SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
13 May 2025

Day 4
16 May 2025
Mary Anne Kane

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10.32

THE CHAIR: Good morning. Now, as I think Mr Mackintosh explained to us yesterday, we have one witness today, Mary Anne Kane, and she will be giving her evidence remotely, and there will not be a livestream today.

MR CONNAL: Yes, that is correct, my Lord. The intention is that it is being recorded and it will be on the website in due course, but it's not being livestreamed today. I think also, my Lord, if I just say, apparently she may require assistance if there are any technological glitches.

THE CHAIR: Right.

MR CONNAL: I think my Lord can deal with that.

THE CHAIR: Now, good morning, Ms Kane. Right, can you-- I can't hear you. Can you hear me? Right, may just be a question of volume. We'll see if we can tackle this at our end. (After a pause) Could you just say something, Ms Kane, just to check whether we can hear you? Right. We can't hear you.

UNKNOWN SPEAKER: I think Sheree(?) is trying to assist, so-- but I don't know how long it's going to be.

THE CHAIR: Right. When you say Sheree, is that----?

UNKNOWN SPEAKER: From East(?), who's here.

THE CHAIR: Oh, right. Colleen, am I seeing the icon for the voice being off?

UNKNOWN SPEAKER: Yes, I can see that too.

THE CHAIR: Can someone do something about that?

UNKNOWN SPEAKER: (After a pause) She's been asked to unmute.

THE CHAIR: Ah.

UNKNOWN SPEAKER: I think----

THE CHAIR: We are? Or----

UNKNOWN SPEAKER: No, so-- so it's from-- it's from her (inaudible 10:35:41)

THE CHAIR: Right. (Inaudible 10:35:47)?

UNKNOWN SPEAKER: Yes. I think it-- it might be her.

THE CHAIR: Ah, right. Now-- (After a pause) So, that's unmuted.

MR CONNAL: It was working earlier, was it not?

UNKNOWN SPEAKER: I think so.

THE CHAIR: Okay, right.

THE WITNESS: (After a pause) Can you hear me now?

THE CHAIR: I can hear you very clearly. Excellent.

THE WITNESS: Sorry about

that.

THE CHAIR: In the end of the day, the technology goes its own way. Now, good morning, Ms Kane. As you appreciate, you're about to be asked questions by Mr Connal, who you should be able to see in due course, but, first of all, I understand you're prepared to take the oath.

THE WITNESS: Yes.

Ms Mary Anne Kane
Sworn

THE CHAIR: Thank you very much. Now, we've seen on the screen that you're accompanied by, as I understand it, Ms Yvonne Steele(?). Is that correct?

THE WITNESS: Yes, she's in another room now.

THE CHAIR: Right. So you are in a room alone?

THE WITNESS: Yes.

THE CHAIR: Right, thank you. Now, your evidence will probably take much of the day. We will break at about half past eleven for coffee, but, at any time, if for any reason you want to take a break, just give us an indication and we'll break. I want you to feel that you're in control of the proceedings.

THE WITNESS: Okay, thanks.

THE CHAIR: Now, I'll hand over to Mr Connal.

THE WITNESS: Okay.

Questioned by Mr Connal

Q Good morning.

A Good morning.

Q I'm going to try to work through what I'd like to ask you using your witness statement as a guide, and I understand you have a means of seeing things that we want you to see on a screen. Can I just start by asking you a formal question that we ask all the witnesses, which is that you've provided a witness statement, and are you content that that should form part of your evidence that you adopt for this Inquiry?

A Yes, I am.

Q Thank you very much. Now, just starting at the beginning, as it were, I understand your original background in the Health Service is in what used to be called "hotel services". Is that correct?

A That's correct.

Q Later became "soft FM", but hotel services at one point?

A Yes.

Q You held a number of positions in that general line, and then you were appointed, in 2014, and we'll

come to the detail in a little while, as interim director of Estates and Facilities for GGC. Is that correct?

A That's correct.

Q That was a fairly senior position covering the whole of the Board, not just a particular hospital. Is that correct?

A That's correct. It was a board-wide position.

Q As I say, we'll come back to that a little bit later, but just so we can set out the framework, essentially you were interim director for about 16 months from 2014, and then an associate director role, and then back into an interim director a little later when Mr Loudon indicated he was leaving. Is that correct?

A That's correct.

Q Can I just ask you about one other post that you held, just so we have it in our minds as we move through the questions? Once you were interim director, were you also a co-chair of the Water Safety group?

A Yes, that's correct. When I took up the position of interim director, I discovered that part of that role was establishing, actually, a Water Safety group for the-- the Board, and I, in the role of the interim director, was expected to chair that group.

Q Were you the only chair or was there a co-chair?

A No, there wasn't a co-chair.

Q All right, thank you. Did that chairing of the Water Safety group bring with it any additional responsibilities for water safety?

A The-- The chairing of the Water Safety group brought with it the role of "Designated person: water", I discovered, and the "Designated person: water" or a "Responsible person: water" is expected to chair the Water Safety group.

THE CHAIR: Mr Connal, just so that I'm keeping up, Ms Kane has said that she became chair of the Water Safety group when she became interim director. Now, you've established there was two dates on which she became interim director. It may be that I'm missing something----

MR CONNAL: That would be in 2014, I think, my Lord.

THE CHAIR: So, we're talking about 2014?

A Yes, that's correct. That was 2014 that that-- That happened in 2014 and I retained that role. That role never reverted back to the director of Estates and Facilities after I was no longer the interim director.

MR CONNAL: Right. So, you took it on, and you kept it with you

when you became an associate director and then still had it when you became interim director again?

A Yes, that's correct.

Q Thank you. If I can just-- Perhaps it's easier if we look at page 386. Now, I'm going to use page numbers for your witness statement, which you'll find at the top of the page, because that's what suits the electronics here. So, you see a number at the top of the page, page 386? You got that?

A Yeah, but I can't see it.

Q Okay, so you've got a page, you just can't see the number?

A I can't-- I can't see the font size or anything on it. (After a pause) I have it now.

Q Okay. Thank you very much. I was just going to ask you about something that you said on page 386. You mentioned technical leads, leading board-wide. On water, that, you say, was Mr Gallacher. Is that right? Alan Gallacher?

A Yes, that's correct. It was Alan Gallacher. At that time he was the head of maintenance for Clyde sector and the structure-- the management structure at that time was that each sector maintenance manager took a professional leadership role for one topic. We established that, after the implementation of the Statutory Compliance Audit and Risk Tool system, which was around about 2012, a head of maintenance was designated to take forward, not just for water, but for ventilation and electrical services, etc. The leadership board-wide, their role was to coordinate and ensure that there was a unified approach being taken in the Health Board to compliance matters in relation to that subject, and to engender professional consensus among the Estates maintenance managers in particular on these topics.

Q Yes. I was going to ask you a question about that. If we could bring up page 388, please, and near the foot you say you started working with Alan Gallacher, and you use the phrase, "the Board's professional lead for water safety".

A Yes.

Q That's not a label, I don't think, that we've heard previously in the Inquiry, that I can recollect, anyway. So, you're then asked on page 389, "Well, what was that, the professional lead of water safety? What did they do?" Is that any different from what you've just been describing to us as the technical lead?

A No. No.

Q So is it the same as a "designated person" under the arrangements for water regulation, or is it different? Do you know?

A On reflection and with hindsight, that role should fulfil the role of the designated person, but at that time it wasn't identified as such, as being the designated person. That person in the water scheme was my post.

Q Right, okay.

A But the role was effectively the same as designated person. It was to coordinate and ensure that authorised engineering reports, that authorised persons, competent persons and Statute and SHTMs were being interpreted and applied across the Board, but that's not the designation that was given to that role at that time.

THE CHAIR: Right. Just so that I'm keeping up, Ms Kane, as I understand it, in 2014, on taking up the interim director position, you learned that among your responsibilities were to act as designated person under the statutory regulatory system. One of the responsibilities associated with that was chairing the Water Safety Group but, as designated person, it was for you to appoint competent persons and a responsible person. Is that right?

A That's correct, sir.

THE CHAIR: Right. Sorry, Mr Connal.

MR CONNAL: No, I think we may find ourselves coming back to that in a little while, Ms Kane, but I'm obliged for that answer to his Lordship. I just wanted to ask you another question about what you said on page 389 when you've been asked by the questioner, "Well, tell me about your role at the new hospital," but then you quite rightly say, "Well, my role was a board-wide role, not simply at the new hospital." Then you set out how things were done just beneath that, and what you say there is:

"[Your] day to day responsibilities in relation to the [new hospital] and the other geographic sectors were based on the interactions I had with [the various managers] and any matters which were escalated to me…"

So does that mean that you're sort of waiting for things to be brought to you? You're just reacting?

A No, no. Not all of the time, no. There were a number of groups established where we looked at individual topics within especially the Estates structure, and we talked about various pieces of Statute, various compliance issues, how the services were being run. So there was

proactive engagement with managers as well as the escalation arrangements that were in place through the head of maintenance and the general management structure up to myself, so it was a kind of combined operational and strategic role.

Q Thank you. Because I'm using your witness statement to help us go through this day, you will find that we jump around a little bit and we'll sometimes hit the same point more than once, so apologies for that. Can we just move on to page 390, because on page 390 you're being asked about a topic which does recur, which is some of the issues that arose at the Queen Elizabeth Hospital over staffing and budget. Now, at the foot of the page 390, you're talking about savings identified as part of the full business case, so that's the full business case for the new hospital, correct?

A Yes, that's correct.

Q

"Savings had been identified as… £1m from existing budgets; inflationary uplifts were not applied to the FBC costings and [then you say] some fundamental tasks had been omitted."

A Mm-hmm.

Q That your understanding?

A Yes.

Q Then you say on page 391 – we'll just move to – and if you have any difficulty with the pages or the numbers, please just indicate and we'll deal with that. Page 391, your understanding was that, therefore, you started out with not enough people on Estates in the new hospital. Is that what you're telling us?

A Yes. Yes, that's correct.

Q I'll just jump down 391 to the question you're then asked, which is the obvious question, "Well, what were these things that were omitted from the budgets?" Can you just take us through what you're telling us about here, because I think you mentioned a number of issues that hadn't been budgeted for. Now, the----

A Okay.

Q -- first one is something about management structures.

A Yes.

Q So what's that about?

A So, the reference there relates to the business case not making provision for dedicated time for, in particular, APs and RPs to fulfil the role. The resourcing was based on the day-to-day operational delivery, but no allowance was built in for additional management to cover fully and give them enough time to undertake their

duties for APs and RPs.

Q These are the kind of statutory obligations that each level of that structure has. Is that what you're telling us?

A Yes, that's correct.

THE CHAIR: Just for the avoidance of any possible doubt, when we're talking about an RP, a responsible person, and an AP is an authorised person?

A That's correct, sir.

THE CHAIR: Right.

MR CONNAL: So there was nothing in the budget for it? Did that affect whether they were appointed?

A The-- there was establishment for maintenance managers within the budget, and the maintenance managers at that time, the role of RP or AP was inherent in their job description. It was just accepted that-- as part of that role, that you would have a range of RP or AP related duties depending on what was required of you at that time, and what was missing was the actual amount of time-- dedicated time to undertake the responsible person's and authorised person's duties by that time; but the time of the production of that, there had started to be discussion within the Board, certainly with me, Mr Powrie, Mr Loudon, and Mr Gallacher that there was a need for us to focus more on statutory compliance and compliance with SHTMs, etc. So, therefore, our view was that there needed to be some dedicated resource, especially in a hospital the size of the QE, but that's not what was included in the business case. The business case was very much a replication of the way that we had previously been set up, in that those dedicated hours were not allocated in that way.

Q Yes, I see, and you then mentioned HAI-related issues.

A Yeah, yeah.

Q So, what's been missed out here?

A So, HAI-related issues are day-to-day issues on the site which can compromise hospital-acquired infection. It matters. Things like broken floor coverings, broken wall coverings, mastic around about showers and wash hand basins, tiles coming off, things that were ad hoc in nature but needed to be prioritised because they presented a potential infection control risk. Those are completed on an ad hoc basis because, whilst you can create a maintenance schedule at a frequency for some of those things, they very often happen on an ad hoc basis due

to the operational demands of the hospital.

Q What you're saying there is that they're addressed on an ad hoc basis, but----

A Yes.

Q -- in a site that size, what you're saying is----

A You need a dedicated resource for that, yeah.

Q You need a dedicated resource, so you need to plan, as it were, for having a lot of these ad hoc things.

A You do. You do need to plan for that, and because of the size of the Queen Elizabeth Hospital, it was the biggest hospital in NHS GGC and I think, indeed, in NHS Scotland, or it was going to be. There was a recognition that we did actually need probably a small, dedicated team to continuously go around the hospital addressing these things, and that wasn't part of the calculations either.

Q Yes, and then you mentioned a few other items----

THE CHAIR: Again, when you say "not part of the calculations", not part of the calculations in the full business case?

A In both the full business case and in the subsequent resource papers that were presented by Mr Loudon and Mr Powrie to the Board, but these things were highlighted in the subsequent business case that was presented, that these had been omitted from the calculations and still needed to be considered.

MR CONNAL: If I just get to the end of the list first, and then I'll come back and ask you a question about this. There's:

"…backlog maintenance requirements, extraordinary breakdowns and ad hoc operational requests for project work resulting from infrastructure issues."

So, are these all things that require Estates' resource?

A Yes, they are.

Q Just help us understand what the issue was. Somebody had deliberately omitted them, or accidentally omitted them, or what?

A No, they were recognised as not being part-- the original business case, by recollection and by looking at the evidence packs, etc., basically was built upon the inputs that were there for the demitting sites that were transferring to the Queen Elizabeth Hospital, so they were very, very broadly similar to what had been on the demitting sites. There had been no work done to identify if-- on the demitting sites, if the resource was

adequate for those demitting sites before they came to the QE, and then the assumption was made that-- because it was a new hospital, that that could go forward. The other challenge in that was that, at FBC level, we had not done any work on Estates resourcing. It had been done on the basis of a price per square metre as opposed to there being a detailed workup of establishment.

THE CHAIR: Mr Connal, it does occur to me that there's quite a lot of material here and, certainly speaking for myself, if you could sort of bear that in mind so that information comes in assimilable chunks.

MR CONNAL: Yes. So, we're just trying to understand the point that you're obviously keen to make here. We've heard a lot about the pressures on Estates team, and we'll come back to that because you also deal with it in your statement, but you started that, if you look at the top of page 391, by saying that "from the point of handover, the Estates structure was not fully staffed to meet the needs of the site".

A Mm-hmm.

Q Are you trying to explain why it was that, as it were, the cover wasn't there?

A Yes, I am. I'm trying to describe why the cover wasn't there when we transferred.

Q And that's because a number of things hadn't been accounted for, you're telling us, is that right----

A That's correct. Yes, they hadn't----

Q -- when the costings were done?

A Yes, that's correct. There were a number of things which weren't accounted for, and the resource business case that was later presented by Mr Powrie and Mr Loudon trying to address that at the time was not approved, so there was a financial-- there was no financial-- there was no additional finance provided to close that gap. We retained the original demitting site budgets minus the savings that had been identified in the FBC.

Q Now, we're jumping about a little bit in time, but on page 391 you tell us about an event in August 2017. I think you'd been off work for some time just before that. Is that correct?

A Yes, that's correct.

Q Was it about six months you were off?

A At that time, it was six months, yes.

Q Yes. So, you come back-- This is August 2017. At that point, you're what? Are you in the associate role or are you back in the interim role by August '17?

A No, in August '17, I came back as associate director on a phased basis.

Q So, you're coming back, and one of the things you're met with is Mr Hunter, Mr Powrie and Mr Gallacher telling you that Mr Loudon, who was the project director and then the designate head of Estates, had agreed to a reduction in the Estates----

A Yes that's correct.

Q -- staffing?

A That's what I was advised. I did subsequently raise that with Mr Loudon, who did advise me that Mr Gallacher had indeed written to him expressing concern about that, which he'd escalated to the chief executive, but that year's financial improvement plan for the Board needed to be met and therefore that was across all services.

Q Yes. So, issues with staffing problems were continuing still in 2017. Is that right?

A Yes, they were continuing in 2017. Some of that was compounded by the number of things that were happening in the hospital, so although there had been a forecast created for workforce planning, the number of things on the site during that period which were going wrong or we found challenges with in getting systems to work and speak to each other was also a compounding factor to the establishment that we did have, so that brought an extra complexity and an extra stress to the Estates staff.

