Scottish Hospitals Inquiry
Witness Statement of
Jonathan Best

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. Jonathan Best retired March 2022. In my final post I reported directly to the Board Chief Executive. The posts I held within GGC are as follows:
Chief Operating Officer January 2019 to 31st March 2022. Direct report to Board Chief Executive.
Interim Chief Operating Officer 2016 to December 2019. Direct report to Board Chief Executive.
Director North Sector April 2015 to December 2016. Direct report to Chief Operating Officer.
Director of Regional Services 2014 to April 2015. Direct report to Chief Operating Officer.
Chief Executive Yorkhill NHS Trust February 2000 to April 2014. Direct report to Trust Chair and Trust Board.

2. Please explain how your roles and responsibilities in NHS GGC related to the delivery of adult services, paediatric services and the IPC Team.

A. In my last role I was responsible for the delivery of all Acute Services within NHS GGC. The Chief Operating Officer has 5 Directors with teams running all the acute hospitals providing acute care 24/7. It is an operational role running

all acute clinical services across GGC. The COO reports directly to the Board Chief Executive and is part of the Strategic Management Team and the NHS Board and its various sub committees. The IPC team did not report to me. Clinical staff within Acute Services worked alongside IPC colleagues as they provided specialist advice on a day to day basis.

Governance Reporting Structures within NHS GGC

3. During your time at NHS GGC please 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. I was not involved in the procurement process for the new hospitals and therefore cannot provide an explanation of the governance structures and reporting lines to the Board in respect of this process. Project Management Team members along with technical staff were responsible for water and ventilation system procurement following national guidance at the time. Any changes or issues would be taken through the appropriate governance group as noted in the published structure.

4. Please 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. The new hospital Project Team established a governance/meeting structure, which reported into the Board Governance structure as published. I am not aware of any informal groups involved in decision making.

5. How is it decided which issues, decisions and reports would be escalated to the full Board or one of the first line of subordinate committees?

A. I was not involved in deciding which issues, decisions and reports were escalated regarding the procurement. A progress and reporting process was established to review progress and deal with issues and changes. Governance arrangements to escalate any issues through the agreed governance structures would be in place. As far as I am aware regular reporting to the NHS Board or relevant sub committees would be in place.

6. What procedures were put in to ensure all significant questions about the issues listed in Question 2 were being taken to the Board or one of first line of subordinate committees, discussed and actioned?

A. I refer to my answer to question 5. Alongside the Project governance process the management structure within Acute Services remained in place as well as the clinical professional reporting lines.

7. 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. All progress was reported through the agreed, established Board governance structure.

a) At any time prior to your appointment as Director of Regional Services were you informed that a decision has been made to procure the new SGH with a ventilation system that supplied air at half the rate than that called for by Scottish Government Guidance?

A. No, I was not involved in the procurement process.

Handover, Commissioning and Validation

8. Describe the Infection Prevention and Control (IPC) input, if any, in respect of critical ventilation. What was the process for obtaining input, who from IPC was involved. Describe the IPC involvement of signing off on critical ventilation. What was the process, who from IPC signed off on critical ventilation, when, and by whom. Was there an audit trail of IPC involvement and sign off, if so, where would this have been kept?

A. I was not involved in this issue during procurement and so do not have requisite knowledge of this matter.

9. In respect of commissioning and validation how were you satisfied the appropriate commission and validation in respect of the water and ventilation system had been carried out? Who provided you with these assurances and when? What concerns, if any, did you have regarding commissioning and validation being carried out prior to handover?

A. I am not able to answer this question, as I was not involved in the commissioning and validation process.

a) Was the energy centre commissioned prior to NHS GGC taking occupation of QEUH? If so, describe what you know about the commissioning of the energy centre. Provide details of the intricacies in relation to its completion/

A. This was not my remit or area of responsibility.

b) The Inquiry understands that NHS GCC decided to forgo the requirement to have an independent commissioning engineer. Who made this decision? What was the impact, if any, of this decision? In hindsight, do you think that it was the correct decision?

A. I was not involved in this decision as it was not part of my remit or responsibilities. This issue would have been within the remit of the Project Team.

c) The Inquiry understand that no validation was carried out in respect of the ventilation system. When did you become aware of this? How did handover come to be accepted without the ventilation system being validated? Who was responsible for this and who signed off on this?

A. I was not involved in this issue and it was not part of my remit.

10. Describe your role in the lead up to accepting handover.

a) At the point of handover, how satisfied were you that all areas of QEUH/RHC accepted by NHS GGC, were designed to the intended specification and suitable for the intended patient cohort, meeting all the relevant guidance requirements?

A. The Project Management Team along with relevant clinical and technical staff worked with operational staff to ensure areas being handed over were ready for occupation.

b) How were you assured that the wards met the requirements of the specific patient cohorts?

A. See answer 10a.

c) Were any wards not handed over, or only partially handed over, please confirm. If so, why they were they held back? Was there any financial consequence to both Multiplex and NHS GGC of the ward(s) being held back? What works were carried out in order to allow this ward(s) to be handed over to the NHS GGC?

A. This was not in my remit.

11. Was an HAI-SCRIBE assessment carried out at any point regarding the proposed site development, design and planning and new construction of the new SGH (including at the time of completion)? If not, why not?

A. This would be the responsibility of ICT colleagues working with the new hospital Project Team.

Beatson/Adult BMT

12. The Inquiry is aware the adult BMT service was to transfer from the Beatson to the QEUH as noted in the meeting minutes from the Quality and Performance Committee dated 2 July 2013 (**Bundle 34, Document 62, Page 542**). This was confirmed in a change order request, issued by you in July 2013 (**Bundle 16, Document 29, Page 1699)**. Please provide details in respect of the following:

a) What risk assessments/ HAI Scribes were carried out prior to the change order request?

