SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
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Day 12
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John Brown

CONTENTS

10:04

THE CHAIR: Good morning. Now, Mr Connal, our witness today is Professor Brown.

MR CONNAL: That is correct.

THE CHAIR: (After a pause) Good morning. Please sit down, professor. Good morning.

PROFESSOR BROWN: Thank you.

THE CHAIR: Now, as you understand, you're about to be asked questions by Mr Connal, who's sitting opposite, but first I understand you've agreed to take the oath.

PROFESSOR BROWN: Yes.

THE CHAIR: Sitting where you are, can I ask you to raise your right hand and repeat these words after me?

Professor John Brown

Sworn

THE CHAIR: Thank you very much. Now, you're scheduled for the whole of today; whether your evidence takes that time, we'll just have to see. We will probably break for coffee at about half past eleven and then break for lunch at one o'clock. If, on the other hand, you wish to take a break at any stage, give me an indication and we'll take a break. Now, Mr Connal.

Questioned by Mr Connal

Q Good morning, professor.

A Good morning.

Q Right, let me start with the formal question that everybody gets, which is you have prepared a witness statement for the purposes of this Inquiry; are you content to adopt that statement as part of your evidence?

A Well, there are actually two things in the statement that I picked up when I was reviewing and doing my preparation for today's hearing. The first one is a fairly simple one. On page 24, at paragraph 101, the actual heading is missing there. It should say, "Performance Escalation Framework" as a heading. It makes the statement flow a bit better.

THE CHAIR: Sorry, professor. Can you just give me that again?

A Page 24, paragraph 101.

THE CHAIR: Right. I wonder if we're working from the same document.

MR CONNAL: I was about to say to you, Professor, that we will use your statement as a guide to work through a number of the issues. At the top of each page, when it comes up on the screen in front of you, you will find an electronic page number which matches the way this has been filed as things are now done

electronically. Now, paragraph 101, you were talking about that. Is that right?

A Paragraph 101 should have a heading, “The Performance Escalation Framework,” to separate it from the previous part, which was the duty of candour questions.

Q Okay. Thank you.

A Yeah. The second thing, and more importantly, really, page 22 – well, sorry, paragraph 93. When I wrote the statement, at that point, I had no recollection of receiving a letter from Dr Redding about a Stage 3 whistleblow, and I hadn’t been able to find any correspondence in the files that I had access to. As part of my preparation, I did actually find it. So, I did receive a letter from Dr Redding, and I did reply to that.

Q I’ve made a note of both of these, and we’ll no doubt pass both of them on our way through the statement. Just to keep the formalities correct, subject to the corrections you’ve just now made, are you content to adopt the witness statement as part of your evidence?

A I am.

Q Thank you. Now, before I turn to the questions, I’d like to ask-- can I just mention something we’ve also mentioned to a number of other witnesses? Clearly, as we are approaching the end of the oral evidence in this Inquiry, we are actively listening for any points that might emerge which would assist in recommendations for the future or the like. So, if at any point either I ask you about that or you want to volunteer something about that, please just indicate and we’ll take what you can offer.

Now, let’s just put the witness statement up, if you don’t mind. So, as you’ll see, we start at-- for our purposes, at page 3, simply because that’s-- we have an electronic bundle of these things. But the paragraph numbers, you’ll be glad to know, remain unchanged from your-- You obviously have a hard copy statement in front of you, do you?

A I do.

Q Well, it’ll come up on the screen in any event. If at any point you’re not sure where I’m pointing to, then just indicate. Just to get the detail first, am I right in understanding that you became a non-executive board director in January of 2015 and then Chairman in December of that year?

A That’s correct.

Q You remained as Chair until November 2023?

A Correct.

Q Yes, thank you. Now, you explain on the first page that some of the questions that you may have been asked you didn’t think were within your technical

knowledge, and others may have been dealt with by the Corporate Management team. So, just perhaps, early in this process**,** the word "governance" is a word that appears frequently in your witness statement for reasons which will become apparent.

One of the areas that we have, in a way, been investigating might be described as the governance of the building project and whether that was successful, adequate, or whatever. Is governance in the context of an organization like NHSGGC an important matter?

A Absolutely.

Q Why is that? Just help me understand that as a backdrop to what we're going to talk about.

A Well, I think all organisations, to successfully deliver the outcomes that are expected of them, have to be very good at the day-to-day operations and very good at the delivery, very good at management in effect. They also have to be very good at change. They have to be very good at moving things forward and ensuring things don't stand still. Leadership is how I would describe that, but the management of the day-to-day operation and the implementation of change have to be taken forward in a manner which is aligned and a manner which produces the right outcomes.

Governance is there to ensure that those two functions actually operate the way they're intended to. So, governance really has five functions in itself; one is to ensure that the direction of the organisation has been set in a way that will deliver the outcomes.

Q Okay----

A Governance is also about holding to account.

Q I'm sorry to interrupt your answer. I'll let you give it again in just a moment. If you're going to give us five points here, I know his Lordship will want to get the gist of these five points into his notes. So, if you could just go a little bit more slowly through the five, that would be very helpful. I'm sorry, I did interrupt number one.

A So, the governance function really starts with setting the direction of the organisation. You could summarise governance as the direction and control of the organisation, if you wanted to keep it a very short statement. But within that, there's clearly five functions. The first one is to set the direction of the organisation to ensure that it can receive-- can deliver the outcomes, and that, in the context of the NHS, is primarily set by government. And the function of the NHS board is to ensure that that direction is delivered. So, that's really the second function of governance which is holding

to account the managers and the leaders in the organisation who are responsible for the day-to-day delivery of the services and responsible-- ensuring that those services change to meet the changing demands of the environment that they operate in.

I think governance is also partly about ensuring that the stakeholders in the organisation are properly engaged with; obviously, within the NHS, that's primarily the patients, and then the staff, and of course the government is a key stakeholder in the organisation as well. But governance is also about risk and risk management, and that's a key function of the governance system. And then, finally, it's a function of governance to set the culture of the organisation to set the expectations of what the organisation's culture should be.

Now, I say all of this having spent a considerable amount of time researching governance and actually developing the policy document for the governance of the NHS in Scotland. And for a number of years, I chaired the Corporate Governance Steering Group for the NHS in Scotland. So, I've got a very clear view in my own head of what governance is, where it sits alongside management, and where it sits alongside leadership, and those three things have to come together for an organisation to be successful.

Q Can I ask you two things about that? We'll come back to touch on a number of these topics, no doubt, in passing through the events; one is that you mentioned culture. Now, if you have an organisation in which the culture is not what you want does that make the governance system more difficult to operate?

A If you get an organisation where the culture is not what you want, it makes the management of the service delivery more difficult and it makes the leadership of change more difficult as well. So, it definitely impacts on the outcomes that the organisation could deliver. So, it's a responsibility of those people accountable for the governance system to ensure that culture is something that's addressed.

Q The other point I just wanted to ask you was that we heard some evidence that suggests that, in a system where there are different layers of responsibility and different either persons or groups at different levels, an organisation might have a system in place in which, you know, Level 2 doesn't know there's an issue unless Level 1 issues what was described as an exception report. If Level 2 doesn't know, it never goes any further because, obviously, something further up the system doesn't know either. Now, a

structure based on reliance on exception reports, would that struggle to meet what you would expect?

A I think an organisation of a certain size which has a tiered management structure, which obviously the NHS is-- has tiered decision making, and therefore it has tiered governance-- So, you have to have a system in place where you have an assurance framework that has, as you describe it, processes and procedures in place to escalate issues to the next level. But it also has to have an active approach to governance where each level is taking its assurance from more than one source.

So, from looking at reports that are given from the next level, you also have to look at external reports; you have to look at what the data is telling you; but you also have to have an interaction with the staff and the managers at the different levels. So, from a board perspective, it's important that you have an interaction with the frontline staff. It's important that you have different sources of information, for example, from the clinicians as well as from the managers. It's important that you're able to compare the data in your organisation to other similar organisations.

Obviously, other health boards would be the best comparator for a health board. And it's important that you're able to work with the commissioners, in this case the government, to take their opinion as well. So, you don't just rely on one source for assurance and you don't be assured by another part of the organisation. You take your own assurance from the information that you gather.

THE CHAIR: You've used the expression "you," that would apply to the Board of a health board?

A Absolutely, they apply at every level though. When I say "you," I'm speaking of a person within an organisation who has governance responsibility.

THE CHAIR: Right, so it applies to individuals----

A Yes.

THE CHAIR: -- and it applies to--

A Applies to individuals and applies collectively.

THE CHAIR: -- the group of individuals who make up a board.

A Yes.

THE CHAIR: Thank you.

MR CONNAL: Well, thank you for that, Professor Brown. I'm going to come back to your governance paper just in a moment, at least briefly. We're not going to read the whole of it for obvious reasons. Can we just go to page 4 of your witness statement? So, that's electronic page 4. You were in place as

a non-exec around about the time that the new hospital – and I'll just call it the new hospital – collectively, was handed over, and in the period immediately thereafter when they were moving towards patient migration, and then immediately thereafter that.

Now, you were not-- you say in your paragraph 7, you were not playing any part in commissioning or handover. As a non-executive member of the Board, were you hearing about any issues that were arising in 2015 before you became Chair?

A No, I think that I'd attended two meetings of the Board during that period and one seminar where there was a presentation on the opening of the new hospital from the program director, Dr Stewart. And at that point, I was certainly not aware of any concerns or issues that had been identified with the construction of the hospital. And there was no discussion at that point around risks that could emerge from such a large project.

Q One of the issues that this Inquiry had quite a lot about was the challenges faced by the Estates team when the hospital was handed over, which led them to be-- used the word "toiling" considerably to get half the stuff done they needed to get done. They claimed they were understaffed. And that was not just people at ground level, but this was escalated to various levels of management. Now, did you come to hear any of that?

A No.

Q Did you ever come to hear about that issue?

A It surfaced as part of some of the reviews that had been taken by the time I was the Chair. And we were looking, as a board, to understand better how we found ourself in this position. So, I'm aware of the points that you've made, but I wasn't aware of them at the time I was a non-executive board member.

Q Yes. No, I'm just----

THE CHAIR: You distinguished the periods when you were a non-executive board member from the time that you were Chairman of the Board.

A Yes.

THE CHAIR: Right, okay.

MR CONNAL: The reason I wanted to ask that was that, obviously, one of the questions about governance that might emerge is that, had knowledge of these issues been-- (inaudible 10:23:04) just use the word "escalated" earlier than when you were having a retrospective review of problems, then would you agree that would have potentially assisted?

A I would agree because I would have expected action would have been taken earlier to support the team.

Q Now, if we move on to the next

page of your witness statement, and we go to a section headed “NHSGGC Board and Governance,” you there reference a document from the Scottish Government, a “Blueprint for Good Governance”. Is that right?

A That’s right, yeah.

Q Now, we might just get that on screen for a moment. That would be bundle 52, volume 1, at page 194. So, that’s just the front cover. This is the document we’re talking about. So, this is a document, I think, that postdates many of the events that we are concerning with, but you were involved as a co-author of that, right?

A That’s the second edition of it. There was an early edition that I was the co-author of. I was the author of the second edition.

Q Right.

THE CHAIR: Right. So, just so I’ve got that, you’re the sole author of the second edition?

A Yes.

THE CHAIR: Right, thank you.

A I should emphasise though that it does represent a large piece of work that involved a large number of contributions from people across both national and local government.

MR CONNAL: In short terms, what’s the purpose of this document?

A The history of it goes back to when I was approached by Shona Robison, when she was Cabinet Secretary, and Paul Gray as Director General, along with Susan Walsh, who was one of the non-executives in Healthcare Improvement Scotland, to undertake a review of governance in NHS Highland. And when Susan and I looked at the request, our first conversation with the Director General was, “What would you measure good governance in NHS Scotland against?” because there was a lack of clear guidance as to what is meant by governance, what good governance would look like, what the individual roles and responsibilities would be.

So, as part of that review, the government commissioned from Susan and I to effectively write the guidance, and that’s what the first version was. We were asked to ensure that it was something that was readily accessible to board members because it was aimed at boards-- at board members who came from a wide range of backgrounds and who would have different understandings and experience of governance. We were asked not to make it a instruction manual.

So, the first version which Susan and I wrote over a period of almost a year-- because we researched both private and public sector, we researched healthcare governance both in Scotland

and in other countries, including NHS England. We produced the first document, which was a high-level document, and boards were asked then to adopt that and adapt that to their own particular circumstances. At the same time, it was decided to set up a steering group to support them to do that, and I was asked to chair that steering group. The steering group was made up of health board chairs, chief executives, board secretaries, and a variety of people from Scottish Government.

And we then helped the Boards to adapt and adopt the Blueprint for Good Governance. And as we were doing that, it became clear that boards were asking for more guidance. They felt the original document was too high level and didn't give them enough detail on how they would do it. They said why we needed good governance and what good governance looked like, but what they were wanting was more advice on how to introduce that.

So, the Corporate Governance Steering Group worked for some time to actually look at how we would do that. And this document, the second version of it, is, in effect, the response to that request, and that was then introduced in 2022.

Q I only want to look at this very briefly because, obviously, we have the document and it covers a lot of ground. Can we just look briefly at page 199? I just wanted to put that up because I was interested in 2.6 because it uses that phrase "hold to account". Where you've got, according to this, "... Board Members [should] hold their Executive Leadership teams to account..."

Now, we've had this phrase used by various people, "Well, X happened, somebody would be held to account." What does it mean?

A Well, firstly, it means that their performance is measured. Now, that's the performance of the organisation and the part of the organisation they are responsible for and, secondly, their own individual performance to the performance management system.

Secondly, it means that there is ongoing discussions on the issues, the risks, the challenges that are being faced. So, it's not just a backward look on what they've actually delivered, but it's also a discussion around what is taking place about things that can-- may possibly arise, the risks in the organisation. It does ultimately impact for the staff through the performance management system. It impacts on their pay. It can impact on their careers, and for some people, can impact on their employment.

Q Thank you. The other paragraph I'd noted just in passing, page

201-- I just picked this up because there was an attempt to define governance in healthcare in Scotland in a single paragraph; we see that in 3.7. I was interested in two things about that: one, "It is the ability to ask questions..." which would tie in with the answer you've just given, I think, that you have to question; and the other thing, "It is to be distinguished from executive-led operational management."

Now, explain the distinction between governance as defined and operational management, because you've just talked about challenging impact on people's pay and jobs and so on.

A Management is about decision-making on the here and now, on the day-to-day delivery of the services, the allocation of resources, the distribution of staff, the processes, the technology, the infrastructure, on the day-to-day current organisation. Governance, as I've explained to you, is setting the direction of the organisation, and then holding the management to account for that delivery. So, management is very much about the day-to-day delivery of the services. It's the decisions around the complexity of allocating resources, training, all the day-to-day decisions that have to be made.

Q Thank you. I think we're able to move on a bit now, but I wanted to ask you one question, going back to your witness statement at page 6, about the structures that were in place in NHSGGC. We've been given to understand that there was one particular-- I may be using the wrong label, but "subcommittee", I think called the Performance Management Group, which actually seemed to do a lot of the heavy lifting, whereas the Board was a group that met so many times a year in public-- the Performance Management Group, it might be suggested, actually did most of the key discussions. Would you agree with that?

A No.

Q Why not?

A Because there were a number of committees that sat underneath the Board and each of them had a specific delegated role and responsibility. I think if you're referring to finance, the Performance Management Committee had a specific role looking at the allocation of resources, looking at the expenditure and where we were, and looking at that in relation to not only what was being spent but what was being achieved. It was also a committee where we were able to look across the six health and social care partnerships' performance alongside the performance of the acute services from a healthcare perspective. But we had a Clinical and

Care Governance Committee that would look in depth at the quality of care that was being delivered, and that would include areas such as infection prevention and control. There's an Audit and Risk Committee, which certainly looked at the risks in the organisation how we were bringing together the risks that were being managed by the individual committees as a whole. There's a Staff Governance Committee that was looking at all the people issues.

So, each of those committees-- And I think there's ten committees in total. I won't go through them all unless you would like me to. Each of those committees then would report into the Board, and the meetings actually went through each of their issues, each of their risks. And the Board Committee then put that-- The board itself put that together in an overarching view of what the healthcare system was actually delivering across Greater Glasgow and Clyde. You know, I mean the Board, if you--

Obviously, I've looked to the Board papers and the Board agendas. They were very comprehensive, and board meetings themselves took quite a considerable amount of time. Now, in addition to having a board meeting every second month, we also had board seminars in the months that we didn't have a board meeting, which gave us the opportunity to ensure that board members were fully briefed on anything that was new, any changes that were coming from Scottish Government, changes in the legislation and so on.

Q I wanted to ask you something then since you mentioned committees. One of the features that's cropped up during the Inquiry, when we've looked at an assortment of committees at different levels, is that it's been at least suggested a large number of the committees didn't ever seem to do anything, that what would happen is that they would sit; they would receive reports; there would be a brief discussion, you know, "So and so reported on such and such," and somebody would say, "Noted," and they would move on. But most of them didn't seem to actually take any action themselves. Now, is that a feature you recognise as being correct for NHSGGC?