Q Yes, thank you. Well, we're going to come back to that because you do deal with that more fully in your statement. Can I ask you move to 393 where you're being asked about your different roles, just so we're clear about these? The first thing that you tell us on 393 is that your role as interim director, which you started in 2014, involved "participation in a number of Board assurance groups". Now, we've heard about the Water Safety Group. Were there any other particular ones that might be of interest to this Inquiry that you were members of?

A I attended the Board Infection Control Committee as the representative for estates and facilities, and I first started doing that when I took up the interim director role and continued that right through. I was a member of the Board Health and

Safety Group. There was a range of assurance groups, like staff governance groups, etc., but they weren't directly related to water. Obviously, there were finance meetings, etc., that were occurring routinely. There were a number of governance groups that I attended routinely, and the list's there – things like the internal meetings that we also had within the Estates and Facilities team which were around Statutory Compliance Group, Partnership Group, which was involvement with Staff Side colleagues, there was an operational management group which consisted of all of the senior managers where we looked at performance within the directorate and discussed performance using a balanced scorecard. So, there were a number of assurance groups which I attended on a range of subjects and sometimes by invitation to discuss a particular subject.

Q Now, if you were invited to attend, would that be because of the position you held or because of any particular expertise that you held?

A It was position. All of the governance groups were due to the position that I held.

Q A small point – in that paragraph there, you, I think, draw a distinction between, when you are interim director, preparing board papers, but, when you're associate director, simply inputting to them.

A That's correct.

Q What are we talking about here that you, as associate director, would input into?

A Into the presentations, for instance, on hospital cleanliness, into the health and safety, I would collate information from-- that were health and safety related in nature for the Health and Safety group and so forth. So, the-- I did not attend and present any of the papers, but if I was asked to or-- routinely in some cases, particularly around about the domestic services information, then that would be produced just routinely by myself and others.

Q Thank you. Okay, can we look at page 394? I wanted to ask you a couple of things here. On the face of it, you're interim director of Estates. That's what you were called, that's what your position was, but you say here that it was "made clear to you", and I'll ask, first of all, who by? Who made you clear what the limits of your role were?

A The chief executive of the Health Board was clear on what my role and remit was.

Q Was that Mr Calderwood?

A Yes, that was.

Q You say that he told you that, although you were interim director, your role "didn't extend into the Project Team" – that's what was working on the new hospital----

A That's correct.

Q -- "or technical advice on subjects you were not qualified to advise on". Now, did you have any particular technical skills at that point?

A I had technical skills in soft FM because that was my background, but I had not managed estates for any length of time. My only experience of managing estates at an operational level had been for a couple of years at Glasgow Royal Infirmary where I was the general manager for North Glasgow and had Ian Powrie, who was head of maintenance, reporting to me about the day-to-day maintenance issues in that hospital and in that sector at that time. So, no, I had no technical background in estates.

Q Yes. Can I just ask you this, just while we're on that page? You mentioned the Project team – did you have occasions during either of your roles, or any of your roles, to be precise, particularly in 2014 to 2015 to come across a firm called Currie & Brown?

A Yes, I was aware of Currie & Brown. I had worked with Currie & Brown in a previous project around about the Board's catering strategy, so I was aware of the company, and then the project team announced that Currie & Brown had been awarded technical advisors to the Board, so, yes, I was aware of Currie & Brown and the Project team relationship.

Q So you were told they were the technical advisors?

A That was my understanding.

Q Thank you. One of the themes that comes through from various parts of your witness statement is – and this is my word, not yours – what I might describe as the responsiveness of Mr Loudon, who was initially project director. Is this something that you encountered, that there was some issue as to how well he was responding to concerns raised with him?

A Yes, yes, but to be fair at the-- to be fair, when Mr Loudon took up post, there was not a lot of interaction with Mr Loudon as the project director, but when things were being escalated to him as we

approached opening and then post opening of the hospital, I did not find Mr Loudon to be particularly responsive round about the issues that were being raised that were of concern to the operational team. It felt like an uphill struggle to get our points across about how issues were impacting the operational delivery of services at local level, and whilst I was associate director, we spent very little time together discussing operational matters. The-- Really, the bulk of the conversations I had with Mr Loudon related to the QE and there was little discussion about the board-wide responsibilities and the other hospitals.

Q You actually say in your witness statement that that you didn't get the impression that Mr Loudon was very interested in operational matters. Is that correct?

A Yes, that's correct. I-- Because of that lack of interaction between myself and him around operational matters, Mr Loudon seemed to be more focused on capital projects, procurement and Board matters than he was on operational delivery of the services on a day-to-day basis.

Q If we just move your screen forward to page 396, that's where you're asked that question. I wonder if I could ask you a supplementary question then. If Mr Loudon, holding the position he did, wasn't particularly interested in operational matters, did this have any impact on how things were dealt with as matters progressed?

A It meant that everything was left to myself to support the maintenance managers, the general managers in the delivery of services and to make decisions round about how we would progress matters that were of concern and of risk.

Q Yes. I think on the same page you list a number of the people you were dealing with, and I needn't ask you to go through that again, but you're making a point there that you didn't really think you had enough time to do a proper job of communicating with them. Is that correct?

A That's correct. I felt that I was extremely stretched and the people that are listed on there cover various positions in the Board, board-wide, and you can see from the range of services and the range of managers that there were a number of areas to be covered in terms of the geography, the number of buildings to be covered, and it became really, really difficult. I felt that I never had enough time to provide the right level of scrutiny on

documentation or to provide the right level of support when it was needed, and that was an area in my role that I struggled with and compensated for by working longer hours and more days a week to try to address that.

THE CHAIR: I want to just clarify my thinking. Mr Loudon had been the project director and, at the end of the project, he took up the position of Estates director for the whole Board.

A That's correct.

THE CHAIR: That's correct. Now, the handover of the hospital was January 2015, so is that the date at which Mr Loudon became director or was it later?

A I think there were-- I don't think-- No, it didn't happen in January 2015. Mr Loudon maintained his role as project director and took responsibility for a number of things that were ongoing on the QE site, like the defect period and the mobilisation, actually, of the site before patients transferred in, so it was later in 2015 that that happened, that he stepped in as the substantive Estates and Facilities director. I don't remember what month that was, sir, but it was probably autumn time 2015, I think.

THE CHAIR: Now, the questions that you're answering from Mr Connal to the effect that Mr Loudon was more interested in capital projects and procurement is a reference to this period after autumn 2015 once he was the director and you were the associate director?

A That's correct.

THE CHAIR: Right, thank you.

MR CONNAL: As we've just touched on it, I want to just move to 398 because what crops up on 398 is the actual handover of the building, which, as you've pointed out to us, was January 2015. Now, here you are, you're in post for a while as interim head of Estates, and you're asked, "Well, presumably, this was quite a big thing that was going on. Did somebody brief you about it?" and you say no. Is that the correct position at the top of page 398?

A In 2014 when I took on the role of interim director?

Q Not so much in 2014, but as the date for handover was approaching in January 2015, were you briefed on what was going on?

A Yes. So, as the date approached for commissioning and patient transfer, yes, I was briefed on what the dates were anticipated for patient transfer and asked to create a work plan round about in particular soft FM for that to happen. So, yes, I was-- I was briefed, but I wasn't briefed on

the technical handover, so I had no knowledge of what was happening with the infrastructure commissioning and the technical components of the Board. My focus was primarily on soft FM and getting the building ready to be occupied by patients.

Q Halfway down that page, you do express what you've described there as a "nervousness", or I might call it a "concern" that was striking you. Was that at that time when the handover was just coming up?

A No, I think-- I think, sir, I've answered that question on the basis of how I felt in 2014 when I was asked to take on the role of interim director, because at-- Yes, I think that is what I've done there by the way that I've responded to that. So, that was my concern when I was asked to take on the role in 2014 of the interim director, that I was extremely nervous about my background and my experience.

In terms of the handover of the building, there was a programme developed and a series of work plans developed to support that based on when patients would be moving into the hospital, so, at that point, I was not worried about the handover of the building.

I became worried about the handover of the building when the keys were handed over to us in January 2015 and the building was supposed to be ready and then, unexpectedly, there were several hundred contractors appeared the next morning to be signed in and come in and complete various pieces of work in relation to the hospital. That's when I began to be concerned about the state of readiness that we were in.

Q Yes. I think you say in that paragraph that your focus was on soft FM and supporting commissioning and migration of patients, and you were told that you were to rely on the technical experts, and then you're asked, "Well, who are these technical experts you're to rely on?" and you produce a list including Mr Gallacher and Mr Powrie, and also Mr Hunter(?), Karen Connelly, and so on, who have different areas of responsibility. So, you were told you were not to be involved with the project, but you were to have some kind of role in the handover of the building. Is that right?

A That's correct.

Q But not on the technical side?

A No.

Q That's your water and ventilation?

A That's correct.

Q I think you're asked on the next page whether you knew anything about the maximum temperature decision that had been made in relation to the new hospital, and you say you weren't told anything about that?

A Not that I can recall.

Q Or the decision to change the ventilation levels from what was in the guidance?

A No.

Q Then, you're asked a question about Ward 4B which I think we can leave aside for the moment. In fact, what you then go on to do on page 400 of your statement is to explain one of the points that his Lordship was looking for earlier, which is, "Well, how long were your interim director?" and then, "When did you go back into being interim director?" and you tell us, late 2017, Mr Loudon was leaving the organisation and you picked up the baton again, as it were, on an interim basis?

Yes, from January 2018, yeah.

Q Yes, thank you. So, if we just follow that through for the moment, we're into 2017, you're being asked to go back into post as interim director, and I think you're being asked, on page 401, "You're having to take over from Mr Loudon again"-- I'm saying "again", actually, technically, for the first time, you're taking over from him.

A Yes. Yes.

Q "Were you concerned at the time?" You say you weren't concerned, but you felt overwhelmed. Now, can you just help us to understand what the issue was at that point?

A I had acted under the role before on an interim basis, and I understood that, acting in an interim basis, I was expected to maintain operational delivery. So, from understanding what was required of me from the organisation, I wasn't concerned. It was a short-term, interim arrangement which was a-- I was assured would be a short-term arrangement, and it was. However, because of what was happening at the QE, and-- and across the Board to a lesser extent, because my duties did cover the whole Board, I did feel overwhelmed about what was potentially in front of me.

However, I didn't expect there to be the series of events that then unfolded immediately after I went into that role. So, on one level, I wasn't concerned because I knew what the organisation's expectation of me was as a senior manager during that interim period, but on the other hand,

because I knew what-- what was happening at the QE and the challenges that were being faced there on an ongoing basis, I felt overwhelmed on a personal basis, yes.

Q Yes, and, in 2017, you'd actually been off for quite a long time, not at work at all?

A That's correct.

Q Then, when you try to get back up to speed, you're told by a number of your reports that they've got concerns about the new hospital. Is that right?

A That's correct. When I returned from sick leave, I came back in August and on a phased basis. I was-- I agreed a set work plan with Mr Loudon when I came back before I resumed my full range of duties, which-- I think my full range of duties was resumed in around about October 2017. But when I returned from sick leave, Mr Gallacher, Mr Powrie, and Mr Hunter expressed concerns to me about the situation at the QEE and the number of defects and issues that were impacting operationally on delivery of services.

Q We're going to come back to that point in a short time, but am I right in thinking that these were not issues that had just suddenly sprung to light in August '17, these were issues that had been around for some time?

A These were issues that had been ongoing since we transferred into the hospital, yes.

Q Thank you. Now, as I say, we'll come back to what was done about that, because you were asked on page 401, "What did you do about it?" and you said you put them together in a document and it was taken forward, but you've dealt with that in more detail a little later in in your statement. Can I just ask you a general question I've been asked to put to you? In 2017, so you're come back into harness again, as it were, on a staged basis, and then you ultimately take up the post at the very end of the year. Do you recollect any discussions in 2017 about any link between patient infections and the environment?

A In 2017?

Q Yes.

A In 2017, when I returned from sick leave, the only discussion that I remember about that was, when I returned, Mr Loudon advised me that there was a whistleblowing complaint being dealt with due to concerns about the built environment by the microbiologist, and in particular they were concerned around ventilation and water, and that I wasn't to get involved

in it if I was asked or requests were made for information because it was being dealt with by the whistleblowing group that had been agreed.

So, in 2017, I became aware that there were concerns being voiced by the clinical teams, but that these were being taken forward by the senior-- the most senior management team in the Board.

Q Were you chair of the Water Safety group throughout the whole period we're discussing?

A Well, I wasn't at work, so-- so----

Q Right, apart from when you were off?

A Apart from when I was at work, yes.

Q Did that give you a responsibility to report, as it were, that the Board was complying with what it needed to comply with on water safety?

A Yes.

Q And how did you go about doing that, can you remember? Because obviously water, as we know, became an issue.

A Yeah. So, I tried to present reports to the Board Infection Control committee about the built environment, and they were taken off the agenda by the medical director

who chaired the group because she felt it wasn't an appropriate place for them to be coming, that there were no building experts in the Board Infection Control committee and therefore there should be a separate route for that type of information to be disseminated.

Q Okay. Well, I suspect we'll come back to talk about water a bit later, Ms Kane.

THE CHAIR: Can I just maybe go through that again? You were the chair, when you were at work, of the Water Safety group. As chair of the Water Safety group, you proposed to bring a report or bring reports on a regular basis to the Infection Control committee?

A Yes. Yes.

THE CHAIR: The Board Infection Control committee?

A Yes.

THE CHAIR: But that suggestion was turned down by the medical director?

A Who was the chair of the ICC.

THE CHAIR: Right. Was any alternative method of reporting from the water safety group to the Board or a Board subcommittee substituted for your suggestion which had been turned down?

A No.

THE CHAIR: No. Right. Thank you.

MR CONNAL: Okay, let me come back, because that's the way that the witness statement goes, to staffing issues. At 403, you're asked about concerns about staff and you say that your main concern was that key staff were under continuous stress. Is that people working in the new hospital?

A Yes.

Q You were head of Estates. Was there nothing you could do to change that position under which they were working under constant stress?

A I tried on a day-to-day basis by providing support. However, the only way that I could have-- the situation could have been alleviated was by more resources and more funding, and we'd already been told that there was no funding, so we tried collectively to manage activity on a day-to-day, week-to-week, month-to-month basis as a team.

Q Do you know whether that meant that things that should have been done didn't get done when they should have been done in the hospital?

A Can you say that again, please?

Q Yes, apologies. As a result of the stress on resources that you've been explaining, were there things that needed done in the hospital that just didn't get done at the right time?

A Yes, there were. We were slow to respond to faults. We were slow to respond to tasks being closed out. We very often made things safe rather than bringing them back into full use, and then had to bring in a third-party supplier. We relied quite heavily on third-party suppliers to come in and supplement us on a range of topics.

Q Yes, in fact, I think that's a point, in fairness to you, that you pick up. On 403, you explain that attempts had been made to get more funding and they'd not worked, because the chief executive----

A Yes.

Q -- had basically said, "There's no more money." Then, on 404, you said that one of the things that you did was, you know, if you can't get more staff money, you might be able to get money to bring in third-party contractors. What kind of contractors are we talking about?

A Well, one of the big areas of expenditure was around about the-- not in 2015, I have to say,

but as time progressed was around about the provision of water services and water support from a third-party contractor. We were using general building trades to catch up on HAI. We were putting that out in lots to try to stay on top of HAI works. We used various contractors for various things when they arose to supplement the Estates team.

THE CHAIR: Again, just so that I'm keeping up, you used the expression HAIs. Is that a reference to what you explained earlier about the – I think you used the word – "ad hoc" failures, tiles----

A Yes, yes. That's right, sir----

THE CHAIR: -- things like that. Right, and as I think you explained earlier, the reason that you used the initials HAI, that's hospital acquired infections?

A Yes.

THE CHAIR: Is it that you recognise that such maintenance matters, such ad hoc failures, can give rise to infection risk?

A Yes, that's correct, sir.

THE CHAIR: Right. Just so that I'm keeping up. I think you've explained that, but I just want to make sure of where we are. Sorry, Mr Connal.

MR CONNAL: Understood, my Lord. Now, I'm now going to come to a topic that you touched on a little earlier, because I know one of the other parties said, "Well, where's the detail of this?" and the detail we'll come to now. You were asked about halfway down page 404, "Did you do anything about these problems?" basically, and you say you went to see Mr Loudon about the pressure that the staff were under and all the stuff that was having to be done. You say two things then happened: one, there was a change of geographic responsibility to provide some breathing space for the general manager. Would that give Mr Hunter more time or less time? How did that work?

