2A was vacated.

(iv) With the benefit of hindsight do you accept that the statement could reduce trust not improve it?

A. The statement I acknowledge could and may receive a different response and reaction from those who are recipients of it.

b) Can you confirm whether a Business Continuity Management Plan (BCMP) was in place for the risks associated with closure of the Schiehallion Unit, prior to occupancy in 2015? How often was this plan tested prior to decant in September 2018?

A. I am unable to confirm whether a Business Continuity Management Plan (BCMP) existed specifically for Ward 2A Schiehallion Unit prior to occupancy of new RHC in 2015. I would anticipate that a BCMP would tend to address hospital wide impacts from failures of technical services or resulting from water and fire damage. The plan was never tested either prior to or since 2015. I can confirm that an updated BCMP was produced for new RHC and the hospital's General Management Team produced it.

Duty of Candour

43. What is your understanding of duty of candour? How do you understand this duty should be applied within a setting such as NHS GGC and the QEUH and RHC? What is your understanding of with whom this duty sits?

A. Duty of candour in an NHS setting is a requirement on an individual, team, organisation to be honest, factual and accurate in their discussions and written communication with whoever is receiving care from us. If affected by a situation and to inform them when something has gone wrong. To apologise for any error or shortcoming in care. Where appropriate, to offer a suitable remedy to correct the omission or provide support to correct the deficiency. I am aware of three principles of duty of candour. These are openness, transparency and candour. This duty sits with all health and care professional staff. In organisational terms,

this applies to all managers to be aware of incidents that may require full disclosure of an impact upon health care and individual(s) receiving care.

44. In his evidence Professor White explained (**see Professor White, Transcript, pages 75 to 79**) that, in discussion with the Board, in his capacity as the appointed Oversight Board lead on communications, he had discovered that the NHS GGC policy on statutory duty of candour had been written to impose a number of hurdles as a requisite of its operation above and beyond what was required by the statutory provisions (including a requirement of causation). He described this, somewhat kindly, as the policy not 'fully reflecting' the statutory requirements. How did the policy he was criticising come to be written and approved? Do you accept that his criticism is fair? Has the policy now been changed?

A. I am aware of Professor White's comments regarding NHSGGC duty of candour policy and I understand that a review was undertaken to address at the time the 'present' policy and to amend it in light of others' experiences. I do not know the outcome of this work.

Executive Control Group

45. Please refer to **Bundle 14, Volume 2, Document 88, Page 95**, your email of 6th June 2018, regarding the establishment of the Executive Control Group of which you were Chair.

a) What was the remit of the Executive Control Group and your role within the Group?

A. The purpose of the ECG was to provide a level of support to the IMT by building greater understanding and a forum to discuss possible 'cause and effect' scenarios in a protected and 'restricted' members meeting. This was the suggestion of the Chief Executive and I duly undertook this task. I chaired the group.

b) What governance procedures were in place for the Executive Control Group? To whom did the Executive Control Group report and who reported to the Group?

A. The ECG aimed to provide a forum to delve deeper and understanding driving factors and issues from each professionals' perspective and to share this information in a safe, enclosed environment whilst trying to gain a level of cooperation and prioritisation to the challenges faced now and future. Members were - myself, Dr Inkster, Mr Steele, Jen Rodgers, Jamie Redfern, and other ad-hoc invitees dependent on the technical knowledge and expertise required to inform consideration of the issue under review.

c) Please refer to **Witness Bundle - Week commencing 30 September 2024 - Volume 7, Document 1, Page 3.** Dr Inkster notes at paragraph 609 of her statement that she did not feel that this group was helpful as meetings were cancelled or never held. Please detail your recollection of the meetings of the group. If meetings were cancelled why was this? Were these meetings rescheduled? Were agendas produced and minutes taken for these meetings?

A. In trying to establish a meeting schedule and members attendance it quickly became apparent that playing another meeting into the working week basically that 'went over' decisions following discussions with relevant professionals at the IMT meetings was a thankless task and I decided it was best for all concerned to cancel all future meetings and concentrate on improving 'relationships' through respect and listening to other experts reasoning especially when it may not sit with your own view of the situation under consideration. A small number of meetings were held or partially held based on lack of attendance although I do not think we met frequently enough to agree terms of reference. I stood the meeting down. I believe some notes were recorded for the few meetings held although I do not know where these will be filed.

Conclusion

46. Is there anything further you wish to add which you think may assist the Inquiry?

A. I would like to express my gratitude to the patients, parents and families for their ongoing support of the consultants and clinical teams who strive and endeavour to provide the best individualised care and treatment to all patients. Despite the unprecedented circumstances presented in the clinical environment they collectively attempted to overcome severe obstacles to persevere in the best interests of children under their care.

It was an astonishing and devastating situation to discover that ventilation systems did not provide the standard level of protection required of the most vulnerable patient group.

I regret, in the light of this experience, and acknowledge that I personally should have undertaken more questioning and obtained documented evidence that the ventilation systems were “fit for purpose” to ensure that a deficiency in a mechanical system did not present a greater risk to patients.

I trust that the lessons learned and omissions raised from this Inquiry are never repeated and that the safety of patients and the environment is always a number one priority in the build and commissioning of new hospital buildings and refurbished clinical areas.

Declaration

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

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

Appendix A

A43255563 - Scottish Hospitals Inquiry - Hearing Commencing 12 June 2023 - Bundle 1 - Incident Management Team Meeting Minutes (IMT Minutes)

A43273121 - Scottish Hospitals Inquiry - Hearing Commencing 12 June 2023 - Bundle 3 - NHS National Services Scotland: SBAR Documentation

A43293438 - Scottish Hospitals Inquiry - Hearing Commencing 12 June 2023 - Bundle 6 - Miscellaneous documents

A35200730 - Scottish Hospitals Inquiry - Hearing Commencing 20 September 2021 - Bundle 7 - Statement of Mark Bisset - Annex MB02 for week commencing 1 November 2021

A47390519 - Scottish Hospitals Inquiry - Hearing Commencing 19 August 2024 - Bundle 11 - Water Safety Group

A48890718 - Scottish Hospitals Inquiry - Hearing Commencing 19 August 2024 - Bundle 13 - Additional Minutes Bundle (AICC/BICC etc)

A49541141 - Scottish Hospitals Inquiry - Hearing Commencing 19 August 2024 - Bundle 14 - Further Communications - Volume 2

A47664054 - Scottish Hospitals Inquiry - Hearing Commencing 19 August 2024 - Bundle 15 - Water PPP

A53671356 – Scottish Hospitals Inquiry – Hearing Commencing 16 September 2025 - Bundle 52 – Miscellaneous Documents – Volume 2

A49677119 - Scottish Hospitals Inquiry - Hearing Commencing 19 August 2024 - Witness Bundle - Week Commencing 26 August 2024 - Volume 2

A50152363 - Scottish Hospitals Inquiry - Hearing commencing 19 August 2024 - Witness Bundle - Week Commencing 30 September 2024 - Volume 7

A43501437 - Scottish Hospitals Inquiry - Hearing Commencing 12 June 2023 - Bundle of witness statements

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

Scottish Hospitals Inquiry
Corporate Witness Statement of the Scottish Government
Re: The Queen Elizabeth University Hospital and Royal Hospital for Children
Advice and Assurance Review Group

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1. This Inquiry has requested a witness statement from the Scottish Government in relation to the QEUH/RHC Advice and Assurance Review Group (AARG). AARG was provided with secretariat support by the Chief Nursing Officer's Directorate, a Scottish Government Health and Social Care Directorate. This statement is compiled based on the collective knowledge and experience of relevant members of the Chief Nursing Officer's Directorate as well as from review of relevant documentation currently available to the Scottish Government. It is hoped that this statement provides assistance to the Inquiry in understanding the function and work of AARG in so far as that is relevant to the Inquiry's terms of reference.

2. This statement addresses:

    a. The QEUH/RHC Advice and Assurance Review Group (AARG); and
    b. AARG's Consideration of the Recommendations of the Independent Case Note Review.

The QEUH/RHC Advice and Assurance Review Group (AARG)

3. During her time as Cabinet Secretary for Health and Sport (June 2018 to May 2021) Jeane Freeman instructed the preparation of a number of reports/investigations into, broadly put, issues concerning the built environment at the Queen Elizabeth University Hospital ("QEUH") and Royal Hospital for Children ("RHC") Glasgow. These reports included:

- The Independent Review conducted by Dr Andrew Fraser and Dr Brian Montgomery (published June 2020);
- The Oversight Board (chaired by Professor Fiona McQueen) Interim Report (published December 2020);
- The Oversight Board Final Report (published March 2021); and
- The Overview Report of the Case Note Reviews (published March 2021).

4. Each of these reports made recommendations. In order to oversee progress around the various recommendations, the Scottish Government established a review and assurance process to monitor NHSGGC's implementation of these recommendations. This led to the creation of the AARG. A key part of this assurance and review process was the creation by NHSGGC of an action plan, which set out how they would address and implement the recommendations contained in the aforementioned reports. The Scottish Government, through the AARG, implemented monitoring arrangements to ensure, and be assured, that the action plan was being delivered by NHSGGC. This assurance was key to allowing the Scottish Government to assess whether the conditions for de-escalation of NHSGGC from Stage 4 of the 'NHS Scotland: support and intervention framework' were satisfied.

5. The terms of reference setting out the membership and scope of work of the AARG are produced at **Bundle 27, Volume 12, Document 35, Page 363**. AARG's members were all relevant senior members/officers of NHSGGC and the Scottish Government. The Scottish Government provided AARG with secretariat support.

6. AARG met on four occasions. The Chair changed on three occasions but was always a senior member of the Scottish Government. Professor Amanda Croft, then Chief Nursing Officer ("CNO"), chaired the first meeting of AARG on 7 June 2021. Professor Croft demitted office on 23 August 2021. The second meeting took place on 19 August 2021 and was chaired by John Burns, Chief Operating Officer for NHS Scotland. AARG's third and fourth

meetings took place on 17 December 2021 and 28 February 2022. These meetings were chaired by Professor Alex McMahon (Professor Croft's successor as CNO). The Chair of AARG reported directly to the then Cabinet Secretary for Health and Sport (Humza Yousaf MSP). Prior to taking up their post, each Chair was briefed on the function and purpose of AARG and, in the case of John Burns and Professor McMahon, its work to date.

7. The Inquiry has asked what steps were taken by AARG to obtain assurance that NHSGGC put measures and processes in place that addressed the 108 recommendations noted above. This can be summarised as follows:

- In June 2021, AARG and NHSGGC agreed a range of proposed outcomes and measures to be taken for each of the recommendations made in the aforementioned reports. Once agreed, NHSGGC then created an action plan where they documented each of the recommendations, alongside the agreed proposed outcome/measures, the status of these and the expected delivery date.
- Evidence of the progress and assurance of completion were recorded within this action plan alongside the specific evidence provided of all associated work undertaken against each recommendation.
- Before each meeting of the AARG, NHSGGC provided documented updates in order to evidence that they were implementing/had implemented a complex programme of works in accordance with the action plan discussed at para 4 (above) to address the 108 recommendations contained in the reports noted at para 3.
- SG officials comprehensively reviewed all submissions made by NHSGGC that related to progress being made, or completion of the implementation of agreed improvements. This process relied on significant interaction between SG officials and NHSGGC staff ahead of the AARG meetings where progress was scheduled for discussion, including seeking further evidence and/or assurance where necessary.

- NHSGGC then presented those updates, together with any other supporting information and/or further updates then available, at the AARG meetings.
- NHSGGC also established an audit process that was reviewed by AARG, with audit actions being monitored, tracked and a portfolio of evidence provided against each completed action, for assurance and completion of the recommendations.

8. At its meetings, the AARG reviewed a summary update prepared by NHSGGC that provided a summary of the progress of the action plan to date and next steps. Presentations were also given from each of the NHSGGC team members, with detailed discussions taking place.

9. Over the course of the lifespan of the AARG, the Scottish Government were content with the culmination of the actions undertaken and reported by NHSGGC to address the recommendations and that NHSGGC provided the required evidence and assurance to accept the closure of the actions. The recruitment of an Associate Director of Infection Prevention and Control by NHSGGC was seen by the then CNO, the Chair of the AARG, as a significant step in addressing the recommendations and providing continuity as the work taken forward in support of the recommendations had been developed in a sustainable leadership and delivery perspective. The newly appointed Associate Director of Infection Prevention and Control would be reporting to the NHSGGC Executive Nurse Director, who undertook work in actioning the recommendations.

10. Following de-escalation of NHSGGC on 13 June 2022 to Stage 2 of the ‘NHS Scotland: support and intervention framework’, the following measures were agreed and implemented between NHSGGC and the Scottish Government: monthly reporting provided to Chief Nursing Officer Directorate; and quarterly assurance meetings between the Chief Executive of NHSGGC, Chief Nursing Officer and Chief Operating Officer for NHS Scotland.

11. In relation to the extent to which the AARG scrutinised NHSGGC, it should be noted that NHSGGC evidenced a detailed and highly complex programme to implement and demonstrate action taken against each of the 108 recommendations. NHSGGC also devised and implemented an audit process, which was intended to provide assurance on the work being carried out to realise the recommendations. This audit process was recognised by the AARG as a means by which progress would be tracked through the provision of documented evidence from NHSGGC and assessed and/or challenged as part of the AARG assurance process. The SG, therefore, did not implement any separate audit process.

12. The last meeting of the AARG was held on 28 February 2022, chaired by the then Chief Nursing Officer, with the Chief Operating Officer of NHS Scotland and Scottish Government officials in attendance, ensuring continued high-level of chairmanship and assurance requirements. NHSGGC reported that of the 108 recommendations identified, 104 were complete. The remaining four were recommended and accepted by the AARG for closure. Those four recommendations were in relation to the completion of the Wards 2A/B refurbishment and the future structure of Infection Prevention and Control. All four remaining recommendations were completed prior to the de-escalation of NHSGGC in May 2022.

13. The work carried out to meet the recommendations was substantial and showed commitment from NHSGGC to continue in a spirit of continued improvement. The NHSGGC Board also provided a robust governance and audit process, which provided the Scottish Government with the relevant assurance regarding the completion of the recommendations provided at the fourth meeting of the AARG. This included the appointment of a Director of Infection and Prevention and Control. The AARG, as a result of the evidence provided, accepted the closure of all 108 actions, noting that four actions remained outstanding but with a clear action plan in place to address each over the following weeks.

14. Furthermore, as part of a series of visits, the then CNO, Professor Alex McMahon, visited Wards 2A/2B on 30 May 2022. This enabled the then CNO to see first-hand the improvements made to the ventilation system, water filtering, IPC systems and processes and to hear from staff.

15. The Inquiry asks for an explanation as to how the public can be satisfied that NHSGGC has implemented all of the recommendations of the three reviews and continues to have processes in place now which meet those recommendations. As outlined, NHSGGC established an audit process, with audit actions being monitored and tracked and a portfolio of evidence being maintained. NHSGGC began its programme of audit and review in November 2021. Each month, a selection of recommendations from across the three reviews are selected for a random audit. The audit was intended to provide assurance on the policy, governance and best practice that was in place and formed a fully embedded part of NHSGGC routine processes. As part of the rolling audit and review process NHSGGC developed an audit and review tracker which shows the status of the audit and where necessary the next audit date.

AARG's Consideration of the Recommendations of the Independent Case Note Review

16. The Inquiry has asked whether AARG was satisfied that NHSGGC addressed the adequacy of the organisation's data systems, for example in the microbiological surveillance of the hospital environment and the extent of building, repair and maintenance work that took place in clinical areas.

17. AARG recognised that the data systems used by NHSGGC to document facilities maintenance activities in clinical areas needed to consistently capture the exact location of the work done; the date which the work took place; the frequency activities occurred and be accessible to inform the IPC process. It was understood that the need to record precise locations and dates taken from any swabs or water sample for microbiological surveillance

which should also be shared to inform the IPC process. NHSGGC demonstrated to AARG that they had updated the NHSGGC Estate and Management System to meet these requirements.

18. For example, the update of NHSGGC Estate & Management System included making maintenance activities more accessible and available to the wider team and the water sampling process was also reviewed and enhanced, with data returns from NHSGGC's water management contractor strengthened.

19. The AARG noted that when a suspected infection outbreak is being investigated, the plans agreed for environmental sampling of the relevant area must demonstrate a systematic approach which was appropriate to the circumstances of the investigation. NHSGGC evidenced that when environmental sampling is considered by an Incident Management Team ("IMT") there was a process to request this sampling which was provided in the Incident and Outbreak Management Framework – evidence of this application in practice was provided to the AARG.

20. The AARG identified that when the Chair of an IMT (or similar future structure) identifies that environmental samples are required to inform an investigation, these should be taken, reported back and evidenced in the IMT minutes. NHSGGC confirmed to the AARG that this was in place, was standard practice across the Board and was able to evidence this within approved meeting minutes showing the process.

21. The Inquiry has asked whether the AARG was satisfied that NHSGGC addressed the adequacy of the organisation's systems, for example the lack of an electronic database of microbiological typing results, and the incident reporting system, DATIX, and methodology, for example inconsistency in environmental sampling.

