Scottish Hospitals Inquiry

Witness Statement of

Dr Milind Ronghe

1. My name is Dr Milind Ronghe.

2. I am currently a Consultant in Paediatric Oncology.

3. I work within the Women's and Children's Acute Directorate at the Royal Hospital for Children in Glasgow.

EDUCATION

4. I studied at the University of Bombay and completed a Bachelor of Medicine degree in 1989. In 1993, I completed a Diploma in Children's Health at the College of Physicians and Surgeons in Bombay and completed post graduate qualifications (MD and DNB) in Paediatrics in 1994 in India.

5. From 1996, I have undertaken UK qualifications MRCP, MRCPCH and obtained Paediatric Certification Completion of Speciality training in 2002 by the Royal College of Paediatrics and Child Health UK. I have been Fellow of the Royal College of Paediatrics and Child Health UK since 2005.

PROFESSIONAL BACKGROUND

6. Since 2005 I have been involved in a number of national and international steering groups. I have been the only paediatric oncology representative within the Scottish Sarcoma Steering Group for number of years.

7. I have been the UK CCLG (Children's Cancer and Leukaemia Group) Centre Co-ordinator for Glasgow since 2002. I have been a Principal Investigator (PI) for a number of oncology trials with the most recent being 2021.

8. I was the Clinical Trials Lead for Paediatric Oncology for Yorkhill from 2010 – 2018. Currently I am Early Phase Clinical trials paediatric lead for Scotland. I am a member of the NCRI CCLG novel agents group and member of the ITCC Europe.

9. I have a specialist interest in Liver Tumours, and have been chair of the UK CCLG liver interest group for several years. I have received a number of research grants and have a number of articles published.

OVERVIEW OF JOB ROLE

10. The main element of my role is as a paediatric oncologist. My principal role is treating patients with malignant solid tumours and brain tumours.

11. I work within wards 2A and 2B at the Royal Hospital for Children in Glasgow (RHC). Within the wards we have three different teams: solid tumour, haematology and a transplant team. I am part of the solid tumour team. My working day consists of ward rounds, daycare reviews, various MDTs, clinics and patient related administrative work along with teaching and training of junior doctors.

PATIENT GROUP

12. My patient group is generally treated by chemotherapy, radiotherapy and more recently immunotherapy.

Vulnerabilities of patient group

13. The patients receiving chemotherapy are immunosuppressed. The extent of immunosuppression depends on the protocol that patient is following and the type of chemotherapy. Some chemotherapy regimens such as high dose chemotherapy cause more immunosuppression than others.

PROTOCOLS

14. Most of the protocols we use to treat patients are Standard UKCCLG protocols/ guidelines which are similar to those in other western European countries.

15. These protocols are available online to the members of CCLG.

16. There are general guidelines for management of patients, and guidelines on how to manage some of the most commonly occurring problems, for example, febrile neutropenia. There are also Schiehallion guidelines for these, which are available on the intranet.

Prophylactic Protocols

17. Where the risk of infection is felt to be significant, we use prophylactic antibiotics. Septrin is the commonly used antibiotic and is used for pneumocystis carinii pneumonia (PCP) prophylaxis.

18. If the patient is undergoing High dose Chemotherapy or following a bone marrow transplant-type protocol, then there would be a recommendation to use antifungal and antiviral prophylaxis during the period when the patients are highly susceptible to infections.

Infection Protocols

19. For our patient population, if a patient develops a temperature, the febrile neutropenia guideline is followed for the management. The guidelines ensure prompt and appropriate treatment as per current recommendations.

20. If a patient attends the hospital with a temperature and the ward is full, they have to be boarded out to other wards. During routine hours, the patient will come through Schiehallion Day Care and be seen by oncology team, while out of hours, they are assessed by the on call Schiehallion team. Cultures are

taken and then they're promptly started on broad spectrum antibiotics. Once blood culture results are available then the antibiotic treatment is reviewed in consultation with the microbiologists. The results may change the antibiotic regime given to the patient.

