Scottish Hospitals Inquiry
Witness Statement of
Gary Jenkins

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

Personal Details and Professional Background

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

A. My name is Gary Jenkins. I am currently the Chief Executive Officer for The State Hospital Board for Scotland, at Carstairs. I have held this position since April 2019. In 2022/23 I completed a one-year programme with the School of Forensic Mental Health 'New to Forensic Mental Health'.

Prior to this appointment, I was the Director of Regional Services at Greater Glasgow and Clyde within the Acute Services Division. I held that position from 2015 to 2019. Prior to that, I was the General Manager for Specialist Oncology Services, based at the Beatson West of Scotland Cancer Centre in Glasgow. I held that role from 2009 to 2015. Before taking up that position, I was the Associate General Manager for Diagnostic Imaging and Clinical Physics, based at Glasgow Royal Infirmary. I held that role from 2006- 2009. Prior to this, I was a Clinical Service Manager within the Medical Directorate of the former South Glasgow University Hospitals NHS Trust. I joined the trust around 2001 and worked as the Clinical Service Manager for the Diagnostics Directorate.

Pre 2000, I held various roles in North Glasgow University Hospitals Trust. I hold an HNC in General Management Science, from the Glasgow College of Commerce.

Governance Reporting Structures within NHS GGC

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

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

A. I worked within the Acute Division of NHS Greater Glasgow and Clyde (NHS GGC) I attended the Strategic Management Team (SMT) and Operational Management Team (OMT) which dealt with issues arising from the Acute Division.

I had a Regional Services Directorate Management Group and a Directorate Clinical Governance Group. The Directorate Management Group would report and escalate issues to either the SMT or OMT. The Regional Directorate Clinical Governance Group would escalate issues to the Acute Division Clinical Governance Group.

Matters arising from these groups that required further escalation would be agreed by the Chief Operating Officer for the Acute Division, who in turn would escalate to the Corporate Management Team, Acute Service Committee or relevant Corporate Director.

I am unaware of the process, from that time, in terms of reporting to the Board or the associated sub committees on the new procurement of the new Hospital. I was an Acute Director, not a Corporate Director or member of the Board or any of the Board Standing Committee Structures during my time at NHS GGC. If I had any issues that required escalation, I would discuss these

in person with my Director (at the time) and latterly, when I was an Acute Director, with the Chief Operating Officer for the Acute Division.

At the time of the construction of the new hospital, and prior to 2015, I would have been a General Manager, and not a Director. Therefore, I was not involved in the structures of the Board or the sub committees.

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

A. **I** am aware from memory (and my reading through the bundles provided) that there was a Board Water Safety Group. From the Acute Division perspective I believe that John Stuart (Head of Nursing, North Sector) attended this on behalf of Acute Directors.

I was not involved directly with any groups or committees that had oversight, responsibility or monitoring of either the water or ventilation system for the new Queen Elizabeth University Hospital, or the Royal Hospital for Children.

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

A. The group I recall, from memory, where this responsibility might rest, is the Acute Infection Control Group, and the Board Infection Control Committee. The Acute Infection Control Committee would receive reports from the local clinical governance structures in place across the Acute Directorates.

I believe that escalation to the Board Infection Control Committee would be from the Acute Infection Control Group, and Acute Clinical Governance Group, depending on the Chairs advice.

(d) The need for and authorisation of works to improve or remedy deficiencies in the water and ventilation systems of the QEUH/RHC
and (e) the processes put in place to ensure that disclosure by staff of evidence of wrongdoing, failures in performance or inadequacies of systems

was encouraged and reacted to by the Board to ensure that the safety of patients and the best value use of public funds were protected.

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

A. I suspect that the correct mechanism was through the Directorate reporting structures as described in my response at question 2, in the first instance.

I was not aware of any deficiencies or remedy required in the areas of water or ventilation until after the opening of the new hospital facility.
In relation to evidence or wrongdoing or failures, staff were able to raise concerns with their line manager, or a more senior manager if they flet the need to do so. I believe at that time, if a member of staff felt this was insufficient, they were entitled to use the whistleblowing mechanisms available to all staff within the organisation. I cannot recall though from memory when the whistleblowing process and roles were introduced to NHS GGC.

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

A. I do not think to my knowledge that there were any other groups that met to discuss the issues cited at question 2, over and above local Directorate reporting structures. There was a project team in place who were dedicated to the new hospital build who had central oversight of the build and project. This was a central process for all issues associated with the new build. There may have been a group titled ‘on the move’ which I think may have dealt with the overall move to the new hospital build.

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

A. As I have stated, I was not a member of the Board or any of the sub committees of the Board.

As with my response to question 2, ordinarily for Acute Directors, you could speak to the Chief Operating Office for advice and support if you felt there was an issue that required escalation to one of the more senior decision-making groups such as the Acute Service Committee, or for discussion and advice from the Corporate Management Team.
The Chief Operating Officer was a member of the Corporate Management Team, chaired by the Chief Executive. I believe that issues discussed at this meeting could be suggested for inclusion at the Board and its Sub Committees depending on the subject and its relevance for escalation.

For major decisions, such as service change, you may be invited to update either the Board or the Acute Service Committee. Invitations such as this would come through the Chief Operating Officer. An example of being invited to the Board was when I put a proposal forward to close the inpatient beds at the Centre for Integrative Care (formerly know as the Homeopathic Hospital) and move to a day treatment model with no overnight provision. This required Board approval and scrutiny prior to agreement and the then subsequent removal of the inpatient beds. Similarly, I recall being invited to the Acute Service Committee to present on an improvement plan I was working on that required investment to drive down the waits for Urological cancer treatment.

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

A. I cannot comment any further than the response provided at question 2, other than to say that any issues I had that may require escalation would be put to the Chief Operating Officer, Acute Medical Director or Director of Estates and Facilities. All of whom were members or in attendance at the Board I believe from memory.

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

A. I refer to my answer at point 5.

7. Please refer to Dr Redding's witness statement at paragraph 186 **(Witness Bundle - Week commencing 2 September 2024 - Volume 3, Document 2, Page 63).** Dr Redding says that "The SMT and Clinical Governance Committees take decisions on what information is discussed at meeting of the full board." Is this statement correct? What is your understanding of how this process works?

A. I have previously commented on this. However, I feel that the SMT that Dr Redding refers to is different form the SMT (Strategic Management Team) meeting that I would have attended as an Acute Director. Dr Redding would have reported through the Diagnostics Directorate structure and has her own Director and Chief of Medicine. This structure may have differed slightly from the Regional Services Directorate.