A It gave him more time. We rotated the general management positions, because Mr Loudon acknowledged that, actually, it had been demanding and challenging in the sector for a period of time, and that me being off sick had further compounded that. So the most difficult and challenging sector to run and manage, in my opinion, was the QE at that time, so moving the general managers around gave a bit of respite to those who had been directly involved at the QE for a number of-- a few years at that point, two years, and

that had been probably the most challenging time. We subsequently rotated and changed that background again. So, the idea was to give a bit of breathing space so that there would be less hours worked, that there would be more ability to focus on given topics, and just really-- really for it to give a break to the managers that had been involved.

Q I think you tell us here that you had concerns about the pressure on you as opposed to the pressure on others. Is that right?

A I had concerns about the pressure on me and others, but on myself, yeah. I can speak for myself.

Q Yes. You went to Mr Loudon, and you say also went to HR to see if you could do something about that. You were asking for a compressed working week.

A That was for myself, yes---

Q How would that have helped?

A Well, it would have helped me on a personal basis. I had been off work for a period of time and I recognised that I was probably coming back to the same environment as that that I had left, and felt, "How could I restrict the number of hours I was working in a working week?" One of

the ways to do that is to be at work less. The easiest way to do that would have been to compress the hours. I was already working in four days my full contracted hours anyway. I was doing considerably over my contracted hours, and on the advice of my GP who felt that it would be useful for me in terms of my own health if I could work a compressed week-- so I made the request. It would have helped me on a personal basis.

Q Thank you, but you didn't get a favourable response to your request?

A No, I didn't. I was advised that-- the post that I had substantively was a five-day-- a week post and that I required to fulfil that, and that the workload at the QE wasn't going to change any time soon. It was what it was, and therefore I needed to return to work on a five-day basis, which I duly did.

Q The other thing that you did was that you raised a number of issues that which had been passed to you by Mr Hunter, Mr Powrie, and Mr Gallacher with Mr Loudon. Now, again, I take it these are issues that were not new ones that had just sprung up in 2017; these were ones that had been around for some time. Is that correct?

A Yes, they had. Most of these issues, however-- when I had went off sick, we were expecting to be completed by 2017, so there was a period-- a two-year defect period for rectification of issues. So, by 2017, we were anticipating that these issues would have been addressed by the project team and Multiplex, etc., and when I returned in 2017, I was advised that things had not progressed significantly while I had been off.

Q Who was supposed to be responsible for making things happen when Mr Hunter, or Mr Powrie, or Mr Gallacher were complaining about stuff? Who were they complaining to?

A They indicated that they had raised these things with Mr Loudon, and that they felt that they hadn't been acted on. However, when I got them to pull together the list and I took it to Mr Loudon, Mr Loudon responded immediately to that and set up a meeting with Multiplex, so I'm actually not sure, while I was off, what the communication was that had occurred between them.

Q Right. The issues that were taken up, and I think the Inquiry knows something about some of these and some of them are also dealt with later in your witness statement, you deal with on page 405, about a third of the way down:

"Lack of asset tagging, ZUTEC content and how it was impacting operational service delivery, lack of CAFM…"

That's the idea of a planned, preventative maintenance system. That was just a label that was given. Is that correct?

A That's correct.

Q When----

THE CHAIR: Well, Mr Connal, when you say that that's the label given to it – I may be misremembering – is CAFM not an acronym relating to a computerised management system, or have I got that wrong?

MR CONNAL: The witness is about to give you an answer, my Lord.

A You're correct, my Lord. It's-- the CAFM system is the computerised FM system where you store your PPMs, your compliance with the PPMs, and it allows you to input all of your assets and match your workforce to the tasks that have been pre-programmed into the CAFM system.

THE CHAIR: Right, and the system that you're talking about in 2017 is the system that continues to be used on the QEUH campus. Am I right?

A The CAFM system that

we use-- that was in use in the QE system, yes, that was a system that had been in pre-existence on the Board, and when we discovered that there was no new CAFM system coming with the hospital, we rolled the existing system into the QE.

THE CHAIR: All right, thank you.

MR CONNAL: Now, you say Mr Loudon arranged a meeting with Multiplex. Were you involved in that meeting?

A Yes.

Q You say halfway down 405 that asset tags were found, asset tagging commenced, "This did not go well." What do you mean by that?

A It did not go well in the context that the asset labels were falling off of the assets, that they were wrongly tagged, matched to the room numbers. The room numbers that should have been linked to the asset tags, not all the doors were tagged. So it became chaotic for the Estates team to use what was in place and, eventually, they took over and developed a local system that made it more comprehensive and easier for them to understand then-- where the assets were, what the assets were, and then start to develop a-- PPM schedules for those.

THE CHAIR: Could I just clarify my own mind? An asset tag is a way of identifying a physical thing. Is that right?

A That's correct.

THE CHAIR: You refer in your statement to a program of attaching tags to physical things in 2017. Do I understand the position to be that, before 2017, there were simply no asset tags to identify specific pieces of equipment in the campus?

A That's correct.

THE CHAIR: Thank you.

MR CONNAL: Now, again, we're touching on some topics that we'll turn to on page 405. Asset tagging has just been put to you by his Lordship, and then, in the same paragraph, you're asking about CAFM, and then you're being told that ZUTEC was basically what you were going to get. Is that correct?

A That's correct.

Q Then you're also told that ZUTEC was fully populated as per the contract and, if there were any difficulty, it was due to the operational teams. Presumably that's the Estates operational teams' competence in using the system.

A That's correct.

Q Who was telling you that the team were not competent to use ZUTEC?

A Mr Loudon said on several occasions that the system was fully populated, and any issues connected to accessing information were due to the team not being able to use the system effectively.

Q Yes, and the position, as I understand it from your witness statement, is that your team were telling you that Mr Loudon hadn't really been listening to them, but when you got involved, something happened.

A Yes, in terms of-- Yes, yes. They told me they didn't feel listened to but, when I did go and raise it with Mr Loudon and took the list of issues that were identified to me by Mr Gallacher, Powrie, and Hunter, Mr Loudon did listen and then arranged a meeting.

Q Thank you. Well, let's come back to your own position, because that's one of the topics that's next dealt with in your witness statement, because you're asked on page 407 what training you'd had for your role in Estates, and you basically say none. What qualifications you had, any specific qualifications: the answer is none, and then you explain the experience that did have. You were asked if you had any formal training in respect of water and the answer is, "No," notwithstanding that you were to be chair of the water group, and it turned out also a designated person for water. Is that right?

A That's correct.

Q Now, on 408, you tell us that the first training you got was in 2019 when you did a Legionella awareness course.

A That's correct.

Q And what I think you're setting out in the next part of your statement at 408 is your explanation of the way the NHS works, that quite often you have a person without technical qualifications running a team where people have more technical knowledge. Is that basically what you're trying to set out there?

A That's correct. I'm trying to describe that it's not unusual-- it's not unusual in Estates and Facilities for the director or the assistant director to come from one of the disciplines within the broader Estates and Facilities categorisation and not be a technical expert. Most commonly, the estates director is someone from a hard FM background, usually either an engineer or a surveyor background, and they don't have the experience of soft FM or decontamination or procurement, depending on what's (inaudible) Estates and Facilities. In

my case, I came from a soft FM background and had no background in hard FM at all, but the management structure was set up in such a way that there should have been enough technical advisors around me for me to be advised by them and their roles and under positions of authority within each of the sectors.

Q So what you've said in that page is in a general sense, the fact that you were not an engineer or water specialist or whatever didn't bother you, but you say it did come to bother you when the water incident took place in the hospital. Is that right?

A That's correct. That's correct. On a day-to-day basis, in terms of workload, I don't feel not coming from that background impacted me directly; however, it did impact me in relation to water, and when the incident at the QE became clear to me, yes, it caused me a great deal of personal stress and I felt very vulnerable and frustrated that, not coming from that technical background, I couldn't challenge any of the hypotheses that were being put before me and had to work on the basis that there was professional consensus amongst the people who were technical experts advising me,

and that's how I tried to compensate for that.

The other thing that I had done in 2015, after discussion with Mr Loudon, was identify that there was a need for a general manager-type role across the estates team to be able to coordinate a standardised approach to the delivery of estates and technical matters related to that, and we created the position of the General Manager for Estates and the Deputy General Manager for Estates. Those posts came into existence in 2016, and then after that, there was a compliance team established in the board to try to get some traction on these issues and to move forward.

Q I think that was-- The compliance team, I think, was probably a little later on, possibly 2016, something like that.

A Yes, that's correct. The general manager and the deputy general manager came into post in 2016, and that would be around about the time the compliance team was created.

Q Yes. Now, at the foot of page 408, you say-- Well, have you any roles or duties in relation to water systems? And you say, well, when you became interim director, you discovered that you were the

designated person for water. It sounds as if it came as a bit of a surprise to you.

A I had no understanding that that was something that was expected of me and had not been aware of the previous director of Estates and Facilities carrying out that role. So yes, it was news to me that I was expected to fulfil that role in that post.

Q And did you understand that that was one of the roles with specific labels on it in these, sort of, statutory controls? You know, there was authorised persons, responsible persons, designated persons. Did you understand that at the time?

A No. The only knowledge that I had at that time was from the development of the board water safety policy, which Mr Gallacher led on. There had been a number of different water policies across the board, and there was a need to develop a single water policy for standardisation purposes; and when that policy was created, I began to understand that there was a role there, and that was the first time that I'd heard that that an expectation.

THE CHAIR: What did you do to, as it were, if I may respectfully use the expression, educate yourself in relation to the role of a designated person?

A I started to read documentation on water safety and I started to read SHTMs, not just about water safety. I realised then that there was a role I was expected to fulfill on a range of actual technical topics which I had been totally unaware of. Those roles came with the post, and I started to read and understand that the SHTMs were more than had been described to me by the general managers and the estates maintenance managers; that the role of the director of states and facilities had a statutory responsibility. I did ask in particular Mr Gallacher when I saw my name in the designated person box, "Do I not need to be trained for that role? What courses can I go on?" and I was advised that I didn't need to worry about that at this stage; that the responsible persons who were the estates managers were well versed in water safety management and compliance with the SHTMs; that the Designated Person Water was a management role and that I would only be required to sign off on authorised persons who they would intimate to me as they were put in place.

THE CHAIR: Right. But----

A I never undertook any

courses.

THE CHAIR: Right. But you did read----

A I did try, yes.

THE CHAIR: Right. And you understood that it was the designated person's responsibility to make appointments?

A I did through time, yes. I don't think I understood immediately that it was my responsibility. I don't think that actually connected, so to speak. People were being referred to as authorised persons, and I trusted the responsible persons and I trusted Mr Gallacher, having been the previous water safety lead, that if there was a requirement for me to do anything in regard to that, I would be advised. It was only through time that I began to discover that there was more to the role than even as it was described by then, in particular, Mr Gallacher to me, and then I realised that, yes, it was the responsibility of the designated person, and to ensure that the training was being done with the APs. Yes. But that took time. I wasn't aware-- I was aware I had a role, but I did not have the necessary understanding of exactly what was involved in that role and the statutory responsibility that came with it.

THE CHAIR: This is probably an impossible question to answer. When do you think you acquired that understanding? 2016?

A I would say it was around about that time, yes.

THE CHAIR: Thank you.

MR CONNAL: Now, we'll just move on to 409, because that's where you give largely the description that you've just given to his Lordship, and then immediately beneath that paragraph, you're in effect asked-- And I think you're aware there's an issue about the appointment of authorised persons for the Queen Elizabeth Hospital, with responsibility for that hospital. But your position is that you didn't do anything about appointments at that time because you didn't understand that that was for you to be on top of.

A That's correct, sir.

Q Yes. And I think we know there were no appointments that covered the Queen Elizabeth Hospital for some years after it had opened. Is that correct?

A It's correct.

Q You're asked on page 410-- This is a specific point that arose from evidence earlier in the Inquiry. I think Mr Powrie told us that he'd filled up some kind of sheet with suggested names and given it to you,

assuming you would do something with it, and what you did with it is set out, I think on page 410-- you issued it to the staff member copying in the responsible person. Who was the responsible person? Do you remember?

A It was either Mr Powrie or Andy Wilson at the time. I think it would have been Mr Powrie if it was before 2016. If it was after 2016, it would have been Andy Wilson.

Q But at that point, you didn't actually make sure that APs were appointed. Is that correct?

A That's correct.

Q That wasn't something you were doing at that time?

A No. No, what I was provided with was a template to fill in and complete and issue to the employee and the responsible person, and on that advice, I issued those letters as they came to me.

Q Yes. And you say further down page 410-- The way you put it is, "My understanding of the role now is very different from what it was then." Now, his Lordship asked you, when did you come to understand that the role potentially had things attached to it that you needed to do? Was that 2016, 2017? Do you remember? I think you told his Lordship possibly

2016.

A Yeah, yeah. 2016, I began to realize that the role of designated person wasn't only a management role, that there were expectations of that role and they were being-- they were part of the guidance. I think I only really understood the full role and understood more fully water safety through the learning-- through the learning of the water incident at the QE. I acquired a lot of knowledge.

THE CHAIR: When you use the expression "not just a management role", can you sort of tease that out a little bit? What is "just a management role"?

A "Just a management role" in this context would mean that I would only act on the advice given to me by the technical managers because of the position that I occupied, rather than being an active participant in the development and the delivery of such matters.

THE CHAIR: Thank you.

At the top of 411, you say again, "My understanding of the role is very different from what it was then." If we're trying to think of things that, with the benefit of hindsight, might be done better, what would have helped you when you found yourself appointed? What could you have been given or

asked for that would have made a difference?

A I could have undertaken training. Well, there are now various courses available round about water safety and water safety management. I could have participated in them, and I think that that would have helped. I could have reached out to HFS, and I didn't do this, to ask them if they could support training me because of the position that I was in, and I think that that would have helped greatly.

MR CONNAL: I think, in fairness to you, with the benefit of hindsight, about halfway down page 411, you now accept that you weren't filling that role of designated water person at that time appropriately.

A That's correct.

Q Based on, obviously, the hindsight that you now have, and that you should have been doing a bit more about it. But you also say in that paragraph that the first two years at the site-- So that's what, 2015–2017, is that right, the years you're referring to there, would have made it----

A Yeah.

Q -- difficult to get anything done anyway? Is that the message you're trying to give us? Sorry, I'm looking at the middle----

A Yes, yes, yes. Yes, what I'm trying to describe here is that those who were fulfilling the roles of APs and RPs, and even myself, because of the first two years in particular-- and it carried on beyond that, but the first two years were particularly difficult and challenging, because there were unexpected events happening on a daily basis that we would not have expected to have happened and could not have actually predicted would happen if things had gone entirely to plan and in accordance with SHTM design, etc. It would have been difficult for them to fulfil the roles in any case due to time.

Q Thank you. My Lord, I'm conscious of time. This might be as good a point to break.

THE CHAIR: Ms Kane, as I said, we usually take a coffee break about half past eleven, so could I ask you to be back in front of your screen for ten to twelve?

THE WITNESS: Yes, that's fine. Thanks.

THE CHAIR: Thank you very much. Thank you.

(<u>Short break</u>)

THE CHAIR: Ms Kane, you can hear me?

A Yes, I can, sir.

THE CHAIR: We can hear you very clearly. Thank you. Mr Connal?

MR CONNAL: Can I just check, Ms Kane, due to an issue with the systems, I think somebody may have picked up that you were having a conversation with someone during the break. Now, was that the PA lady that you were chatting to?

A No, it was the witness support on MS Teams spoke to me.

Q Oh, is that the witness support team from the Inquiry?

A Yes, sir.

Q Thank you. I think you probably know that once you start giving your evidence, we have to make sure that no one is chatting to you about the content of what you're saying. You understand all of that, I take it?

A I do. I do understand that.

Q Thank you very much. The next topic I just want to touch on is the state of the hospital at the time it was handed over from the contractor to the Board. Now, you were asked in the course of your witness statement to look at a defects list, but you said that you hadn't seen that before. In your capacity as head of Estates with this major project reaching a particular milestone, the handing over of the building, would you have expected to know even roughly what state the building was in at that stage?

A I think what I said in my witness statement was, when I looked at the defect list, I didn't immediately recognise or remember it but I absolutely must have had-- I absolutely must have seen it because I know that I participated in trying to resolve some of the defects.

