SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
16 September 2025

Day 2
17 September 2025
Kevin Hill
Gary Jenkins

CONTENTS

10:02

THE CHAIR: Good morning. Now, Mr Connal, I think we're ready to begin with Mr Hill.

MR CONNAL: We are, who appears remotely.

THE CHAIR: Right. Good morning, Mr Hill. Can you see and hear us?

MR HILL: Yes, very clearly, good morning.

THE CHAIR: Excellent, we can hear you clearly too. Now, as you understand, you're about to be asked questions by Mr Connal, but first, I understand you're agreeable to take the oath?

MR HILL: I am.

Mr Kevin Hill
Sworn

THE CHAIR: Thank you. Now, as I understand it, you're joining us from Spain. Am I right about that?

THE WITNESS: You're correct.

THE CHAIR: Right. Now, I suppose that you're probably an hour ahead of us. We're now at ten o'clock.

THE WITNESS: Yes, it's eleven o'clock here.

THE CHAIR: Eleven o'clock, right. Our timing will be that we will sit between now and what is one o'clock for us, taking a coffee break at what is half past eleven for us or thereabouts, but if at any stage you want to take a break, just give me an indication and we will take a break for whatever reason. Whether your evidence will take the whole morning, I don't know at this stage, but I'll now hand you over to Mr Connal.

THE WITNESS: Thank you.

Questioned by Mr Connal

MR CONNAL: Good morning, Mr Hill.

A Good morning.

Q I think it's a good time to be in Spain. Looking out the window in Edinburgh; it's not very clement here. You prepared a witness statement which has been given to the Inquiry, so I ask you, first of all, the formal question that I ask everybody, which is are you content to adopt that statement as part of your evidence?

A I am.

Q Thank you. Now, just before I ask you the next question, by way of explanation, in order to speed the process of obtaining from various participants any questions they might want to ask particular witnesses, the Inquiry circulated a number of statements when they were still in draft form, giving an explanation that these were, of

course, at that stage, only drafts.

Now, at the time that that was done, and yours was one of those statements, in June, of the questions asked in the section dealing with communications, not all of the sections had completed by you and, in particular, one answer hadn't been completed, which is now Question 37 on the version that we have today.

Now, I can look it up if you need me to, but it's simply the question in which you were asked about the statement you're said to have made about Mr Redfern and Dr Inkster not to speak to Professor Cuddihy, and we'll come to the substance of that later on. Now, I've been asked to ask you----

A Can I say one thing, sorry?

Q Yes, of course.

A I did complete a statement on the paragraph, I think you referred to it as 37, so I'm surprised you've not received it.

Q Well, I have a version now.

A Oh, well, that's fine, sorry.

Q Sorry, the fault is entirely mine. The point was that in the draft that we got, or that we had in hand, in June, that that wasn't completed. Now, I can dig out the draft if you want, but perhaps you would just take that from me, that that was a section that wasn't completed, and I've been asked to ask you whether there was any particular reason why that answer wasn't completed at that time. It is now, but was there any particular reason why it wasn't completed at that time?

A Well, I can't recall because I thought I had completed it, but I take your word from what you've said, so therefore if it was omitted by me, that was a mistake. I should have completed it at the time.

Q So, there wasn't any particular difficulty in completing that answer compared to any other?

A None whatsoever.

Q Was there any reason why your statement only came to the Inquiry very recently? It was one of the last we got for this hearing. Was there any particular reason for that?

A Well, as you can probably gather, I live in Spain and I have a very active life out here, so I'm not making any excuses. I did read through the documents early on. I don't have-- The one thing I didn't have was-- Throughout my career, I've always had access to my handwritten notes. Unfortunately, being in Spain and the fact that when I finished my career, none of that documentation was obviously retained by me, and therefore I'm trying to recall from my memory, including the paperwork that was clearly and kindly submitted to me, and therefore I took my time making sure

I racked my brain, if you want to-- for the sake of an expression, to recall as accurately as I possibly could, but my-- It's my omission and it's my way of trying to recall, if you like, things that occurred more than five years ago and before that.

Q Long before that in some cases.

A Yeah, yeah.

Q When did you actually step down from your post at NHSGGC?

A Well, I was sick for about a year beforehand, so in 2021 I no longer was working in the organisation, and in 2022, in March, I finished.

Q Now, I'm going to use your witness statement as a sort of guide to help us go through the questions, if I may, and I think you have access to that, do you?

A Yes.

Q Yes. On the first page, obviously, we identify your title that's relevant to our purposes, which was director of women and children's services. Now, for those of us who are not intimately familiar with the structures of NHSGGC, can you give us just a very brief snapshot of what that job actually entailed?

A You have responsibility for, as it describes, women and children. So for this particular post, women's services were maternity. They were the contracept-- sorry, the-- forgive me, the infertility services, a whole range of other gynaecological services, so it's the entirety of what you'd call women's services, including-- Sorry, maternity services, including midwifery and community midwifery across the whole of the Greater Glasgow and Clyde Board.

There was also then, in that respect, the Children's services, which was the main Children's Hospital, a ward in the RAH-- sorry, the Royal Alexandra Hospital in Paisley, and the services linking into the community, but we did not have-- or I did not have responsibility for community Children's Services. In addition to that, you've got links with labs linked to genetic testing, and various other things for children, and overall 3,000-plus staff, a budget of 400 million, and direct reports through the organisational structure that I'm sure you've seen.

My responsibilities are therefore, from a governance point of view, were to be responsible for, if you like, the corporate governance of the directorate, the clinical and operational aspects of it, financial, but including the budgets and everything else, with-- through my general managers and others with direct responsibility, and also for the, if you like, health and safety and various other aspects – links to trade unions and

everything else – with staff side and others, and there's an extensive list. I'm happy to carry on down the list. Is that sufficient, or not?

Q No, that will suffice for present purposes. Thank you very much. Part of the reason I asked you was that, in the course of this Inquiry, we've discovered that lots of parts of the organisation have people called "directors" and things called "boards", but these are not always directors and boards as a person in the outside world would understand it. But your post as Director of Women and Children Services was one of the senior positions, is that right, at the sort of top level, reporting only to the chief executive?

A I mean, yeah. I reported into director of operations, who reported directly to the chief exec-- chief executive.

Q Yes. So, you were in that sort of top layer of management. Is that correct?

A Yes.

Q Thank you. I don't think we'll----

THE CHAIR: Sorry, probably my fault, Mr Hill. I noted you were saying, "I reported to the director of operations." Is that same as the chief operating officer or is it someone----

A I'm sorry. Yes, it is chief operating officer.

THE CHAIR: Chief operating officer.

A (Inaudible 10:12:39).

THE CHAIR: Thank you.

A Yeah (inaudible).

MR CONNAL: Well, I'm not going to ask-- I'm not going to put up the organisation chart, I suspect, because we can all read that. Apart from anything else, the print is depressingly small, but we'll move on. Can we go to page 4 – that's the next page of your witness statement – just so I can understand the point that you make here. You're asked, well:

"...describe the procedures and governance in place within Women and Children's Services."

You then say:

"I designated the Chief of Medicine to take the lead role, as a practising clinician..."

So, do you distinguish what that person was meant to do from other parts of governance? Is that right?

A Correct, because, as a non-clinician, I feel that it's important for a clinical person to lead the aspects of clinical governance. It's not to say I don't pay attention to it, and did pay attention to it very, very, very importantly, but the reality is-- and also the chief of medicine, who's a practicing clinician and who

happened to be a consultant-- obstetrician and gynaecologist therefore represented, if you like, the body of the (inaudible 10:14:08) and the practicing clinicians, and had influence with them, and also had an ability to interact very clearly and appropriately with the paediatricians and the others in intensive care that-- neonatal intensive care that we were all so responsible for. So hence my decision.

Everywhere I've worked throughout England and Scotland throughout the last 38 years, I've always designated a clinical person to lead clinical governance, which of course then, in turn, he reports in to me in this instance. So, I'm clear about what's happening, I'm clear about the questions I'm asking, and I'm also clear about trying to obtain those answers in an appropriate way, and seeking guidance from a practicing clinician about what was appropriate to pursue further and what was being dealt with through other channels, and we would await the results of whatever inquiries or investigations we were committing to.

Q You described yourself as a "non-clinician".

A Yeah.

Q Was your background essentially as an administrator? Is that how it would be best described?

A Yes.

Q Is that the kind of role that you'd performed earlier in your career?

A Yes, I commenced as an administrator, or a clerical officer, way back in 1981 in the Dumfries and Galloway Health Board, and I progressed and worked to various promoted posts in-- initially in England for 20 years, and then I managed to obtain a post in Glasgow in 2002, and I've been in Glasgow till I finished my career in 2021-'22, as described earlier.

Q The questionnaire, because that's the way that this has been set out, goes on to ask you questions about water safety in clinical areas and so on. You're asked, well, who's in charge of that, and you say, well, that's an Estates matter, so that's primarily director of Estates. Then, you point out that if there are any issues, then they should really come through the clinical governance side, and that's how you would know about it. Is that right?

A Well, not necessarily. They'd come through also the operational hospital side because, clearly, if an issue takes place involving water or a defect in terms of the environment, then, as much as the Director of Estates is responsible for correcting any deficits, the reality is that the operational people will feel the impact of that right away. So we'd be reporting, you know, problems with taps,

problems with showers, mould developing, etc. So, there's a two-way process. So I need to reinforce the fact that it's not one person's responsibility. It is a team but also, at the same time, we have designated areas of-- that's not my area of responsibility. Somebody else deals with that, as you would expect from the organisation chart and the size of the organisation.

Q When you say the "operational people", who do you mean by that?

A Well, I mean, initially, it would be the nurse on the ward, the domestic cleaning the shower cubicles. It would be raised to the-- It could be the patient and the parent raising an issue in the ward environment, and we need to be seen-- and are seen to deal with it, as in raise it further. I don't expect the nursing and other staff and clinical staff to deal with environmental and facilities issues. We have an organisation structure in place with appropriate people who are skilled in those areas to deal with, if you like, in any corrections and improvements.

Q Yes, and I think eventually we turn, in the questions to, well, "What was your role in all of this?" Your answer is that if there are issues of concern, it's your job to take them up with the director of facilities and estates and/or the chief operating officer. Is that right?

A Correct.

Q So you-- you were a sort of a conduit rather than a decision taker. Is that right?

A That's correct, yes.

Q Now, I want to ask you something that crops up on page 6. I'm not necessarily going to ask you to go through every word in your witness statement, otherwise we would be here for longer than we have available. But at the top of page 6 you're asked about the procurement of this-- let's call it the new hospital. This must have been quite a big issue for you, presumably, because here was a new Children's Hospital coming on stream. Would that be right?

A Yes that's correct.

Q Now, what you say here is, well-- you were asked, well, what's your role, and you say:

"[Your] involvement with the CT was in regard to ensuring ward and department plans were signed off as being an accurate specification of the users (Staff and Patients) requirements based upon the purpose and functionality of the patient groups identified."

Now, you say that was your involvement. How did you go about ensuring what you've set out there?

A Well, my-- Well, first of all, my general manager, Mr Jamie Redfern, was responsible for the running of the hospital at that stage, and of course his familiarity

and his links directly with all the clinical areas mean that the Clinical teams were-- as the plans were being progressed, were involved in the, like-- the kind of layout of the ward, the placing of things such as simply as, you know, where will the power points go; where will the, if you like, you know, operating theatre; where will the powerful lights and the beams and this other electronic equipment be placed. So, it was about making sure the functionality of the new room or the new theatre or the new ward met with the way things were practiced and could be practiced going forward in the future.

So, that's about room layout. It is not about the other environmental features. I have no role to play and didn't have in, "What type of air conditioning units are we getting?", "What kind of air filtration are we having?", etc. That was never a feature of any discussions I had.

I was working on the basis that they were following the standard, as I thought we were, latest building note guidelines from NHS Scotland, and as a consequence of that, if there had been any amendments and updates in the time of the building and commissioning of the building, they should have been put in place. That's my understanding of how it works. Having commissioned buildings in England previously, an intensive care unit, that was the approach we took.

Q I did want to ask you one thing more about this because you say in that answer:

"[The] process of signoff and approval for each specified area was the designated responsibility of the General Manager (Mr Jamie Redfern)..."

Now, we've had quite a lot of evidence about signing off of layouts and rooms and so on so forth, and we haven't been able to find anyone else who said that this was Mr Redfern's responsibility. For instance, Mr Seabourne didn't seem to put Mr Redfern in the frame, and I'm not sure Mr Calderwood does either. So, I just wondered why you say that the process of sign off and approval was a specific responsibility for Mr Redfern.

A Right, so, let me correct that. That's-- I don't mean it that way. What I meant was Jamie was reassuring me that this document I was about-- because I signed off every plan, every room layout. I'm sorry if that doesn't say that. It should have said that----

THE CHAIR: Sorry, could you just repeat that, please, Mr Hill. You signed off----

A I signed off every room layout and plan for the new hospital building.

THE CHAIR: Every room----

A (Inaudible 10:22:21).

THE CHAIR: Every room layout and plan?

A Yes. For each area, each floor, each department.

THE CHAIR: Of the Children's----

A (Inaudible).

THE CHAIR: Of the Children's Hospital?

A The Children's Hospital.

THE CHAIR: Can I take the opportunity just to take you, as it were, back in time. The contract was-- construction contract was signed in December of 2009. Now, prior to that, what had your involvement been with clinical output specifications?

A None.

THE CHAIR: Had you any involvement in the----

A None whatsoever.

THE CHAIR: Just-- If I can complete my question. Did you have any involvement in the planning of ward layouts or clinical output specifications prior to December 2009?

A No.

THE CHAIR: None? Right.

A None. I wasn't in post at that time.

THE CHAIR: I beg your pardon.

A Sorry. I wasn't-- I was only appointed in 2010 to the director of women and children's post.

THE CHAIR: Indeed.

A And I think I referred somewhere in my statement to the fact that my predecessor, Mrs Rosslyn Crocket, would have been involved in that discussion, along with Alan Seabourne and others.

THE CHAIR: Indeed you did. Right. So-- but you were involved in the design development process from 2010, and indeed you signed off in the sense of indicating your approval, on behalf of GGC, every room layout and plan for the Children's Hospital during 2010.

A Yes, but that was-- and I reinforced this. It's the internal fittings, such as power points, if you like, power cables, etc. Where were they going to be? Where were the power points going to be located? Where were the-- was the equipment going to be? Was there adequate number of power points? It's very simple in real terms, but it sounds like I'm signing off the entire plan. I wasn't. I was asking Mr Redfern to reassure me that the Clinical teams had seen all these-- these plans, the plan layout, the ward layout, and were comfortable to sign it off on the basis it reflected their requirements as they stood at that time, etc.

THE CHAIR: Mr Connal.

MR CONNAL: That was, you think, in 2010. Would that be right?

A Oh no, it was sometime after 2010. It wasn't immediately as I turned up into post, but it must have been-- it must

have been within the first year of being there because it was the first, like-- one of the main things to do that year was just to confirm, “Has everyone signed them off?”, and I’d asked for a clinical director or the lead person-- clinician to sign off the plans with Jamie’s name alongside it, with mine to finally approve it so that we were clear in the organisation that the people that should have been involved in that-- who were going to inherit that new area for working, were comfortable with the way it was laid out.

Q Right. So, you----

THE CHAIR: Sorry for being so slow about this. Did you simply-- I mean, before indicating your approval by signing layouts and plans, did you simply rely on Mr Redfern’s assurances or did you do something else?

A No, I asked him to complete the process-- Given the fact that, as you rightly have said, the plan was already-- the layout of the wards or the-- Sorry, the structure for the ward environment was already signed off in 2009, so there was no way we were going to be able to adapt or change things in that regard unless there was something critical that the Clinical teams had said.

We were also holding a monthly meeting regarding the commissioning of the new hospitals, so at that meeting I would have the entirety of my Clinical Directorate team as well as my planning manager, as well as Jamie Redfern and other direct reports, who would all be reporting to me when I asked the questions about, “Are we-- Where are we now with the planning for the new hospital? Have you all seen the plans and have you signed off? Are there any issues arising from them?”

So I don’t recall there being a major issue arising from any of them at that time because we were not talking about, as I repeated earlier, environmental provision or electrical provision, we were talking about, “Where are these power points and various things going to go?” and that’s just about making sure, when they came to set the ward properly before commissioning, the electrical points were positioned in the places people needed them in order to functionally attach equipment and other things to patients and to care.

THE CHAIR: So really, to repeat the point, were you relying on what you were told at these monthly meetings of your own team?

A Yes.

THE CHAIR: Right.

A And, of course, the commissioning team because they were also present, I should add. Mairi Macleod was present at every one of our management meetings during the rebuild

process.

THE CHAIR: When you use the expression, “Commissioning team”, you mean the Project team?

A Sorry, Project team, yes, yeah.

THE CHAIR: Mr Connal?

MR CONNAL: (To the witness) So, in fact, although your statement, as we might read it, you know, in print today suggests that Mr Redfern was having to sign things off, he was simply assisting the process of getting information to you for you to sign it off. Is that right?

A Correct, finally sign it off.

Q Finally sign it off. So far as issues like water and ventilation, which was the next question on your questionnaire, your answer is that you’re anticipating and expecting all of this to be done to the latest standards as set out in the latest guidance. That’s what you’re anticipating. Are you doing anything to ensure that, you know, for instance, the guidance needed for any particular service is available or that the specification for any particular ward is available as part of the process or is that nothing to do with you?

A Well, it’s not really my responsibility because clearly people were responsible as the Project team for building an appropriate standard of hospital, including the areas that require above a standard regular specification – for example, with ventilation and air handling, etc., so I don’t see it--

That wasn’t my direct responsibility, therefore I-- you know, I was working on the basis that everywhere else I’d worked and including where I-- where we worked commissioning – for example, the infertility units inside Greater Glasgow and Clyde, commissioning catheter labs – we built them to the standards that was given at the time and, if we knew there was some change coming ahead, we’d try and find out what that change was going to mean and whether we could incorporate it into the design before we built it. So therefore, that’s all I can say.

Q So the clinical output specifications for, say, a specialist ward or a ward which needed particular treatment, that was done before you came into post, I think, prior to 2009 and you weren’t involved in that process, as you told the Chair?

A Yes, yeah. Yes.

Q Your anticipation, as you set out on page 6, is, if there are any issues which are departing from whatever the guidance is, then that would go through a process depending on what the nature of the departure is. Is that right?

A Yeah, there should have been a derogation, as it’s referred to, to say, “Why are we not doing the following and what are the consequences of not doing

that following?", some of which might be budgetary, but others might well have an impact on the safety for patients.

Q Yes, and you make the point at the foot of page 6 that your assumption, in part based on your experience, as you say, of building buildings in England in your previous elements of your career, is that new buildings should meet the current standards and you point out that's particularly important for those who have immunocompromised situations.

A Certainly.

Q Now, let me just move-- The logic of the order in the questionnaire is not always ideal but we'll just stick to that to make life easier. If we just move on to page 7, I think that we start to get here an issue which crops up with a number of witnesses, which is, "Well, if there's an issue, if there's a problem, if there's an allegation that something isn't being done properly or something isn't being responded to, how do you deal with that in the systems that were in place when you were there?" Now, your answer to that, I think it's fair to say, focuses on using the line management system to deal with any issues or concerns. Is that fair?

A That's correct.

Q You say, specifically on page 7:

"Any issues and concerns were able to be reported directly to Line Managers and this approach was encouraged... and supported by [involvement from] professional associations. This... was the main route."

Now, at the end of that paragraph, you then say there's:

"... a 'Whistleblower' policy in place to encourage and ensure any concerns... are able to be raised confidentially."

Perhaps a little difficult to put the two together very easily. Do you have a view as to what the appropriate route for any concern ought to be?

A Yeah, so put the Whistleblower policy to one side, I think the main route should always be-- and I always practice it throughout my career, has been talk to the staff, talk to your line managers and talk to your Clinical teams. So we have various meetings that take place. Whether I attend them all personally or not is not the issue. That's why we have an organisational structure.

So the direct reports that report in to me, if there are issues being raised, they should be raised with me, full stop. We then have to decide whether those issues can be handled and managed locally without me taking them any further, i.e. to my direct reports, the people I report to.

If it's such an issue that we, once having discussed that with the chief

operating officer for instance because that's who I directly reported to, then I would prepare a paper or, through clinical governance, would prepare a paper.

It would be an opportunity to raise issues that were of concern, but I don't mean every single issue. I mean you have to decide on the priority, given the scale and the size of the Board, and also the fact that individually, as a director and a previous general manager and others things in the organization, I'm more than capable of speaking to my fellow directors and fellow colleagues to say, "What are you doing about this? Is this on your radar? How are you dealing with it? What's the time scale? Can we have a meeting to make sure everyone that's involved in this particular concern is going to have an answer and what is the time scale to resolve that issue?" That's the normal approach in an organisation that I have led in my career to date.

People who have ended up choosing to go elsewhere to raise an issue with a trade union are entitled to do that but with the trade unions, again, what we'd expect is there would be some feedback into us directly to say, "This is of concern. What are we doing about it?" So we go through the same pattern I've just described before. The Whistleblowing policy becomes much more difficult and fraught because people feel very vulnerable about opening their mouths and saying what they truly believe.

That's a difficulty in organisations, not just in the NHS but throughout, if you like, organisations potentially just in the UK for the sake of this discussion. I think it's disappointing when people have to use a Whistleblowing policy. Having said that, it's a true avenue for people to express their genuine opinions and those opinions and views need to be investigated thoroughly, normally through some independent means in order to get a judgment on whether one side or the other are just disagreeing about something or whether, in actual fact, there is evidence to take their concerns forward.

Q I suppose that the question that I probably ought to put to you given what you've just said is that, if it's well known that a senior official such as yourself – might be someone else – is disappointed when people have to go down the whistleblowing route, that might be thought to discourage people from doing that because they know that senior management are----

A Oh, no. No, I-- Sorry, are you finished that----

Q Yeah, no I'll stop there in the middle of a sentence, it's fine.

A No, sorry, sorry. Apologies.

So, when I say “disappointed”, I mean it’s a route that’s legitimately there. I accept that, but I think-- I mean, from a management point of view, if it’s a whistleblower within my part of the organisation, then I hope that they’ve raised those issues further down the line before they choose to go down the Whistleblowing policy, but I don’t have any control over that.

So what I’m saying is: it is disappointing if that occurs. It’s still the right to do so, and I honour and I am respectful of that right. It doesn’t just-- It doesn’t stop me from doing the right thing; it just means, “Have they raised it elsewhere and has it been tackled elsewhere, has it been neglected and, if it has, have I and my part of the organisation got any lessons to learn from not having responded appropriately or thoroughly and engaged properly with the individual?” That’s what I mean.

