SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
16 September 2025

Day 6
24 September 2025
Jane Grant

CONTENTS

(10:04)

THE CHAIR: Good morning.

MR MACKINTOSH: Good morning, my Lord. We continue with Ms Grant.

Ms Jane Margaret Grant
Continued

THE CHAIR: Good morning, Ms Grant.

THE WITNESS: Thanks.

THE CHAIR: Mr Mackintosh.

Questioned by Mr Mackintosh
(Cont'd)

Q Good morning, Ms Grant. I've got a few questions that have arisen from yesterday that I've been asked to put to you. They're not necessarily fully in chronological order, but we'll hopefully deal with them relatively quickly and get back onto the rest of the questions. We discussed yesterday the Stage 2 Whistleblowing Report following the whistleblow from Dr Redding, and you, I think, might have said in that context, "It's important to get a balanced view from a range of colleagues rather than just one side."

A Yes.

Q Is that something you recollect saying yesterday?

A Something like that.

Q Yes. Is that what you feel Dr de Caestecker was doing in her report?

A What I was trying to say yesterday was that the whistleblowing process is about investigating things that---

Q No, I understand that.

A Yeah.

Q I was just wondering if that's what you thought Dr de Caestecker was doing, was she was getting a balanced view from a range of colleagues?

A I think she was trying to describe the context within which the overall whistleblow was-- and she felt that was pertinent, I'm assuming.

Q Do you see her as trying to get a balance view from a range of colleagues rather than just hearing from one side?

A Yeah, I think so, I think.

Q Right, okay. Thinking about the decant, a couple of questions here.

A This is the 2A decant?

Q The 2A decant.

A Yeah.

Q Yes, sorry. Do you recognise that the decision to decant the patients from Ward 2A/2B into 6A – obviously some went to 4B – meant that, for the patients who went to 6A, they were going to a ward that definitely didn't meet the ventilation standards for their patient

group and were being exposed, albeit with filters, to the same water supply that they had in 2A?

A So, there was a lot of discussion about what was a suitable environment for them, and we knew that 6A wasn't optimal, but there really wasn't much choice to-- to decant from 2A and 2B, and we took on board all the advice we got from Infection Control and so on about where we could put patients.

Q Thank you. Before the 2A decant-- I mean, you were chief executive for, at that point, about 18 months. Are you aware whether there was a business continuity plan in place that had set out arrangements for an alternative location for the Schiehallion patients should they have to move due to a crisis?

A I think the business continuity plans were done more on a-- a case of, you know, if the-- if the electricity goes off for the whole site and so on. I don't know if there was one specifically for Schiehallion, but the-- the business continuity plans that I've been involved in have generally been the wider kind of classes----

Q A whole site plan?

A Uh-huh, although I understand now that that has changed now and there are specific plans----

Q So----

A -- different to the site-wide ones.

Q So, as far as you-- I mean, you're not completely sure, but you think there probably wasn't a Schiehallion specific plan back then, but there would be now. Is that effectively your position?

A I think that's what the situation is.

Q Yes, okay. We discussed a number of times about how you were reacting to news about the ventilation system in 17, and you discussed on a number occasions the importance of working out how to move forward from where you were. I've been asked to probably re-ask this question: if you don't know how a deficiency or a defect has happened, how do you make sure it doesn't happen again or isn't still happening?

A I guess-- I'm not sure I can add too much more to what I said yesterday, but I'll try. At one level, how it had come about-- So, we knew what the situation was, and how it had come about doesn't in itself help us to address the issue moving forward, because we knew what the situation was and so, therefore, what we were trying to do was say, "From where we are now, what do we need to do?" rather than say, "And how did we get that?", although there was quite a lot of debate about how we got to it, but--

but--

You asked me yesterday several times about why we didn't do an investigation, and I tried to answer that as best I could, but, actually, our focus was really about, "If this is where we are"-- Because, at one level, it-- it-- I was going to say, "It was clear," but it was clearer where we were, and so, therefore, going back to how we got there didn't seem the most appropriate thing. The-- The main focus for us was to try and resolve the issue.

Q I won't reopen the whole territory, but there was an angle that occurred to me last night which was, how can you be sure that you knew the full extent of the deficiencies that you had to move forward from without doing an investigation? I raise as an example the ventilation in PICU which, from my recollection of the evidence, didn't really crystallise as a concern until '19, because we heard evidence from Dr Peters and Professor Steele about how they were involved in a discussion in '19 about ventilation in PICU.

There was ultimately-- I think we've got some correspondence from the Health and Safety Executive about what should be done, and the Board acts and does various things, but that information could have been worked out two years before if you'd done the investigation. So, if you don't know the full extent of the problem, how can you be sure you've understood everything?

A Well, we thought we did understand the situation at-- at that time.

Q Now, you've just answered a question about the decant to 6A, and you've explained that you took advice from a range of different personnel, including Infection Control, about the best options and you said there really weren't an awful lot of choices. This isn't about that, it's about what was told to the patients and the parents. So, given that the DMA Canyon report had emerged in June '18, what was the reason for not telling patients of the risks from the water given it's the same water in 6A?

A So, we had-- The local team had quite a lot of dialogue with the parents, and I don't recall exactly what was said-- I don't-- I don't know exactly what was said. What we were trying to do was be sensitive to the fact that it was really challenging for them and, at one level, it was a separate hospital; the Royal Hospital was separate from the adult hospital.

Q Yes.

A So, therefore, it wasn't as clear as it's being portrayed now or as it is now about the situation, so we were trying to-- to look at how we could minimise any risk but-- and be clear with the parents, and--

and one of the issues which has been difficult is how-- when you're not certain, what do you tell people? That's difficult, and I'm not-- I'm not sure if that----

Q Well, I'm grateful for you raising that because it enables me to sort of think about that. If we take water as an example, we've had some evidence that some of the parents thought there was a separate water supply for the children's----

A Yes.

Q -- and adult hospital. Now, there isn't.

A Yes.

Q At one level, I think we decided in the Inquiry it wasn't profitable to work out how that misunderstanding came about. Given, as you say, you didn't know everything about the system or about events, is there not an obligation to be quite frank with people about what you do and don't know so that they can fully appreciate the situation?

A I think I've got to put it in the context of parents, and we were trying to be as-- as sensitive to their needs as well, and I do understand there's been a lot of discussion about what we should have told them, what we did tell them and so on. We were trying to reassure them that we were doing everything we possibly could to address what was an-- an unclear situation. I mean, we didn't know that-- We weren't sure what was going on, if you know what I mean. So-- But what we did know was, in order to-- drains and wash hand basins, we were being very cautious to ensure that everything that-- that was being advised to us by Infection Control was being dealt with, and that was the kind of emphasis we had at that time.

Q When do you think you did, as it were, know what was going on with the water and the ventilation?

A I think it was an iterative process and I still think there are some questions today as to what the exact situation was.

Q I've pressed the wrong button on my computer. I wonder if we can step on to the investigation into the DMA Canyon events. It's a small thing, but I wonder if we can look at the email at bundle 14, volume 1, page 257, which – if I've got the right page – should be-- Step on to the next page, please? No, this is definitely the wrong page. Give me a moment just to find the right one. Take that off the screen, please. Do you recollect a change in who was to investigate the water, the issue about the DMA Canyon reports in the few days after you found them? There was a series of different ideas about how it would be investigated.

A I'm not sure what you're

referring to there, I'm sorry.

Q I think I'll have to come back to this because----

A I'm sorry, I don't----

Q -- if I wander through bundle 14, volume 1, we'll use up time and I want to use that-- I'll return to that topic later.

A Well, maybe just-- I mean, as part of that, I had asked Mary Anne Kane as the interim director of Facilities and Estates, and she and I discussed bringing in Jim Leiper and we've talked about that, but I don't know-- I don't have any recollection of a discussion other than that, unless there's something specific which, if you can find it, then I'll----

Q No, I'll find it and come back to it after the coffee break.

A That's fine.

Q Let's move onto Ward 2A. So, I want to look at the communications around the decision to upgrade Ward 2A. Now, you touch on this on your Question 56(a) response which is on page 70, if I have my notes correct. So, the actual question starts on 69, and then, over the page, you've been asked-- because the previous question contained a reference to the Board's statement:

"It is not accurate to state that 'ventilation within wards 2A/B was identified as an important issue during the overall upgrade process'."

Now, let's look at the statement which is bundle 5, I think, document 92, page 157. Yes, so this is a statement issued by the Health Board on 6 December 2018. Do you remember the issuing of this statement?

A There was a huge, huge amount of statements, so----

Q I mean, bundle 5 is a big bundle so I appreciate that. The point I want to put to you, however, and the point we put in the question, was there is a statement within it that-- Let's find the right paragraph. Yes, the fourth paragraph:

"Following this work we have decided to upgrade the ventilation system in this area."

Then it says:

"This will cost [the amount it will cost]."

Then Mr Hill is quoted, and then the background note contains-- the final paragraph:

"The drains were also tested... [and then the final sentence] It was during this period that our teams identified the opportunity to upgrade the ventilation system and this work is now being progressed."

Now, what we put to you on 56(a)----

A Sorry, which paragraph?

Q Question 56(a), so we're

looking at your statement, page 70. Am I right in thinking you're accepting that the ventilation issues have been known by GGC before the upgrade process?

A We've discussed the ventilation issues yesterday, so they were----

Q Yes, so you'd accept that the fact that there was a known issue with ventilation was known before the decant?

A What-- What happened is that there was-- during the decant, there was further work done because we thought we would take the opportunity just to be 100 per cent certain about what happened in the ventilation. A report was produced, is my understanding, and, at that point, we decided, as the patients had already been decanted, to-- to do the whole thing at once so that we didn't have any further----

Q But do you appreciate how the way the statement reads implies that the discovery, there was a problem with the ventilation, occurred during the investigations when, in fact, the discovery that there was a problem with the ventilation was known for at least a year or two beforehand?

A The-- The report that we commissioned, though, was the catalyst to do the actual---

Q So, have you read the Innovated Design Solutions report?

A I did back then but I haven't read it recently.

Q Do you recollect that the author described it as, I think, in his words, something along the lines of, "The ventilation system of this ward wasn't designed for the patient group that it was"----

A Yes. Yes.

Q Something like that?

A Yes.

Q Yes.

A It does say that, yeah.

Q So, whilst I appreciate that his clear report might've encouraged you, do you see how families particularly might be concerned to now discover that you knew as an organisation sometime before the statement and the work that there was a problem, and yet the statement seems to imply it all happened as a result of the works after decant?

A So, the-- the organisation knew that there were some issues with some of the ventilation, but, as you say, it was an iterative process in terms of getting to the granularity of that, and the-- the ventilation itself within 2A and so on during that time hadn't been the real critical issue, it had been the issues with the water that crystallised that and made us move, and-- It's a challenge to decant patients of that-- with those conditions anywhere, and so, therefore, we wanted

to make sure that every single thing possible that had been identified at that point had been done.

Q Was done?

A Yes.

Q Right. Why does the statement not say something along the lines of, “We regret that Ward 2A was not built as we expected it to be built when we opened the new hospital,” so you’re very clear and upfront about what happened? Why is that not the approach taken by the Health Board in this sort of situation?

A I-- I don’t remember the exact conversations about how it was drafted. In fact, I probably didn’t-- I wasn’t involved in it, probably. I probably saw it, and-- and-- I think we were trying to balance the-- what we knew then with what we needed to do to resolve the issues. So we weren’t trying to be evasive, it was really about trying to give a message to-- to families and patients because we knew this was difficult for them to-- that we were trying to make this, every single bit within that unit, as optimal as it could be.

Q Do you see how, whatever you were trying to do, it might actually look a little bit evasive once you realise that you had the knowledge for some time before?

A I see why-- and I’ve read those things a lot since we-- since I’ve been-- and I can see why, if you-- that you-- It’s really a difficult balance to try and say-- If you’re not 100 per cent certain about things, we found that quite difficult to be balanced in our communications approach to make sure we-- we described what we knew certainly at that time rather than give any more uncertainty to people.

Q Would you accept that, if you had instructed the Innovated Design Solutions report on ventilation in 2A in 2017, or indeed had been instructed earlier than that, then you would have been certain earlier, but, as you told us, you didn’t carry out an investigation because you looking to move forward? Do you see that the failure to instruct the report is what causes you not to know stuff?

A The thing is that-- That is a statement with, with due respect, a great deal of hindsight. We didn’t know those things at that time, we didn’t know what we know now, and it was an iterative kind of process that was emerging. So, it wasn’t a case of, “There is a huge patient safety issue in 2A,” in 2017, “You haven’t dealt”-- It wasn’t like that. And I can see why there is a thought that that might be the case now, but it really wasn’t like that. It wasn’t.

Q Ms Freeman has told us in her latest witness statement – and she’s due

to give evidence in two and a half weeks – that she never received an explanation from Greater Glasgow and Clyde Health Board as to why it had taken such a long time after the hospital opened to make the required changes to the ventilation in Ward 2A. Did you ever consider giving her an explanation of why it took so long?

A Ms Freeman asked us for a lot of briefings, the Scottish Government colleagues asked for briefings, HPS asked for briefings, and-- and we gave them-- we responded to their requests for information at that time, and I don't recall exactly the detail of what was said. So I-- I'm not sure.

Q So you don't recall receiving a request from either Ms Freeman or the Scottish Government for an explanation of why it had taken so long after opening to rectify----

A I don't recall that, no. I think they, like us, to be fair, and I'm sure they'll tell you themselves, but I think they were focused on moving forward and addressing the issue.

Q Well, I'm sure I can ask that of Ms Freeman.

A Indeed.

Q Let's think about Ward 4C briefly. Question 57 – it's on page 71 – we asked you about the decision-- or we put it in the question at the top of the page-- We asked you whether you were:

"... aware that the ventilation in Ward 4C did not meet the air change rate, pressure differentials and requirement for HEPA filtration set out for a 'Neutropenic Ward' in SHTM 03-01."

And we asked you a series of questions.

A Yes.

Q Your response is to report that the issue was raised by the HSE in 2019 and that:

"...this ward relate[s] to Haematology and renal transplant which may not require specialist ventilation as it is not considered a neutropenic ward [and that you'd] had a discussion with the HSE on that issue."

Now, when the Board reacted to this issue in '19, was anyone looking at the original clinical output specification for this ward from 2009?

A They may have been. I'm sorry. I don't know.

Q Because the problem that I suppose is-- We know now, because we've investigated, that, in 2009, a clinical output specification was produced for the ward, which is bundle 16, document 15, page 1595. This was the original Haematology-oncology Ward before the BMT was moved in, and it was incorporated into the employer's requirements for----

A In 4C or 4B, we're talking

about----?

Q For what is now 4C----

A Yes.

Q -- but was going to be 4B, because, if you recollect, there wasn't going to be an adult BMT unit----

A Sure.

Q -- until you and Ms Armstrong took that paper. So, this is, as it were, the "old money" 4B----

A Sure.

Q -- which the community of those patients are, to some extent, now in 4C. If we go to page 1595, we see at the top of the page in "Introduction", it makes a reference to:

"Advice was requested from Dr John Hood, consultant microbiologist, regarding suitable ventilation to provide a protected environment for this patient group."

Then that is set out under "Ventilation". Do you see how this patient group is thought necessary to have:

"... no opening windows, no chilled beams. Space sealed and ventilated. Positive pressure to rest of the hospital and all highly filtered air, greater than 90 %, probably best HEPA with adequate number of positive pressure sealed HEPA filtered side rooms for neutropenic patients as at the Beatson West of Scotland Cancer Centre. "

Now, I appreciate that this went

through a number of iterations in the project, but what I want to understand is whether-- when you turned to the question of what to do with 4C, did anyone look back to what was originally supposed to be there when the hospital was originally specified?

A I'm afraid I can't answer that. Sorry, I don't know.

Q You received it-- You explain in your statement, if you look at page 71:

"NHSGGC sought further external clinical opinion on this issue which supported that view."

Would that be the report from Dr Agrawal?

A Yes.

Q Did you know that Dr Agrawal gave that opinion without ever visiting the hospital?

A I've no idea how he even came into that.

Q Let's take that off the screen and move to Cryptococcus. Now, you've given a lot of information on Cryptococcus.

THE CHAIR: Right, just-- Ms Grant, if this is a repetition of a question you've already answered, my apologies. In your answer to Question 57, you say that:

"The patients within this ward [this is 4C] relate to Haematology and renal transplant which may not require

specialist ventilation as it is not considered a neutropenic ward."

Now, who does not consider it a neutropenic ward?

A Well, at the present time, we don't consider it to be a neutropenic ward-- the Health Board.

THE CHAIR: The Health Board does not?

A Well, the colleague-- the Clinical teams within it.

THE CHAIR: Right. So, I'm not entirely sure if I understand why we come to that conclusion. As I understand it, 4C does not deal with bone marrow transplant patients, but patients on 4C do receive chemotherapy, and, at stages within their treatment, they will be, to a greater or lesser extent, neutropenic. So, why is it not considered a neutropenic ward?

A The advice we got – and I'm not an expert in these matters of that group of patients – were that they weren't in the same category as-- as others, and I see what Mr Mackintosh is saying about the original thing, but we-- we were advised that that wasn't required.

THE CHAIR: Well, why?

A I think by the Clinical teams, and I'm sure there would have been input from Infection Control, but I can't really-- I'm not trying to be difficult, I just really can't remember. But that was the advice that we got from colleagues.

THE CHAIR: Because we heard evidence from Gary Jenkins, whose responsibility had been in the management of the----

A Yes.

THE CHAIR: -- Beatson Ward, from which 4C came on, that a ward such as 4C was, in his view, a neutropenic ward.

A Certainly the advice from Dr Agrawal's report is that-- that those patients do not need to be in that environment.

THE CHAIR: We can look at Dr Agrawal's report, but I don't recollect – and I might be entirely wrong about that – that Dr Agrawal gives an opinion on that. We can check----

MR MACKINTOSH: We can check that, my Lord. I think the thing, probably, just to clarify with this is that-- I won't take you to it, but we have various exchanges between Dr Inkster and-- I think it's Dr Hart. I'm not 100 per cent sure about that.

A Yes. Yes.

Q Who's one of the consultants in 4C. I think she asked a series of questions-- This is in late '18. She asked a series of questions about, "Are the patients neutropenic?" and his answer is, in broad terms, "Some of them are all the time," or, "All of them are some of the time." I can't remember which, but he

gives that impression. She produces an SBAR. Did you ever see her SBAR on this ward?

A No, I don't recall seeing that SBAR.

Q Because the point when we're talking about Ward 4C is the winter of '18/'19 into '19. That's when this issue was arising, and Dr Inkster produces an SBAR as your lead Infection Control doctor. Did you see that?

A I don't recall seeing that. I think I've said that somewhere in here.

Q So there might well be other clinicians in the Health Board who take a contrary view to your lead Infection Control doctor, but at the point of the first six months of '19, she is advising the Health Board that this ward requires improved ventilation. Dr Agrawal didn't see her SBAR either, and so I'm worried that your team might not have seen all the perspectives of clinicians in the hospital on this. Can you remember anything about the process that was carried out?