21. The patients or their carer will usually phone the Schiehallion Day Care or Schiehallion ward triage phone if the child becomes unwell at home. The patients and the families are well-informed that if they have any concerns about their child then they should phone the ward and inform that they are on their way to the hospital. If the ward is full the patient is reviewed by our team, and if they have to go to go different ward, there is a nursing handover. Staff on the other ward are advised to follow Schiehallion guidelines. Sometimes staff on the other wards are supported by Schiehallion nursing staff in the management of our patients. The medical team does daily reviews of these patients.

Communication Regarding Protocols

22. When the patients and families are first informed of the diagnosis in a new case, the management plan is discussed in detail. After obtaining written informed consent, the treatment commences. The patients and families are aware that during the immunocompromised state on chemotherapy or during the period of myelosuppression, the patients will be at increased risk of infection. They know to contact the hospital or their key worker if they have any concerns.

23. The families are informed of the CCLG website for parents and families where they can access useful information. There are patient information booklets on the ward. For the first discharge, a discharge planning meeting is undertaken with the nursing staff. The patients and families are given all this information and given the triage phone numbers, ward numbers and Day Care numbers, and told who their outreach nurse is. They are also advised that if the child is exposed to someone with chicken pox or measles then they need to contact

us immediately so that we can give prophylactic medication. All the patients have central lines/port-a-cath, and they are advised about appropriate line care.

CHRONOLOGY

PRE 2015 – BEFORE THE MOVE TO THE NEW HOSPITAL

24. I was not part of the project group and did not have a role in the design, planning or site selection of the hospital. The clinicians were contacted at a later stage, and we had a few meetings with the project team. There were some discussions about the design of the ward, for example, number of cubicles, bed bays etc.

25. At the time we did express our dissatisfaction with some aspects. I think the number of beds were cut back. We wanted a bigger unit with more beds. In the Yorkhill Hospital our offices were close to the ward but that wasn't going to happen in the new RHC or QEUH complex. We also raised issues with regard to the lack of a pharmacy room and family room. There wasn't a staff room or a dedicated seminar room.

26. Although some suggestions were taken into consideration, all requests were not addressed.

27. There was a need for dedicated Teenage Cancer Trust unit (TCT) unit which was not there in Yorkhill. This was provided in the new hospital.

THE OLD YORKHILL HOSPITAL

28. The proximity of consultant offices to the ward, and access to the family room, were better at Yorkhill. Yorkhill hospital had a family room close to the ward which was better for the parents. The design of the ward was better in Yorkhill. Supervision from nursing station was easier in Yorkhill, whereas it is more difficult in the new hospital because of the horseshoe design of the ward.

29. Yorkhill had a dedicated paediatric lab, which was advantageous, whereas in the new hospital lab services are amalgamated. The dedicated lab in Yorkhill enabled samples from our patients being processed quickly. In the new hospital, the ability to turn around results really quickly for our patients was lost because samples are processed with those from the adult hospital.

IMPRESSIONS OF THE NEW HOSPITAL

30. When we heard the new hospital was going to be built, we were certainly looking forward to a state-of-the-art facility for our patient population.

31. Initially, the new hospital appeared to be like a decent facility. However, one impact of the move is that our offices are in a separate office block away from the ward area which means that we are least 10-15 minutes away from the ward. Also, we have shared office space in the new RHC whereas in Yorkhill we had individual offices. On the ward we have only hot desks. There were some areas in the hospital where mobile signal was poor. The IT was a problem initially because the Wi-Fi issues created difficulties for families who were unable to access internet. There was no room for pharmacy on the ward initially. The new ward does not have a room for social workers and outreach nurses, which was the case in Yorkhill and which facilitated better and quicker communication in the old location. This was also lost. Parking and vehicle access at the new hospital was extremely difficult, as there are only limited spaces. I think not having a staff room in the new hospital where you can sit down and have an informal chat with colleagues has an impact on the staff.

32. Another issue at the QEUH site is that, as the RHC is co-located with adult services, smoking at the entrances to the hospital is an ongoing issue. This did not affect our patients at Yorkhill to a significant extent as the ward was located near the lab and it wasn't near the main entrance of the hospital.

33. However, individual patient cubicles are very good, including the size of the cubicles and the layout inside. There are better facilities for children's entertainment. The TCT social area is great. The problems with mobile signal improved to some extent over the years as boosters have been placed in certain places. The demand for a room for pharmacy on the ward led to this being implemented, which is useful.

