SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
16 September 2025

Day 11
2 October 2025
Fiona McQueen

CONTENTS

(10:03)

THE CHAIR: Good morning.

MR MACKINTOSH: Good morning, my Lord.

THE CHAIR: Now, Mr Mackintosh, we have, as today's witness, Ms McQueen.

MR MACKINTOSH: We do have Ms McQueen. Ms Fiona McQueen, my Lord.

THE CHAIR: Good morning, Ms McQueen.

MS MCQUEEN: Good morning, my Lord.

THE CHAIR: Now, as you understand – and you've been here before – you're about to be asked questions by Mr Mackintosh, but, before then, you're prepared to take the oath?

MS MCQUEEN: Yes, I am.

Ms Fiona Catherine McQueen

Sworn

THE CHAIR: Thank you very much, Ms McQueen. Again, as you perhaps recall, we take a coffee break at about half past eleven, but if you want to take a break at any time, please feel free just to give me an indication and we'll take a break. Your evidence has been scheduled for the whole of the day. Whether it takes that time or not, we shall see. Now, Mr Mackintosh.

Questioned by Mr Mackintosh

Q Thank you, my Lord. Ms McQueen, I wonder if I can take your full name.

A Fiona Catherine McQueen.

Q And this is the second time you've given evidence to this Inquiry.

A Yes, it is.

Q You provided a further statement in respect to the Glasgow aspect of the Inquiry. Are you willing to adopt that as part of your evidence?

A Yes, I am.

Q Thank you. I want to just understand a few more things about your career. I understand you're currently chair of the Scottish Police Authority.

A Yes.

Q Yes, but, other than that, you're retired?

A Correct.

Q You were chief nursing officer until April 2021?

A Yes.

Q Your professional background is in nursing. I'd like to understand a little bit more about what your professional interests are/were in nursing before you reached the roles in government. Do you have a particular area of nursing professionalism that started you off or in which you've maintained an expertise?

A So, there was no particular

area other than nurse leadership and patient safety, although, earlier on in my career, "patient safety" wasn't terminology we used, but we talked about quality of care. So I was interested in leadership of the profession and how the profession could impact on better outcomes for patients.

Q Thank you. Now, if we can go to your statement, to paragraph 9 which is on page 74 of the statement bundle, you discuss the CNO Directorate within the Directorate of Health and Social Care, and you've given us five bullet points to describe some of the responsibilities of the CNO Directorate in paragraph 9 on page 74.

What I want to understand a little bit is about what's been described, I think, elsewhere in your statement as the "HAI unit". Well, firstly, what was the sort of scale of that unit? How many people are involved, approximately? Or when you were involved, anyway.

A So, when I was involved in it, it wasn't-- it wasn't a large unit, but it didn't mean it didn't have big impact. So, there would be an Infection Control nurse and an Infection Control doctor who were seconded in from the NHS, so specialists, and then there would be maybe three or four policy advisors who were----

Q And they'd be career civil servants?

A Career civil servants, yes, yes.

Q So we're looking at, sort of, less than half a dozen?

A Yes.

Q And had that sort of size been relatively consistent in those years? This is obviously before the pandemic.

A Yes, I think so. For the Queen Elizabeth Inquiry, we-- we needed to supplement that with additional staff, but-- for the-- for the Oversight Board, but in terms of the day-to-day HAI policy unit, it was reasonably consistent.

Q If we look at the whole of the CNO Directorate, what sort of scale in terms of head count is that?

A So, I'm sorry, but I don't-- I don't remember, but maybe 60 or 70.

Q Yes. I'm just really working out how much of your work is dealing with the HAI unit as a proportion of what you were doing before the Oversight Board.

A So, it was a small proportion, but it had big impact. So, even before the Oversight Board, it would be something-- because it was critical for patient safety, there would be reports in-- When boards reported into Health Protection Scotland, as it was then – it moved in to become NHS ARHAI later on in my tenure – then boards would report in infections and whether they were green, amber, or red, and we would then-- The purpose of that was to keep us notified, but also so that I

could be content that it was being dealt with properly and appropriately----

Q What do you say “dealt with”, do you mean reported properly?

A No, I mean the actual overall management of the incident and the infection. Because Health Protection Scotland would have been either round the table or would have received reports from the boards on infection incidents, they would give professional advice. So the professional advice I had extended to that from Health Protection Scotland; it was not only the policy unit. The-- That would--

So, Health Protection Scotland, when they reported-- because it-- it would be onward transmission to us, they would tell us whether or not they thought additional work was needed or whether they were content that the ongoing areas of investigation and management that the boards were doing was satisfactory.

Q To an outsider, it looks like there’s effectively three layers: there’s the actual IPC team in the hospital; there’s ARHAI providing advice and support; and there’s the HAI unit. To what extent are you seeking assurance that things are being well run through this process?

A All the time. That was the purpose, and primarily that would come from Health Protection Scotland, because they would have the close connection with the boards and with the IMTs and have a much greater knowledge, and they would also then have other specialists and experts that they could draw on to come to their conclusion. On the whole, incidents were managed very effectively right across Scotland.

Q Were you being reported both the good cases of management and, if there were any, the bad cases of management?

A Well, typically, anything that needed additional attention. When Health Protection Scotland was suggesting carrying out perhaps additional audit or having a different specialist in to give advice or taking a different approach, almost all of us boards would accept that and do it. So, by the time it got to me, any issues that had been highlighted had been resolved.

Q I suppose one way of asking that is, is this an exceptions reporting system, in that ARHAI, HPS, are coming to you when something isn’t working to their satisfaction, or are they reporting routinely for every board? For example, you know that each month there have been that many infections in that board and it’s been well done, or were you just getting the bad news, as it were?

A No, the green-- those that had been assessed green wouldn’t come up to the policy unit. The amber and red

would.

Q So every amber and red comes to you? Right. You, as chief nursing officer, how are you absorbing that information? What's the sort of process that you had in your routine to----

A So I was absolutely accountable for that system and process, but I had a very good-- a very good team who would deal with that. So I had every confidence in Health Protection Scotland for their oversight and their working with boards, and I had every confidence in the Policy team that they had effective relationships with Health Protection Scotland. On the whole, they had effective relationships with Board teams as well. So, I was-- I was taking advice, rather than me making any professional----

Q No, I understand that. What I meant was, how are you receiving that information? Are you receiving sort of a weekly briefing in a manner that is accessible to a senior leadership nurse, doesn't matter what his or her specialism is, or is there some other mechanism for briefing you?

A No. So, when I first arrived, the briefings that would come up from Health Protection Scotland would then-- we would then brief to the Cabinet Secretary, and that would just come as and when. So, if we had two on a Monday morning, that would go up-- assuming it wasn't urgent, that would go up maybe Tuesday afternoon, and then another four on Wednesday morning, and that would go up.

So, what we then decided that we would do is we would have a weekly briefing, and we would then on a Friday send-- have a comprehensive overview of the reports that had been received. If there had been anything that was particularly concerning, that would have been reported out of sequence. So, on the whole, we got into a rhythm of-- the HAI Policy unit would look at having a weekly review to brief the Cabinet Secretary and obviously myself.

Q So, when that briefing to Cabinet Secretary went, is it going, as it were-- you're looking at it first to go, "Yes, that's what we need to brief," and then are you going and doing the briefing, or are other professionals going?

A No, it would be a written briefing.

Q Written briefing? I mean, this is obviously on one level a truism, but to what extent do you have to adjust the method by which you brief to the interests and temperaments of your Cabinet Secretaries? Is that something that you're doing as well?

A Yes. You-- You would check with the Cabinet Secretary what they

wanted to know when and-- and how they would have that. So, when we went from the ad hoc "as and when" briefing – it was Ms Robison at the time – we put forward a suggestion to her that, actually, it might be more effective if we carried out a weekly briefing, and, on that dialogue, we reassured her that anything of urgency we would brief right away, and----

Q Because presumably she doesn't want to hear about it from some other source before the briefing?

A Exactly, exactly. So the-- the "no surprises" piece, we would want to keep that as best we could for her. Then, if there was perhaps something in the Cabinet Secretary's constituency, they might be a bit more alert to it, or if there was, you know, a serious infection, perhaps with either death or other morbidity that would be associated with it----

Q You might brief those out of the weekly sequence?

A Yes, yes.

Q Right. To what extent was there any route by which boards could come directly to the HAI unit? You've got a process which you've described of going from board to ARHAI, ARHAI to you and your team, and from you and your team to the Cabinet Secretary. We've heard from Ms Imrie about how there is a series of stakeholder groups that ARHAI run around the National Infection Prevention and Control Manual, and evidence on how they develop their practice, but is there any mechanism-- We also know that the director general of Health and Social Care has a regular meeting with chief executives of all the health boards. Was there any system by which your team were, for example, meeting with the Infection Control Managers or the HAI leads or anything like that on operation?

A So, when I first took up post, there was a series of meetings with the HAI Policy team with other networks across Scotland. The advice I received from the Policy team was that they weren't the most effective----

Q Sorry, just before we go on, what other networks are we talking about here?

A So, Microbiology, Infection Control nurses, Infection Control managers, so all within the HAI sphere, and they advised that they weren't productive, they weren't getting good outcomes from these meetings, and these meetings stopped.

Q And when would that have been, roughly?

A That would have maybe been 2016 or so. On reflection, I think we should have worked harder at improving these meetings rather than stopping

them.

Q We know from the Vale of Leven Inquiry that one of the recommendations was that all health boards should have an Infection Control manager, and Mr Walsh was very keen to explain to us how he'd taken on that role and how he thought it was so important. I don't know whether all the other boards do that, but was there a process by which the HAI team was in regular dialogue with those people across all the boards?

A When needed.

Q But not a sort of structured process?

A Not for a period of time that I was CNO.

Q And do you know if it's happened since you left?

A I-- I think it possibly has, but I couldn't be certain. But Health-- NHS ARHAI would do that.

Q No, I mean, I know they do, but I'm just trying to work out what you know.

A Okay.

Q I want to look at what your understanding is of the sort of (inaudible 10:17:07 44:45) purpose, and status of the National Infection Prevention and Control Manual. So, from your point of view, who is producing it and controlling it?

A So, if I may, the National Infection Prevention and Control Manual is produced by NHS ARHAI.

Q And that's their job?

A That is their job, but if-- if I may – and I know you'll know this – NHS ARHAI, and Health Protection Scotland before them, they are the organisation within Scotland who have the expertise and the specialist knowledge and access to-- whether it's, you know, experts in the World Health Organization or the European ECDC, so they have the professional knowledge and expertise on many areas.

But in this area, in healthcare-associated infection-- And they, in 2012, the CNO, I think, launched the first National Infection Prevention and Control Manual. The purpose of it is to reduce HAI, to improve education and training, to look at research, and essentially improve patient safety. So, that's its purpose, and they are responsible and accountable for its production, and they do that in many ways.

Q They've explained that to us. I suppose the only follow-on question then is, to what extent does the HAI unit have any input into that?

A It-- It has. They're part of the-- There are a number of groups that the-- HPS and NHS ARHAI have, and the Policy team would be part of that. There's a very, very close working

relationship between the Policy team and ARHAI.

Q But, whatever the relationship, it's their document, not your document?

A Correct.

Q Right. Now, I think it might be helpful to understand your understanding of the purpose of the reporting system for HAIs in Chapter 3 of the National Infection Prevention and Control Manual. What do you see its purpose is?

A So, good and effective Infection Prevention and Control systems are essential for safety and welfare of patients and staff, and the reporting system has been developed as an iterative process over the decades, usually learning from incidents, but now that NHS ARHAI----

Q Could you lift your voice a little bit?

THE CHAIR: Yes. My hearing is not what it was----

A My apologies, my Lord.

THE CHAIR: -- and a slightly lower voice and faster delivery does make it a little bit more difficult. So if I could encourage you----

A I do apologise.

THE CHAIR: -- maybe a little louder and a little slower.

A Yes, thank you.

THE CHAIR: Mr Mackintosh?

MR MACKINTOSH: You've described what the importance of good Infection Control management is, but, reporting, why is that something that is good, as it were?

A Because there's opportunities for learning in terms of, if you-- if you report one incident, then that in itself may tell you nothing, but if you have a-- if you report every incident and you're looking at a series of incidents, then it allows you to draw comparisons, it allows you to decide whether or not there's any interrelationship, are there any common patterns, and also it's important for good governance in NHS boards so that there can be appropriate and proportionate scrutiny from NHS board committee structures.

Q If it was to be the case that a board was considered not to be reporting in compliance with Chapter 3 of the National Infection Control manual, what would be the consequences of that for general patient safety across the NHS?

A So, if boards are not reporting, then they're missing opportunities for learning, for looking at consistency, looking at underlying factors. It suggests to me there's a-- a closed mindset with regards to what's happening in the wider infection prevention and control system within their organisation, so I think there's a risk that patient safety could be compromised.

Q Can you expand on what you mean by a "closed mindset"?

A So, infection prevention and control is-- is a very complex area, and you'll have heard right across-- this from many, many specialists, and it's important, when you have an infection-- And, unfortunately, no matter how much people wish it were not so, at the moment, hospital-acquired infection and healthcare-acquired infection is a phenomenon, and the----

THE CHAIR: Sorry, I missed that last word and I'm----

A I do apologise, sir.

THE CHAIR: No, it's very difficult, and, if we were having a conversation, I wouldn't be having this problem. I'm trying to-- not make necessarily a verbatim note, but to get the important points. So, again, if I could encourage slightly louder, slightly slower. Now, what I got was, "At the moment," and then you referred to----

MR MACKINTOSH: I think you mentioned the word, "phenomena".

A I did.

THE CHAIR: Yes.

A So, hospital-acquired and healthcare-acquired infections are a phenomenon within modern healthcare practice, and the importance of having good effective infection prevention and control procedures cannot be overstated because that then improves patient safety, and I've now forgotten the question----

Q No, I think that's part of the answer-- part of the question answered, but I think there's a supplementary. You mentioned, when I asked you what your interests professionally were, your interest in patient safety. Now, I took from the way you expressed that it was at a higher level than simply infection prevention and control. Am I right to think that?

A So, it-- it was at a higher level, but there are many aspects of professional practice that make up a safe environment for patients, both psychological safety and physical safety. And when you asked me about making sure you don't have a closed mindset, for infection prevention and control, if one assumes that the infection is inevitable because it's one of these things, or if one assumes that it's only an infection that the patient has infected themselves, then you're not giving due consideration to all possibilities.

And with infection prevention and control, one needs to start wide and then rule out rather than start from a narrow assumption that a catheter-associated infection, for instance, was-- you know, the patient had contaminated themselves.

Q Can I just explore those two

concepts, that of inevitability and the patients contaminating themselves? Because I wouldn't want to put words into your mouth or thoughts into your mouth, or someone else to do it later. We've heard some evidence about the debate around whether particular infections are from colonised patients or from the hospital environment or from clinical care or whatever. Is that that debate you're referring to?

A Yes, because if you assume it's one thing or the other, then you're not necessarily getting to the truth. One has to consider all aspects and then rule out as you go through the incident management process.

Q You rule out with evidence?

A Yes. If you have-- You don't always have evidence.

Q I was going to come to that in a moment, but the other one you mentioned was the idea of inevitability and we've come across that in different contexts. Before I put those to you, what do you mean by inevitability?

A I think there's a number of factors. You can have the patient's own condition; if the patient is immunocompromised, then they're going to be more vulnerable to day-to-day infection. If you have human factors within the healthcare system whereby there may be transmission by a member of staff from patient to patient, or if you have environmental factors where there's contamination either of the ventilation system or the water system--

And areas such as hospital buildings, if you look at single rooms compared to the old Nightingale wards, ought to have significantly less hospital-acquired infection because patients are nursed and cared for within their own single room rather than in a 20-bedded complex.

So there's always going to be risk, and that's why the National Infection Prevention and Control Manual is so important, that you put transmission-based precautions in place, you have standardised infection control procedures and constantly have to be vigilant that these are as most effective as possible, and that's why, when you have incidents, you need to learn from them and recognise where you can make improvement.

So, my interest, going back to-- looking back to one of your earlier questions of what was I interested in, "Was it more high-level strategic?" It was both. It was from the patient to the board in terms of how you can actually have clinical leadership that impacts on a daily basis with patient safety.

Q So, in order to not put words in your mouth, I'm going to use a slightly

different example and check I've understood this correctly. So, if we think about the issue, that I think was a big issue, of patients falling out of bed-- I mean, that was an issue-- still is to some extent, but an issue 10, 15 years ago. Have I got that memory right?

A Yes, patient falls are always problematic within an institution.

Q But you'll be saying that you shouldn't take the view that it's inevitable that patients would fall because they're elderly and frail or confused, and you shouldn't assume that it's their fault because they decide to get out of bed and go for a glass of water when actually you might be better thinking about the design of the bed or the provision of water to the patient.

A That's absolutely correct, and I think, in some areas of healthcare practice, it's easier to make that distinction of inevitability. If-- If you walk into a GP surgery, you would be very surprised if-- if you came out with the wrong limb removed because that just doesn't happen, whereas, in some areas of of practice, whether it's obstetrics or haemato-oncology, these procedures run a higher risk of mortality and morbidity and it is not quite as easy to determine what was preventable and what wasn't. But one should always aim to reduce to the absolute minimum the harm that's been caused to patients.

Q How does the-- What's the effect of the question of blame and who's to blame, which obviously is a natural human response to things going wrong? How does that affect the process of learning and improving in terms of patient safety? Does it have an impact?

A It has a huge impact. You cannot learn and improve and provide as safe care as you want to if there is a culture of blame, and that can be a real problem because people often want retribution. It's perhaps human nature to look at whose fault it was, so a psychologically safe culture within healthcare is so important.

Q Now, what do you mean by a "psychologically safe culture"? Because we hear that a lot in modern discourse, a "safe space" and things. What do you mean by a "psychologically safe culture"?

A So, what I mean is-- and I think Sir Robert Francis has spoken up about speaking out. What I mean is the opportunity for teams to be able to reflect, discuss, be a learning organisation, and that means calling out poor practice. It means being able to raise concerns and know that these concerns are going to be treated appropriately, professionally and respectfully, and that takes a lot of work. It takes work to build a team. It takes work to look at learning, and it also

means organisations have to be able to hear things that they don't want to hear.

Q When you say an organisation has to be able to hear, are you able to help us by examples of how an organisation can demonstrate that it wants to hear, and indeed things it can do that can have the opposite effect?

A So, things that it can do to have the opposite effect would be to-- to blame people, would be to minimise, would be to ridicule, would be to ignore. Things they can do to encourage is, essentially, organisational development work to put patient safety at the heart of what it's doing, and the patient safety programme in Scotland did quite a lot of this along quite a lot of areas, but I think in some areas haven't been taken forwards. So----

Q When you say "area", do you mean areas of practice?

A Both areas of practice, and I think some health boards have taken it on in a-- in a fuller way than others, but some specialties also haven't because it would have meant, perhaps, a shift in practice in the way they do things.

Q I'm sure we'll come back to that, but what I want to do now is to move on to your statement. I think you addressed this, actually. It's quite a long way in at paragraph 33, which is on-- well, actually it's paragraph 32 on page 82. We asked you for details of your involvement in a list of things, and, perhaps unsurprising given your date of appointment, which-- It was November 2014 that you became chief nursing officer?

A Yes.

Q So, I obviously, in one sense, am not surprised, if we go over the page, you explain you didn't have any involvement with these matters. If we go back to the list, what I want to do is understand-- Since you arrived in the post just before the commissioning water tests were being carried out about six weeks before handover, I want to explore what you might have been told about things. I'm conscious that the answer might be, "Nothing at all", but I still need to put things to you.

So, you've taken over in November 2014, and you have the responsibility of the HAI unit. If we go back to your statement on paragraph-- or we won't go back there yet, but if you just think about your responsibility as chief nursing officer, did you have any awareness, in the summer of 2015, of the short period in which the Adult Bone Marrow Treatment ward was in Ward 4B before it returned to the Beatson, and that story and that event? Did you have any awareness of that?

A I may have, but I genuinely

don't remember, and when there's a new build and a commissioning of a new build, there are often hiccups, so, even if I had known, I'm not sure I would have necessarily been alerted in a negative way about it. But I don't recall, or, if I did, it was peripheral knowledge that I accepted as a matter of fact rather than a matter of concern.

Q I want to just look at-- I mean, I think the answer may be the same for the next question, but I want to just put something to you. I'll make sure I just remember what it is before I do that. There is an email that we were putting to earlier witnesses which we were asked to from the sector ICD for South Sector to the Infection Control manager on 26 June 2015, which is bundle 12 document 25 page 225.

Since some of these do mention or touch on healthcare-acquired infections, or at least the potential for them, I feel I should just press you on whether, in '15, you and your colleagues had any awareness of these being even a potential issue. I'm thinking of Legionella and water testing of the system. Is that something that came across the team's desk in '15?

A So, I can't speak for the team----

Q Right.