A I'm sorry, I can't, no.

Q Right. Let's move on to Cryptococcus, which is page 76 of your statement. Now, there's a lot of information here, and you cover it from page 76, which is Question 64, to 69 which is on the foot of page 77. Before we look at those answers, I wondered if you can recollect attending a meeting with Ms Freeman in 2019 to discuss concerns about Cryptococcus in the Queen Elizabeth?

A We-- We had a lot of meetings with Ms-- well, a reasonable number, and I couldn't tell you a specific date, but we definitely did meet with the cabinet secretary.

Q So, the cabinet secretary, or former cabinet secretary now, has told the Inquiry in her statement she was concerned at Greater Glasgow and Clyde's guardedness and downplaying of the situation. Were you guarded and downplaying the situation?

A We certainly were not trying to be. We were trying to address the issues as they arose, and I think it would be important to understand the context was that, during that period, there was a huge amount of political and media attention as well as the issues that we were trying to deal with, and the environment within which we were-- the situation within which we were operating was extraordinarily challenging.

Q Well, indeed Ms Freeman described the response to GGC at this meeting about Cryptococcus as, effectively, in her words, "Nothing to see here."

A Mm-hmm.

Q Would you accept that might

have been how the Health Board's position could be interpreted by her?

A I think we wanted to try and keep a balanced approach to this. We were trying to make sure that we were investigating in a proactive kind of way to see if there were any linked issues or if this was a situation which may or may not have occurred, you know, if there was links and so on, and whether they were linked to the environment. And because of the issues we'd had previously, the-- there was a need to ensure that we weren't just leaping to the fact that it was the environment. We were looking to see whether----

Q Because of what issues that occurred earlier?

A Because of all the media and the issues around the hospital previously.

Q So, one of the ways-- I mean, I don't really understand that, so I want to just explore it. So, this is early '19, January, February, March sort of time, as far as you can recollect? That's when the media interest is high about Cryptococcus?

A Yes.

Q Yes. So, you seem to be saying that, because of all the media interest, you didn't want to leap to the conclusion that it was the environment. Is that what you're trying to tell me?

A No, I was just trying to explain

to you the context on-- within which we were operating. What was really important – and it is an Infection Control-- and I've dealt with a lot of Infection Control issues over the years – is that you don't immediately leap to "It's definitely this or definitely that." I mean, quite often in those situations, there are various hypotheses, and it was important that we didn't just leap to the-- to the issue that it was the plant room or it wasn't the plant room or whatever.

We were, as a senior team, quite concerned that we need to make sure that we fully understand this because, where those patients were-- were not really linked in the ventilation and the air handling unit process. They were-- They were not in the same place, so we were quite concerned about making sure that we weren't leaping to a conclusion that wasn't supported by the work that we're doing and that we did the work to establish what may or may not be the most likely cause or indeed if it was-- if the cases were linked at all.

Q You'd accept that, at the start of the work of the Cryptococcus IMT and its sub-group, one of a number of hypotheses was there was a connection to the ventilation system. You'd accept it was a hypothesis that was being investigated?

A Yes, through the plant rooms

and the air handling units and so on.

Q The reason I raise that is because-- How many other possible deficiencies with the ventilation system had been brought to your attention since you arrived as chief executive by the time that that one was produced as a hypothesis in the IMT?

A I couldn't answer that.

Q Well, we can work it out. So, 4B, there was-- a known ventilation deficiency arose in the summer of 2015, and you eventually learned about that in the autumn of 2017. You accept that?

A Could you repeat that?

Q So, 4B's ventilation system that caused the patients to return to the Beatson in the summer of----

A Yes, yes.

Q -- '15, if I understand your evidence from yesterday correctly, you learnt about that at the time of the SBAR in Autumn '17?

A Yes.

Q Yes? 2A's ventilation system not being fully compliant with guidance outside the BMT isolation rooms, you learnt about that, again, as part of the SBAR in the autumn of '17. You'd accept that?

A I'm not sure it was a specific----

Q But you definitely learnt about it when you read the Innovated Design Solutions report in late '18.

A Yeah----

Q Mr Lambert's reports are quite clear.

A Yes.

Q Yes. You've mentioned, and I haven't pressed you on detail because I don't think you recollect the full details-- of learning of an evolving issue around whether isolation rooms were the right sort, and we've had evidence of them changing; every few years, another couple of isolation rooms are being changed. So, that's emerged over the time you've been chief executive, that there are some isolation rooms that need to be switched to a different sort. Do you remember that?

A I was less involved in that. I was less knowledgeable in it.

Q Then we have the general ward ventilation issue that you learnt about in the autumn of '17. So, that's four, potentially, ventilation deficiencies, or potential deficiencies. Then we add PICU, which we know Dr Peters and Professor Steele were talking about in the late months of '18 and '19, so that's five potential deficiencies. Now, if-- and it's of course only hypothesis at this stage that the cryptococcus cases are connected to the absence of HEPA filtration, that's a potential sixth deficiency.

Now, could it be that the reason

there was lots of media interest is because this was potentially the latest of a number of discovered deficiencies, and, therefore, to some extent, the Health Board's failure to act earlier is what caused the media interest and excitement and stress in early '19?

A So, I don't accept all of that in the way you've portrayed it. It was an evolving situation. You know, it's easy to sit here and-- in hindsight and think it was as clear as that. It was absolutely nowhere near as clear as that. We were trying to deal with issues that were unclear. When Professor Steele came, the chair and I met with him and asked him to do a full review of the-- the-- all the issues in the new hospital and-- and, you know, about that, and he's told you about that, I assume.

Yes, there were issues with the ventilation, but there were a significant other-- number of other issues as well, and it wasn't as clear as you're portraying it that, you know, there was these issues, and that-- that wasn't why the media, I don't think, were doing that. I-- I think it was more a-- a kind of-- just an overall issue around the infections and-- and the history of the hospital. I don't think it was as you're portraying it, sorry.

Q Okay. Ms Freeman has explained in her witness statement that she has no recollection of ever being told by Greater Glasgow and Clyde that the rooms where the two patients who contracted Cryptococcus in that winter, December '18, had stayed did not have HEPA filtration in the supplied air. Did you tell her of that fact even though the cause hadn't yet been confirmed?

A I-- Our general conversations didn't go to that level of detail, so I don't think we were ever asked that. I don't recall that issue being raised. I don't-- I don't remember, to be fair.

Q Now, we asked you a series of questions from Question 65 onwards about the work of the Cryptococcus sub-group, and I'm not going to revisit them because, as you point out, you don't feel you have the clinical/technical experience to comment on them, but what I wanted to just check is, were you aware that NHS NSS decided not to agree with the conclusions of the sub-group when the report was finalised?

A Yes. There was a huge amount of discussion with NSS to try and address some of their concerns, the detail of which I can't recall, but there was a-- a lot of discussion and, because this report had taken quite a long time to come and they're----

Q Well, it took more than two years to come.

A It's quite-- I mean, there were reasons for that, which-- but-- but it did

take quite a long time to come and, therefore, we-- we had to at some point bring the-- the work to a conclusion and make a judgment as to whether it was right or wrong, but I did know that NSS weren't----

Q So, in effect, it's really just Professor Hood's conclusion because, by the time you get to the end, NSS have gone, Mr Hoffman's gone. There's Dr Hood and a series of Estates people.

A I wouldn't portray it as that. Professor Hood was an international expert----

Q Well, I'm not saying he's not----

A Yeah, yeah, but----

Q -- of high value, but it is largely his conclusion.

A I'm-- I'm trying to answer your question. Professor Hood is a-- is an expert. He had, over a substantial period, engaged with colleagues and, at some point, we had to bring that work to a conclusion rather than just sitting in limbo land. So-- So we did bring it to a conclusion. He had taken on external advice. He had also worked with people like Professor Steele to look at what the technical feasibility of some of the issues was, so he certainly wasn't a, kind of, lone person.

Q What I want to do now is to move on to-- well, it's related to Cryptococcus, but it's more contemporary. It's about the reporting of HAIs. Now, most of this will be the subject of questions for Ms Imrie, Ms Critchley, Dr Davidson, and Professor Gardiner next week, but can I ask you to look at an SBAR dated 20 November 2024, which I've been asked to put to you, and it's bundle 52, volume 5, page 148. So, you'd accept this is a SBAR from the IPC team to you in November of last year?

A Yes.

Q Yes, and you received this, then, when you were still in post?

A I presume I did. I haven't seen this recently, so I----

Q It addresses some Cryptococcus cases that have been brought to the Inquiry's attention, and the reporting of them have been the subject of evidence at the end of the Glasgow III hearing. Do you recollect that?

A The-- The Glasgow III hearing evidence?

Q Yes, last year.

A No.

Q On the next page, if we keep this-- It's actually on page 150. There's an assessment, and it contains:

"There have been multiple statements recently made by the whistleblowers, ARHAI colleagues and experts to Public Inquiry criticizing NHS GGC compliance with NIPCM and

requirements for reporting infection episodes to ARHAI. All these opinions have been based on incomplete information biased by people's personal beliefs and interests trying to sensationalise the fact that if there is a case of Cryptococcus sp., it most likely will be found in a patient hospitalised in, or linked to [the Queen Elizabeth]. These statements have been made without providing any evidence or facing any consequences for giving misleading information."

Would you accept that these allegations are quite serious against whistleblowers, ARHAI colleagues, and the experts to the Public Inquiry?

A I think it reflects the Infection Control team's anxiety about the-- the need for balance in the discussion.

Q Because, obviously, the issue that's tied into this, Ms Grant, is the extent to which NHS Greater Glasgow is properly in compliance with the National Infection Prevention and Control Manual, not whether there is a cluster of Cryptococcus neoformans in the hospital. That's not the reason we've raised it in evidence. So, what steps did you take once you were briefed on this to ensure that the Health Board was operating fully in compliance with the National Infection Prevention and Control Manual in terms of reporting HAIs?

A Yes. So, I asked the-- the director of Nursing, who was, at that point, responsible for Infection Control, one, to consider the language within the SBAR. We had the conversation about, "Not sure that is progressing the-- the position as-- as we want it," and also to engage with colleagues in HPS to try and make sure that everybody had agreed a way forward.

Q Yes, because that SBAR was ultimately sent to the Scottish Government by your successor.

A I-- I don't know about that----

Q Was that something that you would have done?

A It depends. I-- I would have asked colleagues to deal with HPS.

Q Right. Did you get involved in the----

A Or ARHAI, sorry, ARHAI.

Q ARHAI, yes.

A My apologies.

Q I mean, I make that mistake as well, so I'm----

A Yeah, sorry.

Q -- entirely understanding. Did you, at any time between the receipt of this SBAR and your retirement, give any instruction or make any personal investigation about the SOP that's in place for deciding whether to report to ARHAI?

A I asked them to look at-- to

discuss it with ARHAI.

Q You asked them (inaudible 10:49:46). (After a pause) Now, Ms Devine has provided a recent supplementary statement which is the Glasgow IV, Part 2 statement bundle, volume 3, page 14, because, Ms Grant, she's been providing statements around this issue of whether the SOP that GGC has in place is compliant with the Manual, and there's effectively a series of statements from her and some evidence from Ms Imrie.

A In-- In recent times, you mean?

Q In recent times, yes.

A Yeah, okay.

Q If we go to paragraph-- obviously, if we get the right document. The big-- There we are. Yes, if we go to page 14, I think. No, I'm not convinced this is the right place. Can we go back to the front page? Ah, volume 3, please, page 14. Yes. So, this is a discussion about----

A What-- What is this document, sorry?

Q This is Ms Devine's statement.

A Oh, right. Sorry. Right, thank you.

Q So, just to put it into context, if we can jump to the previous page, she's responding to a statement by Ms Imrie and, at this point in the discussion, if I understand Ms Devine's position correctly, she's referring to a national environmental pathogen surveillance pilot, paragraph 2 and making some observations about that. That's not what I'm asking about.

If we go over the page onto the next page, and so paragraph 3 discusses whether the SOP aligns with the GGC policy; I'm not asking you about that. It's paragraph 4, and it's a statement made at the second half of that paragraph:

"Additionally, conducting a HIIAT assessment for all triggers, as implied by Ms Imrie [and I think it's fair to say Ms Imrie doesn't think that's what she's saying] would require a multidisciplinary team meeting to review patient and clinical information, temporarily removing front line clinical staff from their duties. This has the potential to compromise patient safety."

To what extent would you-- and I'm not entirely sure I know whether Ms Devine is really saying this. To what extent would you take the view that requirements to report might undermine patient safety or compromise patient safety?

A Could-- Could I just have a second to read the paragraph----

Q Yes, of course. Please do.

A Thank you. (Pause for reading) Okay, thank you.

Q At the very highest level, do you have any concerns that imposing requirements on a health board to report HAIs or potential HAIs might compromise patient safety by distracting Clinical teams from other work?

A I-- I think-- and I-- You-- I guess Sandra would need to respond to that, but I think what that's trying to say, and-- and I haven't seen this before, so it's-- it's the matter of if we spend-- if we report all the triggers, which I think is what she's saying, then that would be a huge amount of work in addition to what we're currently doing, and, therefore, her-- her view is that, if you do that, then you would take Clinical team-- or the IPC team away from doing their work.

Q So you interpret this as, "If there's lots of work, because you have to report all the triggers"----

A If there's a lot of additional work. I think-- I think that's what that says, but I haven't seen that before and I haven't spoken to Sandra about that, so----

Q Thank you very much.

A But she is right-- She is right that, if you suddenly double, for a-- and-- I'll make it up, but, you know, the-- the amount of triggers, then you'd have-- and double the-- then clearly that would have to----

Q Well, indeed, I'll have to put that to Ms Imrie.

A Yeah, I'm sorry, I don't----

Q No, that's helpful.

A Other than that-- But I don't think-- It needs to be taken in the context of-- of the other paragraphs, which I haven't had the chance to read yet.

Q Indeed, it needs to be taken in the context of the pilot that precedes it, which was a particular project. Let's turn to the next section on my notes, which is the events of 2019 and Ward 6A. So, on page 61 of your statement, we asked you about the-- That's on page 61. Question 45, we asked you about-- This is from Ms Grant's statement. Page 61. We asked you about the decant of Ward 6A to the CDU. Now, we asked you quite a general question, "What was your understanding of why the decant was necessary?" and the second sentence contains:

"I sought further clarity on the matter as I was concerned the patients and families would be subject to an additional move which would cause them further concerns and I wanted to be entirely clear as to why it was necessary. I also wanted to ensure that the location that patients were going were going to be decanted to was fit for purpose for these patients. Following a further discussion with colleagues, including members of the IMT, where they provided me with the

necessary information, I believe that the final decision relating to the decant of Ward 6A was undertaken by the IMT with input from Corporate Directors and local management team."

So, the first bit is-- I probably should have put this in the questionnaire, so I'll take this slowly. We have evidence from Dr Inkster last year that she describes you as initially opposing the decision to move patients to CDU, but your tone changed when Dr Inkster's recommendation received the support of Mr Best and Dr Armstrong, and that you might have challenged her on being risk averse. Do you have any recollection of that?

A No. I think-- I think what happened was I was quite concerned that those families had already been-- or the patients had already been moved, and I wanted to be absolutely certain as to why we would have to move them again because that wasn't ideal from a patient's perspective. And I think, at one level, you've asked me a lot of times why I didn't do things and, in this case, I did do something and I'm still getting (inaudible 10:57:05).

And I think there's something about-- I was really concerned that there would be-- Because there was quite a lot of disruption for families and patients moving from 2A to 6A, originally, and to

have another move really was not great, and we'd also put quite a lot of effort-- Because families had raised, and rightly so, that, you know, they didn't have a playroom and a kitchen and a place for-- even a, kind of-- a restroom or something like that – I don't think that's the terminology, but you know what I mean – for families to sit in. So we'd put those in place, and, therefore, we didn't want to go back to a situation where they were in an area which didn't have facilities that they had been very clear that they needed.

And so it wasn't-- it wasn't my reluctance to do it. When IMTs have made discussions-- have made recommendations, the vast majority of the time, you would implement them if they're possible to do, and-- So-- But I think it's right that, on this date, I wanted to clarify what was happening, and it was-- it was a genuine concern that families would be disrupted again, and I wanted to be sure and clear about why that was so. So, it wasn't a matter of-- I can't remember the words you said, "opposing" or something like that.

Q Yes, the words that come from Dr Inkster are "opposing" and you suggesting that she's "risk averse."

A So, I don't-- I don't recall doing either, but I certainly was asking questions about why-- why we were

doing this, but it was for a genuine reason to make sure we were absolutely clear about why we were disrupting patients again.

Q Now, I'd also need to press you on that final-- it's not quite a sentence, but final sentence of that answer about the topic of who actually would have made the decision to decant to CDU.

A I think in this case-- Well, I've tried to describe it. I think the IMNT (sic)-- I can't remember, to be perfectly honest, if-- if their recommendation was to move to CDU. I can't remember if it was specifically that or it was just to move out of Ward----

Q I think the evidence is it was specific.

A Right. I don't recall that, but-- And so, therefore, they made-- quite similar to 2A actually, they made the recommendation. There was that discussion that you've just described, or we've just described, and there were other corporate directors involved in that, and I think then we collectively agreed that it should-- it would have to happen.

Q All right. I want to move on to Question 46, which is the closure of Ward 6A to new admissions at the start of August 2019, and then patients are diverted to other centres and some are sent further afield. It's not immediately clear from the minutes of the IMT the exact timing and the choreography of this decision, and, given some of the evidence we've had, what I was trying to understand by asking this question is who ultimately decided – and it may not be one person, it may be a group of people – to close 6A to new admissions at the start of August? The first sentence, you describe concerns being raised, so that's helpful, and then you've explained that:

"Clinical decisions relating to the individual patient were taken by the local Clinical teams."

Again, I understand that. So, if we go on to the next page, and then you're told there's a recommendation to close 6A. That's what you've said in the answer----

A Yes, yes.

Q -- to 46(a). Ultimately, who made the decision? Is it like the decant of 2A where there was an IMT recommendation, it went to a group of senior people who appear to have decided to accept the recommendation; or is it like the CDU closure where the IMT recommended, and there is some form of ad hoc discussion, and a group of people decide to go with the decant; or is it like an example you've previously given me where the IMT just decide because it's a matter that you're comfortable with them dealing with? Where's the decision

actually made? Because we can't find a minute or a record, you see.

A I think it's similar to-- to that which I've described previously in terms of there being a discussion at IMT and then – this one is slightly different, I'll come back to that in a second – and then that being raised with corporate directors and myself to make sure that all angles had been covered. And then, collectively, we would-- So, I didn't sit in my room and say, on a Tuesday afternoon, "Right, I'm closing this ward."

Q No.

A There was discussion, and that's how it should be. It should not be the chief exec in isolation, or anyone else for that matter, sits and does that. And that generally isn't how it happened and I don't think this is how it happened there. But this one was slightly different because it involved having to send patients away to other boards and so on, and so, therefore, it was right that we had a discussion at a senior level about how we were going to engage with, like, Edinburgh and so on, and what that would mean, and whether they had the capacity to take these patients and so on. So, there was an added dimension to this that hadn't been there previously.