Q Yes, just so we know where that is, on page 413 of your witness statement near the foot, when you've been asked to look at the defects list, and you said you hadn't seen it before but then you go back to the point you made earlier that you remember a large number of what you described as "contractor staff" turning up in January to do work.

A That's correct.

Q You say there the local team felt that shouldn't have been the case if the hospital was ready for handover. Who do you mean by "the local team"? Is that the local Estates team?

A Estates and Facilities team. The Facilities team were also included in that. It felt that if the hospital was ready, there were a significant amount of contractors brought onto site and a significant

number of things which were visible that we would have thought would have been addressed before handover.

Q Now, I think the position that Multiplex take is that the Project Team were happy with the state of the building and happy to take it on. Is that your----

A Yes, that would be true. Only the project team could have signed off on the building for handover.

Q The suggestion also is that a lot of the works going on after handover might have been related to equipment being installed by GGC, which was not within the Multiplex contract. Is that what you were saying?

A No, that's not what I'm referring to, but that is true. There was equipment being fitted that hadn't been part of the Multiplex, so I recognised the fact that that was happening in the hospital, but what I'm referring to is the issues that were happening on an ongoing basis: like the hospital temperature, for instance, not being consistent, being warm and then cool; lights that wouldn't switch off; fire doors coming off their hinges, those types of things. Building issues are what I'm referring to, not the equipment issues.

Q Thank you. Well, let's move on to an associated question, 415. You're asked whether you saw documentation about commissioning and validation of the water and ventilation systems at the time of handover and you say, no, that wasn't your job, you understood that was for the project team. Is that right?

A Yes.

Q Then, you say you were advised that this had happened by Mr Loudon.

A Yes.

Q So what was he telling you?

A So, Mr Loudon advised that the hospital had been handed over and all of the systems had been checked and were ready to go. So Mr Loudon didn't actually specify, "Ventilation has been commissioned and validated and here are a copy of the results," or anything like that. However, as the incoming director of Estates and Facilities, I, not for one minute, thought that things would not be addressed appropriately and was advised that the ventilation and the water system had been signed off – in particular, by Dr Craig Williams – and were ready to go for us to take occupation of the hospital.

THE CHAIR: Are we referring to

here simply a conversation between you and Mr Loudon?

A Yes, there was no exchange of documentation at all.

THE CHAIR: The language that Mr Loudon was using was "sign off" or "good to go"?

A Mm-hmm.

THE CHAIR: So he may or may not have used the expressions, "commissioning" or "validation"?

A He didn't use those expressions.

THE CHAIR: Thank you.

MR CONNAL: In terms of sign-off by Dr Williams, in your witness statement, you talk about Dr Williams signing off the water system after a series of microbiological tests. Is that what you're referring to or did you think he had done something about ventilation as well?

A Yes, I thought he had participated in the sign-off of ventilation. Dr Williams was the chair of the Ventilation Assurance Group within NHSGGC and the infection control doctor who tended to lead on built environment at that time. My understanding was that the water system and ventilation system, in order to be signed off, needed to have been approved by Dr Williams in his capacity as infection control doctor.

MR CONNAL: At page 417, you in effect asked a question, the short version of which, "Well, you were head of Estates, was it not your job to make sure that the commissioning and validation which was necessary had been done?" and your answer is, "No, that was the job of Mr Loudon." Is that right?

A Yes, that's my understanding.

Q Then, you explain, I think, in the middle of 417 that, historically in the Board, what happened is that the capital team, like the project team, presumably, completed the work and supplied the commissioning and validation assurances. Presumably, there's paperwork for that----

A Yes.

Q -- to the local operational teams, and the local operational teams then do verification which is with certain areas of ventilation and annual exercise. Is that right?

A Yes, that's correct.

Q So that was what you were assuming had been happening. Is that right?

A I assumed that the project team, to the point of handover, would ensure that all of the commissioning and validation and pre-

occupancy risk assessments of any kind would be completed and handed over with the O&M manuals and the keys, basically, to the building, and I therefore did not instruct any of those works and was not asked to instruct them or be involved in them, so it was my assumption that that was absolutely the role of the project team up, until the building was handed over to Operational Estates.

Q I suppose that the only question that I might add to that, if you don't mind, is that, if you know from the way things were usually done that you need to do an annual verification of certain areas of the ventilation, which as I understand it is based on it having been validated. Is that correct?

A That's correct.

Q Should you, or could you, have said to Mr Loudon, "Well, thanks very much, David. Can you send a copy of the results to my office so I've got them when I need them?"

A Yes. In hindsight, I should have asked to see the evidence; however, I had no experience of it working any other way than the appropriate way where this would follow through time. I knew that the contract documentation-- this type of information and some of the other information would need to be

populated on ZUTEC for us to be able to access and I didn't ask for copies of them but I should have, and in future, if I was involved in such a project, I would want to physically see these myself.

Q One question I forgot to ask you at the start is, what are you doing at the moment?

A I'm general manager for Property and Support Services division in NHS Lanarkshire.

Q Thank you. I just didn't have a note of it on my file, that's my fault entirely. I should have asked you that much earlier on.

Now, in subsequent pages of your witness statement – and this is probably the fault of those who asked you the questions, not you – the topics jump around a little bit. At 418, we pick up this question of ZUTEC, whether it was fully populated, and you record, at the top of 418, Mr Loudon, I think that is telling you, "No, it's all okay, it's the team that isn't familiar with it." Now, is that what the team were telling you, the Estates people who were having to use it?

A The Estates team who were having to use it were advising me that it was not fully populated, that they were missing documentation and documentation was in the wrong files.

So, therefore, when they looked for a document, what they would often find would be that the wrong model, the wrong specification had been uploaded to ZUTEC or that the documentation was stored in another part of ZUTEC. So they had to look for absolutely everything that they needed. There were no-- They were limited as fitted drawings and areas.

When I raised that with Mr Loudon, he advised that the system was fully populated in accordance with the contract and that it was down to the Estates maintenance team being unfamiliar with the system and not being able to navigate the system.

Q At 418, at the third paragraph, you say Mr Loudon told you this was due to Estates' unfamiliarity and you say he had been advised by the Board's technical advisers it was complete. Then you mention Currie & Brown. Were you told something by Currie & Brown about ZUTEC?

A Currie & Brown also advised me that ZUTEC had been fully populated. I did raise it on a couple of occasions when I met individuals who worked for them, and I particularly remember a conversation occurring during a meeting to discuss the CHP and how that was being progressed, when I raised the issue in the meeting and was advised that it was indeed populated. It was only when HFS, who were participating in the CHP meeting from a technical perspective at that time, advised Currie & Brown that they had been given access to the system and had found that the issues I was raising with Currie & Brown, at that time, were factually correct. It appeared to me that we then were starting to be listened to and slowly the ZUTEC system seemed to be populated. People got access who previously hadn't had access to the system despite requesting it.

I felt that, in terms of ZUTEC, it would have been a great assistance to the local Estates team if ZUTEC had been appropriately populated at the start when we moved over into the hospital, because that was supposed to be the repository for operational manuals, system design information. It's where you should have been able to go and find the validation and commissioning data, so all of that type of information should have been within ZUTEC for us to be able to go and look for and interrogate and look back on, but it wasn't and we certainly felt that we weren't listened to in that respect.

THE CHAIR: Can you recollect

who it was in Currie & Brown who you spoke to?

A Douglas Ross.

THE CHAIR: Douglas Ross, thank you.

MR CONNAL: Essentially, what you're saying is, whatever the contractual position may or may not have been, it would have been helpful to Estates to have as fully a populated ZUTEC at handover as was possible?

A Yes, that's correct.

Q Yes, thank you. Some of the discussions that you mentioned were about the CHP plant. Now, I don't want to ask you lots of material about the CHP plant, but you mentioned hospital temperatures were a problem. Now, we've heard previously from other witnesses about the need for the heating plant to control water temperatures for infection purposes, but was there a wider problem about heating and cooling in the hospital?

A It was linked to the CHP. So there were, particularly when we moved in, numerous reports from wards and departments that the temperature was extremely high in those areas and was causing distress to patients. There were areas where the cooling was also coming on and the area was too cool.

The CHP and the link to water temperatures is something that was explored by the Water Technical Group and it was the view of the Water Technical Group that there had been temperature excursions since before the hospital had opened. However, when we went to try and get that factual data, the building management system had-- there had been a software glitch and most of the archive files had disappeared, so there was no way for us to verify that. But we were aware that there had been temperature excursions and felt that that was a contributory factor to the water incident.

Q Okay. You've jumped forward a little bit. Let me just jump back in the gap that that gives me. I have a note here, which I'd completely forgotten about, that you'd been told by the medical director not to bring your building-related issues, to the BICC. Who was that?

A Dr Jennifer Armstrong.

Q Okay, right. Now, there were obviously discussions about this issue about cooling and other things about the CHP. Now, am I right in thinking from your statement that it was you that then suggested an external third party be brought in to do a report on it?

A It was suggested actually to me, because we were not progressing from the NHS side, the issues that had been identified, and Currie & Brown and Multiplex representatives were of the view that they had done everything that was required to have the CHP accepted by the Board. We were not of that place and I think both, at various points, Mr Gallacher and Mr Powrie described frustration round about the lack of movement on this topic. I'm not sure if I suggested it or they suggested it but I certainly agreed to it and said that we should move forward by getting a third party to come in and look at it and then, that way, we would have a third party looking at it independently rather than the NHS team saying one thing and the Multiplex team saying something else.

Q You kind of bracket Currie & Brown with Multiplex there. Were they not working for the Board?

A Yes, but it didn't feel like that sometimes.

Q Thank you, and was an independent third party then instructed?

A Yes, there was a review completed.

Q Thank you. Now, on page 424, you've listed a number of

the issues that you identified. I'm not going to get you to read through these. I just want to take from you, wearing your head of Estates hat, an idea of why these kind of things were causing particular problems for the Estates team.

A Okay. So, PTS loss of power. So the PTS system is a pneumatic tube system which transports samples, in this case, from where the sample is taken from the patient, and takes it to the appropriate laboratory where they then analyse the sample and produce the results. The PTS system kept losing power and that meant then that what we had was quite often – in fact, most times – was specimens then in the pneumatic tube system that we could not get back out of the pneumatic tube system.

That took quite a lot of technical intervention to find out where they were and to make corrections to the system to get them to move. In some cases, I believe we may have lost some valuable pathological samples as a consequence of this. It also meant that when the PTS went down, we very often had to clean the PTS system.

For the wider hospital, it meant then that we had to revert to manual movement of these things round about

site, for which we did not have adequate Soft FM staff and actually had to bring in temporary staff to supplement that. So the PTS loss was a critical system used by the clinical teams in the laboratories for exchange of information and analysis. The foam cannons-- Sorry?

Q It's all right. I'm not going to ask you to go through each of these and then add your explanation to it. I'm just trying to understand from you – and perhaps I can try and summarise it if I can, you tell me if I'm getting this anywhere near correctly – if an issue with the building or the building systems arose, if it arose in an empty office block, you would just shut the door and wait for the plumber or whoever is needed to fix it. Can you do that once you've got the hospital up and running?

A No, you can't do that. You need to, first of all, think about continuity of services to maintain patient safety and very often these are time critical, and also we need to think about general health and safety. So, for instance, the ETFE roof leaking meant that there were buckets and water running into the main atrium to which most of the public that came to the hospital went through, so that then created a slipped up and fall hazard.

So when the hospital was populated with patients, staff and visitors, the consequence of these things need to be completed within an acceptable timeframe. On occasions, you can just close the door and continue in the same way that you would do in non-clinical but that's very dependent on what the patient activity is in the hospital at that given time.

Q You set out over the next few pages a number of these issues that were causing stress to the Estates team to get done whatever needed to be done. Now, I think the Multiplex position will be that they were cooperative and helpful and working to do what needed to be done as quickly as possible. Do you have any view on that?

A I think that many of the defects shouldn't have been there when we opened the hospital and populated the hospital with patients. So some of these things should have been addressed before the first patient came into the hospital. I don't think that they were uncooperative, but it very much felt like anything that we wanted them to address, it was a fight to get them to address it, that there were constantly issues that we were being told were not part of defect, they were local operational issues. I know

that there became, in the end, a reluctance to even escalate things through the defect process, because the general mood in the team and the Estates team was if you put it on the list, it will not get done, and it will come back to us anyway, so we may as well try and rectify that problem at the time.

Q Is that the point you're making on 426 at the foot of the very large paragraph there:

> "Significant pressure on the stretched Estates team. Due to patient safety concerns, the Estates team tended to address issues on their own."

A Yes, that's correct. Which then further stretched the resource that we did have, because that was not built into any kind of profile of any staff and the amount of defects.

Q I want to return, at least very briefly, to asset tagging and CAFM. Now, we've been told what asset tagging was and you deal with that on 427, and you explain at the foot of 427 the kind of problems that that created if it wasn't in place. Is that right?

A Yes.

Q So another cause of pressure for the Estates team?

A Yes.

Q Does it have an impact on PPM – planned preventative maintenance – as well?

A Yes, it does. Asset tagging allows-- First of all, knowing where your assets are, what they are, how many of them there are, allows you to develop a PPM schedule. So what needs to be maintained, on what frequency and at what level. It can be varying levels from checking things are in place, to temperature control, to anything. The PPMs can be a whole range of different types of tasks at different frequencies. Asset tagging allows you to identify what your assets are and where they are in a concise manner, to attach a planned preventative maintenance profile to them. And then you have a complete asset history, so that you can look back and see when, in fact, the asset was maintained, what condition it was in, and it gives you a complete record of that asset and the work that's been done to it, who did the work. Also, it allows us to issue electronically to staff what piece of equipment we would wish to maintain. So it assists with the CAFM system. So your asset tagging would be used to populate the CAFM system.

Q Thank you. I just want to

ask you then about CAFM. You deal with this at 429, and you're asked, as far as you were aware – and you weren't involved in drawing up the contract – you'd been told that there was a requirement to produce a CAFM system for the hospital. Is that right?

A Yes, that's correct.

Q Then, according to your statement on 429, you're told in 2014, "No, ZUTEC is all you're getting." Is that right?

A Yes, that's correct. Up until that point in time, myself and the Estates team had been led to believe that we were going to be handed over a fully populated CAFM system, which then meant for us that also included the asset tagging, the scheduling of the PPMs, and would allow us then to develop a very robust workforce linked to the number of tasks that we were required to undertake and key skills and be able to skill match staff. We were unclear about what the CAFM system was going to be and, in actual fact, we held off standardising the whole of the Board's CAFM system, waiting to see what CAFM system had been selected for the new hospital with a view that whatever system had been selected for the new hospital could potentially be the standardised CAFM system for across NHSGGC.

However, as time was getting on, Mr Powrie and the e-health lead approached the project team and asked when they were going to get information about the CAFM system, to allow further work to be completed on it, to talk about the roll-out of it and to get things in place for the hospital opening. Mr Loudon subsequently came back and said that a decision had been made earlier on in the project that the CAFM system was not going to be fully populated and handed over, and that ZUTEC would be the only document repository that we were going to get. That took us by complete surprise in 2014, and did not leave us enough time to basically do what we needed to do.

Q So we can understand what kind of thing we're talking about, I wonder if I could ask you look at a document, please, which is bundle 17, page 830. This is something that we've been calling the "M&E Clarification Log" for reasons to do with an entirely different topic, which I'm not asking you about, about the reduction in the air changes. It seems to contain a number of queries and then notes of what's happened about these queries, and you see there's a reference on that page to PPM. You see that on the left-hand side?

A Yes.

And it says:

"BE to provide a full PPM manual and system computer-based software package for all the buildings and for all buildings and building services elements of the project. This system will incorporate as-fitted drawings and specifications, full planned maintenance programme of works that the FM and the Estates managers can review to plan and establish their annual maintenance schedules and annual budgets. b) We're responsible for the purchase and installation of the full PPM system."

If we just scroll on to 831, we see the very end of that, "including PC workstations, barcode readers, and tablets." Just so I'm understanding the position, there seem to become a bit of an issue between the Estates people and Mr Loudon over this. Is that the kind of thing that you were expecting?

A Yes, that's exactly what we were expecting. We were very excited at the prospect of getting a fully populated CAFM system.

THE CHAIR: Right, so I can just clarify, what we see under "PPM"--

Could we go back to 830, please? What we see against "PPM" is a system which would achieve certain things, and just looking at the things that would be achieved, is that exactly what you would understand a computer-assisted facilities management package or programme, or whatever the appropriate word is, would provide?

