SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
16 September 2025

Day 7
25 September 2025
Marion Bain

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(10:05)

THE CHAIR: Good morning, Mr Connal. We have Professor Bain?

MR CONNAL: Correct, my Lord.

THE CHAIR: Good morning, Professor.

PROFESSOR BAIN: Good morning.

THE CHAIR: Now, as you know, you're about to be asked questions by Mr Connal, who's sitting opposite you, but, first of all, I understand you're prepared to affirm.

Professor Marion Bain
Affirmed

Thank you, Professor. Now, you're scheduled for the whole day. It may be your evidence does not take all that time. We will take a coffee break at about half past eleven, but if at any time you want to take a break, just give me an indication and we'll take a break. Could I ask you to speak maybe a little louder and – you seem to have a very measured way of speaking – perhaps even a little slower than you would normally so the room can hear you, and I can hear you. Now, Mr Connal.

Questioned by Mr Connal

Q Thank you, my Lord. Good morning, Professor Bain. It seems everybody is a professor of something. What are you a professor of?

A So, I'm an honorary professor in public health at the-- in Edinburgh University Medical School.

Q That wasn't meant in a critical way. It's simply something we've noticed. Now, you've prepared a witness statement for this Inquiry. Are you content to adopt the content of that statement as part of your oral evidence?

A I am.

Q Thank you. Now, I'm going to use that statement as a guide to move us through some of the issues, although I won't necessarily ask you, orally, about everything in it. So if we could have the witness statement, which is on page 117 of the witness statement bundle.

Now, let me just ask you one or two points of information, first of all. You say there that you're interim deputy chief medical officer. Leaving aside the interim point, which for our purposes doesn't matter, the one thing I did want to ask you there was that you say, at the end of paragraph 1, your current role has no responsibilities relating to NHSGGC.

Now, if you're an outsider to the world of medical admin structures, that may sound a little surprising that the deputy chief medical officer in Scotland

has no responsibilities for the biggest health board. Can you explain that to us, please?

A So, what I meant by that was that I have no direct responsibilities round about delivery functions in NHS Greater Glasgow and Clyde. As deputy chief medical officer, I clearly have general responsibilities round about supporting medical workforce, providing leadership, and also making sure that advice that might be relevant to the NHS in Scotland is clinically informed, but I have nothing specific round about any of the-- any of the health boards.

Q Right. So you're in that group of senior officers who have a sort of overall role, but you're not specifically allocated anything to do with this board? Is that--

A That-- that's correct, yes.

Q Is that a way of summarising it, then? If I put questions like that to you and you don't think I've got them right, please just say. Now, you were in one of the posts that we need to ask you about, or one of the roles that we need to ask you about, for a relatively short period of time between 6 January and 10 May, and we'll come to the terms of your appointment as director of IPC at NHSGGC just in a moment, although I see in paragraph 2 you note that although you were appointed to a post within GGC, you've remained an employee of the central NHS. Is that right?

A That's right. So my contract of employment remained with NHS National Services Scotland, which is-- is where I had my employment, I had my contract, before taking on the post.

Q Yes. Then you say in paragraph 3 that, between January 2020 and 2 July 2021, you acted as a principal sponsor of the Case Note Review. Now, not everyone listening to this evidence may be very clear as to the word "sponsor", which appears in civil service circles. Can you just explain to us briefly what a sponsor is?

A Yes, I can certainly explain it in the context that I've-- that I did here.

Q So, I can ask you about the specific things that you did, but can you just give us some general information as to what a sponsor is?

A Yes, certainly. So, really, I suppose, overseeing the-- the establishment of a piece of work, ensuring it makes progress, reporting back to whoever's commissioned it – in this case, Professor McQueen – and ensuring that the final product is delivered as agreed.

Q Thank you. So, if we go on to page 118, the way you've prepared this statement, you set out the topics you're going to cover, and then you give us a

short summary of your background. So you're somebody who started off as a clinical practitioner but ended up more in management roles. Is that correct?

A Yes, so I started off doing clinical roles and then I specialised in public health medicine, and that, as well as taking a population focus, tends to also lend itself to some more leadership and management roles. So, increasingly, over time, my career was more around about clinical leadership and management roles, although still with a-- a broader focus on public health.

Q Well, you set out some of the posts that you've held later on that page, and I needn't ask you about that. So, if we go on to page 119, you explain what, of course, the Inquiry already knows, that the Board was escalated to Stage 4 of the Performance Framework – and the labelling of that matters not for our purposes at this stage, but you say you weren't really involved in that process. Is that correct?

A I wasn't involved at all in the escalation process.

Q So not----

THE CHAIR: When you talk about the escalation process, do you mean the decision to move the Board to Stage 4, or were you meaning something else?

A No. Yes, I'm sorry if I wasn't clear. I meant the decision to move to Stage 4.

THE CHAIR: Right, yes, thank you.

MR CONNAL: So what position were you in at the time that that was done, before your appointment to the GGC role?

A So I had just finished two years where I'd been attached to Scottish Government as a delivery director for public health reform, and I was back with my host organization, NHS National Services Scotland, as a senior medical consultant there.

Q Right. So, if we then come to the circumstances with which we're at least in part concerned today, we see on page 120 that your first contact was from Professor McQueen. Did this just come out of the blue, or had you some warning that it was coming?

A So, the very first contact was with Catherine Calderwood, who I knew professionally as the chief medical officer, and she called me to say-- just to give-- just very briefly to say that-- give me, obviously, a bit of the background that GGC was being escalated and to say that they were hoping that I might be willing to take on a role within that in terms of director of infection prevention and control, and to ask me if I'd be willing to have a further conversation with Professor McQueen. And then I had the more detailed conversation with

Professor McQueen, where she gave me more of the background.

Q Well, that's what I was going to ask next. We can look at the letter just in a moment, but in terms of that initial conversation with Professor McQueen, was that a long one, short one? Can you remember?

A It wasn't short, but it was probably about maybe 15, 20 minutes. It was-- it was enough to give me-- because I hadn't really had any of the background before that, enough to give me enough of the background and what would be asked of me if I did the role.

Q Just in broad terms, what were you told was the background?

A So, Professor McQueen told me that-- She-- she obviously let me know that Greater Glasgow and Clyde had been escalated to Stage 4. I may have been vaguely aware of that before, but I hadn't really been, obviously, thinking about that, and she told me that there had been ongoing concerns – or increasing concerns, I think she would have said – about how the Board were managing infection prevention and control, and also that there had been two particular doctors who had raised concerns directly with the cabinet secretary and, subsequently, a conversation with herself.

And she told me as well, then, that as part of the Stage 4 process she'd be chairing an Oversight Board, but they were also keen to put a director of infection prevention and control into Greater Glasgow and Clyde. So, she told me about that, and then she also told me about the plans to announce a Case Note Review, and she said that I'd also be asked to oversee that Case Note Review.

Q Did she tell you why it was thought a good idea to put somebody in to an IPC role at GGC?

A I think she positioned it as part of the support to GGC, and I-- I can't remember exactly what she said, but the feeling that there was a need to have a dedicated person in that role, someone with some experience of-- of clinical leadership, someone who could both provide direct leadership into that role and into the team there, but also someone who could reflect to the Oversight Board any particular thoughts about how it could be improved going forward.

Q Now, in your witness statement, when you say that conversation was in late December, now, we know that the letter that you got was 23 December. Was there anything in between the conversation and the letter?

A There was-- I don't think there was anything further with Professor McQueen. There may have been a quick

call, but nothing-- nothing more. I can't remember-- I think I probably also had a conversation with Jane Grant at that point. Fiona McQueen had-- had obviously informed Jane Grant. I think at that point I did have a conversation, just-- just really to talk about start date in terms of-- it was just before Christmas, and to talk about what would-- what would fit best both for me, with commitments I had, and also for her, so I-- My recollection is that I had a telephone conversation. I don't think I went through at that point, although I may have done. I can't remember if it was on the phone or if I perhaps popped through.

Q The other question I should have asked you a moment or two ago was: in this initial exchange, did Professor McQueen tell you why there was going to be a Case Note Review?

A From memory, I remember her telling me that the Cabinet Secretary felt it was appropriate to have a Case Note Review to look at-- look in more detail about which children had been affected. I think that was the extent of what she told me at that time.

Q So when you say, "which children had been affected," is that a reference to, I suppose, the connection between what one might describe as the environment-- hospital environment and the infections encountered by these children?

A Yes, it was, so it was a-- As I remember it, it was a concern that we needed to have more clarity about what potentially had happened and that there needed to be a more in-depth piece of work done to understand if children had been affected. If they had been affected, was there a relationship to the environment, and if that was the case, then what harm might have come to those children? So it was really in the context of having a much more in-depth look at that.

Q Thank you. Now, you were then sent an appointment letter, and perhaps we could just look at that. I know you've reproduced some of it in your witness statement, but it might be easier just to look at the letter. It's in bundle 52, volume 2 at page 446. So is this your appointment letter that you describe in your witness statement?

A It is.

Q Now, I see at that point I think the time commitment is said to be four days a week, at that time, at least, for three months. I'm going to come back to the reporting line that's mentioned in the third paragraph in a minute or two, so can we look at the next page because that's where the detail is set out? Now, as far as you're aware, who drafted what you might describe as the requirements of the

post?

A I'm not aware of who drafted them. I presume it was CNO's office for-- for Fiona McQueen.

Q Right. It contains what one might describe as a mix of internal GGC work and work focused more on the Oversight Board. Is that fair?

A Yes, that is fair, and that was what Professor McQueen had described to me. It was a combination of-- of supporting delivery in NHS Greater Glasgow and Clyde and, as part of the Stage 4 process, providing insights in particular round about any improvements that might need to be made to the Oversight Board.

Q Now, one thing I wanted to ask you about, because it sort of cropped up in some other contexts and with other witnesses, this appointment on the face of it looks slightly-- Well, when I say "schizophrenic", I don't mean that in a pejorative sense. You have a role with the Oversight Board and you're also reporting to the chief executive of Greater Glasgow. Now, at that point, you had relatively little information, am I right in thinking, about what had happened and why it had happened?

A I had-- I think I had the basic facts. There was-- The detail obviously came later.

Q Well, let's just pause there.

We know you've had the conversation with Professor McQueen, and you've had possibly an even more brief conversation with Jane Grant, and you've had a letter. Now, is that all you had at that time?

A I believe that would be all I had at that time. What I suppose I did have was I had, or I believed I had, clarity that it was about that clinical leadership and support role, and also because of Stage 4 contributing to the Oversight Board. So, yeah, that would be the extent of what I had at that point.

Q Mm-hmm. The reason I wanted to ask you this, and if my questions are not clear please just tell me, is that some of the issues that are mentioned in the letter to you might be described as having issues of culture and approach in amongst them. Would you agree?

A Yes, I'd agree.

Q Now, it's at least possible that, if there's a question about the culture in an organisation, that might be driven from or influenced by whoever's at the top of that organisation. Is that a fair point?

A I think that's a fair point, yes.

Q So did it ever occur to you as slightly odd that you, with very little detailed knowledge of the background, were being asked to report to the person who was at the top of the organisation with at least potential cultural issues on

your plate?

A So, obviously, I didn't define the role----

Q No, no.