Q So, if we were to take from that (a) the recommendation comes from the IMT and the clinicians, and that (b), because it has impacts outside the Health Board, you and senior colleagues would have been involved in that decision and would have been making steps that it could work before the decision is made, is that roughly right?

A I'm not-- I'm really not entirely sure whether we decided that it had to close and then we made-- or it was all part of the same----

Q Yes.

A -- thing. I'm not entirely sure.

Q But certainly----

A It was around the same time.

Q You and the rest of the corporate management team, Dr Armstrong, Estates, these people, you would have been involved in making the decision? It's not a decision solely for the IMT in this case?

A I don't think so, no. I think we were involved.

Q Now, I want to turn-- I'm not sure I need to take you to a document, but I can if necessary, which is the decision to remove Dr Inkster as the chair of the IMT. Now, you deal with that in answer to our Question 48 on page 64, and you've given quite long answer. What I'm going to do in order to speed things up is-- I've read the answer, and I want to just check I've got the choreography, first, right in the order, in that you hear from the medical director

and she tells you certain things, which is what the two paragraphs have there.

A Yes.

Q So, is it your position that you're not actually involved in the decision, you're just being told it's happening?

A Being told what's happening?

Q That Dr Inkster is-- There's going to be a discussion and then you're told she's removed. You're not actually involved in making the decision, it's Dr Armstrong reporting it to you, effectively?

A What I think-- What I recall happened was there was a discussion where colleagues made Dr Armstrong aware that----

Q Which colleagues would this be?

A I think-- Well, people who had attended the IMNTs. So, I think----

Q Was the discussion something you were involved in or it's being reported to you by Dr Armstrong?

A No, I was just trying to tell you----

Q Okay, sorry.

A So, Dr Armstrong had, I think, several people come to her. You'd----

Q Yes.

A -- have to ask her about the exact time. And she-- And, at the same time, I do recall one evening in the Board headquarters that a colleague, one of the directors who had been at the meeting, indicated that he was concerned about the style and tone of the discussions at the IMNT, and it was around the same time. And then Jennifer-- Dr Armstrong told me that she was going to pull together a meeting to look at how-- what needed to be done, because it was quite serious that we had been sitting with an IMNT running for some substantial amount of time, and, if the functioning of it wasn't appropriate, then we wanted to make sure that it was-- it was dealt with.

Q So, firstly, in order to see if we can connect that to existing evidence, would that director be Professor Steele?

A No, I think it was Kevin Hill.

Q Kevin Hill, right.

A I think so.

Q Thank you.

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

MR MACKINTOSH: Kevin Hill, I think you said?

THE CHAIR: Kevin Hill.

MR MACKINTOSH: (To the witness) Just on this idea that the IMT had been running for a long time----

A For some time, I said, I think.

Q Yes. So, we have a bundle, bundle 1, in which we've put all the IMT's minutes in, and this IMT starts on 19 June.

A Yes.

Q Of ’19.

A Yes.

Q So, why do you say it’s a long running IMT? Because we’re only on the middle of August now.

A Well, two months is----

Q You feel that’s long?

A I said, “Some time.” I didn’t say, “Long time.” If I did, then----

Q Oh, okay. Yes, no, you’re right there. I recognise I’m coming in this (a) with the benefit of hindsight----

A Mm-hmm.

Q -- and (b) from outside. Looking back through our bundle 1 of all the IMTs that are related to the hospital, the water incident, there are some quite long IMTs going on. Would you accept that?

A Yes.

Q All right. So, the next question is, obviously Dr Armstrong arranges her meeting. We asked you on page 65 whether there was any discussion, top of the page, of “… whether the views of Professor Gibson and the Clinical team in Ward 6A should be sought.” I’m not sure you’ve answered the question.

A I don’t know. My understanding is that discussion (inaudible 11:07:53)-- I do not know if there was any discussion of views of the Clinical team being sought.

Q Right. Because----

A That’s me trying to answer the question----

Q If we go back to something you said about the time when we were talking about the Stage 2 whistleblow:

“It’s important to get a balanced view from a range of colleagues rather than just one side.”

How would you respond to the suggestion that this process, and I recognise it’s a process, might be criticised because (a) Professor Gibson and her colleagues weren’t consulted, and (b) Dr Inkster wasn’t present at the meeting on 20 August 2019?

A So, the-- the responsibility for making sure the IMNT is functioning properly is that of the IMNT chair, and so it wasn’t really to do with the content of the IMNT, it was more about the process of making sure it was working properly, and so I’m assuming that that’s why the Clinical team were not involved in that discussion. In terms of the----

Q But they were at the IMT, Ms Grant, so----

A Aye, but so were a lot of other people, so----

Q Indeed. So-- It’s worth it, I think, to cut it quickly, let’s put the core point. If you look at who was present, it’s Mr Hill, Professor Steele, Dr Kennedy, Dr Armstrong, a group of people, most of whom were at the IMT but not all. The

people who aren't, who are conspicuous by their absence, are the Clinical team and Dr Inkster. I'm just wondering whether there is anything of concern about the fact that this meeting took place and only heard from one part or two parts of the group of people at the IMT?

A Aye. I think the-- I think there's two different issues there. I think the Clinical team being involved, I see why that is so, I don't know if they need to be involved in that kind of conversation about how it's functioning, right? I think the presence or otherwise of Dr Inkster-- I mean, she was invited to the meeting as I understand it. I wasn't at the meeting; I was told there was going be a meeting to discuss how to progress. She was invited to the meeting, and I think you've heard from colleagues that she was unable to attend on that day and, therefore, it was the intention that she was involved in that discussion.

Q Thank you. I wonder if I can just check something which may be inadvertent on your part. In the answer to Question (b)----

A I didn't understand this question, actually.

Q Yes, so that's why it may be inadvertent.

A I didn't understand it.

Q So, if we're thinking of the period before 23 August 2019, who was giving you advice on the different hypotheses that needed to be considered by the IMT? What was your source of advice on Infection Control issues, effectively?

A So, is this when Dr Inkster was still in the chair?

Q Yes, up until the point she's removed. Who's giving you advice on Infection Control issues arising out of the gram-negative bacterium?

A So, the medical director was giving me an update on what was happening.

Q Yes, and you've got no other source other than her?

A No.

Q No, thank you. Right, let's step on and look at Question 49, which is the bottom of this page.

A Sorry, just to go back to that----

Q Yes, of course.

A I mean, there may have been some discussions with Tom Steele and Kevin Hill and so on.

Q Yes, but they've not got Infection Control expertise.

A Yes, but just to say it wasn't all Dr Armstrong, probably there was general discussions----

Q What I want to check is you're not hearing from another microbiologist in the hospital giving you advice about Infection Control?

A No, no.

Q Right. Question 49 deals with when you first became aware that Dr Inkster resigned as lead ICD. Now, of course, we didn't give you a date about that and so you answered initially at the bottom of the page about her first resignation in January 2018, and then, over the page on page 66, you would talk about her subsequent resignation in September 2019 which is what I meant to ask you about:

"The Medical Director informed me that Dr Inkster had resigned. I discussed the position with her and she indicated she was considering the issues raised in Dr Inkster's letter to her, including workload, personal issues and a range of other matters that I cannot recall."

Now, did you see Dr Inkster's resignation letter at the time?

A I've certainly seen it, but I'm not-- Probably, is-- Yes, I think so.

Q You think so? What did you think at the time was Dr Inkster's reasons for resigning?

A As I say, I can't recall exactly what all the issues were, but there was a range of things, I think, about – as I vaguely recall this – that she had-- there was too much work for her to do. She'd had a period of illness and I think she was thoughtful about that, and that she hadn't-- I think there's something about she hadn't been invited to go to a visit or something like that, and that people-- I can't remember the exact thing, but she wasn't particularly happy with the information she was getting and some of the issues that were around the functioning of IMTs and stuff like that. I genuinely can't remember the exact details.

Q Let's look at the letter. It's bundle 14-- It's an email. Bundle 14, volume 2, document 151, page 579. Now, I think it's fair to say that Dr Inkster has graciously allowed us to not redact the sections of this letter that relate to her health and that may help for clarity. If we look at the fourth paragraph, what do you think is her primary reason for going, based on this letter?

A I think it's all of those things, it's a combination of things is what I took from it.

Q The reason I mention this is you haven't mentioned, in either your statement or what you've just described, what she says in the sort of first substantive section, that she's experienced:

"...undermining, a lack of respect and [has] felt unsupported and undervalued by members of my Infection Control team and management."

Now, I mean, I'm wondering why when you provide your written answer to

our questions and when you just then explained what you thought the main issues were, that doesn't stand out. I mean, that doesn't get mentioned by you.

A No, I did try to answer that just a second ago in terms of saying she wasn't particularly happy, and I've recalled that Great Ormond Street visit. She wasn't particularly happy with the way things were operating, as I put it to you a minute ago. So, I wasn't specific, you're right, but I didn't recall the detail of a paragraph in a letter, you know, a few years ago but I was trying to-- it was about the way things were operating and how she wasn't fully supported. I don't----

Q Do you think there's any validity in the issues she raises?

A I'm not close enough to that, and I know that Dr Armstrong did ask colleagues to look into those-- the reasons why she was----

Q Indeed, and that was Dr Deighan's review----

A Yes.

Q -- which we've heard about from him, so I won't revisit that with you. Do you think the resignation of Dr Inkster as lead ICD could have been avoided? (After a pause) We can take that off the screen if that would----

A I don't know the answer to that, actually. I think one of the catalysts was, you know, the change to the chair of the IMT, and I think that was difficult, and I think she considered that she hadn't been appropriately involved in that decision and I'm not sure if there was appropriate communication with her around that, so I do think that that's something that we should reflect on.

But the functioning of the IMT was so serious. I mean, the-- the issues were so serious for the Board in terms of the-- these patients having to be sent away with all the inherent risks of that and a few other things, that it was really, really important that the IMT was functioning properly and that it didn't get distracted by-- by "the wrong thing", shall we put it like that, and that they were absolutely focused on the things they had to.

So, this was a really serious issue for patients, which was the overriding concern of those involved in those discussions about, "How do we make sure the IMT is functioning properly?" Because it has to, because those patients are in a-- in a sub-optimal position, shall we say, about having to be put-- treated elsewhere, and that was not something that we were comfortable with at a senior level at all because we were really concerned about patients and their families.

Q I do know that this question uses hindsight, so we obviously have the original resignation letter from Dr Inkster

in 2015 when she attempts to demit her sessions as the regional sector ICD. Of course, subsequently, she was appointed as lead ICD, and one gets the impression from talking to both her and Dr Armstrong that, at times, relations between the two of them were good.

A Yes.

Q But is there not an echo, a connection, between what she's saying in that letter about not feeling supported and the issues that she was raising four years before? I'm wondering, have you got any thoughts or observations about whether the Infection Control team as a whole was operating effectively in the Queen Elizabeth in the years after it opened?

A There's a couple of things there. I think the senior players within the Infection Control team were managing Infection Control across the Board area, and we really didn't have the same amount of challenge in other parts of the domain. We did not. Even-- Although there were some serious issues, you know, IMTs arose and infection things arose in other parts of our domain-- The Royal Infirmary is a huge site. It's not, you know-- It's not quite as big as the Queen Elizabeth, but it is huge and we didn't have the same kind issues and challenges around working relationships there----

Q So, before Dr Inkster----

A I want to----

Q Sorry.

A The other thing is-- One of the-- the key themes in this is it is really important that all colleagues – including Dr Inkster, but not exclusively, it's everybody – has to work in an environment where there is respect and due weight given to all sorts of people's views, whether it's the Estates department, whether it's the local managers, whether it's the clinicians, whether it's Infection Control, whether it's Dr Inkster, and that has proven to be quite difficult.

It isn't about Jane Grant as the chief exec deciding that this is what-- I mean, my job is to ensure that I have tried to empower the staff and colleagues to do what they need to do, support them where they need that, challenge them where they need to be challenged, but-- but to actually hear what they say as well, and that has been a challenge within that whole Infection Control situation in the-- in the South sector, and it has been difficult to get that team ethos which is an absolute requirement for everybody, including through the GMC, which asks everyone to be a team player.

Q The reason I tried to cut in, and I probably shouldn't have done, was-- What were the issues in the South sector that Dr Inkster was causing before

you get to August ’19? Because you said there were issues in the South sector, in the Queen Elizabeth, that weren’t anywhere else. What was Dr Inkster doing outside the Queen Elizabeth?

A I didn’t say that. I said there were-- You said-- Sorry, you indicated that the relationships in 2015 and so on and so on. There were a lot more issues in terms of interactions and style and tone of operation, shall we say, in the South sector. I never said they were Dr Inkster, nor did I----

Q Well, indeed, that’s the point because----

A Some of them were around how the Infection Control team operated in terms of her role as the ICD and so on, but there was others as well.

Q Well, I suppose there’s a couple of different possibilities there and I want to explore them with you. So, one option is that there were people in the South sector whose way of doing business in some way caused disruption. That’s one option. The other option is there were issues in the South sector which, in some ways, the addressing of caused disruption. Do you see that? Are there any other issues that might have been causing these problems in the South sector that you’re talking about?

A So, there’s a difference between the issues and the method of-- and the way people are working, if I could call it that. You know, there were undoubtedly a lot of issues, as in things happening that required attention, but, when that occurs, it’s even more important that true teamworking is embedded in the way we work, and that’s what I’m trying to say, is that that was quite clunky on some occasions.

Q How do you respond to the suggestion that the way that the September/October 2017 SBAR Stage 1 whistleblow was dealt with and its Stage 2 consequence is separate from the issues that arose about Dr Inkster as chair of the ICD because she wasn’t a whistleblower? Dr Inkster is not a whistleblower, technically. So, at this point, are these two issues connected in your mind or separate?

A I’m not sure I understand the question.

Q So, you have----

A So, the September-- I’ll try and answer it, and, if I don’t, then please correct me.

Q Please.

A The SBAR in 2017 was a genuine-- and I would say that we didn’t realise it was a Stage 1 whistleblowing. You call it whistleblowing, but we thought it was just----

Q No, I understand that.

A That was a genuine attempt to

make sure-- because, in a large organisation, and I've been there many times, people say things but it doesn't actually ever come to a crisp, "These are the things we need to do." You just complain that it's not done, or I just say it's done and it's not done, and it all gets into a mess. So, that was a genuine attempt to say, "Right, let's try and get onto one bit of paper the things that are concerning people."

As part of that-- But that, I don't think-- and it may, in terms of-- Your question is quite a challenging one. Some of that may have been about how things had been communicated or whatever. So, in that regard, it might be connected to what happened in 2019, but I don't think there's a direct-- You know, it's quite a----

Q I'm grateful for that, because I'm worried that I'm using hindsight in an unhelpful way, so let me just put some thoughts out there and see how you respond. So, there seems, potentially, to be a view in parts of the Infection Control management and other parts of Clinical management, including Dr Armstrong, that there is something problematic about the way that Dr Peters, Dr Redding and others raised that Stage 1 SBAR and then Dr Redding took it on to Stage 2.

Now, we've had lots of evidence about whether there was any value in that

statement, but that seems to be a sort of cloud of unhappiness around that process, and there seems to be a separate, potentially, area of concern, a cloud of unhappiness, that emerges in the early part of '19 in the relationship between Dr Inkster and others – including Professor Steele and Dr Armstrong – that in some ways reaches a peak in her resignation.

Now, what I'm wondering to understand is, to what extent, if these are two-- Are these two separate things going on in the Queen Elizabeth, in the Health Board, or are they linked in your mind? Are the whistleblowers and the way they behave and the way they're addressed and what they raise-- is that linked to what Dr Inkster is doing in '19, or are they separate?

A Well, they're part of the overall context within the South-- within the Queen Elizabeth, so, in a loose way, they may be connected. But I think-- I think there are common themes. Some of the people that you've described there are actually responsible for delivering some of these. I mean, Dr Peters was the lead clinician and so on, so-- I was-- She was responsible for dealing with some of this stuff. So, there is a kind of-- but not all of it, in terms of there's things that--

So, there's-- there's-- I don't really know how to answer that question,

because-- and without meaning to be difficult, I think that-- I personally think that putting things down on a bit of paper to stop the kind of to-ing and fro-ing of who's done it and who's not done it and whatever is a reasonable way to address that.

I think yesterday we talked about, on that SBAR, all sorts of things, some of real significance and some, frankly, I'm not entirely sure what they are. But, that aside, there was a structured process to try and address those issues, and I think that's right. As part of that-- The team dynamics, I'm sure, was part of some of that.

So, in that sense-- And, at that point, Dr Inkster was responsible for delivering some of this; again, not all of it. So the dynamics are slightly different, but they're not-- In that whole context of the Queen Elizabeth and some of the challenges, they are-- that kind of team dynamic communications theme might be part of it.

Q Because I suppose it might be suggested-- I'm not actually saying that this is my current thought, but, just as a possibility, it might be said that one of the reasons Dr Inkster eventually is removed as the lead ICD is because she is perceived to be part of a problem that has its roots in the 2017 October SBAR and that whistleblow?

A I don't think that's correct.

Q You don't think that's correct?

A No.

Q Well, why would you say that?

A Because it was-- I don't think someone-- I'm not quite sure what you're saying there, but, you know, I don't think someone's said, "Ah-ha, right, that 2017 thing's just continued till 2019, and therefore we-- and we need to remove Teresa." I don't think that ever happened.

Q My Lord, this might actually be quite a good point to break for the morning coffee break.

THE CHAIR: Very well. We'll take our coffee break, Ms Grant, and try and be back just about quarter to twelve.

A Thank you.

(<u>Short break</u>)

THE CHAIR: Mr Mackintosh.

MR MACKINTOSH: Thank you, my Lord. Ms Grant, I wonder if we can move on to the topic of communications with Professor Cuddihy in the summer and autumn of 2019. In order to do that, let's get your letter up first. So, this is the letter of 27 September 2019, so that's bundle 6, document 23, at page 75-- document 24, sorry, but it's this page.

So, this is a letter you wrote to Professor Cuddihy about his daughter's

infection, and, obviously, this is September. If we can just, as it were, start the story at the IMT when this issue comes up, which is on 3 June-- In fact, we can go back further than that. When did you first get involved in the question of what communications should be given to Professor Cuddihy around his daughter's infection?

A I can't quite remember the chronology, but I think the chair was contacted by him, I think.

Q Okay. Let's try and sort of piece it together.

A Yes.

Q So, there's an email, which is of 19 June 2019. It's in bundle 8, page 67, and so this is an email thread that, if we look at-- low down the page, we see this starts off with an email from Dr Inkster. If we go over the page, we can see some actual details from Dr Inkster, and we see it's sent to Dr Armstrong and a number of colleagues. If we go back to 67, we see that, at the top of the thread, is an email from Mark Dell.

A Yeah.

Q Who was Mark Dell?

A He was in the Comms office.

Q Yes, and he states, on 19 June, he:

"Just spoke with Kevin [I take it that's Kevin Hill]. [He's] letting Jane and Jonathan know."

I'm assuming Jane is you and Jonathan is Mr Best?