A Yes.

THE CHAIR: Thank you.

MR CONNAL: We can depart from that document now, thank you very much, and we can return to the witness statement. I think you explained to us a moment or two ago that eventually you were told ZUTEC was all that was being provided. Who told you that? Was that Mr Loudon?

A Mr Loudon. Yes, Mr Loudon came back and confirmed that to us that ZUTEC was all that was going to be provided.

Q Then there was a debate about whether any issues with ZUTEC were due to, well, I think we've used the word "unfamiliarity" by the Estates staff. At page 431 of your witness statement, in the middle of the bottom paragraph, it says:

"I was advised by Mr Loudon this was due to the

operational team not being able to use ZUTEC competently."

A Yes.

Q So it was your team's fault, was it? Is that what you were saying here?

A Yes, it was. It was the Estates team's fault that they couldn't navigate it and that everything had been provided by the project team.

Q Yes. Now, I think you told his Lordship in an earlier answer that the argument about whether ZUTEC was in order continued for some considerable time, until eventually there was a meeting at which HFS were present when they said it wasn't populated and, after that, things happened. Is that right?

A That's correct.

Q That's what you cover just for the notes at page 432, near the top of that page. I just wanted to ask you about the tailpiece that you put in there – you say:

"It felt like the concerns of the Estates team and Ian Powrie were not believed and our concerns had been dismissed."

A Yes.

Q Is that a bit of a theme of what you've put in your witness statement that as between the Estates and Project team, not much value is being placed on what the Estates people said?

A Yes, that was my view, and I know that was the view of the Estates team on the site, that when we raised things, they were very often dismissed as being our responsibility, because we had failed in some way, or were unable to do what was required of us. That was a consistent theme.

Q Yes, and just to complete that, 433, which is after the discussion about ZUTEC and so on, you use the words "complete disregard on this subject, causing stress." Are you exaggerating there?

A No, I felt we were disregarded, and it didn't matter what we said or how we presented the information, it was never going to be listened to.

THE CHAIR: I think we've heard evidence about this at previous hearings, but could you just explain why ZUTEC is not a computer-assisted facilities management system? What is it that ZUTEC does not do that you would expect a CAFM to do?

A So ZUTEC is, essentially, a document repository software system. A CAFM system contains more and, in that, it gives you

the ability to program tasks at a frequency which can then, in normal cases and in most CAFM systems, be used to electronically notify staff of what tasks need completing, where they are and in some cases what the risks associated with that are, so it's a much more comprehensive document. It allows you to match your PPM schedules to your assets, rather than being in two separate documents, so that you can then maintain a file of the asset history.

THE CHAIR: Thank you.

MR CONNAL: And am I right in thinking that one of the ways these things work is that you have handheld devices, and they can read codes on pieces of kit, and they verify what the code is and what's happening with it? Is that right?

A Yes, you can set them up like that, yes.

Q Okay. Let's ask you about a couple of other things. Was there an issue about HEPA filters not being in place in some rooms where they were needed at the point when patients were due to arrive? Is this what you're touching on at the foot of 433? Is that correct?

A Yes, what I'm saying in that is at the point of handover, i.e. in January, I don't know if the HEPA

filters were in place at that point in time. However, what I did know was that the weekend before we were due to transfer patients to the hospital, it was raised at a meeting in the hospital to discuss patient transfer that there were no HEPA filters fitted in the hospital. The chief-- the chief operating officer at that time, who was the lead senior responsible officer on that weekend, highlighted that the hospital couldn't open if there were no HEPA filters in place. That resulted in Mr Loudon and Multiplex arranging for HEPA filters to be delivered to the hospital and fitted, and confirming that they had been fitted, and that appropriate testing had been carried out for their use in the hospital, and therefore the hospital could open.

Q Were you able to find out how it had come to be that apparently the hospital had been accepted without a piece of equipment that could have prevented it opening?

A No, I never found out why that was the case, and there was no discussion about that.

Q Given the possible significance – and we know what you say, that it was then remedied – did that raise any wider concerns in your mind as to what state the hospital was in?

A Yes, for me, it did raise concerns. It was probably the thing that I was most concerned about when I took over the interim role in 2018. When the chief executive asked me what I was most concerned about, one of the things that I said was the thing that concerned me most was round about ventilation at the Queen Elizabeth Hospital, and the Sick Kids, because I felt that we hadn't directly answered the whistleblowers' queries round about air change rates, etc., and I felt that we needed to have a position, a review of the ventilation and a position from a third-party independent on what the ventilation conditions were in the hospital, and if they were compliant with the SHTM.

One of my main concerns that led me to that thinking was that the hospital, that weekend, there did not seem to be an understanding that HEPA filters should be in place before any patient comes and, indeed, should have been in place while the validation and commissioning was ongoing.

Q We'll perhaps return to the detail of that shortly. I just want to pick up another comment you've made a few pages further on. 43, please. Now, at the foot of that page, when you're talking about defects and getting things fixed, you're saying:

"There was little understanding or appreciation of the consequences of this by Multiplex or the project team on the site or the ability of the Estates team to manage the building."

Now, leaving Multiplex aside for the moment, I mean, the project team was made up of GGC people and advisers, was it not? I'm just a little puzzled at the suggestion that people from the Board did not seem to understand what other people from the Board were telling them about these issues. Is that your perception?

A That's my perception. I would suggest, with hindsight, that we were operating in two separate silos. There was the project team and there was the operational Estates team and there was not close enough working between the two, particularly in the defect period, but the project team was disbanded quite quickly after building handover. I think during 2015, the project team staff went back to their substantive posts and Mr Loudon and, I think, Mr Moir were leading on the defect rectification. So the project team itself was disbanded fairly quickly after patient migration, which I do think made an impact, but I think that, in hindsight, we should've been working in a much closer manner, talking about the defects and the impact, but we

were not.

Q Thank you. Can I take you back to water, please, and we'll find we've covered a fair amount of this ground already. 445, now, you're asked various questions about the guidance that applies and the structures that were in place, and some of these you've already dealt with. You say at the foot of that page, the duty holder was the chief executive, so that's the sort of ultimate person with responsibility. Is that right?

A Yes.

Q So that would be Mr Calderwood who was ultimately responsible for water.

A That's correct.

Q Then you were the designated person, so you discovered, and then you explain your attempts to read into the topic a little earlier in your evidence. I just wanted to pick up something that arose, it would appear, from your reading on page 446. You explain in the middle of that page that you:

"…had been advised by the technical leads and others that this was a management position to coordinate the output from the technical experts."

Then, you say you:

"…became aware of the need to appoint an authorised person."

Then, I just want to make sure I'm understanding correctly what you're saying; you're saying the advice from all the technical leads at this time was that:

"SHTM's were best practice guides which we should try to achieve but that these were not mandatory. Each Sector Responsible Person placed little importance on the appointment of Authorised Persons at that time which was described to me by all of them as best practice, not mandatory or statutory, and that initial focus should be on processes and procedures…"

Can you help us understand what you're being told there?

A So-- All of the-- all of the general managers that were appointed into sector positions, and then subsequently myself when I became the associate director, came from a Soft FM background. The senior Estates management team, i.e. the Estates maintenance managers, did not think that it was the appropriate structure that was in place because they felt that Estates would not receive the attention that it required and that only an Estates person should be the general manager for Estates.

I felt that they were very protective of the Estates service and their role in the Estates-- you know, in the day-to-day management of Estates. When I was asking questions, I felt that the view was that I was not in a position to know or understand these things and that the sector Estates maintenance managers were the people who had the technical expertise, and therefore they should be left to manage that, and that I should accept what was being said to me by them being the technical experts. And there is a degree of truth in that I am not a technical expert, and my role was to manage the technical experts.

What I would say is that we only started looking at statutory compliance in relation to SHTMs and statutory, that I remember on the Board-- Now, bearing in mind I have not been involved with Estates for the whole of my career; I've only been involved since around about 2010. When the National Statutory Compliance and Risk tool was shared with us, there was a desire on the part of the then-director to use this to identify if there were any gaps in services. The Estates managers responded to that by populating that with "yes" and "no" answers and not providing the evidence that would demonstrate compliance.

There was not the focus – I didn't feel – on SHTMs, and I became more acutely aware of that when I had the realisation that I was a designated person and that the designated person role was wider than that. It also made me consider where the general managers for each sector fitted into that scheme of delegation, and that's when the compliance team, as I've said before was pulled together. So, I think my view is that it was not until around about the time of the building of the Queen Elizabeth Hospital and then the opening of the Queen Elizabeth Hospital that we put enough focus or started to put focus on to compliance with the SHTMs, and develop an understanding of what the role of the SHTMs was.

THE CHAIR: Thank you. Could you help me, maybe on two points? Now, you've previously mentioned this in your evidence, and I probably should know the answer, but I don't. You referred to the National Compliance tool.

A Statutory Compliance.

THE CHAIR: Statutory Compliance tool. Now, tell me about that.

A Okay.

THE CHAIR: First of all, this is a document. You refer to it as a tool, but it presumably is a document, and it is issued by Scottish Government?

A No, it's not issued by Scottish Government, so it's-- At that time, initially, it was an Excel spreadsheet. It was developed by one of the boards – I can't remember quite who the board was – as an aid, an aid. It's not an, "If you comply with this everything will be fine." It's an aid to identifying where you may have gaps in your statutory compliance. So it asks a number of questions which are based on the legal situation and is based on SHTM compliance, and it's an Excel spreadsheet. It was shared among the directors of Estates and Facilities as part of the national group, where networking and sharing of documentation frequently happens, and it was adopted by our then-director of Estates and Facilities who thought that it would be very useful.

It has been a very useful document and it's still in use today, but it's not a reporting tool to Scottish Government and it is not issued by the Scottish Government. It is something that has been developed within the technical groups in Facilities that meet nationally to support each other in delivering services.

THE CHAIR: Now, the Inquiry has acquired a large number of documents, but in the event that it has not acquired this particular document, where should we go to look for it?

A NHS Assure can provide you with the current version and I'm sure there will be archive copies.

THE CHAIR: All right.

A I believe there's a reference in the evidence bundle to the statutory compliance. It was a paper that was added to the bundle in the last kind of 24 hours.

THE CHAIR: Right, okay. Maybe my colleagues in the Inquiry are ahead of me. I have not read that but will do so. Now, the other question I had is, at page 446 of your witness statement, you refer to the advice from all the technical leads in GGC at this time was that:

"SHTMs were best practice guides which we should try to achieve but that these were not mandatory."

Could you give me any names of people who gave you that advice?

A Alan Gallacher, Ian Powrie, and it was discussed in some of our SMT meetings where others were in attendance.

THE CHAIR: Thank you.

MR CONNAL: Perhaps we could move on to touch at least briefly on

another topic, which is pre-occupation L8 water assessments, which the Inquiry has heard quite a lot about for a variety of reasons. Are you familiar with what, at least generally, that is: a pre-occupation L8 assessment of the water?

A Yes, I am.

Q Now, you're asked about it on page 447, and you say, well, "This should have been done," and you were asked who was responsible for it, and you say, "Project Team as part of commissioning and signoff of the water system prior to handover of the building."

Is that your position?

A Yes.

Q That's what you think the answer is.

A That's what I think the answer is.

Q It would appear that one wasn't done before handover, and you're asked, "Can you help us understand why not?" Then you say, at the foot of that page, you can't, and then I think you suggest that perhaps, no doubt, with the benefit of hindsight, you, in your then-capacity, should have ensured it was in place. Is that your position?

A Yes. Knowing what I know today on the role of the designated person (water), I should have ensured that that was in place, and that I had seen that, and that the actions were closed out. However, because it was a pre-occupation risk assessment, I assumed wrongly that any pre-occupation risk assessments in relation to any topic actually were completed as part of the handover process and the signoff of the building.

Q Yes, thank you. Another question that arises naturally from that, 449, please, we're talking there about the fact, as we've heard from others, water was in the hospital systems before the hospital opened, and you had a concern about the fact that with so many water outlets, you needed to make sure water wasn't stagnating.

A Mm-hmm.

Q Then, you say about halfway down page 449, at the end of an answer, you say, "It was assumed the water system was clean at handover." You're then asked, well, "Should you have 'assumed' the water was clean at handover … without an L8 report?" I think, again, you're applying a degree of self-criticism there with saying, "Well, actually, now, I probably shouldn't have assumed that." Is that correct?

A That's correct. I assumed that the system was clean

because of the feedback that was given verbally on the sampling regime, that we had checked for TVCs, E. coli, Pseudomonas and Legionella, which I knew were part of the L8. Not the Pseudomonas, but the L8 ACOP guidance, and I placed great value on the fact that I was being told that the system had been checked, that they had found some evidence of contamination, that it had been disinfected twice, and that the re-sampling process had came back clear, and therefore the water system was acceptable for use.

The-- I am being self-critical in that the L8 pre-occupation risk assessment should have been completed at the same time and I wrongly assumed, without checking, that that would be the case and that everything that required to be done was done. I now understand that without the pre-occupation risk assessment, you can't sign the water system off as being compliant.

Q We'll come later to talk about the actual report that was done, and which emerged at a later stage. I just wanted to make sure we have, before we leave this – page 450, please – where you say, third paragraph:

"I did not assess the compliance of the system at handover. I was advised throughout the building process and commissioning process verbally that the water system was compliant with all guidance."

Then, you're asked, "Well, who told you that?" Then, what you do in response to that question is, you recalled a conversation with Mr Seabourne, Mr Loudon's predecessor, when you asked was there anything you needed to do, and he said something interesting about what the best system could be. Is that right?

A Yes, that's right. I remember asking that time, round about the time I discovered there was a designated person for water, I thought, "I have got responsibilities with water that I don't really know what they are," so I decided that I would ask Alan Seabourne, did I-- Since now we were working on the Board water safety and I had kind of discovered this, did I need to-- did I need to do anything in relation to the project, in relation to the water system, and Mr Seabourne came back and said, "Don't worry about that. We have the best designers working on it and it will be absolutely fine. You'll get the best water system that you could."

I subsequently recall a brief conversation with David Loudon about

the water system, and was similarly advised that the best designers had been working on it and it would be one of the best systems in Europe. There was a great deal of pride being taken in the building of the hospital and the work, and the design, etc., at that time and everyone thought that what they were doing and producing would provide the right results.

Q Thank you. Just bear with me a moment. Well, let me just jump ahead a little bit. I'll come back later because the report that was ultimately done was done by a firm called DMA Canyon, and I think you're aware of that name. Is that right?

A Yes, that's correct.

Q Now, there was a report done eventually, but there seems to be a question as to, first of all, who knew that it was being instructed, so not who got the report, but who knew it was being instructed, and I think you're aware of a suggestion from Mr Powrie that you were perhaps aware that he'd instructed it. Now, you deal with this on page 463 of your witness statement, and you say you don't remember any conversation about that, and then you say that you didn't think it was your responsibility because it was the role of the project team, which is the point you've made before.

Were you aware that DMA Canyon were being instructed? Can you help us at all?

A Being instructed to complete the risk assessment?

Q Yes.

A I don't remember the conversation with Ian Powrie. However, if Ian Powrie had said to me, for instance, when we were meeting about other matters, "I've spoken to the project team, and we need to get the pre-occupancy risk assessment. Are you okay if I just instruct that?" I would absolutely, on his advice, have said, "Yeah, we should do that." But I don't actually recall the conversation itself.

Q Thank you. You're asked here, when were you first aware of it?

THE CHAIR: Well, maybe you're taking this forward. It just occurs to me there's a distinction between being aware of an instruction and giving an instruction.

MR CONNAL: Yes. I think your position is you didn't instruct an L8 report, although you now suggest perhaps you should have made sure it was done. Were you aware that DMA Canyon had been instructed and that's the answer you've just given us at the moment, that you've no recollection----

A I can't remember.

Q -- of that? In terms of the report coming in, you're asked, when did you become aware of it? Now, your answer here is, "About May 2018."

A Mm-hmm.

Q How sure are you of that date?

A I'm not absolutely sure of that date, but what I do-- Well, the first recollection I have of seeing it is when it was given to me by the chief executive of the Health Board. That's the first time I am aware of me seeing the report, and it was round about that time of year because I remember that it was very like the weather just now.

Q The reason I'm asking is that one witness told the Inquiry that various people may have known about this in 2017. Are you aware of you being aware of the report in 2017?

A No, no.