Q Thank you. Now, let me just pick up a couple of points of detail briefly. Page 8, you’re asked a question in the course of discussion about structures and report: “How is it decided which issues and reports go where in the system?” You say:

“The escalation of issues... were subject to consideration and deliberation by the Chief Executive, Executive Officers, [etc.]... The decision making level was at the discretion of the Chief Executive.”

I mean, is that right that the chief executive just decides at his or her discretion where the point stops?

A Well, in my opinion, if she considered-- or if he/she considered it to be a requirement, to inform the Board that it would become the subject of a board paper. Not every issue that gets raised ends up in front of the Board, that’s all I’m saying. It depends on the level of the concern; it depends whether the issues have been satisfactorily dealt with already. If they’ve gone away, if you like, then in some respects it’s a non-reportable issue, but it’s not my decision and I-- you know, I’m not at that level.

All I know is that not every single issue would appear in front of the Board. I mean, we’re a-- as I said earlier, a multi-directorate organisation with a number of issues going on every single day, if not repeatedly throughout certain days, and therefore I would not think – and I know – that not every issue went to the Board. That’s all I mean.

Q Can I just ask you this general question? We’ve had some evidence in this Inquiry about a whole series of committees. There seems to be committees, lots of committees, lots of levels of committees operating within NHSGGC at the relevant time that we’re

looking at.

Now, in some of these cases, we have the impression, and I'd like your view on this, that these committees don't actually do anything in the sense of all that happens is that reports are made to these committees and then they are then noted, or something-- similar phrase to that, rather than the committees actually taking any direct action themselves. Is that a fair description, do you think, of the way the structure worked when you were there?

A I think, first of all, a committee structure's important for the Board to make sure it has proper governance in place. I do think they should review the level and number of committees as we go forward every 12 or 24 months just to make sure that they're still relevant and what are they actually-- what is their purpose and are they serving that purpose.

Coming back to your point about action, well, usually what happens is a committee can-- they can recommend action, but they can't take any because they're a collective group of individuals with various responsibilities. So, depending on the issue-- So, for example, if there was an issue for Women and Children's, I would expect the committee chairperson to ask me or through whoever they report to, or run to the chief exec or the next level up to whatever committee it was, to say, "Right, Kevin, can you go and deal with A, B and C and can you report back?"

So, in other words, I need to action it because I'm responsible for operational management and planning and structure and everything for that area of my responsibility.

Q Thank you. Now, I'm probably bouncing back to a point that we got to a little earlier than I had anticipated in one of your earlier answers. If we go to page 9, at the foot of the page, you say there under the heading "Construction/design," it says about the new hospital:

"I had no involvement or responsibility for Construction/Design of the build."

Then you refer to the general manager and the lead nurse and so on getting involved in the layout. We should now read that presumably in light of your earlier evidence today about the sign-off process. Is that fair?

A That's very fair. Thank you.

Q Again, an outside reader might think that you were simply saying, "I had nothing to do with this." That would not be correct?

A That's correct. It would not be correct.

Q Somewhere we found reference to you giving a presentation

about the state of the new building in somewhere in 2013 - so in other words, while it was being put together. Do you remember anything about that?

A Well, I-- well, no, I-- well, I don't recall giving a presentation on it but that may just be an update. I don't know the forum unless someone can advise me, but it may just have been, "This is the layer of the building. These are the levels." I do remember doing something with the planning manager Janice Hughes which was about informing people of how the adult hospital was going to be configured and how we were going to be aligned alongside it because bearing in mind the original plan was only to build an adult hospital not a children's hospital. That came as a later decision by the then Minister for Health.

Q Yes, I had the name at the tip of my tongue and it's gone. Malcolm somebody I think.

A Malcolm-- Malcolm-- yeah, Malcom.

THE CHAIR: Chisholm. Malcolm Chisholm.

MR CONNAL: Chisholm.

A Chisholm.

Q I'm obliged, my Lord, whose memory of these matters is much better than mine. I might come back to lay out a little later, because there's a couple of things I want to ask you about, but particularly, can I just then move on to page 10, which is, in many ways, some of the questions you're being asked either have been picked up by other parties as things that they're interested in knowing about or picked up from what others have said.

Now, you're asked a question on page 10 about what Mr Calderwood thought that you might have been involved in the design, and you say, "Well, I was only there from 2010," and you make the point about Mrs Rosslyn Crocket. Then say that at that point the actual in the sense of the ward layouts and numbers of rooms and so on were pretty much fixed. Is that so?

A That's my understanding.

Q Yes. So if anyone thought you were involved in design, your involvement would simply be the way you described it earlier today, signing off after getting information from other people below you as to what had happened. Is that right?

A Yeah, and Mairi Macleod, the project manager, obviously involved in-- these are the area-- these are the things we need in these places, i.e. plug points, various electrical supplies and whatever.

Q What role was Mairi MacLeod playing in these discussions?

A Well, Mairi Macleod, as the Children's Hospital project manager, she was designated as that and that was her-

- that was her involvement in our Management team. She attended our monthly meetings and she gave an update to the Women and Children's monthly meeting, direct meeting, all in progress with the new build.

Q One of the issues that cropped up, Mr Hill-- centres around the – I might call – skillset of the Project team, particularly those who weren't by their nature building professionals but were largely coming from an administrative background. You were asked one question about that on page 10, which is the distinction between commissioning and validation and you go on on page 11 to say you understand that.

Is that something you'd come across before, this distinction between commissioning by the contractor and validation by the client?

A Yes.

Q You understood that. Was it a surprise to you to learn that validation wasn't done of the ventilation system?

A Definitely. Definitely.

Q You don't remember these things cropping up at any of your discussions with the Project team?

A Not-- not particularly, because the-- the main aspects of the links to the-- to the Project team initially was to do with the design of the new building and how we were going to be integrated in, and

the various levels and floors and what was going to be adjacent-- clinically adjacent in terms of theatres to be close to the Intensive Care unit etc., things like that.

I don't recall us having any discussions about-- I mean, validation is one of those things that in some respect come back to it. If you bought a car, you'd want to go and test drive it, for-- for example. If you buy an oven, you want to test it, and if it's not working properly, you bring somebody back in. I-- I would have thought any piece of electrical functional system has to be validated. Does it-- does it do what it said, what you bought and what it says on the tin? And if it doesn't do that, then-- And if people don't test it, I can't understand how you can commission a building for clinical purposes that are about vulnerable patients because that's what these additionalities were for.

They weren't just the-- the general air conditioning, the-- the turnaround of air changes, the various positive and negative pressures. These things are designed to be standard, but we're now talking about specialist areas that clearly required a certainty and a guarantee that the validation process meant they worked according to the specification. And I'm disappointed that that appears never to have been-- or was either addressed or

was addressed in ways that I don't know anything about.

THE CHAIR: And in this context – and I apologise for the form of the question – you are thinking of validation as something carried out by the client in order to satisfy itself, that what has specified has in fact been delivered? That's----

A Correct, plus-- Sorry. Correct. And also may have to be carried out with the manufacturer or the supplier because sometimes these are very technical pieces of equipment, but there has to be either a third party brought in on behalf through-- via Scottish Government in order to ensure the validation for these heightened areas of required environmental and your changes are validated properly.

THE CHAIR: And that would have been a GGC task?

A GGC with its partners at Scottish Government, I would have thought.

THE CHAIR: Thank you.

MR CONNAL: But your witness statement makes it clear that you didn't think it was your job to check these things because you assumed that these were all being done properly. Is that fair?

A That-- Correct. I mean, I have no legislation-- Sorry, I have no responsibility for validation. I-- When we get handed a building anywhere else I've been, or a unit, or a theatre, the reality is that theatre has been commissioned to design, specified, and built to the specification, including any additionality. And then once it's commissioned and validated, the users are invited to come and occupy it after a period of time. So that's my understanding of how normally within an NHS system – England, Scotland – that would apply.

Q Now, it may just be the way some people use language, but you'll see on page 11, it's been put you that in his statement-- Mr Calderwood hasn't given oral evidence yet. That's to come later in this session. Mr Calderwood suggests that you took the decision that the new Children's Hospital was safe to move children into, which perhaps suggests that you're carrying out some kind of analysis of safety. Is that what you were doing?

A No, I was-- I was confirming to Mr Calderwood that building as such and having previously visited along with all our Clinical teams and anyone who was moving there, we were happy at that stage. We had issues, we had some snag lists, we had some issues that we needed addressed and they were identified as part of that walkarounds with each of the Clinical teams, going to their own specific areas. None of us were

under the impression that we should be-- "Well, can we see the certificates for X, Y, and Z?"

Q Yes.

A "Are you-- can you prove to us"-- sorry.

Q No, no, carry on please. We want to hear your evidence.

A I was just gonna say, can you-- can you prove to us in hindsight? And it is in hindsight. I mean, obviously the lessons that have been learned since the building-- sorry, since the building and commissioning and, if you like, validation or otherwise of this building, it clearly has passed validation because the normal general wards, I understand, are fit for purpose. Other areas appear to have been very-- well, other areas appear not to have been completed to the same standards. I can't comment on that. I wasn't involved in the design specification or the validation process.

Q What you put in your witness statement on this topic appears at the top of page 12 of your statement, where you mentioned snagging and then you've talked to us today about walk rounds, but you say that this didn't involve testing of water drains, air handling or anything else.

A That's correct.

Q That's the approach that you take, so that your approach to, "Can we move in?" is based, as you say, on the physical finish the ward areas rather than on any assessment of the ventilation or water systems. Is that right?

A That's correct. Correct, because the testing of water systems that sits within the director of facilities and estates, for example.

Q You were then asked a number of things about how infection control worked. I don't think we need to take you to your general responses, but just to try to get some kind of chronology in our heads, you are asked on page 13:

"When did you first become aware of concerns raised by IPC about the built environment, [whether it's] water or ventilation within the [hospital]."

Can you remember when you first heard that there were concerns?

A I don't-- I don't recall the specific dates. I-- I know that there was issues being raised and those issues were getting raised obviously at local level, bearing in mind that the Infection Control doctor, particularly with the Children's Hospital and particularly with the-- what was known as-- formerly as the Schiehallion unit, would be part of their ward round each day or particularly each week. So the reality is that the Infection Control doctor plays a significant and very local role in observing and hearing and seeing for herself, at that

stage, what was going on and what were the issues.

They would then be reported up to-- through our general Management team, to the Facilities and Estates people. Very often the ward domestics would come round and supervise and these are the things. They would be raising similar concerns if it was about identifiable mould growing. "Does it look as if that area is clean?" etc., etc. But of course a lot of the things that were going on were going on behind, if you like, within the water systems, within pipe work, within-- behind washboards and-- sorry, showers-- sealed shower units and things like that. So they only became to light in reality once further works commenced to investigate further, and hence why we ended up with a series of actions including ward moves.

Q Well, let me ask you about the Schiehallion unit, Ward 2A/2B.

A Yeah.

Q You were asked the question at the foot of page 13, you know, wearing your hat, and we know now what hat you wear:

"...did you anticipate that the ventilation system in Ward 2A RHC would be of equivalent standard or better than that installed in the Schiehallion unit at Yorkhill?"

And you basically answer that, "Yes." Is that right?

A Yes. Yes, correct.

Q If we look at the top of page 14, you say that minimum equivalent with any upgrades depending on what the regulations required. That's what you thought was to be done.

A I am quite clear on that, and that is definitely my honest recollection and it's my honest opinion.

Q Can I just ask: you mentioned there the SHTM, the SHTM's, plural, which are obviously guidance notes on various topics, including one that we've heard a lot about here, which was SHTM 03-01 on ventilation. Do you have any view as to whether Ward 2A was a neutropenic ward as described in that guidance?

A No.

Q Or is that not something you can comment on?

A I can't comment on that. I cannot comment on that.

Q Then, you're asked whether these----

THE CHAIR: Sorry, if I can interrupt. I just want to absolutely clarify it. Why do you say the Schiehallion unit was carrying out bone marrow transplants, and it was also to dealing with haemato-oncology paediatric patients who were in receipt of other treatments. Why do you say you can't

comment on whether that was a neutropenic ward or otherwise?

A Because bone marrow transplants get to take part in a subsection of the ward. Not all the ward would be-- would have to have been designated to the same standards, so therefore there could well be, as they were in the plans, closed rooms, areas that you can treat neutropenic patients in very safely, hence why they need different facilities and air handling and filtration, including obviously taps filters and everything else.

Other patient areas and other patients in that ward are not as vulnerable at certain times, depending on the phases of the treatment they're going through, and therefore some parts of the ward could be more general than a specific bone marrow transplant unit as you've referred throughout.

So I don't think the whole ward has to be neutropenic, as I said earlier, as I tried to respond, but I do know it has to have a higher standard in those areas where patients'-- sorry, the immunosuppression systems are affected.

THE CHAIR: That is despite the fact that, as I understand it, and correct me if I'm wrong, all areas of 2A would be accessed by patients who were from time to time neutropenic to some degree. Am I right in my factual assumption?

A Yes, you are.

THE CHAIR: Right, thank you.

MR CONNAL: You go on to say on that page, what you've already told us, you can't remember when the issues with 2A were first brought to your attention, but you were concerned if the standards of ventilation weren't what they should have been, and then you asked, well, do you know who had approved the design of the ventilation for the Schiehallion unit before handover and how that was done and what the explanation was, and you say you just don't know. Is that the position?

A That's correct.

Q Now, if we go back a bit, one of the possible uses that you can make of a thing called a clinical output specification as part of the original planning is to either specify or indicate the kind of environment that you need to create for a special unit, but you weren't involved in that process.

Now, Professor Gibson, perhaps to the surprise of many, said that she wasn't involved in putting together the clinical output specification, nor was anyone she knew involved. It seemed to have been done by a manager. Do you have any knowledge of that at all?

A No.

Q Just while I'm on Professor

Gibson, or the topic, we heard from her that she wasn't happy with the layout that was proposed for the Schiehallion unit. There were a range of problems: pharmacy was sort of being stuck in a cupboard, which she thought a very important feature; nurses weren't going to be close enough to the children who might require very swift action, and so on.

Now, she described raising this with the Project team and not getting particularly helpful responses, just to paraphrase a little. Do you know anything about that at all?

A Yeah, I do know that-- I think this follows her site visit. I'm sure it was probably following the site visit, unless she raised it beforehand, but my recollection is following the site visit, a number of people raised a number of issues. They were all collated together and they were, if you like, presented to the Project team to try and address those issues. Having said that, however, the building was already built when we went round it, for obvious reasons, and therefore relocation within the ward area was then subject to operational management with the ward manager to say, should we put the pharmacy etc., in that corner or move it to somewhere else?

But bear in mind everything that goes on in a ward is very important, every

aspect of it, otherwise we wouldn't have it in the ward, but the problem becomes when your space is limited, as it always will be in public builds and in other builds, for example, the design was already complete.

The building was commissioning, or being commissioned, and therefore it was up to us as an Operational Management team to decide, how do we reconcile anybody's concerns, and so----

THE CHAIR: Sorry, my fault, Mr Hill. When you talk about the site visit, I take it that's the site visit you refer to near the top of page 15 in March of 2015? Yes, thank you.

A Yeah.

MR CONNAL: Well, I think it was suggested by Professor Gibson that she made her dissatisfaction known during the process of looking at layouts when people were asking her to sign off, as it were, on the layout for the Schiehallion, and it was at that design stage that she was raising these concerns about what had been put forward, in fact to the extent that she declined to sign off the plans for the Schiehallion unit. Now, that would be at a time when things were still capable of being changed, potentially. Do you know anything about that?

A No. Well, all I can say is if it was prior to 2010, I know nothing about it other than the fact-- I understood when I

was asked to sign off the layouts, I understood that at that time Professor Gibson didn't sign off as the clinical-- well, the clinical leader for that unit because she still had those concerns.

THE CHAIR: Sorry, my fault again Mr Hill. When you're talking about Professor Gibson's concerns, are we talking about the design development period in 2010 or are we talking about the time of the site visit in March 2015?

A So, I was referring to the earlier part when the building design was getting signed off, and then they were going to commission building against the specification. As I said earlier, I was in post from 2010, so which-- you and other-- As you've referred to earlier, the building was actually signed off in 2009 as ready to be built to the specification.

If Dr Gibson's concerns had been expressed at that stage, which they may well have been, from what I've just heard from Mr Connal, the reality is that I wouldn't have known that until, of course, I asked for the room layouts as I'm saying, i.e., the build is already being established, the building is underway, and then when we went on the site visit in 2015 in March, I know that Dr Gibson raised concerns at that stage which are similar to what you're just describing to me now, but at that stage, of course, the building was built. The structure was in

place. The room layouts were already-- The room structures and their locations were already configured within the entirety of what you might call 2A and 2B.

THE CHAIR: I understand that, but what I was looking for help on: were you saying that you were aware in 2010 of Professor Gibson's dissatisfaction with what was proposed or were you not saying that?

A No, I think I was aware she didn't sign the plan because her name wasn't on the plan, so in 2010, if that's when I signed off the plan layouts, Jamie would no doubt have referred to the fact Dr Gibson's signature is not on this; there are no other clinicians' signatures on it because they don't agree with the plan. The problem then is, even if I raise that, which I'm sure we did raise it up the line, the reality is they're not going to reconfigure the building, bearing in mind that the building was already underway.

THE CHAIR: Thank you.

MR CONNAL: Well, let's come to 2015 and to the discovery that there were not HEPA filters in some BMT rooms, we're still talking about 2A. Now, firstly, would you agree with me that that's a serious issue, the absence of HEPA filters?

A Well, in-- Specifically, in 2A, yes, it was a serious issue.

Q Yes, and does it not raise a

second question? Well, first of all, why are there no HEPA filters there, the simple one? Second question is how can this hospital have been validated when there are no HEPA filters here, against the standards that you would have expected? Does it not raise that question as well?

A Yes, it possibly does, but as I understood it, they-- What had happened was the builder had fitted standard sinks throughout the entirety of the hospital – I'm talking Children's Hospital – and thereafter, it was discovered that the types of sinks that were fitted did not have HEPA filters on them, so they ended up with a phased approach to replacing sinks with HEPA filters, or adjusting the tap design etc. I remember lots of conversations taking place about the design of sinks, size of sinks, splashback from the bowl itself, the way the water flowed out the tap, etc. So lots of conversations took place.

My understanding is that was addressed through our Estates and Facilities colleagues as part of the, if you like, refitting certain things that hadn't put in place at that time. I don't know whether they were ever specified in the original specification.

Q Well, the fault may be mine, but I was understanding that the absence of HEPA filters was from the ventilation system in the BMT.

Oh, sorry, apologies, apologies, my mistake. I thought you were meaning the-- Sorry, I thought you were meaning the reference to taps, my apologies.

Okay, well, when you're asked about this in your witness statement at page 15, you say you were made aware of it, can't remember who-- Then, you said:

"I would certainly have held a discussion/meeting with Children's Hospital Commissioning Manager (Mhairi McLeod) to seek an explanation for the omission."

Well, do you remember or do you not?

A Oh, we certainly held-- Well, as I said earlier, she was at our monthly meetings. We often met with her, or Jamie did virtually weekly, so the reality would be those issues would be raised with her and we would be seeking answers to-- and we ended up doing walk-rounds and everything to be able to confirm the priority in order to address this particular issue with HEPA filters, and the rest of the-- Forgive my previous conversations, a senile moment, if you want to call it that, for taps but no doubt we'll come on to them later.

So, my understanding is yes, as soon as we-- anything was raised with us we would be looking to get and obtain

answers because that's my responsibility, as is Jamie's and others within the organisation. This is going to affect significantly our patient groups, or could affect them significantly, and if it's a requirement-- Sorry. If it's a requirement, it should have been in place, hence my earlier conversations about validation.

Q Well, you explain on page 15 that you would have spoken to Mairi Macleod, and you go on to say that you would also have raised it with David Loudon, who was then the project leader. I'm just trying to understand the way somebody in your position approached this, Mr Hill, because if you think about it, it potentially raises three questions: (1) "Why are there not HEPA filters?"; (2) "Who signed this off without HEPA filters?", i.e. you know, "How can you validate it if there's no HEPA filter?"; and (3) "Does this suggest there are other issues potentially in this area which is going to receive vulnerable people?" Now, I didn't find in your answer, and it may be my fault, any indication that you had a good old think about this and pursued it.

A (Inaudible 11:12:34). Sorry. Well, I can only comment on the fact that-- what I can recall-- and a lot of it, it doesn't ring any bells with me, so I'm not-- I can't make any comment on it, but I

can reassure-- at the time, any issues that were raised, David Loudon and others-- including the fact that David would be sitting around the directors table when we met as directors for the entire organisation-- that those conversations would definitely have taken place. That would have been a telephone call to David in the first instance.

The meeting with Mairi would be for the-- what are we going to do about it in terms of the situation, and the reality was there were lots of conversations taking place about the organisation's building and various issues about it that I was never party to, and I've got no clarity about-- I know they talked about water issues. I know they talked about ventilation. They maybe had other issues, BMT in the Adult sector, for example, but the reality is I wasn't party to all those discussions. It depended on whether they took place between-- behind a private door or within a committee meeting that I happened to be a party of, and there'd be a variety of that.

Q Okay. Well, let me ask you this, and I just need to get your take on it. You were head of Women and Children. The Schiehallion unit was something that you were-- if you ignore the chief operating officer and chief executive, you were the top person responsible for.

A Yes.

Q Was it not your job to find out what had happened, why it had happened, how on earth these things had taken place, did it indicate any other issues. Was that not something that was part of your role?

A Yes.

Q And did you do that?

A Well, I can't, hand on heart-- I would have asked questions, as I normally would in this role and any other role I've been in, about what are the consequences of this, how did we manage to commission this part of the organisation without these employees if – if – they were part of the specification. But I'd never seen a specification. I've never seen a clinical outcome document related to the new build. I don't know what paperwork existed.

Therefore, as much as I can challenge people, I've also got to trust them and-- as the experts. I'm talking now about the-- the engineering and various people that came in to build the building and commission ventilation, and yes, perhaps I should have pursued that in a bigger wider area, but I didn't.

THE CHAIR: Mr Hill, I noted you as saying, "I got no clarity". Now, just to understand what you meant by that, were you looking for clarity that was denied to you or maybe you were meaning something else?

A I think the situation is that there are a number of people with responsibilities in Greater Glasgow and Clyde. What they choose to share with you, and at what level, is obviously a personal issue. I am unaware people were withholding anything from me. I am not accusing anybody of anything. All I'm trying to repeat is, and reflect on is, honestly what I recall.

THE CHAIR: Right, thank you.

