**Scottish Hospitals Inquiry**
**Witness Statement of**
**Kevin Hill**

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.** The details of my qualifications and job roles are as described in my application form and CV. Copies of these documents should be retained in my Personal File held by NHSGGC. I understand that the Inquiry has requested these documents from NHS GGC however due to their document retention policy they no longer hold these.

## Role as Director for Women and Children's Services

2. The Inquiry understands that you were Director of Women and Children's Services within NHS GGC from 2010 until 2022. What were the circumstances surrounding your appointment?

**A.** I was appointed following advert for the vacant post and completed an application form and interview.

a) What was the remit of your role?

**A.** Refer to Job Description. I understand that the Inquiry has requested this document from NHS GGC however due to their document retention policy they no longer hold these.

b) To whom did you report in your role?

**A.** Refer to Organisation Chart at **Bundle 52, Volume 2, Document 25, Page 282.**

c) Who reported to you?

**A.** Refer to Organisation Chart at **Bundle 52, Volume 2, Document 25, Page 282.**

d) Please describe the procedures and governance in place within Women and Children's Services during your tenure.

**A.** I designated the Chief of Medicine to take the lead role, as a practising clinician, for all matters regarding Clinical Governance. I retained overall responsibility for Clinical Governance through this direct report. I was responsible for leading Directorate Governance; Human Resources, Financial Governance and reporting any issues of concern to Corporate Governance. This responsibility was enabled with professional qualified designated reporting support managers.

e) Please describe your oversight role regarding maintenance and water safety in clinical areas of the RHC, including how you ensured compliance with maintenance schedules, documentation (such as HAISCRIBE), and water quality testing at source (e.g., taps)?

**A.** The maintenance and water safety in clinical areas is undertaken by Director of Estates and Facilities in conjunction with Infection Control, who will request testing if infection arises at variance with the normal pattern for patient care. The General Manager and Chief Nurse receive update reports and verbal updates from Estates colleagues who are in regular contact with ward/nurse managers and clinical support managers.

The routine maintenance and water safety testing in a clinical area will be discussed and agreed with the relevant nurse manager to ensure minimum interruption to process of patient care. Timings and frequencies will be communicated in advance and can be altered accordingly should the need arise. Documentation would be received by the General Manager and Chief Nurse to monitor compliance and to examine any areas of concern or omission. Any exceptions would be highlighted through Clinical Governance meetings chaired by Chief of Medicine. Any risks highlighted would be immediately dealt with to ensure risks were managed and continuity of care for the patients was not affected.

f) How did you verify that maintenance of the water system of the RHC was being carried out every three months and that relevant paperwork was A. properly completed and submitted?

**A.** I do not recall ever having sight of paperwork confirming a three month testing and results outcomes regarding RHC water system were properly completed and submitted. The results of water testing I understand was reported as described in my response to question 2 e) above.

g) Can you explain your role in ensuring compliance with these maintenance and testing protocols to protect patients from contamination?

**A.** My role would be to address and raise issues of outstanding concern with the Director of Facilities and Estates and Chief Operating Officer.

**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)

**A.** The procurement of the new SGH (QEUH/RHC) was lead by the Chief Executive through the appointment of a Commissioning Team (CT) directly responsible to Chief Executive. My involvement with the CT was in regard to ensuring ward and department plans were signed off as being an accurate specification of the users (Staff and Patients) requirements based upon the purpose and functionality of the patient groups identified. This process of sign-off and approval for each specified area was the designated responsibility of the General Manager (Mr Jamie Redfern) as the senior hospital manager.

b) the safe and efficient operation of the water and ventilation systems of the QEUH/RHC

**A.** I would have anticipated and expected the new building (QEUH/RHC) to have met the current hospital building standards and that specific requirements for patient clinical conditions would be compliant. This includes water and ventilation systems. Any exceptions or omissions should have been communicated and discussed at the Board Water Safety Group and at Acute Infection Control Committee and reported to the Board Infection Control Committee. Documentation submitted to each Group/Committee highlighting potential clinical risks and cost benefit analysis of the implications of each exception and/or omission. The impact on the build schedule from adjustments to the technical specification and cost and time implications would always have to be assessed.

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.

**A.** All new NHS buildings, wards and departments should comply with the current approved national building standards especially, where specified, for specific patient conditions and to ensure safe treatment. This is particularly essential when dealing with immuno-compromised patients who are at higher risk and vulnerable to infections at certain times in their clinical treatment. All patients need to be protected from potentially known sources of infections.

d) the need for and authorisation of works to improve or remedy deficiencies in the water and ventilation systems of the QEUH/RHC

**A.** The Board overall is responsible for the standard and safety of NHS buildings and premises and as such through the Chief Executive and the Director of Estates & Facilities, who is the professionally qualified individual reporting to the Chief Executive. Any design omissions, upon discovery, should be reported and highlighted along with remedial works to correct any deficiencies in the hospital environment and therefore reduce risks to vulnerable patient groups.

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.** Any issues and concerns were able to be reported directly to Line Managers and this approach was encouraged where staff have any concerns and this was supported by involvement from professional associations and trade unions. This approach was the main route for raising individual and staff concerns. The Board would and should receive reports raising any issues through Executive Reporting at Board meetings and by the submission of papers including where relevant attendance by specialist qualified "expert" individuals at the Board meeting to answer questions and explain technical matters, assess risk to patient groups and their potential impact upon patient care. This can be by "expert" verbal statement as well as documented and preferably both. The Board has a "Whistleblower" policy in place to encourage and ensure any concerns by individuals are able to be raised confidentially and for an "independent" investigation to be undertaken.

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.** I am unaware of any formal or informal meetings that made decisions about the issues listed in Question 2. (Or and related to Question 3).

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.** The escalation of issues, reports and decisions were subject to consideration and deliberation by the Chief Executive, Executive Officers, First Line Subordinate Committees, for example, Acute Infection Control Committee, Acute Directors Meeting, and/or Board Meeting. The decision making level was at the discretion of the Chief Executive.

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.** The Board would be updated through verbal and documented reports at its meetings, through receipt of the Board Infection Control Committee minutes and papers and Board Infection Control Committee and separately Acute Infection Control Committee minutes and papers. Details from the Women & Children's Directorate Clinical Governance meetings were distributed and shared with Chief Executive and Executive Officers and any concerns and issues raised were highlighted monthly to Acute Clinical Governance Committee. The same reporting arrangements, as above, were replicated from Women & Children's Directorate Infection Control Committee for Acute Infection Control Committee to ensure issues were raised and actions to remedy and ameliorate and/or eliminate potential source(s) of infection impact were taken in a timely way.

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.** Once a decision was taken to address any and/or all issues arising in relation to Question 2 (and Question 3) the required actions were highlighted at the Infection Control Committee for Children's Hospital along with a description of the remedial works required, the interruption to the ward and the arrangements

for safe patient care and treatment to continue during this period. The decision for the detailed works was the responsibility of the Director of Estates & Facilities with approval from the Chief Executive and Executive Officers, for example, Director of Finance to ensure funding to complete programme of works. The responsibility, during any works in a clinical area, for the safety of patients, parents and staff and visitors was the responsibility of Director of Women & Children's Services (myself). The Board would receive a report on progress via Chief Executive and Director of Estates and Facilities.

