Scottish Hospitals Inquiry
Witness Statement of
Jane Grant

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

Personal Details and Professional Background

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

A. My full name is Jane Margaret Grant. I am currently retired but was previously the Chief Executive of NHS Greater Glasgow and Clyde from April 2017 to January 2025. I hold a BSc. Biological Sciences from Edinburgh University (1983) and a Master of Business Administration (MBA) from Strathclyde University (1996).

I joined the NHS in 1983 and worked in the NHS for 41 years before my retiral in January 2025. During my career, I have worked within 5 Health Boards and have detailed the positions in the table below.

DATES	POSITION	LOCATION
1983-1986	Management Services Officer	NHS Highland
1986-1988	Asst Administrator / Personnel Officer	NHS Highland
1988-1989	Planning Officer	NHS Lothian
1989-1990	Deputy Administrator, Stobhill Hospital	NHS Greater Glasgow and Clyde
1990-1992	Acute Services Administrator	NHS Lanarkshire
1992-1994	Resource Management Project Manager	NHS Lanarkshire
1994-1999	Deputy Director of Planning and Information	NHS Lanarkshire
1999-2000	General Manager, Hairmyres Hospital	NHS Lanarkshire
2000-2005	General Manager, Surgical Division, North Glasgow	NHS Greater Glasgow and Clyde
2005-2006	Interim Chief Executive, North Glasgow	NHS Greater Glasgow and Clyde
2006-2009	Director of Surgery and Anaesthetics	NHS Greater Glasgow and Clyde
2009-2013	Chief Operating Officer, Acute Division	NHS Greater Glasgow and Clyde
October 2013-March 2017	Chief Executive	NHS Forth Valley
April 2017-January 2025	Chief Executive	NHS Greater Glasgow and Clyde

Governance Reporting Structures within NHS GGC

2. For the period you were Chief Executive explain how the governance structure and reporting lines to the NHS GGC Board and its first line of subordinate committees received information and made and authorised decisions in respect of (a) the procurement of the new Southern General Hospital (that became the QEUH/RHC), (b) the safe and efficient operation of the water and ventilation systems of the QEUH/RHC, (c) the management and reduction of risks to patient safety from infections that had the potential to be connected to the environment (particularly the water and ventilation systems) of the QEUH/RHC, (d) the need for and authorisation of works to improve or remedy deficiencies in the water and ventilation systems of the QEUH/RHC and (e) the processes put in place to ensure that disclosure by staff of evidence of wrongdoing, failures in performance or inadequacies of systems was encouraged and reacted to by the Board to ensure that the safety of patients and the best value use of public funds were protected.

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

A. Within NHSGGC, there are Standing Financial Instructions, Standing Orders and a Scheme of Delegation which define how the NHS Board should operate and what decisions should be taken to the NHS Board itself and to each committee. The Standing Orders define the matters that are reserved for the NHS Board. The Scheme of Delegation allows for authority to be delegated from the NHS Board to its committees as deemed appropriate. Each committee has a Terms of Reference which outlines their key duties and remit. The NHS Board's corporate objectives are each allocated to a lead committee to ensure clarity on where issues should be considered. All committees consider the key risks associated with their area of accountability.

The Scheme of Delegation within NHSGGC is a framework that outlines the decision-making authority and responsibilities across different levels of the organisation. This framework is in place to ensure that decisions are made effectively, by the appropriate individual or group, while maintaining accountability and governance across the Health Board. In an organisation of the size and complexity of NHSGGC, with a budget of £4.4 billion and approx. 41,000 staff, it is essential that there is a clear scheme of delegation and that authority is delegated throughout the organisation.

In NHSGGC, the Scheme of Delegation operates by clearly defining what powers and responsibilities are delegated to various officers, committees and groups within the organisation. It also outlines the limits and controls around these delegations to ensure that the organisation functions effectively while meeting its regulatory, clinical and financial objectives.
The Scheme of Delegation is designed to ensure that NHSGGC complies with national health policies, Scottish Government directives and relevant legislation, including financial, clinical and staffing requirements.

During the period that I was the Chief Executive the NHS Board operated a number of sub committees reporting directly to the Board. For example, clinical issues were reported to the Clinical and Care Governance committee, Acute Services issues were reported to the Acute Services committee and Finance, Planning and Performance issues were reported to the Finance, Planning and Performance committee. The Staff Governance committee supported the staff governance issues.

As outlined within the Standing Orders and Scheme of Delegation, certain decisions are reserved for the full Board meeting and the Chair AND THE Chief Executive, along with the Director of Corporate Services and Governance, would agree which issues should be escalated to the NHS Board outwith the scheme of delegation. The non executive Chairs of the subcommittees were also involved in that process, when appropriate.

Regular updates were given to the subcommittees and the NHS Board on a range of issues associated with QEUH and RHC. Issues associated with QEUH and RHC were also discussed at Board seminars as, by the nature of the content, some of the discussions were commercially sensitive.

I understand that a very significant volume of documentation has previously been submitted to the SHI indicating the timelines and details of issues discussed and reported at the NHS Board sub committees and the NHS Board itself. These include a water and Cryptococcus timeline (see **Appendix B**) and the governance associated with Ward 2A (see **Appendix C and Appendix D**), documentation relating to the Internal review (see **Bundle 43, Volume 2, Document 3, Page 34, Document 9, Page 108, Document 31, Page 343 and Document 37, Page 371**), details of the actions and reporting of the 2017 SBAR (see **Appendix E**), and actions associated with the AARG (**Bundle 52, Volume 3, Document 81, Page 589**). It is, therefore evident that there was substantial reporting to the NHS Board and its sub-committees on the QEUH / RHC issues.

a) Would you agree with Robert Calderwood who has stated in his statement that "The Chief Executive is charged with discharging all of the responsibilities that the Scottish Government place on Health Boards and those tasks are delivered through a scheme of delegation through a series of, again, operational chief officers and directors"?

A. NHS Boards are delegated responsibilities by the Cabinet Secretary to plan, commission and deliver healthcare services and take overall responsibility for the health and wellbeing of the population they serve.

The Chief Executive is responsible for the provision of executive leadership and strategic vision for the NHS Greater Glasgow and Clyde healthcare system. This includes leadership and influence across a wide range of inter-agency partners. The role involves joint working with six local Health and Social Care Partnerships (HSCPs), including close working with their Local Authority Chief Executives, as well as colleagues in the corporate departments and the Acute Division to continue to deliver the multiple system-wide interventions at regional and national levels.

The Chief Executive is accountable to the Board Chair, the Director General for Health and Social Care at the Scottish Government and, as the Accountable Officer, to the Scottish Parliament for the appropriate use of public funds and for ensuring the regularity, propriety and value for money in the management of the organisation.

The Chief Executive is responsible for ensuring that health and social care services within NHSGGC are delivered in line with national policy and health and social care priorities as directed by the Scottish Government.

As outlined elsewhere in my statement, in an organisation of the size and complexity of NHSGGC, with a budget of approx. £4.4 billion and 41,000 staff, it is essential that there is a clear scheme of delegation and that significant authority is delegated to operational and corporate Directors and managers to ensure the organisation operates efficiently and this is in place in NHSGGC.

b) Recognising that you were appointed in April 2017 do you now accept that the NHSGGC Board should have been briefed about the fact that the single rooms of the hospital had been deliberately built with a ventilation system that supplied air at half the rate than that called for by Scottish Government Guidance as soon as that fact became known to the Executive Board members?

A. As the Hospital had been open for more than 2 years, I would have anticipated that the NHS Board members would have been briefed prior to my appointment as the Chief Executive.

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

A. During the period when I was the Chief Executive, there were numerous formal and informal meetings which took place in respect of a number of the issues outlined in Question 2.

There were a range of Infection Control meetings including the Board Infection control committee and the Acute Infection control committee which oversaw issues relating to infection control. There were also PAG and IMT meetings when issues arose.

Routine estates and facilities meetings took place on particular issues in relation to these areas including the Water Safety Group.

During 2019, when the internal review process was established, a Programme Board was set up to ensure the different strands of work were progressing in an appropriate manner. There was also a Gold Command group established at QEUH to ensure all the recommendations associated with the published reports were actioned.

During November 2020, an Executive Oversight Group (EOG) was established to co-ordinate all aspects of the QEUH issues as well as a number of other Public Inquiries at a later stage. I chaired that meeting and the membership included the Corporate Directors. Robust programme management processes were put in place as this was a complex and far reaching situation and a Programme Manager was recruited to lead this work.

a) What was the formal remit of the Programme Board in 2019? When did the Programme Board meet and who were its members?

A. The Programme Board was formed to oversee the Internal Review of issues associated with the QEUH / RHC as agreed by the NHS Board on 19 February 2019. It oversaw three principal areas of activity etc.:

- Review of Facilities and environmental issues
- Review of Capacity and Flow
- Review of clinical outcomes

Each area required a separate strand of work led by a Director and it was required to report back to the Programme Board on progress against milestones prior to progress being reported to the CMT, Board Standing Committees and the NHS Board.

The Programme Board met monthly throughout 2019 and its membership included the Chief Executive who chaired the Programme Board, the Director of Estates and Facilities who led the Facilities and Estates work stream, the Chief Operating Officer who led the Capacity and Flow work stream and the Medical Director who led the Clinical Outcomes work stream.

b) With reference to your response to question 3 your statement to the Inquiry of May 2025:
What was the function, scope and remit of the internal review process you described? Who carried it out?

A. The purpose of the process was to ensure that appropriate action was being taken in relation to the three areas outlined in the NHS Board paper of February 2019, namely a review of the facilities and environmental issues in respect of the QEUH / RHC, a review of capacity and flow to assess the position in 2019, against the original model and planning assumptions and a review of clinical outcomes over the period.

The workstream associated with the Estates and Facilities elements was led by the Director of Estates and Facilities with the scope being to systematically consider a range of issues including the initial contract, design, commissioning and maintenance. It was the intention that this review would provide further information for NHSGGC to recommend potential actions to be taken forward. It was agreed that this workstream would report to the Finance, Planning and Performance committee.

With regard to the Capacity and Flow workstream, it was led by the Chief Operating Officer with the overall aim of assessing the capacity and flow issues since the opening of the QEUH / RHC and also to seek an external expert review of the current capacity and flow processes in 2019. The issues included the consideration of the planned demand profile of minor injuries, the assessment unit and the Emergency department itself against the original planning assumptions. This workstream would report to the Acute Services Committee.

In relation to clinical outcomes, this work was led by the Medical Director and was to ensure a robust assessment of overall clinical quality and safety. The main areas to be considered were the Hospital Standardised Mortality Ratio (HSMR), Infection reports, external reports undertaken during the period, patient experience reports and benchmarking with other acute sites across Scotland, with this workstream reporting to the Clinical and Care Governance Committee.

A Programme Board was established, chaired by the Chief Executive with a view to the work being completed within a few months and providing a comprehensive paper to the NHS Board, following consideration by the CMT and Board sub-committees as outlined.

4. During the period you were Chief Executive how was it decided which issues, decisions and reports would be escalated to the full Board or one of first line of subordinate committees?

A. As outlined above, the Standing Financial Instructions, Standing Orders and Scheme of Delegation provide a framework within which the NHS Board operates. These documents outline what decisions are reserved for the NHS Board and what should be considered by each committee. The Terms of Reference for each committee are agreed and reviewed annually and include the key remit and responsibilities of each Committee.

The Information Assurance Framework, which has been approved by the NHS Board, also outlines what information should be provided to each committee and with what frequency.

5. During the period you were Chief Executive what procedures were put in to ensure all significant questions about the issue listed in Question 2 were being taken to the Board or one of first line of subordinate committees, discussed and actioned?

A. The routine Board-level governance structures were utilised to ensure significant matters were reported to the Board committees as appropriate and were underpinned by the Corporate Management Team. As outlined in Q2, there was considerable reporting of a range of issues associated with QEUH / RHC to the NHS Board and its subcommittees.

Major issues were reported to the Clinical and Care Governance committee, the Acute Services Committee and the Finance, Planning and Performance Committees as outlined in their Terms of Reference.

Routine reports were also made to the NHS Board on the Oversight Board progress, CNR and internal reviews.

Serious incidents, including regulatory non-compliance were also escalated to the subcommittees and / or NHS Board, depending on their severity.

Board seminars were also utilised to update the Board members on any key issues, including the litigation claim.

The NHS Board would also approve any significant supporting business cases where remedial actions were required.

a) With reference to your response to questions 4 and 5 in your statement to the Inquiry of May 2025, you discuss the scheme of delegation under which NHSGGC operates. Would you expect that the Terms of reference of the Laboratory Executive Board (NHSGHLPEB) as approved by the Performance Review Group (see **Bundle 34, Document 21 at Page 152**) is part of that NHSGGC scheme of delegation?

A. My recollection is that, at the time of its inception, the Performance Review Group would have been the governance committee tasked with an overview of the project and, thus, it would have been appropriate for that committee to consider and agree the Terms of Reference. As outlined previously, the volume and complexity of issues that occur in NHSGGC is very significant and, thus, a number of issues are delegated to Board committees to ensure appropriate oversight as it would be extremely challenging to have a detailed consideration of all issues at the main bi-monthly Board meeting.

b) What responsibility does a Board staff member who is a voting member of a committee or executive board created under terms of reference or a remit approved by a Board subcommittee or group have for the work of that Committee or executive board?

A. In relation to such committees or executive boards, it would be incumbent on members to ensure that the key issues were being considered and any matters of significance were considered with appropriate expert input. A number of issues are generic in nature, while others are more technical / clinical and members of such committees would require to rely on their qualified and experienced colleagues to advise on such issues.

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

A. Once again, the Board-level governance structures were utilised to ensure progress was being made. Issues were noted on the appropriate Rolling Action

List which each committee maintains, as does the Corporate Management Team, and progress against these Rolling Action Lists is reviewed at each Committee to ensure Board members are assured that the appropriate progress is being made. If the Board members were not content, then further actions would be agreed to rectify the situation. Actions are not removed from the list until Board members are content that they have been concluded.

Individual Chairs of governance committees also sought updates and papers on key issues if they considered further information was required.

7. Please refer to Dr Redding's witness statement at paragraph 186 **(Witness Bundle – Week Commencing 2 September 2024 – Volume 3, Document 2, Page 63).** Dr Redding states, "The SMT and Clinical Governance Committees take decisions on what information is discussed at meetings of the full board." Is this statement correct? Please explain your answer.

A. I am assuming that Dr Redding's reference to the SMT relates to the Corporate Management team (CMT), although each sector / Directorate / HSCP has its own SMT. As previously outlined, the Standing Orders and Scheme of Delegation outline what decisions should go to the NHS Board. NHSGGC also, more recently, has an Information Assurance framework which has been agreed by the Committee Chairs and then the full Board which outlines precisely what information should go to the NHS Board. These documents ensure that there is a structured process which ensures the NHS Board is informed on relevant issues at the correct level within the organisation.

Should there be any ambiguity about whether any issues should go to the full Board, it would be routine to consult the Director of Corporate Services and Governance and seek a view, along with consulting the Board Chair and the Chairs of the relevant committee and the Chief Executive, when appropriate.

In addition, during this period there was ongoing, regular dialogue with the Board Chair to ensure that any issues considered relevant were reported to the subcommittees of the NHS Board as well as the Board itself.

8. Please refer to the NHSGGC Audit Scotland audit reports 2016/17 and 2017/18 (**Bundle 29, Document 13, Page 485 & Bundle 29, Document 14, Page 523**) What led to the changes in the Board's governance structure in 2016/17, specifically the establishment of new committees and the subsequent requirement for the chairs of the standing committees to update on discussions and decisions made at their respective committees (see **Bundle 29, Document 14, Page 532**)? Was the Board satisfied that the implementation of these changes enhanced and strengthened governance at GGC?

A. I was not in post during the period 2016/17 so do not have a clear understanding of what led to the changes during that year. Having read the report, it refers to a review of governance which took place from August 2016 when I was not employed within NHSGGC.

With regard to the 2017/18 changes, this was undertaken to ensure that the full NHS Board had greater oversight of the decisions being made with significant issues being raised at committee level while maintaining a degree of delegation due to the size of the Board's accountabilities and responsibilities.

My recollection is that feedback was sought from Board members and they were generally satisfied that issues were being addressed and that the new arrangements had enhanced and strengthened governance in NHSGGC.

In addition, an annual survey of NHS Board members was undertaken which covered a range of questions relating to this area. Feedback from these surveys was discussed by the full Board and changes were instigated following these discussions, where appropriate.

9. The Inquiry understands you were a member of the Acute Services Strategy Board. When were you appointed to the Acute Services Strategy Board, what was your role and what was purpose of the Acute Services Strategy Board? What decisions were made by Acute Services Strategy Board whilst you were a member in respect of issuing of the completion certificate, approval of changes in the respect of ventilation systems that were not consistent with the terms of SHTM 03-01 (2009) draft, the use chilled beams in clinical areas, the ventilation systems of what became Ward 2A (RHC), Wards 4B, 4C, 5C and 5D of the QEUH and design of the ventilation systems of isolation rooms?

A. During the period when I was the Chief Operating Officer, I was a member of the Acute Services Strategy Board (ASSB). I cannot recall precisely when I became a member due to the passage of time. My recollection is that the ASSB provided a high level, strategic overview of the implementation of the Acute Services Review, which was the strategic direction that the NHS Board adopted to redesign its acute services. In respect of the QEUH / RHC campus the Acute Services Review involved the amalgamation of inpatient services from the Victoria Infirmary, the Western Infirmary and the Southern General Hospital onto the QEUH site, along with the movement of Yorkhill to the RHC.I recall that it consisted of a number of the NHSGGC Corporate Directors, Scottish Government colleagues and the Project Director. It was chaired by the NHSGGC Chief Executive at that time, Robert Calderwood.

I cannot recall the Acute Services Strategy Board making any decisions relating to the areas outlined in this question. This was a high level group which would not have had the technical expertise to make an assessment of the issues relating to ventilation systems and chilled beams.

I am assuming that the completion certificate was not issued until nearer the opening of the hospital and, as I left NHSGGC two years before then, I have no recollection of any discussion on this matter. Again, I am not sure that this would have been an appropriate forum to agree that issue as presumably the Project team would have the technical expertise to sign it off and, thus, I am unclear as to whether this would be an appropriate decision for the ASSB to make.

10. When you were Chief Executive what reporting processes and protocols were in place between NHS GGC and

(i) HPS
(ii) Scottish Government

Please provide details in respect of:

i) The reporting process
ii) Circumstances under which reporting would take place

iii) Actions then taken

A. The standard reporting processes were in place between HPS and NHSGGC. The infection control team would be better placed to provide a detailed response to this area. In addition, the advice of HPS was sought on a number of key issues and members of HPS were involved in a number of the key IMT meetings.
In terms of the Scottish Government, the processes were different at different stages. In the beginning, the nature of the dialogue with Scottish Government was of a routine nature which consisted of briefings from NHSGGC through HPS to the Scottish Government which is the recognised route for communication. In addition, there were discussions between our local team and HPS and members of the CNO's team. NHSGGC sought to utilise the expertise of colleagues both within HPS and the CNO's Directorate at the Scottish Government as the issues progressed. As outlined in Q11, on 20 March 2018 the Scottish Government wrote to the Medical Director requesting that the national support framework be implemented which meant that HPS and the Scottish Government had a pivotal

role in these issues from that time. In addition, members of HPS and HFS attended the IMT. As the issues became more challenging, there were more frequent discussions and, following NHSGGC's escalation, there were a significant number of meetings to discuss the issues, both formally and informally.

During the escalation period, an Oversight Board was established by the Scottish Government and NHSGGC were required to submit papers and provide presentations to this Oversight Board, which was chaired by the Chief Nursing Officer, Professor Fiona McQueen. I understand that she, in turn, briefed other members of the Scottish Government team on progress. At this time, the Scottish Government played a significant role in infection control issues and NHSGGC were required to ensure the agreed actions were addressed.

In person meetings also took place with Scottish Government Directors and with the Cabinet Secretary.

a) With reference to your response to question 10 in your statement to the Inquiry of May 2025 did the Oversight Board have the power to direct action by NHSGGC? If it did, please provide examples of when and how this was done?

A. The Oversight Board was appointed by the Scottish Government as NHSGGC had been escalated to Level 4 of the performance framework and that meant that, for specific areas, the Oversight Board had a lead role and could, therefore, direct issues. Simultaneously, an interim Director of Infection Prevention and control was appointed by the Scottish Government, initially Prof M. Bain and then, Professor A Wallace. In effect they assumed responsibility for the IPC team and, thus, were closely aligned with the work of the Oversight Board. Three subgroups were established from the Oversight Board including Infection Prevention and Control, Communications and Engagement and a Technical Group. All three groups sought assurance on the key aspects of the work and

NHSGGC colleagues provided many papers and presentations to the subgroups as well as to the Oversight Board.

The Terms of Reference for the Oversight Board outline that NHSGGC would work with the Oversight Board in developing plans and would take responsibility for delivery. With regard to examples, the Oversight Board and its subgroups required that all press releases were reviewed by the Scottish Government prior to their issue. Work was also undertaken in relation to the dedicated Facebook page for families. Processes were reviewed within the infection control subgroup to ensure alignment with national policy and that work was undertaken under the guidance of the Oversight Board.

It was the intention that NHSGGC worked collaboratively with the Oversight Board to address any emerging issues from the consideration of the Oversight Board and that approach was adopted.

11. Did you have any occasion to report to the Scottish Government that an aspect of the water or ventilation system of the QEUH/RHC was not as the clinicians of NHS GGC expected it to be, was not in compliance with the relevant STHM or gave rise to a potential issue of patient safety? If yes, when, how and why? If not, why not?

A. The Scottish Government was aware of the return of the adult BMT to the Beatson West of Scotland Cancer Centre in 2015 for remedial action to be taken. Scottish Government colleagues were also members of the ASSB, although I believe that detailed, technical issues we not routinely discussed at that forum.

On 20 March 2018, the Scottish Government wrote to the Medical Director requesting that the national support framework be invoked and thus HPS and the Policy Unit were fully involved in the process. This, in effect, gave HPS and the Scottish Government a central role in the approach from that time.

As outlined in Question 10, regular dialogue was taking place with Scottish Government on a number of issues and, from March 2018, they played a pivotal role in the process, although they had been involved prior to that time.

NHSGGC found itself in a unique position where no other Health Board had experienced this set of circumstances and as outlined were seeking external support and expertise during this period, including from HFS, HPS and the Scottish Government.

a) Was the Scottish Government or NHS NSS told of the issues that arose with the ventilation in the Schiehallion Unit in June 2015 and that HEPA filters had not been fitted in Isolation Rooms in Ward 2A, ITU, HDU? If so, by whom and when?

A. As I was not in post in June 2015, I am unable to answer what communication there was with the Scottish Government and NSS in June 2015. They were involved in a number of areas throughout the whole QEUH / RHC project and, since its completion, in relation to some specific issues, including water and ventilation throughout the overall period, but I am unaware of their knowledge of that level of detail at that time. I understand that NHSGGC has provided a large number of documents detailing their involvement over a wide range of issues.

b) In your response to question 11 in your statement to the Inquiry of May 2025 you state that “The Scottish Government was aware of the return of the adult BMT to the Beatson West of Scotland Cancer Centre in 2015 for remedial action to be taken”. You have not answered the question in respect of Ward 2A RHC. When the Scottish Government was told that the ventilation system was not as the clinicians of NHSGGC expected it to be, was not in compliance with the relevant SHTM or gave rise to a potential issue of patient safety? If yes, when, how and why? If not, why not?

A. I am not aware of precisely when the Scottish Government became aware of the position with regard to the ventilation system in Wards 2A/B. It is difficult to provide precise clarity as there were multiple routes of communication to the Scottish Government either directly or through other channels such as HPS.

12. The Inquiry understands from evidence heard that as Chief Executive you were the Duty Holder in respect of the water system and its maintenance (see **Bundle 6, Document 29, Page 122**). What is your understanding of the roles and responsibilities incumbent on you in respect of this role? How does your role as Duty Holder relate to the work and responsibilities of the Board Water Safety Group? What was your understanding of your responsibilities as Duty Holder for making appointments of Authorised Person (Water) and Authorising Engineer (Water) for the new SGH?

A. In relation to the Water Policy, the Duty Holder refers to the individual or group responsible for ensuring that water systems are safely managed and that the risks associated with waterborne pathogens are properly controlled. The Duty Holder’s role is addressing compliance with water safety regulations, The role involves strategic oversight of appropriate resources and structures to manage water safety risks.