Q So, can you help us at all whether anyone you discussed it with was aware of it earlier than the "around May of 2018" date?

A The project team were aware that a risk assessment was being done, because I found in the evidence pack that was sent out for today a copy of an email dated 15 April 2015, from Ian Powrie to members of the project team, updating them on some of the information it had already started to compile-- started to come through, but before it being given to me by the chief executive, no, I hadn't seen the document. And when it was given to me I was completely-- I was completely shocked because by that time we had started running a water technical group. We were into the water incident, and this had not been highlighted to me, that there had been a risk assessment. We were doing a look back and trying to find all the documentation we could about the commissioning and the water system itself, but I don't know in 2017.

Q Could it have been earlier in '18, like March, for instance, when----

A Yes, it could—yes, it could have. It could've been March/April.

Q But your recollection is May?

A It's around about that time of year.

THE CHAIR: If I've understood your answer, whether it's in March/May, another time, you had your attention drawn to it by the chief executive.

A Yes, that's correct.

THE CHAIR: Right.

MR CONNAL: I suppose that the question that flows from this is along these lines. You now think, well, with the benefit of hindsight, "I should have made sure that the preoccupation assessment was done." Should there have been other assessments done subsequent to the 2015 one, for instance, in '16 or '17, that you should have been aware of?

A Yes. There should have been in my-- So, there should've been a risk assessment done on an annual basis, or you can agree to do it bi-annually with your risk assessor, but normally you would carry these out on an annual basis. At that time, I didn't know that you did them on an annual basis. However, I did ask Alan Gallacher – when the water incident happened, when I asked him about this report in particular – were there any subsequent, to be told that there was a risk assessment completed in 2017. True, this was in 2018, but it had not been received at this point, and when I asked, "Why has it not been received, if it was started in 2017?" he didn't have an answer for that either.

Q Sorry, the reason you didn't, wearing your hat, do anything about annual assessments was initially that you weren't aware that they were to be done annually. Is that right?

A That's correct, that's correct.

MR CONNAL: Yes, and just so we're following where this is covered in your witness statement, at 464, in paragraph 101, you're dealing with the date of the 2017 report not being received until 2018 for reasons that you didn't know. You've touched in your witness statement on the consequences of not dealing with reports of this kind, which we've actually heard quite a lot of evidence about.

On page 465, you explain how you became aware of it. If we just leave the precise date aside for the moment, do you remember the circumstances very well? 104 on page 465. You say the report was given to you by the chief executive. Do you remember that happening?

A Yes, I do.

Q When you say it was given to you, I mean, were you routinely meeting Ms Grant, or was this a special meeting?

A No, it wasn't a special meeting. I think on that day she just might have asked to see me, and that happened about a range of topics, that if there was anything that needed to be discussed, there would be a request

made, “Could I come up and see Ms Grant between such and such a time and such and such a time.” When I went to see her, she physically handed me a paper copy of the document. That’s how I first received the document, that I can recollect.

Q Did she tell you where it had come from?

A Yes, she advised me that she had been provided with the report from Mr Tom Steele, who was the director at HFS, and that it had been sent to HFS as part of the archived documents that Mr Powrie had sent on to HFS as part of the water incident-- Water Technical Group work.

Q Yes.

A It took me completely by surprise, because we had been talking about the water system. Nobody had raised this at all. When I went back-- I left there and went back over to the QE to meet with Mr Gallacher and Mr Powrie to find out if they had been aware of this. Mr Gallacher advised me that he had not been aware of this. This was the first that he’d heard about this. When Mr Powrie came back over from the hospital, he advised me that there had indeed been one done in 2015-- a risk assessment completed in 2015, and when I asked him if I had-- I assumed that I had missed this report in my emails and that, in some way, I had missed it, you know, and I couldn’t understand this. He advised me that he had never sent it on to me, and I asked, “Well, who-- did you share it with Mr Gallagher?” “No.” I said, “Did you share it with Mr Hunter?” “No,” and he advised me that he hadn’t shared it with Mr Loudon. He actually advised me at the time that he couldn’t remember what he had done with it at the time, but he was extremely upset at the-- at this omission.

Q Thank you. My Lord, that might be an appropriate point to pause.

THE CHAIR: Yes. Ms Kane, we’ll take our lunch break, but could I just check on two matters of detail before we rise? Now, at page 450 of your witness statement, you refer to a conversation with Alan Seabourne and, as you say, he was the project director before David Loudon came into post. Can you recollect what Alan Seabourne’s position was at the time of that conversation with you?

A He was the director of the New South Glasgow Hospital build.

THE CHAIR: Sorry, he was the director of----?

A Of the New South Glasgow project.

THE CHAIR: Yes, but at the time

of the conversation, I understood----

A No, that's-- Sorry, sir.

THE CHAIR: Sorry, you tell me.

A He was the project director at that time.

THE CHAIR: Right, okay. Yes. Right, I'm now with you. My fault, and the other point of detail is that when you were asked by Mr Connal about the risk assessment instructed in 2017, you were told by Alan Gallacher that a risk assessment had been instructed in 2017 but it was not received until 2018. Now, it's just that I understand-- when are you having that conversation with Alan Gallagher? Is it after the 2015 risk assessment had been brought to your attention?

A Yes.

THE CHAIR: Right.

A Yes.

THE CHAIR: Right, and was Alan Gallacher saying to you that, as at that date, the 2017 risk assessment had not been received?

A That's correct.

THE CHAIR: Right, okay.

A That's when I said, "Well, I instructed a 2018 risk assessment to be done, and that the risk assessment needed to be done quickly so that we could identify and address any outstanding issues. I had given that instruction before the 2017 risk assessment was received by the Board.

THE CHAIR: All right, thank you. Well, it's, we're now nearly ten past one, so if you could be back at screen by ten past two. Right, we can now have lunch. Thank you.

A Thank you

(<u>Adjourned for a short time</u>)

THE CHAIR: Good afternoon, Ms Kane. Can you hear me?

THE WITNESS: Yes, I can, sir.

THE CHAIR: Right. I think we're ready to resume.

MR CONNAL: Thank you, my Lord. We were talking about DMA Canyon, Ms Kane. Just a few more points of detail before we leave that. You described getting the 2015 report from the chief executive, Jane Grant, having been asked to come and see her. Was it the 2015 report you got in 2018 at that meeting, or did you also get the 2017 report?

THE CHAIR: Ah, right. Ms Kane, I thought I heard you responding to me. I wonder if the mute is still on. We can't hear you.

A Can you hear me? Is that it?

MR CONNAL: I hear you, but less distinctly than I would have

expected.

A Hold on, I'll see if I can-- Sorry, sir. See if I can put the volume up. I haven't changed any of the settings since we last-- No, I can't put it up any further. Would it help if I spoke up?

THE CHAIR: Sorry, I didn't hear that.

A No----

THE CHAIR: I'm hearing you, but not as loudly as we did formerly.

A Can you hear me now?

THE CHAIR: I can hear you very clearly, thank you.

A Right, okay.

MR CONNAL: I'm sorry, we didn't hear the answer to the question I was asking you as to what you received from Ms Grant at the meeting that you said took place in or around May 2018. Was it the 2015 DMA Canyon report or did you also get the 2017 one, which we know didn't appear until sometime in 2018?

A No, it was the 2015 report I received from Ms Grant. When I went over to the QE to speak to Mr Gallacher and Mr Powrie about this report, to ask them if any of them knew about this report, why we hadn't discussed it, etc., that's when I learned that there had also been a risk assessment completed in 2017 which had not been received at that point.

Q Did you take the opportunity of reading through the 2015 DMA Canyon report?

A Yes, I looked at it, yes.

Q You were asked in your witness statement what was the consequence if what was in the report wasn't actioned. Can you just tell us what your position is on that?

A So, there were a number of things in the 2015 report that required to be acted upon and they required to be acted on quickly, either within a month or within three months of receipt of the risk assessment on the basis of the risk that had been attached by the risk assessors. Those issues related to dead legs, vessels not being passed through in nature, multiple temperature excursions, and a number of defects round about things like valves. So there were a range of things on it that could have led to microbiological proliferation in the water system.

Q Put another way, do you accept that not dealing with these matters could have created a risk to patient safety?

A Yes.

Q In due course, did you take the opportunity of reading the 2017 report when it appeared?

A Yes.

Q Can you remember when it appeared? Was it much longer after your meeting with Ms Grant or a lot longer?

A No, I don't think it actually was that much longer afterwards. I certainly had instructed the 2018 one before that one was received, but I don't think it was that long afterwards. I think it was received because I asked for it to be chased up by Mr Gallacher with DMA Canyon.

Q Did you read that report, the 2017 one?

A Yes, it was very similar to the 2015 report.

Q So, it was identifying things that could have caused, I think as you put it, microbiological proliferation----

A Yes.

Q -- or as I suggested to you, risk to patient safety?

A Yes.

Q Thank you. Can I just jump ahead for a minute and just ask you another question, just while it's in my head? By the time you came to leave the post that you were occupying that related to the Queen Elizabeth hospital, had these water issues been resolved?

A The water issues had not been fully resolved. I took up a separate role in 2019, at the end of 2019, which no longer involved Estates management and it didn't have, you know, any locus on what was happening with water system in the South because my base changed to Clyde sector within NHS Greater Glasgow and Clyde, but there were ongoing works still happening within Ward 2A and 2B in relation to the water system. But when we received the '15, the '17 and then the 2018 report, there was a gap analysis completed and an evidence base established to close down each individual task to ensure that everything had been addressed that had been raised through the two risk assessments.

Q Thank you. Well, can we move on to another topic with a short excursion, if we may, into cleaning? Now, you were asked about that at 456 of your witness statement. The essential dispute here is to be that Dr Inkster is saying, "Well, yes, cleaning issues were taken seriously, but they were reactive rather than proactive," and you say, no, you don't agree because there was a lot of work going on anyway regardless of what was being raised with us. Is that a summary of what you've got there?

A Yes.

Q Did cleaning issues continue to be a challenge continuing into 2018, in other words, after you were back?

A After my return to work in 2017, I was asked-- part of the dedicated piece of work that I was asked to complete by Mr Loudon was a review of cleaning services at the QE hospital because there had been two adverse HAI inspections in the time that I had been off. He was concerned that there might be challenges with the cleaning, so part of my return to work plan was to look at cleaning and there was a large piece of work done at that time which looked at, you know, the staff resourcing levels, the hours being achieved on the floor, the cleaning standards, and the supervisory arrangements for cleaning service.

That had nothing to do with Dr Inkster escalating to me anything on cleaning. It was a piece of work that I was asked to take forward by Mr Loudon. We found that there could be improvements in cleaning services but one of the areas which was most challenging for us was round about discharge cleans, which is a result of the single rooms on the QE site, and we spent a lot of time working on that.

What happened while I was off, I

can't-- I don't know what happened while I was off sick, so I don't know what the cleaning standards were but there were a number of measures taken. It was around realigning staff and adjusting hours in wards and looking at improving on standards. So, although we were reporting fairly good levels of compliance against the national standards, there was still room for improvement and that's, in fact, what we did as part of that piece of work.

Cleaning standards in most hospitals remain-- they usually remain around a consistent standard, a consistent baseline standard for that hospital and, at times, those standards can rise or they can temporarily fall because of resource challenges, people for instance reporting in sick, people taking unexpected annual leave, etc., and cleaning services is a service that needs continuous management and supervision to maintain standards.

Q Was that under your responsibility to make sure that happened or not?

A It was the day-to-day responsibility of the general manager for the sector and the domestic manager and the site manager.

Q So, is it possible there

were still problems being encountered from time to time in 2018 as well as earlier?

A Yes.

Q Can I just ask you to look at a document just briefly. This is a fairly short one so I won't take too much of your time with it. Bundle 14, volume 2 at page 230. Can we just scroll back to see if we can see the start of this exchange? Carry on. (After a pause) We'll just leave that document, thanks. But you accept that there may have been issues with cleaning continuing in 2018?

A Yes, in individual pockets, yes.

Q Now, it does lead me to another topic, quite conveniently, which is one that you mentioned, I think, unprompted in relation to an earlier piece of evidence. Can we go to 458? Is this a question of Dr Inkster saying, "Well, Mary Anne Kane's been told not to give microbiologists any results, access to water testing results." You remember being asked about that?

A Yes, in the statement, yes.

Q You say, well, that didn't happen, but you then go on to give an explanation about one particular issue that arose. If we look at 459, this is a point I think you told us about earlier, that Mr Loudon told you there was a whistleblowing thing going on and, basically, you were to keep out of it and if you asked for information by any of these microbiologists, then you were to refer them to Dr Williams. Is that right?

A That's correct.

Q Did you find that an odd instruction to be given?

A Yes, I had never been given that type of instruction in my career before. I was uncomfortable with it but understood that it was part of a whistleblowing case, and whistleblowing cases are dealt with by discrete groups of managers, so I took it that I had not to interact because it was being dealt with through another channel, i.e. the whistleblowing policy.

Q Can I just ask you the general question then? One of the points you've been making throughout your evidence is your lack of training, lack of specialist knowledge of water matters, and so on. You've mentioned that on a number of occasions. One group of people who might have knowledge about water and the issues that arise with water that affect patients are the microbiologists, like Dr Inkster and Dr Peters. Now, did you have occasion to-- Sorry, I'll change

that question. Were you aware of trying to prevent them getting information?

A No, no.

Q I think there's an inference that you were somehow – and of course everybody's perspective is no doubt different – but there's an inference that you were somehow obstructing these people from getting information that they could find useful.

A I understand that that's the inference but I would have no reason not to share that information with them because of the connection between microbiology and infection control to, in particular, water and ventilation. I later saw the whistleblowing exchange of information once Mr Loudon had left, and it was one of the areas that concerned me particularly in relation to ventilation. I didn't understand why we didn't just share with the microbiologists, when they asked for the information from Mr Loudon, what the actual air change rates were, what the-- provide them with a copy of the Legionella testing that had occurred on the site prior to opening.

I don't see any reason why we would not share any of that information with microbiology. I never obstructed microbiology in any way or instructed any of my direct reports not to pass information on.

Q Can I ask you to look at bundle 11 at page 79? See if I have more luck with this one. You see on that document there, we're just looking at the short section in the middle, Ward 7B, "infection control colleagues are looking at historic records." You are noted as saying, "No reason to obtain access to historic records," and then the response is:

"There was an expectation of infection control colleagues for testing to be undertaken. MAK will direct the issue to the director of medicine."

The question is, well, why is there an issue with colleagues looking at historic records? One view is that you're basically saying that, well, "Why do you need to do that?"

A When was this? 2017?

Q Yes.

A Next meeting is in December 2017.

Q Yes.

A I can't answer that. I can't answer why I said that in that meeting.

Q Well, can I ask you to look at another one? Bundle 14, volume 1, page 215, please.

THE CHAIR: Sorry, my fault. Mr Connal, could you give me the bundle?

MR CONNAL: 14, volume 1, page 215.

THE CHAIR: Thank you.

MR CONNAL: (To the witness) This is an email that includes you in the addressees and says there had been positive Legionella samples, not seen any records or result of the cultures, please provide details of the testing. Can you remember, did you provide details of the testing?

A (After a pause) I can't quite see that but I think what it is is a request for information and that was-- When did that happen?

Q This was in 2015.

A June 2015. So, no, I would not have provided the details because I didn't have the details to provide at that time. I did not have access to water testing results. If I wanted access to them in the same way as the microbiologists were asking, I had to go to a head of maintenance and if someone asked me for access to them, I had to direct them to a head of maintenance. I didn't have direct access to the water testing results.

Q Thank you. We'll leave that document. Can we go to 461 of your witness statement, please? Yes, so that's the point that you're making, I think, just under the small letter H, "I did not have access to water testing results. If I'd received a request, I'd have to refer it to the Estates technical lead," but you didn't normally get this.

A No.

Q But you were aware of the inference that for some reason or another you were sort of getting in the way of people trying to get that information, and you don't accept that happened. Is that right?

A I don't accept that I was getting in the way of people, no.

Q Do you know anything about the supplying of water testing results to NSS at all, whether they were given them or not given them prior to 2018?

A To NSS?

Q Yes.

A Water results from the opening of the QE, or, just in general, water results being supplied to NSS?

Q Water testing results. That's----

A No.

Q No. Are you aware of----

THE CHAIR: Sorry, my fault. What is the question?

MR CONNAL: The question is whether the witness is aware of anything about NSS not receiving water testing results until April 2018 from GGC.

