Scottish Hospitals Inquiry
Glasgow 4 Hearings
Second Supplementary Witness Statement of
Laura Imrie

Personal Details

1. Laura Imrie, Lead Consultant, Antimicrobial Resistance and Healthcare Associated Infection Scotland ("ARHAI Scotland") and Clinical Lead NHS Scotland Assure, NHS National Services Scotland ("NSS").

2. I have previously provided a witness statement to the Inquiry's Glasgow III Hearing **(Witness Bundle – Week Commencing 2 September 2024 – Volume 3, Document 4, Page 201)** and a supplementary witness statement **(Witness Bundle – Week Commencing 9 September 2024 – Volume 4 - Document 5, Page 275)**.

3. This statement is provided in response to a request made by Counsel to the Scottish Hospitals Inquiry. NSS submitted a closing statement **(Hearing Commencing 19 August 2024 – Core Participants Closing Submissions – Document 8, Page 147)** following the Glasgow III Hearing. Counsel to the Inquiry has invited NSS to provide information relating to a number of areas covered within that closing statement.

Alert Organism Surveillance

4. As referenced in several points within Counsel to the Inquiry's Glasgow III Closing Statement (**A51312578 – Glasgow III Counsel Closing Statement**), the Inquiry has heard evidence in relation to alert organism surveillance. This, along with the national alert organism list, is discussed at several points in the

closing statement – in **paragraph 16 of the introduction (page 5); paragraph 128 of chapter 3, (page 56); paragraph 359 of chapter 5, (page 307) and paragraph 802 of chapter 5 (page 445)**. I would like to ensure there is clarity regarding the role of the national alert organism list in supporting local NHS Board surveillance.

5. The National Infection Prevention and Control Manual (NIPCM) national alert organism list is evidence based and derived from Scottish epidemiological data, reported outbreaks in Scotland and the UK, and intelligence from ARHAI Scotland systematic literature reviews **(Bundle 19, Document 24, Page 440).** Appendix 13 of the NIPCM hosts the nationally agreed minimum list of alert organisms/conditions **(Bundle 52, Volume 5, Document 29, Page 131).** The purpose of this list is to support NHS Board IPC teams to establish and maintain local surveillance/reporting systems, including the development of triggers for clinical areas. The list is not exhaustive. Specialist units, for example those managing patients with Cystic Fibrosis, will also be guided by local policy regarding other alert organisms not included within these lists.

6. Ongoing local surveillance of other priority organisms, informed by local epidemiology and an understanding of the patient population being cared for, is an essential component of IPC surveillance. In addition, microbiologists working locally have the skills and expertise to identify unusual organisms that require further investigation. An electronic system cannot replace this expert knowledge. The NIPCM Chapter 3 details the assessment, investigation, management and communication guidance for suspected or confirmed Healthcare Infection Incidents, Outbreaks and data exceedances. This is irrespective of whether the organism is on the national or local alert Organism List or is identified by microbiology expertise.

7. Counsel to the Inquiry's Closing Submission **paragraph 220 of chapter 3, page 78,** states;

"ARHAI co-ordinates national surveillance of organisms. Ms Imrie explained that there were two ways in which ARHAI might not become aware of an unusual organism. Firstly, the health board might know about an unusual infection but not report it up to ARHAI. Secondly, the health board's local surveillance may not pick it up, so the health board is unaware of the unusual infection. The Inquiry heard evidence that a HIIAT may be carried out by a health board on an unusual infection but that may not lead to the health board reporting it to ARHAI. As she put it "when boards don't report things in, it's not just that we're not aware of it; it's that we're losing that national intelligence to plan for any emerging issues." However, the ICNET electronic system allows information to be pulled out of the local laboratory systems and patient management systems. It can be set up to look for one case of a particular microorganism and a trigger set if one occurs to alert HPS. In theory, a health board could set up triggers for a list of unusual micro-organisms. It was acknowledged by Ms. Imrie that there was a gap in the system if experienced microbiologists and scientists do not notice an unusual organism and escalate it".

8. I discussed in my oral evidence, provided on 6 September 2024, (**Laura Imrie, Transcript, Page 54, Column 104**) that where an incident meets the definitions within Chapter 3 of the NIPCM, ARHAI Scotland would expect the local NHS Board to report in line with the NIPCM. In my oral evidence I also discussed the challenges faced by ARHAI Scotland as a national body with responsibility for monitoring infection-related incidents when NHS Boards derogate from guidance. As I said in evidence;

   "The effectiveness of reporting healthcare infection risks relies entirely on NHS Boards adhering to the guidance outlined in Chapter 3 of the NIPCM. I am aware that some NHS Boards have local governance structures that differ from the NIPCM, which means that the oversight SGHAIPU can provide is limited to what the NHS Boards choose to report."