The Chief Executive or Board must appoint a Responsible Person (Water) who is qualified, competent and has the authority to oversee the management of water safety across the healthcare facilities. In reality, the Chief Executive role relies on this Person to implement the required actions. This person is typically a senior estates manager with specialist knowledge of water systems and infection control processes. The Chief Executive or NHS Board delegates the operational responsibility for water safety to the Responsible Person.

The Responsible Person has primary responsibility for ensuring that the water systems are managed safely and that all necessary precautions are in place to minimise the risk of waterborne infections arising. This person acts as the primary point of contact for water safety within the organisation. In an organisation the size of NHSGGC, significant reliance is placed on this Person to undertake the necessary tasks, through the delegated structure. At the time of the QEUH / RHC opening, I was not in post and the initial work and establishment of the key roles and procedures was prior to my appointment. As the hospital had been operational for 2 years when I became the Chief Executive, my assumption was that these roles were fully in place before my return to NHSGGC.

a) When you became Chief Executive what steps did you take to satisfy yourself that appointments had been made for the roles of Authorised Person (Water) and Authorising Engineer (Water) for the QEUH/RHC?

A. There are a very large number of areas where delegated arrangements require to be in place across an organisation of the size and complexity of NHSGGC and, thus, as Chief Executive, significant reliance is placed on those who have the expert knowledge in their subject matter areas to ensure all appropriate arrangements are in place for areas such as this one.

The hospital had been opened for over 2 years when I returned and took up the post of Chief Executive. As such, I commenced that role on the basis that all

necessary arrangements and appointments were in place and this issue was never raised with me as a concern until the emergence of the reports in 2018. On being made aware of these reports in 2018, I immediately took steps to ensure that all the recommendations continued within them were fully addressed, including in relation to strengthening the arrangements for the training, clarity of roles and paperwork associated with them.

b) With reference to your response to question 12 in your statement to the Inquiry of May 2025, and in light of the terms of the Water Systems Safety Policy (see **Bundle 20, Document 95, Page 1965**) when you became Chief Executive:

(i) What did you do to familiarise yourself with the Health & Safety Commission's Approved Code of Practice and Guidance L8 (ACOP L8) – Legionnaires Disease, The control of legionella in water systems"

(ii) What did you do to familiarise yourself with Chief Executive's letter CEL 08 (2013) "Water sources and potential risk to patients in high risk units – revised guidance" (see **Bundle 18, Volume 2, Document 114**)?

(iii) How did you ensure that adequate resources were provided to meet the Water Systems Safety requirements at the QEUH?

(iv) The Inquiry has heard evidence that from 2015 Estates staff considered there were inadequate numbers to fulfil their roles and requirements. This appears to be reflected in your answer to Question 41. What steps did you take in 2017 to ensure that there were sufficient staff in the Estates team at QEUH to manage the water and ventilation systems in compliance with guidance and statutory requirements?

(v) In 2017, how did you ensure that the Water Systems Safety Policy was being implemented at all levels?

(vi) In 2017, how did you review and monitor the operation of the Water System Safety Policy through the Board Corporate Management Team and ensuring that clear guidelines are provided for those tasked with legislative and statutory requirements?

(vii) What awareness did you have that by 2017 the Infection Control Manager had ceased to attend meetings of the Board Water Safety Group and that responsibility for chairing that group had largely devolved to Mary Anne Kane?

A. I relied on the Director of Estates and Facilities to ensure that the appropriate mechanisms were in place to address the issues outlined in these documents. It would be extremely difficult for a Chief Executive to familiarise themselves with the current state of play with all guidance purporting to the massive range of technical, clinical and corporate areas that come under their remit. As the Chief Executive of NHSGGC, with a budget in excess of £4billion and approximately 41,000 staff, it is essential that issues are dealt with by senior colleagues and their teams to ensure the Health Board functions effectively. No issues were brought to my attention that led me to believe that the mechanisms were not in place to ensure compliance.

Again, I do not recall any issues being escalated to me in relation to resources associated with the Water Systems Safety requirements at QEUH. This is an issue that I would anticipate the Director of Estates and Facilities would deal with as he would have had the expertise and experience in relation to these matters, along with access to a significant budget and would have the ability to flex his resources should he consider that any areas required additional input. In addition, there is an internal financial process to seek additional funding through the development of a business case for consideration alongside any other proposals to the CMT.

However, it is important to note that all Health Boards are required by the Scottish Government to live within their financial means and, while any significant patient safety issues should always be addressed, the fiscal position has been challenging over the last few years and Directors have been required to deliver recurring savings every year from their budgets.

In relation to my response to Question 41, my response relates to specific senior individuals rather than a generic resource issue. It was evident that, in the period immediately following handover, there were a large number of technical issues still being addressed which placed significant pressure on the senior estates team.

The assurance process would have been addressed through the E&F governance forums, the Water Safety Group and the BICC.

I was not aware that the Infection Control Manager had ceased to attend the meetings but would anticipate that any such concerns would be addressed through the routine line management arrangements.

c) On the second page of the Chief Executive's letter CEL 08 (2013) "Water sources and potential risk to patients in high risk units – revised guidance" (see **Bundle 18, Volume 2, Document 114**) makes reference to the use of the Board's Annual Controls Assurance process. Why did the Controls Assurance process of NHSGGC at Board or Executive Board Member level fail to notice that no L8 Risk Assessment had been reported to the Board Water Safety Group for the QEUH for three years after handover?

A. I would have anticipated that these issues would have been addressed by the Project team and Director of Estates and Facilities through their routine governance channels. In my experience, it would not be the usual process that such issues were considered by the full NHS Board, rather that the relevant technical experts and Directors would address them.

I would have anticipated that any material issues would have been brought to the attention of the CMT in the period after the opening of the new hospital and I cannot answer why that was not undertaken as I was not in NHSGGC at that time.

Significant issues associated with the water were not highlighted to me until Spring 2018 when the IMT process identified a potential link to the water supply so, until that time, I was unaware of there being any significant issues associated with the water supply.

13. What if anything were you advised by your predecessor upon commencing your role as Chief Executive in respect of the risk assessment and maintenance of the water system at the QEUH/RHC?

A. I was not advised of any issues in respect of the risk assessment and maintenance of the water system at the QEUH / RHC by my predecessor.

a) With reference to your response to question 13 in your statement to the Inquiry of May 2025, did you have a handover note, meeting or briefing from Robert Calderwood that set out any issues with the building of the QEUH?

A. There was only a short period of time between me being appointed as Chief Executive and Robert Calderwood's retiral. During that time my recollection is that I met in person with him on two occasions to discuss current issues. I do not recall him raising any issues in relation to the building of the QEUH and there was no briefing or handover note provided on the building of the new hospital

14. Were you aware when appointed of the requirement for a L8 Pre-occupation Risk Assessments to be undertaken in advance of the QEUH opening and for regular L8 Risk Assessments to and Authorising Engineer (Water) audits to be carried out once the hospital was open? If not, why not?

A. At the time of my appointment, I was unaware of the requirement for a L8 Pre-occupation Risk Assessment to be undertaken in advance of the QEUH opening.

By the time I had returned to NHSGGC, the hospital had been open for 2 years so I would have assumed that all the appropriate assessments had been completed at the time of it becoming operational.
In addition, these are areas which require a level of technical expertise and knowledge which, as Chief Executive, I do not possess in order to give an informed view. I would expect the Project Director and his team to have completed the appropriate tasks and to ensure that any outstanding issues were addressed at the time of identification and on an ongoing basis.

a) When did you become aware that an L8 Pre-occupation Risk Assessment had been carried out in 2015 and how did you find out?

A. My recollection is that I became aware of the L8 Pre-occupation Risk Assessment at the end of June 2018 following discussion with Professor Steele who, at that time, was working within NSS. As outlined above, actions were put in place immediately following that discussion to address outstanding issues, including the appointment of additional technical expertise to ensure that the issues were addressed swiftly and comprehensively.

b) With reference to your response to question 14 in your statement to the Inquiry of May 2025 you explain that at the time of your appointment you would have assumed that all the appropriate assessments had been completed at the time of the QEUH becoming operational. Do you accept that delegation still requires the person delegating to undertake some level of supervision over those to whom responsibilities have been delegated which includes, as a bare minimum, ensuring that the delegated tasks are being performed?

A. I would expect that Directors, as very senior colleagues, would ensure that the essential elements of their role were being addressed. At this level in the organisation, Directors have a high degree of autonomy and responsibility for their own areas.

I had a number of 1 to 1 meetings with my direct reports when they could raise any issues of concern with me. During these meetings, we did discuss current issues, actions and any ongoing challenges so I would have expected that any concerns would have raised with me then. In addition, I had regular dialogue with my corporate Director colleagues on a wide range of issues. There was also an informal weekly Directors meeting with all Directors present so there was plenty of opportunity to raise any issues of concern.

c) The Inquiry understands that you were a voting member of the Performance Review Group and the new South Glasgow Hospitals and Laboratory Project Executive Board (NSGHLPEB) during Stage 1 of the new SGH project.

The NSGHLPEB was set up by the Performance Review Group on 19 May 2009 (see **Bundle 34, Document 21, page 145 at page 153**). You were then Chief Operating Officer (Interim) of NHSGGC.

The NSGHLPEB had delegated authority to conduct and conclude negotiations at project critical moments and was required to "oversee the management of change control processes" so that "any change which impacted on the project must be authorised by [it] before it can be implemented (see remit at **Bundle 34, page 152**).

The Inquiry has heard evidence from Mr. Seabourne and Ms Byrne that no such change control system existed. Please review the meeting of the NSGHLPEB on 7 December 2009, shortly before the contract was concluded on 18 December 2009, (see **Bundle 42, Volume 2, Document 18, Page 86**), that suggest the NSGHLPEB did not "conduct and conclude negotiations" but rather this was left to the Project Team (see item 5). This was also Mr. Seabourne's evidence.

(i) Why was there no change control process in place for the Stage 1 of the new SGH project?

(ii) Considering the above, how did the contract come to be signed on 18 December 2009 despite the PRG not being asked to authorise any changes and NSGHLPEB not conducting and concluding the negotiations?

A. Due to the passage of time as this was 16 years ago; I cannot recall why there was no change control process in place for Stage 1 of the new SGH project. However, it would be challenging for a corporate, multidisciplinary group such as the NSGHLPEB to conduct and conclude negotiations and it would have been my expectation that the Project Director would advise the group of any material issues. In relation to my role, my recollection is that, at that time, any significant service issues that would involve a major change in the service delivery profile would have been discussed at that forum but it would be unlikely that any detailed negotiations would have been undertaken by the overall committee but rather would have been delegated to the Project Director, his team and their Advisors.

Involvement in the Procurement of the New SGH in Your Role as Chief Operating Officer for NHS GGC (2009 – 2013)

15. What role did you have as Chief Operating Officer for NHS GGC from 2009 to 2013 in the procurement of the new SGH?

A. As Chief Operating Officer, I attended the full NHS Board meetings (although I was not a Board member) and so was present when discussions and decisions were made. I was also a member of the Acute Services Strategy Board.

16. Describe your involvement and understanding, if any, in the removal of the maximum temperature variant in May/June 2009? **(**see **Bundle 17, Document 26, Page 1063 and Bundle 26, Document 3, Page 247)** When did you first become aware of this decision? Why was the decision taken and by whom? What was the Board level knowledge/ input into this decision? What risk assessments, if any, were taken prior to making this decision? What was the impact, if any, in removing the maximum temperature variant?

a) Describe your involvement and understanding, if any, in the decision to use chilled beams. Why was the decision taken and by whom? What was the Board level knowledge/ input into this decision? What risk assessments, if any, were taken prior to making this decision? What was the impact, if any, in using chilled beams?

b) Who provided the specification for environmental data relating to air change rates, pressure differentials and filter requirements?

A. I had no involvement or understanding of the removal of the maximum temperature variant in May / June 2009. This is not an area that I would have any technical relevant expertise and would not have been involved in any such decisions.

I do not recall ever being told about this issue at the time and thus have no appreciation of the Board level knowledge, awareness of risk assessments or any impact. These types of issues would have been routinely dealt with by the Project team who had the appropriate technical knowledge.

In terms of chilled beams, again, I do not have the technical expertise to make an informed decision on their use. I had no input to the decision making process as, again, it would require a level of technical knowledge that I do not have.

I am unaware who provided the specification for environmental data relating to air change rates, pressure differentials and filter requirements. As a Chief Executive or Chief Operating Officer of an extremely large and complex organisation, these are not issues that I would expect to be involved in, due to their technical nature.

a) When did you first become aware that the QEUH used Chilled Beams in most single patient rooms and how did you find out?

A. Following a review of the available documents, the use of “cooler beams” was mentioned during the discussions relating to the formation of the SBAR in 2017. The use of chilled beams was identified following the publication of the AECOM report. In line with a number of other issues, there appeared to be differing views on their usage and as previously indicated, I did not have any knowledge of chilled beam technology and I would expect that those with the appropriate technical expertise within the Project team and its advisors would be best placed to comment on this area.

17. Describe your understanding and the involvement of you as Chief Operating Officer in respect of the selection process whereby Brookfield Europe LP were selected as the preferred bidder and explain why Brookfield Europe LP were so selected?

A. As outlined above, I was not closely involved in this issue, although I was a member of the Acute Services Strategy Board. I also attended the Performance Review Group Board Standing committees during my time as Chief Operating Officer. In November 2009, the PRG approved Brookfield as the preferred bidder. During these meetings, I had no involvement in the technical details associated with issues such as water and ventilation as I do not have the technical expertise to give an informed view on such matters. My involvement was more in relation to the redesign of services to allow a smooth transition to the new facilities.

a) Should the Chair assume from this paragraph of your statement that the removal of the maximum temperature variant in May/June 2009 was not discussed at the Acute Services Strategy Board or the Performance Review Group Standing committees?

A. I have no recollection of this issue being discussed at these Committees but it is difficult to recall the detail 16 years later.

b) Should the Chair assume from this paragraph of your statement that the use of Chilled Beams in the new hospital was not discussed at the Acute Services Strategy Board or the Performance Review Group Board Standing committees?

A. I have no recollection of this issue being discussed at these Committees but it is difficult to recall precisely after 16 years. In addition, any such discussion would have been led by the Project Director and his team as I do not have the necessary technical knowledge to provide an informed view on their use.

c) Please refer to **Bundle 34, Document 21 at Page 152.**

A. This document sets out the Terms of Reference and Membership of the New South Glasgow Hospitals and Laboratory Project Executive Board, of which you were a voting member, it sets out how the Executive Board "will be accountable for the planning and delivery of all procurement financial and technical measures required to deliver the identified investment and services that fall within the scope of the whole project. This will ensure there is appropriate progress on … "Technical Output Specs, Bid Evaluation Process [and] Test technical viability of solutions". Did this not make the Executive Board responsible for ensuring that the technical changes pre contract (including the removal of the Maximum Temperature Variant in June 2009 and the agreement of the Agreed Ventilation Derogation) were properly assessed on a technical basis?

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

18. When did you first become aware of the ZBP Ventilation Strategy Paper dated on or around 15 December 2009? **(**see **Bundle 16, Document 21, Page 1657).** What did you understand was the purpose and message of the paper? Were you aware that the authors of the paper appear to accept that it proposes a solution which has less air change rate than that set out in the STHM. What action, if any, did you take when you became aware of this document or the proposal contained within it and why? If you did not take any action, why not? What concerns you have on reading this document or learning of the proposal contained within it?

A. I had no awareness of the ZBP Ventilation strategy paper dated December 2009 until the production of the AECOM report in 2019 which described the overall position with regard to the ventilation systems. It would be unlikely that the Chief Executive would be involved in these issues as again a degree of technical expertise would be required. The Project team and its advisors would be the individuals who would take ownership and accountability for such issues. By the time I became aware of the document, significant work had already been undertaken in relation to the ventilation in the most essential areas, with the infection control team, estates and facilities staff and the local teams addressing any ongoing issues.

19. The Inquiry is aware of the agreed ventilation derogation recorded in the M&E Clarification Log. (see **Bundle 16, Document 23, at the foot of Page 1664).** What was your understanding and awareness, if any, the scope of this agreed ventilation derogation recorded in the M&E Clarification Log? When did you first become aware of it and how?

A. I was unaware and had no knowledge of the scope of this agreed ventilation derogation and did not have sight of the M&E Clarification log as that would be undertaken by others within the organisation, rather than at Chief Executive level. I only became aware of its existence more recently as part of the ongoing investigations.

a) The Inquiry Team understands that the M&E Clarification log formed part of the contract between Brookfield and NHS GGC. Given the responsibilities placed on the Chief Executive of the Board should the then Chief Executive have known of and understood the M&E Clarification log and its impact on the conformity of the planned ventilation system with SHTM 03-01?

A. **I**n an organisation of the size and complexity of NHSGGC, the Chief Executive requires to place substantial reliance on their team to deal with very many matters of significance. The Project Director and his team would routinely be those best placed to consider such issues. I would also not anticipate that a Chief Executive of such a large and complex organisation would have the requisite knowledge and expertise to have a full understanding of the detail and significance of the M&E clarification log but, again, would rely on the Project team and their technical advisors to action appropriately.

b) With reference to what the Inquiry has called the Agreed Ventilation Derogation recorded in the M&E Clarification Log and question 19 in your statement to the Inquiry of May 2025 you have not answered the question “When did you first become aware of it and how?”. When and how did you first become aware of the Agreed Ventilation Derogation?

A. I regret that I am unable to recall precisely when I first became aware of it.

20. How was this agreed ventilation derogation signed off by the Board? If the decision to agree this derogation was delegated to an individual, a group of staff or a committee of the board or its staff how was this delegation made and what report was made to the Board of agreement of this ventilation derogation? Why this derogation was accepted, and who advised acceptance? What role, if any, did BREEAM played in the acceptance of this derogation?
You should note:

- That in an email of 23 June 2016 (see **Bundle 12, Document 104, Page 813**) Alan Seabourne sets out he understood that the ventilation of rooms in the hospital was approved,
- That Currie and Brown assert in their response to PPP13 that the GGC Project Team had advised Helen Byrne of the Agreed Ventilation Derogation, alongside Alex McIntyre (Director of Facilities) and Peter Gallagher (Director of Finance), and
- That in evidence Professor Steele stated that he had been unable to find any documentation other than the M&E clarification log itself to explain why the NHS GGC agreed to the derogation. **(Transcript, Professor Steele, Page 36)**
- The Inquiry has seen the February 2010 paper Helen Byrne drafted alongside Alan Seabourne; Drafted Acute Services Review paper which stated the Acute Services Strategy Board will "*Approve change control in that any change which impacts upon the project must be authorised by this Board before it can be implemented".*

A. I am unaware of any process whereby such a derogation was signed off by the Board and I had no knowledge of the derogation agreement / signoff as, again, I assume that this would have been dealt with by the Project team as part of their overall delegated authority. I have no knowledge of the role of BREEAM in that decision. I have no recollection of these issues being discussed at the ASSB. It would be important to note that my main involvement and expertise would have been when service changes and the amalgamation of services were anticipated to ensure that the impact on operational service delivery was fully understood.

a) Once you became aware of what the Inquiry Team has called the "Agreed Ventilation Derogation", perhaps after Mr Powrie's email of 26 May 2016 (see **Bundle 20, Document 68, page 1495)**, what steps are you aware of that the Board took at any time before the appointment of Professor Steele as Director of Estates to understand why the "Agreed Ventilation Derogation" described in that email was agreed to and whether it was carried out under delegated authority or with the approval of the then Chief Executive or any sub group or subcommittee of the Board?

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

b) With reference to your response to questions 20 and 33 in your statement to the Inquiry of May 2025 when you returned to NHSGGC as Chief Executive in April 2017:

(i) What were you told in 2017 about the state of the ventilation systems of the QEUH/RHC, the Agreed Ventilation Derogation, Mr. Seabourne's email of 23 June 2016 (see **Bundle 12, Document 104, Page 813**) or Dr. Inkster SBAR of June 2016 (see **Bundle 4, Document 11, Page 52**).

(ii) What steps did you take before the end of 2017 as Chief Executive and also as a former member of the NSGHLPEB to investigate why NHSGGC agreed to the Agreed Ventilation Derogation or why specialist ventilation systems had not been completed to standards that had been expected by clinicians?

A. I do not recall being told directly of these issues in 2017 and had not seen sight of the emails or SBAR you refer to until I became aware of the series of concerns that had been raised that resulted in the 27-point action plan and, thus, was then aware that work was underway to address a number of issues associated with the ventilation system.

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

c) Mr. Loudon, the second Project Director of the new SGH project, retired in January 2018, what steps were taken before he retired to obtain his understanding of the Agreed Ventilation Derogation or why specialist ventilation systems had not been completed to standards that had been expected by clinicians.?

A. Mr. Loudon moved on to a new role in 2018 rather than retiring. Discussions were as outlined in question 14.

21. As far as you know which members of staff of NHS were aware of this agreed ventilation derogation at the time it was agreed or in the period between contract close and the end of the reviewable design period? What did they tell you about the reasons for the approval of this derogation?

A. I have no direct knowledge of which, if any, members of staff of NHSGGC were aware of this agreed ventilation derogation at any stage of the new build project. I would anticipate that members of the Project team would be best placed to respond to this question.

22. Was this agreed ventilation derogation restricted to general wards only?

A. I have no knowledge of this issue and would suggest that the Project Director and his team with the required technical expertise would be best placed to respond to this question.

a) What steps did you take after you became Chief Executive to discover why and under what authority the "Agreed Ventilation Derogation" was agreed to and whether it was restricted to general wards only?

A. As outlined above in relation to Q20.

23. Was the design and/or specification of the ventilation system as recorded in the Building Contract, in particular in the M&E Clarification Log in accordance with NHS Guidance including STHM 03-01 (2009) Draft (see **Bundle, 16 Document 5, Page 342**)? Explain your reasons?

A. I have no knowledge of this issue, nor do I have the technical expertise to provide an informed view. I would rely on the Project team, its Advisors and our local Estates and Facilities team to provide information on such issues.

24. What risk assessments, if any, whether in compliance with the standards in HAI Scribe or otherwise, did NHS GGC carry out or have carried out in respect of the change in the ventilation strategy that appears to follow the ZBP Ventilation Strategy Paper dated 15 December 2009? (see **Bundle 16, Document 21, Page 1657)**?

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

25. Was the agreed ventilation derogation recorded in the Full Business Case? Who was responsible for doing this? If not, why not? If you were aware that it had not been recorded in the Full Business Case please explain what action, if any, you took?

A. I do not have any knowledge of this issue.

Whistleblowing Process

26. What is your understanding of the whistleblowing process within NHS GGC in 2017 and the extent to which it was designed and operated to ensure that disclosure by staff of evidence of wrongdoing, failures in performance or inadequacies of systems was encouraged and reacted to by the Board to ensure that the safety of patients and the best value use of public funds were protected?

A. The Whistleblowing Policy in 2017 was included within the Code of Conduct and had been updated from the initial document in 2013. The Whistleblowing policy was overseen with regular reporting and reviews by the Audit and Risk Committee and the Staff Governance Committee which are Standing committees of the NHS Board. I have outlined the various routes to promote the whistleblowing process within Q35.

27. The Inquiry understands that in April 2017 you were contacted by Dr Redding about concerns she had about the hospital environment and patient safety (see **Dr Redding's Statement, paras 95 to 102, 110, Witness Bundle, Week Commencing 2 September 2024, Document 2 at Pages 93-95 & 97)**. What do you recall about these messages? What action, if any, did you take in response?

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

I then spoke to the Medical Director as the executive lead for IPC who indicated that she was aware of a number of the issues although there were differing views within the teams at the QEUH / RHC on a number of them. She indicated that

the IPC team was working with the infection control doctors and nurses, and local clinical teams to address the concerns. I also spoke to the Director of Estates and Facilities and the Chief Operating Officer to ensure they were aware of the issues and taking any required actions.

a) With reference to Dr. Redding's call to you in April 2017 (see question and answer 27 in your statement to the Inquiry of May 2025):

(i) You have explained that following that call you spoke to Dr. Armstrong and she informed you that she was aware of a number of the issues Dr. Redding had mentioned. What was the nature of the issues she was aware of and to what extent did those issues include concerns regarding the specialist ventilated areas within QEUH and RHC and the impact on patient safety by ICDs in July 2015?

(ii) You say you then spoke to the Director of Estates and Facilities and the Chief Operating Officer to ensure they were aware of the issues and taking any required actions. To what extent did those "required actions" relate to ventilation in the specialised ventilated areas such as Ward 2A and isolation rooms?

(iii) Do you accept that there were problems with the existing governance and reporting structures, given that consultants such as the whistleblowers, had to bypass them?

(iv) When did the NHSGGC Board first officially become aware of the concerns being raised by the whistleblowers?