22. The AARG addressed the adequacy of NHSGGC organisations systems. NHSGGC were required to develop a comprehensive and searchable database that allowed details of microbiology reference laboratory reports to

allow results to be compared between samples of the same bacteria obtained from different patients or environmental sites. NHSGGC developed a system that provided the capability to report on various data items in relation to samples, patient locations and sampling data. This database system combined data from three separate systems used to provide searchable data which is available through a series of reports to the IC Teams. Reports were provided as evidence with screenshots of new database system available. Joint sessions with stakeholders from IPC, microbiology and estates took place and evidence of clinical review provided as evidence of its completion.

23. The AARG reviewed and accepted the Case Note Review recommendation that NHSGGC should assure and report consistent utilisation of the Datix system and audit the validity of the classification and risk categorisation given to incidents by NHSGGC staff. NHSGGC developed an SBAR (Situation, Background Assessment, Recommendation) for the Datix Governance Group to support consistent utilisation of the Datix system and provided minutes of a meeting held by the Datix System Governance Group highlighting that they were monitoring the agreed key point indicators. NHSGGC highlighted that this group meets quarterly to define the strategic priorities for utilising and improving the risk system. A new integrated incident, risk management and patient safety system was in the procurement process which received support from NSS, with the contract with Datix set to expire in May 2025.

24. The AARG reviewed and accepted the Case Note Review recommendation that a systematic, fit for purpose, routine, microbiological water sampling and testing system was required to provide assurance going forward. How the results from such sampling/testing are recorded, accessible and used to highlight concerns required review, including to ensure that investigations of possible links between clinical isolates and water/environment sources could be informed in a timely way. In addition, investigations of possible links between clinical isolates and water/environment sources should consider whether (short or medium/long term) changes to the routine microbiological water sampling and testing system are required. NHSGGC addressed this by creating a clear Water Plan implemented at all hospital sites, this included site

management arrangements, routine sampling, reporting and SOP for out of spec results. Monthly water reports are created and this information is circulated through appropriate governance.

25. The AARG considered that NHSGGC should ensure that the Standard Operating Procedure (SOP) for Minimising the Risk of Pseudomonas Aeruginosa Infection from Water explicitly stated whether this also applied to high-risk areas other than the adult and paediatric intensive care units and neonatal units. NHSGGC updated the SOP and, in addition, undertook a risk assessment which demonstrated the method by which other areas were included in the areas to sample and what those areas are.

26. The Inquiry has asked if the AARG was satisfied that NHSGGC addressed the adequacy of procedures in place to monitor and trigger concerns about outbreaks of infections, and the modifying of the alert organism list in light of evolving experience.

27. NHSGGC completed its annual review of the ICNet Alert Organism list to ensure at a minimum it reflects the Scottish NIPCM and to give assurance that NHSGGC ICNet Alert Organism list is further updated to reflect the experience with GNE bacteraemia. An SBAR outlining this process was completed.

28. The AARG reviewed and accepted the recommendation that NHSGGC should ensure better communication between the Microbiology and IPC teams. NHSGGC set out for the AARG how this was to be achieved. Through an established forum, these teams would benefit from the sharing of information and actions that occur in real time in order to support and improve quality care to patients, maintain progress and discuss action for any potential change in a patient's condition or linked infection.

29. The AARG further advised that NHSGGC should revisit how they will monitor and, if necessary, trigger concerns about future outbreaks of Gram-negative environmental infections. Reliance on Statistical Process Control (SPC) charts

to determine if episodes of infection caused by unusual/uncommon microorganisms are significant should be re-evaluated. The process in place for much of the review period appears to have been insensitive to identifying clusters that should have raised earlier concerns about potential for a common/environmental source of infection.

30. The Inquiry has asked if the AARG was satisfied that NHSGGC addressed there being inconsistency, including in the approach to Problem Assessment Groups (PAG), Incident Management Group (IMT) structure, final reporting and upward reporting, environmental sampling, cleaning audits, and the way information was stored in the patient records system.

31. The AARG found the process involving the PAG and the IMT structure to have been inconsistent and that the absence of IMT reporting at the closure of an IMT sequence was a breach of NHSGGC's own policy. This was remedied so that practice complied with policy, and a hot debrief incident process was established in NHSGGC. An Incident Management Process Framework was established and an NHSGGC Outbreak and Incident Management Plan was approved.

32. NHSGGC developed a system to provide the capability to report on various data items in relation to samples, patient locations and sampling data, taking into account the need for a streamlined process for the management of reference laboratory results. The database system takes data from the Telepath, Specialist Service Providers and the Strain ID for water, environmental and clinical samples and results. This data is now searchable and available through a series of reports to the IPC Teams.

33. One of the roles of the Infection Prevention and Control Team ("IPCT") is to prevent and control infection through audit by influencing and supporting staff to undertake local Standard Infection Protection & Control (SICPs) audits which are recorded onto the Care Assurance and Improvement Resource "CAIR"dashboard. The updated SICPs tool was launched in November 2022 and the IPCT commenced quality assurance (QA) audits in acute wards in

February 2023 and within Mental Health wards in April 2023. The IPCT continues an annual programme of audit of approximately 20% of in-patient areas and theatre areas and all critical care areas, this process allows the IPCT to compare SICPs outcomes completed by local teams with their results to ensure an on-going quality peer review.

34. To address the issues with the patient records system NHSGGC put in place a new SOP and staff reminders were issued; the monitoring of the implementation of these changes is ongoing. The NHSGGC eHealth Delivery Plan includes implementation of Active Clinical Notes (ACN) to replace scanned patient records. This functionality is available in the TrakCare system following the system upgrade to version T2021 in October 2021. The priority areas for the implementation of ACN were Emergency Department and Nursing Admission Record (known as My Admission Record - MAR). A programme of implementation was completed in 2022, which replaced acute scanned notes.

35. The Inquiry has asked if the AARG was satisfied that NHSGGC addressed the issues of there being too much emphasis on standard definitions, inappropriate reassurance from the use of Statistical Process Control (SPC) methodology, and an unwillingness to accept that there was a problem.

36. The AARG was satisfied that NHSGCC was addressing these issues by noting that a refreshed IPCT Incident Management Process Framework has been established to counter an over-reliance on SPC charts. Additionally, examples of the regular Healthcare Associated Infection Reporting Template (HIART) reports were presented to the NHSGGC Board, and outbreak timelines were produced by the Infection Control Team.

37. The AARG also noted that the NHSGGC Outbreak and Incident Management plan had been approved. As part of this plan an early warning process had been established. Evidence from previous IMT minutes and work undertaken at NICU RHC highlight NHSGGC has operationalised the Outbreak and Incident Management Plan.

38. The IPCT at NHSGGC has also developed an SBAR outlining NHSGGC's approach to undertaking Root Cause Analysis (RCA) methodology. RCA is undertaken when an RCA approach is the appropriate measure.

39. The Inquiry has asked if AARG was satisfied that NHSGGC addressed the concern around minutes of IMT meetings without apparent action logs, which lead to a limited audit trail of the evidence used to support conclusions made or actions taken.

40. The AARG considered these issues and NHSGGC assured the group that appropriate reporting and governance arrangements are business as usual for IPCT IMTs. NHSGGC advised that documentation relating to IMTS include, as a minimum, minutes, action plans, debriefs and a data pack, and that systematic collection of IPC data for IMT is established practice.

41. A full review of the documentation was completed, and assurance was given of IMT NHSGGC compliance. In addition, a hot debrief incident process was established in NHSGGC.

42. An Outbreaks and Incidents folder was created within NHSGGC's IPC Shared Drive to file all the related documentation to any Red or Amber IMTs and PAGs. The IPC Shared Drive is managed by the IPC Business Manager.

43. The Inquiry has asked if AARG was satisfied that NHSGGC addressed the issue of communication between microbiologists, the infection control doctors and the rest of IPCT not being as robust or cohesive as it should be.

44. Following review of the recommendation that NHSGGC should ensure better communication between its microbiology and IPC teams, and that a more collaborative approach for IPC should be taken forward to ensure that IPC is less siloed across the Health Board, the AARG recommended the use of a forum to allow the sharing of information and actions in real time to support

and improve quality care to patients, maintain progress and discuss action for any potential change in a patient's condition or linked infection.

45. The AARG was satisfied that communication issues had been addressed by NHSGGC as a communications strategy was put in place, including gold and silver command meetings, and a multi-disciplinary meeting (known as "the buzz") was established by the Interim Director of Infection Prevention and Control. In addition, an ongoing organisational development process was underway.

46. The Inquiry has asked whether the AARG was satisfied that NHSGGC had introduced, and maintained, a systematic and structured approach to the investigation of all future bacteraemias using Root Cause Analysis ("RCA") methodology. The AARG considered these issues and was informed that RCA methodology is established practice across NHSGGC infection control analysis and monitoring has been in place since 2019.

47. The AARG reviewed and accepted the recommendation that NHSGGC should consider the further and consistent use of the RCA process across the organisation to a) to identify evidence of common themes as a cause of infection over time; and b) what can be extracted from the RCA process for organisational learning and improvement. However, it was recognised that this is a resource intensive process, both for IPCT and for front line clinical teams, and is not mandatory in NHS Scotland. Nevertheless, NHSGGC put RCA in place for high-risk paediatric units (NICU, PICU, 2A).

48. The Inquiry has asked if the AARG was satisfied that NHSGGC addressed the concern that the organisation's focus was more on a task or process being carried out than on causes or consequences of a situation or on quality improvement.

49. The AARG was satisfied with progress on this issue and was assured that actions to address the recommendations in this area had taken place, including:

- A refreshed Infection Prevention and Control Team Incident Management Process Framework was implemented.

- Infection Prevention & Control Activity (IPCAT) established a short life working group and agreed terms of refence with colleagues from HIA?, HIS and an Infection Control Manager from another Health Board as a critical friend. This was to refocus the approach to audit processes, benchmarking areas of good practice (national), and to agree a process going forward in relation to future audit governance.

- The IPCAT strategy aimed at ensuring audit and monitoring improvement following an IPCAT, would be influenced and modified as NHSGGC moved into the CAIR system and the work re SICPs as part of the Network. The CAIR system / dashboard provides data on the quality of care provided by nursing and midwifery staff in Scotland. This information is used by nurses, midwives and senior management to monitor and improve quality of care.

- NHSGGC undertook a project to benchmark its IPC activities against those of other health boards in Scotland. This SBAR reported on four key IPC processes: alert organism surveillance, IPC advice documentation, SSI surveillance and IPC audit. The draft NHSGGC IPC Benchmark Report has been developed from this reviewed and agreed by HIS and other Boards were content with this and the recommendations.

50. The Inquiry has asked if the AARG was satisfied that NHSGGC addressed inconsistencies in the way patient healthcare records were stored and organised within NHSGGC's Clinical Portal system.

51. The AARG was satisfied that work to address inconsistencies was completed. A workshop was held with Health Records Services and eHealth Clinical

Leads to assess the effectiveness of scanned and digitally recorded clinical records. An assessment of areas for improvement was completed and a report was compiled with the detail of the review and recommendations.

52. To address the issues with the patient records system, NHSGGC put in place a new SOP and staff reminders were issued; this is ongoing and monitoring continues.

53. The NHSGGC eHealth Delivery Plan included implementation of Active Clinical Notes (ACN) to replace scanned patient records. This functionality was available in the TrakCare system following the system upgrade to version T2021 in October 2021. The priority areas for the implementation of ACN were Emergency Department and Nursing Admission Record (known as My Admission Record - MAR). A programme of implementation was completed in 2021 which replaced acute scanned notes.

Statement of Truth

54. The Scottish Government officials who have compiled this corporate statement believe that the facts stated in this statement are true and understand that this statement may form part of the evidence before the Inquiry and be published on the Inquiry's website.

Appendix A

A50491351 - Bundle 27, Volume 12 – Miscellaneous Documents

Scottish Hospitals Inquiry
Witness Statement of
Professor Alexander McMahon CBE

1. I am Professor Alexander McMahon CBE.

2. I am retired. Between October 2021 and May 2024 I was Scotland's Chief Nursing Officer ("CNO"). I have previously provided this Inquiry with a witness statement and oral evidence in relation to the Royal Hospital for Children and Young People and Department of Clinical Neurosciences, Edinburgh. This evidence principally concerned my involvement with that hospital in my former role as the Executive Director for Nursing, Midwifery and Allied Health Professionals at NHS Lothian. I refer the Inquiry to that statement for my relevant professional qualifications and experience. I understand that Fiona McQueen has provided the Inquiry with evidence relating to the role and responsibilities of the CNO as a member of the Scottish Government. I confirm that the role and responsibilities of the CNO, as a member of the Scottish Government, remained the same during my tenure, so refer the Inquiry to the evidence of Ms McQueen in this regard.

3. I have been asked to provide this statement to the Inquiry in relation to matters concerning the Queen Elizabeth University Hospital ("QEUH") and Royal Children's Hospital ("RHC") Glasgow Advice and Assurance Review Group ("AARG"). I chaired this group on two of the four occasions upon which it met: 17 December 2021 and 28 February 2022.

4. This statement is prepared based on my own knowledge and experience of the subject matter as well as from review of relevant documentation and consultation with colleagues within the Scottish Government.

5. I understand that the Scottish Government has provided the Inquiry with a "corporate statement" setting out the purpose, function and operation of AARG. I cannot assist the Inquiry in relation to the AARG's operation prior to

the two meetings I chaired. Prior to taking up my role as CNO I was the Executive Director for Nursing, Midwifery and Allied Health Professionals in NHS Lothian. I had no involvement with AARG during my time as an employee of NHS Lothian.

6. I am asked what role did each of the Scottish Government members of AARG play and to what extent can it be said that each hold any personal responsibility for the decision to accept the evidence of NHSGGC that it was implementing or had implemented the "action plan" (the plan prepared by NHSGGC to address the recommendations of the Independent Review, the interim and final reports of the Oversight Board and the Overview Report of the Case Note Review ("CNR")).

7. I note from review of Minutes of AARG meetings that the following persons attended meetings of AARG from the Scottish Government:

SG attendees, 7 June 2021
Prof Amanda Croft, Chief Nursing Officer (chair)
Christine Ward, Deputy Director, Chief Nursing Officer Directorate (CNOD)
Irene Barkby, Professional Nursing Advisor, CNOD
Craig White, Divisional Clinical Lead, Healthcare Quality and Improvement Directorate
Marion Bain, Deputy Chief Medical Officer
Shalinay Raghavan, Head of QEUH Response Team
John Lewis, CNOD (secretariat)

SG attendees, 19 August 2021
John Burns, Officer of Chief Operating Officer (chair)
Christine Ward, Deputy Director, CNOD
Irene Barkby, Professional Nursing Advisor, CNOD
Craig White, Divisional Clinical Lead, Healthcare Quality and Improvement Directorate
John Lewis, CNOD (secretariat)
SG Attendees 17 December 2021:

Alex McMahon, Chief Nursing Officer (Chair)
Christine Ward, Deputy Director, CNOD
Irene Barkby, Professional Nursing Advisor, IPC, CNOD
Shalinay Raghavan, Head of QEUH Response Team
Calum Henderson, QEUH Response Team Leader
John Lewis, QEUR Response Team (secretariat)

SG attendees, 22 February 2022
Alex McMahon, Chief Nursing Officer (chair)
Christine Ward, Deputy Director, CNOD
John Burns, Chief Operating Officer
Irene Barkby, Professional Nursing Advisor, CNOD
Alan Morrison, Deputy Director Infrastructure, Investment and PPE
Shalinay Raghavan, Head of QEUH Response Team
Calum Henderson .QEUH Response Team Leader
Lezli-an Glennie (covering secretariat)

8. Each Scottish Government AARG attendee attended meetings in a professional, not personal, capacity. Some of the attendees' roles were, principally, to provide secretariat support (e.g. Calum Henderson) while others were able to provide relevant professional expertise in relation to matters such as Infection Prevention and Control ("IPC") practices (e.g. Irene Barkby).

9. All the attendees (including those from NHS NSS and NHSGGC) made contributions to the work of AARG that assisted in review and scrutiny of the evidence presented by NHSGGC that demonstrated implementation of the action plan. While I can only speak to what happened at the two meetings I attended, the collective effort of all those who attended AARG meant that the information presented by NHSGGC was scrutinised thoroughly, both before and during meetings.

10. I am asked how I can, as Chair of the final meeting of AARG, be sure that NHSGGC have fully implemented all of the 108 actions from the various reports and reviews (the reports discussed at para 6 above). In short,

NHSGGC presented evidence to show they had implemented, or were in the process of implementing those recommendations. This evidence was scrutinised (collectively) by AARG and, as a consequence of that scrutiny, I was satisfied that the actions detailed in NHSGGC's action plan were either completed or were sufficiently complete such that they did not require further monitoring by AARG. I did not personally review the evidence relating to actions that were accepted as completed prior to taking up my post as Chair. I noted, however, that evidence of the progress and assurance of completion were recorded within NHSGGC's action plan alongside evidence of all associated work undertaken against each recommendation.