A Yes. I'm assuming so, yes.

Q Do you think it's possible that you could have known about this issue as early, as it were, as 19 June?

A About Professor Cuddihy?

Q And his daughter's infection, and the Mycobacterium chelonae that had been found, and the second case.

A I think it-- I think it's more likely that it was part of the overall situation. I'm not sure it would have been identified as being-- Because if you look at the-- sorry, if we could go back----

Q Go back to page 68? Yes, there's no names in the email, obviously.

A Yeah, so it's-- it's quite important as well that----

Q Because the redaction is actually a location, it's not a name.

A Uh-huh, but-- but, quite frequently, the generality of what was going on would have been----

Q Yes.

A -- discussed, rather than the details of an individual----

Q Well, that's what I wondered, and so, at this point, would it be your position you're being told about what's going on but there's no names attached to it?

A I think that's most likely, but I-- I couldn't categorically say that----

Q No, I appreciate that.

A -- it wasn't. We generally tried to avoid, at my level, talking about individual patient names and stuff.

Q Yes. Then, if we look at the IMT from 3 July, which is bundle 1, document 74, page 330, and if we go onto page 332, we see there's a discussion of a hypothesis at the very bottom of the page. The hypothesis might be:

"...that it is due to patients/staff having access to unfiltered water throughout different areas of the hospital."

The reason I've shown you that is because we then have Mr Redfern's evidence in the Glasgow II hearing – and that's, just for my colleagues' benefit, columns 183 to 185 of his transcript – where he seems to understand that the threshold for the engagement of the organisational duty of candour had been reached at this point in June/early July 2019. I just wondered if you could recollect when there was first discussion at your level of whether the organisational duty of candour had effectively been triggered for the Mycobacterium chelonae cases?

A It wasn't dealt with by me. I know that sounds, again, evasive, and I don't mean it to be, but I think there would have been discussions that-- Well, there was discussions, I understand, through the process, but I wasn't involved in those discussions.

Q So, at this stage, you wouldn't have been involved in determining what was told to the families and you see that being dealt with within the teams?

A At the risk of repeating what I said yesterday, you know, we're sitting in an organisation with 41,000 staff and £4.5 billion budget, and that's not to evade my responsibilities in the slightest, but it's just the detail of those things has to be dealt with by other people.

Q Yes. So, what I'm trying to do is to work out, between-- At this point, that seems an entirely sensible position to be in, but, by the time we get to 27 September, you've clearly carried out some form of-- I hesitate to use the word "investigation", but you've got involved in the issue because you've written the letter to Professor Cuddihy.

A Yes. Yes.

Q I'm trying to wonder when do you think you might have effectively been thinking about (a) Mycobacterium chelonae, (b) the Cuddihy family and, (c) "What do we say to him?" Because the next stage in this communication story is a letter by the chair on 4 July----

A Yeah.

Q -- which is bundle 6, document 18, page 53. I hope so. Yes. So, that's

by the chair.

A Yes.

Q I just wondered whether, at this point, you're involved, or whether the chair is effectively dealing with this independently of you?

A No, I was involved at that point.

Q Yes. So, you wouldn't get the chair involved without you being involved as well. It seems a reasonable----

A Well, on something like that, yes.

Q Yes.

A Yeah.

Q Can you help us about whether the chair was being asked to tell Professor Cuddihy about the existence of a second case? Because he doesn't do that in this letter.

A He wouldn't have been involved in that either. Because----

Q But if we look at-- Sorry, carry on.

A I think, and I'd need to go and check this, and I'm sure you know, but I think Professor Cuddihy contacted one of the Board members, if I recall correctly, and the Board member contacted the chair. I think that's-- And so that's how the original thing at our level started, I think.

Q Would you have been aware-- Well, let's find the report in the IMT minutes. (After a pause) Would you have been aware of either Mr Hill or Mr Redfern or anybody like that reporting to the IMT that the chair would report this to Professor Cuddihy?

A The detail of the second case?

Q Well, the existence of a second case.

A I don't think that would be the chair's job to do that.

Q So, if, for example, people think it was the chair's job, you wouldn't see that as his job?

A No, no. I don't think that would be, because he wouldn't be able to-- You know, if there was going to be a discussion with Professor Cuddihy or whoever, then it would have to be with people who could answer the detail of the question. There was a couple of meetings, I think, and I've forgotten the exact date, but the chair and I did, certainly-- with Professor-- with Dr Armstrong met with Professor Cuddihy. And then there was another meeting arranged, as I recall, with Dr Davidson, Jonathan Best, and I think Professor Leanord, I think, to discuss things with Professor Cuddihy, I think.

Q Because what seems to be the case is that the Professor wasn't very impressed, to put it mildly, that he learnt about the second case from the family of

the second case, not from the Health Board.

A Yes, I've seen his-- I saw-- In the bundle you'd sent me was the email that he sent----

Q Yes.

A -- to Jamie, and then he wrote to me about that.

Q And then you wrote your reply, which is this bundle, page 75. Did you understand that was part of his concern at the time?

A About he hadn't been communicated properly with----

Q Yes.

A -- the second case?

Q Yes.

A Yes, clearly I did.

Q Yes. You've given an apology-----

A Yeah.

Q -- of a sort at the bottom page, but can you explain why it was that this, and I use the term loosely, "failure" to tell him this information occurred?

A I can't recall the detail, but there was some email correspondence about-- about that, I think, about there being confusion about who was going to tell him, when they were going to tell him, and annual leave and stuff like that. So, there was a delay, I think, in telling him.

Q Because we've had evidence from Mr Hill in the last week that he told Mr Redfern not to talk to Professor Cuddihy about the second patient's condition so as to not breach confidentiality.

A Yeah.

Q Is that something you found out when you were preparing to write this letter?

A That Kevin Hill had----

Q That Kevin Hill had actually put a block on Mr Redfern telling the professor.

A I think there was a genuine attempt. I think-- I think, when I've looked, and some of this isn't-- well, it is in hindsight and looking at the correspondence rather than my absolute recollection, it was only some of this that I was involved in-- was that there had been some communication blips already with Professor Cuddihy and they were trying to make sure that there was a clear route of communication. I think that's what that was about, rather than trying to-- But it wouldn't be for the chair to get involved in-- His role would be a much higher level.

Q Yes, but if the chair is going to write a letter----

A Yes.

Q -- and if Professor Cuddihy thinks he has an undertaking to be told about the second case----

A Yes.

Q -- then presumably someone would have to tell the chair to mention the second case because the chair wouldn't know about it otherwise. What I'm trying to work out is, is there someone in charge of this communication process, or is it, to some extent, an inadvertence of multiple people doing things?

A So, normally-- normally the chair and myself wouldn't be involved in those kind of discussions.

Q Yes.

A I mean, there would be-- And so, therefore, it wasn't entirely routine to do things in this way, but Professor Cuddihy had asked to be-- or had made contact through that-- I think it was through that route that I've described to you, and so, therefore, the routine processes and this other process were going along at the same time, or maybe not exactly the same time, but if you know what I mean, and so, therefore, that wasn't all that normal to do that.

Q But you knew when you wrote this letter that one of his concerns, and I accept he has many, was that he'd not been told about the second case.

A I think so, yes. I think so.

Q And you say in the third paragraph, second line:

"I understand your frustration regarding our communication with you and Molly about a second child with this bacteria. I have now reviewed the position in this regard. From the outset I would like to assure you that there was no wilful intent in withholding any information."

Now, Mr Hill has given evidence that he'd actually actively told Mr Redfern not for him-- for a reason to do with patient confidentiality----

A Mm-hmm.

Q -- but you don't report that. Is there a reason why you're not reporting that?

A Sorry, I'm getting a bit confused here. Could you repeat the question you've just asked me?

Q So, look at the paragraph here. You say----

A "I note your concern," that paragraph?

Q Yes, that, "I understand your frustration," and then:

"I have now reviewed the position in this regard. From the outset I would I like to assure you that there was no wilful intent in withholding any information."

Now, we could have a debate about what "wilful" means, but Mr Hill's position is that he absolutely, deliberately, on the basis of patient confidentiality, told Mr Redfern not to tell Professor Cuddihy about the second case. Now, one can debate whether Mr Hill was right or wrong to do that, but I am wondering why this

isn't reported to the professor at this point as part of a transparent, open communication?

A You're wondering why Kevin Hill----

Q No, I'm wondering why you didn't tell him about Kevin Hill. Maybe you didn't know, but I'm wondering why you didn't----

A I doubt I knew. I doubt I knew that.

Q Right. Did you work out why it was he wasn't told? I know you haven't said it here, but did you work it out?

A I don't remember. I'm sorry, I just really don't remember. But we were-- The chair and I were concerned about Professor Cuddihy's concerns, if you know what I mean. We weren't taking them anything other than extremely seriously. And I would like to pay tribute to Molly Cuddihy, and she was a remarkable young lady. But we were not taking this anything other than 100 per cent seriously.

So, it wasn't a case of-- We were trying to listen to his concerns and trying to address them. So-- But there's a-- But his concern is over here. We had to rely on the teams to actually give us the information because we didn't know quite a lot of the detailed things that he was asking.

Q I understand that, but, I mean, is there not a risk that, if you acknowledge his concerns, you apologise for not telling him effectively, and you tell him, "There was no wilful intent," and yet we now discover that one of your colleagues, for a reason that is-- is certainly not necessarily wrong, certainly justified in one sense, has actually told Mr Redford not to tell him, do you see how he might feel that you're not being entirely transparent with him?

A I think it's getting a bit convoluted here, though, because I don't remember exactly who told what to who and who said that, and I understand that if Kevin has said that then he's said that, but I think the minute of the IMT suggests-- or some meeting, suggests that he will be told. So, there must have been some debate about whether he was to be told about the second case or not. I don't know the answer to that.

Q I mean, it's entirely possible the IMT might think he should be told and Mr Hill thought he shouldn't, and there's an interesting question about who ultimately gets to decide.

A Mm-hmm.

Q But you don't seem to have discovered that or reported it to the professor.

A I think the-- That last sentence, I think, indicates we weren't trying to be anything other than

transparent, but there were issues about why he was not told. I'm not sure what the reason for that was, to be honest, whether it was just the confidentiality issue, which was an issue and has been an issue throughout all of this where there have been a lot of-- It's really quite important that patients' confidentiality is respected, and there's been quite a lot-- and, even in some of the discussions we've had, some of the patients-- It's not normal to, at all, discuss patients in the public domain. It's not.

Q No, it's not, and I should make clear that I got the consent of the professor and indeed----

A No, no. I wasn't suggesting----

Q -- his daughter to talk about this case.

A I wasn't referring that to you. And so, therefore, there is a lot of-- there has been a lot of attention paid to not identifying patients, and so-- I think that's a genuine sentiment, and I think the other thing is whether that was that, or whether there was a communication blip and people were away, I-- It could be either.

Q Let's move on to the escalation to Stage 4 of the escalation framework. That's 22 November 2019. I'd like to explore your answer to Question 70; it's on page 78 of your statement bundle. Now, what was your feeling at the time about the decision to escalate GGC to Stage 4?

A What did I feel about it?

Q Mm-hmm.

A I was clearly anxious that the Board was escalated to Stage 4. I was concerned about the fact that the Scottish Government felt that we weren't dealing with things in the way they would want and we were-- and, importantly, the impact of that on patients and families and our staff, and-- however, thought that the process would bring with it some additional external scrutiny.

Although, throughout this-- I would emphasise, throughout these whole episodes, we were actively seeking external support and advice which was difficult to get because some of it wasn't-- some of the issues we were dealing with were highly complex and therefore people hadn't experienced them before, so it was quite difficult. So, we were open to having any further external support that we could get, and if there was a new-- if there was another experience or new advice or whatever to try and deal with that. So we did think that that would help.

Q Do you think it was justified to take you Stage 4?

A I don't think it's for me to say that, frankly. It was difficult. We were concerned, but I do understand why the Scottish Government did that.

Q I think I should press you. I mean, you're the chief executive of the organisation that's been taken to Stage 4. I could take you to what Mr Wright says in his statement for his reasons, or even if we really wanted to go and look at the official record of the Parliament, the statement by the minister at the time. You said in your statement that it was quite intrusive, quite a lot of extra work. Do you think that the reasons given in Mr Wright's letter as DG justified going to Stage 4? We can look at them. It's bundle 52, volume 1, document 23, page 310. So, he explained:

"In light of the on-going issues around the systems, processes and governance in relation to infection prevention, management and control at the QEUH and the RHC and the associated communication and public engagement issues, I have concluded that further action is necessary to support the Board to ensure appropriate governance is in place to increase public confidence in these matters and therefore that for this specific issue the Board will be escalated to Stage 4 of our performance framework. This stage is defined as 'significant risks to delivery, quality, financial performance or safety; senior level external transformational support required.'"

Now, is he wrong?

A I think-- I think we had-- we still felt that we could do-- we could get through this. However, I do understand why he thought that it was taking longer than it should and that he wanted to have an external overview of it. I do understand why.

Q In your answer to Question 71, page 79, we ask you:

"What is your view on the effectiveness of the escalation process?"

You start off by saying:

"The escalation process brought an enormous amount of additional work, in addition to the very significant additional work being undertaken locally to address the issues."

Now, inside this answer – and I recognise it's a long answer and should be read as a whole – you say that the volume of papers and presentations and a number of other things-- you can see that line that begins about six lines, about seven lines up, "… this was detrimental to the overall running of NHSGGC." Then you talk about the "overwhelming pressure to the senior team".

A Yes.

Q So, in that sense, as I well understand that creates much more work, was the additional workload on the senior team something that was justified for the outcome that came from escalation? Did you benefit enough to justify the hard

work?

A I think it needs to be considered in the overall context. So, we were already still dealing with difficult issues in terms of the things we've been discussing and the other things that you get in a Board of the size of NHSGGC. We had that escalation that you're referring to. We then had a subsequent (inaudible 12:14:51)-- gosh, ventilation, escalation in-- I think it was January 2020, and, at that point, we were also at the beginning of COVID.

So, the work that we were trying to do, or we had to do, was to try and continue to deal with the issues that were there, to deal with the Oversight Board and the requests of that from the Infection Control escalation, if we could call it that, and then, in addition to that, we had the escalation of the performance issues that are described somewhere else, and then we had COVID. The combination of that was really quite challenging. It was very, very difficult.

Q What I'm trying to say is that I appreciate it was challenging and I can actually well understand, the amount of paperwork we've reviewed, someone had to write it all, and I get that. But did it produce a benefit that justified the work, from your perspective?

A I think things could have been a little bit more streamlined, I think they could have been. I think there was a huge amount of papers and presentations and things, and I think that, at times, there wasn't a kind of appreciation of those blocks that I've described to you and some of the parts of that. So, the Oversight Board did produce-- and I think, at all times, Greater Glasgow and Clyde has been receptive, despite what everybody said, to, if there are additional things that we need to do and recommendations that have been-- that people believe-- those external colleagues believe would benefit patients going forward, then it's absolutely incumbent on us to do that.

So, within the Oversight Board and so on, there are recommendations and things like that that we-- we should address, but I think-- I'm not sure there's a simple answer to your question, was the cost-benefit analysis-- or whatever. I'm not sure there's a simple answer to that, I'm sorry.

Q So, Ms Freeman states in a statement that, when the Board was escalated to Stage 4, she felt the Board thought they were being unfairly dealt with. Did you feel the Board was being unfairly dealt with?

A I think that there was-- I think we thought that there had been an enormous amount of work done by us prior to this. We had tried to take on

board external advice from HPS and so on, and we had sought input from-- through them and also through our own external expertise to make sure we were dealing with the things, because we didn't have-- some of these issues were incredibly challenging. So, I think we felt that we had been involved with HPS and with other experts through HPS and with the Scottish Government, and so, therefore, it was a bit disappointing that we were escalated.

Q She also explains in her statements that she saw no change in the Board's attitude when the Oversight Board was put in place, it actually made it challenging to support the Board because the Board-- and this is not her words, in a sense, the Board wasn't changing its way it's behaved once it's been put into Stage 4.

A I'm not sure I would agree with that. I think we did everything we could support the work of the Oversight Board. Fiona McQueen, who chaired the Board, I think has acknowledged through-- through the Oversight Board report the amount of work that Glasgow and Clyde did themselves but also to support the Oversight Board. So I'm not sure that is correct. We certainly recognised their role and worked hard to support the input that they required.

Q How do you respond to those who suggest that escalation should have actually come earlier than it did, perhaps in the early months of 2019 rather than at the end of that year?

A I'm not sure I could answer that. I mean, it is possible. Would it have been better? I'm not sure. I'm not sure. We certainly were trying our best to address those issues and I think everything that was raised by colleagues we were trying to deal with.

Q I mean, I suppose the observation, which-- it's not the person who answered that question, but it occurs to me that, had Stage 4 occurred at the beginning of 2019, then the challenges over reacting to the Cryptococcus cases or the chilled beams or the IMT would have been dealt with under the eye of the Oversight Board and that would have helped.

A But remember, the-- We had to be-- The framework had been invoked in March '18, I think it was.

Q In Stage 2.

A In Stage 2?

Q In March '18, you went to Stage 2.

A No, the-- In-- There's a framework which Fiona McQueen instigated prior-- way prior to the escalation, just in the normal process when infections are not-- she's concerned, and then I think it was March

’18 that the framework was invoked, and I think it was 20 March----

Q Yes, we talked about it yesterday. You went to Stage 2 at that point.

A Yes, but, as part of that, it was really-- it wasn’t the performance framework, it was the framework for Infection Control.

Q Right.

A I can’t remember what it’s called, it has a title but I’ve forgot what it is. And, as part of that, then----

THE CHAIR: I think we’re talking about two different frameworks.

MR MACKINTOSH: We are.

A I think we are.

Q So I’m going to let you keep talking and I’m going to stop trying to be helpful.

A But the discussion we had yesterday was-- you asked me about-- the thing about the lead, remember the conversation about the lead, and I’d said it was the sole lead? Well, that escalation or that----

Q That escalation.

A -- framework. So, therefore, we were getting, from March ’18, external-- more formal external support from HPS and so on.

Q Right.

A So, it wasn’t that there wasn’t any; there-- that was already there in

March ’18.

Q Before we move on to the work of the Oversight Board, I’ve reminded myself that I was asked to ask a supplementary question based on the evidence before the coffee break. Do you remember how I took you to the November-last-year SBAR around the reporting of those Cryptococcus cases?

A Yes.

Q You mentioned that you asked your colleagues to speak to ARHAI about the SOP that was in place.

A About the issues that were raised, I think.

Q The issues that were raised. Can you remember which of your colleagues you asked to speak to ARHAI?

A I think it was Professor Wallace and then Sandra Devine, I think.

Q Thank you.

A Because we were having that conversation and it would be them who would legitimately have that conversation.

Q What I’d like to do is to look at the Oversight Board itself. I will come back to the Case Note Review in a little bit, but, if we go to Question 80, which is on page 86-- I think it’s a relatively simple question because it may be, the way we asked the questions, I’m not sure you fully answered it. So I’ll just try and summarise it. What’s the impact of

having an Oversight Board on your authority as chief executive, in practical terms?