A -- but it didn't come across my desk and, with hindsight, it certainly is alarming that a hospital would be occupied and the Infection Control doctors continue to have, concerns but, equally, a big hospital like the Queen Elizabeth was all-- So, it's inevitability. It was always going to have snagging, and it's just a question of, "Was it routine snagging or were there serious defects that were causing concerns for the Infection Control doctor?"

Q If we go back to your statement, page 83, paragraph 33, in your answer – 83, sorry – you explain the delivery of major-- in the third line:

"In any event, the delivery of major healthcare facilities is, in so far as the Scottish Government is involved, the principal responsibility of the Scottish Health Finance Directorate, not the CNO Directorate. Mike Baxter may be better placed to address the Inquiry's questions..."

Now, we did address them to Mr Baxter. I think I've got his evidence right in my head, that one of the things he wants me to hear is that his team and his system is not set up to assess-- at least it wasn't then, not set up to assess technical matters. They are finance people, whatever the involvement of a few people in their SIG who have other experiences.

Now, I'm conscious that we now

have NHS Assure, and we will discuss that with Ms Critchley on Wednesday and what it can do and maybe what it can't do, but, thinking back to this period, is it a fair criticism to suggest that the team that were responsible for the commissioning delivery of the hospital from the Scottish Government's end – and there's quotation marks around "responsible" there – didn't probably have access to the critical technical skills that might have existed elsewhere within the director general system, including perhaps your team?

A I don't think it would have been appropriate for policy civil servants to be taking a view on competence of a building. I think that would be delegated to the NHS Board and it would be for them to oversee and manage the contract, ensuring they had appropriate access to professional advice.

Q Because one of the evidences we had yesterday from Mr Calderwood is that, in the months before handover, he and his team went to Australia to look at/experience another Multiplex hospital that was commissioning, and it occurred to me overnight, in fact, that I'm sure that was very interesting, but the regulations are different in Australia.

Is that perhaps a slight oversight, because you are effectively relying on a health board asking for help? When "you"-- I mean "you", the Scottish Government, are relying on a health board asking help and, more importantly, knowing that it needs to ask for help and not doing things like failing to validate or giving the wrong sort of advice. There's no check. Would you accept that there's a weakness in this, or at least there was back then, of a slight level of trust of health boards and no check?

A So, I-- I don't think it's as blunt as you're suggesting, "It was trust with no checks." The Board and the Board chief executive were accountable for delivering on that big construction project. I think you've heard from other witnesses about the transition from PFI into public sector capital spend and the different funding streams and the different responsibilities and accountabilities for technical advice and where that sits.

So, I think there was a vulnerability, as we moved from system to system, to make sure that the appropriate checks and balances were being taken, but I see no reason for a project of this size not to have had the appropriate checks and balances put in place.

Q Okay. I want to move on to, in fact, the next section, interactions with the Infection Prevention Control team. Now, I felt when I was reading the next four paragraphs that I should probably take from this that your memory of this

isn't, perhaps, as vivid as I would like it to be. Is that a fair criticism? What I wanted to do was look at the incident you describe in NICU in para 34. Now, I should say, my Lord, that NICU is in the retained estate, and, in the closing statement from counsel to the Inquiry last year, we made it clear that NICU itself therefore falls outwith the remit of the Inquiry. The reason I'm asking these questions is because I'm interested in HAI reporting, Internal Reference 9, and I thought it's important that I should make that overtly clear.

There's an SBAR you refer to, bundle 3, document 3, page 15. So, this is produced, presumably, by HPS?

A Yes.

Q Yes, and it follows the invocation of the national support framework?

A Yes.

Q And this is Stage 2 of that framework?

A Yes.

Q Right. Now, I wonder if we could also look at the GGC SBAR. Well, before we do that, let's stay with this. . In your statement, if you look at paragraph 36 on page 84, we asked you of your impressions about the GGC IPC team in 2015 and were you aware of:

"Tensions, a lack of clarity related to roles and decision making, relationship difficulties between team members, issues with record keeping, a culture of bullying and the attitude of senior management at NHSGGC to IPC issues."

You said you weren't aware of such tensions. You then convened a meeting with GGC IPC. So, who in the IPC team did you meet with?

A So, I don't recall everyone who was there, and I did ask the Inquiry support team and the civil service to see if they could find notes and that couldn't be found, because I know it would have been taken of that meeting but possibly with document retention because, at that time, we had not anticipated a Public Inquiry. So I met with the executive lead for HAI who was Dr Armstrong, the medical director.

Q Yes.

A And she brought-- I suspect she brought the Infection Control manager and the Infection Control nurse, at least, with her. I can't remember if she brought a microbiologist with her.

Q Might she have brought Professor Williams, who was then the lead ICD?

A She-- She may have, but I don't recall.

Q But you can't remember. But she didn't tell you about sector ICD's remitting office and writing to her complaining about building safety and

culture?

A No, she did not.

Q What I want to do is-- You've referred us to, as it were, your-- well, HPS's SBAR, but there's also a GGC SBAR which is bundle 4, document 8, page 26. Now, it bears to be addressed to the HAI Policy unit, and now that we've put it on your document list, is this something you have any memory of seeing? And we can go over the page just to sort of jog your memory a bit more. The final page is perhaps the relevant bit. Fourth page, sorry, page 29. It's longer than I remember, page 30. Then there's discussion about a meeting chaired by the CNO at St Andrew's House. Is that where you recollect the meeting taking place?

A Yes, yes.

Q And a further meeting with HPS and GGC, and there's discussion of various lessons to be learned. Then there was to be a consensus group facilitated by HPS, chaired by Dr Inkster, and that seems to be a national group, the consensus group. Would that be a right read of it?

A Yes.

Q Right. Now, if we go back to the first page of that document, page 26, this SBAR describes the number of Serratia cases and gives a little bit more detail. What I'm wondering is, can you help us whether-- at the time this was reported and you got involved and the framework was invoked, whether this incident would have been under control?

A So, by the time Health Protection Scotland had been in working with Greater Glasgow & Clyde, I was content that appropriate control measures had been put in place.

Q So what was the issue about reporting that seems to be touched on here?

A I think the-- the issue-- and-- The purpose of the meeting I had with them I thought was a single issue meeting, and that was Greater Glasgow & Clyde were not reporting in a manner that I would expect them to do, and I was articulating to them the fact that that's what I would expect. And for me to have a meeting, to have that dialogue with a board, it would have-- my own team and Health Protection Scotland had probably exhausted all mechanisms to persuade Greater Glasgow & Clyde to change their reporting system and the reporting mechanism.

Q So what was-- Just to grasp, what was wrong, as it were, with their reporting approach or mechanism before the meeting?

A They weren't reporting is what was wrong. They weren't following the guidance appropriately in the Infection

Prevention and Control Manual and they were-- they were rating some of their incidents at a slightly different-- at a lower level than, perhaps, Health Protection Scotland should have.

Q Because back then if you rated a green, you didn't report it?

A Yes.

Q And should we latch on that as the particular issue or were there any other issues?

A No. So, at that time-- at that time, the only issue I had was Glasgow not reporting appropriately.

Q And that's because they, to some degree, were downrating? Or am I putting words in your mouth now?

A You are putting words in my mouth. I----

Q Right. Well, can you-- Perhaps if you can expand on what you mean, because I'm grasping for depth to that sentence.

A So, they weren't reporting in a manner that was consistent with what was expected for boards across Scotland. I believe that they believed they were interpreting it appropriately.

Q Right.

A I don't think they were saying, "We think this should be amber, we'll just make it green so we don't report it."

Q No, I understand that.

A So, they weren't downgrading incidents. It was the calibration that they had of incidents was different from the rest of Scotland.

Q That calibration, or that miscalibration, is this a scenario where that was found to have been written down in a policy, or was it, effectively, as far as you understood, not written down in the policy?

A I think it was custom and practice.

Q Custom and practice, right. We go back to your statement, page 84. In this large paragraph on paragraph 36, you say-- It's about halfway down to the word "outlined" on the left-hand side, the sentence goes:

"At the meeting, we clarified how incidents and outbreaks should be reported. Dr Jennifer Armstrong attended the meeting supported by her colleagues who at that time acted as the IPC leads for NHSGGC. I cannot recollect the names of everyone who attended the meeting due to the passage of time. However, the main issue appeared to be that NHSGGC had not been reporting incidents"

Now, there seems to be a plural there. Can you help us about, to some extent, how many incidents and whether they are within this Serratia SBAR?

A Well, it was wider than Serratia.

Q It was wider than Serratia, right.

A It was something that my team had an increasing awareness of, partly through ongoing relationships they would have with Greater Glasgow & Clyde colleagues, but probably more through Health Protection Scotland when an incident was reported, then they would look back and find there had been other incidents that hadn't been reported. So, no, it was wider than Serratia.

Q Yes, because if an ARHAI-- sorry, HPS then, HPS nurse consultant goes to a meeting at IMT and they start hearing history and thinking, "Well, why wasn't that reported?" It's effectively that process?

A That's correct.

Q Right. You've mentioned in the next sentence:

"At no time, however, was there any suggestion that NHSGGC were deliberately withholding information."

To what extent are you aware whether GGC adjusted their approach following the meeting?

A I think they did adjust the report-- their approach following the meeting, but I think there was a deep-seated behaviour within Greater Glasgow & Clyde and we've seen that, as the years progressed, that meant it was difficult for changes to be made. So I think they intended to, and the letter that was issued-- the director's letter that was issued instructing people to report----

Q Yes, and that was an all-Scotland letter?

A It was an all-Scotland letter, and the advice I had received from my team was the only way that we'll know that we're-- how that we get all incidents reported is if we ask for greens to be reported as well and that's what we did.

Q If it's your view that there was a custom and practice, not a written formal policy, are there any other steps, looking back – and to use the word of the week – "with the benefit of hindsight" that you could look back on and think, "Well, we could have done something else at the stage of issuing that letter to make sure the change, any change was long term and was really bedded in?"

A I think that's difficult because that seemed to be, on the face of it to me, the only issue was the calibration of what was either determined as an incident, because an infection doesn't necessarily have to be an incident or an outbreak, and that relies on professional evaluative judgment. Members of the Infection Control team in Greater Glasgow & Clyde were more than capable of doing that.

So, on the basis you don't know what you don't know, it was always going to be difficult, and you would rely on the

team culture and the team commitment to making these reports. So, at that time, I don't think there were other indicators that would have suggested to me I needed to do anything further.

Q With that, we see in a Board Infection Control committee minute on 27 July 2015, which is bundle 13, document 33 at page 256, is the start of the minute. Then if we go to-- Dr Armstrong's in the chair, and if we then go to Item 6.6 which is page 260, we see, "Mandatory HAI Requirement," is the heading and:

"The Scottish Government issued a letter regarding Healthcare Associated Infections (HAI) and Antimicrobial Resistance (AMR) Policy Requirements and the mandatory requirements that require to be adopted and implemented in all NHS healthcare settings."

Now, what I'm wondering is-- Of course, and in one sense, it's only a minute, it's a minute of a meeting 10 years ago. But did you have the opportunity of looking at this document when we put it on your document list?

A Yes.

Q Do you have any comment on what's been-- appears to have been discussed at that meeting following the issuing of your letter?

A (After a pause) No. Could you point me to something a bit clearer----

Q Well, so, if we look at the letter, what it doesn't say-- it doesn't say, "The Scottish Government chief nursing officer came to us and said we've been underreporting due to customer practice, grading things amber green when we should have graded them amber." I recognise that's a quite pejorative way of summarising what you just said, but it doesn't say anything like that.

Now, of course, it may have been discussed in the meeting and not minuted, it may have been discussed elsewhere, but I'm wondering whether you feel that, when you go to a health board and say what you said, you'd expect things like the Board of Infection Control committee to notice?

A Yes, I would, and I would expect that to have been reported by Dr Armstrong. It may have been she reported it at a different time----

Q It may have been reported elsewhere but, in this meeting, it's not there. Right, if we go back to your statement, paragraph 37, you say:

"Failure to follow the HAI reporting procedures set out in NIPCM was highly unusual during my time as CNO."

So let's explore that. So, if we start where we still are, so in 2015, you've only been in post a year. Were there any other health boards who were being challenged for this sort of behaviour?

A Not to my knowledge. If they

had been challenged by Health Protection Scotland finding an area where they hadn't reported, then, as I say in my statement, that would have been resolved very quickly.

Q Yes.

A So, no, to my certain knowledge, it was only Greater Glasgow & Clyde.

Q Can we infer by the fact that on this occasion you got involved that it wasn't being managed to the satisfaction of HPS?

A Yes, I think both HPS and the Policy team felt they had done as much as they could and they needed me to intervene.

Q So the reference in the second half of this paragraph:

"Occasionally, NHSGGC reported an infection as green that should have been recorded as amber. This was addressed by Health Protection Scotland without formal intervention from me or the HAI Unit."

Is that talking about a different occasion from the one that's talked about in the previous paragraph?

A Yes.

Q So, are you saying that you were aware of other occasions which HPS dealt with informally?

A Yes.

Q Before and since?

A Yes.

Q Right. How would you react to the suggestion that once this had happened, you and, to some extent, HPS should've been a little bit more alert to any suggestion that GGC wasn't reporting compliance, and not simply left it as an informal follow-up for HPS but escalated in the future in subsequent events which, according to this, you've dealt with-- not you, the system, has dealt with informally?

A I think it's a reasonable question, and there is something about NHS boards being accountable for their own practice. Dr Armstrong was an executive lead, and she was committing to making sure that change was made. It would be something that Health Protection Scotland and would come across in terms of the way that they came across it in the first place where they were involved in an IMT and previous infections had been reported. So I think it would be involved-- it would be informed in day-to-day business rather than a formal auditing or monitoring.

Q This is perhaps a question for recommendations, but do you think that-- we've heard lots of examples of HPS/ARHAI team members going to meetings, and sometimes it's been a great success and sometimes not so much success, and we've had examples

which we'll come to of differences of opinion between GGC's IPC team and ARHAI.

But, in this case, you would assume that the invocation of the framework would have been reported up through the Board's government structures. Do you see any value in the system giving you the ability as chief nursing officer, or potentially ARHAI it's ability itself, to send a report to the Board that says-- and you don't have to do this, it's optional, give you the power to effectively force your report onto their agenda so that you can be absolutely sure that the accountable board members know about the issue. Do you see that as a valuable tool in the future?

A So I think-- I've thought about it quite a lot as I've watched the Inquiry unfold, and I do think we need more effective measures that can provide assurance to the public, to boards, to government and the clarity and openness and transparency of that reporting I think is important. I don't think it would be for a civil servant to do that, but there may well be something for NHS ARHAI to-- their remit would have to change, but I do think there is an opportunity for ARHAI to have a greater role in providing open and transparent management of infection prevention and control.

Q I just want to pick up the thing about-- remark about the civil servant. I take what you're saying from that is you don't think that the chief nursing officer and her HAI unit should be pushing things onto the agenda of the health boards, it should either be ARHAI will do it or, I suppose, ultimately, the minister?

A I think so, because the CNO and the Policy unit aren't set up to have that level of expertise. The expertise lies within ARHAI.

Q The other question is we had some evidence from Ms Imrie who came back and she-- last Friday, I asked her about whether ARHAI should have a more of an audit investigatory role, and I think it would be a broad summary to say that she didn't-- she was worried that would change the nature of the working relationship.

If there was a system that enabled ARHAI to elect, perhaps at its chief executive level or something-- force a report onto the board agenda for a health board only to be used when you're a bit worried that they're not getting the message, would that have a chilling effect of the sort that Ms Imrie is talking about? Do you feel that's a fear?

A I think the chilling effect of suppressing even further people reporting concerns is a concern. However, just because ARHAI had that authority doesn't mean to say they would have to

use it. I do think there's something for Healthcare Improvement Scotland, plus or minus ARHAI depending on where the expertise lies, for doing that. As I say, I think the functions of ARHAI would have to be changed, and I heard what Laura had said and I understand her concern, but I think, fundamentally, we need to find-- and we've built on it over the decades.

So this would be a natural iteration of how we would manage to put systems and processes in place that would support boards from a non-executive point of view, from a scrutiny point of view, to ensure that the care and delivery – in this case in Infection Prevention and Control – was as safe as it possibly could be.

Q I suppose this is-- since you're retired, I feel like I can ask the question – it's been suggested, I think, by at least one core participant in written submissions, and I think others have mentioned it – the idea that what we actually need here is some form of formal inspectorate of IPC teams, maybe HIS, maybe a new agency. I know there's a strong view that we've got enough agencies. But, from your point of view, given what we're about to keep talking about for the rest of your evidence, do you feel there's any value in having some formal-- almost like an IPC version of Audit Scotland out there watching health boards?

A I think I would argue it perhaps should be wider than IPC. So, if you look at the way external auditors or Audit Scotland gives a board a clean bill of financial health, I think there are opportunities for other agencies – whether it's ARHAI or Healthcare Improvement Scotland – to give a clean bill of health in terms of patient safety, which would include organisational culture.

I think people are right in terms of saying there's there's a lot of agencies, but it's maybe a time to review what agencies do and what we're needing them to do now as things have progressed. The Healthcare Environment Inspectorate was created after Lord MacLean reported in terms of the Vale of Leven. So the hospital cleanliness inspections carried out by HIS-- not a derivative of that, the derivative was the Healthcare Environment Inspectorate----

Q Yes, and it got merged, as organisations do.

A Yes, so there has-- But that was looking at cleanliness, it wasn't actually looking at professional practice of IPC. So it would almost be a quasi-regulation or accreditation of IPC, and that would perhaps be worth being

considered, but considered alongside other agencies. The burden of oversight and inspection needs to be something that is meaningful and worthwhile and can make a difference.

Q I suppose the question that occurs to me is, there are lots of health boards in Scotland, a huge range of sizes, and all of them might take the view that an accreditation or inspectorate system perhaps run by HIS or something like that might be an administrative burden they're ill-equipped to afford to support. You're nodding. Remember the transcript person. So, if you agree with me, say yes.

A Oh, I apologise. Yes.

Q Do you have any thoughts about how one would devise such an accreditation or inspectorate system so that it didn't create a burden, in the way that sometimes the English school inspectorate system is characterised as a burden on schools. Have you any thoughts about how that might be done?

A So, I agree that it could be seen as both an administrative burden, a time burden, a financial burden, but there's no doubt in my mind that safe and effective patient care – which ultimately needs to have effective IPC processes – has to be at the aim of what care is being delivered and is cost effective. So, if you have improvements, if you have safe care, if you reduce infection, that is going to be cost-effective.

So, I think anything that was being recommended would need some deep thought and reflection, and at the heart of it, it would be what would make a practical, tangible difference and what evidence of effectiveness would be needed for that. I think there's a temptation to add another layer onto what's already happening. I think there's a temptation to then start, "Well, we'll have light touch and it will be self-reporting."

We've already discussed this morning that self-reporting sometimes isn't the most effective thing to do. So anything that we had I think needs to be looked at in the context of other arrangements. There's no doubt having Professional Standards, having an accreditation and inspection model, whether it's peer review, going forwards can be an effective way to improve outcomes.

Q Thank you. You mentioned self-reporting and issues arising. I put on your document list an exchange of letters between the current director general and Professor Gardiner at GGC in August and a subsequent letter between Ms Morgan at NSS and Professor Gardiner to Ms Lamb. Do you recollect reading those three?

A I do.

Q Yes. Having read them, and given, well, how do you respond to what appears to be the evidence that there remain concerns about GGC's reporting of HAIs?

A I'm incredibly disappointed.

THE CHAIR: Sorry, I missed that answer.

A Incredibly disappointed, my Lord.

THE CHAIR: Thank you.

MR MACKINTOSH: So, what is it that disappoints you?

A That in 2015 we had an open dialogue about reporting of infections. We had a series of issues within Infection Prevention and Control within Greater Glasgow & Clyde over the following five, six years, the Board were escalated to Level 4 for problems with Infection Prevention and Control, and yet still things have not been resolved. That bothers me because I worry about the quality of care that's being delivered if safe and effective Infection Prevention and Control mechanisms are not in place in one of our biggest boards in Scotland.

Q I'm going to come back to that topic at the end. What I want to do is to just make some progress on the narrative and to move to the water incident. You pick that up in paragraph 38, bottom of this page-- Can we go back to 84, please? Sorry. You report:

"In 2018 NHSGGC were required to report potential healthcare associated infections to ARHAI who would, in turn, make colleagues in the CNO Directorate aware ... [and that water contamination can be complex]..."

Is that just a sort of narrative structure? You're not actually saying there was a particular extra direction or anything going on at that point?

A That's correct.

Q Yes. You provided a timeline which was prepared by the Scottish Government in respect to one of our Section 21s, which is when we make a statutory request to an organisation to provide information, and this timeline is bundle 52, volume 1, document 37, at page 609. If we go on one page to page 610, we reach the timeline. Now, I'm going to run the risk of further confusing the situation by now using two documents at once, so both your statement and this timeline.