11. I am asked what "audit process" was established by the Scottish Government to review the implementation, by NHSGGC, of the 108 actions contained in the NHSGGC action plan (arising from the various reports preceding the establishment of AARG). The purpose of the AARG was to provide advice, assurance and a review of all the reports, recommendations and closed actions, based on NHSGGC's overarching action plan.

12. In my opinion, NHSGGC demonstrated clear and substantial evidence of their progress towards completion of the various actions arising from the reports. They did so through their annotated action plan, production of evidence on their own initiative as well as any additional evidence specifically requested by the Scottish Government to support what was referred to in the action plan. NHSGGC also provided comprehensive and assured articulation of this evidence during robust assurance and review questioning through AARG.

13. I am asked why I, as CNO, saw the recruitment of an Associate Director of IPC by NHSGGC as a significant step in addressing the recommendations [of the reports discussed at para 6 above]. I saw this as a significant action because it represented a managerial and leadership change in IPC at NHSGGC. It was not just my view that this appointment was both significant and important. I believe that this was also the view of the then Chief Executive of NHSGGC, who was responsible for the appointment and who asked that I sit as part of the interview panel for the post. It was also seen as

significant by the then First Minister and Cabinet Secretary for Health and Sport, who I recall were not prepared to de-escalate NHSGGC on the NHS Scotland support and intervention framework until all of the actions on the action plan had been completed. Successful recruitment of an Associate Director of IPC represented completion of NHSGGC's action plan.

14. I am asked whether, given that some of the issues raised by the whistleblowers related to the culture and working relationships within IPC in NHSGGC, was it premature to conclude on 28 February 2022 that the work of the AARG was complete before the actually appointment of an Associate Director of Infection Prevention and Control, given that in fact that person appointed was an existing member of the IPC team who had been part of the events that had prompted the escalation of NHSGGC to Stage 4 and ultimately led to the creation of the AARG? The advert for Associate Director of IPC went live on 25 February 2022 and was due to close on 11 March 2022. The role was to report to Angela Wallace, the then newly appointed Executive Nurse Director. It was discussed at AARG that this reporting structure would be positive as it would offer a degree of continuity in arrangements that had been put in place to improve IPC culture at NHSGGC. In terms of the question of "prematurity", AARG was assured by NHSGGC that it had a contingency plan in place in order to deal with the eventuality that the recruitment process could not to deliver a suitable candidate. I cannot recall, with the passage of time, what that contingency plan was, but I must have been satisfied that it was sufficiently robust. In terms of choice of candidates and any concerns related thereto, while (as I discuss above) I sat on the interview panel for the role, the choice of candidate is an employment decision for NHSGGC to take. It would not have been appropriate for the Scottish Government (or AARG) to mandate who the person appointed to the role should have been.

15. I am asked whether, in February 2022, I gave any consideration to the point of view that the appointment of Sandra Devine as Director of IPC might, in contrast to a hypothetical appointment of an external figure with no history of connection to NHSGGC and the events that had prompted the escalation of

NHS GGC to Stage 4, give rise to concern that NHSGGC had not in a fact changed in its approach to infection prevention and control in light of the conclusions of, in particular, the Case Note Review? As I discuss above, the choice of candidate was an employment decision for NHSGGC to take. The recruitment process was run by NHSGGC and was open to all candidates. I was one of the members of the interview panel. Ms Devine applied for the post along with one other candidate. Both candidates were suitably skilled to perform the roll, however, Ms Devine was successful in her application because she was, through her skills and experience, the best candidate for the job. This was a unanimous decision of the interview panel.

16. As I discuss above, AARG was satisfied that NHSGGC had demonstrated implementation of the recommendations arising from the various reports that fed into NHSGGC's action plan. Many of these related to improving IPC culture and practice.

17. I have been referred to NHSGGC's core brief (**Bundle 25, Document 61, Page 1260**). I am told that it is the current position of NHSGGC, in its most recent submissions to the Inquiry, that NHSGGC does not accept that anything contained in the CNR Overview Report can properly justify any adverse inference about the safety of the water, drainage or ventilation systems at the QEUH. I am asked whether this lack of acceptance by NHSGGC of the CNR's findings was considered by AARG. I do not recall this being discussed (at the two meetings that I chaired) and cannot see any reference to it in the minutes of its meetings. In so far as the CNR Overview Report is concerned, AARG sought assurance that NHSGGC had implemented its recommendations. Such assurance was provided, regardless of whether or not NHSGGC held the view that any conclusion of the CNR had not been accepted.

18. I understand that, following NHSGGC's de-escalation from level 4 of the NHS Scotland support and intervention framework, the then Cabinet Secretary for Health and Sport, Humza Yousaf MSP, made a statement to Parliament on 13 June 2022, this states:

“Firstly, I want to place on record my thanks to the staff of NHS Greater Glasgow and Clyde who have continued to support the escalation work whilst delivering patient care. I also want to acknowledge and thank the patients and families for their patience and understand during what I know has been a challenging time.

In response to concerns raised in relation to patient safety and healthcare associated infections at the Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC), the previous Cabinet Secretary for Health and Sport commissioned a number of investigations into the built environment at the hospitals and a review of clinical cases in relation to children who had been treated there. On 22 November 2019 the then Cabinet Secretary escalated NHS Greater Glasgow and Clyde (NHS GGC) to Stage 4 of the NHS Board Performance Escalation Framework.

The reports from the investigations that were commissioned between 2019 and 2020 include:

- The Independent Review conducted by Dr Andrew Fraser and Dr Brian Montgomery (published June 2020);
- The Oversight Board chaired by Professor Fiona McQueen Interim Report (published December 2020);
- The Oversight Board Final Report (published March 2021);

The Overview Report of the Case Note Reviews led by Professor Mike Stephens (published March 2021).

There has been significant progress made by NHS GGC regarding the actions of these reviews.

NHS GGC has undertaken a detailed and highly complex programme to implement and evidence action against the 108 recommendations outlined in the Independent Review, Oversight Board and Case Note Review reports.

This represents a substantial NHS GGC wide programme of work, with clinical, managerial and support staff all contributing to the successful completion of the recommendations. An audit process has been established, with audit actions being monitored and tracked and a portfolio of evidence being maintained.

All recommendations have now been completed including both Wards 2A/B being successfully re-opened on 9 March 2022, which has allowed the patients and families to return to the wards and receive the quality care provided by the staff.

As NHS GGC have provided the relevant assurance and evidence to support the delivery of the 108 actions. The Scottish Government therefore accepted the closure of all 108 actions. It was on this basis and on this evidence and assurance that NHS GGC will be de-escalated to Level 2 of the NHS Board Performance Escalation Framework.

As part of this Level 2 escalation, measures will remain in place to ensure Scottish Government officials continue to provide support to NHS Greater Glasgow and Clyde as they continue to deliver quality healthcare with the implemented actions and improvements."

19. I am asked whether, Mr Yousaf's statement is consistent with NHSGGC not accepting 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. In so far as relevant, the statement discusses the work that NHSGGC has undertaken to implement the recommendations set out in the CNR Overview Report. It does not reference any non-acceptance of the findings of the CNR. As far as I am aware, the Cabinet Secretary would not have known about NHSGGC's position (as presented in the question by the Inquiry) at the time he made his statement.

Statement of Truth

20. I believe that the facts stated in this witness statement are true. I understand that this statement may form part of the evidence before the Inquiry and be published on the Inquiry's website.

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

Appendix A

A49585984 – Bundle 25 - Case Note Review Expert Panel, Additional Reports, and DMA Canyon
A50491351 - Bundle 27 - Miscellaneous Documents - Volume 12
A50611329 - Bundle 27 - Miscellaneous Documents - Volume 14
A53429115 - Bundle 49 - Oversight Board, Advice and Assurance Review Group (AARG) and Healthcare Improvement Scotland (HIS)
A53658475 – Bundle 52 - Volume 1 – Miscellaneous Documents

Scottish Hospitals Inquiry
Witness Statement of
Jason Phillips Birch

Introduction

1. My name is Jason Phillips Birch. This witness statement is being provided for the Scottish Hospitals Inquiry "Glasgow IV" hearings.

2. I am currently Interim Deputy Director within the Scottish Government's Health and Social Care Directorate ("SGHSCD"). I am one of two Deputy Directors covering the policy, management and financial aspects of the Chief Nursing Officer Directorate ("CNOD").

3. CNOD sits within SGHSCD. Within SGHSCD, the CNOD focuses on:
   - Nursing and Midwifery
   - Allied Health Professionals and Healthcare Science
   - Regulation of all health professionals
   - Healthcare Associated Infections and Antimicrobial Resistance

4. CNOD provides policy and professional advice to the Scottish Ministers on nursing, midwifery, allied health professions (NMAHP) and health care scientists (HCS), the regulation of healthcare professionals and healthcare associated infection/antimicrobial resistance (HCAI/AMR).

5. Prior to my current role, I held various other roles within the Scottish Government, as follows:
   - February 2009 – June 2009 - Policy Manager in the Regulatory Unit (DG Health and Social Care) - the Team dealt with the policies and legislation connected to the regulation of all healthcare professionals.

- June 2009 – January 2011 - Policy Manager in Lifelong Learning Directorate, (DG Education) - I worked on the ‘Determined to Succeed” educational strategy.
- January 2011 – December 2012 - Policy Manager in the Regulatory Unit (DG Health and Social Care) - the Team dealt with the policies and legislation connected to the regulation of healthcare professionals. During the latter part of this substantive role I was temporarily promoted to Senior Policy Manager.
- December 2012 – February 2017 - Senior Policy Manager in the Regulatory Unit (DG Health and Social Care) - the Team dealt with the policies and legislation connected to the regulation of healthcare professionals. During the latter part of this substantive role I was temporarily promoted to Team Leader.
- February 2017 – March 2018 - Team Leader (DG Health and Social Care) - in addition to the regulatory policy areas, the role also included healthcare associated infection and antimicrobial resistance as well as Excellence in Care work.
- March 2018 – August 2018 - Acting Unit Head (DG Health and Social Care) – in addition to the regulatory policy areas, the role also included healthcare associated infection and antimicrobial resistance, as well as initially, Excellence in Care work; the role included a similar remit to the Team Leader role but at a higher level of responsibility.
- August 2018 – December 2022 - Unit Head (DG Health and Social Care) - in addition to the regulatory policy areas, the role also included healthcare associated infection and antimicrobial resistance as well as Excellence in Care work, however the Excellence in Care work was later paused during the pandemic response period.
- December 2022 – September 2023 - Unit Head (DG Health and Social Care) - the Team dealt with the policies and legislation connected to the regulation of healthcare professionals; the role disaggregated the HAI/AMR work due to the expansion of work levels in both teams.

6. My professional qualifications are LLB (English Law) from Newcastle University (1998) and Dip Law (English Legal Practice Course) from Northumbria University (2000). I completed my legal traineeship and qualified as a solicitor in England in 2004.

Rule 9 Questions

7. The Inquiry has asked the following questions in relation to NHS Greater Glasgow and Clyde ("NHSGGC") health board's compliance with the National Infection Prevention and Control Manual ("NIPCM"):

*With reference 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.*

1.1 *Does Scottish Government have any concern that this NHSGGC SOP results in incidents not being reported to ARHAI Scotland following initial review by the IPCT in NHS GGC?*

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

1.3 *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?*

8. NIPCM was first published on 13 January 2012 and it was communicated to NHS Scotland by the Chief Nursing Officer (CNO (2012)01). It was first updated on 17 May 2012 (CNO (2012) 01-update) and has been regularly

updated thereafter. It is evidence-based and is intended to be used by all those involved in care provision. The manual currently contains:
Chapter 1 – Standard Infection Control Precautions (SICPs)
Chapter 2 – Transmission Based Precautions (TBPs)
Chapter 3 – Healthcare Infection incidents, outbreaks and data exceedance
Chapter 4 - Infection control in the built environment and decontamination
It is a practice guide for use in Scotland. When used, it helps reduce the risk of Healthcare Associated Infection ("HAI") and ensure, in so far as is possible and practicable, the safety of those in the care environment – those being cared for, as well as staff and visitors. It aims to:

i. make it easy for care staff to apply effective infection prevention and control precautions;
ii. reduce variation, promote standardisation and optimise infection prevention and control practices throughout Scotland;
iii. help reduce the risk of HAIs; and
iv. help align practice, monitoring, quality improvement and scrutiny

9. The Scottish Government sent a Directors' letter on 24 October 2024 (DL (2024) 24) to all Scottish territorial health boards detailing the Government's expectations in relation to the NIPCM. The letter stated that the Scottish Government expects all NHS Boards to adopt the NIPCM. In addition, the Scottish Government expects that NHS Boards will maintain local assurance of compliance with, and implementation of, the guidance through continuous monitoring in all healthcare settings.

10. Local compliance and assurance processes should be supported by robust governance arrangements. The Scottish Government also expects that the Healthcare Infection Incident Assessment Tool ("HIIAT") should be used to assess every healthcare infection incident i.e. all outbreaks and incidents (including exposure incidents, decontamination incidents or near misses) in any healthcare setting (that is, the NHS, independent contractors providing NHS services as stated in Chapter 3 of the NIPCM). For information, definitions for outbreaks and incidents as per the NIPCM are as follows:

Definitions of Healthcare Infection Incident, Outbreak and Data Exceedance

The terms 'incident' and 'Incident Management Team' (IMT) are used as generic terms to cover both incidents and outbreaks.

A healthcare infection incident may be:

- *An exceptional infection episode*

A single case of rare infection that has severe outcomes for an individual AND has major implications for others (patients, staff and/or visitors), the organisation or wider public health for example, high consequence infectious disease (HCID) OR other rare infections such as XDR-TB, botulism, polio, rabies, or diphtheria.

- *A healthcare infection exposure incident*

Exposure of patients, staff, public to a possible infectious agent as a result of a healthcare system failure or a near miss e.g. ventilation, water or decontamination incidents.

- *A healthcare associated infection outbreak*

Two or more linked cases with the same infectious agent associated with the same healthcare setting over a specified time period.
or
A higher-than-expected number of cases of HAI in a given healthcare area over a specified time period.

- *A healthcare infection data exceedance*

A greater than expected rate of infection compared with the usual background rate for the place and time where the incident has occurred.

- *A healthcare infection near miss incident*

An incident which had the potential to expose patients to an infectious agent but did not e.g. decontamination failure.

- *A healthcare infection incident should be suspected if there is:*

A single case of an infection for which there have previously been no cases in the facility (e.g. infection with a multidrug-resistant organism (MDRO)) with unusual resistance patterns or a post-procedure infection with an unusual organism)

11. NHS Boards reporting healthcare associated infections via the outbreak reporting tool is essential for our National surveillance, which contributes to improving patient safety, ensuring healthcare quality and targeting public health interventions. National surveillance supports: the identification of emerging infection issues both locally and nationally, the implementation of targeting interventions to reduce infection rates, provides evidence to support the evaluation of infection prevention and control ("IPC") strategies and policies in relation to their stated aim and can help guide where resources and support are directed.

12. The NHSGGC IPCT Incident Management Process Framework Statement of Practice ("SOP") (version 2, effective from December 2023 to April 2025) differs slightly from the process set out in the NIPCM in relation to when outbreaks/incidents will be reported to ARHAI Scotland. This may have resulted in NHSGGC not reporting incidents in line with the Scottish Government's expectations.

13. That version of the NIPCM states that:

"following detection/ recognition of an incident/ outbreak a member of the infection prevention and control team (IPCT) or health protection team (HPT) will:

- *undertake an initial assessment, utilising the Healthcare Infection Incident Assessment Tool (HIIAT)...*
- *NHS Boards are required to report all HIIAT assessed green, amber and red reports to ARHAI Scotland through the electronic outbreak reporting tool (ORT)…"*

14. The NHS GGC SOP states that:

"an initial assessment is required to determine if an outbreak or incident is taking place, in a hospital, this will be carried out by the infection prevention control team, or through a Problem Assessment Group (PAG).

If an assessment is required or a PAG is held the IPCT will complete a NHS GGC IPC Incident summary/ or if no further action is required a situation summary will be completed as a record of discussions held.

There are normally two potential outcomes to a PAG:

- *No significant risk to public health and/or patients; the PAG stood down, but surveillance continues or,*
- *There are some concerns and the situation is assessed using the National Healthcare Infection Incident Assessment Tool (HIIAT) (www.nipcm.hps.scot.nhs.uk/media/2260/2022-02-07-hiiat-v20.pdf) all assessments regardless of outcome must be recorded on the Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Outbreak Reporting Tool (ORT)…."*

15. It should be noted that there is now an updated Incident Management Process Framework in place in NHSGGC (version 3, effective from April 2025), which appears to be in keeping with the process set out in Chapter 3 of the NIPCM. The following is stated in the updated SOP:

"If an incident is suspected or declared, the situation will be assessed using the National Healthcare Infection Incident Assessment Tool (HIIAT) National Infection Prevention and Control Manual: Appendix 14 - Healthcare Infection Incident Assessment Tool (HIIAT). All HIIAT assessments must be recorded on the Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Outbreak Reporting Tool (ORT)."
Section 2.1

16. Whilst there is provision in the DL (2024) 24 for NHS Boards to derogate from the NIPCM, the Scottish Government expects that NHS Boards that choose to derogate from the NIPCM continue to ensure safe systems of work including the completion of a risk assessment which is approved and documented through local governance procedures.