34. The Paediatric Neurosurgery department was always based in the Southern so when we were at Yorkhill patients had to be transferred from the Southern to Yorkhill after neurosurgery. This is now not necessary as the new hospital is at the same site.

35. We were aware of the smell issue at the site of the Southern. This did not raise concerns because there had been a health care facility at the Southern for a number of years.

36. Overall, the new hospital was a decent facility. There wasn't any reason to suspect that anything was grossly wrong.

ISSUES WITH THE BUILDING - Exterior

37. I'm aware of some of the issues with the exterior of the building, but do not have any detail or specific information. The hospital entrance had to be changed temporarily because of repair works. Within the atrium of the hospital there is still some work going on.

ISSUES WITH THE BUILDING - interior

WATER SUPPLY

38. We have meetings with microbiology/infection control on Fridays. We started noticing infections with organisms that we hadn't commonly encountered in patients during their treatment. The general feeling among the clinicians was that these were unusual infections, and literature search suggested that these

could be environmental infections. This was discussed in the Friday meetings with the microbiologists and infection control doctors, including the potential source of infection. These were felt to be environmental organisms and also water-associated. It affected our patients' management as they needed more prolonged antibiotic treatment, or their central lines had to be removed. As clinicians, we raised our concerns to infection control / microbiology.

39. A variety of water related investigations were conducted to assess if the water was a potential source of infection. Water filters were brought in, patients and families were asked to not drink water from the taps and bottled water was given instead for a period of time. At one point, we had portable sinks in the ward cubicles. Therefore, we assumed that there were some concerns about water or water supply. Various actions were being taken in relation to this such as hypochlorite cleaning or treatment with chlorine dioxide, and change of shower heads, but I can't remember the exact details.

40. Scottish Water was asked to look at the way that the water was coming into the building. We knew this was happening, but we didn't know what the outcome was or what was going on apart from all of these measures.

41. We had raised our concerns with infection control and microbiology , and we were treating patients appropriately with antibiotics as per their guidance. I don't think we ever received confirmation that investigations had established a link between the infections and the water supply. Given the frequency with which the infections were happening, and the amount of work that was undertaken, we assumed that there must be some problem which was getting addressed.

42. I wasn't aware if there was an issue outside of Wards 2A or 2B.

43. I think because these infections were happening more frequently or because they were more unusual infections than we would have expected, a group was formed for looking into this called the CLABSI (Central Line Associated Blood

Stream Infection). There were hand hygiene audits, and a variety of things were checked such as the surgical insertion of lines, or whether there had been a change of supplier of the lines or of the bungs that are used at the end of the line. I wasn't a part of that group. There was representation from surgery, oncology, haematology and Infection Control.

44. I think obviously this had a huge impact on staff. I think some staff members felt that they were under scrutiny, and were constantly being watched to see whether they were following hand hygiene etc. Nurses started working in pairs, so that they could prove they were following all the recommendations and precautions of the protocol. So it was very difficult, challenging and demoralising for the staff.

45. We were obviously under tremendous stress because we were at the coalface; we were facing the parents and all the work that was going around. It was very stressful and demoralising.

VENTILATION

46. When we first moved to the new hospital, I had no concerns about the ventilation. It is not my area of expertise. I think we had heard one or two weeks prior to the visit that there was some issue with the HEPA filters. I don't know the details of that, but as far as I understand they were fitted at a late stage, although prior to our move.

47. My concern for my patient population was more about the water. My recollection is that a haematology patient was suspected of having an infection. It wasn't one of my patients, so I don't know all the details, but I vaguely recollect that there were some discussions at Friday meeting with infection control team/microbiology.

48. There were lots of things happening in and around the ward. Portable HEPA filters were brought in to improve the quality of the air, so I assumed that there

must have been some problem. I think the Infection Control and Estates teams were taking all the steps. They were carrying out regular air sampling and we were told that they were taking these steps to try and mitigate whatever the problem is. We were told that they were doing all these things to improve the quality of the air. There were some issues with the chilled beams but I'm not sure if this was connected to ventilation.

49. I think the cryptococcus incident happened when we were on 6A. This is an unusual infection and the involved clinicians raised concerns with microbiology and infection control.