A I think if you're reading the minutes of these committees and that's the only thing you're basing your view on the committee on, then I can see why you would think the reports were presented and simply noted and moved on because you wouldn't be aware of the questions and the discussions that had actually happened.

The approach to recording what happens in the committees that is based on a very straightforward-- like the UK

Government Cabinet Office guidance on minute-taking of listing the topic that was discussed, any decisions that were made, any actions that were requested. So, papers would come for awareness, papers would come for approval, but they weren't all resulting in decisions being made or actions coming out of them. But every committee would be making decisions, either approving things or not approving them. Every committee would have actions that would be coming out of them, and every committee had an action log there.

And the Board was then receiving-- the Board would then receive these minutes, and at each board meeting, the Chair of the committee would be invited to bring to the attention of the Board any issues that they felt the Board needed more information on. And the Board was invited to ask any questions of the committee Chair. Given the number of committees and the fact that we had six health and social care partnerships, that took up a large part of the Board meeting.

Q I think the point I was probably trying to put to you was that what we saw didn't seem to indicate there was much by way of actions at the instance of the committees. There may have been discussions. That there may have been fuller discussions than the minutes might indicate, but it didn't often seem that the committees took any action in the sense of saying, you know, "Do this" or "That's unacceptable," or whatever the action might be. But you say that simply might not be evident.

A Well, I think the action logs for each of the committees would give you the evidence of that.

Q Let me ask you a completely different question that's been suggested to me. Obviously, we're looking at all kinds of possible issues here. One of the questions which might crop up is that a lot of people who seem to have featured in events – obviously, we've been looking at events over quite a number of years – seem to be people who had no clinical responsibilities, whatever their original training might have been by the time they were involved in managerial roles.

One of the questions that's been suggested to me is whether you think it might be a good idea to ensure that managers are usually clinicians who retain an element of clinical role so they don't simply sit in a management role and decide X, but they actually also see what happens to those decisions in practice. Have you any view on that?

A I think there are some senior managers who come from a clinical background but are not practicing as clinicians, and there are some senior managers from a clinical background to

still practice as clinicians. I think the healthcare organisation should be clinically led. I think that, whilst the direction for the organisation is set by government and government policy, I think the design of the organisation should be led by the clinicians because they understand both the patient needs and they understand the science and the medicine that can be delivered with it.

I think it's very important that clinicians have a role in the management of the organisation. I think they also have to be supported and partnered and facilitated by experienced managers who are skilled in management with leaders who are skilled in change management. And you have to have people in the organisation who have governance skills as well. So, it's a multidisciplinary approach, yeah.

Q It should be clinically led in your view?

A Yes, clinically led and managerial enabled.

Q Now, can I ask you another thing about governance structures because it's cropped up quite lot in evidence from others? In an organisation such as NHSGGC, because obviously that's the one we're looking at-- Let me just say, obviously, we appreciate that that's a much bigger organisation dealing with lots of other issues with which this Inquiry is not concerned. But from what we've been looking at, one of the key relationships that's been suggested is the relationship between the chief executive and the Chair. Would you agree that that's an important relationship?

A Absolutely.

Q Because the chief executive may be the decision-maker in many cases and may also control the information in many cases, and the Chair may control the degree to which the chief executive is challenged. Are these both correct assumptions?

A Yes.

Q So, if the Chair doesn't challenge the chief executive, if there's a lax or cosy or-- with any other relationship, would that be quite a problem?

A I think it could be, yes.

Q Part of my reason for asking this is that the evidence we had from Mr Wright from his former position in government, which perhaps came as a surprise to many people, was that the NHS chief executive didn't manage board chief executives. They were accountable to the Chair rather than to him as NHS chief executive, and it was the Chairs that held the chief executives to account. I take it you agree that that's the position?

A I don't think that's actually what he said. I mean, I did see

Malcolm's evidence, and he made it very plain that the chief executive is accountable to the Board as the chief executive but is also accountable to the director general, who's also chief exec of NHS Scotland, through the accountable officer system. So, the chief executive has dual accountability.

Q Now, the other question I wanted to ask you about that was that-- another question that has cropped up, and I'm-- but inevitably, because you're coming relatively late in our list, just the way it's worked; lots of things are cropped up-- is what responsibility the chief executive actually has.

Now, I want to ask you this question against a particular background just to see what your reaction to it is. In the private sector, it's not uncommon to find chief executives either being fired or resigning if something has gone wrong, even if they are not, you know, physically responsible or personally responsible, because that's the way that world often operates; the buck stops on their desk. If something's gone wrong, they're gone.

Now, the impression we may have been given by at least one other witness, is that that kind of idea of the chief executive ultimately being responsible for everything is not accepted in the NHS. Do you have any thoughts on that?

A No. I don't think that is the case. And I think, if you look at the recent history in NHS Scotland, if you look at other health boards where chief executives have gone, they have been held accountable as the person responsible. So, I don't know really where that idea comes, that chief executives aren't responsible, from at all. I mean, back to Malcolm, right. Malcolm referred to when he was put into a health board when the chief executive had gone. That was NHS Tayside. I was put in as the Chair for the same reason; the Chair had resigned. So, there is a history within the NHS in Scotland of senior leaders leaving their posts.

Q Yes. We asked Mr Calderwood, who was chief executive from the signing of the contract to build this very big project hospital by any accounts. I think somebody said it took about half the budget of the NHS for a year. A very big flagship hospital which, as it turned out, had a significant number of issues in it, some of which we'll touch on later. If, ultimately, well, he was responsible for that and he didn't seem to assent to that proposition, would that surprise you?

A Yes.

Q Right, let me--

A Just picking up one point that-- --

Q Of course.

A -- the Queen Elizabeth, at 842 million, wouldn't have been half of the Scottish NHS budget, yeah, which, at that point, would be probably, I think, 'round about 12 billion.

Q Thank you. I'm happy to take that correction from you. The fault is no doubt mine. Let's move on. Let's go to page 9.

Now, I know you're not primarily involved in the whistleblowing processes, but I wanted to ask you one thing about whistleblowing because it has come up with a whole range of different witnesses. I know you had a review done of what the policy provided. But going back to the question of attitudes and culture, we've had a fair amount of evidence from pretty senior managers that their view is – I'm trying to think how to word this very carefully – that people should follow the appropriate processes, and that's what should be stressed, and that, you know, therefore the consequence is they're not really encouraging of whistleblowing as an exercise.

Now, we've had lots of evidence about whistleblowing. We have a very learned report on it by Sir Robert Francis. This kind of approach to whistleblowing, this idea, if you're asked about it, your immediate answer is, "People should follow the due processes through the line management." Is that something you encountered when you were Chairman?

A I can't think of a particular example when I was Chairman that I could say I had encountered that, but I do believe that it's very important that the organisation sees whistleblowing as a good thing, that it sees whistleblowing as a necessary thing, and sees whistleblowing as something that should be supported.

I think you would normally expect staff managers, if they've got concerns, to take them through the usual management processes, usual management meetings and so on. But if that doesn't produce the outcome that the individual's looking for, then whistleblowing is there. I also think whistleblowing is there for people who don't feel confident, for whatever reason, to go through the management chain, if I can describe it as that.

So, I think it's very important it's there. That was why we did the review because we were concerned that, as you've described, people have said that they don't have confidence in the whistleblowing process, or they didn't think the whistleblowing process was something that people were being encouraged to use, and that was why I asked Charles Vincent to undertake his review.

THE CHAIR: At the moment, we're talking about another review, or maybe

you want to-- I think.

MR CONNAL: I think the witness is talking about the review instructed on the part of Mr Vincent into the whistleblowing policies of NHSGGC. (To the witness) As I understand it, that's what you're referring to.

A That's part of it, but it wasn't just into the effectiveness of the policies but it was also about whether the organisation that was utilising those policies.

Q I think the point I wanted to make sure I was getting clear with you is that you can have some very nice policies; they can be beautifully written, they can be appropriately circulated, everybody can sign a form saying they've read them, but if there is a culture which says the right thing to do is to go through process, then you wouldn't get an organisation, would you, that is welcoming, encouraging, regarding whistleblowing as a good thing. Would you agree?

A I think it depends whether you're saying that you should go through the right process full stop, or whether you're saying that the right-- the process-- "right process" is the wrong language I think. You should go through the straightforward management process first. If you're saying that and saying that's a full stop, I think that would discourage people to whistleblow. But if what you're saying is that you should go through the management process first, if you're comfortable with that, and, if having gone through the management process, you still have concerns, then the whistleblowing processes are there to support you to take those concerns further-- So, I think it's the extent of the message that's out there. Now, that's the message that was sent. Now, whether that's the message that was received, well, that's another question.

THE CHAIR: Sorry, just-- can I clarify, when you say, "That was the message sent," what do you mean by that?

A Well, that's the message that was put out through the management line. That was the message that was put through the publications on the staff intranet. That was the message, if you like, that came from the top of the office.

THE CHAIR: That message would include the idea, if I've noted you correctly, that what you describe as the usual management processes are available for those who are comfortable with them, but – this is how I noted you – whistleblowing should be there for people who are not confident with the management processes. What I'm taking from that evidence is that you would accept that having gone through what

you describe as the usual management processes should not be seen as a threshold criterion for consideration of a whistleblow and that that was the message that the Board at least attempted to put out to staff through-- you give the example of the staff intranet.

A Yes.

THE CHAIR: Yes.

A And if I could just add I think that's very important because, if you have-- if the concern is about the management, to expect staff to go through the management process to raise these concerns, I would say, is unreasonable.

THE CHAIR: Mr Connal.

MR CONNAL: Thank you. (To the witness) By virtue of a related question, we'll just turn on to page 10 of your witness statement just to see if I can understand what you did or did not know. One of the issues that's been raised here is the suggestion that some people, particularly IPC doctors, were raising concerns about the environment of the hospital, water, ventilation, and so on, from very early on in the hospital's existence. Now, were you aware of that?

A When are we talking about? When I took over as Chair or as a non-exec before that?

Q Well, either.

A Either.

Q If you can just tell me what your awareness of that issue was, if any.

A As a non-exec, before I became the Chairman, I wasn't aware of that as an issue. When I became the Chairman, I became aware from conversations with Robert Calderwood, when he was the chief executive, that there had been some concerns raised around infection prevention and control within the hospital, and his time on that conversation was firstly around about water, and then it was around ventilation.

Q The reason I wanted to ask you about it is that the-- one of the arguments put forward by those who complain about how they were reacted to was that they were saying, "There are issues here." They're focused on the building, whether it's water or ventilation or both. They're doing that from very early on, and they don't get very much of a response from, as you put it, the management. Were you aware of that concern?

A Not until the point where there was the SBAR when they had the discussions around, specifically, the lists of the issues that the microbiologists had brought to attention. (After a pause) And then----

THE CHAIR: So, there's perhaps two points there. When you talk about the SBAR, that's the SBAR in October of

2017.

A That would be right, yeah.

THE CHAIR: As I say, there's maybe two aspects to that. First of all, microbiologists were concerned about the state of the building and, secondly, that these concerns had been enunciated as early as 2015.

Now, I think, Mr Connal, you're exploring if and when Professor Brown became aware of these two aspects. In other words, concern about the building and the period when the concerns were first articulated.

MR CONNAL: Well, I am exploring that, my Lord. I'm obliged to my Lord for reminding us that the SBAR was in 2017 because that gives a date to Professor Brown's response. I have a follow-up question to that which goes from page 10. If you look at paragraph 33, at the point you're writing the statement, you're saying that you're unable to confirm an exact date when you first became aware of the concerns and issues around the hospital environment. You say there it would have been in 2016, and you, I think, cite informal discussions with Mr Calderwood. So, is that your first intubation and then nothing much more until in 2017, or how did it work?

A Around 2016, my recollection is the discussions were around that there were infections that were having to be managed, and there was suggestions that these could be related to the hospital environment, and that was being investigated. Well, it wasn't until 2017 that that became a much more specific concern about the extent that this was a bigger issue than the normal, I suppose, number of infections in any hospital environment and the difficulties of trying to understand, sometimes, the cause of the infection.

Q I just wanted to get clear when you first understood that there were concerns that the hospital environment may have been a problem, whether it's water or ventilation. When did you first know about that?

A I must admit, there's always concerns with any infection----

Q Of course.

A -- at hospital environment in any hospital-- is the issue. The question I think is at what point was it becoming apparent that the Queen Elizabeth-- the quality of the build was such that this was a significant problem that was more than just an individual infection in a particular ward at a particular time, yeah.

Q Right.

A And I think that started to become apparent as we moved through into 2017, but I couldn't put an actual date. There wasn't a light bulb moment for me or for the Board for that matter.

They said we have a major issue here. I couldn't put the actual date on that. This grew over time.

THE CHAIR: Have you moved from the whistleblowing point?

MR CONNAL: I have.

THE CHAIR: Because it's no doubt my fault: I'm not quite sure if we're talking about Professor Brown's awareness of the fact that the microbiologists had raised questions about the environment, perhaps as early as 2015, and these were the same concerns being articulated in the SBAR in October 2017. So, it's entirely my fault, but are we exploring when Professor Brown became aware of that timing disparity or are we exploring his more general knowledge that there was question marks arising out of incidence of infection and possible connection with the building?

MR CONNAL: It's not for me to say, but I think Professor Brown has just answered the latter questioned.

THE CHAIR: Yes.

MR CONNAL: He said:

"There's no single light bulb moment, but it was only in 2017 did we get the understanding that there may be an issue with the build of the Queen Elizabeth."

I think his Lordship has prompted me to go back to the earlier part of that question because one of the issues is not just, "When did you generally come to the idea that there might be an issue here?" Which you've timed to somewhere around 2017, no specific date for the reasons you explained, but also, "When did you become aware that at least some microbiologists had been basically banging that drum on and off since 2015?" Because it's quite a long time given the topic, is it not? Can you help us with when you learned that that was the case?

A Certainly I would have been aware that microbiologists were working on Infection Management teams and looking for the solutions. I became aware that they were dissatisfied with the support that they'd been given or dissatisfied with the pace of response at the point of the 2017 discussions.

Q I'll move onto another topic, page 11, DMA Canyon. So, you know where we're going here. I understand, from paragraph 35 of your statement, your first knowledge, particularly of-- let's focus on the 2015 report-- was when you were told about it by the chief executive at some point prior to Dr Armstrong making board members aware. Do you know when that was, when you first heard about it?

A It was when the chief executive was made of it by Tom Steele when he was in HPS. In this part of the

review that he was carrying out, he'd asked to see-- these are standard reports that should appear when you're doing this sort of construction. He'd asked to see them and, when he got them, he realised that they hadn't been actioned. He brought that to Jane Grant's attention, and she brought that to mine, and then it was taken to the Board just after that.

THE CHAIR: Your understanding is that it came to light because Professor Steele requested to see them.

A It's my understanding it was part of the review that he'd done.

MR CONNAL: Now, in paragraph 34, you tell us that Dr Armstrong made board members aware of the DMA Canyon reports. I'm focusing on 2015 primarily for obvious reasons. Did she tell you whether she'd read them?

A I can't recall whether she said she'd read them or not, but I would assume that she must have read them to be able to present the findings.

Q Now, the kind of follow up to this I wanted to ask you about-- One can understand that there was a question as to why somebody within the estates department didn't do what the report said; but from a governance perspective, did the emergence of a report dating back to 2015, which hadn't been followed up, to use that word, not raise questions as to the structures above estate-- you know, the individual estates officers as to why this hadn't been spotted earlier?

A It did, and those questions were asked by the Board.

Q Did you get an answer?

A The answer at that point was they couldn't explain it because the individuals involved were no longer with Greater Glasgow and Clyde. And as a result of that, they commissioned a further review by Professor Steele to look at the structures, the resources, and to look at the governance within the estates department and to confirm there were no other reports that hadn't surfaced when they should've.

Q The reason I ask that is that, on the face of it, we've heard-- Sorry, I'll start my question again. We've had from a number of witnesses that water and water safety is an important matter for a hospital of this kind. Would you agree?

A Absolutely, for all hospitals.

Q Indeed. Therefore, there ought to be a governance system which, at various levels, is aware of the need for a report of this kind. Would you agree?

A Yes.

Q Now, it's fine to say, "Well, we made some investigations and some of the people weren't there," but presumably you were able to find out, you know, who knew, who should have known, what committee should have known about it,

what committee should have pursued it. Did you get that information?

A My understanding is the governance system was there, but the individuals who had responsibilities for taking the actions hadn't taken the actions. And it's still not clear, to me certainly, why that happened, why that wasn't picked up further up within the governance system. I don't have an answer to that either because an answer was never given to the Board as to why that happened.

Q I think you'll understand that part of reason for my asking you that is that we've spoken to a number of the people further down the structure who were involved, who did or didn't do things with the report, but I was just interested in what the Board had found out about structures above that. The answer is you didn't really get a proper answer.

