Scottish Hospitals Inquiry

Witness Statement of

Fiona McQueen

Introduction

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

2. This statement addresses:

2.1 My professional qualifications and background;

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

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

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

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

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

2.7 Commonly Recognised Information Pictures;

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

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

2.10 The Independent Case Note Review; and

2.11 My engagement with Drs Inkster, Peters and Redding.

Professional Qualifications and Background

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

incidents and when Scottish Government should be informed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Procurement model

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

Interactions with QEUH IPC Team in 2015

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Commonly Recognised Information Picture ("CRIP")

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Oversight Board

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

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

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

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

Board.

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

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

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

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

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

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

infection prevention, management and control;

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

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

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

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

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

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

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

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

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

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

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

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

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

this statement).

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

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

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

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

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

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

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

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

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

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

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

The Independent Case Note Review

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

My Engagement with Drs Inkster, Peters and Redding

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

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

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

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

which health boards must either meet or exceed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Declaration

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

Name: Professor Fiona McQueen

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

Appendix A

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

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

Appendix B

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

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

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

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

Appendix C

Fiona C McQueen CBE BA DMS MBA RGN

Career History

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

Chair Ayrshire College Board April 2022 –30 June 2025

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

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

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

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

Scottish Police Authority Member April 2021- 31 January 2025

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

Chair from 7 April 2025 - Present

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

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

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

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

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

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

Previous Positions

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

Education

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