9. In my oral evidence I also stated that NHSGGC had "developed its own governance structures around carrying out Healthcare Infection Incident

Assessment Tool (HIIAT) assessments and criteria for reporting infection-related incidents which appear not to align with NIPCM reporting." This was confirmed at the Glasgow III Hearings by the NHSGGC Director of Infection Prevention and Control during her oral evidence (**Sandra Devine, Transcript, Page 12, Column 19 & 20**). NHSGGC has since shared the local Incident Management Process Framework SOP with the Inquiry **(Bundle 27, Volume 17, Document 28, Page 315).** Within this document, "Section 2.1. Initial Assessment/Problem Assessment Group" states;

"An initial assessment is required to determine if an outbreak or incident is taking place. In a hospital, this will be carried out by the IPCT, or through a Problem Assessment Group (PAG). The initial assessment will be based on available information. It may not be possible to make a decision on the information available immediately and further investigations may be required.

A PAG may not always be required, and it is not necessary to hold a PAG prior to activating an Incident Management Team (IMT) meeting. If an assessment is required or a PAG is held the IPCT will complete an NHS GGC IPC Incident summary (Appendix 1)/or if no further action is required a situation summary will be completed as a record of discussions held. There are normally two potential outcomes to a PAG:

- No significant risk to public health and/or patients; the PAG stood down, but surveillance continues or
- There are some concerns and the situation is assessed using the National Healthcare Infection Incident Assessment Tool (HIIAT) (www.nipcm.hps.scot.nhs.uk/media/2260/2022-02-07-hiiat-v20.pdf - **Bundle 27, Volume 1, Document 67, Page 662**) all assessments regardless of outcome must be recorded on the Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Outbreak Reporting Tool (ORT)".

10. This local SOP appears to advise that a separate assessment is carried out locally prior to deciding if an assessment using the NIPCM HIIAT is required. This may account for the variation in reporting against the NIPCM.

11. I would like to make it clear that there is no suggestion by ARHAI Scotland that unusual organisms are not acted on by NHSGGC, either by the labs detecting and reporting these cases or the clinical team treating patients. In **paragraph 220 of chapter 3, page 78** of Counsel to the Inquiry's Glasgow III Closing Statement, it was noted that I discussed that there are instances where an NHS Board identifies an unusual organism but does not report it to ARHAI Scotland. In my oral evidence I provided examples of the reasons why an NHS Board may not report to ARHAI Scotland, including where local surveillance systems do not detect a cluster or outbreak or where the local IPC Team, who is aware of an incident, make a local assessment not to report through the national ORT (**Laura Imrie, Transcript, Page 26, Column 48**). This discussion regarding the identification of unusual organisms is not a reflection on the capability of local microbiology experts to recognise such organisms but rather pertains to the decision-making process around reporting in line with the NIPCM.

12. It remains the ARHAI Scotland position that the national reporting criteria should be standard across NHSScotland. This is to ensure the application of consistent and measurable definitions that allow for early detection and national monitoring of any emerging situations (**DL (2024) 24**) (**Bundle 52, Volume 2, Document 6, Page 69)**. ARHAI Scotland has noted that the Inquiry has recently released the NHSGGC Outbreak/Incident SOP For Outbreak/Incidents Of Communicable Or Alert Organisms In Healthcare Premises 2024 **(Please refer to Bundle 27, Volume 17, Document 28, Page 315)** which confirms there is a local process which may result in incidents not being reported to ARHAI Scotland following initial review by the local IPCT.

13. The Scottish Government has been leading on the development of an outline business case for a national IPC e-surveillance solution. This was completed in April 2025. It is intended that this system will have local and national functionality. ARHAI Scotland is contributing to the development of the national requirements for this system to ensure that intelligence on healthcare associated infections, including unusual organisms and those presenting

environmental risk, can be captured and integrated consistently and promptly within national datasets. Scottish Government published a Prior Information Notice (PIN) for the National Infection Prevention Control Intelligence Solution in January 2025 which notifies of its intention to tender future planned procurements (Public Contracts Scotland - National Infection Prevention Control Intelligence Solution – **Bundle 52, Volume 2, Document 26, Page 384**).

14. The ARHAI Scotland pilot methodology for surveillance of environmental organisms in high-risk units includes the development of local surveillance triggers that could potentially be built into future IPC e-surveillance solutions. At this time, the only funding agreed is to develop the outline business case. The funding to procure a national system for Scotland has not yet been agreed and so the future of such a connected system remains uncertain.

Additional Counsel to the Inquiry Questions

15. NSS was asked in an email from the Inquiry dated **26 March 2025**;

    "We [The Inquiry] would be interested to understand if AHRAI or NSS more widely has a view on the extent to which "Assurance Information Systems" in NHS Boards **(Bundle 52, Volume 1, Document 12, Page 106, Paragraphs 5.2-5.4**) needs to involve an NHS Board being able to understand, through some reporting system, the emergence of and reaction to 'unusual infection' or potentially environmentally related HAIs outwith the nationally reportable infections".

16. It is the NSS/ARHAI Scotland view that local NHS Boards would be better placed to demonstrate what processes and reporting systems were/are in place to allow the Board Executive Team to understand HAI related risks and issues including those that may involve the healthcare environment.

17. In the same email dated **26 March 2025**, the Inquiry also asked NSS to specify;

"Its current concerns about the way that HAI/HCAIs are identified, reported and managed within NHSGGC as a whole and the QEUH in particular and what steps would it like to see taken to address any such concerns."