17. It is important to note that NHS Health Boards have principal responsibility for clinical governance. NHS Boards are responsible through the Cabinet Secretary to the Scottish Parliament for the safe, effective and person-centred delivery of services. Paragraph 9 above, sets out the Scottish Government's expectations in terms of NHS Boards having robust governance arrangements in place for maintaining compliance with and implementation of the NIPCM.

18. Healthcare Improvement Scotland ("HIS") is an independent body from which the Scottish Government seeks assurance in relation to patient safety and quality of care from HIS. HIS carries out "Safe Delivery of Care" inspections to ensure that acute hospital services deliver care that is safe, effective, and person-centred, in line with national standards. With a focus on IPC (as well as nutrition, personal care, leadership and clinical governance), HIS measure NHS board compliance against a range of standards (e.g. Infection Prevention and Control Standards (2022)), best practice statements and other national documents (e.g. NIPCM). HIS Safe Delivery of Care inspections are unannounced. Decisions on where inspections take place are based on all available intelligence, including previous inspection outcomes and hospital infection incidents. Please see paragraph 46 onwards for an example of when the Scottish Government has sought additional assurance from HIS.

19. The Scottish Government has not made a formal assessment of the NHSGGC SOP (either version 2 or 3) and would be guided in this respect by ARHAI Scotland. I would suggest that the Inquiry has regard to Laura Imrie's witness statement and evidence regarding relation thereto.

20. As stated above, however, the process for undertaking a HIIAT assessment and, therefore, reporting an incident and or outbreak to ARHAI Scotland

detailed in the NHSGGC SOP (version 2, effective from December 2023), differs slightly from that which is stated in the NIPCM and, therefore, what Scottish Government expects in terms of Board reporting of outbreaks/ incidents to ARHAI Scotland. Version 3 (effective from April 2025) of the NHSGGC SOP (see paragraph 14) appears in keeping with chapter 3 of the NIPCM. The role of an NHS Board, ARHAI Scotland and Scottish Government in relation to Chapter 3 of the NIPCM is set out below.

21. I do not have the clinical expertise to comment on whether the Inquiry should be concerned by the terms of the NHSGGC SOP when considering its Term of Reference 9 in respect of learning lessons from the process and practices of reporting healthcare associated infections.

22. Within the Chief Nursing Officers Directorate, I have oversight of and responsibility for leading on all aspects of policy regarding healthcare-associated infection and antimicrobial resistance. This includes the development and implementation of national policy in respect of healthcare associated infections. As part of this, the Scottish Government commissions NHS National Services Scotland to provide the service delivered by ARHAI Scotland. ARHAI Scotland is a clinical service that coordinates the national programmes for IPC and Antimicrobial Resistance ("AMR"). ARHAI Scotland provides expert intelligence, support, advice, evidence-based guidance, and clinical assurance. ARHAI Scotland works closely to provide clinical leadership to local and national government, health and care professionals, the general public and other national bodies.

23. It will never be possible for any hospital to eradicate and avoid all cases of infection. As such, it is important that the processes in place to identify, control, mitigate and monitor cases of infection are robust. Whilst ARHAI Scotland is in receipt of every healthcare associated infection incident/ outbreak report submitted by NHS Boards via the Hospital Infection Outbreak Report Tool, as explained above, the Scottish Government receives notification of and information pertaining to all AMBER and RED assessed incidents/ outbreaks. The HCAI policy and strategy team has a process in

place to review these incidents, including review by professional advisors. This process allows us to raise questions about an incident with ARHAI Scotland (and, very occasionally, the Board), enabling a thorough review and helping us determine whether a briefing should be provided to the Chief Nursing Officer, other Scottish Government Directors, the Director General and/or the Scottish Ministers.

24. Since 2010, a framework has been in place to support boards when responding to incidents and outbreaks. This has been updated over time; the extant framework being 'The National Support Framework (2017)'. This framework sets out the roles and responsibilities of organisations in the event that a healthcare infection outbreak/incident, data exceedance or HIS inspection report deems additional support is required in an NHS Board.

25. There are set criteria that must be met prior to the Framework being invoked:

Healthcare infection incident/outbreak(s)/data exceedance

This is contained within the NIPCM Chapter 3:

- *an infectious agent that has major infection control/public health implications and control measures put in place locally have been unsuccessful; or*
- *a higher than expected number of cases in a given healthcare area over a specified period of time and control measures put in place locally have been unsuccessful; or*
- *ongoing exposure of individuals to infectious agent as a result of healthcare system failure.*
- *three consecutive mandatory surveillance data exceptions e.g. clostridium difficile.*

HIS Inspection

If as part of the inspection process:

- *it is observed that there are serious HAI issues that have a direct impact on care provision which cannot be addressed through local resolution or warrants direct escalation or;*

- *there is a pattern of failure to implement sufficient actions to resolve HAI related issues or;*
- *there is a pattern of unsustainable improvements that cause concern to the inspectorate that cannot be resolved or;*
- *there are concerns regarding the implementation of national policies throughout the Board area which require resolution at a national level.*

26. The Framework may be invoked by the Scottish Government HAI/AMR Unit or by a NHS Board to optimise patient safety during or following: any healthcare incident/outbreak(s)/data exceedance or HIS inspectorate visit/report. There is no set criteria/ expected performance set by the framework. In the event of the Framework being invoked, Health Boards are supported by ARHAI Scotland to develop an action plan relevant to the Board and their situation.

27. ARHAI Scotland engages regularly with the Board as they work through the action plan and provide the Scottish Government with performance updates. A decision on whether a Board remains on the framework or whether the framework is stood down is based on the Board's performance against the action plan and recommendations by ARHAI Scotland.

28. In the event that questions arise regarding healthcare associated infection/ infection prevention control governance in an NHS Board, where the processes set out above are not appropriate, it may be necessary for the Scottish Government to engage directly with key staff in the Board. Depending on the nature of the communication/ engagement, which can be at Official level or escalated up to the Chief Nursing Officer or the Director General of Health and Social Care (please see paragraph 31 onwards).

<u>The role of ARHAI Scotland in relation to reporting of incidents</u>

29. DL(2024)24 states:
As Scotland's national-level clinical IPC experts, ARHAI Scotland is responsible for providing expert intelligence, support, advice, evidence-based

guidance, clinical assurance and tailored national leadership to stakeholders in response to outbreaks and incidents. This informs and enables local capability and the development of epidemiological intelligence, underpinned by available evidence.

Therefore, NHS Boards are required to provide information on infection incidents, outbreaks, and data exceedances directly to ARHAI Scotland, as set out within the NIPCM, to ensure comprehensive national-level infection incident data is available.

The Scottish Government expects NHS Boards to engage openly with ARHAI Scotland as appropriate in respect of their role as national-level clinical leaders in relation to the prevention and control of HCAI.

The role of NHS Scotland Boards in relation to reporting of incidents

30. The responsibilities section of the NIPCM states the following in relation to reporting infection incidents:

Organisations must ensure:

- *the adoption and implementation of the manual in accordance with their existing local governance processes*
- *systems and resources are in place to facilitate implementation and compliance monitoring of infection prevention and control as specified in this manual in all care areas*
- *there is an organisational culture which promotes incident reporting and focuses on improving systemic failures that encourage safe infection prevention and control working practices including near misses*

Managers of all services must ensure that staff:

- *have adequate support and resources available to enable them to implement, monitor and take corrective action to ensure compliance with this manual. If this cannot be implemented a robust risk*

assessment detailing deviations from the manual and appropriate mitigation measures must be undertaken and approved through local governance procedures.

The role of Scottish Government in relation to reporting of incidents

31. DL(2024)24 states:

ARHAI Scotland notify the Scottish Government HCAI/Antimicrobial Resistance (AMR) Policy Unit of all Red and Amber assessed incidents/outbreaks and Green assessed incidents/outbreaks where ARHAI Scotland support has been requested.

The HCAI/AMR Policy Unit – which includes Professional Advisers - review each incident reported to the Scottish Government. Depending on a range of factors including the ongoing risk to patients, the type of pathogen and the nature of the incident - will provide briefing to the Chief Nursing Officer, and/or other relevant Scottish Government Directors and Ministers.

Current and future development activity

32. There are a number of deliverables included in the current Healthcare Associated Infection (HCAI) Strategy 2023-2025 (including phase 2 of the strategy) related to surveillance and hospital incident reporting. The Scottish Healthcare Associated Infection (HCAI) Strategy 2023–2025 is a two-year interim strategy, developed to support NHS Scotland in reducing healthcare-associated infections and recovering from the impacts of the COVID-19 pandemic. Developed by the HCAI Strategy Oversight Board, chaired by the Chief Nursing Officer, the strategy provides national direction during a transitional period before a longer-term IPC strategy is developed and implemented. The strategy aims to: reduce the incidence of HCAIs, support

NHS Boards in post-pandemic recovery and lay the groundwork for a whole-system IPC transformation from 2025 onward (see paragraph 33, below).

Responsible stakeholder	Deliverable	Example Activities
ARHAI Scotland	There will be continuous improvement and management of the NIPCM to ensure guidance and resources meet the needs of the service and reflect current available evidence.	Continuous improvement of the functionality and housekeeping of the National Infection Prevention & Control Manual (NIPCM). Review of NIPCM development process which entails the update of the NIPCM methodology. Continue to develop a process for review, update and archive of resources section within NIPCM.
ARHAI Scotland	Will undertake a review of current mandatory surveillance priorities	Report describing current situation with local surgical

	and make recommendations for future priorities, including a review of current mandatory surveillance.	site infection (SSI) surveillance for procedures other than caesarean birth SSI Complete review of existing Staphylococcus aureus national bacteraemia surveillance programme Undertake scoping of new priorities for national HCAI surveillance Undertake review of Clostridioides difficile surveillance Final options paper and recommendations for the future direction of national surveillance programme in Scotland

Scottish Government	Evaluate current mandatory surveillance policy in light of the completed review and will communicate any policy changes timeously	Review final options paper prepared by ARHAI, engaging with relevant stakeholders Policy development and communication
ARHAI Scotland	Chapter 3 and Appendices 14 and 15 of the NIPCM will be reviewed to support the mapping of investigations, to explore hypotheses, and ultimately support the identification of preventative measures to reduce the likelihood of further infection incidents.	Review of Chapter 3 of the NIPCM - Following the outputs at Phase 2 of the Incidents and Outbreaks literature review, Chapter 3 will be reviewed and a plan outlining updates will be developed. Developmental activity - Review and re-write of Appendix 14 (HIIAT, and any supplementary resources and materials (including Chapter 3).

		Continuous review, improvement and management of the NIPCM - Appendix 15
Scottish Government	Review and update as necessary the National Support Framework 2017.	Review and update the National Support Framework to ensure it remains contemporary, inclusive and fit for purpose Consideration of other support/ assurance processes. Scoping the utility of the framework Stakeholder engagement sessions
Scottish Government	Undertake a review of the Healthcare Associated Infection Reporting Tool (HAIRT)	Review to be undertaken

Scottish Government	Building on the completed 24/25 business case for a National Infection Intelligence Solution, Scottish Government to consider methods and approach for delivery in partnership with NHS Scotland.	Engaging with NHS Scotland Directors of Finance, Scottish Government Health Finance and Scottish Government Digital Health and Care Directorate to review the business case for a Once for Scotland National Infection Intelligence Solution (eSurveillance)

- Programmes of work are underway to support the completion of these deliverables.
- Scottish Government also expects HCAI reporting and guidance to be a central theme in our IPC Strategy which is currently being developed.
- The deliverables included in the HCAI Strategy (2023-2025) aligns with the IPC commitments included within the UK Antimicrobial Resistance National Action Plan (2024-2029).

Making the reporting of HCAI healthcare settings mandatory:

33. Significant stakeholder engagement and full consideration of all policy options (a feasibility study and an impact assessment) would need to be undertaken before Scottish Government officials would be in a position to consider making the reporting of HCAIs mandatory. As is highlighted in the table above, one of

the current strategic goals of the Scottish Healthcare Associated Infection (HCAI) Strategy 2023 – 2025 is to consider, "*incident reporting processes which will support the timely identification, investigation, and management of incidents, as well as providing opportunities for preventative measures to be implemented*." This will include the objective to consider: *"the methods of reporting incidents and outbreaks will be reviewed to ensure processes support the assessment and reporting of infection incidents and shared learning."* ARHAI Scotland is the responsible stakeholder in the strategy to provide the following deliverable: *"Chapter 3 and Appendices 14 and 15 of the NIPCM will be reviewed to support the mapping of investigations, to explore hypotheses, and ultimately support the identification of preventative measures to reduce the likelihood of further infection incidents.".*

34. In respect of making the reporting of HCAI healthcare settings mandatory, it would be important to identify fully any unintended consequences associated with such policy change. Whilst these have not yet been scoped, consideration would need to include, for example:

- Clinical governance and assurance is the responsibility of the NHS Board.
- The resource requirement associated with implementing and maintaining any change would need to be understood fully (at both a territorial NHS Board and ARHAI Scotland level). For example, this may mean additional staffing resources within territorial NHS boards and ARHAI in terms of reporting and monitoring reports. In addition, there is likely to be digital resource requirements connected with a national reporting system.
- A system to monitor compliance would need to be developed as would a framework/ interventions for non-compliance. This system would have to be fully integrated with the boards and therefore carefully scoped and programme managed.
- The impact of such a change on other workstreams that are currently underway e.g. the possibility of a Once for Scotland National Infection Intelligence eSystem. The "Infection Prevention Workforce: Strategic Plan

2022-2024" (**Bundle 52, Volume 6, Document 2.1, page 7**) contains further details on such an eSystem;

"Monitoring and surveillance of alert organisms is critical to IPC. Effective utilisation and timely sharing of data both locally and nationally not only helps inform the management of individual patients and incidents but also enables accurate and timely assessments of wider current and emerging threats. High-quality electronic data management systems support this workforce by reducing the risk of human error and preventing the need for repeated capturing, recording and reporting of data in multiple formats to multiple forums. Consistent and interconnected eSystems such as patient management systems (PAS) also support the maintenance of high standards of data quality and comparability; and high-quality data on healthcare associated infections (HCAIs) and AMR trends supporting local and national intelligence; informing and prioritising future policy requirements. Effective use of information and digital systems has already supported and improved management of IPC to varying degrees across NHS Scotland. However, the significant variation between Boards does not accommodate the whole system approach, where patients routinely cross health and care settings as well as Heath Board boundaries. A common approach to the utilisation of information and digital systems would lead to improvements in patient and public safety by enabling up-to-date information to be available at the point of care, irrespective of care provider or care setting."

- What mandating this element of the NIPCM would mean for the rest of the manual, as well as other guidance documents.

As demonstrated above, the option of moving healthcare associated reporting to a mandatory basis would need to be carefully considered.

35. Next year, the Scottish Government will publish a ten-year Infection Prevention Control Strategic Vision and Priorities Statement. The vision and priorities statement will be high-level and aims to support our mission to ensure everyone accessing or providing health and social care is safe from

preventable associated infection. The statement will be further underpinned by multi-year action plans which will be developed after the Vision and Priorities Statement is published and will run the course of the ten years. Whilst it is too soon to provide any detail on what will be included in the action plans, it is likely to closely relate to the Global Strategy on IPC (set by the World Health Organisation). One of the key objectives included in the Global Strategy is *"act to ensure IPC programmes are in place and implemented",* so it is likely that the Scottish IPC Strategy will include work which considers current guidance and reporting and how this is implemented in each health and care setting.

36. Separately, it is noted that within Sandra Devine's statement (page 13, paragraph 1) she states that NHSGGC's incident management process framework is consistent with Public Health Scotland Management of Public Health Incidents Guidance. I would observe that NHSGGC should not be following or using this guidance for Healthcare Associated Infections. The PHS guidance itself, to which she refers, states the following: "*For guidance on the management of all Healthcare Infection Incidents and Outbreaks please refer to Chapter 3 of the National Infection Prevention and Control Manual*." As such, in my view, NHSGGC should be using the NIPCM as the primary source of guidance.

37. The Scottish Government's position in relation to compliance with the NIPCM is that, if NHSGGC are following the SOP detailed in paragraph 15 (version 3, effective from April 2025), then this appears to be in line with the process set out in the NIPCM. If, however, NHS GGC are still adhering to version 2 of the SOP (effective from December 2023), then the Scottish Government has outstanding questions as to whether the NHSGGC SOP may result in incidents not being reported to ARHAI Scotland under the NIPCM following initial review by the IPCT in NHSGGC.

38. There has been ongoing engagement between ARHAI Scotland and NHSGGC in relation to hospital infections and reporting (particularly as regards Cryptococcus).