A. Risk assessments and HAI Scribes would have been provided by ICT, nursing and local operation managers working with the new hospital Project Team.

b) What were the technical and environmental requirements (in particular air change rates, pressure regimes and HEPA and air permeability requirements) to accommodate the BMT Unit at QEUH/RHC?

A. This information would have been provided by technical, clinical and ICT colleagues.

c) Your attendance and involvement in any design review meetings which were held to confirm with the user groups the requirements for the BMT Unit.

A. I would have attended meetings within the Board Governance structure. In general terms there were multiple meetings and I, along with other senior leaders attended to receive updates and progress reports as well as contribute to any discussions and debates. I do not recall any involvement in detailed design review meetings.

d) Discussion with Multiplex regarding the proposed change order and the impact on Air Change Rates and Pressure Differentials?

A. I was not involved in discussions with Multiplex on this issue

e) Involvement with Infection Prevention and Control in respect of the proposed change order?

A. I was not involved in technical discussions as this was not in my remit.

f) What ceiling types were specified and approved for use in Ward 4B? Who from the GGC Project Team approved this? Describe your involvement, if any? What was the impact, if any, of the choice of ceiling tiles? What concerns, if any did you have regarding the choice of ceiling tiles?

A. I was not involved in the choice of ceiling tiles.

g) What concerns, if any, did you have regarding the final design specification of Ward 4B, and what action, if any, did you take in respect of these concerns?

A. Any concerns would have been raised through relevant groups and via the operational line management structure.

h) Whether at any time you were told by anyone that the ventilation system already planned for the hospital would not be able to provide 10 air changes per hour within the proposed adult BMT ward?

A. Any issues would have been raised through the Project Management structure and discussed at relevant governance meetings.

13. To what extent did discussion of the proposed addition of an adult BMT ward in the QEUH consider the application of the specification for air change rate, pressure differentials and requirement for HEPA filtration set out for a 'Neutropenic Ward' in SHTM 03-01 ventilation for Healthcare Premises?

A. Any technical requirements would be dealt with through the appropriate new hospital Project Team working with local operational teams, which would then inform any proposals for discussion at the appropriate management group.

14. The Inquiry is aware that the change order not only confirmed that the Bone Marrow Transplant (BMT) service would transfer to Ward 4B in the QEUH but also that the haematology patients that were originally planned to accommodate Ward 4B would move to Ward 4C.

a) Describe how this change was communicated to the project team and Multiplex and how this change was captured in the design and specification documentation.

A. I am unable to answer this question.

b) To what extent was there discussion at this time as to whether the specification for air change rate, pressure differentials and requirement for HEPA filtration set out for a 'Neutropenic Ward' in SHTM 03-01 ventilation for Healthcare Premises might now apply to Ward 4C is accommodating haematology patients who might well be neutropenic?

A. I was not involved in the technical discussions as this was out with my remit.

c) When did you first become aware of the issues identified within Ward 4B in June 2015?

A. I am unable to recall as I was working in the North Sector at that time.

15. Patients migrated to Ward 4B in June 2015 however less than one month later they returned to the Beatson. The issues identified were present at the point of handover in January 2015, please explain why the ward was signed off and handover accepted given the issues which arose shortly thereafter.

A. I was not involved in signing off the ward nor was I involved in the handover.

16. At a BICC meeting on 27th July 2015 Professor Craig Williams states that in respect of ward 4B "*the unit was not built to the correct specification and Brookfield have agreed to fund the rebuild for this area and the timeframe for this is 12 weeks*". Please discuss this statement.

A. I am unable to comment on this statement as I was not involved in the specification work referred to.

a) Were the issues with Ward 4B discussed with the Board?

A. I assume any issues would be raised through the new hospital Project Management governance structure then through the appropriate Board governance structure.

b) What concerns did the Board have in respect of these issues?

A. I am unable to answer this question.

c) What steps were taken by the Board to address these?

A. I am unable to answer this question.

d) What steps did you/the Board take to ensure these were sufficiently addressed?

A. I am unable to answer this question.

e) With reference to your answer to question 9 in your May 2025 draft statement and, in its most recent Glasgow 4, Part 1 hearing in May 2025, the Inquiry heard evidence about the absence of formal Validation of the ventilation systems of the new SGH prior to occupation of the hospital by patients. It appears that members of the NHS GGC Project Team may not have understood the difference between 'commissioning' a ventilation system to confirm it has been fitted in compliance with the contract and 'Validation' of a ventilation system to confirm that it operates as its users expect it to. Do you have an understanding of the difference between 'commissioning' a ventilation system and 'Validation' of a ventilation system and can you assist the Inquiry in understanding why the ventilation system of the RHC including specialist ventilation areas such as isolation rooms and haemato-oncology wards were not validated before patient occupation?

A. I understand the difference as stated in the question. I was not involved in the commissioning or validation of the ventilation system. This was not part of my remit.

f) With reference to your answer to Question 10(a) of your statement of May 2025 how did you ensure that on the arrival of transplant patients in Ward 4B on 6 June 2025 that ventilation system for both the ward as a whole and the BMT isolation rooms in particular was operating on accordance with the standards then set down in SHTM 03-01 or that there was a derogation in place if it was not?

A. I assume the date in question S3 regarding 4B is an error. Before any move of patients to new wards or departments a range of assurances would be provided by the Project Team, along with clinical, estates, ICT colleagues working with the operation team moving into the new facilities.

g) In question 12 if your statement, the Change Order Request for the Adult BMT is discussed (**Bundle 16, Document 29, Page 1699**).