**The New South Glasgow Hospital Project**

8. Please detail your involvement if any in the following matters in respect of the QEUH/RHC. Where applicable please note where you expressed views and what they were:

a) Site Selection

**A.** I had no involvement or responsibility for site selection.

b) Procurement

**A.** I had no involvement or responsibility for site and general hospital procurement.

c) Finance model

**A.** I had no involvement or responsibility for the Finance model.

d) Value for money in respect of the build

**A.** I had no involvement or responsibility for Value for Money in respect of the build.

e) Construction/design

**A.** I had no involvement or responsibility for Construction/Design of the build. The General Manager Children's Hospital and Lead Nurse along with clinical leaders and clinical staff had involvement in the interior layout of wards, theatres and clinical departments, for example, siting of electrical sockets.

f) Commissioning and validation

**A.** I had no involvement or responsibility for Commissioning and Validation of the build.

g) Derogations

**A.** I had no involvement in decisions regarding Derogations to the build.

h) With reference to your answer to Question 8(e) of your statement of May 2025 you state that you had no involvement or responsibility for Construction/Design of the new RHC. Mr Calderwood who was Chief Executive at the time has suggested in his draft statement that the design of the RHC was initially led by Dr Morgan Jamieson with your involvement. Can you explain why Mr Calderwood might think you were involved in the Construction/Design of the new RHC after your appointment as Director of Women and Children's Services within NHS GGC in 2010?

**A.** I was not involved in any discussions regarding the construction/design of the new RHC as my predecessor, Mrs Rosslyn Crockett, I understand would have engaged with Dr Morgan Jamieson in this regard. Upon my appointment the plans for clinical areas and adjacencies within the new RHC were concluded. Specific ward layouts and number of bed spaces and supporting facilities were already detailed in the plans I recall seeing after my appointment.

i) In its most recent its Glasgow 4, Part 1 hearing in May 2025 in 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.** Yes I do have an understanding of the difference between commissioning a ventilation system and validation of a ventilation system. My previous experience of refurbishment of existing and new NHS buildings and facilities, including paediatric intensive care unit, operating theatres and catheter laboratories. My understanding of commissioning is that the construction firm and supplier provide the match to the specification of the ventilation system and initially builds and fits the system and confirms when it is fully installed and operational. The validation process is when the system is tested to ensure it delivers the ventilation requirements for the area being used to meet the specification for example number of air changes, negative or positive pressure.

It is disturbing to learn that the ventilation system was not validated to ensure compliance with the requirements of the patients who would occupy the ward. The responsibility for validation and ongoing monitoring rests with the Director of Estates and Facilities.

j) With reference to your answer to Question 3 of your statement of May 2025 how did you ensure that on the arrival of patients in Ward 2A on 10 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 did not personally check or ensure that the ventilation system was functional and operational. My expectation was that the specification describing additional ventilation system requirements should have been tested and proven “fit for purpose” prior to occupation and certainly during the commissioning period before acceptance of the building. I cannot recall whether a derogation was in place.

k) In his draft statement Mr Calderwood has explained that you took the decision that the new RHC was safe to move the children into the new hospital in June 2015.

(i) Is that correct?

**A.** The new RHC building was physically completed and ready for patient occupation and therefore my decision to move was a foregone conclusion

given the readiness of the new facilities. Prior to patient occupation and transfer from RHSC Yorkhill environmental “snagging” had been completed by the clinical and operational teams to ensure the facilities enabled highest standards of patient care. This did not include from a hospital operational and clinical team perspective any testing of water, electrical, drains, air handling and ventilation systems as these were within the remit of the Director of Estates and Facilities. My decision to move was based on the physical finish of ward areas I was responsible for and therefore I could form a view on readiness to occupy. At this time the building and wards appeared to be satisfactorily completed and functional.

(ii) Can you describe the process and documentation that constituted the validation of the ventilation system of Ward 2A RHC before occupation by patients? Did this include formal testing, certification or independent audit of the ventilation.

**A.** I am not aware and was never involved in the process or documentation of validation of the ventilation system prior to occupation by patients.

(iii) With reference to your answer to Question 3 of your statement of May 2025 how did you ensure that on the arrival of patients in Ward 2A on 10 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.** This question is the same as 8 j) above. Please refer to my answer to 8 j).

**<u>Infection Control</u>**

9. What is your understanding of how infection within the QEUH/RHC was and is monitored, investigated, reacted to and reported both internally and externally. Please provide full details.

**A.** Daily and weekly and monthly inspections undertaken internally by ward leader and Lead Nurse and Infection Control Nurse designated for Children's Hospital as well as Estates & Facilities Directorate Manager for domestic and cleaning

would participate in walk-rounds and produce monitoring audit reports highlighting any issues and concerns. Any issue requiring immediate attention would be escalated to Children's Hospital Management and actions required agreed and corrected. Any issues for reporting to Senior Management would be highlighted via verbal, written (email) and formally reported at Children's Hospital Infection Control Meeting and Chief Nurse meetings with Lead Nurses. At all times the senior nurse-in-charge could escalate any concerns and Lead Nurse would consider the urgency in conjunction with the Hospital's Clinical Services Manager(s) and General Manager. The internal formal reporting process was to the Children's Hospital Infection Control Committee and to the Women & Children's Infection Control Committee and separately, as appropriate, to the Women & Children's Clinical Governance Committee and then externally to Acute Infection Control Committee and/or Acute Clinical Governance Committee.

10. When did you first become aware of concerns raised by infection prevention control colleagues in respect of the built environment, water and ventilation systems within the QEUH/RHC? What actions were taken in respect of these concerns? Do you think the concerns raised were taken seriously?

**A.** I do not recall the specific month or year. At some future date, following the opening of the QEUH/RHC buildings I was aware through, I believe, the Acute Directors Meetings of discussions pertaining to Infection Prevention Control clinical staff concerns being raised during, I think, the design and planning stages of the build and post-opening of both hospital buildings. I do not know what actions were taken. I am unable to comment on whether the concerns were taken seriously.

**Ventilation in Ward 2A/B**

11. To what extent (before handover) did you anticipate that the ventilation system in Ward 2A RHC would be of equivalent standard or better than that installed in the Schiehallion Unit at Yorkhill?

**A.** I anticipated and expected that the ventilation system in Ward 2A/B would be at a minimum equivalent standard of that installed in Schiehallion Unit at Royal Hospital for Sick Children Glasgow (Yorkhill). I expected that, where appropriate, any upgrades to standards for such units throughout the UK would be incorporated into Scottish Health Technical Memorandum – Technical Building Notes and Design Specifications; to ensure the latest and proven ventilation systems were incorporated into any new build or refurbished units and wards.

a) When was the proposed ventilation system in Ward 2A RHC first drawn to your attention?

**A**. I am unaware that the proposed ventilation system in Ward 2A RHC was ever drawn to my attention prior to the completion of the build.

b) When did you learn that the ventilation system in Ward 2A RHC did not meet the standards anticipated by the treating clinicians in the Schiehallion Unit?