A -- in terms of the parts of it, and it would obviously be for others to talk about why they set it up like that. My understanding was it was like that because there was felt to be a need to be-- have someone directly working in there. I quite take your point about that reporting, and maybe we'll come onto a bit more of in terms of that worked-- how that worked in practice. But I think because it was in a Stage 4 escalation process – so there was the Oversight Board as well – there was a bit of-- it wasn't just how I reported to Jane Grant.

It was also how Greater Glasgow and Clyde was working with the Oversight Board and how I could inform both the Oversight Board and the chief executive about changes that might be required. So that was basically the context with which I understood it.

Q Well, let me ask you another question. I'll perhaps come back to that in a moment. If we go back to your witness statement and we now go to page 121 where we see the end of the list of responsibilities that we've just seen on the letter, and then in paragraph 12 the dual role, as it were, of reporting jointly to Ms Grant and Professor McQueen. Can I ask you about the next sentence, "I had no direct line management responsibilities…"? Now, I'm just looking for your help here, and the reason I'm looking for your help is obviously if-- We're looking from outside at what was going on at the time clearly. You've been appointed as director of IPC, and here you are in a witness statement saying, "I had no line management responsibilities." Now, can you just help us understand how that could be, that you're the director of this service but you don't have any line management responsibilities?

A So I think the first thing I'd want to say about that is, in terms of performing the role, that I didn't find that an issue because of the people that I was working with, but I think that's partly because the expectation was, as I'd been appointed through the Stage 4 process-- was that they-- Infection Prevention and Control Core team and others in Greater Glasgow and Clyde would work collaboratively with me, and that was the expectation.

So I think if there'd been a problem with that, it might have had to be changed, and also at that point there was never an intention I was going to be there long term. So I think if there-- if I'd gone in and said, "Actually this isn't working. I need to have direct line management," then there would have to have been a

discussion about how that would happen. But, as I say, we were able to work positively without having that formal line management responsibility, but anything I requested of the team was done.

Q Well, I follow that, and you've very helpfully confirmed that in the same paragraph of your witness statement when you say that people worked collaboratively with you. I'm just trying to get my head around the idea that you're there in a director role. What do you actually mean by "no direct line management responsibility"? You couldn't tell them what to do? Is that what it amounts to?

A So I think what I mean by that is there was no formal line of management that would say-- I think more generally in terms of line management in the health service, you'll be thinking about setting someone's objectives, monitoring their performance, dealing with all the administrative issues round about them, making sure they were getting adequate professional development, all those sorts of things, and I didn't have that, but what I did have was I had the delivery responsibility.

And so in that context, certainly my understanding was that I could say to them what I wanted done and I would expect them to do it, but I take the point about it not being a typical arrangement, but I suppose the whole thing wasn't a typical arrangement in that I wasn't going to be there for longer term.

Q Now, you say it didn't affect you because people were collaborative, so the fact that you did or did not have a direct line of instruction to them perhaps didn't matter. I am jumping ahead a little bit, but you did consider, did you not, that an operational person with line management responsibilities was needed? Is that fair?

A Yes, I agreed that that was part of what was required. It was-- it was-- it wasn't so much because of the line management responsibilities. I felt there was sufficient work and-- and-- for an operational director to be required, and also someone who would have a-- a more senior role in the Board. And if that person was appointed, then it would make sense then for them to have the team reporting directly to-- to that person.

Q The reason I ask that is that you take up your post just after the new year in 2020, and by 17 February Professor Wallace was in post subsequently, taking on full responsibility from a later date, so you must have come to this conclusion reasonably quickly, am I right, in your examination of what was happening?

A Yes, I would say probably by the end of January. At that point, I'd

been there and there'd been enough going on to bring some-- I suppose my initial thoughts about what needed to be done to strengthen the IPC function. And so certainly by that point-- mainly really, as I say, for the capacity-- the amount that was going on, and also to make sure that there was someone at a senior level taking on that role, I'd come to that conclusion, which I shared with Jane Grant and with Fiona McQueen.

Q I'll perhaps come back to another question about that shortly. So, just so we don't completely lose track of where we are, can we go to page 122? Now, I think in paragraph 13, the question raised is touching around the point that I've been exploring with you, and there may be different types of use of the word "independent" creeping in there.

I don't think anyone is suggesting, Professor Bain, that if you were taking an individual decision on an individual point, that you were doing that, you know, because somebody told you to and not on your own professional judgment, so that's not the issue. I think the question may be around expectation, you know, if people expect you would be independent of Jane Grant in particular. Is that an impression you got?

A It wasn't-- it wasn't something I'd thought about at the time. I do appreciate that some may have that-- may have had that expectation or that perception. From my perspective, it was-- I was clear what I was being asked to do from the beginning and what the reporting lines were, and I felt that I managed to work effectively within that, but others will be able to comment on-- on how they perceived it, looking at it.

Q Am I right in understanding from paragraph 13 that, so far as whether the fact that you had a reporting line to Jane Grant caused you any actual problems, that the answer is, "No"?

A No, it didn't cause me any actual problems in fulfilling the role I was asked to do.

Q Now, you set out at paragraph 14 what you say your priorities were, and in (15) you provided us with a list of things that you were focusing on, and I think I'm right in saying most of these are then touched on in more detail further on in your witness statement.

A Yes, I think so.

Q Now, we then come to page 123. This is where Professor Wallace's appearance comes in. What I'd like to understand from you, if you don't feel you've covered it already fully, is why did you suggest that what one might describe as an external person was appointed to what you described as an "operational director role" in GGC at the time. I mean, there might have been other ways of

dealing with workload, but obviously what's been decided here is that somebody from outside should be brought in.

A I think there was a need-- there was a need for more capacity, as I say, and that-- I didn't think there was that additional capacity within Greater Glasgow and Clyde in terms of someone who had senior-level experience in infection prevention and control in addition-- outside of who was already working in Infection Prevention and Control. So it was partly adding to the capacity rather than taking it from somewhere else, which, actually, it wasn't very evident where else it would be taken from from within Greater Glasgow and Clyde.

So it was partly that, and I think probably partly as well, at that point, I was also forming thoughts around about what would be helpful for IPC going forward, and having more of that external input I thought would be helpful as well, in terms of having someone else who brought in experience from elsewhere in terms of then shaping what would happen in the future.

Q Just a point of detail again, at paragraph 17, you say your role was intended to be time-limited, and you've made that point earlier. Why? You're going into sort of, from your perspective, the unknown because you'd not been involved in the process already. Do you know why your role was intended to be time-limited?

A The way that it was described to me, I think, with Professor McQueen was they wanted someone who would go in and do a bit of work and advise on what else was needed, so it wasn't-- I wasn't being asked to go in and provide that role longer term. It was much more about taking some time to understand what was there, be able to advise the Oversight Board.

At that point as well, I think the Oversight Board had anticipated a much shorter period of time in terms of its work, which was obviously disturbed by-- by COVID. So I think the fact that it was intended to be that shorter timescale generally for the Stage 4 and the Oversight Board and that-- that my role was very much to, I suppose, stabilise things a bit and also inform things going forward.

Also, it was-- it was not something which I would have been expected to do longer term. You know, my specialty is public health. I-- I wouldn't have expected to be-- I wouldn't have been choosing to do that as my longer-term role.

Q You explained in paragraph 17 that you demitted your GGC role on 10

May 2020 because you were asked to take on the interim deputy chief medical officer role in response to the COVID pandemic. Now, was that a decision that was driven by the onset of the COVID pandemic, or was it simply the time limit expiring?

A No, that was driven by the COVID pandemic. I would have-- I probably would have been staying on till end of June, I think. I-- it certainly in my mind-- it was about the end of June that seemed an appropriate time. That would have been six months, but it was specifically the pressures of the COVID pandemic.

Q Yes, but having demitted your role in GGC at that point, you were nevertheless asked to continue the CNR role. Is that right?

A Yes. So, the CNR review, the Case Note Review was always sitting separately from the role of director of IPC. So when I agreed to do the deputy chief medical officer role, I had a discussion with Professor McQueen and she asked if I could continue to do the Case Note Review, having-- having started that already, and whether I could fit that in with the other responsibilities, and so it made sense, and I agreed, to carry on doing that until it was completed.

It obviously, as well, took longer than expected because of COVID, so again, the expectation would probably have been that it had been finished a bit more quickly, but I was-- I was very happy to continue to oversee it.

Q Thank you. Now, just moving forward, could we go to 124, please, at the top of the page. When you say that, "Professor McQueen advised me of the issues with IPC and the built environment at NHSGGC..." was that in that initial call, or at a later stage?

A That was in the initial call. From what I remember, it was-- it was a background which covered basically what was then set out-- set out in the Oversight Board report.

Q Because we're kind of jumping time scales a little bit here, aren't we, that you had this initial conversation, but in terms of how you summarise the issues you refer to the Oversight Board's final report.

A Those were the issues that Professor McQueen, in broad terms, had told me at that time. I think-- the Oversight Board, I think, was setting up to meet then or-- but actually, I think it had already met, actually. It started meeting at the end of the previous year so it already had some of its background in terms of why the escalation had occurred, so-- they may have been refined a bit by the time it got to the final report, but those were certainly my recollection of what, in

summary, Professor McQueen described to me at the time of that initial telephone conversation.

Q Now, I'm just trying to get a chronological context to some of this, Professor Bain. By the time you've been appointed, a lot of the events that this Inquiry has heard about have happened, because lots of things have happened in 2017-18, through into '19. So, you come along after a lot of things to do with, in particular, the building environment have been dealt with. Is that fair?

A Yes, that's-- that's correct.

Q Now, what I wanted to ask you then, if we go to page 125, you say:

"Prior to taking up my post [this at is paragraph 21] Professor McQueen had explained to me that some clinicians and microbiologists in NHSGGC did not feel that their concerns, particularly about water and ventilation safety, had been previously, or were currently, being listened to..."

Now, I'm just trying to get some context here. By the time you were there, were you aware that there had been, for instance, discovery of a report by a firm called DMA Canyon about problems with the water system in 2018?

A I-- I can't remember exactly. I wouldn't have had all the details of it at that stage. Obviously, I became much more familiar when I actually started the role, but I do think it was something that was highlighted when Professor McQueen had that initial conversation with me. I suppose probably at that point I would have understood it in more general terms, that there was some concerns that reports that were relevant hadn't been fed up through the process and only had been discovered later. So, I think I would have been aware of it, although not in the detail that I would subsequently know.

Q I'm just trying to get, again, context. So, by the time you're there and you start to understand more fully the things that Professor McQueen had perhaps outlined to you, some of the things that you've listed, which you've lifted from the Oversight Board's report, the fact that there'd been a report which hadn't been actioned dealing with how the system should be looked at, the fact that there were water testing results suggesting widespread or systemic contamination, that had all emerged. Is that correct?

A That's correct, yes.

Q So far as ventilation is concerned, you would have quickly become aware, I assume, that issues about the environment in the proposed Adult Bone Marrow Transplant Ward 4B had been looked into and were obviously causing a bit of a-- had caused a bit of an

issue. You became aware of that?

A Yes.

Q As far as Ward 2A was concerned, by the time you were on board, the Board had obtained various reports as to the state of the ventilation, and proposals to remedy that state were in hand. Is that correct?

A Yes, that-- that's certainly the case. I don't think I had that level of detail before I started, but that is the case, that-- that they had already occurred.