(i) What do you recall in respect of this change order request?

A. The change order came about as a result of national work to centralise Adult BMT services. A plan was produced to demonstrate the need for the change in service.

(ii) As this change order was issued in your name? Do you accept responsibility for it?

A. It was my responsibility to sign the change order along with the Chief Executive due to the Standing Financial Instructions. The decision to create a centralised Adult BMT Service was a collective decision by the Board Chief Executives.

(iii) What advice did you take in advance of issuing it?

A. As stated, a planning proposal including clinical arguments was produced to argue the case for the service.

h) From whom did you seek advice this advice?

A. See previous answers to question 12.

(i) What assurances were you given that this information on technical and environmental requirements was being provided by technical, clinical and ICT colleagues?

A. I am unable to recall if assurances were given.

(ii) What interactions did you have with Multiplex during this time? Did you seek assurances from them in advance of issuing the change order?

A. I had very limited interaction with Multiplex. The Project Team dealt with contractors on a day to day basis, and through the agreed governance arrangements.

(iii) Given you were responsible for issuing the change order what do you recall in respect of communicating these significant changes to Multiplex and the Project Team? If you did not, then who did?

A. The changes would be issued as part of the agreed governance process. The Project Team would be responsible for communicating agreed changes to the contractor given any financial changes would require agreement. I am not aware of any assurances sought from Multiplex. This would be through the interaction between the Project Team and Multiplex.

i) With reference to question 13 of your statement, were you made aware of the technical requirements set out in SHTM 03-01 for air change rates in a neutropenic ward?

A. I do not recall being made aware of the technical requirements set out in SHTM 03-01. This would be the responsibility of the technical team.

Water Incident in 2018 and DMA Canyon Reports

17. Before NHS GGC took responsibility for the QEUH/RHC building in January 2009 were you aware of the requirement for a L8 Pre-occupation Risk Assessment? When did you first become aware of the recommendations of the DMA Canyon Report 2015 L8 Risk Assessment, see **(Bundle 6, Document 29, Page 122**) and why?

A. I was not aware of the DMA Report until 2017/18.

18. The QUEH/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 (**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? Given these Horne taps were used in the new SGH what was reported to you as Chair of NHS GGC about this issue and specifically what steps were being taken after handover to ensure that these taps were being used safely and without build-up of biofilm?

A. This question is directed to the then Chair of GGC.

19. Please refer to **Bundle 13, Document 132, Page 921**. The Inquiry understands you were involved in a Short Life Working Group known as the "external review" following the discovery of the DMA Canyon Reports. When and by whom was this review established, who was involved in this review, what was your role in this review, what investigations were undertaken and what were the relevant outcomes following this review? What actions, if any, were taken following the outcomes of the review?

A. I was asked by the Board Chief Executive to oversee the implementation of an action plan to ensure the recommendations of the DMA Report were fully implemented. My role was to ensure the recommendations were implemented at pace and I chaired a small group which met frequently to monitor progress. I recall that separate investigations into the reasons why the reports were not implemented were commissioned by the Chief Executive.

20. The Inquiry understands you were also involved in the Executive Water Group which was set up to include yourself, Mary Anne Kane and Jane Grant. What can you tell us about the role of this group, who was involved, what was the extent of your role in the group and details of any relevant outcomes from its work?

A. I refer to my answer to question 19. The main outcome was the monitoring of progress to ensure the actions were fully implemented and a Responsible Person/engineer was identified for water, which was a key recommendation.

21. What was your role in communicating with patients and families in respect of the issues which arose with the water system at the QEUH?

A. I received daily updates from the Director of Women and Children's Services along with his senior colleagues – the General Manager and Chief Nurse for Women and Children's Services. I visited the wards and departments and spoke to clinicians and nursing staff and also parents where possible. The Women and Children's senior team made sure they were available to speak to parents and staff and undertook daily visits to the ward. This was also undertaken in the evenings and at weekends to accommodate families.

22. What was your role in respect of communicating with the Scottish Government in respect of the issues which arose with the water system at the QEUH?

A. Regular updates were provided to SG via the Board Chief Executive.

a) How did you first become aware of the DMA Canyon Reports? As Director of Acute Services what steps did you take to address the concerns raised and to ensure patient safety?

A. I was made aware by the Chief Executive. The actions to address concerns were not within my remit.

b) At question 19 of your statement the "external review" is discussed following the discovery of the DMA Canyon Reports.

(i) Is the "external review" you refer to that conducted by Mr Leiper (**Bundle 8, Documents 34-40, Pages 150-206**)?

(ii) What can you recall about progress made in terms of ensuring the recommendations from the DMA Report were implemented?

A. Yes, the external review was the report conducted by Mr Leiper. The report stated that many of the recommendations had been actioned.

(iii) In undertaking this work what insight did you gain into the reasons behind why these recommendations were missed in the original report?

A. The DMA Report was the responsibility of the Estates and Facilities Directorate. I am not in a position to comment on the details of why the recommendations were missed.

(iv) What is your view on who was responsible for implementing the recommendations of the DMA Canyon Report?

A. See above answer

Decant of Wards 2A/B

23. What involvement did you have in the decision to decant Ward 2A/B to Ward 4B/6A in September 2018? What was your understanding as to why a decant was necessary?

A. In my role as Interim Chief Operating Officer I was involved in assessing the proposed decant options along with other senior leaders. Any proposals would have been developed by the local team, including advice from ICT colleagues and clinical staff managing the patients, all of which would be based on clinical risk and patient safety. Advice from technical estates staff would be part of the process.