39. The current Director General for Health and Social Care ("DGHSC"), Caroline Lamb, asked to receive assurance as to the nature of the Cryptococcus cases and whether these cases were healthcare associated. In light of this, the DGHSC met with Professor Jann Gardner, Chief Executive Officer of NHSGGC, on 20 August 2025 to discuss matters. Immediately following this meeting, the DGHSC wrote to Professor Gardner in the following terms:

Information request regarding Cryptococcus healthcare associated infection (HCAI) cases in the Queen Elizabeth University Hospital (QEUH)

I am writing to you further to our conversations last week in relation to a number of historical cases of Cryptococcus which it would appear that NHSGGC did not report, as would be expected, (per chapter 3 of the National Infection Prevention and Control Manual) to Antimicrobial Resistance Healthcare Associated Infection (ARHAI) Scotland.
My Officials in the Chief Nursing Officer (CNO) Directorate commissioned ARHAI to engage with NHSGGC following evidence provided in relation to these cases at the Scottish Hospitals Inquiry in November 2024.

In order to gain a national picture, ARHAI contacted every NHS Scotland Board requesting data on Cryptococcus. The data provided demonstrated that NHSGGC are an outlier for this organism in relation to the number of cases in the QEUH. Following receipt of the ARHAI SBAR on the issues, the Scottish Government instructed ARHAI to write to NHSGGC requesting more information on the specific cases in order to determine whether these cases should have been reported. ARHAI wrote to NHSGGC on 21 February 2025 requesting case details. Following a letter prompting a response to ARHAI's request from the CNO to Angela Wallace on 15 April 2025, all of the information was received from NHSGGC on 20 July 2025.

ARHAI's assessment has identified an area of the QEUH retained estate with Cryptococcus cases potentially linked in time and place. ARHAI observe that it would be prudent for NHSGGC to undertake further investigations into these

cases in order to determine whether they should be defined (and reported nationally) as a cluster and that a further root cause analysis should be undertaken to explore the possibility of an environmental source in the estate. ARHAI state that the information they have received from NHSGGC does not contain the detail that they would require in order to make an assessment on whether there is an ongoing risk to patient safety in relation to this matter at this time.

Therefore, I would like NHSGGC to provide the following information to Scottish Government:

- *immediate confirmation that these cases have been escalated via the appropriate IPC governance channels in NHSGGC,*
- *immediate confirmation that the Board are fully aware of these cases and have been provided with the relevant information to assure themselves that there is not an ongoing patient safety risk in relation to Cryptococcus in QEUH,*
- *immediate confirmation that reporting of HCAI incidents and outbreaks are handled as Scottish Government expects as per DL (2024) 24 and the NIPCM.*

The information above is requested as priority, by noon on Monday 25th August 2025.

In addition, I would like NHSGGC to provide the following information to ARHAI:

- *Confirmation as to whether NHSGGC held a Problem Assessment Group/Incident Management Team meeting in relation to these cases*
- *Detail of the environment and clinical investigation in relation to these cases,*
- *The hypotheses tested in relation to acquisition,*
- *Detail on the clinical management of these cases and,*
- *Detail on the control measures in place to prevent onward transmission.*

We expect this information to be provided promptly to ARHAI, no later than 8th September 2025, so that any potential risks to patient safety can be assessed and mitigated as necessary.

40. In response, the DGHSC received two letters from Professor Gardner, dated 22 and 26 August 2025 (**Bundle 52, Volume 5, Documents 30 and 32**) I do not repeat their full terms here, but they indicate that Professor Gardner has received reassurances from her Infection Prevention and Control Team ("IPCT") that their processes *"are fully compliant with the reporting requirements of Chapter 3 of the National Infection Prevention and Control Manual (NIPCM) and DL (2024)24"* and that colleagues from NHSGGC have submitted a statement to that effect to the Inquiry.

41. Further, Professor Gardner advised that *"In May 2025, the GGC Infection Prevention and Control Doctors (IPCDs) reviewed in-depth each of the cases of suspected or confirmed cryptococcus 2020-2024. They did not identify a cluster and would respectfully ask that the information provided to Scottish Government by ARHAI colleagues be shared with the IPCT in GGC to ensure that any relevant information can be included in the review of these cases."*

42. DGHSC responded to Professor Gardiner on 4 September 2025 (**Bundle 52, Volume 6, Document 4, Page 49**) in the following terms:

Information request regarding Cryptococcus cases in the Queen Elizabeth University Hospital

Thank you for your response of the 26 August 2025 to my letter requesting information regarding Cryptococcus cases in the Queen Elizabeth University Hospital (QEUH).

In my letter, I asked that NHS Greater Glasgow and Clyde (GGC) provide the following information to Scottish Government (SG) by noon on Monday 25 August 2025:

- *immediate confirmation that these cases have been escalated via the appropriate IPC governance channels in NHS GGC,*
- *immediate confirmation that the Board are fully aware of these cases and have been provided with the relevant information to assure themselves that there is not an ongoing patient safety risk in relation to Cryptococcus in QEUH,*
- *immediate confirmation that reporting of HCAI incidents and outbreaks are handled as Scottish Government expects as per DL (2024) 24 and the NIPCM.*

You note in your response that these cases were not escalated to the Board via the Infection Prevention and Control Team (IPCT) governance structures. You further describe that assurance was sought from the IPCT in November 2024 by the Chair and the then Chief Executive due to these cases being reported to the Scottish Hospitals Inquiry.

This assurance was provided in the form of a situation report (SBAR) created by the IPCT, titled "NHS GGC IPCT response to the public criticism of our approach to case management and reporting of Cryptococcus sp. cases to ARHAI." This SBAR provides information on how and who was involved in considering each case and why the IPCT did not feel each case meets the criteria for reporting as per Chapter 3 of the National Infection Prevention and Control Manual (NIPCM).

It is assumed that the detail provided in the background section of this SBAR provided the assurance in relation to patient safety to the Chair and Chief Executive at the time; as the assessment section focuses wholly on reporting, and comments on whistleblowers, ARHAI and experts appointed to the Public Inquiry. You also note that in May 2025, the NHS GGC Infection Prevention and Control Doctors carried out a further review of these cases and did not identify a cluster.

With regards to the reporting of HCAI incidents and outbreaks you state that NHS GGC are fully compliant with the reporting requirements of Chapter 3 of the NIPCM. I note that there is an updated process in place (effective from April 2025) which states that:

If an incident is suspected or declared, the situation will be assessed using the National Healthcare Infection Incident Assessment Tool (HIIAT)

This updated process differs from what was in the previous version (Infection Prevention & Control Team (IPCT) Incident Management Process Framework, version 2, effective from December 2023) and appears in keeping with what is expected as per the NIPCM; again, assuming that the HIIAT and onward reporting to ARHAI Scotland is not dependent on a Problem Assessment Group or Incident Management Team taking place.

You request in your letter the opportunity to understand the evidence for the suggestion that NHS GGC has been identified as an outlier. It should be noted that this suggestion is in relation to the reporting of cases of Cryptococcus species potentially linked in time and place (as per chapter 3 of the National Infection Prevention and Control manual).

You also ask that the information provided to SG by ARHAI Scotland be shared with NHS GGC. ARHAI Scotland was commissioned by SG to review nationally available data of Cryptococcal cases from January 2020 in Scotland. ARHAI reviewed NHS Scotland level intelligence from three sources of data: ECOSS, Outbreak Reporting Tool submissions and a direct request to laboratories. Therefore this data (for NHS GGC) is already available to NHS GGC.

Thank you for acknowledging my further request detailed in the letter of the 20 August. ARHAI Scotland expect to receive this information on the 8th of September and following their review will provide a report to SG. I will return to you following receipt and review of the ARHAI Scotland's report by Officials.

In the meantime, I would like you to meet with Mary Morgan in order to formally discuss HCAI incident reporting and interpretation of the guidance within the National Infection Prevention and Control Manual (NIPCM). My expectation is that together you will find a common path to ensuring that SG expectations are realised and that both Boards work effectively together. I would like to be kept updated on the progress of your meetings. I will also be writing to Mary, to inform her of my request.

43. In addition, the DGHSC wrote to Mary Morgan, Chief Executive Officer, NHS National Services Scotland ("NHS NSS") on 4 September 2025 (**Bundle 52, Volume 6, Document 3, Page 48**) in the following terms:

Information request regarding Cryptococcus cases in the Queen Elizabeth University Hospital

I have been in recent correspondence with Jann Gardner, Chief Executive Officer of NHS GGC regarding information concerning Cryptococcus cases in the Queen Elizabeth University Hospital.

Having considered the situation and the details which have been provided, I have asked Jann to contact you in order to discuss HCAI incident reporting and interpretation of the guidance within the National Infection Prevention and Control Manual (NIPCM).

I would be very grateful for your involvement in order to ensure that SG expectations are realised in relation to incident reporting and that both Boards work effectively together. I would also be grateful for an update on the progress of your meetings.

44. Notably, both letters request that the Chief Executive Officers of NHSGGC and NHS NSS meet to ensure that the Scottish Government's expectations are realised and that both NHS NSS and NHSGGC work together effectively. The DGHSC requested to be updated on the progress of this intervention.

45. On 5 September 2025, Professor Gardner wrote to DGHSC (**Bundle 52, Volume 6, Document 5, Page 51**) in the following terms:

Information request regarding Cryptococcus cases in the Queen Elizabeth University Hospital Thank you for your letter of 4th September 2025.

I write to confirm that I met with Mary Morgan on 2nd September 2025 to discuss HCAI incident reporting and interpretation of the guidance within the National Infection Control Manual (NIPCM). Both Mary and I are committed to working together to find a common path. I can confirm that we have submitted the requested information to ARHAI Scotland today. I hope this provides you with the assurance that NHS Greater Glasgow and Clyde are committed to working in collaboration with NSS.

Update on other ongoing Scottish Government assurance

46. In addition to the information above, I would take this opportunity mention a further update that was provided to the Inquiry on 4 August 2025 in relation to ongoing additional assurance work being undertaken by the Scottish Ministers.

47. Questions were raised in the Scottish Parliament in March 2025 as regards the current safety of the Queen Elizabeth University Hospital as a result of concerns in that respect raised within Counsel to the Inquiry's closing statement at the end of the Glasgow III hearings. The Cabinet Secretary, Neil Gray, advised the Parliament that, in order to provide additional assurance, he had written to HIS asking them to undertake a formal review of the action plan arising from their IPC inspection in 2022, to check NHSGGC's progress made against the HIS recommendations and requirements (see Scottish Parliament record here: https://www.parliament.scot/chamber-and-committees/questions-and-answers/question?ref=S6W-35969). That letter was dated 12 March 2025 (**Bundle 52, Volume 4, Document 17, Page 116**).

48. On 20 March 2025, Robbie Pearson, HIS's Chief Executive, provided an initial response to Mr Gray (**Bundle 52, Volume 4, Document 18, Page 118**). This reply refers to various inspection/assurance procedures conducted by HIS in 2022 and how the resultant improvement plans managed by NHSGGC have been tracked and monitored by HIS. A subsequent letter from Mr Pearson dated 7 May 2025 provides a further progress update on these outstanding points. The responses would indicate that HIS are satisfied that NHSGGC has made satisfactory progress in the areas identified.

49. In summary, I have set out what the Scottish Government expects from NHS Scotland Boards in relation to adherence to the NIPCM and how this has been communicated. I have detailed that local compliance and assurance in relation to the implementation and adherence to the NIPCM is the responsibility of the Boards. I acknowledge that there is provision for Boards to derogate from the guidance in the NIPCM, however, it is expected that the Board ensures safe systems of work, including risk assessment and documenting of any derogations from the NIPCM, per their delegated responsibility from the Cabinet Secretary.

50. The Scottish Government seeks active assurance from HIS, via their Safe Delivery of Care unannounced inspections, which include a focus on IPC in relation to the published IPC standards and NIPCM.

51. With regard to incident reporting, I have set out the roles of Boards, ARHAI Scotland and the Scottish Government. The role of the Scottish Government is to review AMBER and RED assessed incidents and provide briefings to the Chief Nursing Officer and or the Cabinet Secretary. The Scottish Government may (as necessary) engage with ARHAI Scotland, or occasionally an NHS Board, to elicit further information in order to prepare a full briefing. When NHS Boards require support in relation to an incident or outbreak, they can request this from ARHAI Scotland. Alternatively, the National Support Framework (2017) can be invoked to activate formal support in relation to an incident, outbreak, data exceedance or HIS inspection finding. Reporting of healthcare associated infections is not currently mandatory and a full

feasibility study, including an impact assessment, would need to be carried out before this could be considered to be moved to a mandatory footing.

52. ARHAI Scotland are due to receive further information in relation to the cases of Cryptococcus from NHSGGC by 8 September. Whilst the issue of whether these cases should have been reported by NHSGGC is still being investigated, the DGHSC directed both Chief Executive Officers (NHSGCC and NHS NSS) to meet with the purpose of them forging a common path to ensuring that the Scottish Government's expectations are realised and that both Boards work effectively together. The first such meeting between the boards took place on 2 September 2025.

Declaration

53. 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.

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

Appendix A

A50853873 - Bundle 27, Volume 17 – Miscellaneous Documents
A53995861 - Bundle 52, Volume 5 – Miscellaneous Documents
A54055794 - Bundle 52, Volume 6 – Miscellaneous Documents

Scottish Hospitals Inquiry
Glasgow 4 Part 3
Witness Statement of
Jeane Freeman OBE

Introduction

1. I am Jeane Tennent Freeman OBE. I am the former Cabinet Secretary for Health and Sport.

2. I provided Witness Statements to the Inquiry on 18 December 2023 and 23 February 2024. I provided oral testimony to the Inquiry on 12 March 2024.

3. I address the following in this statement:

- Background;
- Role of the Cabinet Secretary for Health and Sport;
- Awareness of water and ventilation system issues at QEUH/RHC after appointment as Cabinet Secretary for Health and Sport
- Retro-fit work at QEUH/RHC
- NHS Scotland Assure
- Whistleblowing
- Stage 4 of the Performance Escalation Framework and the Oversight Board
- Independent Review
- Case Notes Review
- Substantive Concerns about the procurement of the QEUH/RHC
- Conclusions

Background

4. I confirm that I was the Cabinet Secretary for Health and Sport from June 2018 to May 2021. I further confirm to the Inquiry that I had no involvement with the Queen Elizabeth University Hospital ("QEUH") or Royal Hospital for Children ("RHC") prior to my appointment, including as to whether any aspect of the water or ventilation system of the QEUH/RHC met relevant standards.

5. I pay sincere tribute to the patients, family members and dedicated NHS staff who supported every patient's journey and have been affected by the events being examined by this Inquiry, whether or not they have provided evidence to the Inquiry.

Role of the Cabinet Secretary for Health and Sport

6. I have previously provided evidence to this Inquiry as to the role of the Cabinet Secretary for Health and Sport and how I operated when I held that role. I refer the Inquiry to paragraphs 9 to 26 of my witness statement dated 18 December 2023, within which I set out the duties of Ministers, the Scottish Government and Health Boards in relation to the delivery of healthcare in Scotland. I do not repeat that evidence in full here but confirm that it applies equally to this section of the Inquiry's investigations. I will summarise the position as being that the Cabinet Secretary for Health is responsible and accountable to the Scottish Parliament for the safe and effective delivery of all health services across Scotland. Through that accountability, the Cabinet Secretary for Health is also responsible to the people who live and work in Scotland. The operation of the National Health Service in Scotland ("NHSS") is delegated to the Chief Executive of the NHS who is also the Director General for Health and Social Care ("DGHSC") in the Scottish Government.

7. I should make clear from the outset that, as Cabinet Secretary - a politician with responsibility for a Governmental portfolio - I asked questions of and relied heavily upon the expertise of my advisers, Directors and others within the Scottish Government and its agencies, through our regular meetings and their

briefings to me, on all matters related to the QEUH/RCN. This included technical issues that I have been asked to address within this witness statement, such as the standards set out in documents such as SHTM 03-01. I am not personally equipped with a background in engineering or building standards or possess specialist knowledge of Infection Prevention and Control. My evidence to this Inquiry should be read in that context. I was and remain hugely grateful to all Scottish Government colleagues and others who advised, supported and took leadership roles in addressing the situation that emerged in relation to the QEUH/RHC during my time as Cabinet Secretary.

8. The day-to-day operation of the safety of NHSS is delegated through the DGHSC/ Chief Executive of NHSS to individual health boards, including agencies such as National Services Scotland ("NSS") and Health Improvement Scotland ("HIS"), which are the two main agencies in terms of safe delivery of healthcare in Scotland.

9. The Cabinet Secretary for Health is also assisted by advice from clinical advisors including the Chief Medical Officer ("CMO"), Chief Nursing Officer ("CNO") and the National Clinical Director ("NCD").

10. I met regularly with the DGHSC, who is the strategic lead across the whole of NHSS, as well as the various Directors who operate within the Scottish Government's health directorates.

11. In relation to the QEUH/RHC, the CNO was the lead Director with responsibility for Infection Prevention and Control ("IPC") and that is because that role sits within the remit of the CNO.

12. I agree with the proposition 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.

13. As will be clear, I was not the Cabinet Secretary when the QEUH was commissioned, procured and built. Prior to my appointment as Cabinet Secretary for Health and Sport, I had no role or knowledge in relation to any matter regarding the procurement and build of the QEUH (originally referred to as the "New South Glasgow Hospital" ("SGH")) nor can I comment on whether any previous Cabinet Secretary for Health and Sport had such responsibility or knowledge.