**A.** Following the opening of the RHC, I am unable to recall a date, month and year, when the issue that the ventilation system did not meet the standards of ventilation of previous Schiehallion Unit at RHSC Yorkhill was raised with me.

c) To what extent was this a surprise to you and why?

**A.** The information that the new RHC did not as a minimum have the previous standard of ventilation system installed to ensure safest standards of ventilation to one of the most vulnerable group of child patients' was extremely serious and of great concern.

12. Which members of NHS GGC staff had approved the design if the ventilation system for Ward 2A before handover, when and how had they done that and did they ever give you a reason for doing so?

**A.** I do not know who approved the ventilation system installed in Ward 2A as part of the QEUH/RHC build.

13. Dr Brenda Gibson gave evidence to the Inquiry that in March 2015 she raised concerns regarding the safety of Ward 2A prior to patient migration and that on

a visit to Ward 2A shortly before the move, it was discovered that HEPA filters were not in fact installed in the BMT rooms on Ward 2A. Were you aware of Dr Gibson's concerns? Who told you and when?

**A.** I was made aware following Dr Gibson's visit to Ward 2A in March 2015, prior to the transfer of RHSC Yorkhill two months later. I am unsure who told me initially and can only speculate that my General Manager Children's Hospital and/or Chief Nurse/Lead Nurse and/or Clinical Services Manager briefed me on the discovery of this omission. I would certainly have held a discussion/meeting with Children's Hospital Commissioning Manager (Mhairi McLeod) to seek an explanation for the omission.

14. Once you became aware of issues with the ventilation system in Ward 2A RHC what steps did you take to find out why it did not meet the standards anticipated by the treating clinicians in the Schiehallion Unit and what was the result of that investigation? Was any consideration was given by the Board to undertake a review to understand why this had happened?

**A.** I would have contacted Children's Hospital Commissioning Manager to seek clarification and to understand whether the requirement for HEPA Filters had been incorporated into modern fitments that had been installed? Thereby omitting the need for a separate fitment. I would have also raised this personally with the Director with responsibility for New Build and Commissioning of the new hospitals (David Loudon). The outcome was to retrospectively install HEPA filters throughout clinical departments at New RHC. I am unaware of whether the Board undertook a review to understand why this had happened.

15. Why was Ward 2A handover accepted by NHS GGC in January 2015 without HEPA filtration being in place?

**A.** I am unaware why Ward 2A handover was accepted by NHSGGC in January 2015 without HEPA filtration being in place.

16. Who signed off handover without HEPA filters being in place?

**A.** I am unaware of who signed off the handover without HEPA filters being in place.

17. The Inquiry understands that the isolation rooms in Ward 2A were Positive Pressure Ventilated Lobby rooms built to SHPN 04-01 standard however this design was not suitable for neutropenic patients and the rooms should have been built to SHPN 03-01 standard. Were you aware of this? What information were you provided about this? Why did this happen?

**A.** I was made aware of this information regarding the Scottish Health Planning Note at the time this was discovered and the resulting Positive Pressure Ventilated Lobby Rooms. These Lobby Rooms were unsuitable for Neutropenic Patients' and therefore a non-compliance in ventilation requirements in the overall treatment environment for such highly vulnerable patients. Following the discovery of this issue then discussions and meetings took place between Hospital Management, Ward 2A Clinicians and Clinical Teams, Ward Nursing Leader, Lead Infection Control Doctor, Infection Prevention and Control Lead Nurse and with Director/Senior Managers and Estates & Facilities. The aim and purpose was to ensure alterations to the ventilation system to meet the standards required. I do not know the reason(s) why this occurred and how erroneous air pressure happened.

a) When concerns about ventilation system of Ward 2A RHC were raised for the first time in 2015, did you take these concerns seriously at the time? What specific actions did you take to address them in line with your responsibility for safety?

**A.** I was absent from work from July 2015 until December 2015 due to an infectious eye condition therefore I am unable to respond. The General Manager would be temporarily covering my areas of responsibility

b) Given your role, should you not have initiated a formal investigation into the omission of HEPA filters from the ventilation system? If not, why?

**A.** Please see response to Question 17 a) above.

c) Following disclosure of the HEPA filter omission, were you concerned about the overall integrity of the ventilation system? What steps did you take in response?

**A.** Please see response to Question 17 a) above.

**The Water Incident**

18. Before NHS GGC took responsibility for the QEUH/RHC building in January 2015 were you aware of the requirement for a L8 Preoccupation Risk Assessment? Are you aware of what steps were taken to ensure that one was carried out? What steps did you take to ensure that the water system of the RHC was safe and not subject to widespread contamination before patients moved in?

**A.** Not aware and not my responsibility. No. Not my responsibility.

19. When did you first become aware of the recommendations of the DMA Canyon Report 2015 L8 Risk Assessment (**Bundle 6, Document 29, Page 122**) and why? What steps, if any, did you take to ensure sufficient steps were being taken to address the issues identified within the reports?

**A.** I was not aware during 2015/16 of the publication of this report or its contents. I later became aware of reference to a DMA report during 2018 but was still unaware of its contents. I am unsure whether I ever received a copy of the 2015 DMA report. My understanding is this report highlighted issues related to hospital QEUH/RHC water system and identified the build up and presence of legionella. My understanding is the hospital water system should be tested every two years as part of conformance with regular water testing regime for the presence of legionella and other water-borne organisms. The responsible director of Estates and Facilities would be expected to action the issues arising from this report.

20. 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 (Refer to **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 Children's hospital what was reported to you, as Director of Women and Children's services, 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**. I do not recall being directly involved during 2014 in the discussions or meetings regarding the use of Horne Optitherm Taps in QEUH/RHC. My recollection is that discussions regarding model and types of taps within clinical areas were part of general issues, including fitments and shape and style of sinks, formed part of ongoing discussions between the New Hospital Commissioning Team and General Manager and Chief Nurse for Children's Hospital along with their direct reports responsible for operational management. The advice of Infection Prevention and Control would have been sought to determine the safest outcome for patients. I understand that the solution reached was to test the taps for build up of biofilm and presence of contaminants. I think there may have also been discussion about replacement of such taps in phased way commencing with the highest risk patient group ward areas as a priority.

21. What is your involvement in or understanding of any water contamination issues in the QEUH/RHC and the extent to which infections suffered by patients in the Schiehallion unit cohort may be linked to contamination of the domestic water system?

**A.** My involvement in potential water contamination issues as a direct source of infections in patients in Schiehallion unit; was a member of an Infection Management Team (IMT) either through attendance or briefed following attendance of Chief Nurse and/or General Manager or Lead Nurse or Clinical Services Manager with responsibility for Children's Hospital Services. The presence of professional experts lead by the Lead Infection Control Doctor (Dr T Inkster) would outline the issues and the types of bacterium found infected in patient(s) and scenarios would be described as to the possible source(s) of infection by organism type. This was a dynamic picture and weekly IMT meetings would highlight potential sources of infections and remedial actions to be taken to reduce risk of further patient contamination. It is always regrettable and a failure in hospital systems management whenever a patient is infected by a bacterium from internal (ward environment) and/or external source wider hospital environment and/or from out with the hospital itself. It is always a serious concern and resultant anxiety for the impact on patients and

families when such infections occur especially in an immune compromised patient group.

a) With reference to your answer to Question 19 in your May 2025 statement:

(i) Having been made aware of the DMA Canyon reports and the high-level risks identified, what concrete steps did you take as Director to ensure the water system was safe for patients in the RHC?