MR CONNAL: I'm really trying to-- We're creating a jigsaw puzzle here, Mr Hill, from recollections of things that were a long time ago. So apologies for that, but I suppose what I'm trying to get at is you're somebody who is assuming that what you're going to get in the Schiehallion unit is going to be at least as good, possibly better, than they had at Yorkhill in terms of all the facilities, ventilation and everything else. Did you get any assurance from anyone at the time of 2015 that that's what you'd been given, or did it----

A No.

Q -- not get that far?

A No.

Q Do you remember whether you were asked?

A No.

Q Now, is that you don't-- Sorry, this is my fault. Is that you don't remember, or is that you didn't ask?

A I don't recall asking.

Q Thank you. Well, we'll move on, Mr Hill. Deal with one or two other things. You were asked about isolation rooms, and you say in your answer on page 16 you were made aware of an issue, the rooms were unsuitable, and then a discussion ensued as to how to deal with it. Is that correct?

A Yes.

Q But you weren't aware in advance that there was going to be an unsuitable provision. That was not something you were involved in?

A No.

Q Okay. Let me just move on, then, to some other issues. Page 17, we turn to the topic of water. Now, I accept that you're an administrator. You're not a water engineer, so we'll take it-- we're bearing that in mind. We're asking everybody about the DMA Canyon report of 2015 and when they knew about it.

Now, I can dig it out if we need to, but I think you know what I'm talking about here. Now, you say on page 17 you weren't aware of it in 2015 or 2016, and you became aware of reference to it during 2018. Can you remember at all when in 2018 or not?

A I think I was in attendance at a director's meeting with the chief executive, and there certainly was reference to some-- there had been some rumours going around that there had been a report done, and it suddenly got-- it was mentioned at a meeting I was at. I remember them by reference to the DMA. I knew nothing about a DMA report and knew nothing about its contents, etc. It became appropriate at that stage, and indicated it was to do with the testing of water quality.

Q So, you're-- Just so I'm clear, you were at a board meeting----

A No, I'm at-- sorry, I'm at an Acute Directors meeting, which is----

Q To direct----

A Yeah, yeah.

Q My apologies. An Acute Directors meeting but, prior to that meeting, as you put it, rumours had been circulating that there was some report. What report-- a report that hadn't been actioned, a report that was missing? Can you help us at all?

A I understood it was a report----

Q (Inaudible 11:20:21).

A I understood it was a report that had been published, had been received by the Board, or by the director of Estates and Facilities, that there were a number of recommendations within that report, and that-- my recollection is a number were either outstanding or it had been-- it had not been addressed in its entirety.

Q Were you involved in any

further discussion of the DMA Canyon report, or is that not something that really crossed your desk?

A No, I wasn't involved in it, but I knew meetings were taking place about it. But, again, that's back to meetings that I wouldn't have necessarily been invited to anyway.

Q Okay. Let me just ask you about taps, since you volunteered some material on that, as you put, it earlier. We've been talking about things called Horne optitherm taps, which became an issue because there'd been a report from Northern Ireland of neonatal deaths associated with flow straighteners, and these taps had something that was equivalent to a flow straightener in them. If I'm not getting the technicalities correct, you'll forgive me. Now, do you remember being involved in discussions about the Horne taps or not?

A Not specifically about the design of the tap or otherwise, but I do recall conversations taking place between the general manager and-- and Estates colleagues about the design of the taps that were in place, and the solution was to replace them in a phased way, as I think I referred to earlier, across a number of clinical areas to ensure that we weren't heightening the chance of infections amongst the patient groups.

Q In 2014 – so, this is still when the hospital is being built – the information we have is that it was a discussion which centered around the fact that many of the taps had already been installed or ordered or supplied, and the question was, "Do we have to take them all out again and do something different or do we just press on?" Now, in your witness statement, at page 18, you say:

"The advice of Infection Prevention and Control would have been sought to determine the safest outcome for patients."

Is that what you would have expected to happen?

A Yes, definitely.

Q Were you aware that the decision was taken to press on and use Horne taps, but to create a maintenance regime designed to produce the biofilm issues? Were you aware of that at all?

A No.

Q Because I think some parties to the Inquiry might suggest it was a decision which was driven by the financial consequences of ripping stuff out and starting again. Were you not involved in these discussions?

A No.

Q Can I ask you a sort of-- almost an administrative question which appears also on page 18. You're asked about how did you get involved in some

of the water contamination discussions. You say:

"My involvement in potential water contamination issues as a direct source of infections in patients in Schiehallion unit; was a member of an Infection Management Team (IMT)..."

Now, I have two questions about that. You're, by qualification, an administrator, and you're a very senior administrator for most purposes in NHS GGC. What are you doing at an IMT?

A Because, given the seriousness of what-- if you think about the events that have taken place since we, if you like, physically moved into the hospital, it was regarded as very important that at senior level-- first of all, I was paying attention to what's going on and, secondly, I was reporting back through to the chief executive entirely about what was happening and, clearly, what are we doing about it. Given the entirety of the sensitivities that were clearly apparent, and the risks to patients, that's why I was there.

Q Right. Perhaps you can answer me another general question. If we go to page 20 of your witness statement----

THE CHAIR: Could I just, sorry, return to that?

MR CONNAL: Yes.

THE CHAIR: (To the witness) When you were talking about attendance-- or when Mr Connal was talking about attendance at IMTs, I take it that was in 2018. Have I got the time scale correct?

A Yes.

THE CHAIR: Now, if we look at the minutes of the IMTs from March of 2018, would we expect to see you as one of the attendees at the IMTs or, alternatively, Mr Redfern as your manager?

A Well, Mr Redfern would normally be in attendance, and if he was-- sometimes I would not be able to attend, depending on my other conflicting areas to be responsible for and what was happening, but wherever possible, if Jamie couldn't attend, I would attend on his behalf so we kind of, if you like, made sure that either Jamie or myself were at the meeting and that's the way we kind of managed it as we moved forward. I wouldn't be at every IMT and Jamie would probably be at most of them. That was the way it worked.

THE CHAIR: That would reflect your understanding at that time of the seriousness of the concerns over water contamination. Have I got that right?

A Correct.

THE CHAIR: Thank you.

MR CONNAL: You express your view on that, I think, at the foot of page 18 and running on to 19, and we needn't get you to read that out.

I wanted to ask you another general question that we've struggled with a little bit and maybe you can or cannot help us. If you go to page 20 of your witness statement, we're talking about the decant of patients from 2A and B. Quite a big thing in itself, but this is being discussed in 2018.

Now, we've heard that concerns about particularly the ventilation, never mind the water, in the Schiehallion unit started in 2015. Is it not fair to say that, by the time you come to 2018, it was reasonably well known that the ventilation system wasn't what it ought to have been?

A That's not my understanding. My understanding was that whatever was required to improve the ventilation system had been undertaken. I know we were doing-- tests were being carried out in terms of the positive/negative aspects, the isolation and the-- the readings within the rooms and the readings in the environment outside so-- and our infection control colleagues were also part of that reporting back, so I am not aware that we were continually talking about ventilation since 2015.

Q I think we know from other sources that in 2018 some formal reports were prepared which indicated that 2A had not been built in the way that had been anticipated, if I just use that as a neutral way of putting it for the moment, in terms of air change rates and protective environment and so on. But there's also been a number of witnesses who have said, "Well, yes, that's when we got the formal reports," but it was pretty well known before that that the environment was not what should have been of the Yorkhill plus equivalent that you've spoken of. Were you not aware of that, no?

A Well, I don't recall us forever talking about air ventilation systems and I do recall the fact that it was flagged early on in 2015. We were treating patients in the unit, therefore there was certainly-- it was certainly a clinical environment that was deemed safe at that time to treat patients.

The other thing is that standards throughout the UK-- oh, sorry, the build standards for air ventilation, I understand, in these types of units, some units don't have them. They run on a general ward and I'm sure Dr Gibson refers to that in one of her statements so-- because she's one of the GC accredited visitors so she looks at the standards as part of visiting other wards and units.

So I'm not-- I can't comment on the fact that-- why-- I mean, to be fair, in order to upgrade the ventilation system, I'm not involved in what is the requirements to do that. My

understanding was the ward was deemed safe to transfer to, that's just-- and that was the decision we took at the time.

Q I suppose that the question some might want answered, Mr Hill, is that we know reports in and around 2018 said lots of things were wrong with the ventilation system of 2A, and then we know ultimately it was stripped out and replaced. I think the question is: why did it take from 2015 when the first signs of concern arose until 2018 for this to be done? Can you help us at all on that or is it not your area?

A I don't know. I mean, I think there were a lot of investigations. People were visiting every six months, reports were being prepared. I can't explain why it's taken three years to get to that point. It's not my direct area of responsibility but the clinical area is my area of responsibility.

Q (After a pause) You were involved in the decision to decant. Is that right?

A Yes, yes.

Q You've set out fairly fully what some of the issues were. Again, some people have said, "Well, if there's a problem with the water, it's the same water in 6A, is it not? What's the benefit of moving there?" Do you remember that discussion?

A Yes, and the reality was that the 6A cohort of patients were not the immunocompromised patients. The immunocompromised patients moved into the ward area 4B, which was the current adult bone marrow transplant area.

THE CHAIR: When you say "not immunocompromised", you mean not in receipt of bone marrow transfer treatment?

A Yeah.

MR CONNAL: Yes, thank you. My Lord, I'm conscious of the time. This might be the appropriate point to pause.

THE CHAIR: Very well. Mr Hill, as I said, we usually take a coffee break. Can I ask you to be ready to resume at what I take to be ten to one your time and ten to twelve our time? Thank you.

THE WITNESS: Thank you very much.

(<u>Short break</u>)

THE CHAIR: Mr Connal.

MR CONNAL: Thank you, my Lord. A couple of questions that have been passed to me following your recent answers about the decant, Mr Hill. When I suggested that moving into 6A wasn't necessarily a cure for the water issues because it was the same water supply, you said, "Oh, yes, but the BMT patients are going into 4B". Is that not also using the same water?

A Yes.

Q The other question I have really relates to this issue, which we're approaching with hindsight, and I accept that, but from a start in 2015 when issues started to be raised about the environment, the protective environment in 2A to 2018 when various reports were produced, which demonstrated that it hadn't been built as had been hoped for, were you not aware that at least by 2017, at a management level, it was known that the kind of "Yorkhill plus" specification hadn't been built?

A I don't clearly recall.

Q But the other question – I'm probably turning the clock back a little bit – is: remember we discussed validation and what it did, what it was intended to do. If you had a specialist ward, with specialist ventilation requirements that you, the client, were expecting to be "Yorkhill plus" – that's my phrase, not anyone else's – validation would you whether you'd achieve that, wouldn't it?

A Yes.

Q I just wondered whether it didn't occur to you or others that that was something that really needed to be checked because validation hadn't happened.

A I was unaware at that stage that validation to what would have been-- I-- Well, come back a minute. I suppose

the first thing is: what specification was it built to? And, secondly, the expectation was-- the assumption was – those are my phrases – that it would have been built to the same standard, if not higher, as I described query Yorkhill plus as you've referred to. I was unaware at that stage and as clearly time went on and in hindsight, I now understand that that wasn't the case. In fact, it was far from it. It was really built to a standard ward-- a general standard ward. Therefore, of course I'm concerned on hearing that, but that's in hindsight.

Q I wondered if at any point as matters progressed and we're heading into 2017, 2018, so on, did it ever occur to you that you should engage assistance from any of the Scottish Government agencies, like HFS or HPS – whatever the right name was – at that time?

A I have no direct route to them. That would be done through the chief operating officer or the chief executive to engage at the next level up at the Scottish Government. Bearing in mind, my understanding would have been they would have been involved in-- Health Facilities Scotland, Health Protection Scotland should have been involved in the-- I would have thought the pre-commission of the building, the fact that we were building a brand new building, what were the standards we were going

to build it to because they are the owners of the standards in that regard.

Q Okay. Well, just to come back to my question, I can understand that, in your view, triggering assistance from these agencies might have been a matter for somebody one or two pay grades above your own, but would it not have needed somebody to prod them from below like you or----

A I suspect-- I suspect-- Sorry. Sorry, apologies.

Q No, I was just saying someone like you or someone in your position, that kind of position, to say, "There're all these issues arising. We need some external help."

A I suppose, in hindsight, my failing, if any, would have been that I did not ask to see a validation report. I should have done, in hindsight. I did not see any paperwork that confirmed the standard of what was actually put in place. I mean ventilation, taps, whatever failings were further and eventually discovered.

So I, in hindsight, accept, and I'm saddened, that I didn't do any of that. It's certainly a lesson-- not that I'm going to be working any further, but it's a lesson to be learned by not just me but any fellow manager who's currently managing, and their organisations as they go forward.

As I said earlier, I was astonished to

understand that the-- first of all, the commissioning process did not meet whatever specification was described. I don't even know what the specification was for those ward areas. So, yes, saddened that patients were affected as a consequence of any inaction on my part.

Q I'm going to move to a slightly different topic. Some questions that we were asked to put to you but weren't put to you in time to get into your written statement. On page 22 of your witness statement, there's some exchanges near the foot of that page where you were quoted as talking about the need for a multidisciplinary team reaching a consensual position about, in this case, the decant of patients from 6A to the CDU. I think the response to that-- we've been asked to put to you is, well-- you're talking-- to talk about a multidisciplinary team. Is that not what an IMT is?

A Yes, it is but it's-- come back to the point. It's not a decision-making body other than in the context of what is the source of infections, what is causing them, how do we think we should treat and manage them. The operational responsibility for the ward environment, ward areas, etc.-- the operational responsibility for that rests with the Clinical and Managerial team. So that-- if you like, the select group of individuals

who were asked to meet were charged with-- through IMT, trying to find a alternative location-- a safe alternative location despite the concerns and issues that were rife throughout the adult/children's hospital with regard to water, filtration, etc., and that's what we endeavoured to do, and I'm pleased to say we were able to reach that conclusion. That's not to say everyone agreed with the final conclusion, but we had to reach one given this that-- given the issues and the recurring issues that were taking place on Ward 6A.

Q That small group, I understand from the thrust of the questions, didn't have clinicians in it. It was----

A No.

Q -- managers, if you like. Is that right?

A Correct. Correct. Well, there's one clinician, but that's Teresa Inkster, but she's not responsible for the clinical service. She's responsible for giving us advice and recommendations to do with infection control.

Q Yes. Okay. So, the sort of two-stage process, then-- the IMT says, "This is what we're proposing you do", and then a separate group meets and says-- and considers whether that is what will or will not happen.

A Well, the IMT was talking to us about-- or asking us to seek alternative locations in order to safely allow Ward 6A and the patients who are presently-- currently occupying it to be safely transferred elsewhere, given the nature of what-- the extent of the water, shower cubicles, filtration issues were, and it was deemed safer at that time.

We had been doing, if you like, smaller works within that ward while we were still treating patients, but it was then deemed, in order to get to the entirety of what lay behind shower cubicles, shower coverings, etc., behind outlets and various other things, we would have to have dismantled parts of the wall structure, create dust, workmen and women going throughout the place. So we really had to decide it's no longer a safe place to try and do all that alongside a functioning ward.

Q You've also been asked a question that seems to infer, at least, that you might have disagreed with Dr Inkster about risk from mould in shower rooms, and you say, no, you didn't disagree. That's still on page 23 of your witness statement----

A Yes, I don't think I-- sorry, sorry.

Q No, no, carry on. About two thirds of the way down.

A Yeah. I don't recall disagreeing with her. I don't recall it, and therefore I think that's what I've said.

Q Yes.

A I was as keen as anyone to find out why we were getting the various outbreaks, the various developments in the ward environment, and clearly hence why, ultimately, the decision was taken to move to the Clinical Decisions unit in order to allow a full thorough Estates and maintenance investigation into what all the sources were, and potential sources.

Q Well, I see also on that page, there seems to be an inference that you might have disagreed with the IMT decision to sample drains. Now, was that something you disagreed with or not?

A I think I expressed the opinion that I would expect drains to have bacteria within them in organisms. Having said that, however, it was not my decision whether we tested drains or whatever. So, I'm not saying-- I don't have any jurisdiction over whether we were going to test drains or not. I think the debate was more to do with that we're going to find things in drains. It's the nature of any drainage system.

Q Now, if we move on, on page 24, you are asked about a decision to close Ward 6A to new admissions. Now, was that something you were involved in?

A No, I wasn't involved in the decision-making itself. That was a clinical decision taken between the clinicians, the ward nursing staff, and

Jamie as, if you like, the general manager in charge of that area, and the decision was to avoid admitting anyone-- new patients into the hospital during this period of time. That was a decision that was supported by me, and therefore that's what we implemented.

Q I think that the narrative that you inserted on page 24 running onto 25 suggests that it wasn't perhaps quite as simple as just saying "no new admissions" because some people were not happy with the alternatives. Is that something you were involved with or something you were simply told about by others?

A I was aware of that, and we were aware of that as part of the discussion about trying to avoid taking any new admissions. It was-- The decision whether to admit a new patient or otherwise was the clinician's decision. If they then said they were admitting them, we had to make whatever workarounds we had to do, we had to cater for that, and be able to respond to that appropriately.

If they decided to refer them elsewhere, which they did on a handful of patients, is my understanding, most of those patients who were referred elsewhere didn't like where they were subsequently-- where they were transferred to. They also didn't think the

standards across there were any-- well, they didn't think the environment across there was any better than the one they were leaving.

Q Another thing I need to ask you about – well, you've actually been asked in your witness statement, but I just want to come there – appears on page 26, where there's a discussion about an IMT on 18 January 2019, where Dr Inkster, from her statement, says that she felt she was being pressurised, possibly bullied even, at that time. Now, I think this is a meeting you were there. Can we just make sure we understand what your position is on that suggestion that she was being-- put under pressure?

A Well, I think I said in my statement I appreciate the-- having to chair a meeting and also report into that meeting, given the detailed information that Dr Inkster used to have to share with us. It's obviously a very difficult position to be in. I respect her for trying to do both tasks at the same time. Secondly, I might never-- I might not agree with Dr Inkster in terms of her approach, but I cannot argue against the facts and figures and various details she shares with the committee, and I'm not in a qualified position to do so. So, I take her advice on board, just like other members of that group.

I'm not aware that I would ever put her under pressure. I was very supportive, I thought. That's my usual approach in the meeting. Whether I'm a participant or whether I'm chairing, I'm looking for people to participate, I'm looking to support the chair because it's a difficult role, and also I find it difficult to recollect how I could put her under pressure or additional stress.

So, I don't recall anything different with that meeting than I do with some others. I could certainly have asked some questions, and would be directing my questioning but that's part of my role, and that's part of the way I have operated throughout my career, but I'm certainly not treating people with disrespect, and I'm certainly not trying to humiliate them in public.

Q In your answer, in your witness statement on page 26, you say you suspect you would have asked questions and challenged points. Were you in a position to challenge what Dr Inkster would be saying?

A No, not in a position to challenge her from a technical and professional point of view. But if some of the statements were about, "We need to now move out of the ward" or, "We now need to do this", some of those points were challengeable and were rightly challengeable because we needed to discuss it to understand fully because the

consequences of moving from this ward had to be addressed properly if we were going to move. I mean, at one time, people were talking about closing the ward down.

So, if you're talking about closing the ward down, I'm going to challenge that because that means there's nowhere else in Scotland that these patients can go. There's not an equivalent unit in Scotland. There's a equivalent lesser unit, as I think I've indicated elsewhere, in Edinburgh. It couldn't have dealt with the entirety of patients in the first instance. So, we've got to work on the basis that we are operationally responsible for trying to maintain a service, yes, but also taking into account professional advice, facts and figures, in order to make that as safe as possible for the patient groups we're dealing with.

But I don't recall directly challenging Dr Inkster about-- I mean, my general point is if somebody says-- for example, I can give you one quote. We were originally told at one time that the infection that was arising was only discovered previously on Mars on the spaceship, right? That was a quote from somebody at a meeting, an IMT meeting. At that point, of course, me, like any other, would say, "Well if it's only been discovered there, how come we're now dealing with it on Earth?" So, there's some ridiculous comments made, I would say, in my opinion, which clearly needed to be, if you like, challenged and therefore not entertained any further.

Q Yes, I suspect you're referring to – and I've probably forgotten the full name now – an organism called Elizabethkingia----

A Yeah.

Q -- and then there's a second part to that which is said to have been discovered in the space station-- first recorded in the space station. Is that what you're talking about?

Q Can I ask you to have a look at bundle 8, please, page 85? (After a pause) Now, this is a letter in September '19 to a band of consultants who've raised concerns. I see your name appears. Was this an uncomfortable time for you to have consultants coming together to say they're not happy?

A No, I think it's important that consultants tell us when they're not happy.

Q And were you involved in the process of speaking to them?

A Yes.

Q What form did that take? Did you meet them individually or was it in a bigger meeting?

A Yeah, I used to attend their-- they had a weekly meeting. From what I understand, they would sometimes have

a bigger monthly meeting. Jamie would always probably be present there, but occasionally I would be invited to come and meet them and catch up with them, and I would do that and that would be quite a normal situation for us. That gave the consultants a chance to ask us any questions, what was going on elsewhere in the Board and whatever, etc. But, clearly, the concerns here were raised and, legitimately and rightly, they were responded to as-- in the form of a meeting.

Q Do you think you were able to reassure them that their concerns were not well founded?

A I don't think we were trying to reassure them that at all. They clearly had concerns and they were right to raise those concerns and they sought answers whether we were able to provide the answers there and then or whether we went away to do other pieces of work, and clearly it was part of the ongoing issues which resulted subsequently in the moves of ward-- to Ward 6A and to the CDU and to the ultimate upgrading of 2A and 2B in the new Children's Hospital.

Q Thank you. I just want to ask you about one or two places where you've used particular language. If we can go back to the witness statement and go to page 27, you're talking there about Cryptococcus, and I don't really want to ask you very much about that subject, but I wanted to ask you about a communications point that appears at the foot of the page. You say:

"If the source of infection(s) was unknown then the statement could not include speculative or multiple reasons without conclusive evidence."

Now, is that your understanding, that you need conclusive evidence before you can explain this to patients and parents?

A No, but you need to be clear that any communication about Cryptococcus or an infection would be led by and I would seek – as the Board did and the Communications team did – Dr Inkster, who was lead for this area at that time, her wording in order to ensure anything we were going to say was factually correct and was-- if you like, could be challenged in an evidence-based way. So, it's not for me to talk about the source of infections, given the fact at that stage we had multiple sources-- potential sources of infection, and we were, if you like, trying to address those on every occasion when they arose and did do.