24. The Inquiry has the minutes of a meeting from Tuesday 18 September 2018 of what was called the Water Review Meeting of which you attended that appears to have made the decision to decant the patients from Ward 2A (**Bundle 19, Document 35, Page 614**). What was the Water Review Meeting? What was its remit and membership and how often did it meet? Who chaired that meeting of the Water Review Group on 18 September 2018?

A. As I recall, the meeting was called by the Board Medical Director and the aim was to agree what actions were required, taking clinical, ICT and technical estates advise to ensure the safety of our patients.

25. 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 (**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. My understanding of the SBAR was to provide a situation report and proposed actions to ensure the safety of the patient cohort. The SBAR was used to assess the situation and inform decision making.

26. 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. As Chief Operating Officer, I would have received regular communication and updates from the Women and Children's Directorate team, and along with Deputy Medical Director – Acute and Deputy Director of Nursing – Acute review the options presented to us. We would also take advice from ICT and technical colleagues on the best course of action to maintain patient care in a safe environment. It is important to note that we all worked closely together to agree the way forward in challenging circumstances. I am unable to recall my exact involvement in the decision without reference to relevant papers from that period.

27. The Inquiry understands that ward 6A was closed to new admissions at the start of August 2019. Patients were diverted to other centres, including Aberdeen and Edinburgh (**Hearing Commencing 12 June 2023, Bundle of witness statements, James Redfern, Document 7, Page 396, para. 118**). Some were sent further afield (**see Hearing Commencing 12 June 2023, Bundle of witness statements, Dr Jairam Sastry, Document 4, Page 219, para. 127**). The Minutes of the IMT of 1 August 2019 (**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, who made it and who approved it?

A. Any decision to divert patients to other centres would be taken after careful consideration and based on clinical advice. I was involved in the discussions given the magnitude of the decision for patients and their families.

28. 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 by the Chief

Executive or a group of senior managers and executive Board members given the wider service impact of such a move?

A. I was not present at the meeting, however I do not think it is fair to assume that ward decants were decided by the Chief Executive. I am not sure what a group of senior managers refers to. In the case of ward 6A, IMT members, senior clinicians and senior nurses along with Estates colleagues worked together to look at all options for the ward and to deal with any work required to ensure the facility was safe for patients. Given the impact on the hospital and ongoing review of the environment it was appropriate to seek senior sign off by the Chief Executive.

29. What steps were taken to ensure that ward 6A was safe to reopen for admissions before the decision was made to re-open the ward for admissions?

A. A number of steps are required before a ward can reopen for patients. Estates, cleaning and microbiology work are key requirements, along with staffing. Daily updates would be provided to senior clinicians and managers. Infection Control will recommend a ward can reopen.

30. Dr Gibson alongside other clinicians wrote to both Jane Grant 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, (**Bundle 6, Document 43, Page 1416**) to which they responded September 2019 (**Bundle 8, Document 17, Page 85**). The Inquiry understands that on 2nd September 2019 you, alongside Dr Scott Davidson, met with the clinicians. What do you recall in respect of this meeting? Who attended? What was discussed? What was the outcome of this meeting?

A. I am unable to recall the precise details of the meeting. Senior clinicians attended along with members of the Women and Children's Directorate senior leadership team. We met to listen to the clinicians concerns and to ensure that actions were underway to resolve any issues. We discussed all the issues and

also wanted to ensure that ongoing communications were in place for clinicians and staff.

31. 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 (**Bundle 6, Document 25, Page 77**) and do you consider it accurate in all respects?

A. I was involved in the final draft. The issues were wide ranging and required information from a number of sources. I believe the response was detailed and accurate.

a) With reference to question 24 of your statement, what were the proposed decant options? Which option did you proceed with and why? You may wish to refer to Mr Redfern's Options Appraisal of 17 September 2018 (**Bundle 6, Document 13, Page 38**).

A. Mr Redfern along with clinical, nursing and operational colleagues prepared a detailed options appraisal proposal for the decant of wards 2A/B for the Director of Women and Children's Services. Advice from a range of experts including estates, technical, microbiology and ICT was sought to inform the options. Following debate and discussions with senior colleagues the decant option was agreed based on patient safety and service continuation.

b) With reference to question 24 of your statement, what was your role in the Water Review Group? What responsibilities sat with you?

A. I was invited to the meeting in my management role. I do not recall having any actions from this meeting.

c) With reference to question 24 of your statement was there any member of the Water Review Group who had professional expertise in IPC or microbiology? If not, who was providing you, as Chair of the group, with advice on the microbiological impacts of decisions in response to the water incident and potential environmentally related infections in the Schiehallion Unit?

A. I was not the chair of the Water Review Group, the Board Medical Director chaired the group. I attended the meeting in my role as interim Chief Operating Officer given the implications of maintaining a safe service for patients. I understand that Infection Control were present at the meeting.

d) With reference to question 25 of your statement, did you agree with the conclusions and recommendations of this SBAR?

A. The SBAR was produced to provide details of the current situation and is commonly used within the NHS in Scotland. I am not qualified to comment on technical or clinical aspects but in general the SBAR is a fair reflection of the situation.

e) From everything that YOU are aware of relating to the water incident, was it the right decision to decant patients from Wards 2A and 2B to Wards 6A and 4B?

A. At the time of the water incident everyone was working tirelessly to ensure patients remained safe. Clinician concerns and IPC/microbiology work indicated that action was required to ensure patient safety and maintain services. Multiple discussions took place with many clinicians and managers to consider the way forward. The consensus was that a decant was the best option.

f) What was wrong with Ward 2A and 2B when the decision was made to decant the patients to Wards 6A and 4B in September 2018?

A. I am not qualified to answer this question.

g) What was wrong with Ward 6A when the decision was made to decant the patients to the CDU in January 2019?