I believe that the Board Clinical Governance Committee, or the Board Infection Committee, would have been able to escalate matters on to the GGC Board itself.

a) Explain the oversight the Board had over issues escalated from the standing committees until they were resolved.

A. I cannot comment on that as I was not a Board member or member of any of the sub committees within NHS GGC. I was an Acute Director and reported to the Chief Operating Officer for the Acute Division.

b) Explain the types of decisions that were made at standing committee level and what decisions were made by the Board. What were the delegations to the Standing Committees?

A. I cannot comment on that as I was not a Board member or member of any of the sub committees within NHS GGC. I was an Acute Director and reported to the Chief Operating Officer for the Acute Division.

8. Please refer to **Bundle 29, Document 13, Page 485 and Bundle 29, Document 14, 523).** What led to the changes in the Board's governance structure in 2016/17, specifically the establishment of new committees and the subsequent requirement for the Chairs of the standing committees to update on discussions and decisions made at their respective committees (see

Bundle 29, Document 14, Page 523)? Was the Board satisfied that the implementation of these changes enhanced and strengthened governance at GGC?

A. This is not something that I can accurately comment on as I was not involved or aware of any of the points referenced at question 8. I would guess that the Audit Committee would have taken an action to discuss the recommendations from Audit Scotland and put in place a series of actions to address the points you cite.

Director of Regional Services

9. The Inquiry understands you were Director of Regional Services within NHS GGC between 2014 and 2019.

(a) What were the circumstances of your appointment to this role?

A. I was the General Manager for Specialist Oncology Services and Clinical Haematology between 2009 and 2015. I was part of the Regional Services Directorate along with two other General Managers.

I was acting Director from 2014. I applied for the actual Director role in 2015 (I believe) and was appointed following an open recruitment process.

(b) What did this role involve?

A. The role was that of an Acute Director working alongside five other operational Directors covering the Acute Division. The Regional Services Director role involved the operational oversight and direction of five Clinical Specialties (this was initially three) that were provided from within the Acute Division of NHS GGC, to the West of Scotland or all of Scotland. Those services were:

- Specialist Oncology & Clinical Haematology
- The Institute of Neurosciences
- Renal Medicine, Plastic Surgery and Burns
- Forensic Mental Health Services
- Glasgow Dental Hospital & School

The role involved coordination and direction of service delivery and performance, sometimes across multiple NHS Board areas. Development of services to meet the needs of the population served, clinical, financial and staff governance of the teams that worked within the Directorate itself. Linkage with the objective of the Acute Division and delivery of wider government performance standards for access to healthcare.

(c) Who reported to you in this role?

A. The five General Managers of the service stated at point 9b above reported to me in my role as Director. In addition, I was the direct managerial reporting line from the Chief of Medicine, the Chief Nurse, Chief AHP (Allied Health Professional), Head of Finance, Head of People and Change.

(d) Who did you report to?

A. I reported to the Chief Operating Officer for the Acute Division alongside the other Acute Directors.

The New South Glasgow University Hospital (SGUH) Project

10. Please describe your input, if any, in relation to the design and specification of the QEUH? What were the circumstances under which you became involved and at who's behest?

A. I was not involved in the design and specification of the QEUH until the addition of the Bone Marrow Transplant Unit was added in July 2013. Renal, was the only other service that was within my Directorate, however it was always planned that renal services would be located in the new build so the process for that was well established in advance of me taking up with role of Director.

11. Please describe your input, if any, in relation to the commissioning and validation of the QEUH? What were the circumstances under which you became involved and at who's behest?

A. I was not involved in the commissioning stages, other than what I have described at point 13 in this statement.

My only involvement in the issue of validation was prior to the completion of the ward we were due to occupy. This was when colleagues and I visited the ward itself. At this meeting in the actual ward, myself and the clinical team in attendance, questioned the validation process for the hospital. We were informed that all of this was being managed centrally as part of the Project Team arrangements and building handover process.

12. Please describe your input, if any, in relation to the handover of the QEUH? What were the circumstances under which you became involved and at who's behest?

A. I had no handover of the QUEH, other that that which I have described in this statement. I was not involved in any corporate handover of the building.

I recall that as Acute Directors we involved in the actual physical transfer of patient services timeline. I believe this was coordinated through Anne Harkness, who was the Director of the South, and coordinated the service moves timetable in collaboration with the Scottish Ambulance Service and patient transport services.

a) With reference to your answer to question 11 in your statement:

(i) Was there a reason that you asked about validation when you visited the hospital? Was it linked to what you observed regarding ventilation?

A. The reason I asked about validation was due to the lack of visible pressure monitors outside the patient bedrooms. In the Beatson West of Scotland Cancer Centre, each patient room has a pressure monitor on display at the entrance to the rooms.

This was the reason I asked the question. This conversation relates to the discussion about pressure monitors and their visual absence. I was informed that the process was being managed centrally and not by individual services.

(ii) Do you have an understanding of the difference between commissioning' a ventilation system and 'Validation' of a ventilation system and can you assist the Inquiry in understanding why the ventilation system of the RHC including specialist ventilation areas such as isolation rooms and haemato-oncology wards were not validated before patient occupation?

A. I have a broad understanding of the two terms; however, I do not have any specific technical expertise in this area. I would be reliant of the Estates and Facilities team manager for that type of granularity.
If I had 'interchanged' these terms in my earlier statement, that is not deliberate.

As I stated in my previous statement, I was not involved in the RHC process at all as I did not have any services transferring into RHC. That was part of the Women and Children's Directorate team.

Beatson/BMT Service

13. The Inquiry is aware the adult BMT service was to transfer from the Beatson to the QEUH as noted in the meeting minutes from the Quality and Performance Committee dated 2 July 2013 (**Please refer to Bundle 34, Document 62, Page 542**). This was confirmed in a change order request, issued by Jonathan Best in July 2013 (**Please refer to Bundle 16, Document 29, Page 1699)**. Please provide details in respect of the following:

a) What risk assessments/ HAI Scribes were carried out prior to the change order request?

A. From memory, I am unable to recall of any specific risk assessment or HAI Scribes processes that were specifically carried out at this point in the process. That is not to say they did not take place, rather I have no records to accurately cross reference.

I recall being made aware of this decision, I think through Jonathan Best (Chief Operating Officer), that there had been a discussion or meeting between the Medical Director, and I believe (from memory) with the BMT

Consultants. I recall being informed that BMT was now going to be transferred the new QEUH as it had greater clinical synergies with being collocated on an acute site, with access to ITU and HDU. I believe the BMT Consultants were supportive of this proposal and indeed had a desire to more the service as they were concerned about a lack of clinical infrastructure on the Gartnavel campus.