Q My question is really focused on the word "conclusive" because we've had some debate about this. The indications from other witnesses are that in the context of many infections,

however many investigations you do, however quickly you move and so on, you may never ultimately know exactly what the source is, but you're able to make an assessment based on the material available to you that it was probably X or probably Y.

A Yes.

Q Now, I just wondered why you were looking for something that was conclusive, because that might involve a slightly higher standard.

A Yeah, well, in hindsight, I suppose what you're saying to me, and you're right, a lot of infections, having dealt with them outwith Greater Glasgow and Clyde in my previous role, we would have infection intensive care units and theatres, etc., and very often, as you've rightly said, the source came from X, but we're not sure how it entered, and we're not sure-- sorry, the infection occurred in X area, but we're unsure where the source came from, so I-- perhaps my use of that word is erroneous in this instance, I agree with you.

Q Now, I'm jumping back again. Remember we were talking about investigating drains?

A Mm-hmm.

Q One of the things that you instructed was to try to find out what other hospitals did about drain sampling.

A Mm-hmm.

Q Now, I think that what lies behind the question that's been put to you is probably that someone says, "Well, if there's gunk coming out of the drains here, what does it matter what Hospital A, B or C does? Should we not be focusing on what we've got here?" Why did you think it was appropriate to go particularly to the English picture?

A Well, two things. One is we were still investigating the gunk, as you describe it, that was coming out of the drains in our hospital facilities and we would continue, no doubt, to carry on doing that. The issue with-- People can test for a whole load of things and eventually they might find it, so there's an issue about how much testing are people doing to find A, B, C or D organisms. It was more in the context of that.

Whether the-- Is there any kind of standard approach throughout England? And, as I understand it, later on, I think Health Facilities Scotland or Health Protection Scotland, it may have been, ended up getting some kind of indicator of what was going on, but we were never able to conclude.

We didn't conclude that piece of work at that stage, but it was to try and work out the range of testing that people were doing in these kind of clinical areas and how did they respond to what they found, but that answer or the answers, if

it was ever completely answered, came back later, as is referred to, I think, in other IMT minutes.

Q Now, I need, unfortunately, to turn to another area where I've been asked to put a number of questions to you, and that's about communications around Professor Cuddihy and who was to say what and who was not to say what to Professor Cuddihy, and I think you'll know from your witness statement that you're going to be asked about that.

If we go to page 30, we see that the narrative starts by referring to Dr Inkster's statement and Dr Inkster saying that she's made aware of a conversation between you and Jamie Redfern, during which you instructed that they – that's neither Inkster nor Redfern – were to contact Professor Cuddihy in relation to the issue of Mycobacterium chelonae, and you're asked for your recollection.

Now, my understanding – and I'd like you to correct me if it doesn't match yours – was that the question here was that an undertaking had been given to the professor to tell him if there was another case of this relatively rare organism in the hospital and that's what this communication issue was about. Is that correct?

A I don't know. I was never aware of that first point about an undertaking.

Q The way you respond to the question on page 31 is, I think, if I'm reading it correctly, to complain that Mr Redfern has breached confidentiality with you. Is that your position?

A No, no, he hadn't breached confidentiality with me. He would have breached confidentiality on behalf of the other patient and parents whose child had the same infection as Professor Cuddihy's doctor.

Q Well, am I not right in thinking that you do accept that you told him not to contact Professor Cuddihy?

A I am completely clear on that. Yes, I told him not to contact and talk about another patient's condition.

Q Well, in your witness statement at page 31, you say:

"The content of a private telephone conversation between Mr Redfern and myself was made known to Dr Inkster by the recipient ..."

Well, that's Mr Redfern, and you say, "This was a breach of confidentiality." So that's your complaint, isn't it?

A Well, my complaint is that, clearly, if I give Jamie Redfern an instruction and in order to, I suppose-- I just have to wonder why he needs to tell someone else why I said, "You can't meet to have a conversation about a patient that's going to breach confidentiality." I

mean, he could easily have said it to-- He obviously chose to make it that I told him and instructed him, which is fine. I'm-- I've defended that in terms of my-- and justified it in terms of my statement. That's what happened. I know that he obviously breached my confidentiality in having that conversation, but the point was I only got to know that when I read Teresa Inkster's statement.

Q Now, can you help us to understand what you say in the next sentence? You'd "suspected Mr Redfern was briefing and speculating with Dr Inkster and Professor Cuddihy throughout this period". What is it you're suggesting that Mr Redfern was up to?

A No, I'm just referring to the fact that-- Mr Redfern is a very kind and generous man, I've worked well with them throughout the years I was there and we got on very well. What I'm saying is Jamie's natural reaction to a confrontational-type discussion or a challenging issue would be to try and appease the other side.

Now, that's not to say-- he's not wrong in that, but the reality is when it comes to a general manager's responsibility to be able to defend and uphold patient confidentiality, you can't have a discussion about other patients and parents, first of all, without their consent and, secondly, you need to

decide whether-- because, let's be fair, a singular individual patient can easily be identified, even if you call them "Patient X", in this instance. The cohort of these patients is too small to be able to have a general conversation and keep the identity, if you like, hidden. So, my point is that, as far as I'm concerned, my discussion with Jamie Redfern was a private conversation. It's been breached – he's told someone else. That was my point.

Q Well, let me-- I've been asked to put some follow-up questions to you on that basis. I'll just use the wording I've been given. You accept your instructed Jamie Redfern not to contact Professor Cuddihy, so that's clear. You say it was "a direct result of the Chief Executive and Chairman informing me that they had received a letter from Professor Cuddihy and they would be responding to it".

A Mm-hmm.

Q You also seem to indicate in your answer – and we can see that in what you've just told us orally and also in what you say here – that you were concerned Mr Redfern would breach confidentiality in his conversation with Professor Cuddihy by revealing information about the second child. Now, can I ask you this: was there any involvement in this instruction that you issued to Mr Redfern from Ms Grant or

Mr Best?

A Yes, I had an instruction from the Chief Executive and the Chairman to not get involved in the conversation with Professor Cuddihy, including any of my direct reports. I was unaware of the content in the letter, as I think I've indicated in my statement, to them, the letter to them.

Q So, let's try and understand this. If there hadn't been the risk of a breach of confidentiality, would you have been content for Mr Redfern to discuss matters with Professor Cuddihy?

A No, because my instruction from the Chief Executive was that the Chairman will deal with this inquiry. "We've received a letter," which I had never seen at that stage, "and we are going to deal with that."

So, therefore, I would have, like, separately, if Jamie had come to me and said, him and Dr Inkster were going to speak to Dr Cuddihy about a second case, then given that I didn't-- He'd never, ever told me that they'd made an undertaking, so I was never aware of that undertaking, and therefore, if you like, guaranteed to Professor Cuddihy. I was unaware of that until you've raised it now and through my previous reading. Therefore, the reality is I would have told them the same thing. Patient confidentiality is the number one rule in

hospital management.

Q Were you aware that Dr Inkster had been involved with Professor Gibson in a duty of candour conversation with the family of the 2019 Mycobacterium chelonae case?

A I don't know. Don't know.

Q Were you aware that Dr Inkster would have been a party to any conversation that Jamie Redfern was going to have with Professor Cuddihy?

A I would have assumed he was going to meet Dr-- sorry, Professor Cuddihy in the presence of Dr Inkster. That was the way Jamie normally operated, or he would have met Professor Cuddihy in the presence of Dr Gibson or whoever the treating consultant was at that time for his daughter.

Q Well, no. Jamie----

A Sorry.

Q No, no, carry on. Tell me what you were going to say.

A Well, just-- Well, I was just going to advise, Jamie Redfern, like myself, has no clinical background. He has experience, just like I have, of running, operating, and managing clinical services throughout decades, etc., but the reality is we are not qualified clinicians.

So whenever there's a clinical discussion taking place, the minimum requirement is either to have the

practicing clinician in there, sometimes supported by another clinician if they think a second view is required to provide some greater clarity, and the reality is no one who's a non-clinician should be having a clinical conversation with a parent-- a parent or anyone else without a clinician being present.

Q Well, the follow-up question that comes inevitably from that is, you'd be aware that Dr Inkster was a very experienced practitioner. Would you be aware that she's obviously regulated by her regulator, the GMC, and she would also be aware, would she not, that revealing details of a case of another family is a serious matter? She would be aware of all of that.

A Yes, she would.

Q So, is it your position that the conversation involving Professor Cuddihy, Dr Inkster, and Mr Redfern created a risk of breach of confidentiality?

A Yes, because they were going to declare-- Well, breach of confidentiality on the basis that was the second case patient and parents aware that their case is going to be discussed and shared with a third party? I don't know the answers to that but those are the questions that, clearly, I would have posed to Jamie because he can't have that conversation and that's why I described to him, you're in breach of confidentiality.

Q Well, I suppose I'm coming back to the question, whatever the conversation was going to be, if it involved Inkster, Redfern and Cuddihy, I'm just keen to know whether you thought there was a real risk of some breach of confidentiality in that exchange?

A Well, by the very nature of duty of candour, unless the patient who you're going to talk about, i.e., Case 2, if I describe them as that, along with the parents, given the age of the child, they need to consent to information being shared about their child. If they do not do that and are not approached to do that, it therefore becomes a breach of confidentiality.

Q And you're suggesting that might have happened?

A If the meeting went ahead without those previous explorations and guarantees that the family were happy to proceed on that basis, but I got no reassurance from Jamie that the second family knew about the conversation because he didn't tell me. I asked him whether the family were going to be approached; he couldn't tell me. Therefore, the reality is, it was definitely a breach of confidentiality in my opinion, if that conversation had taken place without the knowledge and consent of the patient

and parents concerned.

Q If we carry on, on page 31, at the IMT on 3 July, 2019, you reported John Brown was in contact with Professor Cuddihy, and then it was followed up at a later one when apparently you said that he'd been in touch and the thing is finished. Your response to that is, what, that what you said was what you were told to say by the Chairman?

A Well, my understanding is I was told at the time when I was instructed that Jamie was not going talk to Professor Cuddihy here about the second patient, was the fact that Mr Brown was going to deal with it directly. I'm unaware that-- that, as I said, at that stage of the content of the letter and what it raised.

My understanding was I was waiting for confirmation to be able to report back to IMT that that conversation had taken place or an exchange of letters had taken place, and whatever form they took, and they may have taken both, and the reality is once that was concluded I would report back. I wasn't-- I'm not trying to make an issue of that particular communication. All I'm saying is that's what I was instructed to do.

Q We know that the Chairman wrote to Professor Cuddihy on 4 July 2019. We didn't dig it up just now, but for the record it's bundle 6, document 18, page 53. Were you involved in the preparation of that letter?

A I don't recall.

Q Because, apparently, the one thing it doesn't do is refer to the infection or give any explanation about that. Do you know why that is?

A No.

THE CHAIR: Sorry, Mr Connal, could you give me that bundle reference again?

MR CONNAL: Bundle 6, document 18, page 53.

THE CHAIR: Thank you.

MR CONNAL: Mr Redfern's given some evidence around this. I think he was on holiday for a bit and then he came back, and he explained what he says that you said to him, so can I just ask you about this?

A Mm hmm, okay.

Q At some point, and this is, I don't have an exact date, between 4 and 17 July 2019, did you tell Mr Redfern that the matter was "sorted"?

A I don't recall. It's not a word I would normally use.

Q That's apparently what Mr Redfern recalls, you said to him. I wouldn't know what you had in mind if that didn't represent an accurate note.

A Well, depending on the date of the letter from the Chairman to Professor Cuddihy, if I was referring to anything and if I'd seen sight of it, I think I may have

been copied in on it, eventually or got a copy of it, the reality is that I certainly wouldn't have said, "Oh, it's sorted." I would just have said it's been dealt with, or it's been addressed, or-- Those would be my types of expressions.

Q The other thing that Mr Redfern says that you said to him was that it had been dealt with "corporately." Do you remember saying that?

A Yes. I probably would have used those words, yes.

Q What did you mean to convey by that statement?

A Well, I would have explained it to him that in actual fact the Chairman had received a letter, along with the chief executive and they have responded. Therefore, it's been dealt with corporately. That's the corporate part of the organisation.

Q Did you have any understanding at that point as to whether an explanation had been tendered about another case of Mycobacterium chelonae or not?

A No.

Q Do you know why there was no contact with Professor Cuddihy between the IMTs on 26 June and 3 July, because at least some people thought they ought to have been contacted at that stage?

A No, no idea. Who did he think

was going to-- I'm not aware he was expecting me to contact him and I've no idea why.

Q Well, there's a later letter from the Chief Executive to Professor Cuddihy on 27 September 2019, which is, for the reference, in bundle 6 at page 75. Can I ask you, did you have any involvement in drafting that letter? Do you want to have a look at it?

A I-- If possible, yes, please.

Q Yes, can we have bundle 6, page 75, please? Now, can we just go on to 76, just to double-check there's no other text? Yes, okay there's a limited amount of text. Having seen this, albeit fairly briefly, go back to 75 please, do you remember whether you had any involvement in its preparation?

A I do know that I don't recall having any involvement in the final wording, but clearly I was always briefing the Chief Executive, given the heightened issues that were going on, as I say, within my area of responsibility. So, some of those words may reflect some of the things I've told her previously and-- etc., but I didn't prepare the letter. I was not involved in the draft or redrafting the letter, from my recollection.

Q Now, I'm told, and we can check if we need to, that the IMT's view was that the duty of candour required some kind of communication with the

Cuddihys about this Mycobacterium chelonae. Do you know where the explanation for the delay in providing an explanation came from? In here, it's said to be waiting for typing results.

A No, but then that would be a laboratory issue, if they were waiting for typing results, and I'm not blaming them; I'm saying that sometimes these results take a while, depending on what you're trying to grow and what you're trying to, if you like, disaggregate from any growth in a-- in a tube or in whatever the wee tablet thing is called, my-- forgive me. So, no, I don't.

Q So, that's not something that came from you; that must have been obtained from somewhere else?

A Correct.

Q Do you think waiting for typing results is a good reason to delay the communication?

A Well, with-- Well, it's not me who's written the letter and I'm not responding to it. So, the letter says the position is as was the case from Jane Grant at that particular time. If it's to do with the fact that typing results take longer, then perhaps it could have been phrased differently, but I'm not aware of the detail and I wasn't involved in the detail of it.

Q The other thing I wanted to ask you about was that the inference from some of the things you said earlier today and also some of the things you've said in your witness statement is that one of the drivers for Professor Cuddihy not hearing from others, as it were, was to avoid cutting across the Chairman's communications. Do you know why that's not mentioned in this letter?

A No.

Q With the benefit of hindsight, would you describe the communications with the Cuddihy family at this time as transparent?

A Well, I'm not aware of what those-- all those conversations were, so I can only work on the basis that I knew that Teresa Inkster, the clinician concerned, but mainly Teresa Inkster and Jamie Redfern were meeting with Professor Cuddihy from very early on in his daughter's admission, and particularly given the increased situation affecting his daughter, then clearly, that communication became more regular.

I appreciate your reference to earlier; Jamie was away on vacation. He usually did take the first two weeks in July off, so that would be the case. If doctor-- If Professor Cuddihy expected somebody to communicate with him during that time, I certainly wasn't aware of it, because Jamie could have briefed me and said, "Would you be in touch with Professor Cuddihy?" or whatever, and I'm sure I

would have done that, etc.

But the reality was I'm unaware of all of that, and therefore Professor Cuddihy received communication about his daughter on a daily basis from the clinic-- practicing clinician etc., including, no doubt, Dr Inkster when she accompanied them on ward rounds. If it's other types of communication not affecting his daughter or potentially affecting his daughter, then I wasn't aware he was expecting some updates or regular feedback.

Q Well, from your experience, can you suggest any lessons that might be learned from what happened here? Because clearly, Professor Cuddihy wasn't very pleased with the way the communications went.

A Well, in terms of regular communication and updates, it-- it depended on, did I? And I don't think I did, which is why we didn't do anything-- was that, you know, if Mr Redfern's dealing with-- with Professor Cuddihy and says he will report back in a week or two weeks or three weeks, then unless he describes that to someone else and passes it across and the other receiving person takes responsibility for ensuring that happens and that's been done on other occasions with different issues and matters, then that could have been handled better in the instance you're

describing. At that stage, that's all I can say.

Q Thank you. Since I've got the advantage of having you here, I just wanted to ask you another question about communications-- well, another couple of questions about communications. Can we go back to your witness statement at page 33? This arises out of discussions with others, so I hope I'm not too oblique when I ask the question. About two thirds of the way down your answer on page 33, you say:

"NHSGGC attempts to robustly and timely answer all media enquirers and present a factual situation from the Board's perspective."

Now, about three lines prior to that, you say:

"... any press release would be based upon the factual situation as far as patient care was concerned."

Is there a difference between the facts and the facts from the Board's perspective?

A No, there shouldn't be because it's same Communication team at Greater Glasgow and Clyde that would prepare the Board statements and statements on behalf of a directorate or on behalf of the chief executive. So it's the same team. They'd be using the same data and facts that were obviously available to us at that stage and to them

and the statement would be prepared accordingly.

Q Can I ask you another question? If we go to page 34, talking here about-- you will remember a time when as part of the communication exercise there was a whole list of issues framed in a whole variety of ways, some of which were repetitive, which were raised and it was decided put out a statement dealing with all of these.

Now, that's in bundle 6, document 25 at page 77 and you've had a chance to look at that, and you said you had some involvement in providing answers and reviewing drafts and you think the answers were accurate. We're now in 2019, late on in 2019. By that time the Board has had the decant, it's had reports from experts on the state of the ventilation in Ward 2A, and so on, from which it must have been plain, would it not, that, at least so far as the Board's concerned, what was built so far as ventilation and the like in Ward 2A was not what it ought to have been?

Now, I think the general criticism that's been made, and I'd like your view on it, is that that's the one thing that the Board didn't say. They didn't say, "We're very sorry, this ward should have been built differently. We've got lots of material to show it wasn't. That's why we're spending lots of money fixing it." They said they're spending lots of money fixing it, but they don't say, "It wasn't built correctly in the first place." Now----

A I've never heard anyone-- Sorry, carry on.

Q No, I'm just wondering what your view on that point is.

A I've never heard anyone throughout the time I was in Greater Glasgow and Clyde saying it was not built appropriately despite the findings.

Q Were you not aware of investigations carried out on half of the board into the specification of Ward 2A against SHTM 03-01 air change rates? I think you said earlier, did you not, that it had been built just as a standard ward?

A Well, that is my understanding in hindsight, having read all the paperwork that I received as part of preparing my statement.

Q Well, you're not aware of that at the time, at least by 2018, no?

A I would have known some bits of it, but not the entire picture.

Q Sorry, my Lord.

THE CHAIR: Mr Connal, I wonder if perhaps we might have missed quite what Mr Hill was saying. Mr Hill, I noticed you were saying, "I have never heard anyone saying that the building was not built as."... and then my note runs out. Then you said "despite" and I think "the investigations."

Now, what I took from your answer – and tell me if I'm wrong about this – is that you never heard an admission or a statement, or however one wants to describe it, to the effect that the building had not been built as required. And then you contrasted that with what had been revealed by investigation. I'm just concerned that I wasn't quite sure if Mr Connal had picked up, as it were, the weight of your answer. So, I've gone on for some time. Let me just give you a chance to state it as you would wish to state it.

A Well, thank you. As I said – and I'll repeat that part – I have never known anyone admit to the building not being built to-- well-- So, let me just put a precursor in here. The specification that the building was built to, I'm not aware of the contents against specifically Ward 2A/2B-- Excuse me. Therefore, it is very difficult to say the building may have been built to the standards that they-- they commissioned from the builder, and the technical ventilation could have been built and to the standards that were in the specification.

I am unaware of whether there was an additional specification requirement for this particular ward that enabled the builder to be held accountable, if you like, because they'd made an error in only putting a standard system in. Therefore, what I'm saying is that no one's ever admitted to me, or anyone else that I'm aware of, in my time during employment of Greater Glasgow and Clyde, that there was an error made because the builder might have built it to specification.

But what might have happened is, at that stage, the additional specifications that should have been included in operating theatres, Intensive Care units, the Adult BMT wards, the Children's BMT area wards were never included anyway. So the builder built what the client specified but that wasn't appropriate enough given the patient cohorts that were going to occupy certain parts of the building. Is that clearer?

THE CHAIR: I'm not suggesting what you said originally was not clear I just wondered----

A No, no, no.

THE CHAIR: -- if we had we had picked it up correctly.

A Yeah, absolutely.

THE CHAIR: So what I'm taking from that is that you've never heard any expression of admission that the building was not built as it should have been.

A Yes.

THE CHAIR: Now, as I say, Mr Connal, my apologies if I'm just confusing matters but I just wondered if that was the weight of your question or rather whether you and Mr Hill were exactly on the same

page?

MR CONNAL: Well, we're possibly slightly at cross-purposes. I'll try again. Leave aside-- because we're not here to decide any disputes between the board and the contractors. That's not part of our job at all. So, we're not really interested in anything from that angle. That's a matter for someone else to sort out.

We know that you thought – and I don't think you were alone in that – that the ventilation requirements for the Schiehallion unit should have been in accordance with guidance SHTM 03-01 and at least as good as Yorkhill, possibly better. So that's what you thought – and you're the head of Women and Children – you wanted. And you subsequently discovered that it had not been built in that way because it was built as an ordinary ward.

A Yeah. So, first of all, when you say, "I wanted it," it wasn't me that wanted it. We're talking about expectations. So expectations of anyone going into a brand new hospital would be, it would be built to the current standards and any other additionality that you can forecast as part of-- before you move patients into it.

Q Yes. Well, don't worry, I'm not seeking to lay the specification on your shoulders----

A Yeah. No, no, I-m not----

Q -- Mr Hill, at all----

A Yeah.

Q -- because others have said very similar things. The question I think in terms of communications is if that was the general Board expectation, that's what they thought should have been provided, never mind whether it was done properly or not, was that not known pretty clearly that you hadn't got what you hoped you would get by the time of the answers to the issues paper in 2019?

A Well, we clearly hadn't got what we expected to get for part of that building at that time from what we'd known from infections that had occurred and from investigations that had revealed the extent of, if you like, the misalignment between what we would have regarded as a standard build for that specific area versus what we did get, which appeared to be more general.

Q Yes. I think the criticism that's been made of that piece of communication is that the one thing it doesn't say is, "We expected it would be X. It wasn't. It's our building. So far as you, the patients, are concerned, that's our problem. We may have an issue with someone else or not, that depends, but so far as the patients are concerned, it's our building." And would you accept that wasn't made clear?

A That definitely wasn't made clear.

Q I think I only have one-- well, two things I want to ask you and then we have a process here, Mr Hill, whereby after I finish we take a very short pause to see whether, in the course of our exchanges, others here have some thoughts about things that should have been asked, which I have missed.