**A.** Testing of water systems is the responsibility of the Director of Estates and Facilities and the safety of the water system for patients in the RHC would be considered as part of the role of Infection Control. Any variances and highlighted risks would be considered in conjunction with the Clinical and Operational teams in the RHC. If required, an IMT would be established to highlight issues of concern and address actions to alleviate risks to patients.

(ii) Was testing for biofilm and contaminants in taps ever carried out? How did you ensure this testing was performed and results acted upon?

**A.** The evidence to answer this question will be held by Director of Estates and Facilities and Infection Control colleagues. My understanding from IMT meetings was that testing was discussed and therefore where applicable undertaken although I am uncertain as to the results of such testing due to the design of the taps and whether the issue was more to do with the design and efficiency of this type of tap in the clinical area concerned. I do not recall whether testing for biofilm and contaminants in taps was carried out. I think the debate may have considered that there would be the presence of such contaminants in all taps. Testing and acting upon results were reported through Infection Control at IMT and on daily briefings/updates to Operational and Clinical teams in RHC.

(iii) With reference to your answer to Question 20 in your May 2025 statement you state that you “understand that the solution reached was to test the taps for build-up of biofilm and presence of contaminants”. When did testing and maintenance of the Horne Optitherm taps commence?

**A.** The details of the testing of taps and results will be found through Director of Estates and Facilities along with Infection Control colleagues with the Laboratory function who will have processed the samples

**Decision to Close Wards 2A/B and Move to 6A and 4B**

22. Discuss the issues surrounding and leading up to the decant of patients from Ward 2A/B in 2018.

a) What was the lead up to and background to this?

b) What was your involvement?

c) What risk assessment and additional measures were put in place to ensure patient safety?

d) What concerns, if any, did you have about where the patient cohort was being moved to? If so, why did you have these concerns

e) Discuss and detail the works done to Ward 2A/B what was required to be done and why, what has been done and when the work was completed. Please include details of your involvement. **Please note IMT minutes are contained within Bundle 1.**

f) Any other relevant information.

**A.** It became apparent throughout the IMT meetings that the types and varied number of infections impacting upon this vulnerable patient group and the anxiety of parents, who often reside on the ward during inpatient duration or periods when their child receiving critical and intense treatment, was unsustainable. The impact of the situation on clinical and ward staff members was stressful and unbearable. The ward 2A/B and whole children's hospital was attempting to maintain safe clinical care during this unprecedented time. The ward was basically subject to incremental works disruption as each scenario arising from the decisions of the IMT were quite correctly investigated in order to try to identify the source(s) of infection(s) and consequently resulting in higher risk environment for patients. The relentless and ongoing situation whereby potential sources of infection were potentially widespread within the ward environment could not continue. Therefore following an options appraisal to consider ward decant options it was correctly decided to decant the entirety

of patients treated in Wards 2A/2B to the adult hospital QEUH. The decision would also impact upon adult patients and their respective clinical teams and management. The most appropriate adult wards were Ward 4B and Ward 6A. This was not an easy decision as it involved the transfer of the most vulnerable children patients as well as the entirety of the functioning ward staff and provision of equivalent space for parents. However despite concerns the main reason the move was supported enabled the entire Ward 2A/B to be emptied and 'stripped back' to expose pipework, shower cubicles, sinks and drains. It also allowed for all wall partitions and facings to be completely removed to investigate the source of damp/mould/water ingress and any other build/material defects that may have caused source/incidence of patient infections. The decant freed up the entire ward environment to facilitate a 'root and branch' forensic assessment of the environment overseen by Director of Estates and Facilities to address all of the areas requiring examination as per the recommendations from IMT meetings and including the review of chilled beams, ventilation system, drains, sinks and shower cubicles, taps and water filters, positive and negative pressure rooms, as appropriate.

g) Discuss the issues surrounding the ward 2A patients when in occupation of ward 6A and your views in respect of:

(a) Chilled beams
(b) Gram Negative Bacteraemia
(c) Water filters
(d) Ventilation
(e) Issues/ testing/ escalation/ response/ IMTs/SBARs impact on patients
(f) Patient communication
(g) Internal escalation - HAIIT scoring
(h) External escalation

**A.** The questions arising from the occupancy of Ward 6A QEUH were highlighted, discussed and actions agreed as part of IMT meetings. The discovery of potential sources of infection in this vulnerable children patient group created a situation of extreme anguish and concern for both patients and parents as well as management and staff. The daily situation of increased concern from clinical staff, parents and patients and further interruption to their planned care and

treatment consequently resulted in the “temporary” relocation of the Ward 6A group of child patients, inpatients and outpatients and day care, to the clinical decisions unit of the Royal Hospital for Children. This move was to enable a review of the technical and ventilation facilities within Ward 6A that may be causing concern and consternation that the location chosen as part of the decant of Ward 2A and 2B required to be vacated to enable works to be undertaken to reduce further harm to inpatients. This action was taken to safeguard patients and to facilitate a ward environment supportive to provide the highest standards of care and treatment by paediatric clinical staff. All decisions taken were considered at IMT meetings and risk assessment concluded the need for such actions.

h) The Inquiry is aware of Mr Redfern’s Options Appraisal for the decant of 17 September 2018 (**Bundle 6, Document 13, Page 38**) and that based on the evidence of Ms Rodgers, Ms Dodds and Mr Redfern steps were taken to prepare Ward 6A to receive Ward 2A/2B patients, but prior to the decant on 28 September 2018 did you ensure a comprehensive review of the technical and ventilation facilities in Ward 6A to confirm the environment was safe for patients?

**A.** No I did not request a comprehensive review of the technical and ventilation facilities in Ward 6A. The existing BMT adult patients were already receiving treatments on Ward 6A and the children who required this facility would also be treated in this area utilising single rooms designated for such purposes. This area therefore for the patient cohort appeared safe to use.

i) With reference to your answer to Question 28 in your May 2025 statement you explain when referring to the decision to decant patients from Ward 6A to the CDU to how “A multidisciplinary team needs to reach a consensual position that all parties can support even with reservations on the part of some participants”.

(i) In this context why was not the relevant multidisciplinary team not the IMT itself?

**A.** The decision to decant patients from 6A to the CDU was taken following a meeting of the IMT where the managerial and operational and clinical

concerns were appreciated by the IMT members and therefore as Director it was my responsibility to review risks of such a move from with colleagues who met separately to the IMT to determine the suitability of the CDU.

(ii) Why was a meeting called with a small number of individuals after the IMT?

**A.** Please see response to question S14a above.

(iii) Was this meeting truly multidisciplinary with no clinicians present?