If we go to the timeline on page 613, we see March 2018, top-left hand corner. If we go back to your statement on page 85 of the same bundle, at paragraph 40, we see you making reference to 1 March, and we have an email which seems to be relevant at this point, which is bundle 52, volume 8, document 2, page 39. So it's an email from Jan Liddle, who I assume

effectively works for you?

A Yes.

Q Yes, to Dr Armstrong, copying in-- I get the impression that most of the CC line there is civil servants?

A They were all civil servants.

Q Yes, and this is on 20 March, and you're passing on-- What's the purpose of this email?

A I think it was essentially advising Jennifer that we were directing Health Protection Scotland to carry out the work, because there's a subtle but distinct difference. Boards can ask for support from Health Protection Scotland themselves, and that's what Greater Glasgow & Clyde did.

Q They'd done that before this date?

A They had. However, if the CNO – or in this case, the Cabinet Secretary – wanted a more direct link into Health Protection Scotland, then the instruction would come from-- from government.

Q What do you mean by a more direct link?

A Well, they're essentially being instructed to provide-- and the instruction isn't necessarily for Health Protection Scotland, it's an indicator and a signal to the Board that the government have asked Health Protection Scotland because they want to have confidence that everything that needs to be done is going to be done, and it takes away anything that was optional for the Board, and we would be requiring them to conform to what Health Protection Scotland was doing.

Q So, when Dr Armstrong told us that she asked for HPS to be involved early March, she's asking for help.

A She is.

Q And this is you telling her she's getting help whether she wants it or not.

A Yes.

Q But it's still just help, you're not taking over, are you?

A No, not at all.

Q So, who is responsible for making sure that the outcomes that are needed happen?

A So, the Board are, and that's why the whole infrastructure of the NHS Board, the Chief Executive-- we've required there to be an executive lead for HAI, there's Clinical Governance committees, and the Board then is responsible for providing the appropriate level of scrutiny and oversight, and the operational delivery is the responsibility of the Chief Executive to ensure that all action is taken.

Now, I recognise this is a small part of delivery compared to the overall size of Greater Glasgow & Clyde, but that's ultimately the responsibility of the Board.

It would be for them, and I would expect them to provide advice to the Clinical Governance committee about Health Protection Scotland's advice to them and the fact that they had taken the advice and implemented it.

Q What I'm going to do is I'm going to return to that point, the Clinical Governance committee, because we were looking at two sets of minutes of the Clinical Governance committee with Ms Grant, and at this precise moment I haven't got that note to me. I'm saying that partly so that my colleagues next door can pull up the references for me, but after the coffee break, I might take you to them. I will ask you about what views you have on the necessary internal scrutiny governance systems that are needed in a health board that's receiving this. Is this Stage 2 of a framework?

A Yes.

Q Or have I got confused? It is? Is the same framework as you took it to in 2015?

A Yes.

Q Yes, but for a different reason?

A Yes, so if that-- So, if the CNO-- That's not necessarily unusual in a big board with a lot of patients, to have the framework invoked at a certain----

Q No, I mean, I get that, but just for our own clarity, because I don't want to get confused, on this particular occasion, if we were to go and look at the framework structure document, we would see that this stage of the framework could be invoked by the chief nursing officer.

A Yes.

Q So although in the second paragraph we see that the Cabinet Secretary is involved, technically it's you doing the invoking.

A Yes.

Q Whereas, at Stage 4, it's invoked by the director general, although we've of course learned that Ms Freeman, who was then Cabinet Secretary, has an involvement in that process.

A Yes.

Q Right. So as you step up through the stages, the seniority of the invoker gets more senior.

A Yes, but in terms of the CNO algorithm or the support framework, that can be invoked any time.

Q Now, I'm going to have to challenge you on that, because I'm not convinced it is an algorithm. Can you explain why it's an algorithm?

A So I think it's no longer called an algorithm. I think it-- When it first came into existence, it was an algorithm because it was a decision-making structure that people went through. I think it's now called the support framework, rather.

Q Right. So all it means is that structure of a series of steps you can pull in in certain circumstances to provide certain support or ultimately control is what some people used to call the algorithm and we now call a framework?

A That's correct.

Q Because it's not actually an algorithm. Right. Okay. Now, is this all really exists at a Stage 2 with an email? There isn't a term of reference like there is for the Oversight Board in Stage 4?

A Yes, so the Stage 2 within the-- the escalation policy, I think, is almost a red herring to this, in terms of this would be-- this would be carried out regardless of-- of escalation.

Q If we just think about the moment you are arranging for this email to be sent, what are you hoping to achieve by sending this email and changing the status of the HPS support?

A I'm hoping to achieve a firmer grip by Greater Glasgow & Clyde on action that's necessary be taken for safety of patients.

Q Does that mean that you didn't think they had a firm enough grip at the time?

A It meant I wasn't sure.

Q You weren't sure, right. To what extent is it about providing them with more technical information than they were previously getting?

A So, Greater Glasgow & Clyde is a big, big health board. It has a lot of expertise and a lot of specialists within Estates and within Infection Prevention and Control, so they do already have a lot of expertise available to them. Health Protection Scotland, as it was then, have more, and they can do the legwork of-- of searching for documents, looking at international best practice, and then translating that into day-to-day practice. So, yes, it was an element of providing access to improved expertise-- or further expertise that would be of help.

Q Now, at this point in March, can you help us with the extent to which you understood the nature of the problem?

A I don't think-- Do you mean in terms of the poor commissioning of the water system?

Q Yes, that----

A I think then I had no idea.

Q And effectively all you really have is the second paragraph there.

A Yes. I think I was becoming uneasy because of the-- over the years, the challenge of reporting or not reporting, the incidents that were being managed, and now installation and maintenance of-- of taps.

Q Yes, now I see that. Is this any indication that at the time you wrote this email, you would have been aware of

the Horne tap meeting back in 2014? I mean, it would have preceded your arrival, but would you have learned about it?

A So I-- I think so, because I think by that time, the team were, I think, gathering momentum in terms of better understanding what was happening within Greater Glasgow & Clyde and the Queen Elizabeth building in particular. Therefore, although there wasn't anything concrete-- and for me, I think the discovery of the lack of action in the DMA Canyon report was later on in the autumn, so there was nothing to suggest there was anything untoward about the commissioning of the building at this time.

Q So the only untoward thing, other than the infections and the story you've learnt about it, is the fact that, by this point, someone would have brought to your attention there had been a meeting in 2014 about the Horne taps, which says what it says.

A Yes.

Q Right. So, this must be before Mr Storrar and his team find the DMA Canyon report in the data they've received.

A Yes. I don't know when they found it, but yes.

Q No, but you hadn't been told about it.

A I hadn't been told about it.

Q Right. Let's move on to May. So, paragraph 41 of your statement, page 85, you refer to a report being received from HPS regarding Stenotrophomonas bloodstream infections in Wards 2A, 2B. Now, is that effectively a red or amber being reported up to you, or is it something more substantial, like a draft of the report that's published that month, written by Ms Rankin?

A So it was probably both, in terms of, there had been incidents reported up and Annette Rankin was was carrying out further work within Greater Glasgow & Clyde.

Q Just to sort of make connections and see if it connects, bundle 7, document 1, page 3, is the final version of a 29-page report by Ms Rankin, and it's the initial report of the findings of her investigation. So, would we be right to think that this paragraph is probably in the context of you seeing an early version of this?

A Yes, and there would be ongoing dialogue between my Policy team and Health Protection Scotland, so that would be a regular aspect, that they would be kept up to date with what was happening, and they would be briefing me on that, and it would be early briefing; not quite sure what was going to come out of the report, but alerting me to

concerns.

Q What-- We'll just connect this to the timeline for completeness, so we go back to the timeline, bundle 52, volume 1, but page 618. Might this be, top right-hand corner:

"18 & 30 May..."

"HPS provide a further update to the Scottish Government. "

A Yes.

Q Right. It shouldn't be-- Whilst I'm going through, probably implying that I'm disappointed there aren't footnotes in the document, it's not an unhelpful document. I should just make that clear. You talk in your statement, page 85, second line:

"At that time, I was advised that there was an understanding amongst some at NHSGGC that the source of certain gram-negative infections in patients in the Schiehallion Unit was the water systems in the hospital. That understanding was not, however, universally accepted."

Now, I need to understand the context of this and, if it's the case that you're not sure exactly when you heard this in the sequence of events, please tell me, because we've had evidence from a lot of the people involved in these events about who thought what when, and who is claiming they thought what when.

So this, chronologically, is just after the water debrief meeting on 15 May, which is bundle 14, volume 2, page 211, chaired by Ms Imrie. Would you have been briefed about that taking place?

A Yes, yes.

Q Yes. So, that's the minute that-- Ms Imrie has been brought in from HBS to chair that. Now, the evidence that we've had from those who were there described this meeting in quite positive terms, and I don't know whether you heard anything to that effect.

A No. Well, I may have, but I don't remember.

Q You don't remember. We then have the full Incident Management team report on 6 June, which is bundle 27, volume 5, document 19 at page 46. If we go to page 47, we see the source of exposure, second line, "Contaminated water supply." The highlight immediately - and water is not a highlight; it's an indication that's the answer, according to Dr Inkster anyway.

So what I need to know, going back your statement page 85, is who, as far as you recollect, in GGC did not accept at this date in May '18 that the source of the infections was not the water system in the hospital?

A So in many aspects of-- of healthcare, there are often a number of concepts that need be held simultaneously and, in Infection

Prevention and Control, that is true. So, my understanding is some of the clinicians, Infection Control clinicians at least, believed it was translocation, so the patients had essentially infected themselves, which is----

Q Did you say "Infection Control physicians" or "clinicians"?

A Clinicians, although it was the doctors that I'm referring to who believed it was translocation rather than necessarily an infection from the external environment. So I think there were a number of possibilities that needed to be ruled out and therefore it was difficult, I think, for Dr Armstrong, the medical director, who would be advising the chief executive. There would be general managers, there would be senior nurses, there would be the treating clinician. They would-- There would-- As far as I recall, there was not clarity and agreement that the infection necessarily was coming from the water.

Q I think I need to, sort of, press you a little bit.

A Okay.

Q Because I'm-- If we go back to the debrief meeting minute, which is 14, volume 2, page 211, we've spoken to Dr Inkster and, not that it's necessarily relevant, Professor Gibson; spoken to Dr Peters, but she wasn't an Infection Control doctor at the time. We've spoken to Professor Leanord, but he wasn't an Infection Control doctor at the time. We've spoken to Ms Devine, but she's not an Infection Control doctor. We've spoken to Dr Armstrong, but she's not an Infection Control doctor.

I'm now worried that I've missed a witness because I don't recollect being told of the existence of Infection Control doctors who, in May '18, thought, in a sense-- Although some people do take the view that the world's changed afterwards and we've learned more, it's fair to say that, but there's a general, I've understood-- a consensus amongst the witnesses we've had who were Infection Control doctors in May '18 that they thought at the time it was the water, and you seem to be suggesting that, out there, there's another Infection Control doctor.

A So, I-- I don't know. What I'm saying is I was told there was a mix-- So, I didn't sit and interview Infection Control doctors----

Q No, I appreciate that.

A -- and just because one wasn't employed as an Infection Control doctor, the microbiologists probably all have the capability of being Infection Control doctors.

Q Well, indeed.

A So, just because weren't designated that at the time, didn't mean

to say they didn't have that professional judgment of what was happening.

Q So it could be a microbiologist you're thinking of?

A Yes.

Q Right, well, that's fine.

A Sorry, I do apologise.

Q That's just-- I just suddenly got a bit worried that I'd missed a witness. So, just to finish that topic, how would you have learned of this of this viewpoint within----

A My policy team would have advised me. So, when we were talking about-- you know, this is-- again, my unease was growing about what was happening within Greater Glasgow & Clyde, and it was the ruling out rather than ruling in.

The assumption-- People were becoming polarised, I think, by this time, of, "It was definitely the water," "It was definitely the environment," or, "It definitely wasn't," rather than actually being able to hold a number of concepts and-- and look to-- to rule out. So, look for specimens, look at the clinical condition of the patient to see whether it was translocation rather than contracting from the environment.

Q If it's a problem to be too definite in one direction that it's colonisation, surely it's actually a problem if you're definite in the other direction.

A Yes.

Q Yes, but when do you have to make your mind up? Because we know, for example, that Ms Rankin, at the end of the month, has picked as her hypothesis two water-related sources. So, is there anything wrong with her doing that at the end of May?

A None whatsoever.

Q And so why-- What's the distinction? Am I just misunderstanding you? What's the distinction between "Dr A" taking the view that, like Dr Inkster does in the Incident team management report, that it's the water, Ms Rankin taking the view at the end of May that it's the water, and whoever this other person is taking the view that it's translocation. What's, in a sense, wrong with any other three positions?

A So, I think you have to come to-- ideally, if you can have a direct causal relationship with finding the organism in the environment, whole genome sequencing, and finding that same organism in the patient-- that's the most straightforward piece, how you can say it was definitely from the environment and this is where it was from.

If the best judgment is it was from the water, given the variety of assessments that expert Infection Prevention and Control colleagues carry out, then the important thing would be

openness and transparency. So, duty of candour in terms of advising the patient or their family, it would be about putting control measures in place and making sure other patients were protected from that source of infection.

And, as long as that was done, then that-- that was the important matter, and other aspects of professional disagreement could be taken-- What was important was the control measures were put in place. If there was professional disagreement about whether or not it was the water, then that could be an ongoing factor as things progressed.

Q So you're thinking this will come back as an issue in 2019, but you appear to be saying that, if there's a professional disagreement, the important thing is the need to act, but in the case of, well, what's about to happen in September, acting is complex, difficult and expensive because it's a decant unit.

A Yes.

Q So doesn't there get, in one of the in these processes, a point when you actually have to make a decision and pick a hypothesis, and then holding out for the other one is actually unhelpful, or is that just too much of an exaggerated position?

A I think that then means you've ruled something out that was a possibility, and if you don't keep that bubbling away as a possibility, then you're perhaps narrowed down too quickly. Now, because we now know it was the water, it-- it's perhaps easy to take that view but, if there are other possibilities that-- that remain possibilities, I think that's important not to ignore.

Q Why do you say we now know it was the water? If I understand, it's NHS Greater Glasgow & Clyde's position it's not the water.

A Well, the water was contaminated, is my understanding.

Q I think it's NHS Greater Glasgow & Clyde's position the water wasn't contaminated.

A They may well think that, but the advice that I've received is that there was contamination within the water.

Q I think that's probably, my Lord, an appropriate point to stop for coffee. I'll go and find these Corporate Governance committee minutes that I mentioned, and if they need to be looked at, I'll make sure you get a copy.

A Thank you.

THE CHAIR: We'll take our coffee break now, Ms McQueen, and if I could ask you to be back for 10 to 12.

A Yes. Thank you.

(Short break)

THE CHAIR: Mr Mackintosh.

MR MACKINTOSH: Thank you, my

Lord. Ms McQueen, one of the features of this is that the colleagues in the room get to suggest questions I should ask, so I've got a couple of things to go back to. The first one, you mentioned the use of whole genome sequencing to confirm connections between environment and infections. Do you have a view on whether in 2018 there was any sort of requirement in terms of professional practice or what should have been done at the time to collect such samples in a systemic way for whole genome sequencing in 2018?

A So, I don't have a view, and, if I did have a view, it would have been formulated from professional advice from Infection Prevention and Control experts. So I don't think it was the expectation that that would be happening, I'm just using that as an illustrative example of where you can be definite about the source of infection, but just because you haven't identified an organism doesn't mean to-- that's the same as the patient has been infected by, doesn't mean to say it wasn't contracted from the environment.

Q Thinking back to 2018, do you remember any discussion about the possibility of using whole genome sequencing?

A I don't. There may well have been a possibility, but I don't remember.

Q The next thing is I think I might have confused you about the framework. So what I'd like to do is to go back to your statement and to go to paragraph 24 on page 18. Now, this is where you discuss the National Support Framework, previously known as the CNO Algorithm, and that's in-- the 2017 version is in bundle 27, volume 4, document 15 at page 161. 27, 4, 161, please. So is this the framework that you invoked in that email to Dr Armstrong in 2018?

A Yes. Yes.

Q And it's, if we go back to your statement, on-- well, in fact, if we stay where we are, look at the first paragraph there, last line in the first paragraph:

"This framework supersedes CNO algorithm (2015)."

Would the CNO algorithm 2015 have been what you would have invoked in the Serratia cases in '15?

A Yes. Yes.

Q Right. Is that not, in fact, different from the Stage 2 and Stage 4 framework activated by the CNO and others in 2019 into '20?

A Yes.

Q That resulted in the Oversight Board?

A Yes.

Q Brilliant. Thank you. Now, what I want to do now is-- You mentioned the need to report. If we go back to the email to Dr Armstrong from

20 March ’18; that’s bundle 52, volume 8, document 2, page 39. Now, you mentioned, I think, if I understood correctly, that you felt that it should be reported to the Clinical Care and Governance committee.

A Yes.

Q Yes. So I’ve dug out the minutes of the next meeting, which is 12 June 2018, and that is bundle 38, document 7, at page 44, and we gave you a copy over the copy break.

A So, I do have a copy. Sorry, could I-- could I have the-- So I have a copy of the minute here.

Q Yes.

A May I have----

Q The email back?

A The email back, please?

Q Certainly, yes; 52, volume 8, page 39. Yes. Sometimes the computer gets a bit sad.

A Thank you.

Q Right. So, we go to the minute which is, as I said, 38, document 7, page 44. This is a meeting of the Clinical Care and Governance committee chaired by Ms Brimelow and in attendance, amongst others, is Dr Armstrong. I think the item that we might be looking at is Item 22 on page 47. Presumably, you won’t have seen this before.

A No. No.

Q The minute presents this as a presentation by Dr Inkster. Do you find in the minute a reference to the invocation of the framework?

A No.

Q I mean, it may be it’s reported elsewhere.

A It may be that it was in Dr Inkster’s presentation, but it just hadn’t been noted in the minute.

Q Yes. How unusual is it for a health board to be the subject, if that’s the right word, of an invocation of that CNO framework?

A I would think it’s quite unusual, and I would have expected the committee to have been advised of that, and had I been the committee chair, I would have wanted that recorded.

Q I mean if we think back to that sort of period, so 2018 and earlier, approximately how many times in a year might you or anyone in your office invoke?

A I’m sorry, Mr Mackintosh, I don’t know, but it would have been-- I would need to go and count, but it would have been-- I would have thought less than eight. So not-- not----

Q That’s across all the health boards in Scotland?

A Yes.

Q How many were there then? Thirteen is ringing a bell in my brain, but I might be wrong----

A I was going to say 15, including the island boards. I don't know, but yes.

Q But it's not a weekly occurrence?

A Absolutely not.

Q Fine. Now, I think probably I'll pick this up now. We talked briefly about the need or potential need or was there a need for some form of enhanced audit inspection functionality, and it's been put to me that what we probably would-- How do you feel about this: the idea of creating something similar to the Care Quality Commission that exists in England? A statutory body that can inspect on its own account rather than requiring a board to self-inspect or audit. Do you have a view on whether that would be a good idea?

A Do you mean have the self-inspection or a regulator?

Q A regulator like the Care Quality Commission south of the border.

A So, just because there is a regulator south of the border doesn't mean to say they don't continue to have problems, because there are problems, if you watch what's happening in the media with the maternity services, and they've had a regulator now for a number of years. I do think it's worthy of consideration and, as I said earlier, there are layers of bodies and agencies, either

to be supportive, or to inspect, or to look at improvement, and there's other-- there's many, many others that perhaps people aren't aware of in terms of looking at the radiology standards, in terms of IR(ME)R regulations have to be progressed, there's laboratory regulations that have to be processed.

So there's many, many bureaucracies that are put in place, rightly so, for safety. So I don't think I would be-- I would be arguing automatically for a regulator, but I do think consideration of it in the overall round of things would be helpful, because I think in terms of looking at the range of outcomes you would be expecting on perhaps a more regular basis than we're seeing just now from Healthcare Improvement Scotland, and I also think the autonomy to choose where to go.

Q Sorry, what do you mean by "the autonomy"?

A So rather than be directed by the Cabinet Secretary or follow a programme to actually pick up an intelligence and then go in and inspect on an unannounced basis, it would be helpful.

Q So it's a combination of ability to be autonomous from the political leadership and the ability to actually do the inspections yourself?

A Yes, although I do think we live

in a democracy-- a representative democracy. If the Cabinet Secretary for Health is concerned about an area of the health system, I do think they should be able to ask the regulator or the inspectorate to go in and inspect. So, although you're saying independent from politics, I do think there's quite a relationship there that you wouldn't want the Cabinet Secretary for Health not to be able to direct agencies.

Q Right. Am I right in thinking from what you've just said that there's also a need to remember there are lots of other relatively small regulators and inspectorates out there, and perhaps think about them at the same time? So there might be some that would get merged into such a thing; we need to think about it.

