SCOTTISH HOSPITALS INQUIRY

Hearing Commencing
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Day 5
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Jane Grant

CONTENTS

(10:03)

THE CHAIR: Good morning. Now, Mr Mackintosh, we have Ms Grant.

MR MACKINTOSH: We do have Ms Grant, my Lord.

THE CHAIR: Please sit down, Ms Grant. Good morning.

MS GRANT: Good morning.

THE CHAIR: Now, as you know, you're about to be asked questions by Mr Mackintosh, who's sitting opposite, but first I understand you're prepared to take the oath.

MS GRANT: I am, yes.

Ms Jane Margaret Grant
Sworn

THE CHAIR: Thank you very much, Ms Grant. Now, we've allowed two days for your evidence. We will sit in the morning until taking a lunch break at one, but we will also take a coffee break, usually about half past eleven. But if you at any stage wish to take a break, feel free just to give me an indication, and we can take a break.

Now, the other thing I would say at this stage is that we have a space to fill. It's very important that we hear what you have to say. Now, the microphones are there to help that, but if I could ask you to speak maybe a little louder than you would in normal conversation, and maybe even a little bit slower. I'm taking notes, as are other people.

Now, Mr Mackintosh.

MR MACKINTOSH: Thank you, my Lord.

Questioned by Mr Mackintosh

Q Ms Grant, good morning. I wonder if you could start with your full name.

A Jane Margaret Grant.

Q You retired as chief executive of NHS Greater Glasgow and Clyde in January of this year.

A I did, yes.

Q You produced a statement in response to our questionnaire. Are you willing to adopt that as part of your evidence?

A I am, yes.

Q Thank you. Now, before we go any further, did you have access to your email inbox at the time you were preparing your statement?

A Yes, I did.

Q Thank you. Now, the first question deals with governance and reporting structures in NHS Greater Glasgow and Clyde. It's a simple question. We'll pick up most of these as we go, but the one I wanted to understand first is: to whom are you

accountable as chief executive at NHS Greater Glasgow and Clyde, or were you accountable?

A I was accountable to the chair of the Board and also to the DG of Health and Social Care.

Q And to what extent do you require to report matters to the Board in order to acquire authority to do things?

A That's set out in the standing orders, and I had a good relationship with the chair, so I would have an ongoing conversation with him about what he wished to-- But it is set out in the Board's standing orders.

Q Does that include the scheme of delegation?

A Yes. Yes.

Q Now what I wanted to do is to go back to your time when you were chief operating officer of NHS Greater Glasgow and Clyde. When did you arrive in that post?

A In the chief operating officer post?

Q Yes.

A In 2009.

Q And when did you leave?

A 2013.

Q Can you help us, when in 2013?

A When I left?

Q Yes.

A I always forget this, (inaudible 10:07:01) March.

Q I think it's in your CV----

A (Inaudible) my CV.

Q -- which we can go to. It's on page 4 of the statement bundle. So you went to Forth Valley in October of '13.

A Yes. Uh-huh. Sorry. My apologies.

Q Now, if we look at your statement, and we go straight to page 31 of the statement bundle and Question 16, we asked you a series of questions about the removal of the maximum temperature variant from the proposals in May/June 2009 and, and to be fair to you, you've said in A., halfway down the page, you had:

"...no involvement or understanding of the removal of the maximum temperature variant. This is not an area that [you] would have any technical ... expertise and would not have been involved in any such decisions."

Now, we're still trying to out how that decision was made.

A Yes.

Q It's been suggested that it might be related to temperatures in the Stobhill and Victoria ambulatory care centres, if I've got the names correct, PFI centres. Were you aware of issues around high temperatures in those buildings in 2009?

A No, I was not.

Q Right. Were you aware of whether there was-- I'll come back to that question. So, the next question is, if we look at your statement on page 31-- not on page 31, page 32, we asked you about your involvement in the selection process. At the bottom of the page, you answered, "I was not closely involved in this issue," and you then list two of the meetings you attended, the Acute Services Strategy Board, as a member, and the Performance Review Group, which is a board standing committee to which you attended.

Now, were you also a member of the Executive Board for the project?

A For the new hospital?

Q Yes.

A I think I was, yes.

Q Yes. If we look at the term of reference of that, which is in bundle 34, document 21, page 152. So, this is the term of reference of the "New South Glasgow Hospitals and Laboratory Project Executive Board," and it appears as Appendix 2 to a paper for the Performance Review Group, which approved it.

Now, we put that to you when we asked you a question, 17(c), and we asked you various questions about what this group did. The question is on page 33 of the statement bundle, but I want to look at your answer on page 34 of the statement bundle at the top. So, if we go to page 33 first, the question we asked you, we sent out various quotes from document, and then the four lines at the end:

"Did this not make the Executive Board responsible for ensuring that the technical changes pre contract (including the removal of the Maximum Temperature Variant in June 2009 and the agreement of the Agreed Ventilation Derogation) were properly assessed on a technical basis?"

If we go over the page, we have your answer:

"The Terms of Reference outline a requirement for issues to be duly considered by the appropriate personnel. As outlined above, any such issues would require to be fully assessed by the Project team and their technical advisors, before coming to a multi-disciplinary Programme Board who would pay due attention to the technical recommendations about the suitability of any course of action."

Now, if we go back to bundle 34, page 152, what I want to do is find where it says that in the terms of reference. So, this multi-disciplinary Programme Board, as which you described it, is this the Executive Board?

A I believe so, yes.

Q Right. Why do you see it as

multi-disciplinary?

A Because there would have been-- My recollection of this, I'm afraid, is not----

Q Freeze there. Let's go to the next page with the membership in front of you because it might help you with your answer. Sorry, carry on, please.

A So, if you look at the voting members there, you have the medical director, you have the directors of various services, you have a finance person, you have Alec (sic) McIntyre who was the director of facilities with technical knowledge, you have Alan Seabourne who had technical knowledge. So, there was a range of professionals on that group.

So, it wasn't just a case of myself or others doing that, it was a case of taking the advice. So, if a technical matter came in-- I really need to stress I don't have a good recollection----

Q I appreciate that.

A -- of this because it was a long time ago. My expectation would be that if there were a technical issue, they would bring a paper which would describe what the issue was and make a recommendation to the (inaudible 10:12.58).

Q So, you see this as a non-expert or non-technically expert decision-making body effectively?

A Yeah, certainly.

Q Yes.

A Yes.

Q The reason that we have asked you about this is because these two issues, the removal of the maximum temperature variant, whereby the maximum temperature of the building was reduced from 28, 26 degrees, and the decision which we have called but it wasn't called at the time, the "Agreed Ventilation Derogation"----

A Yes.

Q -- where it was agreed to have not six air changes per hour in the general wards but less. Knowing what you now know about the hospital and its problems, if we can use that, or its issues, shall we say, around ventilation, would you have expected these issues to be brought to this Executive Board for a decision?

A I think it's quite hard to see that because some of them are quite-- In hindsight is-- perhaps, but I think there was a huge amount of discussion and issues going on within the Project team, with the project director and with the contractors and so on. So, I think it's a matter of materiality as to what would have come. I would have expected that if there were issues with substantial implications either to the service or to the environment or to the financial situation,

that they would have come to a board for a discussion and an agreement.

Q I take it you won't have read the employer's requirements from the bid documentation?

A No.

Q No.

A No. I may have way back.

Q Yes.

A Or at least parts of it, but that wouldn't have been something that I would do.

Q What I'm going to propose to you is that-- put to this to you is what we found out. So, within the very long document, 200 pages, there is a requirement that the new hospital follow a listed list of guidance documents.

A Yes.

Q One of which is Scottish Hospital(sic) Technical Memorandum 03-01 2009 draft. Now, it wasn't enforced at that point, but that's listed in the employer's requirements. I understand what you're saying about the importance of only reporting material things otherwise you don't get any work done, but would building a hospital not in compliance with Scottish Government guidance not be something that shouldn't be-- decisions shouldn't be made just by the Project team?

A Yeah, I think that's why I said that I would expect that anything of materiality, and some of those issues certainly are material, would have come for ratification or agreement or whatever. I don't recall them coming there for that----

Q I mean, I don't think they did. I mean, that's-- Unless the minutes are inaccurate.

A Yeah.

Q Ms Byrne, I think, takes the view they weren't there. She can't remember the meetings, but she reads the minutes.

A I think----

Q We had evidence last week----

A Could I just add----

Q Sorry, do continue.

A -- something else? Sorry, my apologies.

Q No.

A But I think it's important to recognise the number of decisions and discussions that would have been going on with the Project team and the contractors, and there would have been a huge amount. I'm not downplaying at all for a single second the issues that you've described, but there would have been a huge amount of issues going on and a lot of dialogue on a lot of issues.

So, it is important just to put that in the context of the complexity of building a hospital of that magnitude and with those national and regional services, as well as

just a normal district general hospital. It wasn't that. It was quite a different thing. So, I think it's just important to put it in the context of the size and challenge of the whole hospital bill.

Q Indeed. I think if we were to go and look at the M&E clarification log, which resolves all these issues by the time contract is-- it's a huge document with, I don't know whether it's hundreds or thousands of rows, but it goes on a long time.

A Mm-hmm.

Q So, I understand that. We had some evidence last week from Mr Stewart from Partnerships UK. Do you recollect dealing with him at all?

A I don't----

Q No.

A -- I'm afraid. I'm sorry.

Q So he, I think, has some expertise in project management and governance----

A Yes.

Q **-- a**nd at the time, Partnerships UK was offered, at least according to Mr Seabourne in his-- not Seaborn, Mr Calderwood in his statement, to help the Health Board with issues around this procurement exercise. He talked, when I asked him, about concepts of assurance, of having systems of checking of whether decisions were being properly made within a project.

Are you aware of were there any such systems running in the project that you were peripherally involved in as chief operating officer?

A Back in 2009?

Q Back in 2009.

A I couldn't answer that with any certainty. I assume there were systems. I had no reason to doubt that there weren't, and I didn't-- I don't have a recollection of thinking, "Gosh, the systems and processes are not in place for assurance," but I couldn't answer that.

Q Because one of the issues that arises that I need to take you through is-- if we go back to page 152 on this list, the role and remit of this group, this multi-disciplinary Programme Board as you call it, is described on this page. There are six, seven paragraphs here, and you'll see that the fourth one is that:

"[The Executive Board] will have delegated authority to conduct and conclude negotiations at project critical moments."

There's nothing in the minutes to suggest it ever did that, and if it was done, it was done by the Project team. Do you have any awareness of whether you were asked for your view as a member of this Board on what terms should be in the contract, what should or shouldn't be accepted in terms of the contract or any of that level of detail?

A I really don't recall ever being asked that, and I probably don't have the expertise to know it either.

Q Well that was Mr Stewart's point, that-- I mean, a board like your Board has a large number of people who don't do contract procurement, and so it seems odd that you would give this Board the power to conduct and include negotiations when, as you've just said, it's not your area of expertise.

A The wording might, in hindsight, have been better, one would assume, in the sense of-- I would assume that the aspiration was that there would be discussions about, in that Board, about anything of significance and then the Project team would actually do the negotiation.

Q Indeed.

A I don't think a multi-disciplinary Board, Executive Board, like that would undertake negotiations. I don't----

Q If we look at the next one:

"[The Board] will oversee the management of change control procedures in that any change which impacts upon the project must be authorised by this Board before it can be implemented."

In a sense, is that the sort of point you were making a few minutes ago about reports would come to this Board if people wanted to make material changes?

A That, I think, is the expectation. And if you look at some of the major changes, and there were a few, then that would be the expectation, but I understand there has been discussion about the change control process.

Q Yes. I mean, do you remember anything about the absence of a change control process from the time?

A I really don't----

Q No.

A -- remember the precise details, no.

Q Ultimately, however, when you were chief executive, there was an investigation internally within the Health Board, after Professor Steele arrived, about why the contract was signed in the way it was signed. Do I understand that correctly?

A Yeah. There was some undertaking of that, yes.

Q Yes. Was the Board able to ever find any documents other than the M&E clarification log itself to describe why this change was accepted?

A Are we talking about the ventilation as the----

Q The ventilation aspect, yes.

A No. We tried to ascertain that, but it was difficult to do that in terms of the paperwork. And some of the people who were in involved in that had left, and-

- and it was very difficult to understand exactly what the rationale was.

Q But could it be that had there been a proper change control process in compliance with this paragraph of the remit, and terms of reference of the Board, then it would have been much easier to find out the reason because you would have had a report and you could have gone and found the report, and Professor Steele and his colleagues could read it and understand the reason? And the fact that he didn't find one, might that not entitle someone to infer that there was no change management process actually at the time?

A I think it's difficult to try and go back and say, "If that had happened, this would have happened." I think that's quite difficult, but I think if there had been a clearer, I was going to say log, but I don't mean the log of the M&E log, but if there was a clearer process.

However, I do think that the change control processes, there was some process. I just cannot recall exactly what it was. Because if there were changes that required, for example, some additional cost or they required some change to the clinical service, then they would have had to be understood quite clearly. I think some of the decisions and issues that you were describing were done prior to that, and so, therefore, it isn't easy to be straightforward and say, "If this had happened, that would have happened," but I do think it was disappointing that we couldn't understand quite easily where those decisions had been made, and more importantly what the rationale was.

Q Well, let's, I think, look at the-- Well, I'll put something to you and I'll wonder whether you want me to look at the documents.

So, we've been through the meetings of this Board from its establishment in June through to its last meeting in February, and there is at no point a report to it about any changes. So, not only is there no report about maximum temperature variation being reviewed in the summer, May/June, and there's no report to the final meeting saying, "We still have an outstanding issue over the ventilation of the general wards, what do you want me to do about it?", that's not there, there isn't anything else.

There's a report of the evaluation process, there's discussion of the terms of the contract in financial terms, but there is never a report saying, "We need to move this ward," or "we can't provide as many rooms," or any clinical change, it doesn't happen.

So, what I'm putting to you is that all the members of that Executive Board,

however long ago it was, to some extent, bear a responsibility for the fact that there are no records because you were the Board whose job it was to hold the Project team to account. How do you respond to that? We can go to the minutes if it would help.

A No, I think there are, in hindsight, I think it would have been better to be explicit about what those decisions were. And I'm in no doubt that they were going-- some of the issues that you've discussed were going on in good faith in the background. And when I've looked at one or two of the minutes, there were a lot of issues discussed at those meetings. And the clinical changes we were trying to a minimum, and I know there have been some, and I'm sure we'll come on to that at some----

Q Yes.

A -- point during the-- but, because if, as we progress with this project, if we had allowed significant changes to happen, you know, all over the place, then loads going on, then it would have been very difficult to manage this project with the size and complexity of it. But I think it is fair to say that there has been-- that it would have been better if we could see clearly where those decisions were made. I think that's fair.

Q Mr Calderwood – I think it's in paragraph 199 of his statement – suggests that your responsibilities in respect to the project were more associated with the clinical input to the project than anything else.

A My----

Q Yes.

A My personal responsibilities?

Q Would that be a fair description of what your main input was to the project?

A Yeah. At the time, I was the chief operating officer, so my recollection is that I had to make sure that if there were any substantial issues coming forward in terms of where-- how services would operate or if there were changes to the clinical service, then that was my responsibility to----

Q So, for example, we've looked at a series of clinical output specifications for haematology wards, adult, pediatric, and for general wards. To what extent would you have been involved in ensuring that clinicians had an input into those clinical output specifications, or was that not what you mean by what you've just said?

A So, there would have been, there was a process whereby clinicians were involved in having those discussions. If I go back to my time as the general manager and the director of a service before I was the chief operating officer, I recall that there were some

instances where, you know, clinicians were being taken away from their day job to go and have those discussions. So, there was some-- There was definitely input from clinicians. And if there had been any difficulty in releasing them, there would have been conversations about how to do that and how to release people. But I would not have been involved in the detail of exactly what happens in that clinical output spec because there was a lot.

Q So, are you the right person to sort of direct this observation, which I think has been made by a number of people, including one of the architects, that these clinical observations are rather different. Some of them are much more structured, rigorous documents that cover everything and some of them are somewhat lighter in areas of detail, and there's not a sort of standard quality across them. Would you have any involvement into the quality assurance of that process?

A No, absolutely----

Q No.

A -- not.

Q One particular issue that arises out of the Employee's Requirements, and it relates to isolation rooms. Now, are you aware that once the hospital was open it became clear that all the isolation rooms in the hospital, almost all of them, were positive pressure ventilated lobby rooms?

A No.

Q No, and were you aware that some of them had to be changed over the following years where some were converted to positive pressure rooms and some to negative pressure rooms?

A I am aware that there was discussion about that and that there had to be some changes , but I wasn't involved in the detail of that.

Q Well, the reason I ask you is because we have worked back to the employer's requirements and I know you haven't seen this, but it just gives us context. So, if we go to bundle 46, volume 3, document 1, page 5, with a bit of luck, that should the front page of the employer's requirements. There we are.

What I'm going to do is I'm going to jump to page 177, which is a section-- yes, ventilation of isolation rooms. Now, this is quite technical. I understand that the important point to draw from this is 8.2.14.6 and 8.2.14.7, which list various guidance documents that should apply to isolation rooms. Do you see at 8.2.14.7 at (c), SHPN 4 is listed?

A Yes, I see that.

Q Now, we are told that the consequence of this section is that the bid documents from Brookfield Europe specified that all the isolation rooms

would be positive-pressure ventilated lobby rooms, which of course, are only suitable in certain circumstances. I'm just wondering if the Health Board ever worked out why its own employer's requirements required all the isolation rooms to be compliant with SHPN4 as part of your investigations that you ultimately carried out?

A I can't answer that. I don't know the answer to that. I don't know why that was there and I wasn't involved in that level of discussion. I really don't have the technical expertise either to make an informed judgment on that. The other thing I think, just to put it in context, the chief operating officer's job – despite the fact it's not as big as the chief executive's job – is pretty big.

Q I appreciate that.

A A massive amount of hospitals to deal with a huge amount of issues and, you know, 25,000 staff or something like that.

Q Sure.

A So, it's a huge job.

Q How as a chief operating officer involved – we can take that off the screen – in the procurement of one hospital, which is huge, in a huge job----

A Yes.

Q -- how do you make sure that people who are working for you are checking particularly safety aspects, but also clinical aspects of new procurement are right? What's the process that you want to ensure has happened?

A So, there was a regular dialogue with the directors of the services and we did have discussion about if there were things where our clinical teams weren't happy or whatever. In a hospital build that size, there would be because people wanted, for example, bigger space or they wanted more rooms or whatever, and there was discussions about that. I do vaguely remember some of those.

Q But was there a process of internal checking so that-- I appreciate a clinical team might say, "We want A," and the Board's technical consultants might write that down in the form of the employer's requirements. Was there anybody back checking that it actually made sense in accordance with higher level guidance, the Board's wider policies?

A So, there would have been discussions with both the clinical teams and with, for the purpose of this, I would say the general manager, but I don't remember exactly who it was but who is a senior player as well, and also members of the Project team. They were the ones that really held the ring on making sure that if Jane said, "I wish, this is essential," then this is what we need to have. So,

rather than-- There would have been a dialogue with the general managers and the local teams, but they're-- they've got another alternative job, you know.

Q Well, that's the thing, because not only do you, as chief operating officer, but all the managers who report to you have a day job----

A Yes.

Q -- you're also not technically qualified.

A Correct.

Q The clinicians who are treating the patients, they've sort of got a day job too.

A Absolutely.

Q We've heard evidence there are certain-- if we just pick ventilation as the topic we're interested in, but as you rightly say, there were lots of other issues in the hospital. We know there were some clinicians back then who knew their stuff on this. We know that Professor Hood – well, was Dr Hood then – had an interest in ventilation; we know that Dr Jones, as he was then, had an interest in ventilation; we know that Dr Redding had some interest and we know that Ms Rankin at ICN had an interest.

So, one can envisage an ad hoc process, but what system was in place to ensure that when the Health Board specified the hospital it wanted, it was thinking about things as high level as

following Scottish Government guidance and not making inadvertent mistakes along the way?

A I'm afraid I can't answer that. I think it was-- I would assume it was the Project team who were involved in that, but it certainly wasn't my team.

Q Okay. What I want to do now is to move on to almost the end of your time as chief operating officer and the decision to move the adult BMT unit into Ward 4B.

A Yes.

Q Now, I don't think we asked you about this in your questionnaire, so I think we should take the opportunity of picking it up now. Can you recollect what involvement you had in that?

A I vaguely remember that there was a paper taken to, I think it was the Quality and Performance Committee, I think it was called then, to seek authority to make that change.

Q We have an email, which admittedly is Pamela Joannidis, not you, but bundle 14----

A Could you say that again, sorry? I----

Q Pamela Joannidis has written an email, I think.

A Yes.

Q Bundle 14, volume 1, document 2, page 45. No, it's Fiona McCluskey, sorry. Fiona McCluskey,

who was the nurse advisor on the project in 2014, reporting about various changes and who signed them off. The second paragraph is:

"The transfer of the BMT was approved by Jane Grant late 2013 and the ward design was amended to incorporate this change."

To be fair, Dr Armstrong is very keen, I think, to point out that it was her paper that went to the committee.

A Yes, I think she and I sponsored the paper.

Q Yes. So, the question really becomes is-- I appreciate that deciding to move a service like this into a new hospital is a difficult conversation with lots of different factors. I think Dr Armstrong spoke very clearly about the need to ensure that the service was near a high dependency critical care unit.

A Yes.

Q But when you decided to move something and you and she are the sort of sponsoring minds, what steps did you take to ensure that what came, what was built, was what was needed?

A Well, I think that paper came just as I was going out the door to Forth Valley but even if I had been there, I think that email-- I didn't have the authority to approve it myself.

Q No.

A It had 800----

Q £800,000.

A Yes. So, from that perspective, it might be a kind of loose language a little bit in that email. There was a process, and it was approved but at that point, it would have been handed over to the Project team and they would have been involved with the clinical team about what was required.

Q So, we've had evidence from Mr Jenkins explaining how it's his recollection that he went to visit the Project team and told them exactly what they had at the Beatson and how they wanted it.

A Yes.

Q Would you have any awareness of that process taking place?

A No.

Q No.

A Well, I wasn't there then. You know, I wasn't at-- But even if I had been there, I don't think I would have had a knowledge of the process.

Q But just to return to the question I asked you again, was there a system that you can describe of effectively ensuring that when you make a decision as a board or Board sub-committee to move a new ward, move a new service into a hospital, that someone is making sure that what is provided to the clinicians is exactly what they need before they walk in the door? Was there

a system to do that?

A I assume there was, but it would have been through the Project team because neither general managers or colleagues like that or the clinicians, it's not their job to establish that, you know, the technical aspects of this have been adhered to.

Q Who would have been advising the Board on the technical aspects of the new BMT ward at the time this decision was made?

A I'm not sure I understand that question.

Q Well, I mean, we've had evidence about this, but what's your awareness of whether the Board had a Technical team, including an M&E engineer, healthcare planners, and that sort of thing, advising it in 2013 on the new project? Did it have a team?

A I assume so. I can't remember, I'm afraid. It would have been part of the Project team's remit.

Q What I'll do now is to move on to your return from Fife-- from Forth Valley, sorry, (inaudible 10:38:34) of Forth Valley. You've answered quite a lot of them as the earliest questions, but I think probably what I want to do is to go to-- to put to you and discuss in slightly more detail the way Mr Calderwood described----

(After a pause) No, I won't do that at this stage, I'll do that later. What I want to understand is how your role relates to various other people because we've obviously, as an Inquiry, been hearing from different people over a long period of time and it's important, I think, to understand the working relationships and who has authority over whom and that sort of thing. You explained at the beginning of your evidence that you are accountable to the chair.