18. ARHAI Scotland does not have any concerns with NHSGGC's identification or clinical management of unusual organisms. Indeed, it was the proactive testing by clinical teams and identification of these unusual organisms by the clinical laboratory team that has provided the data on what unusual organisms have been present with this healthcare setting. ARHAI Scotland has seen no evidence to suggest that these organisms have not been reported by clinical laboratory staff to clinical teams in a timely and appropriate manner.

19. ARHAI Scotland has raised issues regarding the lack of a consistent approach by NHSGGC to the reporting of possible healthcare related infections, in line with NIPCM guidance. ARHAI Scotland has highlighted the challenges in obtaining information from NHSGGC to enable further assessment of incidents reported. During my oral evidence (**Laura Imrie, Transcript, Page 47, Column 89 and 90**) I have discussed some of the concerns ARHAI Scotland has continued to encounter when receiving requested information from NHSGGC.

20. In a further email dated **9 May 2025**, the Inquiry asked NSS;

"Are you able to assist the inquiry about whether an issue has arisen this year about NHS GGC failing to respond promptly to a request from the ARHAI to produce material about suspected Cryptococcus cases. Did you have to raise an issue about such a request with anyone at NHS GGC? Please set out the background to the request, the material sought and any issues that arose in obtaining the material from NHS GGC?."

21. On 15 November 2024 I received an email from Colin Urquhart, Policy Lead, Scottish Government, inquiring whether the ARHAI Scotland team was aware of

NHSGGC reporting additional Cryptococcus cases. Mr. Urquhart noted that this had been discussed during Drs. Sara Mumford and Linda Dempster's oral evidence to the Inquiry on 13 November 2024 (**Dr Sara Mumford and Ms. Linda Dempster, Transcript, Page 35, Column 66**). On the same day, Shona Cairns, Consultant Healthcare Scientist, ARHAI Scotland confirmed that ARHAI Scotland was not aware of the four cases that the witnesses had discussed during their evidence and that the last Cryptococcus case that NHSGGC had reported to ARHAI Scotland was in 2020 **(Bundle 52, Volume 4, Document 8, Page 72)**.

22. On 18 November 2024 **(Bundle 52, Volume 4, Document 8, Page 71)** Mr. Urquhart requested that ARHAI Scotland, as the national experts for IPC, contact NHSGGC to ask:

- Did the four Cryptococcus cases referred to by Drs. Dempster and Mumford exist?
- If they did, why were they not reported to ARHAI Scotland?
- Would NHSGGC now report the cases to ARHAI Scotland?

23. NHSGGC confirmed in an email on 19 November 2024 that the NHSGGC IPC Team had reviewed 7 cases of Cryptococcus in patients cared for in the QEUH since 2020 **(Bundle 52, Volume 4, Document 9, Page 77)**. Staff stated that the cases were not reported to ARHAI Scotland through the Outbreak Reporting Tool (ORT) because, at the time, NHSGGC "believe[d] that none of them fulfil the NIPCM Chapter 3 criteria for reporting" however, "one of the cases was reported to ARHAI in 2020".

24. In a meeting between Mr. Urquhart and myself on 22 November 2024, it was agreed with the Scottish Government that ARHAI Scotland should undertake a retrospective analysis of Cryptococcus data across all NHS Boards in Scotland, to better understand cases from a national perspective.

25. There was some challenge in extracting data from the national system and so a Pro Forma was issued by Dr Teresa Inkster, Infection Control Doctor/Consultant Microbiologist, ARHAI Scotland to the Scottish Microbiology Virology Network (SMVN) on 27 November 2024, to facilitate the return of local NHS Board data. Dr Abhijit Bal, Consultant, Head of Service Microbiology and Infection Control Doctor, NHSGGC, queried whether Caldicott approval was required to submit local data to ARHAI Scotland **(Bundle 52, Volume 4, Document 10, Page 80)**.

26. On 27 November 2024 I shared this response with the NSS Medical, Nursing and NHSScotland Assure Directors internally and the Scottish Government Chief Nursing Officer Directorate (CNOD), as I anticipated that this might cause a delay in the information being available. It was also agreed with Dr Sharon Hilton-Christie, Medical Director, NSS, that she would contact Dr Scott Davidson, Medical Director, NHSGGC to discuss any concerns in relation to Caldicott approval. It should be noted that there has been an Intra NHSScotland information sharing agreement in place since 2023. Dr Inkster informed Dr Bal of this in an email dated 28 November 2024 **(Bundle 52, Volume 4, Document 13, Page 102)**.

27. On 2 December 2024, NHSGGC informed ARHAI Scotland that we would only be provided with anonymous and de-duplicated data within the suggested time frame of 6 December 2024, to which ARHAI Scotland agreed. ARHAI Scotland received this information on 10 December 2024 **(Bundle 52, Volume 4, Document 15, Page 109)**. It should be noted that anonymous and locally de-duplicated data does not allow ARHAI Scotland to carry out a national assessment. This information was shared with the NSS Medical Director. Following a further conversation between NSS and NHSGGC Medical Directors, NHSGGC provided the full data set.