A No, we didn't.

Q Was it in the course of these investigations that you became aware of issues about staffing and pressure of work and so on?

A Yes.

Q Now, once you became aware of these issues as a board and yourself as a chair, did-- well, first of all, did it concern you to hear-- because I suspect you heard stories of people overworked, understaffed, couldn't get things done, just to paraphrase. Is that correct?

A Yes, and it was a great concern to the Board that the resource hadn't been in place to deal with any issues that come up as part of the handover. As a result of that, then this important report hadn't been actioned, and then the same again in 2017.

Q Well, I can understand that Professor Steele may have reviewed the structures and systems and checked to see it shouldn't happen again, but did you find out why that unsatisfactory situation had been allowed to exist?

A No. We were never given an explanation because, as I said, the individuals that had been responsible for that were no longer there. And ultimately, the responsibility for ensuring that the water safety system was operating would rest with the director of facilities, yeah, and he had since left. I would presume he would be a better placed to answer these questions.

Q At the moment, I'm trying to understand what the Board did or didn't know and what the Board did or did not discover. It may sound slightly odd to those listening to this that the Board was unable to find out why a situation of understaffing, under resourcing was allowed to continue with some of the consequences, possibly, that we've heard about.

A From the Board's perspective, we were looking to find out what had happened, why it happened, what was necessary to put it right, and what was necessary to avoid it happening again. Yeah, so we knew what had happened, but we couldn't get to the bottom of why it happened. So, we made sure that Professor Steele took steps to ensure that it was no longer the situation and that it wouldn't happen again. It was not a satisfactory situation for the Board.

Q Now, I wanted to ask you this particularly because, later, on the same page of your witness statement, you touch on a topic about Horne taps, which the Inquiry has had a lot of about, where, reading it short, what had happened was a decision had been made during the construction process to continue to use Horne taps, notwithstanding an issue that had been raised about safety following an incident in Northern Ireland and elsewhere. But that was – and this is my word – conditional on appropriate maintenance arrangements being put in place and implemented so as to ensure a safe system.

Now, one of the concerns of many participating in this Inquiry is how that situation arose. At the lower level, somebody says, "Yeah, I was meant to deal this, and I never got around to it because I was doing a thousand other things." You presumably understand why not be able to find out why something as important-- that that was not done would be of concern to a lot of people here.

A It was a concern to the Board as well, but I'm not able to give an answer as to why these things occurred prior to the time that I was responsible and accountable as the Board Chair. We did ask the questions, the same questions you're asking, as a board, but were unable to get the answers because the people who had the answers were no longer available to us. And I do think that they're the people that should be answering these questions to the Inquiry.

THE CHAIR: Well, you can proceed on the basis, professor, that the Inquiry has endeavoured to lead the witnesses who are available to it, who are able to give evidence. But I've noted what you say about the previous director of estates having retired, but were there not subordinate people in estates able to provide you with information, Mr Powrie, for example?

A We were told that that information wasn't available to us.

THE CHAIR: Right.

MR CONNAL: (To the witness) But let me ask the question one more time with a particular reference to it. Just sticking to the Horne taps, I mean, we know DMA Canyon wasn't dealt with till

2018.

Now, there was a thing later on that was generally called “the water incident” when water suddenly became a big issue, and that started in 2018. We’re told that, by the time of the water incident, a maintenance regime for Horne taps hadn’t been put in place. There was a special disinfection arrangement that was to be created and still not done. Now, you must have had people available, you know, in 2018 to explain to you why, did you not?

A The whole question around the maintenance, the technical details of what was required, all of that was presented to the Board by this facilities director. And the Board’s focus was very much on what needed to be done to resolve the issue, but I don’t have any clear recollection of explanations as to why things weren’t done. It was more about what wasn’t done and how that would then be remediated to ensure that the systems in place were to the appropriate standard.

Q Well, let’s see if I can just finish this piece of narrative by looking at page 12 of your witness statement, where there’s-- we ought to deal with it because it’s not been much discussed. Communication with an MSP, which touched on this topic, now, that’s dealt with in paragraph 40 of your witness statement. Now, can we see bundle 52, volume 1, page 96? Inevitably, we’re going get bits of an email chain which don’t really matter. So, there’s obviously some discussion going on about boarding here involving you, Sandra Bustillo, and Jane Grant about the letter to Monica Lennon, with Jane Grant saying she’s changed it back to an original wording. Can we just move on? 97. Do you remember being involved in the preparation of this letter?

A I do.

Q It would appear from the header to this bundle of papers that the content was prepared among you, Sandra Bustillo and Jane Grant. Is that right?

A Yeah, and the Scottish Government.

Q Now, if that’s to do with DMA Canyon, or at least in part, where is that explained? Am I missing it somewhere? You can look at the second page if you like. The explanation is the part that starts in the first bullet point:

“... the technical reports and the water supply were not reported by the external advisors to the Board’s Senior Leadership team...”

Just pausing there, that suggests that, if it’s DMA Canyon’s fault for not reporting to the Leadership team-- which is not a suggestion that we’ve heard

discussed so far. Would you agree?

THE CHAIR: Sorry, which--

MR CONNAL: The first bullet point.

THE CHAIR: All right.

MR CONNAL:

"... the technical reports and the water supply were not reported by the external advisors to the Board's Senior Leadership team... "

THE CHAIR: Well, I suppose it might depend exactly on what's--

MR CONNAL: Was that intended to refer to the DMA Canyon?

THE CHAIR: -- that the professor is in a position to help us with that.

A I don't think it is a suggestion that DMA Canyon should have reported. I think it's simply stating the fact that it was not reported to Senior Leadership team. So, it hadn't been reported by DMA Canyon. It hadn't to been escalated, so the Senior team didn't have that. You would have to see Monica Lennon's question about when and how did the Senior Leadership team come to know to understand that's the response to it. At no point is anyone suggesting the DMA Canyon should have taken action.

MR CONNAL: I'm just wondering where we find any-- Sorry, let me rephrase that question. Is there any point in the letter to the MSP in which you basically put your hands up and say, "We haven't been able to find out why our systems at various levels did not spot this?"

A I don't think it does. It states the fact that-- what happened in response to it, but doesn't go into the detail of why.

Q I'm content to move on, my Lord. Happy if my Lord has other questions on this.

THE CHAIR: Just give me a moment. It's maybe not a fair question, professor, but can you look at the paragraph below the bullets?

"The water supply was then re-assessed by an independent authorising engineer, who described it... "

Now, it's presumably the water supply:

"... as wholesome, which is the industry term to say that it is safe, as defined in the... [regulations]. This means the water in both the [hospitals] is safe."

Does that second sentence actually follow from the first sentence?

A I think it does.

THE CHAIR: Right. You would understand that-- The point being that, if one was to take a certain reading, the fact that the supply, point of supply from the public water supply, is wholesome doesn't necessarily tell us about the state of the-- all the water in the system.

A I understand the point you're making, but I think I'd need to see the

actual report. Somebody authorised an engineer and see what his definition of the water supply-- Is it to the point where it arrives at the hospice-- at the hospital, I should say, yeah, or is it the water supply within----

THE CHAIR: At the point----

A -- at the point of the----

THE CHAIR: The point of the tap.

A Yeah.

THE CHAIR: Thank you.

MR CONNAL: Well, let's take that off the screen thank you and go back to the witness statement at page 12, where we find we're coming onto a different topic. Now, the Beatson BMT unit/Ward 4B issue has been much discussed for reasons you probably understand. Now, you say, well, you weren't involved in the decision in July, although you were on the Board at the time. That correct?

A Yes.

Q That was during your period as a non-executive director. Now, it's been suggested by a number of witnesses that a situation in which a leading unit like the Beatson BMT unit turns up at a brand new hospital, stays for a very short time, and basically says, "This is not good enough; we're going," is shocking, unprecedented, words of that kind. Would you agree?

A I don't know whether it's unprecedented, but it is surprising.

Q I mean, is "surprising" quite a mild word for such a thing to take place in a brand new hospital? Would you agree?

A I think you would be surprised if you relocated in those circumstances. You might also be shocked.

Q What was your reaction?

A I was certainly surprised and I was disappointed, concerned.

Q Although they actually moved back in July, the issue continued for some considerable time. So, it continued into your tenure as Chair. Can you remember what, if anything, you did to follow up on your concerns, surprise, shock, whatever it might be, as to how on earth you'd got into that situation?

A Yes, I'd had the discussions with the chief executive, but I also went to the Beatson, and visited the BMT unit, and spoke to the consultants there and asked them how this has come about, what they thought the best solution to it was, and how keen were they to move back into the Queen Elizabeth?

Q Well, I can understand that they might be able to help you on a number of these topics. We've heard from other witnesses that they were quite keen in principle to be in the Queen Elizabeth because of what we've described as the co-location issues with other services. But at least at first blush, a situation in which something like

happens suggests the need for some kind of pretty serious investigation to find an answer. Do you know if that happened?

A Well, my understanding was that we knew the answer, that it hadn't been properly specified what was required, and therefore it wasn't built to the requirement. And rather than have patients in a ward that we knew wasn't up to the standard, we returned them to where they had previously been until it was brought up to standard.

Q So, who told you that it hadn't been properly specified?

A That would be Robert Calderwood.

Q One of the pieces of evidence we've heard here is that, when the move was originally proposed, which was a late move, in 2013, Mr Best signed the piece of paper about the move and understood that discussions would then take place about the details. His then colleague, Mr Jenkins, and a consultant and various others went to the Project team and spelled out what they thought was to happen. Now, did you get any more detail as to, I mean, how what appears to be a pretty serious failing had taken place?

A No, I didn't have that level of detail as to who made the decision or what the process was. All of that predated me, and I accepted that as it was a fact that we had this issue and that the best resolution was to return the BMT unit to the Beatson until the problems in the Queen Elizabeth had been resolved.

I mean, I think it's fair to say that this conversation so far highlights that the approach that the Board took, certainly in my time, was to resolve the issue. That was the priority. The priority was always the patient, and giving the patients the best possible care and the best possible environment that we could create, and that, whilst it was important to understand what had happened and why it had happened, it was more important to come with the resolution and implement that as quickly as possible.

Q Well, I'm sure that's a very creditable approach, professor, and no doubt that was in your mind. But once the decision had been taken in July to take the patients back to the Beatson, they were back in the Beatson then for some considerable period of time. So, it's not as if there was no time to find out. Were you aware of anyone else investigating this if you weren't pressing for it?

A No.

Q Let's just look at the tail piece to that, which is what then happened. Can we have bundle 27, volume 7, page 158, please? Now, this appears to be an

options appraisal. Now, there's some debate as to whether the Board ever saw this options appraisal, which was one prepared-- Sorry, it runs under the name of Mr Jenkins, but it was prepared by a group with specialist assistance on ranking risks and how to look at options and so on and so forth, including IPC and clinicians. Do you remember seeing this?

A I think I was possibly at that Acute Services Committee meeting.

Q Can we just go onto the next page and the next one, please? The paper goes on for some time, so I'm not going to ask you to read all of it, but what you have there is a sort of background narrative of the events that have happened. Then you see, at the foot of that page:

"A group representing the Clinical Team, Infection Control, Capital Planning, Estates and Regional Service Management met twice... to consider the report, review... options [and so on]."

We go onto the next page. There's a description of the current service, and then we go to "Options Appraisal". So, this was intended, as I understand it, to set out for decision a number of options as to what to do about the situation that had been encountered.

So, if we go onto the next page. Essentially, we have there a summary of what is set out in much more detail later in the paper, if you just take that from me for ease of reference, where there are eight options considered. 4, 5, 7, and 8 are considered but not really followed through. So, you're left with four options that this group is putting forward. One, stay where they are in the Beatson, and that was an issue because the co-location and other support services weren't available – just summarising.

I'll just look at Option 3, which was build another unit elsewhere in the new hospital. 6 is also another new location. I just wanted to ask you about the second option, return to Level 4 in the Queen Elizabeth, because the point made there is "Unlikely to be a long-term option". That's the conclusion of this review.

Now, we know that, ultimately, a decision was made on a balance to go back to the new hospital. However, assuming you saw that, did it concern you that you were being told that, in this flagship hospital, the accommodation of the BMT unit was unlikely to be a long-term option because of the quality of the built environment?

A It did. And my understanding from memory is that that was on the basis that work had to be done to improve the environment.

Q But by that time, you knew, did you not, that, for instance, achieving what Mr Jenkins told us was 10-12 air

changes, just to take that as an example, couldn't be done within the existing building which is why options to build somewhere else were being looked at? I'm just trying to understand the response to that. I can understand you're surprised; you're concerned when this unit has to leave because things are not the way they want.

Now, you're in a situation where there's been a lot of investigation and people are still telling you this place is not suitable long term. Do you remember what discussion there was about that?

A Not specifically from that meeting. But clearly, by that time, it had become very obvious that there were major issues to be addressed across the new hospital's campus – both the adult hospital and the children's hospital.

Q Thank you. My Lord, I was going to go onto a new topic, so this might be an appropriate time. I just see the time has slipped past 11.30.

THE CHAIR: Professor Brown, as I said, we usually take a coffee break about now. Can I ask you to be back for five-to twelve?

THE WITNESS: Yes.

THE CHAIR: Thank you.

(<u>Short break</u>)

THE CHAIR: Mr Connal?

MR CONNAL: Thanks, my Lord. (To the witness) Can I just, first of all, pick up on the words with which you left us when I was asking you about the BMT relocation and the information in the options appraisal indicating that, at least according to the group who prepared that options appraisal, moving back to the new hospital wasn't a long-term pollution due to built environment?

You said something along the lines of, "Well, yes, I may have been concerned about that but, by that time, we had a lot of other information about the state of the building." I'm paraphrasing what you said now. Can you just explain to us what you meant by what you knew at that time about the state of the building?

A Well, I think by 2017, it was clear there had been issues. I mean, the timeline would show that, after it opened, the BMT was one of the first things that surfaced; but as we've already touched on this morning, there was issues around infections in the children's hospital. There had been an HAI visit to the PICU. We had concerns about isolation rooms. It was all starting to build up into a picture that was suggesting this was more than a problem in a particular area of the hospital.

Q I don't want to know about disputes with contractors in this

environment, you know, in terms of detail, but getting that kind of information, would that not suggest to someone with governance as their topic that the governance arrangements which had been in place previously had not been effective?

A (After a pause) Like you, I'm conscious of the fact that there is a legal case with the contractors. Yeah, but I think it would be fair to say that, had there been effective governance in the construction process, then you would've-- I would have expected there to have been fewer problems.

Q Now, can I just go back, if you don't mind, to a couple of things you touched on this morning?

THE CHAIR: Just so I understand that last answer, governance in which organisation, the contractor or the Board's Project team?

A Integrated governance would require-- A good governance would've required the governance systems to have been integrated across all three aspects of it, really. The construction, from the construction company, the oversight of that by the Board's advisors, yeah, and by NHSGGC itself.

THE CHAIR: Thank you. Sorry, Mr Connal.

MR CONNAL: I was just going to go back just so I-- I've been asked just to make sure I'm getting your answers quite clearly. One of the topics we talked about was the DMA Canyon report which relates to water safety. Do you know who the duty holder under Scottish Government guidance was under the regulations of water?

A The duty holder is appointed, and my understanding is that would be the director of facilities.

Q Well, if you take it for me, the duty holder under the 2014-- sorry, SHTM 04-01 was the chief executive. I'm just wondering whether-- I mean, you've told us several times you've tried but failed to get to the bottom of why things had happened as they'd happened, and another thing I want to ask you about that, but would you not be able to identify, even if you didn't know instantly, who the persons were who held responsibility for the safety of the water system and therefore what each level of responsibility ought to have done?

A The organisation-- the size, complexity of the organisation, the levels within the organisation, the detail within the management, the governance of it, is such that, no, I couldn't have, as a board member or as the Chair, been able to name precisely who was responsible for what, yeah, at every level in the organisation. And clearly, you know, I got it wrong when I thought it was the director

of facilities that was responsible for water----

Q I'm not suggesting----

A -- rather than chief executive.

Q Sorry, I'm not suggesting to you that you should have been able to say, "Ah, yes, I know the structure is as follows, A, B, C, D, E" with different levels of responsibility at each level. I am suggesting, and that's the question I would like your comment on, that you might have been able to find that out had you been sufficiently determined to get to the bottom of this unsatisfactory situation.

A Yes, I think that's a fair comment.

Q I've also been asked-- At one point you said, "Well, part of the problem in investigating was that some of the people were not there." Now, does that not suggest that the governance of information, you know, when people depart and arrive and move on, was not effective?

A I would agree with that.

Q I think I have you noted as saying that, when you first heard of problems from Mr Calderwood, you may have been concerned, but you didn't directly take any action at that time. Is that correct?

A Yeah, that's correct. As far as I was concerned, the chief executive was taking a necessary action to take these things forward. That was his responsibility, and he would account to the Board for what he was doing to resolve these issues.

Q Yes. So, it was your job to lead the Board to make sure that the chief executive accounted to you for what was done on all of these issues. That fair?