A Yes.

Q You're not accountable to the Board then?

A No, to the Board through the chair.

Q Through the chair. How does your working relationship, as it were, or authority relate to that of the medical director? Do you have any authority over her or is it sort of an equal relationship? How is the authority divided between the two of you, as it were?

A The medical director reported to me.

Q Medical director reported to you, right. The director of finance reported to you as well?

A Yes.

Q And the director of public health?

A I beg your pardon?

Q Director of public health?

A Yes.

Q So, even though some of these people are executive members of the Board, they also report to you?

A Yes.

Q Right. If we go to page 5 of your statement, I asked you a series of questions, which I don't want to go through in full detail because you've given a very long answer about how things are reported to the Board. I want to check my understanding because I think it's important I do this at this stage. There are a series of Board sub-committees, each has its authority and area of responsibility and that's effectively the core structure of the Board; the main Board and then sub-committees. Am I right in that?

A Yes, and they have (inaudible 10:41:08).

Q Yes, and so they will consider, at a subcommittee level, a particular series of standard reports and exceptional reports and those reports will be put into their minutes-- or the decisions are recorded in their minutes?

A Yes.

Q Those minutes go to the Board?

A Yes.

Q If a paper is sent to, say, Clinical Care and Governance Committee – if I've got that title right – does the paper go with the minutes to the Board? Do the Board members get the full set of papers for the sub-committees or do they just get the minutes?

A I think they just get the minutes, but any Board member can ask for papers if they wish.

Q I do appreciate they can ask but the issue I'm trying to get my handle on is who is telling the Board as we go through the next two days. So, if we think about the period, you've arrived at chief executive, and we know with the benefit of hindsight that there are going to be issues around ventilation and water systems over-- between '17 and into '19. We know they're going to come and we're going to talk about them in a moment. What sub-committees of the Board would be the natural places to report emergencies of issues around the ventilation system in the hospital? Is there a way this divides up?

A So, the terms of reference describe – I'm sure you have them somewhere – what issues would go where. So, the Finance Planning and Performance Committee was the main committee that looked at the Estates and Facilities issues, Clinical Care Governance Committee would have looked at any clinical issues, and the Audit and Risk Committee would obviously look at audit and risk and----

Q So, if we are----

A The Acute Services Committee as well also dealt with all things acute-- or a number of things acute.

Q Well, that's the thing that I've been a little confused by and I want you to help me, is that I do understand the division between the Financial Committee, the Clinical Care Committee, and the Audit Committee. That makes sense to me; I'm comfortable with that. How does the Acute Services Committee fit into that? Because at one level, it overlaps with the Clinical Care and Governance Committee, doesn't it?

A Yes, so the Acute Services Committee, my understanding was it was established because at the time of the Integration Boards being established, you know, there was six HSCPs and six IJBs within Glasgow and Clyde.

Q Yes, that's the Integrated Joint Boards.

A Yes, yes. At that time it was felt that the Acute Services – which was a huge part of the Board – needed to have some kind of forum to discuss some of the kind of issues that, in essence, would have gone to the IJBs. The Acute Services Committee agreed a programme with the chair and the vice chair of the committees around, you know, things like, theatre utilisation or, for example, there was other things around performance and they looked at things like, you know, their cancer performance and this kind of stuff. The chair and vice chair of those committees, along with the executive lead for the committee, would agree what was going-- as well as what's in the terms of reference or in the scheme of delegation.

Q So, in the question, if we look at ventilation issues as they arise after you arrive, they might go to Financial Performance because that has Estates functionality. If there's money to be spent or fitting out the building, that might go there?

A Yes.

Q Yes. They might go to the Clinical Care and Governance Committee because they relate to the clinical services being provided in those parts of the hospital?

A I think only if there had been some impact on patients and so on, and I'm not saying there wasn't, I'm just saying that I think----

Q Yes.

A -- it would have been a different intonation to the Clinical Care and Governance Committee.

Q So, it's more they might have gone to Acute Services if it affects the running of a service?

A Generally, but it's difficult to be entirely specific because it does require a conversation quite often about where

they would go, how best they would go----

Q Right.

A The head of-- Or the director of governance and corporate services for the Board along with the executive lead and the chair and the vice chair of the committees would be clear about where it was going.

Q So, there's a process that happens involving the director of corporate governance, the chairs of the committees, the executive leads, potentially you as well, steering the paper to the right committee?

A Yes, yes. Not always, it's not as----

Q It doesn't always need to happen, but if there's a debate, then there's a process. Now, you did that thing, which I now say there's a person doing a transcript. If you meant to sort of mouth "yes", then you'll probably need to say it.

A Sorry, yes, that is my understanding.

Q Thank you.

A My apologies, sorry.

Q Would the same----

A (Inaudible 10:46:11) the right tone and the right volume and the right speed----

Q It is a problem, yes.

A -- so my apologies. I will not do that.

Q That's particularly helpful.

THE CHAIR: It's not easy to give evidence, I appreciate that.

MR MACKINTOSH: So, if we stay with the topic of committees, how does the Board Infection Control Committee work? Does that feed into Clinical Care and Governance?

A Yes.

Q Right. So, the next thing is to think about water. Now presumably, the same sort of debate about where things go is happening for water-related issues as they arise in the hospital?

A Yes. I think the water though, because when the water became an issue, it was generally through the IMT and that's when it all started in the beginning of 2018.

Q That's why it feeds into Clinical Care and Governance, because IMT is feeding into Clinical Care.

A Yes, yes.

Q So, a handy thing to remember is that IMT issues go up to Clinical Care and Governance, they don't go to Acute, generally speaking?

A Yes. I mean, there might have been some discussion at the Acute Services Committee as well about the overarching kind of process, but that it would have been mainly the Clinical Care and Governance Committee.

Q Where does the water safety

group feed into? Is that into Facilities-- finance programme and Facilities?

A Yes.

Q Right. Now, we've also heard about Board seminars.

A Yes.

Q So, what's their status?

A So, the Board seminars were agreed with the chair and the director of corporate services and governance and the Board members were asked if they had things they wanted to particularly hear more about from their engagement through the Board or through sub-committees or things that had occurred, they were able to ask for things to be added. The executives, you know, thought perhaps there would have been a report issued or something and they thought that the Board should be briefed on that.

And ultimately the chair decided which issues would come to the Board seminar, and Board seminars were generally, at that time – and I think they might have changed now – but were generally-- there would be two or three items on the Board seminar. And, generally, at the beginning of the Board seminar as well, the chair would ask me to brief the Board members on anything of pertinence-- you know, if there was something of pertinence.

Q Yes, so we see that in Board agendas, the sort of chief executive's report at the beginning of the meeting.

A Yeah, and the Board seminar was similar.

Q As well? Right. Can a board seminar make a decision?

A Beg your pardon?

Q Can a board seminar make a decision?

A Not generally, no.

Q When could they make a decision?

A There was a discussion to inform the decision. So they didn't-- Because they weren't minuted, so there wasn't a----

Q Exactly. So if there's a decision, it comes in one of the sub-committees or in the Board itself?

A Yes.

Q So, if, for example, you've received a Scottish Government report on something, you might have a seminar to inform the Board, and then make a decision at a later meeting?

A Yes, and some stuff would have just gone to the Corporate Management team as well, so-- bearing in mind the Corporate Management team is a-- is an executive arm of the Board decision-making process.

Q And the Corporate Management team decisions are all minuted?

A Yes.

Q So there won't be an occasion when-- So, what's the materiality test for whether you take something to the Corporate Management team? Because obviously not everything goes to the Corporate Management team; you'd never get any work done. So, when do you decide to take things to CMT? Does it have a formal agenda and papers?

A Yes.

Q Yes, and so something has to be decided as to whether to put it on the agenda of the Corporate----

A Yes. Generally what happened was people-- There is a terms of reference and there are-- is-- there is a description of what should go to the Corporate Management team, but people generally asked for things to go to the Corporate Management team, then the director of corporate governance – I've got the title wrong but Corporate Services and Governance – would pull together, or her team would pull together, a list of those things.

Sometimes she would say, "No I don't think it's appropriate", because she was very experienced in what should go, and then a draft agenda would be pulled together for the Corporate Management team, and then, at that time, there was some discussion because, as you say, there was quite lot of things on it

sometimes, and some of them we didn't take to the Corporate Management team, because there was too much, and because they weren't of the right level.

Q So there's another group or committee I wanted to understand – this concept of what you call the later on a Gold Command Group.

A Yes.

Q Now you deal that, actually, at Question 83, which is page 88. You've given an answer, what it is. What I wanted to understand-- not so much what it is, but did it exist before the Oversight Board was created, or was it a novelty at that point?

A No, I think it was-- My recollection-- It was established after the Oversight Board report, because it was a more localised-- And there was a Silver Command underneath it to-- It was a more localised kind of group to make sure that the issues in the Oversight Board were being progressed.

Q So it was a "doing" group arising from the Oversight Board report?

A Generally, but it wasn't exclusively that because we thought that it would be an opportunity – and the local team wanted an opportunity as well – to talk about some things that weren't part of the Oversight Board report, like things like patient experience and the complaints, for example – you know, how

many complaints there had been and whether there were emerging themes from that and whether that should link into some of the processes we had or some of the performance issues. Or, indeed, occasion-- I think there was some discussion about finance, and so on, as well. So, it was a wider group. A big part of it was the Oversight Board, but not----

Q But it was a Queen Elizabeth University Hospital-only group, and it's post Oversight Board?

A I didn't hear the second----

Q It was a Queen Elizabeth Hospital-only group----

A Yes.

Q -- and it's post Oversight Board?

A Yeah, I think so. Yes.

Q Yes, so there was nothing like it before the Oversight Board arrives?

A No, I don't know. But the size of the-- It's rally quite important to understand the size of the sectors within Glasgow and Clyde. Some of them are as big as health boards.

Q Well, that's interesting. Before I moved on to the more specific, I thought we could just explore that. We've heard a lot about South Sector, North Sector, Regional, Clyde.

A Yes.

Q Now, it doesn't matter whether you want to count this in terms of headcount or budget, or any measure you think is appropriate, but can you explain to us the scale differences between the various parts of GDC in, say, 2017 – for a feel of size?

A So, I couldn't give you the numbers; I can't remember that----

Q No, I appreciate that.

A -- but the South Sector, for example, has the Queen Elizabeth Hospital in it, has Gartnavel General Hospital in it, and has the Victoria's Ambulatory Care Centre in it. So, it has more than just the Queen Elizabeth, and it is the size – and forgive me but, you know, I am familiar with it more-- but it is the same size – in fact maybe slightly bigger – than the whole of Forth Valley Health Board.

Q Right.

A So the North Sector, equally, has the-- it has Lightburn Hospital, it has the Glasgow Royal Infirmary in it, and it has Stobhill's Ambulatory Care Hospital, so it's slightly smaller as well. Then you have the Diagnostics Directorate, which covers-- There's a kind of matrix kind of organisation. So the sectors – I should probably do this first. There are geographical sectors, which is the North, the South and Argyll-- and Clyde. And Clyde has the Royal Alexandra Hospital in Paisley, and it has Inverclyde Royal,

and it has the Vale of Leven Hospital in it. So those are the geographical sectors.

Q And Clyde was his own health board until it got merged in?

A It was until, I think, 2006 or something----

Q Right.

A I-- I forget the exact date, so-- But it was quite a long time ago. And then there is the Diagnostics Directorate, Women and Children's, and Regional Services.

Q And they provide services within the other hospitals, but they----

A Yeah.

Q -- are sort of specialist within their services.

A Yes.

Q In terms of scale, Women and Children or Regional Services or Diagnostics, are they comparable in size, in terms of budget and staff, to the geographical sectors or much smaller?

A So the three geographical sectors are all roughly the same-- No, they're not, actually. The Queen Elizabeth is the biggest, but Diagnostics, I think, would be smaller. Regional Services would be at the same size, because it had a lot of services in it – like, it had the Institute of Neurological Sciences----

Q So it's quite a big sector?

A Oh yes, it is. Yes.

Q So if we see the five six sectors you've named----

A Yes.

Q -- some are bigger than the others, but they're all large organisations within the Health Board. There's no one that's exceptionally small is what I'm trying to get across.

A Absolutely not.

Q Not. Right. Okay.

A They're all large, and some of them, as I say, are as big as other health boards, as----

Q Can we take that off the screen for a moment? We wanted to understand-- I want to understand how your role as chief executive of the Health Board relates to the person who holds the job title as chief executive of the Scottish NHS. What's the relationship there? The DG in Health and Social Care?

A So she has a discussion with the chief execs, and so on, but there wasn't a reporting mechanism where every day, hour, or every week-- or any of that sort of-- So----

Q So she doesn't actually have a sort of line management control over you?

A Not generally, but she does-- there are regular meetings with the Board chief executives, where the Board chief execs, and she, and some of her executive team discuss issues, and we're

asked to do various things.

Q But the relationship between, say, you and the medical director and the director of public health is a rather more line managerial relationship than between the DG Health and Social care, and you?

A Yes.

Q Yes, right. These meetings with the DGs Health and Social Care, were these monthly, broadly?

A Yes, they were monthly. Yes.

Q Now, if we think back to the period when you arrived, later on, I understand, you gave an interview to the BBC in which you indicated that you inherited a number of issues from the previous administration, if I have the words right. Do you recollect that?

A Vaguely, yes. Yes.

Q Did you inherit any issues from the previous administration?

A Well, I think I had clearly been in Glasgow before, when I came back from Forth Valley, so I knew the complexity of the organisation, I knew there were huge issues, and a large number of them. And some of the issues that I had been dealing with before I went away related to the old estate in the South Sector.

You know, the Southern General had been there for a long time – I don't know how long, but a long time – and I really hadn't anticipated that-- the amount of issues would come with the Queen Elizabeth. It was a brand new hospital, it was state-of-the-art and, therefore, I had thought that it would be-- there would be less issues emerging from the new hospital than there had been from the old real estate, which really was very old. You know, between that and the Western and the old Victoria Infirmary, there was a huge amount of issues about----

Q So you were expecting issues from the old hospitals; you weren't expecting it from the Queen Elizabeth, in essence?

A I wasn't expecting the same amount. I was expecting a lot less.

Q A lot less. Did you have any sort of handover briefing or handover note from Mr Calderwood when you arrived and he left?

A So I think I've said in my statement that there wasn't much time between me being appointed and him going. I've forgotten exactly how long it was, but it wasn't very much time. And then as part of that, I did meet with him, I think twice, but it's-- that-- it's not exactly clear in my mind. I can't remember exactly how long it was. And we discussed a number of issues at those meetings.

Q Did he tell you anything at those meetings about any concerns about the building of the Queen

Elizabeth?

A I don't recall him telling me any issues at that time.

Q Because we're going to discuss, for the rest of the morning, I think, how you learn about issues in Ward 4B and Ward 2A and the general wards and possibly PICU and possibly isolation rooms – we'll get to all of that – and what I want to understand-- You arrive in April, I think.

A Yes.

Q When is the first time that you realise that there are issues around the ventilation system of this building? In the broadest sense, because obviously we know you arrive in April. When When do you first think, "Oh, that's not what I expected" or "That's interesting" or "That's concerning"?

A So, I've tried hard to remember this because I've been asked it a-- several times in this, and in 2017 there wasn't a huge amount of discussion about the ventilation at my level, though as part of the process that Jennifer led with-- around-- sorry, the medical director led with the whistleblowers – or those who are now perceived as whistleblowers, but at that point, and we'll come to that I'm sure, about----

Q I'm sure we will.

A -- whether it was or not – but that discussion which had that meeting at the beginning of October, ventilation was raised there. And at that point-- So I must have known about some of it by then.

Q Well, indeed, that's what I think is what I need to sort of try and drill down to, because-- Let's sort of do it methodically and see where we get to. So you arrive in April, you have some handovers from-- two meetings with Mr Calderwood. As far as you can recollect, he doesn't tell you any of this stuff. Is that broadly right?

A Certainly not in the detail. I don't remember him mentioning it at all, but it's not impossible he did, but I don't remember that.

Q Now, we know that in March 2017 a paper is prepared about Ward 4B – Ventilation Options Paper for Acute Services Committee.

A Yes.

Q And we know from Dr Armstrong's evidence – and I think, from recollection, Mr Jenkins' evidence – that she pulls back the paper for some changes to be made, and it goes to a later meeting of that committee. When did you first become aware that money needed to be spent, somehow, on one of a number of options to do with Adult BMT?

A I think by the time I came back it had been agreed.

Q You think it had been agreed?

A I think so, yes. And I was aware of some of the issues at that point. I was----

Q Were you aware of the different options, the different locations it could be placed – in fact, at one point, on a roof in a car park site and a new site in the building in the back of Ward 4B? They discussed various choices.

A Yeah. I think there would have been some discussion with me, but I don't have a clear recollection of, "On, you know, 24 June, I was told this, that and the other," but I'm reasonably certain that there would have been some discussion with me about that, but it had already been agreed is my understanding of it.

Q Right, because the paper we have, bundle 27, volume 7 document 6, page 158-- So, bundle 27, volume 7, document 6, page 158. 27, not 47. So, this is a draft report targeted to go to March 2017's Acute Service Committee. This is the one that, when I showed it to Dr Armstrong, her evidence was this is the version that she asked to be redrafted, for reasons that I'm not going to, I think, go into with you. And that's before you arrive, and so you think it might have been decided before then, before you actually arrived?

A I certainly don't recall being involved in a discussion about what the options were. I don't recall that.

Q Would it be normal, given the scale of the job, for something like this, with a relatively significant capital cost and a national service, to not come, even informally, to you as chief executive.

A There's a sort of double negative in there.

Q There is a bit.

A Yes.

Q I'll re--

A So, you-- you're----

Q I recognise that your life is big and complicated, you've got lots of things to do, so I'm putting that out as a sort of statement. So, I understand that.

A Yes. Yes.

Q So, taking that on board, that you have a large job carrying a large amount of services----

A Yes.

Q -- but equally observing this seems to be quite an important service----

A Yes.

Q -- would you expect to be briefed on it, if it was a live decision to be made?

A Yes, there would have been discussion about it. I'm sure there would have been.

Q So, what I'm going to do is, I'm going to just say-- We've got the coffee break coming up soon. I'm going to ask

my colleagues in the back room to go through bundle 36 and find the decision point. So we'll come back to that after the coffee break.

A Yes. Okay.

Q Let's think, now, about Ward 2A. We can take it off the screen. So this is obviously Schiehallion.

A Yes.

Q When do you think you first became aware that parts of the Schiehallion unit were sitting at three air changes an hour and no HEPA filtration, when there were views – including, I think, held by its own consultants – that it required more significant ventilation?

A Yeah. Again, my-- I think it was part of the-- Perhaps not in the detail you're describing, but in terms of the generality of there being issues there, I think it was in that later autumn of 2016.

Q Around the time of the SBAR.

A I think so. I'm not 100 per cent certain, but I think so.

Q Because we know – because we have it – there was an SBAR in January 2018 by HPS. I'll just put that on the screen, so that's bundle 3, document 8, page 62. So, we know that's dated a date in January of 2018, and I wondered again, given the importance of the Schiehallion unit as a national service, would you expect to be informed if Health Protection Scotland were getting involved in advising on its ventilation systems in this 2018----

A I think there was some discussion about that, yeah.

Q Right.

A But it's very difficult-- I'm really not trying to be evasive in the slightest, but I-- I-- it's very difficult to remember exactly when I knew what. And I'm sorry about that----

Q Not at all. So, I'm getting from your evidence so far that you can be relatively certain that you weren't told about it in a handover process.

A Absolutely.

Q On the other hand, you're not quite sure when you get told between April, but by the time we get to September/October – and we'll come to that period in a moment – that's when you think you would definitely have known by then. Have I got that roughly right?

A I would have known there were some general issues with it. I knew exactly that-- The number of rooms and so on, I'm not certain of that, but I would certainly have known that there were emerging issues. And I think the other thing is, sometimes when those questions come, some of these things were emerging rather than, on 10 June somebody came to my room and said, "There are 20 things really bad here."

Generally, some of those things were emerging over a period, rather than----

Q I appreciate that but, I mean, we'll come to (inaudible 11:07.43) to do that, but Ward 4B had happened – you can take that off the screen – in July of 2015. So, it had emerged well before you arrived----

A Yes.

Q -- and Ward 2A had got on everyone's agenda at the same point in 2015. So, to that extent, neither of those emerged, and so that's why I'm asking you when you were told about it, and we'll explore the autumn in a moment.

A Mm-hmm.

Q I asked you earlier about the issue around isolation rooms, whether they're the right sort. Now, you said you had some awareness of changes around isolation rooms. Might that have been in 2017 or later?

A I think it was part of the-- I think it was part of the discussion around that autumn in 2017----

Q Right, okay.

A But I wouldn't have been involved in it. I mean, I don't know enough about positive pressure rooms and so on. I would have been involved in the, "Clinicians are not happy with that."

Q So, who should? I mean, when I arrived at this Inquiry, Ms Grant, I didn't know the difference between positive pressure, negative pressure----

A Mm-hmm.

Q -- positive pressure ventilated lobby, and I think I was getting it wrong for about the first six months. Because it's not easy, I understand that.

A Yeah.

Q But who in the organisation should know the difference? At what level? What function?

A So, the Infection Control teams, the local teams, and the Clinical team would look at what was required for individual----

Q So, they should know what they need?

A Yes.

Q Anyone else? Should Estates know?

A Yes. Yes.

Q Should the Project team have known?

A Yes.

Q You sure about that?

A That they should-- They would----

Q They should know the difference and when they're needed in certain cases.

A Well, they would be in dialogue with the clinical teams. Yeah, I mean, so it's not a case of----

Q Because the----

A It's not a case of, in isolation,

Jane sitting saying, “Well, I think, you know, we need this.” There would be a dialogue because quite often-- Clinical teams very often, and not in this case, I’m not suggesting that, but they want X, Y, and Z, and sometimes that’s possible and sometimes it isn’t. Clearly, if there’s a patient safety issue which is pertinent, then it needs to be addressed. But if you go back to the things like space and so on, clinical teams will say they need 10 rooms or whatever----

Q Yes.

A -- I make it up but-- and perhaps that isn’t possible, they can only get 8 rooms. I’m completely making this up, but over my career of, you know, 40-odd years, I-- there’s been a lot of dialogue about those kind of things. So, there then has to be a discussion about what is absolutely critical and essential for patient safety and why that is and what the parameters of that need to be, but that has to be an absolute discussion with the clinical teams because they would know what it is they need. But it’s not a case of one person, it’s a----

Q So if, for example, a clinical team or the Infection Control team or members of those say, “We need X rooms to have X, Y ventilation for Z reason,” you would expect there to be a dialogue between them and Estates and then the appropriate managers?

A Yes.

Q Right.

A Because, for example, if I could take that a little bit further?

Q Of course.

A Then if you say-- if you, being a clinician, say “I need eight rooms,” right, then the managers would work with them to say, “Well, how many patients do we have? What is the length of stay of those patients? What is the-- What are the conditions of those patients that require that environment,” and therefore is that eight rooms the right number or is it more or less? Are there subsets of those patients who require something or is it as simple as saying, “Well eight equals eight,” if you know what I mean. So, there would be dialogue. It’s not-- It’s not a single-- There’s not a single person sitting in room saying, “Well, I think I need this so therefore it”----

Q No, I appreciate that.

A It would be an ongoing dialogue. That multidisciplinary process really is part of how we work on a lot of things.