28. On 21 February 2025 following a review of the national data, the Scottish Government CNOD requested that more details of cases from two separate NHS Boards be sought to establish any possible links to the healthcare

environment. ARHAI Scotland requested further information from NHSGGC regarding the seven reported Cryptococcus cases, with a return deadline of 14 March 2025. On 6 March 2025 NHSGGC requested a deadline extension, to which the ARHAI Scotland team responded by requesting a data submission timeline of NHSGGC. NHSGGC confirmed on 13 March 2025 that the team would "have a better idea of timelines [to return the requested information] once we contact clinical colleagues" **(Bundle 52, Volume 4, Document 16, Page 113)**.

29. Between 14 March 2025 and 17 April 2025 there was correspondence between NHSGGC and ARHAI Scotland, including both Medical Directors, as we looked to agree a deadline for information to ensure that our retrospective analysis could be finalised **(Bundle 52, Volume 4, Document 21, Page 127)**. NHSGGC noted that they needed answers from ARHAI Scotland to follow up questions, due to the "unusual request for patient-sensitive information" and confirmed that the delay in providing the clinical information was because the IPC Team "would need to contact the patients' consultant." NHSGGC also noted that "The ICDs do have concerns and requested answers to a list of questions to provide some context to these clinicians."

30. The final email from my records is dated 17 April 2025, in which Dr Scott Davidson confirmed that NHSGGC would provide the follow up information as soon as it was available **(Bundle 52, Volume 4, Document 21, Page 127)**. We still hope to receive this information and are in continued discussion with Scottish Government colleagues, who have now taken a lead role to retrieve this local data.

31. I am happy to provide the Inquiry with further information on this matter to assist its understanding of events.

The QEUH/RCH Advice and Assurance Review Group (AARG)

32. With reference to paragraph 9 of this statement, I have been asked to review Ms Devine's response to Question 19 in her statement for the Glasgow 4, Part 2 hearing that addresses questions about the *NHS GGC 'Incident Management Framework SOP*' (**Bundle 27, Volume 17, Document 28, Page 315**).

a) I have been asked to comment on whether I accept that "NIPCM's definition of an outbreak/incident is open to interpretation".

Yes, it is reasonable to acknowledge that the National Infection Prevention and Control Manual (NIPCM) definition of an outbreak or incident may appear open to interpretation for a lay person, but this is not the case for trained Infection Prevention and Control (IPC) specialists. The definitions are intentionally not overly prescriptive, allowing for professional judgment to be applied by those with the appropriate expertise.

NHS Board IPC specialists should be suitably qualified and experienced to interpret and apply the guidance based on local intelligence, including factors such as pathogen type, incubation periods, potential sources, and the patient population. This flexibility ensures that responses are context-specific and proportionate.

Furthermore, NHS Board Infection Prevention and Control Teams (IPCTs) are actively involved in the development and review of the NIPCM. As such, they understand it as a working document, designed to support real-time decision-making. IPCT interpretation is also guided by the expectations set out in the Scottish Government Directorate Letters. In April 2017, Chief Nursing Officer Letter (https://www.nipcm.hps.scot.nhs.uk/media/1653/2017-04-03-nipcm-endorsement-letter.pdf) **(Bundle 52, Volume 5, Document 11, Page 72)** introduced Chapter 3 of the NIPCM stating:

"The NIPCM is mandatory for all NHSScotland employees and applies to all NHSScotland healthcare settings, NHS provided services as well as, independent contractors providing NHS services and private providers of

healthcare."

Most recently, **DL (2024) 24** (https://www.publications.scot.nhs.uk/files/dl-2024-24.pdf) **(Bundle 52, Volume 2, Document 6, Page 69)** reinforces the responsibilities of NHS Boards to adopt the NIPCM:

"3. As Scotland's national-level clinical IPC experts, ARHAI Scotland is responsible for providing expert intelligence, support, advice, evidence-based guidance, clinical assurance and tailored national leadership to stakeholders in response to outbreaks and incidents. This informs and enables local capability and the development of epidemiological intelligence, underpinned by available evidence.

4. Therefore, NHS Boards are required to provide information on infection incidents, outbreaks, and data exceedances directly to ARHAI Scotland, as set out within the NIPCM, to ensure comprehensive national-level infection incident data is available.

5. Scottish Government expects NHS Boards to engage openly with ARHAI Scotland as appropriate in respect of their role as national-level clinical leaders in relation to the prevention and control of HCAI.

National Infection Prevention and Control Manual

6. Scottish Government expects all NHS Boards to adopt the NIPCM. NHS Boards will maintain local assurance of compliance with, and implementation of, the guidance through continuous monitoring in all healthcare settings. Local compliance and assurance processes should be supported by robust governance arrangements.

7. The Healthcare Infection Incident Assessment Tool (HIIAT) should be used to assess every healthcare infection incident i.e. all outbreaks and incidents (including exposure incidents, decontamination incidents or near misses) in any healthcare setting (that is, the NHS, independent contractors providing NHS services as stated in Chapter 3 of the NIPCM).

8. As you will be aware, early detection and timely assessment of a possible incident, outbreak or data exceedance supports implementation of appropriate control measures to prevent ongoing transmission. An early and effective response to an actual or potential healthcare incident/outbreak is crucial. Your local infection prevention and control team and health protection team should be aware of and refer to the national minimum list of alert organisms/conditions in Appendix 13 of the NIPCM.