A It was my job to chair the Board, and the chief executive was accountable to the Board rather than to me as an individual. But I worked closely with the chief executives to ensure that that happened.

Q From the answers we've had so far from you and from other witnesses, it doesn't sound as if getting to the bottom of all these problems adequately and reporting to the Board ever happened. Would you agree?

A I think it depends what you mean by "getting to the bottom of it". We certainly identified what the problems were, and we identified what was necessary to resolve them, and then we put the steps in place to resolve them. Whether we spent enough time and energy trying to get an understanding of why they occurred-- Yeah, I think that's a fair criticism. That wasn't our priority, as I said earlier, to come to a conclusion as to why; we were interested in what-- how we could then take that forward and resolve

the issues.

Q I think that cropped up in the context of the options appraisal when I suggested to you that it would be of concern to find, even after all the investigations that had taken place, that you're still being told going back to the Queen Elizabeth isn't a long-term solution. So, you accept that getting to the bottom of why that was perhaps wasn't taken on in the way it should have been?

A Yes, I would accept that, but I mean we were looking as to what had to be resolved, what the problem was, rather than why had it occurred. It has to-- You know, just to be clear, very much the attitude of the Board and the chief executive and this Corporate Management team was to look-- We saw ourselves as solving the problem that we had-- that we were being faced with, and it was a problem that kept changing. There were new problems, different problems, different solutions. There were different opinions coming as to what was causing it.

So we were concentrating very much on, "How do we make this hospital the best possible environment for our patients?" As you point out, perhaps we should have been spending some more time looking as to why had it happened in the first place.

Q But the reason I wanted to ask the question was because, much earlier in the day, we discussed the phrase "hold to account". Now, on one view, a governance system would hold to account the person, group, individual, whatever it was, who was responsible for a problem arising. Is that not fair?

A Yeah, that's fair.

Q Well, let's move on for the moment. We may come back to some of these topics. I've got some questions that I've been asked to put to you, but let's move on for the moment in your witness statement. We're on page 13, electronic page 13.

You then separated out a heading about ventilation concerns, and you say that you were first advised about the topic of air changes when you were briefed on the reasons why the adult BMT unit had been relocated back to the Beatson. You say, "Mr Calderwood also refer to the situation other parts of the hospitals..." What was he telling you?

A Basically, the situation in the BMT had come about because the number of air changes wasn't to the standard that had been expected or was required, and that there might be other parts of the hospital where it was the same.

Q So, if that was so, would that not ring alarm bells, wave red flags,

whatever metaphor you like, about air change rates way back in 2016?

A It did, and we had the discussions at the Board around whether these air change rates were causing risk to the patients, and, if they were, were they being effectively managed?

Q When did you first, if ever, discover that the standard rooms in the hospital-- not the specialist areas, the standard rooms in the hospital, had been built at half the air change rate recommended by Scottish Government?

A I couldn't put a date on that.

Q Even roughly?

A I would think it would be around 2017. I think, by 2017, it was clear that there were a number of issues----

Q All right, I understand that.

A -- about water and ventilation. I can't today recollect which issue was raised or what point-- when I became aware of a specific one, unless there's a specific decision that was made at the Board or a specific paper that came to the Board that would help me.

Q I just wanted to ask you about that one because you're the Chairman; you're used to moving in areas of governance, working with people at a high level. If somebody comes and says to you, "You know we've just built this brand new flagship hospital at half the air changes rate that the Scottish Government would ask for as the standard guidance for a standard single room," I think it might be suggested by some that that would make you go probably mutter a few expletives, no doubt under your breath, and then say, you know, "What the heck happened there?"

A My first response would be-- is "What's the impact on the patients, and what are we going to do to mitigate that?"

Q Okay, after that, would you ever want to know how that happened?

A Yes.

Q To use your reference earlier to the importance of risk assessment, would you want to know whether any decisions on that had been risk assessed?

A Yes.

Q Did you find out?

A Yes. The risk assessments for the construction work-- The risk assessments were at project level and had been signed off through the governance of the programme. But I did not go back and review the governance of the programme that delivered the hospital or go back and review the risk registers around the project to come to a view on where the governance potentially, or the lack of governance potentially, might have caused the problem. I concentrated the Board's

energies and efforts and my own energies and efforts on resolving the situation. Very much we saw our role, as I said earlier-- as we were trying to resolve the problems.

Q With a bit of a hindsight, do you think you should have tried to find out whether any decision taken on a topic of that at least possible significant-- certainly possible-- the possibility of it being of concern to Scottish Government and others-- had been what steps had been gone through to reach that decision, how it had been processed, where the checks and balances were. Do you think, with the benefit of the hindsight, you should have done more?

A I think that the-- it's necessary that that's done. I think it was, "At what point was that the best use of the resources and the time of the people that were available to deal with the situation?" I think there has been internal reviews, independent reviews, Oversight boards – I mean, now with the Public Inquiry, they're asking these questions. Had we asked those questions and come to answers earlier, would we still be having these conversations this number of years after it? I don't really know, but I do believe that, at the time, the decisions that we made were in the interests of resolving the issues from the patients' perspective as quickly as possible.

And that's where we put our time and our energy of the Corporate Management team, the time and the energy of the Board. I'm not sure that knowing why and spending the time to understand why we made what decisions and so on would actually have helped us resolve the situation any quicker. If anything, I think it would have slowed things up.

Q Would it have allowed you to hold to account those involved?

A It would have allowed us to identify those involved, and it would have allowed us to hold them to account better, yes. But as I say, the priority was resolving issues from the patients' perspective, not looking for accountability at that point.

Q When you were first told about the problems in different areas, were you told about possible problems in Ward 2A, the Schiehallion unit?

A Yeah, I must have been told about that.

Q Because you say, in paragraph 45 of your witness statement, immediately after your reference to talking to Mr Calderwood in 2016, that:

"The... Board was aware of this situation and was satisfied that any risks to patient safety had been identified and were being effectively managed."

Now, given what we now know

about what had to be done to Ward 2A, you can put any label you like on it, but very substantial works had to be carried out to produce something that people were satisfied with. How could you be satisfied, in 2016, that matters were being properly looked after?

A The board was advised of what the understanding of the problem was and then what the response to it was, yeah. As they worked through the situation, it became clear that the initial identification of the problems and the mitigation of those problems wasn't resolved in the situation. So, there was more in-depth work done to identify what the problem was and therefore more risk mitigation put in place, including the decant of the ward eventually.

So, it was a question of, "How quickly could they get to the bottom of it?" But at each stage, the Board was given a summary of what the problem was and details of what actions were being taken to resolve it. It wasn't always clear what the cause of the infections-- for example, where it was coming from. And as each of the IMT decisions were made to mitigate what they thought was a potential cause-- if that didn't work, they moved on. But from a governance point of view, the Board was satisfied that the right people were looking at determining the problem and the right people were being asked to provide the solutions.

Q I wanted to ask you about it because the next paragraph of your witness statement, 47, on page 14, explains that there was a review of ventilation by Mr Leiper in 2018.

Now, we know there were other reviews in 2018 as well, particularly on Ward 2A. One of the questions that parties have been keen to understand is, given that these reviews essentially discovered that this ward had not been built in the way the Board had hoped it should have been built – it had been built more like a standard ward than one for specialist patients – is it not surprising that, with all your governance systems in place and your assurances, that you're now in 2018, years after the hospital is open, that you're only now discovering this? Is that not a concern?

A It is a concern. I accept that the time taken between problems arising and actually coming to a conclusion as to the cause of the problem and putting in the final solutions was far too long from anyone's perspective, particularly from the patients and their famlilies' perspectives and from the perspective of the staff.

Q I wanted to ask that because of your last answer, which is you were told that the right people were doing the right things. Yet, in 2018, there were two

reports, one from Mr Leiper, one from, I think, a company called IDS, if I remember correctly, which basically go through 2A, you know, like a knife through butter saying, “Wrong, wrong, wrong, wrong, wrong, wrong, wrong” – a whole list of defects.

Now, did that not immediately suggest to you as a governance expert that what you were being told was not correct or inadequate or too slow or something? Did you not do anything about it?

A Well, I certainly felt it was inadequate. I certainly felt it was too slow, yeah.

Q What did you then do when you reached these conclusions?

A Well, we looked to the Executive team to actually put in more resources, to put in better governance and better reporting.

Q Okay. You’re looking to fix the physical problems, I understand that. Better reporting structures-- but if you’ve just discovered that what you’ve been told is inadequate and too slow, as a governance expert, are you not wanting to hold somebody to account for that at the time while it’s all fresh, while the people are there? They haven’t moved on. You can understand why I’m now (inaudible) ask you the question; there may be others that we’ve asked similar

questions to.

A I understand where your question is coming from, yeah, and I’m reflecting on what actually happened at the time and what the Board’s reaction at the time was. The board very much took the approach where, if we had a problem which was a failure of information flows and a failure of governance, then we would look to improve the system and move forward on that basis.

As far as holding an individual to account where the system was inadequate, then that would not have been appropriate because it was the system. If someone had followed the system and passed on the information through the right committee or through the right reporting mechanism, then certainly you wouldn’t be holding an individual account; you would change the system. Where there had been a failure to apply the process or the systems, then the expectation would be that the management of those individuals would them to account.

THE CHAIR: I lost the opportunity just to confirm precisely what you meant, professor. I’ve noted you as saying, about two minutes ago, “... certainly felt it was inadequate and too slow.” I just failed to follow what you meant by it.

A The response.

THE CHAIR: The response? The

response by subordinate management.

A Within the Executive team and within the management that was doing the problem identification and identification of the solutions and the implementation of the solutions.

THE CHAIR: Thank you.

MR CONNAL: So, I'm still not quite following your answer, and the fault is perhaps mine. I understand if the system says, "Fill up a form," and the person fills up a form, and nothing happens, that's a fault of the system. But if you've identified that the response to dealing with, say, Ward 2A, was both inadequate and far too slow, perhaps those not familiar with healthcare administration would assume that somebody, somewhere in that mix, is responsible for it being inadequate and too slow, and that someone further up the tree can find out who that is and hold them to account. Now, am I wrong about that?

A No.

Q Was that done?

A I would say so, yes. I think there was some difficult conversations, as I understand it, with individuals over the period.

Q I apologise for what seems to be repetitive questions, but a theme seems to be emerging that, you know, if you assume that you have a hierarchical structure that ends up going through the chief executive informally to you and formally to you and the Board, it's not obvious what the Board actually does other than focus on getting things fixed about the problems. I want to put to you another paragraph. The next topic you deal with, paragraph 48 onwards, is Schiehallion. We've touched on Schiehallion, as it happens, already. Top of page 15, paragraph 51, "My recollection is that the Board members were surprised and disappointed."

Well, I suspect many of us might suggest, the next question is, "So, what did they do about it?" You know, because it's all very well to say, "Here we are. We're on a board that's just made a lot of public money from a flagship hospital, and we're disappointed." Well, you know, "And?"

A We looked to the executives to give us the proposals on what it was that they were planning to do to resolve the situation that had arisen. And we scrutinised those proposals that came to us.

Q Did nobody say, you know, "How the heck did we end up in this situation?"

A I'm sure that that question would have been asked.

Q Do you not remember?

A No, I'm sure it would have been asked.

Q No, I mean, people quite often say in their witness statement something would have been done when what they actually mean is, "I don't remember, that's just what the routine would have been."

A Sorry, what I meant was the question was asked.

Q Right.

A Yeah.

Q The answer was?

A The answer was back on the construction of it hadn't been constructed to the standard that had been requested. And then that was the issue around the construction, the issue around the oversight of the construction by the advisors, and then the issue around the governance of the project by NHSGGC.

Q You go on, in paragraph 52, to point out that isolation rooms was also a topic that came up amongst the various topics of things that weren't satisfactory, but I won't take time asking you about that. Can I ask you about Ward 4C?

Now, the Inquiry has been told that the patient cohort originally intended to be in Ward 4B, which was then later designated for the BMT unit, were being moved into 4C. Did you see the clinical output specification for the original 4B?

A No.

Q The reason I ask is it talks about immunocompromised patients and high degree of protection necessary. Were you aware of that?

A I didn't see the specification.

Q Well, can I just ask the question again? Were you aware that that kind of patient was being accommodated in that ward?

A (After a pause) I think so, yes.

Q Quite a simple reason: we have a problem here that we don't know the answer to. I'll explain this in the background to a question that relates to your period of time. When the decision was taken to move the BMT unit in, the proposed location was what we're now calling Ward 4B; and that had previously been scheduled, we are told by another witness, for a haemato-oncology ward moving from the Southern General.

A clinical output specification, which is part of the contractual documents, was prepared which went on about the number of immunocompromised patients and the need for special protections and so on. What we've not been able to find out is who then thought, "Oh, well, they're going to 4C. What do we do about 4C?" That's an unresolved question. You're coming at this after the event because you weren't there at the time of the construction decisions. You're saying that a very cautious approach to risk was being adopted by the Board, that correct?

A Yes.

Q Now, if we go to page 16, we'll find where you say that. Now, one of the questions is, well, would that not involve finding out what the specification originally intended for that cohort of patients was, and ensuring, so far as possible, that that was reproduced in Ward 4C? Would you agree?

A I would agree that that action should be taken, but not by the NHS board. That would be a decision that would be taken within the management structure, within the programme board. That level of detail would not normally be decided at NHS-board level: the allocation of specific patient cohorts to specific wards.

Q So, when you talk in paragraph 56 of an extremely cautious approach to risk management at NHS board level, is that relevant to the question I'm asking you or had nothing to do with it?

A Our risk appetite for patient safety is very low at corporate level, which means that the expectation is then further down the organisation at operationalist level is also very low, and that risk appetite is applied by the people making those decisions.

Q Right. Can I just ask you something about paragraph 56? The paragraph discusses some different views, and I want to ask you about that in a moment. But I wanted to ask you this first of all: you've referred there to views about the number of air changes that should be in place; were you aware that there was Scottish Government guidance on the number of air changes that be in place in different wards?

A Yes.

Q Were you aware that that guidance was the same guidance, broadly speaking, that applied throughout the UK?

A Yes.

Q It's just that you talk about a debate about the relevance of air changes, but you don't mention the fact that, for right or wrong, the governments of the UK have decided what the air changes should be. Is there any reason for that?

A I think the point that I'm referring to there is that, where there was debate about patient impact of any aspect of the building, for example, and there was choices as to what approach was taken by the Board, the Board would always look to have a low risk appetite for patient safety.

Q Who were the competing arguments being advanced by that you mentioned in paragraph 56? Sorry, if we could go back to page 16.

A I think this was presented to the Board as they were different opinions from different experts. I don't have a

particular-- Peter Hoffman was one name that I remember being quoted. As you say, there's the government guidance as well.

Q Where were these discussions happening? Can you help us at all?

A They'd be happening at the committees who were looking at the issues as they were being discussed. The standing committee, so that would be the acute services or clinical governance, or perhaps finance performance, or even the Audit and Risk Committee.

Q Do you remember when this was?

A Not specifically a date, no. These conversations were going on at the committees over a number of years, around a number of different aspects of the building, around the impact that was having on the patients and what the resolution should be. These conversations, these discussions, these decisions should be documented within the minutes of these committees and the minutes of the Board over that period.

Q Yes, I mean, the reason I wanted to ask you is because of your reference to risk appetite. Because if one person says, "Well, I know the regulations say you should have X air changes, but my view is it doesn't matter," and another one says, "Well, that's what the regulations say, and I think it does matter," the low risk appetite would presumably then opt for the safer of the two options, correct?

A Yes.

Q Okay. Now, the next detail you come to is the-- what I mentioned earlier, we just called "the water incident," for want of a better a better word. Am I right in thinking that your evidence, as summarised in paragraph 59, was that the way that was responded to was in accordance with the low-risk appetite of the Board as far as you were aware?

A Yes.

Q Now, of course, one of the problems you were facing then, if I'm getting this correctly, is you're through in 2018. Some people have been suggesting that the problem with the water (inaudible)-- for a lot longer than that. The DMA Canyon report may have emerged. Problems are being multiplied. Does it not suggest the further need for somebody to find out how you got into that water incident, and something that you should have been leading as Chair?

A Again, when it became clear that there was this water incident-- We'd given the knowledge about the 2015-2017 DMA Canyon report. The effort went into looking for a resolution to the problem, looking to define what the problem was. Who was responsible for what and when? That was an issue that

came up as part of the updates, but it wasn't an issue that was taken out as a separate review or investigation. It was all part and parcel of the one thing.

Q Let me ask you about a completely different question which does go to one of the issues that you dealt with in a question from me earlier, page 17, paragraph 63. We agreed, I think, earlier that the relationship between chief executive and Chair was important.

According to this paragraph, you were told by the chief executive that Dr Inkster had resigned as lead infection control doctor in 2019 for personal reasons. You've subsequently seen the resignation letter. You say here, "Well, it's clear that that wasn't an accurate description." Now, what does that say to you about the relationship that you had at that time with the chief executive?