A Yes, or think about the burden of oversight of organisations in terms of making sure that what you're expecting to get at the end of it is actually what happens. So it would need careful consideration.

Q Thank you. I want to go back to your statement to paragraph 41, which is on page 85. I'd ask you about the sentence in the middle of the paragraph, that:

> "That understanding was not, however, universally accepted. [Then I think we've already discussed this] Nonetheless, because 'water' was one hypothesis for the source of infection, control measures were put in place by NHSGGC."

Now, it's the next sentence I wanted to try and understand:

> "It is important to note that the fact that water was considered to be a source of infection does not necessarily mean that the water system, as constructed and commissioned, was itself defective."

Now, what do you mean by that?

A So you can have-- you can have a perfectly formed water system that meets all the regulations, the authorising engineer for water is content, it has excellent and outstanding maintenance, and to all intents and purposes the water system is safe and effective, but something can happen – there could be splashback from drains, there-- there could be biofilm forming, there could be stasis, there could be lack of proper flushing that then causes the contamination. So, just because there was water contamination in the Queen Elizabeth doesn't necessarily mean that there was wholesale contamination from construction.

Q Now, you've obviously

expressed that view. We obviously can see the two 2018 reports from HPS, we can see the draft later report from HFS, we can see Intertek's report, we have Dr Lee's opinion, we have Dr Mackin(?)'s opinion, we have the Water Technical Group's opinion, and we have our Inquiry experts and other experts. I want to just check: during 2018, is there another piece of work that's been instructed by the Scottish Government?

A Not that I know of.

Q No, so this is your view taken from all the material and your general understanding?

A With hindsight, but it was not my view in 2018.

Q Okay. What was your view in 2018?

A That there had been water contamination that happens because you have that-- Right across the country there will be areas where there's water contamination, but control measures are put in place, whether it's flushing or other treatment of the water, and that then rids the system of contamination.

Q Now, I appreciate what you've said is not a statement of fact, because have you made study of, for example, the actual authorising engineers' reports----

A No.

Q -- or Mr Poplett's reports?

A No.

Q No. So this is just an observation of what might be the case?

A Yes.

Q Right. Then on paragraph 42, over the page, you mentioned the 2018 report from HPS, but before you do that, I want to go back to the timeline. So that's bundle 52, volume 1, page 619. At the foot of that page, on the right-hand side, you mention:

> "September 2018, A series of weekly teleconferences with NHSGGC and HPS begin during September 2018 until approximately January 2019. These were Chaired by the Scottish Government and concerned handling of the incidents."

Now, I'm not convinced I've seen the minutes of these. I may have misunderstood, but who was participating in these?

A So, I don't have the detail of it. It would have been-- I would have been advised that they were happening.

Q But this might be towards the physical building systems end of the discussion, rather than Infection Prevention and Control.

A So-- It may have been.

Q If I understand it correctly, the HAI unit has Infection Control Nurses in ARHAI to some extent reporting into it.

It's not, as far as you recollect, an IPC teleconference system. It's something else.

A No-- Yes.

Q Right. You then report an escalation. Now, if we go over the page, the timeline of the Scottish Government reports, "[Deputy Chief Nursing Officer] escalates the situation in NHSGGC to DG Health". Now, that's not you. That's your deputy.

A Yes.

Q Do you know why that escalation took place?

A I think she was concerned that the DG needed to know, because a lot of routine policy work is-- whilst it's not routine to the individual patient if they're infected, the-- the routine of having information reported, incidents reported, and-- is-- is taken in one's stride, but I think the DCNO felt that this was material and the director general needed to be aware of it.

Q We have on the left-hand column a 23 September date about case numbers and the wards being decanted. Now, we know the decant decision happens on the Monday, 17-- or might now be 18, I can't quite remember, September. Are we to take it it would have been not until the 23rd that the Scottish Government learnt about that?

A I think if that's in the timeline, then in terms of maybe formal notice-- but again, I couldn't say without----

Q You may have heard about it through ARHAI?

A -- looking at the documents.

Q It's entirely possible that on 23 September, it's simply that you're on annual leave?

A I was on annual leave.

Q Right. Okay. Now, at the risk of having a conversation about frameworks I might get wrong, should we read anything into the word "escalate" here? Or is it simply, "I'm going to tell you because you should know," if there's nothing formal?

A You're reading too much into it.

Q Right, okay. Now, the redacted section below makes reference to the AECOM report, which the Inquiry hasn't recovered because we understand it was produced by GGC in anticipation of legal action, but you knew about the ACOM report at this stage?

A Yes.

Q Yes, so I'm going to use this as a hook to work out what you knew at the time. So, we're looking at November 2018. What would you have understood to have been the what we've called potential deficient features of the building at this point? So this is November '18.

A So, I don't remember what I

knew when. I don't think I was advised of AECOM-- the AECOM report being commissioned, but I certainly would have been told once it was in progress and when there was information and knowledge about some of the faults that had been found.

Q But what was your knowledge, as far as you can recollect, towards the end of '18? I'm choosing that as before the Cryptococcus cases. We've obviously got the DMA Canyon report emerges, both of them, we've got the water incident, and we've got both reports from HPS, so I'm assuming you have a knowledge about water as an issue.

A Yes.

Q And you know about the Horne taps.

A Yes.

Q And you know about what you call contamination and what others call contamination of the water?

A Yes.

Q What's your state of knowledge about issues around the hospital's ventilation system at this point, before we get to Cryptococcus?

A So, I don't know. It would depend when the AECOM report was made available to----

Q But it's after this date. So, that's the point. There's a point here when AECOM is about to turn up, and so I'm thinking before you get any knowledge you might get, do you know of issues around ventilation in 2A, general wards, isolation rooms, 4B, at this point?

A I can't remember the sequencing of it in terms of when I knew and when I didn't know of the way that the system's ventilation-- the way the hospital's ventilation system had been designed and built.

Q I'll try and explore it a bit more, because it may be possible to extract something. If I'd seen you end of October '18 and I asked you, and you'd be willing to give me an answer, would you have said, "This is a water-based problem", potentially, or would you have seen that ventilation had anything to do with it?

A I-- So I would have taken advice, but I probably would have seen it as a water-based problem rather than ventilation, because the organisms were growing-- were cultivated in water, rather than, well.

Q Thank you. Now, if we go back to your statement, paragraph 43, page 86, you say you believe you were made aware of the DMA Canyon report in autumn of 2018. Now, we have evidence from quite a few sources that it's end of June, start of July, when Professor Steele from HFS visits Ms Grant with the reports which he's received, I think, from Mr

Storrar or his team, who've received them from a GGC data dump, as a consequence of which there's been a presentation to the Board in July. Do you think that would have happened before you learnt about them, or would you have learnt about them before GGC learnt about them?

A So I-- No, I did not learn-- and I would be surprised if I learned about the DMA Canyon reports before GGC. I believe I was advised that they existed, but by that time, both Health Facilities Scotland and GGC knew about it and were-- were working on a solution.

Q You mention the summary of incidents by HPS – bundle 7, document 2, page 32 – in paragraph 42, and it's December '18. Now, I probably should have asked this question to Ms Rankin last year or this year and I didn't, but it occurs to me reading your statement that this is a question to ask. Can you help us about why this report doesn't mention DMA Canyon?

A So, my understanding is Health Protection Scotland, in part of their investigation, asked Health Facilities Scotland to assist them, and it was in-- by providing that assistance that Health Facilities Scotland came across-- When I say came across, I don't know how-- whether----

Q No, it's not quite clear, but it seems to have been found, yes.

A -- they found the DMA Canyon report, and that was being dealt with through Health Facilities Scotland. So, it was being dealt with almost by a separate-- not in a secret way, but being dealt with in a separate stream. So, my understanding-- And then I think the Health Facilities Scotland created a report, I can't remember if it was published or not, which would have been early in January or February the following year.

Q Well, that's the thing, because there is a draft, but it's a draft, it's not a final. There's two reasons that made me ask this question. One is this point that there's no HFS report, effectively, to you and your colleagues in director general, in the DG, about, "We found the DMA Canyon reports, this is what they might mean". That doesn't seem to exist in '18. We also have the slight oddity that an epidemiology situational assessment that's started by Ms Rankin in the summer of '18 does not get shown to GGC in draft till January and isn't published till later in '19. I'm wondering whether there's any observations you make about the resource level that was available to HFS and HPS to address, not so much the Infection Control things, because there's nurse consultants in every meeting, but the rest of it – the

epidemiology, the water systems. Were these organisations set up to deal with incidents of this scale?

A So I think it probably hadn't-- it hadn't been anticipated there would be an incident of this scale or complexity when-- when they were set up, and it would have been-- I do remember that some of the-- I think it was actually Annette Rankin, underwent additional training in terms of water so that she had the expertise to carry out some of her duties. It would have been for both organisations to request further help and further resources, but it may well be that the level of technical expertise was being stretched but I-- I couldn't say.

Q I just wonder whether-- because we know, for example, that within GGC Dr Inkster felt stretched, and at one point there's a suggestion there might be further sessions for ICD doctors and it doesn't quite come to pass but that is certainly on the agenda and therefore I wondered whether, from your perspective as CNO, the idea of, "Do we on the"-- I know NSS is separate agency but, "on the government side of this incident, have enough resource?" Did that topic come up?

A I don't remember it coming up but it's it's something that I think, with hindsight, we should have reflected on and-- and asked the-- NSS did they have sufficient resource to be able to meet the needs of Greater Glasgow & Clyde.

Q What I want to do now is to move forward into the new year, and we pick that up in paragraph 44 of your statement at page 86, which is the Cryptococcus cases emerging. Now, you discuss the death of a patient towards the end of '18 at the bottom of that page, and over the page another patient who ultimately dies, and you receive an update from HPS towards the end of January. Now, there is a letter by DG Health on 25 January 2019, which is actually in Edinburgh hearing bundle for the hearing on 26 February 2024, bundle 4, document 3, page 8. No. So, it's the Edinburgh hearing-- Edinburgh 3 hearings, hearing commencing 26 February 2024, bundle 4, document 3, page 8. Thank you. Yes. Now, I appreciate that if we just step over the page, it's from-- back again, sorry. This letter, page 8, is from the director general himself, not from you, but are you aware of the reasons this letter was sent?

A Yes, I am.

Q Can you help us understand what was driving the decision to issue it?

A I think it's about how the whole NHS system learns, and if there were issues discovered in the Queen Elizabeth, rather than as expecting by osmosis that information and knowledge

to-- to go around Scotland, the director general decided that there were certain things, again, regardless of-- of causality, that needed to be-- be looked at in terms of, in this case, it was pigeons, but-- well, I don't need to repeat what it says, so it was to advise chief executives of boards that they needed to take action to review their current situation within their boards.

Q One of the things that's not or might not be present is in the fourth bullet point:

> "All critical ventilation systems should be inspected and maintained in line with [SHTM 03-01]: Ventilation for healthcare premises'"

Can you help us about why it doesn't say, "All critical ventilation should be inspected to see if they are in compliance with SHTM 03-01: Ventilation for healthcare premises"? There is a difference there which I understand, but I wonder if you can help us why it doesn't go that far.

A So, I think there's probably a number of factors. If we have a hospital estate across Scotland of varying ages and therefore the ventilation in the estate is a variety of-- of standards of ventilation, and I don't-- so therefore that-- that is one thing in terms of what the standard of ventilation is across Scotland, that there will be different air change rates in different rooms depending on when the building was built. My understanding, and what I recall from this aspect, was it was actually about the maintenance, and essentially cleanliness, so in terms of making sure that there couldn't be contamination of ducts, so air handling units need careful tending, they need to be maintained, they need to be cleaned, the ducts need to be in a good position so that there's adequate air flow, otherwise mould and other organisms can grow. So I think this actually was not-- I don't think there was a conscious level of the ventilation rates and the air changes that-- that came about through ACOM----

Q This is more a maintenance issue.

A This is about maintenance, yes.

Q Right. I want to pick up your awareness of what's going on in the IMTs around Ward 6A in 2019, and I wonder-- you had invoked your framework in March. At that point, around the time of the Cryptococcus cases, what was your, sort of, state of-- I'm not sure "concern" is the right word, but your level of interest/concern about the way IPC was being managed in the Queen Elizabeth over that winter?

A So, incident-by-incident would be looked at, and I hadn't been alerted to issues of IMT management with regard to

the Cryptococcus patient cases. I think there were other areas that were beginning to come through, I think from AECOM, that there had been mould and other aspects within the building, but in terms, as far as I recall, of the IMT for Cryptococcus, I don't recall any concern----

Q You don't remember that coming to your attention?

A No.

Q I mean, to be fair, there is a professional judgment in ARHAI about whether to tell you things.

A Had ARHAI been concerned, they would have alerted us.

Q Yes, and their decision to withdraw from the-- not withdraw, to not accept the conclusions of the Cryptococcus subgroup is many months away at this point. I want to look at an email that was sent from Miss Imrie at ARHAI to Mr Birch. Would Mr Birch have been part of your team in 2019?

A He was a policy lead, yes.

Q Yes. And this is on 16 August 2019. So it's bundle 27, volume 5, document 7, page 24. So, we've had some evidence about this in the inquiry and it's fair to say that Dr Peters has identified herself as the whistleblower and we have the correspondence so there's no point-- we don't have to maintain that at the moment, but this appears to be-- from the covering sheet, we know it's 16 August '19. We don't know the date of this email. We know that the contact by Dr Peters is on 16 August '19 after an IMT on 14 August. Was this issue brought to your attention around about the time in August of '19?

A So, it may have been. I can't recall, because as we moved into the autumn of 2019, there was increasing, I hesitate to say intelligence, but there was increasing messaging back and forward from Glasgow and Health Protection Scotland about the-- the way that IMTs were being conducted and I can't quite remember when this would have fitted in. I would be surprised if Jason Leitch hadn't advised me.

Q Birch.

A Sorry, Jason Birch hadn't advised me.

Q The reason I wanted to go on with the chronology and see if that helps you-- So we obviously have had evidence about an internal meeting on 20 August chaired by the medical director, which decided to remove Dr Inkster as chair of the IMT. Was GGC still subject to the invocation of the framework at this point, or had that dropped off?

A It-- it tended to be for incidents at a time----

Q So it would have ended.

A So it would have ended.

Q Right. And the national framework, had that been engaged at this point?

A No.

Q No. And so, given that the GGC medical director and number of senior managers had met and decided to remove Dr Inkster, and then there's the meeting of the IMT on the 23rd, which appears to have been relatively bad tempered and, in and amongst that, there's ARHAI discussion of whether it was all handled properly, to cut it short, did you learn about those events in August?

A No, I didn't. Day to day, bad tempered meetings, issues with relationships, that is for the Board to manage and deal with in a-- in an appropriate way. I am likely to have been told because I think-- and again I'm not quite sure when it happened, but Health Protection Scotland started to double up---

Q They did.

A -- because they felt they needed moral support.

Q Would you have known about that?

A I don't know when I knew about it, but I certainly was told about that in terms of they were concerned about the tone of INTs.

Q And then Dr Inkster resigns as lead ICD at the start of September '19. Now you met her on 4 September. Had she resigned by that point?

A I don't think so. She may have told me she resigned. I-- I can't remember.

Q Did GGC tell you she resigned?

A No, and on the one hand, whether or not there's an Infection Control doctor resigns from their role because they remain a microbiologist, it's an additional responsibility. That-- that would happen-- Well, I would say quite frequently. Doctors change their roles. They change their specialties. That, in itself, isn't unusual. I think my understanding about why Dr Inkster resigned is unusual.

Q But you didn't know that at this point, did you?

A I can't remember. Dr Inkster may have told me at the meeting, but I really don't remember.

Q If we look at her resignation letter, which is bundle 14, volume 2, document 151, page 579, we see in the fourth paragraph, quite a precise summary of her position. Now, you've had an opportunity to read this in your document list. I'm not going to go through it now, but how much of this would you have known in August, September of '19?

A I don't think I knew much of it at all, but again, one-- because clearly this is signaling a big problem. So, I'm not suggesting it's not, but workload of clinicians, you know, is a reason for them demitting office, but I think in this case, it's clearly a signal from Dr Inkster that there was insufficient resourcing and the culture----

Q Well, I think it's more than resourcing. I think it's undermining and lack of respect as well.

A Yes.

Q The reason I ask you this is because, in a few months time, you're going to, if I understand correctly, authorise the reopening of Ward 6A to new admissions, and when you made that decision, did you know, in a sense, how it was that Dr Inkster-- even from both sides because Dr Armstrong has a different take on this. Did you know either sides of the story at that point in November when you authorised that?

A So, I did know there was conflict in the team, and I did know there was more than two sides in all of this in terms of difficult relationships, lack of transparency, and I got that from a variety of sources. So when-- when 6A opened, I was content that it opened on the basis of Health Protection Scotland.

Q Because Dr Inkster tells us in her statement, which is witness bundle of

30 September for Glasgow 3-- I won't put it to you on the screen, but she tells us in paragraph 556 that she told you about a number of issues, including concerns she had about some historical cases in 2017. Do you recollect that?

A Yes.

Q Yes, and that she also told you about the way she'd been treated, because that's why she comes to say, which you deal with in your written statement, that you said that someone was being mean to you.

A Yes.

Q So the reason that she thinks you said that, and I accept you don't remember saying it, is that she tells you the way people are behaving towards her.

A Yes.

Q So, what I'm suggesting is that by the time you met her on 4 September, you had at least heard from her, if not through ARHAI, and you maybe had heard through them as well, if not from Mr Birch because of that email from Miss Imrie, that there was at least two microbiologists who were expressing concern about undermining culture and so on and so forth. Would that be a fair, sort of, summary?

A Yes, yes.

Q Did you attempt to find out more by, perhaps, asking ARHAI for

more of their take on it, because presumably they'll be more on the ground?

A So, I would have asked my own policy team rather than necessarily ARHAI and they would have-- have asked ARHAI, so the-- the intelligence I was gathering was one of conflict in the Infection Prevention and Control space. I don't remember the sequencing of it, but I absolutely knew that there-- there was a retired microbiologist and two microbiologists who were actively working in GG&C who were concerned about the culture, lack of transparency, and the way that IPC was-- was running.

Q Because I suppose I have to put to you that, in a different context-- different way; same context, different way, you've previously in 2015 had some concern about the way IPC is being run at a very high level in the Queen Elizabeth and, again, you were careful to say it was a concern rather than a reason for thinking it. You were concerned about the way they were handling the water incident to some degree in the previous year. At this point, there's been a lot of media interest. You'd accept that?

A Yes.

Q How would you react to the suggestion that, in September of '19, you actually have pretty much available to you the same evidence that we have available to us now, what is it now, nearly six years later?

A I think-- I think as the-- as the weeks went on-- so I would ask my team to find out more about what was actually happening within Glasgow, and as the weeks led up to the formal escalation of using the-- the governance framework rather than the CNO----

Q Format algorithm.

A Yes, then that was influencing and shaping my thinking. So my meetings with Drs Peters and Inksters and the retired microbiologist helped shape my thinking about what needed to happen because it was clear that intervention was needed, but talking to the chief executive and the medical director, they knew and understood that there were problems and they were trying to manage it, because in September I hadn't sent two of my team to go and observe an IMT. We hadn't spoken to the parents in Wards 2A and we hadn't had a wider view, so that was perhaps a catalyst to-- to further activities that were happening.

Q Well, you now know that Dr Inkster and Dr Peters had raised broadly similar issues in '15.

A Yes.

Q I mean, you didn't know that then.

A No.

Q No. You weren't told by the medical director and chief executive why Dr Inkster resigned. You heard it from Dr Inkster, to some extent.

A Yes, yes, yes.

Q Is that not a bit of a red flag, that you meet the chief executive and medical director of a health board who's under this high level of scrutiny-- You know-- I mean, you can't remember the full details of what Dr Inkster told you, but you know in broad terms she has concern about infection, she has concern about duty of candour, and she has concern about the way people are being treated including herself, and then when you meet the medical director and the chief executive, you're telling us they didn't tell you why she'd resigned.

A So, I think their perspective was their perspective, and there were other issues that were surrounding Drs Inkster and Peters, that they needed to take into consideration.

Q What other issues?

A Well, I think there were other members of the team who were unhappy with their-- with Dr Inkster's and Dr Peters' response. So it wasn't as a straightforward binary, "They're right, they're wrong."

Q No.

A It was much more complex and, therefore, it maybe was a red flag, but I think already my thinking had started that this needed more significant intervention than was already been----

Q Just to be clear, my point is not that there wasn't, perhaps, multiple perspectives on this, because that may well be the case, and we've heard of all those perspectives in evidence, and we have to ultimately decide what to do with that information. But it's the fact they didn't tell you. If your position is that you weren't told why Dr Inkster resigned, even if it turns out that she's wrong to have all those views, it's the fact they're not up front with you to tell you that this is what's going on in their IMT. Isn't that a problem?