Q Yes. The reason I ask that is just thinking about how you approached the matter. You're told some people have been complaining that their issues about the water and ventilation aren't being taken seriously, but by the time you arrived, actual issues with water and actual issues with ventilation had been established. Is that right?

A Yes.

Q So if somebody was complaining there were problems, that had been made clear. Is that fair?

A I think those-- that problems had definitely been made clear before I started and, as you say, action had been taken. What was put to me was that there-- there was felt to be an ongoing need to ensure that infection prevention and control, generally, in Greater Glasgow and Clyde was where it needs

to be, or how improvements might be made in order to ensure that it-- it delivered what it needed to deliver.

THE CHAIR: Could I just ask you to repeat that answer? It's just to make sure that I've got it. "There was an ongoing need," and then----?

A So, there was an ongoing need to ensure that the infection prevention and control that Greater Glasgow and Clyde had was as fit for purpose as it needed to be, and also, if there were improvements, to make those improvements and put those in place, and given that-- sorry, I'm just adding a bit now, given that although these things had been recognised, they were still in the process of being addressed.

THE CHAIR: Thank you.

MR CONNAL: When you arrived in post, assuming you've got all this list of things to think about that you've summarised on pages 124 and 125, what did you do to inform yourself of, obviously, a pretty long and extensive history of issues, and actions, and developments?

A Mainly-- mainly, it was through-- Initially, it was mainly through speaking with people, so I met early on with Dr Peters and Dr Inkster. I met with-- I obviously met with the current members of the Core IPC team. I met with other senior managers in Greater

Glasgow and Clyde and, obviously, with Jane Grant as well. So, initially, I gathered a picture, really, by speaking to lots of people, and then, because I was attending the Oversight Board it was also gathering a lot of information, a huge amount of information about what had happened previously. So, that allowed me also to become much more familiar with that, and there was a lot of additional work done by others to bring that together. So I was able to use that to make sure that I was-- I was fully up to speed with what happened previously as well.

Q Now, I might just ask you to look at one document in bundle 14, volume 2, at page 579, just to see if this is the kind of thing that you might have had drawn to your attention. Now, this is a 2019 letter of resignation from Dr Inkster to Jennifer Armstrong, the medical director, which complains of a variety of things being undermined, lack of respect, undervalued, and goes on to raise a range of topics. Now, first of all, have you seen that before?

A I've only seen it in the context of the Inquiry.

Q Right, but the types of points raised there, are these familiar to you from your investigations?

A Yes, they are, so I would have heard about this both from Dr Inkster, and

my discussions with Dr Inkster and Dr Peters. I also heard about it from the Core Infection Prevention and Control team, I think also from Jane Grant, and from Jennifer Armstrong herself. So this was described to me by various different people.

Q We can take that down, thanks. Can we go back to your witness statement? I want to come to the very foot of that page because there's a kind of general point I want to discuss with you, if I may. You say:

"My task, once appointed, was forward facing. My responsibility was to ensure effective delivery of IPC and to inform future plans, not to review past actions."

So, first of all, who decided that your role was to be either "limited" or "defined", depending on which adjective you prefer, in that way?

A The ask from the start was-- was round about the current situation and looking forward, so that was my expectation of what my role was. Also there was a huge amount of work going on, and it's still going on, in reviewing previous actions. So, in the-- in the role of director of infection prevention and control, I wouldn't-- I wasn't expecting to look at previous actions or to review them.

I obviously was expecting to be

aware of them, and some of them impacted me when I was there, but it was-- it was never my expectation, or, I believe, the expectation of either Professor McQueen or Jane Grant, that I would be-- Other than giving input based on my understanding of the current situation at that time, I wasn't involved in reviewing past actions.

Q At the usual risk of misquotation, one of the quotations attributed to Confucius is that to define the future, one must study the past, and there are other variations on that theme. Would you not need to understand, at least broadly, what the position was about the past in order to allow you to move forward?

A Absolutely, completely. In terms of the context for the work I was doing, I absolutely needed to understand the past and-- and that was a lot of what-- certainly my initial-- Probably all the way through, it was looking at things, understanding what had happened in the past. I think what I mean by that was I wasn't-- in the role that I was in, I wasn't in a position to take a judgment on some of those things beyond what people told me, and I wasn't being asked to do that, but-- but definitely-- I definitely agree that, in fulfilling the role I was asked to do, I very much was looking at what had happened over the past five years.

Q The reason I say that is that at least one of the themes running through, as you call it, your instructions, just for want of a better word for the moment, is that some clinicians and microbiologists had been saying, "We've been going on about ventilation and water and people haven't been listening." That's my summary of it, and you can create a much longer summary if you wish.

Now, did you not need to understand whether complaints that there were problems with the water and ventilation system were justified, or not justified, before you could try and form any view as to how you should move matters on?

A So, I agree to a certain extent. Yes, I had to understand how those had been dealt with or not dealt with, and-- and-- in order to make sure that what was happening when I was there was-- was appropriate for effective IPC, and also to inform what else might need to be done. So I-- I did need to understand it from that perspective, yes, but what I couldn't do was-- what I didn't feel in a position to-- to-- was to judge how adequately those things had been addressed beyond what I was hearing from people.

So, I don't know-- I don't know if I've put that terribly clearly there, but I think in terms of what you asked, yes, I had to be aware of it, but it was in the context of

then thinking about, “How is IPC working at the time I’m there, how might it need to change, and what learning has there been from what’s been done already in terms of both what’s worked and what hasn’t worked?” So I had to take a judgment on what might have not worked so well in the past five years in order to think about what might need to be put in place in the future.

Q Let me just ask another question around the same theme, if I may. This is a hypothetical I’m putting to you. If somebody had complained that, I don’t know, a paint used in a particular type of room was causing fumes and poisoning patients, and that had ultimately been investigated-- and they complained repeatedly, “Nobody was listening to us about it.” Then, eventually, it was investigated and then, eventually, it was found to be completely wrong. Would that not be a very different background to a situation where people have complained about the environment and it’s turned out there are problems with the environment?

A I’m not sure exactly what the question is.

Q Well, in terms of your response, you’re the new face, arrived on the scene, no pre-involvement, no preconceptions beyond what you’ve been told by the chief nursing officer. Do you not need to understand whether the complaints were, at least in principle, well-founded complaints – because, as matters have gone on, they’ve been investigated – or, alternatively, were not well-founded complaints and, therefore, you’re in a different position as to what should be done? Perhaps I--

A No, I think-- I think I did have to understand that, and that was part of the background in terms of both listening to people who were in Greater Glasgow and Clyde and, also, the work of the Oversight Board. So I think I got that from-- from those sources, and I agree, I did need to understand that adequately.

Q Did you form any view?

A So, I-- I think the view that I formed was that it was absolutely appropriate that anybody who has-- any clinician, in particular, who has concerns should raise them, and that those concerns should be considered and addressed. What was harder was judging in retrospect, and not having been there, to what extent that was done. So I would have, in particular, Dr Peters and Dr Inkster feeling and expressing to me that things had not been addressed and hadn’t been listened to, but I would hear from others in GGC that they felt they had listened, and they had responded and had made changes.

So, what I didn’t feel in a position to

do was to-- to go further than just noting that was the case, and the other thing-- the other, probably, main thing was, which is-- I obviously touch on it, and you may want to leave it just now and come back to it. What was really evident was that some of the constructive discussion that might have been needed along the way hadn't happened in that-- in that there were difficulties in sharing differences of opinion in a way that allowed things to be completely discussed, or-- or was helpfully discussed in a way that came to a conclusion.

So, again, what I found when I was there was that those-- especially between the two doctors and other parts of the organisation, those working relationships were not there. And-- and that was really key because some of the issues that had been raised previously, they needed people to get round a table to be able to express their view, and their views did differ, but be able to discuss that in a way that then came to a conclusion that was the best, I suppose, analysis of what was likely to be the problem and what needed to be done about it.

Q Well, I will jump ahead a little bit, then, and just follow this up while we've got this theme in mind, if I may. Can we go to page 131 of your witness statement? I was going to ask you about this later, but we'll do it now. Paragraph 34, here you're being asked a question, you know:

"…if there was a lack of trust of senior management and the Core IPC Team from Drs Inkster and Peters that this might… have its roots in their perception that those senior management and the Core IPC Team had failed to respond to their concerns about culture… and the safety of the water and ventilation… [which went right back to 2015 just shortly after the hospital had opened]"

Now, bearing in mind that a lot of the actions that we've talked about were dealt with in much later years, you say in response to this question:

"I agree, based on my conversations with Drs Inkster and Peters that this is very likely."

This is why there was an issue, but then you say, "Well, I can't comment on whether the concerns were justified," but is the point not that they say, at least, that they were raising these concerns about the environment way back and it's taken a long time for actions to follow? At least that's the line that was being put, was it not?

A Based on the conversations I had, then I think that definitely was the perception that, I think, they had been failure to respond. I just-- I don't feel-- I'm sorry, I don't feel able to comment on

what happened in that period when I wasn't there-- before I was there. There certainly-- with the timelines-- there certainly was-- as you say, there was a timeline where-- at which point the Board were doing more work.

I was very aware of that, but I just don't feel in a position to be able to talk about a period before I was there. But I do agree that that was-- that that lack of trust that Drs Inkster and Peters felt was because of those circumstances.

Q Okay. Well, let's come back to your earlier paragraph we left, paragraph 22 on page 125, please. Now, I jumped past this, but I just wanted to be clear. You say when you commenced your role:

"…it was evident that there were significant issues in terms of working relationships between Drs Inkster and Peters and NHSGGC senior management."

Now, anyone in particular, or just generally senior management?

A So, the people that I would have generally spoken to and would have been involved with in my role were the ones that I would refer to here. so, that would include the director of facilities and estates, the director of communications, to a certain extent, others-- others that I worked with as well, but because infection prevention and control, while it's everybody's business, it tends to-- especially in this particular situation, it's tending to involve Facilities and Communications in terms of the senior management then.

Those would be the main ones. I'm trying to think if there was more beyond that. I think it would certainly apply to Jane Grant as the chief executive as well. I think-- I think there was-- Generally, the senior managers I spoke to, they expressed finding it difficult to work with Dr Inkster and Dr Peters.

Q And when you got that impression from them, did you get any acknowledgement that concerns raised dating way back to 2015 had now turned out to be justified?

A I wouldn't say as such. I think, generally, the impression I got was that they-- the people I spoke to felt that they had been listening and they'd been trying their best to respond along the way. That was generally what-- what-- the feedback I-- I would have got.

Q Thank you. Now, you asked a question in paragraph 23 on the next page about the DMA Canyon report, and you say, well, you became aware of it, but you weren't really involved in any investigations as to how things had turned out as they did. Is that right?

A That's correct, yes.

Q Then you go on to refer to IPC governance at the Board and what you

found, and whether you thought it was being operated in accordance with the way in which manuals, and so on, might be.

A Can I just-- can I just add something----

Q Yes, of course.

A -- from Chapter 23. So----

Q Yes, sorry.

A So, it is, as I say in my statement, as the director of IPC that was definitely-- I wasn't involved in, looking back, but I was, of course, involved when I was sitting on the Oversight Board, and-- and-- that did, more generally, quite a lot of work, and I'm thinking back to your previous questions as well, because maybe-- I don't want to compartmentalise things too much, albeit obviously I had to think about my different roles within it. So a lot of the things-- it was really relevant to look back, but that was also what the Oversight Board was doing quite a lot of work on.