**A.** The decision and the meeting that took place was to identify and manage any foreseeable risks in moving to CDU. The Ward 6A area was already close to being a “building site” with the volume of works underway and the impact from shower areas being designated unusable for patients. The task of the small meeting group was to reach a decision on whether it was suitable to move patients and in doing so was there a higher risk from CDU compared with the current situation in Ward 6A. The decision to move was taken in the best interests of patients, families and staff to maintain a safe clinical environment for children.

(iv) Did you disagree with Dr Inkster regarding the risk to patients from mould in the shower rooms?

**A.** No I did not disagree with Dr Inkster regarding the risk to patients from mould in the shower rooms. The issue to resolve was how to remedy the situation whilst continuing to treat patients. The only two options were continue to undertake work arounds whilst patients remained in-situ on Ward 6A or move to another ward area. The decision, after considering risk assessment, to move patients, in order to continue treatment and care was the correct decision.

j) With reference to your answer to question 35 of your May 2025 statement:

(i) Did you think it was wrong for the IMT to sample drains and if so why?

**A.** I understand and appreciate the decisions of the IMT as a participant and will always refer to facts, specialist opinion and discussion to inform my view. I may not support every decision however the specialist opinions inform the meetings on why certain hypothesis need to be ruled out or developed further

to identify the source of infection. I understand the debate regarding testing drains was that you would expect to find biofilm and contaminants in a drain system. Therefore the results would be unsurprising if contaminants were positively identified.

(ii) Were you concerned about the methodology for sampling drains and if so why?

**A.** Please see my answer to question j) (i) above.

23. 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.** A decant was considered necessary to safeguard patients from an unknown source of infection suspected to be arising from somewhere within the ward environment.

24. 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 (see Witness statement of James Redfern, para. 118 - **Hearing commencing 12 June 2023 - Bundle of witness statements , Document 7, Page 371**). The Minutes of the IMT of 1 August 2019 (**see Bundle 1, Document 75, Page 334**) imply that a decision was previously to close Ward 6A to new admissions and patients requiring higher risk chemotherapy. What knowdledge did you have of that decision at the time. Why was it made, who made it and who approved it?

**A**. The decision to close Ward 6A to new paediatric admissions was discussed and considered at length by the IMT and by separate meetings involving the paediatric clinical team. Although this was the stated position, to inform staff, patients and parents, each patient case would be determined in detail by the consultant responsible for the patients care or in the event known patients ongoing care in conjunction with the parents concerned. A small number of patients and parents were offered and referred to Royal Edinburgh Children's Hospital and Aberdeen Children's Hospital and some parents accepted the alternative, however I understand that very few took up the offer and of those

who did they did not consider the alternatives to be as conducive as RHC Glasgow. All decisions regarding patient care were determined with the full involvement of the named consultant, with clinical team input and infection control and senior hospital management. The ultimate decision rested with the patients' consultant in conjunction with the respective parents.

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

**A.** Once the initial works required, as identified through IMT, and upon closer inspection of the vacated ward and any other changes technically assessed, as required to the ward and replacement fittings were completed. Following satisfactory testing and assessment of ward 6A environment the final stage was for the entire ward area to be treated using HPV process it was deemed "fit for purpose" and a safe clinical area.

26. Please outline the governance procedures and reporting practices which were in place in respect of the decant.

**A.** There was regular daily contact with the "decanted" ward as occurs on every day to every clinical area through the Lead Nurses and Clinical Services Manager. The children's hospital has for a number of years pre-move held once daily at 8.00 Hospital Huddle to enable hospital wide issues to be raised and for attendees to suggest ways to manage any pressure points in the care system to reduce or eliminate interruption to patient care. This process is continuously monitored and reported at 12.00, 16.00 and 20.00 and midnight to ensure support for hospital coordination and immediate assistance to ward and clinical areas requiring planned assistance. Whenever there is an urgent issue emerging the routine alert system would be to report to the most senior person on duty in the first instance. Escalation beyond this throughout 24 hours 365 days a year is in place to ensure safety and support staff. The normal reporting arrangements for clinical governance were in place; escalation by verbal contact; written SBAR; online Incident Reporting Sytem Datic; formal reports to Hospital Clinical Governance Forum and Acute Directors Meeting. In addition, depending on the nature of the issues arising, discussion and reports would be considered by Directorate Health & Safety Forum including

professional staff representatives. All reporting lines were maintained prior to and during the decant, throughout the decant period and post return to ward 6A.

27. Refer to Dr Inkster's statement at paragraph 710 (**Witness Bundle – Week commencing 30 September 2024 - Volume 7, Document 1, Page 3**). Dr Inkster refers to a meeting with yourself, Tom Steele, Jamie Redfern and Jennifer Rodgers following the IMT of 18 January 2019 where it was agreed to move patients to the CDU. She states that she felt "under pressure" and "bullied". Please detail your recollection of that meeting.

**A.** I was astonished and shocked to read that Dr Inkster felt "under pressure" and "bullied" during a meeting with myself and colleagues to discuss and consider the adequacy of Clinical Decisions Unit (CDU) RHC as a temporary transfer ward area for the patient cohort being treated in Ward 6A. We are all colleagues from different backgrounds and professions working for the same organisation to ensure the highest quality of patient care and had been required to consider and finalise an alternative to the "decant" Ward 6A; given the incidence of infections affecting patients arising from source(s) suspected from within the Ward 6A area.

I do not believe I personally bullied or Dr Inkster under pressure to reach a decision to move Ward 6A patients to CDU. I suspect I would have asked questions and challenged points and sought suggestions and possible solutions at the meeting as was my 'modus operandi' throughout my 36 years of NHS management positions. A multidisciplinary team needs to reach a consensual position that all parties can support even with reservations on the part of some participants.

a) Did you oppose the decision to move the 6A patients to the CDU? If so, why?

**A.** I was in full agreement with the temporary move of the ward 6A patients to the CDU.

b) Did you feel that children should remain on the ward whilst the work took place? Please explain your answer.

**A.** I did not want to increase the risk to patients whilst works were underway in ward 6A. I therefore felt it was clinically, technically and managerially appropriate to temporarily transfer ward 6A patients to CDU.

**Cryptococcus**

28. What were the issues with Cryptococcus at QEUH? When did you first become aware of these issues? What happened in response to these issues? What was your involvement, if any, with i) the cryptococcus IMTs and ii) the cryptococcus sub-group?

**A.** I would whenever available attend IMT meetings when the issue of mould in Ward 6A had been raised and during discussion regarding chilled beams leaking/dripping water onto patients/beds. I do not recall the specific dates when I first became aware of Cryptococcus affecting patients in Ward 6A. The ultimate decision was to decant Ward 6A to CDU to facilitate a full and thorough technical investigation into mould, water leaks, materials and fitments used, likelihood of bacteria build up in existing ward water systems. Cryptococcus organism is found in soil and bird droppings particularly pigeons. I do not recall any personal involvement in the Cryptococcus sub-group.