A So I don't remember when-- although I'm saying I don't think they told me, I don't remember being officially told that she had resigned by the chief executive and medical director. There were so many things that happened over that period of time, I can't-- but if they didn't tell me then, given the circumstances, it perhaps was unusual but, equally, a doctor resigning from a role when there are thousands of doctors involved in Greater Glasgow & Clyde may not have been at the top of their mind.

Q I mean, it's been put-- I think it was a question I was asked to put to Professor Stevens when he gave evidence last year that there's a view,

and it was suggested that he might hold that view and he gave his response, but the view that was put to him was that – and it might have been put to Professor Wilcox as well – there's a reluctance to engage with whistleblowers because there's a sort of slight assumption that they might be somehow aggrieved and, therefore, not entirely unbiased. Was that your response?

A Did I have that, do you mean?

Q Yes.

A Absolutely not.

Q If we look at-- I want to step on to the meeting that we talked about earlier on 25 September. So that's bundle 52, volume 1----

A Mr Mackintosh, I do apologise.

Q Yes?

A May I come back to the whistleblower piece?

Q Yes, of course.

A I engaged with the three microbiologists but, in particular, Dr Peters and Dr Inkster. I invited them to meet with me. I asked my Specialist Infection Control nurse to link with them and liaise with them. I had serious concerns about their welfare. I absolutely took what they were saying at face value and I believed what they were saying, and I recognised and understood their distress. So at no time was I thinking that they were not to be listened to.

Q I understand. I'm sure we will return to this----

A Okay.

Q -- but what I want to do now is to look at the meeting on 25 September. So that's bundle 52, volume 1, document 37, which is the timetable again, page 624. So do you see in the right-hand column there's a series of events described, 9 September, "HPS notify the Scottish Government – HIIART red," 17 September, we are announced as a Public Inquiry. Then on 25 September, you meet with:

> "GGC, HFS and HPS to discuss the management of the ongoing incident in relation to increases in Gram-negative bloodstream infection on Ward 6A."

What I want to understand is, can you help me who might have been present from GGC at this meeting?

A I think Dr Armstrong was there.

Q Yes.

A I think there was a senior Infection Control nurse. I can't remember of microbiologists.

Q Might this have been around the time of Professor Leonard and Professor Jones' SBAR suggestion the ward was safe to reopen, and I think the ARHAI nurses, attending in pairs, took a different view? Does that connect to this

or is it a different----

A So, the reason I called that meeting was because there was an increasing intolerance of differing views and there was differing views, and what I wanted to do was understand what was happening within Greater Glasgow & Clyde. I do remember them giving a presentation about their infection rates and the ongoing dialogue that we had because there was senior clinicians from Health Protection Scotland, because there seemed to be disagreement across the organisations and I had wanted to understand-- I wanted to have everyone in the room so we could talk about the best way forwards to make sure that we could get the hospital as safe as it needed to be. So I can't remember when the SBARs were coming out, but I knew there was certainly conflict between----

Q So if we see this as of the process that ultimately leads to the reopening of the ward as an assurance process, that's the way to see that?

A Yes, but it wasn't always routinely planned to be that.

Q No, but that's where it ended up?

A Yes, yes.

Q Right. Just while we're talking about the way you express that, you talked about increasing intolerance to different views and you talked about the complexities, the technicalities of it, and we had an earlier conversation around about eleven o'clock around different views in IMTs in the context of relatively calmer periods in 2018. You mentioned Sir Robert Francis' report and the importance of being able to speak up and be heard. Have you got any thoughts about how that task of enabling people to speak up and be heard and the organisation to listen is made harder or more difficult – of course, you might disagree with me – in an area where it's quite technically complicated, like, is there an infection link? And where some people claim to have expertise and actually do, and some people have just acquired knowledge over their years, perhaps like an Estate officer. How do you resolve that when it is both a question of culture and a question of what's right?

A So there is something about-- and if you take Infection Control, clearly, Estates and Facilities have a huge part to play. Consultant microbiologists, nurses, general managers, the treating clinician, so they all bring a different perspective. I think in the seeking to understand and the being respectful of other colleagues, then the dissent is good, because by working through that dissent, you actually find the best possible solution. So I don't think we should be afraid of having

different perspectives. I don't agree it becomes much more complex when-- well, it becomes more complex, but I don't think it should matter because most boards around the country actually can manage this perfectly well.

So I think the culture of speaking out, of being respected needs to be created, and it's a leadership issue, so that people can feel safe and secure in raising issues that other people either are not wanting to raise or are testing something out that might be unpopular. There needs to be the space and time, and maybe we'll come to this later, about the organisation of IMTs, so that people feel they've got papers in advance to read, they can reflect and they can have open active discussion about it. That's what I would expect to happen at an IMT or higher up the organisation in terms of the organisational boundaries.

Q Thank you. What I want to do is just pick up-- I think we've actually already answered this, but we're obviously conscious from reading SBARs that HPS, HFS were providing support around 4B and 2A from, in 4B's case, from 2017, and we have a January 2018 SBAR for 2A. We know that in May/June '16, senior members of the Board, that includes the medical director, the director of Estates who was the project director, and indeed Dr Inkster, and quite possibly the chief operating officer and, I think, the chief executive all knew that the general wards of the hospital had a ventilation air change rate of three or less rather than six air changes. Now, they all have a different take on what should be done about it at the time. So that's not the issue. The question is, when did you learn about all 1300 wards-- rooms in the hospital are operating at half the recommended air change rate?

A I suspect it would have been in the autumn of 2018 when the rest of the-- I hesitate to say building deficiencies, but when the rest of-- either through the ACOM report or when HFS found the water issues, I was maybe also told that there were other issues within that.

Q Right. Now, we've also had a lot of evidence about the three microbiologists you've mentioned. Well, not the three-- actually, not the three, a different three microbiologists, raising an SBAR on 3 March 2017 and that results in a 27-point action plan which goes to Corporate Clinical Care and Governance Committee on 5 December 2017. So it's bundle 20, document 48, about page 793. Go back one page to 792. So this is the paper, and then we go to 793, is the key lists of the themes raised by these consultants, and then 794 is a 27-point action plan. Now, as far as you can recollect, when was the Scottish

Government first told about the existence of the 27-point action plan and how it had come about?

A So having an action plan in response to issues wouldn't necessarily be something to let the Scottish Government know about. I think I knew about this through doctors-- through the microbiologists speaking to me, saying that they raised issues and they hadn't been responded to. When I'd raised that with Dr Armstrong or Mrs Grant, they said, "Well, it had been because the SBAR had been created and an action plan had been created." So again, there was a difference of opinion about whether or not the concerns had been responded to or not, and I think that was probably in 2018.

Q What I want to do is to think back to something you said last year on 7 March 2024. It's in column 199 of your transcript of your evidence. I think it'd probably be only fair to put it on the screen. You're asked a question by my colleague about a line in the table, the guidance, at the back of SHTM 03-01 that deals with, I think, neutropenic areas or something like that, and you go, "Yes," and it's put to you what it recommended. Then you're discussing what's going on in the Edinburgh hospital at the bottom of the column and the role of the Oversight Board in Edinburgh.

It seems only appropriate to ask you to look at that table and ask you a question about it in the Glasgow context. So it's bundle 19, document 40, page 940, which is SHTM 03-01 2009 draft. No, it's not. I have to get the right one. Can you just go to page 1108 just in case I've corrected myself? No, that's the wrong one, sorry. Sorry, bundle 16, document 5, page 483. So this is the table from the 2009 version. If we could zoom in to the top half of the page, please. Now that's a bit close. Thank you. Do you see there's a row there, nine rows down, "Neutropenic ward, ventilation, and it describes the 10 air changes, positive pressure, 10 H12 air supply filter," and so on? Now, am I right in thinking that you've actually looked at this version, at least in the later version of this report, in order to----

A Yes.

Q -- yes. When all these events are going on in '19/2020, did you look at this version of SHTM 03-01?

A About the air changes?

Q No, it's about the definition of a neutropenic patient ward. Now, I realise you're not a haematologist, but what do you understand to be a neutropenic patient ward, and why do you understand it to be whatever you understand it to be?

A So people who have neutropenia can be needing a variety of

care. So would be expected to be nursed or cared for in a variety of areas. So haemato-oncology patients may be neutropenic, because it's not necessarily a long-standing issue. So you may have haemato-oncology patients. Transplant patients may be neutropenic, people with autoimmune diseases may be neutropenic. So I'm not as familiar with a neutropenic ward as such as what environment would you care for a patient who is neutropenic?

Q Well, that prompts me to say this. If we put ourselves into the shoes of, in this case, Mr Pardy, who designed the ventilation system for Ward 2A and 4B and so on so forth. Someone, an M&E engineer, is looking at this table and it says, "Neutropenic ward," and nowhere else in the document does it say what that means, and there's no row for Bone Marrow Treatment Ward.

A Yes.

Q There's just "neutropenic ward." I suppose one version of events could be a neutropenic ward is a strange, unusual specialist space, it's quite rare, and the other version of events could be a neutropenic ward is any ward on which you treat patients who are neutropenic, which might include a Cancer Assessment unit. It might include, well, in the Glasgow context, Ward 4C. So appreciating that it's not your technical

field, but you were the chief nursing officer and then the chair of the Oversight Board, I wondered if you'd ever got a handle in your own mind about what it means. Is it quite a broad-brush thing, where there are lots of them? Such that (inaudible 12:56:36)----

A No, but-- so I'm not a building services engineer, you're absolutely right.

Q No.

A But I do understand the importance of a safe and effective environment for patients, and people with neutropenia can be a transient state, so if you're a haemato-oncology patient, you may be neutropenic, and then you're treated and then you're no longer neutropenic. So it's not permanent in terms of labelling individual people. So I think any design engineer who's designing healthcare systems should be well aware of the fact that there needs to be facilities for patients with neutropenia. And that may not be all 1200 beds, it may not be two beds, but the dialogue that would go on when commissioning a building should include, "Where do you need that level of care?" If you don't know what a neutropenic patient-- if you're a building services engineer and you don't know what a neutropenic patient ward is, then you would ask.

Q So it's a combination of the engineer should ask and probably the

clinical output specification should say, "This is a neutropenic ward"?

A Yes, or, "These are the areas where"-- whether it's-- let's keep it to the positive pressure, "These are the areas where we need that within a hospital," and it may be pockets across the hospital or it may be everyone-- sorry, everyone grouped together.

THE CHAIR: Can I just explore this a little? Just in my attempt to understand what the table is attempting to say, it does seem to me – and I want to be corrected if I'm wrong about this – that a natural meaning of a neutropenic patient ward is the whole of the space in which a patient who is neutropenic, possibly transiently, may be treated. Now, there's two elements in that. In other words, what I have in mind is the whole of the clinical space and the other is where a patient may be treated, bearing in mind the possibility that at a particular point of time, no patients in the ward may be neutropenic, but it being probable that at some time, some of the patients will be neutropenic. Now, that's how I come to the text. From your perspective, is that a right way to come to the text or not?

A So I think so, my Lord, but you wouldn't necessarily have all-- although I think two ended up being that, in terms of all-- at the 10 air changes. If you would have a sufficiency of rooms for

neutropenic patients, that may be satisfactory. So, yes, if you can have the en-suite bathroom and shower room and their bedroom, that may be sufficient for them. I think it might be alluding to the patient pathway in terms of, if that patient has to leave that room, where do they go? So that would be an on balance decision, because you're not going to have that across the whole hospital and you would need to make a decision about how you're treating that patient, but I don't think it would necessarily mean you have to have a whole ward built at that air change rate. What you would have to do is build a sufficiency to give you space if you're having a peak of patients with-- who needed that 10 air changes. So, half of your wards could be built like that.

THE CHAIR: Yes. I appreciate one can become too detailed about this, but I have heard quite a lot of evidence about the way the Schiehallion Unit in Glasgow was designed and used, and again the evidence indicates that certain periods of time children remained within a specific room, and at least some of the rooms were isolation rooms designed to a specification which, broadly speaking, met the specification in Table A1, but I also heard evidence about the desirability of allowing all children to play in the corridor, for example, and interact with other children and indeed their parents.

Now, if one, starting from scratch, was designing a patient ward for the paediatric cohort treated in the Schiehallion, who might from time to time be neutropenic, would you consider a neutropenic patient ward to include the whole space, including the play area, maybe the other facilities for interaction with other children and parents?

A So, I think if you were neutropenic as a child, you're unlikely to be mixing with other children.

THE CHAIR: Sorry, say that again?

A You're unlikely to be mixing with other children, because you're at risk of infection. So, by the very nature of having a low white blood count and being prone for infection, you're going to-- you'd probably be quite unwell, but you would also be restricted to your room. Therefore, the-- whilst I fully agree children should have space to play, it's unlikely that that would be in a communal area. I feel I'm creeping now onto building engineers' advice and specialist advice about what size of ward you would want to have with that positive pressure, and I do think eventually 2A did build it across the ward so that they had the flexibility, but I-- I don't think you would be looking for children to be mixed when they're neutropenic. But-- And it's something that should have been, in my mind, easily thrashed out at design stage

of the building.

MR MACKINTOSH: Just to be clear, am I right in thinking your primary point is that the users and the designers should be really clear about this at design stage?

A Yes.

Q Along with the patient pathways?

A Yes.

Q So, if we have clinical output specifications that have patient pathway, but don't say which bit is in the neutropenic ward, that's probably a gap that, to be fair, the engineer should probably have spotted, but it's certainly a gap.

A Yes, and I suppose it depends if-- what stage it's at. If it's at the competitive tendering stage, then it costs more money. So, if a lower spec has been specified, the question is, why would you want to increase your prices? Because your competitors aren't going to increase their prices. So, it's in the specification before you go out to tender, but, yes, a good building services engineer should know about neutropenic wards and the requirement-- I mean, it's quite clear on the table.

Q Thank you. My Lord, this might be a good point to break for lunch.

THE CHAIR: We'll do that. Ms McQueen, could you be back for five past

two?

A Certainly.

(Adjourned for a short time)

THE CHAIR: Could I remind legal representatives that conversation can be distracting to the witness and therefore perhaps should be avoided?

A Good afternoon, sir.

THE CHAIR: Good afternoon, Ms McQueen. Mr Mackintosh?

MR MACKINTOSH: Thank you, my Lord. Ms McQueen, I wonder if we can go to your statement on page 88 and look at paragraphs 47 to 48 and just check that I understand what you're discussing here. Is this CRIP system an internal Scottish Government----

A Yes.

Q -- data system or presentation system?

A It's a communication system. It's a way, when something happens, the Resilience-- usually, but not always, when the Resilience Room opens, which gives a bit of extra administrative support to whichever director is needing it. The director general at that time, it was Paul Gray, found it very helpful as a means to communicate. So, just as you saw-- or you asked me to look at the letter coming out about the pigeons and the ventilation, then the Resilience Room might have been opened, and that commonly recognised information picture is essentially just a way of managing the amount of information, because you might have 15 reports every day from boards, it might all be saying the same thing, you want to get a sense of what the information is, brief the Cabinet Secretary. So, it's a communication system, I think.

Q And it's an aggregation process?

A Yes.

Q But it's internal?

A Yes.

Q So GGC don't see it?

A No, not at all.

Q And ARHAI don't see it?

A No.

Q No, right. I wonder if we can just pick up an issue which I've been asked to put to you which relates to-- There were some Stenotrophomonas infections in 2017 in Schiehallion. Were you aware of these infections in late 2017 as something that had been reported to ARHAI and escalated to your unit?

A So, if GG&C had reported it to HPS, as it would have been at that time, and it had been amber or red, they would have reported it to us, but-- Possibly I'm not remembering exactly, but I think the

Steno infections weren't all reported right away, but I-- I can't remember.

Q The reason I mention it is because there's an SBAR – well, actually an email, but it takes the form of an SBAR – from Dr Mathers on 1 March 2019 on this topic, and it's in bundle 4, document 36, page 151. So this is then raised with the medical director. I think this is bundle 4, Edinburgh, 151. Yes. I wondered, in 2019, if you had awareness of the Board looking retrospectively at 2017 Stenotrophomonas cases.

A I think it was certainly something that Drs Inkster and Peters had talked about in terms of-- So they would certainly have been raising it in terms of having cases that haven't been properly looked at. So, I couldn't say. I do apologise, Mr Mackintosh.

Q I just wondered if it had been brought to your attention by the Board.

A If it had been brought to our attention, I think it would have been through ARHAI, and then the Policy unit.

Q What I want to do is think about the events prior to escalation within the national four stage framework, but before we do that, there's a document that appeared attached to your statement when we received it, which is bundle 52, volume 1, document 38, page 733. When you see it, you might recognise it. I don't know whether you've seen it before. So

52, volume 1, document 38, page 733. It bears to be a meeting note of what looks a bit like an interview----

A Yeah.

Q -- by, quite possibly jointly, Sandra Aitkenhead from the Scottish Government-- Would she be in your own directorate or a different directorate?

A For the purposes of this, she was working on behalf of my directorate.

Q Right-- and Professor Steele, who was director of Estates for GGC at the time, speaking to Mr Leiper, who'd written previous reports. Now, can you help us about why this interview took place?

A So, I-- I think so.

Q Because it is in December '19.

A Yes. Sandra Aitkenhead was a forensic accountant. She created what we-- we were calling internally the super timeline, so that the timeline from start to finish, she----

Q In the Oversight Board report?

A Yes. So, she was a forensic accountant, she had been doing work, I think, for the Finance team, and was available, and therefore we asked her to help us critically analyse all of the infections and try and map together when infections happen. So you see there's the timeline of from, say, 2015 to 2019. Then she overlaid on that what came to pass, so both what was known when--

and sometimes retrospectively, something I'd say happened in September, but we didn't know till the following March. So she was responsible for that. When I was asked to look at this, I imagine that it was actually more Sandra interviewing Tom Steele and Jim Leiper.

Q Right.

A So that she could retrieve information that she could populate the timeline----

Q Into her timeline.

A That's-- That's-- I don't think I had seen that, but when I was asked to look at it----

Q So although this turned up, from our perspective, with your statement, it's not your document?

A I don't think so.

Q I think it's probably worth saying, because it's quite interesting – it contains lots of information – that we asked the Scottish Government why we didn't get it two years ago when made requests, and I think the response that we've heard is there isn't a single file in the Scottish Government for the Oversight Board, and therefore this document was located in July '25 by separate searching of their records. So that's the explanation they've given. I'm not necessarily asking you to comment on it, but just in case anyone who is watching is wondering why this document is being referred to now and we didn't put it to Mr Leiper and Professor Steele.

A No, and-- and I will comment on it. I think it would probably have been-- Bearing in mind it was Sandra Aitkenhead who was doing work for the Oversight Board under my direction, I think it would have been filed within the CNO's directorate.

Q Right. Can you help us with-- So you've given what (inaudible 14:14:05) documents for the timeline----

A Yeah.

Q -- but within the document, if we step forward through it-- (After a pause) On page 744, there's the "Lessons Learned" section. I'm conscious that Ms Aitkenhead would no doubt have used the timeline information to construct her timeline. I wonder if the "Lessons Learned" made it into the Oversight Board's conclusions?

A No. So now that I've had a chance to further reflect on this, I wonder whether Sandra was asked by Alan Morrison's team----

Q For the independent review?

A Yes.

Q Right. So this could well have fed into the independent review, but you wouldn't know.

A Correct.

Q No. You can take that off the

screen. If we go back to your statement-- In fact, what we'll do is we'll-- I'm not going to take you to it, but you explained in your Edinburgh statement-- So paragraph 51 of this statement, which is on page 89, you make a reference back to your Edinburgh statement, and you describe the framework. We asked you some questions about the legal basis of the framework in Question 53, and what I wanted to understand, because you ultimately became the chair of the Oversight Board in a Stage 4 process, as far as you understand it, to what extent does escalation to Stage 3 or 4 supplant the authority of the local board or its executive board members such as the Chief Executive?

A It doesn't.

Q Does it put the Scottish Government in charge of delivering health in the health board's area?

A No.

Q Does it put the Scottish Government in charge of fixing whatever problem is the reason for escalation?

A No, that stays part of the accountability of the Board.

Q If we see in a terms of reference of an Oversight Board it's limited to a certain thing, that is the limit of your authority?

A Yes, unless the Oversight Board decided they needed to look

further, in which case they could rearrange terms of reference by agreement with the-- If it was Stage 3 or 4, it would be with the director general's agreement, but the Cabinet Secretary would also be involved.

Q So if you meet an issue where you think, "I need to get into that," you can widen----

A It wouldn't have stopped me, yes.

Q Right. In paragraphs 56 and 57, you describe the escalation to Stage 2 of the framework in 2018. So, that escalation to Stage 2, that's not the chief nursing officer's framework?

A No.

Q This Stage 2, what was that in respect of?

A This Stage 2, it's my understanding, was for Performance and Finance. It was not to do with Infection Prevention and Control.