A. I am not qualified to answer this question.

h) What was wrong with Ward 6A when the decision was made to stop receiving new admissions in August 2019?

A. I am not qualified to answer this question. Any decision to stop receiving admissions would be carefully considered by the senior clinicians treating the patient cohort with advice from Infection control and Microbiology colleagues.

Cryptococcus

32. What was your role in respect of communicating with i) patients and families in respect of cryptococcus infections and ii) the Scottish Government?

A. As Chief Operating Officer I was involved in responding to complaints or queries, also any meetings with relatives. Communication with SG would in general go through the Chief Executives Office.

33. Please refer to **Bundle 27, Volume 13, Documents 5, Document 6, Document 7 and Document 8, from Page 26**. The Inquiry understands a meeting took place on 30th September 2020 with Beth and Sandie Armstrong, which you attended, in respect of the Significant Clinical Incident Report of 28 April 2020 following their mother's death. What do you recall in respect of this meeting? What concerns were raised? At Document 6, page 34 they state, "confidence in the management of QEUH is now so damaged it has become very distressing to engage with it". Is this an accurate statement in terms of the management of the QEUH? If not, why not? Were the concerns raised by the Armstrong's valid?

A. I recall the meeting with Beth and Sandie Armstrong. Meetings with relatives are sensitive, especially following the death of a loved one. The Armstrong family raised a number of issues, which we tried to respond to and in particular Dr Hart was present as the Consultant who cared for their mother. I recall he was able to describe in detail the illness and the clinical aspects of their late mothers infection. It was particularly difficult at the time due to the many hypotheses regarding potential sources of infection surrounding the hospital.

34. In your letter of 13th October 2020, you write to Ms Armstrong acknowledging her concerns and apologise? On reflection how might this have been dealt with differently?

A. I believe it is important to meet families who have concerns and I also think it is important to apologise to relatives who raise concerns. In hindsight I am sure some aspects of the interaction with Ms Armstrong could have been handled differently. It was important to provide accurate information to Ms Armstrong and I hope the meeting helped explain the clinical issues regarding their late mother.

35. 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 am not qualified to comment on this question.

36. Why and how was the Cryptococcus Subgroup set up and who was chosen to serve on it and why? How were you and the Board provided with updates from the work of the Cryptococcus IMT and the Cryptococcus Subgroup?

A. I am unable to recall who established this group.

37. 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 (**Bundle 14, Volume 2, Document 125, page 455**)?

A. I was unable to open or download Bundle 14.

38. 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 do not believe this to be the case.

a) With reference to your answer to Question 33 do you accept the criticism made by Beth and Sandie Armstrong on 30th September 2020 that,

"confidence in the management of the QEUH is now so damaged it has become very distressing to engage with it" is accurate?

A. I fully understand the criticism from Beth and Sandie Armstrong about the management of the QEUH. It was particularly distressing for the family dealing with their mother's illness and the press speculation about the hospital. I felt it was important to meet with the family along with senior clinicians to listen to their concerns and try to explain the issues relating to their mother's illness. The family had a good relationship with Dr Hart the consultant in charge of Mrs Armstrongs care, and he was able to answer questions about their mother's illness

b) With reference to question 35 in your questionnaire why was it that severely immunocompromised patients who later 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?

A. I am not qualified to answer this question.

c) You have not answered question 35 of your questionnaire. You should be able to source the bundle from our website at **Bundle 14 - Further Communications - Volume 2 of 3 | Hospitals Inquiry**. Once downloaded can you please answer this question.
Question 35: 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 (**Bundle 14, Volume 2, Document 125, page 455**)?

A. I am not able to answer this question. However, I would think that many hypotheses would be considered and narrowed down using the expertise available.

<u>Concerns Raised by Infection Prevention Control Colleagues</u>

39. When did you first become aware of concerns raised by IPC colleagues in respect of the increase of infections in paediatric haemato-oncology patients and risk of the built environment within the QEUH?

A. I am not able to recall when this issue occurred.

40. What awareness did you have of the resignation of Dr Inkster and Dr Peters from their ICD sessions in July 2015 and their concerns about the safety of the water and ventilation systems of the hospital (**Bundle 14, Volume 1, Document 26, Page 414; Bundle 14, Volume 1, Document 27, Page 416-420; and Bundle 14, Volume 1, Document 45, Page 472**)?

A. I was Director for the North Sector at the time and did not have responsibility for QEUH.

41. In November 2015, Dr Peters wrote to Dr Stewart regarding the discovery of Mucor in the paediatric BMT despite ongoing transplants and expressing doubts about the functionality of the PPVL (**Bundle 8, Document 24, Page 121**). What do you recall about this incident? What steps did you take, if any, to address these concerns? Were Dr Peters concerns in respect of the environment justified?

A. I was not responsible for Paediatrics in 2015.

42. 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. NHS GGC like all other NHS Boards in Scotland developed a Board wide whistleblowing policy and promoted the policy via internal communications. Appropriate governance arrangements were established to implement the policy and report to the appropriate Board governance group.

43. Dr Redding and others made a stage 1 whistle blow to Dr Armstrong for which they produced an SBAR (**Bundle 14, Volume 1, Document 75.1, Page 732**)

and a meeting on 4 October 2017 (**see minute at Bundle 14, Volume 1, Document 83.1, Page 753**) which you attended. What do you recall about this meeting? Why did you attend? What action points from that meeting became your responsibility? Was this Stage 1 whistle blow discussed and reported on at Board meetings? What actions were taken in respect of the concerns raised in the whistle blow? How did the 27-point action plan (**Bundle 20, Document 48, Page 792**) come about?