9. Whilst there is provision for NHS Boards to derogate from the NIPCM, Scottish Government expects that NHS Boards continue to ensure safe systems of work by the completion of a risk assessment and escalation approved and documented through local governance procedures."

b) I have been asked whether I accept that paragraph 2.1 of the *NHS GGC 'Incident Management Framework SOP* is "entirely consistent with the guidance in the *Management of public health incidents: guidance on the roles and responsibilities of NHS led incident management teams,* section 6.4 (**Management of public health incidents: guidance on the roles and responsibilities of NHS led incident management teams - Management of public health incidents: guidance on the roles and responsibilities of NHS led incident management teams - Publications - Public Health Scotland**).

I accept that Paragraph 2.1 of the NHSGGC 'Incident Management Framework SOP' appears to be a direct lift from Section 6.4 of 'Management of Public Health Incidents: guidance on the roles and responsibilities of NHS led incident management teams document' (https://publichealthscotland.scot/publications/management-of-public-health-incidents-guidance-on-the-roles-and-responsibilities-of-nhs-led-incident-management-teams/management-of-public-health-incidents-guidance-on-the-roles-and-responsibilities-of-nhs-led-incident-management-teams/) **(Bundle 27, Volume 14, Document 18, Page 88)**.

It is, however, unclear why a local NHS Board framework document addressing healthcare infection incidents would incorporate elements from broader public

health guidance, given that the Management of Public Health Incidents document consistently references the NIPCM as the primary source of guidance for healthcare associated infection incidents, as listed below:

- The Purpose, Statement and Scope section (page v) states,

  "for guidance on the management of all Healthcare Infection Incidents and Outbreaks please refer to Annex C and Chapter 3 of the National Infection Prevention and Control Manual (NIPCM): http://www.nipcm.hps.scot.nhs.uk/"

- Page 8 Table 1: Classification of public health incidents and suggested level of response,

  "Levels 0-3: The Healthcare Infection Incident Assessment Tool (HIIAT) should be used to assess every healthcare infection incident i.e. all outbreaks and incidents (including decontamination incidents or near misses) in any healthcare setting (that is, the NHS, independent contractors providing NHS services and private providers of healthcare)."

- Page 33, 125,

  "NHS boards and HPS/PHS must notify suspected public health incidents to the SGHSCD, if possible, prior to the first meeting of the IMT. Notifications should be made to a SGHSCD representative (e.g. SMO or policy officer) in line with the protocol agreed with Scottish Government Ministers in 2007 (excluding all infection incidents and outbreaks in any healthcare premise for which separate arrangements apply, see Annex C)."

- Page 64 Annex C clearly directs NHS Boards to follow the NIPCM guidance including the assessment using the Healthcare Infection Incident Assessment Tool (HIIAT),

  "The Healthcare Infection Incident Assessment Tool (HIIAT) should be used by the Infection Prevention and Control Team (IPCT) or Health Protection Team (HPT) to assess every healthcare infection incident i.e. all outbreaks and incidents (including decontamination incidents or near

misses) in any healthcare setting (that is, the NHS, independent contractors providing NHS services and private providers of healthcare)."

- Page 67,

  "Healthcare Infection Incidents and Outbreaks - please refer to Chapter 3 of the National Infection Prevention and Control Manual (NIPCM) http://www.nipcm.hps.scot.nhs.uk/. The purpose of Chapter 3 is to support the early recognition of potential infection related issues, to minimise the risk of cross-transmission of infectious agents within health and other care settings; and outline the incident management process".

c) I have been asked to comment on the relevance of section 6.4 of the *Management of public health incidents: guidance on the roles and responsibilities of NHS led incident management teams* on the operation of Chapter 3 of the NICPM.

Section 6.4 of the *Management of public health* incidents document is not relevant in the context of HAI incidents, particularly where specific national guidance is already in place. Assessing an incident within the community can often be relatively straightforward, particularly when individuals with the same pathogen reside in different geographic areas. In such cases, it is usually easy to determine that there is no clear link in terms of time, place, or person, allowing for a quick initial assessment.

However, when two or more individuals are linked to a healthcare setting, the assessment becomes more complex. In these situations, further investigation is often required to determine whether there are shared exposures, such as overlapping procedures, common environmental factors, or links in care pathways. It may also be necessary to consider background infection rates within the facility to distinguish between coincidental cases and a potential outbreak. Therefore, more time may be required to establish whether there are meaningful links within healthcare and whether the situation constitutes a potential incident. However, this should not delay the initial reporting process, which must still be carried out in accordance with the NIPCM Chapter 3,

ensuring timely escalation and appropriate oversight.

Given this context, and my response to paragraph 32 (b), I do not believe it is appropriate to selectively apply sections of the Public Health guidance while disregarding others that clearly state healthcare infection incidents should be managed in line with the NIPCM. The guidance is designed to be used holistically, and selective interpretation risks undermining the consistency and effectiveness of incident management across NHS Boards.

d) I have been asked how I would respond to the suggestion that the reference to *Management of public health incidents: guidance on the roles and responsibilities of NHS led incident management teams* at the start of Chapter 3 of the NIPCM would entitle NHS GGC to create an SOP which operates in the manner described by Ms Devine.