So I just want to ask you a couple of things. If we can just go to page 37, there's a reference there to something called an "Exchange Control Group." Now, I think there's maybe some debate as to whose idea this was, whether it was the chief executive's or Dr Inkster's. If you think it's the chief executive's, it doesn't matter. But this was an idea for an additional group. Is that fair?

A Yeah, and just for your reference it was called "Executive Control Group."

Q "Executive Control Group."

A "Executive Control Group." Yeah, I think you mentioned "exchange", but it's just a----

Q Oh, sorry, my fault.

A It's-- it's for the record.

Q My fault entirely. "Executive Control Group" as it says in the statement.

A Mm-hmm.

Q I've read your witness statement. Now, I understand that basically this started but didn't get very far and then was wound up. Is that what happened?

A Yeah, we tried to get it off the ground, bearing in mind that there were frequent meetings taking place about Infection Control, official IMNT meetings taking place in the same weeks. This was a means of trying to get a greater understanding between the different views that were coming across between certain-- particularly between the Estates and Facilities and my Infection Control colleagues and operational management by our-- from ourselves. So it was to try and get clarity around what are we going to-- what are we trying to say and how are we going to manage the operational consequences and how we take some of those things forward?

But to come back to your point, it-- it was-- it was such a busy time. People would either commit to it at the beginning. So, we got one meeting, I think, where we got full attendees; second meeting it didn't take place; third-- So in other words, it was not going to be constructive. In fact, it-- it-- a kind of-- it basically impacted on people trying to do more around their daytime jobs and addressing the issues of the IMT in advance of the next IMT than it did for improving communication, because

unless you meet, you're not going to improve communication anyway. So, that was it in a nutself.

Q Yes. So, it might have been a good idea at the time but it didn't work in practice.

A Yeah. In practice, yeah. Totally.

Q Okay. The only other thing I wanted to do, Mr Hill, is that we always ask contributors to the Inquiry, you know, have you anything else you want to add. Sometimes people have come up with factual things, sometimes more general. But could we go to page 39 of your witness statement because I think, in fairness to you, in response to the question of whether you want to add anything, you have made a statement there. I think it might be appropriate, since this is a public event, that we allow you just to take us through what you've said in that conclusion, if you wouldn't mind.

A No, definitely not, and thanks for that opportunity. I suppose the first thing is it is regrettable that patients, carers, staff and others-- well, patients came to obviously harm, or potential harm, from the things that were going on in the building and in the facility and in the environment. That's despite the best endeavours of our staff, our carers, our families, and working together with any other parties, including those clinicians that were outwith my direct responsibility. I think it was devastating for everyone going through that at that particular time, and I know they're still going through part of that despite moving into the new, upgraded facilities, but the reality is that these issues and these wounds won't-- take a long time to heal, basically.

I have expressed something, maybe not in that part of the statement, about my own-- in hindsight, perhaps I should have approached this in a slightly different way, and I can only give my sincere apologies that I didn't do that as thoroughly as I may have done in the light of the knowledge I now have, but I hope others will learn from that as we go forward as part your recommendations from the hospital Inquiry.

I do think that one thing I might not have referred to, if I may, would be that, in future, I would always ask. So, show me the ward layout, show me the specification for that word, and show me the detailed list. Not the detailed list that gets briefed to the technical person but, upon validation, what does this ward produce? Air handling, turnover, "What pressures does it produce?", etc.

That, to me, would be part of a validation process that no doubt we would have learned from in Greater Glasgow and Clyde had we had it, but

clearly errors were made or mistakes were made or decisions were made not to include certain things in what we appeared would have been an appropriate clinical unit and facility for the types of patients, those vulnerable patients, that we were meant to be caring for, treating, and hopefully improving their care, although in some instances, that's never-- not possible given the clinical conditions we're dealing with.

And, finally, all I would say is that Greater Glasgow and Clyde is a tremendous board in the sense of its scale and its people, but I do think they didn't trust individuals who were running operational areas enough to let them get on and deal with that instead of having to go through endless meetings, some of which were just repeating the week's before performance, and in such a time scale, it's difficult to give any further progress.

So, all I'm saying is I've always had the criticism of how boards or organisations can operate if they don't give you the trust and freedom to actually get your staff to get aligned to do the proper jobs that they want to do. So, the quality of service always comes back to how you lead the organisation, and that's all I'd conclude on, and thank you.

Q Thank you, Mr Hill. My Lord, I have no further questions, as I indicated a moment or two ago.

THE CHAIR: Mr Hill, thank you for that. As Mr Connal has explained, he will want to check with colleagues in the room as to whether there's any questions that he should have asked which have not been asked, or when I say "should have asked", might be asked. So if you could give us, I hope no more than 10 minutes, if you could just stay connected. We will come back to you as soon as Mr Connal has had the opportunity to have a discussion with colleagues. So----

THE WITNESS: Yes, no problem. Thank you.

(<u>Short break</u>)

THE CHAIR: Mr Connal.

MR CONNAL: I have a small number of questions which have been suggested to me. Mr Hill, thank you for coming back. I've got one or two questions that I've been asked to put. They jump about a bit just by their nature. Can I first of all ask this? You remember you described the situation in which you'd become aware that Professor Gibson wasn't happy to sign off the layout of the new Schiehallion unit in the new hospital.

A Mm hmm.

Q Now, given that she was the lead clinician on that unit or whatever you want to describe her as, what was the

basis on which you and others decided that notwithstanding she wasn't going to sign it off, you would?

A Well, because it was reflecting of the build that was going to be in place and was in place, so-- and as you referred to earlier comments about Dr Gibson's early statements what to do with the ward and how it would be configured, i.e., pharmacy versus a staff room or whatever else, so those were issues that, clearly, we either could address once the operational situation had got underway and people in the light of practice were able to further inform that discussion.

Bearing in mind over the years some of these ward units didn't have a pharmacy in situ, didn't have a staff room etc., so I'm clear that those things can be addressed once we get into the building and can-- and given the fact that we couldn't address them prior to that because the build was, if you like, already underway and was completed. That's my-- That's what I mean by that, and therefore the plan itself reflected the layout of the ward areas that they were going to inherit on the basis of the new build being commissioned and opened and accepted.

Q Well, am I not right in thinking that this was all at a time when the design was still being done? The building hadn't been built at that stage----

A Yeah, but what you-- Sorry. You referred to that prior to my time in 2009 and 2010, so-- and also the fact that those discussions could have been picked up and alterations could have been made, you're right, before the physical build commenced, but the specification had already been signed off. So, if someone somewhere has to take responsibility for going back and saying, "Hold on a minute; we're altering the specification." I'm sure conversations like that would have taken place. They're not unknown to have taken place in any type of build situation, but normally the answer will be, the build's being built.

If it's an issue, we'll address it when we get into it, given it was about accommodation, not about the, if you like, technical features at that stage of the building, because as we've known from the Inquiry and from experience, those only came to light later on.

Q I think I may have touched on this with you earlier. In the period between the first concerns arising about the environment in Ward 2A in July '15 – it doesn't matter exactly when – and 2018, when formal reports were obtained, whose job was it to determine, ultimately, that it was safe to continue operating in the existing environment, which as you quite rightly pointed out, you subsequently discovered was not what

you thought it should have been? Where did that buck stop?

THE CHAIR: You have a specific-- Sorry, my fault. Did you introduce a specific date?

MR CONNAL: Between 2015 and 2018.

THE CHAIR: Right, sorry, Mr Hill.

A So, where does the responsibility lie? Well, I suppose you will recollect, as we have from the evidence etc., that there wasn't just one issue affecting this ward, there was multiple issues, consequently, which resulted in it being transferred. Not each one of these incidents would have resulted in us ever considering transferring a ward, given the, if you like, the situation and the graveness of having to transfer out of an existing clinical area, particularly being in the Children's Hospital. It wasn't as if we had an empty Children's ward we could adapt. We were then transferring to the Adult sector, as you know.

Therefore, that was a very serious, but at the same time appropriate decision to make, given the situations that were then known, the situations that we were trying to further investigate and therefore was deemed to be with the-- if you like, the consent of our adult colleagues, because they clearly had to decant to elsewhere as a consequence of that.

Therefore, everyone as a corporate organisation rallied together and made that transfer possible. To come back to your point, I-- There wasn't one issue that basically said, "This is now gathering up to be a completely unsafe ward." That-- those decisions were reached further on, is my-- my view.

MR CONNAL: Right. So far as what was happening between 2015 and 2018, there wasn't a single decision somewhere that said, "We're doing the best we can; we carry on."

A Well, we were carrying on. They were, by their very nature-- Sorry, sorry.

Q Yes, you were carrying on, I can see that. Yes, well, let me ask you a much more technical question. Were you aware whether there was a business continuity management plan in place covering the risk of closure of a ward like 2A?

A Yes.

Q There was one in place?

A Sorry, there is one in place, sorry, I should have said. There wasn't one at the time.

Q Oh, there wasn't one at the time? That's all right, but I misunderstood your answer, so the answer was, there is one in place now, but there wasn't one in place then. Is that correct?

A Or if there was one in place then, it certainly was out of date, put it that way.

Q Right. We've touched on the duty of candour. Can you just explain what your understanding is of the duty of candour that is incumbent on a health board?

A To be-- to be open, transparent in dealing with patients and their affairs, including, in the case of children, with their parents, and it's about the clinical practice, and the organisation, environment, and everything in which their patient is being cared for, and the board-- Sorry, go ahead, sorry.

Q No, no, carry on, please. Finish your answer.

A And, of course, the board's responsibility is undertaken through its structure and its directors, through the chief executive that it puts in place, and it's for other individuals to be able to ensure that on a daily basis, given the thousands and thousands of interactions that take place, that we are maintaining those standards as best we can as practicing clinicians and practicing managers.

Q The follow-up question to that is this: were you aware that the relationship between at least some parents and patients and the board had deteriorated so that the view was that there wasn't transparency, and in fact, or as you probably know, there was a well-known quote by another senior official that it was either a battle or a war or both, presumably with the board on one side and patients on the other. Were you aware of that happening?

A I was aware that, clearly, as soon as an event or an issue takes place in a clinical area – let's refer to the one we're describing in your-- that the Inquiry is about – that clearly the trust and the understanding and the-- of the parents and the patients and the Clinical teams as well, as well as our staff, was deteriorating by the week, and I mean because there was events taking place every week, whether an IMT or something else.

People were asking questions. Some those questions we did not address or fully address, as we referred to earlier, and the-- and when you say the Board, of course, the Board is, if you like, the top level of the organisation, but really what they meant was management locally in Women and Children's, because we were the face of the organisation.

And secondly, the Board in its-- terms of its communication would be through the Communications team, which of course I was involved with, as was Jamie Redfern, Jane Rogers, Alan

Mathers as part of their roles in briefing around Women and Children's, but the reality is the Board as an entity is a committee as such, but in terms of individuals, clearly, that's where you really build trust.

Q Yes. I have nothing further, my Lord.

THE CHAIR: Thank you, Mr Connal. Thank you very much, Mr. Hill. That is now the end of your evidence. Thank you for providing it this morning, but also for the background work that will have gone into preparing that evidence. So, thank you very much, but you're now free to break off communications.

A Thank you. Thank you very much.

THE CHAIR: Thank you.

MR CONNAL: Thank you.

(The witness withdrew)

THE CHAIR: Now, we will resume, again with Mr Connal leading a witness, Mr Jenkins, I think.

MR CONNAL: Mr Jenkins, this afternoon.

THE CHAIR: If we try and be back for quarter past two?

(Adjourned for a short time)

THE CHAIR: Now, the next witness is Mr Jenkins.

MR CONNAL: Mr Jenkins it is, my Lord, and he is physically present.

THE CHAIR: Good afternoon, Mr Jenkins.

MR JENKINS: Good afternoon.

THE CHAIR: Please sit down.

MR JENKINS: Thank you.

THE CHAIR: I should first apologise for us starting later than the time that you were given notice of. We sat a little longer in the morning than we'd anticipated, but I appreciate you'll have been here in full time for a two o'clock start. You're about to be asked questions, as you understand, by Mr Connal, who is sitting opposite to you, but first, I understand you're prepared to take the oath.

MR JENKINS: Yes.

Mr Gary Jenkins

Sworn

THE CHAIR: Thank you very much, Mr Jenkins. Now, you're scheduled for the afternoon. I don't know precisely how long your evidence will take but, if you want to take a break at any stage, just give me an indication and we'll take a break. Could I encourage you to maybe speak a little louder than you----

THE WITNESS: Yes.

THE CHAIR: -- would normally? I

mean, you've got microphones and they're there to make you audible, but we've got quite a space to fill and I have hearing aids. My hearing is not as it was. Now, Mr Connnal.

Questioned by Mr Connal

Q Thank you, my Lord. Good afternoon, Mr Jenkins.

A Good afternoon.

Q I'm going to start by asking you the same formal question I ask all of the witnesses, which is that you've produced a witness statement for the purposes of this hearing. Are you content to adopt that statement as part of your evidence?

A Yes, I am.

Q Thank you. Have you got access to it?

A I do. I've got it here.

Q You've got it there in hard copy, and we'll bring it up, if need be, on the screen in front of you as well. If we do that, you'll find that there are electronic page numbers at the top that we might refer to.

A Thank you.

Q I want to ask you a little bit about your career in a moment. I notice from your witness statement that you're the chief executive officer at the State Hospital Board at Carstairs, which sounds a fascinating job, but unfortunately we don't really have the time to discuss how fascinating that might be, but a very different role from the ones you've had previously.

A Yes, that's-- that's my current employment. I moved to the State Hospital at Carstairs in 2019.

Q Right, thank you. Now, I'm going to ask you about the two most recent employments that you held at NHSGGC just so we can get a picture of who you are and what you do or don't know. If we go back, first of all, to 2009.

So, between 2009 and 2015, you say you were the general manager for specialist oncology services based at the Beatson. Now, just in a couple of sentences, what does being the general manager for specialist oncology services mean, or did it mean at that time?

A Thank you. So it meant that I was effectively in charge of the operational running of the Beatson West of Scotland Cancer Centre and also the provision of specialist oncology-- cancer service provision out to boards across the West of Scotland, because it was a regional cancer centre for the West. Within that role also sat clinical haematology, including the Bone Marrow Transplant unit, which is a subject of today.

Q Right, so that was all under your sort of general manager control, is

that right?

A Yes, that's correct.

Q Who was immediately above you in hierarchical terms?

A So immediately above me was Jonathan Best, who would be the Director of Regional Services, which is the job that I then went on to apply for in 2014/'15.

Q Right. So in your role in the Beatson, were you concerned only with bone marrow transplant or with other types of cancer treatment?

A It was all cancer treatment, so the Beatson specialised in all specialist cancers and it specialised obviously in the clinical trials aspect, it specialised in the chemotherapy services for patients, it was the West of Scotland radiotherapy provision unit, and so treatments took place in the Beatson. We had inpatient beds which covered all ranges of cancers and, when it came to haematological malignancies, we had a ward, which was B7, that specialised in blood cancers, and then Ward B8 and B9, which specialised in bone marrow transplantation.

Q Now, you'll have to excuse our ignorance about these matters, but is there a dividing line somewhere between specialist cancers and non-specialist cancers, the specialist cancer you mentioned?

A Yeah, so for some very small tumour groups, as in there's not a-- if you take breast cancer for example, that's a population-- it's a cancer that will affect a large amount of people in the population. So you would have local service provision perhaps in Ayr and in Crosshouse and in different pockets of services across either Glasgow or the West of Scotland.

When it came to very specialist cancers, which would be very small in number type, if I think perhaps of sarcoma, some of the rare blood cancers, the-- the treatment service would be consolidated in the Beatson where the specialist expertise was, rather than a-- a larger tumour group where you had a more dispersed model, where people would be treated more locally, rather than to Glasgow for treatment in the specialist cancer centre.

Q Thank you. Now, I'm going to ask you about your next post----

A Yes.

Q -- as director of regional services within the Acute Services division. If we go to your witness statement, which I'll use as a kind of guide to help us go through the issues if I may.

A Yeah.

Q We'll find that page 150 you were asked a number questions about reporting structures, and you've clearly done your best to explain what you do and in some cases don't know----

A Yeah.

Q -- because of the issue that we get that everybody who's called "director" isn't a member of the Board at the top level of GGC, just as might be elsewhere. I just noted in passing on page 150 that you say you attended the Strategic Management team, SMT, and Operational Management team, which dealt with issues arising from the Acute division.

You go on to explain a little more about your role, I think, on page 155. So, if we could just go there and I see it under the heading, "Director of Regional Services." Oh, this is, I think, between 2015 and 2019, is that right----

A Correct.

Q -- rather than 2014 as the question incorrectly states? Can you kind of sum up for us what the director of Regional Services in the Acute division does?

A Yeah, the-- so the director of Regional Services at the time initially when I took the role up had three portfolio areas and these were services that were provided from Glasgow, either on a regional basis or on a national basis. So the collection of services that either boards contracted with Glasgow to provide or that were agreed to be provided on a West of Scotland or national basis were housed within the Regional Services directorate. So those initial three services, Clinical, Haematology and Specialist Oncology, was Grouping 1.

The next service, the Institute of Neurosciences - there are four neuroscience centres in Scotland; there are five cancer centres in Scotland. So those were managed on a regional basis, hence they sat within the regional portfolio, and similarly with the Renal Medicine, Plastic Surgery and Burns. At a slightly later date, the Glasgow Dental Hospital in the school was also aligned to me. And then, again, probably about six months into post, Forensic Mental Health Services, which is a medium secure, low secure and community services for mentally disordered offenders was then added into my portfolio. And perhaps hence the connection to the job that I do now, if that makes sense-- sense.

Q So the name Regional Services is descriptive in a sense. It explains that the services that you're in charge of are ones that are provided, not simply to the population of Glasgow but to a wider population?

A That-- that's entirely correct. So, I think I had 14 different hospitals across the West of Scotland where services were provided from. So quite often I would be in negotiation, perhaps with Ayrshire and Arran. I would be in

negotiation with Lanarkshire or Forth Valley in relation to services that we provided. We would provide for example consulting cancer doctors, consultant oncologists to those hospitals to meet their service need. And then as their service need changed, and similarly with the Glasgow service need, we would alter and tailor the provision of services as to how they were provided, where they were provided and-- and we would agree on combined governance and other processes associated with that. And that was the same across the other five-- the-- the whole five portfolio areas.

Q The five portfolio areas I think that we see from what's on the screen and then narrated at the foot of page 155 and then you give a general description of what you did. Then you're asked on page 156, if we can just go there, "Who reported to you?", and you say, "Well, the five general managers of the services" that you've listed reported to you.

Then, just so I'm understanding this correctly, you say that you were the direct managerial reporting line from the chief of medicine, chief nurse, chief allied health professional, head of finance, head of people and change. What are you trying to explain there? Are these who you report to?

A No, no, these people reported to me in my director role.

Q Right.

A So those individuals, the chief of medicine, the chief nurse, the chief AHP, the head of finance and the head of people and change, were a directorate-wide function, so they covered the five directorate portfolio areas. The general managers covered directly their own directorate areas, if-- if that helps.

Q Yes. If you were drawing it, you would say they were on a sort of horizontal line and you were in a vertical box.

A That-- the-- the five pillars, the five vertical boxes were the specialties. Each had a general manager and at the top was the director with those individuals around about working across the five portfolio areas.

Q And so they in effect might provide services to your directorate, in which case they report in to you. Is that right?

A Yes, that's correct.

Q And then if you go the other direction, who did you report to as director of Regional Services?

A Yes, as director of Regional Services, I then reported to the chief operating officer for the Acute division.

Q And at the time you were there, who was that?

A It was Grant Archibald and then Jonathan Best.

Q Jonathan Best being the previous holder of the post that you moved into?

A Correct.

Q Now, I'm particularly interested obviously, given the nature of the Inquiry, in your connection to events at the – let's call it – new hospital in Glasgow. And the first question you're asked is the general one, "Well, what's your input into the design and specification of the hospital?" And you were asked that on page 156 and you say, "Well, I didn't have any at all until the BMT unit was due to come from the Beatson." Is that right?

A That's correct, yes.

Q Yes. Because you only became director of Regional Services in 2015, you weren't involved in any way in the design of the hospital before then?

A No, we-- we had no services that were moving into the hospital at that point in time because, as I said, most of the services that we had were either in the retained estate, if I take the Southern General Campus so, for example, the Institute of Neurosciences was staying where it was; the Beatson was staying where it was. So there were no services from my area as general manager that were moving into the new Queen Elizabeth Hospital.

Q So your first involvement would be before you were director of regional services when you're in your previous post in 2013. Is that right?

A As-- as general manager.

Q As general manager. At the Beatson?

A Yes.

THE CHAIR: I may have simply misunderstood things. You mentioned among the services provided in the Beatson was the-- if I remember correctly, was it Haematological Cancers in the Beatson Ward 7B?

A That's correct.

THE CHAIR: Did I get that right?

A That's correct.

THE CHAIR: Now, I think I've understood, and there's opportunity to correct me, that it was from a date earlier than 2013 the intention to move that service, not the BMT service, but that service to the new South Glasgow Hospital. Am I wrong about possibly sharing an area with Renal Services? Now, am I wrong about that?

A So the-- Yes, but-- but it was---

THE CHAIR: Sorry, I am wrong?

A It would-- Haematology-- There were two general haematology wards. One was at the Beatson, which was in Ward B7 and there was a general Haematology ward in the Southern General. It was the ward that was in the Southern General that was moving into

the new hospital. B7, which was the Haematology ward at the Beatson, was not moving into the new hospital.

THE CHAIR: Right. I'm grateful for that. So, just for my note, the service, how would you describe the Southern General Service that was moving into the new hospital?

A So that was a general haematology service. It would have offered some chemotherapy treatment for leukaemia and for blood cancers. That service was moving from the old medical block in the Southern General Hospital across into the fourth floor of the new Queen Elizabeth University Hospital. But I think that was only at 2013. It was following on from the change note that may come up later on.

THE CHAIR: Sorry, that----

A The decision to----

THE CHAIR: -- the BMT service followed from the change note?

A Yes, yes.

THE CHAIR: Right.

MR CONNAL: So, I may just follow this up. So far as the movement of the Haemato-oncology ward at the Southern General to the new hospital and such provisions as we've made for that and specifications for what they required and so on, were you involved in that process at all or were you focusing on the Beatson?

A It was part of that 2013 change process. So the two ward----

Q I think I'm wanting to go back. Sorry to interrupt you. I think we may be getting slightly lost here. The planning of the move to the new hospital goes back before 2009, but a lot of the detailed planning took place in 2009/2010.