Q Yes, and so we’ll come back to that as we go, I’m sure, but just thinking about if it’s a multidisciplinary process to what extent do you, as the chief executive, and indeed the people who report to you, have a responsibility to ensure that those disciplines are there,

that they exist? So, for example, that you have Estates people who are literate in this field of ventilation or in water, or that conversations take place. What responsibility do you have to make sure that those multidisciplinary meetings take place?

A So, that would be through the sector director or the director of estates. They, you know-- That's common practice. So-- You know, that would be how it would work. So, I wouldn't sit and say, "Well"-- because it would be completely impossible to do that with the volume of-- You know, as we sit today, there's probably a lot of discussions going on, you know, but-- across all the hospitals about things like that. So, it would be the local teams who would deal with that.

Q How do you create the culture in an organisation to foster such multidisciplinary discussions? Because we, for example – and this is just an example – we had evidence from a number of people on the Project team about how they dealt with the consultants in the Schiehallion, during the build process, who wanted their offices to be in the ward, effectively.

A Yeah.

Q And you might think, listening back to the evidence, that it wasn't really a multidisciplinary team, it was an expectation management process. I'm just wondering, how do you create a culture in an organisation where the not unreasonable response of managers saying, "Well, I haven't got the room. I haven't got the money. I haven't got the resource," doesn't just brush aside clinical concerns that are actually quite important?

A Yeah, but each sector has a director, but they also have an associate medical-- a chief-- sorry, a chief of medicine, and they have a chief nurse as well who-- as well as other colleagues and general managers, but they also have, in essence, that triangular, that triumvirate-- That process is replicated through the Acute division. So, there's the Board, i.e. the chief exec and her team. Then there's the Acute team which has also got-- So, the chief operating officer has an acute medical director and an acute nursing director, and then the sectors also have a chief nurse and a chief of medicine as well.

So, those clinical people are tasked with making sure that those processes are-- So, it's not just a case of Jane, the general manager, sitting in isolation, they have clinical advice and-- The general managers and the chief exec, for example, work very closely with their medical and nurse director, as with the finance director and HR and so on as

well, but that-- When I was a general manager way back a long time ago, the nurse and the doc and the general manager worked really closely together.

Q What happens if they don't work closely or if the general manager rather rules the roost and decides just to make decisions him or herself? Does that not cause problems that voices aren't heard?

A It could but, equally, it could be that the chief of medicine-- You know, so those people are professional, serious, senior people. So, it's generally not a case of-- Because each sector also has a management team, so-- and they have minutes-- meetings that are minuted and so on. So, it's not impossible that that would happen, but it's also unlikely that-- You wouldn't ignore your clinical advice if there was a safety issue.

Q Right.

A Well, I wouldn't, anyway.

Q Now, what I should probably do is to look at something that arrived before you were in post.

A Okay.

Q So this is Mr Loudon's email of 21 June 2016, and it's a bundle 12, document 105 at page 816. This is an email sent by Mr Loudon reacting to-- who had been project director, and he was your director of facilities and capital planning. So, did he answer direct to you, Mr Loudon, at this point?

A So, he had a-- When he came, he was the project director----

Q Yes.

A -- and then he-- and there was a director of estates and facilities, and when it moved into the full new hospital then he became the director of estates and facilities.

Q So, he's answering directly to you? Not at this point because you're not there----

A Yes.

Q -- but in his role as director of facilities and capital planning he answers to the chief executive?

A Yes.

Q Yes. So, this is before you arrive----

A Could I just read it for a second?

Q Do, please.

A Sorry. Thank you. (Pause for reading).

Q This is basically an email to the Project team from him asking some questions. Now, the reason he's asking the questions is an earlier email from Mr Powrie on 26 May 2016, which is bundle 20, document 68, page 1495.

A Sorry, I'm not finished reading that yet.

Q No, I'll give you a chance to read them again----

A All right. Sorry.

Q -- I just want to set it up because what I'm going to do is-- we're about to have a coffee break, and so I'm going to ask my colleagues and witness support to show you these three emails again.

A Right, that's fine.

Q So, I'm reading them out really for their benefit in the back room. So, document 20-- bundle 20, document 68, page 1495. So, this is an email from Mr Powrie to Dr Inkster and Mr Loudon, Anne Harkness and Mr Walsh.

A Okay.

Q It explains why single rooms with ensuite are supplied with air at a rate of 40 litres per second, equivalent to 3.19 air changes per hour and extract derived via ensuite at 45 litres per second. This is a move away from the requirements as SHTM 03-01 for six air changes. Now, I'll let you read that (pause for reading). So, this is in May 16. Then I'll go back to the next email when you tell me to (pause for reading).

A Okay.

Q Happy?

A Yeah.

Q Yes. Going back to the one we looked at before. So, that's bundle 12, document 105 at page 816. So, this is an email-- Now, you'll see it says, "All, I have attached a copy of an SBAR." So, this is an SBAR, a single page SBAR, by Dr Inkster and this is in June 16. It's fourth line:

"...Robert Calderwood has instructed me to establish why there was an agreed variation to recommended air changes for a single room on a ward [that has] 6 air changes / hour as per HTM 03-01... and from a governance perspective the process for sign off of the specification as delivered."

And then there's a discussion of about when it was supposed to have happened. Do you see the reference the competitive dialogue in the----

A Yes.

Q -- second paragraph?

A Yes.

Q Now, it's fair to say that Douglas Ross is a Currie and Brown consultant, and he's asked to contact David Hall. Alan is Seabourne, Peter is Moyer, Heather Griffin was the manager for the Children's Hospital-- sorry, the adult hospital, and Shiona Frew provided administrative support.

A Yeah, sure.

Q Right. Let's go to the last document in the sequence. This is Mr Seabourne's email, 23 June 2016. Bundle 12, document 104 at page 813. Now, this is quite long and this is why I'm showing it to you now. If we just jump to the next page, you'll see the penultimate

paragraph of the text begins, “We are where we planned to be...” and that’s what I’ve been calling this email.

So, what I’m going to ask you to do is just to take a moment, because I appreciate document list was very long, to read these three documents – this is bundle 12, document 104 at page 813 – because what I want to do is explore with you when you were told about this general ward ventilation issue in 2017. I appreciate that Mr Seabourne gives an explanation for what happened.

I wonder whether, my Lord, this might be a convenient point to break for a coffee break because it is a long email, and I do feel that Ms Grant should have a chance to read it properly.

THE CHAIR: We can do that. I would plan to take a coffee break of 20 minutes but, please, take as much time to these three emails which, if I’ve followed Mr Mackintosh, you’ll be provided with it on paper.

THE WITNESS: Thank you.

THE CHAIR: And I hope you’re also provided with a cup of coffee.

THE WITNESS: Thank you.

THE CHAIR: Right. We’ll take a coffee break now and try and sit at about twenty to twelve.

(<u>Short break</u>)

THE CHAIR: Mr Mackintosh.

MR MACKINTOSH: Thank you, my Lord. Ms Grant, the reason I showed you those letters is not because they are by any means of complete correspondence – I’m sure there’s lots of stuff missing from events around this time – but I wanted to understand about what of each stage of that you might have learnt about. Even if you can’t be totally precise about when you learnt about it, if you might give us a feel for what part a year or even a year we’re talking about.

So, if we start with Mr Powrie’s email, so that’s 26 May 2016 and that’s bundle 20 at page 1495. Now, we know obviously it went to Mr Loudon, Dr Inkster, Anne Harkness and Mr Walsh, but we know from Dr Armstrong that she was aware of this. It contains within it the facts of what the derogation was and attached to it – albeit I haven’t shown it to you – the document from ZBP, who were the Multiplex M&E engineers who came up with the idea.

A Yes.

Q Now, what I wanted to understand from you is, when do you think you understood the nature of this particular, quite widespread, derogation?

A I think it was as part of the autumn 2017 discussion, although I’m not sure it was entirely as detailed as this is.

Q Right. The Ward Ventilation

Design Strategy, the ZBP document, and the extract for the M&E clarification Log, which you've already mentioned in discussion, would any of these have ever been shown to you whilst you remained as chief executive? Even during the work that Professor Steele was doing in 2019?

A I think I saw them as part of it. I mean, they've never been sent to me to say could you, you know, give us a view on this or----

Q No, I appreciate that.

A I think as part of the process, I have certainly seen them but but only the design-- the Ward Ventilation Design Strategy, I don't-- I've not seen until recent times----

Q I understand.

A -- and the M&E clarification log I have seen as part of the discussions both with the police and with yourselves but I wouldn't have seen that, I don't----

Q No. The reason I'm asking, I'm just trying to sort of-- I appreciate there's a number of layers between Mr Powrie and you and this is a year before you arrive as well, so----

A Yes.

Q -- but I think what you're saying is that the nature of the derogation, if that's the right word, to some degree comes up in the autumn discussions but the documents that underlie this probably don't. Is that-- would that be broadly right?

A I'm not even sure that-- Yes, just in terms of the nature of the of the derogation, I'm not even sure that there was a process. I mean, at a high level, yes.

Q At a high level?

A Yes.

Q I'm going to show you the SBAR and the 27-Point Action Plan, and that contains detail----

A Yeah.

Q -- so maybe I won't press you at this stage. Let's look at the bundle 12 document. So, we'll start with Mr Loudon's email from June 2016, which is page 816. So, this is Mr Loudon to, effectively, the members of the Project team, and he's attaching an SBAR (inaudible 11:48.47) about the "3 air change" issue with a request that he wanted-- Mr Calderwood wanted to establish why there was a variation.

So, what I'm wondering here is, did Mr Loudon, while he was in post as director of facilities and capital planning, ever tell you about either, in broad terms, this ventilation derogation or whatever investigation he may have carried out after this email was sent?

A So, my recollection is that, as part of that SBAR process, I asked him-- I had a conversation with him to say, you know, "How did this happen? What's the

issues?" and he-- we had great difficulty in-- I had great difficulty in establishing, "Show me the paperwork," and so on, and I asked him what the issues were, and he had indicated that it had been done-- the decision had been a long time ago – I think, 2009, something like that, but I can't be 100 per cent certain of that – and that it had been very difficult to find paperwork as to who had agreed what, when. But that was the only conversation about that, but it was around that time in the autumn of 2017, or at the end of-- It might have been after that, actually, maybe, but it was sometime in 2017, at the end of the year. I can't remember exactly what----

Q In this letter, on the third paragraph, there's a reference to chilled beams. Now, it's in the context of a particular email, which we might come back to, but the reason I'm just pointing it out-- When's the first time you hear the word, the phrase, discussion of "chilled beams" in the context of the Queen Elizabeth?

A There was a reference, I think, in the SBAR to "cooling beams", or something. I've forgotten.

Q But it might be around about then?

A Yes.

Q Right.

A It certainly wasn't before that.

Q Okay. If we then look at Mr Seabourne's email, which may or may not be a reply to this; it's slightly unclear. If we go to page 813. Now, it's fair to say that Mr Loudon claims he never saw it, but it is recorded as being sent to him. However----

A Mr Loudon says he never saw this email?

Q Yes.

A Right. Okay.

Q Though, to be fair, I think it's worth saying on the record that Mr Loudon's draft statement is only a draft statement. He's not able to help us, and therefore there's no finalised statement. We've produced it acknowledging that it is a draft that he produced at one point to us, and he, of course, hasn't seen documents produced since then, and he hasn't seen the evidence, hasn't had a chance to respond to the evidence due to his health reasons.

But this is quite a nuanced explanation by Mr Seabourne of how it came to be, and I'm wondering if you could look-- If we look at this, at a very high level, it's an explanation of why this happened. and you know, it may or may not be right, but it's an explanation. Were you ever aware of Mr Seabourne producing this explanation before we get to the Mr Steele, Professor Steele's arrival?

A No.

Q No. Did Mr Loudon tell you about Mr Seabourne's explanation when you spoke to him?

A No.

Q Now, do you see the second paragraph from the bottom, there's a reference to the temperature?

A Yes.

Q And it says that:

"One of the key issues we faced from the outset of the project was Facilities specified that the building could not rise in temperatures above 26 degrees in the summer months (not usual) as this has been problematic with previous new buildings such as the [ambulatory care hospitals]."

He explained this drives the "change in ventilation design." When was the first time it was put to you that this issue of 26 degrees – the ambulatory care hospitals – might be an issue behind this change?

A Not until recent times.

Q Not until recent times?

A So it wasn't-- Yeah, I mean, as part of the investigations and so on----

Q I understand. If we go to the next page, there's a discussion--there's a paragraph here where he reports:

"We had a discussion during design process about natural ventilation which is acceptable in the guidelines but we asked infection control for their view and approval through Annette and they advised against it, I think I'm correct in stating the infection control person who gave the advice was Penelope Reading."

Now, it's fair to say that neither Annette Rankin or Penelope Redding agree with this characterisation of what they did, but they were involved to some degree. When, if ever, did you become aware that there'd been some infection control input into the design of the hospital?

A No, my understanding is-- My recollection actually is that there was infection control. It was a nurse., a nurse----

Q I realise there was a nurse in the form of Jackie Barmanroy, but when did you first learn that there'd been any IPC input, perhaps by use of names like Dr Redding or Miss Rankin?

A I couldn't tell you who they were, but my recollection is that there was certainly a nurse, an infection control nurse, as part of that.

Q Right.

A I think there was a doctor as well, but I don't remember if it was Penelope Redding. I-- I really don't remember, but my understanding is that there was infection control input.

Q It does occur to me that-- In a moment we'll discuss your communications with Dr Redding in the

spring of 2017.

A Yeah.

Q It occurs to me that if you'd known she was part of the Design team in April '17, you might have told her.

A Mm-hmm.

Q So can we infer that you probably didn't know in April '17 that she had some involvement?

A No, I didn't know that.

Q Right.

A I didn't. And I still don't, actually. I don't really know that.

Q Right. I mean, I think it's quite complex evidentially, but what I want to do now is step back from these document, and so put them to one side, take them off the screen, and just think about the extent of the impact-- or, not the impact, the effect. What parts of the hospital are affected by this decision that's recorded in Mr Powrie's email – the decision to have 40 litres a second rather than six air changes an hour.

There's been quite a lot of discussion amongst witnesses about which parts of the hospital it applies to, and I wondered, thinking about your knowledge in '17, maybe '18 – not what you've learned as part of the investigation – when you discovered about this air change issue, to which parts of the hospital did you think it applied?

A From the six to the three?

Q Yes.

A Or the whole thing?

Q The six to the three. Where was that impacting, if we think about your knowledge in '17 or '18?

A I think the general wards, but I know no more than that, I think.

Q Would you have known, for example, that it affected rooms within 2A?

A I wasn't involved in that level of discussion, and I----

Q Yes. Would you have known that it affected PICU and the first floor Critical Care in the Children's Hospital?

A So my expectation was at that point that there was the general ward and then there was the additional requirement for those areas. Yeah? So, I knew that it was part of the overall picture. My knowledge of how ventilation works, and what's additional to what, is quite small, to be honest. So I wouldn't have known-- So I didn't think-- I knew there was ventilation issues across the piece.

Q Okay, so before we go on to the next question, you mention you had a various in-tray of issues at the Queen Elizabeth. Apart from ventilation, which we've just discussed, were there any other issues around the Queen Elizabeth that were on your in-tray, as it were, when you arrived?

A So the issues around--

Bearing in mind the Board is-- is-- The issues were, when I arrived-- were around, just, rebuilding the Corporate Management team, which had been a bit-- had been a bit challenging over the last few months, was around our financial position – was it really quite dire? – and there was range of other issues about what the structure and processes were. But I don't remember the ins and outs. There would have been a lot----

Q But they weren't related to the building itself?

A No. No.

Q The physical building?

A No.

Q No. Right. Okay. So what I want to do is take you to page 37 of the statement bundle, which actually is your answer to Question 20 (a). Now, we asked you a question, which, to be fair to say, I'm not sure we phrased it very well, given what you knew, but we said:

"Once you became aware of what the Inquiry team has called the "Agreed Ventilation Derogation", perhaps after Mr Powrie's email of 26 May 2016 ... what steps are you aware of that the Board took at any time before the appointment of Professor Steele as Director of Estates to understand why the "Agreed Ventilation Derogation" described in that email was agreed to and whether it was carried out under delegated authority or with the approval of the then chief executive or any subgroup or subcommittee of the Board?"

So focusing on-- We wanted to know, in part, what steps the Board took to find out why it was agreed to. Your answer is:

"During my time as chief executive, efforts were made to establish how this decision was made through a review of the appropriate paperwork but NHSGGC had difficulty in clarifying precisely how and where that decision was made as it was not immediately evident from the papers that were reviewed."

Now, when were the first steps taken when you were chief executive to investigate why the agreed ventilation derogation was agreed to?

A I don't think I can say any more than I've already said in the sense of, at one level, when-- when-- In 2017 what we were trying to do was address the issues that the microbiologists in the Infection Control team had raised, and as part of that I asked David Loudon how that came about, and I think, without meaning to be in the slightest bit discourteous, I've answered that as best I can. He-- But the emphasis was about, "Okay what do we need to do to fix this or to address the areas of concern?" as opposed to-- Because I remember having a conversation with him about –

and I also had it with Tom Steele when he came – is to say "Can we not just turn up the dial?" kind of behaviour, which is clearly not appropriate, but----

Q No, it's a good question, and, I mean, we asked it too. But, yes, you asked it.

A So I had asked them those kind of questions, but in terms of-- We did try to establish who had made the decision, exactly when and where, and where was it documented, and it was very difficult to find that decision.

Q But – this is the crucial question – when was that investigation carried out?

A So I'm not sure if there was an investigation in 2017 in the sense of what you're saying. I asked David Loudon how it came about, and he said it had been very difficult to find that, but I didn't ask him to do a further investigation.

Q Yes, because, I mean, obviously Professor Steele did. I mean, he's given clear evidence, which, from my recollection, is that he arrives in post, and very rapidly he instructs a company called ACOM to do a review and that report eventually feeds into various----

A Yes.

Q -- steps the Board takes in terms of litigation.

A Yes. That's correct.

Q So there is a model for what could have been done in '17 in what was done in '18/'19 by Professor Steele, and one of the disadvantages he explained to us when he gave evidence is that when they did it in '19, Mr Loudon, Mr Seabourne and others were no longer available to them----

A Yeah.

Q -- because they'd left and retired. When you spoke to Mr Loudon at the end of '17 – and we don't quite know when, but at some point in '17 – he was in post, and Mr Seabourne had retired, but he had engaged with the Board the year before, other members of the team were in post, Currie and Brown were applying to emails – not that they stopped, but they were there. Would it not have been better to carry out the investigation earlier in 2017 and find out, from the people who were there, what had gone wrong? Maybe more information would have been recovered?

A So I think the conversation was around-- Because it was multifaceted that conversation around 2017, in terms of all the issues that have been raised in the SBAR, and quite a lot of them had been raised previously, and I understand that, but the issue was really around what areas do we still have to fix rather than-- And-- Because it was portrayed to me that the decision had been made a long time ago, and that

efforts have already been made to understand how, who and what and where, and that hadn't proven to be fruitful. And, so, my approach to that was, "Well, today we need to move forward and try and look at how some of those issues were."

Q Did you know from any source other than Dr Redding and her fellow whistleblowers – what eventually became described as whistleblowers – what the problems were in the ventilation system in the autumn of 2017? Did you have any other source of the detail?

A I don't recall that that was----

Q No. Because, we'll look at their responses, but would it be fair to say that there's a level of uncertainty in the autumn of '17 about which parts of the hospital are affected and how they are affected?

A By me or by the organisation?

Q For the organisation as a whole?

A I think that certainly there was uncertainty for me.

Q I understand that.

A And I couldn't really answer for who knew what at a lower level. I'm not certain of that, but I think there was a much greater understanding at different levels in the organisation of what had occurred, from people like Mr Powrie, and so on.

Q Because you described the hospital as "world-class", I think it was your words, a few minutes ago. I'm just wondering whether it might have been "world-beating". I have to say, I didn't exactly write it down in the moment, but do you accept that you might have described as that earlier on this morning.

A I don't know if I did or not, but----

Q But would you accept the hospital was a big, exciting, new hospital that you weren't expecting problems with?

A Yes.

Q You arrived and – not immediately, but by the autumn – you discovered there were problems that you weren't expecting or anticipating.

A Yes.

Q What I don't understand is why you wouldn't want to get the bottom of why it happened, what the implications are, and what it would cost to fix – and whether it's possible to fix it – in 2017.

A So there were a lot of issues raised in that SBAR in 2017 – all sorts of different things from significant to less so-----

Q Yes.

A -- and as part of that, as I've said, it was more about, "What are the really critical issues that we need to fix and move forward?" Because at that time

we weren't clear on exactly who had done what, when, but we were-- it was emerging about, you know, what the issues were, as opposed to, on a particular day, suddenly there were a lot of issues. So, there was more of an emphasis on moving forward than doing a----

Q Yes, because I suppose there's a couple of options, a few options, that you could have been faced with had you investigated, and they might have been different for different parts of the hospital. You might have found that, for some parts of the hospital, the Project team had agreed what was fitted, and then, in a sense, the Health Board would be stuck with that. And that's one of the things you might have found. Do you accept that?

A Yes.

Q Another thing you might have found is that the Health Board thought it was getting something better, and it didn't get it, and therefore there might've been a reason to seek to recover funds from the contractor. That might have been an option as well.

A When we describe it now, yes----

Q Yes.

A -- but at that time it was a much different kind of discussion.

Q Yes, but what I'm trying to understand is, in 2019/2020, the Health Board did a significant investigation and, as a result, decided, for some of these issues, to seek to recover its losses from the contractors – and in other issues, not to. I'm not getting into which bits are which.

A Yes.

Q What I'm trying to say is, would there not have been an advantage of doing that work in '17 for clarity and for ensuring that you understood the nature of the problem properly?

A So I don't I think-- So, now, then we understand a different situation than we understand in 2017. It was not as clear as it is now that there had been a number of things. It was an emerging situation – to me, certainly – about how those issues were coming to the fore. So it wasn't a case of, there's 10 issues, and suddenly they're all-- It wasn't like that.

Q So let's look at the conversation with the project director, just so we've got-- we're connecting up to the correspondence. If we go on to the next page of the statement, page 38, you're answering Question 20(b), which is, if you go back one page:

"What steps did you take before the end of 2017 as chief executive ... to investigate ...?"

So that with that context, go over the page until 38. You've said:

"My understanding following a conversation with the project director which would have been during 2017 [and you're saying, now, the end of the year] following the production of the SBAR and the subsequent action plan is that decisions relating to the ventilation system had taken place many years before. I was also subsequently informed that technical experts for NHSGGC has advised NHSGGC on this issue. It proved extremely challenging to try and establish precisely when and who made that decision, even after 2017."

Now, when did you learn about the technical expert's involvement? Was that in the conversation with Mr Loudon in '17 or later?

A No, I think it was in that conversation with Mr Loudon.

Q Right. So----

A It might not have been then. It mightn't have been on that exact date, but it was in that time frame.

Q Did you think of telling-- Did you tell the chair about this conversation?

A I can't remember. I'm sorry.

Q Did you tell the Scottish Government about this conversation?

A See, it wasn't-- It wasn't-- So, now those issues are quite-- are that-- are to the fore. At that time, it was much more about, "There are a number of issues with the new hospital and we need to deal with them," and that's what we're trying to do.

So, it wasn't that someone was saying, "There is a massive issue here that we need to resolve." It wasn't like that. It was a matter of, "There are some parts in the new hospital, including the ventilation, that need to be addressed," but it wasn't exclusively that. There was a range of issues.