The NIPCM explicitly states:

> "The purpose of this chapter is to support the early recognition of potential infection incidents and to guide IPCT/HPTs in the incident management process within care settings; that is, NHSScotland, independent contractors providing NHS services, and private providers of care. This guidance is aligned to the Management of Public Health Incidents: Guidance on the Roles and Responsibilities of NHS-led Incident Management Teams."

This statement is intended to assure the reader that the two documents (the NIPCM and *Management of public health incidents: guidance on the roles and responsibilities of NHS led incident management teams)* are aligned. It is for this reason that the Management of Public Health Incidents: Guidance on the Roles and Responsibilities of NHS-led Incident Management Teams consistently references the NIPCM as the primary source of guidance for healthcare-associated infection incidents.

My answer to whether it is reasonable to use a section from the Public Health guidance simply because it is referenced in the hospital outbreak guidance is not without context. While cross-referencing the documents may be appropriate,

neither document advises nor supports the selective use of isolated sections. Both are designed to be used holistically and in alignment, particularly when managing healthcare infection incidents.

Selective interpretation or application of guidance risks undermining the consistency, clarity, and effectiveness of incident management. Therefore, any use of content from the Public Health guidance must be contextually appropriate and aligned with the overarching principles and processes outlined in the NIPCM, especially when applied within healthcare settings.

National reporting definitions and protocols ensure consistency, accuracy, and comparability of data across healthcare settings, supporting system-wide learning and improvement. If individual reporting bodies develop local protocols using a mix of guidance documents, it can lead to fragmented reporting, reduced data reliability, and missed opportunities for coordinated national responses and learning.

e) I have been asked whether I accept that response that Ms Devine has made to question 19(b) as fully addressing my concerns.

Ms Devine’s response appears to place emphasis on identifying links between cases prior to conducting an assessment using the Healthcare Infection Incident Assessment Tool (HIIAT), which is the agreed national framework for assessing healthcare infection incidents.

Relying on subjective judgment to establish links before applying HIIAT may lead to underreporting or delays in reporting. This approach risks missing early signals of potential incidents and can result in a loss of valuable national intelligence, which is critical for monitoring trends, informing policy, and coordinating effective responses across NHSScotland.

The HIIAT is designed to support objective, consistent, and timely assessment, and should be applied at the earliest opportunity when a potential healthcare infection incident is suspected, not after links have been confirmed. It is an ongoing process that allows for updates and reassessment as further

intelligence becomes available.

f) I have been asked whether the number of reports by NHS GGC to ARHAI described by Ms Devine in her answer to Question 9(c) satisfies me that NHS GGC is fully complying with its reporting obligations in the NIPCM.

Having reviewed the data held by ARHAI Scotland between 01/01/2024 and 28/02/2025, NHSGGC submitted a total of 223 incidents via the ARHAI Scotland Outbreak Reporting Tool (ORT), of which 180 were on Respiratory Short Forms (minimum dataset for COVID-19, influenza or RSV) and 43 were full Healthcare Infection Incident and Outbreak Reporting Template (HIIORT) form submissions.

Of the 43 full submissions the highest HIIAT assessments recorded were:

Hospital	Red	Amber	Green	Total
Glasgow Royal Infirmary	6	0	6	12
Queen Elizabeth University Hospital	1	1	8	10
Royal Alexandra Hospital	0	4	5	9
Royal Hospital for Children	0	1	5	6
Gartnavel General Hospital	1	2	1	4
The Princess Royal Maternity Unit	0	0	1	1
Inverclyde Royal Hospital	0	1	0	1
Grand Total	8	9	26	43

The reporting of these incidents does not provide sufficient evidence to confirm either compliance or non-compliance.

33. With reference to paragraph 7 of this statement, in order to assist the Inquiry in understanding the significance or otherwise of the issue of the terms of the *NHS GGC 'Incident Management Framework SOP,* I have been asked to give an example or examples of how the operation of the SOP could result in ARHAI not becoming aware of an unusual organism and what impact that could have on the work of ARHAI and the health of the Scottish population.

If NHS Boards do not consistently follow national guidance for reporting healthcare-associated infections (HAIs), it can lead to gaps in national surveillance, delayed outbreak detection, and inconsistent risk assessments. This undermines the ability to monitor trends, share learning, and make informed policy decisions at a national level. Ultimately, it risks a loss of national intelligence, reducing the effectiveness of Scotland's overall infection prevention and control strategy.

34. I have been referred to paragraph 12 of this statement and my reference to *The NHSGGC Outbreak/Incident SOP For Outbreak/Incidents Of Communicable Or Alert Organisms In Healthcare Premises 2024* and made aware that the Inquiry only holds a 2019 version (**Bundle 43, Volume 3, Document 52, Page 1569)** 2019 NHSGGC Outbreak SOP V9 details - Objective).

a) I have been asked to produce the 2024 version if ARHAI holds it.