I am aware that there were wider concerns being raised by the Beatson Oncologists in relation to the infrastructure support that was being left behind on the Gartnavel General Hospital campus. I cannot accurately state if the BMT decision was resultant from those discussions, or if this happened prior to concerns being raised about HDU support for cancer patients being treated at the Beaston West of Scotland Cancer Centre.

However, I was informed that the service was transferring, it was not a proposal that I wrote up or developed for consideration. It stemmed from the discussion between the Medical Director and Consultants as I recall.

b) What were the technical and environmental requirements (in particular air change rates, pressure regimes and HEPA and air permeability requirements) to accommodate the BMT Unit at QEUH/RHC?

A. I do not have access to any documents from that point in time as I left NHS GGC in 2019. However, I have tried at point ‘c’ to describe what information we provided to the Project Team.

c) Your attendance and involvement in any design review meetings which were held to confirm with the user groups the requirements for the BMT Unit.

A. I recall that the Project Team, who were situated at Hillington, either contacted us, or we made contact with them in relation to the BMT specification.

I think all, or certainly the majority of meetings, took place at the Project Offices in Hillington. At these meetings, I recall that we were presented with large scale drawings of the ward layout, which was pretty much ‘fixed’ by that point in the planning process.

I recall that these meeting being attended by the whole team, i.e. the Clinical Service Manager (Myra Campbell), the Lead Consultant (Dr Anne Parker), the Lead Nurse (Laura Meehan) I also think that the Dr Grant McQuaker was present at these meeting too. From the Project Team side, I recall Heather Griffin, Mhairi (someone) and Fiona McLuskie (I think) who was the Project Infection Control Nurse Lead.

We were asked about the specific requirements of the BMT service.

I recall that we outlined that the specification of the Beatson wards (B8 and B9) were the specifications that were required for unit at QEUH. We were specific about the pentamidine room, air exchanges, positive and negative pressure monitoring and the very strict criteria required for patients undergoing this form of treatment. I recall that we discussed the specific challenges and delays that were faced when BMT service initially transferred from Glasgow Royal Infirmary to the Beatson. We explained that there had been a delay to that move at the time due to issues with the building. We highlighted that we did not believe that there was a standard building note for a BMT service, therefore it was of key importance that the information developed by the microbiologists was used as the baseline for the unit itself. We highlighted that contact should be made with Dr John Hood or Dr Brian Jones (Microbiologists at GRI) as he or they had worked on the resolution of issues with that service transfer from GRI to the Beatson. We suggested that he / they would be a good point of contact to ensure that all of the specifications for the Beatson were mirrored at the QEUH unit.

We then went on to discuss the ward layout and had to sign some drawing and mark up our comments on the specification. These drawings as I recall were held by the team at Hillington.

There was an acknowledgement about the very specific needs of BMT patients, how these differed to a haemato-oncology service, and we all had confidence that the description and overview we provided was sufficient for the project team to take forward on our behalf.

d) Discussion with Multiplex regarding the proposed change order and the impact on Air Change Rates and Pressure Differentials?

A. I do not recall any time that we, as the service team, or I as the Service Director, had any direct discussions with Multiplex regarding the BMT Unit.

The main point of contact for the team and I was through the Project Team at Hillington. I understood that the Project Team then relayed on behalf of all services, the specific needs and requirements for each clinical speciality to be considered by Multiplex and the wider project structure.

The Project Team were the key conduit for information and communication in relation to the Project as we understood it. I do not believe there was any other mechanism in place for relaying information to multiplex, certainly from a service user level.

e) Involvement with Infection Prevention and Control in respect of the proposed change order?

A. As I have mentioned at point 13c above, the infection prevention and control support was provided from the Project Team at each of the meetings. I believe we send documentation to the Project Team as I previously stated outlining the specification for the Beatson West of Scotland Cancer Centre. We would have made the Project Team aware of the air sampling and testing procedures that we had in place at the Beatson and why these measures differed from what you would expect in a general haematology and haemato-oncolgy ward environment.

f) What ceiling types were specified and approved for use in Ward 4B? Who from the GGC Project Team approved this? Describe your involvement, if any? What was the impact, if any, of the choice of ceiling tiles? What concerns, if any did you have regarding the choice of ceiling tiles?

A. I do not specifically recall any descriptions of ceiling tiles, or any samples of materials being shared with us as a service team. I recall us discussing that the rooms required to be sealed rooms, the air locks, the layout of the

Beatson Unit, but I do not have any recollection of us being involved in the actual materials themselves chosen or installed for use in the QEUH.

g) What concerns, if any, did you have regarding the final design specification of Ward 4B, and what action, if any, did you take in respect of these concerns?

A. I don't recall that we had any issues with the final 'physical' layout of the ward itself. The main concern we had was in relation to the specification for the ward environment which we clearly stated at the Project Team meetings. We were pleased that we had the clinical synergies of ITU, HDU and the overall infrastructure support that was available on site at QEUH.

h) Whether at any time you were told by anyone that the ventilation system already planned for the hospital would not be able to provide 10 air changes per hour within the proposed adult BMT ward?

A. I do not recall being every informed that the ventilation system for the QEUH was unable to provide 10 air changes per hour prior to the transfer of the BMT Unit from the Beatson West of Scotland Cancer Centre.
My recollection is that the first time I, or anyone in my team heard this could be the case was after the service had transferred and moved back to the Beatson West of Scotland Centre.

14. To what extent did discussion of the proposed addition of an adult BMT ward in the QEUH consider the application of the specification for air change rate, pressure differentials and requirement for HEPA filtration set out for a 'Neutropenic Ward' in SHTM 03-01 ventilation for Healthcare Premises?

A. That is the very point that we made to the Project Team, we highlighted that the ward should not be considered as 'general haematology or heamto-oncology ward' we referred to this being similar to ward b7, which was a Haematology ward in the Beatson, but it did not undertake BMT; the specification for these two wards was different. I believe we articulated this specific point clearly and on several occasions. There was never any concern raised that the information provided was misunderstood or could not be achieved in the QEUH.

15. The Inquiry is aware that the change order not only confirmed that the Bone Marrow Transplant (BMT) service would transfer to Ward 4B in the QEUH but also that the haematology patients that were originally planned to accommodate Ward 4B would move to Ward 4C.

A. I think this related to moving the general haematology patients who were transferring from the Southern General Hospital, and to allow a better layout and environment. I suspect this could have been related to the 'retained estate' on the Southern General campus, and I think there were plans to either demolish or reconfigure the Medical block where ward 4b was housed. Again, I do not recall specifically or in any detail anything more that that.

a) Describe how this change was communicated to the project team and Multiplex and how this change was captured in the design and specification documentation.