THE CHAIR: Right. Another way of formulating that question is, "Were water testing results provided to NSS?"

A Not that I'm aware of.

THE CHAIR: Right.

MR CONNAL: Do you know anything about Dr Peters, who is said to have been repeatedly requesting water testing results following the emergence of the DMA Canyon report of 2015? Do you know anything about that?

A No, sorry. I don't remember anything about that.

Q So far as you're concerned, do you remember any such requests coming to you?

A Only the one when I came back from sick leave directly to myself. I may have been CC'd into things along with various others but I don't-- no, I don't recall.

Q Now, can we move on? You've mentioned, I think, what's been described as "the water incident," or at least that's what we've started to call it, in 2018, and you had an involvement in that to some extent. Is that correct?

A Yes.

Q So, if we look at 468, you say, prior to March '18, you were unaware of concerns around water. So that's the description you were

giving us a little earlier, was of the water incident having started and people are trying to work out what's going on. Then, all of a sudden, the DMA Canyon report appeared, which nobody had mentioned.

A Mm.

Q Do you remember telling us that?

A Yes, yes.

Q Then there's a reference on 468 to the whistleblowing point, you say that was very odd. I just wanted to pick that point up with you, that you felt you had to comply with Mr Loudon's instructions, and you say you were fearful for your continued employment.

A Yes.

Q Why were you fearful for your continued employment in relation to that point in time?

A Because I had returned from an extended period of sick leave and, at the same time, I was being asked not to share information. I had just been told that should I be off work again, then there would be very serious consequences for me on a personal basis, in terms of my employment.

Q Who said that to you?

A Mr Loudon.

Q You say at the end of that paragraph with the A on it, on 468,

that you did your best to get to the bottom of what was going on. Is that your position?

A Yes, I did do my best at that time, yes.

Q Do we find an explanation as to why you got involved? Because obviously you weren't a direct Queen Elizabeth hospital member of staff, you had an overall role. You say you got involved because both Alan Gallacher and Ian Powrie said that you need to know there's a meeting that might relate to a water incident. Is that why you joined?

A Yes. That's why I joined the IMT in March, yes.

Q You say on 469 that the first thing you did was try to find out what had happened in any meetings that you'd not been at. Is that right?

A That's correct.

THE CHAIR: Was your joining the IMT a matter of your choice or were you----

A Yes, I wasn't invited to the IMT and I only found out that there was an IMT running of this nature from Mr Gallacher and Mr Powrie. Both of them, within a couple of days, had said to me that they were concerned about it and they felt that I needed to come and attend it as a senior member of the management team because of the patient safety concerns that were being expressed.

THE CHAIR: I should know the answer to this question but had either Mr Gallacher or Mr Powrie attended previous meetings of the IMT?

A They had been attending the meetings since January.

THE CHAIR: Right, thank you.

MR CONNAL: Now, you say at the top of 469 that you realised the Estates' response did not seem coordinated. Just tell us about that.

A So, when I went along, I went to the meeting and observed and listened to what was being said, and then when I left the meeting that I asked-- I immediately had a conversation with both Mr Gallacher and Mr Powrie about what had been discussed before, what actions had been taken, if any, by the Estates team, what information did we need to gather or supply for the IMT.

It became clear to me that Mr Gallacher appeared to be carrying out activities, Mr Powrie seemed to be carrying out activities, there were certain activities that the local hospital Estates team seemed to be doing, but there did not seem to be any coordination or leadership of all of those activities to get a more holistic view of all of the work that was being

done in connection with the IMT. I felt that we needed to come together as a team and start sharing that information to try to avoid duplication and to avoid unintended consequences, i.e. somebody doing something which might make the situation worse rather than better, that someone else was unaware of happening at that time. So I felt that we needed, as a group, to be meeting and sharing that information.

Q Did you do something about that?

A Yes. I started having an Operational Estates group and the Estates group was pulled together to talk about these things, to talk about each individual strand of work or tasks that need to be done. Teresa Inkster then raised the issue that there were secret meetings occurring and that potentially this wasn't appropriate, at which point I was clear, anybody can come along to the meeting if they like, there is nothing to hide, we are talking about operational matters, trying to get a resolution to the ongoing water safety issues.

Q Now, I think Dr Inkster would say that she didn't accuse you of having secret meetings. What she did express concern about was that she and Annette Rankin had not been included in meetings. Is that not correct?

A That's not how it felt, no. However, these were Operational Estates meetings. These were meetings for the Estates team to come together, to come together to talk about technical solutions, to talk about future potential solutions, to try to gather information on what had happened and where the potential sources of contamination were coming from. They weren't closed meetings but initially they were only the Estates team. They were not intended to be a wider technical group, but that's what it turned into.

Q That's why I was going to ask you, the initial bringing Estates together to make sure the right hand knows what the left hand is doing. You say in your witness statement at 469 that it turned into the Water Technical Group with a whole lot of other participants. Is that right?

A Mm-hmm. That's correct.

Q Can we look at 472? Now, I think you're asked a very specific question at the top that page, "Did you have any concerns about Stenotrophomonas and patient safety?" but your answer is you were concerned about the whole range of organisms and possible links to patient

safety. Is that right?

A That's correct. I was concerned that we had, by that stage, identified that there was Cupriavidus and now Stenotrophomonas and as we were testing we started to identify other organisms. I was concerned about what potentially the contamination of the water system was, and how we might address with that, with there being a number of organisms identified.

Q Yes, and you're trying to explain, I think, in that paragraph why this was all quite stressful.

A Yes. Yes, it was stressful. It was stressful for everybody involved. The Estates team had no experience of these organisms. There was no reference point for us to get advice on these organisms or standards, even in regard to testing levels, if you were to test the water, what the upper and lower levels were. So it was extremely stressful in that context.

Q Now, I just want to touch, hopefully fairly briefly, with you on a not unconnected topic which relates to water safety, which is Horne taps, a couple of words you've probably seen before in the materials. Now, we know from other material that there was a meeting in 2014 when, after various discussions with various parties, a decision was made to continue to use or to continue to install Horne taps. Were you involved in these discussions in 2014?

A No.

Q And on page 472, you say that you were trying to find out what was the correct story between two different versions. Is that right?

A Yes. That's correct.

Q And what was the key difference in the versions?

A The key difference in the versions were that I had Mr McLaughlan telling me that the Health Board had been instructed or told not to use the Horne taps and had chosen to go against that advice which immediately caused me concern, and I had Mr Powrie saying there were a number meetings and it was agreed that we would continue with these taps. It was recognised that the taps were not conforming with current guidance and it was acknowledged that they'd been implicated in the Belfast Pseudomonas outbreak, and that the reason that they had met was this implication, that they'd been connected to the Belfast Pseudomonas outbreak where neonatal babies subsequently died, and that the purpose of the meeting

was the taps had already been selected and, in fact, installed in most of the hospital when this was coming to light, and that there had been meetings with HPS, HFS and the Health Board.

There had been a couple of meetings, two or three meetings, and then an SBAR had eventually been produced which agreed that the taps could stay in situ. Now, that was two opposing views. Mr McLaughlan's view was the Board was advised to remove them and had chosen not to go down that route and, therefore, knew that there was a huge risk associated there and Mr Powrie's view that, whilst there was a risk associated with them, the install and keeping of the taps at the QE had, in fact, been agreed.

Q You mentioned the Belfast outbreak. Were you aware of the follow-up to the Belfast outbreak and, in particular, the chief executive's letter that had come from that?

A No, I was aware of the Belfast-- Well, maybe I was. The Belfast outbreak I was aware of, because of the neonatal deaths and there had been discussion with Tom Walsh and-- who was the head of infection-- he's the infection control manager, and Pamela Joannidis about

the need for us to take action in NHS Glasgow for what is now called "augmented care areas," or the areas where we have high risk patients including neonates, but wider than neonates, and that there would need to be an education piece completed and we would need to consider flushing of taps.

There then was developed a programme which was delivered to every one of those wards by Alan Gallacher and Pamela Joannidis, where they went through the implications with nursing staff and signed off that all staff had received that training and reported back to the Water Safety Group. So I was aware of it from the Water Safety Group. The DL content today, I don't know what it says. I would have been aware of it at the time, but I don't remember what it says today.

Q Am I right in thinking that the HFS advice continued to be not to deploy taps with flow straighteners in them, following that?

A Yes. Yes.

Q You say that the decision that was made, you weren't involved in the project team's decision as to whether to keep the taps, chuck them out, replace them with something else, that wasn't your decision. But were

you not aware that the decision to retain them was, in a sense, conditional on appropriate maintenance being put in place?

A I didn't know about the issue until 2018. I didn't know about the issue until Mr McLaughlan raised it with me. There was no discussion in the Water Technical Group up until that point about the Horne taps not being compliant or being a potential issue.

Q We heard from, I think, Mr Powrie that although a decision had been taken after some investigation as to what kind of thermal disinfection would work, and plans had been put in place for the creation of a location where this could be done; by the time of the water incident, that had never actually been implemented. Do you know anything about that?

A Not specifically about the implementation of the tap cleaning, but what I was aware of was that the QE had opened with no Estates workshops created for them to do any tasks and that it took some time to create those workshops, and contained within those workshops were things like ultrasonic baths and areas for pieces of equipment to be cleaned down. So I can't honestly say that I was aware that specifically

missing was around about this issue, but I was aware that there was a requirement for the creation of workshops throughout the hospital to allow the staff to be able to undertake the full range of duties.

Q The question I have to put to you, given the roles that you held from 2014 onwards, is this: here, we have a type of tap which has been implicated in a very serious incident – a particular feature of the tap, to be precise, the flow straightener. A decision has been taken on the one hand to keep it in place, on the other hand, in order to avoid, presumably, the risk that you've mentioned. An appropriate maintenance system has to be put in place because otherwise the risk remains. Should you not have known about that, given the hats that you were wearing at the time, the need for that risk to be eliminated?

A Yes, I should have.

THE CHAIR: I mean, if a particular maintenance schedule or maintenance programme was necessary to retain – I think I've understood there's something of the order of 1,800 taps – that's the sort of information that would come to you. I mean, I appreciate that every detail of what's being done wouldn't necessarily come to you as interim director, but

would I be right in thinking that if a particular-- 1,800 taps, let's say I'm right about that figure, required a particular cleaning regime as a condition of their continued use, that's the sort the level of information that an interim director should be aware of if that is happening?

A Yes.

THE CHAIR: Thank you.

MR CONNAL: Just a point of detail, you probably know that there's a debate about, should the Water Technical Group have been reporting to the IMT that was in place at the time or not? Are you now saying that, on reflection, you should have arranged for some kind of communication between the Water Technical Group and the IMT?

A I'm saying, in hindsight, that that should have happened and we should have reported in that way. The Water Technical Group was not established as a subgroup of the IMT. It was established, initially, as an operational group, and then others were added to it and it became what was then referred to as the Water Technical Group. So it was never formally put in place as a subgroup of the IMT and, with hindsight and on reflection, it should have been and it should've reported on a routine basis and the minutes should have been shared, but at the time that's not what happened.

Q We've heard from other witnesses about the Water Technical Group. One of the questions you were asked, and I'll show you the page in a second, is basically how did people get on at these meetings, obviously in a difficult situation, and you I think described them as "quite difficult." Is that right?

A Yes.

Q I think that's on page 480. You say:

"The atmosphere was extremely difficult at times due to the pressure of the work, the scale of the problem being encountered and the lack of clarity on where potential sources of contamination were coming from in order to identify a solution."

Then you mention the novelty of the issues and the fact that the press were interested, there's other factors. Is that right?

A Yes.

Q Did the Water Technical Group conclude that the water was contaminated, the hospital water?

A Yes.

Q Did the group reach a conclusion as to what the source of that contamination was?

A Not while I was chairing it.

Q Did the group have a view on what the impact of that contamination was or might be on the patient population?

A The contamination was considered to be a-- to be the source of where the patient bacteremias were coming from.

Q Thank you. Bear with me a moment, Ms Kane.

THE CHAIR: Maybe I can ask a question. When you use the word "contamination," what do you mean?

A That there was microbiological contamination of the system. In other words, that there was organisms, alert organisms and organisms in the water. That's the contamination, but there were also things like debris the Water Technical Group discovered within the water system, and when we looked at the tanks, we discovered a sponge in one of the tanks. So there were other sources of contamination. We found valves that were rusty. Rust can be a contaminant of your water system and encourage growth, microbiological growth. So there were a number of reasons to say that the system was contaminated. It was both contaminated with debris particles and the sponge, and it was also contaminated with microbiology alert organisms.

THE CHAIR: You mentioned "alert organisms." These are the organisms that are specifically mentioned in the National Infection Control Manual. Am I right?

A Yes, that's correct.

THE CHAIR: But, if I noted you correct, in explaining what you meant by contamination, you meant the presence of alert organisms and other organisms. Did I note that correctly?

A That's what I said, sir.

THE CHAIR: Yes, and what did you understand these-- either what these organisms were or what was their significance?

A So, the-- So, at the time where organisms were being identified, linked to patient bacteremia, the reason we looked was because there was patient bactererimas from potentially sources that could be linked to the built environment. So those are the alert organisms. However, when we looked further, we found that there were other organisms where there were no patient bacterermias identified. So there were other organisms in the water, although that had not manifested as a bacteremia in a patient, and those are the organisms

I'm talking about, but most of those organisms were alert. I'm sorry that that's the way that I've put that-- I've put it over wrongly.

THE CHAIR: No, not necessarily. I take it you are discussing specifically the situation in early 2018?

A Yes.

THE CHAIR: Yes, right. If anyone was to suggest to you that there was no contamination of the water system in 2018, what would your response be?

A There had to be some form of contamination in some way because there were organisms contained within the water system that subsequently caused patient bacteremia.

THE CHAIR: Do you recollect anyone suggesting in 2018, either in the context of the meetings of the Water Technical Group or any other meeting that you had with colleagues, that there was no contamination of the water system?

A I don't remember that at all.

THE CHAIR: Right, thank you.

MR CONNAL: Can I move you to a topic other than water for the moment, if I may, ventilation? In terms of hospital ventilation requirements

and so on and so forth, you don't claim to be an expert in that either. Is that right?

A That's correct.

Q Although in a number of your answers, you clearly understand phrases like commissioning and validation and verification. Is that correct?

A That's correct.

Q Now, if we go to 486 of your witness statement, thank you, we find there a section starting on commissioning and validation of ventilation, and you're first asked about an email that Mr Walsh had asked for about confirmation of commissioning and validation and he'd got a reply from someone called Frances Wrath. Do you remember that happening?

A Yes.

Q And then you were asked, "Well, wearing your hat, were you aware of any concerns"-- Now, this is fairly early on in the opening of the building to patients, "…any concerns about ventilation and commissioning?" You say on page 487:

"I was aware of concerns around the isolation rooms and ward 4B. The isolation room locations, ACH's and pressure regimes were unclear and

there was a number of clinical teams including ICT trying to understand what facilities were in the hospital to address patient isolation requirements. [Then you say] The easiest way to do this is to ask for the commissioning, validation and specifications of the rooms."

A Mm-hmm.

Q Now, do you know if that information was readily available, commissioning, validation and specifications of the rooms that people were interested in?

A Well, I know now that it wasn't readily available but, at that time, I assumed it was readily available.

Q So you assumed it was readily available, but you didn't have that information directly yourself because you thought that would be dealt with by the project team. Is that right?

A No, I didn't. That's correct. I didn't have that information myself.

Q Now, one of the topics that I mentioned to you a minute or two ago was a validation as opposed to commissioning. Do you know what validation is, just in general terms, of a ventilation system?

A Yes. Validation's when-- So, the system's been commissioned, each individual part of the system has been commissioned as per the-- and checked as per the design. Validation looks at the whole system as a whole and ensures that all of the components of that system are delivering the final output that you expect from the design. That's a very simplistic way of putting it.

Q Now, you're asked on page 490 whether, within the remit that you had, you should have sought reassurance that validation had been carried out, and you say there, "Well, I should have done, but I relied on verbal updates from Mr Powrie, who I think may have got it from Mr Loudon." Is that right?

A Yeah.

Q Because you say there were possible risk if it's not been done.

A Mm-hmm.

Q And you touch on permeability tests which hadn't been done. We've already touched on HEPA filters earlier. So, if we go to 492 to see your view on this, at the foot of the page, the question:

"If validation was not in place at handover, how did the hospital open? Who would have had the authority to allow the hospital to open without validation in place?"