So I both was able to, I suppose, enhance my information and intelligence through being on the Oversight Board, but I was also able to then feed some reflections in that Oversight Board context as well. So, it may be just-- I don't think I really made that very clear, so just-- Hopefully that's helpful.

Q Just so I make sure I understand that answer – and, again, correct me if I'm picking this up incorrectly – something that might not have been at the forefront of your forward-facing IPC role, but which you discover in the course of your investigations, might be of interest to the Oversight Board who are trying to work out how things got to where they got to.

A Yes.

Q Is that fair?

A Yes, that's fair.

Q If you found such information, you would pass it on or communicate it the next time you were in touch with the Board. Is that the way it worked?

A Yes, and obviously, on the Oversight Board, there were discussions about all these things, so it was-- as part of that – those discussions – I was-- I was able both to gather insights, but also contribute as well.

Q Right. Thank you. Now, I'm keen to just understand the way you approach the next section, this section on IPC governance, because what you do in paragraph 25, which we'll just put up on the screen-- It's on page 127. (After a pause) Thank you. You say:

"NHSGGC undertook its IPC functions [in accordance] with the guidance provided in the National Infection Prevention and Control Policy Manual..."

Then you refer to an internal

document, and I don't think we need to get these out. Can I jump to the foot of the page, just in that context? You start the page by saying, "Well, there are these manuals and things seem to be done in accordance with them," and then at the foot of the page – and I'm keen to understand what you mean here – you say:

"The complex and evolving IPC environment… presented challenges which required broader approaches to problem solving beyond what was sometimes adopted. There were agreed approaches to IPC which were being followed… but the particular challenges being faced also required consideration and thinking beyond the routine guidance…"

Now, I want to ask you about that so that you can allow us to understand what you mean by it. It's perhaps sitting in my head, particularly, because I recall very recently reading a piece of evidence in which a distraught parent is talking to a senior person from the Board about one of the distressing incidents that happened, and the person on the Board is saying, "Well, we followed appropriate procedures", and I remember thinking, "That might be true, but not necessarily much comfort."

Now, I'm keen to understand, in your context, why you thought it was

helpful to this Inquiry to make that point at this stage, and understand what you're trying to say to us.

A Yes, so-- and this was stuff that I-- I also fed back both to Jane Grant and to the Oversight Board.

Q Can you speak up a little bit just at the moment?

A Sorry. Apologies.

Q Thank you very much.

A So----

THE CHAIR: And perhaps take it quite slowly because, to be absolutely frank, I don't understand this paragraph.

A I'll-- I'll try my best to explain it a bit more clearly, then. So, there are agreed processes for infection prevention and control and they're well documented in the IPC manual, and it's extensive, and it's what you would absolutely expect to be followed, and it-- it's rigorous, and my-- when I was in GGC the team followed it. The things that is said in it, they did it, and it's obviously important to have a standard way of approaching things, and you want that to be done.

MR CONNAL: Okay, so that-- that's the first point.

A Yeah, that's the first point.

Q Yes. Okay. Thank you.

THE CHAIR: So when we say "agreed", nationally agreed----

A Yes----

THE CHAIR: -- considered national

policy?

A Considered national policy, and would be-- and would be expected to be followed throughout the NHS.

THE CHAIR: Yes.

A Yeah, and there's a-- there's a manual that covers that----

THE CHAIR: Yes.

A -- and it runs-- it's an extensive manual. And, as I say, I believe that was followed – certainly in my time in Greater Glasgow and Clyde – and I've no reason to suspect not previously either.

THE CHAIR: You are speaking quite quickly.

A Sorry, I'll try-- I'll try my best to slow down, but if I speed up again----

THE CHAIR: I'm trying to take, not a verbatim note, but a sufficient note, you know?

A Well, please just tell me and I'll-- if I speed up again. So, the standard stuff was there and being done conscientiously but, given the-- given both the ongoing-- Well, given the background of a new hospital, concerns about the environment, and then subsequent actions to try and address those, and given the ongoing occurrence of-- of sometimes unusual organisms, then I-- I gathered-- My view-- and my view was and still is, that because of those different challenges, they didn't fit always in the manual. So they didn't fit in terms of some of the organisms.

It's not that they-- It was more that there was additional. It wasn't-- you still needed the basics, but I felt that there was a need to be able to think more broadly because of the particular challenges that they had and were having, and that applied both in terms of what they might look at, but also how they might look at it. So, rather than----

MR CONNAL: Okay, let's just pause there. Let's catch up with that. So you were, essentially-- "Look more broadly" in two ways?

A So, "Look more broadly" both in terms of, "Sometimes you need to go beyond what was in the manual," and also sometimes in approaches. So the standard approach would be: if you think there's a problem; you have a problem assessment group; you have an incident management team; it does its work; it completes its work. And then you wait and then, when something else happens, you do that again. nut in situations like this – and the Case Note Review found this as well – it's-- it's important to be able to have a more proactive approach as well as a reactive one.

So what-- And then the-- I suppose the third thing is, some of the-- the way you look at data-- the way that you look at data may be very appropriate for the vast majority of organisms that cause

infections, but it may-- you may need to look slightly differently at something else, and you need to be open to thinking about not just, "Does this show me something either that's going well or not going well?" or-- you need to be able to think, "Is there more that I could be-- we could be looking at in order to investigate this?"

So that-- that's what I mean by that paragraph, that-- that because of the challenges in GGC, I felt that it was important to be having a broader approach that went beyond just what was the-- the standard. I hope that's a bit clearer.

THE CHAIR: We have come across the manual in the context of mandatory reporting to NSS, and I think I've probably approached that paragraph with that in mind, but I don't think you're talking about reporting in this context?

A No. The-- the manual sets out the processes that you would follow, the organisms that you might-- that would trigger more work because of concern about infection prevention and control. It's-- I wasn't talking about the reporting up. I was talking about the actual delivery of IPC on the ground.

THE CHAIR: Right. Now, is it fair or is it unfair to conclude from what you've just said that what you found at the beginning of 2020 in GGC may have been compliant with the recommendations in the manual, but displayed a lack of flexibility? Or am I not understanding what you've said?

A To a certain extent. It's more going beyond. So, it's not-- You wouldn't-- you would want people to apply what was in the manual as it was said, but I think in these particular circumstances there was a need to look beyond that.

And it-- it was very challenging because a lot of these things were new to everybody, you know, in terms of the-- the nature of some of the stuff that was-- that was going on, and what you would want is, you would want things like this to be expressed in the manual, but at that point they hadn't been – some of these things – in terms of-- of what you do if you get unusual organisms.

So I think it's more than just-- It's-- it's not really flexibly applying what's in the manual; it's about, if there's something that needs broader thinking, making sure that there are mechanisms to do that too.

THE CHAIR: Well, when you talk about "need", are you talking about having identified something lacking in the IPC approach in Glasgow, or are you pointing to something that's maybe lacking in the manual? I'm sort of understanding the words, but not maybe

grasping the idea that you're trying put across.

A I think it's both, actually. So, this was-- this was a different experience of what had happened before in terms of some of the issues that were arising with infections potentially from the environment, and I think-- so there needed to be, perhaps as you put it, flexibility to go beyond the manual in the-- in Greater Glasgow and Clyde, but there probably also needed to be, or needs to be – which wasn't there at that time – more national guidance round about that to help people, because some of these things were new things that people didn't-- didn't have experience in.

THE CHAIR: Thank you.

MR CONNAL: Well, thank you very much for that. I make no apologies for drawing it out because that's the whole point of having a witness such as you here. Now, the views that you reached are where I've lifted that paragraph from. We see that at the start of paragraph 26, and you say a number of things on that page: IPC services were under pressure because there were still issues going on; the pressure was really focused on – let's just call it – "the new hospital" for the moment; and then the paragraph we've just discussed.

Then on the next page, page 128, the final bullet point of your views is:

"…a need to strengthen effective linkages and joint working for IPC, with clarity about respective roles and responsibilities."

So that goes back to the point I think you made earlier in answer to a question I asked you about, the need for better communication, is it? Is that the same point, or is that different?

A No it's the same point, the same point about being able to have linkages, and both communication and also discussion and agreement around about issues.

Q Yes. Then, as you say on page 128, this summary of your views was based on your own direct assessment, and you then passed that into the discussions at the Oversight Board, and you point out that it is then reflected in the Oversight Board report.

Now, you then go on to deal with "HAIR" and a template. Is there a particular reason why you selected that as a topic which would assist us?

A I think I was asked in my questionnaire about reporting to the Board, so it's really in that context that that's-- That's the basic report that's-- that is reported to the Board that's relevant to infection prevention and control----

Q Right.

A -- and the Board meeting that

occurred when I was there, that was-- that was the report that went up. So that-- that was the reason for mentioning that.

Q Now, we'll look at the Board minutes just in a moment. Again, I'm keen to understand why you say what you say. You say in the middle of paragraph 27:

"[It's] the responsibility of the IPC Executive Lead to decide what additional matters should be reported. I attended one Board meeting [and you] included an additional (i.e. beyond what would routinely appear in the [report]) update on an increased incidence of gram-negative cultures…"

Now, is that an indication that you thought more should be said?

A So, the-- the report that goes to the Board should always include the Healthcare Associated Infection Reporting Template as a standard, but the report that goes to the Board should also include anything that wouldn't be routinely included in that that might be of relevance to the Board, so I was answering-- I was really answering the question which was asked of me about who decides what should be reported to the Board.

So, the IPC exec lead should decide what additional matters should be reported, and at the time that I was there, there was a-- well, there was an incident in the Paediatric Intensive Care Unit, and so I-- I included that as part of the report to the Board.

Q Maybe just have a quick look at that, bundle 42, volume 4, I think at 1479. Is this what you mean here? We see a heading, "HEALTHCARE ASSOCIATED INFECTION REPORT", "The Board considered the paper"----

A Yes, that's right.

-- "... presented by the Director of Infection, Prevention and Control", and various things are set out there, and then you say:

"Prof Bain went on to note that there was an increased incidence of gram-negative cultures in patients in the Paediatric Intensive Care Unit (PICU)."

So is that really the point you're trying to make that what should happen is not that it's just a standard report containing standard material but additional material should also be given to the Board?

A Yes, and-- and the executive lead should decide what that should be. If it's helpful, I maybe-- just say another word about that because it perhaps illustrates a bit-- hopefully a bit more about what I was saying earlier about going beyond the standard approaches, and this isn't so much about reporting. It's about what was actually done. So the particular area which I note about these--

the Paediatric Intensive Care Unit would be an example of where things wouldn't necessarily fit neatly into the-- the standard processes, and so we adopted a different-- we adopted a different approach to go beyond what was just in those-- with the help of Health Protection Scotland.

So we had different ways of identifying or defining what was an outbreak, which would go beyond what was in the-- the manual, and we tried to use a much broader approach to the data in terms of trends in the data, and we also looked at it over a longer period of time. So we weren't saying, "Oh, this incident's finished. That's fine. We don't need to do anything else in other incidences." So, I hope that's a useful illustration of the sorts of things which is-- which we talked about previously.

THE CHAIR: I find that helpful, Professor Bain, because, at risk of just repeating back to you what you've said to me, when I was preparing for this hearing and reading that, one thing that struck me was it seemed to be a very full report, and so I think what I've taken from what you've said this is an example of maybe not a typical filling out of the template, but what is possible and may in unusual circumstances be appropriate as the conduit of information from the Infection Prevention and Control team to the Health Board.