A. I believe we notified the Project Team, but beyond that I would have no idea how this was communicated to Multiplex, other than through the Project Team themselves which was the agree mechanism for the coordination of the new build.

b) To what extent was there discussion at this time as to whether the specification for air change rate, pressure differentials and requirement for HEPA filtration set out for a 'Neutropenic Ward' in SHTM 03-01 ventilation for Healthcare Premises might now apply to Ward 4C is accommodating haematology patients who might well be neutropenic?

A. I would refer to point 13c above where I believe I have answered this point.

c) When did you first become aware of the issues identified within Ward 4B in June 2015?

A. My first recollection of any issue being identified with ward 4b was on or around the 30 June 2015. I believe I was alerted either by a phone call or an email from Myra Campbell. I believe that Myra had received the results of the first month's air sampling and these were showing a far higher count than would have been expected for this type of ward environment.

I am sure that Myra indicated that she had been in contact with, or was about to contact, the Infection Control team and Clinical Lead, Dr Anne Parker.

16. Please refer to the SBAR by Anne Parker **(Bundle 12, Document 34, Page 234)**. Patients migrated to Ward 4B in June 2015 however less than one month later they returned to the Beatson. The issues identified were present at the point of handover in January 2015, please explain why the ward was signed off and handover accepted given the issues which arose shortly thereafter.

A. I can see no reference to the statement that 'issues identified were present at the point of handover in January 2015. I was certainly not aware from memory of any issues being identified and brought to my attention or anyone else's attention in January 2015.

We were invited to look around the ward prior to the transfer of the BMT. There was several of us in attendance and we asked all the relevant questions about the ward at that meeting.

We had remarked about the absence of pressure monitors and room lobby areas. We were informed at that point that as this was a state-of-the-art building all of the control systems were monitored centrally. We were assured by Ian Powrie or perhaps Peter Moir (I think) that all the commissioning had been completed and that the ward was compliant with the specifications that had been set out. I believe this was stated to the entire team, not just myself. In fact, I think Dr Anne Parker refers to this in her statement.

17. In her statement at paragraph 203, Dr Inkster describes how she and Dr Peters were met with what they perceived as 'fierce resistance' when raising concerns about air sampling issues on Ward 4B on 30 June 2015 **(Witness Bundle – week commencing 30 September 2024 – Volume 7, page 74).** Do you agree with this description of your response? If so, do you believe your reaction was influenced by the belief that the ward was compliant at that time?

A. I was rather surprised to see the term ‘fierce resistance’ being used. It is entirely fair to say that this meeting was called at very short notice to try and understand what the actual issue was with the BMT unit and the air sampling results.
I recall Myra Campbell alerting me in advance to the fact that one of the infection control doctors (possibly Dr Peters) had expressed a concern that she felt she was not being listened to more widely, so I was aware of the sensitivities in the room. I feel that we were challenging each other on the facts that were in front of us as this was a totally unexpected event.

I recall that we were all at ‘different places’ for example I was asking how this could be the case if the initial commissioning process had shown that the ward results were within a satisfactory level. So, for example, could these be spurious results given the ward had just opened and there may have been a higher level of footfall and activity affecting the ward environment. It became apparent however from the meeting that the infection control team were stating that they had not been involved with, or seen, the results of the building commissioning.

I feel that we all assumed that each person had been involved at different stages and once we had clarified that the infection control team had not been involved, and that the service teams had not been involved, we were clearer about the issues and matter at hand and were in a more focused place about what we were trying to address.

I distinctly recall thanking the ICD for their input and stated that I would take on board the issues and ensure these were escalated and acted upon immediately. It would not have been my intention to display ‘resistance’, I don’t believe I showed any resistance. This was a short notice urgent meeting to establish a set of facts and determine what actions were necessary a result. I then followed up on those actions and felt we had a very good relationship with the infection control doctors.

18. Please refer to your briefing note dated 6 July 2015 **(Bundle 13, Document 116, Page 840)**.

(a) How concerned were you when you were informed about the air sample results exceeding the recommended standards? Was there an immediate recognition of the potential risks to patient safety?

A. I was very concerned about the results of the air sampling. We had a longstanding programme of testing in place at the Beatson and were aware of the risks that a sub optimal clinical environment could place patients in. I was concerned and that was why I took clinical advice on what immediate steps we should take.

(b) When the air sample measurements were found to exceed the acceptable particle count, what was the immediate clinical response? How did you assess the level of risk to the patients in the BMT unit?

A. Yes, the clinical team attended the meeting with me; therefore, we spoke through a number of immediate measures for implementation.

These were to ask estates to increase the ventilation to its maximum capacity, undertake further air sampling to ensure that this was not a set of spurious results, increase the cleaning schedules to twice daily, introduce prophylaxis to allograft patients. We agreed that we would meet again on 03 July to review the results and assess a course of action from there.

There may be further documentation that states the actions; however I do not have access to any emails or correspondence from my time at NHS GGC.

(c) The note mentions that only one of the 24 rooms met the air quality specification, while others far exceeded the acceptable standard. What were the potential or actual consequences of non-compliance with the air quality and ventilation standards for BMT patients?

A. Having been General Manager for these services from 2009, I was aware of the risk of treating immune compromised patients in a sub optimal environment. The environment could expose the patients to infections and jeopardise the effectiveness of their treatment. The risks were explained to me

by the clinical team, and it was based on their advice that we agreed what actions to progress.

19. Please refer to email exchange dated 7th July 2015 regarding the ventilation issues within Ward B and the original building requirements and validation process for the BMT unit **(Bundle 27, Volume 3, Document 18, Page 311).**

a) Professor Craig Williams states that, “if the building is provided to the original specification it will provided a safe environment for patients”. What are your views on this statement? Is this accurate?

A. I believe this is a similar point to the one that I answered earlier.
I had asked for copies of the original drawing and notes that we had made on the various occasions when we met with the Project Team at Hillington. I wanted to assure myself that we had not missed anything in relation to the specification we had described and the comparable level of environment to that of the Beatson. These documents, I was told, were now destroyed owing to storage space. I was surprised by this and met with the Clinical Service Manager to discuss and assure myself that we had given sufficient information to the Project Team at the time. We both believed that we had been explicit about the specific requirements, particularly given that there had been similar issues with the original transfer of BMT from Glasgow Royal Infirmary.

I believe Dr Williams in this statement is highlighting that point, in so far as if the building systems were designed in the way that we asked and specified, then it would be a safe environment in the same way the Beatson was for these patients.

b) What measures should have been put in place during the design and commissioning of the BMT Unit to prevent the issues with ventilation and air quality from arising in the first place?