So, it wasn't a case of somebody coming into my room and saying, "There are massive, massive issues here that we need to fix right this minute." Bearing in mind the hospital had been open for two and a half years at that point, so one would assume that if there had been serious really big significant patient safety issues, that they would have been dealt with long since. So, I'm not saying there wasn't any issues, but the way you're saying that is quite how it happened.

Q I understand that. I suppose I could only do is draw a contrast, and I do understand there may be an answer to this. In some point-- In this process, and we'll come to the SBAR in a moment, you learn various things and you speak to Mr Loudon as described here.

A Yes.

Q And we're taking that towards the end of '17. In the summer of '18, the following year, Professor Steele turns up with the DMA Canyon L8 Risk

Assessments.

A Yes.

Q Now, on that occasion, you act rapidly. You cause investigations to take place. You're responsive and you ask questions. On this occasion, I'm putting to you that you don't act with that level of responsiveness, questions, challenge and seeking information. What's the reason for the difference?

A So, the SBAR, which generated some of this conversation, had a number of things in it. So, it wasn't-- So, in terms of the water reports, there was clearly, within that, issues that the Board had not dealt with fully. Shall we put it like that? Whereas over here, it was a much more general debate about how do we move forward. But in terms of them moving forward-- So, we didn't have a report. There wasn't-- So, the DMA reports were handed to me, as I've described in my statement----

Q Yes.

A -- and at that point, we were already in the middle of having some issues with the water-- well, at that time, which were perceived to be part of the water. And so therefore, when you get a report, when you're in the process of having some discussion about the water, which says, "You haven't done all these things," then absolutely clearly, "Gosh, we need to deal with that right now."

Whereas over here, it was a much more slow burn kind of situation where, you know, the microbiologists were raising some issues and we were trying to deal with them, but it was actually to be specific about how we are within those things in the SBAR are the really critical issues. So, they are quite different the way they came to the fore.

Q I understand that, but I suppose the response would be the SBAR and the ventilation issues within it arrive more than two years after the BMT unit has come and gone----

A Yes.

Q -- which is quite a big event, and after initially, anyway, it's been found there's problems with the ventilation in the Schiehallion unit. So, how do you respond to the suggestion that whilst perhaps not at the same level of urgency in terms of public attention, patient concern, as in '18, that the ventilation issues when they do emerge, they don't just come out of nowhere, there have been these previous issues around key national services and their ventilation systems, which you should know about, and therefore the Health Board should have reacted to carry out an investigation in '17?

A But we were trying to move forward in a positive kind of way and make as many changes and alterations to

the ventilation system as we could. So, it wasn't that we were sitting saying, "Nothing to see here," it was actually-- the dialogue was ongoing in that 2017 and I think probably before that as well, I just can't remember exactly, but basically we weren't sitting doing nothing. But the question you've asked me is, "What was the investigation?" It's more about we were trying to move forward. And I totally understand what you're asking me, but it's not-- our emphasis was on trying to resolve the issues that had been highlighted.

Q How would you respond to the suggestion that had a bigger proper investigation, rather like the one that happened in '19, being carried out into the ventilation system systematically across the whole hospital in '17, you might actually have found out about the water stuff earlier as well, because it might have actually got into how the whole building was being run? How do you respond to that suggestion?

A If we'd----

Q If you'd investigated the ventilation earlier, might you have picked up the water issue earlier?

A I couldn't really answer that. I mean it's difficult to say.

Q Now, let's look at when you might have learnt about the issue of the ventilation. Now, if we go to question--

Well, before we go to the question, you seem to be suggesting that you became aware of the issue around the ventilation through the SBAR and the Action Plan. Should I be hearing that correctly? It's through those events that you learn about this stuff?

A Generally.

Q Generally.

A I mean----

Q And what----

A It's quite a long time ago, and it's quite hard to remember exactly who said what to who when.

Q No, I understand that. Well, we have some text which we're going to come to later between you and Dr Redding. This is bundle 14, volume 1, document 61, and I think it's page 663. Oh, that's definitely wrong. Let's try again. 14, volume 1, 633. Sorry, my mistake. Yes.

So, we're going to come to the earlier exchanges in April with Dr Redding, but the bottom-- If we go to the next page. This is April. If we go to the next page and we see the top of the page, we have a message on the left, which Dr Redding explained comes from you on 28 April in grey, ends, "OK. Jane." Then we have a reply from Penelope Redding. Then after the note, 27 April 2017, you say, "I feel I need to let you know"-- She says, rather:

"I feel I need to let you know that I have had to contact Jennifer Armstrong and David Stewart to alert them of my concerns in relation to infection control..."

Over the page, and that's quite long email (sic), she says she's going to go to, "Stage 2 of the Whistle Blowing Policy if a meeting isn't arranged." Keep going. And then you reply, this is page-- on 27 April-- September rather:

"Thanks for you text. Jennifer had already updated me on the emerging issues and I know she plans to be in touch with you shortly to arrange a meeting. I have asked her to keep me updated on progress to ensure the issues are addressed."

Do you think it could be that Dr Armstrong would have told you about issues such as the ventilation in that conversation or exchange in September that you're referring to there, or would it have had to wait till the actual meeting took place?

A In September '17?

Q Yes.

A Yes. I can't actually see on the screen now that text, the second text----

Q So, if you zoom into the middle of the page.

A Oh yeah, sorry. Sorry, my apologies.

Q So, 27 September 2017, 8.27 in the evening, and you're acknowledging that you've spoken to Dr Armstrong, one gets the impression from the exchange, on that day, 27 September. I'm wondering whether it would have been before the SBAR meeting, which is 4 October, that you learned about the ventilation issues, or did you have to wait to get a report back from the SBAR meeting?

A I really can't remember.

Q You can't help.

A I'm sorry. I just really can't remember that.

Q But – if we take that off the screen – would you accept that the reason you learn, as chief executive, that the ventilation systems of the hospital are not as guidance would suggest is because Dr Redding and her colleagues raise an SBAR which starts a process which results in you learning that?

A From my personal perspective, yes, that's correct.

Q Yes.

A However, others were already dealing with the issues and knew about them.

Q Yes, but they hadn't told you?

A I have no real collection of them telling me.

Q Right. Now, what I want to do is pick up on issues to do with HAI-SCRIBE. What sort of knowledge would

you have had in 2017 about the HAI-SCRIBE process?

A I know it exists and I know that it's to be done, but other than that, none.

Q Are you aware there's a four-stage process that's used in the procurement of new or rebuilt healthcare facilities?

A I'm aware of that generally, but that's not something I've ever dealt with, actually.

Q Because the evidence we've had is that in NHS Greater Glasgow, the HAI-SCRIBE process administratively is generally led by the Project team or the Estates team who are managing that facility, and then is signed off by Infection Control nurses and/or doctors. So, when you learnt that there were problems with the building, would you have not wanted to look at the HAI-SCRIBEs that have been done at the time?

A I wouldn't have done that as a chief executive, no.

Q No.

A I would have expected the teams to do that. I would not have done that.

Q So, what system, as chief executive, exists to satisfy-- to assure you that processes like HAI-SCRIBE have been carried out at lower levels in the organisation?

A I think you need to-- I need to go back to my statement already. I mean, the organisation's absolutely massive.

Q Yes.

A And there are HAI-SCRIBEs going on all the time, and I wouldn't expect to see them. I never have. When there was a chief operating officer, I never saw it. And there is a process there. I have a professional team, or had a professional team, to look at these things, and they would have done that. But there was no report to me about HAI-SCRIBEs getting done, and I've never known that on any board.

Q Because during one of the meetings for the procurement of the hospital we have a note of Mr Calderwood inquiring whether there had been an HAI-SCRIBE.

A Mm-hmm.

Q I think he might have said, "Stage 3," I can't, at this point, recollect, but he certainly inquires whether there was an HAI-SCRIBE. I just wonder, at the stage you learn, albeit in the context of all these other issues as you've explained, might not asking to see the HAI-SCRIBEs help you work out quickly whether this problem had been properly managed before?

A I didn't do that, no.

Q Now, on page 39, in answer to Question 24, we asked you if there had

been risk assessments:

"...whether in compliance with the standards in HAI Scribe or otherwise... carried out in respect of the change in ventilation strategy that [follows] the ZBP Ventilation Strategy Paper..."

And you said:

"I do not have any knowledge of this issue, nor do I have technical expertise to provide an informed view."

And I do appreciate that you don't have a technical expertise, but would management of risk be something that falls onto the chief executive's responsibility?

A Yeah, but I'll go back to the-- At no point in any of my chief exec posts have I dealt with those kind of HAI-SCRIBE-- I would expect the local team, the Estates and Facilities guys and the Infection Control team to deal with that. And----

Q But there were 1,300 rooms in this hospital that have-- that are not in specialist isolation rooms, and all of them have an air change rate that's below the Scottish Government recommendation. I just wonder, given the size and complexity of the hospital, and it's important to the Health Board, when you think-- Are you saying that should never really cross your agenda unless someone brings it to you? You shouldn't go and ask questions once you find out there's a problem?

A I don't think that's what I said.

Q No, but I-- Is that-- If I put to you that-- Well, you've said to me that you didn't carry out an investigation because, at the time, it was in the context of everything else and----

A No, what I said was that we were more focused on moving forward and trying to resolve the issues.

Q How can you move forward without knowing where you've come from?

A I think, without meaning to be discourteous in slightest, but you asked me about why we didn't go back and investigate who decided what when, yeah? And I've said that we tried to move forward in a positive way to say, "Okay, where are the key priority areas? Where are the issues that have been emerging?" Because they were emerging.

And the issues about ventilation are now much, much more pertinent or much more visible than they were back then. There were some issues, but they were principally around the specialist ventilation rather than around the general air changes.

Q So, I'll ask a question in a different way then. In order to understand how to move forward and what issues you've got, do you not need

to look at what the drawing said, what the contract said, what the original requirements were in order to understand what actually has been built?

A And some of the work that was done in that, even before that autumn, my understanding is that those issues were around where do we-- if there are-- if there are issues about the ventilation, particularly around the specialist ventilation, where do they-- where are they?

And also, as you pointed out before, some of them were around, "Has the requirement changed?" You know, "Has the expectation changed?" or was there an issue where we thought we were getting X and we got Y, and what was the issue? So, those dialogues were going on, on a subject-by-subject basis to say, "If you need X in this environment, then we need the right people to have the conversation about that" and they would have been doing all that.

Q Okay. What I'm going to do is jump ahead to a little bit more about ventilation that for some reason we put in a different part of the questionnaire. So, if we can go forward to question-- page 72 which is Question 59. We've already covered some of this ground. We, again, ask you when first aware of the issue and you give an answer which is, broadly speaking, as you just said, but if you see

the second paragraph, "I was also informed..."?

A Yes.

Q So, what was it that you were informed in September 2018?

A I'm not sure. I answered on the question----

Q So, you say here:

"In September 2018, I was forwarded an email exchange between Dr Peter Hoffman from Public Health England----

A Yeah, sure.

Q -- ...and Dr Inkster." Now, let us go and look at that email. So, that's bundle 14, volume 2, document 31. I think it starts at page 140. Now, just so we can go back to the start of the conversation, it goes to 147. And that's 146, 145, 144. The email starts, 15 September, at the bottom of that page from Dr Inkster over the page, and she has a question for him. Okay? Can we go back to 140? Were you shown the whole conversation in September '18?

A I'm not certain to be honest. I'm not certain. I certainly saw that top part, the whole of the top part.

Q Yes.

A Whether I saw the-- those pages you've put up now, the 8, I don't recall.

Q I wonder----

A And that's what I mean in my

statement when I say, “I saw the whole email.” I thought that question meant, “Did you see the whole of that first email?”----

Q Yeah.

A -- as opposed to the whole?

Q Because it could be – and I think it might be the view of Dr Inkster – that this is a result of a question by her about HEPA filtration and air changes, and Mr Hoffman expresses the bit you’ve quoted in the context of HEPA filtration. So, you see on the third line, it says:

“For their rooms, all air in them needs to have passed through a HEPA filter. The rooms should be at positive pressure so all gaps leak outwards, preventing the inward ingress of unfiltered air. Positive pressure without HEPA filtration is just an expensive way of channeling spores from outside to inside. The air change rate is irrelevant.”

And then he goes on to say what you say. Now, I just wondered what technical advice you’d have about whether Mr Hoffman is talking about general wards without HEPA filtration or specialist ventilation spaces.

A The only point I was trying to make in my statement was around the fact that my understanding of that email was that there were different views about what was required where.

So, I’m not trying to make any technical

view of-- But this whole-- the whole range of issues that have been identified at the Queen Elizabeth, it has been extraordinarily difficult to find a way to get through all these issues because there are different views, different clinical views, different views from the Estates guys and different views from----

So, what I was trying to say there was, there appear to be different views, I mean even today there are still different views, I mean, that’s why we’re sitting here in a public inquiry, you know, years later, and it’s not-- there’s not-- there has been a lot of dialogue and there are completely different views on a lot of things.

Q So, how do you respond to the suggestion that you’re taking that out of context?

A I certainly wasn’t deliberately doing that.

Q Okay.

A There was absolutely no intention to do that, and I want to make that clear. If that’s the insinuation, then I was definitely not trying to do that.

Q But, as a sort of higher level question, when did you, as chief executive, get access to technical advice on the ventilation question in the general ward? When was the first time GGC instructed someone to investigate whether it was a problem that you had 3

air changes rather than 6?

A I can't answer that.

Q So, I mean, one of the things it seems to be is that in '17, there's no external report produced.

A But there was work ongoing to try and address the issues that had been raised.

Q Yes, but no external-- there's discussion of it in various meetings around the SBAR, but there's no report produced. In '18, there is a report produced for 2A by Innovative Design Solutions----

A Yes.

Q -- Mr Lambert, but there's no report on the general wards. There's obviously been people working on 4B because that work was done, so the patients returned in '18 in the summer. But GGC, as far as we can see, not until Dr Agrawal is instructed in 2019, does GGC obtain any external expert advice on the general ward ventilation. I just wonder why that was.

A But that would have been something that was dealt with by the Estates and Facilities department and so if they felt they needed that to make their way forward, they would have had the authority and the wherewithal to do that. That would have been done by them rather than by the chief executive.

Q But wouldn't you have wanted to know whether this really was a problem? Because, as you say, there is a debate about whether 3 air changes in a general ward with robust patients matters. So, would it not have helped to obtain some advice, externally from the Board, early about whether this was a real problem or not? I just wonder why you didn't think you should press for that.

A As part of the discussion at the end of 2017, then what we were trying to do was prioritise the areas-- I've said this a lot and I'm sorry if I'm repeating myself. They were trying to prioritise those areas where people felt there was significant issues or issues that needed to be dealt with and we were trying to move forward rather than doing what you've described.

Q Perhaps I've forgotten to mention Mr Leiper's work in 2019----

A Yes.

Q -- so that was a source of independent advice in '19.

A Yes.

Q I think I've already asked you why you didn't report this to the Scottish Government; you've already explained that, so I'm not going to go back over that. Ms Freeman has said in her statement that she's unsure of whether she was ever told by the Health Board that these general rooms were non-compliant with SHTMs. She had to learn about it by other routes, and I wondered if

you'd accept that might be the case.

A So, the normal route for those things-- So, you know, there was there was input from HPS, from HFS, and so on and the normal routes for those kind of-- and also from the-- so, the normal routes would have been through those—

So, it isn't all that normal for the Board to go straight to the Cabinet Secretary. I mean, we're in a different position now because of all the issues that have happened but if there were emerging issues, then that would have gone through HPS, HFS, and so on and they would have then taken them up through that route. Generally, infection control issues and so on would go through HPS at that point through to the---

Q HFS and HPS weren't brought in on the general wards, were they, in '17 or '18?

A They were part of the overall discussions though, so-- It didn't happen the way you're portraying it though----

Q Right.

A -- and I'm sorry to be----

Q So, it's this point about it being part of a larger pot of issues that you're trying to move forward on that you want to return to, effectively.

A Yes, I mean, we didn't sit and say, right, the general, how do we deal with that? We did talk about what are the priorities and, "Where are the areas…?" because it was principally around-- the issues that people were concerned about and were raising at that point were around, is the specialist ventilation areas, are they getting-- do they need to be altered?

Q I suppose the reason that I'm asking all these questions is because of these different events as they occurred in Edinburgh. Now, I accept in Edinburgh they occurred after the water incident in Glasgow.

A In Edinburgh, the new hospital?

Q Yes. But I think if I remember correctly, the medical director receives a call from the director of Infection Prevention and Control and phones the Scottish Government almost immediately when she realises there's a problem with the ventilation in a two-build unit. I'm just wondering why the senior executive members of the Health Board don't do the same thing when they realise that 1,300 rooms are not built in accordance with Scottish Government guidance.

A But it's a different scenario because they were opening this hospital. We had already been running for three years by that time and so I think----

Q Does that make it better?

A No. No, it doesn't make it better but it's a different scenario.

Q Right.

A That's all I'm saying. It's not a case of-- So, if you go back to your comparison with the DMA, the DMA reports came into my room, I had not seen them before. "Gosh, we've already got some issues with the water," or we thought we had.

Q Yes.

A "We better make sure that all these things in the DMA report are done." That is quite a different thing from an emerging position, and it was emerging over 2017/18 that some of those issues were not to the satisfaction of individuals.

Q Right. I think probably what I'd better do now before we get to lunch is start on the whistleblowing process itself. We've talked about it a lot. I wonder if we can go to Question 27 in your statement, which is on page 40. It's worth saying that we have read your statement and by not going to individual questions, it doesn't mean I'm ignoring them. So, we explain in 27 that you were contacted by Dr Redding and we asked you what you recall about that in April '17. You described that:

"Towards the end of April 2017, shortly after I had taken up post as the chief executive, Dr Redding called me one evening. She stated that she wished to have an off the record conversation about a range of issues. I recall that she indicated that at the Easter weekend there had been a lot of work for the ICD and she had gone into the hospital to assist. She also stated that the relationships within the infection control team were not optimal. She stated that there had been a number of issues, including estates and facilities, associated with the new hospital. Due to the passage of time, I do not have a full recollection of the conversation."

Now, I don't think Dr Redding has a complete recollection of the either, so just trying to work out what you might have been told. You've obviously remembered that she was told something about relations in the Infection Control team.

A Yes.

Q Can you be a bit more specific about what the issues, including Estates and Facilities, associated with the new hospital might have been, from your recollection?

A She certainly mentioned the cleaning because I remember that. It is such a long time----

THE CHAIR: My fault entirely, I just missed that. She certainly mentioned---- ?

A She mentioned the cleaning.

THE CHAIR: Thank you.

A And she mentioned, and I can't-- I really can't recall whether she-- she mentioned there were a range of

issues with the Queen Elizabeth including cleaning but she didn't say, or at least I don't recall her saying, and there was this and this and this and this. I don't remember that.

What she was most focused on was the fact that, I think the weekend before – I've not checked this actually, I should have – but it was the Easter weekend and I don't know if that was the weekend before, but very soon, near that time, there had been a lot of work for the ICD.

She talked about the fact that she'd had to come in to assist. She talked about the relationships between Infection Control and Microbiology were not optimal and that-- She talked about the doctors and the nurses weren't gelling as one team, and so on. She talked about that and she talked about and this is becoming more difficult as there are a number of issues with the Queen Elizabeth or something like that.

MR MACKINTOSH: Right.

A I do not recall her saying, "and there's this and this and this."

Q I see.

A She may have, but I don't recall that.

Q Beyond cleaning, that's the only specific, in a sense----

A She said Estates and Facilities, including the cleaning, I vaguely remember that. The reason I think I remember that is because I had previously had conversations with her in the past, you know, when I was the COO about things like cleaning.

Q Right. Now, if we look at the bottom of it:

"I then spoke to the Medical Director as the executive lead for IPC who indicated that she was aware of a number of the issues although there were differing views within the teams at the QEUH / RHC on a number of them. She indicated that [over the page] the IPC team was working with the infection control doctors and nurses, and local clinical teams to address the concerns. I also spoke to the director of estates and facilities and the chief operating officer to ensure they were aware of the issues and taking any required actions."

Before we go back to Dr Armstrong and what she told you, would I be entitled to assume from the fact that you didn't say this about-- that the director of estates and facilities didn't then tell you about the ventilation problems in the hospital because your evidence is you learned about them later?

A Yes.

Q Yes. Right, okay. If we think about your conversation with Dr Armstrong, you've been away from GGC since 2013.

A Yes.

Q Would this have been the first time you were aware, in your new role as chief executive, of anything to do with relationships within the IPC team?

A From my previous role or----

Q No, at this point. You've just arrived.

A Well, yes, yes.

Q Okay. What detail did Dr Armstrong give you about the relationships within the IPC team and how they were, how they had been since the hospital opened?

A My recollection is that we talked about the challenges between Microbiology and the demands of those jobs and the Infection Control sessions, if you know what I mean, in terms of that whole discussion about how that interface works. We talked about the fact that nurses were quite important to this team as well and how we would support them. It was that kind of general discussion rather than----

Q Did the conversation extend to the names of individual members of the IPC team: the lead ICD, the sector ICDs, the ICNs, the nurse consultant, the manager?

A I can't remember, sorry.

Q Because one of the pieces of evidence that the Inquiry has had – and I put these in your bundle – was that Dr Inkster, who at this point is the lead ICD but had been the regional sector ICD, and Dr Peters, who was the sector ICD, had attempted to demit their role as sector ICDs in June 2015 in letters that raise both relationships issues, but also safety issues. Were you aware that they had been raising safety issues as early as July 2015?

A Not then, no.

Q No. When did you become aware that they had been raising safety issues since 2015?

A Probably as part of that SBAR. I'm not certain but even at that point, I'm not sure I was aware that-- no, I probably was, that they had been raising them for some time.

Q The SBAR time is when you're thinking of it.

A I would say roughly. I don't have a clear recollection of exactly when but that's my understanding of it, yes.

Q In the conversation with Dr Armstrong in April '17, would she have told you about issues around the ventilation and the ICD's concerns about it?

A I don't recall having that conversation.

Q I mean, given what your position is about when you learned about it, would you accept it seems unlikely that she would have told it?

A Yes.

Q You discuss that in slightly more detail on page 41 at the bottom of the page and then over on page 42, I think we've covered this now in some detail. Second paragraph, I wonder if we can explore your reference in the third line to:

"I did not regard the conversation as 'bypassing' the existing governance structures."

I wonder what you mean by that.

A So, I think your question somewhere in here was around----

Q Yes, it's over the page and it's, it's probably (v) or it might be (ii).

A Yes, I think it's (iii), actually. "Do you accept there were problems with the existing"----

Q Yes.

A So, I took that to mean that interaction with Dr Reding to me. That's why I'm replying in that way. So, the question I thought was, did you accept there were problems with the governance in that Dr Reding had to phone you?

Q Yes, and that's what we meant.

A I beg your pardon?

Q That's what we meant.

A Well, and my answer to that was no, I didn't think that because I knew Dr Redding from my previous life, I'd had some discussions with her on a number of issues when I was the COO and so therefore, I thought she was trying to alert me to some of those things, but I didn't regard it in a-- as that question asks.

Q Her evidence is that the reason she phoned you is because she'd not got very far with Mr Calderwood and Mr Archibald and others, with Dr Stewart, I think, who she'd phoned in this earlier part of the year, and she waited until you arrived and then, having had some relationship with you, she phoned you.

A Yes.

Q Now, at one level, if you're a purist about this, that is going outside the formal structures of the Health Board----

A Yes.