A Yes, I think that's-- I think that's-- that's a very fair reflection, yes.

THE CHAIR: Right, thank you.

MR CONNAL: Thank you very much, and the bit where it says "Prof Bain went on" is an indication that that bit was not included in the HAIR report for that Board, that this was additional material that you contributed?

A Yes, although there would-- there would always be a healthcare-associated infection report, part of which was the template.

Q Yes.

A So there's always-- there's always scope in the report to add additional information.

Q Thank you. Now, let's go back to your witness statement and go back to page 129, "IPC Concerns Raised by NHSGGC Staff". You say in paragraph 30 you were told that some of those concerns dated back to completion and handover of the building, and you met with Drs Inkster and Peters. Is that right?

A Yes, I met with them very soon after I took up post and I met with them regularly during my time with Greater Glasgow and Clyde.

Q I think you cover this in that paragraph, but did you find that a helpful meeting?

A Yes, I found-- I definitely found

it helpful in terms of-- both in terms of understanding where they were and also the context, and also in terms of where they might have ongoing concerns.

Q At least at that point I think you then suggested to Drs Inkster and Peters that if they had anything moving forward that they should get in touch with you.

A Yes, that's right, and so I did that-- I did that, I suppose, for two reasons. First of all, it was clear that they continued to be, I suppose, upset by the whole process and to feel frustrated, but also upset. So on a-- on a human level, I was keen to be meeting them and showing them some support going forward.

So I felt it was important from that perspective, but also in-- in terms of fulfilling my role appropriately. I suppose I wanted to make sure I wasn't missing anything that was important, and in the absence of them being directly involved in IPC and, as I say, in the absence of there being, I suppose, constructive working relationships with others, I wanted to ensure that if there was a concern that they had, that I knew about it and that it was being addressed. So that was my reason for-- for meeting with them regularly.

Q Then you come back in paragraph 33 on the next page, 130 in that paragraph to make the same point, I think, you've made already about what you saw was a breakdown in positive working relationships, and you wanted to see if you could do something about that. Is that right?

A Yes, so I wanted to see-- I wanted to, as I say, make sure that any of their concerns were addressed, and I was-- hoped to do that by making sure that I was aware of them and I was actively taking them forward, but that really-- I mean, it could only ever be seen as a short-term solution, so alongside that I was obviously looking into what could we do to try and-- and make those working relationships work better?

Q Now, if we go on to 131, we come to paragraph 34, and I've already asked you about that so we won't return there. Paragraph 36, am I right that you recognise there that listening to concerns isn't really enough? You need to do something about it.

A Definitely. It was never my intention just to listen to the concerns. It was with a view to-- to addressing them.

Q Then you list a series of ways in which you say that you tried to do that, and you say at the foot of page 131, running onto 132, that there were:

"... differences of opinion between the views of Drs Inkster and Peters and others involved both in IPC roles... and

associated roles such as communications and facilities."

Now, I think we've heard quite a lot about differences in IPC. Differences with communications: is that something that cropped up?

A So, that would-- that would be relating to some of the public communication switch. Dr Peters and Inkster, one of the things they raised with me at the first meeting was their concerns about accuracy of some public statements, and so that's what I'm referring to there, that sometimes what was being put out by Communications, or previously being put out by Communications, that Dr Inkster and Dr Peters felt wasn't accurate.

I've said-- We've been into this already a bit, but my-- my job was more looking forward, but there were some things that had gone out that-- that Drs Peters and Inkster didn't agree with, and my conversations with others who'd been involved in producing those, they were of the opinion that they were absolutely accurate and as they should be, and had involved a large group of people, so there were things that had happened in the past.

What I was able to do with that was I agreed that, at that point as director of IPC, all public communications came through me as well. So I-- When that occurred, I actually did work directly with Dr Inkster and Peters so that they could highlight to me if they felt that something was inaccurate, and then I would work with director of comms to make sure that we-- we got something that was fully accurate.

So that wasn't so much-- I suppose that was-- that wasn't really answering your question because that's an example of when we managed to come to an agreement about what was a fully accurate statement, but I was conscious that some of-- One of the things which they'd raised was previous communications which they hadn't been comfortable with but the director of comms had been fully comfortable with.

Q The other department you mention at the top of 132 is Facilities, disputes with Facilities also?

A Well, not-- not so much disputes but-- but certainly lack of agreement about-- about things that had been done. Again, some of this was-- related to in the past and where they didn't feel things had been done, and we rehearsed that a little bit already, I know, but going forward, they----

It was-- it was quite tricky because Drs Peters and Inkster didn't have a formal IPC role at that point. They were clearly still microbiologists, and they were very knowledgeable in their areas, so

sometimes they would raise a Facilities issue with me. It may be something like, you know, a leak somewhere or something like that, or mould somewhere in a-- in a bathroom or something, in a shower room, and in some cases Facilities did actually already know about it and were dealing with it, but they weren't aware. In other cases, Facilities would say, "Well, we think what we've done is perfectly adequate and we've done the due diligence round about it."

So that's what I mean about I-- I was sitting there in the middle in some of these things where the ideal would've been to have-- been able to have more of those direct discussions.

Q Now, we move on in your witness statement to touch on this topic of what's called organisational development. Now, it's an interesting topic in and of itself. In the middle of paragraph 38, you say, "I ensured the concerns raised were being considered and addressed." As you quite rightly say, just listening isn't good enough. You have to make sure something is done. I'm reminded-- There used to be a joke about a government of a certain political colour which adopted a definition of consultation which said, "Listen to extremely carefully and then completely ignore." So you would be conscious, I would take it from the way you've framed this, that making sure something happens is important.

A Yes. No, no, absolutely, and for some things-- I think I cover this in my statement. For some things, that was relatively straightforward. So, if-- if they'd identified an organism which might be of relevance to-- to IPC, I could check, or I did check, with the core team that they were aware of it. Often, they were. Sometimes they-- they might not have been, but I could make sure that-- that they were aware.

And if-- Again, an example of something I was able to take forward was if there was a lack of a policy for something, so a policy hadn't-- either wasn't in place or needed some amendment or needed finalisation, I could push forward with that. That was-- that was straightforward to do, and so those were the sorts of things that, working with those two doctors, I was able to take forward.

The ones that were-- that were more difficult were sometimes a historical-- well, the historical ones which we've touched on, but ones where there continued to be a disagreement about-- about things.

Q Well, I'm conscious of the time, so I might just ask you one more question and see if you can assist us. If the thrust behind a lot of the concerns was focused

on problems with the environment, the water, the ventilation, and people have been, we choose the phrase, “going on about them” for some time, can you understand why someone who comes in and focuses on “let’s do some organisational development work” might be thought to be missing the point from the perspective at least of the complainers?

A I think it’s fair that that might be perceived like that. I-- I hope I’ve been reasonably clear in the fact that in order to resolve some of these things, you need to do both things. You need to make sure that you’re doing your IPC effectively and appropriately, but in order to do that, some of the mechanism of that is being able to work across the different parts of the organisation that are involved in IPC.

So that was why this was felt to be important, and I think it’s probably quite common that people who-- who end up involved in organisational development don’t necessarily, at least at the beginning, see it as the core thing. They want what they consider to be the problem fixed. But I-- I think it was reasonable, very reasonable here, to think that in order to get some of the issues resolved, it needed-- it needed this sort of, as it’s called, organisational development work.

Q My Lord, I’m conscious of the time. This might be an appropriate time to have a short break.

THE CHAIR: Professor Bain, as I said, we usually take a coffee break about this time. Can I ask you to be back for five to twelve? Thank you.

(<u>Short break</u>)

THE CHAIR: Mr Connal.

MR CONNAL: Thank you, my Lord. Welcome back, Professor. Can we go to 133 of your witness statement? You’re a very diplomatic presenter, and I’m going to suggest to you that you’ve been very diplomatic in your answer to the question you’re asked here. Essentially, the question you’re being asked is, “Well, if you’ve got a very experienced microbiologist who thinks that they’ve identified a possible source of infection, what do you do if IMT members who don’t have any experience in microbiology are challenging them on that as to whether there’s any merit in what they say?”

Now, I would paraphrase your answer-- and I want to ask you the question again. I’d paraphrase your answer as saying, “Well, of course, if there’s an IMT, there’s value in having lots of different people with different experiences and everybody chipping in

their own thoughts," and that is, no doubt, absolutely correct, but we, for instance, heard evidence of managers, not technical specialists at all, being at IMTs and challenging or testing, depending on your perspective, what's being said.

Now, I think the question, you can probably understand where this question has derived from, is more, "Do you not need to have some control over the extent to which the view of the experienced person is allowed to be challenged by those who don't have any expertise in the topic?"

A It's quite difficult to answer it in-- in the abstract, but I would absolutely expect that the clinical expertise that someone brings is not challenged by someone who doesn't have clinical expertise, and usually the IMT is chaired by an infection control doctor, so you would expect the chair to be able to-- generally, to manage that and to ensure that that-- that place of the importance of the clinical view is fully taken into account.

I think I was, more than being diplomatic, just trying to go a bit further in answering the question, though, because when you're thinking about infection prevention and control, it's not just about the clinical expertise; it's about how that fits into what else is happening. So you-- the point I was really trying to make was that you need someone who understands what the facilities are to be able to say, "Are they appropriate or not?" and-- and you know, the validation and everything like that.

Other than that, you know, I think it's-- the reason you have an IMT is because-- rather than just having one person decide, it's because you do need that combination. So it was-- I was trying to make that point as well.

Q Thank you. I'll move on. On 134, you explain that you've got email correspondence from Drs Peters and Inkster, and that's what you asked them to do, is to email things to you. I don't think we need to read through that, because, I think I'm right in saying, they go through the issues that they say existed--

A Yes.

Q -- but I am going to have to come back to the topic at the end. Just moving on, for the moment, to page 135, just because I'm not sure I understand how this worked, what you're given there is a quotation from a witness statement by Dr Redding, one of the IPC doctors, referring to Mr Ritchie:

"Mr Ian Ritchie began looking at the bullying culture within GGC and said he was keen to address this. He spoke with Professor Marion Bain who planned to get some external advice…"

Now, you then go on to say, "Well, this was during the discovery phase." First of all, do you remember a communication with Mr Ritchie?

A Yeah, and probably it's more helpful to give bit more context than is just in my statement. So, Mr Ritchie, who's a non-executive director-- or was a non-executive director in Greater Glasgow and Clyde Board when I was there, he'd asked to speak with me because he'd been asked to look into some of the-- I don't know all the details, but some of the-- the whistleblowing issues, and he'd obviously been speaking with Dr Redding round about this.

Mr Ritchie wouldn't have told me specifically who the whistleblowers were at that meeting, but he wanted to ask me about what I was doing in my role and, also, whether I had any suggestions round about how things could be improved, based on what I'd been doing and, in particular, this context of the fact he'd been asked to look at bullying.

So, I had explained to him what I'd found, which is pretty much what I've been talking about earlier today, and the fact that we felt it was really important to get the relationships right, and that was why we were undertaking the organisational development work.