A. I believe we had articulated that case for a BMT unit, we had specified the difference between a general haematology ward and a BMT unit, we had given examples of the issues associated with the transfer form Glasgow Royal Infirmary; importantly we given assurances that this would all be implemented into the new BMT unit at QEUH.

There were no follow up communications stating that the specification could not be met or achieved. We perhaps in retrospect could have been more vociferous, however we were never under any form of impression that there may have been an issue with anything that we had specified.

In retrospect, I would have asked for evidence locally, of the outcome of the building commissioning and validation process rather than it being a centralised process of commissioning.

c) At what point did you determine that the risks associated with staying in the unit outweighed the potential impact of transferring the patients?

A. I believe that decision was reached on 03 July after the follow up meeting with Infection Control and the Clinical Team. There had been a slight improvement in the air changes, pascal count and to some of the rooms. However, I determined with clinical advice and support that the safest option for the patients was to transfer them back to the Beaston, and they would remain there until we could be satisfied that the ward environment was of standard that would safeguard patients from the risk of infection.

I recall this decision specifically as the meeting and decision occurred on the day of the actual visit and opening of the Hospital by Queen Elizabeth II.

d) Did the early issues concerning Ward 4B raise any concerns about the safety of other areas within the hospital? How did you ensure the safety of the other wards under your responsibility?

A. I recall discussing the issue with two colleagues specifically, they were the Director of the South and the Director of Woman and Children's services. I also briefed the Chief Operating Officer in relation to the events that were emerging from the BMT transfer. I also recall informing colleagues at a dinner on the evening of the 3 July about the decision to transfer patients back to the Beatson.

I recall also having discussions with the General Manager for the Renal Unit. They had already reviewed the renal unit as there had been issues with two of the rooms on that unit. Anne Parker refers to this in her SBAR. Those issues had been resolved. I was also aware of an issue with a second water filtration system that was required for renal dialysis patients; there was a process in place to resolve this and a second unit would be installed. Again, this is all from memory so I cannot confirm if these events were concurrent or at different time intervals.

I am also confident that I circulated the briefing paper of 06 July to Acute Director colleagues for awareness of this issue. We also had a Friday morning Directors meeting where I recall discussing the issues that were arising from the transfer.

20. At a BICC meeting on 27th July 2015 Professor Craig Williams states that in respect of ward 4B "*the unit was not built to the correct specification and Brookfield have agreed to fund the rebuild for this area and the timeframe for this is 12 weeks*". Please discuss this statement.

A. I was not present at this meeting where Dr Williams stated this point nor was I a member of the Board Infection Control Committee.

However, I believe that by this point there was a realisation that the BMT unit was not built to the specification that we had set out. I suspect that Dr Williams was making the committee aware of this issue as part of an overall update on issues associated with the new hospital. There is evidence of this in the email contained in **Bundle 27, Volume 3, Page 295** – where Dr Williams appears to confirm to Dr Hood that 'the rooms were not built to the spec and as you clearly say they should have been to the same spec as the Beatson'.

There had been meeting with Brookfield and the Estates team, involving David Louden as the Director of Estates and Facilities. I suspect it was around this point in time that it was formally recognised that the ward did not meet the specification we had set out.

a) Were the issues with Ward 4B discussed with the Board?

A. I was not a Board member, nor was I a Corporate Director. I was an Acute Director. I anticipate that the updates were being provided to the Board either through the Medical Director (who I recall was the 'on the move' lead) or by the Chief Operating Officer for the Acute Division who I reported to, or by the Director of Estates and Facilities; all of whom would have been either members or 'in attendance' at the Board itself.

b) What concerns did the Board have in respect of these issues?

A. I was not involved in direct discussions with the Board.

c) What steps were taken by the Board to address these?

A. I was not involved in direct discussions with the Board.

d) What steps did you/the Board take to ensure these were sufficiently addressed?

A. I was not involved in direct discussions with the Board.

21. Please refer to the Report by Multiplex of Remedial Works to Ward 4B (**Bundle 27, Volume 3, Document 9, Page 175**).

(a) After the decant of ward 4B, what remedial works were undertaken?

A. From memory and review of the correspondence bundles, the work that was undertaken related to: Bedroom and Ensuite walls and ceiling being sealed, I think the ceilings were refitted and 'smoke tests' were performed. Hepa filtration was installed, lights fitting were sealed, pressure monitors were to be added, the pentamidine room air flow was rebalanced, room maintenance and cleaning schedules were implemented, and I believe the rooms and ceiling were painted or coated with anti-fungal materials. Finally, the nurses station was fitting with a monitor and alarm system.

There were several iterations of remedial work, therefore I cannot recall what order they occurred. I again state that I am writing this from my memory of events rather than drawing facts from documents or emails from the time.

(b) In this document, there are several assessments and validations in relation to ventilation, air flow etc. Were similar assessments and validations received when the hospital was initially handed over in January 2015? If not, why not?

A. From a service perspective, we had asked the question of building validation on the walkaround of the ward. As previously stated, we were assured that the environment was built to the specification that we had outlined at the Project Team meetings.

I was not involved in this aspect of the process, nor did I see any validation data in advance of the BMT service transfer. I do not recall any services being provided with this information from memory. I recall that there was a process for sign off and acceptance of the building, but I believe this was undertaken centrally and not on a directorate-by-directorate basis. I believed at the time that validation checks and the specification for the new building were being undertaken centrally between the Project Team, the On the Move team, Infection Control and the Estates team. I do not recall any of my Acute Director colleagues being presented with data on either ventilation schedules or water quality schedule. From an infection control perspective, I believe that the Project Infection Control Doctor, Dr Williams, had reviewed and signed off on the building performance.

The first time that we had any discussion about with was then we met with the Infection Control Doctors following the outcome of the air sampling. This was when it became clear that the Infection Control Doctors, locally, had not seen the validation data. I believe there was a suggestion that Dr Williams had been involved in the sign off process from the Infection Control perspective. It was clear at the meeting that if this was the case, then the local ICDs who were involved and providing support to the services, had not had access to that information.

(c) Were you satisfied with the remedial works outlined in the report, and the results of the assessments and validations within?

A. I think it is reasonable to state that expert advice had been sourced, and we had a level of confidence that the remedial works would create a suitable clinical environment.

The process however involved a number of multi professional opinions to formulate a view that environmental issues were satisfactory. I think there were several attempts to get this right. In fact, I believe that there were ongoing concerns expressed by the Infection Control Team and that Health Protection and Health Facilities Scotland advice was sought. I believe this may have been when Annette Rankin became involved at the behest of Dr Inkster or Dr Peters.