50. Ventilation is not a vital requirement for some of the patients under my care, but it is vital for those who undergo certain types of treatment such as autologous stem cell transplant or if it is in the protocol that they need to be treated with high dose chemotherapy. In those circumstances there are transplant cubicles which are recommended to be used or preferred when the patients are neutropenic.

Communication

51. The communication with staff was in the form of core briefs. We used to get information from Professor Brenda Gibson, who is our Lead Clinician, sometimes through the minutes of the IMTs and core briefs.

52. I think later on, the management was updating the parents and the families with written letters. Communication at the start could have been better. It improved significantly towards the end of the process. I wasn't a member of the IMT group so did not attend the meetings regularly. I remember that the minutes were sometimes circulated quite late.

53. I think management also developed a Schiehallion Facebook page to try and improve communication with the parents and families.

54. As far as I can remember there wasn't a formal process for giving information to staff. It was coming through various channels such as core briefs, unit meetings, governance meetings and IMT minutes, emails or by talking with colleagues.

INFECTIONS

55. Cupriavidus and Elizabethkingia are infections that we do not commonly see. Some patients had mixed Acinetobacter/Enterobacter infections. These are all unusual infections which have links or association with the environment. Clinicians were asking microbiologists and the Infection Control team to review this. I think this was discussed in the IMTs and we were told after the move to 6A, that the infection rate in 6A was similar to that in any other hospitals in Scotland, but clinicians were concerned about not just the number but the type of infections, and questioned if the environment was safe.

56. As our patients were on chemotherapy and other cancer treatment, they were prone to infection, so we didn't necessarily think there was a link to the environment initially, but it evolved later. It was difficult for the clinicians as we could not see the whole picture. We were aware of individual cases of infection in our patients, or on our wards. However, all of the blood cultures for these individual cases would have been known to Infection Control. They had all the data and were best placed to put it all together and note an overall increase in unusual infections. Although we had our regular Friday meetings with Infection Control, these were not attended by all the clinicians every week, and so we did not necessarily know about patients other than those under our care. As clinicians on the wards, we did not become aware of any overall pattern or trend until much later.

57. Gram-negative infection is more serious; gram-positive infection is usually not life threatening. Gram-negative infections can lead to ITU admission if not treated promptly.

58. Another impact of infections is delay in the ongoing treatment. This is because the infection needs to be treated first and sometimes the central line (which is used for administration of drugs) needs to be replaced. The decision about replacing the line is complex, as there may not be another suitable vein available. As a clinician, we have to consider the balance of risks and benefits of line removal. We were in a situation where most of the lines, I think, needed to be removed in order to treat these unusual infections.

59. We make the individual decision on a case-by-case basis, after discussion between the microbiologist and the patient's clinician.

60. The nature of infection sometimes gives us clues as to its possible source. When oncology patients get infections, they are usually from endogenous bacteria. However, we noticed that our patients were getting infections with unusual microorganisms, and that is what raised concerns.

61. We discussed these issues with the Microbiology and Infection Control teams. My role is really to treat the infection appropriately when it happens, including taking the decision to remove the line if necessary. Looking for the source of the infection does not come under my remit. When we noticed these unusual infections, we had discussions with the microbiology and infection control team who then further investigated this to assess if the source was likely to be environment related (water or ventilation). We were relying on them to advise us on this issue. The infections were the reason for the IMTs and for the introduction of precautionary measures.

    The parents and families were told if the patients had infections. It is routine procedure to inform families if the patients have infection. The families of cancer patients are aware that the patients are at increased risk of getting infections due to their immunocompromised state. I cannot remember if the families were informed about a potential outbreak or multiple linked infections initially. However, they were aware of the work being undertaken on the ward.

Later on, there was communication with the families in the form of letters and leaflets produced by the management team.

PROPHYLACTIC MEDICATION

62. A group was formed to assess the need for prophylactic medication over and above the standard practice. This group had representation from a haematologist, oncologist, microbiologists and infection control. The group reviewed the literature. I was not part of this group. They advised us to use Ciprofloxacillin to minimise the risk of infection, and that is what was prescribed to the patients following discussions with the Infection Control team.

63. I spoke to my patients once the decision was taken to use this prophylaxis. I can't recall whether there was an information leaflet for the families regarding this. My patient population was made aware that we were starting this additional antibiotic to minimise the risk ofinfection.