A What was the impact?

Q Yes. How does it restrict you in it? If it does; I mean, it may not. How does it restrict you?

A In this respect or in the other escalation or just in terms of----

Q Yes, the Oversight Board Stage 4 escalations.

A Well, there were-- As I've described somewhere about-- you know, things like we had to get all of our comms agreed by and authorised by the Scottish Government, which was incredibly difficult because it took time and we were majorly criticised by some of our media colleagues for not responding and so on.

So, there's things like that which were really quite difficult. Not about us being difficult, but just in terms of-- we were perceived to be not paying attention, if I could call it that, but, actually, there was a huge amount of to-ing and fro-ing where statements were changed, and then there was ongoing debate, sometimes quite a lot of times, and then, clearly, colleagues had other jobs, whether it was the-- Fiona McQueen or Craig White or indeed the cabinet secretary who had to authorise. So they clearly had other things as well on their plate, so some of those things took quite a long time to get authorised, so----

Q But in terms of, as you explained at the beginning of your evidence, that, as chief executive, you're accountable to the chair, and through the chair to the Board, and you described how there's a scheme of delegation for the Board. Did any of that really change when the Oversight Board-- Are they inserted into the structure above you? Below you? Can they tell you what to do, or can they only issue requests?

A So, we were duty-bound to-- to implement-- you know, if there was things that came from the Oversight Board, so-- and they didn't have to instruct, shall we say, because we worked with them and that was a collaborative kind of engagement, and we were trying to ensure that, if there were things that were raised-- And, as you're aware, they had also put in place Marion Bain and subsequently Angela Wallace to support those-- that work.

So they were having a two-way dialogue with both myself and with the Scottish Government, so it worked in a-- It was-- It was quite challenging at times, but we did try to work in collaboration with them.

Q But, at one level – and I recognise this may not be very well phrased – you and the medical director and all the other senior directors in the

corporate management team have, to some degree, an ability to tell people who report to you what to do. I wondered if the way the Oversight Board works is either it's a extra layer of authority on top of you that can give you instructions, or a group that effectively watches what you do to whom you have to report who make suggestions.

A No, I think in-- I think, because we're at Level 4 escalation, they could instruct, but we tried to work with them so that it didn't become a kind of-- Sorry, I need to say what I mean. So that the recommendations or views that they had were absolutely implemented.

And the chair and I met with the chair of the Oversight Board on various occasions, and I'm sure he'll tell you when he comes, but basically to (a) ensure that they were content with the progress we were making, (b) to ensure that, if they had information requests or information requirements that they needed, that they felt they were getting the appropriate support from the Board.

In those meetings, Professor McQueen did indicate that she was satisfied with what was going on----

Q Well, indeed, she says in her statement----

A -- but we did meet her on a regular basis to try and make sure we were doing what we were being asked to do it.

Q She says in her statement that all requests she gave were complied with.

A We did try to do that.

Q But she does also say in her statement at paragraph 73 that the responsibility for delivering healthcare remained with NHS Greater Glasgow throughout the period of the Oversight Board. Is that your understanding as well?

A Yes, we were still responsible for it. Yeah.

Q She also says in the same paragraph that the director of Estates and the director of IPC reported to the Board and not to the Oversight Board.

A I think the director of Estates certainly did report to the Board, that's correct. I think the director of IPC, who had been appointed by the Oversight Board, or by the government, had a dual relationship, you know, in terms of reporting and working with me, but also to the Oversight Board.

Q Did the director of IPC have line-management responsibility for the IPC team?

A Yes.

Q Yes. You think they did. Right. Professor McQueen also explains, at paragraph 82 – because we asked her a question, I think – that ensuring the water and ventilation systems were

compliant with guidelines, regulations, etc., was not part of the remit of the Oversight Board, but it did monitor the work. Would that be a fair description?

A Could you read out the first part of that again? Sorry.

Q So, ensuring the water ventilation system met standards – and I'm using that very loosely – wasn't part of the remit of the Oversight Board, but it remained the responsibility of the Health Board because Stage 4 doesn't extend to, as it were, checking that buildings are compliant with standards; that remained your responsibility as a board.

A But in the sense of Infection Control responsibilities, then clearly it was a key part of that.

Q Right.

A So it wasn't, perhaps, just as simple as that----

Q Okay.

A -- because they're not-- they have-- They are inextricably connected.

Q Now, before we leave the Oversight Board, you explain a lot in your statement about the work of the Gold Command, and that obviously feeds into the AARG process or working on the recommendations of the Oversight Board and the Independent Review. How did you track progress on compliance and recommendations? What was your approach to this?

A On-- Of the-- Question 82, are we at?

Q We could be. Yes, we are.

A Yeah. So----

Q What was your process to make sure they were covered?

A So, one of the recommendations in-- I think in the Oversight Board was to-- or it might have been the Case Note, I can't remember which, was to actually pull together an overall action plan, and we did that. We put together all of the recommendations from the Independent Review, which hasn't mentioned very much, but there has been a lot of-- there was a lot of work done on that Independent Review as well, which had recommendations which weren't exactly the same as the Oversight Board.

So, it was quite a difficult, kind of-- sometimes, occasionally, just a wee bit tricky to try and manoeuvre our way through that, but-- So, the Oversight Board, the Case Note Review, and the Independent Review, and we put them all onto an overall action plan, and-- and we had to divide the recommendations, because some of them are kind of one-off things that you need to do, some of them were things that you had to do in new builds, if you know what I mean, in the future to make sure the processes were there, and some of them were an ongoing

thing.

So, we put them all into that and then we tasked-- we allocated a lead for each recommendation, and we monitored progress through that action plan.

Q So, when you say "we", is that you or a team of people, or-- What's the process?

A It was myself and I think the corporate directors but, if need be, I was having a conversation with a director if their part wasn't done, and I think we were given admin-- well, we allocated admin-- reasonably senior admin support to chase that up.

And we also then did an audit. Once we'd got to a position whereby colleagues had told us that the recommendation was implemented or was in place or whatever, then there is, in the Board, evidence. We had pulled together some evidence to make sure that, if we were asked to prove that, that we could do that.

And also there was a kind of audit of-- I've forgotten the number now, but it was a number of the recommendations, every month or every quarter – I've forgotten exactly what it was – to make sure that, if they were in place and we'd been told they were in place, that they were still in place.

Q Who's doing that audit?

A The admin support.

Q Not the actual corporate director who's implementing it, but the admin support?

A They were asked to produce the evidence.

Q I mean, at one level, there is a criticism advanced that the reason that many of those recommendations had to be made was because the Health Board, led by its senior management team and its core management team, had not addressed those issues before. So do you see there might be some anxiety that the Board, to some degree, is effectively marking its own homework and checking it's complied with the recommendations when, to some degree, the people who were in post when things didn't happen, or happened in the way the Oversight Board or Independent Review didn't like, actually took place?

A No, I think we were required to report to the AARG----

Q Yes.

A -- which was not really a successor of the Oversight Board, but you-- you've got that in your-- in the thing. And we were required to report to them and they asked for evidence of same, and they asked us to explain, you know, things that had been done, and so on. So we did have quite a lot of discussion with them about whether they were content, and they had to be content, as

did the NHS Board. So it wasn't just a case of, you know, Jane marking her own homework, as you've put it. It was more a case of-- We did have external scrutiny to that.

Q The material that went to the AARG in terms of these audits and the reports – and I've seen some of the tables of lists and things – did they all go to Board members as well?

A I doubt that level of detail went to the Board. They would have asked for assurance that-- I can't-- I can't absolutely remember, but-- But also, even-- The AARG actually asked for-- Because, within the report, there are some areas that are very much more important than others, so there was-- there was a level of degree of discussion about some more than others, is my recollection of it.

Q I'm just wondering whether-- You've described how you and your senior management team, effectively, chased on the implementation of recommendations. You've described how you then had a sort of internal audit by admin support who weren't the directors but were working with you.

A Yes.

Q You've described how the AARG are reviewing things. The way you've described all three, it involves people asking hard questions and looking at the issues.

A Yes.

Q Was the Board itself, the non-executive members of the Board, conducting any form of scrutiny audit themselves of this process, or were you just reporting to them that you were doing it?

A I don't think they would come out and say, "Show me," you know, "these." I don't think they would personally come out and do audit, no, or-- --

Q Well, I mean, you sometimes get, in local government, in fire and police authorities-- and it's quite common in formal structures south of the border for Board members, non-executive members, councillors, to have scrutiny panels where they ask questions of the implementation of audit or particular assurance programmes, and they themselves review material and challenge and ask questions of the officials; if not in public session, certainly in a formal setting. That doesn't sound like what you were doing with your Board members.

A So it would have gone through the normal committee structure.

Q There wasn't a separate committee?

A Not that I recall, no.

Q No. Okay. What I'd like to do

now is to move on to the Case Note Review, which we've had back on page 79. We asked you in a sort of open question – it's at the bottom of page 79, Question 72 – what you understood about the process of the CNR from the point of view of GGC, and you mention first being told about it by Professor Bain in early 2020. Was that before or after the minister had made the announcement in the Parliament?

A I can't remember, but I think we would have been told before. I think probably.

Q You note, over the page on page 80, that you were:

"... regularly involved in the various working groups but I was updated at a high level by Professor Bain as NHSGGC had limited involvement in its establishment, processes or progress, with the main input being the provision of information at a very detailed level. NHSGGC was not provided with the detailed outcome of each patient's review or the methodology associated with that conclusion."

Now, before we get to the draft report, which we will come to, when did you learn that GGC would not be provided with the detailed outcome of each patient's review or the methodology?

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

Q Because when----

A Probably-- Probably-- At the beginning, we probably knew that-- I think the Case Note Review was done over here, and, as part of that, it was a separate process, if you know what I mean.

Q I can understand that.

A So I'm not certain if at the beginning they said, "And you won't get the individual--" or what. I-- I don't remember that, to be honest.

Q What I'm wondering is whether, if you knew relatively early on that ultimately you wouldn't get the details of each case and what they thought about the question of whether there was a connection to the environment in each case, you raise that with anybody in the Scottish Government or with Professor Bain as a concern?

A So, I think, at this point, we're at Level 4 escalation, so we really didn't have much-- It was quite a challenging time to make observations. We were trying to work hard with the Case Note Review team, we were trying to work with these other boards that I just described, and we were at Level 4 escalation, so we weren't in a position, nor did we have the capacity, to get involved in every discussion with everything. But the Case Note Review was quite a separate

process.

Q I suppose the reason I'm asking is because, down the track, not knowing the reasons for each individual decision will become a feature of the concerns raised by the Board when the draft report is produced.

A Yes.

Q Therefore, I'm wondering-- It might be thought, if you don't raise the issue at the beginning and express concerns at the start, it rather limits your position to complain about the outcome at the end. So----

A I don't think we really knew what-- We were told-- Our main involvement in the Case Note Review was responding to their information requests, and it was in a completely separate-- Whereas the Oversight Board was-- was not in that-- you know, if I could call-- contrast that. So we didn't know exactly what was happening.

There was some discussion about things like the paediatric trigger tool, whether the methodology was correct or not, and the Case Note Review team did take on board some of the consultant-- our consultants' concerns, and we did make some representations to them about how the Case Note Review would be conducted. But-- But, as I say, it was quite difficult time, because we were sitting at Level-- Level 4 escalation, and

our main-- I mean, it was reported to us by Marion Bain what was happening rather than us being involved in-- in its drafting.

Q Because it occurs to me that, if we look at the term of reference of the Case Note Review in its final report, which is bundle 6, document 38, and I think it's the foot of page 999, we see:

"Purpose... The Case Note Review will review the medical records of all children... diagnosed with qualifying infections... and who were cared for... [and it gives a range of dates over the page] to establish several key issues... "

One of which you see is the number of children who were likely to have been put at risk because of the environment in which they were cared. What I'm suggesting is that either you knew, or you ought to have known, when the CNR was set up that that was one of the questions it was going to provide an answer to. That's why you were giving, corporately, all this information. So, if there was an anxiety that you might not see the full outcome, should you not have raised the concern at the beginning?

A I don't think that discussion took place at that time. In hindsight, it was-- you know, I-- it was more about how-- the questions are there, or the issues that were to be dealt with, but I think we're making a leap to what we

were told at the end, and I don't think that conversation really took place at the beginning. It was more a case of trying to make sure, bearing in mind the environment which I've spoken to you about already so I won't repeat it, of all the other things that were going on.

So we-- We were in a position of trying to support all of these things at an incredibly difficult time, especially as we go into the later period when COVID was on and so on. It was very, very difficult.

Q Well, indeed, Professor Stevens describes how you only had one physical meeting with Professor Bain and his colleagues before lockdown put everything online, so I do appreciate the timings.

A But also, it was-- if-- you read out a little of Fiona's statement-- or Professor McQueen's statement, sorry, and talked about the information requests or something, I can't remember what you said, that we complied with her information requests. But we had her things going on, and we had a lot from the Case Note Review, and we had, also, information requests from the other escalation process as well. So it was a lot, quite-- really a lot.

Q In essence, could it be that your position is that you may well have not appreciated that was the outcome, and you certainly didn't have the capacity or the status to raise the issue even if you'd had the time?

A I think we were told quite firmly that Case Note Review was going to be managed in an independent kind of way, and that our job was to support it by producing information rather than anything else.

Q Well, let's step forward to the end of the process, because we've been supplied with the draft Case Note Review, which at-- the front page you can see in bundle 25, document 2, at page 45, and it's February 2021. We've heard at length from Professor Stevens how there was a response supplied by the Board to this document, which I'm assuming you're aware of.

A Yes.

Q I just wondered how much notice you got of this draft.

A I'm not-- Can't remember.

Q It wasn't months, or----?

A Oh, no, certainly not months. No, no.

Q Right, so this arrives in February, and it's published in March.

A Yes, yes.

Q Yes, and then your colleagues produce a detailed, almost line-by-line response document.

A Yes.

Q Yes, and then you sent a letter to the expert panel on 1 March which

we've already looked, which is bundle 25, document 3, at page 151, and it's on 1 March. I'm just wondering, what was the purpose of writing this letter once you'd seen the draft?

A I think it was a higher level than the-- the detailed comments to outline some of our more generic-- "generic" is not the right word, but to summarise some of the issues that had come from the-- from the----

Q So you're attempting to provide a sort of higher-level summary to some degree?

A Yes.

Q Right, and we've already discussed the discussion on the third page about events in 2018. What I wanted to understand is-- It seems quite clear from this document, and from the long document produced by your colleagues, that there was a clear understanding in GGC at this point that you weren't going to see the individual assessments. Would you accept that?

A Yeah, I think so, yeah.

Q There's then a Teams meeting with the Case Note Review expert panel. Were you involved in that?

A Around March 2021?

Q Yes.

A Yes.

Q Yes.

A Yes.

Q (After a pause) I'll come back to that later, sorry. So, you had the meeting on 4 March and you wrote a second letter on 5 March, which is the next document, at page 155.

A Yes.

Q Now, this is quite a long letter, a page and a bit----

A I think-- I think it's that page and just a little bit on the second page----

Q Yes, but why did you send it having had the presentation to Professor Stevens?

A Because, again, we wanted to summarise what-- what we had discussed, and it is quite normal for us to send some sort of documentation after we've had a-- after we've a discussion.

Q Because he seems to have felt that you were trying to provide a further nudge.

A Yes, I saw that, but that wasn't the case.

Q Right.

A At-- At all times, and as I've said-- and if you go to my statement and-- also, to the first paragraph:

"We entirely understand this is an independent report and it is for you to consider the content."

So we understood that it was his report and that he would write whatever he thought was appropriate, but we just wanted to make sure. It's back to the

point that we've discussed on several occasions over the last couple of days; it's about the balance and trying to make sure that we have a balanced approach.

And that's what we're trying to do, but we were in no way trying to stop him from saying-- you couldn't do that, it wouldn't be-- you couldn't do that anyway, even if you wanted to, but even----

Q So----

A We were trying to be-- We were just trying to record the-- the ethos of the conversation and to say that we would like to try and get some balance. So that was all we were trying to do.

Q Were you, as Professor Stevens put it, "trying to turn the screw" on him? Sort of trying to make him change his mind?

A No. He's already put in the-- the comments that we had, so we weren't-- We were just trying to put our position forward and make sure that the report was factually correct.

Q What was the purpose of adding in this section about the generic email address at the bottom of the page?

A I think there had been some discussion about that. I think we were asked----

Q Would that be at the meeting?

A I beg your pardon?

Q Would that be at the discussion----?

A I think so. Yes, I think so.

Q Okay.

A I-- I've tried hard to remember exactly the conversation from that, but-- but there had been some discussion, I vaguely recall this, about the dynamics and so on, and so I think that was just to try and put some clarity on the position.

Q So, the Case Note Review is published. Go to bundle 6, please, and we go to document 38 and we go to page 980. In the bullet points, bullet points 5 and 6, they set out, in summary form, their conclusions on whether there was any relationship between the episodes of infection and the hospital environment.

What I want to do is focus on one particular aspect of it, which is the professor and his colleagues explained that 30 per cent of the 118 infections they considered probably had a connection to the hospital environment. Now, that's 33 infections. Once they're published as a final report, did NHS Greater Glasgow and Clyde accept the conclusions of the Case Note Review on the issue of connection to the environment?

A NHS Greater Glasgow and Clyde accepted the recommendations because we were keen to ensure that, if there was learning, that we took it on board.

Q Did NHS Greater Glasgow and

Clyde accept the conclusions of the Case Note Review at the time it was published?

A We-- We didn't really discuss that. It was more that, "We need to make sure the recommendations are implemented," because we were at Level 4 escalation, so we weren't in a position to (inaudible 12:50:16) Infection Control. We weren't in a position to start making comments about content and process and what was in the report. Our-- Our clear focus was in implementing the recommendations and making sure that the learning was taken on board, so----

Q You had made comments.

A I beg your pardon?

Q You had made comments, detailed comments, to the authors----

A Yeah, sure, but at-- You asked me "at the end of this", though. At the end of this, we had made comments, but we-- we decided that it was not appropriate to have an ongoing discussion about whether the-- all the comments had been taken on board or whether they hadn't. But our main focus was in saying, "Okay, if external colleagues who have looked at some of this have made recommendations, we should implement them," and that was our approach.

Q You said two things, and I want to check which is right. You said it was "not appropriate" to discuss these things, but also you said that you were under the Stage 4. Did you have the authority to accept or reject the conclusions of the CNR as a Board, or was that restricted by the Stage 4 process?

A I-- I don't know the answer to that question of whether we had the authority. I don't think it would've been wise, and the Board would expect us to move forward and implement the recommendations, and----

Q Why would it not be wise to express the view on whether you accept or reject the conclusions of the Case Note Review?

A We accepted the recommendations----

Q I do appreciate that, Ms Grant. You have said that four times----

A We were at Level 4 escalation, and we didn't-- we wanted to be positive in our approach to external reviews of the process, but it was incredibly difficult at that time because we were under Level 4 escalation, and also because we didn't have the detail of how-- how those conclusions were-- were made. So our approach to that was to say, "Well, if there's learning, and they have outlined a number of areas where we should seek to improve, then we'll do that," and that's what we did.