22. Please refer to the BMT Options Appraisal **(Bundle 27, Volume 7, Document 6, Page 158).** On what basis were you asked to prepare this options appraisal and by whom?

A. I suspect that the commission was agreed with either Jonathan Best, or Jennifer Armstrong. I seem to recall that it was felt that there should be an assessment of available retained estate on the QEUH campus in the event that the BMT Unit might never reach a satisfactory specification for either the Infection Control Team, or the Clinical Haematologists.

(a) Please explain the key objectives and criteria used in the options appraisal, such as the Benefits matrix and scoring system?

A. We used an experienced project manager to take this appraisal process forward using Capital Investment Manual agreed criteria (I seem to recall from memory) All parties would have agreed on the criteria and methodology etc. The Planning Manager was had previously undertaken such exercises and guided us on the process and how the option appraisal process would work. I think each section was agreed and weight added so a baseline scoring document was developed and then scores applied by the various teams and individuals involved in the process.

b) The options appraisal accepts that ward 4B did not meet standards set out by SHTM-03-01. What upgrades or modifications were made to Ward 4B between 2015 and 2018 that made it suitable for the BMT service again?

A. I don't have access to that specific information. However, there was considerable work undertaken, which again did not appear to achieve the level of specification that Infection Control Doctors felt comfortable with. I recall the Teresa Inkster had requested the support of Health Facilities Scotland and Health Protection Scotland as previously stated. This is where Annette Rankin and other colleagues become involved. I think wider advice was sought from a Dr Hoffman who was able to give expert opinion on BMT services.

c) Considering that two of the options assessed in the appraisal process scored higher than the QEUH 4B option, could you explain why the recommendation was made in favour of the QEUH 4B location? How were environmental standards balanced with factors such as staffing and timescales in reaching this decision?

A. This was a complex discussion and hence why the paper drafted for the Acute Service Committee had a specific caveat that the outcome was based on the Clinical Haematologist's views and wishes, and that these were being presented as the 'service' view.

The Clinical Haematologists were of a view that the QUEH was preferable to the Beatson, and the other options would be too far off in the future and would result in patients remaining at the Gartnavel Campus where there was less clinical infrastructure to safely manage their clinical presentation.

I felt I had to be explicit in stating this in the paper so as not to mislead anyone that there was a consensus way forward that all multi-disciplinary colleagues agreed with. This simply wasn't the case despite going through the options appraisal process.

d) In her oral evidence to the Inquiry, Dr Jennifer Armstrong stated that this was not the paper presented to the Acute Services Committee, and that she felt

'uncomfortable' with the recommendations. Were you aware that this options appraisal was not the version presented to the Acute Services Committee? Have you seen the version which was presented to the Acute Services Committee? How did it differ from this version?

A. I recall having a meeting with Dr Armstrong as she was not comfortable with the was that the paper was written.
I explained to her exactly what I have stated at point c above. There was no consensus and therefore as a Service Director, I stated what the preferred views were of the clinical haematology team, but these views were not universally agreed or supported by the Infection Control team.
I think that Dr Armstrong has hoped that we would be able to reach a consensus view from all parties, but this was not case even at this stage in the process. I think Dr Armstrong had asked me to reconsider some of the points in the paper and how I had stated these. I actually recall having a disagreement with Dr Armstong as there was no clear option that brought infection control and clinical haematologist to the same viewpoint on this issue.

I do not think that the paper actually went to the Acute Service Committee at all. Again, I state this from memory and the fact that I was not a member of the Acute Service Committee so would not have had paper circulated to me for the meeting.

e) Did you have any involvement in updating or adapting this appraisal? If so, could you describe your input in the process and how it differed from the previous version?

A. As I mentioned above, I do not this this paper went to the Acute Service Committee following my discussion with Dr Armstrong.

23. Please refer to the Transplant Service Relocation Proposal **(Bundle 52, Volume 1, Document 46, Page 843).**

(a) Did you have any involvement in this proposal? If so, please detail your involvement.

A. The reference relates to an email and there is no paper attached. Therefore, I am not able to answer this point accurately.

(b) The proposal mentions air monitoring and water monitoring alongside other measures undertaken to ensure Ward 4B is appropriate for transplant patients and facilitate the proposal to return the BMT to the QEUH. What was your involvement in ensuring appropriate measures had been taken to allow the return of the BMT to the QEUH?

A. There was a number of detailed ‘go’ and ‘no go’ decisions prior to the service transferring back to the QEUH. These decisions involved the General Manager for the service who was leading the process with representatives from the Estates team, the Haematologists, the Infection Control team and I seem to recall external advice from Health Facilities Scotland and Health Protection Scotland. I was being briefed by the General Manager directly. I think from memory these updates were also provided in to the Directorate Management Team and Directorate Clinical Governance Group.

(c) Following the relocation to Ward 4B, how did you ensure that air and water quality were continuously monitored to safeguard patient safety? Were regular checks, audits, or risk assessments conducted, and how were the results used to resolve any potential issues?

A. Yes, as previously stated, there are a number of checks that take place to monitor and sample the environment, as was the case at the Beaston. I do not have access to records that allows me to write these in any detail, but I am confident these could be sourced from the service if required. These would have included a similar schedule to that already in place at the Beatson West of Scotland Cancer Centre.

24. With reference to your answer to Question 13(c) of your statement:

a) In which year or years did these meetings take place?

A. From memory, those meetings would have occurred in the second half of 2013, and possibly the first half of 2014.

b) Are these meetings related to the Reviewable Design Process for Ward 4B described in PMI 228 **(Bundle 16, Document 27, Page 1697)** and then completed before the NEC Compensation Event CE 051 **(Bundle 16, Document 30, Page 1700)**?

A. The meeting that I reference at 13c are the meetings that followed from the initial 'Directorate Change Control Procedure Document' on page 1699 completed by Jonathan Best.
I suspect that the NEC Compensation Event document is as a result of the meetings that we had as a service team. I do not recall however seeing these change control documents at the time, I suspect they were held centrally by the Project Office.

c) At the end of the meetings were you and your colleagues ever asked to sign drawings or room data sheets to confirm agreement with the design?

A. Yes, we were all asked to sign our names on the large A2 / A3 drawings to say that we had reviewed the documents and agreed with the layouts or any changes that had been marked up on the floorplans following our team discussions with the Project Team.

d) Who (if anyone) was present at any of these meetings to provide technical advice on ventilation issues?