(v) Do you now accept that the NHSGGC Board should have been made aware of these concerns (which have been shown to be justified and related to patient safety) much earlier?

A. My recollection is that Dr. Armstrong indicated that there had been some challenges between different colleagues who had differing views of how issues should be addressed including the issues that had occurred during the Easter weekend. My recollection is that Dr. Redding indicated that she had a number of concerns about the new hospital and the input from infection control colleagues and my recollection is that Dr. Armstrong and I discussed the overall input from infection control rather than specific detailed issues.

Again, my recollection is that the conversation with the Chief Operating Officer related to the interface between infection control colleagues and the microbiologists who were managed within the Diagnostics Directorate in order to ensure he was fully sighted on the fact that there were different views on how the system should operate. With regard to the Director of Estates and Facilities, my recollection is that he was aware of a number of issues concerning the QEUH / RHC but I do not recall specific discussion on the specialised ventilation areas.

In relation to the conversation with Dr. Redding, she stated that she wished to have an “off the record” conversation as I had recently returned to NHSGGC. I had known Dr. Redding from my previous role as Chief Operating Officer and, thus, I did not regard the conversation as “bypassing” the existing governance structures. On the wider issues, it was a complex situation as there were a number of different departments involved in these issues and, thus, there was a need to ensure they were all addressed and co-ordinated and that was undertaken later in 2017 through Dr. Armstrong.

The concerns of the NHSGGC whistleblowers were highlighted to the Clinical and Care Governance committee of the NHS Board in December 2017 when a detailed paper was provided to the committee. Further communication was provided to the NHS Board meeting in December 2017 so they were aware of the concerns at that time. I regularly briefed the NHS Board Chair on the position so he was aware of the issues soon after they occurred.

It is normal practice for the detailed scrutiny and discussion to take place at the NHS Board subcommittees to ensure a full examination of the issues. Significant efforts were being made to ensure that all these issues were addressed and the minute of the Clinical and Care Governance committee in December 2017 clearly outlines the position from a non-executive perspective.

28. Dr Redding and others then made a stage 1 whistleblow to Dr Armstrong for which they produced an SBAR (see **Bundle 14, Volume 1, Page 732)** and a meeting on 4 October 2017 (see minute at **Bundle 14, Volume 1, Page 753)**. As Chief Executive what steps did you take to keep yourself informed of the progress of this whistleblow and the concerns raised?

A. Initially, NHSGGC were not aware that Dr Redding regarded her concerns as a "whistleblow" and they were, therefore, dealt with through ongoing dialogue and then through the production of an SBAR requested by the Medical Director to ensure all issues were recorded in one document.

I was updated on progress by the Medical Director, Director of Estates and Facilities and the Chief Operating Officer. In addition, the issues were reported to the Clinical and Care Governance committee (CCGC) by the Medical Director and, on occasions, members of the IPCT.

29. Was this Stage 1 whistleblow discussed and reported on at Board meetings? What actions were taken in respect of the concerns raised in the whistleblow? How did the 27-point action plan (see **Bundle 20, Document 48, Page 792**) come about?

A. I do not recall the SBAR being discussed at the NHS Board but, as in Q28, it was discussed at the CCGC. The Medical Director ensured that an action plan was drafted and it was monitored regularly by her and the local teams. Its progress was also reported to the Board subcommittee as outlined above.

a) With reference to your response to question 29 in your statement to the Inquiry of May 2025 you appear to accept that the 3 October 2017 SBAR and the 27 point Action Plan were not discussed at the Board meetings but were reported to the Clinical and Care Governance committee. Would you accept that this prevented the whole Board from understanding that there were issue with the new QEUH building that remained unresolved more than two years after the hospital opened?

A. The NHS Board has to deal with a wide range of complex and challenging issues. It would be normal process for issues such as the SBAR and the Action Plan to be considered by the appropriate subcommittee. This would ensure more detailed analysis and scrutiny could take place and would ensure that the executives were held to account by the non-executive Board members in a more detailed manner than could be undertaken at the full NHS Board meeting. In addition, those non-executive Board members who had a clinical background were members of the Clinical and Care subcommittee and were thus best placed to ensure that all the patient safety issues were being fully considered. Following discussion at the subcommittee, updates were provided to the NHS Board, both at the public NHS Board meetings and in seminar format.

This format is followed in all areas of the NHS Board's business to ensure a full examination of the issues that require more detailed discussion.

30. To what extent is it fair to say that the 27 point action plan come about as a direct consequence of the Stage 1 whistleblow raised by Dr Redding and others?

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

31. What steps did you take to satisfy yourself that the issues raised personally with you by Dr Redding and in the Stage 1 whistleblow were addressed by NHS GGC?

A. I spoke regularly to the Medical Director on the issues raised and with the Director of Estates and Facilities in relation to estates and cleaning issues. I also spoke with the Chief Operating Officer, as well as the Medical Director in relation to the working relationships between the infection control team and colleagues within the Diagnostics Directorate.

a) With reference to your response to question 31 your statement to the Inquiry of May 2025 in which you describe speaking regularly to colleagues about "estates and cleaning issues" and "working relationships between the infection control team and colleagues within the Diagnostics Directorate", what assurances (if any) did you receive in 2017 and the first half of 2018 about:

(i) The safe operation of the water system of the QEUH

(ii) Whether the isolation rooms in the QEUH were appropriately specified for the patients to be treated within them?

(iii) Whether there had been infections that had the potential to be connected to the water or ventilation systems of the hospital

(iv) An HPS review of the NHSGGC system for surveillance and reporting of infections.

Concerns about the water system only emerged in 2018 and thus I do not recall there being discussion on this subject in 2017. However, once the issues began to emerge in 2018, and the IMT process was instigated, there was ongoing dialogue with regard to these issues. The situation initially was very unclear in relation to the potential for issues to be related to the water system so any emerging issues / actions from the IMT were discussed and actioned and my conversation with colleagues related to ensuring that progress was being made on issues raised by the IMT.

I do not recall directly discussing issues such as the specification of the isolation rooms for appropriate patients at that time although I appreciate they were raised through the SBAR process in late 2017 and the action plan was agreed through that process.

As outlined above, there were a number of ongoing issues but I do not recall any specific significant issues being raised with me in relation to these areas until after the IMT process in Spring 2018.

I have no recollection of discussion with me of an HPS review as outlined at that time.

32. When did you first become aware of the Stage 2 Whistleblow by Dr Redding about which Dr de Caestecker prepared a report (see **Bundle 27, Volume 4, Document 6, Page 81**). When did you see that report?

A. In February 2018, I was made aware that Dr Redding had indicated that she intended to move to Stage 2 of the whistleblowing process. It would not be routine practice for the Chief Executive to see whistleblowing reports. I was kept abreast of the issues by the Medical Director and the Chief Operating Officer and was aware of the issues involved. I cannot recall precisely when I saw the report.

33. Specifically what steps did you take (or had taken by the end of 2017) to find out why 6 ACH was not achieved across the hospital in compliance with SHTM 03-01? If you did investigate, what did you find out. If you did not, why not?

A. Dr Redding and her colleagues had raised a number of issues relating to ventilation during the period leading up to the production of the SBAR. At that time, I spoke to the Director of Estates and Facilities to seek a view on the situation. It was not easy to establish the reason for the ventilation position due to the lack of appropriate documentation from the contractor and also due to the fact that many colleagues were no longer in post. The issues raised, however, were systematically considered as part of the SBAR process and high priority areas were addressed following advice from infection control and estates and facilities colleagues.

34. Specifically, as Chief Executive what steps did you take to keep yourself informed of all future whistleblows and the concerns these raised?

A. It is not normal process for a Chief Executive to have sight of the details within whistleblowing reports due to the need for confidentiality for those involved. I would get a monthly summary of ongoing items and any summary recommendations but would not generally see the reports in full to ensure that the confidentiality of the process is retained.

a) Why is it "not normal process for a Chief Executive to have sight of the details within whistleblowing reports" when the overt purpose of making a protected disclosure would appear to be to bring issues relating to patient safety to the attention of the organisation?

A. In an organisation of the size and scale of NHSGGC, it is important that the delegated structures are utilised to ensure the local senior teams are aware of, and addressing, the issues. As Chief Executive, matters of significant importance were brought to my attention, although the need for confidentiality of the process remains of considerable importance to those involved.

NHSGGC follows the National Whistleblowing Standards which are clear on the approach to confidentiality. They state that organisations should "recognise and respect that everyone involved has the right to confidentiality" and continue "as far as the law allows, respect the confidentiality of any person who raises a concern, unless they agree that you do not have to". The Standards also state "confidentiality must be maintained as far as possible in all aspects of the procedure for raising concerns". Finally, the Standards also indicate "it is important that all of the issues raised in the investigation are treated confidentially unless there is a lawful basis or requirement for sharing information with others". Thus, confidentiality is a key requirement and focus throughout all whistleblowing investigations.

The summary documents contained a high level overview of the recommendations in order that the Chief Executive, the CMT and the appropriate Board committees can ensure they are being addressed fully.

35. Whilst you were in post what steps did the Board of NHSGGC take to encourage staff to raise concerns and highlight issues, including by whistleblowing policies and processes. If it were suggested that raising concerns and highlighting issues, including by whistleblowing policies and procedures, was not encouraged between 2017 and 2019, what would your response be? What evidence can you point to which supports your position?

A. Significant efforts were made to promote whistleblowing within NHSGGC, including throughout the period when I was Chief Executive. In 2014, NHSGGC launched a new Code of Conduct including whistleblowing through the use of the Core Brief and the Area Partnership Forum, supported by the Chair and Employee Director and this Code of Conduct was updated annually.

In October 2015, a non executive whistleblowing champion was appointed who ensured that appropriate action was taken in relation to this area. This role was to act at a strategic level to assure the NHS Board that appropriate actions and training were in place to promote whistleblowing, monitor performance against timescales and identify any emerging trends. Reports were also given to the CMT and to Board committees. This role added a non executive perspective to the issue at a strategic level and the initial whistleblowing champion sought information on the current position and worked with the executive lead to embed the process.

Since 2015/16, information for staff has been available on HR Connect which is available 24/7 and is used by staff to gain information on all types of HR issues. Action plans have been produced since that time and include issues such as publishing local and national whistleblowing routes and regular communication through Staff Net, and the Core Brief. Work was also undertaken to support the

Champion Assurance role, including supporting the Whistleblowing Champion in preparing an Assurance Overview Report on the previous year's cases for the appropriate governance committees and in developing action plans to ensure the Champion's role was best placed to adopt the assurance role. Training was also provided to support Level 2 and 3 cases, along with training for the Corporate Directors to ensure an overall awareness. There were, therefore, a significant number of actions undertaken to promote and support the whistleblowing process and, thus I believe that it would be incorrect to suggest that it was not encouraged between 2017 and 2019.

In 2019, the culture framework was also launched in NHSGGC and in 2020 I established the Gold Command group within the South sector. One of its objectives was to ensure that the QEUH and its associated hospitals within the sector were addressing all staff governance issues in a robust and appropriate manner and that group met on a regular basis for some time. In 2020, the post of Head of Staff Experience was created and a review of whistleblowing was undertaken by the then whistleblowing champion, with external support from an HR professional. In 2021, following the publication of the whistleblowing national standards, NHSGGC developed an action plan to create confidential contacts and to further improve a range of issues, including additional training.

Routine communication in relation to all these issues takes place at local Partnership forums, the Area Partnership forum, the CMT and Staff Governance committee.

During this period, NHSGGC also worked over a number of years towards the achievement of the Investors in People award and were successful in achieving this award in 2024, following a lengthy period of work across NHSGGC, including all the acute hospitals within NHSGGC.

a) In light of the recent publication by HIS of their report into the A&E Department at the QEUH (**Bundle 51, Volume 1, Document 7, Page 904**) and its conclusions that there was, “a lack of compassionate, respectful and positive leadership at all levels of the organization, especially in responding to concerns raised by staff”, is there anything you would like to add to Paragraph 35 above?

A. It is clearly of concern when issues such as those within the HIS report are raised. Considerable efforts were made to ensure staff felt supported but further work will require to be undertaken to address the concerns raised. Particular pressures exist in relation to Emergency departments across NHS Scotland and these pressures may need to be considered in a different manner to those elsewhere in the hospitals to ensure due attention is paid to the particular complexities of that area.

b) With reference to response to question 35 in your statement to the Inquiry of May 2025 Dr. Redding has given evidence (see paragraph 112 of her statement, **Witness Bundle – Week Commencing 2 September 2024, Volume 3, Document 2 at Page 98**) that: “Staff were not encouraged to use the Whistleblowing procedure. Prior to either the Stage 1 or the subsequent Stage 2 whistleblow (I cannot now recall which), I was urged not to Whistleblow by Jane Grant. I recall her specifically saying to me that she “urged” me not to do it”. Do you accept Dr. Redding’s position that you urged her not to whistleblow?

A. I received a several emails from Dr. Redding between November 2017 and January 2018 raising a number of issues, principally relating to the infection control structure and the role of ICNs. In the initial email of 24 November 2017, Dr. Redding indicated that she “may have to go to Stage 2 of the whistleblowing process”. I responded to Dr. Redding on 29 November indicating that I considered it essential that all infection control colleagues, both nursing and medical staff, work as a team to ensure there is coherence across the service and that everyone recognises the essential nature of that supportive team

working environment. My response goes on to stress the importance of everyone working together to seek realistic solutions and address any communication issues. I also outlined that where there is a difference of opinion between colleagues a professional discussion needs to take place to ensure all voices are heard and considered.

My email then suggests that the most appropriate way forward would seem to be through a meeting to be chaired by Dr. Green (the Chief of Medicine for Diagnostics) at the beginning of December. My email then states, “I would urge you to continue to work with Dr. Green, Professor Jones as the NHS Board’s interim lead ICD and your colleagues to seek an appropriate solution to these issues.”

Dr. Redding responded on 30 November stating “I agree with what you are saying and am happy to follow your advice”. Her email also states, “I am happy to comply with your request to wait”.

I, therefore, was seeking to ensure that colleagues continued to work in a collaborative manner to address ongoing concerns, I was not seeking to influence Dr. Redding in relation to whistleblowing but rather to seek a resolution to the issues raised.

I would also confirm that, other than the phone call in April 2017, I do not recall speaking in person to Dr. Redding rather the dialogue was through email.

Duty of Candour Policy

36. In his evidence Professor White explained (**see Professor White, Transcript, pages 75 to 79**) that, in discussion with the Board, in his capacity as the appointed Oversight Board lead on communications, he had discovered that the NHS GGC policy on statutory duty of candour had been written to impose a number of hurdles as a requisite of its operation above and beyond what was required by the statutory provisions (including a requirement of causation). He described this, somewhat kindly, as the policy not 'fully reflecting' the statutory requirements. How did the policy he was criticising come to be written and approved by the Board? Do you accept that his criticism is fair? Has the policy now been changed?

A. NHSGGC has fully engaged with the Scottish Government and other Health Boards in the development of the Duty of Candour Policy. In April 2018, the NHS Board approved the Duty of Candour Policy (2018-2021). In December 2018, an update was provided to the CCGC who noted "In summary, the committee was content to note the report and update on the implementation of the Duty of Candour Policy. The Committee noted that the policy had been implemented and were satisfied that this was being managed in line with policy requirements."

In 2020/21, NHSGGC also asked its internal auditors to undertake a review of the Duty of Candour policy in order to assess compliance with the Duty of Candour legislation, including training and guidance provided to staff. The audit was generally positive with only minor improvement required. It stated that policies and procedures had been developed and implemented to fulfil the Board's obligations under the applicable legislation and regulations. It also outlined that relevant staff had received adequate training and that all incidents giving rise to obligations under Duty of Candour were identified and recorded with actions taken in line with the regulations. It also stated that a formal review of the circumstances of incidents was undertaken, including a written report. This report was presented to the NHS Board's Audit and Risk committee who were assured of the position.

Given the challenging nature of the situation with regard to Ward 6A, Prof White attended 3 meetings of the IMT in October and November 2019. Duty of Candour was discussed at each of the meetings. I understand that Prof. White did not raise his concerns at those meetings". In addition, I do not recall Prof. White raising any issues relating to the Duty of Candour with me at that time.

In addition, NHSGGC's policy was commended by other NHS Boards and was used as a template for other Health Boards. Given that Duty of Candour legislation was reasonably new, further consideration and refinement may reasonably be required. In late 2020 the Scottish Government held two workshops, chaired by Prof. White. I understand that NHS Boards identified that there was inconsistent practice across Boards in relation to Duty of Candour and two main points were raised) i) the guidance was not clear enough; and ii) there was little understanding / lack of clarity around definitions (e.g. meaning of unintended and unexpected) with NHS Boards interpreting issues differently leading to inconsistent application as well as reporting. Thus, at that time, there was a need for further clarity on a national basis.

One of the key issues relates to the interpretation of the legislation when assessing whether organisational Duty of Candour is engaged, as the legislation does not set out a clear definition of an "incident". NHSGGC has interpreted this as a situation where something has gone wrong due to an act or omission for which NHSGGC is responsible. The interpretation in the Final Report of the Oversight Board is a wide interpretation of when Duty of Candour may commence. In summary, it is acknowledged that further national work should be undertaken to be more precise with regard to the triggers for organisational Duty of Candour, particularly where causality is not easily indicated, so that this may be more easily interpreted and implemented more uniformly by Health Boards in Scotland.

Within the Fraser / Montgomery review, it also sets out that the NHSGGC policy on Duty of Candour is adequate but also notes that the Scottish Government requires to undertake some further work as the legislation is not really intended for these types of outbreaks and that more work is needed nationally.

NHSGGC has always taken Duty of Candour seriously and, in light of the issues outlined above, as well as the external view sought, I would contend that NHSGGC had adequately adopted the legislative requirements into its local policy. It is incumbent on all parties to keep these issues under review and to recognise that there will, in all systems, require to be refinements and learning as new legislation is implemented. NHSGGC has sought to ensure that occurs at every stage.

In line with the scheduled review cycle and the recommendations in the Oversight Board report, the NHSGGC policy was reviewed and updated in 2021.

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

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

The 'Water Incident' and Events in 2018

37. When did you first become aware that there were concerns in the QEUH/RHC that there was a potential link between the water system of the QEUH/RHC and a number of infections in patients the Schiehallion Unit? How were you briefed and what were you told?

A. I first became aware of the potential link between the water systems and a number of infections in Wards 2A/B in March 2018, although at that time, it was one of a number of hypotheses. I was briefed by the Medical Director on the situation and there was ongoing dialogue with an extensive action plan being developed. On 15 March 2018, the interim Director of Estates and Facilities forwarded an urgent briefing note to the Medical Director and me. It outlined the current position and a significant number of actions that had been taken to address the situation. I understand that this note has already been made to the SHI team (see **Bundle 27, Volume 8, Document 12, Page 68 and Bundle 27, Volume 8, Document 13, Page 69**).

38. What were you told about the Water Incident Debrief meeting of 15 May 2018 (see **Bundle 14, Volume 2, Document 95.1, Page 211**) and/or the Full Incident Management Team Report covering the IMTs from 2 March 2018 to 13 April 2018 dated 5 June 2018 (see **3 Bundle 27, Volume 5, Document 19, Page 46 and Bundle 8, Document 6, Page 53**)? To what extend did you in May/June 2018 understand that the source of exposure of infection risk to immunocompromised patients in the RHC was considered to be the water supply?

A. I was briefed by the Medical Director on the issues being considered. I recall being told that there was learning identified over a range of issues and that colleagues were committed to ensuring that any learning was addressed.

During May / June 2018, HPS were working with NHSGGC and there had been no new cases since April. As the Framework had been invoked, NHSGGC no longer had the lead role and were working closely with colleagues in HPS and

the Policy Unit of the Scottish Government. A report was produced by HPS during this time with a number of recommendations associated with the water and NHSGGC was working collaboratively with them to ensure that all recommendations were enacted. At that point, the hypothesis was that the infections were associated with the water.

39. To what extent was the 'Water Incident', the work of the IMT and the Water Technical Group reports to the NHS GGC Board? What actions were taken by you and/or the Board to address these concerns? How were the Board kept up to date as this incident progressed?

A. Regular updates were given to the appropriate sub committees of the NHS Board and to the Board itself. The issues were reported to the CCGC in December 2017, March 2019 and June 2021.

40. How and when did you first find out the terms of the 2015 and 2017 DMA Canyon L8 Risk Assessment Reports in 2018? What role did Professor Steele play in that discovery?

A. At the end of June 2018, I was made aware of the existence of 2 reports by DMA Canyon from 2015 and 2017. Prof Steele came to meet me in his role in HFS and provided me with a copy of the reports which I had not seen before. I was unaware of their existence until Prof Steele provided me with copies of the reports.

41. What steps did you take upon discovering these reports? Did you inquire as to how the Estates department appeared not to have brought the report to the attention of the Board or the IPC Team? Did you inquire of the Co-Chairs of the Board Water Safety Group why it had not notice that L8 Risk Assessments for the QEUH/RHC had not been reported to it in the three years following handover? What were the results of any investigations you did carry out?

A. I sought advice and support from Jim Leiper, an experienced senior technical estates leader on the content, the implications and asked him to review the reports, the NHSGGC systems of operation and provide an action plan for implementation of the recommendations. I asked Mr. Leiper to also assess why these reports had not been made available at a higher level within NHSGGC.

The investigations indicated that there had been a very large number of issues for the estates team to deal with following handover and that, due to pressures of the overall work, the reports had not been fully actioned.

a) Did you raise the terms of the 2 DMA Canyon Reports with the then Co-Chairs of the Water Safety Systems Group Ms Kane (see **Bundle 20, Document 95 and Page 196**) and if so when did you do that and what was their response?

A. Following receipt of the reports from Prof Steele in 2018, I did raise the contents of the DMA Canyon reports with Ms Kane who was unaware of their existence. We discussed the steps that needed to be taken as a matter of urgency and she put in place immediate actions with her team to address them, including the appointment of additional external expertise.

42. How were the Board kept informed of the developments in respect of these DMA Canyon L8 Risk Assessment Reports and what mechanisms, if any were in place to update the Board in respect of the progress being made addressing the recommendations of the report and of the Authorising Engineer (Water)?

A. Following receipt of the reports, I spoke to the Medical Director and made her aware of their existence. She, in turn, ensured that they were brought to the

attention of the infection control team, including the ICD. On 3 July 2018, the NHS Board was updated at a Board seminar on the position regarding these reports. An action plan was drafted and colleagues within Estates and Facilities addressed the outstanding issues as a matter of urgency.

a) It has been suggested that the Board Infection Control Committee did not take sufficient control of the Water incident in 2018 and subsequent concerns about potentially environmentally related infections in 2018 and 2019. With reference to the BICC Minutes available to the Inquiry in Bundles 13 and 35 can you assist the Inquiry in understanding what committees or groups of NHSGGC or within NHSGGC took control of the Board's response to concerns about potentially environmentally related infections in 2018 and 2019?

A. The main issues associated with the water incident were addressed through the established IMT processes rather than the Board Infection Control Committee, which is essential to ensure that the issues are addressed in a systematic manner with the correct professional and operational input. Regular discussion and action was required and the IMT had the ability to adapt to emerging issues in a prompt manner. Issues were considered by the CMT and by the Clinical and Care Governance committees as well as the Acute Services committee and the Finance, Planning and Performance committee.

b) Dr Inkster has given evidence that as Lead ICD and Chair of the Water Incident IMT that in May 2018 she proposed the establishment of an "Executive Control Group" to provide director-level oversight of the incident. (3 Dr. Inkster, Transcript, Day 1, Page 173-176). Dr. Armstrong has been asked about this (Transcript, Dr. Armstrong Cols 101 to 103). Do you have any recollection of discussion of such an "Executive Control Group" in 2018 and to what extent was the "Water Review group" discussed in your answer to question 43 in your statement to the Inquiry of May 2025 a response to a similar concern or to meet a similar need?

A. I do not have a clear recollection of the discussion relating to this issue. However, my understanding is that a Water Review Group was established to ensure that all aspects of the issues that had been raised were being addressed. This group was chaired by the Chief Operating Officer and met during 2018 to ensure actions were being progressed.

c) To whom or to what committee did the "Water Review group" report?

A. My recollection is that the "Water Review Group" operated as a short life working group to ensure progress was being made on key issues. I do not recall whether there was a formal reporting mechanism although progress was discussed with key Directors and myself.

43. The Inquiry has the minutes of a Tuesday 18 September 2018 meeting of something called the Water Review Meeting that appears to have made the decision to decant the patients from Ward 2A (see **Bundle 19, Document 35, Page 614**). What was the Water Review Meeting? What was its membership and when did it meet?