A. I am unable to open or download bundles 14 or 20. I do recall the meeting and it was called by the Board Medical Director as a genuine attempt to bring all parties together to agree a way forward and develop an action plan. An action plan was developed as agreed at the meeting.

44. 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. This statement is a matter of opinion. Personally I believe that staff should raise issues through the agreed line management processes within the NHS Board general management and professional management structures. Line management and professional line management processes need to be followed to ensure resolution or not before other avenues are explored including using the Whistleblowing Policy. In this case I would need to see any relevant papers or emails from Dr Redding and others as evidence that the agreed processes were followed prior to making a decision to invoke the Whistleblowing Policy.

45. What steps were taken by the Board to ensure that the issues raised by Dr Redding and in the Stage 1 whistleblow were addressed by NHS GGC?

A. I was not involved in the Stage 1 process.

46. What was your understanding and involvement, if any, in any subsequent whistleblow during your time at NHS GGC?

A. I was involved in some discussions to try to establish suitable working arrangements within the Laboratory management structure to accommodate all parties.

47. In your view were Dr Peters, Dr Redding and other microbiologists raising valid concerns?

A. In my personal opinion if the issues were raised and escalated via the agreed internal managerial and professional structure many of the concerns would have been dealt with at the time.

48. Please refer to **Bundle 6, Document 22, Page 70**, a meeting took place on 20th August 2019 in which the decision was taken to change the chair of the Gram Negative Bacteraemia IMT. What do you recall in respect of this meeting? What was your understanding as to why this meeting was being called? Why were you invited? Were you aware of concerns in respect of the running of the IMT in advance of this meeting? What is your view on the outcome? Do you think it was fair to make such a decision in Dr Inkster's absence?

A. I attended the meeting and the discussion considered the need to ensure that complex IMTs had the correct membership and admin support to make decisions. The minute clearly details the concerns of some staff attending IMTs and the huge burden on the chair. It was important to ensure that all IMTs were run on an agreed basis with appropriate membership. I was invited in my role as Chief Operating Officer for Acute Services.

49. 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. I do not believe this to be the case. I am happy to review any correspondence regarding any claims that raising issues was not encouraged. In my senior leadership roles I regularly met staff groups, worked with staff side organisations, visited acute sites and ensured communications with staff were a priority. Also, as previously stated a clear general and professional management structure was in place across GGC. As I recall the Board

promoted the Whistleblowing Policy through various forms of communication internally and a senior leader was identified as the lead for Whistleblowing.

a) You have not answered question 37 of your questionnaire. You should be able to source the bundles from our website at **Bundle 14 - Further Communications - Volume 1 of 3 | Hospitals Inquiry** and **Bundle 20 - Documents referred to in the Expert Reports by Andrew Poplett and Andrew Bennett | Hospitals Inquiry.** Once downloaded can you please answer this question

Question 37: Dr Redding and others made a stage 1 whistle blow to Dr Armstrong for which they produced an SBAR (**Bundle 14, Volume 1, Document 75.1, Page 732**) and a meeting on 4 October 2017 (**see minute at Bundle 14, Volume 1, Document 83.1, Page 753**) which you attended. What do you recall about this meeting? Why did you attend? What action points from that meeting became your responsibility? Was this Stage 1 whistle blow discussed and reported on at Board meetings? What actions were taken in respect of the concerns raised in the whistle blow? How did the 27-point action plan (**Bundle 20, Document 48, Page 792**) come about?

A. I was invited to attend the meeting by the Board Medical Director. The purpose of the meeting was to consider all the issues raised by Dr Redding and agree actions to be taken by the various attendees. I don't think I had any actions from the meeting. I understand the action plan was developed from the meeting. I

cannot recall if the Stage 1 Whistleblowing was reported at a Board meeting.

b) With reference to your answer to question 47 of your statement are you aware the principal point being made by Dr Peters, Dr Redding and other microbiologists is that they raised issues in 2017 as earlier attempts to raise the same or similar issues had not succeeded.?

A. I was not aware of any previous issues raised as I was in a different role.

c) Were the concerns raised by Dr Peters and Dr Redding in October 2017 invalid?

A. I am not able to comment on any clinical issues which may have been raised. My focus was in attempting to ensure that all parties involved worked through the agreed Directorate General Management structure and the professional reporting structure.

d) With reference to your answer question 48 of your statement:

(i) In advance of the meeting of 20th August 2019 were you aware the meeting had been called to discuss the removal of Dr Inkster as chair of the IMT?

A. No, I was invited to the meeting to discuss how to support the IMT due to the complexity of the issues and the membership to ensure consistency of attendance.

(ii) Why were the clinicians who were responsible for the care of the patients in Ward 6A led by Professor Gibson not informed of the meeting of 20 August 2019 or asked to attend?

A. I was not the organiser of the meeting therefore I cannot comment on who was or was not invited to the meeting.

Procurement of What Became the QEUH/RHC

50. What role and responsibilities did you in respect of the procurement, design and construction of the new SGH that became QEUH/RHC?

A. At the time I was in a different role within GGC. My involvement was in terms of the centralisation of Renal Services to the new hospital following an interim centralisation in the Western Infirmary prior to transfer to QEUH. Also, I chaired a working Group to plan outpatients within QEUH. Latterly I attended governance groups preparing for the migration to the new facilities.

51. Refer to **Bundle 52, Volume 1, Document 22, Page 308** where you approved changes to reduce haemato-oncology beds from 14 inpatient beds and a day

area to 10 patient beds and no day area. What ward was affected? What was the intended patient group? What was the rationale behind this decision, who was involved and what advice if any, was sought in reaching this decision?