A. I don't specifically recall anyone other than Heather Griffin, Fiona McLuskie and Mhairi (cannot recall surname) being present at these meetings. These were the three individuals that I recall being in attendance.

I have referenced in my earlier statement (question 16) that I recall having a conversation with Ian Powrie, or Peter Moir. Whilst reflecting on this comment, I also recall the name Colin Purdon (I think) although I cannot state with any certainty that he was at any meetings either with myself and the clinical team. I think he may have become involved at a later stage or after the transfer had taken place.

e) Were minutes taken of these meetings, and if so, by whom? Were those minutes or notes circulated after meetings?

A. As I recall, these are the same meetings where we signed the drawings. I don't think that the large drawings were circulated electronically, I recall asking for a copy of the drawing at one point so that the clinical teams could share the information with their colleagues back at the Beatson.

We all certainly took notes when we were in attendance, I seem to recall that Mhairi (cannot recall her surname) did take notes on behalf of the Project Team. These I believe were used as part of the overall progress monitoring of the QEUH Project.

f) Were such minutes or notes held electronically?

A. I have a recollection that these may have been manual, hence why I mentioned trying to recall the notes of meetings (19a) once we were aware that something was not right from the air sampling results.

25. With reference to your answer to Question 13(e) of your statement, can you remember the name of the Infection Control team member present at these meetings?

A. I am reasonably confident that it was Fiona McLuskie from the Project Lead Infection Nurse and that she was the conduit for Infection Control issues. I also seem to recall that oversight on Infection Control issues was given by Dr Craig Williams, he was the IC Doctor associated with the project.

26. With reference to your answer to Questions 13(c), (f) and (g) of your statement you have explained that when you went on to discuss the ward layout you had had to sign some drawings and mark up our comments on the specification. The Inquiry has seen drawings for Ward 4B from 2015 (See Bundle 47, Volume 1, Documents 2, 3 and 4) that do not have an air lock at the entrance to Ward 4B. Are you saying that the drawings you signed did show an air lock at the entrance to the ward or was it the case that you did not have any issues with the final 'physical' layout of the ward itself despite the absence of an airlock on the drawings?

A. The drawings in the bundle refer to July 2015. The questions at 13c, f and g relate to the period of time when we were meeting the project team at Hillington this would have been late 2013 or early 2014.
I cannot accurately comment without being able to reference the drawings that myself and the team reviewed in 2013 /14.

27. With reference to your answer to Question 13 of your statement how did you ensure that on the arrival of transplant patients in Ward 4B on 6 June 2015 the ventilation system for both the ward as a whole and the BMT isolation rooms in particular was operating on accordance with the standards then set down in SHTM 03-01 or that there was a derogation in place if it was not?

A. We established the air sampling process in conjunction with the microbiologist. This was in place almost immediately if I recall correctly. That would correlate with the fact that we moved the service back in such a short space of time.

I would also reference my answers given at questions 11, 12 and 16 of my initial statement.

28. With reference to your answer to Question 14 of your statement:

a) Did you set down this instruction (that the adult BMT ward would be a 'Neutropenic Ward' in terms of SHTM 03-01 ventilation for Healthcare Premises) down in writing at the time?

A. I cannot add anything to this question as I believe that I have answered it as best as I could from memory in question 13 and 14 of my initial statement. We had been clear with the Project Team that a BMT Unit was not the same as a Haematology or Haemato-Oncology ward, hence we had also outlined that we did not think there was a standard building note and to reference the drawings and systems in place that were used to build the Beatson around 2009.

b) Why does the explanation that you give here not appear in your 6 July 2015 briefing on the issue (Briefing at **Bundle 13, Document 116, Page 840** and your cover email of 6 July 2015 in **Bundle 27, Volume 3, Document 12,**

Page 291) or in your May 2018 briefing on the return of the BMT Service to the QEUH **(Bundle 52, Volume 1, Document 46, Page 843).**

A. I don't see the relationship to question 14 and the briefing note or email that I issued on 06 July. The briefing note was an overview of the events that had occurred and were coming to my attention at the time. The briefing note was used as an overview of the live issue that was arising from the air sampling process.

29. With reference to your answer to Question 16 of your statement could it be the case that if Mr Powrie or Mr Moir told you and your colleagues "that the ward was compliant with the specifications that had been set out" he was just referring to the drawings that had been signed off and approved for construction after the design process?

A. This conversation related to the discussion about pressure monitors and their absence, plus the layout of the ward when we visited it.

The context of that conversation related to the fact that it was a state-of-the-art building. We were discussing how the clinical teams would be alerted to issues if there were no physical monitors present in the ward.

I, and I believe the others present, understood this statement to mean that despite the absence of the pressure monitors, the process for alerting the ward to changes in the pressure was in place, albeit it was part of a central building control system. I recall that myself, Myra Campbell and Anne Parker all thought that was an advancement in building design and technology.

30. With reference to your answer to question 19 and the destruction of records:

a) Who told you the drawings and notes were destroyed due to "storage space"? When was this?

A. I do not recall which individual it was, but it must have been either Heather Griffin, Fiona McLuskie or Mhairi. It would have been on or just after the meeting of 30 June, or at the very start of July. I do recall being informed it was due to a lack of storage space. I am also confident that I mentioned this

fact immediately to Jonathan Best as I was briefing him on the events at the time.

b) Did you understand the lack of “storage space” to be physical or electronic?

A. I understood it to be physical space - the drawings I am sure were all ‘hard copy’ as I have previously stated.

c) Was the Clinical Services Manager with whom you checked about notes/drawings and the information passed to the Project Team, Myra Campbell?

A. Yes, I met with Myra Campbell and we discussed the issue and what correspondence and notes we had. I am sure I attended a meeting with Robert Calderwood and David Louden around this time and I wanted to be sure that I had as much information as possible to hand.

I recall discussing with both these individuals the information that I had available to me at the time of this meeting.

d) Were those drawings held electronically? If not, how were the requirements passed by the NHS Project Team to the design/construction teams? Who would have been responsible for that?

A. Again, as stated at 13 d of my initial statement, it was my understanding all information was being passed through the Project Team at Hillington.

As I have also stated, the layouts were all on paper as far as I can recall, hence why we used to attend that physical location for our meetings and discussions about the ward.

e) Following the response that you describe to your query, did you report the destruction of these records to any of the persons involved in the response to the state of the ventilation system of Ward 4B including Dr Armstrong and Mr Calderwood? If so, how?

A. I certainly recall informing Jonathan Best. Robert Calderwood was aware as I mentioned in relation to 8c above. I am also confident that Jennifer Armstrong was aware too as I recall having a conversation with her.

I am sure I would have stated this in writing somewhere, but again I have no access to my former GGC account.