Q -- and you'd accept that?

A Yes.

Q But you think this is, you would see this as sort of broadly helpful that people you know phone you if they think there's something you need to know about?

A Well, I thought it was-- that's why she did it.

Q Yes.

A I thought that she had contacted me because I knew her before and we had dealt with some issues in the past, and I thought that's why she was doing it.

Q Right. So, you then speak to Dr Armstrong and Mr Loudon and others----

A Yes.

Q -- and Mr Archibald and you-- We then have the stage, what becomes realised as a Stage 1 whistleblower.

A Uh-huh.

Q Now, before we get to that, let's deal with what it's called because I think it's probably a better way of dealing with this. Do you think there's some level of-- Is there a level of confusion about whether this is a whistleblower or not, the emails to Dr Armstrong and then the SBAR, is that a Stage 1 whistleblower or is it not a whistleblower or is it just it was unclear at the time? What was it?

A I think it was unclear, and also, certainly in the documents you sent me, Dr Redding says that she told me there was a whistleblow. I'm afraid that my recollection of that is quite different in that she was having an off the record conversation with me. At one level though, the-- So, in terms of, she did not-- I do not believe that it was clear that she regarded that as a Stage 1 whistleblow.

Q The April communication with you?

A Yes, or indeed the subsequent stuff after that in the two calls----

Q Because she maintains that the thing afterwards definitely was a whistleblow.

A Yes, what I'm saying is we didn't-- well, I certainly didn't appreciate that and I don't think others did either.

Q Right. Now, can I just show you bundle 14, volume 1, page 635? So, this is that thread that we looked at earlier. It's a little bit before you-- it's the message to which you respond that you've spoken to Dr Armstrong.

A Yes.

Q Do you see how the second paragraph:

"Today I alerted them that I feel I will need to go to Stage 2 of the Whistle Blowing Policy if a meeting is not arranged by 11 October."

A Yes.

Q Now, I think she might be stages out at this point because there hasn't been a Stage 1 at this point.

A Yes.

Q But would you accept that she tells you on 27 September that she is proposing to use the whistleblowing policy?

A Yes, certainly when I saw that, we then had a conversation internally to say, "Gosh, is this a different process, or-- how do we deal with this in terms of moving forward?" But the key was that the medical director organised a meeting quickly to try and resolve something.

Whether it was called whistleblowing or not, we were trying to deal with the issues that she was raising and in some ways, that's what

whistleblowing is about. If people have concerns about issues, then it's to try and get the most optimal way to deal with them as opposed to what label it has on it, if you know what I mean?

Q Would you accept that the policy as it then stood was a little bit unclear about this first stage of whistleblowing?

A I beg your pardon?

Q The policy, as it then stood, was a little bit unclear about how the first stage works in the whistleblowing, whether you have to call it that?

A Well, there were-- there were individuals though that people could go to if they wanted to establish, you know, how should I go about this?

Q Right.

A I think there's more than one mechanism to ensure that that was appropriate.

Q But in any event, there is an SBAR and then there is a meeting.

A Yes.

Q Now, would you have been briefed about the meeting of 4 October, I mean, soon after it happened?

A Yes.

Q Yes. What I want to do is understand how it's reported into the Board process. So – if we take this off the screen – I think your statement refers to the Clinical Care and Governance Committee. So, if we go to the minutes of 5 December 2017 committees, that's bundle 27, volume 4, document 8 at page 90. It seems problematic. Ah, there we are.

Obviously, you're not a member of this committee. It's a small committee, but if we go to page 93-- let me check that, sorry. Page 93, the bottom of the page. Yes, item 56. So, Dr Armstrong turns up with Mrs Devine, Mr Powrie, and Mr Loudon. Are we to understand that it is this report that basically is the way the Board would learn that this Stage 1 whistleblow, this SBAR process had started?

"Committee was advised that there been a series of issues raised by a small number of microbiologists associated with the facilities in QEUH and RHC and the structure of the Infection Prevention and Control (ICPT) Service..."

Is that effectively all that Clinical Care and Governance is told at this stage?

A So, I'm sure there would-- I wasn't at the meeting but I'm sure there would have been discussion about what those things were.

Q Yes, there would have been more discussion, but this is reported through to the Board. I'm wondering, given the Board structure that you report the minutes through the Board but not

necessarily the papers, the Board itself is only going to see what's in this minute.

A So, the Board though-- the way it operates is that the chair of the committees, if they have things they want to raise with the Board, and you'll see in the Board minutes now that they have a slot, shall we call it----

Q Yes.

A -- to say "and I want to bring to the Board, to the attention the Board these three things" or whatever. But I think we're looking at this through the lens of now as opposed to then because I think it would be perfectly normal process to raise things that colleagues have raised through the Clinical Care and Governance process. That would be how it would work.

Q No, I understand that but you've just explained to me that as part of this process of the SBAR, you were trying – well, not you actually but the people working on it – were trying to work out how to move forward to address the issues that have been raised.

A Yes.

Q Some of those issues were that the ventilation system of the hospital, across the entire hospital was not in compliance with guidance. Now, I accept that the context is not as-- there's not that sense of urgency that might have been in place the following year with all the developments going on but how do you accept the suggestion that this is quite a gentle way to report such a discovery to the Board, because this is how the Board's going to find out about it? I mean, there's a better report in the next meeting but this one in December doesn't really tell you there's a problem if you're a board member.

A I wasn't at the meeting, and I can't recall this, but I'm perfectly certain that they would have been asked, you know, what were the issues, what are they and can you explain----

Q Right. So, the sub-committee knew and therefore it's up to the chair to put it forward?

A Well, from the minute it's hard to tell that but one would assume that the-- I mean, there a range of stuff on that SBAR from, you know, the dishwashers weren't appropriately plumbed in or commissioned, or something, or they weren't cleaned, to ventilation, to there was delays in the-- and then there was things like in the plumbing, in the institute and so on. So, there was a range of things. It wasn't just one thing.

Q I understand that, but I suppose the question – and I realise we're going to come around in a circle a few times, but just finding a neat way of doing it – is that at this point, December '17, if I understand what you've said and

what we've found out correctly, this minute, for better or worse, is what gets to the Board about the existence of all the issues in the SBAR at this stage?

A Yes. I would need to see what the papers were that went and what the presentations were to the committee as well, and I don't have that so I don't know. But I'm perfectly certain that the committees were not – how shall I put this? – they weren't just a matter of people coming and saying, "Well, there was an issue" and we deal with it. The non-executives rightly gave it a level of scrutiny and challenge and asked questions about well, what does that mean, what are you doing about it, what are the issues, you know, so in all the Board Committees, there's quite a lot of challenge to the executive team.

Q Right, so if we now look at the paper which is more detailed which is bundle 20, document 48, at page 793. Go back one page, please. Yes. So, this is the report at 792, and it explains the purpose of the report that three consultant microbiologists raised series of concerns about the facilities in the Queen Elizabeth and the RHC and the structure of the IPC service within the Board.

Then there's discussion of the meeting, the tabling a list of concerns and the minutes are attached to this. Go over the page. These are the issues listed

and the themes are identified as the PPVL rooms, the presence of filters – third bullet point – in 2A, the 4B upgrade, single room specification, and then we have the actual minutes and the SBAR attached. So, your view is that that's a safe way of reporting things up to the Board?

A I think it covers the ground of what the issues were. I'm sure there was discussion about, well, what does that mean? What are we doing about it? Certainly, the majority of the committees that I've been at, those are the things that are----

Q But it's the committee chair who decides whether, in a sense, to flag it to the Board itself.

A Committee chair in a----

Q With the executive lead.

A Yes, yes.

Q So, the Board itself won't see this paper, it will just see the short minute.

A Yes, but I think somewhere in my statement I've tried to explain how that works because the Board Committee, the Board itself, the NHS Board meeting is-- there's such a wide range of things in a board the size of Glasgow and Clyde that come to the Board.

So, it's a bit like the question you asked about the corporate management

team. If you put everything onto there, then you'll be here for a long time, I think is what you said or something like that.

Q Yes, so you feel there has to be some form of filtering process.

A I think the process works better with things going to the Clinical and Care Governance Committee for example, because they would ask, you know, what's happening with these things, but they would also ask what's the impact of those things?

Q Yes.

A Has there been an impact on infection rates? Is there an impact on patient safety? Is there an impact on the outcome of some of those things? Because some of them are more substantial than others. So the committees, in my experience, generally ask, "Well, what's the outcome?"

Q Right.

A **"**What is the impact of those things on the clinical services? What's the impact?"

Q Thank you. Now, what I want to do is move to page 44 of your notes, a couple of questions before the lunch break. Your statement, Question 30. We asked you:

"To what extent is it fair to say that the 27-Point Action Plan come about as a direct consequence of the Stage 1 whistleblow raised by Dr Redding and others?"

Your response is:

"The action plan was drafted following these discussions as, although a number of issues had been previously highlighted and various actions in respect of those issues were already underway, this process brought increased focus to the issues, with clarity of timescales for action. It also ensured greater clarity on the progress that had been made in a number of areas."

So, I suppose, a couple of questions. Was it legitimate for Dr Redding and her colleagues to raise these issues?

A So, people have the right to raise any issues they want. If people have concerns they should raise them and we should consider them and, if necessary, deal with them.

Q But in this particular case, given that the response of the parts of the Board or maybe even the Board itself has not been entirely positive at all times to the raising of issues by Dr Redding, Dr Peters and others, at this moment, is what they're doing a legitimate thing for them to do?

I think there's a range of issues, as I've said already, on that SBAR, there's a range of issues. I think it's quite important, and part of the issue around some of this is if everything's important,

nothing's important, if you know what I mean? What are the areas that are really critical to moving forward? I think that's one of the challenges in all this.

But I think the process to try and get everything down on one bit of paper to say, "Right, okay, whether they're minor or major, put them onto a bit of paper, and then we'll be able to be clear that those are the issues," because there was a bit of divide about, "What are the issues that are of concern?" Put them onto one bit of paper with an action plan, then we can monitor the fact that they're getting dealt with.

So, I don't characterise this as, "Were they're right or were they wrong?" I think the fact of the matter is some of them had already been dealt with, is my understanding of it, but it's better to put everything down and make sure it's visible and then people are addressing them and making sure they're done.

I realise you say that, but I think I have to press you. The three clinicians raised these issues. It's their evidence – which I accept is not accepted by the people they're talking about – that the atmosphere in the meeting was not entirely warm and happy to see them.

A In the beginning of October meeting?

Q Yes. Now, I absolutely have to make it clear that that is not the view of Dr Armstrong, who chaired the meeting. There's a difference, which this Inquiry has to grapple with. But if we then look about what later happens when the Stage 2 whistleblow, which we will come to after lunch, I'm just keen to press you on-- and if you want to use a different word, suggest it but is it legitimate for three microbiologists to raise the issues as they did in the method they did it in September 2017 that they put in that October SBAR? Is that a legitimate thing for them to do as clinicians who work for NHS Greater Glasgow?

A Yes. I mean, it is right that people, if they have concerns, that they put them into a process, whether it's a whistleblowing process or any other process because every single day in Glasgow and Clyde, groups of clinical staff or non-clinical staff are putting things onto a bit paper which they're-- you know, they want dealt with or they've got ideas, so it's just a normal part of process that people raise things and we have to deal with them.

So, I don't think it's not legitimate, if you know what I mean? That's a sort of double negative. I think it's right that if people have concerns, we put them onto that paper, we have a discussion, and we have an action plan to deal with them.

MR MACKINTOSH: Thank you. I think it's probably a good point to break

for lunch, my Lord.

THE CHAIR: Yes. We'll take an hour for lunch, and we'll try and be back convening at two o'clock. So, if I can invite you to go back to the witness box.

(Adjourned for a short time)

THE CHAIR: Good afternoon, Ms Grant.

THE WITNESS: Good afternoon.

THE CHAIR: Now, Mr Mackintosh.

MR MACKINTOSH: Thank you. Good afternoon, Ms Grant. I wonder if we can look at the Action Plan itself now. So, that's bundle 20, document 48, page 794.

A Is this the----?

Q The 27-Point Action Plan.

A Right.

Q Because what I thought I'd do is, effectively-- I'll not ask you to answer this question yet, but I'll come back to it at the end-- which, effectively, amounts to this: how do you respond to the idea that the way that the issues are addressed in the Action Plan should have required you, as chief executive, to act? I'll come back to that at the end when I go through it, but I want to give you, as it were, notice of the question that's to come. While we do it, I wondered when you would have seen this. In 2017?

A Yes.

Q Are there any of the particular 27 items that stood out for you at the time?

A I don't remember. What we were trying to do was make sure that they were all being actioned, some of them were short term, some of them had been done, and some of them were more major.

Q Yes, indeed. That's what, I suppose, I wanted to pick up with you. I think we've already-- I had planned to ask you, in respect to Items 1 and 2, which is related to the PPVL rooms, whether you spoke to Mr Loudon about why these happened at the time. Is there any particular reason? Did you speak to Mr Loudon about why the PPVL rooms were not compliant with SHTM or weren't appropriate for infectious diseases patients?

A I think it was part of that general conversation I've described to you already.

Q Right. Okay.

A We didn't go through the Action Plan in detail, or at least, if we did, I don't recall it.

Q Let's go to Item 6. The issue, as recorded by whoever wrote the Action Plan, is:

"It's HEPA filters in PICU for the protection of patients in the Bone Marrow Transplant Unit (BMTU) that might need

critical care during treatment. The BMTU is ... also referred to as Ward 2A."

And, do you see, the "Current Position" is:

"HEPA filters were installed within PICU/Ward 2a week commencing 6 November 2017, within room numbers 12 and 17 – previously installed within room 18. HEPA filters still to be fitted in room 5 (access to be agreed with clinical colleagues)"

And:

"HEPA filters were also fitted into [Children's Hospital] Ward 3c, week commencing 13 November 2017 within rooms 9 & 10"

Now, given that we're more than two years since the hospital opened, should the fact that HEPA filters were being fitted then not have alerted you to the suggestion that problems weren't being addressed by the existing management structure, because it took two years for this issue to be addressed.

A So, I really can't answer that because I don't know whether-- what the circumstances and the context around that would be. If it's as-- Yes, clearly there should have been-- If there was issues that were raised in 2015 when the hospital was opened, and there were issues, and there had been some impact on patients, and so on, then, yeah, clearly they should have been dealt with before that. But I don't know enough about the detail of this. I don't.

Q But if we just, kind of, think of it this way: if it's the case – I'm taking this from this document – that somebody thought, "You know what, we should now fit these HEPA filters", in 2017, then isn't one of the possibilities that no one had thought of that issue or addressed it – you don't know which – in the previous two years? Doesn't that require some greater level of action on your part as chief executive, when you see that it hasn't been done in the previous two years?

A So, I think we're going back to the questions I spoke about in the morning. You know, I would expect others to deal with us. You know, we had a big team of people. I totally understand if things are being raised that are of substance, but the role of a chief exec is to empower others to do things, as well as take action on serious things.

So, I don't recall what-- I don't recall the detail of what was discussed around that, and I don't recall the reasons why it had taken so long. So I don't want to conjecture about why it wasn't done, why it wasn't-- because I don't actually know.

Q I think the point that I'm-- The reason I'm raising it, the question, is when does an issue become sufficiently serious that the chief executive has to

step in and say, “No, you need to act and do something else other than follow the existing processes”?

A I guess that depends on the seriousness of the issue. And the whole reason for pulling together where the Action Plan was some of the things in the Action Plan had either been dealt with, is my understanding, or they should have been dealt with at a much lower level in the organisation, and indeed probably were, and some others were much more complicated.

And, therefore, Dr Armstrong rightly pulled together a meeting to try and differentiate the things that were important and asked, I think, the Infection Control team to-- I think it was the Infection Control manager to keep a grip of this to make sure that things were done. But some of those things that were in the Action Plan were relatively modest, shall I call it that, and some of them were more major, but those things were getting dealt with. So, yeah, the Action Plan was highlighted to me and we did discuss the fact that it was all happening, and that-- and our focus was on trying to resolve things.

In terms of the-- I was just thinking also about your points about the DMA reports. And in some ways when we got the reports, it was about moving forward as well. It wasn’t about how-- In some

ways it was about, you know, the history, but actually this was about from where we are now, what is it we need to do to move forward and get these things sorted?

Q But if we look at page 3. If we go forward two pages to Item 17 – one more page – which is the 3 air change things, and the current position is:

“There are three air changes in the single rooms within both QEUH and RHC. Director of Facilities agreed to take this issue forward with NHS D&G...”

What’s NHS D&G?

A Dumfries and Galloway, who had just bought a new hospital as well. I assume that’s what that means.

Q Yes.

A With single rooms in it.

Q How do you respond to the suggestion that some of these things, not all of them, I’d accept that, but some of these things are actual examples of failures to manage the ventilation system that are effectively the same sort of failures as are eventually found in the DMA Canyon Report? Because the DMA Canyon Report shows a failure to manage risk, in particular discrete ways, but here we have a failure to manage issues that later emerge, and what I’m wondering is should this Action Plan have not prompted you to take similar actions and investigate these key issues,

particularly ones around ventilation?

A So, I think I have answered-- as best I can, I've answered that. We were trying to move forward rather than saying, "How did this happen?" I've explained to you that I had a conversation with David Loudon, who-- and I've explained that already, so I'll not repeat it.

And also, "What's the outcome? What's the impact of that?" Because, as I said to you, I initially thought, "Oh well, this is simple. Just turn up the thing and it'll be fine," and clearly that wasn't the case. Because it wasn't a matter of saying, "Well, actually, if you just do X, then this will all be fixed." It was, if you go to look at what happened to 2A, 2B, it was a massive, massive undertaking to actually change all that.

So, there has got to be a risk assessment of what's the impact to patients, and therefore, what is it we can reasonably do to address that issue, or indeed, do we need to address that issue because of the other mitigating things in place?

Q Was there a risk assessment of the item in Row 17, the 3 air changes?

A We were looking at the outcomes – was there----

Q No, but you've just told me that you would look at it, discuss it----

A Yeah, I was trying to----

Q -- and get a risk assessment as an example, and you didn't get a risk assessment for Item 17.

A I was just trying to answer your point. The-- What we were looking at was, "What was the outcome in terms of the infection rates and what"-- and so what the impact had been, right, and whether there was any impact on patients, and also the areas which were the biggest focus was around the specialist ventilation rather than the general wards where it wasn't the same kind of issue.

Q How do you know that? At this point, how do you know it's not the same kind of issue?

A Because the patients in the areas with specialist ventilation are either immunocompromised or they have particular characteristics.

Q I appreciate this, but in the general wards, which includes a wide range of patient groups, but doesn't include-- or it does actually include the immunocompromised patients in Ward 2A, but apart from them, the general community of the hospital are all in these rooms. Why do you know that it's not an issue in terms of patient safety?

A Well, the risk was perceived to be less.

Q By whom?

A By, I think, everyone. I don't----

Q But there's-- No risk assessment has been done. There's no discussion of that in this report or action plan. Who assesses the risk that this poses? I appreciate now we have the debate from Mr Hoffman, all that – I appreciate that – but back then, what steps were taken by the Health Board to reach that conclusion----

A I'm sure----

Q -- that there was a different order of risk?

A I'm sure there would have been a discussion about where we should focus our efforts and where but I can't remember the discussion. I just can't, so----

Q I want to go through to the next page, just the next page, and look at two water-related things. So, this is 21 and 22, and it's another question about when you learnt something. So, 21 relates to, "Cleaning of Temperature Control Values-- Valves (sic)." I suppose this is probably the Horne taps. When did you learn that there had been a discussion before the hospital opened about using these Horne taps and the risks they might pose?

A Probably as part of this. I don't remember exactly when I knew it, but I did.

Q Right.

A In recent times-- I'm not saying recent time, but I do-- I have been briefed on that.

Q Would you have known about it before the DMA Canyon Report arrived?

A I'm not certain, to be honest, because the water issues really only came to my attention in terms of the seriousness of some of those issues when the DMA Canyon Reports-- and when we were looking into the issues in 2018.

Q Yes, because I think the point that's made around these taps is they're fitted widely across the hospital, and there is a meeting in March 2015-- I doubt I've got that right, sorry.

THE CHAIR: 2014, I have.

MR MACKINTOSH: 2014. Thank you, my Lord. I'm assuming you wouldn't have seen that minute or anything at the time?

A No.

Q No. But we understand from evidence that the maintenance of those doesn't really start until 2018. So, it's not actually in place at this point.

A In 2017?

Q Yes.

A I couldn't comment on that. I'm sorry.

Q Yes. So, we then have a statement at 22, "Water testing is not as per national guidance," and the response:

"Board water safety is in place and water systems and processes are monitored as per national guidance."

Was that actually true at the time, knowing what you now know about the water management in the DMA Canyon reports?

A My understanding is that that was a particular thing about the water testing and that the water testing was being done.

Q No, I get that, but someone has written in here:

"Board water safety is in place and water systems and processes are monitored as per national guidance."

What I'm putting to you is that what the DMA Canyon Reports, both of them, are saying is that's not actually strictly correct because there weren't, for example, authorised persons and authorising engineers.

A I guess if you go to the issue, water testing is not as per national guidance. My understanding is that we believed that it was, that testing----

Q No, no. I very much accept that. I'm not saying that because there wasn't much guidance around at the time and that's part of the point, but somebody has written in here and told you and have also read the report that, "...water systems and processes are monitored as per national guidance," and what you will later discover, in the DMA Canyon Report, is that's not the complete picture.

A Yes.

Q And I wonder if you'd noticed that?

A I think we were focused on the water testing.

Q Right. Now, in your questionnaire we asked you some questions about being duty holder for the Board.

A Yes.

Q And so, that's on Question 63, which is on page 75. In '17 and '18, what did you know about your responsibilities as a duty holder for the water matters in terms of L8 and HSD 278 and SHTM 04-01?

A I had a generally high-level awareness of the duty holder responsibilities, but there are many, many similar responsibilities on a chief executive.

Q Yes, and did you appoint somebody as a responsible person?

A I assumed they were already in place. Because when you come to a new role, you couldn't really take in a board that size or in any board, at a chief executive, every single bit was in place. You assume that, as the hospital had been open for two and a half years, that those things were in place. And in fact, in the majority of the Board area, my

understanding is they were in place.

Q So, you very much assumed that these roles were being properly carried out and they were in post and there were people in place?

A I think it's-- In hindsight, and that's a different thing, but I think in general terms there are many, many areas within the Board where there are equivalent of duty holders----

Q Yes.

A -- and when you come into a new role, it would be very difficult to check every single thing to make sure it was in place, but because there are many, many, many things like that in that line of----

Q I mean, thinking-- Again, I get with the benefit of hindsight, because now since the water incident, there's been a high level of water testing by Greater Glasgow and Clyde, we've heard the evidence of Mr Kelly and Mr Clarkson and Professor Steele on that subject. We've had Mr Poplett's audit. So, we know things are different now, but what lessons do you derive from what will turn out to be what was found in the DMA Canyon Reports and things in terms of the management of the duty holder responsibility? How would you encourage other duty holders to act differently if at all?

A I think there needs to be some

kind of recognition of how to make sure that the principle issues have visibility and have an appropriate status in the organisation, if I could call it that. But as I say, there are many, many, many of them for a chief executive. So, I think there are issues about when you're going on to a new site to make sure that the processes that one would assume are in place are actually there.

Q Yes, because when we look at the ward safety-- the Board Safety Group minutes from '15 and '14, they're not discussing those sort of aspects of the new building – who's going to be the appointed person? Who's going to be authorising engineer? They don't discuss that. So, you feel there should be some system of pushing that up the visibility, as it were, so more people can see it?