A Well, it tells me that I wasn't fully informed.

Q It could tell you you were misled, could it?

A Yes.

Q Does that shed any other light on how effective your relationship was with Ms Grant?

A I suppose it does bring into question whether I was fully informed or misled in other issues.

Q The next perhaps not unconnected topic we find at the top of page 18, where there's a reference to concerns expressed by Professor Gibson about the hospital environment. Now, at points today, we've been talking about concerns expressed by microbiologists and so on and so forth. We're aware that some members of management thought they were not accurate in their concerns, if I put it politely for the moment. Now here you have Professor Gibson. Now, I take it you knew who Professor Gibson was?

A Yes, I know Professor Gibson.

Q Certainly, somebody who's been described in fairly glowing terms by lots of people including parents of children. So, what did you think when you were told that she and a bunch of clinicians were really unhappy about the systems that you were overseeing?

A Obviously, I was concerned about it. As I said there, I was advised that it was being taken forward by the chief operating officer. I visited the children's hospital. There was a conversation with Professor Gibson and, I think, two other consultants, yeah, to speak to them and hear what their concerns were and to get the assurance that they felt they were being listened to and it was being addressed.

Q Does that communication suggest to you that whatever governance arrangements were in place prior to the

letter had not been effective?

A I'm not sure what governance arrangements that you're referring to from that letter-- and that the concerns, as I understand it, that the consultants had was around the environment and the need to improve that environment more quickly than they understood that was being done.

So, that, for me, was more about the speed of response and the operational arrangements that were required to give the consultants, staff, and most importantly the patients and the families the confidence that they were in a safe environment. So, I'm not sure that's governance as such. But, either way, whatever you want to call it, it was an issue that needed to be resolved and addressed to the satisfaction of the consultants and the staff that were working in the hospital.

Q Maybe I'm misusing the term governance but, to an outsider to the system, it suggests something that's not quite right when a group of consultants basically have to write a pretty angry letter to the person at the top in the hope of getting action. It suggests whatever processes were in place were not functioning, at least in their adequately. Would you agree?

A I would agree, yeah. Whether you call it governance or you call it

management, I don't think-- The issue is that it wasn't being resolved to their satisfaction quickly enough.

Q Can I ask you another topic about communications, in particular, communications with Professor Cuddihy. There's no issue over using Professor Cuddihy's name; he's consented to that long ago. You deal with this-- if we go to page 19 of your witness statement. I think it's fair to say Professor Cuddihy wasn't very happy with what he saw as the treatment that-- and circumstances of his child. Is that fair?

A Yes.

Q You were in touch with Professor Cuddihy. Is that right?

A Yeah, Professor Cuddihy got in touch through the Vice Chair with me to say he would like to discuss the situation with his daughter. And I telephoned him initially, and he gave me the background. And I asked the chief executive, the medical director, to give me a briefing on it. And then I went back to Professor Cuddihy, and we did have a meeting with him.

Q Now, can we maybe just look at some documents in this context? Can we have bundle 6, page 53? Now, for reasons that I needn't go into, a lot of this has been redacted. The first thing you're doing here is apologising for delay. That right?

A Yes.

Q So, were you unhappy with the delay?

A I was unhappy in principle with the delay because I recognised the level of concern, upset, and distress that the Cuddihy family were under, but the complexity of the case, Molly's condition, and the background to the decisions made around their treatment were such that it took time for the report to be brought together-- was my understanding. And I would have rather that the report came later-- what was accurate than was rushed through.

Q Right. Let's see what else we have on the publicly-available document. Page 54, essentially all you're dealing with on that page is responding in a broad sense to concerns about infection control generally that Professor Cuddihy has raised with you. Is that right?

A Yes.

Q 55. Now, this is moving on now to, I think, a slightly different part of the saga because there was a bit of an issue, to put it no higher, about Professor Cuddihy not being told about another incident of the same unusual organism having been encountered. Now, rather dot around the documents, I mean, were you aware that he should have been told about that and wasn't?

A I was aware that he was unhappy in not being told about it because he had been told he would be told about these things. After he wasn't told, I wasn't aware that they'd put that in place-- that arrangement was already in place. So, I did know that Professor Cuddihy was not happy that he hadn't been notified of something he was told that he would have been.

Q Now, what I'm keen to understand is what your role in that was because what seems to have happened is a decision was made he needed to be told. People would have gone to tell him. So, to all the usual constraints about what you can tell people about another person -- but we're stopped from doing that because it was said the Chairman is going to deal with it.

A I was not aware Mr Cuddihy had been told he would be told of future of infections, and at no point had I issued any instructions or advice to anyone that I would be dealing with Professor Cuddihy. I dealt with Professor Cuddihy's initial contact. I arranged for the meeting with him. I responded to any letters he sent directly to me, but I wasn't acting as the point of contact for Professor Cuddihy at all. So, why he decided that I would be dealing with it, I don't know.

Q Certainly most of the others involved in the saga seemed to think that you were the intended means of contact

with Professor Cuddihy. That comes as news to you, does it?

A It certainly does. There was a point with the initial contact when I spoke to Professor Cuddihy, met with Professor Cuddihy, responded to his letters, but it was never my understanding or my instruction that I would be the person dealing directly with Professor Cuddihy.

Q Can we just look at bundle 1 at page 330, please? I'm just looking to find the correct reference here. Can we just go onto the next page? Just trying to find the reference. The next page, please. Now, finally, onto the next one. Sorry, this is an IMT minute. Now, you see, under "Duty of candour"-- you know roughly what we're talking about in the context of "duty of candour", I take it?

A I do, yes.

Q It seems to have been intended by the IMT meeting that a duty of candour communication should take place with Professor Cuddihy because he's the father of the first case mentioned under that head. It said, "The Chairman is in communication with him." You're not aware of this?

A Well, I haven't seen those minutes because I don't receive the minutes of the IMT, but that communication presumably refers to the earlier contact with Professor Cuddihy. If the interpretation of this is that Professor Gibson would speak to the most recent patient and I would speak to Professor Cuddihy, no one passed that on to me.

Q The reason I wanted to ask is that that meeting was on 3 July. Part of the reason why this saga has created so much angst is that, on 4 July, you wrote the letter we looked at which, whatever it did, didn't mention the additional case. That's, you say, because you didn't know you were meant to do that.

A I did know I was meant to do it. I was not aware of the additional case. It wasn't part of the briefing or part of the draft letter to Professor Cuddihy, otherwise it would have been included in it.

Q When you did write the next day, because this is 3 July, your letter was the 4th, to Professor Cuddihy, who did you get briefing information from to assist you in preparing that letter?

A That'd be the medical director and a chief executive.

Q So, Dr Armstrong and what?

A Jane Grant.

Q Jane Grant. Were you then made aware that Professor Cuddihy was further angry about the fact that he hadn't been told?

A Yeah, I think Jane Grant told me that, yes.

Q Were you then involved in further communications with him?

A Not that I remember.

Q Can we just look at bundle 6 at page 75, please? Now, this is not a letter from you, so be clear about that. It's a letter from Jane Grant. Were you involved in discussing what should be said to Professor Cuddihy in the context of this letter?

A No.

Q We know the IMT was 3 July, your letter was the 4th. We're now at the end of September, and this is the point at which more communication is taking place with Professor Cuddihy. Do you agree that that delay was unfortunate?

A Most certainly.

Q Now, the explanation given for the delay, which is in the paragraph 3 up from the bottom, says that communication with you should wait until typing results of the next child's bacteria are available, and also confidentiality with the second child.

Now, if the point was to tell Professor Cuddihy there had been another incident of the same microbacterium, are these good reasons, in your view, for delay?

A No, I would have expected them to tell Professor Cuddihy, and also at the same time to tell him about the action that they were taking around the typing, and then to tell but the result was after that.

Q Okay. Is there anything you think we could learn from this communication exchange, you know, thinking about things that could have been done better?

A I think that there is something in this communication – and I think it is a bit of a theme – of waiting until all the information was available or waiting until there was test results conclusive, a conclusive position achieved before contacting and giving information out. I think communications would have been better had we told people what we didn't know and when we would know it rather than waiting until we knew things before contacting them. I don't think it was just this case; I think there's been other cases where we could have even said that there's been no change since the last time, yeah, but we are doing other work to find out.

Q Yes. Now, I think in fairness to you, if we look at-- go back to your witness statement at page 20, we see, in paragraph 76, in fairness to you, you say:

"As far as the quality of the communication by the Royal Hospital for Children is concerned, I believe that NHSGGC could have done better..."

Is that what you're referring to----

A Yes.

Q -- in your answer a moment or two ago? One of the points you raised

was speed. Can I ask you about another one? It's been suggested in various quarters that the general approach of GGC communications was what might be described as "defensive". Would you agree with that?

A I think it has been described as defensive. That's how people have reacted to it. I think this approach of trying to give a complete description of any situation, waiting until the full information was there – I think that hasn't helped with not only the turnaround but also with how people have perceived the response. We have given out some very detailed responses with a lot of information in it which have given the impression that we haven't accepted that the problem existed.

I've always said to the Communications team, to the Management team, to the Board, that the first thing we have to do is accept responsibility. We should then be apologising or we should then be explaining what we did to fix the current situation, and we should then explain what we're doing to ensure it doesn't happen again. But I do recognise that the communications have been seen as being defensive on occasion.

Q I wanted to ask you-- Actually, I should have asked you a moment or two ago. Can we go back to page 19 at the

foot of the page where you're talking about a meeting with Professor Cuddihy where, obviously, the medical director is also present? Now, I'm just looking at the way you've written this paragraph:

"The Medical Director explained the... Government's policy on the investigation of single cases of infection and the guidance on linking cases for the purposes of infection prevention and control. She... confirmed that... policy and guidance had been properly applied in Molly's case."

Reading that as an outsider, so not as a lawyer, expert, or anything else, I just I wonder whether dealing with a potentially angry, potentially distraught, certainly upset patient – I better not use the word "distraught" or Professor Cuddihy will ring me up and tell me he wasn't distraught – but concerned patient and saying, "Well, I can tell you we followed the proper procedures," might be regarded as particularly unhelpful and not empathetic response. Would you agree?

A From my recollection of it, Professor Cuddihy was suggesting that other things should have happened and the medical director explained what the policy-- the process was and how it had been applied in Molly's case.

I don't think, at any point, was there any argument with Professor Cuddihy that what he was suggesting would not

have helped because it would have certainly helped with his understanding of what happened and why it happened, yeah. So, I think it's important that we should be following policy procedures, but it's also equally important-- if these policies and procedures are not delivering the best possible outcomes for our patients, we should be looking to change them.

But if it's considered defensive to say that the policies and procedures have been followed, yeah, I would still argue that that's the starting point, that you follow the procedures and the policies. The question then is, did those procedures and policies deliver the best outcome for the patient?

Q I wonder, with your permission, my Lord, if I might just take a few minutes more to deal with some more communication questions while we're on this theme – I'm conscious of the time – unless my Lord would prefer to break for lunch now.

THE CHAIR: I'm in your hands, Mr Connal.

MR CONNAL: (To the witness) Well, perhaps I can just ask you a few more points about communications then while we're here. I mean, you've accepted and you've set out on various pages "Communications could have been better". I think you would probably accept that, when Professor White was first engaged, so before the Oversight board-- So, he came in. He wasn't particularly happy with tone and content of a number of the communications, and was concerned about that. You would agree?

A Yes.

Q I just wonder if I can ask you one of the points that you've touched on in paragraph 80 on page 21, which is this. We've had a lot of discussion about how communications were prepared, and one of the questions that we've sort of gone round the houses a bit on is, "Why do members of management have to see these?" Sorry, "Why do members managed to have to be involved in their content?" Now, we were told well they need to approve them before they go out; they need to know they're going out.

Well, second question, they need to go-- they need to know they're being issued? Fine, but the question is why does a member of management, as opposed to a clinician or an IMT Chair or whatever, need to be involved in that process? Because they should have no-- On one view, they should have no substantive input into the content. Now, do you have any view on that.

A I'm not quite sure I understand the situation that you're describing. I mean, the clinicians would obviously deal with the clinical issue with the patients

direct with no management input, so----

Q But when public statements are being made or press releases or the like----

THE CHAIR: I'm not sure that your question was clear on that, although I did understand what you were talking about were the preparation of press statements. Is that the context?

MR CONNAL: That's essentially the context because I think the question that's been raised – and I'll put it as bluntly as I can to you – is that the only purpose-- I'll put the suggestion to you the only purpose of members of management, so not the comms people, not the clinicians, not the doctors, being involved in the content of communications was to ensure that, as they saw it, the Board's position, the Boards approach as they wanted it was being presented. Do you recognise that situation?

A I'm trying to understand what the alternative to senior management signing off communications that relate to the delivery of the services would be. Are you suggesting the communications director would do that? That's not the normal practice in the NHS or the normal practice in parts of the public sector.

Q I'm not concerned with what normal practice is. I'm concerned with what good practice might be. What I'm trying to get from you is this. I can understand----

THE CHAIR: Sorry, Mr Connal. I think I understood that answer as being that what Professor Brown said was that you would not recognise the involvement of management necessarily, in press statements, as usual practice, or did I fail to pick you up?

A No, it's the opposite----

MR CONNAL: It's the opposite.

THE CHAIR: Or it's the opposite, they always are.

A I mean, the other parts of public sector-- I've worked in press statements, media statements and so on, that certainly may well be written by the Comms team, certainly informed by the professionals in the organisation, but normally there'd be some senior management oversight of them actually being issued.

MR CONNAL: I understood your----

A And that applies across the health boards----

Q I understood your answer.

A -- and of course the situation changed with escalation.

Q I understand the escalation point and I also understand your earlier answer. I think the question we've been trying to find our way around is, accepting for the moment that a member of management needs to know that a

communication is going out-- They can't be blindsided because somebody's issued a press release that they don't know about. Leave that aside.

One of the questions that arose, particularly over timing, was why a member of management should input into the substantive content of that press release where it had been prepared by the professionals with assistance from the Comms professionals, because why are they chipping into it? What's the purpose of that?

A I'm finding it hard to understand the circumstances where the professional clinician, say, has written a statement, the Commerce people have ensured that it's presented in a way it's accessible, yeah, and appropriate. The Management would sign that off to ensure that there was a full response. I mean, signing off any test statement or any response, the management role is fundamentally, firstly, to ensure that the question has been answered or the issue has been addressed, and then it's to ensure that the answer is complete, accurate. I'm not sure when I can imagine a circumstance-- where a manager would re-write and change. I mean, I'm assuming you've got something in mind or specific.

Q No. I think what we had in mind was the question of timing, largely, because what seemed to have been happening was that a number of communications went to someone in management and couldn't go out until management had reviewed them.

Now, if management was simply saying, "Thank you for letting me know this going out [tick]," that wouldn't be necessary. If management weren't involved in the incidents which were giving rise to the communications, they would have no need to check them for completeness. The suggestion being made by some is the only purpose of them looking at them is saying, "We don't like the tone. It's not putting the Board in a good light. It doesn't present the Board's position in the way we would like to have it, therefore hang on till we change it." Do you recognise any of that is happening?

A I can recognise what you're saying about tone but not the content. I mean, you referenced Professor White and communications going through him, and the occasions when he felt the tone, as we discussed earlier, might have been defensive in changing some of the wording, but not changing the content. And I do agree with you; it does cause delay. Every time you put another step it causes delay. I mean, as I said in my statement-- that, after the escalation when----

Q There was another level of delay.

A -- communications, there was another level added. And that did cause delays. And the more senior the person that's signing it off, the more likely there's delays because they have other demands on their-- on their time. Yeah, so I can see where you're coming from an efficiency point of view, but I'm not aware of it being introduced from changing content or ensuring that management, as you described it, and management's views were somehow pushed through.

MR CONNAL: I think now, given the time, I should pause my questioning here and take the lunch adjournment, if that's acceptable.

THE CHAIR: We'll take our lunch break now Professor. I'd ask you to be back for ten-past two.

THE WITNESS: Certainly.

(Adjourned for a short time)

THE CHAIR: Good afternoon, Professor.

THE WITNESS: Afternoon.

THE CHAIR: Mr Connal.

MR CONNAL: Thank you, my Lord. I was asking some questions about communications when we were last facing each other. Can I go to page 22 of your witness statement? Now, in the first paragraph on that page, paragraph 83 in your version, you comment on the statement from Ms Bustillo that-- something along the lines of Professor Cuddihy may think he's "won the battle, but he won't win the war", which you say was unacceptable. Two things: what action did you take on that being drawn to your attention?

A I spoke to the chief executive and asked the same question of her that you've just asked of me: what action was she planning to take as part of her holding to account of the communications director, who's a direct line report of hers? Yeah, and the response I had was that it would be dealt with within the appraisal system that's currently in place, or the performance management system.

Q Now, the other question I wanted to ask you was this: the director of communications, a reasonably senior member of the team at NHSGGC, appeared to be expressing a feeling, a view, whatever, that what was going on was really a war between patients, perhaps, on one side and the Board on the other – something along these lines. That seemed to be the impression generated by the comment. Now, if that was right, did that not suggest that you had a culture problem?