And you say:

"I don't know. The hospital should not have been opened to patients without validation. Only the CEO would have had the authority to make that decision but I doubt any CEO would make that decision if they were aware that a critical system validation had not been completed."

So do you know why the hospital was open without validation having been done?

A Absolutely not. I don't know why the hospital was open with validation not done. No, I don't.

Q Can I ask you to look at bundle 12, page 263, please?

THE CHAIR: Just a matter of detail, Ms Kane. In that last question and answer when you were talking about validation, I understood from your answer that you had in mind all systems in the hospital as opposed to any specific system. Am I right?

A No, no, critical systems. The ventilation for the hospital should have been as national standards.

THE CHAIR: Yes.

A But, in particular, you validate what's classed as critical ventilation systems, those that have the biggest impact on the highest risk patients is what you validate. They tend to be areas like theatres. So it's not just isolation rooms, there's areas like theatres, there may be some ITUs, neonatal units. There's various areas in a hospital which have an increased level of ventilation and are classed as critical systems. Those are normally validated and then verified on an annual basis but, at some point, all of the systems should have been looked at in their totality and checked.

THE CHAIR: Right, so that's very helpful. So, you're aware when we're talking about validation that, as far as ventilation systems are concerned, SHTM 03-01 requires validation----

A Yes.

THE CHAIR: -- in contrast perhaps to 04-01, which does not have a specific requirement for validation. So when Mr Connal uses the word "validation," you are understanding it to be used in a specific sense in relation to ventilation----

A Yes.

THE CHAIR: -- but you added that you would expect all systems also to have been validated, or have I got that wrong?

A No, what I'm saying is all-- Yes, well, any air handling unit that's fitted in any part of the hospital should have been commissioned and validated at the point that it was

connected. It would not necessarily be the case that on an annual basis you would go back in and verify those systems. You would only go back in and verify the systems which were classed as critical systems.

THE CHAIR: Right.

A So every air handling unit should have been commissioned and validated, i.e. checked that it was working and checked that it was working up to the standard it was meant to.

THE CHAIR: Right, thank you.

MR CONNAL: I'm just looking at what you say in this email chain that's in front of us now on the document we have on screen, where you say:

"It is imperative that we get the validation data now for all HEPA filtered areas of the hospital. We are at risk of losing all of the areas from use unless we provide this data which will be a PR nightmare for the Board."

Why was it going to be a PR nightmare?

A Because we had already populated the hospital with patients. This was a significant patient safety issue, it needed to be addressed quickly. It would have meant that we would needed to have escalated to the Scottish government, the Health Board and various other parties and that there would be a high degree of media scrutiny but, for me, the biggest issue was there would have been a complete loss of confidence in the general public and the hospital and the safety concerned with the hospital. I also didn't see-- I couldn't understand why the information wouldn't be available just to hand over in any case.

Q Yes, because at that point, you were assuming it was just sitting metaphorically on somebody's desk somewhere and somebody just had to say----

A Correct.

Q -- "Oops, here it is. Have a look."

A Yes.

Q Yes. I think you told us earlier, and I'll identify this now in your witness statement, if we go to 494, please, I think you said that, "This was the one thing that jumped out at me that you wanted to mention"-- out at you that you wanted to mention to the CEO when you became interim director, what your biggest concern was, why information hadn't been provided. Is that right?

A Yes.

Q You say in the paragraph on page 494:

"When I returned from sick leave in August 2017 and saw at that stage

the request for information from the whistle-blowers, I could not understand why clear answers were not being provided on the commissioning and validation data to inform clinical decision making. When the CEO asked me during a 1-1 meeting around March 2018 when I became the Interim Director in 2018 what my biggest concern was, my response was the QEUH/RHC Ventilation as I did not feel that we had responded fully."

Did you understand why the information hadn't been provided?

A No. At that stage, no.

Q Thank you. I don't think you were much involved in the works on Ward 4B from what you say in your statement. Can I just take you to one of the issues that arose in relation to 2A and 2B, which was the decant into 6A and 4B, to be precise, which you deal with on page 500. You explain what was going on, and you say, near the foot of page 500, that you raised concerns, largely amounting, I think, to saying, "Well, if there's a problem with the water, it's the same water in 6A, and if there's a problem with the ventilation, it's no better in 6A," or words to that effect. Is that right?

A Yes, I was concerned that we were moving patients from one

level of risk to an equivalent, or potentially to a higher risk.

Q Who did you raise these concerns with?

A I spoke about it at the executive Water Oversight Group. I think I mentioned it to the CEO, and I also raised it in the IMT.

Q Because what you record at page 501 of your witness statement is that then you stop being invited basically to IMTs.

A That's what it felt like, yes.

Q Did you follow that up?

A No.

Q Because you've raised concerns to various people, and the next thing you find is you're not going to the IMTs anymore. I mean, what response did you get to the people that you raised the concerns with?

A They took the-- They took it on board and prepared clinical risk assessments, and the decision was made that that's where the patients were being moved to.

Q Okay. We're almost heading towards the conclusion of your evidence, you'll be pleased to know. I just have a couple more things to ask you about, hopefully fairly briefly.

THE CHAIR: Perhaps, can I just

check up on a date? You were asked about the proposal to decant patients from 2A and 2B to, as I understand it, Ward 6A and you explained to Mr Connal your concerns about that, and you articulated these concerns to the CEO, also at an IMT and what was the other group?

A The Water Oversight Board.

THE CHAIR: Right, the Water Oversight Board.

A Yeah, which was the chief operating officer. The external ventilation expert had began to get involved in water safety at that point as well. We met regularly so that it was-- so that there was a route for me to escalate any concerns and discuss any concerns when the chief executive wasn't available.

THE CHAIR: Right, so this is after September 2018. Now, you went on to explain that you stopped attending the IMTs because you were not invited. When did that happen?

A I felt it happened-- I can't tell you the date that that happened. I did attend two in October. I don't remember why I attended them, but I felt as if I was dismissed for raising concern.

THE CHAIR: So whenever it was you stopped attending, sometime towards the end of 2018?

A Yeah.

THE CHAIR: Right, thank you.

MR CONNAL: Now, I'm going to take some of the other items reasonably short from you, and then we'll probably have a short break. On page 502, you're asked about reports prepared into Wards 2A and 2B by a company called Innovated Design Solutions, and you say that you think you had instructed these reports. Is that right?

A Yes.

Q Your reasoning for doing so I think appears at the top of 503, where you say, despite the passage of time, there are still concerns about whether the ventilation was up to scratch.

A Yes.

Q Interesting point you then make:

"By this stage I had little confidence in the information I had seen in correspondence from the technical advisors, Multiplex and the Project Team and Director which was always defensive and contradicted anyone else's viewpoint…"

Now, no doubt different people can have different views on the matter, but the project team and director were all GGC people, were they not?

A Yeah.

Q But by that time you weren't confident in what you were getting.

A No, I wasn't confident in what I was getting, particularly around ventilation. When I considered what had happened with the PPVL rooms and the time it had taken us to get the isolation rooms sorted out, even basic information, like even knowing where they were and what the parameters in which they operated on, I felt-- no, I just had lost confidence.

THE CHAIR: Now by that time of course, the project team had dissolved, but is that a reference-- when you refer to the director at the top of page 503, is that a reference Mr Loudon?

A Yes.

THE CHAIR: Right, thank you.

MR CONNAL: Now, I'm just going to ask you really one question. You were asked in your witness statement about Cryptococcus, which led to its own series of meetings and so on and so forth. Now, you say you weren't really involved in that. Is that right?

A That's correct.

Q Did you not attend various meetings about it?

A I think I attended one meeting.

Q Were you involved in the action plan coming from the Cryptococcus meetings?

A Not that I recall at all, no.

Q Now, you were asked general questions thereafter, at 506, about staffing levels, and we've heard a lot about that already and I don't want to go back over all of it. You were asked about training on 507. I mean, I suppose a simple question is, were you aware what the state of training in technical subjects was for the people under your control when you took on the interim director role?

A No.

Q But you----

A Not in Estates.

Q You later discovered that training wasn't what you would have liked to see. Is that right?

A Yes, that's correct.

Q There were various reasons for that. Then, in page 510/511, you're talking about some of the working hours that were experienced by the team that was working under your control six or seven days a week, often 14/16-hour days. Is that right?

A Yeah.

Q Now, when you narrate that material, is that material you've

gained directly from speaking to the people involved?

A That-- What I've written is my experience and what I observed.

Q Thank you. Now, you're asked, as a lot of witnesses are when you get to the end of the statement, "Well, thanks very much for all these answers. Is there anything you want to add that you might think would be helpful to the Inquiry?" You deal with that on page 513, and you say there, "The Estates team in particular worked as hard as they could," and then you say a couple of lines further on, "The situation they were faced with was untenable." Is that an exaggeration, or is that what you feel?

A It's what I feel. I feel that-- Sorry.

Q No, no, take your time. Would you like to take a break just now?

A Yeah, please.

Q I wonder if that might be in order, my Lord. We might take a short break just now. Anyway, I'm close to the end of matters I'd like to put to this witness.

THE CHAIR: Do you want to take this opportunity to check if there's any more questions?

MR CONNAL: I'll do that while we're offline.

THE CHAIR: Right, well, I mean, to give Ms Kane an indication, shall we decide that we will sit again at, what, maybe ten to four? Right, well, on the basis that I have been able to give an indication to Ms Kane, which I may not have, we will sit again at ten to four. Unless, Mr Connal, you feel that we have more to do than that timing would allow.

MR CONNAL: Yes, no, we'll work on that basis now.

THE CHAIR: All right.

(Short break)

THE CHAIR: Mr Connal.

MR CONNAL: Thank you, my Lord. Thank you for coming back, Ms Kane. I have a small number of hopefully short-ish questions for you. They're in a little bit of a random order, so please just forgive me for that.

Can I just ask one general question, first of all, then? You've described the issues that you had with challenges over any proper planned preventative maintenance in the building, for the reasons you've explained to us very fully. Now, that must have given you concern that not doing things in that way was possibly putting patients at risk. What kind of things did you do to try to mitigate that

risk, if any?

A I repeatedly asked Alan Gallacher and Ian Powrie, and Andy Wilson when he was in post as well, and Billy Hunter if we were doing enough to keep the patients safe. I was extremely worried-- I was extremely worried about this in particular. I authorised payments, which there really was no budget to authorise, so that things would be done, and I worried a huge amount.

Q Okay. Can I ask you a very specific question, if I can? Remember we were talking about Horne taps and the issues about thermal maintenance and so on, because they----

A Yeah.

Q -- had these flow straighteners in that had been implicated in the Northern Ireland outbreak? I'm told there was a Standard Operating Procedure, an SOP, prepared which required six-month sampling of any area where taps with flow straighteners were operating. First of all, were you aware there was an SOP to that effect?

A No, I wasn't aware there was an SOP to that effect.

Q Yes. So, you wouldn't be----

A Was this-- was this SOP created after the SBAR was created?

Q It would be in April '15 I'm told.

A So, after the decision was made to keep them. No, I didn't know about that.

Q Right. In the course of being asked about contamination of the water system----

THE CHAIR: Sorry, Mr Connal. It's the question rather than the answer. So what you were putting to Ms Kane was there was an SOP, a Standard Operating----

MR CONNAL: Yes.

THE CHAIR: -- Procedure, which required what?

MR CONNAL: Sampling every six months of areas where taps with flow straighteners were in use.

THE CHAIR: Right, of areas where----

MR CONNAL: Well----

THE CHAIR: -- taps with flow straighteners had----

MR CONNAL: Had been installed and were operational, if I can put it that way.

THE CHAIR: I take it that that's pretty well all over the hospital?

MR CONNAL: Well, it will have been. But I think the idea was that there should be samples taken if these taps were in use, given the issues that

have been identified with them.

THE CHAIR: Thank you.

MR CONNAL: Now, in the course of giving us a description about the Water Technical Group and what was found and contamination and so on, I think you may have said something about contamination and the link to bacteremia. The question of whether the contamination did or did not cause particular infections, is that something within your expertise?

A No, not at all.

Q Thank you. Now, I tried to ask you a question earlier about a document and, it's entirely my fault, I got the wrong document because I had the wrong document number. I think I might now have the right one, which is bundle 14, volume 1, page 214. Now, you remember I was asking you about this question of giving water testing results to people?

A Yes.

Q This appears to be an email from you to Christine Peters, copied to various other people, saying:

"Why are you writing to Heather and myself about this? Ian Powrie is the Sector Estates Manager with responsibility. We've shared this data via sector water groups involved, with other people [and so on]. It's a water policy which describes the governance and arrangements. Somebody can take you through these arrangements."

Now, depending on your perspective, could that be viewed as you basically expressing the suggestion that they should go away with their water testing requests because there are routes for getting these which are not coming to you and asking for them?

A Yes, I'm sorry. It's a really cheeky email, and I shouldn't have written it like that. However, that was after being instructed to respond in that way and refer her back to Craig Williams in particular. But on reading that, that's-- I'm sorry about that. That's a very cheeky email.

THE CHAIR: Now, that's an email dated on 1 July 2015.

MR CONNAL: Yes. I don't think at that time you'd been told, had you?

A No, I hadn't been. No.

Q That's much earlier than being told there's a whistle blowing thing going and----

A Yes, it is.

Q -- passing information.

A It is.

Q But in any event, do you accept that it's perhaps an unhelpful response, if I can put it that way?

A I do. I do.

Q Can I just ask you,

almost finally with my questions, this business of being told to refer matters somewhere else because of the whistleblowing, can we just get up 459 of your witness statement, please? Thank you. Now, you see the answer near the top:

"Mr Loudon advised me if I was contacted... I was not to provide this but I referred them to Craig Williams..."

Now, this was said to be in August 2017. So, this is when you come back, having been off.

A Yeah.

Q But was Craig Williams not long gone by then from the hospital? Did he not----

A No. No, Craig Williams left around about that time.

Q Did he not leave say in 2016? Just I'm being asked to check if that's what you were actually told.

A That is absolutely what I was told.

Q So, whatever the date of Professor Williams' departure, that's what you recollect being told?

A Yes.

Q Well, if I can just come back then to the question I was asking you before the short break, and this is the last point I just want to give you the opportunity of dealing with. You were explaining to me that the position the Estates people had found was untenable. Then I was going to say, on page 513, you said that, "They were made to feel that their opinions were worthless." Is that what you feel?

A On many occasions that's how I feel, yes. I feel that the way we were working, the pace we were working at, the uncertainty of what each day would bring in terms of, you know, something not working that we didn't about the day before, and the number of issues was going to inevitably lead to making either flawed decisions or making mistakes that would result in adverse consequences.

I feel that we were stretched. I've never been in a team that's been so stretched and under such a great deal of pressure as that team was at that time, and that was everybody working in that hospital in Estates and Facilities. It was very, very, very demanding.

Q Thank you very much. I have no further questions for you.

THE CHAIR: Ms Kane, that is now the end of your questioning and therefore you are free, in a moment, to turn off your computer if that's what you want to do. But before you do that, can I thank you for the work you've put in in providing answers to the questionnaire, which allows us to

provide a witness statement, which is an important part of your evidence, and thank you for giving evidence today. I'm very grateful for that. It will be helpful to the work of the Inquiry. So thank you, but you're now free to log off. Thank you.

THE WITNESS: Thank you.

MR CONNAL: Thank you.

(The witness withdrew)

THE CHAIR: So, next week?

MR CONNAL: Yes, my Lord. Things have been going on while I've been in this chair, and I regret to report that the previous arrangements for Monday to be occupied with the evidence of Mr Fernie have not materialised because, without going into details, Mr Fernie cannot readily make himself available on Monday, and we have not been able to make arrangements for an alternative witness. So although I much regret the situation, I'm afraid I'm not in a position to present any evidence on Monday.

The current proposal is that Mr Fernie will now give evidence on Wednesday afternoon of next week instead of Monday, and Mr Redmond, who was scheduled to give evidence on that date, has been asked if he can move to the Wednesday, the 28th, in other words, the week after in the afternoon. That slot was normally occupied by Mr O'Donovan of Mercury. That is still an open issue as to Mr O'Donovan's availability at all, and further information will be issued as soon as we have it.

THE CHAIR: Right. Well, if we have no witness for Monday, we will not sit on Monday. I regret that situation, but you've heard what Mr Connal has to say. We will, in that case, sit again on Tuesday of next week at ten o'clock. So if I can wish everyone a good weekend, and I look forward to see you next week.

(Session ends)

16:25