A I guess there needs to be a more structured approach to make sure that some of those-- that all of those issues are up.

Q However, there has been some evidence from, I think, mainly Mr Powrie and Mr Purdon as well, I think, and some of the other members of the team about lack of resourcing in Estates in the years after handover, including in '17 and '18. Were you aware of their concerns at the time? Lack of staff to do the work?

A No, I don't think I was.

Subsequently, there had been some discussion about the volume of work. And in 2018, when there was issues about, you know, "Why were the DMA reports not actioned?", then there was a discussion about-- there was a review at-- a discussion about why those issues had not been addressed, and then there was discussion about that the number of snagging incidents, if I could call them that, were very significant in that period immediately after the hospital had been opening, and therefore had been very difficult for Estate staff.

Q So, do you think there should have been more resource made available to them?

A Well, I wasn't there so I don't know, but I think----

Q But even in the period you were chief executive, do you think----

A I think----

Q -- there should have been more resource in '17 and '18?

A I think the snagging issues were greater than had been anticipated, and I think that put huge pressure onto the system.

Q But in the period you were chief objective in '17/'18, do you think there should have been more resource for Estates in the Queen Elizabeth?

A What we did was there was some discussion about whether there was enough resource and we asked, as you know, Jim Leiper to come in and look at how some of those issues and what we needed to address them. And we also looked at some of the work where some of it could be done by external contractors and so on, and how we used the in-house staff and how we used external contractors to make sure that the breadth of the work was covered.

Q But in the period between you arriving and chief executive and Mr Leiper's report, do you think there was enough resource in Estates?

A I couldn't answer that. I mean, no one came to my office and said, "There really is not enough resource." That was not----

Q But looking at Mr Leiper's conclusions, do you think that's a reasonable inference that there wasn't enough resource provided?

A I think it's a reasonable inference that in the period following the occupation of the hospital – if I could call it that – then there was a lot of snagging and therefore they were under pressure. And one couldn't really say whether there was enough resource or not because I wasn't there, I don't know. In '17/'18 things had calmed down a bit and, therefore, there was no issues raised with me about, "We need more resource."

Q I understand that, MS Grant,

but I'm wondering whether looking back on what you now know, having read Mr Leiper's reports, having considered the reasons that he understood the DMA Canyon work wasn't actioned, that you might be able to help me about whether in '17 and the first half of '18 there was enough resource provided to the Estates team at Queen Elizabeth?

A I've no reason to believe there wasn't. I do think there was a lot of pressure on them, and we had tried to support them by putting some of the-- by putting some resource into external contractors and so on.

Q Thank you. I want to move on now to the Stage 2 Whistleblow. When did you-- Well, let's look at your answer. In Question 32, that's page 46, you are asked when you first became aware of the Stage 2 Whistleblow by Dr Redding, and you were told in February 2018. Am I right-- Who would you have heard that from? Is it from Dr Redding or is it from someone else?

A I think it was from Dr Redding, but I think it was from-- I can't remember exactly who it----

Q See, her evidence is that she communicates with you in '17.

A Yeah.

Q But in '18, she looks up the policy----

A Yes.

Q -- and she emails Dr de Caestecker, who's the person she's supposed to email.

A Yes.

Q And so, would you have heard about it from Dr de Caestecker or Dr Armstrong or someone like that?

A Probably, yes.

Q Probably. Now, you----

A I certainly did know about it.

Q Yes, you knew about it. So, explain-- We asked when you saw the report and you say:

"It would not be routine practice for the chief executive to see whistleblowing reports."

And I understand that. And:

"[You] were kept abreast of the issues by the Medical Director and the chief operating officer and was aware of the issues involved. I cannot recall precisely when I saw the report."

We asked you about what you knew about the reporting-- the investigation, and over the next page, on 34, we ask you:

"...as chief executive what steps did you take to keep yourself informed of all future whistleblows and the concerns these raised? "

And you say:

"It is not normal process for a chief executive to have sight of the details within whistleblowing reports due to the

need for confidentiality for those involved. I would get a monthly summary of ongoing items and any summary recommendations but would not generally see the reports in full to ensure that the confidentiality of the process is retained."

Now, I appreciate that's the normal policy, but why was there any need for confidentiality this case?

A No, the-- I need to say this without talking about confidentiality if you know what I mean. There have been other instances of whistleblowing where issues have been raised and people have specifically asked for them to remain confidential, so.

Q I under stand that.

A No, but even associated with this kind of stuff, so.

Q Yes.

A There are-- It's really important that people feel supported to make comment without feeling that they have to be identified or their content needs to be identified.

Q But you knew that Dr Redding and colleagues had raised the Stage 1 or whatever it was called time, and you knew that Dr Redding had raised the Stage 2.

A Yes.

Q So, in that sense, it wasn't confidential anymore.

A Yeah, I guess so, but we were dealing with issues. So, it's not-- I mean, whistleblowing, in itself, in terms of the process is-- I mean, it's back to this thing-- The processes were working, Linda de Caestecker's, an experienced whistleblowing person, in to investigate those things. That's the process, and she would have dealt with it. So, I wouldn't go along and say, "I want to know exactly what Dr Redding has said," and so on. That-- that's not-- she----

Q So, Dr Redding, in very high level, was not satisfied with the work done in response to the SBAR, I think partly because she wasn't told----

A Yes.

Q -- looking at it with the benefit of hindsight, but she wasn't satisfied, so she raised it in the Stage 2. Now, without getting into too much of the facts, if she's not satisfied with something, she's raising a concern about the way the people who should have dealt with it did deal with it, and those people would have been Dr Armstrong, Mr Loudon, Sandra Devine, the people who were at the meeting in October.

So, she's gone to Stage 2 whistleblow to say, "I'm not happy with this," and yet somehow, it almost feels as if you're not listening. You're not listening as team executive, because you're the one above the people she's to some degree complaining about.

A I don't-- I wouldn't accept that. I think the issue was we were trying to make sure that those things were dealt with. I-- I was reasonably assured that progress was being made and that the issues were being treated seriously. The timeframe wasn't huge between when the original thing was raised – in this time frame; I appreciate there's now been discussion about, "It was much earlier than that" – and therefore I was satisfied at that point that we were taking it seriously and that we were making progress with the issues that had been raised.

Q If we look at the report, which is bundle 27, volume 4, document 6, page 81, and we look-- Now, it's fair to say that Dr Redding thinks she raised more than five points, but if we just look at the five points that are here, these focus on 5 of the 27 issues and she's going to the hospital, the Board, to say, "I'm concerned these issues aren't being addressed. "When did you find out she had these concerns?

A I-- I think it was all part of the continuum, if you know what I mean. Those issues had-- had been raised, were getting dealt with, and so I don't think in my mind they were separate, if you know what I mean? In the 2017 process, those things were getting addressed, and I knew she wasn't satisfied with that, and we had some conversation about, "How do we make sure that the progress is-- is appropriate so they're not stalling," and I think that's-- --

Q Because, effectively, her complaint is that these five issues are not being addressed, notwithstanding what's in the Action Plan. So she raises the issue, and then Dr de Caestecker investigates it, and I'm wondering when you were told the results of the investigation, because the report ends, I think, in May-- it's produced in May.

A I can't remember, I'm sorry. I think we need to recognise as well that, you know, there was a sector director, there were this chief operating officer, there was always people as well, so some of this wasn't-- and I don't want to sound as if I'm not interested or wasn't doing it, but-- but there are-- there are a lot of people around me who would be-- who were dealing with this. It wasn't a case of "they weren't"; we were.

Q Let's go back to bundle 20, page 800, which is the people present at the 4 October meeting. So, let's look at the top half of the page. Effectively, the people you've just identified are the ones at the meeting. So she's complaining, for better or worse, whether she's right or wrong, that the issues that they have set out to address are not being addressed.

I'm suggesting that you're not listening.

A I think-- I think the issue that she was principally raising was that the pace wasn't quick enough and she didn't know what was going on, and so the-- the issues were around, "Are we doing these things? Which of those things are we doing?"----

Q Yes.

A -- "Which of those can we never do?" because one of them was infeasible, as I understand it.

Q Which one was infeasible?

A The-- the one about the ED department. I've forgotten which one it was, but there was one about room in the ED department.

Q In the Action Plan?

A Yes.

Q Yes.

A And-- but the rest of those issues were making progress and people were absolutely dealing with it, but if you look at those people, there are senior people there who were dealing with it, and I think if you look at the-- the December meeting that we were looking at earlier, there was decent progress being made on a lot of the issues.

Q To what extent do you think the whistleblowing could have been avoided if there'd been better communication Dr Redding about that progress?

A That is possible.

Q Now, if we go back to the whistleblowing report – so that's 27, volume 4, page 81 – Dr de Caestecker describes speaking to a number of people, and that's on page 82, at (3). I wondered to how many of these people you had spoken about the Action Plan by the time we get to February 2018.

A The people I would have spoken to about the Action Plan would be the chief operating officer, the medical director, and the director of estates.

Q So you wouldn't have spoken to these people? Okay. Now, what I want to ask you here is what were you told about the conclusions of this whistleblowing report?

A I don't remember, I'm sorry. I don't recall that. I mean, it's eight years ago. I don't----

Q Well, ultimately, it went to a Stage 3.

A Yes.

Q Then, whilst you were chief executive, Dr Redding gave evidence about it as part of the Inquiry, so----

A Yes.

Q -- I just wondered if at any point you'd remembered what you were told about the conclusions of her Stage 2 whistleblowing.

A The discussion that I recall was around, "Are we dealing with the

things that were in the Action Plan, are we content that the progress is being made, and are there any that are really not possible?" and I was assured that the actions were being taken. We were making good progress with them, the ones that were possible, and that the governance was going through things like the Clinical Care Governance Committee to make sure that these issues were getting dealt with, and that-- that has-- there is evidence of that.

Q If we look at the findings, there's a discussion of Dr de Caestecker's investigation results. How much of these will you have seen in terms of findings?

A On-- where-- where are we now, sorry?

Q Bottom of page 82, section 4. It goes on for a page and a half. How much of this would you have seen?

A That-- that bit about the three sets of issues? Is that you're asking me?

Q Yeah, well, anything from "4. Findings" onward. I'm just wondering how much of this document, in a sense, would you have been told about?

A I-- I was-- I would only have been generally told about the fact that the issues were part of the Action Plan we were dealing with.

Q So, I wonder if that's really-- Dr Redding raised a bunch of issues with some colleagues and an action plan's produced. She contacts you-- Sorry, I'll rephrase that. She contacts the Stage 2 process because she's concerned to some degree that some of them aren't being they are being actioned on properly. It goes into a Stage 2 process. You are told they are being actioned. So does, in fact, the Stage 2 process just go back to the people she's complaining about?

A No, Linda de Caestecker was an independent for the purpose of this conversation person who was making a judgment, who hadn't been involved in this. So she was making a judgment outwith the-- the people that you've described on that page.

Q All right. Looking at her judgment, can we go to the bottom of page 83? She decided to include in her report criticisms of Dr Peters' working style. These are the bullet points at the bottom. Would you expect that to be in a whistleblowing Stage 2 report about a different member of staff?

A Can I just read it for a second?

Q Please, of course.

A The last paragraph, is that we're talking----

Q And the bullet points below it.

A (Pause for reading) So, I think when you write a report, I mean, what-- what I would stress to you is that when

things have been-- when things have come to the fore, the main thing is to try and address some of the issues that are happening and think about how we move forward, and there were certainly some concerns about the style and tone of communication of some of our colleagues.

And, as part of that-- you'd-- you'd have to ask Linda why she put that in the report, but I think it's pertinent to say that we are-- we are supposed to be team players and-- and, from that perspective, we have to-- and it's back to the point of what-- what is significant and what isn't, and how we deal with that? And so-- and it doesn't-- The report should reflect Linda's view of what the main points are of the-- of the situation that she's doing the whistleblowing for.

Q Why do you----

A If she thought that was pertinent, then that's why she put in, I assume.

Q Why are these sections relevant to the issue raised by Dr Redding in her Stage 2 whistleblow? I have asked Dr de Caestecker for her reasons.

A Because I think they were impacting on how the whole discussion was going on in a wider sense, because it was-- became, at some times, quite tense, and that didn't help matters in terms of moving the-- the issues forward.

Q To what extent does including this sort of content in a Stage 2 whistleblow report ultimately end up deterring whistleblowing, because if you know you're going to be subject to personal criticisms, or your colleagues are, you might not raise an issue?

A Yeah, I think-- I think that's a legitimate concern, but I do think we need to try and portray the overall context of what was happening as opposed to-- some of the conversation this morning-- this afternoon was about this-- this part but, actually, I think it's important to understand it in the context of the overall position and the overall issues that are getting dealt with at that time.

So I-- I do think it's-- your point is is-- one that is-- is important and-- and, as part of that, we also need to-- and that's why some of the confidentiality issues are quite important as well, that people do not deal with it in the public domain things are-- are noted in.

Q Right, so you don't feel that you should put in the public domain criticisms of whistleblowers, then?

A I think, in general terms, that's why I was-- I was trying to link that to the confidentiality aspects of it, so it is difficult to-- but it is sometimes difficult to do.

Q Can I take you to a letter that you wrote on 1 March 2021 to Professor

Stevens – bundle 25, document 3, page 151 – and we'll come back to the (inaudible 14:41:53) place this letter sits in the CNR tomorrow.

THE CHAIR: If I can interrupt, before we leave Dr de Caestecker's report, I mean, the view might be taken that it's, at very least, remarkable that issues which are summarised as the main points, which I don't think----

MR MACKINTOSH: Should we go back to bundle----?

THE CHAIR: Yes, sorry. My apologies. So that's going back to bundle 27----

MR MACKINTOSH: Volume 4.

THE CHAIR: -- volume 4, document 6----

MR MACKINTOSH: Page 83.

THE CHAIR: -- page 81.

MR MACKINTOSH: 81. Sorry, my Lord.

THE CHAIR: Yes, a report which sets out as addressing the five points summarised, none of which mention Dr Peters, ends up with conclusions and recommendations which are largely, if not exclusively, about Dr Peters.

A That list of bullet points, you mean?

THE CHAIR: Yes.

MR MACKINTOSH: They're over on to page 84.

THE CHAIR: Yes, including page 84.

A (Pause for reading) Yeah, so if we look at that-- It's quite hard to do it in isolation, if you know what I mean, but-- but, basically, I think these reports are about trying to-- while they are about answering the whistleblower's concerns, they are also about trying to do a-- I don't know the word, but "dispassionate", shall we say, view of the situation and the factors that are leading to this, and undoubtedly, from that report, it looks as if those issues were being raised by colleagues about the-- the behaviour of an individual, which was impacting on how to deal with the situation. I'm not sure if that answers your question. Obviously not, because you're----

THE CHAIR: Not immediately. I mean, the whistleblowing report, as I would understand it, is intended to give the reader a response to the issues raised by the whistleblower. This report identifies, or summarises, the issues, and then seems to become pretty well directed at something entirely different, and that's the behaviour of not the whistleblower, but the person who happened to attend with the whistleblower.

A Yes. I think-- I think it's part of the overall situation within which the whistleblower was-- was sitting terms of the-- the factors that are making it

incredibly difficult to deal with some of these things, because they were getting dealt with and then-- but in some of these areas, more and more things were getting raised all the time, and so, therefore, I think that statement-- those statements that you have highlighted and-- and Mr Mackintosh has highlighted, are trying to get the wider context of how difficult it was to make some progress in a sustained way, but I do understand the point of, "Well, why was that in there?"

And I think the other thing is – I'll go back to the confidentiality thing – that's why it's important and in some whistleblowing reports-- and I-- I don't really see a lot of the detail of them, there are things that are difficult and-- and-- for individuals and we need to make sure that they are kept confidential.

So I think they were trying-- I think Dr de Caestecker was trying to outline the overall context within which the things that Dr Redding was raising were trying to be addressed. I think she was trying to-- to confirm the complexity of the situation, or outline the complexity of the situation, around those issues that were part of the whistleblow.

THE CHAIR: Thank you.

MR MACKINTOSH: Thank you, my Lord. What I want you to do is, you talked about confidentiality and keeping these matters confidential, if we look at this letter that you wrote to Professor Stevens in 2021. It's on bundle 25, document 3, page 151. I will go and do the context of this letter tomorrow when we deal with the case notes review, but if we go-- It's 1 March 2021. If we go on to the final page----

THE CHAIR: Sorry, my fault, Mr Mackintosh. Could you give me the reference----

MR MACKINTOSH: Yes, it's 25, document 3. The letter starts page 151. It's a letter of 1 March '21, and I'm taking Ms Grant to the third page, page 153, where there's a heading at the top of the page, "Anecdotal references," which I think is a reference to elements within the overview report, the draft one you've seen, that report the views of certain microbiologists that have been repeated to the CR. Is that broadly the context of here, Ms Grant?

A Well, the report talks in quite a lot of places about "we have heard" or "some people say" or "some people feel," whatever the words are, but it doesn't actually say it could have been me, it could have been you, it could have been anyone, and so it wasn't just specifically about any individual, but it was-- because the report's not specific in some areas about who said it. What we were trying to get to was as part of this whole process, there's been an awful lot of people

saying, not just the whistleblowers, a lot of people just generally, people who have said things but there hasn't been evidence or investigation or whatever to support what they've said. So, we were trying to get away from that "I said and he said", to what is the evidence? That's what that means.

Q Then you quote, and the paragraph begins, "It reads" a section that deals with, and we have seen evidence and this discussion of an issue in Infection Control, but then the bit that follows that, you say:

"We are of course unable to see this evidence, however the Review team should be made aware that in 2018 several members of the IPCT senior nursing team met with the Royal College of Nursing with concerns about the behaviour of one microbiologist in QEUH."

Now, why is that there? Is that not exactly the same as the thing Dr de Caestecker is doing?

A I think it's trying to-- So, in part of the whole general management process that we have in the Board and in all the teams, it's not just about one individual, whether it be the docs or the nurses or whatever, it was about the whole team. What we were trying to do was put this in the context of it's very difficult to operate in a professional and

sensible manner if people are feeling under pressure and so on. What we were trying to do is support the case note review team to actually understand the context within which this was operating because the nursing staff, particularly, had felt that they were under serious pressure from----

Q Who is your source for that information?

A The nurse director.

Q That would be Ms Devine?

A No, no, the Board's nurse director at that time was----

Q Right, because the reason I raised that is because we have explored in evidence this matter as it was raised in statements by Ms Devine and I also discussed it with Ms Pritchard and it seems to be in 2015. Were you aware of that?

A When they raised the issue?

Q Yes.

A No, I'm not aware of exactly but it was to Mags McGuire rather than to the people that you've displayed.

Q I can show you the email. It's bundle 27, volume 11, document 11, page 70. We took this with this, Pritchard. It's 27,11,11 70. It's a thread on 15-16 September '24 but the original email, if we keep going back to the bottom of this down to the next page. Next page. Do you see, here we are, 15

December 2015, to Lynn Pritchard from an IPC nurse:

"Christine Peters just phoned to ask that we advise the staff in ITU caring for patients with RSV to wear surgical masks."

Now, that's the issue that causes this incident that you refer to in your letter to Professor Stevens and what I'm putting to you is that you've misinformed Professor Stevens and you've raised an event which is years before the events of the CNR.

A So, my understanding – and I could be wrong – is that there were issues raised during the time that I was the chief exec about, so I----

Q You don't think it's this?

A I think this was probably part of it but it was part of the whole environment, shall I put it like that? That's probably the wrong word in this Inquiry but you know what I mean. But I do believe there was issues raised later than that.

Q How would you respond to the suggestion that putting this into your response to Professor Stevens has the effect of discouraging people to raise issues with people like the case notes review because if you raise issues, someone like the chief executive will write and set out your flaws in public.

A Yes, I think it's important,

though, for people to understand the context within which we're operating because no one has said it was, you know, it's not a person wasn't named or so on, it was just, I think it's important that people understand the context was incredibly difficult and the intensity of some of the dialogue was quite difficult and therefore, this is not all about----

Q No, indeed, and Dr Peters has discussed that in evidence and she's explained what she did and how it was dealt with at the time. What I wanted to do though is----

A Could I just----

Q Please continue.

THE CHAIR: Certainly, yes.

A I think it's important that when we come back to, this is about a team. So, it's not the – and you didn't say this, and I don't mean it the way it's going to sound – it's, you know, the docs and the nurses need to work, and other colleagues need to work as part of a team.

So, I think one of the characteristics of some of this is we need to respect the view of the Estates guys, or-- not in this case, but you know what I mean, or the nurses. The nurses actually are hugely important in this process. As part of the conversation with Penelope Redding, for example, there was some comments about, you know, they weren't doing their

job properly, or there was friction in the camp, shall we put it like that.

So, I think it's a bit about, "How do we actually look and see how we can respect the individual talents that people have and experience and so on?", rather than it's a kind of "them and us" and I don't think that's helpful. I think some of that was difficult during those periods. We all, whether you're the chief exec or anybody else, need to think about how to make sure you're getting the balanced view from a range of colleagues, rather than----

MR MACKINTOSH: Just one side?

A Yes, or just one person, or just one kind of cohort of people. I mean, in my time, as I described to you, when we were in, you know, when I was lower down in the organisation, it's really important that the docs, the nurse, the general manager or whatever level it's at, or your Estates colleagues or whatever, it's important that they have the opportunity to make a contribution and that it is listened to.

Q Well, can we look at bundle 14, volume 1, and it's within document 25, it's actually page 414. So, this is a letter which I'm sure you never saw. It's Dr Peters' letter resigning from her role as ICD sector for South, although Mr Walsh would want us to call it "demitting office".

Would you ever have been told that Dr Peters had been raising these issues as far back as 2015 when the SBAR and then the Stage 2 whistleblow were going on?

A Would I have been told that Dr Peters was raising them?

Q Yes. So, in '17/'18, when you're told about the SBAR and then the Stage 2 happens and you're discussing your concerns about the team dynamics and how everyone felt, did someone ever tell you – I presume Dr Armstrong, but it might have been Professor Jones – did someone ever tell you that Dr Peters has been raising the same issues since 2015?

A I think as part of the dialogue around the 27-Point-- the SBAR and so on, there was a discussion about, "When did some of these issues emerge? Were they dealt with? Had they been fully dealt with as opposed to a bit of them dealt with?" and so on. So, I don't recall the exact conversation but certainly as part of that 2017 discussion. It says, I think, in the Action Plan and in the SBAR that some of them have been raised for some time.

Q Okay. Let's go back to the Stage 2 whistleblow and then finish that off and move on. The final issue is the question of whether you urged Dr Redding not to whistleblow. Now, we

asked you about this in Question 35(b), it's on page 48. Then we asked you in further details 48(b) which actually is (inaudible 14:58:09) on page 50, so let's go to page 50.

You've given a long answer on whistleblow, we've taken that all on board, but let's look at this paragraph (b) question. Dr Redding has given evidence. She says:

"Staff were not encouraged to use the whistleblowing procedure. Prior to either the Stage 1 or the subsequent Stage 2 whistleblow (I cannot now recall which), I was urged not to whistleblow by Jane Grant. I recall her specifically saying to me that she 'urged' me not to do it."

We asked you whether you accepted that position. You said, in the next sentence:

"I received several emails from Dr Redding between November '17 and January '18 raising a number of issues."

Then you quoted from the emails of 24 November from Dr Redding and your reply on 29 November and then, on the next page, you describe what's in the rest of your email of 29 November through two paragraphs ending:

"I would urge you to continue to work with Dr Green, Professor Jones, as the Board's interim lead ICD or colleagues to seek an appropriate solution to these issues."