14. I refer back to evidence already before this Inquiry as to the role of the Scottish Government in the procurement of new largescale hospital building projects. The Scottish Government's role is to agree (or not) that the funding being asked for by a Health Board for a new hospital infrastructure project represents good value for money, in accordance with Scottish Public Finance Manual ("SPFM") and Scottish Capital Investment Manual ("SCIM") rules. I am aware that Mike Baxter (former Deputy Director (Capital Planning and Asset Management) within the Scottish Government Health and Social Care Directorate ("SGHSCD")) has already provided the Inquiry with evidence on this and would refer the Inquiry to him if any further questions in that respect arise.

15. Meeting those relevant standards is the responsibility of a Health Board's Chief Executive and Chair. Health Board Chief Executives are accountable to the DGHSC/ Chief Executive of NHSS. The Chair of the Health Board is responsible for ensuring that the Chief Executive of the Health Board is doing everything necessary to comply with the relevant rules that apply to any activity of that Health Board. The Chief Executive is the Accountable Officer. They are responsible for ensuring compliance with all health and safety regulations, safety standards in the delivery of healthcare, rules around public finance and how you spend it and account for it (per SPFM and SCIM, referred to above). The role of the Health Board Chair is to ensure that the Chief Executive is doing all of that. The Chair should make use of the Health Board's committees, internal/external auditors and their clinical advisory committee and medical director to ensure that all rules and regulations and standards are being met.

16. Similarly, prior to my appointment as Cabinet Secretary for Health and Sport, I had no formal or implied responsibility to ensure that new build hospitals funded by Scottish Government capital funding were built in a process that complied with HAI-SCRIBE procedures mandated by Scottish Health Facilities Note 30, nor can I comment upon whether any previous Cabinet Secretary for Health and Sport had such responsibility. At this distance removed, I cannot recall the specifics but, within the process of approval of finance for a healthcare infrastructure project, the Scottish Government would have had a reasonable expectation that HAI-SCRIBE was being met. I cannot recall how the Scottish Government assured themselves of that at the time. NHS Scotland Assure ("NHSSA") would have a role in relation to new-build hospitals now.

17. As I have said, I was not the Cabinet Secretary for Health & Sport when the QEUH was commissioned, procured and built, however, what I can say is that if it came to my attention, as Cabinet Secretary for Health & Sport, that the build of a hospital did not meet standards, then it was my responsibility to ensure that it became compliant in so far as possible. That was my rationale for not opening RHYCP/DCN, as set out in my previous evidence to this Inquiry. The QEUH/RHC, however, was different from the RHYCP/DCN because by the time the issues came to my attention, the QEUH was functioning with staff and patients and there was no alternative hospital facility to utilise in its place (as had been the case at RYCYP/DCN). In that case, as Cabinet Secretary for Health & Sport, if a hospital is not in compliance you have to seek information and take advice from the skilled advisers around you (CNO, CMO, CND and others) in order to understand in what way is it not complying, what (if any) risks are presented for patients and then work out how it can be retrofitted to make it compliant, in so far as possible. What is possible through retrofitting in an occupied hospital may be different from what is possible in a hospital that is not yet occupied.

Awareness of water and ventilation system issues at QEUH/RHC after appointment as Cabinet Secretary for Health and Sport

18. I took up my role as Cabinet Secretary for Health and Sport on 26 June 2018, I received a Briefing Note from Scottish Government Health Finance Directorate on 27 July 2018 **(Bundle 52, Volume 4, Document 4, Page 18)** which outlined the issues at QEUH/RHC as understood at that time. The content of the briefing note speaks for itself, so I do not repeat its terms here. Upon considering the Briefing Note I liaised with the CNO, who was directly engaging both with NHSGGC and Health Protection Scotland ("HPS"). The CNO had written to HPS on 11 June 2918 to confirm that The National Support Framework should be updated to ensure that a board "would be supported with management of any/ all subsequent incident(s)/ outbreak(s)/ data exceedance within the same ward/ area that occur while the original incident(s)/ outbreak(s)/ data exceedance is still under investigation". The Deputy Chief Medical Officer ("DCMO") had also chaired a call on 15 June 2018 with NHSGGC to discuss the situation as known to the Scottish Government at that time. Fiona McQueen would be able to assist the Inquiry on the detail in relation to this.

19. I have been asked when NHSGGC first disclosed to Scottish Ministers that, in its own assessment, Ward 2A as built did not meet SHTM 03-01 **(Bundle 27, Volume 7, Document 6 at Page 172)** and when NHSGGC first disclosed to Scottish Ministers that the air change rate for the whole QEUH/RCH was less than 6 ACH, as described in the 26 May 2016 email from Mr Powrie to Dr Inkster **(Bundle 20, Document 68, Page 1495)**. I cannot give the Inquiry a definitive answer to these questions. I am not sure whether NHSGGC did actually make such disclosures to the Scottish Government: it may be that this information first came to the attention via other sources.

20. I am asked to refer to paragraph 29 of my witness statement to the Inquiry dated 18 December 2023 **(Hearing Commencing 26 February 2024 - Witness statements - Volume 1, Document 8, Page 160)**. I am noted as saying that by September 2018 "all Board CEOs had been kept up-to-date with the ventilation and water issues arising at QEUH" and asked "What was the

information that had been passed to the Chief Executives of "all Boards", what the basis for providing that information and when had that information been given to the Scottish Government or NHS NSS?" Upon re-reviewing the detail, I may have had in mind here a briefing given by the then DGHSC, Paul Gray, when he met with the Chief Executives and Directors of Estates of all Health Boards in Scotland on 22 January 2019 to update them on the emerging issues at the QEUH and RHC and to seek assurances, in conjunction with Health Facilities Scotland, about the maintenance and testing of water and ventilation systems, as well as plant rooms within their acute estate. **(Bundle 13, Volume 4, Document 1, Page 5)**. Malcolm Wright, the subsequent DGHSC, has provided evidence to the Inquiry in relation to this (including that the Health Boards required to respond to NHS National Services Scotland ("NHS NSS")) and I can do no better than refer the Inquiry to that evidence and suggest that any follow-up questions be directed to him.

21. I am asked by the Inquiry about my interactions with Dr Peters and Dr Redding in the first three months of 2019. I described my interactions with Dr Peters and Dr Redding in my Supplementary Witness Statement for the Edinburgh III hearing and gave further oral evidence in this respect at the hearing on 12 March 2024. There is little more I can add to that.

22. I agreed to meet with Dr Peters and Dr Redding at the request of Anas Sanwar. They told me their roles and concerns. Their primary concern, at that point, was that they were not being listened to and also that they were being sidelined because they were raising those concerns. My next step was to discuss the issues raised with the CNO and DGHSC in order to see what could be uncovered and corroborated regarding the substance of their concerns. I was mindful that one cannot ignore people's perceptions of being ignored, sidelined and bullied.

23. That initial meeting with Dr Peters and Dr Redding was an informal confidential meeting - just me and them with no civil servants or notetakers in attendance. That was the start of ongoing engagement, including further meetings, with Dr Peters and Dr Redding, which did involve me but primarily took place through

my office and the CNO. The Inquiry will have been provided with copies of email exchanges and notes, including the CNO advising me of the outcome of her engagement on the issue. I then met Dr Peters and Dr Redding again once, or possibly twice, as we moved forward and commissioned the Independent Review ("IR") and the Case Note Review ("CNR") to ensure that they were kept up to date and given the courtesy and respect of that insight before it became public knowledge.

24. My recollection, albeit quite some time has passed, is that issues raised by Dr Peters and Dr Redding included concerns about the way that the Infection Prevention and Control Team ("IPCT") at NHSGGC had been operating for some time, particularly in respect of access to water testing results and microbiologists being asked to sign off HAI-SCRIBEs for work on ventilation systems. Issues were raised in relation to the ventilation system of Wards 2A RHC, Wards 4B, 4C and Infectious Diseases and isolation rooms throughout the hospital not being in compliance with relevant standards. Healthcare Improvement Scotland ("HIS") was commissioned by the CNO to undertake work to investigate this. I would defer to the CNO in relation to the detail of this but would observe that the results produced by HIS were quite shocking. In general, the results of the commissioned work indicated that what Dr Peters and Dr Redding were saying required further investigation, which led me to commission further work to develop a fuller understanding of what was going on. The report was extensive and it is worth noting that the unannounced inspection followed on from two previous inspections, in respect of which not all of the recommendations had been implemented. With specific reference to this 2019 report, there are aspects of what I would consider basic infection prevention and control highlighted as unmet and aspects of assurance that necessary procedures were carried out as required are not provided sufficient for a board to be assured in this area. Infection prevention and control is basic to creating a safe environment in both the physical aspect of this and the daily practice. It will not always be possible to prevent every infection in a hospital but the prioritisation of work and practice to minimise that risk must be of the highest priority. The HIS report is clear that, even in the context of ongoing infection issues in QEUH, this was not consistently the case.

25. The Inquiry has indicated that it understands that in 2019, following awareness of concerns regarding cryptococcus at QEUH/RHC, I sought assurance regarding the RYCYP/DCN ventilation system and asks what assurance I sought. I did seek assurance and actioned this by instructing the DGHSC to write to all Health Boards, as referenced at paragraph [20] above.

26. Upon becoming aware of concerns regarding cryptococcus at QEUH/RHC I was party to a meeting at the QEUH along with the then CMO (Professor Calderwood) and DGHSC, along with the Chief Executive, Chair, and Medical Director of NHSGGC and NHSGGC's newly appointed Head of Estates, at which they briefed us on what they were doing in relation to identifying where this infection had come from, in other words, how had an infection that was rooted in pigeon droppings found its way into a hospital and the consequent connection to two patients.

27. I clearly recall from that meeting being surprised that NHSGGC's medical director asked me why I was there and what this matter had to do with me. I came away from that meeting with a general impression of surprise and concern about NHSGGC's guardedness and down-playing of the importance of the situation, particularly in light of the then known issues and concerns about water and ventilation. In the background, for fuller context, were also broader concerns being raised by that time about the location of the hospital being close to waste disposal facilities at Shield Hall. My impression, at that time, was that there was a general "nothing to see here" response from NHSGGC.

28. I recall that there was an opening within a ventilation unit at the top of the building in the QEUH, which pigeons had gained access through. There was a discussion about the new Head of Estates addressing this through general maintenance, undertaking maintenance checks and ensuring that the Board allocated appropriate resource to undertake regular checks in relation to this issue. The DGHSC followed up on this in writing (referenced above).

29. I do not have any recollection of you being informed by NHSGGC or Scottish Government staff in late 2018 or early 2019 that the rooms where the two patients who contracted cryptococcus had been accommodated in the QEUH did not benefit from HEPA filtration of their air supply.

30. In my previous witness statement to the Inquiry dated 18 December 2023, at paragraph 34, I stated: 'The focus was on maintenance of existing estate because, at least in part, the issues arising at QEUH appeared to have been exacerbated or contributed to by inadequate maintenance performance'. The relatively recently appointed Head of Estates for NHSGGC, who I met at the meeting referred to above, indicated that his initial view was that the maintenance routine and rota was not as he would want it to be. That was the first time that I was aware that there may be an issue regarding general maintenance at the QEUH. One needs to understand that the maintenance of a hospital includes matters of significantly higher importance than, for example, the changing of lightbulbs. The maintenance team need to know what they are looking for when they do regular water and waste testing and when looking at the fabric of the building. There should be a maintenance rota that provides regular checks of both the external façade and internal workings of the building to provide assurance that it complies with all relevant standards. The Health Board needs to ensure that the content and frequency of that maintenance schedule are appropriate to the nature of each healthcare facility. For example, you would check water on a higher frequency in an acute hospital than you would, for example, in a health centre. For me as Cabinet Secretary, my understanding and appreciation of complexity and criticality of maintenance was significantly increased following that meeting.

31. In my previous witness statement to the Inquiry dated 18 December 2023, at paragraphs 123 to 125, I referred to the NHS NSS Review of: Water, Ventilation, Drainage and Plumbing Systems of the RHCYP/DCN dated 9 September 2019. At that point, I understood the ventilation issues within different parts of the QEUH/RHC, where vulnerable and immune suppressed patients were being cared for, would be different. With respect to the cancer ward for children, that this was inadequate. I understood much better than before how infection could

enter a hospital. I would also have been aware then of many of the issues around water supply and the actions the Board was taking to improve filtration of water.

32. The Inquiry may find it helpful to refer to various of the Ministerial Briefings that were prepared by Scottish Government officials and which have been provided to the Inquiry. For example, the briefing dated 17 January 2020 includes a helpful timeline of key developments, as known to the Scottish Government between 14 November and that date **(Bundle 52, Volume 1, Document 5, Page 29)**.

Retro-fit work at QEUH/RHC

33. I recall there being two main areas of significant retrofit in the QEUH/RHC: i) wards 2A/2B which included changes to the ventilation system and frequency of Air Change Rates ("ACR"); and ii) individual room areas including changes to sinks and, where necessary, showers in order to improve the water filtration system. In both of those cases, the retrofit required the decant of patients to another area, which inevitably reduces the number of new patients that can be admitted due to a reduction in the number of available beds. Additionally, there is the risk that any new work will in and of itself produce dust and disturbance, which may leak into spaces/areas where there are patients, thereby producing potential Infection Prevention and Control ("IPC") risks, for example such as risk of respiratory infection. These retrofits can never be risk free when patients are there. Even with the best measures, you cannot eliminate all dust (as an example) in a retrofit situation. As such retrofitting is inherently risky because patients receiving healthcare in a hospital are vulnerable to infection simply by being there. That risk of infection is then compounded when these patients are immunosuppressed and vulnerable because of their specific condition. In those circumstances the risk of retrofitting can be substantial.

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

35. In relation to the need to retrofit at the QEUH/RHC I had a range of concerns. I was concerned about the fact that these changes were needed in the first place. I was nervous about whether retrofitting would meet the standards given that these standards were not met initially. I was concerned about the impact upon patients and staff from the works being completed (from the inevitable upheaval and reduced available bedspace through to management of IPC and clinical risk). I was also concerned that appropriate steps would be taken to ensure that, even on a temporary basis, the intended location for decanted patients had the right level of ACR. My over-riding concern to be sure, with the benefit of advice from my experienced advisors, that every step was being taken to understand and minimise the risks.

36. I have been asked to expand on paragraph 177 of my Witness Statement to the Inquiry dated 18 December 2023, where I commented 'that retrofitting does not work for something as critical as ventilation. I had seen that on the QEUH project'. Retrofitting applies when patients are *in situ*. RHCYP/DCN had no patients *in situ*. What I learned from the QEUH/RHC situation was that you would not choose to admit patients (to what in the case of the RHCYP/DCN was then an empty hospital) and then retrofit. The QEUH was not in that situation because it was a major fully operational hospital. It was necessary to fix the problem, so the only way to do that was to retrofit and manage all of the additional factors that come with a retrofit situation. This is something that the NHS have extensive experience of managing across older parts of the NHS estate. But you would not choose to put patients into a new hospital and then retrofit when the option was available of ensuring that such a major system as ventilation met the appropriate standards when that new hospital was still empty. The retrofit situation in the QEUH/RCN led to the situation where not only were some patients decanted, but also some patients were admitted to other parts of NHS estate in other health board facilities for their treatment.

That is clearly not a situation that was in any way desirable or acceptable in the context of a new multi-million pound 'state of the art' hospital.

37. I made inquiries, through my own staff, of NHS NSS, the Oversight Board ("OB"), NHS GGC as to the extent to which it would be possible to carry out works to the ventilation systems of the QEUH/RHC to bring them up to the required standards for a new build hospital (which I understand to be those described in SHTM 03-01 at the relevant point in time). I should make clear that, as Cabinet Secretary - a politician with responsibility for a Governmental portfolio - I asked questions of and relied heavily upon the expertise of my advisers through our regular meetings and their briefings to me, including upon technical issues such as the standards set out in documents such as SHTM 03-01. I am not personally equipped with a background in engineering or building standards. My evidence to this Inquiry should be read in that context. I was regularly speaking with and seeking advice from the CNO and also seeking advice from HIS and NHS NSS on their assessment of the adequacy of the works planned or undertaken by NHSGGC. I also received advice from the OB once that had been set up. The OB was set up as a result of concern as to the seriousness of the issues and the escalation of NHSGGC to Stage 4 of the NHS Board Performance Framework ("the Framework"), discussed further below. The OB gave me a direct channel of advice and direction I wouldn't otherwise have. I was able to get additional input from the OB once it had been established; up until that point my primary advisors were NHSNSS, HIS, and the CNO. The OB and NHSGGC's Board had to take a view on what to prioritise in relation to works to be carried out – air change rates not meeting the standard across the hospital is not unimportant, but the priority had to be the wards and rooms housing the most vulnerable patients, whether adults or children. Consideration had to be given to the order of that and is reflected within the TOR of the OB.