Q Infection Control? So in fact, it's a little bit of a red herring from our point of view.

A Yes.

Q At paragraph 57, Mr Wright, escalates to Level 4. Now, were you involved in proposing or one of the people who proposed going to Level 4 of the framework?

A It was me.

Q It was you?

A Yes.

Q It was your idea? Right. Okay. It's 22 November. I'm assuming this idea doesn't occur to you as you walk into the office that morning, so what's the sort of lead time to get from having the idea to convincing Mr Wright and actually making it happen?

A So I think from the summer it-- There was a repeated pattern from Greater Glasgow & Clyde in terms of Infection Prevention and Control. The experience of engaging with Glasgow found them to be defensive, and the tone was sometimes dismissive, of saying, you know, "Drs Peters and Inkster are concerned," then-- at times, tone was dismissive. There seemed to be a desire to protect the organisation. When I discussed that with the chair and Chief Executive, the reason they want to do that is-- and Jane was very, very loyal to all of her staff. She said, "We have-- employ over 4,000 staff, they do an amazing job, we provide services for over a million people, they need to have a confidence." So, although I'm saying they were protective of the organisation, I'm confident it came from a place of wanting to do the right thing for their staff and wanting to do the right thing for the population to keep them having public confidence.

Q Is there anything wrong with that?

A No, but when I'm talking about them protecting the organisation, rather than being open and transparent.

Q Is there something wrong with that?

A Well, I think you need to be open and transparent, and actually I do think openness and transparency is the most important thing you can do when things go wrong, and be honest with staff, be honest with the public, because otherwise it creates a culture of suspicion, and I think that's what I was walking into in-- in the late summer, early autumn of-- of that year. So by the time-- So pre-22 November, there had been the variation across the years of reporting/not reporting. There was tension within the Incident Management teams, and at one stage I asked two of my members of staff to go-- because it-- it wasn't clear to me what was happening. I knew that HPS started----

THE CHAIR: Again, Ms McQueen----

A I do apologise, my Lord.

THE CHAIR: This strikes me as quite an important part of your evidence.

A Right. So, the Health Protection Scotland team had started to double up going to IMTs, and this was in the day before COVID, so most meetings were either-- were usually in person or

something like this. We'd been advised about the-- the conflict that was happening in IMTs and therefore I asked two of my team to go and observe, and they came back and reported to me that it was less than satisfactory.

MR MACKINTOSH: Roughly when would they have been going to do that?

A I think they went in October.

Q Right. So this is the IMTs that, in a sense, might fall between the initial view of Professor Leanord and Professor Jones that it's safe to reopen, but before that conclusion is reached when the other SBARs are flying around and Ms Rankin and her colleagues are asking questions?

A Yes, yes. So, it was less than satisfactory, so that gave me confidence that, actually, this was an important issue that needed to be resolved. There was the meeting in September that I had with HFS, GG&C, and ourselves.

Q This is 25 September?

A Yes. When we had been presented with data from GG&C about infections-- and they had lumped them together rather than-- or grouped them together rather than having gram-positive and gram-negative separately, and therefore there was an impression that, actually, the-- the number of infections, when averaged out, seemed reasonable, but not when you stripped out the gram-positive and gram-negative; the gram-negatives looked very starkly high. And when I asked them about root cause analysis of infections that they had, I was advised that that did happen. Now, when I followed up for-- looking for data to support that, that didn't exist. So I was uneasy about the overall grasp of-- of what was happening within GG&C.

Then we had Christine and Teresa, who were clearly distressed in terms of meetings with-- with them, and, although I didn't meet with them that frequently, my Infection Prevention and Control nurse specialist advisor was in close contact with them and-- and she would then keep me informed about what was happening. And then the meetings with the families that the cabinet secretary had.

Q And those are in September/October?

A Late September, early October. So, put all of that together and I knew something had to happen, I just wasn't sure what.

Q Just before we move on, you seem to be mentioning a number of different things.

A Yes.

Q So, working backwards in the order you mentioned them, we have the conversations with the families----

A Yes.

Q -- which, presumably, you-- communications is a major issue?

A Yes, but not----

Q Not just communication, but it's a major issue. We then have a series of IPC issues related to what you're being told by the Board itself, what your staff are seeing at IMTs, and what you're being told by whistleblowers.

A Yes.

Q And all these together are informing your views.

A Yes.

Q Does the existence or otherwise of how the water system is being managed/remediated and the state of the ventilation system feed into that process, or is that not something that's crossing your radar?

A So, by that time, it had crossed my radar, but that was being dealt with by-- and I say "by another team", but I felt that-- that had actually-- that was being dealt with. So, Health Facilities Scotland, they had the ACOM report-- I think, since Tom Steele had arrived at the Board, things seemed to be grasped more comprehensively. So I had more confidence that the physical side of the building was-- whilst not ideal, was being dealt with and therefore didn't need to be brought under greater scrutiny.

Q There are two aspects of the ventilation system that I need to to put you. One relates to what is the appropriate response to the ventilation in Ward 4C. So, we know that that's a live issue in '19. What awareness did you have of whether GGC had risk assessed 4C's ventilation and indeed taken account or considered Dr Inkster's SBAR on the-- and generally thought it through as an issue?

A So, I was advised that they had responded to the SBAR. I had accepted that the-- the ventilation and the physical part of the building was being dealt with appropriately.

Q When it comes to the general wards, we now appear to be in a position where I think it's accepted that there's never been a risk assessment of what we ultimately call the "agreed ventilation derogation" of two and a half to three air changes – 40 litres per second – rather than six air changes. There'd never been a risk assessment of that. Was that something you were aware of as an issue in this run up to November?

So, if I was, it-- it would have been a matter of fact for me rather than an area that would require further-- closer investigation. My view is that was being dealt with separately.

Because there is a point of view, I suppose, that the Oversight Board should have had supervision over the remediation works as well, and it ultimately didn't. I wonder why that was?

A So, that wasn't within my

sphere of responsibility. On talking to Alan Morrison, although we-- we brought the technical sub-group in under our auspices, that was more about keeping an eye on pace and delivery rather than necessarily giving any expert advice or expert overview. And Christine McLaughlin, who was the finance director at the time-- or maybe at that time it was Richard, that team were taking that forward. So, that was being dealt with, and it, from my understanding, was in an appropriate way rather than being part of the Oversight Board responsibilities.

Q Because I think there was a viewpoint from a number of core participants, related to adult patients, that ventilation in the general wards has a connection to the Aspergillus infections that their family members suffered from. I suspect they might want me to ask, and so I'll sort of pre-empt it. How do you react to the suggestion that, had the Oversight Board's remit extended to checking what the Inquiry has to check, as the deficient features of the hospital defects have been remedied, that these issues might have emerged faster and been addressed, either in changes or in the way that risk was managed?

A So, when we put the Oversight Board together, there was the Independent Review that was happening, we knew the Public Inquiry was

happening, and we were being particularly focused on the Haemato-oncology children. It wouldn't necessarily have been for me to then expand that to say, "I want to look at the whole of the building of the Queen Elizabeth and all the remediation work." That would have lain with the-- the team within the finance directorate to do that because I think there's probably a number of areas there. So, was it about the maintenance of the ventilation? Was it the quality of the ventilation that had been fitted, or was it the air changes itself that-- that was the problem of that?

So, I fully accept that the air changes should have been six, but I didn't see it that time and I don't know that it would have been my Oversight Board that would have dealt with it. I think it would have been either in the Oversight Board-- the fuller escalation for-- that put GG&C to Stage 4 for everything may have been appropriate, or a separate bespoke arrangement from the finance directorate. I don't think it was for my directorate.

Q Are you effectively saying that your focus was on Schiehallion?

A Yes.

Q And IPC and Schiehallion seemed to be the driving issue, and so that's why you stayed your attention?

A Yes.

Q Right, okay. Now, we don't often see background papers for these sorts of decisions, so, since one is in a bundle, I should ask you why it is like it is. This is bundle 52, volume 1, document 6, page 34. So, is this the background paper that would have been produced before the escalation?

A Yes, this would-- this would have gone to the Health and Social Care Management Board. Clearly, before taking it there, I would have talked to the DG, the Cabinet Secretary, my colleagues around the table, so that they were-- they understood my rationale for escalation.

Q I understand that. I just want to make sure I understand what it is and what it does-- what it isn't. So, it starts on page 34 with a "Background", "Action(s) Required", and that's a sort of introductory page/page and a half.

A Yes.

Q Yes, and then we go on to page 36, which is a more narrative description of background. Now, what I wondered was, if you look at paragraph 6, for example, and in fact the whole document, it isn't quite as specific as what you just said. The way you described your emergence of concern was by reference to Dr Peters, Dr Inkster, a conversation with the chief executive, what your staff had observed. This paper doesn't go to that level of granularity. Is there a reason for that?

A Well, when you-- you create a paper, you have to decide what-- what to put in it, and there's an element of-- I believed what was in the paper had a sufficiency of understanding and rationale, and I suspect I probably gave some verbal feedback that enhanced that.

Q Right. If we go back to your statement, page 92, you discuss from paragraph 62 your appointment to the Oversight Board, and you quote the recommendation from that paper we've just looked at. Are the issues that the Oversight Board face the same ones you've just described, or did they evolve by the time of your appointment?

A Yes.

Q The same ones, right. If we look at your terms of reference, which is also bundle 52, volume 1, and it's now page 25, document 4.1, one of the issues that-- I think we've discussed already that you don't have the authority to supplant the chief executive and the management structure. You're not even supervising, you're-- What's the right verb to use?

A I think it's "supporting".

Q I mean, "supporting" is quite a broad concept.

A Yes.

Q I mean, you can be supported in a way that makes you feel happy to be supported, and you can be supported in a way that makes you feel slightly under pressure.

A Yes.

Q Can you give us any more colour or detail to that description, that word?

A So, I saw my role as chairing the Oversight Board to be able to assess what the current issues were in an-- an objective way, supported round the Oversight Board by other people with experience. I'm-- I'm not necessarily saying they were experts, but there were people around the Oversight Board table who could give advice and take a view on what was happening and therefore make recommendations that, when implemented, would correct any deficits that were identified.

Because this-- This was quite a novel thing; this had never been done before. When boards had been escalated in the past, it had always been around-- or almost always around performance and finance, and it was almost always the whole board. So, actually, in the pre-November reflections and discussions I was having, it was, I knew something needed to be done, I just didn't know how to-- to do it because it had never been done before.

And that's then when the idea of the-- the oversight escalating to Level 4 for IPC in Schiehallion-- and putting an Oversight Board in place to oversee the corrective action, if identified, which it was, that was needed to provide safe and effective care.

THE CHAIR: When you say, Ms McQueen, "This had never been done before," I understand from that term other boards had been escalated to Stage 4 but, as you explained, for financial and performance reasons. Is this the first time that there had been an escalation to Stage 4 which had involved an Oversight Board being put in position, or did I misunderstand your answer?

A It-- It was the first time, as far as I am aware, that a section of the board was escalated rather than the whole board, and it was for Infection Prevention and Control rather than-- So, the Oversight Board-- And I think, over the years, the-- the arrangement that's put in place for overseeing escalation has been called a variety of things, and we-- we chose Oversight Board.

THE CHAIR: Right, okay. So you weren't taking something off the shelf----

A No.

THE CHAIR: -- it was specific to the issue that presented itself at the end of 2019?

A Yes, that's right.

THE CHAIR: Thank you.

MR MACKINTOSH: Just technically, is the Board required to implement decisions or recommendations of the Oversight Board?

A Well, I would say yes.

Q But, legally, no?

A Legally, no.

Q Whenever you asked it to do something, as far as you understand, did it do it?

A Always.

Q Now, I think I need to put to you a concern I have about a couple of things you've said that I might be exaggerating to you the words and inconsistency. So I want to explore this with you.

A Okay.

Q So, just to recap, this morning, around about half past ten, I asked you whether blame affects processes and you talked about-- this isn't the transcript, it's my junior's notes and my notes, that you can't secure learning in a culture of blame and that retribution makes it harder and you need a psychologically safe culture, an opportunity for teams to reflect and discuss practice concerns, and then it's a bad things if concerns are ridiculed. These sort of concepts as you talked about. Later on, you said dissent is good for working through-- looking for a solution, and you made reference to Sir Robert Francis' report and speaking up and that sort of thing.

Now, at the same time, you have just now described some of the reasons that the reasons caused you to think of this concept and to report it, and they related to, partly, the families' experience, including communications, but also, to some degree, what were you being told by Dr Peters and Dr Inkster, and also what your own team observed at meetings where Dr Peters and Dr Inkster were not present. You're happy with me so far summarising where you've been?

A Yes, I'm very happy. I'm not sure that Dr Peters and Inkster weren't present, but I'm happy to go with----

Q I'm pretty sure Dr Inkster wasn't present for that point.

A No.

Q I mean, I may be wrong, but I have a suspicion that, if we checked bundle 1, we wouldn't see her in the September/October meetings. How do you respond to the suggestion that, in order to resolve two of these issues – that is, the communications experience of patients, and the experience of not being listened to, being minimised, or whatever word Dr Inkster used, undermined, by Dr Peters and Dr Inkster and also separately Dr Redding-- that both of those, in order to learn and move forward, require a decision to be made? Whether both

criticisms – that's the patient's concerns about communications, and these concerns from the whistleblowers – are, if not right, valid? Would you accept that?

A Yes.

Q So that brings me to the inconsistency and, if we look at-- I thought of taking you slowly through the whole of the Oversight Board report, but I think I'll take you to one document first and then put something to you, which is-- If we go to bundle 6 to the timeline, the one that Ms Aitkenhead produced, and we go to page 952 of bundle 6, we see the July to August timeline. Now, I recognise I'm zooming in on one row in the timeline, but there's a reason I think I can do that. Do you see the final bullet point in the middle box:

> "Change of chair on 23 August. Chair notes asked to demit but IPCT advised that following a conversation between them about the complexities of being the Chair and an active participant, the Chair was in favour of another chair."

Now, is that true? Is that the chair's views about what happened?

A So, I-- I don't think it is, but that was the timeline that Sandra Aitkenhead produced.

Q So, that's (inaudible 14:39:24), because it's a piece of information, she's the author of it, and I'm not criticising her for constructing a fantastically complicated timeline, and you can't be right in everything, so I park that. Let's look at the Oversight Board report itself. So, that starts on document 36, page 795. Now, I reread it-- Well, I didn't read the whole thing. I read it quickly at lunchtime having reread it a number of times before. I don't find in it a discussion of the need to encourage a speaking up environment.

A No, you wouldn't.

Q No. More importantly, I do find in it a criticism lifted from the independent review of, I think, Dr Peters. So if we go to page 831-- I must get the right place. 830, sorry, and there's a quote in middle of paragraph-- at the end of paragraph 75. Do you see, four lines from the end of the paragraph, is:

> "A number of clinicians and microbiologists raised whistleblowing procedures within the Health Board. Also, as already noted, it is clear that were were notable tensions between staff. The Independent Review has commented on this more extensively, and noted: 'The whistleblowing episode beginning in 2017...'"

Which, of course, isn't true, it began

in 2015:

> "'... lack of resilience of management arrangements and instability in the lead IP&C Team's relationships set the scene for a contested leadership into a particularly turbulent period, when the microbiologist community could not find the capability that would have enabled them, when it was important, to be able to agree to disagree respectfully.'"

Do you see how the whistleblowers might see that as a criticism of the whistleblowers who were the parts of the microbiology community because they can't disagree respectfully? I know you didn't write it, but you did quote it.

A So I do think the micro-- if the whistleblowers are saying they found that was them singled out, then I don't-- reading this, I do not think that is the intention. I think it was about the whole system.

Q Because----

A Not about two individuals.

Q Because there's no discussion in the Oversight Board about the removal of the chair, for example.

A No.

Q Apart from Ms Akerhead's(?) summary, and we accept the risks that you pose by giving a huge task to one person on that. So----

A Can I-- I don't know if you're going to ask me about the organisational development work, Mr Mackintosh?

Q I probably will, but I want to just pick up one question before I get to it. The Oversight Board was an important part of these developments, and unlike this Inquiry, it was quick. I'm happy to accept that. And you clearly give the impression of caring quite a lot about the importance of the ability to speak up.

A Yes.

Q But the Oversight Board report does not contain that. It doesn't take that opportunity to say that, and that's the inconsistency that I'm getting to. I wonder how you respond to that?

A So, when-- I saw the Oversight Board as being-- so for me, for things to be fixed, there was the Oversight Board and the governance arrangements; so the technical, almost administrative issues that needed to be put in place, as well as attitudes about empathy and compassion, particularly in the communication subgroup and openness and transparency. The other side of that coin was the organisational development work that was commissioned, and it was agreed with Jane Grant, Marion Bain, but I had asked that-- essentially, indicated that organisational development work was urgently required and Jenny

Copeland was put in place to lead that.

When in January or February, the other Oversight Board, so a turnaround team was put in along with a chief executive on performance and finance. So, essentially, the whole Board by this time was excluded.

And at Health and Social Care Management Board, we had a discussion that said, "Do we have one Oversight Board? Do we merge them into one and have performance and finance as well as Infection Prevention and Control?" Because, by this time, the whole board was at Level 4 through the second escalation or do we keep the board separately? I thought if the Infection Prevention and Control aspect of it had been tucked in, it may have lost focus, but I would have been content to do either, depending on what the management board thought was the best thing to do or the director general. But culture was something that was appearing and featuring in the other Oversight Board, and therefore it was agreed that the organisational development work with regards to culture would be taken in from a whole organisation point of view to the other Oversight Board. So that then-- it left my remit.

Q But it doesn't say that in your report.

A No, it doesn't, and that's obviously-- or perhaps-- that's perhaps an omission in terms of saying the work was instigated but was not for my Oversight Board or the Oversight Board for IPC to deal with. That was for the other Oversight Board to deal with.

Q Because one of the things one notices about these developments in the Health Board is that just as the whistleblowers and Dr Inkster, who of course wasn't a whistleblower in that technical sense, speak about a long series of events over many years and how they feel about raising all these issues and not having them listened to, those who they perceive as the-- as those who are who are not acting, who are putting them under detriment, when they speak about it, they also perceive it as a long-running experience. So when we see Ms Grant's letter to the chair of the CNR, or the Stage 2 whistleblower report of Dr De Caestecker, they both-- they mention perceived failing as largely of Dr Peters, but they make perceived failings of the whistleblowers. So it's clear that both of these positions are, "entrenched" might be the right word, they are long held. Therefore, I'm wondering why it is, how it is, however diligent Ms Copeland was, how work in private with the whistleblowers and Dr Inkster could be expected to break through that

entrenchment and find the resolution?

A So had the OD work stayed within the Oversight Board I chaired, then I would have expected that to have been written into the recommendations. So the oversight-- so it was confidential, and the work was not just with Teresa and Christine, it was with the whole Infection Prevention and Control team and Facilities and Estates. A report was submitted to Mrs Grant, and I would have expected that to have been responded to with active work on taking it forwards and reported to the other Oversight Board.

Q Because, I have questions which I'm not going to put to you because they're quite technical, but if you look at the IPC management framework document generated in '19, it has details about who can attend IMTs and who should be involved in the hot debriefs and all these things. And when you look at those questions, they never say, "Oh, and talk to the microbiologist," and that's the criticism that I'm asked to put to you. But actually, it occurs to me this. If you don't resolve the entrenched issue, will it not simply continue? Even if the people involved leave the organisation, as some of them have, it'll still be there and people will know about it, and the next whistleblower will think, "I think I'll keep quiet. I don't want to be like that."

A So I think the systemic

behaviors that that generates is a real challenge in terms of changing culture and, unfortunately, I resigned from my job when the Oversight Board had concluded, but was not there to oversee implementation and effectiveness of the recommendations, because one of the things I would have done would have been to triangulate with the whistleblowers in terms of check and test that that work had been carried out.

Q I suppose part of it, at that point, we were well into Covid and there was that as well.

A Yes.

Q I think I want to just ask you a little bit about something you say on this subject in the statement at paragraph 76, so that is the bottom of page 96. We asked you about a meeting-- the first meeting of the Oversight Board and so we'll look a minutes. Bundle 49, document 2, page 8. So what I might do is just make sure that I'm looking at the right page because this jump forward of the pages I think is quite annoying. So I'll-- we go to page 11 while we start. So these are the people who attend the Oversight Board. So Oversight Board meetings don't contain the Board's staff, they are just your team?

A So that-- if you look at the terms of reference, that will give you the membership of the Oversight Board.

Q Right.

A And I think this has been mixed up with attending, so the ACF and the APF chair. Oh, yes, they're in attendance.

THE CHAIR: Yes. So----

A So they're not all my staff. So Andrew Murray is the board director for-- medical director for NHS Forth Valley, Hazel----

MR MACKINTOSH: But they're not GGC?

A No, there's no GGC as members of the board.

Q No. So in the meetings, are the GGC people there?