Now, first question is, is that statement that you've quoted, "I would urge you to continue to work with Dr Green," etc., in effectively an urge not to go to a Stage 2 whistleblow?

A No, absolutely not.

Q Why not?

A It was to try and-- because at this point we were-- so there's a lot of issues raised by clinical staff or all staff a lot of time. As part of that, it was nothing to do with-- that sentence was not about urging her to stop doing whistleblowing. If so, I would have said that. It was more about trying to work collectively with those colleagues to make sure we get a solution, so it was nothing about urging her not to whistleblow.

Q She responds, you say, on 30 November; she hasn't got these emails anymore:

"'I agree with what you are saying and I'm happy to follow your advice'. Her email also states, 'I am happy to comply with your request to wait'."

Now, why didn't you produce the emails to us? You just quote them.

A My apologies, I had assumed you already had them, so----

Q We don't.

A Certainly an oversight on my part. I'm sorry, I didn't realise.

Q Yes, I mean, because there

are further emails, you say, in January and December that you haven't, you know, you've said exist but you haven't provided.

A I didn't realise that, so my apologies.

Q Yes, well we don't have them. I'd be grateful if you could supply them. I can undertake-- we won't bundle them without redacting them first. Because the difficulty is without seeing them, we can't see the full context of what you said, can we?

A No, that's fine. I certainly agree with that.

Q Now, I need to put to you Dr Redding's conclusion, which I don't know whether we're going to be able to put this on the screen of her statement, but it's Dr Redding's statement from her hearing bundle, page 135, paragraph 212. I think I might just have to read it to you, it's quite short:

"During the whole process, there was no recognition or understanding of the stress experienced by the whistleblowers. We were treated as troublemakers throughout. I thought of giving up on several occasions."

How do you respond to that observation by Dr Redding?

A Yes, it's unfortunate that she felt that way but, certainly, we were trying to take on board her concerns as part of that whole process and there was significant effort made by a significant number of people within the Board to try and support her and to communicate with her.

Q She makes the observation that "we [by which she means the whistleblowers then] were treated as troublemakers throughout." How do you respond to the suggestion that the way that Dr Peters is discussed in the Stage 2 report is suggestive of the fact that people were treating them as troublemakers?

A I think I've described that in the sense of trying to understand the context of the overall situation. I can't really add anything more to that.

Q Do you see how, now reading the Stage 2 report, Dr Redding and Dr Peters might see that as an example of them being thought of as troublemakers?

A I guess they might not be-- I guess they might see that as being an issue, yes.

Q Yes. I wonder if I can turn to a report that emerged, I think just after you left, which is the-- I'm not going to take you to the report, I'll take you to the press statement that accompanies it. The HIS report into the A&E consultant's whistleblowing.

Now, the report is addressed in, on page 48 of your-- sorry, not page 48, my

page numbers are out. It's page 50 of your statement, the top of the page. We put to you-- page 50, sorry. We put to you the conclusion that there was:

"...a lack of compassionate, respectful and positive leadership at all levels of the organisation, especially in responding to concerns raised by staff."

Now, that isn't actually a quote from the report, Ms Grant. I need to put this in the record. That's actually a quote from the press statement that was issued on the website of Health Improvement Scotland and that's now, for completeness, in bundle 52, volume 7, document 50, page 450. I don't propose to go to it because we quoted it here. You respond:

"It is clearly of concern when issues such as those within the HIS report are raised. Considerable efforts were made to ensure staff felt supported but further work will require to be undertaken to address the concerns raised. Particular pressures exist in relation to Emergency departments across NHS Scotland and these pressures may need to be considered in a different manner to those elsewhere in the hospitals to ensure due attention is paid to the particular complexities of that area."

I wondered whether, looking at this report and what conclusions it reaches, whether the Inquiry would be entitled to see it as consistent with a view that the treatment of the whistleblowers that we've discussed in the Queen Elizabeth wasn't compassionate or respectful in a response to the concern raised by staff, that actually corroborates Dr Peters' and Dr Inkster's concern-- and Dr Redding's concern.

A So, I think in an organisation the size of Greater Glasgow and Clyde, there will be areas within the Board where-- I mean, each hospital has a kind of-- and even within that, wards and so on have different kind of pressures, different approaches they have. I mean, the emergency department pressures are quite different from those which are described in this Inquiry and the issues.

I think one of the things that I thought when I saw that was it was around how do we ensure that the voices of everyone is heard? Not just the docs; it's the nurses as well, and so on because within the ED departments, there were some concern from nursing staff about how some of their colleagues were operating. So, we were trying to manoeuvre or work our way through the difficult dynamics of some of those issues.

So, I think it's difficult to read across similarities. They are quite different, the circumstances, and in an organisation the size of Glasgow and Clyde, you will have

pockets of areas which we do need to work harder with.

The ED departments particularly have particular challenges because of the volume of patients coming, because of the fact that we need to treat people – as in, patients – within a particular time frame, and that there is a public expectation that they will be. Within some of these departments there's a variation of approaches to whether they think the time is appropriate or whether other things are more important.

Q Doesn't this ultimately end up at the door of the corporate management team because whether it's this particular HIS investigation concern or the concerns arising out the Queen Elizabeth, ultimately, when you get to Stage 2 of the whistleblowing process, it's on the desk of the medical director, the chief operating officer, the director of public health, because that's how the Health Board set it up. So, is it not the case that these cultural issues are set from the top down in a great degree?

A Yes, that's true but you don't have-- it's quite hard to have one culture in a board the size of Glasgow and Clyde. I mean, the issues in the Queen Elizabeth are quite different from those in Inverclyde and the whole atmosphere is quite different. I just use them as examples.

So, I think it is important, and the Corporate Management team made some significant efforts to address some of those issues. During a period of-- incredibly difficult period for the Board and-- we set out to do Investors in People, and I set that out and asked colleagues to do that when I first came back to Glasgow, in order to ensure that we had processes, structured processes, in place across the board to make sure that people at a local level were having the opportunity to contribute. I'm pleased to say, and I've said it in the statement, that actually, despite the COVID issues and despite all the other issues, we did manage to achieve that for the Acute sector during the period for which I was the chief exec.

So I think-- And there was also a lot of initiatives around Civility Saves Lives and so on, and I'm not saying that there's not more to do, but I think the Board can demonstrate that they made quite significant efforts and the Corporate Management team made quite significant efforts to deal-- to ensure that the environment-- that people were supported.

Q So, I suppose to wrap this topic up, how would you respond to the suggestion that, if we effectively have two examples in different contexts of whistleblowers feeling they weren't heard

– one in Queen Elizabeth arising out of infection control and one in the A&E department arising out of different factual circumstances – if both of them feel that the organisation is not listening and responding, does that not raise the question about if the organisation is responding well and encouraging whistleblowing?

A So, I think in all of these situations that the key thing is to look at what has emerged and to actually move forward in terms of making sure that the issues that have been raised are being addressed and that we redouble our efforts to ensure that people are supported.

Q You've mentioned moving forward a few times, and you obviously think it's important. How can you move forward from a situation if you don't know how you got to be in the place you're in?

A Well, we know what the situation is at the moment, in any situation, and therefore-- and what the issues are that are of concern to people, and therefore what do the facts say to support that – of the current situation – and therefore how do we address our efforts in terms of going forward, to ensure that the issues that are being raised and the outcomes – which is really quite important here – and the impact is being acknowledged and addressed?

Q But I think, to wrap up this section, if-- In fact, I'll probably wrap it up by reference to an observation by Professor Cuddihy. He tells us in his statement, paragraph 278, that he said this to you and Professor Brown – and no need to put it on the screen – that, in a sense, if you can't withstand scrutiny internally, how can you withstand it externally? So, would you accept that there was an issue with understanding internal scrutiny in the Health Board arising out the Queen Elizabeth incident?

A With accepting internal scrutiny?

Q Yes.

A Could you just clarify what you mean by that?

Q So, effectively, the point I think he might be making is that when there were people who were raising issues internally----

A Yeah.

Q -- from 2015, 2017, and through – we'll get to the rest – to 2019, the Health Board wasn't good at listening to those criticisms if they were not, in a sense, something that people wanted to hear – that you weren't good at listening, as an organisation, to criticisms by whistleblowers in that period from '15 onwards.

A So, I think there was a process whereby issues that were raised through

the whistleblowing process – and I think I've said it in my statement – those-- the actions that were required to be taken from them-- there was a process in the Board to ensure that those actions were addressed, and when you go to the whistleblowing report that-- The chair commissioned a review of the whistleblowing process.

Q From Mr Vincent?

A Yes, and from a retired HR director, so it was both of them. They looked at that, and there were some recommendations from that to improve the situation, and we dealt with them and we have embedded them into the organisation. The whistleblowing champion, in this case Mr Vincent but it's now someone else, has got that external scrutiny as well to make sure that issues are getting dealt with.

During my time, at the beginning of this, the whistleblowing champion was a different person, and they did raise with me some issues, you know, that if things-- if things weren't getting done – nothing to do with this Inquiry – then why were they not progressing? So there is some-- So, it's not just a case of not actioning things that come from whistleblowing. There was a review done which was commissioned by the chair and was visible through the Board Committees. There were recommendations from that,

and they were dealt with, and as part of that there was discussion, as I recall, with the people who had whistleblown – or blew, whatever – to actually see their view of the world.

So the Board was trying hard to actually deal with some of those issues and, as I say, within that-- There's not a huge amount of whistleblowing, but there are some, and you've picked out two of them, but there are, you know, a number of others.

Q This whistleblowing review, did it speak to all the Stage 3 whistleblowers? There were two of them. Did it speak to both of them?

A I don't remember exactly the ins and outs of it. I don't.

Q If it didn't speak to one of them, what would that say about the Board's attitude to learning about whistleblowing? If it only spoke to one of the two Stage 3 whistleblowers in that review?

A Well, I think it spoke to-- I-- I don't know exactly who it spoke to, but it certainly spoke to a number of whistleblowers.

Q Let's move on to the water incident. So, you deal with this on page 55 of your statement, and you refer in your answer to a briefing note that was prepared for you by the medical director, and that is bundle 27, volume 8,

document 13, page 69, and it's on 15 March 2018. Page 69, with a bit of luck. Next page. Thank you. Now, firstly, it appears to have come from Mary Anne Kane. Was she the interim director of estates?

A She was, yes.

Q She was. Right. She'd just taken over from Mr Loudon?

A She was on an interim position for a few months in 2018.

Q Yes. So, if we look at this report-- I'm not going to go into it in great detail. I just want to really just check in with you about whether, at this point in March – so it's early in the water incident – you understood this to be a local incident to Ward 2A or a wider issue across the Children's Hospital, or even wider than that?

A I think there was a high degree of uncertainty about what was actually going on, whether it was a water at all or whether it was-- But, at that point, I recall that we thought it was around 2A.

Q Yes. Were you told about the request for support from Health Protection Scotland and Health Facility Scotland on 16 March 2018?

A I probably was. I probably was, but I can't-- I'm sorry.

Q I mean, there's a minute of a teleconference at bundle 14, volume 2, page 107, and I'll show it to you because it gives you the names of who was involved. That might help. 107. So, if we just look at the top of the page, we see Professor Steele is involved, Mr Hoffman has become involved on the phone call, and then we see Annette Rankin from HPS and Claire Cameron from HPS and Jim McMenamin from HPS. So there's a good turnout. What I wondered was to what extent you would have been aware that help had been requested from HPS and HFS for the water incident.

A Yeah, I probably was.

Q I mean, you might have answered this already, but just to keep it in context, why is help requested now on water in March 2018 when it wasn't requested the previous year on ventilation?

A Because at this point there had been issue-- There was a perception that-- There had been patients who had been-- who were part of an IMT to actually move----

Q Right. So, because there were infections that's what-- part of the reason?

A Yes.

Q Right.

A Yes, and we were very clear, and we were very concerned about what were the issues and how could we deal with them as soon as we could. So it was

really, really important that if there were colleagues with expertise that we didn't have, were we taking on board the issues that they would suggest were hugely important? So that's why there was an early engagement with those colleagues.

Q What I want to do is just move on to the Water Technical Group. Now, this first met on 6 April, and we can just see its membership – bundle 10, document 1, page 5. I just wonder whether you were aware of the water-- It was rather unhelpfully sometimes called the "Water Review Meeting" and sometimes the "Water Technical Meeting", and of course you held a later Water Review Meeting in September. So, this is the Mary Anne Kane Water Technical Group, if we can call it that. Were you aware that this had been set up and was beginning to work?

A I think I was, yes. I think I was.

Q Yes. Because if we look at the minutes of the second and third meeting and we go to page 9 of this bundle.

THE CHAIR: Just give me the bundle number again.

MR MACKINTOSH: Sorry, my Lord. Bundle 10. We're going to documents 2 and 3. (To the witness) So, this is a meeting on 13 April. It's the second meeting of what becomes the Water Technical Group. If we go on to the next page, page 10, and do you see in the middle of the page, just above POUF:

"It was noted that every floor had positive and negative readings thereby this would indicate a widespread water infection."

Although this seems to be just outlet testing at this point. Then if we go on to page 14, which is the next meeting, bottom of the page:

"Way Forward

Every floor is showing some contamination with various species so we can assume there is a widespread contamination in the buildings. A review of the commissioning data indicates there was TVC [total viable counts] which were off the scale but now we need to determine the way forward and solution to the contamination."

What I'm wondering is: to what extent were you briefed in April 2018 about these sorts of conclusions?

A Yeah, I think it was-- it was-- At that point we weren't entirely sure what was happening, and there was a huge amount of work going on to see what was happening and where the issues had come. So, I wouldn't have been involved in the detail of every single bit, but I certainly would have been briefed on the-- some of the issues that were emerging.

Q Or the scale of it? Would that be fair?

A Probably. I don't recall, but probably.

Q Because at Question 38 – so that's back to your statement, page 55 – we asked you about the Water Incident Debrief meeting and, perhaps more importantly, the Full Incident Management team report. So we see at Question 38, halfway down the page, we ask you about two documents, and your response is:

"I was briefed by the medical director issues being considered. I recall being told there was learning identified over a range of issues and that colleagues were committed to ensuring that any learning was addressed.

"[And then] During May/June 2018, HPS were working with NHSGGC and there had been no new cases since April. As the Framework had been revoked, NHSGGC no longer had the lead role and were working closely with colleagues in HPS and [over the page] and the Policy Unit of the Scottish Government."

Now, you were in Stage 2, at this point, of the escalation?

A Yes.

Q Is it fair to say that during Stage 1, 2 and 3, and indeed 4, the Health Board still is responsible for its own actions?

A Yes, but in a different way at Level 4.

Q But at Level 2 it wouldn't-- I mean, is it fair to say that GGC no longer had the lead role?

A It should probably say "no longer had the exclusive lead role", if you know what I mean.

Q Right.

A That should probably-- Whatever the words are, if you know what I mean. The single lead role.

Q So, I realise that we're only a matter of weeks before the DMA Canyon report arrives with Professor Steele at your office.

A Yes.

Q But, at this point, is this a point where the chief executive should think, "I need to step in. Things aren't working properly, because we now have learnt there are problems of some seriousness with the water system and we learned last year there were problems with the ventilation system"?

A So, I think the problems with the water were more-- more acute in the sense of we had patients who had infections. So I think the situation is different.

Q I understand that, but if you add the two together, does that not tend to suggest that there is something to investigate about the way the hospital has been run for the last few years?

A I think we were more trying to

look at how-- you're not going to like this, but how to move forward and how to, you know, address the issues that had emerged, rather than seeing as part of that-- I mean, when we were in March '18 and so on, in that '18 period, we were really trying hard to get to grips with what had happened, and we weren't entirely sure what was actually causing this. I mean, the hypothesis from the IMT was this, but it wasn't-- because the tasks that were getting done were actually not leading to the desired outcome. So we were completely focused on trying to address those issues because of the impact on the patients.

Q Did you still have confidence in the people who were doing the investigation? So the interim director of Estates, the medical director, the chief operating officer, Dr Inkster – those people. Did you have confidence they had it under control?

A I think within infection control issues-- I mean, over my experience of many years, then quite often there isn't a single-- You know, it's not a case of if-- "That has been identified. That's the issue, and if you do X, then that'll be fixed." That's not my experience of how infection control works in a lot of areas and a lot of times.

So, I believed that they were doing everything they could to look at what the

data was telling them what the issues were. We had involved HPS and HFS, as you say. We were Involving Public Health and some of the colleagues within that, and we were trying to deal with what was emerging. So I think the complete focus was on trying to address those things through the normal processes of IMT.

Q But given – I mean, I come back to this again, and I suspect we'll get the same answer, but I appreciate why – that in the autumn of that year, you and Professor Steele will start the investigation that leads to the AECOM report and a greater understanding of what happened, did you have any thought at this point in the spring of setting somebody to do something like Mr Leiper's investigation on water and ventilation, actually find out what's going on with the building?

A I think we were more focused on trying to deal with the issues that were emerging from the IMT.

Q Now, if we go to the-- I'm going to ask you a question that will sound as if it's a technical question, but it's deliberately-- I'm not being technical. It's about use of language. So, we've just looked at the Water Technical Group, which has used the word "contamination" quite frequently, about what they found, and if we look at the HPS May 2018

Report, Annette Rankin's report, bundle 7, document 11, page 3, and that's from 31 May 2018, and then we go to page 10, and you look at the "Hypothesis", and it's concluding that they think the "cause of the widespread contamination", middle of the page:

"… is a combination of hypothesis B [regressional contamination] and C [contamination at installation/ commissioning]."

Now, what I want to understand here is use of language. In 2018, the Water Technical Group of Health Board employees, HPS, HFS, and this report by HPS seemed happy to describe what was then being found as "contamination", widespread or otherwise. What's wrong with using that word to describe what they were seeing?

A It's up to them how they would describe it in that sense.

Q Yes, but now, when we talk about this issue, there's a view advanced that we shouldn't call it contamination because contamination is limited to things that are foreign to a water supply. So, if there's something like building waste, that's contamination, something like fecal waste, that's contamination, but something that you get there in small quantities isn't contamination. We get into a semantic debate.

Given that you were chief executive of the Health Board until January, have you got any issue with us discussing what was found in 2018 by use of the word "contamination", using your own staff as the source of that description?

A I think-- I mean, things are-- have moved on quite a lot since then and, as part of that, there was a view at that time that there was contamination – whatever the word is – and I think things have moved on quite a lot with some of the reports and so on, and what-- I mean, there has been-- and I've been around this with my team a few times, you know, that water supply is never sterile. It's never sterile and, therefore, what are the things that we should be looking at, and what are the normal things that should be monitored, and what are the things that now, in hindsight, going forward, might be monitored in a different way? So, at that time, that was the view of HPS, and-- and I think the other thing is----

Q Was it also the view of Greater Glasgow and Clyde Health Board?

A It was the view that that was likely one of the hypotheses, yes, and also I think it's important to recognise that within the Infection Control Manual the IMT has-- has a degree of autonomy itself, and----

Q I'm not looking at the IMT. I'm looking at the Water Technical Group.

A Oh, right. Sorry, my apologies.

Q So the Water Technical Group are the people who describe it as "contamination".

A Yes.

Q That's your staff.

A Yes.

Q Your interim director of Estates. Does that not mean that's where it ends? We can use that phrase without being criticised?

A We were certainly trying to-- and that was the view at that time.

Q Right, and you think it somehow changed?

A I think things have moved on and there are other issues that need to be considered now.

Q So, admittedly from a high-level position, what's your understanding of whether there was widespread contamination in the water system in 2018 in the spring?

A I think there were issues with the water system, and I think the issue is: what impact did they have on patients? Was it a-- a routine level of issues, or were there other things, and I think it's a---

Q Just to check, you think that it's possible that the amount of contamination in that water system was routine?

A No, no, I'm saying that, as part of that-- I can't remember the question you asked me, so----

Q So, the question is: are you accepting or disagreeing with the idea that in April 2018 there was widespread contamination in the water system of the Queen Elizabeth? Do you accept that, or do you say there's some evidence that suggests the contrary?

A So, certainly at that time, the view was that there was contamination in the system.

Q Yes, I understand that, but what's your view now?

A I think it's less clear now about what contamination there was, but I do think there was something in the-- and we've-- we wouldn't have spent the amount of money we have and the amount of effort and so on to try and deal with that if we hadn't thought there was contamination in the system----

Q Yes, because, I mean, putting aside the impact of whether the infections were unusual/usual, high/low, putting that to one side, just focusing on whether the water itself-- how we describe the water system, your staff described it as "widespread contamination" in 2018. Are you now saying that we shouldn't use that phrase?

A No, I didn't say that. You suggested that.

Q Okay. Let's look at how these events were reported to the Board.

Sorry, my Lord.

THE CHAIR: Ms Grant, did I note you correctly as saying, "I do think there was something," or did I not note you correctly?

A Yes, we thought at that time there was issues, and that's why we put on the point of use filters and we put on the chlorine dioxide dosing and so on, and we did think there was issues there, and that's why we spent money on doing those things and trying to do-- It's really important to think, you know, that everything that was raised we tried to deal with.

So, we-- if the hypothesis was "X in the water" and we saw infections in children, then we didn't wait to think about whether that was the-- you know, whether the hypothesis would change, whatever. We actually took action right away to try and deal with the things that were emerging, very quickly.

MR MACKINTOSH: I wonder if we can go to page 56 of your questionnaire, which is Question 39. We asked you-- Well, we asked you two questions, but you've answered the second one. That's the one I'm interested in. "How were the Board kept up to date as this incident progressed?" and you said:

"Regular updates were given to the appropriate sub-committees of the NHS Board and to the Board itself. The issues were reported to the CCGC in December 2017, March 2019 and June 2021."

I'm confused as to how CCGC could receive a report in December '17 about the water incident that started in March 2018. Could that be a mistake?

A Yeah, probably. I'd need to go and look at that, but it probably was----

Q Because what I found was a report to CCGC on 12 June 2018, and I wonder if we can go and look at that. That would make sense, I suppose, in terms of the report from Dr Inkster has come in, the report from Ms Rankin has come in, the Water Technical Group has met. Bundle 38, document 7, page 44. Yes, page 44.

Now, on this occasion, sometimes-- Yes, page 44. So, there's a meeting on 12 June, and we notice that Dr Inkster is present, along with Ms Kane for Item 8, which is the one we're going to look at. If we go to page 47, it's described as the "Review of Water Incident at QEUH" and there is a minuted report of Dr Inkster's involvement. Now, we don't have a copy-- at least I can't find – I may end up looking very silly if my colleagues tell me about it in the next half hour – the written report, but it does rather read from this as it might have been a verbal report from Dr Inkster.

Again, going back to the reporting process to the Board, this minute doesn't

say that the hypothesis at that point from HPS and from the IMT and the Water Technical Group was of contamination, either during installation or regressional contamination. So, I'm wondering, is this the only way that this incident was being reported to the Board itself, i.e. in a draft minute, as this one's never actually been approved, a draft minute of the Clinical and Care Governance Committee?

A So, the minute-- I'm just reading this, sorry, as you're speaking----

Q Of course.

A The minute says that there was a widespread problem, right?

Q Yes, it does.

A And then it also talks later down about significant contamination.

Q But it doesn't talk about the cause. But, even if it does, is this the only the report to the Board in that late summer/spring period?

A So, to the Board itself, then quite-- quite often what happened-- and I wouldn't-- someone would need to check this, that Board seminars were used to update on what was happening. So, therefore, there might have been----

Q There might have been a board seminar?