Q Shall we look at your public statement, which is-- We have it in the form it was presented in the Core Brief, so that's bundle 25, document 61, page 1260. In it, it states, in the second paragraph:

"The reports highlight a number of significant issues for the Board. We fully accept that there is important learning for NHSGGC and are committed to continuing to address the issues within the reports."

You don't say, "We accept the conclusions of the Case Note Review," or, "We reject the conclusions." Who would read this statement and need to know what you thought? Who's the audience for this statement?

A The Core Brief's audience is the-- is the internal----

Q Yes, but this is the same words as went in the public statement as well, so who's the audience for your public statements?

A The external environment----

Q Yes. So, let's imagine for a moment that a parent of one of the children who has suffered one of the 33 infections that the Case Note Review have concluded have a probable connection to the environment and is holding in their hand a letter from Professor Stevens, Professor Wilcox, and Ms Evans to that effect, with an analysis which you don't have-- and they read this statement. What are they supposed to do? Are they supposed to think it's good? They accept this conclusion I have in my hand or they reject it. How are the families supposed to react to you not answering the statement of whether you accept or reject the conclusions?

A So, we weren't-- So, we're looking back here, and I've explained to you the Board's position and I don't know if I can add anything else to that. We were-- The question was a difficult one to answer for the reasons I've already given, and what we were trying to do was say, "Okay, it talks about a number of issues that we had to improve and therefore we should get on and approach them." So, I don't know what was in the reports to the families. I've never seen one, so I don't know what level of detail there was. I don't know any of that and neither do any of my director colleagues. So it's quite hard to answer that other than in the way I've already answered your previous question.

Q Did you think of asking?

A Asking?

Q The families. You have the list of the families who are considered by the Case Note Review. Three extremely eminent people in this field, in their fields, have reached a conclusion. You don't know exactly which cases are the ones

that they think have a connection to the environment because, a year and a half before, it was decided-- or, a year before, it was decided that you wouldn't know. Do you think, "Maybe we should contact the families and ask to see the reports so that we can learn"?

A No, we were told quite firmly that the Board was not to see the reports by the Case Note Review team. I'm clear about that.

Q But the system existed where the families were able to give consent for the Case Note Review Report for their child to be sent to their own consultant.

A Yes.

Q That existed.

A But that's a different clinical conversation from the Board. That's different. And that was the position.

Q So, did you vocalise to anybody outside the Board this quandary that you're describing about not feeling able to comment and, therefore, not commenting about whether you accept the conclusions? Did you discuss it with the ministers or civil servants?

A There was ongoing discussion about our angst about the process, there was, but I can't-- I recall can't who said what to who when, but we certainly were clear about-- we were concerned about the process.

Q So, what's a parent to do when they see this statement, if they're holding in their hands a letter that says, "Yes, there is a connection," and your statement doesn't address whether you accept or reject the conclusions of the CNR?

A I think that parents would expect that, if there was recommendations, we would move forward on them, and that's what I think their concern would be. And their individual concerns were-- were dealt with in some cases, and some parents did ask, as I understand it, to see the individual reports, but not all of them-- for the consultant to see the individual reports, sorry. But I think we were not in a position to-- I mean, we were told very firmly that that was not an appropriate thing for us to see.

Q Ms Freeman has explained in her witness statement that she believes the Board initially accepted the Case Note Review's conclusions to avoid having a row with her. How do you respond to that suggestion?

A We accepted the recommendations.

Q But you never accepted the conclusions?

A I'm just trying to think if we even-- We were certainly concerned about the conclusions, but the key thing was to move forward and accept the

recommendations to improve. That was-- So, I'm not sure it was just as explicit as you're stating, but there was the difference between processing content and the implementation of the recommendations. I'm not sure I can----

Q So, Ms Freeman has said in her statement that she expected the Health Board to accept the conclusions of the CNR and the recommendations. Were you aware of any such expectation on her part that you accept the conclusions and the recommendations?

A I don't think it was as explicit as that, no.

Q Right. My Lord, this might be quite a good time to break for lunch.

THE CHAIR: We'll do that, Ms Grant, and if I could ask you to be back for two o'clock.

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

THE CHAIR: Good afternoon, Ms Grant.

THE WITNESS: Good afternoon.

THE CHAIR: Mr Mackintosh?

MR MACKINTOSH: I wonder if we can go back, Ms Grant, to bundle 25, document 61, page 1260 which is the statement. We looked at the second paragraph. Can we look at the second line of the third paragraph in which the Health Board states:

"For those whose infection episodes were judged by the Case Note Review panel to be possibly or probably linked to the hospital environment, we apologise unreservedly."

A Yes.

Q Now, does not an apology on an unreserved basis amount to an acceptance of the conclusion?

A I think we wanted to acknowledge that there had been upset and stress in the system for patients and their families, and that's what we were apologising for, the fact that----

Q Were you just apologising for upset and distress or something else?

A It's hard to tell from the words, to be honest, but we were apologising for the fact that it appeared from the report that some of the patients had been affected.

Q Was this an apology for harm that might have occurred to patients?

A It was an apology, I think, because there was a report which said that patients had been affected in a negative way, and we were thoughtful about how-- because these patients had already got a whole set of difficult circumstances to deal with, so we were apologising that these things had added to their distress.

So, we didn't look at it in the way you're trying to ask me about, you know,

"Was it the recommendations or was it this?" We just said, "Okay, if the report says that, then we should move on and try and implement the recommendations." So, we were to be sensitive to the fact that a report had been published which said that we had lessons to be learned and things to do and we were moving forward, but we didn't – well, I didn't – crawl all over the words in the way that you're describing.

Q I want to just check that are you apologising solely for distress or for actual harm, physical harm, caused by infections?

A I don't think we broke down into that way. We were just apologising to the patients because the report-- because of what the report had said.

Q Earlier on, just before lunch, I may have misheard you. You seemed to imply that the reason that you didn't address whether the Board would accept or reject the conclusions of the CNR was somehow tied up to the fact the Board was in Stage 4 of the escalation framework. Have I misunderstood you?

A So, we were in a situation whereby we were at Level 4 of the escalation process and we had a number of reports which talked about needing to make improvement, and so, therefore, our view was that we should accept the recommendations and move forward.

We were also thoughtful about at Level 4. We're not in a position to start pushing back on all of the recommendations. Our position was that, in terms of moving forward, we should accept that there was improvements to be made, accept the view that people had made recommendations, and that we should put our focus on implementing the recommendations.

Q How would you respond to the suggestion that, by taking such an approach, the Board to some degree loses the right to later turn around and reject the conclusions of the Case Note Review?

A I think we know things now that we didn't know then. I think, you know, we-- we had a set of circumstances; we had a report written in 2021; I think, in 2024/25, other things had emerged. But I still think, rather than focusing on whether the content – and we've put back a lot of comments, as you know – our view was that we should accept the recommendations. And I'm sorry I'm saying the same thing a lot of times, but that's----

Q No, I appreciate that, but I----

A But I do understand the, "Well, if you didn't complain at that"-- But when you're in a Level 4 escalation, and if you truly want to be sensitive to your patients – and, despite what everybody said, we

were absolutely focused on the families and the patients – then we didn't want to spend our time having the debate about whether it's right or wrong. We wanted to focus on what can we do to improve and build confidence and move the organisation and the service for the patients forward. And if we----

Q Just-- Carry on, please.

A Sorry. We had hoped that if we-- We had sought, as I've said to you a few times, external expertise – and some of it was easier to get than others, just because of the availability of people and the expertise – because this was the most complex set of circumstances that I think, certainly, we'd ever experienced, and I think probably the whole of the NHS in Scotland and maybe the UK.

And so, our-- It's important that, if there are different focus on different issues emerging, that, as an organisation, we try to ensure that those things that people, having spent time looking at things, had said needed to be better or could help us in the future, then that's what we should do.

Q No, I do understand that's what you were going to do and implement the recommendations, but you, effectively, have described a thoughtful, rational decision by the Health Board to focus on the recommendations and not set out your criticisms of the conclusions.

Is that fair?

A The first part is, but we didn't really have a lot of debate about the conclusions. We were thoughtful about the-- Sorry, I'm saying the same thing again, but we were thoughtful about methodology and we didn't know which patient was which, and so on, and so on, and how that had come about. So it wasn't so much at that point that we're critical of the-- Well, we-- We were, we were thoughtful about the whole methodology and so on, but it was really-- our real focus was on moving forward. So I can't-- I'm sorry, but I can't----

Q Yes, but other people are moving forward too. The patients and their families, they're moving forward too.

A Yeah.

Q They see this statement; they see this apology. Some of them have had a CNR letter saying that there's a probable link; some of them have had a CNR saying there's a possible link.

A Yes.

Q And they've moved on. Yet, at some point later, the Health Board, as you described, new evidence emerging, takes a particular line. Do you see there's any difficulty with changing your mind later on when they've already moved on themselves, the patients and families?

A I think the difficulty is-- I do

understand the point you make, but I think the difficulty is, you know, when we got that report, we were trying to think about, you know, what would families feel like. We were-- I mean, despite-- We were trying to think about that, and if a report says, you know, that there was possible or probable or whatever, then we should apologise that that-- that that has added to their whole-- I don't know, distress or challenge or whatever the word is. So we should apologise if the report says those words, so that's what we were trying to do.

Q One of the things that we've received recently – well, in the autumn of last year – is a document sent at the very end of the CNR's exercise to the Scottish ministers. It's bundle 27, volume 18, document 2, page 4. Most of this document is actually the overview report, but at the front of it is this chronology.

Do you see how, at the bottom of the section, it has-- well, just over halfway, "Overall Report Published" 22 March '21. There's then "Individual Reports sent to families"; then there's a series of individual (inaudible 14:13:54); "Final meeting with ... clinicians"; and then there's a "Final Core Project Team meeting", which is followed on 6 July by the "Final individual family meeting".

So, people have been moving forward since 22 March, and these

people, these families, don't know that you've decided to reserve your position on whether to accept the conclusions, do they?

A We didn't look at it like that.

Q No. Okay.

A You know, I think, in hindsight, you're describing a-- a-- I don't know what you're describing, but you're describing a series of thoughts, and so, on, that-- We didn't look on it like that.

Q You've just explained to me that you have noted there's been-- some more evidence has emerged, you said, about these issues.

A Yeah.

Q Would I be right in thinking that that evidence largely comprises a report by Professor Leanord and Mr Brown, three reports by Professor Evans, and the HAD report?

A Yes.

Q Yes. So those would have had to be instructed by the Health Board, wouldn't they?

A Certainly the HAD report was. I'm not sure if the Professor Leanord-- Again, probably. I'm not sure----

Q Yes, so someone would have had to ask them to do it.

A I'm not exactly sure how that came to be.

Q Yes. When did the Health Board decide to revisit and look at the

question of the Case Note Review and challenge its conclusions?

A I don't know.

Q Because Professor Brown says in his statement, paragraph 125, that he was not involved in "2024 discussions, if there are any," resulting in him to revisit what he describes as:

"… the Health Board's acceptance of the findings and conclusions of the CNR".

Did you discuss these issues with Professor Brown before he retired?

A I don't remember. I don't remember.

Q No. I wondered if we can just think about this. You've explained that you weren't thinking about this issue in the way I've set it out, i.e. a question of, "Well, do we accept the conclusions?" and you've explained how you were focusing on the recommendations and moving forward. Did you report any of this to the Board?

A Of our thoughtfulness about the----?

Q Yes.

A I'm sure we would have said to the Board that we'd sent back a large number of comments.

Q Well, can we look at the Board----

THE CHAIR: Sorry, my fault----

MR MACKINTOSH: "A large number of comments", my Lord.

A All right. Thank you.

Q If we look at the Board report – your report to the Board – on 27 April 2021. So the report is at bundle 37, document 58, page 1049. Well, the report is actually referred to at 1054. So, there's a minute here, describing paper 21/11, do you see at the top there, presented by you?

A When was this meeting, if you don't mind?

Q Go back to April '21. Go back to page 1049.

A April '21?

Q Yes. So, it's the-- I think it's the first board after the CNR is published.

A Okay.

Q If we go back to 1054, we see a recording, in the formal minute, of your report. We'll come to what your report says in a moment but, the second paragraph, you describe how the Oversight Board and Case Note Review papers had been published in March. You said that the Health Board:

"... acknowledged that there were lessons to be learned and recognised the impacts these issues have had on patients, their families and our staff… [and you] reiterated the Board's sincere apologies for the distress caused."

Then, if we look at the report, which is the same bundle but it's document 59,

page 1068-- So, this is the report sponsored by you, and the CNR is addressed in paragraph 3 on page 1072. So, you see, if we look at this description-- I'll give you a moment to read this.

A (Pause for reading) Okay.

Q And on the next page. (Pause for reading) Just for completeness, when you say so, we'll go on to the next page, but please let me know when you want to go.

A (Pause for reading) Okay.

Q The next page, please, and we have a summary----

A I beg your pardon? What did you say?

Q The summary continues here, covering both the Oversight Board and the CNR. Now, what I want to put to you is that nowhere in this report by you or in the minute of your report to the Board do you set out that the Board had a large number of concerns about the CNR presented to it in those documents that were presented in February.

A So, the Board were notified through a kind of notification from-- I can't remember if it was the the chair or the Comms department, but about the publication of the reports, and there was also two Board seminars – briefings, whatever – in the weeks after the publication of the Case Note Review and the Oversight Board to brief the Board in more detail on what the issues were. So, there was two opportunities, and we did do that.

Q So you briefed them about the concerns?

A We briefed them about the overall position, including that we had sent back a large list of factual accuracy questions.

Q Factual accuracy questions?

A Well, in terms of our feedback to them.

Q So, the thing that I'm trying to work out is-- I suppose there's two parts to this: one is what the Board know, and the other is what's actually in public record in the meetings where decisions are made. So, let's just look at the minute first. If we go to page 1054, at the end of your report, on 1055, we have the Board noting the update. So, what I'm going to put to you is that the Board take no decision about accepting the recommendations, or indeed accepting the conclusions, of the CNR. They simply note what you are doing. Would that be fair?

A I haven't read that minute in detail, but, yeah, that's what it looks like.

Q And if you did report the nature of the concerns that were raised in that long document sent in the end of February and March, that was done in the Board seminar?

A Yes.

Q Right.

A And there was also a discussion, as I recall. I don't remember the exact conversation, but there was also discussion about what we're going to do about things, but also, in amongst all of this, there was still, within the report, within the Case Note Review, a kind of level of-- There wasn't absolute certainty on-- because it says "probable", "possible", and so on. So one of the issues I think we were concerned about was (a) what does that mean? And so it wasn't certain in the Case Note Report about "A equals B" or "A has this impact on B". So there was quite a lot of uncertainty still about whether A caused B.

I mean, the report says that there is a "probable/possible"-- and says, somewhere in it-- I've forgotten the exact words but, you know, to the parents, "We recognise that"----

Q So they point out they can't have a definite link for any of the----

A Something like that.

Q Yes, they do that. Now, does that make any difference to the need to-- or do you need to obtain the approval or be accountable to the Board for the decision you have taken not to address the question of the Board's conclusions specifically in the Board statement?

A We didn't really discuss it in the way you're describing----

Q Right.

A -- and I can't say it any more firmly than that. We said-- Rather than arguing about, and spending our time arguing about, whether the content was right, wrong and indifferent, or whether the methodology was right or not, we took the view – and I think the Board did as well – that, if there are lessons to be learned, whether there's 100 per cent certainty or there's other things, then we should move forward and put in place actions to ensure that we've done everything that everyone can think of for the future should anything else ever occur in terms of those things.

Because quite a lot of the recommendations in all of those things were about more generic things, if you know what I mean, that the Board-- like data, and so on, that would be helpful for the future in making sure that we had the data and it was in the format that-- that people had-- had recommended. So, those kind of issues, rather than having an argument about-- you know, we're splitting it into a-- in here into a kind of-- different categories that I'm not sure really was the subject of the----

Q No, I'm going to have to push back. The CNR have done two things, they've-- one thing. They've done one

exercise and produced two sorts of conclusions: a conclusion on infection link, and a bunch of recommendations. You would like us to think that these are separate in some way. Is that----?

A No, what I'm saying is we didn't-- You're-- I can't say it, actually, more clear. I'm trying to. We focused our mind on not arguing about whether the conclusions were right or wrong in the-- but how to move forwards. That's what we did. We didn't sit and----

Q Do you, therefore, lose the right to change your mind three years later?

A No, I don't think so. I think we've-- I think that we were trying, in a due process, to try and be as clear as we could be and to remove some of the uncertainty.

Q To what extent do you think that this Case Note Review report engages the Board's corporate duty of candour?

A There's been quite a lot of discussion about the duty of candour, and I think it has been an issue in all of the reports, actually, in terms of what the definitions of "duty of candour" are, of organisational duty of candour, and when there's an incident-- not an incident, there was all issues about patient safety and all that sort of-- And so I think those definitions didn't help matters, and I think

I've explained in my statement about-- we thought the policy was correct. We had tried to validate it externally, and----

Q That wasn't the question I asked you. The question I asked you is did the publication of the Case Note Review engage the duty of candour because it comes after Professor White has done whatever he's done about the policy?

A I don't remember if there was an actual discussion-- I don't remember----

Q Should there have been a discussion, because----

A There may have been. I'm not saying there wasn't. I don't remember.

Q Because you've got three eminent medical professionals, albeit in a report where you can't see the individual conclusions, expressing the view in public that 33 infections more likely than not have an infection (sic) to the environment. Does that not engage the Board's duty of candour to address that with those families if you can identify them?

A So, there was certainly discussion about duty of candour throughout the process, but I-- I just can't recall, and, I'm sorry, I can't-- At what point the discussion took place, I don't remember.

Q Okay.

THE CHAIR: Are you moving on, Mr Mackintosh?

MR MACKINTOSH: I'm just checking myself. Just a couple of things I've just got circles on. I really just have one question left, which was-- You've explained, I appreciate, multiple times your understanding of what decision you made and how you approached it in that spring.

A About the Case Note Review?

Q About the Case Note Review. Do you think that response would have helped to build trust with the families whose children were in the Case Note Review now that they hear it years later?

A I don't know. We acted in good faith to try and move forward and make sure that we were doing the-- the recommendations. I'm-- It's a kind of-- I'm not sure that I can answer that question.

Q Were you trying to build trust with the families at the time you produced this response?

A We were, and we were trying to make sure that we were responsive to things that had been pointed out to us as being-- needing attention.

Q Thank you. My Lord, I'm sorry, I think I've probably got to my end of CNR, unless there are----

THE CHAIR: (Inaudible 14:28:23) with you, Ms Grant. First of all, can I just check I heard you correctly and that my note reflects what you've said? Now, in the context of the terms in which the CNR report in relation to connection between individual cases and the environment is concerned-- Now, you said – correct me – that they expressed their view on connection by using the words "probable" and "possible".

A Yes.

THE CHAIR: Now, if I heard you correctly, at that point in your evidence you said, "There was a degree of uncertainty."

A Yes.