Jenny Copeland then started to do that work, and Dr Redding, I think, was involved in that, so I think she was aware of it. So she was referring to that in terms of her statement, and so I was asked about the context, about-- about-- I was asked about that particular statement. So that's-- that was the context for it. It was-- Dr Redding had been involved with a non-executive director who had also talked to me about what I thought about IPC and what was being done about it.

Q Now, I understand the answer you've just given. I'm just keen to understand what happens to the bullying point. If Mr Ritchie is saying, "I'm keen to look at this question of a bullying culture within GGC", do you say, "Well, don't do that because we're doing something else" or just where does that go, because, on the face of it at least, a bullying culture might be relevant to any form of relationship developing?

A Yes, so it was Mr Ritchie who had the responsibility to look at the bullying culture, and so he-- he didn't actually-- I think when we discussed it, he just-- from memory, he just said he was being-- looking into some of the whistleblowers-- what had been happening with whistleblowing. I can't remember if he specifically mentioned bullying to me, but he wasn't asking me about what to do about the bullying culture. He was really asking me what I had experienced with-- within my role

around IPC and the suggestions I had for addressing some of those issues, but it-- there was-- but-- So I wasn't asked specifically to look at the-- or to comment on the bullying culture aspects.

Q Right. Well, just so we're absolutely clear, in paragraph 44, at the end, you say, "It was not part of my remit or role to consider issues of bullying." If you'd come across issues of bullying in the course of your discussions of how things happened, what happened in the past and so on, that you've explained to us, presumably it would have formed part of your role.

A Yes, it certainly would, if-- if I'd come across that. That-- Bullying was never specifically mentioned to me. I-- I never met Dr Redding, but bullying wasn't-- wasn't an issue that came up. There were-- there were lots of other issues, but there was never-- Bullying never came up in my-- in the discussions people had with me.

Q Well, let's move on to another chapter, at least for the moment, page 136. Well, you already explained you weren't involved in the decision to escalate, but you were involved with the Oversight Board. Now, you say you attended the Oversight Board and you were a member of the IPC and Governance Sub-group. Were you attending two different groups, the Board itself and the sub-group?

Q Yes, so I can maybe clarify that a bit. So, the Oversight Board had-- I think it was three sub-groups, and I was a member of the Infection Prevention and Control and Governance Sub-group, so I was a full member of that sub-group which reports into the Oversight Board. But then with my role as director of IPC, I was invited to attend the Oversight Board as well.

It-- it had-- probably had a-- did have a two-way aspect to it. So, partly, it was because I could give some more direct insights where I could, but, also, I continued because I was doing the Case Note Review, so I was able to update on anything relevant from the Case Note Review work as well. So I wasn't formally a member of the Oversight Board, but I did attend the meetings.

Q You attended because you had this----

A Yes.

Q -- separate role. Yes, and of course you had the Case Note Review responsibility as well.

A Yes, that's right.

Q So, where did your responsibility for the Case Note Review sit in relation to the Oversight Board? Was that in between, or----?

A Well, I had the responsibility of delivering the Case Note Review to Fiona

McQueen as chair of the Oversight Board.

Q Right.

A But I also-- before that was finalised, I was providing updates on progress to the Oversight Board.

Q Right. You say, if we go on to 137:

"[You] contributed to the reports (interim and final) of the Oversight Board as a member of the IPC and Governance Sub-group and during [your] attendance at ... the Oversight Board [itself and you] agree with the Oversight Board's recommendations."

Now, would I be right in thinking from the thrust of what you were saying that you weren't simply an attendee who sits in the second row back and listens; you were a participant in Oversight Board discussions?

A Yes, I was a participant in the discussions.

Q Thank you. Thinking of culture and general approaches, we start to pick that up again in Question 51, because you're asked, "Well, did GGC take a nothing-to-see-here approach to this escalation process that was underway, of which you were a part in the various ways you've described?" Now, again, you've given a nicely diplomatic answer – the first part of it anyway – in response to that, where you say, "Well, the Oversight Board 'made regular requests'. These were often time consuming, or 'sometimes time consuming'." Then you say:

"... those with whom I interacted at NHSGGC to be fully committed to delivering and supporting patient care, including by responding appropriately to any demands placed upon them by the work of the Oversight Board."

Now, if you just pause there, you haven't really answered the question at that stage. So can we go on to paragraph 53, where you say, well:

"[Well] I would not describe NHSGGC's attitude as being 'nothing to see here' in so far as it might be implied that they were dismissive of, or obstructive towards, the work of the Oversight Board..."

Well, let's leave "obstructive" out of the way at the moment, because you've told us that you got co-operation where you needed co-operation. If you go to the end of that paragraph, you say:

"My reflection on that was that NHSGGC did not generally accept that further support was required for them to help address the underlying causes of their escalation."

Now, a cynic might describe that as pretty close to being dismissive, "We don't need this." Is that not a fair point?

A I think that-- Well, I suppose

"nothing to see here" wouldn't be my words, because I-- I don't think that would be fair, but at the same time-- and I don't think-- They weren't dismissive in terms of in any way disrespecting the process or not participating, or indeed I think, possibly, of even feeling that there might be things to learn, but definitely in my discussions with Greater Glasgow and Clyde colleagues, both in the IPC team and with the senior managers, they often expressed that they felt they had done what was required in terms of the process and in terms of responding both previously and when I was there. So, that's why I say my reflection was that they didn't really feel that they-- that they did need further support.

Q If you're doing whether you call it "organisational development work" or anything similar, if one party doesn't think there's any point, is it not quite difficult to move to a point where that party learns?

A So, I think the organisation definitely recognised that-- at least my impression was they definitely recognised that organisational development was required, or at least they recognised that the working relationships had to become more positive and that organisational development could be a mechanism to do that.

Q Maybe I've misled you with my question. I'm not going back to the OD work that was aimed for in IPC. I'm thinking more broadly now. If you have an organisation which has been "escalated" – whatever phrase you want to take – "the government has stepped in", whatever-- you can come up with various phrases for it. If that organisation doesn't think there was any point to that process because they didn't need any intervention or support, then does that not create an obstacle, in your experience, for them learning from it?

A I think that goes beyond what I could really comment on. My-- my-- Having said what I said in my statement, I do think that Greater Glasgow and Clyde were willing to take on additional support where they thought it was-- it was helpful in terms of-- I'm thinking more generally now, probably, in terms of whether national bodies could help them more or whether guidance should help them more. So I don't think I can be more specific in terms of answering your question. I don't know I'm best placed to-- to answer that.

Q But the view that you reach at the end of paragraph 138 was a view that you formed having discussed the matter, among others, with the senior management in GGC.

A In terms of my final sentence----

Q The final sentence in

paragraph 53. That was after discussions with, among others, senior management of GGC?

A That was-- that was just based on my general working with them. I-- I didn't ask them specifically, but in terms of what they communicated to me.

Q Now, I wanted to ask you, I think, only one question about Cryptococcus, because we've had a lot of evidence about Cryptococcus, and it's not a topic that you particularly majored in, although you had one intervention. Let me see if I can work backwards. You were asked a question on page 141, which is essentially, "Did you think the Board was trying to push the Cryptococcus investigation process towards a particular result before the process was really finished?" and you said, "Well, I've no evidence that that's the case."

Can we then go back to what actually happened insofar as it involved you, and that is that someone had produced a Board paper that said a particular possibility had been categorically ruled out. Now, first of all, who produced that Board paper?

A I don't know the detail of that. It was part of Chief Executive Jane Grant's report; it wasn't part of my report. I understand, having looked a bit more into it, that it was based on a presentation which the director of estates had given internally.

Q Probably Professor-- Professor Steele, perhaps?

A Professor Steele, that's right.

Q Yes. Now, let me rephrase, then, the question that you were asked at the end of this section. If a senior executive of the Board produces a paper for the Board which says that the topic has been categorically ruled out, when Professor Hood says, "No, it hasn't" – he uses different phrases, but that phrase is wrong – does that not support the proposition, rather than move away from the proposition, that the Board were trying to push towards a particular conclusion?

A What-- what I don't think I was-- was or am able to say is whether this was an interpretation which was-- which wasn't in line, obviously, with what the chair thought, it was an interpretation too far, or whether it was deliberate. I-- I don't have any way of-- of saying that or-- or really knowing what the case was there.

The-- When I brought it to Jane Grant's attention, she had no-- she certainly had no issues in clarifying it at the Board, but I don't know how-- to what extent it was an-- just a misinterpretation. As you'll see, Professor Hood does still consider this to be very unlikely, so I don't

know how much it was an over-interpretation of that or how much it might have been more than that.

Q Thank you. We go on to another topic – or in some way if it's, again, the same topic – 143, please, "Culture within the NHSGGC IPC Team". Now, you're asked, "Did the culture in the IPC team," and we're talking about the IPC team associated with the new hospital – it's no wider than that – "actively encourage people to bring forward concerns about possible links between infections and the environment," and you say you can't comment on culture prior to your appointment. Now, do you not need to know the answer to that to know how to move forward?

A I can only directly reflect on what the result of that previous culture was when I was in post, and I think we've spoken a good bit about that. I-- I certainly got the views of people about what the culture was like. I was just concerned in my statement not to go beyond that to interpreting something which I can't interpret because I wasn't there.

But there-- there was-- Certainly because I was meeting with people, both with Drs Peters and Dr Inkster and others who worked with them, I-- I got a very strong view of-- of the different issues that people had found round about that

and the-- and, actually, the different perspectives they had round about, you know, what was-- what was leading to that. But I didn't want to go beyond that when I wasn't actually in a position to-- to see what was happening.

Q Well, this probably brings me back, I'm afraid, to a question I've already asked you in a way, and I'll ask you again, which I intended to do at the end but I'll do it now. In order to be most effective in resolving matters, do you not need to form a conclusion on what has happened in the past so that if somebody complains, for instance, of a problem with the water and, whatever the intentions were, nothing is really done until in some cases years later when it then emerges there are problems with the water--

Do you not need to form a conclusion on that before you can then say, "Right, well, on the basis of what I've got, that complaint was justified on one hand or not justified on another. Because I now know it was justified or not justified, I can then take appropriate action, either in respect of saying, 'Well, you know, you, the complainer, have to acknowledge that you're not always right, and let's do some work on that,' or alternatively, 'You, the recipient, need to understand that you got this completely wrong and it's you that we need to work with'"?

You see where I'm coming from, because the reason I'm asking you the question – I should be transparent about it – is that if somebody had done that in that way much earlier, on one view, we probably wouldn't be here now?

A No, I completely-- I completely appreciate the question and I'll try my best to-- to reflect on it. Yes----

Q I mean, obviously, please give us your view on these matters.

A Yes, so if I-- if I take the culture thing first of all, yes, I absolutely-- and I agree. I absolutely need to understand what had gone before in order to think about taking things forward, and I did form a view, and the view was clearly that there had been issues with the culture and the working arrangements because, otherwise, we wouldn't be where we were when I arrived.

So there was a strong view about that and, also, about the fact that different people who contribute to the IPC team had not been able to work effectively together and that, from a number perspective, they didn't feel that they were being adequately listened to. So that was-- that's thinking about specifically-- if I go back to the particular paragraph we're in.

But in terms of your broader question-- and-- and, again, I hope I'm not compartmentalising this too much, but in the IPC director role, it was very much about, "What do we need to do to move things forward while understanding the past?" but that was what I was doing.