A. The Water Review group met during 2018 to ensure there was high level oversight of the overall actions required. I was not a member of this group, although attended one meeting. Its members included the Chief Operating Officer, the interim Director of Estates and Facilities, the Infection Control Manager and Jim Leiper, with other attendees on occasion.

I was not directly involved in these meetings and do not recall details of when it met.

a) With reference to your answer to Question 43 in your statement to the Inquiry of May 20125, what person, committee or group made the September 2018 decision to decant the patients from Ward 2A RHC to another area in the hospital? (See **Bundle 19, Document 35, Page 614 and Bundle 1, Document 40, Page 175 at 177**)?

A. In relation to my response to question 44, I have indicated that the IMT discussion recommended a decant of Ward 2A. As outlined, the Director and members of the management team of the Women and Children's Directorate were involved in the discussions as were members of the Acute Division management team. My recollection is that further discussion took place with Corporate Directors, including the Chief Executive, Medical and Nurse Directors and the Chief Operating Officer as well as the local team and the decant solution was agreed.

44. The Inquiry has an SBAR that we understand was used to brief the Chair of NHS GGC, Mr Brown, on or about 13 November 2018 (see **Bundle 4, Document 32, Page 133**). Why was it necessary to decant the Ward 2A/2B of the RHC to Ward 4B/6A of the QEUH in September 2018 and what role did concerns that the domestic water system posed a risk to the safety of patients play in that decision?

A. The water IMT was reconvened in early September 2018 as 3 further patients had been identified and there were concerns that the domestic water supply may be contributing to that position.

At the IMT meeting on 13 September 2018, the IMT indicated that they recommended a decant of Ward 2A. There appeared to have been lengthy discussion at that meeting about the risk involved but there was a clear view that the issue could not be addressed while the ward remained occupied. The corporate team took advice from the IMT and the local operational teams and agreed to the decant solution in order to ensure that all possible actions that could be undertaken were fulfilled at the earliest possible opportunity.

Ward 6A and Events in 2019

45. What involvement did you have on or about 18 January 2019 in the decision to decant Ward 6A to the CDU? What was your understanding as to why a decant was necessary?

A. I was informed that mould had been located in a number of the shower rooms in Ward 6A and that remedial work would require to be undertaken to address the issue. I sought further clarity on the matter as I was concerned that patients and families would be subject to an additional move which would cause them further concerns and I wanted to be entirely clear as to why it was necessary. I also wanted to ensure that the location that patients were going to be decanted to was fit for purpose for these patients. Following a further discussion with colleagues, including members of the IMT, where they provided me with the necessary information, I believe that the final decision relating to the decant of Ward 6A was undertaken by the IMT with input from the Corporate Directors and local management team.

46. The Inquiry understands that following concerns regarding the safety of the environment, ward 6A was closed to new admissions at the start of August 2019. Patients were diverted to other centres, including Aberdeen and Edinburgh (see **Witness statement of James Redfern, para. 118.**). Some were sent further afield (**see Witness statement of Dr Jairam Sastry, para. 127**). The Minutes of the IMT of 1 August 2019 (see **Bundle 1, Document 75 at page 336**) imply that a decision was previously to close Ward 6A to new admissions and patients requiring higher risk chemotherapy. What knowledge did you have of that decision at the time. Why was it made and who approved it?

A. I was informed that concerns relating to Ward 6A had been raised through the IMT process and by clinical colleagues. Clinical decisions relating to the individual patients were taken by the local clinical teams based on their knowledge of the patients and I had no involvement in that process, although further details are provided below in relation to the overall position.

a) What knowledge did you have of the decision to close Ward 6A to new admissions at the start of August 2019 at the time?

A. I was informed of the recommendation to close Ward 6A following advice from the IMT and clinical colleagues.

47. The Inquiry understands that at an IMT meeting on 8 August 2019 there was a discussion of a potential further decant of patients from Ward 6A and that whilst the IMT might make a recommendation the "final decision will be endorsed by the Chief Executive" **(**see **Bundle 1, Document 76 at page 340)**. To what extent would be correct to say that a decision to decant patients from one ward to another would not be made by the IMT, but either by you as Chief Executive or a group of senior managers and executive Board members?

A. Decisions relating to decanting of wards require to be considered by a number of stakeholders, depending on the circumstances. When an IMT makes a recommendation to decant patients, it is normal practice that the rationale for such a move would require to be discussed with the senior site team, the Corporate Directors and the Chief Executive to ensure a full understanding of the circumstances. However, when an IMT makes a recommendation of this nature, significant efforts are made to ensure it is enacted.

However, in order to undertake a decant an assessment of the risks, potential options and overall implications for the whole QEUH site would need to be clearly understood. Where wards require to be decanted, other services will also be impacted and those considerations also need to reviewed. These actions are complex and require input from a range of staff, including the local clinical and managerial teams, as well as infection control and estates and facilities colleagues. The process is, therefore, a multidisciplinary decision with oversight by the Corporate Directors and the Chief Executive.

In this instance, the potential closure of Ward 6A had an impact outwith the QEUH / RHC as some patients would require to be treated elsewhere, and, therefore, the overall implications were significant .The executive team and myself, therefore, required to consider the issues in order that we could fully understand the implications and risks that would require to be addressed to ensure all aspects of patient safety were considered, including the potential impact on other centres.

a) To what extent would be it be correct to say that a decision to decant patients from one ward to another would not be made by the IMT, but either by you as Chief Executive or a group of senior managers and executive Board members?

A. The process would involve input from a range of colleagues as outlined in my previous responses.

b) With reference to your answer to Questions 43, 45, 46 and 47 in your statement to the Inquiry of May 2025 which person, committee or group in NHSGGC in 2018 and 2019 had the authority to order the decanting of a whole ward to another ward, arrange to address the consequential movements from that ward, spending money on such a move and issue the necessary public and internal communications?

A. Decisions such as the decanting issue would normally be taken by the local team with input from the relevant professional colleagues including infection control and estates colleagues. Ward decants take place for a number of reasons throughout the year and within the Acute Division such decisions would be taken by the relevant Sector Director with input from the Acute Management team, including the Chief Operating Officer, Acute Medical Director and the Acute Nurse Director. In this case, the issues were discussed with members of the CMT due to the complexity of the situation. The process is, therefore, a multidisciplinary action with oversight by relevant professional colleagues.

c) With reference to your answer to Question 47 in your statement to the Inquiry of May 2025 what person, committee or group made the decision in September 2018 to close Ward 6A to new admissions and at the start of August 2019?

A. The position is similar to that outlined above with IMT advice being followed and a multidisciplinary discussions taking place to ensure all aspects considered.

48. When did you first become aware that Dr Armstrong might have concerns about how the Gram Negative IMT was being run and that a decision was made on 20 August 2019 to replace Dr Inkster as Chair of that IMT? What reasons were given for those decisions and by whom?

A. In mid-August 2019, I was informed by the Medical Director that several colleagues had raised concerns with her about whether the IMT, which had been ongoing for some time, was functioning in an optimal manner. She informed me that limited progress was being made and that she had been told by senior colleagues that some behaviours within the meeting on 13 August 2019 had been reported as being inappropriate. Her major concern was patient safety and to ensure that the IMT was functioning appropriately, due to the severity of the situation and the need to ensure the IMT was fully focused on the delivery of appropriate solutions to this complex issue.

The Medical Director informed me that she was going to have a meeting to review the operation of the IMT and that it may be necessary to alter the way in which it was operating to ensure appropriate progress and that all possible hypotheses were being considered. We also discussed the need for a range of views to be heard in a respectful manner, as the issues were proving to be very complex and our major concern related to how we minimised the risk for patients and their families. The over-riding principle was to ensure that all parties used their knowledge and expertise to drive an optimal solution rather than the meetings becoming dysfunctional as had been reported.

a) Do you recollect whether there was any discussion about whether the views of Professor Gibson and the clinical team in Ward 6A should be sought about these issues around the operation of the IMT that was dealing with an incident in Ward 6A?

A. My understanding is that the discussion focused on how to ensure optimal progress was being made on the issues associated with the IMT. I do not know if there was any discussion about the views of the clinical team being sought. However, it would be important to note that there were serious concerns raised and it was incumbent on senior colleagues to ensure that they were addressed as a matter of urgency due to the patient safety issues involved, which is why urgent action was taken.

b) With reference to your answer to Question 48 at the point before Dr. Inkster was removed as Chair of the IMT, who was giving you advice on the different hypotheses that needed to be considered and what expertise did those people have in microbiology or IPC?

A. This question is a little unclear as the IMT led by Dr. Inkster was providing advice to the organisation while she was in the Chair and subsequently the new IMT Chair, who was an experienced public health consultant, then fulfilled that role. The IMT is a multidisciplinary meeting where all views should be considered and thus many experienced colleagues were attending these meetings, including HPS and other external colleagues on occasion.

49. When did you first become aware that Dr Inkster had resigned as Lead ICD. What information were you given about her reasons for her resignation and what steps did you take in response?

A. In January 2018, I received an email from Dr Redding indicating that Dr Inkster had resigned from her post as Lead ICD. The following day, the Medical Director forwarded me a copy of an email from Dr Green, Chief of Medicine for Diagnostics at that time, indicating that Dr Inkster had agreed to continue in her post as Lead ICD.

In respect of her subsequent resignation in September 2019, the Medical Director informed me that Dr Inkster had resigned. I discussed the position with her and she indicated that she was considering the issues raised in Dr Inkster's letter to her, including workload, personal issues and a range of other matters that I cannot recall. The Medical Director indicated that she was going to respond to Dr Inkster's letter and would take forward the issues.

50. What Briefings (other **than Dr Crighton's email of 14 September 2019 see Bundle 27, Volume 8, Document 43, Page 149**) did you receive about the progress of the IMT after the change of chair?

A. Progress in relation to the issues involved continued to be reported to me by the Medical Director and by the formal routine governance channels. I cannot recall any further formal briefing as the IMT members would be undertaking their routine roles which did not involve regularly briefing the Chief Executive on the functioning of the meeting. However, the new Chair of the IMT did inform me that progress was being made and that a more structured process had been put in place to address the issues and ensure progress was being made.

51. What steps did the Board take to satisfy themselves that ward 6A was safe to reopen for admissions before the decision was made to re-open the ward for admissions?

A. On 18 September 2019, I was copied in to an email whereby the Medical Director had sought input from HPS on their view on what was required to allow Ward 6A to re-open. A range of issues were contained within the email and these were copied to the Chair of the IMT as well as some of the Corporate Directors.

Following discussion with NSS, on behalf of HPS, communication was received from HPS outlining their view of the tasks to be undertaken prior to re-opening. An internal action plan was drafted and progressed with input from the IMT and, following ongoing discussion with HPS, the actions were put in place.

NHSGGC was informed that the Chief Nursing Officer would make the final decision, once all HPS actions had been completed.

The review of data by HPS was received on 25 October 2019 which indicated that there was no further reason for the ward to remain closed and thus arrangements were made to re-open it, following agreement with the local IMT, HPS and the Chief Nursing Officer.

52. Dr Gibson alongside other clinicians wrote to both you and Dr Armstrong on 30 August 2019 highlighting their concerns about infection and environment issues which had affected the unit for the past 18 month and sought an external review, (see **Bundle 6, Document 43, Page 1416**) to which you responded on 4 September 2019 (see **Bundle 8, Document 17, Page 85**). What actions were taken by you or at your direction in respect of the concerns raised and why?

A. Dr Gibson and her colleagues did write to the Medical Director and me on 30 August 2019, outlining their concerns and we responded to that letter on 4 September 2019. We had arranged for the Chief Operating Officer and the Acute Medical Director to meet with the clinicians on 2 September 2019 in the first instance to discuss their concerns. We then met with the consultants on 9 September 2019.

At that meeting, we had the opportunity to discuss the overall situation, including infection control issues, estates and public health perspectives and we collectively reviewed the work to date. Further actions were agreed at that meeting including an external peer review and the review of individual patient pathways by infection control / public health colleagues to establish any common factors for further examination. It was agreed that, in order to ensure a structured visible approach, these issues would be fed back through the IMT process.

53. What role did you have in the preparation and approval of the NHS GGC response to a list of issues raised by the families of children in the Schiehallion Unit published on 30 October 2019 (see **Bundle 6, Document 25, Page 77**) and do you consider it accurate in all respects?

A. The preparation of the NHSGGC response to the list of questions raised by the families was undertaken by a range of senior colleagues within NHSGGC, with input from Scottish Government / HPS colleagues. I was copied into these responses and have no reason to question their accuracy.

The Adult BMT Service and Ward 4B

54. The Inquiry understands the case for the return of the adult BMT Unit from the Beatson back the QEUH was the subject of a report to the Acute Services Committee in March 2017 (see **Bundle 27, volume 7, Document 6, Page 158**) albeit that this document may have been re-drafted before being presented to that committee. What was your knowledge and involvement in process?

A. I was not in post within NHSGGC at that time as I was working in NHS Forth Valley and had no knowledge of the position.

55. Dr Armstrong, in her evidence regarding the Beatson returning to the QEUH, described the balancing exercise required when considering patient safety which involves risk assessing clinical advice against governance considerations. What can you tell us about this balancing exercise and risk assessing which you, as the Chief Executive, and the Board require to undertake?

A. It is incumbent on a Chief Executive to take account of all known factors when making decisions. This covers a range of factors, primarily patient safety and quality of care but must also include complex factors covering all manner of issues, including the availability of resources. These decisions need to be informed by other senior Directors, clinical teams and the NHS Board members must be assured that all appropriate risks have been assessed. There is a clear risk management process within NHSGGC which is implemented at all levels and is actively considered at the CMT, the Board subcommittees and the NHS Board itself.

56. The March 2017 draft options appraisal document for the NHS GGC Acute Service Committee in respect of the Adult BMT unit accepts that Ward 2A RHC did not meet the standard in SHTM 03-01 (see **Bundle 27, Volume 7, Document 6, Page 158**). When were you first aware of this acceptance? Do you agree with assessment of the authors of that draft options appraisal document? Why was action not taken to ensure that Ward 2A did meet the standard in SHTM 03-01 at that time?

A. As previously stated, I was not in post in NHSGGC in March 2017, and thus I cannot comment on the option appraisal. However, the operational, estates and infection control teams would be better placed to make comment on the options appraisal as they were presumably fully involved in its construction.

My recollection is that, following further investigations during the upgrade process and the production of a specific report in relation to the ventilation, it was agreed to incorporate a full upgrade of the ventilation system into the overall scheme.

a) It has been suggested that it is not accurate to state that "ventilation within Wards 2A/B was identified as an important issue **during** the overall upgrade process" as the fact that the ventilation system in Ward 2A was not in conformity with SHTM 03-01 had been known since at least March 2017. How do you respond to that?

A. For clarity, ventilation issues had been known to NHSGGC prior to the upgrade process. As part of the upgrade scheme within Wards 2A/B, it was agreed that all known issues within Wards 2A/B should be addressed to ensure that the ward fully complied with all technical requirements. This was very complex due to the substantial technical challenges, the complex clinical arrangements that had required to be put in place for these children and the high level of capital resource required.

b) Does your answer to Question 56(a) 47 in your statement to the Inquiry of May 2025 amount to an admission that the Board's press statement of 6 December 2018 **(Bundle 5, Document 91, Page 157)** was not entirely accurate to the extent that it gives the impression that the board only became aware of the need to upgrade the ventilation system of Ward 2A after the decanting of the patients in September 2018?

A. My response to the question sought to clarify that NHSGGC had been aware of the ventilation issues prior to the upgrade rather than the original wording. While the ward was vacated, a further review of the performance of the ventilation system was undertaken and, following that review, it was agreed to fully upgrade the ventilation system in the wards while the ward was decanted to ensure every aspect of the ward had been fully addressed.

Ward 4C

57. To what extent were you aware that the ventilation in Ward 4C did not meet the air change rate, pressure differentials and requirement for HEPA filtration set out for a 'Neutropenic Ward' in SHTM 03-01 ventilation for Healthcare Premises? When did you become aware of this? Was this discussed with the Board? What risk assessment or HAI-Scribe was carried out to assess the ventilation system that was fitted to Ward 4C?

A. The ventilation within Ward 4C was raised by the HSE in 2019. The patients within this ward relate to Haematology and renal transplant which may not require specialist ventilation as it is not considered a neutropenic ward. Colleagues within NHSGGC had a discussion with the HSE on that issue. The NHS Board would have been updated on the HSE investigation as part of the routine health and safety reporting

NHSGGC sought further external clinical opinion on this issue which supported that view. However, to provide additional assurance, portable hepa filtration was deployed within the ward as an additional measure.

I cannot comment on what risk assessment or HAI-Scribe was undertaken and other colleagues within NHSGGC would be best placed to assist in that regard.

58. What awareness did you have of the concerns raised by Dr Inkster in December 2019 about the ventilation system of Ward 4C that involved a meeting with Dr Hart on 7 December 2018 and a meeting with Professor Steele on 10 December 2018 and resulted in her SBAR of July 2019 (see **Bundle 27, Volume 7, Document 22, Page 380**). Why were the recommendations of Dr Inkster's SBAR not implemented?

A. I do not recall having seen Dr Inkster's SBAR, although I understand that the issues raised were similar to those outlined in Q57.

Ventilation Concerns/ Review of Ventilation

59. When did you first become aware of concerns that the air change rate for the ventilation within the QEUH/RHC did not meet what is set down in STHM 03-01? What was the concern? Who informed you about it? What steps did you take to address these concerns? Were these concerns discussed at Board level?

A. I cannot precisely recall when I became aware of the issue relating to the air change rate for the ventilation system within QEUH / RHC .However, in 2017, I was aware of some of the concerns being raised through the SBAR process led by the Medical Director which involved the Director of Estates and Facilities and the Chief Operating Officer as well as infection control colleagues and the local management teams, Prior to this time, I assume that the Project team would have been aware of the issues.

I was also informed that there were different views associated with regard to the ventilation. In September 2018, I was forwarded an email exchange between Dr Peter Hoffman from Public Health England (who was providing external clinical and technical support) and Dr Inkster in relation to the chilled beams and ventilation. With regard to general ventilation he states that “the air change rate is irrelevant.” It goes on to state “Three or six air changes – doesn’t matter. Six air changes is the generally accepted level for temperature and odour control – no relevance to infections”. Thus, I was aware of his view on the air change issues as well as the local concerns.

a) With reference to your answer to Question 59 in your statement to the Inquiry of May 20125 is the email exchange between Dr. Inkster and Mr. Hoffman to which you refer to be found in **Bundle 14, Volume 2, Document 191 at pages 140-147** and did you see the whole of the email from Dr. Hoffman of 16 September 2018 at 22.12 at the time?

A. My response to Q59, relates to the question of when I became aware of the concerns that the air change rates for the general wards did not meet STHM 03-01. I have seen the email from Dr. Hoffman outlined.

60. What risk assessments, if any, whether in compliance with the standards in HAI Scribe or otherwise were carried out by NHS GGC during the period you were Chief Executive into whether the lower air change rate outside isolation rooms and Ward 4B were causing any risk to patient safety?

A. I am unaware of the detailed, overall position with regard to risk assessments in Ward 4B. I am aware that work was undertaken in relation to any potential risk within Ward 4C and with regard to Wards 2A/B. However, the majority of these issues would be undertaken at a local level and would not routinely involve the Chief Executive, although I appreciate a number of them they were being considered as part of the SBAR process.

61. The Inquiry understand that Jim Leiper was appointed to conduct a ventilation review of the Queen Elizabeth Hospital (see **Bundle 23, Document 89, Page 872**). What was your involvement in instructing Mr Leiper's review? What was the Board's involvement in the instruction of Mr Leiper's review? What was the outcome of the review? Was this discussed at Board level? What actions, if any were then taken?

A. Following a discussion with the interim Director of Estates and Facilities, Jim Leiper was appointed to provide additional technical expertise into the Estates and Facilities department. He was asked to review the systems, improve governance and support training accreditation for the AP / CP. The review provided a better, full understanding of the systems. I do not recall his specific work being discussed at Board level, however, his findings did inform the work within Wards 2A/B and, thus, to that extent, there was awareness of his work at Board level.

His work had a number of strands, including water and ventilation and he worked on both areas to support the ongoing actions in line with the other reports that were being drafted.

a) In her statement of June 2025 at paragraph 36, Jeane Freeman discusses remedial work to the ventilation system of Wards 2A and 2B that was then planned. She advises that you told her that this work was “going beyond the standard in place when QEUH was built”.

(i) Do you recall this conversation with Ms Freeman?

(ii) Would it be accurate to say that the remedial work to the ventilation system of Wards 2A and 2B went “beyond the standard in place when the QEUH was built”?

(iii) What standard did you have in mind?

A. The Chair and I had many conversations with Ms Freeman during that period and, while I do not recall the precise detail of that conversation, we did discuss the position with regard to Wards 2A/B on a number of occasions.

My understanding is that the ventilation system that was eventually put in place within Wards 2A/B was an optimal solution to ensure that all known risk had been considered to address any future issues, recognising that no solution can be entirely risk free for this group of patients.

Horne Taps

62. The QEUH/RHC uses large numbers of Horne Optitherm Taps. Following neonate deaths at hospitals in Northern Ireland and Western Australia a meeting was held with representatives of HPS, HFS and others on 5th June 2014 (see **Bundle 15, Document 9, Page 692 and the HPS SBAR of 2014 Bundle 3, Document 1, Page 5)**. What is your understanding of the decision that then faced NHS GGC in respect of the use of Horne taps within the new SGH? Who ultimately made the decisions to continue with the use of these Horne taps in the new SGH and what was reported to you at the time?

A. I was not present at these meetings and was not working in NHSGGC at that time so cannot comment on the decision that faced NHSGGC.

63. What steps did you take as Chief Executive and Duty Holder to ensure that these Horne Optitherm Taps were maintained in such a manner as to prevent the growth of pseudomonas and other micro-organisms in and from these taps? What instructions did you give to members of the Board Water Safety Group and what reports did you request and receive on the installation, operation and safe maintenance of these taps?

A. As previously outlined, I was not in post at service commencement in 2015. I would have expected that colleagues within Estates and Facilities would have put in place appropriate mechanisms to maintain these taps. These matters would routinely have been addressed by the Estates and Facilities team or, during construction, the Project team.

Cryptococcus

64. Why did you write your letter to patients and parents of 23 January 2019? Who provided you with advice on the terms of the letter?

A. Letters were sent to the families of patients attending for both inpatient and outpatient treatment. The contents were drafted by senior colleagues, including the Site Director and members of the Communications team. The Chief Operating Officer also had oversight of the letters. The purpose of the letter was to notify them of the ongoing investigations into Cryptococcus, confirmation that there had been no new cases and also to notify them of work being undertaken in the shower rooms.

65. What is your understanding of the role (if any) that the fact that both patients who died in the QEUH/RHC after contracting Cryptococcus neoformans were accommodated in rooms without HEPA filtration whilst unable to be prescribed prophylactic anti-fungal medication played in them contracting that infection?

A. I cannot comment on the clinical condition of patients as I do not have that expertise and the clinicians would be best placed to respond to that question.

a) Have you read Professor Hood's subgroup report? If you did, do you know whether both patients who died in the QEUH/RHC after contracting Cryptococcus neoformans were accommodated in rooms without HEPA filtration whilst unable to be prescribed prophylactic anti-fungal medication played in them contracting the infection?

A. I have read Professor Hood's report but I do not have the appropriate clinical or technical expertise to comment on the clinical treatment of these two patients. In my role as Chief Executive, I would not make decisions in relation to individual patients as the clinical teams are best placed to make such decisions.

66. Why and how was the Cryptococcus Subgroup set up and who was chosen to serve on it and why?

A. The Cryptococcus subgroup was established by the IMT as a subgroup of the IMT. I cannot comment on who was chosen to serve on it and the reasons associated with that decision as I was not involved in the establishment of the Group.

67. How were you and the Board provided with updates from the work of the Cryptococcus IMT and the Cryptococcus Subgroup?

A. I was provided with updates from the Director of Estates and Facilities, the Medical Director and by updates to the various Board committees.

68. How was it that the decisions of the work of the subgroup at the Board (including on 25 February 2020) appear to have included the reporting that certain hypotheses had been discounted in advance of the final report (see **Bundle 14, Volume 2, Document 125, page 455**)?

A. I am not aware of the detailed reasons why certain hypotheses were considered less plausible than others as this work was being undertaken by those with both the clinical and technical experience to consider these matters in detail. The information to the NHS Board would have been provided by those undertaking the investigations.

69. Were the Board seeking to rule out hypotheses and force a conclusion on the likely cause being reactivation before full investigations had been completed?