A Mm-hmm.

Q Now, at that point, we know from other evidence that there was to be a Haemato-oncology ward in the new hospital. I think we were taking it from you that the occupants of that ward were, as it was then planned, before the BMT move was decided upon – as it was then planned – were coming from the Southern General?

A Yes.

Q So the planning for that move would be part of the general planning for moving services into the new hospital, would it not?

A Yes, that's correct, at an earlier stage.

Q At an earlier stage. Then the question I was asking you was, so far as we've heard a lot about people specifying what they needed by way of environment, things called clinical output specifications and so on, for that move from that ward of Southern General into the new hospital, were you involved in that process or were you dealing with the

Beatson?

A I was dealing with the Beatson, yes, yes.

Q But not with the Southern General?

A The Southern General planning cycle, as you indicated, had taken place around 2008, 2009, which is essentially the services that were moving from the Southern into the new build on the Southern and I believe Haematology at the Southern was part of that. The general Haematology ward at the Beatson, Ward B7, was not part of that. That was staying, but it was at the Beatson.

THE CHAIR: With Mr Connal's permission, can we look at bundle 27, volume 3, page 157? Now, this is a document headed, "Clinical Output Specification." Having regard to what you've said, Mr Jenkins, there's no particular reason that you will have seen that before.

What I'm seeking your help with, if you can provide it, is just quickly looking at that "Clinical Output Specification," whether that would be consistent with your understanding of the service provided at the Southern General which we understand to have been moved into what became Ward 4C in the new hospital. I don't know if you want to take a moment or two, maybe to look at that page and maybe subsequent pages.

MR CONNAL: I was just checking, my Lord. I don't think this witness has been previously shown this----

THE CHAIR: No, no----

MR CONNAL: -- particular document.

THE CHAIR: I----

A May I see the next page as well----

THE CHAIR: Yes.

A -- just in case it gives me a date and an author?

THE CHAIR: Can we, sort of, move to 159 and maybe on to 160. As I say----

A Yes, I would-- I would-- this is the Southern General----

THE CHAIR: Yes.

A -- service. It mentions the Beatson, but I think it's referencing the Beatson. This isn't the Beatson----

THE CHAIR: Right.

A This is Southern General. I think the 14 beds were the Southern General, which is a number that rings a bell. So, that was part of the earlier process.

THE CHAIR: I'm grateful to you, and I apologise for interrupting, Mr Connal.

MR CONNAL: So, the-- you had under your wing, if I can put it that way, at the Beatson, a non-BMT----

A Yes.

Q -- Adult Haematology Oncology ward----

A Yes.

Q -- which you described as "B7"----

A Yes.

Q -- which did not transfer either in 2009 as a plan or in 2013.

A No, I believe it's still there today.

Q Can I just ask so we've got this for completeness. What kind of things was the B7 Ward doing in the Beatson, just briefly?

A B7 would have done, just very briefly reading that specification, very similar to the Southern General Hematology ward. They would have delivered chemotherapy, they would have treated different types of blood cancers, and they would also have dealt with different blood diseases. So, it would be the same type of service as the service that was in the Southern General, and that would have been borne out of the days in the past when you had a North Glasgow service and a South Glasgow service probably under an old structure.

Q Thank you. Now, I apologise for the fact that, by the nature of the process, not all the questions I ask you will come in ideal chronological order, so please bear with me that.

You were asked basically what your involvement was in the design of the new hospital, and you said, "Well, I didn't have any involvement until the proposal came up or the decision was made to move the BMT unit in" , and we'll come back to that in a moment. Then we asked a question about commissioning which, of course, takes you forward to 2015, and I just wanted to ask you about that.

So, if we go to page 157 of your witness statement, you're saying your only involvement in the issue of validation-- and I think, in fairness to you, at one point later, you say you're not an expert in the distinctions between "commissioning" and "validation".

"My only involvement in the issue of validation was prior to the completion of the ward we were due to occupy."

So, that would be the completion of the what was Ward B, or the BMT unit, and you visited the ward, and you say that you and the Clinical team questioned the validation process for the hospital. Now, what were you doing there? Just tell us what you were asking about.

A So, in advance of the Bone Marrow Transplant unit – B8 and B9 – occupying the ward, we were invited over to see the ward and to meet with-- I think it was Ian Powrie, who was leading up on the visits to the environment. I believe at that meeting myself, Anne Parker, who was the lead haematologist----

Q I'm sorry, just make sure we get that name, if you may. Who was the lead haematologist?

A Dr Anne Parker.

Q Anne Parker.

A Yeah.

Q Thank you very much.

A Myra Campbell, who was a clinical service manager for haematology, and I believe Laura Meehan, who was the lead nurse for haematology. We went over to the ward to see what the ward looked like, to understand the layout, to understand, for example, what items we would be transferring, how the ward worked, and generally to see the ward. We hadn't actually seen the completed ward. So that was at this point where we were across at the----

Q If you were asking questions, was it just Mr Powrie you met or was there anyone else? Who were you directing the questions to?

A It was to Mr Powrie. Mr Powrie was definitely there, and we asked a number of questions when we were across at the Southern General-- or at the new Queen Elizabeth, sorry, as I should call it, and the first-- if you wish me to expand on that, the first point that was immediately obvious to us was the lack of pressure monitors.

Q All right. This is why you later commented on the use of the word "validation"----

A Yes. Yes.

Q Because, in the first answer at the top of the page, you say-- well, you asked about validation and you were told it was being managed centrally, but you then explain in response to a follow-up question near the bottom of the page-- you were asked, well, "Why did you ask about validation?", and you then explain it's due to the lack of pressure monitors. Now, just explained to us the point about pressure monitors, please.

A So, in the Bone Marrow Transplant service at the Beatson West of Scotland Cancer Centre, if you walk into the ward, outside each room you will see a pressure monitor. It's essentially a dial that will tell you the air pressure – positive or negative – of the room that you're about to walk into. So, visually, when you're on the ward, you can see if the pressure is within tolerances.

When we walked into the fourth floor, Ward 4B, at the new Queen Elizabeth Hospital, those were not visible. We did not see pressure monitors, and therefore that led to myself – and I think the team had a discussion – to say, "There are no pressure monitors on these-- visible on the outside of each individual bedroom. How do we know that the pressure is correct and how the validation for the ward works?" If that----

Q So, that's what you mean by "validation", then? The checking that it meets what you require. Just----

A Yes.

Q If we try not to speak over each other----

A Sorry.

Q -- it will help for the transcript later. It's partly my fault. I just want to make sure I'm understanding you correctly, that when you use "validation" in this context, what you mean is, validating-- are you checking that the pressures are within the tolerances that you're looking for.

A That's correct.

Q Sorry, my Lord, I'm not sure----

THE CHAIR: Maybe just-- At risk of repetition, just teasing this out: we've learned in the Inquiry that if one is constructing a ventilation system in a hospital, there is guidance available, and we may further discuss that. In that guidance, certainly in its current form, there is a discussion of a need to commission a new ventilation system which is, generally speaking, a function that the contractor or the subcontractor-- or his subcontractors carry out, and the validation of a ventilation system, which is something that the guidance indicates that the client health authority should do.

Now, I appreciate that we have been introducing, in the questions to you,

these words, "commissioning" and "validation". When you were visiting-- I take in about maybe June of 2015 or maybe May----

A Probably just slightly earlier, but it would have been around 2015.

THE CHAIR: Yes. I mean, was that notion of commissioning or validation in your mind or was it not?

A At the point of-- and if I come to the term "validation" , I wasn't describing it in the way that you have mentioned about the formal commissioning of the building and the validation of the building. It was how we validated ourselves, that the ward in the absence of pressure monitors, was working on the air exchanges, was working on the specifications that we set out, and furthermore how would we be alerted in the ward if we couldn't see a visual to tell us that the pressure was at a level that we wouldn't have expected?

THE CHAIR: Okay, thank you. I think you already gave that answer to Mr Connal, but I'm very grateful personally for having----

A Thank you.

THE CHAIR: -- you having confirmed that. Mr Connal.

MR CONNAL: We can understand entirely why, given the-- what we've sometimes called the protective environment that's required in these

situations, you are thinking, “Well, how do I know? Is this pressure gradient not what I’m looking for? Is there an alarm going off?” or whatever. Did you ask-- or you or one of your colleagues ask, “What do we do if there are no pressure monitors”?

A Yes, yes.

Q What was the answer?

A That was the subject of that conversation. We were told that there was a central building management system that would alert us at the ward by phone call if there were any changes to the environment or to the pressure within the ward area itself. We questioned that, and I distinctly recall we questioned that, and we were informed that it was part of the central building management process, and that was the way that the new Queen Elizabeth Hospital was working.

I also recall we remarked, because the Beatson wasn’t that old, about how technology had obviously moved on since the time of building the Beatson, insofar as there was now a central system that would contact the ward in the event that there was a change to air pressures within the ward itself.

Q So, the impression you gained was that the march of technology had meant that instead of having physical dial, if you like, in front of you, someone

somewhere else got that information and conveyed it.

A It was a central control system for the Queen Elizabeth University Hospital.

Q I see. Thank you. Now----

THE CHAIR: Can you recollect who gave you that information?

A It was definitely Ian Powrie, who was there on the day.

THE CHAIR: Definitely Ian Powrie.

MR CONNAL: I’d now like to turn to the actual-- some issues around the actual move. So, if we could go to 158, please. Now, I’m not going to ask you, Mr Jenkins, unless it crops up later, about why somebody decided it was a good idea for the Beatson BMT unit to move to the new hospital. We know there was discussion at committees, and there was some to-ing and fro-ing, and a decision was made. So, we can just leave that aside. The only-- So, we have documentation about that. We have minutes and so on.

In the main, after that, the only other document we have is something called a change order - because, under the contract, a change order had to be given, given that the contract was already underway and something was changing - which was signed by Mr Best. Perhaps we might just look briefly at that. I’m not going to pause too long on it because of

a reason which will become obvious fairly quickly.

Can we look at bundle 16 at page 1699, please? If you excuse the fact that this is probably a copy of a copy of a copy. You'll see that this is a particular procedure for the project. It's in a particular form, no doubt, for that reason. There are some details listed in the first narrative paragraph, "Form breakthrough at Wheelchair Bay" and one or two other details. There's a "business justification":

"To move the national unrelated donor bone marrow transplant programme..."

Is that-- that was what was going?

A Yes.

Q

> ".. and regional related donor programs (and potentially national sibling donor program if agreed...) from Beatson... to a site with full ITU and HOU support 24/7.
>
> 2. To meet accreditation and clinical standards for delivery of cyclotoxic chemotherapy…"

Is that a special requirement?

A Cytotoxic chemotherapy, yes. So, it's very potent. Cytotoxic, again, would mean that it's got a toxicity to the body, so it's specialist chemotherapy for acute leukaemia patients.

Q That's dated 9 July 2013. Were you involved in the production of that document at all?

A I believe I was the recipient of the document. I don't think I produced the document.

Q Thank you. Well, we may come back to it, so we can take that off the screen for the moment, thank you.

THE CHAIR: Can I take the opportunity, Mr Jenkins, just to explore with you what the purpose of that document is? Would I be right in thinking it is a request for the authorisation to spend the £840,000, with Mr Best directing this to somewhere else in the GGC hierarchy with the authority to give the approval?

A That's exactly correct, and there are-- In the bundle that I looked at, there are a number of documents that surround this. One, it gave a change control instruction to Brookfield through the Project team, two, through the-- through GGC itself, it acted as an alert to state that there was a change to the function of Queen Elizabeth University Hospital; this service was being added in. And, thirdly, it then came to me as a document to show that this change was being progressed. So, that would have been used in numerous different areas to initiate a change into the programme that wasn't expected.

THE CHAIR: And a copy, or a

digital copy, was being sent to you for your information, you going to do anything in relation to that document, or were you?

A Well, yes. That was really the first notice document around about what we had to move, so that was like a baseline document, and then from there I had a discussion with Jonathan Best to say, "Can I run through the process for this because we are moving late?" And also, there was some terminology in it that I was aware we would have to explore and change further, prior to us coming up with a plan about how you would move the bone marrow transplant unit across to the Queen Elizabeth hospital.

THE CHAIR: All right. Mr Connal.

MR CONNAL: Can I just explore that last answer, that having seen the document, you were aware that something had, let's call it "developed", something was still to be developed, and what was that? What was it you were going to have to do?

A So, we would have to meet with the Project team who were in charge of the building and the development of the Queen Elizabeth University Hospital. It obviously-- Without stating the obvious, it's not as simple as, here's 24 rooms for you just to move into, and there was some really specific requirements of a

bone marrow transplant service, and----

Q Okay, and we will come to that point shortly.

A So, we use that as data to then say, "Okay, who do we now connect with through the project structure to enable us to take this forward in a planning cycle to reach a conclusion?"

Q Right, so if you'd been a general ward with no special technical requirements, you might just have been able to say, well, instead of being in a ward in one place, we're going to be in a ward in another place, but you had particular issues.

A Oh, yes, yes.

Q Yes. Can I ask you then, just before we leave the page, can we go back to 158 of the witness statement, because this is a topic that has cropped up? You're asked, can you remember before that change order was done, whether any risk assessments or HAI-SCRIBEs were carried out? And you say, I can't remember any of that being done. Now, are you familiar with the HAI-SCRIBE process?

A Yes. Yes, I am.

Q What do you understand its function is?

A So, the HAI-SCRIBE process is where you would bring together the function of the environment, the types of patients in the environment, the

equipment in an environment. You would use it almost as a multi-source risk assessment with mitigations with various different professional groups – for example, Infection Control, Estates and Facilities, your own team, and various other members – to use as a consolidation document to make sure that you were all working on the same risk assessment to bring risk down. It was a central document that we would use, a central process.

Q For a move such as the one you were contemplating, where you had an existing unit that you were seeking to shift over into a new building which was partly constructed, how would you have understood HAI-SCRIBE to be deployed?

A So, the HAI-SCRIBE, once we had assessed and had a discussion with the Project team about our very specific requirements and laid those out and assured ourselves that those requirements could be met, in terms of then developing the ward environment, there would be an HAI-SCRIBE process which would contain all details of the service, the status, for example, of the ward environment, the types of patients that would be treated in there, and then how the mitigations would work around about the HAI-SCRIBE process from all of the teams involved.

Q I'm going to suggest to you two things that, at least the version that we have does, and we can put it up on the screen if you feel the need to look at the detail, but in a document which governs HAI-SCRIBE Development Stage 2, SHFN 30 Part 2 of 2007, two of the questions that are asked are, first of all:

"Does the design and layout of the healthcare facility inhibit the spread of infection?"

Now, just pausing on that one, would it have been important to your service to be able to answer that question clearly?

A Yes.

Q So, when you say you don't know whether HAI-SCRIBE was done or not, is that simply you can't remember, or----

A At that point in time, I don't recall there being-- I don't recall there being a pre-existing HAI-SCRIBE that had been done for the service.

Q Right. I'll come back to the detail in a moment, but on the basis of what you told me a moment or two ago, you would have anticipated that process to have followed discussions with the Project team where you sorted out what you wanted.

A Correct,

Q Basically?

A Correct.

Q Is that correct, and another of

the questions in that section, if you just take it from me for the moment, of the same document is:

"Is the ventilation system design fit for purpose, given the potential for infection spread via ventilation system?"

Now, would that also have been an important question to be able to answer for your purpose?

A Massively important, yes, massively.

THE CHAIR: Just really for the purposes of my notes, you're referring to SHFN 30 in the 2007 version.

MR CONNAL: Part 2.

THE CHAIR: You're referring to Design Stage 2, and you're referring to, is it Question 3.151 and 3.52, or have I got the numbers wrong?

MR CONNAL: 3.1 and 3.2, but I simply didn't put it up----

THE CHAIR: Indeed.

MR CONNAL: -- on the screen for the witness.

A But for my note, 3.1 and 3.2----

Q 3.2, right, in that order, are the ones that I have quoted to the witness.

THE CHAIR: Yes, thank you.

MR CONNAL: Now, as your witness statement continues at this stage, you've touched on some of the reasons why people thought it was a good idea to move the service across, particularly the question of co-location with ITU and

HDU. It doesn't matter; we know the decision was taken. But then you're asked, on page 159 about your attendance and involvement in any design review meetings held to confirm with the user groups the requirements for the PMT units.

Now, the way that question is written it suggests you need to meet with the clinicians, but in fact the questions go on to deal with meetings with the Project team and can I just ask you before we turn to the detail of what you set out there, we know from your narrative that you tell us that there were a number of meetings and you tell us who was there and so on. We'll come to that. Did it ever occur to you that given the massive importance of some of the issues you were discussing, the need to protect your vulnerable cohort, that there should be some kind of formal record, minutes, report or something of these meetings?

A Yes, it-- it did, and I believe we received notes of the meetings that we attended. We did keep our own records of those meetings but yes, that is an important fact.

Q But I don't think the Inquiry has any of these records.

A No. I'll maybe come on to that later on.

Q Right, fine.

A I'm sure you will cover that.

Q Okay, well, I'll come back to that. Now, at the foot of page 159 you say the Project team situated at Hillington either contacted us, "or we made contact with them..."

And it doesn't perhaps matter which is which, then you go on to say:

"I think all, or certainly the majority of meetings took place at the Project Offices in Hillington."

Now, can I just pause for a moment there and say that clearly indicates there was more than one meeting?

A Yes.

Q Can you remember how many there were?

A There were certainly five, six, perhaps more than that. It wasn't a one-off meeting that we had. I would say around five or six meetings to define the specification, and to look at plans, and to continue to work with the Project team on the needs of the BMT service.

Q And at these meetings, were the same participants present on each occasion or did this vary?

A The same participants were generally there at each meeting. I think in one of the meetings, Ian Powrie or someone from the Estates and Facilities team was involved, but the core individuals from my side, myself, Myra Campbell, Anne Parker would meet with Heather Griffin, Mairi Black, I think her

name was, Fiona McCluskey, at the project offices in Hillington.

Q And just before we move from page 159, you say you were presented with large-scale drawings. Now, what were these showing? Were these showing lots of detail or were they just general outlines, or what were they?

A So, the drawings related to the layout of the ward and the Queen Elizabeth, so-- and they were not-- I think at one point we got to what we called 1:50s, which were more detailed drawings where you could look at rooms and you could look at where things were, but the drawings that we looked at essentially showed the shape, if you like, of the Queen Elizabeth build. It showed where the location of Ward 4B was. It showed the through traffic routes etc. of the ward, and those were the basis of when we started to talk about the type of service that we'd be moving in.

THE CHAIR: You gave us certain names that you recollect, Helen Griffin, Mairi Black, you said, who may have been Mairi Macleod?

A Mairi Macleod, sorry, I think that was somebody else. Apologies.

THE CHAIR: Yes, and Fiona McCluskie.

A Mm hmm.

THE CHAIR: On one occasion you recollect Ian Powrie being at one of

these. Was Alan Seabourne at any of these meetings?

A No.

THE CHAIR: Do you remember anyone else who seemed apparently expert in mechanical engineering?

A No, apart from Ian Powrie----

THE CHAIR: Apart from Ian----

A -- he would be the only person. I think that location in Hillington is where all of the Project team, including, I believe, Alan Seabourne, may have been based but they were not in attendance with us in those meetings.

THE CHAIR: Right. Are you moving on from the theme of Hillington meetings, Mr Connal, or are you still----

MR CONNAL: I'm going to pause, for a little while, on Hillington meetings. If I may, my Lord. Can we just----

THE CHAIR: Right, so you are moving on? (After a pause) Can I just float something with you, Mr Jenkins, which is speculative on my part. If I understand your evidence so far, you would have seen as a purpose of your coming to these Hillington meetings as setting out what you were requiring from a service point of view in the new ward, which became Ward 4B, and you would be including in, as it were, your agenda matters such as pressure monitoring, pressure differential----

A Exactly that.

THE CHAIR: -- air change rate----

A Yes.

THE CHAIR: -- filtration----

A Yes.

THE CHAIR: -- sealing of ceilings.

A Yes.

THE CHAIR: Now, as I say, this is speculation on my part. Is there a possibility that the people who you were meeting with had a different understanding of what the purpose of these meetings were? Might they have understood the purpose of the meeting to be concerned with layout, placing of beds, placing of soft furnishing? I mean, this is purely speculation my part. Is there a possibility of perhaps you and your colleagues, on one hand, and the Project team being somehow at cross purposes as to the precise purpose of the meeting?

A I feel we explained what we had to explain because we were concerned about a full understanding of the environment that was needed for a BMT service. My feedback in the room and in discussion with Heather Griffin and others at the time was that wasn't an issue, or wasn't a problem, in relation to what they were there for. I feel that they had-- Because we were very late in the process, I feel that they had probably been working with so many different services, had so many different types of

specification that they were comfortable and were the team. Never at any point did they relate to us that we would need a separate conversation with somebody on mechanical engineering or a separate conversation elsewhere.

We were talking way beyond things like curtains and beds and layouts and things like that, we were really specifying the uniqueness of a BMT service and, if I might, highlighting that, when the BMT service moved from Glasgow Royal Infirmary into the Beatson, there were a number of problems at that point in time and we were talking through what those issues had been at that point in time, hence our concern.

THE CHAIR: Thank you. Sorry, Mr Connal.

MR CONNAL: No, I'm likely to stay on this point for a little while yet, my Lord. If we go to page 160, this is, first of all, just a touch on the attendees. You say:

"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)."

Grant McQuaker, are you saying he was there or he wasn't there or he may have been there once?

A So, Grant and Anne were both haematology consultants. I think there was an occasion when Grant may have been there. He-- Again, being a BMT doctor, I think he'd come along on one of the occasions to the meeting.

Q Yes.

A The key individuals were Anne, Myra and Laura.

Q Thank you. The Project team, you've given the same names you've just given us. Heather Griffin, Mairi Macleod possibly, Fiona McCluskey you thought was the Infection Control nurse lead. Was anyone, as it were, chairing the meeting, running the meeting?

A Heather was, yes.

Q Because the next sentence appears to indicate that they asked you what your requirements were: "We were asked. " Is that how you remember it?

A Yes, yes.

Q Now, I'll maybe need to come back on one or two of these points, but just let's look at what you say in the next paragraph. You outlined that:

> "... the specification of the Beatson wards (B8 and B9) were the specifications that were required... [You] were specific about the pentamidine room, air exchanges, positive and negative pressure monitoring and the very strict criteria [we may come back to some of these] required for patients

undergoing this form of treatment."

Now, I think what his Lordship was trying to sound out was whether, you know, one party thinks you're going to talk about bed placements, the other party thinks you're going to talk about air exchanges, but is your evidence that this was very clearly set out?

A We very clearly set this out, yes.