A. I have reviewed the Change Control Sign Off but without back up papers I cannot recall the rationale for this decision. Any decision would have been carefully considered with evidence and proposals based on options involving the clinical team at the time.

52. The Inquiry understands that you then later approved the increase of the number of beds to 24. What was the rationale behind this decision, who was involved and what advice, if any, was sought in reaching this decision?

A. Please see my answer to question 50.

53. Did you have any role in the site selection process in respect of QEUH/RHC and if so what was it? Were any risk assessments carried out in respect of the selection of the site and its proximity to Shieldhall Sewage Treatment Works? What consideration, if any, was there in respect of the Shieldhall Recycling Centre? What concerns, if any, did you have regarding site selection? What action, if any, did you take in respect of such concerns and what was the outcome?

A. I was not involved in selecting the site for the new hospital.

54. Did you have involvement in the preparation of the Employer's Requirements (ERs) for any part of the new SGH project and if so which parts?

A. No.

a) Who was responsible for providing the requirements for the Clinical Output Specifications and who approved the COS for inclusion in the ERs?

A. I am unable to answer this question. I assume a process following the published national guidance at the time was put in place.

b) Who was responsible for confirming what the relevant NHS Guidance was for the project?

A. I was not involved in this part of the project.

c) How was the impact of sustainability and energy targets on the ER and the project as a whole defined by NHS GGC?

A. This was not in my remit.

55. How was the Clinical Output Specification (COS) for the design of each of the Wards confirmed and signed off. What system was put in place to define the technical requirements of the ventilation system (air change rates, pressure differentials and filter requirements) for the rooms in the hospital?

A. Local teams were involved in the design of wards working alongside project architects. Any technical requirements would be provided by technical/ ICT/Microbiology experts following the appropriate national guidance available at the time. This would lead to a collective decision on design and layout of wards.

56. During the period of procurement (including construction) what guidance was considered in the design of wards to accommodate immunosuppressed patients, what processes were in place to ensure guidance compliance? Were there any changes to the specification of the ventilation systems for the hospital after the start of the competitive dialogue, if so, please describe any such changes, describe the impact, if any, on compliance guidance with SHTM 03-01, and describe the sign off process for any such changes, your involvement and how any changes were communicated to the Board?

A. I was not involved in the specification of the ventilation system.

57. What member of the NHS GGC IPC Team was responsible for confirming the acceptability of filtration and HEPA requirements, air change rates and pressure differentials for wards in the new SGH before construction commenced? What was the Board's awareness at the time, if any, of such a process and responsibility?

A. I am unable to answer this question.

58. Describe your involvement and understanding, if any, in the removal of the maximum temperature variant in May/June 2009? **(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. I was not involved in this issue.

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?

A. I was not involved in the decision to use chilled beams.

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

A. See answer to 57a.

59. Explain your understanding of the ventilation design strategy contained in the Contractor's Tender Return Submission (11 September 2009) **(Bundle 18 Volume 1, Document 8, Page 205)**. Was the ventilation system to be a mixed mode ventilation system (dependent on a non-sealed building) or a mechanical ventilation system (dependent on a sealed building)?

A. This was not in my remit. I was not involved in the choice of ventilation system.

60. Was the design and/or specification of the ventilation system as recorded in the Building Contract, in particular in the M&E Clarification Log **(Bundle 16, Document 23, Page 1664**) compliant with NHS Guidance?

A. See answers to questions 57 and 58 above.

a) If not, please explain:

(i) Why this design was proposed;

(ii) Why this design was accepted, and who advised the Board regarding acceptance; and

(iii) What role, if any, BREEAM played in the acceptance of this design.

A. See answers to questions 57 and 58.

b) If you are of the view that it was compliant, please explain why, with reference to SHTM 03-01 2009 (Ventilation Design) **(Bundle 16, Document 5, Page 342).**

A. See answers to questions 57 and 58 above.

61. The Inquiry is aware of the agreed ventilation derogation recorded in the M&E Clarification Log. **(Bundle 16, Document 23, Page 1664).**

a) What was your understanding and awareness, if any, the scope of the agreed ventilation derogation recorded in the M&E Clarification Log?

A. I was not involved in this technical issue.

b) When did you first become aware of it and how?

A. See answer to question 60A.

c) Was the agreed ventilation derogation restricted to general wards only?

A. See answer to question 60A.

d) If so, how is this interpretation evidenced within the documentation (such as the M&E Clarification Log) and where is the specification located for areas that required specialist ventilation and isolation rooms?

A. See answer to question 60A.

e) Who else from the GGC Project Team and Board were aware of the Ventilation derogation?

A. I am unable to answer this question.

f) How was the agreed ventilation derogation signed off by the Board? The Inquiry understands from the response from Currie and Brown to PPP13 that the GGC Project Team had advised Helen Byrne of the Agreed Ventilation Derogation, alongside Alex McIntyre (Director of Facilities) & Peter Gallagher (Director of Finance). Please also confirm how this was discussed with the Board having regard to the paper Helen Byrne drafted alongside Alan

Seabourne; Drafted Acute Services Review paper in 2010 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".* **(Bundle 30, Document 6, Page 36)**

A. I was not involved in this issue at the time.

62. When did you first become aware of the ZBP Ventilation Strategy Paper dated on or around 15 December 2009? **(Bundle 16, Document 21, Page 1657)**

A. I was not involved in this issue at the time.

a) What action, if any, did you take when you became aware of this document and why? If you did not take any action, please explain why not.

A. See answer above.

b) What concerns if any did you have on reading this document?