A. I believe that colleagues who were undertaking this investigation undertook the work to the best of their ability in difficult circumstances. I have never seen any evidence that any conclusion was “forced” by any colleagues and there were extensive investigations undertaken to try and establish the precise nature of what had occurred, and, therefore, I do not consider this to be a true reflection of the position.

The Performance Escalation Framework

70. Please explain the circumstances surrounding the escalation of NHS GGC from Stage 2 to Stage 4 of the Performance Escalation Framework and then back to Stage 2. Why did it occur? What explanation was given to the board? Was it justified?

A. On 22 November 2019, NHSGGC was escalated to Stage 4 of the Performance Escalation Framework in relation to the systems, processes and governance surrounding infection prevention, management and control at the QEUH and the RHC and the associated communication and engagement issues. The Chair and I received a letter from the Director General for Health and Social Care and Chief Executive of NHS Scotland, indicating the escalation to Stage 4 and that an Oversight Board would be put in place, chaired by Professor Fiona McQueen, the Chief Nursing Officer at Scottish Government. The letter stated that Stage 4 is defined as “significant risk to delivery, quality, financial performance or safety; senior level external transformational support required”.

The complexities associated with the situation at QEUH / RHC were multiple so I anticipated that additional support would be helpful to bring some balance and additional external expertise to the debate and also to ensure that, within NHSGGC, all possible areas were being explored to address the situation. Following significant work and the agreement of the Advice, Assurance and Review Group, which was a joint group with Scottish Government, NHSGGC was de-escalated in 2022.

71. What is your view on the effectiveness of the escalation process?

A. The escalation process brought an enormous amount of additional work, in addition to the very significant additional work being undertaken locally to address the issues. In addition on 24 January 2020, NHSGGC was further escalated as a Board in relation to a number of performance issues which brought further additional work. The work of the three subgroups associated with the initial escalation – Infection Prevention and Control, Communications and Engagement and a Technical Group as well as the Oversight Board generated a very heavy workload and took time to service and support, as there were a large volume of papers and presentations required which took time from key senior personnel who were already trying to deal with an enormous range of issues and, at times, this was detrimental to the overall running of NHSGGC. The timing of these escalations and the work involved put a very significant strain on an already seriously stretched system. In addition, this was at the very beginning of the COVID pandemic and, thus, the combination of all these factors, as well as continuing to manage the day-to-day issues associated with the largest NHS Board in Scotland and one of the largest in the UK brought overwhelming pressure on the senior team which was difficult to overcome.

The Case Notes Review

72. Please describe the process involved for the Case Note Review from the point of view of NHS GGC. Please include how this was established, who established it, who from NHS GGC was involved, what work was done by NHS GGC to support it, what access NHS GGC had to its reports and conclusions and any relevant outcomes?

A. The Casenote Review was established by the Scottish Government and led by Professor Marion Bain who had been appointed by the Scottish Government. She informed me of a plan in early 2020. I had no direct input into its formation or its method of operation. It was led externally by the CNR team, with NHSGGC being asked to provide detailed information to inform the Review. I was not

regularly involved in the various working groups but I was updated at a high level by Professor Bain as NHSGGC had limited involvement in its establishment, processes or progress, with the main input being the provision of information at a very detailed level. NHSGGC was not provided with the detailed outcome of each patient's review or the methodology associated with that conclusion. NHSGGC were given sight of the draft report in order that any matters of factual accuracy could be outlined and NHSGGC sent back a detailed response to this draft report as we considered there were a number of areas where the report was not factually accurate.

73. Referring to the Case Note Review Overview Report March 2021 (see **Bundle 6, Document 38, Page 975**) what was the conclusions of the Case Note Review in respect of the role of the hospital environment as a source of infection?

A. The Casenote Review made 43 recommendations covering a number of issues, with the majority being applicable to NHSGGC but some had implications for NHS Scotland and to the Managed Service Network for Children and Young People with Cancer.

Within the Casenote Review, it outlined a range of possible scenarios ranging from unrelated, weak positive to strong possible and possible for the number of episodes and the likelihood of them being linked to the hospital environment. The Casenote Review also acknowledges that there is a degree of uncertainty and recognises that this may be distressing for families and also highlights the fundamental challenge of identifying a specific source in all such infections.

74. Did NHS GGC make any public statement after the publication of the Case Note Review Overview Report? What was that statement and why was it made?

A. NHSGGC did make a public statement on 22 March 2021 following the publication of the Casenote Review which sought to reassure the patients, families and staff that NHSGGC were taking the issues extremely seriously and accepted that there was important learning for NHSGGC and would ensure that all appropriate actions were taken to address the issues indicated. We also wanted to outline the actions that had already been taken and to recognise and apologise for the added pressures and distress caused to the patients, families and staff. The statement also indicated that NHSGGC was fully committed to continuing to improve and to implementing the recommendations from these reviews.

75. Why did you write your letter to Professor Mike Stevens of 1 March 2021 (see **Bundle 25, Document 3, Page 151**) in the terms that you did? What was the source of the information on the third page of the letter about an approach being made to the Royal College of Nursing about the conduct of an un-named microbiologist in 2018?

A. The draft CNR was sent to NHSGGC for comments on factual accuracy. It was shared with a number of colleagues who expressed some disquiet about some of the statements within it and also, NHSGGC wished to ensure that the report could be used as a basis for further improvement and continued learning rather than become a source of ongoing debate. There were a range of issues highlighted which are outlined in the letter and colleagues wanted to ensure that the CNR team were fully appraised of their views.

I was informed of the approach to the RCN by the Nurse Director who informed me of the situation and that she would progress the matter with the Medical Director as outlined in the letter.

76. Why did you write your letter to Professor Mike Stevens of 5 March 2021 (see **Bundle 25, Document 3, Page 155)** in the terms that you did? What was your objective in writing the letter?

A. A further letter was sent to Professor Stevens on 5 March 2021, following a meeting we had with him and his team on 4 March 2021. The letter stated that "we entirely understand that this is an independent report and it is for you to consider the content", however, we wanted to seek some support from him in a number of areas. It was to confirm the discussion that had been held, to seek some assistance from him and his team in providing their view on the current infection rates and to bring one further issue to his attention relating to the dynamics of the team working issues that had been raised. The letter also thanked him and his team for their work and expressed our appreciation for his offer of assistance with implementing some key recommendations.

77. How were the conclusions/recommendations of the Case Note Review received by GGC?

A. NHSGGC accepted all of the recommendations within the Casenote Review and publicly stated that position in the statement of 22 March 2021.

a) With reference to your answers to Questions 74 and 77 in your statement to the Inquiry of May 2025 please review the Core Brief of 22 March 2021 (see **Bundle 25, Document 61, Page 1260**):

(i) Does the Core Brief contain an accurate statement of the public response of NHSGGC to the publication of the CNR Overview Report at the time it was made?

(ii) Would a reader of the Core Brief of 22 March 2021 be entitled to conclude based on that statement that NHSGGC accepted the principal conclusion of the CNR Overview Report (see **Bundle 6, Document 38, Page 975 at Page 981**) that 30% of the infection episodes they reviewed were probably related to the hospital environment? If not, why not?

(iii) It is the current position of NHSGGC in its most recent submission to the Inquiry that NHSGGC does not accept that anything contained in the CNR can properly justify any adverse inference about the safety of the water, drainage or ventilation systems at the QEUH. If this was the position of NHSGGC on 22 March 2021 why this was not made clear in the public statement of 22 March 2021?

A. I consider that the Core Brief did reflect NHSGGC's response to the publication of the Oversight Board report and the Case Note Review at that time.

NHSGGC fully accepted the recommendations outlined within the reports and also recognised the significant concerns raised by the issues for patients, their families at an already difficult time and the Core Brief sought to recognise the very difficult position of patients and their families and wanted to fully apologise for the additional concerns caused to them. It was difficult to establish how exactly the conclusions were reached as NHSGGC were not party to any detailed analysis but it was absolutely recognised that there was learning from the situation for the future.

NHSGGC accepted the recommendations within the CNR report and the Core Brief states that position.

Since that time, considerable further work has been completed including Whole Genome Sequencing developments and the provision of the more recent, external expert reports which were not available at the time outlined and offer additional information and a differing perspective to the position outlined within the Casenote Review. This information was not available at the time of the publication of the Casenote Review. However, as stated above, the main issue in 2021 related to ensuring that NHSGGC took steps to address the recommendations to ensure that everything possible was being completed.

78. What steps have been taken by NHS GGC to implement each of the separate recommendations of the Case Note Review, when they were taken and to what extent do you consider the implementation to have been effective?

A. A comprehensive action plan covering all 108 recommendations from the various reviews (including the Fraser / Montgomery report, the CNR and the Oversight Board Review) compiled and individual recommendations allocated to a number of senior colleagues who were required to report on progress at regular intervals. The overall action plan was also monitored by the AARG at Scottish Government and they sought to assure themselves that all the actions had been completed prior to de-escalation in 2022.

The actions covered a range of issues and all continued to be monitored on a cyclical basis to ensure ongoing compliance for those that were of a recurring nature.

79. How can the Inquiry and the general public be satisfied that NHS GGC have implemented the recommendations of the Case Note Review?

A. As outlined in Q78.

a) Please review QEUH – Case Note Review – Feedback from meeting with RHC clinicians and wider reflections for the Oversight Board – 17 June 2021 and the enclosed letter to you dated 1 June 2021 from Professor Stevens, Chair of the CNR.?

(i) What steps did you take to investigate the issue raised by Professor Stevens?

(ii) Why was the microbiology and other data generated within NHSGGC and collated for use by the CNR not made available to a Consultant Microbiologist working at the QEUH / RHC in the first half of 2021?

A. In relation to the letter of 1 June 21, I discussed the position with the Chief Operating Officer and the Acute Medical Director as I was unaware of the details. They agreed to investigate the position and provide a response following discussion with colleagues in the Acute Division. That response was sent back to

Professor Stevens on 25 June 2021, outlining the communication process and the fact that the data would now be shared. Unfortunately, at a later date, I was informed that one element of the letter was incorrect and a further letter was issued to Professor Stevens clarifying the position.

b) The Inquiry understands that on 13 June 2022 on the occasion of the reduction of NHSGGC from Level 4 to Level 2 of the escalation framework the then Cabinet Secretary for Health, Humza Yousef stated that he was assured and confident that all the recommendations from the published reports were complied with:

(i) Who provided him with that assurance and what form did it take?

(ii) How is the Minister's statement that he had been assured that all the recommendations from the published reports (including the CNR) had been complied with, consistent with that NHSGGC not accepting that anything contained in the CNR can properly justify any adverse inference about the safety of the water, drainage or ventilation systems at the QEUH?

A. An AARG (Advice, Assurance and Review Group) had been formed which included representatives from the Scottish Government and colleagues from within NHSGGC which reviewed all the recommendations from the reports, considered progress and ensured that the recommendations had been implemented. SG colleagues on this group sought further, more detailed information on a number of issues prior to any acceptance of the NHSGGC position. I am not aware of the precise mechanism to brief the Cabinet Secretary as it was undertaken by Scottish Government colleagues but I believe it was informed by the work of that Group.

As outlined in Q30, additional insight and analysis in relation to whole genome sequencing and the more recent, external expert reports has provided additional information which provides a differing perspective from the one outlined at that time.

However, NHSGGC, in 2021 / 22 was keen to ensure that all recommendations that had been made were implemented to ensure that all issues identified by external parties had been addressed. As these issues had been recommended by external parties, NHSGGC took the view that every effort should be made to implement the recommendations to strengthen the infection control and operational management processes for the future.

The Oversight Board

80. Please describe the process involved for the Oversight Board from the point of view of NHS GGC. Please include how this was established, who established it, who from NHS GGC was involved, what work was done by NHS GGC to support it, what access NHS GGC had to its reports and conclusions and any relevant outcomes?

A. The Oversight Board was established by the Scottish Government following the escalation to Stage 4 of the performance escalation. Three subgroups were established to support the Oversight Board. I was not a member of the Oversight Board, although did attend a number of the meetings. The Oversight Board was chaired by Prof. F McQueen, the Chief Nursing Officer within the Scottish Government and members included Dr K Morris, Hazel Borland, Prof Craig White, Irene Barkby, Dr A Murray, Lesley Shepherd and Phil Raines. Senior managers within NHSGGC were asked to attend on particular issues but were not members of the Oversight Board.

NHSGGC were required to produce updates on the key issues as requested by the Oversight Board and members of the NHSGGC team presented to the Oversight Board on a range of issues. NHSGGC did have access to a number of reports from the Oversight Board and sought to work collaboratively with them over the issues identified.

81. Have you read the Interim Report and/or Final Report of the Oversight Board and noted its local recommendations in respect of (a) Governance and Risk Management and (b) Communications and Engagement?

A. Yes, I have read both reports and the appropriate recommendations were addressed as part of the overall action plan.

82. What steps have been taken by NHS GGC to implement each of the separate recommendations of the 'Local Recommendations' of the Oversight Board, when were they taken and to what extent do you consider the implementation to have been effective? Please provide evidence to support each effective implementation?

A. As outlined above, an overall action plan was developed and monitored through the AARG process to ensure external scrutiny of its contents and the progress being achieved. The recommendations cover different timescales as some are only applicable to certain projects, while others are a recurring requirement. Steps were taken to ensure that all the recommendations had been implemented and Scottish Government colleagues were provided with evidence of the work on the local recommendations. Following that assurance process, NHSGGC was de-escalated as the Scottish Government was content with the progress that had been made.

83. Please refer to the annual audit report for NHS GGC from Audit Scotland for 2021 (see **Bundle 29, Document 17, Page 653)**. At pages 25 and 26 it states that a Gold Command delivery group has been established to oversee the delivery of actions in response to the Oversight Board Report and Case Note Review of which you were Chair. What was the role of the Gold Command Delivery Group? What was your role within the Gold Command Delivery Group? What did the Gold Command Delivery Group do to implement the 'Local Recommendations' of the Oversight Board?

A. The Gold Command delivery group, which I chaired, was established to ensure that all areas within the action plan were being addressed and that wider issues

such as patient feedback were also being considered to ensure the quality of care at the QEUH was appropriate.

a) What did the Gold Command Delivery Group do to implement the 'Local Recommendations' of the Oversight Board?

A. The Gold Command Delivery Group was established to ensure a dedicated programme approach to sustained quality and service improvements on the QEUH site. Four key areas were identified as being within scope – Better Performance, Better Care and Experience, Better Together and Better Safe, Clean and Clinical environment. These areas directly aligned with a number of the external and oversight processes. The Group covered a wide range of issues including a number of those outlined within the various external reports, including the Independent Review and the Oversight Board report and progress was monitored on a number of issues through that forum.

This Group, however, as outlined, had a wider remit relating to issues within the QEUH campus. There were also some issues within the external reports that were dealt with in other fora as they had Board-wide implications and were, thus, not exclusively related to the QEUH site.

84. How can the Inquiry and the general public be satisfied that NHS GGC have implemented the 'Local Recommendations' of the Oversight Board?

A. As outlined in Q82.

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

A. This has been an extremely challenging set of circumstances for NHSGGC to address. NHSGGC is by far the largest health care system in Scotland with a very large budget, £4.4 billion, and a workforce of around 41,000 staff. It provides local, secondary and tertiary services to some of the most vulnerable in our society. Clinical services within NHSGGC are of a high calibre and I regret that

significant concern and distress has been added to the patients, families and our staff over the last few years associated with these issues.

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

There has been a very significant amount of political and media scrutiny which has led to a huge amount of additional work in order to try and ensure that a true and balanced view of the situation is portrayed in the interests of ensuring that the public does not have an unjustified view that the hospital is unsafe. That approach has not always been easy or optimal and we have reflected long and hard on how such issues can be managed in the future to ensure there is learning for NHSGGC and, more widely, across Scotland.

NHSGGC at all levels is fully committed to ensuring patient care and safety are afforded the highest priority and this has always been the case.

Declaration

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

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

Appendix A

A43255563 - Bundle 1 – Incident Management Team Meeting Minutes (IMT Minutes)

A43273121 - Bundle 3 – NHS National Services Scotland Situation: SBAR documentation

A43299519 - Bundle 4 – NHS Greater Glasgow and Clyde: SBAR documentation

A43293438 - Bundle 6 – Miscellaneous Documents

A43955371 - Bundle 8 – Supplementary Documents for the Oral hearing commencing on 12 June

A47390519 - Bundle 11 - Water Safety Group

A47069198 - Bundle 12 – Estates Communications

A48890718 - Bundle 13 – Additional Minutes Bundle (AICC/BICC)

A49525252 - Bundle 14, Volume 1 - Further Communications

A48541141 - Bundle 14, Volume 2 – Further Communications

A47664054 - Bundle 15 – Water PPP

A47851278 - Bundle 16 – Ventilation PPP

A49342285 – Bundle 17 - Procurement History and Building Contract PPP

A48408984 - Bundle 19 – Documents referred to in the Quantitative and Qualitative Infection Link expert reports of Sid Mookerjee, Sara Mumford and Linda Dempster

A48946859 - Bundle 20 – Documents referred to in the Expert Reports by Andrew Poplett and Allan Bennett

A49618520 - Bundle 23 – Queen Elizabeth University Hospital and Royal Hospital for Children, Isolation Rooms PPP

A49585984 – Bundle 25 - Case Note Review Expert Panel, Additional Reports and DMA Canyon

A49615172 - Bundle 26 – Provisional Position Papers

A49799834 - Bundle 27, Volume 4 – Miscellaneous Documents

A50091087 - Bundle 27, Volume 5 - Miscellaneous Documents

A50002331 - Bundle 27, volume 7 – Miscellaneous Documents

A50039563 - Bundle 27, Volume 8 – Miscellaneous Documents

A50976317- Bundle 29, NHS Greater Glasgow and Clyde Audit Reports

A50976001- Bundle 29, NHS Greater Glasgow and Clyde Audit Reports

A50976005 – Bundle 29, NHS Greater Glasgow and Clyde Audit Reports

A53511130 – Bundle 51, Volume 1 – Sir Robert Francis Whistle-blowing Expert Report and Supporting Documents

A43501437 - Bundle of witness statements for the Oral hearing commencing 12 June 2023

A49847577 - Witness Bundle - Week commencing 2 September 2024 - Volume 3

A50581587- Transcript of Professor Steele

A50766285 – Transcript - Professor White

Appendix B

NHS Greater Glasgow & Clyde

Timeline of events and actions from March 2018 –June 2019

Date	Situation	Evidence

02/03/18	March 2018: Water Incident Management Team IMT was convened following the identification of a gram negative bacteraemia in Jan 2018 with an organism which had been seen in 2016 in the aseptic pharmacy, on this occasion	**Minutes form IMT**

	when this area was investigated again all samples were negative. It was reported by the Lead Infection Control Doctor (LICD) that the same organisms had been isolated from samples taken from the drains in the ward. Further bacteraemia with separate organism also reported, one outlet reported to be positive with same organism. HIIAT was RED HPS not in attendance Water dosing with Silver hydrogen peroxide organised in 2 phases. Replacement of outlets commenced	1. Water Incident Ward 2A RHC IMT Mi **[A36690451 - Bundle 1, Document 13, Page 54]** HIIORT 2A Water supply 130418.doc **[A36690585 - Bundle 52, Volume 3, Document 11, Page 54]**
06/03/18	IMT held No new cases reported LICD reported on another organism which had not been found in any patient in ward 2A but had been found following the sampling. *NB: at this time the hypothesis was that the source is the outlets themselves, confirmed by microbiological testing of the taps and showers and negative samples from the water tanks. The most likely mechanism is via contact. Discussion took place around the possibility of contact from domestic staff and parents* HIIAT was RED HPS not in attendance Water dosing still to be completed. Water testing increased to monthly	2. Water Incident Ward 2A RHC IMT mi **[A36690471 - Bundle 1, Document 14, Page 56]**
09/03/18	IMT held No new cases reported. HIIAT was RED HPS was not in attendance Control measures agreed and replacement of taps ongoing.	3. Water Incident Ward 2A RHC IMT Mi **[A36690458 - Bundle 1, Document 15, Page 60]**
12/03/18	IMT held No new cases reported. Water samples continue to be positive. Samples sent for typing	4. Water Incient Ward 2A RHC IMT Minutes

	HIIAT was RED HPS not in attendance Replacement of taps and showerheads in progress. Portable clinical hand wash sinks to be put in place as all taps out of use until silver hydrogen peroxide dosing completed and taps retested.	**[A36690457 - Bundle 1, Document 16, Page 63]**
16/03/18	IMT held 4 new cases reported of gram negative bacteraemia with different organism from previous cases. 3 HAI - 2 in ward 2A and one in PICU. 1 non HAI. HIIAT was RED HPS in attendance LICD requested support from Health Facilities Scotland and Health Protection Scotland as the original Hypothesis of the incident is different due to positive water results in other ward areas and not the transmission of the organisms from sink to showers by staff only on 2A. The outlets appear to be the problem. Point of use filters to be fitted to all taps. Ward 2A to be completed first.	 5. Water Incident Ward 2A RHC IMT Mi **[A36690477 - Bundle 1, Document 17, Page 66]**
19/03/18	IMT held No new cases reported HIIAT was RED HPS was in attendance. Control measures in place for both the ward and water system	 6. Water Incident Ward 2A RHC IMT Mi **[A36690507 - Bundle 1, Document 18, Page 70]**
21/03/18	IMT held No new cases reported. HIIAT was RED HPS was in attendance Public Health and Health Protection Scotland have been asked to assist with the epidemiology of the incident.	 8. Water Incident Ward 2A RHC IMT Mi **[A36690549 - Bundle 1, Document 19, Page 75]**

23/03/18	IMT held No new cases reported. Epidemiology shows no link between case in PICU and cases in ward 2A HIIAT was RED HPS was in attendance Ward control measures in place Water system control measures in place	9. Water Incident Ward 2A RHC IMT Mi **[A36690544 - Bundle 1, Document 20, Page 81]**
27/03/18	IMT held No new cases reported. One of the cases reported 02/03/2018 - The group has decided to exclude this patient case from the incident as it is not linked to any of the samples taken. HIIAT was AMBER HPS in attendance IMT closed. Several control measures remain in place.	10. Water Incident Ward 2A RHC IMT Mi **[A36690556 - Bundle 1, Document 21, Page 86]** Full Incident Management Team R **[A43872127 - Bundle 8, Document 6, Page 53]**
04/06/18	IMT held 7 new cases reported of gram negative bacteraemia associated with 2A/2B from April 2018 to May 2018. 3 were HAI. One of the actions of following various PAG's was to have the swabbed. This was the first meeting held specifically in relation to the contaminated drains. HIIAT was RED HPS were in attendance Control measures in place. Plan for HPV cleaning of the wards. Concern voiced by clinicians about admitting patients to the ward. Admissions to ward restricted	1. IMT Water Incident Ward 2A RHC 04 06 1 **[A36690448 - Bundle 1, Document 23, Page 94]** HIIORT Water system incident 6.6.18 (3).doc **[A36690593 - Bundle 52, Volume 3, Document 11, Page 95]**
06/06/18	IMT held No new cases reported. Admissions to ward remain restricted. HIIAT was RED HPS in attendance All gram negative bacteraemia's noted to be unique strains on typing.	2. IMT Water Incident Ward 2A RHC 06 06 1 **[A36690461 - Bundle 1, Document 24, Page 99]**

	Noted in the minute " Scottish government have a list of questions sent to HPS which Annette Rankin and Dr Inkster will answer" HPV cleaning had been started in ward 2A	
08/06/18	IMT held. No new cases reported HIIAT was RED HPS in attendance HPS updating Scottish Government daily HPV cleaning will be finished 08/06/2018 in ward 2A, and commenced in ward 2B over the weekend. Meeting to be held with clinicians, management and microbiology to discuss concerns.	 3. IMT Water Incident Ward 2A RHC 08 06 1 **[A36690464 - Bundle 1, Document 26, Page 109]**
11/06/18	IMT held No new cases reported Admission to be decided on a case by case basis HIIAT was RED HPS was in attendance Plan to replace waste pipes drawn up with Facilities and Estates in 2A Further HPV cleaning to be carried out following waste pipe replacement.	 4. IMT Water Incident Ward 2A RHC 11 06 1 **[A36690462 - Bundle 1, Document 27, Page 114]**
12/06/18	IMT held 1 new case reported HIIAT was RED HPS in attendance Waste pipe replacement and HPV cleaning continuing in wars 2A	 5. IMT Water Incident Ward 2A RHC 12 06 1 **[A36690486 - Bundle 1, Document 28, Page 119]**
14/06/18	IMT held No new cases reported. Ward 2A taking admissions but restricted to give access to single rooms for work to be carried out. HIIAT was RED HPS in attendance.	 6. IMT Water Incident Ward 2A RHC 14 06 1 **[A36690460 - Bundle 1, Document 29, Page 123]**
15/06/18	IMT held 2 new cases reported. 17 in total HIIAT was RED	 7. IMT Water Incident Ward 2A RHC 15 06 1