A I don't believe that was right. I don't believe that was widespread. I

don't know where that comment came from. I certainly don't approve of it. It's totally unacceptable.

Q If your director of communications thinks there's a war going on, is that not something that ought to have caused you to consider the cultural side of this case?

A I don't think that comment from one individual would lead me to believe that that was the view of-- widespread within the organisation. That wasn't a view that I'd heard. It wasn't a view that I'd picked up from the many conversations I'd had with many staff across the organisation. The whole focus of the organisation was on trying to ensure that the patients were safe, the patients were receiving the best possible clinical care that they could, and that the problems that were in the environment, the problems that we had in establishing what was wrong with the building were all things that had to be addressed as quickly as possible. So I'd never seen it and never heard it represented as a war anywhere else.

Q Yes. Well, perhaps that you hadn't heard it from anyone lower down the chain isn't surprising. Is it possible that it was the view held in senior management circles?

A I don't think so. I saw no evidence of that at any level in the organisation.

Q Did you investigate that?

A I'm not sure how you would investigate that. I mean, I can only base my judgment on what I'd seen, what I'd heard. I can't see how I could go out and ask the question of, "How many people think it's a war?" I really don't understand what more could have been done, other than the individual who'd made the comment was dealt with under the performance management system that's in place for when individuals do things that are not acceptable.

Q I only ask these questions, Professor, because one possibility is that this was a complete outlier, an individual expressing an unacceptable view. The other possibility is that the senior management did feel embattled at the time and it did reflect the position that they probably wouldn't come and say to you, "Hey, John, we think we're in a war," but that's what they were thinking. Is it not at least a possibility?

A I certainly think the Senior Management team were under a huge amount of pressure throughout the period that I was the Chairman. I think the NHS in general has been struggling for some time. The building of the new hospital put a lot of pressure on the organisation, with the expectation that when it opened it would relieve pressure and improve

things. That didn't turn out to be the case initially, and then of course we had the pandemic on top of that.

So you had a Senior Leadership team, middle management, front line managers, all the doctors, all the nurses, the AHPs – everyone felt they were in a very difficult situation. But I come back-- I never heard it expressed as, "This is some sort of war that has been waged with who?" It was a-- They were in the centre of quite a storm.

Q Can I just move on to the next paragraph? You're talking about some of the challenges, manner of some communication, some of the delays and so on and so forth, which you now accept could have been done better, I think, just taking the matter generally. Another suggestion perhaps is that at the time the Board were trying to present a kind of "There's nothing going on here" approach. Is that not right?

A No, the Board certainly weren't trying to present that there were no problems. I think-- well, I know that we were very concerned about what was happening, very concerned about not knowing the cause, very concerned about not being able to resolve some of these situations quickly. I don't think at any point, whether it was the Board or the Senior Management team-- were suggesting that all was well. It clearly wasn't.

Q If we look at paragraph 85 and can we have bundle 6, page 77, please? Now, this is where we have the famous list of issues. I think you saw that at the time. You were asked to look at the wording and tone of that document.

A Yeah.

Q Can we just look at page 78? Now, you see the way that starts:

"When the hospital first opened in 2015, there was no indication that there was a problem with the water in the RHC."

Now, the DMA Canyon report was instructed and received by somebody at some level of seniority within the Board in 2015, which revealed, at least potentially, a whole series of problems, did it not?

A Yes.

Q So is this statement not less than transparent?

A I think it could certainly be worded better, that when the hospital opened that we were not aware at senior level there was a problem with the water. I think that would have been a better way to express it, rather than, "there was no indication".

Q Yes, and then you'd have to get into a debate about what a senior level was, depending on which manager knew about it and which----

A Yeah.

Q -- should have known about it, would you not?

A That's a fair comment.

Q The other thing I wanted to ask, because it's been asked of other witnesses, just while we've got that document – this was issued in 2019. Now, by 2019 the Board knew through a whole series of reports, and we don't need to go into which ones they were, that Ward 2A had not been built in the way that the Board-- let me just use the phrase "hoped it would be built", correct?

A Yes.

Q This statement doesn't say that anywhere. Should it have done?

A I think it could have. I think that would have been more complete, yeah.

Q The point is----

A I understand the point.

Q -- one of the issues that's being raised is transparency.

A Yeah.

Q Now, if you know by that time that the Ward 2A issue-- whatever exchanges had taken place in the past, you now know it has a range of problems which meant it wasn't in the condition that you would have wished it to be, without getting into the contractual side of it, it would have been transparent to reveal that to the audience, i.e. parents, patients and others, that this was intended for, wouldn't it? That would have been something that would've been more transparent.

A I agree, it would have been more transparent. It would have been more complete because the answer in the individual questions doesn't state that upfront.

Q Yes. Okay. Let me move on. Take that document down. I just want to deal with one or two bits and pieces now that have cropped up. First of all, you should have a letter in front of you from yourself to Professor Cuddihy dated 27 September.

A Yeah, I've got it.

Q Have you got that?

A Yes.

Q Now, my Lord, what has occurred here is that during the lunch break we've been advised that a further letter dated 27 September 2019 was sent by this witness, Mr Brown, to Professor Cuddihy. It's the same date, I think, as Jane Grant's letter – different source – and it's not, so far as we can currently ascertain in the time we've had over the lunch break, in any of the Inquiry bundles. I've made copies of that letter available to CPs in the room. It's not intended to publish it in its current format because it contains, first of all, an address and, secondly, a name other than Molly Cuddihy's near the end, which we will

redact before it reaches the public domain in accordance with our normal practice of not revealing that information.

Now that you've got this letter, Professor, do you recognise this is something that you sent?

A Yeah, I certainly do. It's a letter of apology to Professor Cuddihy because he had raised with me that he hadn't had that communication that he'd expected. Yeah, I had not remembered that, yeah, but now that I've seen it, I clearly do.

Q We've touched on timing of communications-----

A Yeah.

Q -- and so on later-- sorry, earlier when we dealt with Jane Grant's letter, but essentially you regard this as an apology to Professor Cuddihy for not being in touch quicker. Would that be a reasonable summary?

A I think it's-- it's an apology for not giving him the information that they had expected to get.

Q Thank you. Now, I'll leave that letter for the moment. As I've said, my Lord, we'll arrange for it to be bundled in due course, subject to the redactions, as far as I'm aware at the moment, just of the ones that we've mentioned, but we'll check that.

Can I ask you a couple of other things before we move on to a different topic that linked back to where we were before? Remember, we were discussing Ward 4B and the options appraisal, which basically said, "Not compliant with the rules, but we recommend on balance you go back in the short term." Inevitably, what's happened is that somebody has said, "Ah, well, that's what was put to the Board at the time that this was not a long-term solution." What happened during your time in Chair to change your mind and regard it as a long-term solution to stay there?

A I don't-- I don't recollect the Board revisiting that decision and making another decision that said it's now a long-term decision. I can recollect the discussion around that being the best of the options that were available at the time, but I don't recollect it coming back to the Board at any point.

Q Thank you. Let me ask you another question, and I'll tell you why I'm asking it and then I'll ask the question.

One of the possible criticisms of what was done in Ward 2A was that steps were taken to try and fix things – different steps at different points – none of them ultimately resolving it. Now, the question I've been asked to put to you, is this not because if you simply look forward and say, "How can we fix things?" and don't look backwards and find out, "Why have we got this problem?

How did it get here? What were the issues?" then you run the risk that you may engage in short term or ineffective solutions around the surface, without getting to the bottom of it. Is that a fair criticism?

A I think it's a very fair criticism. I think that each time, whether it was an IMT, a-- an separate report that said, "We think we have identified what the problem is and here's the solution," the Board took that in good faith and went ahead with that. But I think hindsight tells us that the circumstances that you've just described actually was what was the outcome of that approach, as we fixed things, as we went without that step back to say, "Is there more needs to be done?" We eventually got to that point, as you know, and stripped Ward 2A----

Q 2----

A -- all the way back to the bare walls to see what was actually going on there.

Q Yes.

A Had we done that sooner, that would have been better all around, both for the patients and for the staff.

Q Thank you. Can we go back to your witness statement, please, at page 23? I want to ask you about this because of a point that emerged in discussion with another witness recently. Now, if you read paragraph 87 of your witness statement which, as I say, in our version is on page 23 electronically.

A Yeah.

Q You see that some problems have been drawn to your attention. Then halfway down:

"…the Medical Director confirmed that although senior infection control doctors and microbiologists had been part of the team of clinicians involved in designing the [new hospitals], the whistleblowers remained concerned regarding the specialised ventilated areas ..."

Now, there are two questions that arise from that. One is this, that there is a sort of underlying tone in that communication, which might suggest that the problem here is the new people on the block who are raising all these questions, although their equivalents were involved in the design? Now, is it fair to criticise that statement that was made to you for that point?

A No, I don't think so because the reason that I made the point was because I had asked the question, that when it was brought to my attention that there were these concerns from the microbiologists, I had asked the question, "Well, was microbiology not something that was taken into account in the design?" and it was confirmed to me that it was. So if what you're taking from that

is I'm trying to say there are two opinions, yes, there are two opinions, but that wasn't the point that I was trying to make. The point I was trying to make was that microbiology had been a feature in the design.

Q Well, can I ask you two follow-ups to that? One is we've been trying to find out what involvement there was of IPC or microbiology in the design, and I think it's probably fair to say, without labouring a point that would take me all afternoon to put into a question, that we haven't been very successful in finding anyone who accepts that they had any significant input from an IPC position into the design of the hospital. Do you know where the medical director got that information from?

A No, I don't, but that's what she told me.

THE CHAIR: I mean, did that information inform your perspective on the microbiologists who were drawing attention to deficiencies in the ventilation in 2015? In other words, did you conclude from the information that you'd been provided by the medical director that there had been, as it were, a change of position in IPC?

A No, I didn't actually. I-- I suppose, if anything, I took this to be another area where the specification hadn't been met.

MR CONNAL: So you didn't take from that communication that the issues raised at the time, not what happened during the design, but recently, were inaccurate or wrong or more demanding?

A Yes, so on the-- No, I-- no, I've always taken the position-- the Board's always taken the position that the microbiologists who had raised concerns, the clinicians who had raised concerns that-- that were kind of, you know, wider beyond the microbiologist were justified in doing that and should be encouraged to do that, should be listened to and these concerns should be investigated and then a conclusion taken as to whether or not they were justified. And if they were justified, then action should be taken to rectify it. I was not influenced in any way by what I was told at-- at the design stage; microbiologists and clinicians were all involved.

THE CHAIR: Were you ever advised – and I'm taking it right up to at least 2019 – that the points being made by the microbiologist were inaccurate?

A Not-- No, would be the straightforward answer to that. Their-- their concerns were investigated through the SBAR process initially and the SBAR process generated a number of actions which, for me, confirmed that the points they had made were valid and needed to be actioned. There were further

concerns that were investigated through the whistleblowing process. And, again, they were investigated and they were then actioned or not actioned, whether they were upheld or not upheld, the-- and the SBAR activity was reported up through the Clinical Care Governance Committee. The whistleblowing was reported up through the Staff Governance Committee.

So from my perception of it and the Board's perception of it, was that we were listening and acting on the information that people were giving us, but listening didn't always mean that we agreed. So not every concern would have been-- from every part of the organisation about the new building was actually action taken on it because there would be other information that would say that wasn't required.

THE CHAIR: Well, I mean, you may or may not know the answer to this question, but was it ever drawn to your attention, or was it ever represented to you, that as far as points being made about the environment of the hospital, the microbiologists were in error?

A No, it was never put to me or to the Board that microbiologists were an error in totality, but-- but there would be some things where-- that suggested that the original hypothesis put forward by the microbiologists, the IMTs for example--

when these hypotheses were tested, they turned out not to be the cause of the problem, and therefore other hypotheses had to be tested.

If we just go back to our earlier conversation about why we appeared to be fixing a thing that didn't work and we tried another one and tried another one, yeah? So if you look at things like the Cryptococcus and the pigeons in-- in the plant room, that was originally put forward as being part of the problem, and then the investigation that went on and subsequent investigations came to the conclusion that wasn't where the Cryptococcus had come to the patients. But there-- there wasn't a blanket, "Are the microbiologists right or wrong?"

THE CHAIR: When you were talking about hypotheses, I take it you're talking about what was thought might have been causal connections?

A Yes.

THE CHAIR: Concentrating on physical features of the building, on the information provided to you, was it ever said to you that what was being said by the microbiologist was inaccurate?

A The discussions on the physical features were always in relation to the impact on the patient. So I've got no recollection of any conversation that was specifically about simply, "There's a feature in the building works which is right

or wrong." It was about, "There's a feature in the building work, the impact on the patient."

It goes back to my other conversation about the focus being on, "What was the problem rather than why was there a problem?" And I do accept that if we had spent more time and energy on looking at the root cause that we may well have come up with the solutions quicker.

THE CHAIR: Thank you.

MR CONNAL: Thank you, my Lord. Can I ask you another question on a different topic? Duty of candour. Go to page 26, please, of your witness statement. For reasons you'll understand, we're not reading every paragraph openly today. I just wanted to tease out the phraseology a little bit. In paragraph 100, you talk about a disagreement between Professor White and NHSGGC about the NHSGGC policy.

Now, is that an appropriate way to describe the points that Professor White made about the policy? And this, you know, it sounds like a bit of a spat about the interpretation of a word or something.

A Well, I mean, once again, you're asking me about the tone and what I-- I'm inferring here. I'm not inferring anything other than Professor White had a view that the Duty of

Candour policy that was in place in GGC wasn't fit for purpose. GGC had a view that it was-- it had been drafted based on the advice from Scottish Government. It had gone through the appropriate governance committee and been approved. So it was a disagreement. I wouldn't describe it as a spat.

Q The reason I ask is that when we heard from Professor White, the issues that he described, which were essentially the creation of hurdles before the duty of candour was engaged – which were not part of the act at all and which he knew as one of the contributors of the drafting of the provision were never intended to be part of it – had been inserted by GGC, presumably to reduce the number of times in which the Duty of Candour was engaged and he pointed this out to them and they subsequently fixed it.

Now, sounds a little more straightforward than a kind of disagreement over wording, does it not?

A Well, I think it's about the interpretation that GGC put on it, which was different from Professor's White's intentions when he was involved in the drafting of it and when he pointed this out, as you say, it was changed, but I-- I don't believe there was any hidden agenda of writing a Duty of Candour policy to reduce the number of times that

we would be delivering that outcome.

Q Now, if we now go on in your witness statement to the bit where the heading was missed out from the typing, which was, “Performance Escalation Framework,” if I noted it correctly this morning----

A Yes.

Q -- just before paragraph 101. I suppose the first point I have to put to you, given your expertise, is here you were the Chair of a major health board, with governance in your CV, written large, and here’s this Board being escalated in part due to what are said to be governance issues, was this not a significant criticism of your own position?

A We were not escalated for governance issues. When you’re escalated, the Cabinet Secretary and the Director General are very clear about what issues were in those boards that are being escalated for governance issues. It says quite clearly in the letters that are issued. And then that’s followed up by an external governance review, yeah, which-- In fact, I’ve been one of the people who’s been conducting the external governance reviews for Scottish Government.

But given that governance is always an issue – as we discussed at the start of this about the link between governance, management and change – then INT’d commissioned an independent review of governance from the Royal College of Physicians Quality Governance Collaborative, the-- the-- which I presume the Inquiry has seen to look at the governance, certainly at board and committee level.

THE CHAIR: Could you just give me that reference so that I will check what we have seen?

A It’s the Royal College of Physicians of Edinburgh’s Quality Governance Collaborative. A review of board level governance in GGC was undertaken by Professor Michael Deegan.

THE CHAIR: Sorry, undertaken by?

A Professor Michael Deegan.

THE CHAIR: Thank you.

MR CONNAL: In paragraph 104, page 27, you say, “The intention of the escalation to Stage Four was to ensure appropriate governance was in place ...” for certain purposes. So, you yourself have said in your witness statement that the aim of the escalation was focused on governance.

A Well, the-- the letter’s quite clear it’s about increasing “public confidence and strengthen current approaches that were in place to mitigate avoidable harms.” That’s a direct-- direct quote from the letter, I believe. Governance has to be appropriate. It has

to be effective, but were not escalated because the Cabinet Secretary and Director General were concerned about the effectiveness of governance in GDC at board level.

Q Is that not what that sentence just says that you've quoted?

A Yeah, it does, no.

Q So is that wrong?

A Yes.

Q (After a pause) So, your position is that the Board wasn't escalated for anything to do with governance?

A It wasn't escalated for governance at board level. Clearly, there were governance issues around the delivery of infection prevention and control. Clearly, there were governance issues around water management, governance issues that go back into the construction.

Q Mm-hmm. That's all very well, but ultimately----

A No----

Q -- it's a matter for the Board, isn't it?