A Yes, I think we had-- the chair came sometimes, the chief executive came sometimes, Jennifer Armstrong came. They were there. So, going back to learning and improvement----

Q Yes.

A -- they were there so they could listen, so partly provide information if that was needed, but where they could listen and learn. So, it seemed reasonable that Greater Glasgow & Clyde were not members of the Oversight Board, but they could be in attendance to listen, learn, reflect.

Q I mean, it's been suggested I should ask that having them present might in some way invalidate the independent nature of the Oversight Board. How do you respond to that?

A I understand where people come from, but by not having them present, then they could argue they're totally excluded and don't know what's happening. They've not been part of the dialogue and discussion and debates.

Q Did you have discussions in their absence about certain items that you felt it was appropriate to do that?

A Occasionally. So there was one, I think, near the end of it, where-- when I was looking through the minute, I noted that it was exclusively members of the Oversight Board. I didn't get a sense that there was anyone around that table who would not be able to speak because there was Greater Glasgow & Clyde members there.

Q I suppose I'm conscious that when you were describing your reasons to form the Oversight Board, you did appear to raise suggestions about confidence that you had in what you were being told by the chief executive and, I think, the medical director. So-- at least definitely the chief executive. So----

A I think that was about perspective.

Q Right. Not that they were keeping something from you?

A Well, they might have been if they didn't think it was relevant for me to hear.

Q Right. Did you feel, as the Oversight Board, was developing that they were telling you things?

A No, I think once the Oversight Board was in place, whilst it may have taken time, but I think that was just how Greater Glasgow & Clyde functioned, we received everything we needed to.

Q Okay. If we go back to page 8, please, sorry, there's a discussion-- actually, it's on page 9, that one of the members, I think a staff rep, references the third paragraph at the bottom:

> "DM referenced the recommendations from the Sturrock Review and noted this could be an opportunity to change ways of working at board level to enable the NHS to become more open and transparent, so it was essential the OB takes people with them."

Well, we asked you about that. If we go back to your statement, page 96 at the bottom:

I am asked about the discussion of the "Sturrock Review" [over the page] that took place at the meeting.

And you obviously provide clarity of what it was, and there's a copy in the bundles and we've reviewed it. Ms McErlean, the employee director says what she says, and you think that this was about:

> "Encouraging the Oversight Board to work in a way that was in accordance with the recommendations of the Sturrock Review."

A Yes, because I think that's what she said.

Q But the minute doesn't seem to say that, it says the Board needs to change.

A So that would be, in my mind, how we worked with the Board.

Q Because one way of reading that minute, and I appreciate you were at the meeting and I wasn't, is that it might be being said that the GGC Board should change the way it works to enable it to become more open and transparent, and if that was what was said, then is it not slightly striking that that isn't a heading, a topic in the Oversight Board Report at the end?

A So I don't-- I don't think it-- Let me run back. So that was said at the meeting in terms of the Sturrock Review, and I took that as how we were-- because it was in the context of how we were going to work as an Oversight Board, and I took that as an indicator that Dorothy was hoping that we would be around the table, be open and transparent and therefore model the behaviour. We also, when we looked at the terms of reference, put, "Upholding the NHS

values." So it was to be a value driven approach that we were taking. So that was the approach we had taken. On reflection, when I've worked in boards, so I had experienced when NHS 24 had problems with their IT system and the Cabinet Secretary-- they weren't escalated, it was kind of predated that sent me in to oversee, essentially, the integration of the new IT system and the employee director there was very vocal about what needed to be done and what didn't need to be done.

I chaired the NHS Lothian Oversight Board and that had members of NHS Lothian on the Board; it was set up before I had been having elective surgery and so I'd been on planned sick leave, so it was set up before I arrived. That didn't prohibit good conversations, the fact that members of NHS Lothian were on the Board. Again, either the employee director or his substitute was there, and from a trade union point of view, it was very helpful. On reflection, the ACF and APF chairs were very silent during the Oversight----

Q Can I just help you for acronyms, ACF and AP----

A Sorry, area clinical forum, which was the other member who was in attendance.

Q So that's the doctors and nurses representive, in a sense?

A Yes, and the area partnership forum, who Dorothy McKellen(?)----

Q Which is more staff?

A -- was the employee director, yes.

Q Yes.

A They were very silent, and I'm now wondering if that had been a signal to me that I didn't pick up from them.

Q About the culture of NHS Lothian?

A Yes. They didn't pursue it, which I'm disappointed if it was a signal that I didn't pick up, but when I was preparing to come, I did then wonder if-- I mean, the Sturrock Review was very topical at the time, and I think that's-- I didn't look any deeper than that.

Q I mean, given what you have described as the reasons you set up the Board in the first place, is that not a different end of the same issue, potentially?

A So, it may be, but I did take that as how the Oversight Board-- so rather than come in and blame people and criticise people, that the Oversight Board would behave in a way that was supportive and facilitative.

Q Now when it comes to the appointment of Dr Bain, we-- sorry, Professor Bain, we asked Mr Wright what steps the government took to ensure that the operation of IPCT was being carried

out in compliance with the manual, and he felt unable to assist and deferred to you. Am I right in thinking from what you said that that exercise is sort of inherent to what you were trying to do within the Oversight Board, is trying to make sure they follow the manual and they stick to the manual?

A Yes, but I think it wasn't as stark then as it was after the peer review, when it was obvious that Greater Glasgow & Clyde had translated the manual into Greater Glasgow & Clyde standard operating procedures rather just going straight-- straightforwardly for the manual to use. So again, we know with hindsight, but I'm not sure at that-- when Marion was appointed, that we necessarily-- it was much wider than the manual.

Q So one of the issues that's now live is a standard operating procedure, a framework document, which I think I will put up on the screen. It's not in the document list. Allow me a moment just to make sure I've got it. I'll just have to check my other note. I'll just take my notes from Ms Imrie on which I have these written down. So, it is at bundle 27, volume 17, document 28, at page 315. This might take a moment to load up. So this is version 2 of the Infection Prevention and Control team incident management process framework. One

can see in the top right-thand corner that it's effective from December '23, which is long after the Oversight Board is in place, and if we go to the third page, we see "2.1, Initial Assessment/[PAG]", and there's a discussion here about an initial assessment. The first bullet point is:

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

We've had evidence from Ms Imrie and we've seen correspondence that says that that's not in compliance with the manual, and I wondered if you could help me about whether that approach of having a pre-assessment in some way-- To be fair, that's not the way Ms Devine in her statement would have us describe it, but that view as expressed by ARHAI was present in the GGC processes that you were looking at at the time of the Oversight Board?

A So the Infection Prevention and Control sub-group would be looking at processes, and the peer review that was carried out over the summer of 2020 would have looked in a more detailed way about processes, and they made recommendations that said, "GG&C should follow the manual; they should not have their own standard operating procedures".

Q But you can't help me about what the nature of their own procedures said?

A I beg your pardon?

Q You can't help me about what their own procedures actually said on this point?

A No, but if ARHAI think it's a-- a sifting out, pre-decision making version that shouldn't be there, then I would support that.

Q No, I understand that, but what ARHAI are saying, if I am understand the evidence, is that in December '23, there is a sifting out process, and I'm wondering whether there's a sifting out process in what your technical sub-group, your IPC sub-group, are looking at in 2020/21?

A I couldn't say, but I do apologize.

Q Fair enough. Take that off the screen. We put to Ms Bain a series of questions about her role. In very broad terms, the criticism that was put to her was that she didn't look at the validity or otherwise of the views taken either by the whistleblowers or indeed by those managing them and responding to them, around the issues of the SBAR and culture and IMT meetings and behaviour in IMT meetings and that topic. She didn't look at that, she just wanted to look forward. To some extent, her response was, "Well, wasn't in my instructions, my terms of reference". Do you have any recollection about why her terms of reference don't include looking at those issues?

A So I would have expected that the director of Infection Prevention and Control would have looked back. It was-- It was a broad remit. Part of the-- the issue was the executive medical director had executive lead for healthcare-associated infection, and I found that untenable going forwards, because-- Not judgmental. I didn't know where the truth lay in terms of what was happening, but I didn't think it appropriate that the incumbent of the executive lead for HAI continued, at least in time when the Oversight Board was in place. That, therefore, meant either we needed to have another executive taking that responsibility, or someone placed there which would add capacity, be more neutral than having been a current GG&C member of the Executive team, and be able to look at things afresh. So that-- the brief was to go and be the IPC director.

Q And so you'd have expected Professor Bain to look at----

A So I-- I think it depends, and I don't remember having a dialogue with Professor Bain about saying-- Well, I certainly didn't say, "Don't do it," but I

don't remember her coming to say, "We're just going to leave that". Because actually, as part of the restorative healing work that would be needed, then one would have to reflect on how you've got to where you are today, so having a better understanding. So again, the OD work I think would have done that.

Q Would the OD work have not only been in place after she left? Because she wasn't there for an awfully long time.

A I thought the OD work started-- I thought Jenny started early in the new year, but I don't recall.

Q This may be too convoluted a piece of thought on my part, but if it's the case that Professor Bain didn't feel this was something she felt able to go into, that would tend to suggest that she wasn't talking to you about it. The way you've described not only your interest in it – it's part of the reason the Oversight Board was set up – and the evidence you gave about the transfer to the other Oversight Board and the need to have the development work in place suggests that you must have talked to her about it.

A So, we did talk. Not-- Not every week, but we talked. She came and she briefed me on what she had found. We talked going forwards, and it may have been that she had decided-- So I-- That it wasn't-- When I say wasn't, of course it clearly was of consequence to Christine and Teresa, but it wasn't sufficiently material, because sometimes things in the past need to stay there, but other times they need to be brought through so that that restorative conversation can be had and the team can actually be finally established. But again, I would have expected the OD work to have picked up on that.

Q How would you respond to the suggestion that, to some degree, the Oversight Board was a missed opportunity to address whatever was going on in terms of culture in NHSGGC's IPC team?

A So I think it's-- Again, with hindsight, if we look at the Healthcare Improvement Scotland report that was published in the-- the spring about culture at GG&C, Oversight Board-- pre-Oversight Board, I recognised the work on culture needed to take place, and the other Oversight Board on Performance and Finance also recognised culture had to take place. So, yes, I think it needed to be done, whether or not it sat with my-- Whilst I would have loved to have taken it, it seemed a logical argument to say the Oversight Board with greater responsibility in terms of the expanse of the whole Board would look after culture, rather than a small part of Infection Prevention and Control, because what

was happening, I think, was Christine and Teresa were butting against that systemic culture of-- where internal truth-tellers aren't necessarily welcome. That needed a broader approach. So at the time, it didn't seem unreasonable for me to accept that, but with the passage of time, it looks as though it's something that continues to need attention.

Q What I want to do now is to move on to the Case Notes Review. Now, you dealt with this from paragraph 87 on page 101, but given the time, I'm quite keen to sort of drill it down a little bit. We've obviously heard from Professors Stevens, Wilcox, Ms Evans, and we've also heard from Ms Grant, Dr Crighton, Dr Armstrong, their perspectives on it too. From your perspective, who was the Case Notes Review effectively reporting to?

A The families. So, I understand that there's a variety-- You know, in preparing for today, I see a number of statements that I commissioned it as chair of the Oversight Board, Professor Bain was in charge of it, the Cabinet Secretary commissioned it. In a way, I don't know that that necessarily mattered. The Case Note Review, I think was a subset of the Oversight Board work.

Q In a sort of formal sense?

A Yes.

Q Right.

A But it stood as an independent piece of work by the three experts.

Q What was the core question it was being asked to resolve?

A I think the core question was, if I mind back, perhaps-- The families who the Cabinet Secretary and I met were perplexed. They-- They didn't feel confident about the state of the building, they didn't feel confident because they were being told there had been no contamination from the building, that the infections were-- were not caused by the environment, but they struggled to-- to accept that, and the communications really needed to improve. So the dialogue I had with the Cabinet Secretary was, these families need to know what has happened to their children. So I think the actual question being asked is, "What happened to the children, and was their infection caused by the environment at the Queen Elizabeth?"

Q One of the features that's troubled us, and certainly troubled me, and it may be only from my narrow perspective coming years afterwards that this is relevant, but I'll put it to you, is that the individual assessments of the 84, I think, children and the 118 infections they had are not visible to NHS Greater Glasgow. They're not visible to Scottish Government either, but they're not visible to NHS Greater Glasgow. They're not

visible to this Inquiry. But thinking about NHS Greater Glasgow, was there any discussion that you are aware of – and it may be I need to ask Ms Freeman, ultimately – about why that came about and what the reasons for it are?

A Something I've thought-- I've heard the oral evidence being given, and it's something I've thought a lot about, and I wonder, if we had had a slightly broader remit for the Case Note Review, if it would have helped the Inquiry better, but I didn't see that at the time. For me, the Case Note Review was almost a compact between the Cabinet Secretary and these individual families so that we were appointing experts in their field who would come, review the cases, and make a decision, on balance, about whether or not the infection was contracted from the building.

Q That decision they made, or they were going to make, who were you expecting to follow it, to act as if it's true?

A So I would expect Greater Glasgow & Clyde to act as though it's true, and one of the dialogues that we have-- When I say "we", probably Ms Freeman, CMO, my team, about-- The Chief Medical Officer is the CMO-- about how do we make it effective and meaningful? Because there's no point in expecting experts to come, do quite a lot of work, produce reports, and then not

listen to it. The families-- I took advice from my Chief Medical Officer colleague who had overseen a Case Note Review in a Neonatal unit in Scotland, and her advice was, "Make sure that individual families have-- or are offered"-- Not everyone took it. Although there were individual cases summarised, not every family wanted to see it, but it was there if they did. She said that the families in the Neonatal unit had want-- had expected something individual about their child, so that's why we did that here, because we wanted every family to have as much information as they had.

I think if we were bringing Greater Glasgow & Clyde into this, I think we would have lost the trust of the families. My understanding is that Mike and the team had the individual Case Note Review for each family, and if the family agreed, that could be shared with their treating clinician. So, it wasn't a blanket, "Nobody's going to see it," it would be up to the families whether or not they wanted to have that shared. But as I've said in my statement, all of the information, all of the data, was given to the Case Note Review by Greater Glasgow & Clyde. So it's their data. They understood the methodology, and therefore that's the position we landed at, but at the time, it was to give the families access to expert advice of what had happened to their

children.

Q So before you sort of demitted office as chair the Oversight Board and produced your report-- which is effectively the same time – you stopped when you produced the report-- You're doing a nodding thing again.

A Oh, sorry. I do apologise. Yes, I-- I produced the report, then stopped.

Q Yes. For that point – and I think it's a matter of weeks after the Case Notes Review is finalised – did anyone in Greater Glasgow & Clyde Health Board tell you that they did not accept the conclusions of the CNR in terms of infection link?

A No.

Q Had they done so, how would that have affected practically the work of finishing the Oversight Board review report? Your own report?

A So I think I would have wanted to have time to reflect and discuss with colleagues about that in terms of what action would needed to be taken, because I'm not sure – and perhaps you can help me, Mr Mackintosh – what it is they don't accept about the Case Note Review, because the team say there are probable and highly probable-- So I don't know whether Greater Glasgow & Clyde are just saying, "Well, there's no definite link, therefore that's-- that's our position,"

or whether they're saying, "Actually, we don't even agree with the highly probable and probable". I've not had a dialogue with them. I don't know and I don't understand their perspective. I'm not even sure when they came out and said that.

Q Well, I'll come back to that bit in a moment, but have they ever told you personally that they had accepted?

A No.

Q No. Just staying within the Oversight Board, because I'm about to ask you about what the Cabinet Secretary and the DG might have done, and I'll ask the Cabinet Secretary next Friday anyway, but just staying with-- The Oversight Board report summarises the Case Notes Review, doesn't it, and its conclusions? You have a section on it.

A Yes, yes.

Q So you'd have had to rewrite that?

A Yes.

Q Were you aware of the large document sent by GGC to Professor Stevens and his colleagues a few days before publication in response to the draft report setting out a large number of concerns that they had about the work of the review, one of which was, "We haven't seen the final results for each child". Were you aware of that at the time?

A So, when you produce a report, it's normal that you send for accuracy to interested parties. What I was aware of was the Oversight Board report had gone in draft to Greater Glasgow & Clyde, and they also came back with many comments that they would prefer to have changed or want to have put differently. So, it wouldn't have surprised me that they did the same for the Oversight Board report-- for the Case Note Review.

Q Did you, for example, see that at the time?

A Did I see the Case Note Review at the time?

Q No, the big GGC response document.

A To the Case Notes Review or to----

Q Yes, to the Case Notes Review.

A No.

Q No, but you saw the ones to yours?

A I was aware of them. Phil Raines dealt with it.

Q But to what extent is the conclusions of the Case Notes Review by adoption one of your conclusions?

A I- I think it-- I think it would be. We asked the experts in their field to come, do a piece of work for us, and we accepted their advice.

Q Because if we go to bundle 6, document 36, which is the Oversight Board report, and we look at the index, will we find-- Sorry, can we go to page 795? Will we find the conclusions of the Case Notes Review of 30 per cent probable?

A I can't recall exactly, but I don't think so.

Q No, right. Okay, so in that sense, you're not absorbed into your document----

A No, no, no.

Q If we think administratively-- Obviously the political question of what should happen is a matter for Ms Freeman, and I will ask her, but given your experience within DG Health and Social Care, in terms of process and the steps that might have been contemplated, what do you think would have happened had you been told in March 2021, "We don't accept the conclusions. We will accept the recommendations, but we're not accepting the conclusions"?

A So, I would need to have had conversations about it, but one of the options would have been, "Does this need an escalation to Level 5?" and-- or, "How would we resolve it?" in terms of, "Did Greater Glasgow and Clyde have legitimate concerns, but I have sufficient confidence in Mike Stevens and the team

that they would have reflected and taken into consideration anything that was legitimate," or it may have been a different intervention.

Q I mean, you've talked a little bit earlier on about having intelligence around IPC teams. I'm assuming that means people talk to you?

A Yeah, so they talk-- They wouldn't talk necessarily to me, but they would talk to my team.

Q Yes. Am I right in thinking that, as the Oversight Board chair, there are people in your team who are talking to non-executive members of the Board?

A No.

Q No?

A No.

Q You had no intelligence connection----

A No, no.

Q Would you look at Board papers when they came out?

A The-- The team might have, but, in terms of routinely, that would have been not necessarily at the forefront of my mind.

Q Because if it's the case that the Board report about the Oversight Board and the Case Note Review doesn't say, "We reject the conclusions of the Case Note Review," wouldn't going to Stage 5 be a little unfair on all the non-executive members of the Board?

A Yes, and I think that's why I'm saying I would need to-- to have dialogue and conversation with people about where the-- where the position was. So, probably it would start off with-- I'm saying that Level 5 would have been an option. I would have started off speaking to the chair and-- well, the DG might have been starting off speaking to the chair, with my support, to-- to check and test what the rationale was and what-- what approach had been taken. Because I left my role believing that Greater Glasgow and Clyde had accepted the Case Note Review recommendations.

Q Now, if I recollect the evidence of Ms Grant correctly, I think it's broadly along the lines of, "We didn't accept the conclusions, but we didn't feel, to some degree, we could say that because we were on the Oversight Board, and so we said nothing." I mean, she didn't quite say that. I think I'm adding a bit to her meaning. This is quite hard to tell exactly what the position is. But, if that was the position, how would you react to that?

A Well, the conversation we had at the first Oversight Board meeting of Sturrock and doing things in an open and honest and transparent way-- We set the terms of reference in the context of the NHS values. I have never been in Jane Grant's presence and she's not told me exactly what she thought, so I would be

very surprised if-- because clearly she didn't, because at no time did either the chair or the chief executive contact me to say, "Fiona, we're not happy with this."

Q The evidence that she then gave was that she felt there'd been development since then in the field of whole genome sequencing and other work that she described moving at a pace. Now, I'm not going to ask you to comment on those; we've heard evidence about them, we can comment on them. One of the things that she explained to us is that there'd been a briefing in which Professor Leanord came and presented to some of the executive team, and maybe the chair was there, but you were there, about whole genome sequencing. Do you remember this?

A I have an inkling about it, yes.

Q Would this have been before the Case Note Review was finalised?

A Yes.

Q Did you say something at that meeting about how it would have been very helpful if further knowledge of whole genome sequencing had been available earlier in the process?

A I-- I wouldn't be surprised if I said that, yes.

Q When would you be talking about it being helpful in this context?

A So, I think it would be helpful for the Case Note Review team in terms of, if there had been whole genome sequencing, it wouldn't-- I think I've already said, it wouldn't automatically, just because you can't match-- If you can match with whole genome sequencing organisms and infection, then that's ideal, but just because you can't match an organism in the environment with the patient, doesn't mean to say the patient hasn't contracted the organism from the environment. I-- I would have said that on the basis that all information, additional information, for the Case Note Review would have been helpful. I-- I wouldn't have been judging it would have altered the case note reviews recommendations one way or another.