29. What was your role in respect of communicating with i) patients and families in respect of cryptococcus infections

**A.** My role in communicating with patients and families regarding Cryptococcus was indirect as the persons responsible direct patient care, the consultant with the involvement of Infection Control professionals and the senior hospital management provided support and they as a team performed the direct communication with patients and families. My role was in conjunction with the Boards Communication Team to prepare a general communication following the outcome of each IMT meeting. To ensure that the communication was sensitive to the situation affecting patients and parents and ward staff whilst maintaining factual accuracy. If the source of infection(s) was unknown then the statement could not include speculative or multiple reasons without conclusive

evidence. Truth and honesty is vital to maintain trust with patients, parents, staff and public.

30. and ii) the Scottish Government?

**A.** The communication with the Scottish Government was direct from HPS as they were present at the IMT meetings. My involvement would also include assisting

31. Refer to the Action Plan from the IMT of 16 January 2019 (**Bundle 1, Document 58, Page 264**). What is this document? What was its purpose? What actions were you responsible for and why? Did you complete your actions? Were all the actions in the plan completed? How did this contribute with the overall management of the cryptococcus incident?

**A**. This document states the actions arising from the IMT meeting of 16/01/2019 and indicates against point 18 that the communication for adult patients and paediatric patients (and parents) was completed on 17/01/2019 by the colleagues named collaborating to reach an agreed statement(s).

32. Describe your understanding and involvement, if any, in the media and press statements released in respect of the Cryptococcus incidents at QEUH/RHC in and around 2018/2019? Were you satisfied with how this was managed? If so, why and if not, why not?

**A.** The outcomes agreed at the IMT meetings would form the basis of patient, parent and staff briefing meetings. I would be fully involved in the preparation and drafting versions of such statements usually including the General Manager and Chief Nurse for the Children's Hospital. This involvement could be a long process given the need for iterations to be approved before a final 'agreed' version was produced. With regards to preparing media and press statements I would usually be contacted to review a draft version and if appropriate, I may suggest amendments to the content however the final approved version would be the responsibility of the Chief Executive along with the Director of Communications and following extensive engagement with the Scottish Government. Satisfaction with the content and timing of media and press releases is not something I can conclude one way or the other as it depends on the amino of facts available to inform the briefing and the accuracy to be able

to define and conclude what caused “x”. This unfortunately is very rarely clear and unambiguous especially when dealing with cases of infection and therefore unless it is categorically established then possible multiple sources and speculation only cause greater degrees of anxiety and worry and stress at the time when we are trying to maintain hospital services and confidence in the expertise and skills of our medical and clinical teams. We have a duty of candour to communicate clearly and precisely what we know to patients, parents, staff and the wider public.

33. Please refer to IMT minute of 17 September 2018 (**Bundle 1, Document 39, Page 171**). At this meeting you advised that the executive group had not approved the decant of Ward 2A/B. Please explain why this was not approved. What other options were considered? Who do you understand to have made the final decision to decant the ward?

**A.** The decision of the Executive Control Group not to approve the decant at that time of Ward 2A/B to the preferred ward was to allow the initial assessment by a drainage expert to take place and to be in receipt of a preliminary scope report on their methodology and where appropriate, any findings at this stage that may inform IMT decision making. I did confirm to the IMT that a decant option was actively under consideration, reflecting the current recommendations of the IMT.

34. Please refer to IMT minute of 25 June 2019 (**Bundle 1, Document 73, Page 325**). The minutes note an action point in that you and Chris Deighan will establish whether other hospitals sample their drains. Did you complete this action? Why were you seeking to understand other hospitals’ practices? What do you understand the reasons behind drain sampling to be?

**A**. The action to try and obtain a picture throughout the NHS England of frequency of drain sampling and incidence of potential linked infection(s) was undertaken by Dr Deighan and myself following the IMT meeting. My recall is that we discussed how we could obtain this information and concluded that national meetings of Health Protection Services in England and cross country meetings involving Scotland, Wales, Northern Ireland and England may be a potential source to obtain the information we required. Ultimately I think this action was

completed through HPS Scotland in collaboration with the Department of Health England. I think the outcome of the enquiry was incomplete as the testing regimes were different across and throughout the UK.

**Communication**

35. Refer to the Core Brief of 6 December 2018 in respect of the decant of Wards 2A/B **(Bundle 52, volume 2, Document 3, Page 66).** Here you state "As our patients and staff had already relocated to another ward, this provided a good opportunity to carry out this upgrading of the system", why did you not address the issue of the ventilation not meeting the required standards? Do you feel this statement is open and transparent?

**A.** Please see my answer to 42 a) (ii) and 42 a) (iii)

36. Refer to Dr Inkster's statement at paragraph 322 **(Witness Bundle – Week commencing 30 September 2024 - Volume 7, Document 1, Page 3).** Dr Inkster notes that she had concerns with your communication in relation to the decant. Do you feel that communication with staff and patients' families was accurate, honest and transparent? Please explain your answer.

**A.** My statement at the IMT of the 03/07/19 was an accurate 'repeat' of what I had been told directly by Mr Brown, Chairman and perhaps also, although I do not recall clearly, in the presence of Jane Grant, Chief Executive. I was not party to the content of the conversation(s) that occurred between Mr Brown and Professor Cuddihy.

37. Refer to Dr Inkster's statement at paragraph 826 (**Witness Bundle – Week commencing 30 September 2024 - Volume 7, Document 1, Page 3).** Dr Inkster notes that she was made aware of a telephone conversation between yourself and Jamie Redfern, during which you instructed that they were not to contact Professor Cuddihy in relation to his daughter having contracted M. Chelonae. Please detail your recollection of this. Did you instruct Jamie Redfern not to contact Professor Cuddihy? Please explain your answer.

**A.** The content of a private telephone conversation between Mr Redfern and myself was made known to Dr Inkster by the recipient of the conversation. This was a breach of confidentiality. I had suspected Mr Redfern was briefing and possibly speculating with Dr Inkster and Professor Cuddihy throughout this period. Mr Redfern in my opinion and from direct observation did not like confrontation and disagreement (I do not think anyone is a supporter of it especially being at the receiving end of it) however this would result in him conceding and sharing information and who was requesting the action. This is undermining of the position of Senior Management and causes barriers to communication of facts. The instruction from myself to Mr Redfern was a direct result of the Chief Executive and Chairman informing me that they had received a letter from Professor Cuddihy and they would be responding to it. My concern when speaking on the telephone with Mr Redfern was that the details of a second child who had caught the same infection was going to be discussed with Professor Cuddihy therefore a "breach of confidentiality" would arise without prior consent from the parent of the second child concerned. A failure of "duty of candour" to the parents of the second child. I would have sought Mr Redfern's view on the appropriateness of such a conversation and the rationale for the meeting. I do not recall whether Mr Redfern provided a response to my points. At this stage I had no idea of the content of the letter from Professor Cuddihy to the Chairman.

a) Dr Inkster further notes that at the IMT of 3rd July 2019 (**Bundle 1, Document 74, Page 330**) you reported that John Brown was in contact with Professor Cuddihy. She followed up on this at the next IMT where you reported that John Brown had spoken to Professor Cuddihy but that she subsequently became clear that John Brown had not informed Professor Cuddihy. Why did you report that this had been the case if it had not?