Q Yes, and you go on to say, as you said a moment or two ago, you discussed some problems that you'd hit when the BMT service initially transferred from GRI to the Beatson. There had been in delay due to issues with the building. I just wanted to ask you about the next bit:

"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."

Now, is that the specification of the Beatson?

A Yes.

Q In terms of air exchange rate, do you remember what that was?

A The rate that I recall was 10-12 air exchanges per hour in the rooms.

Q Pressure gradient?

A So you had-- Some rooms were positive pressure, some rooms were

negative pressure. For example, the pentamidine room, you needed the air sucked out, if that makes sense. In the treatment rooms, as you opened a door, you wanted the air in the room to push out, you didn't want to draw air in from the corridor, so each room had a different function and would require a different positive or negative air pressure for the activity-- the clinical activity that was occurring within the room.

Q For a bone marrow transplant room, we understand the pentamidine room is a different issue. Can you remember what the pressure gradient was?

A The pressure gradient, I think-- In terms of air exchange, is that what you----

Q Oh no, we've done air exchanges, but the difference in positive pressure between inside and outside.

A I can't recall that off the top of my head but we did say-- go through all of these measurements.

Q Did you explain what you had at the Beatson, what specification you had?

A Yes, we did.

Q Now, is that what you've just told us or was there anything else? The specification that you explained to them that you had at the Beatson, were there any other features?

A Of the Beatson or of the----

Q Of the Beatson.

A We-- The core components that we explained about the Beatson was the pressured lobby area to enter the ward. It was the corridor area being----

Q That's what people sometimes perhaps loosely call an "airlock system"----

A Yes----

Q -- to get in.

A An airlock, yes. So we explained through the layout of the Beatson, we explained the different functions of each room and what those rooms were used for. We explained this was different in terms of the specification to a neutropenic room, a haemato-oncology room, and the reason that we had said about we didn't think that there was a building note for this is that the Beatson was the only service in Scotland that provided the bone marrow transplantation service and, following on from the 2009, I believe it was, from Glasgow Royal to the Beatson, there had been a number of late amendments to bring the Beatson up to the desired specification that it was working to.

Q It might be useful just to ask you to look at Bundle 23, page 199. If we just scroll down because the top of the page just gives you a short email, this is an email from John Hood----

A Yeah.

Q -- to various people, "Transplant ventilation." This has a list of things: sealed rooms; waterproof paint; fungicide in the plasterboard; positive pressure, at least 5 but better 10; digital readout. Well, we touched on that. Particle counts, and so on. Then, we'll just go on to the next page. So is that the kind of thing you discussed or did you not get into that kind of detail?

A We did go into that level of detail on those points.

Q So, just pausing there for a moment. I accept you've had a number of meetings, so am I right in assuming that this didn't all happen in one single meeting because----

A That's correct, yes, we had a number of meetings.

Q Why did you need a number of meetings?

A Because we wanted to go back and have clarification that the spec was understood. We also had to provide more information that I believe we sent from the Beatson. We also had-- Let me just think back. Yeah, we wanted to assure ourselves that the spec was understood and then, as I said to you, I think it went from the point that my Lord had made. It went from looking at the wider, topological diagrams to looking at more detailed, in-room layouts.

So it would have changed from that more complex outline at the start into the more-- I think, as I say, they were called 1:50s, the ward layout and the service heads and different things that were coming in to the ward.

Q Now, if we go back to page 160 of your witness statement, you say that you provided names for contact if anybody wanted to discuss the problems that you'd had before but the point at the end of your paragraph is this was to ensure that all of the specification for the Beatson were "mirrored at the new unit", and then you say:

"We then went on to discuss the ward layout and had to sign some drawing and mark up our comments."

First of all, what kind of drawings were you being asked to sign?

A So these were the large A3, A2 drawings where we would write our comments down the side in relation to the conversation that we had about the ward in relation to any changes, and then all of us in the meeting room signed our name at the bottom of those-- on the same sheet on those actual drawings.

Q Can I just ask, because we don't have them, for a reason you'll be telling us about later on, what kind of comments were you writing on?

A So we would write any changes. We would write, for example-- If I give you the pentamidine room again as an example, we would highlight that that area was used for pentamidine administration, that there was a specification in there that would be, for example, a negative air pressure. We would talk about any specifics in the ward layout of the functions of each of the rooms, and we would have been labelling them as such.

Q Did that include things like pressure gradients and air change rates?

A It did and, if I might, the previous email that you just put up, would it be possible to look at that?

Q Yes, absolutely. Can we go back to the last one?

A Yeah.

Q Yes, and go back onto the previous page.

A Thank you. And just-- this-- this might be helpful or not helpful, is that email from John Hood on the 23 June 2015. And you'll see my computer changed last Christmas and a decade of emails still reside. I've scanned the document which includes the spec for the Haematology BMT rooms in the top floor of the Beatson. Now, this was in June 2015, when Craig Williams was asking for the spec.

And then he goes on to say, "Ian had already asked me this question some time ago," which is Ian Powrie, and had

pointed him in the direction of the Estates department at GGC, which was Gartnavel General Hospital. So, again, I just maybe referenced the point that I feel from that, despite us not then being able to recall any of these after the move in-- in June 2015, that the reassurance that we were getting that all of this would be taken into account was being taken forward through the Project team.

Q I mean, this is the question I think his Lordship probably asked you, but I'll just ask you at this point. You're laying all this out, you're saying we need this, we need that, we need the next thing. Is anyone saying, "Well, you can't have that"?

A No.

Q Or "That's not on"?

A No.

Q Or "Don't be silly," or any other form of pushback?

A The-- the only point-- and I can't recall when this came up, if we go back to the lobby rooms when you enter into a patient's bedroom. So in the Beatson, if you go to enter a patient's bedroom, you'll go into a hallway first and then the door will shut behind you. You open the door and walk in. I never can't remember at what point that that was not going to be possible. And I-- I've racked my brains trying to think about this, but I think that was the only compromise that

we may have given.

Without those earlier drawings, I cannot recall if we knew that at the time or if that was something that occurred later on. But that, I believe, was the only thing that we perhaps had a compromise about, but there was-- there was absolutely no feedback to say that anything that we were outlining was unachievable.

THE CHAIR: My fault for just losing attention for a moment. The one point that you compromised on was?

A I believe it was the entrance room to the room that-- the hallway almost going into a patient's bedroom. In the Beatson, if you go to enter a patient's bedroom, you go into almost a box room first and the door closes behind you, you open the door and go into the bedroom. So, the corridor pressure doesn't go straight into the patient's room.

In the Queen Elizabeth, because of the way the wards were laid out and the bedrooms were laid out, that wasn't possible. And I can't remember at what point we had a discussion about that. It must have been when we saw the drawings, but I can't remember now did we say, "Can that be amended?" or with the other mitigations in place, "Would that be a risk that could be tolerated?"

THE CHAIR: I think the Inquiry has been using the expression, "a positively-

pressured lobby"----

A Yes.

THE CHAIR: -- to describe what I think you've just described to me.

A Yes, a lobby room that you would walk-- a room before you go into a room, if that makes sense.

THE CHAIR: Right. Thank you.

MR CONNAL: Just to try and complete this story if we can. If we go back to the witness statement, please, at 161, you asked various things. We won't pause on all of them, but you say, about two thirds of the way down:

"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."

So is that you giving yet more information?

A Yes, yes.

Q And then you're asked about ceiling tiles and you say, "I can't remember what ceiling tiles were discussed," but you do remember discussing the rooms were going to be sealed rooms?

A Yes, absolutely. They had to be sealed rooms.

Q And airlocks, is that the entrance airlocks into the ward generally?

A Yes.

Q You also discussed the way the Beatson was laid out, but you don't remember discussing materials as we see on going on to 162. And you didn't have any particular concerns about layout because you were more concerned about having the synergy with the ITU and HDU.

A So-- so that was part of the core reason for moving, is that the High Dependency unit at Gartnavel was no longer there and therefore the ability for the BMT unit to remain there in the long term was not feasible. The unit would not have been accredited; it would not have passed accreditation because there was no Level 2 or Level 3 facility at the Gartnavel campus.

Q Just so we have that clear, Level 2 facility?

A So if you take High Dependency unit and level 3 being Critical Care unit, it's the step and up of intensity of-- of care treatment to the patient.

Q Thank you. Now, you're asked on page 162, about halfway down, "Did anyone ever tell you you can't get 10 air changes?" And you're shaking your head.

A No.

Q The answer to that is no. Well, then in your witnessed the statement you were told this much later on after the

service had gone back to the Beatson post.

A That's correct.

Q The initial move. And then you were asked a question, "Well, were you discussing air change rates, pressure differentials and requirements for HEPA filtration set out for a Neutropenic ward in SHTM 03-01?" And your answer to that is, "That is the very point that we made..." So does this return into the same thing? You're trying to make the point that this is not a general haemato-oncology ward.

A Absolutely. And-- and, and if I go back to the-- the 2013 document that was written by Jonathan Best, it does indicate on there, I'm sure, "SHTM 03-01 – Neutropenic ward". And so, using that as my reference document, I was really keen to say that this is different to a haemato-oncology word.

THE CHAIR: Could I maybe seek your help on a question of definition, really? As you say, if one goes to SHTM 03-01 as it now is, or as it was in the 2009 draft, there are recommendations for air change rate, pressure differential and filtration for what the table in the SHTM describes as a "Neutropenic Ward."

Now, I fully understand why the BMT unit, which you were concerned with transferring, would come within the definition of neutropenic. What I want to explore with you is whether what you describe as a General Haematology or Haematology-oncology ward, such as the service that we've identified as being in the Southern General and then becoming 4C in the new hospital, would you not describe that as a Neutropenic ward as well?

A I would describe the 4C service, the haematology service that was in the Southern General and the service that was in B7 at the Beatson as the Neutropenic ward. Yes.

THE CHAIR: You would describe them as neutropenic?

A Yes.

THE CHAIR: Thank you.

Thank you very much. Well, I think that that may be helpfully moves me past the next question because you're asked something very similar in your witness statement because, as we know, what happened was that whoever was going to be in 4B before was being moved and we're told they were moved into to 4C, but that wasn't, if you like, the cohort that were being moved-- to use that phrase, were not your cohort. This was a cohort that was coming from the Southern General?

A Yes.

MR CONNAL: Yes, as we discussed earlier. Can we look at bundle 52, volume 4, document 3? (Inaudible

15:36:37) miss it. Now, you are on this list of attendees. This is July 2015 so we've moved on a bit. And I think you can take it that this is one of the products of the issues that then arose in 2015. I just wanted to ask you about it while you were here:

"RC outlined that the purpose of'the meeting was to determine the current position re the BMT Unit and the way forward in order to transfer the patients back to QEUH as soon as possible. We should address: What we sought. What we built. how we rectify and what other areas might be affected.

CONCLUSIONS

It was concluded that the current ward is not suitable for BMT patients due to air pressure issues and high particle counts and that the focus of efforts is to be on rectification in the first instance."

Then there are a series of action points. If we could just scroll down here and we'll just carry on. Now, what I think we've then got is, as I understand it, an explanation from the contractors-- or a partial explanation from the contractors as to what seems to have happened. And what that says is:

"BOARD'S REQUIREMENTS Requirements are set out in the following documents;

• Clinical output specification for Haemato-oncology."

Now, that's the original Southern General Haemato-oncology----

A Yeah.

Q -- specification that we talked about earlier. SHPN 04-- SHTM 03-01 ventilation. In summary, it says:

"These documents set out the following design parameters: sealed room, HEPA filtration, single room, sub-positive pressure of the rest of the hospital and an enhanced air change rate. Compensation event, 51."

Now, that's-- didn't worry you too much, that process under the particular contract under which the contractor gets more money if something is changed.

"…instructed an additional number of rooms should be built to the same specification as those in the Haemato-Oncology ward. No detail within the change control form from the service to suggest these rooms should be anything other than more than HEPA filtered and built to the same standard."

But I suppose that the question I need to ask you is: do you know what happened to your explanations to the Project team of what you required? Because there's no (inaudible) thing said, you know, "Number 4, material produced by Gary Jenkins and team from Beatson----

A Yeah.

Q -- or some other such

description to cover the period that you sat down over, you say you think, possibly five meetings. There's no mention of that. Have you ever understood what happened to that material?

A So, I asked for that material to be recalled, our planning material, all our notes, following the initial set of results that we get back. This was in June, obviously when the first sets had come back and they were not within the expected tolerance parameters at all. I believe either contacted Heather Griffin or Fiona McCluskey, one of the Project team, to ask, "Could we recall all the drawings, all the notes, everything that we had submitted, everything that we had discussed?" because I could not fathom at all how the specification that we outlined was given us the results of the air samples that we were receiving.

I then, as I told you in my statement, was informed that the notes had been destroyed. I was told, I believe at the time, it was to do with storage and demolition of other buildings. So there was a whole bundle of paperwork associated with the project that had been destroyed.

I then called Myra Campbell and, again, I believe Ann Parker, to say, "We need to get all our notes from our notepads to assure ourselves here that we have actually specified the correct thing."

Now, as I've indicated, obviously I left the organisation in 2019. Had I not, and I still had access to my account, I am pretty sure I would be able to produce email evidence of those conversations of that follow-up, and of some of the communications that were going on around about that time.

Q Right. Thank you. So, you were bemused, if I-- that's my word, not yours. Perplexed----

A Perplexed, yes.

Q -- as to how it happened that conversations which you tell us did not lead to any pushback/challenge/dispute/debate. Is that right?

A Absolutely, that's correct.

Q Which you thought had been very clear as to what you needed-- had somehow not gone anywhere.

A They hadn't materialised into the outputs that we would have expected but the first awareness of that was the air sampling results. That was the trigger to say something is not right in relation to the ward's environment.

Q Yes, thank you. Well, with my Lord's permission, I'll leave this document. So, we come out of that. We'll go back into the witness statement because I need to move to one or two

other topics if I can in the time we have with you, Mr Jenkins.

I think you explain in your witness statement, particularly at 163 at the foot, that your first knowledge that there was any issue was when somebody said there were high air sampling results, and we know a number of issues were then identified but we probably don't need to go into it in any detail just at the moment.

Can I ask you about a side issue-- what's probably a side issue? Page 164 at the foot. In the way that happens in these type of exercises, we end up putting things that "A is said to B". Dr Inkster says that she thought she was getting resistance from you when she was raising concerns about air sampling in June 2015.

Now, you, I think, explain on 165 that-- Am I right in getting the picture that you were both coming at this from very different positions, and until you understood each other's position, there was a bit of an issue?

A Yeah. If I may, first of all, say I was astonished to see fierce resistance. I actually thought I'd quite a good relationship with colleagues but that-- on reflection, I think that was the case, and I recall asking the question of how can we go from a building that's just opened with validated intelligence to having results that are so far out, and at that point, I'm talking to Teresa that-- she would have signed off the validation and understood, and she's saying, "I haven't signed any of this off."

And I was saying, "Well, you're an Infection Control doctor", and I think Ian Powrie was in the meeting, and I'm saying, "Ian, you told us what was the validation process? Has Dr Peter's seen this", and so I think we were all at very different places about what we all did or did not feel we knew or understood about each other's role on the day in that particular discussion.

The other reason, if I might, in terms of the-- just around about the fierce resistance from me, I would simply highlight that probably within the space of six days and from that meeting - which, at the end, I thanked the ICDs for their input and that we would act absolutely on what they had informed us, and on the outputs - we moved the patients back. I wasn't given any resistance around the clinical need.

What I was trying to understand was how could we have gone from a state of a validated hospital that had just opened to having results coming back that were way in excess of what we would have expected to see, and I think Teresa Inkster was saying, well, she didn't have that answer that I expected from her. She was asking Ian Powrie, who

validated the building. I'm saying, "Well, Ian, you told me the building was validated" , and it turned out, I think-- that was Craig Williams who was the Infection Control doctor, and I think I would still have expected that the lead Infection Control doctor for the organisation would have communicated the results to the Infection Control doctors in the different parts of the hospital service.

So, it really was, probably, a sharp meeting of trying to find facts and establish how had we got to where we-- where we were after just having the patients in literally two and a half/three weeks----

Q So, am I right in understanding – just correct me if I'm not getting this correct – that your point initially was, well, you've got this brand new validated, checked super-duper building, and here we are getting way off the scale results. How does this happen? Then two things. They're saying, "Well, I didn't tell you it was validated and checked" , and it went from there.

A That is exactly how it unfolded, and, as I say, I think we were all at different places in each other's understanding. This, as you know, is the first that we came together in light of Myra Campbell alerting me to the results. I think it was the day before but Myra Campbell had also alerted me to the fact – I go back to the fierce resistance – that she felt that Dr Inkster was feeling particularly vulnerable or that she wasn't being listened to, and I said, "Well, thanks for letting me know that in advance of going into the meeting", and as I said-- I made a note to actually express my gratitude and thanks to the Infection Control doctor at the end of it.

Q Thank you. Now, if I can move on-- if I could, I need to ask you about a number of documents. So, I'll move reasonably quickly past a number of points. You made the point earlier that when this all cropped up, you weren't looking for your records and notes and the drawings that you'd signed.

A Yeah.

Q You deal with that, for the record, on page 167 on your witness statement. You also explained to us that you'd met with your clinical service manager. Is that Myra Campbell?

A Yes, yes.

THE CHAIR: And to what-- check that you'd done what you thought you'd done?

A Absolutely----

MR CONNAL: Did she agree with you or was there any dispute?

A Yes. As did Dr Parker. They had been the constant with me at the development stage of the BMT specification.

Q Yes, and then you, you make the point at the foot of page 167. You believe you'd articulated the case for a BMT unit, specified the differences, given examples of issues, and been given assurances that this would all be implemented. I mean, did somebody actually do that: give you an assurance that this would all be implemented in a new BMT unit?

A If I perhaps just go back to the point I made earlier. Without having any of that document or emails and anything that I can go back and check, if I specify, for example, we said you must check with Dr Hood. Dr Hood was the lead ICD microbiologist that was involved in the Beatson commissioning, and I go back to the email that Craig Williams had sent to John Hood, and then John Hood indicating Ian Powrie had been in touch some time ago about this. It was issues like that that no one at all was coming back to say this was not achievable at all, and I felt, and was pretty sure, that everything we put forward was achievable, you know, within the building.

I mean, the main issue is around about the air handling and the plant and the aid exchanges. So, we had to be really clear about the supply feeding the ward-- that it had to be capable of the air exchanges. I think it was an air rate of 10 to 12, and so we were explicit about that upfront, recognising that the building was being built as we were doing this particular exercise.

And some of the other stuff, again, that was not as complex but, again, around about-- it needs to be sealed units, you need to have a-- for example, you need to have maintenance hatches because you have to be able to go in and do different bits and pieces, they have to be sealed, and the testing, etc. that goes on.

So I think we were very, very prescriptive about it, and, as I say, I also, in other correspondence that I was reading, associated some of these bundles did know-- Anne Parker as well had corroborated that. I think it was in an email correspondence on 5 July, I think it was.

Q The reason I'm asking you quite so many questions about this exchange is that-- I think it's-- the fault may be mine, and maybe there's something that I've missed or predates me, but this is the first time we've actually seen a description in any form of a detailed process of information giving for the BMT unit, which seems logical, but we hadn't actually seen it elsewhere. I'm not sure we've seen it in writing anywhere.

I mean, that's a question I'd probably need to ask you. I mean, there

was a big fuss, to put it no higher, over the fact that the BMT unit was turning up and then thinking of leaving. We'll come to what happens after that in a moment. Is there a reason why we don't find anywhere in any of the exchanges a document from Gary Jenkins saying, "Look, Anne Parker and Myra Campbell and I went over there, and we made absolutely plain in one syllable what we needed, and nobody said there was a problem".

A Possibly if I had access to my old email system, I may be able to go in and find documents to that effect that would have been sent. There would be correspondence, I believe, between myself and Myra Campbell. There would have been correspondence between the Project team at Hillington(?) and myself. It wasn't really the case that we would have sat and done everything with them and then not had any conversation once we left.

I also think there will be information contained within the Regional Services, either Directorate Management team minutes or the clinical governance minutes of this process but, again, as I've indicated, I left the organisation in 2019, and I don't have access to, obviously, the system that I use. If I did, I would happily take an action to go away and find whatever correspondence I had in relation to that.

Q Well, let's leave the written record art for the moment. If we ask you this. You describe yourself as "perplexed", but obviously there was quite a big issue here, which ultimately involved clinicians moving their patients out just having moved them in, which I think many of the witnesses have said was almost unprecedented. Did you make your point about what you had spelled out to anyone else within the hierarchy of NHSGGC? Did you explain this to anyone?

A Yes. I was quite clear, and I obviously had to brief Jonathan Best. He was the next in line, and I believe that Grant Archibald was back at that point as well. He was the chief operating officer, and Jonathan had been in that role too, covering when Grant Wilson had been off. I also attended a meeting, I recall it, with David Loudon and with Robert Calderwood, I believe Dr Armstrong, and I then produced just a very high-level briefing note.

I was aware that Kevin Hill, who was the women and children's service director, also had services moving in. I spoke to my colleague, Anne Harkness, around about: had any of them seen validation data; was this something that I had missed, because I was really, really concerned that I had missed something,

and that we had inadvertently put in-- you know, individuals at a risk, and so there was correspondence and communication from me, and there was certainly verbal correspondence, and as I say, there was a discussion.

In fact, there was a meeting as well with Robert Calderwood, Craig Williams, and David Loudon that I attended in the Southern General Hospital, directly after these events occurring.

Q Okay, I'm conscious of the time. Can I try and jump on a little bit? You've hit the problem and there's some exchanges about air change rates and so on and so forth, and testing results. Let's leave that for the moment. A decision is then taken, as I understand it, to take the patients out of the new hospital and put them back in the Beatson. Is that right?

A Correct.

Q That's what you describe, I think, on 168 of your witness statement and you helpfully tell us when that decision was taken, because it was the same day that Her Majesty came to open the hospital, irony of ironies, that the decision was taken to remove one lot of patients. So they're gone, they're back in the Beatson, and then there's a debate to be had about, "Well, what now?" You've moved them back out, what should you do? You were then involved in that process.

So, if we go to 172 of your witness statement, we're going to look at the document just in a moment, but you were asked to do an options appraisal. Is that right?

A Yes, this is a bit later on. This is-- this is----

Q Yes.

A Yeah, yeah.

Q So----

A There's a number of events before that but, yes, this then moves us onto a different path.

Q And you're asked, "Well, who asked you to do it?" and you thought it was either Jonathan Best or Jennifer Armstrong. Is that right?

A Yes, that's correct.

Q What was the idea of doing this approach?