64. Later a decision was taken to change the prophylactic antibiotic to TauroLock. This decision was taken after further discussions with microbiology/infection control (CLABSI group). I think this was decided in order to reduce the side effects and possible development of drug resistance to Ciprofloxacillin. There were also concerns about potential drug interactions with other medications.

65. Posaconazole (an antifungal drug) was used in some patient populations. I think it predominantly would have been in haematology patients, who are more immunocompromised, or transplant patients, but in our patient population, again, certain patients would have been prescribed it. Posaconazole interacts with some of the chemotherapy drugs (Vincristine), so Posaconazole had to be discontinued two days before giving Vincristine. It was intermittent prophylaxis rather than ongoing regular prophylaxis. Some of the High dose chemotherapy patients were prescribed Posaconazole prophylaxis, but for some patients it wasn't the appropriate so they were prescribed a different antifungal drug, AmBisome, instead. Within the solid

tumour group there were fewer patients who would have been prescribed antifungals than the leukaemia or haematology transplant-type patients.

THE CLOSURE OF WARD 2A/2B AND THE DECANT TO WARD 6A

66. I can't remember being significantly involved in the decision to close Ward 2A and move to 6A. I can recall there was a meeting with the management to look at various options, and a risk assessment was done after that. I think what prompted the decision was that it became clear that it was unsafe to continue in 2A, because of the rate and nature of infections. I think Ward 4B was our most preferred option because it was the adult transplant unit. However, I think that was deemed to be not possible. Schiehallion was given four beds on Ward 4B for our patient population. From an infection prevention and control point of view, Ward 4B would have been ideal, but it was not possible to have all of our patients moved there.

67. I don't know how Ward 6A was selected. We were not entirely comfortable with the decision because the ward wasn't really designed to look after the immunocompromised patients. The other potential problem we had was that it was away from the children's hospital, so out-of-hours middle grade cover was difficult as juniors were not on site. Pharmacy was far away. It was away from intensive care, which was a problem. Then there were problems with the lift (one of the lifts had to be reserved only for our patients). Patients were having to come through the adult entrance. There were no dedicated Day Care facilities because it was just one ward, so we had to make some of the beds of Ward 6A into Day Care beds. It was really not ideal. There was no playroom in that ward. There were lots of drawbacks, but we were informed that this was the best-possible option under the circumstances, and we thought it was going to be a temporary measure for just a few weeks. Our other option would have been to divert the patients to different hospitals. We had anxieties that we might face similar problems with infections on this ward as well, as QEUH was on the same site as RHC and so the environment (water and air) would be the

same. I don't know who exactly decided or how it was decided that this is where we had to go.

68. I can't really remember the exact nature of communication about the move and what was done, but I would assume there must have been some communication as it was a substantial move. Parents and families would have been told. In-patients certainly would have been told by the ward nursing staff including the reason for the move. I believe that there would have been a letter done by the management to send to the families to inform them of the move, but I can't remember the exact nature of the communication as it was a while ago.

69. We were on high alert when we moved into Ward 6A because of everything that had happened in Ward 2A. Then, similar problems re-occurred in 6A. I can't remember the exact details, but obviously the team was probably much more aware of things, so the problems probably were identified sooner. Infection control probably did more sampling of the air and tested the water more stringently. I remember at various time points a different kind of work was going on in various cubicles on 6A. Sometimes we were just told you can't use this cubicle because of ongoing work. We did not question it because we were just assuming that the work was being done to improve the quality of air or water.

MOVE TO CDU – January 2019

70. There was a time when we moved from Ward 6A to CDU. I think that was related to infections. I remember the line infections problem recurred and, again, the similar unusual organisms started appearing in our patients. That's what prompted the closure of 6A.

IMPACT

71. The management had done some leaflets and letters to the families to keep them informed of the ongoing work regarding this. I can't remember the exact content of the letter, but the letters were done to reassure or to tell the families that all the appropriate steps were being taken.

72. At some point we had to stop new admissions, and the patients had to go different hospitals. All this obviously had an adverse impact on those families.