**A.** My statement at the IMT of the 03/07/2019 was an accurate 'repeat' of what I had been told directly by Mr Brown, Chairman and perhaps also, although I do not recall clearly, in the presence of Jane Grant, Chief Executive. I was not party to the content of the conversation(s) that occurred between Mr Brown and Professor Cuddihy.

38. What is your view of the quality of the communication with parents of patients in relation to increased infections and the decants? Do you consider updates were provided in a timely and transparent manner? In your opinion could GGC have done better and if so, how?

**A.** The timing of communication is always a point of potential contention especially when the situation was dynamic and evolving and the headline content of communication was determined by IMT meetings. The involvement of multiple people and layers of organisations as well as Scottish Government before 'approval' to release is granted can be and often is perceived as tardy. I believe despite this content and factual accuracy was relevant and the adjustment of written statement releases dependent upon the audience receiving them was tailored and appropriate. Improvements to communication can always be made especially the verbal updates to allow questions from staff, parents and patients that was successfully managed mainly through Ms Rodgers Chief Nurse and Mr Redfern General Manager, who were the senior management for the operational Children's Hospital. The opportunity in the future to issue statements before the evening of a Friday would be an improvement.

39. Please refer to Annex MB02 of the statement of Mark Bisset **(Hearing commencing 20 September 2021 - Bundle 7 - Statement of Mark Bisset - Annex MB02 for week commencing 1 November 2021).** This screenshot shows a statement posted by you on the private Facebook group for parents and families. Who provided you with advice on the terms of the post?

**A.** The compilation of this statement would have been the outcome of engagement with Communications Team, Chief Executive and Board Medical Officer and Scottish Government Oversight Board and specifically Professor White along with a review of extracts from all previous statements output from IMT meetings.

a) Had there been no issue with the ventilation in Ward 6a would these enhancements been carried out? Why was there no mention of the water/ventilation issues in the post?

**A.** I believe that the statement refers to further accessible information in the form of reports and investigations and explains the content subject of such materials are available and readily accessible. This statement does not mention water

issues and refers to technical review undertaken by the Board in 2018 and the Cabinet Secretary's wider external review into design, construction and maintenance of the QEUH/RHC. All papers are accessible for public scrutiny.

40. Please refer to IMT of 14 November 2019 **(Bundle 1, Document 88, Page 402)**. In respect of communications and advice to parents/patients regarding lifting of restrictions to the ward and parents' anxieties in respect of articles in the media. In respect of the Facebook page, you are noted as commenting that, "we have been factual in our account and all controls are in place". What do you mean by this statement? What communication strategies were in place to ease parents' anxieties and to keep them fully informed?

**A.** Media articles by their very nature can give rise to worry, stress and anxiety especially amongst child patients and parents and in particular when related directly to the ward children are being treated on. I do not recall the specific media headlines or story. My statement at the meeting was to reinforce that all communications affecting patients and parents was discussed and recommended from IMT meetings and any press release would be based upon the factual situation as far as patient care was concerned. Throughout the period following the opening of RHC in 2015 and until the conclusion of works to upgrade Ward 2A and 2B the media headlines could be alarming and draw attention to the claims within any article. NHSGGC attempts to robustly and timely answer all media enquirers and present a factual situation from the Board's perspective. Whether this is reflected in the public media article is out with NHS control. The communication strategies exist firstly at ward level and between the consultant and patient/parent and the wider clinical team. Secondly during times of heightened risk then the presence of Hospital Senior Management assists in supporting staff and interaction to support clinical staff with parents and where age appropriate child patients, in communicating the situation and the cause (if known). This is reinforced by written communication. Thirdly, action plans arising from IMT meetings and recommendations are communicated verbally and in writing as described in previous responses to earlier questions. Fourthly, wider communications usually in the form of proactive press releases and responses to media enquirers will also be shared. All of the above is reinforced daily through management walk rounds by

representatives of the Senior Hospital Management such as the Lead Nurse and Clinical Services Manager and usually weekly Mr Redfern and Ms Rodgers would visit the clinical areas. At any time if parents had concerns then they would be advised to raise them with the Ward Manager and/or named consultant for their child and they would attempt to answer and address any comments and concerns. If this did not resolve the situation then the issues would be raised to the next level of management for progressing. The key issue is open and factual communication and if you do not know something or the cause then say so and refer it to Senior Hospital Management.

41. Please refer to **Bundle 6, Document 25, Page 77**.
What role, if any 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 and do you consider it to be accurate in all respects?

**A.** I would have had direct involvement in providing answers to some questions and reviewing the final draft answers prior to conclusion of the content along with other colleagues. This would consequently result in a composite response addressing all of the questions raised. I think the responses provided are accurate and factually correct given the “knowns” at the time of preparation.

42. Please refer to the statement of Susan Dodd (**Witness Bundle – Week Commencing 26 August 2024 – Volume 2, Document 5, Page 223**). At paragraph 103 she notes that there was a lot of tension and frustration conveyed at IMTs by Senior Management. She recalls both you and Tom Steele being very frustrated and that she observed this to be directed at Dr Inkster. Please detail your recollection of this.

**A.** I would need to understand how I was conveying “tension” and “frustration” through my presence at the meeting. I fully supported the work of the IMT and had respect for professional colleagues especially the chair, Dr Inkster, as the dual role she undertook meant her providing the information to the group of the hypothesis and this would often be very scientific as well as chairing gathering of ‘experts’ in their respective professional fields often whom would expect a number of answers to their questions. This was an evolving picture and what

was thought to be a potential source would be addressed to then find the infections continued. As a leader in the organisation I am always conscious of my behaviour, words and actions and certainly would never try to undermine any colleague in a meeting or in private. I will however, when the opportunity arises, ask direct questions and often challenge and may play devils advocate to ensure the discussion considers all points before it reaches a conclusion. That is a key role of a director. To maintain calm whilst debating difficult and awkward questions and encourage others to share their expertise, thoughts, concerns and possible solutions.

a) Refer to the Core Brief of 6 December 2018 in respect of the decant of Wards 2A/B (**Bundle 52, Volume 2, Document 3, Page 66**). Here you state "As our patients and staff had already relocated to another ward, this provided a good opportunity to carry out this upgrading of the system":

(i) Had the need to carry out work to the ventilation system of Ward 2A only been identified by NHS GGC after decant on 28 September 2018?

**A.** I do not recall the exact date when the need for the ventilation system in Ward 2A to be upgraded was identified. This information will be available from Director of Estates and Facilities following expert and technical assessment report. My statement refers to "carry out this upgrading of the system" therefore I understand the decision to upgrade was already committed however the extent of the works and the scale of upgrade were I understand unknown at this time.

(ii) Why does this Core Brief not address the issue that the ventilation in Ward 2A not meeting the required standards had been recognized in March 2017 options appraisal document from the NHS GGC Acute Service Committee in respect of ventilation systems of Ward 4B **(Bundle 27, Volume 7, Document 6, Page 158 at Page 172**)?