I accessed this document, published on 28 February 2024, ("evidence not in bundles relevant to Angela Wallace's testimony on 25.10.2024 and provided to the Inquiry") from the Scottish Hospitals Inquiry website (https://hospitalsinquiry.scot/inquiry-document/incident-management-process-framework-sop) **(Bundle 27, Volume 17, Document 28, Page 315).**

b) I have been asked whether I see any inconsistency between the terms of section 5 of the 2019 version and the statement that refers to a HIIAT assessment of green where there is no significant risk to patients or the public

and the terms of paragraph 2.1 of the *NHS GGC 'Incident Management Framework SOP'.*

Yes, there are inconsistencies between the different versions as noted below:

- Section 5 of the NHSGGC Outbreak/Incident SOP for Outbreak/Incidents of Communicable or Alert Organisms in Healthcare Premises (**A50811313 – NHS GGC – Infection Prevention & Control Team – Incident Management Process Framework – Dec 2023 - Bundle 43, Volume 3, Document 53, Page 1600**), published in October 2019, covers the initial assessment and considerations for convening a Problem Assessment Group (PAG) or Incident Management Team (IMT). This appears to align with the NIPCM Chapter 3, referencing the use of HIIAT assessment even where there is no significant risk identified.

- The updated document, NHSGGC Infection Prevention & Control Team (IPCT) Incident Management Process Framework, published February 2024 paragraph 2.1 (https://hospitalsinquiry.scot/inquiry-document/incident-management-process-framework-sop) **(Bundle 27, Volume 17, Document 28, Page 315)** advises either of two outcomes following initial assessment by a PAG:

  - "No significant risk to public health and/or patients; the PAG stood down, but surveillance continues, or

  - There are some concerns and the situation is assessed using the National Healthcare Infection Incident Assessment Tool (HIIAT) (www.nipcm.hps.scot.nhs.uk/media/2260/2022-02-07-hiiat-v20.pdf) **(Bundle 27, Volume 1, Document 67, Page 662)** and all assessments regardless of outcome must be recorded on the Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Outbreak Reporting Tool (ORT)."

This appears to suggest that no formal reporting is required unless the assessment made by the PAG determines that there are "some concerns" and

therefore does not align with the NIPCM Chapter 3.

35. With reference to paragraph 15 of this statement, I have been asked whether there is any risk that the operation of NHS GGC 'Incident Management Framework' SOP might have the effect that the board's internal reporting system might not become aware of an infection or infections that would, but for the SOP triggered an HIIAT assessment and report to ARHAI.

The NHSGGC Infection Prevention and Control Team (IPCT) Incident Management Process Framework (**Bundle 43, Volume 3, Document 53, Page 1600**), Section 3 – Reporting and Governance (page 6), indicates that only outbreaks or incidents assessed as amber or red via the HIIAT assessment are reported through formal governance structures. Based on this guidance, it appears that internal reporting mechanisms under the NHSGGC IPCT framework may only be activated for incidents meeting these higher-risk thresholds.

Therefore, it would appear that incidents of no concern (as assessed in 2.1 of the NHSGGC Framework) and HIIAT assessed green incidents will not be reported through internal governance structures.

Cryptococcus

36. With reference to paragraphs 20 to 31 of this statement:

a) I have been asked how Caldicot approval would operate in this context (please see The Caldicott Principles - GOV.UK and 3. Role of the Caldicott Guardian? - NHSScotland Caldicott Guardians: Principles into Practice - gov.scot).

In Scotland, when a public health body requests information from an NHS Board to support an outbreak investigation, the sharing of confidential patient information is governed by the Caldicott approval process and the Intra-NHS Scotland Information Sharing Accord (**Document – Intra NHS Scotland Information Sharing Accord 2023, Bundle 52, Volume 4, Document 10.1,**

Page 83). The Caldicott Guardian, a senior figure within each NHS organisation, ensures that any data sharing is lawful, ethical, and proportionate. Clinicians responsible for sharing data or using data outwith the primary purpose have access to a Caldicott Guardian who can support any requests and ensure the NHS Board follows the Caldicott principles and is compliant with UK GDPR and the Data Protection Act 2018.

The Intra-NHS Scotland Information Sharing Accord provides a national framework to support consistent, secure, and timely sharing of information across NHS Scotland. It outlines the responsibilities of NHS organisations when handling personal data, ensuring that sharing is compliant with data protection legislation and aligned with public interest. The Accord promotes a culture of trust and accountability, enabling NHS Boards to respond effectively to public health needs, such as outbreak investigations, while maintaining high standards of data governance. It also supports the use of standardised agreements and documentation to streamline the approval process and reduce delays in urgent public health responses.

In alignment with the Caldicott Principles, ARHAI Scotland requested only the minimum necessary data for the Cryptococcus enquiry, clearly explained the purpose and intended use of the information and ensured that all received data was stored securely in a restricted-access folder on a secure server. Access was limited exclusively to designated ARHAI Scotland staff responsible for working with the data.

In addition, the Medical Research Council (MRC) provides guidance titled 'Research, GDPR and confidentiality – what you really need to know' (RSC LMS: All courses), which outlines essential requirements for researchers handling personal data. All ARHAI Scotland staff involved in handling personal data have completed the 10 MRC training modules.

b) I have been asked to comment on whether a Caldicot approval process was carried out for these four cases and if so, by whom and on what date.