A So, the passage of time-- There'd been, I think, two-- I'm not-- I think this was 2017, roughly, this time period. So between 2015 to 2017, there was a failed attempt, if I call it that, to relocate BMT back to the Queen Elizabeth. This was on a specification that Dr Williams worked on immediately after the service moved back out to the Beatson.

Q Who was doing this options appraisal in terms of the producer of the document? Was that just you?

A This one here rather than the

event that I was mentioning?

Q Yes, the options appraisal ultimately came up with the----

A Oh, so this option appraisal in 2017?

Q Yes.

A Yeah, okay.

THE CHAIR: So, now, Mr Jenkins, did you get the opportunity to finish what you were saying about the failed attempt?

A No, do you mind if I could?

MR CONNAL: Yes, my fault.

A No, it's fine. It feeds into why there was an option appraisal, I believe. There were-- I think it was two failed attempts to take BMT from the Beatson back to Queen Elizabeth. We initially-- Craig Williams, the Infection Control doctor, along with various other colleagues in Estates, and myself, and the Haematology Team essentially redefined what was needed, what had been asked for, and that ties into the earlier email you saw, I think where they contacted John Hood.

Around about October, there was a decision that the service would be transferring back but, for some reason, Dr Williams transferred the service back to Dr Inkster, and then, essentially, when Dr Inkster looked at the work that had been done, she disagreed and felt that there was significantly more work that needed to be done, so the service didn't move back, point-- first point. There was then, I believe, a second attempt to try and involve Health Facilities Scotland and various other groups, various other agencies.

I think we had a discussion around about, "Goodness me, is this ever going to be able to move back? Are we ever going to be able to get to the specification that we need? And if not, well, what are we going to do with the service?" There's no intensive care unit, there's no high dependency unit. The longer the service stays in the Beatson, albeit we had strengthened the infrastructure, we had an on-site anaesthetist, we had developed a high acuity unit that covered the Beatson and Haematology, thinking, "Where would you go with this? What would you do with it?"

And I think it was from that discussion, it was either with Jonathan or with Jennifer, that we said, "We need to look-- Is there a different opportunity in the retained estate?" That was the estate that was still left on the Queen Elizabeth site or at Glasgow Royal Infirmary, again, because those sites had intensive care facilities, high dependency, renal dialysis, the other infrastructure services that were needed to support a bone marrow transplant unit.

Q Yes, okay, well, I apologise for interrupting you earlier. Can I go back to

the question I think I asked, which is when we come to the options appraisal that we're talking about now, which is mentioned on page 172, and which we'll put up on the screen shortly, who prepared it? Was it just you?

A No. The option appraisal was prepared by-- We had a planning manager, Marjorie Johns, who was very experienced in developing option appraisal processes around about weightings and scoring and criteria. Marjorie led that process. Marjorie was very experienced, very competent. She had worked with NSS previously, and this was a process that she was most familiar with, probably out of all of us.

The option appraisal process is multisource; it's not one person. You all agree on different benefits and weights and criteria that is used to prepare the option appraisal, and then there's a scoring process that follows that. And that, if I recall, involved haematologists, Infection Control doctors, and some other clinicians around about the feasibility of different options around about the Glasgow and Clyde estate.

Q So, this is not just Gary Jenkins' idea of what we should do next. Other people input into the process.

A Oh, gosh, yes, absolutely. It's actually-- It's more of the consolidation of a multi-professional group's opinion that comes out of that, and it was to try and determine, were there options that were available to us? And I believe in the eventuality that we would never achieve an optimal environment for a bone marrow transplant service, for example.

Q Yes, so perhaps we could have a look at bundle 27, volume 7, page 158. Now, the way this document works, it actually starts with the end----

A Okay.

Q -- because that's the recommendation, and we'll see that through. The recommendation, as I read it, is that the Acute Services Committee is asked to agree the temporary relocation of BMT services to 4B. So, first of all, back to 4B is the option; secondly, temporary, correct? That was the recommendation of this process.

A Yeah. I'm trying to think why we would've used the word "temporary."

Q Well, I think we'll come to that in a moment, if we can. The next paragraph:

"This recommendation is made on the basis that service delivery considerations require prioritisation over ICD teams' concerns on meeting national standards and HPS recommendations."

Now, we can look at the entire document but, in terms of summary, am I understanding rightly that what was happening here was that there was

pressure to get you back in to co-locate with all the things that people wanted to co-locate with and, at least temporarily, the recommendation of this group was that, for the moment, trumps concerns about the specification not being correct?

A Yeah, I can clarify those two points. The first one, if you like, on temporary, I can come back to that just as I read the next sentence. The challenge at this point, as I say, was to come up with options. The clinical haematologists who were providing the service, obviously to the patients, were working in a really difficult pattern. They would have patients off-site. I think there was something like 48 patients had been transferred on and off-site in the period of a year.

The difficulty in an option appraisal process is that the haematologists – this goes onto a paper that was later discussed for the Acute Services Committee – felt that they could live with the risk of a slightly lower spec unit in relation to, was it 6 air changes to 8, rather than 10 to 12, and that the-- if those risks were known, but the overriding risk was the risk to the patient of being on a cold site, a non-acute site that has the HDU, ITU renal facilities, etc.

The haematologists were absolutely adamant by this point, because of their experience having been at the Beatson

now – now that's March 2017, for probably over a year, a year and a half – that they really wanted to get into an area that meant that they could consolidate the work and reduce the clinical risk that they had, and develop the synergies with the other services in the way that they had anticipated.

And the second point, if I may, just when I say, "Agreed a temporary area relocation of BMT services to 4B," I think that correlates to the next sentence which at the same time:

"BMT services should be considered as part of the Acute Services review of Cancer Services to deliver a long-term sustainable option that will meet both service and environmental considerations."

If I might just explain that a tiny bit further, if that's helpful.

Q Tell you what we might do, Mr Jenkins, let's have a look at the document----

A Sure, okay.

Q -- and then we can very happily ask you to elaborate. So, the first page we're on here gives a list of key issues to be considered. We don't need to read them through. We can see these.

Can we go on to the next page, please? "Financial implications," okay, that's a kind of standard thing that you find on policy papers of this kind. Move

on to the next page, page 160, and this is where you start the narrative of what is summarised in the early page that we looked at earlier. So, we see background, paragraph 2, "...unit had to return to the Beatson ... following the identification of air quality issues, the service began to make plans to move back..."

And then you reference input from HPS about the specification and the Infection Control team's view on specification. So this is your reference earlier to more than one attempt to sort this, before you got to this point.

A It is, yes.

Q So, you then get to near the foot of that page. If we could just scroll it up a little, so we can see the remainder of the page. The conclusion there is that:

"While further improvements could be made, due to limitations of current plans and lack of space to expand the fourth floor, Queen Elizabeth Hospital could not be configured to meet the full specification of requirements as detailed by HPS and Infection Control."

So, that's your conundrum.

A Yes, sorry.

Q There was a further feasibility study and so on mentioned. So, we go onto the next page, which is 161, that's description of the current service and the numbers and so on and so forth. We needn't pause on that.

At the foot of the page, "Option Appraisal," two meetings in February 2017: one to look at options, the other one is criterion weighting. Now, I take it these were not 10-minute meetings, these were longish discussions. Am I right?

A That's correct. Now, I am pretty sure I wasn't at the meeting. It was a dedicated session. I think it was probably two afternoons.

Q Right.

A It wasn't a-- Yeah, it wasn't an in and out and add your score. It was a-- Having been involved in these, and then having had feedback from Marjorie, it's a full stakeholder team that are discussing the various factors that play into the options appraisal.

Q Okay, well, let's move on to the next page: options considered, long list of eight, four were removed. Four options: remaining at the Beatson, returning to Level 4, going on to the roof of the new maternity building-- sorry, the Queen Elizabeth Hospital maternity building or going to the Institute of Neurological Sciences neurology building.

Then I think what we find in the next paragraph are summaries, as it were, of considerations against each of these options. One:

"Remaining at the Beatson requires significant changes to clinical support." Going back to Level 4, see here, "Unlikely to be a long-term option." So that's the summary conclusion, which we discussed briefly earlier. Would you agree? "Quality of built environment is main issue." "Maternity roof technically feasible, we can forget options 4, 5, 7 and 8," and then the remaining one is, "Neurology ground floor with external extension, difficult but feasible."

And then we go on to, as it were, the mechanics of the process, I think the different criteria which were built into this options appraisal: benefits, criteria and weighting. I don't think we need to read through all of these. So if we can just scroll on to the next page and, again, we can see there's a fairly extensive list of criteria being taken into account. Is that fair?

A Yes.

Q On to the next page again. That's your scoring matrix. So move on, and this is where your planner was helping you to work out how you balance the different issues. Is that right?

A Yeah, the planner was leading on this, yes.

Q Yes. The option scoring, each member of the scoring team. How many members? Do you know?

A I've got a funny feeling there's

seven or eight but, again, it should be contained. There should be membership----

Q Right.

A -- within this----

Q Let's move on. 166.

A Yeah.

Q So here you have, "Option 1: remain at the Beatson," and then there's a summary of what that showed and you end up with what's described as a weighted score: 448. Is that right?

A Yes.

Q You've got 1, 2, 3, 4, 5, 6, 7, 8.

A Yes.

Q So service clinicians, Infection Control and two others, "IP" and "MM."

A MM must be Melanie McColgan who's the general manager of the Beatson, the specialist oncology and clinical haematology. IP makes me think it would be Ian Powrie.

Q Then we go to Option 2, which is the one that perhaps, in some ways, we're particularly interested in, "Failed to deliver an improved patient journey with consolidation of services." However, let's go on to the next page:

"Option 2 did not score well against criteria to meet environmental standards nor was it felt to be a sustainable option for the longer term."

So, although you kind of talked around the temporary point earlier, this

process – good, bad or indifferent – has clearly identified this "not a long-term solution" more than once. Is that right?

A Yes, that point correlates into the opening summary, as I read it back.

Q Yes, and the weighted score for that is 600, and then we'll find that there are weighted scores for the others. If we just move on to 168, we'll find a score of 614 for the maternity building option. Institute of Neurological Science is also 614.

So, onto the next page, "Risk assessment," and then clearly what's been done here is that each of the options have been risk assessed. Is that right?

A Yes, that's a detail of the explanation, I think, around about the clinical risks, probably service risks and other risks as the document goes on.

Q Yes, and the risks to be considered are listed at the top of page 169. So if we go on to the next page, if we go to the next one, because this is still looking at the Beatson which we know wasn't the option ultimately selected, can we go on to find-- Yes, here we are. So here's Option 2 being risk-assessed:

"Facility in 4B did not meet the standards set out in SHTMO 301 or HPS guidance. Main concern is of airborne infection."

Now, if it was to be suggested there was no risk to operating the BMT unit in the new hospital at the levels that we've talked about, i.e. not achieving what you asked it to achieve, what would you say to that suggestion?

A That there were----

Q No risks.

A That would be untrue, that there were no risks.

Q There are mitigations which are mentioned. Antifungal prophylaxis is one of them, although I think we know from other evidence that that's not always suitable for every patient, or can produce side effects and so on.

A That's correct, yeah.

Q So if we just go on to 173, that's Options 3 and 4, and 174-- Sorry, I may have missed the start of that paragraph on 173, that's my fault. 173, please. Yes, "Conclusion." Sorry, it just slipped off the bottom of the page:

"3 and 4 scored the highest [so that's your 614s] with regard to delivery of environmental standards with other concerns. Given the close scoring, the group discussed Option 2 as an interim solution for a time-limited period. It could not provide the required environmental standards but only those services that have moved into purpose-built facilities are currently delivering this standard."

That was something you checked out. The recommendation, you're

basically asking the Acute Services Committee in this paper to consider Option 2 as an interim solution. That's the way the paper ended up, as we found out at the start. Is that right?

A I believe so, yes.

Q Then we go on to the next page, just to see how it finishes. At the same time, this is your point about the Acute Services Review, you ought to think about something wider to meet all the considerations, if that's possible.

A Yes. I believe at that point – and I'm sure you might have come across this in other discussions – we had a discussion about what is the future of Gartnavel but also the Beatson West of Scotland Cancer Centre and, therefore, if you were doing a review of strategic cancer services and their placement and you were potentially creating another environment, you would then think about taking BMT as a new build.

The only way that you were going to get the panacea, the perfection, was to rebuild from-- you know, from the ground up. And I believe when I said the temporary-- that is in the context of thinking about what a redevelopment of the cancer model, the cancer strategy for Glasgow was. I think that is what that context is that is cited in the paper.

Q What you tell us in your witness statement – if we can just leave the paper for the moment and then go to 174 of your witness statement – was that Dr Jennifer Armstrong wasn't happy with this paper that you'd produced and the conclusions in the way that they were expressed. Is that right?

A I didn't think it was that version of the paper, but it was a very similar paper. I think in my bundle, it was marked "Finance and performance," but it's essentially the same paper.

Q Yes.

A The paper that Dr Armstrong and I were at odds, if you like, about was a paper – I thought or I believed it was – for the Acute Services Committee, and the way I had wrote the recommendation on the paper highlighted that the consideration to move patients back to 4B-- the recommendation to move patients back to 4B, essentially, was taking a view that the haematologist's opinion of the clinical risk was a greater factor than the microbiologist's, Infection Control Team's view of the risk.

What I was trying to say to Jennifer at the time was, I cannot get a consensus between the haematologist and the Infection Control doctor.

Teresa and the Infection Control team, it had to be 100 per cent-- the environment had to be 100 per cent perfect and I can understand why. The haematologists were happy to live with

the risk but felt they were dealing with a higher level of risk, because they were transporting ill patients by ambulance through the Clyde Tunnel into high dependency facilities at the Queen Elizabeth; once they recovered, having to transfer them back to the Beatson and there wasn't the backup support on site at the Beatson.

So the haematologists, and I think it comes up earlier than that, that there was feedback from families and from others who were expressing that the service they wanted, and were used to, was becoming sub-optimal because it was split. So what I was trying to say in the paper, and this is where Jennifer and I were having a disagreement, I couldn't write something that says there is a consensus here. There was not a consensus and, therefore, the only recommendation I could put was with the caveat that this is taking the haematological opinion over the Infection Control-- the microbiology opinion, because there was no compromise between two that would have allowed you to get to a position where both parties were entirely happy.

Again, if it's helpful just to clarify what I meant about the disagreement with Dr Armstrong in there, if that's helpful just for the record----

Q No, thank you very much. I'm

conscious that time is running on and I probably have put this point to you but, in your witness statement, you were basically asked, look, there's a whole series of documents in and around this topic, to which you have put your name, running from 2015 to 2018 and so on, and then the suggestion was made to you, in none of them do you say what you've said in your witness statement, which is that, "I and my team turned up and laid down very clearly what we required and got no pushback." That seems, perhaps to an outside viewer, rather odd that, you know, if the service was faced with a difficult problem, you were making the point that you and your team from the Beatson had done everything, dot and comma, that you thought you had to do.

A I could, if it's helpful, perhaps write either subject access request or by some other way, for my previous correspondence if it could be reconstructed and I would be happy to take time to go through any correspondence, if I could bring paperwork or documentation to answer that point. If that would be useful, I would be happy to take that on.

Q Well, let me just put one thing to you, just as an example. If we look, please, at bundle 27, page 291, this should come up for us. Sorry, volume 3.

(After a pause) 291. Now, this is fairly early on when this problem is quite hot, if I could call it that. 6 July 2015, bottom of the page, you are writing to Grant Archibald, David Stewart, copied to Craig Williams:

"Please find attached briefing note with regard to the discussion today and BMT issues. Preferred clinical view [is to go back] to the Beatson on Wednesday... I'll come in to discuss it."

So this is fairly early, you know, before the difficulties perhaps have been fully explored and all the different options have been gone through. If we look at the briefing itself, which is in bundle 13 at page 840, there's a discussion about the Pentamidine Room and some of the possible solutions and there's a conclusion that you should go back to the Beatson. I suppose we just have to put this point to you, Mr Jenkins, that you describe yourself as "perplexed." Another way to put it might well have been "aggrieved" that you'd gone to all this trouble, you and your colleagues, to spell out a specification, as you thought, that was clear and detailed and referenced to documents and other experience. Here you are reporting on what's happened and you're not sort of saying, you know, "We laid this down in detail." It might just appear a little odd, so I wonder if you could help us at all as to why not.

A Sure. Do you know the date of that document? I may have put a date on it.

Q Sorry, yes, your email is 6 July 2015.

A Yeah. Okay, so that would have been the Monday. So, on 3 July, which was the Friday, I think we received the second set of results back. If-- if you recall-- If I'm getting my dates right, 30 July was when we were notified, we had a meeting on the 1st; we met on the 3rd. That was the Friday. I think that was the-- the night, or the-- the day the Queen was-- was there.

We then were taking immediate action over the course of that weekend to clear the Beatson, to relocate the patients back. So this is less than seven days since the results of the tests have become available. So this is written as an immediate briefing note. It's not written as any kind of retrospective of processes, etc., at that point in time. This is a briefing note that's saying, "As of today, we are moving these patients back across."

If I refer to points earlier on, we still-- I had no idea if this was only Ward 4B. Was it everywhere? What-- what was the issue? So, that's-- looking at the date of that, it's 6 July. That is within days of us getting those results back. It was not

meant to be, “Here’s a-- a hypothesis,” or, “Here’s a work through of everything that was done.” It was an immediate briefing note and I think that was sent round my Acute director colleagues as well, just so that they were aware of it.

But, also, given that I was raising the issue of our environment not being correct also to highlight, “Were there any concerns?” or till here, that there may have been concerns coming together. So that’s not what that document is about.

Q You did pen later documents, but these are way on, in 2018, when you’re actually looking more closely at bringing the thing back. So I’m not going to ask you to look at these.

A Again, I would just state, unfortunately, I can’t access any information of my own that I could have brought or submitted to the Inquiry. I can only rely on the documents that have been sent to me.

Q Of course. I appreciate that. (To the chair) My Lord, I think, in the circumstances, this is where I would intend to pause my questioning.

THE CHAIR: Mr Jenkins, at this stage, what we do is give counsel the opportunity to discuss with his colleagues whether there are any other questions in the room. Shouldn’t take more than 10 minutes. So if I could ask you to return to the witness room and we will be back in touch as soon as we can.

THE WITNESS: Thank you very much. Thank you.

(Short break)

MR CONNAL: Three or four questions, my Lord.

THE CHAIR: We have some more questions.

THE WITNESS: Okay.

THE CHAIR: Mr Connal.

MR CONNAL: Bouncing around a bit, I’m afraid, is the nature of the beast. The process that you’ve been discussing is one where you had a reasonably senior role and issues were being encountered. Somebody in that kind of manager/general manager, director level, would you expect them to sort of do due diligence on any significant step, perhaps moving a cohort of patients, to take that as the obvious example, and then, if there were issues, get on quite quickly to investigate it? Is that the kind of reaction you would expect from somebody around that level?

A Yes. If I might, if you relate it to the BMT transferring back to the Beatson.

Q Yes, of course. Yes. Now, purely administrative point, given some of the evidence you’ve given us, I think you indicated – and, again, I’d like corrected if

I've not picked this up – that you think you probably emailed a number of people to explain what you and Parker and your manager colleague----

A Myra Campbell.

Q -- Myra Campbell, thank you, had done, and what you had laid out, and why you were "perplexed," or words to that effect. Can you remember who you put that in writing to?

A No. The point I was making is I would be happy, if my inbox was reconstructed, to go through-- This would be 12 years ago. I'd be happy if those are reconstructed to go through and try and find any evidence. It was-- I think what I was trying to answer was the point that you had made that it seems light on information from me, but I didn't submit anything. I've only used the documents that have been provided by the Inquiry.

Q No, I understand that the Inquiry has processes by which it can go looking if it knows where to look. So, if you said, "I remembered, I've probably sent an email to Jonathan Best"----

A Oh, yes, I mean, I could----

Q -- well, we can do that.

A Yes, I can----

Q So, can you give us any indication as to the likely persons that you sent such communications to?

A I can. I can give you a list. I mean----

Q Right.

A -- I would like to go away and write it down and consider it, if that's helpful.

Q I think the easiest thing to do is to take you up on that offer. If you go away, think about it, write it down, and email the Inquiry Team here with the list of people that you think you may have emailed along the lines we've just discussed, then that would be very helpful if my Lord is happy with that.

THE CHAIR: Yes, thank you.

MR CONNAL: And then we can decide whether anything further can be done at our end. Thank you very much.

By the time you left your post-- Sorry, I'll restart that question. The discussions that you participated in – the options appraisals and so on – revealed at least a level of concern about taking the option of going back to the new hospital. It wasn't the new hospital by then, it had been open for a while. By the time you left, were you still concerned or were you happy or where were you sitting?

A So, by the time I left, I was more comfortable, is a reasonable way to put it, and I will indicate why. We ultimately had brought together Health Protection Scotland, Health Facilities Scotland, I think every specialist microbiologist that existed in the UK, with

the Clinical team, with the haematologist, and had taken the consolidation of all of that to put into the remedial plan for 4B at Queen Elizabeth University Hospital. So I was comfortable that the patients were in an environment that had the infrastructure that was needed, the Clinical team were happy with that, and that the expert advice had been consolidated and to give the best product that could be created.

Q Yes. So, you had done the best you possibly could.

A At that point, I was----

Q At that point.

A Yes, at that point, I wasn't leaving thinking, "Oh my gosh, this is a"-- unless something else had come up, which I think there was then a series of water incidents, but that's not to do with the BMT service.

Q I may have asked something similar to this earlier because this is really my last question, filtration, HEPA filtration----

A Yeah.

Q -- air change rates, pressure differentials, do all of these matter to the protection of patients in the BMT unit, in your view?

A In my view, from my experience of what I have gone through with this, yes, they do.

Q Thank you. (To the Chair) I have nothing further, my Lord.

THE CHAIR: I have no further questions. Mr Jenkins, you're therefore free to go but before you do, can I thank you for your evidence this afternoon, but also what's behind that evidence, preparing the statement and doing the necessary reading in order to back that up. So, as I say, free to go, but many thanks indeed for your contribution to the Inquiry. Thank you.

THE WITNESS: Thank you both. Thank you.

(<u>The witness withdrew</u>)

MR CONNAL: Now, tomorrow, my Lord, we return to Mr Mackintosh, who has another remote witness, I understand, Mr Stewart.

THE CHAIR: Is that Mr Stewart?

MR CONNAL: Yes, and then I am returning in the afternoon with Mr Gallagher.

THE CHAIR: Mr Gallagher. Very well. Well, can I wish everyone here a pleasant afternoon and evening and, all being well, we'll see each other tomorrow at 10.

(<u>Session ends</u>)

16:47