73. The impact included the move to 6A and CDU, sending patients to other hospitals, the need for prolonged antibiotics, the removal and replacement of lines, and patients being looked after in wards that were not designed for their care. Additionally, we were having to give prophylaxis, drugs that potentially they may have avoided. These drugs have side effects or drug interactions and that all had an impact. We were concerned about all of that.

74. There was an impact when we moved from Ward 6A to CDU too. It impacted on the families because infections led to more antibiotic treatments, more line removals, more trips to theatre, sometimes delays in chemotherapy. Then obviously the closure of the ward led to patients going elsewhere for chemotherapy cycles. That obviously had impact on the patients and on the staff.

Impact on Staff

75. The move from 6A to CDU had an impact on staff again too. It was very stressful and demoralising. We were felt to be under constant scrutiny about hand hygiene. It led to more sickness in the staff or staff exhaustion. The root of the problem was not getting identified which was frustrating. We were doing all these things without actually knowing whether there was an outbreak or not, because it wasn't very clear.

COMMUNICATION

76. I can't remember exactly when any communication was received. I found out about the issues with the water because of the work that started happening around in the ward, and then through colleagues or IMT briefings or meetings among the staff and clinicians.

77. I think we should have probably received more frequent or more formal, regular, timely updates from the Infection Control team, IMTs or the management. I don't think there was a definite formal process to keep staff updated. The dissemination of information could have been better. Sometimes the IMT minutes were circulated quite late, and a pre-read wasn't possible. My feeling is that communication got better with time.

78. I think with time, information leaflets were created for the families. Also, management started doing walk-arounds on the ward. Also later in the process, if a child had an unusual infection, then the patient's clinician along with the Infection Control doctor used to go and see the family to inform them of the infections and answer any questions, rather than just clinicians seeing them. That was really helpful for the clinicians. The infection control team and management were reviewing the cubicle the patient was in, sampling the air and checking the water supply etc for that cubicle. A process was set up towards the end where there was root cause analysis being done in consultation with the clinician. I can't remember the exact timeframe for this.

79. There were unusual infections, which we were discussing with Microbiology / Infection Control team in our weekly meetings. To each individual clinician, it would have been one or two rare cases, but I think collectively the Infection Control team would have had a grasp of the total number of infections in the unit. We were telling the involved patient and the family something like, "Your child has got an infection with a Gram-negative organism. It's a sticky bug and an unusual organism, and the Microbiology advice is to pull the line out and give a course of antibiotics for treating that". In the beginning stages, we were talking to Microbiology, saying that we have not seen these infections before. There was no suggestion in the initial stages that this may be associated with

the hospital environment, because the patients do go home in between treatments so could potentially catch infections outside.

80. I expect that, as the microbiology/infection control departments had overall data of cases from the unit, they would have escalated this issue within their departments. As clinicians we were questioning whether these were waterborne infections because we did literature search on these organisms and learnt that they could be water-associated infections. Over time, work was carried out to address the dampness or the drains. We then felt that there was likely to be a problem when patients were told not to drink water, and water bottles were supplied and portable sinks installed. The drains, the connections and showerheads were changed. I can't remember now the exact timescales and what happened or when, but at that time we were under the impression that there was a problem with the water. I don't think we were ever told that there was a confirmed link between the water and the infections. We were told that these cases were sporadic and there wasn't an obvious link.

81. Towards the end of the process, an Infection Control doctor would join clinicians when informing the family of an unusual infection. I don't know if management saw every patient, but they were doing a walk-around on the ward, trying to inform the families that they were doing everything that they could to try to enhance the ward environment. I think they were briefing the families that wanted to be briefed. I think I can remember there were one or two meetings which were open to Schiehallion patients and the families to come and attend. They thanked the families and acknowledged that this was a concerning matter for the families. They were happy to answer any questions that the families may have had.

82. I think there were a few management walk-arounds. Jamie Redfern was the main point of contact. Towards the later part of the period, he used to attend our unit meetings and governance meetings, and share an update about what work was going on. So there was support from local management. Also, there

were some rounds which were done by the senior Health Board representatives.

83. Towards the later stage, there were letters that were produced by management, which were given to the parents or the carers.

84. The Schiehallion Facebook page was set up to disseminate information. I think the parents had a Facebook page too. I am not on Facebook so I'm not sure what the content was. I understand that management subsequently felt that they needed to be more proactive rather than reactive regarding their communication.