A Well, the beginning of a board seminar might have described some-- it would have described some of the issues that were going on, and then quite often as well the chair asked for an update to be sent round Board members of what was-- If there were things that were coming that were of importance, he asked for a note to be sent round Board members, as well as the debate at the Clinical and Care Governance Committee, which is where the larger discussion would take place.

Q What I'm just wanting to be clear is that, at this point, of course, there was considerable public disquiet around these events, it's fair to say.

A Yes.

Q I think there's an observation that's been made by a number of the families that they weren't seeing reports of this issue in the main Board papers. Now, they may have been coming up through this route or through seminars, but would you accept that part of the sort of public accountability of a health board is to show that you are taking an interest in something, as opposed to just taking an interest in it and acting?

A So, I think that minute describes-- and I appreciate it's at the Clinical and Care Governance Committee as opposed to the Board, that the Board-- "the Board" is not the right term, that the organisation was taking this incredibly seriously and that we were really trying hard to do that. And, as I say, the whole point of having discussion at the Clinical

and Care Governance Committee is to make sure there is enough time, because the Board has not got much time-- you know, there's a lot of issues at the Board, and that these issues were fully discussed at the Clinical and Care Governance Committee where there could be quite a lot of detailed scrutiny, and that minute, I think, shows that the-- at least the breadth or the amount of discussion there was at the meeting, because in the Board itself it wasn't really easy to do that because of the volume of business.

Q I mean, I appreciate that this is a trite point that I'm about to make, but is there an issue about Greater Glasgow and Clyde Health Board being just too large to deal with these issues?

A I think there is a-- there is a structured-- a delegated approach, which I've tried to say this today, perhaps not as well as I might.

Q You have, I think, very successfully explained the delegated process and the structure, but I'm just wondering whether-- A lot of your answers are that, "There was lots going on. It's a big health board. There were many, many issues. We were trying to deal with it. We were trying to move forward," and what I'm suggesting is that might it be that part of the weaknesses-- a weakness is that this Health Board is so

large, actually, it hasn't got time to deal with, to some extent, crises that emerge in a way that, with hindsight, one might hope they would be dealt with – the Board, not the institution.

A Yeah. I think you need to be clear about what your expectation of a "board" board is, as opposed to a-- you know, those-- I don't remember the number in Greater Glasgow and Clyde, but say 30 people for the purpose of this.

Q Yes.

A That's the "board" board. I mean, there are-- in all boards, and when I was in Forth Valley it was a much smaller board, but you have a range of experience, a range of approaches to things, and I think the approach that's been adopted in Glasgow and Clyde to try and-- to try and address what you've said is that, you know, the-- quite a lot of the detailed discussion goes on at committee level, I think has been quite successful.

And certainly it's not-- You don't go to these committees and the non-execs to just accept what you say. There's quite a lot of challenge, and it might not look like that from the minute and so on, but there's certainly quite a lot of challenge, quite a lot of issues that the Board members are not content with, you know, on occasions, and quite a serious expectation on the executives that they

would deal with things that have been raised by the non-executives, and, as I've said somewhere in all this, those points are put on to a rolling action list or whatever and the chair of the sub-committee ensures that they're done, and if they're not done to their satisfaction, then they request further work.

Q I want to move on to the emergence of the DMA Canyon L8 risk assessments but, before I do that, I've been asked to ask a couple of questions about the Ward 4B works that took place, resulting in it reopening in the summer of 2018. What awareness did you have of the nature and the extent of the works that were being carried out for 4B?

A I would have had an awareness of the generality of it, but it depends what you mean. Did I have----

Q Did you know that what was being done would not actually bring it up to the standards set out in SHTM 03-01?

A No, I don't think I would have known that level of detail.

Q It's just that one of the striking things is that there's an options paper to Acute Services Committee which looks at various things. We've looked at an early draft of it, and one of the options is to go into the old space, 4B, where it was always going to be, and as a consequence it can't achieve 10 air changes.

A Yes.

Q It only achieved 6.

A Yeah.

Q As a consequence, the corridor is not HEPA filtered. Now, you can get into a debate about whether that's important, but is it not slightly troubling that the chief executive wouldn't have been aware of that reality?

A I think the difficulty I have in some of this is I just really can't remember what you're asking me, and I appreciate that and I really don't want to look as if I'm not-- But I knew that the ventilation, as I've described before, would have difficulty in complying with the SHTMs because of some of the issues we've discussed.

Q That being the building was designed for something less----

A Yes, and what were the options to try and move forward? And there was judgment made by colleagues about how to-- how we could improve the situation as best we could, and also what the impact on patients would be, and were there are any increased infections or were there are any issues around that that we would have to take?

Q So, effectively, there's been a balanced judgment made by colleagues, possibly before you arrived, if I understand your evidence correctly, and you effectively think, "Well, that's been

done. That's good. They can do it"?

A Yes, and colleagues would have given me that advice, so the people who understand these things better than I would have given me that advice to say, you know, "This is acceptable," or, "No, it's not."

Q Thank you. Let's go back to 2018 and the DMA Canyon report. You've explained how they came to your attention in Questions 40 and 41, so that starts on page 56. I won't go over Question 40 on page 36, how you heard about that, "I heard about it in some detail from Professor Steele," but we've got your version of events there. What was your reaction when you learned of these reports?

A Yeah, I was quite shocked, is probably the word, and anxious that those things were in the reports and they hadn't been addressed.

Q Why were you shocked?

A Because the reports said that some things had been raised in 2015 and hadn't been dealt with, and that the second report, which I think we got-- although it's dated '17, I think it was earlier in '18 that it appeared----

Q Yes.

A -- that some of the things that had been there before were not----

Q Had not been addressed?

A Some of them had, but some

of them had not.

Q I'm sorry to sort of press on this, but why is it shocking that that wasn't dealt with?

A Because there was a report which was generated by an external company at that time, and all of the issues hadn't been fully dealt with.

Q So you----

A And we were in the middle of a water situation.

Q Right, I understand.

A So, as part of that-- So we have a water situation which is impacting on patients – and that was the hypothesis at that time – and we have a report which says these things need to be done and-- or there was issues that had-- and I was concerned about that.

Q Did you see any connection between what you've been told about the conclusions of HPS and the Water Technical Group and the IMT about the water incident and the DMA Canyon report?

A Well, I didn't map across all the issues, but what I did was say, "Right, well, if those are the things that DMA Canyon, who have the expertise on this area, say that are important to this, then we must make sure they're all done as soon as we can."

Q You mentioned on the next page, page 57, that you asked Mr Leiper

to assess the reports and why they hadn't been made available.

A Yes.

Q What I want to do is to look at one of the conclusions of them. So, if we go to bundle 6 and we go to the reports, which-- They're actually broken up into documents 34 to 40, but we'll go to page 150. (After a pause) I've gone the wrong place, sorry. (After a pause) Might be a different bundle. Yes, it's bundle 8, sorry, at document 34, if we go to page 150. (After a pause) If we look on page 152, we have the high-level findings. Do you see at (2.7) one of the inclusions is "Operational Preparedness and Readiness at Handover"? I appreciate that is at handover in 2015 when you weren't here:

"The Board's Estates team was relatively small and inexperienced. Despite their huge effort, it is clear they were overwhelmed by the wave of demand. They worked extremely long hours over a protracted period of time and their overall contribution to sustaining the functionality of the hospital should not be underestimated…"

Do you accept that one of the sort of broad conclusions from Mr Leiper is something to do with resource levels for Estates?

A Certainly, due to the amount of-- I think I described them as "snagging" before, but they might not be-- that mightn't be appropriate. The volume of work that had to be addressed by the Estates team was difficult in that period after handover.

Q And they may not have had sufficient resources at the time?

A It's hard to say whether they did or not, but they certainly had a huge amount of work that they weren't anticipating. So, if it had been a steady state, that's a different thing from where they found themselves.

Q Okay. Now, if we go back to your statement and we go to Question 42 – so, that's page 57 – the question's at the bottom of the page:

"How were the Board kept informed of the developments in respect of these DMA Canyon... Reports and what mechanisms, if any were in place to update the Board in respect of the progress being made addressing the recommendations... and of the Authorising Engineer (Water)?"

And you say:

"Following receipt of the reports, I spoke to the Medical Director and made her aware of their existence. She, in turn, ensured they were brought to the attention of the infection control team [over the page, page 58, please], including the ICD. On 3 July 2018, the NHS Board was updated at a board

seminar on the position regarding these reports. An action plan was drafted and colleagues within Estates and Facilities addressed the outstanding issues as a matter of urgency."

Now, if we go to bundle 27, volume 8, document 7.1, we're going to look the Board seminar at page 57. That's the review-- the brief of the, "Review of the commissioning and maintenance of Water Systems". I'm assuming that's effectively the background paper for the Board seminar?

A I'm assuming so.

Q Yes, and if we look at the present----

A And there was a presentation as well.

Q If we look at the presentation on the next page, on page 58, we have a presentation by Dr Armstrong. Do you remember the presentation of Dr Armstrong?

A I remember the fact that there was one, but I don't remember the detail, no. I mean, I've read it since then, but----

Q Yes. I mean, at the point of the seminar, had you read parts of the DMA Canyon report?

A The DMA Canyon report was pretty technical----

Q It's a pretty big document.

A I beg your pardon?

Q It's a pretty big document.

A Yeah, and it's also got a lot of things in it that I'm not qualified to say whether they're right or wrong. What I was concerned about was the amount of things that they had identified as needing done.

Q But you'd read it at the time to see what they were to be concerned?

A I mean, I didn't read it, but I certainly had familiarised myself with the content.

Q Yes, exactly, because it was Dr Armstrong's evidence that she actually hadn't read it before she made this presentation. Were you aware of that?

A It probably wasn't her who-- I don't know the answer to that, but----

Q Well, but were you aware that she hadn't read it?

A I don't think so, no.

Q Okay.

A But, in terms of the presentation, Jennifer would have been-- or, sorry, Dr Armstrong would have been the person who was presenting this, I assume, around the issues because of the infection control issues at that time, but it wouldn't be reasonable to expect her to know the ins and outs of the data. That's not-- It would be the technical Estates----

Q But you reviewed it sufficient to be worried.

A Aye, at a level. So, in terms of

the issues within it, you know, I think it's reasonable that she would expect that the Estates people would have looked at the importance of some of those issues. Because, when I read it, I wasn't sure what was the really big ticket issues and what weren't. I mean, you could see which ones weren't-- "compliant" is the wrong word but you know what I mean. So----

Q You can see the ones that were flagged red in the risk register?

A Yes, but apart from that it's-- I think her expectation would have been that the Estates guys would have done that, and I think that is how it would normally work.

Q Does the-- Obviously, Mr Leiper wrote his report and focused on the actions of the Estates people who received the report, what they did and didn't do.

A Yes.

Q Do you see any issues about the work of the Water Safety Group and what it was doing, in the sense that it was not aware that there wasn't an appointed person or an authorising engineer, that it wasn't aware there needed to be a risk assessment for a new building? Did you consider that to be an issue?

A So, I'm not sure if they weren't aware or it just hadn't been done, if you know what I mean, because within the

Board area, those issues-- those things had been dealt with in other----

Q Yes, they had been in other places.

A So I'm not sure whether the group that you're referring to assumed that it was in place because of the fact that it was in place in the other parts of the Board, if you know what I mean, so----

Q Why would you be entitled to assume that a new hospital has a fully set up team of authorised person, authorising engineer?

A Because I assume they would read over from those who had been there in the old Southern General or wherever.

Q Is that not quite a big assumption, Ms Grant? It's a new hospital. It's 700 and whatever million pounds, 1300 rooms. Should there not be some thought at the Board Water Safety Group level that, "We need to proactively make sure this system is set up right to start off with"?

A I think that the Water Safety Group should have assured themselves of that, yes, I agree with that, but I also think that the Estates and Facilities colleagues should have made sure that the arrangements were in place.

Q No doubt that's the case. Right. If we think back to the water incident, so we step away from DMA

Canyon for a moment, the water incident started in March. In May, people thought it was over, but sadly it wasn't. Who in the Board was taking control of its response to the water incident in the Schiehallion unit in 2018? What bit of the Board structure was in charge?

A Sorry, could you repeat that question? My apologies.

Q So, what bit of the Board structure – person, committee, team – was in charge of the Board's response in the water incident from March through to decant?

A The IMT was in the driving seat of the issues.

Q What was the extent of the IMT's authority?

A So, they are-- It's not-- It's not absolutely clear cut in the sense of it-- I mean, you've talked about-- in my-- about the decanting. If there had been a basic bog standard decanting, then those things happen all the time and you wouldn't expect, you know, senior, senior colleagues to be involved in that, but in some instances, where there's a bigger impact or there's more significant issues, then they were. So they had authority to do a lot of things----

Q Yes.

A -- but if-- there were some senior managers on those IMTs as well and they-- their job would have been to highlight any that had significant implications. And the chair of the IMT's role is quite pivotal in this and making sure that they are clear to their line management that these are the issues.

Q I mean, would you accept there's more to the water incident than the investigation and the work of the IMT? There was more more bits of team-- There were other institutions, bits of the structure, working on the issue?

A Yes.

Q Yes. So, there was a Water Technical Group.

A Yes.

Q And I think there was a communication subgroup.

A Yes, and there was-- and the local team, the local management team as well would have been involved.

Q Yes, and the manager in Schiehallion. Would the Corporate Management team have had discussions about this incident as the summer went on?

A Yeah, they would have.

Q Yes, and would the Clinical Care and Governance Committee be the right people to be in charge of this sort of thing?

A So, the Clinical Care and Governance team are an Assurance Committee.

Q Yes.

A So----

Q They're not in charge in that sense. They're not executive.

A I mean, they hold-- they can't do it if they're holding me to account, if you know what I mean.

Q I understand.

A So they have to be content or otherwise with the actions----

Q Because----

A -- that are in place as opposed to doing it. They wouldn't do it.

Q What about the Board Infection Control Committee? Could they have been in charge?

A No, they weren't in charge. It was more the IMT. It was more the IM----

Q Right, because----

A I mean, they also can commission bits of work, and if they're concerned, they would ask for additional things, but it would generally be through that more operational----

Q What I want to do is look at your answer to Question 43, so that's on page 59 of the statement bundle. In fact, we probably ought to start a little bit further back on the previous page at (b):

"Dr Inkster has given evidence that as Lead ICD and Chair of Water Incident IMT that... she proposed the establishment of an 'Executive Control Group' to provide director-level oversight..."

Now, I'm going to come back to that, so I'll ask you just to park that for a moment. Then we mention for the first time the Water Review Group, which you discuss in your next question, because this question is a supplementary question. So, if we go over the page, you say:

"... my understanding is that a Water Review Group was established to ensure that all aspects of the issues that had been raised were being addressed. This group was chaired by the chief operating officer and met during 2018 to ensure actions were being progressed."

Was it effectively the Water Review Group, the higher level executive group, was dealing with the Board's response to the water incident?

A My recollection is it was principally around trying to make sure that there was progress on the recommendations within the DMA reports and, therefore, their implications for the situation, rather than taking charge. They didn't, I don't think, take charge of the-- as you've described.

Q Because we then asked you to whom the Water Review Group reported at (c), and you said:

"[It was] a short life working group to ensure progress... I do not recall whether there was a formal reporting mechanism although progress was discussed with

key Directors and myself."

Now, to go back to the issue Dr Inkster raised – that's the previous page, page 58 – she had discussed proposing – perhaps they're not assisting with proposals, what with all the events that were going on – the establishment of an, "'Executive Control Group' to provide director-level oversight of the incident." Was there any discussion of such a group in 2018, or is the Water Review Group effectively a somewhat more informal equivalent of it?

A I'm not entirely certain, to be honest----

Q Because the point that I think Dr Inkster makes is that – and to be fair, the Inquiry's experts make a similar point – there is some value in having a single meeting that makes the key decisions around something as important as this water incident.

A Yes.

Q How would you respond to that as an observation?

A I think we were relying on the IMT to do that and to progress the issues. I think we were.

Q I mean, you later, with the Oversight Board, had the Gold Command Group.

A Yes.

Q Do you see-- Wouldn't it have been better to have a Gold Command

Group and then the IMT is the Silver Command Group, if I understand the difference between the two?

A Yeah, one of the challenges in all this is that the Infection Control Manual describes the fact that IMTs need to have a degree of autonomy, if I could call it that, and there is always a challenge between at what point do you step in and what-- how do you----

Q Yes.

A Because they should have the experts to deal with the issue, and if you step in, then there is always the assertion perhaps that you're trying to take over the situation, where in the IMT you have the experts who should make the recommendations on anything of substance, and then we should take the recommendations as opposed to-- if you understand what I mean.

Q Well, I mean, that's why I'm wondering whether one way to manage such a fear or anxiety would be to have a clear structure so that the IMT knows that its recommendations will be taken to the Gold Command Group----

A Mm-hmm.

Q -- the Executive Group.

A I think one of the things that we do need to reflect on as we go forward is when there is a protracted issue----

Q Yes.

A -- if I can call it that, then at what point do you-- and I've thought about this quite a lot since all these things have happened. At what point does it have to switch from that normal, if I could call it that, IMT process to something quite different? And I think the answer to that-- and I think-- I haven't bottomed that out, but it does need to be.

Q Well, I mean, I suppose that gives me three options to put to you. One option is that you do it the way you did it. So you have an IMT which attempts to make decisions semi-independently throughout the incident and, in fact, stops in the autumn of '18.

A Yes.

Q And one of those decisions is to decant the Schiehallion unit, which is a big decision.

A Yes.

Q **T**he other option is you still have the IMT doing its work, but it and the Water Technical Group and the Communications Group are feeding into an Executive Control Group, a Gold Command Group, which has got probably-- it might have you, it might have the chief operating officer, senior people of the Board, including someone who knows about infection control, who can make sure that all the support that is needed for the IMT is provided and take responsibility for the really big decisions.

A Mm. But the role of the chair of the IMT is to do that with support from the other people who are at the meeting. I think hindsight is a great thing, and I've spent a lot of my time, you know, thinking about, "Well, how-- you know, what else could have been done? What should have been done?" etc., and I think the IMT chair has the ability to seek resource or to do whatever and also reports generally, if it's the lead ICD, to-- through Jennifer Armstrong. So they have got a conduit to senior people in the Board pretty quickly.

Q Well, they've also got senior people of Board on their meetings, haven't they?

A They have, yes. So, therefore, that group in itself now, on some occasions, it might have been a bit unwieldy and too many people----

Q So why were people like deputy medical directors and director of Estates turning up at IMTs?

A Because of the seriousness of the issue.

Q So, I'm wondering----

A In some ways-- In some ways on this one, we'd be criticised if we didn't put those senior people on because, "You're taking this seriously," and on the other hand, "Why did you put them on because then you're curtailing the"----

Q Well, no, I understand that.

A -- "independence?" So you're kind of between a rock and a hard place there, frankly.

Q So, obviously, I won't get to it today. Tomorrow, we will get to what happens in 2019, where I think tensions do get rather high.

A Yes.

Q I'm just wondering if, looking at the benefit of hindsight, might it have been better for the management of this whole incident, this reaction to concerns about the Schiehallion unit, if at some point in the late spring/early summer you had put in some sort of structure to effectively make it clear that, when it came to a really big decision, you, the Executive team, were standing ready to make a decision, and then leave the IMT to get on with doing the job it was doing and producing its recommendations?

A But I think the IMT did have senior reps on it later, and at that point they were coming back and talking to-- not, perhaps, in the formalised way you're describing, but they were certainly ensuring that the big issues were getting dealt with. So we did make a response. It wasn't a case of we just ignored-- it didn't change as the process went on. But, in hindsight, I think, for prolonged issues like this, then there needs to be thought about how that might be managed, but we were trying to follow the Infection Control National Manual because if we didn't do that, we would have been, you know----

So, I think when times get difficult it is really important to stick to the tried and tested processes as well, because that, in my experience, leads to-- if you don't, then it leads to everybody, with the best of intentions, trying to do things but getting in a bit of a difficult situation.

Q I think what I'll do, my Lord, is just look at one more document before we finish up, which is the Water Review Group meeting on the-- that makes the decision, or might make the decision – we don't know – to decant the patients. If we just look at that on bundle 19, document 35, page 614. So, this is a draft meeting note of the Water Review meeting on 18 September at 8 a.m., and you are recorded as being present with Mr Best, Mr Leiper, Mr Walsh, Ms Kane, Dr Armstrong and Mr Archibald.

Now, reading that document through, is it fair to reach the conclusion that that was the group of people who decided taking on board advice from the IMT, and indeed I think possibly Mr Redfern's options paper, to go ahead with the decant of Ward 2A to another ward in the tower when it became available?

A So, I think some of the terminology of some of the meetings is kind of-- I'm not sure they're all the

same, even if they're the same title. I think there might have been another----

Q This is a different Water Review----

A Yes.

Q This, I'm assuming, is your one.

A There's too many Water Review Groups. I think-- My recollection of how we decided was that it was clear from the ongoing issues that we weren't going to be able to do the amount of work that was being suggested with the patients continuing to be in the ward. Those patients, we were very sensitive to the fact that they were quite ill and we wanted to make sure they were handled sensitively, rather than staying in a ward where there was work going on and it wasn't-- As part of that, the IMT made a recommendation, which was supported by the clinical staff, that we needed to find another ward-- or, sorry, no, we didn't make that recommendation, that we had to come out of that ward.

Q Yes.

A As part of that, then how would we ensure that an appropriate ward or an appropriate area for those patients to be treated was accommodated? So I think the Executive team with those people, but not exclusively those people, supported the recommendation of the IMT.

Q So, this is one of the things I'm finding a little hard. You've just said, "supported the recommendation of the IMT", and it may be that I'm just being too much of a lawyer here, so please stop me. Go to page 60 of your statement. We asked you at (a):

"… what person, committee or group made the September 2018 decision to decant the patients…?"

You've stated in that answer, the first sentence, that it was the IMT who recommended to decant, and you've listed the various people who were involved in the discussions, and a further discussion took place with various people and the decant solution was agreed. What I'm trying to find – and it may just be because I'm a lawyer and I don't really understand healthcare management – is it really a hard question who, i.e. one person or a group of people, decided to decant the patients? At the end, having taken advice of all the recommendations, taken soundings, been involved in discussions, who ultimately made the decision?

A I think I've tried to answer that there. So, the IMT did, as I've suggested----

Q They made the recommendation.

A And then "the chief executive, Medical and Nurse Directors and the chief operating officer as well as the local

team" said we should implement the recommendation of the IMT.

Q If we go back to the minute of the note of the Water Review Meeting in bundle 19 that we were just looking at, go over the page, page 615, and we look at the first bullet point – let's not look at that – of "Decant of 2A/2B and 4B":

"It was agreed that due to the bio film being found in some sink areas within this ward and the patient demographic it would be appropriate to decant this patient group to another area in order to carry out investigatory works and get to the bottom of the problem"

Is that this group of people, having received all the advice they've discussed, including the recommendation of the IMT, deciding to do the decant?

A Yes.

Q Right. I think, my Lord, this might be a good place to break for the end of the day. I have asked colleagues from the core participants that if anyone has any Rule 9 questions that relate to evidence that Ms Grant and I have discussed today, they should let me know overnight so I can ask them first thing in the morning.

THE CHAIR: Ms Grant, we'll take our break until tomorrow. Could I ask you to be back for a start at ten o'clock?

THE WITNESS: Of course, yes. Thank you.

THE CHAIR: I wish everyone a good afternoon and evening and we'll see each other, all being well, tomorrow.

(Session ends)

(16:12)