38. I am asked why, before leaving office as Cabinet Secretary, did I not order retrofit or remedial work to the ventilation system or an investigation into how such a step could be taken at the QEUH/RHC to ensure that, as was then the case at the Edinburgh hospital, the ventilation system throughout this hospital

was in compliance with the relevant statutory regulation and other applicable recommendations, guidance and good practice? I think that when Wards 2A and 2B were retrofitted, and maybe Ward 4A too, they went beyond the requirement of the standard in place when the hospital was built. From memory, Jane Grant told me that they were going beyond the standard in place when QEUH was built but I cannot recall whether that applied anywhere else or not (I would need to see what was being said at the time, as well as what the OB was saying). The general point is, though, that the situations in Edinburgh and Glasgow were very different, because the issues at RHCYP/DCN were discovered before the hospital became occupied with patients and staff, whereas the issues at the QEUH/RHC did not come to light until the hospital was fully functioning and occupied. This meant that the course of action available at RHCYP/DCN, i.e. delay the opening of the hospital and fix all the problems while the hospital was unoccupied, was not available in relation to the QEUH/RHC.

NHS Scotland Assure ("NHSSA")

39. I have previously provided the Inquiry with evidence in relation to the reasoning for creation of NHSSA, with the intention that it would provide additional assurance that NHS infrastructure projects would be built in compliance with relevant statutory regulation and other applicable recommendations, guidance and good practice. I set out to the Scottish Parliament why it was needed, it then went into the Scottish Government's manifesto and then it was set up. I was not involved in the setting up of NHSSA. Civil servants carried out work to scope this out, along with its possible responsibilities and powers, in anticipation of the 2021 Scottish Parliament election results, in order to brief a future Cabinet Secretary and Government on this body. This work would have been carried out by Civil Servants because all parties were in agreement about the need for this body, so it would likely have been established regardless of government being elected. I am not able to comment upon any steps taken since I left office by the Scottish Government or NHSSA to provide the greater scrutiny and assurance I thought should be in place.

40. The Inquiry has asked “If as set out in the Inquiry’s Provisional Position Paper 13 **(Bundle 26, Document 3, Page 168)** it is the case that a decision was made a few days before contract close in 2009 that the QEUH/RHC would be built with ventilation that was not in compliance with SHTM 03-01 in respect of air change rates, that this derogation was not subject to a risk assessment in the manner envisaged in SHTM and that this derogation was not disclosed to Scottish Minsters in the Business Case or at remaining Gateway stages to what extent do you think that the new NHS Assure system would be able to stop a similar event happening in a future hospital procurement?”. I would hope that this would be the case; this was the intention when I set out the proposal in the Scottish Parliament for the creation of the new body, but I am not in a position to comment on how NHSSA operates in practice. Before I left office, I stated publicly that a body like NHSSA should be established for reasons I already explained.

Whistleblowing

41. I described my interactions with Dr Peters and Dr Redding in my Supplementary Statement from the Edinburgh III hearing and my evidence to that hearing on 12 March 2024. In my Supplementary Statement I set out how the information from Dr Peters and Dr Redding and others impacted upon decision-making regarding RHCYP/DCN. The information I received from Dr Peters and Dr Redding from January to June 2019 had a significant impact on the actions I took in respect of the QEUH/RHC: firstly, in seeking to verify the extent and degree of concerns expressed to me; and then in pursuing the various decisions and actions that I did take to try to ensure that the necessary improvements for patient safety were taken timeously and also that the Health Board’s governance and communications were significantly improved.

42. The meetings I attended with the whistle-blowers and the meetings I held with families had the biggest impact on me. I also separately met some of the families who didn’t want to be in the larger group meeting. As I discussed in my previous evidence to the Inquiry, putting Professor White in place was intended to improve transparency and communication of the NHSGGC Board,

including two-way transparent communication with families and full compliance with the statutory duty of candour, in light of NHSGGC's continued apparent "nothing to see here" attitude together with their expressed view that relatives were not up in arms and bothered, and that it was simply the FB group that was causing bother.

43. I also met with staff who cared for these patients. One of the striking things about meeting families was that they had no criticism of staff because these staff had no knowledge of what was going on. So, the families were doubly cross about not being told what was happening, but also that trusted clinicians and other hospital staff who cared for patients could not answer their questions. The meetings highlighted to me that the Board was failing in their organisational duty of candour; and individual clinicians were being hampered in the exercise of their individual duty of candour as a result of not being provided with relevant information.

44. It was equally clear that the Board did not accept a failure of their statutory duty of candour and did not have the necessary approach and historical practice to have open and transparent communications with patients and families, which I firmly believed was absolutely critical. That is why I decided to ask Professor Craig White to act, because of his previous roles and experience in the Scottish Government and experience in relation to duty of candour, because he is an expert in this area. Professor White is well-versed in open and transparent communication, which is why I asked him to take this role on in terms of dealing directly between the Board and families. I am aware that there has been some criticism made by other witnesses to the effect that my involvement and intervention in relation to communications caused delay and indeed prevented the NGHGGC Board from effectively communicating with patients, families and staff. I don't believe that it caused any delay or prevented communication. It required the Board, with Professor White's assistance, to communicate frequently and with transparency; and it provided the Board with the tools to do so.

45. Around this point in time I also appointed Professor Marion Bain as a new Medical Director to deal with IPC. I understand that she is providing evidence to the Inquiry about what she did. I also appointed Calum Campbell to assist NHSGGC in response to the situation at the QEUH. He was brought into the role of Turnaround Director in NHSGGC, to directly manage operational delivery (see my letter to Lewis Macdonald MSP dated 24 January 2020 – **Bundle 52, Volume 6, Document 1, Page 3**). He reported to the Chief Executive of NHSGGC from a governance perspective and also reported to the DGHSC (through the NHS National Performance Oversight Group) on all matters pertaining to the recovery plan. He brought many years of relevant experience to the situation, having begun his career as a nurse before moving to management and senior leadership roles - he had held Director posts in Wales and Scotland before serving as Chief Executive at NHS Borders and then NHS Lanarkshire. He became Chief Executive at NHS Lothian in June 2020 (and retired in June 2024). I was clear in that letter that the arrangements I put in place (which also included the establishment of a Performance Oversight Group chaired by NHS Scotland's Chief Performance Officer, with a focus on performance recovery) were intended to allow the Chief Executive of NHSGG to focus on the strategic direction of the board and provide the visible leadership required to address the infection control at the QEUH and RHC and related issues. I was clear that this approach did not involve the exercise of any statutory power by Ministers and the Board of NHSGGC would retain oversight of all business of the Health Board.

46. In summary, having heard the concerns of patients, families and staff, I took steps to ensure that the best resource available was made available to NHSGGC and also to provide me with advice and assurance. I discuss this further below in relation to escalation and the OB.

Stage 4 of the Performance Escalation Framework and the Oversight Board (OB)

47. NHSGGC was escalated from Stage 2 in the Framework to Stage 4 on 2 November 2019. The Inquiry has already received detailed evidence on the purpose and operation of the Framework from Malcolm Wright and Fiona McQueen, so I do not duplicate that here. In short, 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 Scottish Ministers to meet their statutory duties under the 1978 Act.

48. At Stages 1 and 2 of the Framework, the relevant policy lead within the Health and Social Care Directorates is responsible for deciding whether a health board should be escalated and, if so, to what Stage. At Stages 3 and 4, the decision is taken by the DGHSC. Any decision to escalate to Stage 5 of the Framework is made by the Cabinet Secretary for Health. Any decision to escalate or de-escalate a health board to a different Stage on the Framework is made with the advice of officials from different Health and Social Care Directorates. In relation to stages 3, 4 and 5, the decision maker's principal adviser is the Health and Social Care Management Board ("HSCMB"), as explained by Malcolm Wright at paragraphs 15 and 16 of his statement dated 18 December 2023.

49. In the period leading to the decision to escalate NHSGGC to Stage 4, I was receiving updates on the situation from the DGHSC, CNO and other advisers. I also met the NHSGGC Chair, Chief Executive and Board, although I cannot recall the date of that. The decision to escalate to Stage 4 was formally made in terms of the Framework by the DGHSC, Malcolm Wright. The DGHSC'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 prepared by the CNO, Fiona McQueen, entitled "Consideration of Escalation", dated 21 November 2019 **(Bundle 52, Volume 1, Document 6, Page 34)**. The paper sets out the CNO's concerns in relation to Hospital Acquired Infections ("HAI") and IPC at QEUH and her recommendation for escalation. In particular, it says:

> "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".

The CNO prepared this paper as the concerns raised fell within the "policy" areas of the CNO Directorate.

50. The DGHSC consulted me on the intention to escalate NHSGGC to Stage 4. I wanted to go to Stage 5 because NHSGGC appeared to be refusing to accept the idea that there was an issue; and I remember asking the DGHSC why he would not escalate to Stage 5. His view was that escalation to Stage 5 would mean the dismantling of the Board and the level of disruption and uncertainty of the wholesale dismantling of a Board the size of NHSGGC would carry significant risk for effective operation of health services well beyond the QEUH/RHC (i.e. across the whole of the estate and services operated by NHSGGC). I ultimately accepted the recommendation that Stage 4 was sufficient for the DGHSC and the Scottish Government to do what was required in order to provide support to and receive assurance in relation to steps to be taken by NHSGGC specifically in relation to the QEUH/RHC.

51. I am asked by the Inquiry whether it might assist a future Cabinet Secretary if legislation gave Scottish Ministers to remove only the executive board members of a Health Board and leave the non-executive board members in place. I don't see how that would assist. Executive members of health boards are employed by the Health Board and, even if there were to be a move to one single NHS employer, that would not be Scottish Ministers.

52. On 22 November 2019, the DGHSC escalated NHSGGC to Stage 4 of the Framework. A copy of the DGHSC's letter to the Chair and Chief Executive of NHSGGC is produced at **(Bundle 52, Volume 1, Document 23, Page 310)** It sets out:

> "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."

53. I am asked why the escalation had not taken place earlier. That would primarily be a question for Malcolm Wright, as the person appointed in terms of the Framework to make a decision to escalate to Stage 4 on the Framework. I would observe, however, that escalation is a serious matter with a number of significant implications that require to be fully considered. It is wise to take a measured approach to deciding what is required and, in the process of making that decision, to give the Board time to come to the view that they need to take specific actions. The level of escalation is a balance between the seriousness of the issue against the measured assessment of what the Board needs most, be that support or direction. In all but the most extreme circumstances, it is not a decision to be reached quickly.

54. I still saw resistance from NHSGGC following escalation to Stage 4 and a sense that they were being unfairly dealt with; and I did not see their attitude changing when the OB were in place. That made the interventions set in train, both in terms of the work of the OB and other steps taken to provide support to the NHSGGC Board and assurance to the DGHSC and me, more challenging.

55. The remit and authority of the OB was set out in its Terms of Reference ("TOR") **(Bundle 52, Volume 1, Document 4, Page 24).** The OB was formally convened at the direction of the DGHSC/Chief Executive of NHSScotland, further to his letter of 22 November 2019 to the Chairman and Chief Executive of NHSGGC. The Oversight Board first met on 27 November 2019, when it considered and finalised its draft terms of reference, which were then approved by the DGHSC following discussion with me. I agreed that the CNO should be appointed to chair the OB because in her role as CNO she was one of my most experienced and senior advisers and, in particular, she had significant experience in relation to IPC and HAI, which were within her policy brief.

56. The purpose of the OB was to support NHSGGC in determining what steps were necessary to ensure the delivery of and increase public confidence in safe, accessible, high-quality, person-centred care at the QEUH/RHC and to advise the Director General that such steps had been taken. In particular, the OB was tasked with seeking to:

a. ensure appropriate governance was in place in relation to infection prevention, management and control;
b. strengthen practice to mitigate avoidable harms, particularly with respect to infection prevention, management and control;
c. improve how families with children being cared for or monitored by the haemato-oncology service had received relevant information and been engaged with;
d. confirm that relevant environments at the QEUH and RHC were and continue to be safe;
e. oversee and consider recommendations for action further to the review of relevant cases, including cases of infection;
f. provide oversight on connected issues that emerge;
g. consider the lessons learned that could be shared across NHS Scotland; and
h. provide advice to the Director General about potential de-escalation of the NHSGGC Board from Stage 4.

57. The OB was to agree a programme of work to pursue the objectives described above. In doing so, the OB was expected to establish sub-groups with necessary experts and other participants, with remits set by the chair of the OB, in consultation with OB members. The OB was to receive reports and consider recommendations from the sub-groups.

58. In line with the NHSScotland escalation process, NHSGGC was expected to work with the OB to construct required plans and to take responsibility for delivery. The NHSGGC Chief Executive, as Accountable Officer, continued to be responsible for matters of resource allocation connected to delivering actions agreed by the OB. NHSGGC representatives were invited and expected to attend OB meetings in order to provide the OB with any information it required and also, importantly, to listen and learn from the support and guidance the OB was able to offer.

59. The OB members were expected to adopt the National Performance Framework ("NPF") and NHSScotland values in their delivery of their work and in their interaction with all stakeholders. The OB's work was also to be informed by engagement work undertaken with other stakeholder groups, in particular family members/patient representatives and also NHS GGC staff.

60. The TOR made clear that the work of the OB was to be focused on improvement, with OB/sub-group members ensuring that a lessons-learned approach underpinned their work in order that learning would be captured and shared both locally and nationally.

61. The TOR set out various objectives for the OB:

- improve the provision of responses, information and support to patients and their families;
- if identified, support any improvements in the delivery of effective clinical governance and assurance within the Directorates identified;
- provide specific support for infection prevention and control, if required;
- provide specific support for communications and engagement; and

- oversee progress on the refurbishment of Wards 2A/B and any related estates and facilities issues as they pertain to haemato-oncology services.

Matters unrelated to the issues that gave rise to escalation were assumed not to be in scope, unless OB work established a significant link to the issues set out above.

62. In order to meet these objectives, the OB was tasked with retrospectively assessing issues around the systems, processes and governance in relation to infection prevention, management and control at the QEUH/RHC and the associated communication and public engagement; having identified these issues, it was to produce a gap analysis and work with NHSGGC to seek assurance that issues had already been resolved or that action was being taken to resolve them; compare systems, processes and governance with national standards and make recommendations for improvement and how to share lessons learned across NHSScotland. The issues were to be assessed with regard to the information available at the particular point in time and relevant standards that were extant at that point in time. Consideration was also to be given to any subsequent information or knowledge gained from further investigations and the lessons learned reported.

63. I am asked by the Inquiry, in particular, whether the OB had the authority to direct NHSGGC to act or prevent it from acting or to act on behalf of NHSGGC and, if such powers of action were not given to the OB, why not. I think it is clear from the TOR, as noted above, that the role of the OB was to work with NHSGGC to seek assurance that issues identified in the OB's GAP analysis had been resolved or that action was being taken by NHSGGC to resolve them. It was not the role of the OB to stand in place of NHSGGC or control it to make it act or prevent it from acting in a certain way. At Stage 4 of the Escalation Framework, as I mentioned above, NHSGGC's Board was still in place and its Chief Executive was still it's Accountable Officer. NHSGGC was still responsible for the delivery of healthcare. As I have already mentioned, the TOR made clear that NHSGGC representatives should attended the OB

meetings as observers, but were not members of the Oversight Board; they attended for purposes of providing information and receiving the support available to them through the expertise of the OB. The appointment of, for example, Marion Bain as NHSGGC's Director of IPC, provided further additional support directly to NHSGGC and also provided the OB and me with the assurances we sought. Had NHSGGC not co-operated with the OB and failed to provide it with the assurances it sought then, depending on the nature of the failure, consideration might have had to be given to escalating NHSGGC further on the Framework. As I have already mentioned, Stage 5 of the Framework, which would be invoked only in the most extreme circumstances, results in the responsibility for the provision of healthcare being removed entirely from a territorial health board and assumed by the Scottish Ministers. Very serious as the situation was at the QEUH/RCH, it was not considered necessary or proportionate to move NHSGGC as a whole to Stage 5, with all that would entail, in order to deal with the issues at the QEUH/RHC.

64. Once the OB had been established, I had regular update meetings with the CNO as chair of the OB - at least weekly but more frequently if there was something that she wanted to discuss with me. From time to time, I would also receive written briefings from CNO, the purpose of which was also to keep me up to date. The CNO was also regularly reporting to the DGHSC, with whom I also regularly met. I was satisfied that the OB was fulfilling its TOR, so had no cause to raise any concerns in that respect with either the CNO or DGHSC.

65. I did have concerns as to what I saw as a continued reluctance of NHSGGC to act in a way consistent with its organisational duty of candour and co-operate fully with the work of Professor Craig White in that respect. I discussed that with the CNO and also with the Chair and Chief Executive of NHSGGC directly. Ultimately these discussions with NHSGGC led to a satisfactory outcome, but the issue with NHSGGC was that, in those discussions, almost without exception, the Chair would seek to reassure and convince, and the CE would rarely say anything. We'd reach an agreement about what they were going to do, but that would not necessarily be what they did. By way of example: NHSGGC's whole attitude in dealing with relatives of children was that they

maintained a view or approach that there was nothing of substance to parents' concerns that they were not being communicated with effectively; that it was simply a small number of parents causing trouble. In my view, this attitude did not leave that Board at any point. I think that we probably got to a place where they suppressed it and grudgingly did what we were asking them to do. That was their view for other things like whistle-blowers too. The approach was one of "nothing to see here and no need for all of this".