	HPS in attendance Plans discussed for the introduction on Chlorine dioxide dosing of the water system, Not likely to be in place until November 2108 Teleconference with HPS, NHSGGC and Scottish Government	**[A36690521 - Bundle 1, Document 30, Page 128]**
18/06/18	IMT held. No new cases reported. HIIAT was AMBER HPS in attendance.	 8. IMT Water Incident Ward 2A RHC 18 06 1 **[A36690540 - Bundle 1, Document 31, Page 132]**
21/06/18	IMT held. No new cases reported. Ward open to all admissions HIIAT was GREEN HPS in attendance IMT closed with agreement that if there were any new cases in the next 2 weeks the IMT would be reconvened.	 9. IMT Water Incident Ward 2A RHC 21 06 1 **[A36629264 - Bundle 1, Document 32, Page 136]**
5/09/18	The Water Incident Management Team (IMT) was reconvened after three cases of gram negative bacteraemia was identified in haematology/Oncology patients in ward 2A. It was reported by the Lead Infection Control Doctor (LICD) that the same organisms had been isolated from samples taken from the drains in the ward. None of the 3 patients were an HAI by the 48 hour rule but by definition were healthcare associated. Health Protection Scotland (HPS) and Health Facilities Scotland (HFS) were both represented at this meeting, therefor our obligation with regards to reporting as outlined in Chapter 3 of the National Infection Prevention and Control Manual were met. HPS are responsible for reporting any incidents/outbreaks which score RED or AMBER to the HAI Policy Unit in Scottish Government Health Directorates. Each time the group meet the incident is score using a national tool called the Hospital Infection Incident Assessment Tool (HIIAT) At this meeting the incident was scored as GREEN.	Minutes from IMT  IMT minutes 5 9 18 FINAL.docx **[A36629284 - Bundle 1, Document 35, Page 149]**

	Board Medical Director/Chief Operating Officer/Press Office updated after the meeting by the LICD. This was also reported in the Board Directors weekly report on the 5th September. NB *At this time the hypothesis was that the insertion of pall filters into the sinks to filter any bacteria in the water reduced the space between where the water come out of the system i.e. end of filter and the drain. Because this space was reduced the pressure when the water hit the drain was subsequently increased and this pressure was causing aeroionisation of bacteria from the drains into the general area around sinks and that this was subsequently being introduced to patients via environment or equipment. Drain inspection and cleaning were the main actions. It is noted in the minute that at that time drain cleaning was not recommended because of the potential risk of legionella.* Copy of NHSGGC SOP attached for information on normal process for managing outbreaks and incidents.	 HIIAT.docx **[A36690583 - Bundle 52, Volume 3, Document 47, Page 330]**  IPC 05.09.18.doc **[A36690669 - Bundle 52, Volume 3, Document 21, Page 134]**  outbreak-sop-final-version-oct-2017-_2_.p **[A36690673 - Bundle 52, Volume 3, Document 4, Page 20]**
10/09/18	IMT One new case. At this point the four cases were added to the overall time line taking the number to 21 for 2018. The cases included all that had organisms grown from blood cultures that were also that were also grown from water or drains. HPS in attendance. HIIAT assessed as GREEN Programme of drain cleaning in progress and review of some parts in the drainage system.	 Minutes Ward 2A IMT 10.9.18.docx **[A36629302 - Bundle 1, Document 36, Page 154]**

12/09/18	Weekly Directors report attached which includes an update on the situation in 2A/B	IPC 12.09.18.doc **[A36690605 - Bundle 52, Volume 3, Document 22, Page 137]**
13/09/18	IMT New case – Cases now 22 HPS in attendance Prof. Gibson reported that she was meeting with the Director of Women and Children Directorate on the 14/09/18 to discuss her concerns and those of the other clinicians. HIIAT assessed as RED This minute records that: "The Scottish Government have asked a couple of questions regarding the patients in Ward 2A/B and if there are any options to move patients out with the hospital or to any other area. They also asked for assurances that children are safe. Senior Managers and directors met that afternoon to discuss options listed in the minute.	Minutes Ward 2A IMT 13 9 18.doc **[A36629307 - Bundle 1, Document 37, Page 160]**
14/09/18	Senior members of the IMT met with staff from the unit to update them.	
14/09/18 pm	IMT HIIAT assessed as RED. Contingency arrangements discussed (see minute attached) Recommendations from IMT went to Board Directors. It was agreed that admissions would be restricted to emergences meantime. HPS in attendance	Minutes Ward 2A IMT 14 9 18.doc **[A36629309 - Bundle 1, Document 38, Page 164]**
17/09/18	IMT New case – total now 23 HIIAT RED – Board Exec Group will wait for results from drain survey before a decision is taken possible decant. Admission restrictions remained in place. HPS & HFS in attendance.	Minutes Ward 2A IMT 17 9 18.doc **[A36629315 - Bundle 1, Document 39, Page 169]**

17/09/18	Paper re options prepared by W & C SMT Decant operational log SOP TITLE - PAEDIATRIC EMERGENCY TEAM RESPONSE (including PAEDIATRIC MAJOR HAEMORRHAGE TEAM) TO PAEDIATRIC PATIENTS TEMPORARILY DISPLACED TO WARDS 4B and 6A of QEUH Child Protection Paper	 ward 2a decant paper 2018.docx **[A36591715 - Bundle 6, Document 14, Page 38]**  Copy of Decant Operational Log forW **[A36690559 - Bundle 52, Volume 3, Document 28, Page 169]**  SOP for RHC patients in QEUH wards 4B 6A **[A36690661 - Bundle 52, Volume 3, Document 29, Page 179]**  NHSGGC Child Protection Service dec **[A36690636 - Bundle 52, Volume 3, Document 25, Page 154]**
18/09/18	IMT Chief Operating Officer (COO) confirmed that after taking advice from the IMT and Water Group that plans would be put in place to decant the ward to 4B and 6A in the adult hospital (4B was is adult BMT). HIIAT assessed as RED HPS and COO in attendance.	 Minutes Ward 2A IMT 18 9 18.doc **[A36629310 - Bundle 1, Document 40, Page 175]**
19/09/18	IMT HIIAT assessed as RED Plans to decant being put in place including patient pathways, medical and nursing ratios etc. HPS/HFS and COO in attendance	 Minutes Ward 2A IMT 19 9 18.doc **[A36629316 - Bundle 1, Document 41, Page 180]**

20/09/18	IMT New patient – total now 24 (this was the last cases associate with this incident) HIIAT assessed as RED HPS in attendance.	Minutes Ward 2A IMT 20 9 18.doc **[A36629320 - Bundle 1, Document 42, Page 185]**
21/09/18	Decant meeting with Directorate	
21/09/18	Inspection pre decant report	Pre Decant Inspection 6A 21.9.18.docx **[A36690653 - Bundle 52, Volume 3, Document 26, Page 155]**
25/09/18	IMT HIIAT assessed as RED HPS in attendance. Inspection of 6A prior to move undertaken – assessment documents attached. "Annette Rankin(HPS) has shared further questions from the Scottish Government and MSPs. "	Minutes Ward 2A IMT 25 9 18.doc **[A36629324 - Bundle 1, Document 43, Page 190]** 6A inspection post works & pre clean 28. **[A36690530 - Bundle 52, Volume 3, Document 50, Page 337]** Pre Decant Inspection 6A 21.9.18.docx **[A36690653 - Bundle 52, Volume 3, Document 26, Page 155]**
26/09/18	Reported at Board Infection Control Committee (BICC)	4. Item 2 - Minutes of BICC 26-09-18.doc **[A36690472 - Bundle 13, Document 54, Page 391]**

28/09/18	IMT The full decant of patients from Ward 2A and Ward 2B was undertaken on Wednesday 26th September into Ward 6A and Ward 4B BMT in the QEUH. HIIAT AMBER The group agreed that an AMBER HIIAT score would remain for the duration of Ward 2A/2B decant and will not be re-assessed until the patients have moved back into ward 2A and 2B. (NB because the decant extended the LICD e mailed HPS and reduced to Green on 19 February 19). Epidemiology Report referred to attached. Return to normal triggers. Reported that a ventilation survey would be undertaken at the same time as the drain survey.	 Minutes Ward 2A IMT 28 9 18.doc **[A36629328 - Bundle 1, Document 44, Page 194]**  ExternaltoGGCRe Ward 2A IMT Minutes **[A36690562 - Bundle 52, Volume 3, Document 41, Page 265]**  RHC gram negative descriptive epi.docx **[A42362089 - Bundle 6, Document 27, Page 95]**
04/10/18	Teleconference with SGHD re situation update	 Water Telecon Minutes - 04.10.18 - e **[A36690667 - Bundle 52, Volume 3, Document 30, Page 182]**
05/10/18	IMT Teleconference noted in minute. HIIAT AMBER HPS in attendance Dosing with chlorine dioxide agreed for adult hospital.	 Minutes Ward 2A IMT 05 10 18.doc **[A36629290 - Bundle 1, Document 45, Page 199]**
10/10/18	Teleconference with SGHD re situation update	 Water Telecon Minutes - 10.10.18 - d **[A36690671 - Bundle 52, Volume 3, Document 32, Page 195]**

11/10/18	IMT Reported that the drain survey had been complete Decision to use chlorine for both hospital confirmed with a start date some time in November. HIIAT AMBER HPS in attendance	Minutes Ward 2A IMT 11 10 18.doc **[A36629306 - Bundle 1, Document 46, Page 204]**
16/10/19	NHS Greater Glasgow & Clyde Board Minutes	item-3-nhsggc-m-18 05.pdf **[A36629298 - Bundle 37, Document 52, Page 687]**
18/10/18	Teleconference with SGHD re situation update	Water Telecon Minutes - 18.10.18 - e **[A36690670 - Bundle 52, Volume 3, Document 34, Page 226]**
19/10/18	IMT Scope of work in 2a/b discussed. Chlorine dosing Taps all changed Sinks all changed Plumbing components replaced. HIIAT AMBER HPS in attendance	Minutes Ward 2A IMT 19 10 18.doc **[A36629317 - Bundle 1, Document 47, Page 208]**
26/10/18	IMT Change to treatment and prep room proposed and scoped. HIIAT AMBER HPS in attendance Information for staff re dosing and the issue that there will be no hot water for 24 hours.	Minutes Ward 2A IMT 26 10 18.doc **[A36629329 - Bundle 1, Document 48, Page 212]**
26/10/18	Reported at Acute Infection Control Committee (AICC)	4. Item 2 - AICC Minutes of 26 Octobe **[A36690459 - Bundle 13, Document 18, Page 137]**

October HAIRT	Hospital Associate Infection Reporting Template (HAIRT) paper submitted to Board Clinical Governance Forum, AICC, BICC & NHS Board Meeting. Incident on page 8. Board Clinical Governance Forum noting contents of HAIRT.	 5. board-hairt-oct-2018 **[A36690576 - Bundle 52, Volume 3, Document 33, Page 202]**  002 Item 02 - BCGF October Minutes - API **[A36690567 - Bundle 52, Volume 3, Document 27, Page 157]**
30/10/18	Local meeting held to discuss recommendations from national water expert – recommendations regarding the removal of some sinks and some types of sinks.	
02/11/18	IMT Ventilation discussed HPS SBAR re the use of trough sinks. HIIAT AMBER HPS in attendance	 Minutes Ward 2A IMT 02 11 18.doc **[A36629288 - Bundle 1, Document 50, Page 223]**  SBAR NHSGGC whb ante room (4).pdf **[A36690666 - Bundle 3, Document 13, Page 115]**
9/11/18 & 13/11/18	IMT This date seems to have been moved forward to the 13th November. Extent of possible ventilation works discussed. Decant date extended to February. HIIAT AMBER HPS in attendance	 Minutes Ward 2A IMT 13 11 18.doc **[A36629308 - Bundle 1, Document 51, Page 227]**
22/11/18	IMT Options appraisal from a ventilation engineer discussed. SGHD requested a SBAR on ventilation noted that this was done and waiting approval from Chief Executive before being sent on. Agreed two weekly meetings HIIAT AMBER HPS in attendance	 Minutes Ward 2A IMT 22 11 18.doc **[A36629319 - Bundle 1, Document 53, Page 237]**

28/11/18	Teleconference SGHD	Water Telecon Minutes - 28.11.18 - e **[A36690794 - Bundle 52, Volume 3, Document 38, Page 243]**
28/11/18	Minutes of Board Infection Control Committee	Item 2 - Minutes of BICC 28-11-18.doc **[A36690620 - Bundle 13, Document 55, Page 398]**
30/11/18	IMT Dosing of site with chlorine dioxide took place on 28/11/18 HIIAT AMBER HPS in attendance Discussion re parents and comms. Final HAIORT for HPS attached	Minutes Ward 2A IMT 30 11 18.doc **[A36629326 - Bundle 1, Document 54, Page 241]** HIIORT Water system incident 18.9.18.docx **[A36690601 - Bundle 52, Volume 3, Document 24, Page 149]**
Cryptococcus Incident Starts		
21/11/18	Patient A (adult patient) had a blood culture (BC) taken on 21/11/18 and this was positive for Cryptococcus neoformans. This patient was unable to receive antifungal prophylaxis due to concerns regarding liver function NB Cryptococcus species, which is harmless to the vast majority of people and rarely causes disease in humans. It is caused by inhaling the fungus *Cryptococcus*. These fungi are primarily found in soil and pigeon droppings	
December 18	December HAIRT Board Clinical Governance Forum minutes where contents of HAIRT was noted.	2018_12_NHSGGC HAIRT final.docx **[A36690592 - Bundle 52, Volume 3,**

		Document 42, Page 268]  002 Item 02 - BCGF December Minutes ap **[A36690554 - Bundle 52, Volume 3, Document 39, Page 247]**
[redacted]/2018	Patient B (paediatric patient) [redacted].	
14/12/18	Patient B (paediatric patient), blood culture taken on [redacted] subsequently identified as Cryptococcus neoformans and multiple [redacted] samples taken on [redacted] were also positive for Cryptococcus neoformans. Reported to ICD on [redacted]. [redacted]	
17/12/18	Lead Infection Control Doctor (LICD) informed of two patients with Cryptococcus neoformans on the QEUH campus.	
18/12/18	Problem Assessment Group (PAG) held. After review of the cases the following actions were undertaken: • Review of drugs given to patients by the aseptic pharmacy. • Review of Paediatric Intensive Care Unit (PICU) to review possible contamination with pigeon excrement on window ledges etc. Findings – excessive volumes of pigeon droppings have been noted outside of PICU in enclosed external atriums. There is no window or door access to the external atrium for staff or patients. Pigeons have been reported to be nesting on the sills of the external atrium throughout the summer months and as a result nets were placed overhead and spikes applied to window sills. The extensive pigeon excrement is no longer visible although some pigeon droppings do remain on the external windows and sills. The same was also visualised on overhead canopies at entrance way to the Royal Hospital for Children. • Review of plant room on the roof of the adult hospital.	 PAG Cryptococcus neoformans - 18.12.1 **[A36690657 - Bundle 2, Document 45, Page 118]**

	• Air sampling of ward areas.	
19/12/18	Review of plant room on the roof of the adult hospital – evidence of pigeon droppings and feathers in the plant room. Action: • Sample air and droppings. Samples of faeces will be sent for further analysis – Ayr vet lab • Estates to decontaminate area – instructions given by PAG group.	
20/12/18	Teleconference with SGHD	 Water Telecon Minutes - 20.12.18 - e **[A36690655 - Bundle 52, Volume 3, Document 44, Page 301]**
20/12/18	Incident Management Team (IMT) convened. Hospital Infection Incident Assessment Tool (HIIAT). Assessed as RED Actions: • All high risk patients to receive prophylaxis. • Place spikes on all areas where birds might nest in both buildings. • Review plant room daily and put measures in place to prevent further access to the areas by birds. Investigate for access points. • Vet Consultant at Health Protection Scotland (HPS) contacted by Consultant Public Health Medicine to establish incidence/epidemiology. • Epidemiology of cases will be reviewed by Consultant Public Health Medicine (CHPM). • Bristol mycology – typing not routinely available but they will attempt sequencing. Advice sought re epidemiology – they have not seen hospital acquired cases before, usually sporadic community cases. • Ongoing surveillance – clinicians and microbiologists will consider as part of differential diagnosis and send serum antigen and blood cultures. Lab contamination had been ruled out Heath Protection Scotland Informed as per chapter 3 of the National Infection Prevention and Control Manual.	 IMT Cryptococcus 20 12 18.doc **[A36605178 - Bundle 1, Document 55, Page 245]**

27/12/19	Board Directors Wednesday Report	IPC 27.12.18 - SAB and CDI.doc **[A36690608 - Bundle 27, Volume 9, Document 23, Page 427]**
27/12/18	IMT– Actions and Update HIIAT assessed as AMBER Update Adult patient responding to treatment*. No new cases. Actions update: • GP Environmental Ltd carried out Pest Control and Housekeeping Inspection of Various Plant rooms (31, 32, 33, 21, 22, 41 and 41A at QEUH, Glasgow). Deep clean completed in response to recommendations within the report. • Additional bird proofing implemented in an area identified within their report "Pigeons had gained access through what appears to be weather damaged cladding and have been using the pipes and high beams as a roosting point. The roosting areas were mainly at the roof access point below the large roof overhang". • Family of paediatric patient unavailable to meet clinical team. To be arranged as soon as possible. • Provisional report from samples of bird faeces is negative, however, there may have been some issues with sampling. • Air sampling results are not available yet. • Plant room D (1, 2, 3) pigeons in situ now removed. • Public health epidemiology confirms a general increase in cases although numbers are very low. 5 cases since June 2018. Update from HPS Consultant Vet still awaited. • Typing by Bristol lab still awaited. • All high risk patients will continue to receive prophylaxis. Additional agreed actions: • Plant rooms will now be inspected every two weeks for evidence of pest, infestations.	IMT Cryptococcus 27 12 18.doc **[A36605180 - Bundle 1, Document 56, Page 250]**

	• Water tanks reviewed and they are covered so unlikely to be a source. • Estates will check window seals for any obvious gaps. • Public health to update HPS Consultant Vet re findings of epidemiology. • Occupational health will consider any issues for staff who would normally work in the plant room in respect of Personal Protective Equipment (PPE). • Confirmed that specialist contractors wear appropriate PPE. • Estates will plan for cleaning of window ledges in PICU. • Continue to review epidemiology. • Estates to look at removing vegetation from level 4 QEUH rooftop and place spikes on patients windows • Review carts taking patient supplies to ward to ensure clean. *adult patient was not on prophylaxis has liver complications with immunosuppression.	
03/01/19	Board Directors Wednesday Report	 IPC 03.01.19.doc **[A36690611 - Bundle 52, Volume 3, Document 48, Page 332]**
7/01/19	IMT meeting - HIIAT assessed as Green. **Update** No new or suspected cases. Adult patient had planned discharge home for palliative care but died before discharge ([redacted]/19). Cryptococcus was not on the patient's death certificate either as a primary or secondary cause of death. IMT held to update clinicians with available air sampling results. Fungal counts identified in plant room 12 including Cryptococcus. Isolate being sent to Bristol to confirm species and compare with patient isolates. Fungal growth on plates from wards 6A and 4C (these are not hepa filtered wards). Plates left to incubate for longer than specified which may account for some overgrowth.	 Cryptococcus minutes IMT 7.1.19 S **[A36690566 - Bundle 1, Document 57, Page 255]**

	Prophylaxis continues in adults without any issues. Paediatric prophylaxis has been challenging – paediatrics do not tolerate long term prophylaxis and there have been 2 episodes of anaphylaxis Additional actions from the meeting; • Repeat air sampling as well as await results still outstanding from initial sampling. • Estates to Clean window ledges visible from PICU • Report awaited from GP environmental detailing options for reducing pigeon infestations in and around the QEUH site • Review of portable HEPA filter options for use in ward 6A • Await feedback from HPS re: national picture relating to Cryptococcus cases amongst humans. Outcome – no evidence/epidemiology available.	
7/1/19	Acute Infection Control Committee Minutes	 5. AICC Minutes of 7 January 2019.doc **[A32181797 - Bundle 13, Document 19, Page 145]**
9/1/19	Board Directors Wednesday Report	 IPC 09.01.19.doc **[A36690607 - Bundle 52, Volume 3, Document 49, Page 335]**
9/1/19	Meeting called by Board Medical Director to address clinicians concerns re air sampling and to review of some issues highlighted in minutes from 7/01/19: Actions • Asked that confirmation that review of antifungal prophylaxis in the paediatric cohort had been completed. • Escalated procurement/placement of portable HEPA filtration units. • Requested repeat air sampling pre and post HEPA unit placement. • ICD and Infection Prevention & Control Nurse (IPCN) to advise ward on the placement of HEPA units.	