Q Can I just put to you part of the Case Note Review Overview Report report? So that's bundle 6, document 38, it's section 8.3.1 of the report, and actually it's on page 1070. Third paragraph, this is in the context of whole genome sequencing:

> "Most of these data were not received by us until December 2020."

And then they discuss it. So, whole genome sequencing was available to the Case Note Review. Does that help you place this meeting in time, or am I just clutching at straws?

A No, I-- I fully accept that I was

at a briefing meeting; Al talked about whole genome sequencing and what they were doing, and I said Case Note Review people would value that.

Q So it's quite possible it was before December 2020? I mean, you can't be sure, but----

A I can't be sure. I-- I think it would be-- I'd be surprised if it was after December 2020.

Q Right. What I'm proposing to do now is to move on to later parts of your statement. Now, we've asked you a lot of questions from page 105 about your engagements with Dr Inkster, Dr Peters, and Dr Redding. A lot it we've covered already and of course we can read it and we will read it. If we go to paragraph 113, which is on page 110, where the final sentence of that paragraph is, "Likewise, the doctors"-- I think that means the whistleblowers in this context. Does it mean the whistleblowers in this context?

A Yes.

Q Yes:

> "Likewise, the doctors helped inform the work of the Case Note Review by meeting with Professor Stevens (whose work fed into the work of the Oversight Board)."

Now, are you aware that Dr Peters and Dr Inkster had a single brief meeting with the CNR expert panel

when their work was nearing completion?

A So, my understanding is-- So I don't think there would have been heavy involvement, but I think it would have been inappropriate. Nobody had from Glasgow, or-- or government, even, had heavy involvement. This was an independent Case Note Review.

Q Right.

A My understanding is, and it must be through some of the bundles that you've sent me, that-- because I've read it quite recently, that Dr Peters joined an early meeting influencing the Case Note Review where she joined by teleconference and she made a number of helpful comments, so I knew that that had happened.

Q So you're not seeing this as a big involvement?

A No.

Q No, and, in fact, we had evidence of Professor Stevens meeting Professor Leanord and others in the hospital and largely discussing data with them at the very beginning of the work of the Case Note Review before lockdown. If we go to paragraph 115, this, I think, returns to the topic of the work done by Ms Copeland. I think you might have answered this question. So, you say here:

"I also received regular updates from my Deputy CNO in respect of the organisational development work being undertaken by Jenny Copeland and was assured that Drs Inkster and Peters were engaged in this process which formed a part of the overall range of processes overseen by the Oversight Board and by me as its Chair."

Did Jenny Copeland report directly to Jane Grant?

A So, the report was submitted to Jane Grant. I'm not sure that we necessarily had a formal commissioning-- well, there must have been a formal commissioning arrangement for Jenny, and I don't know whether it was-- She probably-- not probably, she would have worked independently as well, but the report went to Jane Grant is my understanding.

Q How would you respond to the suggestion that that's actually a little bit problematic? If you're going to have an organisational development exercise in an environment when there are in fact two oversight boards available, might it not be better to have that report go to the Oversight Board first rather than the chief executive of the organisation that is to some extent being criticised?

A Or perhaps both, because

Level 4 escalation means the chief executive is still the accountable officer and still in charge of the organisation. So, you can't not give them information, but I would have expected it, and it's-- the other aspect is it depends how much confidential information is in it because people speak very freely. It depends whether there was person identifiable information, whether or not it would have been appropriate to go to the other Oversight Board.

Q I mean, one of the thoughts that occurs is, if you're a whistleblower and you're meeting an organisational development professional and you're telling them things, and they're reporting to the organisation that you're worried about, the only control you have is either not to tell them or trust the person you're talking to not to tell them. So, can you see why it might constrain what they say?

A Yes, although I'm not aware that either Drs Inkster of Peters were constrained, but it may have constrained other people, if that's what you're meaning.

Q Right. I think we've probably already addressed 116; I've asked you questions about that, so I won't return to that. If I go to an email from you dated 26 January 2020, so that' bundle 52, volume 1, page 773. So, it's-- Actually, let's go to the bottom of 772 to get the thread. I

get impression what's happened here is someone's pasted a lot of emails into a document. Have you seen this before?

A Yes.

Q If we go on to page 771, we eventually get the start of this document, which is an email to the Cabinet Secretary from you, 26 January 2020, and you're sending a lot of information in this-- Let's go to the bottom of 772. It says:

> "Thursday
> [Over the page] CNO met with Jane Grant and discussed a number of issues around IPC. In particular discussion took place around the fact there was now a significant split among the clinicians, with the RCN and BMA advising a number of members of the microbiology team and the IPC around the behaviour of [Dr Inkster] and [Dr Peters]. "

Now, the point by Dr Peters is made that this wasn't raised with her at this point, and the only feedback anybody provided to her was by Dr Inkster in 2018. The reason I'm being asked to ask it is, what information was provided to you about concerns about the behaviour of Dr Inkster? This is in 2020.

A I think understanding the-- the trauma that people experience when they're regularly raising issues about safety within healthcare is well understood, and that then means that their response sometimes isn't as collegiate as-- as would be. So it may not-- It may be that Dr Inkster or Dr Peters' behaviour wasn't what one would have expected, but that's set in the context of the-- the difficulties and the perpetual raising of things that they felt weren't being listened to. So, when Jane told me that there had been the Royal College of Nursing and the BMA talking about the team and team behaviours, I-- I didn't know of anything other than that had been raised.

Q So, you weren't provided with any specification?

A Oh, no. No.

Q Who was the highly-skilled mediator that was going to be appointed?

A Was that Jenny, maybe? When was this, in 2020?

Q Yes. So, if we go back to 771, we'll get the date for you. It's 22 January 2020. Back to 773. Might the highly-skilled mediator and OD practitioner actually be Ms Copeland, eventually?

A So, the OD practitioner was certainly Ms Copeland.

Q Do you remember there being a highly-skilled mediator ever engaged? I appreciate this is six weeks before lockdown.

A So I think what I was saying

there is, mediator and OD practitioners were-- were needed as a matter of urgency. So I would have expected these roles to be put in place, and I know that another colleague supported Jenny to do that, and it would have been taken as a whole package.

Q So, if there's any outcome from this it, is going to be Ms Copeland?

A Yes.

Q Right. Can we take that off the screen? I'm going to ask you a few questions about your conclusions but, before I do that, you raise this idea that, and I think you make it as a general point, someone who is raising patient safety issues finds it very traumatic and they may behave in ways that are informed by that trauma. One of the features that we've noticed is a desire by NHSGGC to refer to that behaviour in a number of occasions. So, they do it there, it's in the letter to Professor Stevens, it's in the Stage 2 whistleblow report by Dr De Caestecker. What view do you have about the impact of such a approach?

A So, I think it would compound the harm that has been experienced by Dr Inkster and Dr Peters in terms of-- again, if you look at Sir Robert Francis' work about the impact on-- on speaking out, it talks about how often, when people do speak out and there's an investigation, in a way it's almost turned on that person that's spoken out and becomes-- they become the problem rather than the truthteller who needs to be welcomed. So, I-- I would be looking at it in that light in terms of, has the organisation truly understood what has been happening with regards to whistleblowing within the organisation? Because whistleblowing is a protective policy for the organisation. It keeps you safe if you listen to it.

Q I've been asked to ask this question. We've had a lot of evidence from senior managers within GGC that, if you have no or very limited clinical background or experience, often a career path is to be rooting around your low levels in a management role and step up through that often within the same health-- or maybe going to another one once or twice. Do you have any views, I mean, being chief nursing officer, about whether that model of NHS managers who have no clinical background to some extent dominating the management space within health organisations is a problem? Because other jurisdictions effectively require clinicians to spend portions of their time doing management as part of their job planning, and it's considered to be a different approach.

A So, just because you're a clinician, doesn't mean to say you're a good general manager, and just because you're a general manager, doesn't mean

to say you understand clinical services. So I think what is important is-- and I heard Malcolm talk about it, is the clinically-led, manager-- managerially enabled. So I think, if you have a dominant general management culture, that then sometimes can screen out the clinical voices, and that can be problematic. So, I think the culture has to be important. The organisation, in my mind, has to be clinically led, but that doesn't necessarily mean-- You also need good general management skills to run a big organisation. So it's not mutually exclusive, but I think there is a risk of having a heavily dominated general management culture within the organisation.

Q I'm going to ask a question that may expose a stereotype on my part, but I think it's an interesting question. I've been worrying about it, so I'd be interested in your thoughts. A general manager succeeds by managing whatever they're doing well within budget, achieving the outcomes, and then is promoted.

A Yeah.

Q Most of the clinicians retain a practice. Maybe it's not a huge number of sessions when they're in a management role, but they often appear to retain sessions in their original specialism. To some extent – and this is where you may correct me, this is maybe the stereotype – senior nurses, to some extent, step away from their specialisms as they go into management. Firstly, have I got anything roughly wrong there? Am I wrong?

A No, I think that's accurate.

Q Right. To what extent is it relevant-- If a doctor is in a management role and they're not enjoying it for whatever reason, they can go back to being a clinician, and, in a sense, it's a safe space, they're used to it. So they often do, and therefore it ends up being an organisation run by managers and senior nurses who-- to some extent, the managers never had a clinical practice, and the nurses have rather burned their bridges, they can't go back. Is that something that you've got any thoughts on?

A I think there's a number of factors. If you talk about that-- The other aspect is we have allied health professions, healthcare scientists, so there are more clinicians than doctors and nurses, but let's stick with the doctors and nurses. If-- The nursing workforce is significantly larger than the medical workforce, so a lot of operational management is about managing the workforce, and that is difficult to do on a part-time basis. So, I think what's required between operational

management of, say, nurses compared to the healthcare system is different, and a clinical director, if they're a doctor, could do that in two or three sessions a week because they have-- that they have a rigid job plan and they can do that.

So I think, increasingly, there are different roles. So there are consultant nurses. You see them in HPS; they're very expert, very specialist. But to actually provide operational management requires, I think, a wider scope that I think would be tricky on a sessional basis for nurses.

Q And to some degree, the reality is you're stuck with the people who have the time to put into it are the general managers and the senior nurses?

A Well, I think----

Q Even if you, without being quite as judgmental as I was in that sentence, the reality is that it's hard for a doctor to put in huge amounts of hours to management?

A A doctor could come out of clinical practice and go into general management. Nothing would stop them if they had the skills; and good performance management is incredibly important and you talked about a general manager managing, I think you did, budgets and managing the service. I think one of the very important things that we're needing to see more of is, just as

you have a balance sheet with pounds, shillings and pence, or you have numbers of patients that are seen, so activity numbers, I think data and metrics on psychological safety of an organisation needs to be given equal merit with other aspects of management. That then would mean you're measuring the culture and the psychological safety of an organisation, and whoever has the skills and competence to do that would be held accountable for it, whether they're a doctor, a nurse or a general manager.

Q Thank you. I've got two further questions. Do you have a view on the status of Hospital Technical Memorandum? Now, you're not a technician, but one of the issues that we've got to deal with is should SHTMs remain guidance or should they become rather more regulations? Do you have a view on that?

A I think-- so I would like to see them having a firmer status than guidance, but if used in the right way, there's nothing wrong with them being guidance because I think they should be followed and I think they should be put in place because that's the best possible evidence that's available at the time. Evidence and research in building and in healthcare is progressing, but it's not the finished article. So if you make it-- put it in statute that it has to be followed, it then

becomes problematic when you can't follow it, and there may be times when you can't follow it for a legitimate reason.

Q Okay. Ms Imrie used this word, and so I feel able to put it to you. Knowing what you know now, do you think NHS Greater Glasgow can be trusted to report HAIs in compliance with Chapter 3 of the National Infection Prevention and Control Manual?

A So, had you asked me that in April 2021 just before I left, I would have said, yes, I'm expecting to see that followed through the Oversight Board recommendations and following that through. I don't know what's happening at the moment with the exchange of mail.

Q So, you don't feel able to give a view?

A No, but I'm concerned to read that due process isn't being followed because why else would Health Protection Scotland have anxieties about it? Sorry, NHS ARHAI.

Q Thank you. My Lord, that I think concludes the questions that I have. I wonder if I might have the opportunity of seeing over a 10-minute break whether there's any questions in the room I should be asking.

THE CHAIR: As you might recall, Ms McQueen, counsel wants just to check if there's some unasked questions in the room. So, as he says, this should take about 10 minutes, so can I invite you to retire to the witness room?

A Yes, thank you very much.

(<u>Short break</u>)

MR MACKINTOSH: My Lord, I have eight questions.

THE CHAIR: Some more questions, Ms McQueen. Mr Mackintosh?

MR MACKINTOSH: Thank you, my Lord. The first one isn't so much a question but a correction. I asked you why it was that the December 2018 HPS report by Annette Rankin didn't discuss the discovery of the DMA Canyon reports, and I have the answer already. It's in paragraph 21 of her statement. She didn't know.

A Okay.

Q To what extent is the escalation of an NHSGGC to Level 4 in 2019 and the establishment of an Oversight Board evidence of governance failure in respect of IPC and communications?

A So, in as much as the Oversight Board came up with recommendations and improvements, one might argue that there has been failures in governance within GG&C.

Q Because those things weren't

already done, effectively?

A Correct.

Q Thinking about the DMA Canyon reports, when you learned in autumn 2018 there had been two DMA Canyon L8 risk assessments and these had not been acted upon or been reported upwards in the system, did you have any concerns, and if so what were they?

A So I was perplexed that such important pieces of work had not been progressed within the organisation, and my concerns were around safety and what was happening if things hadn't been actioned. Doesn't necessarily mean things were unsafe, but my concern was safety of staff, safety of patients, if there were outstanding actions needed to be taken.

Q What actions did you take in respect of these reports when you found out about them?

A So I asked what was happening and was told it was being dealt with through Health Facilities Scotland and GG&C, so I was assured that my colleagues in the Finance Directorate would be overseeing that action.

Q So that's HFS?

A Yes.

Q And that would involve them working with Professor Steele and GGC?

A Yes.

Q Once we get into the autumn of 2019 and the thoughts about, "Do we need to go to Stage 4?", did you take any steps to, as it were, check back in with HFS to see if that was being properly progressed? Because it could have been added, I suppose, to the escalation in November 2019.

A So, it could have been, but that would have been for the Finance team in the government to indicate that they were-- Because this was essentially an infrastructure issue, and would be for either the Chief Operating Officer or the finance director who oversees infrastructure within Scottish Government. That would be for them to deal with. That wasn't for me to deal with.

Q If, however, you initially saw it as a possible safety issue, was it for you to at least bring the safety issue aspect of it to their attention, and advise them that you were working on IPC anyway and, "Would you like me to take this on board?"

A So, I think it was well known there were safety issues, or potentially safety issues. Just because things weren't actioned didn't mean to say it was unsafe.

Q I appreciate that.

A So, I think it was well known,

and there was action that was being undertaken, and my view was that that was appropriate.

Q You gave some evidence about your impression of why particularly the chief executive, I think also the medical director, were seeking to have confidence in the organisation, the idea that they wanted to do the right thing by their staff, 4,000 staff. To what extent do you feel, while looking back on it now, they were doing the right thing by the whistleblowers?

A So I don't think-- I think the whistleblowers could have been treated with more empathy and compassion and a more proactive approach could have been taken. There was a whistleblowing champion on the Board, there's national procedures and processes, but I do think more care could have been taken. Again, reflecting on Sir Robert Francis' report, particularly-- and I hadn't thought of this before in terms of-- my view is, consultant medical staff are senior people, but actually the hierarchy of speaking out against executives and the executive medical director, chief executive, does put them in a vulnerable position. So I think more care could have been taken to treat them with empathy and compassion and support them back into practice in a-- in a way that was psychologically safe.

Q I think you were describing – I hope we've got this right – that-- Well, just before escalation to Stage 4, am I right in thinking that the perception of GGC was they had incidents under control?

A Yes.

Q Does the escalation to Stage 4 entitle one to feel that that belief, that perception that (inaudible 16:14:52) was, at best, misguided?

A Yes.

Q Is that attempt to persuade you that they had everything under control to any extent a cover up?

A I don't think they were covering up. I think they genuinely believed that to be the truth. I don't think they were-- they knew of things knowingly and didn't raise them or flag them deliberately to obscure things.

Q I don't think we put it in your bundle, but I'm sure you're familiar with the existence of the Vale of Leven Inquiry, I we mentioned it briefly.

A I am.

Q To what extent is it concerning that this is now the second public inquiry to look at, to some extent, the governance of Infection Prevention and Control in-- I mean, not NHS Glasgow, it's two boards, but they're connected by history-- two Glasgow-based health boards? This is the second one. And to what extent is it relevant that some of the

same staff appear in both narratives? How concerned should we be about this historical fact?

A I think looking at the recommendations of the Vale of Leven Inquiry, there were two or three that I think were notable for Greater Glasgow & Clyde and what has happened here. The-- I think it was-- I think it was number 71 or so, but I can't be exactly sure, when it talked about when there is a reorganisation, then due care has to be taken to make sure that teams are well organised and well integrated so that two teams coming-- or teams coming from different areas can actually work effectively together, and there would then be oversight to make sure that happens. I don't think there's any evidence of that from--

So therefore the learning from the Vale of Leven, I'd-- from people who should have known better, because they were part of it, I don't think has been palpable in that respect. In other respects, because I had responsibility for leading the government's response to it, I think they did respond, but I think there were one or two areas that they could-- having had experience of the Vale of Leven, they should have been able to put that into play for all of the staff coming together and----

Q And when you say "coming together", you mean coming together in the Queen Elizabeth as it's set up?

A Yes.

Q Now, if we return to the issue of the Case Notes Review, do you think that the lack of acceptance of the Case Notes Review-- (After a pause) Sorry, rephrase that question. Given that GGC appear to have reported to the AARG group, which you weren't involved in, after you went that they'd implemented all the recommendations of the Case Notes Review and the independent review and the Oversight Board, and then were de-escalated to Stage 2, does that raise the question that, had it been known that at the very least senior managers and corporate directors of the Board didn't accept the conclusions of the Case Notes Review on infection link, it might not have been de-escalated?

A I think that would have been a possibility, because of course on AARG, Greater Glasgow & Clyde's staff are members. So they are part of that. In fact, looking at the terms of reference, the majority of members of AARG are Greater Glasgow & Clyde staff. So they're part of it, and I do think not implementing all of the recommendations, or at least most of the recommendations, without a good reason-- If I had been in post, I'm not sure that I would have recommended de-escalation----

Q I think the position is that they did implement the recommendations. They just didn't accept the conclusions.

A Yes, and I would have had to-- Again, I would need to go back to have more dialogue with them or with colleagues about what in particular it was, but I do think they would have been at risk of not being de-escalated, had that been----

THE CHAIR: Sorry, again, your allowed your voice just to drop down at the end. Could I ask you to repeat the last two sentences?

A So I do think they would have been at risk of not being de-escalated, had they indicated that they weren't accepting the findings, albeit they were implementing the recommendations and actions.

MR MACKINTOSH: If it's the case that either the Corporate Management team or the chief executive or the whole Board of NHSGGC didn't accept the Case Notes Review conclusions on infection link and didn't tell anyone. To what extent does that amount to misleading the Oversight Board and, potentially, the government in that process of going through Stage 4?

A I think it wouldn't have been open and transparent for them not to say that, and therefore I would be curious as to at what point in time did they come to that view? Was that right from the start? I think perhaps you said, Mr Mackintosh, it was or was that more recently when-- just after they were de-escalated? I don't know and, is it a board view or is it the executive view?

Q We haven't found a board paper that suggests there's a paper to the Board, but then it may have been said in a briefing and not minuted. I think I've got no more questions for Ms McQueen unless my Lord has anything. I'm looking around the room to check.

THE CHAIR: Just really to repeat that last question, what I'm putting to you is a hypothesis. I'm not taking a position as to whether it's a (inaudible 16:21:16) hypothesis or not. If GGC, either at board-level or at chief executive level, took a deliberate decision in the face of the CNR report to make the Board's position on whether or not it accepted the conclusions ambivalent, in other words, deliberately decided just to leave this-- I can't think of a better word, ambivalent. Would you consider that to have been misleading?

A Yes.

THE CHAIR: Yes. Ms McQueen, your evidence has now concluded and you're free to go, but before you do go, can I thank you for your attendance today and, indeed, your previous attendance to give evidence in the Inquiry and the

evident careful work that has gone in preparing that evidence, but you're free to go. Thank you very much.

A Thank you very much, my Lord. Thank you, Mr Mackintosh.

(The witness withdrew)

THE CHAIR: Now, Mr Mackintosh, tomorrow we have Mr Connal and Professor Brown.

MR MACKINTOSH: We do, yes, my Lord. I imagine it'll be the whole day.

THE CHAIR: All right. Very well. Can I wish everyone a good afternoon and we look forward to seeing each other again tomorrow.

(Session ends)

(4.23 p.m.)