A No, but the point I'm trying to make is your question was about me personally, as you described as someone who has a degree of expertise in governance and how did that mean that there was governance problems. Now, the governance that I'm responsible--

accountable for at board level and how the Board operates, those governance systems were not part of the reason for escalation.

Q Mr Wright, in his statement, said something like, "Once we looked at all the materials, we just weren't convinced that NHSGGC had a proper grasp of things." Now, that sounds a bit like a criticism of the organisation as a whole rather than of IPC or any particular element which is covered as well. Is that not fair?

A Well, I think it depends which things that Malcolm Wright was referring to.

Q Well, I suppose the next question is, if it's nothing to do with the Board that's caused the escalation, did the Board, at that time, have the same concerns over governance related to IPC, water management, building systems and so on?

A Yes, we did.

Q Because I suppose it's the usual thing: somebody has decided that special measures should be employed at that time because they weren't content that the current system was doing what needed to be done. Is that not fair?

A Yeah, I agree with you.

Q Mm-hmm.

A The point is: if there had been a concern around the governance at

board level, if there had been a concern around my role as the Chair, then those conversations would have been had between myself and the Cabinet Secretary, and I'm quite sure, if Ms Freeman had felt that I wasn't delivering the level of governance at board level or I wasn't fulfilling the role of the Chair, then she would have removed me as the Chair, as has happened in recent years in other parts of NHS Scotland.

The fact that there wasn't a separate governance review instigated by the government tells me that that was not an area of concern for them that was driving the escalation. That has been the case in other boards.

Q Can I ask you a point of detail – and it may just be the way it's been formulated, it hasn't come over correctly – that paragraph 106, you're talking about the appointment of Professor Bain. Now, we've obviously heard from Professor Bain and we've seen her letter of appointment and so on. You say here in paragraph 106:

"This decision meant that the Scottish Government were directly responsible for the management of infection prevention and control in NHSGGC and accountable to the Cabinet Secretary."

Is that not wrong?

A That's the Board's

understanding. Professor Bain was appointed by the Scottish Government to a post within NHSGGC that would normally be appointed by the Board.

Q Yes.

A Yeah, the decision to take that responsibility from the medical director and put it firstly to Professor Bain and then Professor Wallace was not made by the Board, wasn't made in consultation with the Board; that was a decision made by Scottish Government.

Q Well, we're agreed up to that point. We know these decisions were made-- Although we understand they were discussed with the chief executive, they were certainly made by Scottish Government.

But the question we've had to ask of Oversight board people, and we asked of Professor Bain, is, "Well, how does this work?" and we've been told that the way the escalation works is that NHSGGC remain the party responsible for delivery of the medical services that they were always responsible for in all aspects. The Oversight Board wasn't responsible for doing that, nor was the Scottish Government. Is that not correct?

A The responsibility sits with that director, and that director reported into the Oversight Board and was appointed by the Scottish Government.

Q Well, Miss Bain said – and

maybe she's wrong – that she reported in terms of her appointment to Miss Grant and advised the Oversight Board also.

A She reported in to Miss Grant and she reported in to the Board as well.

Q Yes.

A She came and delivered the infection prevention control papers and the health report at the Board meetings.

Q Before I get squealed with a protest from people in Scottish Government, I just want to make sure we're getting this right because the suggestion that the Scottish Government were responsible for IPC in NHSGGC during the time of the Oversight Board is not our understanding from previous evidence, but you're saying that was the Board's understanding?

A That was the Board's understanding.

Q So, the Board had no responsibility for that anymore, that was taken over by Scottish Government?

A That was the Board's understanding.

Q (After a pause) Can I ask you about another thing relating to escalation, because we've touched on culture and one of the questions that we're having to grapple with is how far you can deal with matters by, as it were, writing policies, documents, systems, and how far you need to have an arrangement which deals with culture.

Now, one of the things that Professor Bain told us – and I'm told that Miss Grant said something not dissimilar but leave that for the moment – was that she got the clear impression from senior management of the Board that they just didn't see the need for any of this. They didn't need the help of the-- well, what had been put in place, you know, the escalation. Now, first of all, were you aware of that?

A No, I wasn't aware of that. I think-- I know from my conversations with the senior managers that the escalation was viewed as being assistance-- help to overcome what had become a really difficult situation over a long period of time. The escalation was seen as bringing in other resources. It also brought with it a degree of bureaucracy and reports and all that sort of thing but, ultimately, having additional people like Professor Bain and Professor Wallace who could focus on the one thing, that was seen as being of assistance and great help, actually.

Q Now----

A But both Professor Bain and Professor Wallace brought a lot to the Board to help us resolve these issues, including the culture question around the Infection Prevention and Control team and the Microbiologist team, where-- I

think it was under Professor Bain, started looking at the organisation and development work as to how we could improve the team working within there.

Q I wanted to ask you about it because of this culture question. Now, this is what Professor Bain told us. She told us that in her witness statement. She told us that, in her oral evidence, and she was asked where she got it. She said she got it from discussions with senior management. First of all, does that surprise you?

A It does because it wasn't how they presented to me.

Q The reason I wanted to ask more than one question about it, why it might be important, is that, when I put it to Mr Wright in the course of exploring with him, you know, possible solutions, issues and so on and so forth, his response to that was this was a big red flag. An organisation that really-- It may be saying, "Yes, of course we will do what you tell us," but it doesn't believe you should be there in the first place, Mr Oversight Board. That's a red flag to him. Would you agree it causes a difficulty?

A The difficulty I have with that is Malcolm Wright didn't discuss that as being a red flag with me. Fiona McQueen, the Chair of the Oversight Board, didn't discuss that with me. Any meetings I had with Fiona McQueen in particular, I asked her specifically, "Was she getting the support? Was she getting the cooperation that she required?" and she said yes. Malcolm Wright said the same thing about Jane Grant.

So I must admit to being surprised and disappointed again to hear that colleagues within the Oversight Board felt that the Senior team didn't see the process that we were going through as being helping us to overcome the difficulties that the organisation faced, and again, I would go back to Miss Freeman. If Jeane Freeman had felt that the Oversight Board weren't getting the support that they needed or the cooperation, then she would have been very quick to tell me that.

Q Yes, I'm not suggesting that anyone, you know, declined to cooperate or was obstructive or anything like that. I'm simply saying that Professor Bain got the clear indication that, really, they didn't think they needed this process at all. So, you know, "What's the problem? We don't need the help," and you're surprised at that?

A I am, because we were working our way through, as we've discussed, a number of different scenarios, a number of different solutions, and we still weren't getting to where we needed to be, which was to have the public's trust and confidence

that the hospital was safe, the trust and confidence that the leadership of the organisation was effective.

We certainly didn't have-- reached a point where we knew that everything that needed to be done had been done, so I'm surprised by any idea that that wasn't seen as being helpful. I mean, we had gone through earlier reviews with our own three internal reviews, then we had the review by Dr Fraser and Dr Montgomery, so----

Q Thank you.

A Can I just add as well that the relationship between the Senior Leadership team and the people working in the Oversight Board was very good. They were colleagues; most of them had knew each other, they had worked together in other health boards, they had worked together in Glasgow, some of them. Yeah, so I can't see where this is coming from.

Q Can I ask you about the Case Note Review? You remember the events surrounding that? Can I ask you, first of all, to go-- I'm going to have to work back a little bit in this case, to go to page 32 of your witness statement and to paragraph 125. Now, you'll understand in a moment why I'm working backwards. What you say in the first sentence there is:

"As my second term as NHS Board Chair ended in November 2023, I was not involved in any discussions that resulted in the NHS Board's decision in 2024 to revisit NHSGGC's acceptance of the findings and conclusions of the Case Note Review."

I've two questions; one's quite a small question, one's quite a big one. Where did you get the 2024 date from?

A I assume that's when the decision was made. It was made after my time, so I assumed.

Q Okay. Working back from that, that's the small question. The big question is this. Am I correct in reading that sentence as indicating that, as far as you were concerned as Chairman of the Board of NHSGGC, NHSGGC accepted the findings and conclusions of the Case Note Review.

A Yes.

Q (After a pause) If it was to be suggested that, "Well, you accepted the recommendations but you didn't really accept the conclusions but just didn't want to say anything about it," what would you say to that possibility?

A I don't think that's a fair reflection of the situation at all. The Case Note Review, the Oversight Board, the Fraser Montgomery Review, all of these reviews submitted an initial report to the Board, to NHSGGC, for our comments, to look for factual inaccuracies or whatever, yeah? And all of them resulted in a

number of iteration of these reports, and I think the Oversight Board final report was about-- maybe the third, been back and forward, yeah? The Case Note Review was the same.

There were a number of comments that went back and forward but ultimately, where either Corporate Management team or clinicians disagreed with findings, the Board had to accept whether or not our position was such that we would not accept recommendations and, given that our risk appetite is low, very low, this is concern, we took the line that, where the report was ultimately accepted by the clinicians and the managers-- as all these reports were, where the recommendations were accepted by them, then, notwithstanding that there might have been some discussion going back and forward before it got finalised, we would accept it.

So, the recommendation-- I think a total of something like 108 recommendations across all these reports, all these recommendations were accepted and then put into action plans and then overseen by the committees.

THE CHAIR: Just at risk of repetition, your position is that the Board of Greater Glasgow and Clyde accepted as well-founded the conclusions of the Case Note Review as well as the recommendations of the Case Note Review?

A I'm fairly certain that the minutes of the meeting would reflect that we accepted the findings and recommendations because that's the normal phraseology that's used, and there was no question of us saying, "We accept that finding but not that one, we accept that one and not that one," and then go through that with the recommendations.

I mean, the paper came to the Board saying, "That's the final report," and the Board are asked to accept the findings and the recommendations. I mean, I haven't got the paper in front of me but that would normally be how it would come. I mean, as you know, there was a debate about the methodology, there was a debate about the statistical evidence, there was a debate around the use of whole genomic sequencing, an expression. So, notwithstanding these discussions and debates, it was still accepted.

MR CONNAL: Can I just ask you to look, please, at bundle 25, page 1260?

A Yeah.

Q Now, his is headed, "Core brief," which is, of course, the internal communication mechanism that was used for a while at NHSGGC, but it contains the text, if you just take it from me, of the public statement issued by

NHSGGC following the Case Note Review.

Now, I'm just keen to understand what you-- you were involved in the preparation of this document. In fact, you're quoted in it. We'll come to it in a moment. I'm keen to understand what you think would be taken from a reader of this document. If you look into the third paragraph of the narrative there:

"For those whose infection episodes were judged by the Case Note Review panel to be possibly or probably linked to the hospital environment, we apologise unreservedly."

Now, to many people who are not necessarily examining this in forensic detail, that reads fairly clearly, does it not?

A Yes.

Q It's a straightforward apology to those who are in that "possible or probable"----

A Yes.

Q From the Board.

A Yes.

Q Then there's some comment, quite rightly, about action taken, so we go on to the second page. There are quotations from Jane Grant and from Professor Gibson and then from you, and I know how these things are done but, nevertheless, the quote that's attributed to you, which presumably you signed off on, says:

"On behalf of the Board, I offer my sincere apologies to all the children and families who have been affected by these issues."

Now, did you intend that to be an unqualified apology?

A Yes.

Q Now, I need to ask you two follow-up questions on this topic. If it were to be suggested that in reality what was being done here was that the recommendations were being accepted but the conclusions – particularly the conclusions that 30 per cent of the infections were probably related to the environment – were not being accepted but it was probably better not to say that at the time, something along these lines, would you accept that that would be misleading the people who are reading a document such as this?

A I would, but that wasn't the case.

Q Well, there was a suggestion it was so I just wanted to understand your reaction because the other thing that was happening at the time was that patients were-- sorry, parents mainly were being contacted by the Case Note Review and I think the Board was aware of that, with individual reports on their individual----

A Yes.

Q -- situations, some of whom

would be in the 30 per cent group. So, if the conclusions were not accepted, it would be misleading not to say so, clearly.

A Clearly, but also, if the conclusions weren't accepted by the Board, then the Board would have put an action in place to challenge them.

Q Yes.

A Whether that would have been challenging them at the Oversight Board or – this happened after I had left – was to look for another review.

Q There is a reason I'm asking these questions, it's not just academic. We asked Professor Bain what the sort of principle-- as far as she was concerned, because she was the sponsor of the CNR after she'd ceased to be in post at the Board. You know, "What was the main ask of the CNR?" and she said, "Well, the principle conclusion was the 30 per cent figure that they came up with." Lots of other recommendations as well, but that's what she regarded as a principle conclusion.

Now, would you agree that, if the Board wanted to say, "Well, this report has said, you know, so many percent possible, 30 per cent probable, we don't accept that," that would have been quite a different type of press release?

A It certainly would have been, yeah.

Q Yes, and it's been-- I mean, it almost certainly wouldn't have been done in the form of a press release, it would have been done elsewhere first, but we've also wanted to ask on this hypothesis, what would have happened to the Board in their then current position if they had come out and said, "You know this Case Note Review? We don't accept their conclusions at all. We don't accept the possible and probable numbers at all," for whatever reason, and the general question I wonder whether you agreed with is that that could have had quite significant consequences for how the Board was run after that point. Would you agree?

A I think it would depend on what evidence that the Board actually presented. I mean, the decision on what would happen to the Board would be made by the Cabinet Secretary.

Q Indeed.

A Yeah, and I would rely on Jeane Freeman's judgment that she would look to ask the Board, "Well, why do you say that?" and she would weigh that evidence up, but the Board was not going down that route. The Board did not have another case to put.

Q Thank you. I'm sorry, my Lord, I may have cut across a question.

THE CHAIR: Just in risk of repetition, the Board did not go down that

route. In other words, the Board did not challenge the CNR report in any respect.

A The Board accepted the findings and the recommendations and the knowledge that there had been discussion and challenge between the clinicians in GGC and the Case Note Review team.

THE CHAIR: I think I heard you say the Board did not have a contrary case to put?

A No. There was not a contrary case put to the Board. It wasn't presented, "Here's the Case Note Review, here's a counter point of view, we would recommend that you don't accept some of these findings, you do accept others or whatever." That was not a discussion. The discussion was, "That's the Case Note Review, there has been input from GGC, we've had our opportunity, here are the findings, here are the recommendations, can you accept them?" and they did.

THE CHAIR: I think I've noted-- Well, I have noted, I just wanted to check if it's noted accurately, had, for any reason, the Board decided that they did not wish to accept the conclusions, if I've noted correctly, the Board would have had to put in place an action to challenge them. In other words, you would----

A Yes.

THE CHAIR: The responsible thing to do would be to provide an evidence base for any challenge.

A Yes, we would have had to have gone to the Oversight Board and to the Cabinet Secretary and said, "We do not accept this for the following reasons"----

THE CHAIR: "For the following reasons."

A -- and we would have had to have had that evidence and then the Oversight Board and Cabinet Secretary would have considered whether they thought that was an acceptable position to take or not.

THE CHAIR: Thank you.

MR CONNAL: Thank you, my Lord. (To the witness) Now, I'm conscious you've summarised some of your views on some of these topics at the end of your witness statement and we have a note of what your summary is. As the system works here, parties have suggested a number of other questions that I should put to you, so I'm going to have to jump back into one or two of these and then we'll have a short break to make sure whether there are any others coming.

One of the questions that inevitably arises, I suspect, with a board like NHSGGC where, for instance, there are a number of people nominated – I know that they're all appointed by the Cabinet

Secretary but they're nominated by different bodies like local authorities, and you have a range of different participants – is, "Well, how does this group of people have the skillset to interrogate what are often very technical and challenging issues involved in healthcare?" Now, is that something that you as Chair had to get involved in, trying to work out how to do that to best advantage?

A There is a process where all boards have a skills matrix that describes the experience and the skills that should be within the group. So, you have clinical skills, financial skills, construction skills. There's a wide range and there's a matrix for each board and, when the recruitment is done, you look to see where there are any shortfalls, usually because someone has left. So, if you were to lose a clinician, you would replace them with a clinician, so that's how you actually construct your Board to have the cover.

You then have the subcommittee set up and you allocate people to the subcommittee to make the best use of their skills. So, the Clinical Care Governance Committee, for example, the Chair and the Vice Chair of that, both of them are clinicians, yeah? So you try and work it through that. The Chair of the audit committee is an accountant, so that's-- I mean, there are 30 people in Greater Glasgow and Clyde, it's a large

group of people. There are a number of them who are Cabinet Secretary appointments as external non-execs, such as myself. There are a number who are stakeholders, so some of them come from the six local authorities they each nominate, someone-- usually the Chair of the Health and Social Care Committee or the leader of the council, although, in recent years, I think that changed.

You've also got the stakeholders from the staff and you've got the stakeholders from the clinicians. So, you'll get the Area Clinical Forum Chair, and then you have the executives who are on it, and a number of them, of course, are clinicians as well. You've got the medical director and nurse director and the Public Health director on the Board. Within the people who are appointed by the Cabinet Secretary, some of them do have clinical background. So, for example, you can have a GP on the Board who's been appointed through the public appointments.