	• Escalate repair of two damaged rooms in 6a. • Information would be issued to parents and staff regarding the deployment of HEPA filters. At this meeting estates colleagues confirmed: • Smoke tests carried out in the plant rooms and that there was no leakage into the ventilation system. • The building was triple glazed and no obvious leaks were detected but that they would carry out thermal imaging to detect any drafts.	
10/01/19	HEPA Units installed in ward 6a. All families verbally briefed on situation. All staff given information.	
11/01/19	Meeting with clinical staff to address concerns.	
13/01/19	All staff and inpatients given written brief, alongside verbal communication.	
16/01/19	IMT Update Results from air sampling from 9/1/19 (This was before portable HEPA filters were in place but after the plant rooms had been decontaminated) Cryptococcus has been isolated, however it was a different type from the one isolated from the patients. After discussion with expert from Bristol it was proposed that the most likely source is a breach of the ventilation system and that GGC should consider HPV cleaning of the system. Cryptococcus was not found in samples from PICU. In the absence of post filter insertion sampling ICD was asked if there were any other indicators that could be used to reassure clinical staff that filters were working. Lead ICD agreed to carry out repeat air sampling and particulate counts on the evening of 16th January. Actions • Obtain additional units for the 6A corridor and deploy additional units to complete coverage in corridor of 6A and ward 4C (adult general haematology) inpatient rooms.	 IMT Cryptococcus 16 01 18.doc **[A36690590 - Bundle 1, Document 58, Page 261]**

	Update Post Meeting Particulate sampling results although lower than previously reported remained higher than expected. LICD conducted through examination of the built environment and identified areas of mould/damp in some joins in the shower rooms e.g. skirting board joins. The hypothesis is that this could account for the higher than expected particulate count.	
17/01/19	IMT To discuss results and actions from particulate counts and findings from the review of the environment. Summary: • Portable HEPA filtrations units have been deployed to ward 6a with additional units being delivered into the adult general haematology ward (4C) today. • All high risk patients are receiving antifungal prophylaxis. • Air sampling has confirmed that wards in the 7th floor have Cryptococcus in samples, however, patients in this area are at extremely low risk of developing this type of infection • Very high risk patients in ward 6a were relocated to the adult bone marrow transplant unit as an additional precaution until estates issues are rectified. • Facilities have engaged contractors to check with thermal imaging on the windows within the wards to see if there are any possible leaks. • HAI SCRIBE will be completed 18/1/19 to enable estates colleagues to commence work to rectify issue in showers over the next couple of days. Written and verbal brief given to patients and staff. Update from national expert on ventilation (P Hoffman) Lead Infection Control Doctor has contact Public Health England to ascertain if this problem has occurred in other hospitals and if so what action was taken to resolve it. Advice from a National Expert is that over time the system will through dilution clear itself. As an additional control measure Estates have contacted a specialist contractor to assess the feasibility of decontamination of the system using hydrogen peroxide vapour (recommendation from	 IMT Cryptococcus 17 01 19 Part 1 AM.doc **[A36690588 - Bundle 1, Document 59, Page 266]**  IMT Cryptococcus 17 01 19 Part 2 PM.doc **[A36690599 - Bundle 1, Document 60, Page 270]**

	mycology lab in Bristol). In addition the system will be assessed to establish if there is any other source of contamination.	
18/01/19	HIIAT assessed as AMBER Severity of illness - minor Impact on services- moderate Risk of transmission - moderate Public anxiety - moderate Summary No new cases have been identified. All at risk groups remain on prophylaxis. Air sampling complete as requested at IMT 17/01/19. Hepa filters in all key areas with more being delivered tomorrow for renal transplant areas. HAI SCRIBE complete for works which will progress over weekend. Teleconference with Peter Hoffman and microbiology – results of which will be communicated at next IMT. High risk patients moved to adult BMTU. Other patients on ward risk assessed to ensure highest risk are in rooms with no issues with showers. Proactive press statement released. Comms prepared for patient and parents. Members of IPCT and SMT Women's and Children's continue to make themselves available to address specific concerns of patients, parents and staff. Actions • Pursue report on thermal imaging action re windows. • Review of filtration within ventilation system is ongoing with estates colleagues.	IMT Cryptococcus 18 01 19.doc **[A36690595 - Bundle 1, Document 61, Page 274]**
21/01/19	IMT HIIAT assessed as AMBER Severity of illness - minor Impact on services- moderate	IMT Cryptococcus 21 01 19.doc

	Risk of transmission - moderate Public anxiety - moderate Summary No new cases. Water ingress in shower areas was more significant than thought (6A). There was visible mould evident when flooring was lifted and as a consequence all patients were risk assessed and four patients were moved to PPVL rooms in Clinical Decisions Unit in RHC. The rest of the patients (4) were relocated to the beginning of the ward were the showers appeared to be in the best condition. An operational group met today to consider options in terms of relocating patients in RHC. HSE have indicated this morning that they will make visit to the site on Thursday 24th January. **RHC Air sampling** Air sampling done in RHC (PICU, Renal Unit) all negative for Cryptococcus. 6a & 4c 4c results not available as yet. Ward 6A results show a single colony of yeast in one bedroom and some in a corridor but several rooms are negative for Cryptococcus. Full fungal cultures not available yet. Actions • Work is ongoing to repair shower rooms. 8 should be repaired by Wednesday. Directorate review of options to move patients from adult back to children's hospital is ongoing. • Thermal work on windows complete. Some minor issues identified but no major concerns noted. • Communication via other forms of social media will be put in place today to reach the wider population of NHSGGC. • All families who are inpatients or who are due to come in have been spoken to by clinical staff – this has been ongoing. They also received information on Friday18th.	**[A36690569 - Bundle 1, Document 62, Page 278]**

	• Further communication to parents by member of NHS Board to be considered (letter). • Nursing staff in both 6a and 4c have raised concerns and have been spoken to. • Review showers in 4c and rectify any issues noted. • Haematology consultants (paeds) briefed today. • Continue with air sampling on site twice weekly.	
22/01/19	IMT HIIAT assessed as AMBER Severity of illness - minor Impact on services- moderate Risk of transmission - moderate Public anxiety - moderate **Cab Sec visit – statement to parliament.** Update All patients from 6a now in CDU. BMT patients remain in ward 4b No new cases. Plan in place for new admissions. Actions: • Work still ongoing in rooms used by low risk patient, one room with some issues in shower will be used as an OPD room for low risk patients. • On target to complete works on at least 6 rooms by 23/01/19. A further 8 rooms should be complete by next week at the earliest. Air testing will take place once the rooms are all complete, they have had a HPV clean and before HEPA filters are put back in place. Once this is complete the rooms will be tested with the HEPA filters in place. • Some repair work also scheduled for ward 4c. • Letter for patients/parents will be approved by CEO and will be issued to all in-patients and out patients. • Core briefs have been issued to staff to update them on the situation. Going forward social media will be used to also send this message out.	IMT Cryptococcus 22 01 19.doc **[A36690573 - Bundle 1, Document 63, Page 282]**
24/01/19	IMT HIIAT assessed as RED Severity of illness - minor Impact on services- moderate Risk of transmission - minor Public anxiety - major **No new cases**	IMT Cryptococcus 24 01 19.doc **[A36690579 - Bundle 1, Document 64, Page 286]**

	Additional Hypothesis In radiology there is a door which smoke testing has confirmed in not sealed when closed. Outside this door is a courtyard and within this area there is a heat exchanger. Bird dropping were evident in this area and the hypothesis is that the heat exchanger may be causing spore dispersion close to an air inlet. **Summary** Haematology/Oncology now located in CDU. Day cases on first floor. Actions • 6A scribes complete. Repairs and HPV cleaning should be complete by Monday 28.01.19. Air sampling will commence after this has been completed – probably Wednesday 30.01.19. Sampling will be done pre and post HEPA filter placement. • Ongoing investigations in plant room. • Courtyard near radiology being reviewed. • Letter to patients/parents developed. Both in patient and outpatients will be issued with same. • Supplies boxes reviewed – procurement confirm no problem in Hillington distribution centre with pigeons. • Roof top garden assessed (QEUH)– no signs of nesting. Will need to be assessed to develop solutions to remove garden material. Pest control in attendance. Guidance will be sought re mid term solutions. • Twice weekly air sampling in level 7 (QEUH) as a control.	
25/01/19	IMT HIIAT assessed as AMBER Severity of illness - minor Impact on services- moderate Risk of transmission - minor Public anxiety - moderate No new cases **Update**	 IMT Cryptococcus 25 01 19.doc **[A36690577 - Bundle 1, Document 65, Page 291]**

	Shower repairs and cleaning of chilled beams (6a) will be complete by Monday, Air sampling will commence on Wednesday. Action • Review of types of filters to be added to ventilation system to prevent ingress of Cryptococcus. • Haematology/oncology paediatrics patients now in CDU. BMT patients in ward 4b adult BMTU. • Vet lab Ayrshire – results, crypto albidus in bird faeces these will now be sent to Bristol. • Air sampling – results not available as yet. • Peter Hoffman has asked for some information re ventilation, the answers are currently being developed. • Review of helipad. Downdraft airflow and patient transport equipment. • 6a will be reviewed by LICD and LIPCN on Monday after repairs are complete.	
28/01/19	IMT HIIAT assessed as RED due to public anxiety Severity of illness - Minor Impact on services- Moderate Risk of transmission - Minor Public anxiety - Major Update • Vet lab Ayrshire – results, crypto albidus in bird faeces these will now be sent to Bristol – post meeting – these samples were discarded. New samples will be obtained. • One patient transferred to Edinburgh (new patient). One [redacted] currently in Beatson Oncology Centre but plans to transfer are ongoing, one other patient receiving treatment in Edinburgh. • 13 patients in CDU. • Letter issued to all inpatient parents – no issues raised. Letters being sent to outpatient cohort.	 IMT Cryptococcus 28 01 19.doc **[A36690584 - Bundle 1, Document 66, Page 295]**

	• Adult BMT (4B) three patients remain on ward. • 2a functioning as acute admission – no issues identified in haematology/oncology in this area – only in extremis and four BMT rooms would be used. • Micro – air sampling - Level 7(indicator ward) most recent results all negative therefore may be able to lift some control measures. Lead ICD to review • Work on 6a should be complete today. • Additional HEPA filters purchased. • Hepa filters will be left in wards 6A and 4C long term, pending works to upgrade them. Maintenance programme to be put in place. Hypothesis Update Visit to helipad – obvious birds and faeces. Trolleys will have bird faeces on wheels cannot be transferred onto new trolleys as they are trauma patients. Other centres with helipad being contacted re what they have put in place to address this. Not likely to affect haematology patients as not admitted via this route New Actions • After discussion recommendation is that HEPA filters remain in situ in high risk areas • SLWG to further develop hypotheses , and explore further future preventative methods we can put in place . Communications • Letter issued to all inpatient parents – no issues raised. Letters being sent to outpatient cohort. • Families will be advised that they can contact GGC comms if reporters appear at their home. Formal communication with numbers etc will be developed. • W & C senior management team have briefed clinical directors for each specialty or their equivalent regarding incident. This will be	

	followed up with some formal written communication. • Family of adult family has asked for additional information this will be actioned by clinical team and LICD. Next IMT 30 January 2019	
20/01/19	Inspection post works pre clean by IPCT	6A inspection post works & pre clean 28. **[A36690467 - Bundle 52, Volume 3, Document 51, Page 340]**
30/1/19	**IMT** HIIAT assessed as RED due to public anxiety Severity of illness - Minor Impact on services- Moderate Risk of transmission - Minor Public anxiety - Major Update • New bird faeces samples have been obtained and further samples to be obtained from the helipad and these will now be tested. • Adult BMT (4B) 4 paediatric patients remain on ward. • Micro – air sampling - PICU – initial air samples obtained on 21st December 2018 showed no growth of Cryptococcus however the chair of the IMT has now been informed that that further sample taken on this date have grown cryptococcus albicus. Discussion with expert in Bristol suggests that the counts of Cryptococcus in the air may have now reduced due to natural dispersion. • Work on Ward 6a is now complete and HPV cleaning has been undertaken prior to air sampling and HEPA filters being installed	IMT Cryptococcus 30 01 19.doc **[A36690591 - Bundle 1, Document 67, Page 299]**

	• Additional HEPA filters purchased. • Prophylaxis and heap filters remain in place for all high risk patients. **Hypothesis Update** Due to updated air sampling results from PICU the hypothesis generated at the last IMT has now changed. PICU is served by Plant Room 41 on Level 4 and this area was previously inspected and found to be contaminated with pigeon faeces but no sign of infestation. A separate subgroup will now be convened to review all possible hypotheses. Air sampling of plant room 41 will take place **New Actions** • Jamie Redfern will review all patients who was admitted to the PICU via the helipad in December. • Guidelines for heap filter changes is being developed. • Dr T Inkster has requested a review of all samples related to the incident. • SLWG to further develop hypotheses , and explore further future preventative methods we can put in place. • Facilities to review down drafts created by helicopter landings and any potential dispersal of pigeon faeces. **Communications** • Dr T Inkster will speak to the family of the adult patient who have requested update of all development. • Facebook page to be set up by comms dept with 2 members of Paediatric SMT as administrators to allow parents to raise any concerns and GGC the opportunity to respond. • Letters being sent to outpatient cohort. • Media enquiry from BBC regarding the cause of death of the adult patient and a response has been prepared.	

4/02/19	**IMT** HIIAT assessed as AMBER Severity of illness – minor Impact on services- moderate Risk of transmission - minor Public anxiety - moderate **Update** • SLWG will meet this week for the first time. • One case with a positive Aspergillus PCR but normal CT scan – to be reviewed by lead ICD • Air sampling of ward 6a is still outstanding but the plates are negative so far (final results should be available this week). • Plant room samples associated with PICU not available. • Other samples from RHC not available as yet. • Filters arrived and now in place • Pigeon faeces samples sent to Ayrshire lab. • Maintenance guidance for HEPA filters sent to group. This will be put into place. • TAC mats for trolleys in helipad– samples being sent to facilities colleagues for review. **New Actions** • Filters are being sources that will improve filtration associated with general ventilation. **Communications** • Board supported facebook page is being set up to support parents of this patient group**.** • Letters to parents will be sent to LICD. LICD will forward to HPS/SGHD as requested when received. • NSD will be updated re press releases as requested. • Public Health Protection Unit have developed information for the general public. This will be sent to LICD for comment. • Occupational health update for staff to be sent out.	 IMT Cryptococcus 04 02 19.doc **[A36690558 - Bundle 1, Document 68, Page 303]**

8/02/19	**IMT HIIAT AMBER** Severity of illness - minor Impact on services- moderate Risk of transmission - minor Public anxiety - moderate **Update** • Air sampling ward 6a (QEUH). Results are that most room are free of fungal spores. Minimal positive samples with Penicillium which is not significant. Particulate counts are also much improved. • IMT decision is that we can now move patients back into the ward. BMT patient will continue to be looked after in ward 4B (Adult BMT). • Tac mats ordered for helipad. • Interim report from Ayr lab – yeast but final results are not available. **New Actions** • LN IPCT will check ward and feedback to estates/facilities any final issues before children move back. • HEPA filters will remain on 6A long term. • Prophylaxis guideline will be developed for paediatric haem-oncology with micro and ID consultant and pharmacy. • LICD will initiate fortnightly air sampling in 6a. • Maintenance programme will be put in place for HEPA filters. These are cleaned between patients with actichlor. • Draft water damage policy has been prepared but is still to be ratified. Possibility for named estates colleague allocated to each high risk area is being explored. • Vent cleaning frequency being increased to three monthly.	 IMT Cryptococcus 08 02 19.doc **[A36690561 - Bundle 1, Document 69, Page 307]**

	Communications • Face book page in development, should be available soon. • Occupational advice to go out to staff as soon as possible. • W & C senior management team will develop a briefing with communications to give to parents regarding the move back. LICD, consultants and SMT W & C will be available if anyone has any questions or concerns.	
15/02/19	Last HAIORT (summary of reporting to HPS throughout) assessed as GREEN by ICD e mail attached	 HIIORT QEUH crypto Dec 18.doc **[A36690564 - Bundle 27, Volume 4, Document 20, Page 246]**  ExternaltoGGCRE HIIORT - NHSGGC - W **[A36690548 - Bundle 27, Volume 4, Document 10, Page 222]**
19/02/19	NHS Greater Glasgow & Clyde Board Minutes	 item-3-nhsggc_m_-february-v4-final-jb.pdf **[A36690603 - Bundle 37, Document 53, Page 702]**
February 19	February HAIRT Board Clinical Governance Forum Minutes	 Feb HAIRT.docx **[A36690550 - Bundle 52, Volume 3, Document 59, Page 402]**  002 Item 02 - BCGF February Minutes.pdf

		[A36690456 - Bundle 52, Volume 3 Document 54, Page 359]
5/03/19	Clinical and Care Governance committee	CCG committee March.pdf **[A36690543 - Bundle 38, Document 11, Page 81]**
25/03/19	Board Infection Control Committee Minutes	7. Item 2 - Minutes of BICC 25-03-19.doc **[A36690476 - Bundle 13, Document 56, Page 407]**
16/04/19	NHS Greater Glasgow & Clyde Board Minutes	item-03-nhsggc-m-19_02-april-2019-tbr.p **[A36690610 - Bundle 37, Document 54, Page 718]**
April 19	April HAIRT Board Clinical Governance Forum Minutes	April 19_validated Q4 data FINAL.doc **[A36690551 - Bundle 52, Volume 3, Document 72, Page 491]** 02 Item 02 - BCGF April Minutes - V3.pdf **[A36690454 - Bundle 52, Volume 3, Document 69, Page 470]**
June 19	June HAIRT	June 19_DRAFT final 18 06 19.docx **[A36690615 - Bundle 52, Volume 3,**

		Document 75, Page 545]
June 2019	HPS report – Epidemiology of water borne infections in ward 2AB RHC.	 2019-6-5 ggc 2a 2b report v9 final report. **[A32308315 - Bundle 20, Document 52, Page 1001]**
July	Draft minute of the Expert Advisory Group who were tasked with testing the hypothesis. PLEASE NOTE THIS IS A DRAFT AND SHOULD BE APPROVED BY 26 JULY – FULL REPORT IS STILL AWATED	 06.06.19 - Crypto IMT Expert mins - dra **[A39233761 - Bundle 9, Document 9, Page 45]**

Appendix C

[RHC Water Incident timeline – governance and communication – March –June 2018 (first incident)

February 2018	**South Sector Water Safety Group Meeting** 16.2.18  Minutes 16.02.18.doc **[A36399519 - Bundle 52, Volume 3, Document 56, Page 370]** Item 5: cupriavidus patient incidents noted as reason for water sampling requests for RHC 2A, indicated that within meeting that outlets rather than water system would be source of any contamination.

	South Sector Terms of Referencewater.p **[A36399496 - Bundle 52, Volume 3, Document 82, Page 596]** See Terms of Reference for context of discussions.
March 2018 **Water IMT convened 2.3.18, continues throughout March**	**Board Water Safety Group** 6.3.18 Minute 06.03.18.docx **[A36399507 - Bundle 11, Document 27, Page 83]** Discussion of bloodstream infections believed to be connected to water outlets and actions to be taken. See 2017 timeline for terms of reference for group, for context of discussions. **Acute Services Committee** 20.3.18 https://www.nhsggc.org.uk/media/248857/item-14-asc_m_-18_02.pdf **[A51535513 - Bundle 36, Document 24, Page 211]** Item 17b notes that discussions are being held with HPS and water treatment has been carried out, additional testing to be performed, taps may need to be replaced. **Board Infection Control Committee** 28.3.18 Item 2 - Minutes of BICC 28-03-18.doc **[A38759228 - Bundle 13, Document 50, Page 364]** Item 6: Background on discovery of cupriavidus, water testing regime, actions taken in response, hypotheses, short and long term solutions and how to take these forward. Draft Water Safety Group Terms of Reference with papers. 2018/19 workplan notes requirement to implement legionella and pseudomonas controls with Board Water Safety Group Item 6.5 - RCH Ward 2a incident - Dr Inkst **[A36399506 - Bundle 52, Volume 3, Document 8, Page 46]** Paper on 2A water incident presented at meeting: Detailed coverage of water testing regime, current situation re bacteraemias found in patients and water, hypotheses and proposed actions. **South Sector Facilities Infection Control Group** 28.3.18 Minute 28.03.18.doc **[A36399518 - Bundle 52, Volume 3, Document 9, Page 50]**
April 2018	**Water Review Group (Technical)**

	Convened as IMT subgroup with Infection Control, Estates, HPS and HFS attendance to manage 2A water incident.  Minutes 06.04.18WRGT.docx **[A38668906 - Bundle 10, Document 1, Page 5]** Detailed presentation on taps, discussion and actions on investigation and remediation of water concerns. Group met weekly at this period – selection of minutes inserted within timeline. **Full Board** 17.4.2018 https://www.nhsggc.org.uk/media/248831/item-3-nhsggc_m_-1802.pdf **[A51851759 - Bundle 42, Volume 4, Document 59, Page 1099]** Item 39 'Dr Iain Kennedy, Consultant in Public Health Medicine, was welcomed to the meeting to provide an update on the recent identification of infections which may be linked to the water supply at QEUH and RHC. Dr Kennedy provided the Board with an overview of the circumstances, ongoing work to identify the potential cause and the measures put in place to prevent further contamination, advising that the risk rating had been reduced to amber and that investigation had confirmed that there had been no cross-transmission in identified cases'. **HAIRT** 17.4.18 https://www.nhsggc.org.uk/media/247336/18-17.pdf **[A51850921 - Bundle 52, Volume 3, Document 13, Page 65]** Outbreaks entry outlines water situation with detailed description of actions taken including IMT meetings held and work with HPS and HFS. **Water Review Group (Technical)** 20.4.18 Detailed discussion of investigations and remediation options for system decontamination, and concerns over taps and showers.  Minutes 20.04.18.docx **[A38668913 - Bundle 10, Document 3, Page 14]** **Acute Infection Control Committee** 27.4.18  Item 2 - AICC Minutes of 27 April 20 **[A38759215 - Bundle 13, Document 15, Page 111]** Item 12: update on incident, investigations, actions and hypotheses, noted that no new cases since precautions taken and long term actions being examined by working group. **Water Review Group (Technical)** 27.4.18 Detailed discussion of short and long term actions relating to water incident including water dosing, drain cleaning and tap and sink replacement options, in context of investigations and involvement of HPS and HFS.

	 Minutes 27.04.18.docx **[A38668909 - Bundle 10, Document 4, Page 18]** **Facilities Governance (Infection Control) Forum** 30.4.18  Minutes 30.04.18.docx **[A36399523 - Bundle 52, Volume 3, Document 15, Page 92]**
May 2018	**Water Review Group (Technical)** 18.5.18 Detailed discussion of short and long term actions relating to water incident including water dosing and taps.  Minutes 18.05.18.docx **[A38668902 - Bundle 10, Document 7, Page 29]** **Board Infection Control Committee** 23.5.18 Item 6.7: water incident update noting long terms actions planned and that information has been passed to Informal Directors group.  Item 2 - Minutes of BICC 23-05-18.doc **[A36399500 - Bundle 13, Document 51, Page 371]**
June 2018 **Water IMT held 4.6.18, HPS and Scottish Government in communication, IMT closed 21.6.18**	**Board Clinical Governance Forum** 4.6.18 Item 54: brief update on water incident including immediate actions and note that work is ongoing. Has HAIRT. **Care and Clinical Governance Committee** 12.6.18 https://www.nhsggc.org.uk/media/250045/item-17-ccg_m_18_02-tbr.pdf Item 22 **Review of Water Incident at QEUH and RHC** 'Dr Armstrong introduced Dr T Inkster, Consultant Microbiologist, who presented an update on the Water Contamination incident at QEUH, and RHC which included current and future infection control measures (Paper No. 18/12).' Paper discusses incident, actions and future plans in detail.  CCGC paper water incident.doc **[A50093282 - Bundle 27, Volume 9, Document 7, Page 94]** **South Sector Facilities Infection Control Group** 18.6.18  Minute 18.06.18.doc **[A36399509 - Bundle 52, Volume 3, Document 17, Page 98]**

	Item 4 discusses action re water incident, notes that Estates actions complete for 2A/B. Notes ongoing discussions re tap and sink design and chemical dosing. **Full Board** 26.6.18 https://www.nhsggc.org.uk/media/250034/item-3-nhsggc_m_18_03.pdf **[A51851762 - Bundle 42, Volume 4, Document 61, Page 1283]** Item 63 'Dr Armstrong advised that following the bacteria in the water system incident at Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC), a number of immediate actions had been undertaken to address the issue including domestic cleaning, cleaning of equipment, hand hygiene, the installation of end of tap filters and the installation of new drain spigots. The longer term plan was to chemically dose the water supply and then replace taps in high risk units.' **HAIRT** (presented to Board and BCGF) 26.6.18 https://www.nhsggc.org.uk/media/248856/item-13-18-28.pdf **[A51851775 - Bundle 52, Volume 3, Document 18, Page 101]** Outbreaks entry presents detailed information on incident, actions, formation of water group, hypotheses, involvement of HPS, HFS and international experts including planned review. **Acute Infection Control Committee** 19.6.18  AICC Minutes of 19 June 2018.doc **[A32181721 - Bundle 13, Document 16, Page 120]** Item 3: brief summary of incident and actions, water group and executive water group responsibilities noted, HPS review noted. **Water Review Group (Technical)** 22.6.18 Detailed discussion of short and long term actions relating to water incident including water dosing, drain cleaning and tap and sink replacement options.  Minutes 22.06.18.docx **[A38668896 - Bundle 10, Document 11, Page 44]** **Water Review Group (Technical)** 27.6.18 Detailed discussion of short and long term actions relating to water incident including water dosing, drain cleaning and tap and sink replacement options.  Minutes 27.06.18.docx **[A38668894 - Bundle 10, Document 12, Page 48]** **Acute Strategic Management Group** 28.6.18

	 10a - SMG - 28 June 2018.pdf **[A36399497 - Bundle 52, Volume 3, Document 19, Page 125]** Notes water remediation actions being taken. Incident is now closed.
July 2018	**Acute Services Committee** 17.7.18 Item 40: update on water incident noting that action plan in place, water group meeting weekly and monitoring situation, HPS and HFS involvement, planned HPS review. https://www.nhsggc.org.uk/media/250039/item-11-asc-_m_-18_04-tbr.pdf **[A51535447 - Bundle 36, Document 26, Page 223]** **Water Review Group (Technical)** 20.7.18 Detailed discussion of short and long term actions relating to water incident including water dosing, drain cleaning and tap and sink replacement options.  Minutes 20.07.18.docx **[A38668888 - Bundle 10, Document 16, Page 65]** **Board Infection Control Committee** 25.7.18 Item 6.7: water incident declared closed. Update on water dosing plans and tap replacement.  Item 2 - Minutes of BICC 25-07-18.doc **[A36399504 - Bundle 13, Document 53, Page 384]** **Water Review Group (Technical)** 27.7.18  Minutes 27.07.18.docx **[A38668892 - Bundle 10, Document 17, Page 68]** Detailed discussion of short and long term actions relating to water incident including water dosing, drain cleaning and tap and sink replacement options.
August 2018	**South Sector Facilities Infection Control Group** 6.8.18 Item 4: notes that remedial works relating to water incident completed or  Minute 06.08.18.doc ongoing. **[A36399513 - Bundle 52, Volume 3, Document 20, Page 131]** **Full Board** 21.8.18 https://www.nhsggc.org.uk/media/252257/nhsggc_m_-1804.pdf **[A51852815 - Bundle 42, Volume 4, Document 62, Page 1300]** Item 90: 'Dr Armstrong went onto advise the Board of the current position with regards to the cases of blood stream infections associated with Ward 2A Royal Hospital for Children, which initially was proposed as possibly linked to a contaminated water system. There have been no triggers since 11th June and a

	number of actions were undertaken to mitigate the risk including a number of points of use filters installed, drains decontaminated using chlorine dioxide, cleaning with hydrogen peroxide vapour, replacement of aluminium spigots with plastic spigots in wash hand basins, and a longer term plan to pulse the water supply with chlorine dioxide and replace taps.' **HAIRT** 21.8.18 https://www.nhsggc.org.uk/media/250040/item-12-paper-no-18_38.pdf **[A51851763 – Bundle 52, Volume 4, Document 5, Page 22]** Detailed discussion of water situation including actions and HFS/HPS involvement. No new cases since 11.6.18 and situation now assessed as HIIAT Green. **Water Review Meeting (Technical)** 31.8.18  Minutes 31.08.18WRGT.docx **[A36399529 - Bundle 10, Document 22, Page 83]** Detailed discussion of short and long term actions relating to water incident including water dosing, drain cleaning and tap and sink replacement options. **Care and Clinical Governance Committee** 4.9.18 https://www.nhsggc.org.uk/media/250808/item-17-ccg-m-18_03-tbr.pdf **[A51535595 - Bundle 38, Document 8, Page 51]** Item 35 'water update' covers actions taken, surveillance ongoing, report from HPS/HFS awaited, no further cases of infection identified to date, noted that Tom Steele due to take up appointment and will be crucial to long-term plans.