85. As a part of the IMT process, Health Protection Scotland was involved. Also, I think there was a water group who were looking at water samples and sources of infection. Estates were there too. Subsequently, all the cases were reviewed by the independent case review. Before the independent case review, I think there was some review done by GGC as well. Following the independent case review the report came through which was circulated to clinicians. It was also circulated to the individual patients and families who were affected by the problem.

86. I don't think the families would have been told that there was an outbreak of infection.

87. I can't recall if there was any formal communication regarding the prophylactic antibiotics from management. There may have been a letter handed over to the families explaining prophylaxis. I can't remember the details of that communication. My patients would have known why they were on Ciprofloxacin. It was not the case that they were taking it without knowing reason behind it.

88. We prescribed prophylactic antibiotics based on the advice we received from the group that was set up to consider prophylaxis.

89. The media reports had a negative impact on staff. I think sometimes we were informed that there was going to be news reported regarding this on the TV or in the newspaper so it was stressful. That is when we suggested to management that they should actually be proactive and try and produce a leaflet or a statement giving an appropriate response. That got better towards the end of the process.

90. When we were at the point where we had experienced all the infections on Ward 2A and then encountered further problems with infection rates on Ward 6A, we were still asking if the hospital environment was safe. There were unit meetings, IMTs and governance meetings where we raised the question. Eventually, the consultants wrote a joint letter to the Health Board management to ask that question.

91. Following the refurbishment, things have improved now. We continue to have regular meetings with Microbiology/ Infection Control on Fridays. We discuss each and every infection that happens. There is a formal process of recording all that now, which wasn't there in the past: notifying parents of what infection is there, what root cause analysis has been done, etc. There are processes in place now, which are so much better, but fortunately we are not seeing the same unusual infections anyway. We are still very stressed with the Inquiry and all the time that it is taking. The whole process has been very, very stressful and demoralising for the staff. Our outcomes are still as good as any other national benchmark, but it's all been a very stressful period for the duration that it has happened. It has been extremely time consuming and brings back stressful memories.

MOVE BACK TO WARDS 2A and 2B – May 2022

92. We do not have any concerns about the water now because since the move we are not seeing the same infections as we did previously.

93. I am not aware of any concerns about the ventilation now. We were shown around before the move back to Ward 2A. If you were to come into 2A now, externally, there isn't really anything new that appears to have happened, but we were shown the amount of work that has been undertaken. Since the move back, I have not had or heard of anyone having concerns and we no longer use prophylactic antibiotics in the ward for environmental reasons.

94. The ward now looks exactly the same as it did in 2015 but a lot of work has been done. We've been reassured by the work that has been undertaken to improve the ventilation and water and drains, etc. We had visits arranged by the Estates team when the work was being undertaken to show us what was being done and we have been told the ventilation is now "state of the art". The infection rates have dropped significantly.

IMT MINUTES

95. I wasn't a regular attendee of the IMT meetings. I was not part of the IMT group but I did attend from time to time. It was meant to be a closed or select number, but I think as the process became quite long, stretched, then there was a need for me to attend as a member of the clinical team when the member representative from Schiehallion wasn't able to attend because of their own clinical duties. I wasn't attending each and every meeting. I was there to represent a clinical team and raise concerns about infections that we were concerned about.

96. If Professor Brenda Gibson wasn't able to go, then she would delegate somebody else to go. I think at times it was the "consultant of the week", which was the on-call consultant, who would go, but I can't remember the exact circumstances. The IMTs took place quite often and there would be minutes of the meetings, but if you hadn't been to the previous meeting or hadn't had the chance to read the minutes, it was difficult to get a grasp of what the decisions were and how the risk assessment was being done etc.

97. We are a big team so each consultant is the "consultant of the week" (or on-call consultant) every 6 to 8 weeks. If you're the on-call consultant then you need to know what is happening with the environment, what work is going on in the ward and what decisions have been taken at the IMT. As clinical link, Brenda Gibson had to communicate this information to the on-call consultant.

98. I did not receive all the IMT minutes. I can't remember the exact process of how we received them. Perhaps I only got the minutes when I was added to the IMT email list but I'm not sure.