But with the Oversight Board, I had a broader scope, and I think the Oversight Board work did very much look at what-- the sorts of things that you're asking about, and I was much-- much more comfortable thinking about it in that context, because there's much more broader information to bring to that to bring a kind of more informed view.

And the Oversight Board did make conclusions about things that weren't done at the time they should have been done, in particular with the-- the water report. It does make a lot of comments about-- about the culture. So, yes, definitely, but probably more in my Oversight Board role, which I-- which I know I don't-- I don't particularly cover here.

Q Part of the reason I asked you the question, and I'll ask a very brief supplementary on that basis, is that one of the-- let me call it – "complaints" just for the moment, from the whistleblowers and so on was that they wanted to know what was being done about the water or the ventilation or whatever, and people kept talking about relationships and so on. They said, "Well, yes, fine, let's talk about relationships, but what are you

doing about the water?"

I just wonder whether your organisational development thrust became part of that narrative, as it were, because you weren't saying, "Well, look, people pointed out the problems of the water. You, Mr Recipient, didn't do anything, Ms Recipient," whatever it was, not, "Well, let's forget all of that. Let's talk about how we should work together in the future."

A Yes.

Q You see the point I'm trying to put as a supplementary just to understand what your reaction to it is?

A Yeah, no, I definitely see the point. So, in the job that I was doing, I felt it was really important that I didn't just hear what Drs Peters and Inkster were saying, but-- and, as I said, actioned it, but also fed back to them. So I do think it was really important.

It was a bit different at that point, of course, because they weren't-- they'd no longer got formal IPC roles, but I absolutely recognise-- So my-- The primary thing I did was not to suggest that we need OD. It was to make sure that IPC was being effectively delivered, and part of that was making sure that those-- any of those doctors' concerns were heard and, also, the responsibility to feed back to them about what was being done.

So I definitely agree that that's the

case. I think it did need the-- the OD stuff as well, and I can't comment for how people felt. I think people were-- when I was there anyway, were-- were willing to participate in it, which I think was a good start, but I don't-- I wouldn't have expected them to think this is the only solution, but it was part of the solution.

Q Thank you.

A I hope that makes it a little bit-- a little bit clearer, especially from my perspective.

Q Thank you. Let's move on to the second main topic, which I suspect we can deal with rather more directly, the Case Note Review. Now, you were the sponsor. You were the person who was overseeing, checking and so on. Can I just acknowledge, first of all, we have noted your comment that at points you had to delegate some of this to a colleague because of the other pressures that were arising at the time? We understand that, but we can ask you to do your best to assist nevertheless. So----

A And I suppose, to be fair, by that point it was-- it was well established in getting on with its work, so it was mostly the-- the reporting back that I may not have always had the opportunity to do, the reporting back to the Oversight Board.

Q I'm going to go backwards a

little bit.

THE CHAIR: Sorry, just clarification of detail. You worked with a Scottish Government colleague who's mentioned in paragraph 71. You said it was mostly reporting back, so did you mean his particular responsibility was more to do with reporting back, or did I take what you said out of context?

A So, I worked with him on all aspects of it and he provided support.

THE CHAIR: Mm-hmm.

A By the time that I was working on COVID as-- as DCMO, most of the requirements at that stage were some of the reporting back ones, so my colleague, Phillip Raines, would have done more of that, whereas previously I would probably have done all of that.

THE CHAIR: Thank you. Sorry, Mr Connal.

MR CONNAL: Just for my Lord's reference, what I described as the "delegation" – that might not be the technical correct word – to the other colleague is mentioned in paragraph 73 of this witness's----

THE CHAIR: Right, thank you.

MR CONNAL: -- witness statement. I just wanted to start the narrative by picking up a point that you make later, and we'll put it up on the screen just at the moment, though we'll get there later. You talk about the conclusion that around 30 per cent of infection episodes were probably related to the hospital environment as being the "principal conclusion" of the Case Note Review. That's your phrase. Are you happy with that, that being the principal conclusion?

A Yes, it obviously had additional----

Q Of course.

A -- information, but yes.

Q So----

A I think because that was what the ask was.

Q Yes, yes. No, I just wanted to make sure we weren't putting words in your mouth and you were comfortable with the proposition that the principal conclusion of the CNR was that one, and you've added now today, "Well, that was the ask."

Some of the explanation as to what you actually did can be found helpfully set out, as you quite rightly say, in the overview report, but you've helped us by putting out some of the material on page 145, particularly in paragraph 71. So, you were involved in establishing a group, talking about who might be appropriate members. Is that right?

A Yes, I didn't-- I didn't-- I wasn't involved in identifying the three experts but, subsequent to that, I was involved in-- yes, involved in identifying what was--

really what was required in order to take-- take the Case Note Review forward.

Q So when you say in paragraph 71 "identify relevant individuals to contribute", you're thinking about those others who are working with the three experts to get the job done?

A Yes, that's right, and also the overarching group, which involved the three experts which was the Core Project team, so establishing that group.

Q Right, and so you say in that paragraph that you were facilitating access to data, overseeing communications with patients and clinicians, and updating NHSGGC colleagues. These were all part of your role. Is that right?

A That's right.

Q Then once things got underway, you describe your main role as overseeing progress. Is that poking it to make sure it's still moving, or----? How do we understand that?

A It's probably a bit more than that. Although it was-- it was-- the review-- The first few meetings were round about agreeing the process, what was likely to be required, also a bit about the-- you know, how we were keeping, in particular, the-- the patients and the clinicians informed. Once it was underway, there was quite a lot about resolving any issues with things that might be needed, or revising any timelines. We also had COVID, so it was agreeing about what we would do in terms of-- of that, discussing whether, when--

There was bit of refining some of the-- the methodology – not changing it, but agreeing some of the practicalities of it – so there was-- there was quite a lot. We met monthly and really considered anything that needed addressed in terms of it continuing to-- to progress. It didn't need-- It didn't need-- poked much at all. It was just----

Q No, no, that's my fault. I was just keen to draw you out, and I've at least succeeded to that extent. Is this the Core Project team meetings that you mentioned in the second half of paragraph 71 that we're talking about here?

A Yes, it is.

Q That includes the three CNR members, leads for two main groups, the clinical and epidemiological data collection groups. Is that right?

A That's right, yes.

Q Members of the Scottish Government, QEUH Support Unit. What was their role?

A So, that was part of the CNO directorate, so it was really-- it was-- it was Philip Raines again. So, it was-- They were responsible, through Fiona

McQueen and the Oversight Board, for commissioning the Case Note Review and then supporting progress. So I think it was-- it was, I think, usually two people. It wasn't a-- wasn't a huge amount, but the-- I think the QEUH Support Unit had a broader role in terms of supporting the Oversight Board, so they also supported round about the Case Note Review.

Q Yes. Now, if we move on to paragraph 74, which appears on page 146, you say, "Well, you can find the CNR conclusions in Chapter 10 and you can take it"-- We've looked at this more than once. You say you agree with the conclusions. What's your basis for saying that, because, obviously, this was-- I suppose, on one hand, it's an expert group and, on the other hand, it's an expert group that you've had quite a lot of meetings with.

A Yeah. So, the-- the reasons I agree with it-- Overall, the reasons are: I think it was a very comprehensive approach; I think the experts involved brought a very high level of expertise to it; the process was very detailed and they spent a lot of time doing it and ensuring that they had considered it appropriately; they gathered huge quantities of data which-- which hadn't been brought together before, so, although they would have liked more and more comprehensive data in some cases, they had a lot of data; and they-- they were independent, they came into it not with any particular views.

So, I think that combination and being close enough to see that is what gives me-- you know, I-- gives me confidence to say I'm-- I'm satisfied that-- that the conclusions they reached were-- were fully valid and accurate. They were also, of course, quite-- you know, they were quite careful to make sure they were both objective but also didn't go beyond what could be said, which is-- I know you discussed this already with Professor Stevens and others, that they-- they didn't try and say something categorically where they couldn't have 100 per cent certainty, but they tried to give, you know, really a useful indication of how likely they thought that the infection episodes were related to the environment.

Q I'm going to come to the sort of end part of the CNR just in a moment, but can I perhaps jump ahead and, in terms of at least your witness statement, the way it's been formulated by the Inquiry team, and ask about the issue of privacy of a lot of the material, particularly the individual family details? Now, the way this was approached was that these were kept confidential. Do you remember discussing whether that was a good idea, a bad idea, or-- How did it crop up, do

you know?

A I don't remember us discussing whether they should be kept confidential or not. That obviously came later in terms of-- of some of the questions that have been raised. My recollection is that we'd always thought of these as something which would be valuable for patients and families, that it was important, in doing the review, that it wasn't just, you know, an abstract review that came up with some conclusions, but also that it fully involved the families and they had the opportunity to-- to learn from or to have some discussion round about our input to it, and also be able to see and discuss the conclusions if they wanted to.

So, that was primarily the reason for agreeing that we should do that, so that wasn't-- that wasn't part of, you know, the core remit, but we felt it was important to do that and we agreed to do that. The-- the discussion beyond that was-- was really that-- that the core report would have all the findings in it; this bit was for patients and the families. They could choose to share them with their clinician if they wanted to, but they-- they didn't need to.

And then, in terms of subsequent conversations-- and I-- I didn't see them, I didn't have any expectation to see them, I didn't feel I had any need to see them, but also, in terms of patient confidentiality and Caldicott principles, not sharing beyond what's required is a really important one for patient confidentiality, and-- and that was in line with that as well.

Q As you will understand from the questions you were asked for the purpose of your witness statement, one of the issues that has at least arisen is, well, if no one else can see the detail that underlies the conclusions, does that mean that anyone who can't see the detail can simply say, "Well, we can't see the detail, so we've no need to accept that report"? You understand that the thrust of that-- I think you answer that question, if I get it correctly, in paragraph 80 of your statement, which is on page 148, where you say:

"... the review was undertaken by independent and respected experts... The approach taken was both thorough and comprehensive. A wide range of relevant data and information was gathered and considered [all described in the report]."

Then you make the point I think you've just made a moment or two ago, that:

"The individual reports were intended as specific feedback to patients..."

You say, well, in your view, not

seeing the reports is not a valid reason to reject it. Is that your view?

A Yes, that-- that's my view. I-- I don't see the rationale for that. The overview report itself was a detailed report of the findings based on the same material that was used for the individual reviews.

Q The underlying data that was used to assist the formulation of that presumably came from GGC?

A Yeah, the vast majority of the data came from GGC. There might have been some that came from Health Protection Scotland, but it-- it would originally have come from GGC, so yes.

Q Thank you. Now, having asked you that, let's now move towards the conclusion issues. We have some controversy bubbling around over this topic. You say, on page 147, paragraph 75, that a draft was shared with NHSGGC. That's presumably a deliberate decision to let them see the draft first. Is that correct?

A Yes, yes.

Q They prepared a response, and then Professor Stevens, who was the lead member of the trio, if I can call him that, whatever the technicalities are, provided a response. Just so we can see what kind of thing we're looking at, can we have bundle 25, page 157, please? Is this the response that we're talking about here?

A It is, yes.

Q If we scroll down, we would see each point is considered and then responded to by the CNR, but I think Professor Stevens was the lead in producing that. Is that correct?

A Yes, I think he did-- He had some input from the other-- other members of the panel, but he took the lead, yes.

Q Thank you. You've looked at both the GGC comments and the CNR responses. Is that right?