66. As I should be clear to the Inquiry, the OB was not responsible for the operations of NHSGGC. At all times, NHSGGC remained responsible for its operations. The OB was responsible for the actions it required to take to meet its TOR. As explained above, the OB had clear set of terms in the TOR, with knowledge of which its members agreed to be members. In carrying out those TOR, individual members may be independent of the Scottish Government but still working to a set of TOR agreed by a Cabinet Secretary. So, in that respect, you could equate it to the Scottish Hospitals Inquiry itself – the Inquiry is established by a Scottish Minister, but Inquiry Chair is independent and reports to the Scottish Parliament. It may be important to say that the CNO, like her colleagues the CMO and NCD, are senior officers within the Scottish Government, but also have a set of professional standards that they are required to meet independent of any requirements of the Scottish Government. For example, if I ask the CNO/CMO to do something, it must be in conformity with the professional standards from their professional regulators like (Nursing and Midwifery Council, General Medical Council, etc.). These professional advisors are unlike Civil Servants in that regard. Professional advisors such as the CNO/CMO must meet their own professional standards at the same time as what you are asking them to do; they advise and report to you and are accountable to you, but they are one step removed from you, which makes their role quite unique and special.

67. The TOR of the OB make clear that the OB was accountable to the DGHSC. As already explained, the role of the OB was to seek and obtain assurance from NHSGGC. It did not have the power to direct NHSGGC to do or prevent it from doing things. I did not have the power to direct NHSGGC to act in a particular manner through the OB. The Cabinet Secretary has no power to direct the NHS Board or its Chief Executive because they are accountable to the DGHSC/Chief Executive of NHSS. A Cabinet Secretary can appoint or otherwise require actions of a Board Chair. In that sense, I had no power to direct NHSGGC to take particular actions. This is one of the reasons why, when the Covid pandemic occurred, I triggered emergency powers under the 1978 Act, which allowed me to direct the health boards – without these emergency powers the Cabinet Secretary cannot direct health boards. My role was to ensure that the OB was meeting its TOR and, if there was anything additional that I wanted the OB to do in fulfilment of its TOR, to ask the OB to do it; but I cannot direct either the OB or NHSGGC.

68. I am asked to what extent I "would accept that, by December 2019, the Scottish Government 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 QUEH/RHC had been validated, (c) that the ventilation of the general wards of the QUEH/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 QUEH/RHC, (e) no HAI-Scribe had been completed for the construction of the QUEH/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". In so far as the question relates to the Scottish Government's state of knowledge, I can only speak to my knowledge as Cabinet Secretary. As I have indicated previously, by December 2019 I was aware of a number of concerns related to the construction and maintenance of the hospital. By that time, through the actions of the DGHSC (with my support as Cabinet Secretary), NHSGGC had been escalated to Stage 4 of the Framework and the OB was appointed, primarily, to provide governance support in relation to the

delivery of IPC at the QEUH/RHC. The Scottish Government relied upon information provided to it by NHSGGC and others. I asked questions of NHSGGC, HPS, NHS NSS, the OB and others in order to have as full information as possible available both to me and to the patients/families, staff, wider public. It was neither the responsibility of the Scottish Government, nor within the remit of the OB, to directly undertake the type of investigations/technical reviews necessary to obtain the information lists in this question – factual information was sought and obtained from NHSGGC together with specialist input from others with relevant expertise. The Final Report of the Oversight Board, dated 22 March 2021, **(Bundle 6, Document 36, Pages 795-921)** contains a very detailed timeline detailing "incidents" of infection, what was done to investigate those incidents and the measures taken to mitigate harmful consequences. A timeline describing the actions of the different organisations involved in responding to those incidents was also prepared by the Scottish Government and provided to the Inquiry as part of its May 2023 s21 Notice response **(Bundle 6, Document 37, Page 922)**.

69. I am asked by the Inquiry about what steps were taken by the Scottish Government during the Stage 4 process variously to ensure that the water and ventilation systems of the QEUH were then in compliance with relevant statutory regulation and other applicable recommendations, guidance and good practice; ensure that the operation of the IPCT within the QEUH/RHC was being carried out both in compliance with the National Infection Prevention and Control Manual and to the satisfaction of both myself and HPS/ARHAI. NHS NSS and HIS were commissioned to check and report on the water and ventilation systems, which they did. As explained previously, I met regularly with the CNO as Chair of the OB throughout the period of NHSGGC being at Stage 4 of the escalation process and was satisfied with the work of the OB. Professor Marion Bain was appointed to be NHSGGC's Director of IPC as part of the Stage 4 supports in order to provide senior-level support to NHSGGC and assurance to the OB and me in that respect.

70. The OB produced an Interim Report and Final Report **(Bundle 6, Documents 35 and 36, from Page 700)** containing local recommendations in respect of

Governance and Risk Management, and Communications and Engagement. I was content, in the circumstances, with these recommendations and thought they adequately addressed the issues that caused the Oversight Board to be established. By "the circumstances" I refer, in no small measure, to the fact that by the time the OB reported we were in the Covid-19 pandemic. The Oversight Board met on 19 February 2020, but then did not meet again in person until 4 September 2020. During this period, Covid-19 spread to mainland Europe and then our shores, so the whole NHS in Scotland had to adapt and re-focus to meet the threat, which became the pandemic. The UK Covid-19 Inquiry has ingathered a large body of evidence on what required to be done, including from me, the CNO, CMO and others, on what had to be prioritised during this time. Suffice to say that, to very significant extent, those responsible for the safe delivery or IPC across Scotland (a number of whom were members of, or attended, the OB) had to dedicate their time to the Covid-19 response. Whilst the OB did not meet in person, it did continue with work on a remote basis and I did receive updates. A Peer Review was established and the findings were compiled into a report. A copy of that report is produced at **Bundle 52, Volume 1, Document 7, Page 45**. On 13 May 2020 officials provided me with an update 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 49, Document 9, Page 38**. As has been said on many occasions, the Covid-19 pandemic was unprecedented and its impact, including upon available specialist government healthcare and NHS resource, was wide-reaching. One impact was that the OB did not progress its work in the traditional way that might have been anticipated, through regular in person meetings, however, other ways of working were adopted to adapt to the circumstances that presented.

71. I am not aware of what steps NHSGGC have taken to implement each of the separate recommendations of the 'Local Recommendations' of the OB. As the Inquiry is aware, I left the office of Cabinet Secretary and the Scottish Government in May 2021.

Independent Review

72. As the Inquiry is aware, I commissioned the Independent Review in response to the concerns arising from the QEUH/RHC. I established the Independent Review because I thought the situation sufficiently serious and the concerns sufficiently considerable such that it was in the public interest to seek an Independent Review, with the view to understanding what had happened and what was required to be done, both then and, importantly, in the future. Everyone was saying that the QEUH has not been right since it was built and there was nothing to do but tear it down to fix it. It seemed to me that the only way to take this forward was to have the whole situation independently reviewed - from design, through procurement, to build - to try to understand (and get us past the "he said she said" situation, which was not going to resolve anything). That is what they were asked to do. The issues being raised were so serious that you couldn't dismiss them; and at the same time you are dealing with evidence of infection and work needing to be done to improve the build because it did not meet standards, so taking all of that together, in a major public hospital (the largest hospital in Europe), it was clearly in public interest to have that looked at, which is why I commissioned the Review.

73. I consider that the Independent Review had sufficient authority to carry out its work. Likewise, I am satisfied the Independent Review adequately dealt with the concerns arising from QEUH. It dealt with the concerns it was asked to address: design, procurement and build. It was not asked to address individual cases where patients had died or been harmed where relevance of infection required to be considered; that is why I commissioned the independent Case Note Review ("CNR"). In my view, the authors fully met the remit they were given and reasonably, in my view, expressed a view on the basis of that work with respect to the impact on infection prevention and control. They did not consider or comment on, specific cases.

74. The Independent Review was a non-statutory review and reported (see para. 1.6.6 of their Report- **Bundle 27, Volume 9, Document 11, Page 145**) that there were documents it could not obtain. I had given consideration to

establishing the Independent Review using powers under section 76 and Schedule 12 of the National Health Service (Scotland) Act 1978 but, on balance, took the view that I wanted the work to begin as soon as possible. I had every expectation that all material they wanted to look at would be made available to them, especially from public bodies, and could see no good reason why that would not happen. This comes back to the Organisational Duty of Candour. In considering the question of whether to have a statutory or non-statutory review, the difference is the power to compel, but downside of setting it up on a statutory basis is the length of time it can take to establish. I wanted the review to begin quickly and had no reason to think they required power to compel when they were looking for material from bodies who had an Organisational Duty of Candour. An Inquiry under section 76 might have produced a more complete report than that of Independent Review and might well have produced a faster response than this Inquiry, but if that was the route to be chosen it might be that the TOR of the section 76 Inquiry would have been broader, so it is hard to say with certainty what the outcome of that hypothetical would have been.

75. When the Independent Review produced its report, the whole of the health service and Scottish Government was dealing with a global pandemic, so I do not believe that there were other actions that could practically be taken at that point.

Case Notes Review

76. I established the CNR because I considered it necessary and appropriate for individual cases to be looked at. The purpose of the Case Note Review was to investigate how many children and young people with cancer, leukaemia 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 wanted the Case Note Review to provide patients and families with a professional and independent view as to the cause of the infection(s) that they or their family member(s) had been affected by.

77. The decision was made by the Chair of the CNR to have the CNR established in such a way that the individual reports, explaining why the Overview Report reached the conclusion it did on infection link, are confidential to the patients and their families and were not made available to NHSGGC. My understanding is that the data set used by the expert panel was provided by NHSGGC. The approach and methodology adopted by the Case Note Review expert panel is set out in the Overview Report.

78. I am asked "To what extent would you accept that the decision to ensure that individual reports that explain why the Overview Report reached the conclusion it did on infection link 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?". Firstly, it is my recollection that NHSGGC did accept the findings of the Overview Report when it was first produced, so I suggest that it is for NHSGGC to explain why they could accept findings of Report without sight of individual cases but now feel unable to do so. Secondly, I would mention that the person who chaired the CNR and wrote the report, Professor Mike Stevens, had significant credentials both in terms of his qualifications and experience. He undertook the Morcombe Bay Inquiry and other inquiries into situations where children/babies have been harmed as a result of action or inaction in a hospital environment. My role was to have him appointed and agree what he would look at, i.e. the TOR. Having done that, it was then for Professor Stevens to decide who would assist him, how he would do so and who to share results with. I don't think that not "seeing the workings" justifies NHSGGC's change of heart. The standing of Professor Stevens is such that we should be prepared to accept his findings.

79. I am asked "To what extent would you accept the criticism that this structure of the CNR that was selected in January 2019 has had the effect of resulting in a situation where around 30% of the patients who received a report from the CNR indicating that a link between their infection and the hospital environment was "probable" might well have anticipated receiving an appropriate duty of candour acknowledgement from NHSGGC for that connection, but now have not done so as a consequence of the position of NHSGGC?" I do not accept this proposition. There is a statutory duty of candour and that should be exercised in all instances.

80. The CNR report was published in March 2021. I would not expect NHSGGC to reject the conclusions of the CNR. I would expect them to accept the conclusions of the CNR and take whatever actions were required, both in relation to patients and families of those individual cases and to ensure that they are or have taken all steps to ensure no repetition of the circumstances that led to the situation in those individual cases. Sadly, given the overall approach of NHSGGC, I am not the least bit surprised that they have taken this stance now.

81. I am not aware of whether, by the time I left office, NHSGGC had completed actioning the recommendations of the CNR, although, to re-state, I am aware that they accepted the conclusions of the CNR in full at the time. I expect that they accepted them all because they didn't want to have a row with me. I find it genuinely shocking that the findings of Professor Mike Stevens are in question given his high standing in relation to child healthcare.

Substantive Concerns about the procurement of the QEUH/RHC

82. I am asked "What impact do you consider the change of funding model change from private-partnership procurement model to a standard procurement model had on the management of estates and facilities within the new hospital, particularly as it effected the safe operation of the water system? How can such an impact be prevented or the risk of any such impacted be prevented in future

projects?". I'm afraid that I am not an expert in procurement, so cannot assist the Inquiry in this respect.

83. I am asked "Had the Scottish Government known of the ventilation derogation proposed in the ZBP Ventilation Strategy Paper dated on or around 15 December 2009? (Please refer to **Bundle 16, Document 21, Page 1657**) and recorded as agreed in the M&E Clarification Log. (Please refer to **Bundle 16, Document 23**, **at the foot of Page 1664**) should and would the Scottish Government had required compliance with SHTM 03-01 in the design and construction of the proposed hospital before approving the final business case?" Again, I don't know the answer to the first question and in relation to the second, I would assume so. In approving the final business case, the Scottish Government assumes that what is about to be built will meet all legislative and other standards required. The purpose of NHS Scotland Assure is to avoid assumptions and provide assurances.

84. I am asked by the Inquiry "aware that NHSGGC declined an offer by NHS Assure to visit wards 2A and 2B after refurbishment? If so, would this approach restrict the ability of NHS Assure to achieve the aim you mention? Would it suggest to you the continuation of a 'nothing to see here' approach?" I have not been in government since May 2021 and therefore am not aware whether NHSGGC refused an offer from NHS Assure as described. I am also not aware of any reasons that may have been offered for that refusal.

85. I am asked "At paragraph 4.6.6 of the Independent Review, it states 'In turn, the balance shifted toward achieving the "BREEAM Excellence" target instead of air change rates that met NHS guidance standards.' What action, if any, has been taken to avoid such issues in future builds?" I'm not equipped with the technical detail, but I think the setting up of NHSSA would be part of the action taken - less presumption and greater evidence-based assurance.

86. I am asked "During the period you were Cabinet Secretary what consideration was given to seeking mandatory compliance with SHTM in respect of new healthcare projects?" I don't know the answer to this. If it was considered, it would have been considered by NHSNSS and perhaps officials in Scottish Government Health Finance.

Conclusions

87. I think that, as Cabinet Secretary, I took all reasonable steps at the time to ensure that all concerns raised in respect of QEUH/RHC were addressed. The Inquiry has asked "what prevented me from removing or replacing the appointed NHSGGC Board members to 'ensure a fresh start'". The Cabinet Secretary can only appoint or remove non-executive board members. An NHS territorial board will also have local authority appointments and may also, depending on the Board, have a senior Director within its membership. I did give consideration to the non-executive Board members and whether or not I felt, during my time, that they were undertaking their roles with the level of scrutiny and challenge that I required. I met the Board and made it clear to them what my expectations were, but I was also conscious that many of the issues had a historic component pre-dating their terms of office. There was nothing in their actions that indicated to me that they as individual non-executive Board members were unwilling to undertake the steps that I required of them. I therefore did not consider it reasonable at that point in time to create instability and uncertainty by removing them and replacing them. Taking such a step would not be an action that would be completed quickly. A couple of them didn't like what I had to say to them to the extent that they said that they would resign. I said I'd be happy to accept their resignations but they didn't tender any.

88. As to the Inquiry's follow-up question as to whether removal/replacement of the Board members "would this have ensured clearer lines of accountability for issues with QEUH/RHC at Board level" – I don't think so. Lines of responsibility are clear regardless of which health board it is or what issues they are dealing with.

89. Finally, I am asked by the Inquiry whether I consider that there are now appropriate measures and check points in place to prevent the issues seen in QEUH/RHC from happening with future health care projects and, if so, why. I consider that the creation of NHSSA goes someway to provide that assurance, but I cannot comment on performance or behaviour of individual health boards at this point. NHSSA could be doing everything that I'd hope but if you have a health board that has a poor, non-challenging, non-scrutinising, culture then you could be faced with similar problems again.

Declaration

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

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

Appendix A

A43293438 - Bundle 6 - Miscellaneous documents

A47193110 – Bundle 13 – Miscellaneous Documents – Volume 4

A47851278 - Bundle 16 - Ventilation PPP

A48408984 - Bundle 19 - Documents referred to in the Quantitative and Qualitative Infection Link expert reports of Sid Mookerjee, Sara Mumford and Linda Dempster

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

A49585984 - Bundle 25 - Case Note Review Expert Panel, Additional Reports, and DMA Canyon

A49615172 - Bundle 26 - Provisional Position Papers

A50002331 - Bundle 27 - Miscellaneous Documents - Volume 7

A50125560 - Bundle 27 - Miscellaneous Documents - Volume 9

A53429115 - Bundle 49 - Oversight Board, Advice and Assurance Review Group (AARG) and Healthcare Improvement Scotland (HIS)

A34216901 – Bundle 52, Volume 1 – Miscellaneous Documents

A47231435 - Scottish Hospitals Inquiry - Hearing Commencing 26 February 2024 - Witness Statements - Volume 1

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

Appendix B:

A34216901 – Bundle 52, Volume 1 – Miscellaneous Documents

A50967356 – Bundle 52, Volume 1 – Miscellaneous Documents

A41416821 – Bundle 52, Volume 1 – Miscellaneous Documents

A34264952 – Bundle 52, Volume 1 – Miscellaneous Documents

A44685543 – Bundle 52, Volume 4 – Miscellaneous Documents

A54051182 – Bundle 52, Volume 6 – Miscellaneous Documents

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 5

A54071466