99. I can't recall the exact conduct of these meetings because I wasn't a regular attendee, but I think there were lots of issues that were discussed in the meeting: the Estates' input, the water samples, the public health input and the spectrum of bugs that were seen.

IMT meeting – 13 September 2019

100. I attended an IMT meeting on 13 September 2019. I was the only clinician present. The discussions at the IMT related to the possible reopening of Ward 6A. At this meeting, I stressed that they needed to have separate meetings with us as clinicians. The IMT should not make any decisions based on what had been discussed at the meeting that day. I said it was important that the data should be presented to clinicians, and we should be given enough time to analyse the data rather than just being presented with conclusions. For example, they would present conclusions such as 'the data shows this is not an outbreak', but we wanted the opportunity to review the data ourselves and to discuss it with them. A separate meeting was arranged after this IMT for 16 September 2019 with the clinicians. I believe this meeting did happen but I can't remember the details. It would have been minuted but I can't remember seeing the minutes.

(A37993497 – Incident Management Meeting, dated 14 November 2019, relating to Gram Negative Blood Ward 6A, Bundle 1 page 402)

101. I have been provided with the minutes of this meeting. This related to the reopening of Ward 6A.

102. We were told by the management that the conclusions of the IMT following investigations and the report from Health Protection Scotland were reassuring and that the GGC site did not have an increased number of infections compared to other Scottish hospitals. The point we wanted to stress was that it was not about the number but the type of infections that concerned us. We still had anxieties and we were not entirely happy. We were being told that it was a pseudo-outbreak. I can't remember all the details. To reassure us, they did some analysis. There was a Professor of Microbiology from Glasgow University, Alistair Leanord, who did some genotyping as part of a scientific project, which suggested that these were all different sporadic infections rather than linked to the environment. We were not reassured and remained anxious.

103. We were trying to tell management that even though the Infection Control and Microbiology team were saying that it was okay now to reopen again, we still had some reservations. We were concerned that the real cause for the infections had not been found. The potential for infection within our patient population is high. We wanted to know what was going to happen when the next infection occurs. We wanted to know the Health Board's strategy to manage that. We felt that it was important to have a strategy in case of any future infections. So that's when we were assured that there would be an enhanced surveillance program and the Problem Assessment Group (PAG) was set up to arrange a root cause analysis for each case, which would be undertaken by the Infection Control team. We were saying that this needed to be in place before the ward shifted, rather than waiting for the infection to happen. We had reservations as no definite cause for infections was found and eliminated.

104. I think we were asking for external review at that point too. By external we meant someone out-with Scotland to come and review the whole situation.

105. I think the process got better as we were on 6A, because that's when we insisted that, as clinicians, somebody else needed to come in and talk to these families because they needed explanations which infection control were better placed to give. I remember the Infection Control doctor having discussions along with the clinicians with the families to tell them about what investigations were being undertaken and what was being done. So, the root cause analysis and the other things I mentioned above, started happening in 6A after the ward was reopened.

CLOSING COMMENTS

106. It is for the management and Health Board to give us a safe clinical environment. Infection Control are the specialists looking at the environment. We are responsible for giving optimum care to our patients in terms of treatment of their cancer.

107. Our outcomes are still as good as any other national benchmark, but it has all been a very stressful period.

108. Everything that happened made it hugely difficult for staff. We felt we were under scrutiny all the time. Sometimes the nurses were feeling too vulnerable to go alone into a room and so they would take another person to be a witness. Two nurses would go to make sure they could back each other up to say that they were doing all the right things and following the guidelines. You don't want to work in an environment where you're being watched all the time, and to feel that you are constantly under scrutiny.

109. It was all very stressful and we were the ones facing the patients. We were trying to raise our concerns to Microbiology and Infection Control, and it took a while for them acknowledge the problem. It was very, very demoralising and

stressful to face all this because we were hoping for a state-of-the-art hospital with no problems of this level. We lost so much time that we could have been spending on our science and research and publications, or on building teams and advancing the Glasgow brand. The time that has been spent on this would have been time that could have been spent on something else, on improving the science or improving the reputation of Glasgow. Similarly, my colleagues and I have spent a tremendous amount of time contributing to various investigations, including the Public Inquiry.

110. 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.