A In this document, yes.

Q Yes. Did you do that at the time as part of your role as the sponsor?

A I saw it at the time. I-- I didn't have input to it, but I saw it at the time. I think it-- it came to one of the Core Project team meetings before it went back to Greater Glasgow and Clyde.

A Your response to this, in general terms, is picked up in paragraph 76 of your witness statement. You say, in your opinion, the response was appropriate. Is that your position?

A It is, yes.

Q Why do you say that?

A He goes through all the points and considers them. I think, in some cases, there were-- there were some factual accuracy comments which were able to be corrected, which is part of the

point of sharing a draft. There were some areas where Greater Glasgow and Clyde felt they wanted additional material, and I think it was up to the expert group to decide whether that was appropriate for the report or not, and in some cases it was and some it wasn't.

And then there-- there were ones where he responds in terms of both areas where Greater Glasgow and Clyde have made some comment, maybe, about the data, and he indicates that, actually, that was not the case. I think those were the sorts of things that we discussed with the Project team to make sure those were accurate. And, also, he discusses the-- the methodology. So, I think-- I think he went through-- he, with the assistance of his two other experts, went through this in-- in a lot of detail and provided appropriate responses to it, and-- and I-- I certainly was comfortable with his responses.

Q So we can just be clear on the timeline of these events, I wonder if we could have bundle 27, volume 18, page 4? Now, there's a very short document that follows this, but I'm just using this primarily to give us the timeline of events. Do we see there:

"22 February 2021 Draft of Overall Report issued to Stakeholders for comment… 22 March 2021 Overall Report published draft overall report

issued or published… 19 April 2021 Individual Reports sent to families…"

And then some reference to family meetings. Do you remember that?

A Yeah. So, those were-- those were the-- having produced the individual reports, all the families were offered that meeting. So that was when the first meeting after they-- they'd had their reports was made. So, the process was that, after the report was published, the families who wished it were provided with their individual reports and they were offered, if they wanted, to have a meeting with the-- with the expert group as well.

Q As you say, the principal conclusion of the CNR is focused on the extent to which infection episodes are possibly or probably linked to the environment, which is no doubt very important for the families concerned. After you've got to the point where GGC had commented and Professor Stevens' response has gone back, which I think I'm right in saying was in March before the report was then finalised, did you have any discussions with anyone from GGC about the report?

A No, I don't believe I had any discussions. No, I'm-- I'm certain I didn't actually have any discussions at-- at that point.

Q There seems to be at least a question as to what the GGC response--

reaction, if you like, was to this report. Did anyone get in touch with you to tell you, from GGC, what their position was?

A So, I clearly saw the-- their response to the draft, and then, as far as I was aware, and I-- I think what was published was that they were accepting and taking forward the recommendations. So I wasn't actually aware that there was any issue with that until I was preparing for the Inquiry (inaudible 12:50:08). I-- I did-- I had completed-- I mean, I fully completed my work on 2 July round about this, and so didn't have any direct involvement in it afterwards.

Q Now, may we just briefly look at bundle 25, page 1260? Now, this is-- well, I've called it a press release. I know it has a slightly different title, but it is a response, and this is from the Board in March after the report has been issued. You see it talks about learning, a difficult period, a question over potential links having persisted for a number of years, a very difficult question to answer. It says, "Whilst it has not been possible to provide conclusive answers..." and that's what the report says, of course. That's a mention of action. Can we go on to the next page? Have you seen this before?

A I hadn't. I haven't seen that. I don't-- I don't recollect having seen that. I think I-- I think there was something in the Scottish Government release at the

time that said something similar about-- Well, so if we just go back to the previous page, sorry, that said something similar about GGC fully accepting there was learning and a committee to address their issues. So, I remember seeing that, but I think the core brief-- the core brief goes out to GGC staff.

Q It does.

A So I wouldn't have seen it ahead of seeing it as part of the documentation for the Inquiry.

Q Right. Can we just look at the at the next page, just for a moment? Now, if the principal conclusion, as you put it, is the 30 per cent probable, and higher number possible, I haven't been able to find anything that says, "The Board rejects this report." Did you get any information to that effect?

A No.

THE CHAIR: You may need to repeat that answer. Speaking, presumably personally, you have never had any indication that GGC rejected the conclusions of the CNR report?

A No. As I said, I only became aware of it when preparing for the Inquiry.

THE CHAIR: Right, thank you.

MR CONNAL: There has been a suggestion in evidence that, well, they accepted the recommendations but not the conclusions about infection link. Was that suggestion ever put to you, apart

from today?

A Sorry, could you repeat?

Q Yes, sorry, I apologise. There are recommendations in the CNR report. One suggestion that's been made is that the recommendations were accepted, but the conclusions about infection link were not. Has that suggestion ever been put to you prior to my asking you just now?

A No, and not prior to listening to some of the earlier testimonies, and I think -- I think I would have assumed, based on-- based on what went out at the time and this, that they weren't distinct things until this more detailed discussion had happened.

Q Can you help us at all, and if you can't then just please say so. I mean, the release of this report focused, as you put it, on the ask, "Establish the link if you can", was obviously part of the broader process that was undergoing Oversight Board, CNR and so on. Are you able to help us at all as to what the result would have been if the Board, on receipt of the report, had said, "We don't think this is a valuable document and we entirely reject the suggestion that 30 per cent of the infections are linked to the environment"? I mean, you've been around the senior echelons of the medical world for a while. Can you help us at all on that question?

A So, I'll try based on what I would expect. First of all, I wouldn't expect-- I wouldn't expect the first time for someone to know that it was going to be completely rejected to be once it was published. If there'd been engagement, which there had been along the way-- and if there was, I would expect an organisation to have a very good basis for-- for saying that.

Like I say, I think I would have expected, if they've seen draft, for them to have raised that earlier, but-- and I'm sure that there are circumstances where reports are produced and organisations don't agree with them, but I think to not agree with a report that's been so comprehensive, there needs to be something very strongly presented which either shows that it's not the case or says, "Actually, we think more work needs to be done round about it." That would be my -- that would be my thoughts on your question.

Q Well, that I think, in attempting to answer my question, you've said, "Well, the first thing I would say is we would have expected to know," and you would have expected to know, presumably, as the sponsor, from the engagement that you had – "you", I mean the CNR group with the Board throughout – "if there was going to be a rejection at the end of it." Can you help us at all as to what the consequences of a plain

rejection being made at that stage of events might have been?

A I don't think I can answer that comprehensively. I think the Oversight Board would have to have taken a view on that. I think it would have been up to the Oversight Board, which-- who had commissioned the review to look at whether they felt there was any justification for that.

And given, of course, I mean, Greater Glasgow and Clyde were still in Stage 4 escalation, that would also have been appropriate because they were still within that-- within that oversight in terms of infection prevention and control.

Q Yes. Thank you, Professor. I have no further questions, my Lord.

THE CHAIR: Very well. Do you want to take the opportunity to check if anyone else considers there are outstanding questions?

MR CONNAL: I think I ought to do that for completeness, my Lord. Previous indications before starting today's events were that there might not be, but it might be convenient, if we could, just to do that now so then we'd at least know whether there's-- I know we're running up to one o'clock, but we would then know if there was going to be nothing much to add or a lot.

THE CHAIR: Well, if I'm following you, it would allow us to either conclude

Professor Bain's evidence this morning or otherwise.

MR CONNAL: it would be useful, I think, to know that and, as my Lord is aware from other witnesses, sometimes even if there are further questions, there's two or three short ones and we can deal with them very quickly.

THE CHAIR: Professor Bain, the procedure we've been adopting is to give those in the room the opportunity to raise additional questions if they consider additional questions should be raised, so can I invite you to return to the witness room and we'll call you back in about 10 minutes or so?

(Short break)

THE CHAIR: Mr Connal.

MR CONNAL: My Lord, I've been asked to put two very short questions, which, with my Lord's permission, I feel might be sensible just to do now.

THE CHAIR: Right. Well, we'll ask Professor Bain to return. (After a pause) (To the witness) Two questions, I'm told. Mr Connal.

MR CONNAL: Thank you. We were talking about processes in IPC and the following of process a little earlier in your evidence, and, if I got it correctly, you were making the point that there will always be processes but, from time to

time, when unusual or difficult incidents arise, it may be necessary to look a little more broadly – not necessarily the word "flexible," but a little more broadly to deal with the situation you're faced with.

I've been asked to ask you an associated question, which is the point I've just made related to the following, in particular of processes in the National Infection Control Manual. Are you aware that that manual has been developed since the dates that we're concerned with by the addition of additional material, particularly on IPC in the built environment?

A So, I don't know the detail of that, but I believe there have been some amendments made to that, and I think also – and I didn't mention this earlier but this may be relevant as well – there's an understanding that people need better expert information and better support. So ARHAI now, I think, has got that as part of their-- clearly part of their remit, so I think both those areas have developed further.

Q Thank you. We were asking you about the reporting of material to the Board. In context, and just for my Lord's reference, this was a matter that arose in paragraph 27 of the witness statement. I don't think we need to bring it up on screen – it's just for the note – and the point was that there was a template to be completed which had to be done, no dispute over that, and you were suggesting that it was useful, and something you followed, to add something more if there was something else of interest or importance that had emerged. Am I summarising that correctly?

A Yes, and part of the routine report to the Board include both the template and the opportunity to add additional stuff.

Q I think the suggestion was that the-- well, the suggestion I've been asked to put to you was that the PICU outbreak that you've reported on as additional material was a report that was subject to the national framework at the time and should, therefore, have been reported in accordance with that framework. Now, can you help us on that or not?

THE CHAIR: Sorry, you allowed your voice to drop, Mr Connal.

MR CONNAL: I'm sorry, my Lord.

THE CHAIR: "It should have been reported----?

MR CONNAL: In any event, at that time. So it wasn't material which was added in the spirit of adding more material; it was material that should have been there anyway due to the fact that it was covered by the national framework at the time.

A So, again, I'll-- hopefully my

recollection of this is right. I think it was covered in the template in terms of the organisms that had been identified. The point was that I wanted to let the Board know a bit more information round about it, so I don't think it would have been missing from the bit above, but what there was, there was the opportunity to say a bit more about it and-- particularly because the Board was-- clearly should be seeing things about gram-negative outbreaks.

Q Thank you. These are all my questions, my Lord, thank you.

THE CHAIR: In that case, Professor Bain, that's the end of your evidence and you're therefore free to go, but before you do, can I thank you for your attendance today and the work that will have gone into preparing the statement and reading the background material necessary to doing that? So, thank you very much, but you're now free to go.

THE WITNESS: Thank you.

(<u>The witness withdrew</u>)

THE CHAIR: (After a pause) Well, I think that brings us to an earlier finish to today's evidence than had been anticipated.

MR CONNAL: That is so, my Lord. We have no further witnesses scheduled for today. The next witness, I think, is Ms Imrie, scheduled for tomorrow morning with Mr Mackintosh, followed by Mr Wright, who has now been----

THE CHAIR: In the afternoon.

MR CONNAL: -- moved in the afternoon.

THE CHAIR: And in both cases the evidence will be in person?

MR CONNAL: As I understand it, my Lord, yes.

THE CHAIR: All right. Well, can I wish everyone a good afternoon, and we'll see each other tomorrow at 10.

(**<u>Session ends</u>**)

(13:14)