Caldicott assessment for releasing data is the responsibility of the NHS Board releasing the data. I am unable to answer this, and the question should be directed to NHSGGC.

c) I have been asked, in reference to paragraph 27 of this statement, whether after a further conversation between NSS and NHSGGC Medical Directors, NHSGGC did in fact provide a full data set that had not been anonymised and de-duplicated.

Yes, NHSGGC provided the information in the requested format (not anonymised or de-duplicated) on 17 December 2024.

d) With reference to paragraph 30 I have been asked when the information described was received by ARHAI.

As noted in paragraph 23 of my previous draft statement, the NHSGGC IPC team confirmed that there were 7 cases of *Cryptococcus* in patients cared for in the QEUH since 2020. A full response for 6 cases was received on 3 June 2025 with further information for one case received on 20 July 2025.

e) I have been asked whether ARHAI is now in a position to answer the three questions asked of ARHAI by Mr Urquhart on 18 November 2024 and what the answers to the questions are.

ARHAI Scotland asked NHSGGC the following three questions as requested by Mr Urquhart and received the following response from Sandra Devine on 21 November 2024 in an email entitled ‘Scottish Hospitals Inquiry: Four cases of Cryptococcus’,

Question 1 “Are you able to confirm how many cases of Cryptococcus cases have been reported since 2020?

NHS GGC IPCT has reviewed 7 cases of Cryptococcus sp. in patients cared for in QEUH since 2020

Question 2 Why were the cases (reported through the Public Inquiry) not reported to ARHAI through the ORT and [Question 3] will the Board now

report these cases?

NHS GGC responded to information request from PI team regarding the Cryptococcus sp. cases identified within a specific time period.

All cases were thoroughly reviewed by NHS GGC IPCD group and we believe that none of them fulfil the NIPCM Chapter 3 criteria for reporting.

One of the cases was reported to ARHAI in 2020.

On repeat review of the cases, we remain of the opinion they do not meet the criteria for reporting."

These responses to Mr Urquhart's original questions were shared with CNOD on 21 November 2024.

f) I have been asked if ARHAI has yet to answer Mr Urquhart's three questions, to provide an update as to why that is the case.

I can confirm that Mr Urquhart's questions have been answered.

37. I have been asked whether I believe there is evidence to at least underpin a suspicion that NHS GGC has failed to engage with national monitoring as they should have done.

I believe NHSGGC has implemented local monitoring processes that may have led to a more selective approach in reporting incidents and outbreaks to ARHAI Scotland, compared to the national guidance outlined in the NIPCM.

Declaration

38. I believe that the facts stated in this witness statement are true. I understand that this statement may form part of the evidence before the Inquiry and be published in the Inquiry's website.

The witness was provided access to the following Scottish Hospital Inquiry bundles/documents for reference when they completed their statement.

Appendix A

A49847577 – Witness Bundle - Week Commencing 2 September 2024 – Volume 3
A49882926 - Witness Bundle – Week Commencing 9 September 2024 – Volume 4
A51844565 - Hearing Commencing 19 August 2024 – Core Participants Closing Submissions
A51312578 – Glasgow III Counsel Closing Statement
A48408984 – Bundle 19 – Documents referred to in the Quantitative and Qualitative Infection Link expert reports
A50853873 – Bundle 27 – Miscellaneous Documents – Volume 17
A49968596 - Laura Imrie, Transcript
A50581675 - Sandra Devine, Transcript
A49643362 – Bundle 27 – Miscellaneous Documents – Volume 1
A53671356 - Bundle 52 - Volume 2 – Miscellaneous Documents
A53674650 – Bundle 52 – Volume 1 – Miscellaneous Documents
A50988497- Dr Sara Mumford and Ms. Linda Dempster, Transcript
A53995861 – Bundle 52 – Volume 5 – Miscellaneous Documents
A50611329 – Bundle 27 – Miscellaneous Documents – Volume 14
A52861985 – Bundle 43 – Volume 3 – Procurement, Contract, Design and Construction, Miscellaneous Documents

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

Appendix B

A53011856 - Bundle 52 - Volume 2 – Miscellaneous Documents
A53760710 - Bundle 52 - Volume 4 – Miscellaneous Documents
A53760706 - Bundle 52 - Volume 4 – Miscellaneous Documents

A53760702 - Bundle 52 - Volume 4 – Miscellaneous Documents

A53761545 - Bundle 52 - Volume 4 – Miscellaneous Documents

A53761351 - Bundle 52 - Volume 4 – Miscellaneous Documents

A53761347 - Bundle 52 - Volume 4 – Miscellaneous Documents

A53761537 - Bundle 52 - Volume 4 – Miscellaneous Documents

A53760715 - Bundle 52 - Volume 4 – Miscellaneous Documents

A53761284 - Bundle 52 - Volume 4 – Miscellaneous Documents

A53761331 - Bundle 52 - Volume 4 – Miscellaneous Documents

A53761358 - Bundle 52 - Volume 4 – Miscellaneous Documents

A53761359 - Bundle 52 - Volume 4 – Miscellaneous Documents

A53982952 – Bundle 52 – Volume 5 – Miscellaneous Documents