**A.** The Core Brief was prepared and finalised with NHSGGC Communications Team and approved for issue by the Chief Executive.

(iii) Do you feel this statement is open and transparent?

**A.** The statement fulfils its purpose to inform what was planned during the time Ward 2A was vacated.

(iv) With the benefit of hindsight do you accept that the statement could reduce trust not improve it?

**A.** The statement I acknowledge could and may receive a different response and reaction from those who are recipients of it.

b) Can you confirm whether a Business Continuity Management Plan (BCMP) was in place for the risks associated with closure of the Schiehallion Unit, prior to occupancy in 2015? How often was this plan tested prior to decant in September 2018?

**A.** I am unable to confirm whether a Business Continuity Management Plan (BCMP) existed specifically for Ward 2A Schiehallion Unit prior to occupancy of new RHC in 2015. I would anticipate that a BCMP would tend to address hospital wide impacts from failures of technical services or resulting from water and fire damage. The plan was never tested either prior to or since 2015. I can confirm that an updated BCMP was produced for new RHC and the hospital's General Management Team produced it.

**Duty of Candour**

43. What is your understanding of duty of candour? How do you understand this duty should be applied within a setting such as NHS GGC and the QEUH and RHC? What is your understanding of with whom this duty sits?

**A.** Duty of candour in an NHS setting is a requirement on an individual, team, organisation to be honest, factual and accurate in their discussions and written communication with whoever is receiving care from us. If affected by a situation and to inform them when something has gone wrong. To apologise for any error or shortcoming in care. Where appropriate, to offer a suitable remedy to correct the omission or provide support to correct the deficiency. I am aware of three principles of duty of candour. These are openness, transparency and candour. This duty sits with all health and care professional staff. In organisational terms,

this applies to all managers to be aware of incidents that may require full disclosure of an impact upon health care and individual(s) receiving care.

44. 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? Do you accept that his criticism is fair? Has the policy now been changed?

**A.** I am aware of Professor White's comments regarding NHSGGC duty of candour policy and I understand that a review was undertaken to address at the time the 'present' policy and to amend it in light of others' experiences. I do not know the outcome of this work.

**Executive Control Group**

45. Please refer to **Bundle 14, Volume 2, Document 88, Page 95**, your email of 6th June 2018, regarding the establishment of the Executive Control Group of which you were Chair.

a) What was the remit of the Executive Control Group and your role within the Group?

**A.** The purpose of the ECG was to provide a level of support to the IMT by building greater understanding and a forum to discuss possible 'cause and effect' scenarios in a protected and 'restricted' members meeting. This was the suggestion of the Chief Executive and I duly undertook this task. I chaired the group.

b) What governance procedures were in place for the Executive Control Group? To whom did the Executive Control Group report and who reported to the Group?

**A.** The ECG aimed to provide a forum to delve deeper and understanding driving factors and issues from each professionals' perspective and to share this information in a safe, enclosed environment whilst trying to gain a level of cooperation and prioritisation to the challenges faced now and future. Members were - myself, Dr Inkster, Mr Steele, Jen Rodgers, Jamie Redfern, and other ad-hoc invitees dependent on the technical knowledge and expertise required to inform consideration of the issue under review.

c) Please refer to **Witness Bundle - Week commencing 30 September 2024 - Volume 7, Document 1, Page 3.** Dr Inkster notes at paragraph 609 of her statement that she did not feel that this group was helpful as meetings were cancelled or never held. Please detail your recollection of the meetings of the group. If meetings were cancelled why was this? Were these meetings rescheduled? Were agendas produced and minutes taken for these meetings?

**A.** In trying to establish a meeting schedule and members attendance it quickly became apparent that playing another meeting into the working week basically that 'went over' decisions following discussions with relevant professionals at the IMT meetings was a thankless task and I decided it was best for all concerned to cancel all future meetings and concentrate on improving 'relationships' through respect and listening to other experts reasoning especially when it may not sit with your own view of the situation under consideration. A small number of meetings were held or partially held based on lack of attendance although I do not think we met frequently enough to agree terms of reference. I stood the meeting down. I believe some notes were recorded for the few meetings held although I do not know where these will be filed.

## Conclusion

46. Is there anything further you wish to add which you think may assist the Inquiry?

**A.** I would like to express my gratitude to the patients, parents and families for their ongoing support of the consultants and clinical teams who strive and endeavour to provide the best individualised care and treatment to all patients. Despite the unprecedented circumstances presented in the clinical environment they collectively attempted to overcome severe obstacles to persevere in the best interests of children under their care.

It was an astonishing and devastating situation to discover that ventilation systems did not provide the standard level of protection required of the most vulnerable patient group.

I regret, in the light of this experience, and acknowledge that I personally should have undertaken more questioning and obtained documented evidence that the ventilation systems were “fit for purpose” to ensure that a deficiency in a mechanical system did not present a greater risk to patients.

I trust that the lessons learned and omissions raised from this Inquiry are never repeated and that the safety of patients and the environment is always a number one priority in the build and commissioning of new hospital buildings and refurbished clinical areas.

## Declaration

47. 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** - Scottish Hospitals Inquiry - Hearing Commencing 12 June 2023 - Bundle 1 - Incident Management Team Meeting Minutes (IMT Minutes)

**A43273121** - Scottish Hospitals Inquiry - Hearing Commencing 12 June 2023 - Bundle 3 - NHS National Services Scotland: SBAR Documentation

**A43293438** - Scottish Hospitals Inquiry - Hearing Commencing 12 June 2023 - Bundle 6 - Miscellaneous documents

**A35200730** - Scottish Hospitals Inquiry - Hearing Commencing 20 September 2021 - Bundle 7 - Statement of Mark Bisset - Annex MB02 for week commencing 1 November 2021

**A47390519** - Scottish Hospitals Inquiry - Hearing Commencing 19 August 2024 - Bundle 11 - Water Safety Group

**A48890718** - Scottish Hospitals Inquiry - Hearing Commencing 19 August 2024 - Bundle 13 - Additional Minutes Bundle (AICC/BICC etc)

**A49541141** - Scottish Hospitals Inquiry - Hearing Commencing 19 August 2024 - Bundle 14 - Further Communications - Volume 2

**A47664054** - Scottish Hospitals Inquiry - Hearing Commencing 19 August 2024 - Bundle 15 - Water PPP

**A53671356** – Scottish Hospitals Inquiry – Hearing Commencing 16 September 2025 - Bundle 52 – Miscellaneous Documents – Volume 2

**A49677119** - Scottish Hospitals Inquiry - Hearing Commencing 19 August 2024 - Witness Bundle - Week Commencing 26 August 2024 - Volume 2

**A50152363** - Scottish Hospitals Inquiry - Hearing commencing 19 August 2024 - Witness Bundle - Week Commencing 30 September 2024 - Volume 7

**A43501437** - Scottish Hospitals Inquiry - Hearing Commencing 12 June 2023 - Bundle of witness statements

**A50766285** - Hearing Commencing 19 August 2024 - Day 35 - 24 October 2024 - Transcript - Professor Craig White