31. In respect of your answer to question 20 of your statement, did you report your concerns that Ward 4B had not been built to the standards you had supplied to the NHS GGC Project Team to your line manager, the Chief Operating Officer, the Medical Director or the Chief Executive?

A. This was the unfolding question, and I believe it is what Craig Williams and the Infection Control team were trying to determine based on the air sampling results.

From a service perspective, I / we would not be aware of any of the mechanical engineering build aspects themselves, nor could we have commented on them if they were available without estates and engineering expertise. Therefore, we were at a stage of trying to work out why the air sample results were not to a standard that would be expected based on the information we had provided as a service team.

I certainly reported that air sampling results were not what we had expected, hence why the service returned after a further set of air sampling had been undertaken.

32. In respect of your answer to question 21 of your statement and your evidence that “we had asked the question of building validation on the walkaround of the ward” did you ask about validation of the ventilation system in the sense of an independent assessment of the operation of the system against external standards? Did you see any validation reports? If not, why not?

A. I believe I have answered this at 21b second paragraph of my initial statement, and at question 7 above. I do not explicitly recall asking about independent assessments prior to the initial move.

However, following the return to the Beatson, the infection control team plus estates and facilities colleagues were involved in looking at and giving advice on the amendments required for ward 4b.

33. In respect of your answer to question 23 of your statement the attachment to the email in **Bundle 52, Volume 1, Document 46, Page 843** was not bundled when you received your question. It has now been bundled and the attachment has been added to your Objective Connect space. Please review your answer to Question 23 of the initial questionnaire in light of the attachment.

A. I have reviewed the email and the paper that was sent to me by the Inquiry. 'Proposal to Relocate Adult Haemopoietic Stem Cell Transplant Service from Beatson West of Scotland Cancer Centre to Queen Elizabeth University Hospital.

I believe this is the paper from the Group that was addressing the rectifications to the environment of ward 4b. The paper was sent by Melaine McColgan. I do not believe I was part of the Group itself, however, I recall receiving progress updates through the Regional Services Directorate Structure. This may have been through the Directorate Management Team meeting, Clinical Governance Meeting, or directly from the General Manager for Specialist Oncology and Clinical Haematology Services.

Water Incident

34. **Please refer to Bundle 1, Document 19, Page 75.** You attended the IMT meeting of 21 March 2018 in relation to the Water Incident.

(a) What is your involvement in or understanding of the water issues in the QEUH/RHC?

A. I do not recall having had any involvement on water management issues to the QEUH site prior to this meeting taking place.

I would not have any knowledge of water handling systems, other than an earlier episode in relation to the renal unit requiring a second water 'loop' system to be installed.

(b) At this meeting it states, you will "communicate with Mary Ann Kane regarding what areas should be prioritised within the QEUH for the fitting of water filters into Ward 4A,4C,4D,7A and 7D". Why was there a need to fit water filters? Can you describe the process and criteria used to determine which wards should be prioritised for the fitting of water filters? What was the outcome of this?

A. It is likely that in the meeting we identified high risk areas; therefore the 4th floor was where Haematology, BMT and Renal services were located. My only recollection of 7A and 7D (which I think was respiratory) was that I seem to recall that occasionally outreach dialysis may have taken place in that area and therefore this was relevant. The only other reason I can think of that I would have been allocated respiratory may have been in the South Director was off on leave at the time of the meeting. I do however note that my title is not recorded correctly in the minutes of the meeting, it states that I am North Director, therefore there could have been an accuracy issue with the minute.

(c) What steps were taken following the identification of the water issues to ensure the safety of patients and staff at QEUH/RHC?

A. I believe there was a whole series of investigations into the water supply, alongside continual monitoring of the water tanks and environmental testing took place to try and identify the root cause of the issues affecting the water system.

(d) What role did the clinical governance structures play in managing the water incident?

A. I believe there was a specific incident management process for the water issues as this was a new issue with the hospital; these are likely to have linked through local directorate clinical governance structures.

Cryptococcus

35. Please refer to **Bundle 1, Document 59, Page 266.** You attended the IMT meeting of 17 January 2019 in relation to Cryptococcus.

(a) When did you first become aware of the presence of Cryptococcus at QEUH, and how quickly were the appropriate infection control measures initiated once the issue was identified?

A. My first awareness of this issue would have been when I attended the meeting on 17 January. The minutes give an account of the actions that were initiated at the time.

(b) Had you seen or heard of Cryptococcus in a healthcare setting prior to at the QEUH in 2018?

A. No, I had not heard of Cryptococcus prior to that point in time.

(c) How was communication managed between the infection control team, clinical staff, and external health authorities, and how did the coordination of these efforts ensure a swift and effective response to the outbreak?

A. I would only have been involved from the perspective of the ward areas affected and the actions that would have been necessary at operational level. I would not have been involved in linking with external agencies.
All of the clinical specialties within my portfolio were represented at the meeting and would have been made aware of the issues that were emerging.

(d) What immediate infection control measures were put in place to contain the spread of Cryptococcus within the hospital, and how were these communicated to relevant teams?

A. I recall there was an incident management group; I think most of the communication, actions and advice would have been led through this group.

(e) What role did clinical governance structures play in managing the incident? Was patient safety prioritised in the management of this outbreak?

A. I left the organisation in March 2019 and have had no further contact since that point; therefore, I cannot comment.

(f) In light of the Cryptococcus incident, what steps have been taken to strengthen infection control practices at QEUH, and how are these changes expected to prevent similar issues from arising in the future?

A. I left the organisation in March 2019 and have had no further contact since that point; therefore, I cannot comment.

Conclusion

36. Is there anything further you wish to add that you feel may assist the Inquiry?

A. Nothing that I can think of over and above what I have stated in this document.

Declaration

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

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

Appendix A

A43255563 – Bundle 1 – Incident Management Team Meeting Minutes
A47390519 – Bundle 11 – Water Safety Group
A47069198 – Bundle 12 – Estates Communications
A48890718 – Bundle 13 – Additional Minutes Bundle (AICC/BICC etc)
A47851278 – Bundle 16 – Ventilation PPP

A49756324 – Bundle 27 – Miscellaneous Documents – Volume 3

A50002331 – Bundle 27 – Miscellaneous Documents – Volume 7

A51483446 – Bundle 29 - NHS Greater Glasgow and Clyde Audit Reports

A53674650 – Bundle 52 – Miscellaneous Documents – Volume 1

A49847577 – Witness Bundle – Week Commencing 2 September 2024 – Volume 3

A50152363 – Witness Bundle – Week Commencing 30 September 2024 – Volume 7