THE CHAIR: Now, did I hear you correctly and note you correctly?

A There was some still-- Because it was "probable" or "possible" or whatever, then there was-- it's not 100 per cent.

THE CHAIR: It's not 100 per cent? Now, again, if I heard you correctly and noted correctly, you used the expression "100 per cent certainty". In this context, whether or not there was 100 per cent certainty, the thinking was – and at this point I'm paraphrasing what you said rather than the exact words – "we should implement the recommendations". Now, again, did you say something to that effect? In other words, whether or not there was 100 per cent certainty, the view was taken that the recommendations

should be implemented?

A Yes, because quite a lot of the recommendations were about things like data and how to collect things and how to report things, and-- not exclusively, but quite a lot of stuff like that, which, to be-- to be honest, would be helpful in going forward, because what we wanted to do was make sure that we-- we weren't sitting, you know, three years later and still things were-- those things hadn't been addressed.

So we wanted to make sure that, if the Case Note Review said, "It would be much better if you collected data in this way," or, "You did this and this and this," that we actually put in place the steps to-- to deal with them so that, for the future, we would have a more robust position, or whatever the word. I don't know the word, sorry.

THE CHAIR: Now I come to my question. Was the position of the Board that you were describing to Mr Mackintosh, and indeed your own position, that one requires 100 per cent certainty before one should proceed on the basis that there was a link between the building and the incidence of infection within the building?

A So, perhaps my wording is not correct. I mean, it's not about the 100 per cent certainty. It was a degree of uncertainty and, as I say, we didn't know

which patients were in which cohort, but it seemed inappropriate to start thinking about, "Well, actually we shouldn't accept this and we shouldn't accept that." It seems more appropriate to say, "Okay if that's the position that the Case Note Review having looked at all evidence that we haven't looked at, then we should accept what they've said and the recommendations, and move forward."

THE CHAIR: Can I press you on this? Was the Board's position that, before they could accept a link, they required 100 per cent certainty----

A No, no, that's what I'm saying is-- I think the word wasn't correct, and I'm sorry about that.

THE CHAIR: Sorry, could you repeat?

A I don't think-- and we didn't have the conversations about, "We need to be of 100 per cent certainty," and so on. That-- That was my language. We didn't-- We had some concerns about the factual accuracy of the report. We had some concerns about methodology, but we didn't have the conversation about, "Well, unless it's 100 per cent certain, it's not this"-- We didn't, and I'm-- if I'm portraying that wrongly, then I apologise.

It was really about-- Whether we disagree or agree with all of that is-- is-- not immaterial, but, on one level, it's

really about trying to apologise for the fact that that report says that a number of these patients had been impacted on and tried to move forward. So, I'm maybe portraying it wrongly just because-- I mean, we didn't have those kinds of conversations. It was more about, "How do we move forward with the recommendations?" And if a report says that you've impacted on patients, then that really isn't good and we need to move forward.

THE CHAIR: Thank you. Mr Mackintosh, is anything coming out of that?

MR MACKINTOSH: Two questions arise. One is if-- I think you've said it twice now, that it wasn't appropriate to get into whether you accepted the conclusions back in March 2021.

A Mm-hmm.

Q Why is it appropriate in 2023 or 2024?

A I think there was new things coming forward, the whole genome sequencing that we wanted to check, and, also, we wanted to get our own view of an external report to see what their view was. So I-- I'm not sure-- I don't really remember the exact rationale for doing that, to be honest.

Q Because there's two issues there. One is that Professor Leanord, who wrote his report with Mr Brown, and Professor Evans reviewed an understandably relatively limited number of samples, and it's Professor Wilcox's evidence that he had access to that-- the first go at that during the Case Note Review. In fact, there's a section in the Case Note Review where they discuss why they don't find it useful.

A Yes.

Q Then, in the HAD report, Professor Hawkey challenges that conclusion. He feels that they should have taken account of Professor Leanord's whole genome sequencing. So, the whole genome sequencing conclusions, to some extent, existed before March '21. It's in the CNR, I think it's 7.3. It's in there.

A So, I think the whole genome sequencing was moving at a pace of-- substantial pace and, at some point, and I can't recall when exactly, there was a-- Professor Leonard came and presented to some of the Executive team – I don't remember if the Board members were there; the chair might have been there, and Fiona McQueen was there – and talked about whole genome sequencing and the fact that things were changing and moving at a pace. And her view was it would have been very helpful if those things had been at that position earlier in the process, and I don't remember exactly when that meeting was, but it did

take place.

Q Then, in respect of the HAD report, you mentioned that you wanted to get their views----

A I think-- Sorry.

Q -- on it, I think is what you said. Do you mean you wanted the HAD office to give a view on the Case Note Review?

A No, no, no. I think we wanted to get some additional advice on-- on-- "Because the whole genome sequencing and the whole thing was still a bit uncertain, could we get an additional report?"

Q Was that targeted at working out whether there were flaws in the Case Note Review, as you understood it?

A No.

Q No. Okay. The final thing is actually reminding me, Professor Stevens made a suggestion. So, in evidence, when we discussed these topics with him, he suggested that the Board could have carried out their own root cause analysis of the same data that he had access to, because it's the Health Board's data. Was there any thought given to doing that?

A The-- The root cause analysis came, as I recall, more-- later when Emilia Crighton took over the----

Q So, there was one in 2019. That's what you're probably thinking about. This is in '21. Once the CNR is back, did you, as a Board, think, "Oh, what we should do is use the data the CNR have been given, because we gave it to them, to do our own root cause analysis"----

A Others would have been involved in that rather than the chief executive, and I don't remember the----

Q Do you remember discussions about that as an idea?

A I don't remember.

Q Right. What I want to do now is to move on to the risk registers, and bundle 45 is the NHSGGC Corporate Risk Register. It is one of those documents that is so heavily redacted for very good reasons, that it contains an awful lot of stuff that's nothing to do with this Inquiry. It looks rather like one of those reports you used to get in the early 2000s from the Americans.

If we go to the only entry that we can find that relates to water policies, it's in August 2018 at page 333, and it's a risk that appears to have been added in August 2019. You can see that from an earlier page, and the "accountable owner" is you-- It's not you, but Dr Armstrong, for some reason, and the description of risk is:

"Failure to implement national guidance, systems and policies in relation to water safety."

Then the current risks and controls

are listed. Now, what I'm wondering is why is the appearance of water safety on the Risk Register not-- Why doesn't it actually mention the Queen Elizabeth? Because that's the issue you're dealing with in August 2018; it's the DMA Canyon Report and all the consequences of that. When you put it on the Risk Register, it doesn't actually contain any reference to the hospital.

A I can't answer that. I'm sorry. I don't know why.

Q Do you think there's any responsibility of a chief executive to keep an eye on the Corporate Risk Register and put the major high-level risks on it?

A Yeah, we do. The Corporate Management team reviews the-- the Risk Register, and, as part of the overall process associated with these inquiries, then the whole risk management process has been reviewed and updated and----

Q Because one of the things that we've discussed in evidence, largely yesterday, a series of potential deficiencies – the Horne Optitherm taps, the air change rate in general wards, Ward 4B ventilation, Ward 2A ventilation, the isolation rooms – and you've explained carefully what you did about them when you learned about them, and I understand that.

What I want to simply put to you is that none of those appear on the Risk

Register before August '19. So I'm wondering could it be that the maintenance of the Corporate Risk Register, before that exercise in '19 of reviewing the policies, wasn't really up to scratch, it wasn't picking up risks out of the new building?

A So, I think there certainly was learning around the Risk Register, and, as part of the process, as I've said, we did completely review. So, I think that risk there doesn't specifically say the QE, as you've described, but I think it also recognises that, while the QE was an issue, or was the-- the area that we're focusing on, that actually the Board needs to be safe as well, so-- Because this is the Corporate Risk Register as opposed to individual sites or directorates. So, I think it is reasonable that we put it as a Board risk. I do get your point about, "Well, the Queen Elizabeth was causing the issues, so therefore"-- I'm sorry, what was the second-- Oh, the second question is it didn't refer-- it didn't----

Q No-- Do you think that, before the late 2019 change of policies and change of approach to the Risk Register, the Board was actually properly using the Risk Register to manage the risks from this new building?

A I think we were trying to, but I think undoubtedly it has improved in the

last few----

Q Right.

A -- years, and it's now a much more-- it's given a lot more attention and it's discussed at every committee meeting. It's discussed at every Corporate Management team-- and it's discussed regularly at the Board. So, it has a----

Q Because----

A -- greater prominence now than it had then and greater attention to it.

Q Isn't the Risk Register a tool for the non-executive Board members to understand their organisation? They can look at the Risk Register, see what the risks are, and, if something's not there, they can challenge why it's not there, and, if it's not going away, they can challenge why it's not going away? Would you accept that----

A It's a tool for everyone----

Q -- as part of----

A It's a tool for everyone, the executives and the non-executives.

Q So, if the use of the Risk Register wasn't as effective as it could be in the past, would you accept that was perhaps a slight governance-- if not "failing", sort of "under-success"?

A I think it's something that we had to improve, yes.

Q Right. Let's talk about

communication with parents. Take that off the screen, please. What role did you have in the approval of press statements? But before I ask that, I'll ask you to answer in a particular way. We obviously have you arriving in April '17, and we have the Stage 4 escalation at the end of '19. Perhaps the easiest way to ask it is, is there a point when you start, as chief executive, taking interest in what's in the press statement?

A So, press statements associated with-- There's a lot of press statements and a lot of press queries and so on, a huge amount. So it's not possible for the chief executive, in the same way as I've described to you as the issues when we were trying to get them approved by the Scottish Government-- It wouldn't be possible for the chief exec to-- nor would it be appropriate. There are really senior players in the organisation who have the ability to do that and do it. A lot through the Acute division with the Acute Management team in terms of the COO, the Acute medical director, Acute nurse director, a lot through that process.

There wasn't a date when, you know, "From 1 June, Jane decided to"-- It didn't happen like that. There were-- The vast majority of press statements were signed off by or viewed by others in the organisation. Some were brought to

my attention, some were, and if you're going to ask me which ones were, I'm very sorry, I can't answer.

Q No, I'm going to ask you, with a due recognition of the fact this answer will be somewhat soft, is there a point in the narrative, as things emerge-- So, if you think about the relevant times – the water incident starts, the first decant, CDU decant, the summer of '19, Cryptoccocus – is there a point when you recollect you're taking a significantly greater interest in the press statements about these events?

A Yeah, there was-- there was that situation, but it also depended on what the press question was, if you know what I mean. So, it wasn't a case of, "From that time to this time, you did this." And I'm going to go back and be really annoying, and I'm not trying to be. The size of the organisation requires that senior players-- I mean, the players who are in, that I've described, in sector teams and so on, they're really senior players and, therefore, they do sign off things. But there was a time where more came for me to----

Q When was that?

A During that period, but I couldn't tell-- And it wasn't like, "From June till July, Jane looked at..." It wasn't-- It depended-- It was quite issue-dependent as well. If there were issues that-- Some of them came to me to review, depending on what the issue was. So, it wasn't a case of, "From that date to this date," and it still wouldn't be today, I don't think.

Q Are you able to give us a feel for, over that period, how many press statements you would have looked at? In tens, hundreds? One? Two?

A I couldn't-- It certainly wasn't one, and it wasn't 100. I'm sorry, that's----

Q Thinking about----

A -- not something I've ever thought of.

Q -- what you can recollect, how would you respond to the suggestion that Greater Glasgow and Clyde's external communications during the period 2018 and 2019 were carefully worded to protect organisational reputation and not open or transparent enough?

A Yeah, we certainly tried to be-- With the information we had at that time, we tried to-- to put out a position that did describe the situation. I know that others have made comment on, you know, "You should have described everything in those statements." I think it's difficult to get the balance right of what you should say and what you shouldn't say. But we certainly did try, with the information we had, to do it in a constructive way.

The stuff that was coming from the

IMNT generally was signed off by the IMNT chair, and there were other statements that didn't come through that process, but----

Q So, I think the IMT chair's view is that some words were changed, for example, "mold" to "damp", or "sewage" to "effluent", in a way that-- we should see it as softening the impact of those words in statements. Is that something you recognise?

A I couldn't tell you if that was done or not, I don't know.

Q Now, Ms Freeman's position in her statement appears to be broadly that the Board did not have open and transparent communications with patients and families. How would you respond to that?

A Yes, that-- that's why she asked Craig White to look at-- to help us, why----

Q Yes. What do you think about whether that had any merit as a point of view?

A I think we were in a very difficult set of circumstances, and we thought we were, and still think, that we were doing the best we could with information we've had. I think, on reflection, that we should have paused and thought about how to engage directly with families at an earlier stage, I think, because we were trying to get the routine

normal processes to do that when perhaps we should have stepped in earlier and tried to do----

Q I wonder if I can put to you part of a statement by Ms Darroch, which she gave evidence in the 2021 Glasgow I hearing, which is – thank you -– page 327, please. It's the top half of the page. She's describing the period after the death of her child, and then she says:

"They're not communicating with the families at all. They keep saying in the media that they are more than happy to meet with families but they've never once invited me personally to have a meeting with them. So their communication, or lack of communication, is absolutely shocking. I think it would be really good for them to meet families that have gone through this unnecessary pain but they're staying away from all of us as much as they can."

How would you respond to that?

A So, we did meet the families. We had a meeting, the chair and I, and other colleagues were there, and we also did offer families the opportunity to meet with members of our team. I'm sure we did do that. Whether it was in the-- Whether it was in a more generic kind of way or whether it was individual, I'm not sure, but we certainly were happy to meet with families. We did meet with a group of families, and I know the local teams

have also met with families on a number of----

Q I mean, this particular witness in September '21 didn't think you had. I mean, I know----

A (Inaudible 14:49:35).

Q -- we're not going to get into it, but do you see there's a sort of inconsistency there?

A Yes, I don't remember when exactly that meeting was, so----

Q Okay.

A But-- Certainly, there were some, but I do accept that, at a corporate level, rather than just relying on-- There was our local team, management team, were engaging with families on a regular basis. I think the other thing which we didn't get to was around the families of patients who weren't inpatients. If they were-- If they had been inpatient but they weren't now, then I think we didn't pay enough attention to that at the beginning and we should have, and I'm sorry about that.

Q Okay. Let's take off the screen please and move on to the duty of candour policy. Now, most of this is actually about Professor White and his interactions with that.

A Yes.

Q It may be the fault of our questions to you, but I wanted to clarify something. If we go to page 52 of your statement bundle, with a bit of luck, that should be Question 36. Question 36. Now, we asked you a series of questions in this Question 36. Do you see how the second last line is, "Do you accept that his [Professor White's] criticism is fair?" I didn't get the impression that you'd fully answered that in this rather long answer that continues over the page onto page 53 and ends on page 54. We re-ask you the question in Question 36(a):

"Do you accept that Professor White's criticism of the NHS GGC Duty of Candour policy as it stood in 2019 was fair?"

And your response is:

"I believe that Professor White's comments need to be considered in the overall context of the situation. NHSGGC had sought external validation of its policy to ensure it was fully addressing the legislation and understood that to be the case. In addition, as previously stated, there was some national clarity required to ensure consistency and NHSGGC welcomed that clarity."

Now, for the third time, was his criticism fair at the time it was made?

A I'm sorry, but I don't think it's a yes or no question. That's the----

Q Right.

A That's the difficulty here. So, I think I've explained in my answer, or I've tried to, that we did seek to make sure

our policy was appropriate. We did ask our internal auditors to look at it and they all agreed that it was. There was some recommendations in the Independent Review around the fact that further national clarity was required and Professor White was in the middle of that, because I think he was the leader for this. If he wasn't the leader, he was one of the components-- key leaders and colleagues who addressed that.

I think the difficulty is around some of the words and the definition of those words, and I think there was some confusion about that which didn't help matters. And I think that was our position, rather than us saying, "We don't think the policy is adhering to the legislation." We thought it was, and some of the definitions were not entirely clear and national work is required, and I think that has been done now, to try and clarify that.

Q So, one of the----

A And we've changed our policy.

Q So, one of the criticisms that Professor White made is that the 2019 version of the policy required causation to be determined before the policy could be activated. Do you remember that?

A I remember him saying that.

Q Yes, yes. Now, understanding what you say about clarity and guidance, do you see why having such an element within the policy might actually substantially reduce the number of times the Board had to activate its duty of candour policy, if it required to show causation before it activated its policy?

A I think we did some work to see whether our-- the number of times we were using the-- The organisational duty of candour was different from other people's in terms of size and scale, and-- and we believed that we were similar to other Boards. So, we did try to look at that to see if we only had one and you had ten or whatever. We did do that, and-- and we thought we were in the pack, so we thought that we were similar to other people. We did understand that there was some some-- some lack of clarity around for Infection Control incidents, how would that be reported, so that emerged----

Q Yes, because there was a suggestion----

A -- during this time.

Q -- that you might expect-- because the risk of infection is a known risk for Paediatric Haemato-oncology patients.

A Yes, so there was no intention to do anything other than be open and transparent and to try and do that. There was absolutely none. It was really around what are the definitions and how does that work and do we need national--

because in all these things, you can interpret it one way and I interpret it another way, and also, with new legislation, certainly in my experience in the Health Service, and-- I mean, you guys are all the experts rather than me telling you, but there are times when when the policies-- when the legislation is put in and then policies, first round, are drafted, then they do have to be amended as things emerge, and that-- I think that is fair.

Q I'm thinking back to the end of your office as period as chief executive. By that point, do you think the Board had issued all duty of candour statements to all affected families for whom the law requires you to do that? You're confident that you've made all the necessary duty of candour declarations?

A I can't answer that, I'm sorry.

Q What steps did you take to ensure that you had done that?

A Other colleagues within the organisation would have dealt with that----

Q You didn't----

A -- so I personally didn't do that.

Q Because I realise you got involved in understanding why Professor White said what he said----

A Uh-huh.

Q -- and revising the policy. At that point, did you do anything to sort of look back and to check that there haven't been examples of incidents in the past, particularly related to the Queen Elizabeth, where the Health Board should, if it had had the policy that was actually correct, have made a duty of candour declaration----

A No.

Q -- but didn't do that? No. What I want to do now, Ms Grant, is to-- I've got a section which, rather unfortunately, I've described as "significant criticism". I want to pick up some series of criticisms at the end, and what we'll do is, when I've done that, which might take about half an hour, we'll have a short break to see if there are any further questions from my colleagues, from the core participants in the room. The first question is, thinking about the just the Queen Elizabeth and no other part of your duties, and perhaps the period from your arrival until the commencement of the Stage 4, what do you think personally you should have done differently?

A I think, in hindsight, you know, if there had been-- if all the information that's available now had been available then – which it wasn't – then, clearly, action could have been taken sooner, but I would need to stress to you that there wasn't the information available and during that period, we were trying to deal

with the issues that were raised.

Q Are you saying that you should have done something differently in there? Because I didn't quite get it if you were trying to say that.

A I think, if the information that we have now-- The problem is we're looking back in hindsight and, at that time in 2017, some of these issues weren't to the fore that they are now and later on, when-- In 2017 we certainly started to take action and things were already going on in 2017 around things like ventilation, so I think we're-- I think it's being portrayed that nothing was happening and that isn't correct, it was happening.