A. See answer above.

63. 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? **(Bundle 16, Document 21, Page 1657)**

A. See answer to question 61.

64. Was the 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 was not involved in this issue.

65. Describe your involvement and understanding, if any, of the decision to remove carbon filters from the ventilation system of the QUEH/RHC? What was the rationale behind this decision, who was involved and what advice, if any, was sought in reaching this decision?

A. I was not involved in this issue.

Ward 2A – The Schiehallion Unit

66. The Inquiry understands that Ward 2A/2B is the paediatric-oncology Unit and includes the Teenage Cancer Trust and the paediatric Bone Marrow Transplant (BMT) Unit - the department is known as the Schiehallion Unit.

a) What is your understanding of the intended use and purpose of the Ward 2A/ 2B?

A. The intended use and purpose of ward 2A/2B was to transfer the extant Schiehallion Unit on the Yorkhill Hospital campus to brand new facilities in the new RHC. The Shiehallion team led by the senior clinicians were involved in the design of the ward and facilities to ensure children could receive the best treatment in modern facilities'.

b) What guidance was considered in the design of these wards?

A. I assume the latest available guidance was used along with visits to other new units in the UK. Also, research into current facilities in similar units across the globe would have been considered.

c) What processes were in place to ensure guidance compliance?

A. The Project Team were responsible for ensuring guidance was followed in developing the final design for sign off.

d) Were there any changes to the design during the design and build? If so, please describe any such changes, describe the impact, if any, on guidance compliance, and described the sign off process for any such changes, your involvement and how any changes were communicated to the Board. Was external advice ever sought in respect of design changes?

A. I am unable to recall the detail of any proposed changes. Any changes would be subject to approval through the agreed governance process established by the NHS Board.

e) Describe the IPC involvement in the design of Wards 2A and 2B, who was involved and who signed off the final design and when.

A. I am aware of IPC involvement but cannot recall the detail and who signed off the final design.

f) What concerns, if any, did you have regarding the final design specification of Wards 2A and 2B, and what action, if any, did you take in respect of these concerns?

A. I cannot recall any specific concerns, however the process to reach sign off of design specifications involved the multi-disciplinary team from Schiehallion along with advice from IPC and technical colleagues.

Isolation Rooms

67. Describe how was the number and location of isolation rooms agreed? Who approved the final number and locations in the QEUH and RHC?

A. I am unable to answer this question.

68. Who was responsible for producing the drawings and the specification for isolation Rooms; who approved these from the GGC Project Team?

A. I am unable to answer this question. The Project Team would have been responsible for this area.

69. What concerns, if any, did you have regarding isolation rooms and compliance with SHTM/HTM? What action, if any, did you take in respect of any such concerns?

A. I am unable to answer this question.

70. The Inquiry has reviewed the RDS in excel format and note there is an entry under ‘Design Notes’ relating to Ward 2A isolation rooms; the entry states:

WARNING NOTICE: This room is based on a theoretical design model; which has not been validated (see paragraph 1.8 of HBN 4 Supplement 1). Specialist advice should be sought on its design. The lamp repeat call from the bedroom is situated over the door outside the room.

a) Was this note entered on the RDS? If so, why and by whom?

A. I am unable to answer this question. The Project Team was responsible for the technical design issues.

b) What specialist advice was sought relating to the design of these rooms?

A. See answer to question 69A.

c) What was the final agreed design for isolation rooms and who approved this?

A. See answer to question 69A.

71. What ceiling types were specified and approved for use in isolation rooms? Who from the GGC Project Team approved this? Describe your involvement, if any? What was the impact, if any, of the choice of ceiling tiles? What concerns, if any did you have regarding the choice of ceiling tiles?

A. I was not involved in this issue.

<u>Case Note Review</u>

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? What was your role in the Case Note Review, if any?

A. I was involved in liaison with the Review team to ensure access to any information on a day to day basis. I am unable to recall how the case note review was established, my role was minor, ensuring the review team were supported during their work.

73. Referring to the Case Note Review Overview Report March 2021 (**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. I am unable to answer this question.

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. I am unable to recall if any statement was made.

Conclusion

75. Is there anything else you would like to add which you think would assist the Inquiry?

A. I worked in the NHS in Scotland for 41 years and at all times I was committed to putting patients and their families first, closely followed by our staff providing services at all levels. Some of the questions relate to a period some time ago and it is difficult to recall the detail. I have tried as best I can to answer the questions, however I have neither clinical nor technical/estates qualifications. During my career I have always tried to build a team approach to managing complex services to the population we serve. This has to be done through professional and general management accountability structures within the Boards governance arrangements. It is also important that all staff recognise that they are part of a team providing health care and respect each other and their contributions.

a) When you learned that the BBC was to air the Disclosure Scotland Programme about the patients at the Schiehallion Unit: Did you email staff in NHSGGC prior to the programme being aired?

A. I am unable to recall if I emailed staff regarding the BBC Programme, however any email will be available to the Inquiry on the NHSGGC server.

c) Did you take any steps to warn current patients and families at the Schiehallion Unit prior to the programme being aired?

A. A system of regular visits and engagement with patients and families in the Schiehallion Unit was in place and I visited the ward to meet staff and patients and families.

The Women and Children's team visited regularly including evenings and weekends to be available for patients and families. The team would have advised the patients, families and staff of the programme.

Declaration

76. 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 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
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

A48235836 - Bundle 18, Volume 1 – Documents referred to in the expert report of Dr J.T. Walker

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

A49615172 - Bundle 26 – Provisional Position Papers

A50527456 - Bundle 27, Volume 13 – Miscellaneous Documents

A35560136 – Bundle 30 – Acute Services Review Papers

A51785179 - Bundle 34 – Performance Review Group and Quality and Performance Committee

A53674650- Bundle 52 – Volume 1 – Miscellaneous Documents

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