Appendix D

2018 RHC ward 2A/B water incident – second stage timeline (September-October, ward decant)

September 2018 **5.9.18 Water IMT reconvened, HPS and Scottish Government in communication.** **26.9.18 RHC wards 2A and 2B decanted into QEUH wards 6A and 4B (BMTU).**	7.9.18 **Water Review Meeting (Technical)** Continued detailed discussion of water investigation and remediation. 'Further cases of bacteraemia found and drains issues are reporting a match to the patients.'  Minutes 07.09.18.docx **[A36407735 - Bundle 10, Document 23, Page 88]** Group has continued to meet –selection of minutes inserted in timeline. 10.9.18 **Acute Clinical Governance Committee** Women's and Children's Directorate update notes '3 bacteraemia found since 5th August', notes investigations and enhanced cleaning and inspection regime.  1 2 - ACG Minutes OCTOBER - approved **[A36407730 - Bundle 52, Volume 3, Document 31, Page 189]** 13.9.18 **Water Review Meeting (Technical)**  Minutes 13.09.18.docx **[A38668809 - Bundle 10, Document 47, Page 178]** 13.9.18 **Corporate Management Team** Noted that further water-associated infections found at RHC ward 2A, HPS notified and onsite, Mary Anne Kane in emergency meeting that day after discovery of further evidence of contamination. Noted that chlorine dioxide treatment ongoing on QEUH site.

	FINAL Minutes CMT Meeting 13.09.18 - u **[A36407721 - Bundle 52, Volume 3, Document 23, Page 139]** 18.9.2018 **Acute Services Committee**. Item 40: 'Dr. Armstrong advised the Committee that three further cases had occurred in August and September which could possibly be related to issues with water and drains at the Royal Hospital for Children, and that these cases had come about subsequent to significant work undertaken by the Board in response to earlier cases. She further advised that an Incident Management Team had been instituted as per policy, and that children required to be transferred from current wards to enable investigation of the environment.' https://www.nhsggc.org.uk/media/250804/item-14-asc-m-18_05-tbr.pdf **[A51535516 - Bundle 36, Document 27, Page 231]** 20.9.18 **Water Review Meeting (Technical)** Chlorine dioxide dosing, 2A/B works, investigations and decant. Minutes 20.09.18.docx **A36407748 - Bundle 10, Document 24, Page 92** 26.9.2018 **Board Infection Control Committee** Water incident detailed update including ward decant. Item 2 - Minutes of BICC 26-09-18.doc **[A36690472 - Bundle 13, Document 54, Page 391]**
October 2018 **IMTs and communication with HPS and Scottish Government continue.**	5.10.18 **Water Review Group (Technical)** Detailed discussion of chlorine dioxide dosing, 2A/B works. Minutes 05.10.18.docx **[A36407736 - Bundle 10, Document 26, Page 102]** 12.10.18 Water Review Group (Technical)

	Detailed discussion of ward 2A/B works following decant.  Minutes 12.10.18.docx **[A36407745 - Bundle 10, Document 27, Page 106]** 16.10.2018 **Full Board** Item 118 discussing HAIRT relating to RHC water. 'Dr Armstrong went on to advise the Board of the current position with regards to the cases of infections associated with Ward 2A Royal Hospital for Children (RHC), related to the water system. There had been no trigger incidents since June 2018; however on the 5th September the Incident Management Team (IMT) was reconvened to discuss three additional cases of bacteraemia, likely to be associated with drainage issues in Ward 2A. As of 27th September, six additional cases had been identified.' Mentions ward move, dosing, remediation. https://www.nhsggc.org.uk/media/251900/item-3-nhsggc-m-1805.pdf **[A36629298 - Bundle 37, Document 52, Page 687]** **HAIRT** Detailed discussion of infections, numbers and remediation including decanting. https://www.nhsggc.org.uk/media/250807/item-16-hairt-18_52.pdf **[A36690576 - Bundle 52, Volume 3, Document 33, Page 202]** 19.10.18 **Water Review Group (Technical)** 2A/B works discussed.  Minutes 19.10.18.docx **[A36407749 - Bundle 10, Document 28, Page 110]** 26.10.18 **Acute Infection Control Committee**: Discusses ward 2A/B decant in detail including works planned. QEUH water dosing update given.  Draft AICC Minutes of 26 October 2018.d

	[A36690459 - Bundle 13, Document 18, Page 137]
November 2018 **IMTs and HPS/Scottish Government communications continue.**	9.11.18 **Water Review Group (Technical)**  Minutes 09.11.18.docx **[A36407737 - Bundle 10, Document 30, Page 116]** Water dosing, 2A/B works, HPS report. 12.11.18 **South Sector Facilities Infection Control Group** RHC/QEUH works discussed including negative pressure rooms, chlorine dioxide dosing, 2A/B taps/sinks.  Minute 12.11.18.doc **[A36407738 - Bundle 52, Volume 3, Document 36, Page 231]** 12.11.18 **Acute Clinical Governance Committee** South Sector update notes impact of chlorine dioxide dosing on QEUH. Women's and Children's Directorate update notes ongoing investigations and resulting decant of RHC wards 2A and 2B.  1 2 - ACG Minutes November - Approve **[A36407722 - Bundle 52, Volume 3, Document 37, Page 234]** 16.11.18 **Water Review Group (Technical)** Chlorine dioxide dosing, 2A/B works, HPS report.  Minutes 16.11.18.docx **[A36407746 - Bundle 10, Document 31, Page 121]** 23.11.18 **Water Review Group (Technical)** Chlorine dioxide dosing, 2A/B works  Minutes 23.11.18.docx

	[A38668862 - Bundle 10, Document 32, Page 123]
December 2018	10.12.18 **Water Review Group (Technical)** Chlorine dioxide dosing, 2A/B works, HPS report.  Minutes 10.12.18.docx **[A36407739 - Bundle 10, Document 34, Page 131]** 10.12.18 **Acute Clinical Governance Committee**: Women's and Children's Directorate update notes 2A 'decant arrangements' may be prolonged by need for ventilation works.  1 2 - ACG Minutes December - APPROVE **[A36407723 - Bundle 52, Volume 3, Document 40, Page 258]** 11.12.18 **Clinical and Care Governance Committee** Discussion of water situation. https://www.nhsggc.org.uk/media/252957/item-11-ccg_m_18_04-tbr.pdf **[A51535586 - Bundle 38, Document 9, Page 60]** 18.12.18 **Full Board** https://www.nhsggc.org.uk/media/252972/item-3-nhsggc_m_-1806-tbr.pdf **[A51851755 - Bundle 42, Volume 4, Document 63, Page 1313]** **HAIRT**: Detailed list of remediation of water systems (under Outbreaks). https://www.nhsggc.org.uk/media/251908/item-13-paper-18_63-hairt.pdf
	[A36690592 - Bundle 52, Volume 3, Document 42, Page 268] 20.12.18 **Acute Strategic Management Group** 'Mr Hill noted that Wards 2a and 2b had been relocated to Ward 6a at QEUH due to the ongoing water issue. It was likely that this would remain the case for up to 12 months. Mr Hill noted thanks to colleagues for their ongoing support in relation to this matter.'  Item 12a - SMG_M_18_12.docx

	[A36407728 - Bundle 52, Volume 3, Document 43, Page 293] 20.12.18 **Water Review Group (Technical)** Chlorine dioxide dosing, 2A/B works  Minutes 20.12.18.docx **[A36407750 - Bundle 10, Document 35, Page 134]**
January 2019	31.1.19 **Acute Strategic Management Group**: 'Mr Hill advised that the Haemato-oncology inpatient ward 2A & day care ward 2B had initially moved from RHC to QEUH ward 6A and Bone Marrow Transplant (BMT) to ward 4B. Following concern about shower mould the ward 6A patients had been temporarily relocated to RHC in the Clinical Decisions Unit (CDU). The CDU therefore was consequently decanted to the empty ward 2A.'  Item 12b - SMG_M_19_01.docx **[A36407733 - Bundle 52, Volume 3, Document 52, Page 343]**
February 2019	19.2.2019 **Full Board** **HAIRT**: Noted that RHC water incident is HIIAT AMBER since 28.9.19 with no new cases associated with water since September 2018. HPS, HFS and international experts consulted as to remedial actions and continuous chlorine dioxide water treatment system installed in RHC. https://www.nhsggc.org.uk/media/252956/item-10-paper-19_04-hairt.pdf **[A39913795 - Bundle 52, Volume 3, Document 58, Page 374]**
March 2019	5.3.19 **Care and Clinical Governance Committee** Discussion of HPS water report of December 2018 (*https://www.gov.scot/publications/qe-university-hospital-royal-hospital-children-water-incident/*) . **[A33448003 - Bundle 7, Document 2, Page 32]** https://www.nhsggc.org.uk/media/255419/item-13a-ccg-m-19_01-final.pdf **[A51535580 - Bundle 38, Document 10, Page 71]**

April 2019	16.4.2019 **Full Board** Detailed discussion of HAIRT paper. 'The report provided an update on the water and ventilation system at QEUH and RHC, and Dr Armstrong noted that installation of a continuous (low level) chlorine dioxide water treatment system was now complete and there had been no cases of bacteraemia associated with water since September 2018.' https://www.nhsggc.org.uk/media/254799/item-03-nhsggc-m-19_02-april-2019-tbr.pdf **[A36690610 - Bundle 37, Document 54, Page 718]** **HAIRT** Update on water incident. Incident HIIAT GREEN since February 2019. Notes chlorine dioxide dosing in place for RHC and QEUH, Water Technical Group continuing to meet, point of use water filter still in place, learning points from incidents being shared locally and nationally. https://www.nhsggc.org.uk/media/253878/item-17-paper-19_20-2019_04_nhsggc-hairt.pdf **[A32348957 - Bundle 52, Volume 3, Document 73, Page 517]**

Appendix E

The timeline below details the response to the 2017 October SBAR and the development of the associated Action Plan.

Executive Summary

- In September 2017 Dr Penelope Redding raised concerns with Dr Jennifer Armstrong about infection control in the QEUH/RHC.
- Dr Jennifer Armstrong requested that their concerns be formally documented in an SBAR (Subject, Background, Assessment and Recommendation tool), detailing specific areas of concern so that appropriate actions could be taken. She also agreed to convene a meeting of key staff to discuss concerns and next steps. (*See Item 1 below*.)
- In response, Doctors Christine Peters, Penelope Redding and [redacted] (and not Dr Teresa Inkster) (the "Consultant Microbiologists") drafted an SBAR re Infection Control and Patient Safety at QEUH/RHC dated 3 October 2017 (the "October 2017 SBAR"). (*See Item 2 below*.)
- A meeting was convened as a matter of urgency on 4 October 2017 with the Consultant Microbiologists, Senior Directors and Senior Clinicians of GGC. (S*ee Item 3 below*.)
- Many of the various issues raised within the October 2017 SBAR and discussed at this meeting had already been identified and were in progress prior to the submission of this SBAR. (*See minutes of meetings below*. *Further information is available on request*.)
- A 27 Point Action Plan (the "Action Plan") was developed to address each of the separate issues raised.
- Regular meetings of the following committees were convened to discuss and progress the Action Plan:
    - Board Infection Control Committee (BICC);
    - Clinical and Care Governance Committee (CCGC);
    - Acute Infection Control Committee (AICC);
    - Board Clinical Governance Forum; and
    - Partnership Infection Control Support Group.
- The concerns raised in the October 2017 SBAR were thoroughly investigated and actions taken in respect of each separate issue.
- The October 2017 SBAR and Action Plan were signed off as being complete on 1 September 2021. (See email at Item 17 below.)

2017 Infection Control SBAR Governance Timeline

Item	Date	Document(s)	Notes
1.	28.9.17	 FW Invitation to meeting from Pamela **[A38759263 - Bundle 14, Volume 1, Document 73, Page 722]**	Email from Dr Armstrong to Dr Redding suggesting a meeting on 3rd of October and asking Dr Redding for an SBAR in advance of the meeting setting out the areas of concern
2.	3.10.17	 FW Infection Control Meeting - 4 **[A38759259 - Bundle 52, Volume 3, Document 1 and 1.1, Pages 8-9]** **[A38694873 - Bundle 4, Document 20, Page 104]**  3rd October email from PR to JAmsg **[A38759263 - Bundle 14, Volume 1, Document 73, Page 722]**  SBAR RE Infection Control and Patient S **[A38694873 - Bundle 4, Document 20, Page 104]**	Email invitation sent to stakeholders to attend meeting to discuss SBAR Email sent by Dr Redding to Dr Armstrong SBAR received by Dr Armstrong - SBAR was compiled by Drs Redding, Peters and [redacted] (Consultant Microbiologists) (and not by Teresa Inkster) regarding concerns over infection control issues at QEUH and RHC. SBAR is summarising emails sent by Drs Redding and Peters to Dr Armstrong and has been referred to as a 'whistleblowing' SBAR. Themes within it: • Positive Pressured Ventilated Lobbied (PPVL) Isolation Rooms. • Royal Hospital for Children (RHC) – Protective Isolation – Haematology Oncology Unit. • RHC – HEPA filters in Paediatric Intensive Care Unit (PICU). • Queen Elizabeth University Hospital (QEUH) – Ward 4B – Upgrade to the Haematology Ward. • Single Room Specification and Location of Areas that can be used for Protective Isolation. • Cleaning of QEUH, RHC and Office Block • Cleaning of Dishwashers in QEUH and RHC linked to a potential outbreak of exophiala • Water Quality and Water Testing • Plumbing in the Neurosurgical Block • Decontamination of Respiratory Equipment • Structure of the Infection Prevention and Control Team

3.	4.10.17	Infection Control Issues 041017.pdf **[A38759279 - Bundle 27, Volume 6, Document 2, Page 22]**	Meeting chaired by Dr Jennifer Armstrong - content of SBAR above discussed in detail with input from Infection Control and Estates Directors, Senior Managers and Clinicians. Included with papers for the Board Infection Control Committee (BICC) held on 27/11/2017. This Committee was chaired by the Medical Director, and provides leadership and support to the IPC services.
4.	27.11.17	BICC Agenda 27.11.17.docx **[A38759266 - Bundle 52, Volume 3, Document 5, Page 42]** Item 2 - Ward 2A Update for BICC Nove **[A49401474 - Bundle 27, Volume 8, Document 14.1 Page 74]** Minutes of BICC 27-11-17.doc **[A32221779 - Bundle 13, Document 48, Page 349]**	Board Infection Control Committee Meeting on 27/11/ 2017 Paper (Item 2 on the agenda) presented by David Loudon and Jen Rodgers providing an update on Ward 2A
5.	5.12.17	08 - Infection control1724.pdf **[A38759270 - Bundle 20, Document 48, Page 792]** 00 - Clinical Care Committee Agenda.d **[A38759250 - Bundle 52, Volume 3, Document 3, Page 18]** 03 - CCG(M) 1704 APPROVED.pdf **[A51535581 - Bundle 38, Document 5, Page 30]** 03 - NHSGGC(M) 1801.pdf	Clinical and Care Governance Committee (CCGC) held on 5th December 2017. Paper 17/24 refers to the Infection Control meeting (held on 04/10/2017) and associated Action Plan addressing each issue raised; presented and discussed at agenda item 8 at CCGC meeting; and actions taken approved by meeting. CCGC held 5 December 2017 notes *"Committee were advised that there has been a series of issues raised by a small number of microbiologists"* [CCGC minute noted at Board meeting 20/02/18]

		[A38759238 - Bundle 42, Volume 4, Document 58, Page 1088]	
6.	31.1.18	 Item 13 - Minutes of BICC 31-01-18.pdf **[A38759245 - Bundle 13, Document 49, Page 356]**  BICC Agenda 31.01.18.pdf **[A38759237- Bundle 52, Volume 3, Document 6, Page 43]**	Board Infection Control Committee item 7.3 – BICC received and discussed paper 17/24 as above.
7.	13.3.18	 FW Email from TI to CP and AD on progre **[A38759280 - Bundle 52, Volume 3, Document 12, Page 64]**  AICC paper.rtf **[A36591655 - Bundle 27, Volume 4, Document 5, Page 61]**  Email 13th March 2018.doc **[A38759221 - Bundle 52, Volume 3, Document 7, Page 44]**	Email from Dr Inkster to Drs Peters, Redding and [redacted] regarding SBAR – attaches paper dated 05.03.18 with Action Plan noting that seen by BICC and CCGC and due to be reviewed by AICC (Action Plan substantially same as that discussed in meetings above, slight emphasis change re item 1). Response from Dr Peters to Dr Inkster to the above email.
8.	28.3.18	 Item 13 - Minutes of BICC 28-03-18.pdf **[A38759228 - Bundle 13, Document 50, Page 364]**  BICC Agenda 28.03.18 - amend **[A38759224 - Bundle 52, Volume 3, Document 10, Page 53]**	Board Infection Control Committee – Update to Action Plan: Dr Inkster indicated that a paper concerning air changes as per item 17 on the Action Plan has been sent to microbiologists and Acute Infection Control Committee.

9.	27.4.18	 Item 2 - AICC Minutes of 27 April 20 **[A38759215 - Bundle 13, Document 15, Page 111]**  AICC Agenda - 27 April 2018.pdf **[A38759213 - Bundle 52, Volume 3, Document 14, Page 89]**	Acute Infection Control Committee meeting item 19 – paper 17/24 discussed.
10.	5.3.19	 Item 00 - CCGC Agenda 05.03.19 fina **[A38759212 - Bundle 52, Volume 3, Document 74, Page 543]**  Item 9a - Paper 19_05 - QEUH RHC re **[A38759147 - Bundle 38, Document 12, Page 89]**  Item 9b - Appendix 1 SBAR Action Plan 15t **[A49401499 - Bundle 27, Volume 8, Document 48.1, Page 172]**  Item 03 - DRAF CCG(M)19_02.p **[A36591693 Bundle 27, Volume 4, Document 10, Page 106]**	Updated Action Plan from 2017 SBAR with position as at January 2019 presented and discussed at item 9 at CCGC meeting; in compliance with item 12 of issues raised from HEI inspection. Actions taken approved by meeting. [CCGC minutes noted and discussed at full Board meeting 16/04/19] CCGC Minute of 11/06/2019 approves Dr Inkster's requested revisions to the 05/03/2019 minute.
11.	12.3.19		AICC meeting item 19 – cover report and updated Action Plan shared as above.

		 AICC Minutes 12 03 19.pdf **[A38759166 - Bundle 13, Document 20, Page 152]**  AICC Agenda - 12 March 2019.pdf **[A38759183 - Bundle 52, Volume 3, Document 77, Page 579]**	
12.	14.3.19	 Item 6.4 - PICSG Minutes 140319.pdf **[A38759192 - Bundle 52, Volume 3, Document 61, Page 429]**  Item 19D - Appen 1 SBAR Action Pla **[A49401499 - Bundle 27, Volume 8, Document 48.1, Page 172]**  Item 19D - Pape 19_05 - QEUH RH **[A38759147 - Bundle 38, Document 12, Page 89]**	Partnership Infection Control Support Group meeting – cover report and updated Action Plan as above shared (item 11.2). *NB CCGC meeting mentioned at item 11.2 was convened in March not February as noted.*
13.	25.3.19	 Item 2 - Minutes of BICC 25-03-19.pdf **[A36690476 - Bundle 13, Document 56, Page 407]**  BICC Agenda 25.03.19.pdf **[A38759157 - Bundle 52, Volume 3, Document 62, Page 435]**	BICC item 18 notes cover report and updated Action Plan as above. *NB CCGC meeting mentioned at item 18 was convened in March not February as noted.*

		 Item 4 - Paper 19_ - QEUH RHC repo **[A38759147 - Bundle 38, Document 12, Page 89]**	
14.	8.4.19	 Item 15b - BCGF April Minutes.pdf **[A38759154 - Bundle 52, Volume 3, Document 76, Page 570]**  Agenda and Pape BCGF - April 2019 **A38759217** • **Pages 1-2 [A53721950 – Bundle 52, Volume 3, Document 67, Page 466]** • **Pages 3-12 [A53721954 - Bundle 52, Volume 3, Document 53, Page 349]** • **Page 13 [A53721955 - Bundle 52, Volume 3, Document 83, Page 597]** • **Page 14 [A53721995 - Bundle 52, Volume 3, Document 55, Page 369]** • **Page 15 [A53721981 - Bundle 52, Volume 3, Document 35, Page 230]** • **Pages 16-17 [A53721979 -**	Updated Action Plan and cover report as above presented at Board Clinical Governance Forum item 4(e).

		Bundle 52, Volume 3, Document 57, Page 373] • **Pages 18-21 [A53721951 - Bundle 52, Volume 3, Document 84, Page 598]** • **Page 22 [A53721977 - Bundle 52, Volume 3, Document 60, Page 428]** • **Pages 23-24 [A38759147 - Bundle 38, Document 12, Page 89]** • **Pages 25-37 [A49401499 - Bundle 27, Volume 8, Document 48.1, Page 172]** • **Pages 38-60 [A53721953 - Bundle 52, Volume 3, Document 63, Page 437]** • **Pages 61-73 [A53721952 - Bundle 52, Volume 3, Document 45, Page 304]** • **Pages 74-86 [A53721994 - Bundle 52, Volume 3, Document 46, Page 317]** • **Pages 87-88 [A53721996 - Bundle 52, Volume 3,**	

		Document 64, Page 460] • **Pages 89-90 [A53721980 - Bundle 52, Volume 3, Document 68, Page 468]** • **Pages 91-92 [A53721978 - Bundle 52, Volume 3, Document 65, Page 462]** • **Pages 93-94 [A53721982 - Bundle 52, Volume 3, Document 66, Page 464]**	
15.	15.4.19	 1 2 ACG Minutes 15 04 19 (2).docx **[A38759151 - Bundle 52, Volume 3, Document 71, Page 482]**  00 April Agenda.docx **[A38759136 - Bundle 52, Volume 3, Document 70, Page 481]**  4e Appendix 1 SBAR Action Plan 15th Fe **[A38759147 - Bundle 38, Document 12, Page 89]**	Updated Action Plan presented and discussed at Acute Clinical Governance Committee (item 4).
16.	March 2021	 NHS GGC and QEUH Oversight Boa **[A33448010 - Bundle 6, Document 36, Page 795]**	Oversight Board Report published in March 2021 with paragraph 127 stating *"The Oversight Board has been informed that work has been substantially completed on the action plan, but the most recent version of the action plan seems to be dated to January 2019 (with several actions shown*

			as still in progress); a further update (and closure) of the action plan should be put forward and reviewed by the Clinical and Care Governance Committee".
17.	08.06.21	 Item 00 - Agenda CCGC Jun 2021.pdf **[A38759131 - Bundle 52, Volume 3, Document 80, Page 587]**  item-15c_paper-21-36_cccg-chairs-repo **[A38759134 - Bundle 52, Volume 3, Document 79, Page 584]**  Item 9b_SBAR Action Plan.docx **[A38759230 - Bundle 4, Document 51, Page 220]**  Re Action from Clinical and Care Gow **[A49401499 - Bundle 27, Volume 8, Document 48, Page 167]**  Item 03 - CCGC (M) 21-01-V2 APPROVED. **[A51535606 - Bundle 38, Document 21, Page 159]**	Updated Action Plan presented and discussed at Clinical and Care Governance Committee on 8th June 2021 (Paper 21/06)-. Committee asked to note that 26/27 actions now completed and one action technically impossible. Chairs Board report of meeting dated 29 June 2021 attached. Under Section 3.5, Committee approved the closure of the Action Plan subject to some further narrative on three actions. Email sent to Chair and Vice Chair of CCG with update of requested action on points 3, 17 and 24 from secretariat and from Director of Clinical and Care Governance. SBAR signed off as being complete on 01/09/2021