Q If we go to your final part of your statement, so actually at the end, Question 85 on page 88 was:

"Is there anything further you want to add that you feel could be of assistance to the Inquiry?"

Over the page on 87, you start-- There we are. Yes, 89, sorry, my mistake, 89, thank you. The second paragraph you see, you said:

"It is, however, incumbent on all parties to reflect and consider how best to address very complex issues often do not have an easy solution. The period from 2018 onwards was one of unimaginable complexity with the Infection Control and performance escalation, the COVID pandemic, and the need to take legal action against the main building contractor of the QEUH/RHC."

How do you respond to the suggestion that the period from 2018 could have been significantly less complex if the Board had reacted promptly to concerns about the ventilation system as they emerged, both before you arrived and after you arrived in 2017?

A We were trying to deal with things as they emerged, so we were trying to do that. I think the set of circumstances that then came upon us could never have been imagined, frankly, or I certainly didn't and I don't think anyone did, and then the multitude of things that happening was very difficult to deal with all sorts of issues.

I think the ventilation only became a bigger issue as we went on. In the first period in 2017, the hospital had already been open for two and a half years and it hadn't been a huge issue in terms of infections and so on. So, now looking back, there's a different lens to be applied to that, but, at that point, there was not.

Q Again, thinking about this paragraph, how do you respond to the suggestion that events since 2018 could have been significantly less complex had the Board responded in a more welcoming manner to the raising of issues by three whistleblowers in September 2017?

A But the issues from the whistleblowers, we were addressing them.

Q But what I mean is-- Part of Dr Redding's reason for going to Stage 2 is that she didn't know you were addressing them. So, if the Board had been a bit more-- I wouldn't go as far as saying "grateful" because that pushes it too far, but gave the impression that it was glad to be told these things, would that not have prevented some of the later problems occurring?

A Certainly, in my interactions with Dr Redding, there was no-- I can't remember what the language you used there, but "unfriendliness" or whatever. I can't remember what you said.

Q I (inaudible 15:01:11) welcome and glad and----

A Unwelcome, then. There was no unwelcomeness about my response to her and I'm unaware-- and I do know you said yesterday, I think, that there was different views of how welcomed or otherwise their contributions were, but the key matter here is that we took action when they raised them, we tried to deal with them.

I'm unable to make a comment, really, about whether they were-- how they felt about they were welcomed or otherwise, but, certainly, the Board, at that point in the autumn of 2017, took on board the points that were being made and tried to address them.

Q This is perhaps a small question. We've discussed how the Board sub-committees have their minutes sent up to the main Board----

A Yes.

Q -- but, as I understand it, the minutes of the delegated committees are not publicly available. Do you think it would help for visibility and transparency if, in the future, they were because so much of the Board's business is done in sub-committees?

A I think there's two things. One is they are available through FOI if required. I appreciate that's a different thing from what----

Q Yes.

A -- you're suggesting and I think that also the reason the chair asked for the sub-committee chairs, if you understand what I mean, to give an update on the Board of the three significant-- So, at the end of each committee now, then the committee is asked to agree what issues should be put into the sub-committee report, if I could call it that, that goes to the Board.

So, if the sub-committee chair says that that should be raised or whatever, then the-- generally three, but it can be more than that, is reported to the Board and the-- and then sub-committee non-

executive chairs update the Board on those issues.

Q But would it help transparency to actually put the sub-committee minutes on the website so people don't have to do a FOI or it doesn't have to be an issue that the sub-committee chair realises is of interest in order to get noted?

A Yeah, it could be, it could be but, as I say, the attempt to do that was around trying to get the sub-committee chairs to update the full Board on the key issues from their committee so that, rather than the people having to go through the whole minute, then the sub-committee chairs were asked to bring to the attention of the Board key things.

Q Thank you. I think I've got this in a not very good order, but I'll come back to this now. So, do you think there's an apology to be given to the whistleblowers and Dr Inkster for what happened to them for raising concerns about infections in the environment of the Queen Elizabeth? If not, why not?

A I think that the whistleblowers-- It's been a very difficult debate with whistleblowers. I think we have tried to treat them with respect and with due process. I think they have been dissatisfied with some elements of that, but we have put in place senior people who hadn't got things to do with this to look at their concerns. I think that we

have tried to address their concerns in a constructive way.

Q Is that a yes or a no?

A It's really neither, sorry.

Q If the question is, "Are you willing to apologise?" one of the answers is, "Yes, and here's an apology," and the other answer is, "No, and this is why not." Is there another position?

A I think, in order to apologise, you have to be sure that-- how shall I put this. There have been a significant amount of issues raised. There has been different approaches from-- the whistleblowers are not all one person, you know, they're all different and so therefore, some of them have been incredibly challenging to try and work with in a constructive way. We do require to have people to be team players and so, therefore, I don't think it is. And that doesn't mean that they shouldn't whistleblow, that is absolutely what people should do if they feel that they are not-- for all parts of the Board, and that does happen, there are whistleblows throughout the Board. I think it's difficult to answer your question in a yes or no way, because I do believe that, in good faith, we try to deal with the issues that are being raised.

THE CHAIR: Really, it sounds to me like a no. What you're saying is----

A Probably-- It probably is no,

yeah.

THE CHAIR: -- and this is the answer which the question invites, is you have nothing to apologise for.

A I do understand that they have concerns, I do understand that, but I think we tried to deal with them, so probably it is no.

MR MACKINTOSH: Taking your answer as a whole, so I'm not going to attempt to repeat it or pass it, but taking your answer to those two questions as a whole, do you think answers like that encourage future whistleblowers to step up and raise issues?

A So, as I think I've described to you, we've done a huge amount of work around whistleblowing and I won't go through all that again. I think we have tried and do try with all whistleblowers to address the concerns. We also try to support those who whistleblow and we try to support those who have been whistleblown against, if that's a word-- I don't know. You know what I mean.

Q I know what you mean.

A As I said to you yesterday, there was a review done by Charles Vincent and an external HR person. There were recommendations from that and we've continued to move forward on that.

Q But, if you take all those things together, do you believe – I think there is a yes or no here – that the effect of all that is that disclosures of concerns about wrongdoing or failures in performance or inadequacies of systems or any of these things is now encouraged in NHS Greater Glasgow?

A Yes, I do believe it is.

Q Now, Ms Freeman has, in her witness statement-- that she considered that, in 2019, there was a failing in the organisational duty of candour; not the policy, but the implementation of it. Do you accept that criticism?

A Certainly, my understanding – and I wasn't involved in this conversation, I don't believe – was that there was a lot of discussion about whether organisational duty of candour-- or what the situation was. It was felt by those in the conversation that it shouldn't be and that was a judgment they made.

Q Do you think that clinicians were being provided with sufficient information to exercise the duty of candour policy in 2019 in the Schiehallion?

A I couldn't answer that because I don't know, I'm sorry.

Q I'd like to end-- Oh, no, before I end, I've got another question, sorry. This is the problem about changing my mind when I listen to your questions. Can I take you to the Vale of Leven report? So this is bundle 51, document 2,

and it's the summary, so it's page 230. Now, just as sort of a matter of history (inaudible 15:09:08), you were actually part of the internal investigation team and gave evidence to the Vale of Leven Inquiry?

A Yes.

Q So, I'm presuming you've, a long time ago, read this.

A A long time ago.

Q Long ago. Page 230. Now, it's actually on page 232 that I want to go to. In fact, it's not at all. It's on 238. Sorry, my Lord. Yes. So, "The importance of questioning". Do you see on the right-hand side, there's a heading in blue, "Management":

"It was surprising how managers at different levels within an organisation like NHSGGC failed in one of the most fundamental aspects of management, namely to ask questions."

Now, obviously, the rest of the discussion is the facts of the Vale of Leven Hospital, but do you think there's a criticism that can be made of of you and the senior management team that, prior to the DMA Canyon report emerging and the arrival of Professor Steele, for the reasons you have explained, you weren't asking the right questions, for the reasons you've explained, that you were looking forward and trying to work-- But you weren't asking the right questions?

A So, I think it's easy to look back in hindsight and think, "Well, actually, knowing what we know now--" At that time we were asking quite a lot of questions of our Estates colleagues and our Facilities colleagues and so on about exactly what was happening. There's quite a lot of emails and correspondence asking people what's happening about this and what's happening about that, and certainly the Acute Division team were also asking questions, Dr Armstrong was asking questions, and, as part of that, they were briefing me and I was asking them questions.

So, I think there was quite a lot of questions, and I also think that the Board, as I'd said to you before-- And sometimes we are confusing the Board, the organisation, and the Corporate Management team, if you know what I mean, but I think the Board, in its sense of the non-executives and so on, were asking quite a lot of questions and continued to do so.

And some of those discussions-- I mean, all of the discussion on every topic isn't in all the minutes, but I can assure you there was a lot of scrutiny and questions to executives from the non-executives about issues that were emerging. And there was.

Q The final question is to put to you the views of a parent set out in a

statement to the Inquiry. Now, this is the Glasgow I, statement bundle 6, page 142. It's the statement of Professor Cuddihy, and it's paragraph 318. Now, this is in a section called "Duty of Candour Overview" by the professor.

One of the difficulties, Ms Grant, is that, not only did we give you a lot of documents, we gave the computer a lot of documents, too. If we go to page 142-- So, I want to look at paragraph 318. So, paragraph 317, Professor Cuddihy describes the care provided to his daughter by Dr Sastry, and then, in 318, he then says this. If we could zoom in, please.

"The same cannot be said for my experience with NHSGGC corporate services; Chief Executive, Directors and Senior Managers who I found individually and collectively to be duplicitous, overly defensive, devoid of emotional intelligence and lacking in integrity with concern more for their reputation rather than patient safety. They infused a sense of distrust through a culture of secrecy, fuelled, at best, and as stated previously, by dysfunctional or at worst, corrupt practices."

Now, I should point out that I've not seen evidence of corrupt practices, but, looking at the rest of that paragraph, how would you respond to that as chief executive at the time that he's dealing with?

A Yes, Professor Cuddihy did make his views known to us, to the chair and I, and we did try to answer his questions.

THE CHAIR: Sorry, I missed the beginning of that.

A Sorry. Professor Cuddihy did make his concerns, or some of them, known to the chair and me, and he did talk about some of those issues when we met, and we tried to address some of his concerns, and we did work, through the Oversight Board as well, with Craig White to try and make sure that we did address some of those-- the concerns that the families had raised to be more proactive and also to ensure that the mechanisms for feedback of concerns were much easier for families to address.

I think we did put too much emphasis on the local teams who-- which is what we normally would have done, and I'm aware that Professor Cuddihy had some serious concerns.

MR MACKINTOSH: Are there any of those concerns that you, to any extent, would accept?

A I think-- As I've said, I think at a corporate level, I-- colleagues didn't stop and look at the issues, and we-- we struggled, I think, to-- when we weren't certain, to put things out into the public domain of which we weren't certain,

because, if we did, then we were-- If we-- If we weren't sure, then we didn't want to add to the complexity of the situation, and I think that, on occasions, didn't help matters. And so I think we have reviewed that and thought carefully about "We should have done that in a different way."

Q Thank you. My Lord, I think, for me, that's where I am at the moment, and I wonder if we might have an additional 10-minute break at this point.

THE CHAIR: Ms Grant, as Mr Mackintosh has explained, he wants the opportunity to check with legal representatives as to whether there are other questions to be asked. So, if I could invite you to go back to the witness room, and I would hope to be able to start again, if we need to start again, in about 10 minutes or so.

A That's fine. Thank you.

(Short break)

THE CHAIR: Mr Mackintosh.

MR MACKINTOSH: My Lord, there are four or four and a half questions I have from the room.

THE CHAIR: All right. (After a pause) Perhaps four questions, Ms Grant.

MR MACKINTOSH: Ms Grant, the first question relates to an email, which you've probably never seen before, from 26 June 2015, and the question of whether there was sufficient information for the Board to know to act. It's bundle 12, document 225. I think it might be bundle-- document 25, page 225. There we are. So, it's an email from Dr Peters, who was then sector ICD for South Sector, to Mr Walsh, who was ICM at that point, co-chair of the Water Safety Group, copied to two other sector ICDs, Dr Inkster and Dr Wright.

What this email contains is a series of lists of issues, and the first one:

"Legionella in new build: requested results in writing to enable clinical risk assessment..."

And this third one:

"Water... need full reports to ensure legionella not in any of these outlets when that information becomes available as above..."

Is that not actually a request for L8 risk assessments? That's something that would have been in the DMA Canyon report that she was asking for in 2015.

A I couldn't answer that. I don't know. I'm sorry, I've never seen that email before.

Q Yes, and then the second item, "Ventilation"----

THE CHAIR: Well, I appreciate you haven't seen the email, but did you answer counsel's question?

MR MACKINTOSH: Yes, so what

I'm trying to say is do----

A Sorry.

Q -- you understand why one might think that a reference to Legionella in a request from a sector ICD to the co-chair of the Water Safety Group in June 2015 is an early indication that Dr Peters was asking for this information as early as 2015, and you didn't find out about it until three years later because you were told by Professor Steele?

A I guess there's probably a lot of emails in that period, around 2015, about things that were going on. I'm not sure-- Sorry, could you repeat the question, if-- if that's all right?

Q Well, let's just look at it, and then I'll ask a better question, I think. If we then look at the-- The second item is, "BMT, accommodation Adult's: ventilation."

A Yeah.

Q Third item is "Water". Fourth item is about the details of lobbied isolation rooms, and the request at the end is:

"Please advise how best to tie all this together and take matters forward in as efficient and a co-ordinated manner as possible."

What I'm putting to you is that the Board, in the form of its ICM and its co-chair of the Water Safety Group-- and this is just one example of a number of

emails, including the letter of resignation that follows a week later, of these issues being brought to the attention of the Board as early as 2015, so one can't say the Board didn't have information about these issues as early as 2015. How do you react to that?

A So, was there an answer to that?

Q We don't have the answer.

A So we don't know?

Q We don't know.

A So, it's quite hard to-- certainly, that's clear about the-- the issues that were being raised, but what I don't know is what was done about it, and-- and some of them I recognise, some of them I know little or nothing about. So, yes, it is clear that colleagues were raising issues. That's clear.

Q The next issue relates to a statement that was reported in the press in, I think, 2023, if I have the year right, by Sandra Bustillo. If I remember it correctly, the statement was that she was reported to have said to a colleague that one of the parents, "He may have won the battle, but he won't win the war," or something like that. Do you remember that----

A Yes.

Q -- in the press reports?

A Yes.

Q What did you think about that

when it happened?

A I thought it wasn't appropriate for people to speak about colleagues like-- and families like that.

Q Did you do anything about that?

A I spoke to the director of Comms who fully apologised for that, and she apologised and gave an undertaking that that wouldn't happen again, and also apologised to other colleagues within the Board.

Q The next issue relates to the water issue in the summer of '18, so when you received the DMA Canyon reports, and you've explained carefully how you received it and who you passed it on to, and we know that Dr Armstrong then passed it on to Dr Inkster, and you've explained you passed it on to Ms Kane, and we know you set up a working group. What did you do, personally, to review the water testing and the work done in the past to manage the water system and risk?

A The water testing?

Q Yes, what did you do yourself?

A So, the water----

Q Look backwards.

A So, the water testing had been raised as part of the 2017 SBAR, and so that piece of work was ongoing through that process and I was given regular updates on-- on what was happening

about----

Q So you already knew there was-- I'm not sure "issue" is the right word, but you would know that there was a desire to have access to water testing results----

A The water testing----

Q Yes.

A -- which was in that SBAR in 2007.

Q But when you think about-- the DMA Canyon report arise-- it has all that red on it, if you remember.

A Yes, yes.

Q What's your actions as the chief executive and duty holder that you take to work out how the-- whether the water system is being safely managed at that point?

A In 2018?

Q In 2018.

A Well, that-- that's why we tried to take immediate action to make sure that the-- the issues that were raised-- because some of them were about paperwork and training and stuff, and some of them were about actual things. So Mary Anne and her team absolutely got on top of that very, very quickly and-- and put in place the issues, and reported that back on a regular basis.

Q We've already discussed the entry in the Corporate Risk Register, number 45, in August of that year. Did

you do anything to ensure that this risk was on the Risk Register, or is that-- the arrival of that item, is that caused by some other investigation by Mary Anne Kane, or by Mr Leiper, or one of the other----

A It probably was, but I'm-- I'm not entirely sure which was the catalyst for putting on-- I'm not entirely sure of that.

Q Thank you. If we can go back to your statement, this is page 89-- well, 88, actually, the very bottom of it. I didn't ask you about this paragraph. After describing the Board, you say:

"Clinical services [the last line] within NHSGGC are of a high calibre and I regret that [over the page] significant concern and distress has been added to the patients, families and our staff over the last few years associated with these issues."

A Yes.

Q In respect to the patients and their families, do you feel any need to turn that expression of regret into an apology?

A I think it's-- I am sorry that patients who already had-- and families who already had a-- a series of incredibly difficult situations to deal with in terms of illness had this additional-- yeah.

Q Thank you. My Lord, I'm just going to glance at the people who asked those questions and-- Thank you, my Lord. Thank you, Ms Grant.

THE CHAIR: Ms Grant, that is now the end of your evidence and, therefore, you're free to go, but thank you for your attendance today and yesterday, and thank you for the work that has gone in reading background material and preparing your statement. You're now free to go. Thank you.

A Thank you.

(<u>The witness withdrew</u>)

THE CHAIR: Now, Mr Mackintosh, am I right in thinking it's Professor Bain tomorrow morning?

MR MACKINTOSH: It is. Mr Connal is taking that witness.

THE CHAIR: Right, and----

MR MACKINTOSH: It's probably worth----

THE CHAIR: -- Ms Imrie in the afternoon.

MR MACKINTOSH: No, it's Ms Imrie on Friday morning and, in the afternoon-- I think we've previously told core participants, but I'll make it very clear to anyone watching online, the afternoon will be Mr Wright on Friday afternoon.

THE CHAIR: Right, okay, so I've got these time's wrong. So that's----

MR MACKINTOSH: So, we did

think we would have an early finish on Friday, but we won't now, the consequence of which will be a week on Tuesday in the Tuesday of the final week, when Professor McMahon and Ms Ward give evidence in the morning, there won't be an afternoon witness, so we're going to run the full days this week, the full days next week, but in the final week we'll have a shorter first day on the final week.

THE CHAIR: Right, okay. So, let's-- If I'm following that: Professor Bain tomorrow morning and then, in the afternoon----

MR MACKINTOSH: No, on Friday we then have Ms Imrie and Mr Wright.

THE CHAIR: Right.

MR MACKINTOSH: So Bain is the whole day tomorrow.

THE CHAIR: Right.

MR MACKINTOSH: I'm not sure she will be the whole day, but that's what we allocated----

THE CHAIR: Right. No, that's what I'd forgotten. All right. Well, if I could wish everyone a good afternoon, and we'll see each other tomorrow.

(<u>Session ends</u>)

(15:53)