Q Can I ask you a completely different question? We've heard, and we've touched on this in your evidence and also in the evidence of others, about concerns being expressed by microbiologists, some of which ended up in whistleblowing processes. Now, this may be too general a point, but tell me if

it is: what mechanisms did you put in place, if any, to check that everything that had been raised had been dealt with?

A The whistleblowing process?

Q Yes. Yes, I mean, they were initially expressed as concerns about the environment and also some then repeated in the whistleblowing process.

A Yeah. So, the whistleblowing process itself records what the whistleblow was about. It records the response to it and that then gets reported up through-- it was originally the Staff Governance Committee and then it moved to the Audit and Risk Committee because it was felt that staff governance had the expertise around staffing issues but, given that whistleblowing could be around anything at all, it was better to sit with the risk side of Audit and Risk, so it moved to that.

The steps that I took to ensure that the system was running properly was to instigate the review by the whistleblowing champion, supported by an external HR expert, and Charles Vincent undertook that review and gave the Board assurance that his investigation of a number of cases that were undertaken by him and by the independent HR person showed that the system was being properly and effectively run, and you have seen that report.

Q Can I ask you, because this

was a little bit of an issue between Miss Grant and Mr Calderwood. Miss Grant made a public statement when she took over that she'd inherited a difficult situation, or words to that effect. Did she discuss that with you?

A Well, we discussed the situation as she took-- Well, I discussed the situation before she took up post because as part of the process for applying for the job, the candidates were given the opportunity to have a discussion with me about the situation that was faced within NHSGGC, and I discussed that with the candidates.

She also obviously had a previous history and connection with the organisation, and would know from her personal contacts, the difficulties and, of course, much of it was in the media, so I think Jane had a good idea of what she was coming to.

Q Were there any particular issues that she wanted to discuss with you would be in her mind when she made a statement like that, do you know?

A No, I can't think of-- I mean, we had issues around finance. The Health Board starts every year with a projection of £100 million overspent. The eight years that I was there, we managed to balance the books at the end of the year. That was always a big challenge. We had an even bigger challenge around

access to services, waiting times, not just for elective but also for A&E and the non-elective demand on the system. I had recruitment issues around specialities. I mean, I can go on and give you the list, but we had a very big issue around the Queen Elizabeth, the children's hospital, and the problems that were emerging there.

I think it's important, you know, that context of just-- not just how big a job it is for a chief executive in terms of the size, the complexity of the organisation, but also the number of big issues that were all sitting there at once. You know, any organiation that's got a big hole, a structural deficit in its budget, it's got a big problem but, when you add all these other things to it, it makes that a much more challenging job.

It's a difficult job to recruit to. Robert Calderwood extended his time; Robert was going to retire earlier but we couldn't find a suitable candidate first time around to replace him. That's probably the biggest – I think one of the biggest, certainly – challenges in the public sector in Scotland, is the Chair of the Health Board that covers a third of the population.

Q Can I ask you another general question, if I might? We've talked about communications to patients at the time when there were issues, and I'm not going to go back over that. One of the questions that's come up in a variety of forums is how effective were the communications between the Board, Corporate Management, Clinical teams, including IPC? Do you have any view on how that was working when you were there?

A I think-- I've clearly got a better view of the communications between the Board, the committees and the Senior team than I have further down the organisation, if I can describe it as that, between the different levels of management. The Board had very good communications with the Senior Management team.

Each of the subcommittee Chairs and Vice Chairs had an appointed lead executive so, as you would imagine, the finance director, for example, was the lead for Audit and Risk; the nurse director and the medical director were both leads for Clinical and Care Governance. So they met with them, discussed issues, discussed what the agenda should be, discussed what the challenges were. We had quite a structured approach to how papers were presented, when they were presented, the annual cycle of business that showed what came to what meeting. So the actual information flows and the communications were good.

Personally, the office I had was next

door to the chief executive's office and in the same corridor as the Board headquarters as the Senior team, so yeah. I was there five days a week. It was advertised as a three-day-a-week job, but I spent five days a week in the role at the Health Board and that meant that I saw them every day. They come in and out my office, I come in and out their offices, so I think the communications at that level were very good, yeah. But, as I say, it would be wrong of me to have a firm view of as you go further down the organisation.

And the other thing I would say relates to your culture questions as well, is the organisation is based on-- I think it's some 120, 130 different locations. I hate to think how many different specialities we have, how many teams. But now, you don't have one culture in an organisation with 41,000 people. You have a variety of cultures and part of the culture is driven by the task, part of it is driven by the people you recruit, part of it is driven by the organisation's value and part of it is driven by the leadership. So the communications, the culture varied across the organisation.

I remember being asked by Shona Robison, when she was Cabinet Secretary, about, "Why is it you can go into some wards and find that it appears to be very well-run and go into other wards and it's not?" And my response to that is you've probably met the answer because it's about the leadership, and it's the thing that the Board can do to influence the culture.

It does three things: it sets the organisation's values and it demonstrates them by our own behaviours, but the most important thing a board can do is to appoint the right Leadership team, yeah and I do believe that the Leadership team that was in place in Greater Glasgow and Clyde during my team-- time was the right leadership team.

And I don't think we would have got through COVID if it hadn't been for Jane Grant and her team, and not only the skills and the experience that they had, but commitment and the energy and the time that they put in, and I've never worked with other people who are so resilient. The number of things that went wrong, the number of things that were out with our control, the external things that just kept coming and coming at them, and they stuck with it, and we've got the organisation today and the hospitals we've got today because of that.

Q Can I ask you this, and this is, for the moment at least, the last question I want to ask you? Given the benefit of hindsight, and thinking back to these challenging times, and I'm focusing on the Queen Elizabeth, not COVID, and

that's for other inquiries, are there any areas where, looking back, you feel your involvement could have been more effective or more proactive or better? I mean, we're obviously interested in the perceptions of the different witnesses.

A I think in the communications front I could have had more involvement and more to say. I think the fact that the Scottish Government decided that they would manage the communications and that communications would have to go through their scrutiny meant that I came out of that middle step.

But prior to the Scottish Government taking on that role, Jane Grant and Sandra Bustillo would on occasion say to me, "Would you have a look at this and give us your feedback to see how you think that will be received, understood, and how does it look?" Because I've always taken a view that you need to look at things both from the inside out, but just as importantly, and perhaps more importantly, from the outside in and I've always seen the role of the Board, including the Board Chairman is to bring that outside-in perspective to the management, who by the nature of their business tend to look from the inside out.

So, stepping out of that space, I could possibly have been more active in that space, but the reason I didn't, and as we discussed earlier, was because every

time you add another step to it, or another level of scrutiny, you delay it, and you do move a lot into that question about-- it's about tone, yeah.

It's about how people's written style is, you know, debates about, do you start by saying you accept there was a problem and then apologise, or do you start with an apology? Personally, I start by owning the problem and then apologise. Jeane Freeman will start by apologising, you know. So there's things around all of that, but I think in the communication space, post-escalation.

Q My Lord, for the moment at least, these are all the questions I propose to ask. As the witness is aware, our practice is to adjourn for a short time to see if other parties wish other questions put.

THE CHAIR: Well, as Mr Connal has explained, we must make provision for any questions which legal representatives consider should have been asked and have not as yet been asked, so maybe there are further questions, but for the moment, can I invite you to return to the witness room for 10 minutes or so.

THE WITNESS: Yes.

(<u>Short break</u>)

THE CHAIR: Now, Mr Connal.

MR CONNAL: I have agreed to ask a number of further questions, my Lord.

THE CHAIR: All right. Lest I forget, can I just draw legal representatives' attention to the fact that the paper letter that was provided at the beginning of this afternoon is not for publication beyond the legal representatives at present. Now, when I say, "at present" all the information on the piece of paper is not for publication. The letter will appear, suitably redacted, on the website within a few days.

MR CONNAL: Thank you, my Lord.

THE CHAIR: (After a pause) Some further questions, Professor. Now, Mr Connal.

MR CONNAL: Obliged, my Lord. (To the witness) A pretty broad question, first of all. We may have got the impression from your evidence so far that, so far as the Scottish Government is concerned, you feel that you at board level got a pretty clear bill of health. Have you had a chance to read Ms Freeman's statement to this Inquiry?

A No.

Q So, you wouldn't be aware that it levels various criticisms at the Board at a fairly high level?

A No. These were not criticisms that Ms Freeman had shared with me.

Q Thank you.

A I mean, I'd be happy to respond to what they are if you want to----

Q Not at all. The----

A Can I just add, I find that somewhat puzzling because in 2019 Ms Freeman asked me to stay on as the Chair for another four years. In 2022, the Scottish Government asked me to conduct the governance review of Forth Valley Health Board. I continued as the Chair of the Corporate Governance Steering Group up until I left Glasgow and Clyde in 2023, and I continued to chair the Global Citizenship Advisory Board for Scottish Government. So if Ms Freeman had concerns about my capability or what I was delivering in my role as the Chair, I don't think the evidence actually reflects that.

Q Thank you. You mentioned, or one of us mentioned, I forget now who, the report prepared by Mr Vincent on whistleblowing. Now, the Inquiry has been given some evidence that one whistleblower's account, which is said have got to a Stage 3 level, was not mentioned in that report. Do you know anything about that?

A I couldn't say for the specific-- but my understanding is that Mr Vincent did a comprehensive review, but it may be that the whistleblowing report that you're referring to is from a whistleblower where Mr Vincent might have been conflicted?

Q No.

A It's not that one.

Q No. I'm just avoiding using names for----

A I'm-- I'm trying to do likewise, but----

Q No, no.

THE CHAIR: Yes, right.

A -- I'm just----

MR CONNAL: It's not a conflict question at all.

A Yeah, I know, but I'm assured that you understand which whistleblowing and whistleblower I'm referring to and why it would----

Q I understand the point you're making----

A Yeah.

Q -- and we're not talking about that. Now, it's simply I've been asked to ask the question, you know, if that was the case would that be of concern, that one had been omitted?

A It would be. It would concern me if it hadn't captured the full sample that was agreed in the terms of reference and I would be surprised by it, because he's very conscientious, Charles Vincent.

Q I'm trying to ask you these questions so that we don't necessarily have either questions or answers that go on at great lengths. That Vincent report, am I right in understanding from-- or to take from your evidence that that gave GGC a clean bill of health?

A It gave us assurance that the system was operating as we'd expected, but with-- with any system, it's only as good as the time that you're looking at it, so it has to be kept under constant review.

Q Thank you. Now, I may have asked you the next questions before, in which case I apologise, but we have this question about hearing about the concerns of microbiologists, and we know that in part that was dated to 2017 when the SBAR came out. Were you concerned to discover that there were clinicians who had been raising concerns since 2015?

A Yes.

Q What did you do, if you were concerned about that, to establish why these concerns had not been responded to?

A We only discovered that not only was there concerns in 2017, that these concerns had been there for some time, that the position was adopted that said where these concerns-- are these concerns now being actioned, and that's where the focus of the Board's attention was, having identified a problem, what was being done to actually resolve it? And as I said earlier, that was the nature of the situation that we were in. We had a number of issues that were of great

concern to the Board and the Board was expecting, demanding really, that they get early attention.

Q A small question and big question coming now. Small question: at one point I asked you about a particular problem, were you're not happy about it, and you said, no you weren't happy about it. I said, "What do you do about it?" and you said you'd have had difficult conversations with one or two people. Do you remember saying that or words to that effect?

A If you remind me of the problem, it'll help----

Q No, I can't now remember what the problem was. I'm just interested to know what you mean by having a difficult conversation with someone. Because there's no immediate sign on any of the issues that we've encountered today that anybody, you know, got demoted, got fired, or anything. So, I'm just trying to put into context what you mean by "having a difficult conversation with somebody."

A No. I don't mean that, as the Chair, I would fire someone. That's-- For someone to lose their job would have to be done through the normal HR performance management approach, and the only person that I do performance management for is the chief executive now, although I do have oversight of the performance management for the people that the chief executive reports on. I'm effectively the second signatory to the report, and then it goes to the Remuneration Committee, who are second signatories to the chief executive, and then, as you know, it all goes to Scottish Government, and they do comparisons between the Boards to make sure the standard's there.

So, as far as firing someone for a performance issue, that would go through the appraisal. Firing someone for a conduct issue is a different thing altogether. So when I was saying I was having a difficult conversation, it wouldn't be that I was taking someone and firing them. I would be having the conversation about why-- how/why was it not avoided. It would depend exactly on what it was, the questions that I would be asking, but that would be a good example of holding them to account, asking them to explain what they did and explain what they didn't do, yeah.

Q Now, the final question from-- it's been suggested to me, my next question is simply this. Given all of the issues at the hospital, all the steps that had to be taken, the escalation to Stage 4, is it your position that you, and I mean, you, the Board, had the right people in place, given everything that happened?

A We did. That was our view.

Q One of the things that you've done in your statement quite properly is point to your expertise in governance. I've been asked if you can provide any examples in relation to NHSGGC where your leadership directly influenced decisions or improvements in governance or patient safety.

A Well, firstly, I led the work looking at the information flows to the Board, yeah, looking what data the Board should have, how that should be presented. Secondly, I looked at the structures of the committees when I took over and introduced the Finance Planning and Performance Committee to have a place where they looked at a number of issues, including those in the community that were covered by the Health and Social Care Partnership.

I changed the way that we did feedback to the Board, which originally had simply been the minutes and then an opportunity for the Chair of the Committee and the Board members to raise any issues from the minutes, to actually looking for a formal report and actually encouraging everyone to speak at the meeting.

I introduced a development programme, changed how we did induction. It's quite a long list. I basically implemented the blueprint for good governance, but as one of the authors, you know, then you would expect that.

Q Yes, thank you. I suspect the next question is probably focused on communications. How do you balance the need for public transparency on the one hand, with patient confidentiality on the other, and then on top of that, sort of operational sensitivity. How do you manage that balance?

A It's a difficult balance that has to be managed, and it has to be managed on a case-by-case basis. Clearly, if there's a group of patients, it's quite easy to communicate about a group, but if you're looking at a series of individual patients, it's difficult to publish any detailed information, certainly about their clinical treatment and so on, so the rules are quite tight around that, and the clinicians quite rightly guard that confidentiality. Clinicians are quite clear about the need not to disclose anything that might identify a patient.

Q We've talked a bit about governance and also risk management. How did the Board monitor and ensure compliance with both government policies and risk management frameworks in practice? How did you do that?

THE CHAIR: Sorry, could you just-- My fault, Mr Connal, I didn't really quite follow on the question.

MR CONNAL: I will read the question again, because it's been given

to me. (To the witness) How did the Board monitor and ensure compliance with governance policies and risk management frameworks in practice?

A There was the risk management system in place. The board approved the risk management policies. The Audit and Risk Committee had oversight of the corporate risk register before it came to the Board, so they did a deep dive. The external auditors as part of their audit, their annual audit, looked at governance and looked at how risk was being managed so there was a clear view of what the risk management system should be and how it was operating. As a board, twice a year we went through the entire corporate risk register. As a standing committee they had allocated-- each of the corporate risks were allocated to a standing committee so they also-- they also looked at them, and they, if you like, were the deep-dive or the expert looks.

Q So a financial risk would be with finance, planning and performance. An infection control risk would be with clinical and care governance. It's all part of the Board's scheme of delegation. Each of the committees, as well as having delegated decision making, has a list of strategies of their own and a list of risks of their own and then that is all integrated back up and that's the

assurance framework which was part of the work that I put into Greater Glasgow and Clyde back on your earlier question of what my contribution has been.

Q I asked you a question about communication, how effective communications were at different levels and you explained a number of the areas where you felt able to comment and then others elsewhere where you didn't feel able to comment. The follow-up to that I've been asked to put arises from the Vale of Leven inquiry and this concept of communication between board and ward and vice versa. Did you take any action about that?

A Part of my role as Chairman involved actually visiting wards of-- My first year as the Chair of Greater Glasgow and Clyde, although it's a three-day-a-week role, I always worked five days a week and I spent a day a week just going round the organisation. There's, I think, around 130 different locations in Greater Glasgow and Clyde and that was something that I continued apart from COVID when I stopped actually going out to visit.

So I've had that direct relationship with the wards and the staff magazine used to publish an "out and about with the Chairman" every month with the photographs and where I'd and what-- what I'd found.

The board standing committees have, with their lead executive, the opportunity to go and visit any ward to look at any issue and they take that-- they take that up. Individual board members that have got a particular interest also do visits and some-- and some of the Board members are champions for different things, which you probably gather. Whistleblowing you'll be familiar with but we also have the quality, diversity, inclusive primary care and so on. So they do a bit around that as well.

So the Board does-- As I said earlier, doesn't just take what the executives tell us. We try and triangulate what they give us against the data benchmarking and also against what we see ourselves when we're out interacting.

Q You mentioned whistleblowing. Obviously there was some of that going on in the time that we've been talking about. What lessons were learned from these whistleblowing investigations and what did you do with them in terms of incorporating them into your arrangements?

A I'm not sure which whistleblowing. Are you talking about specific ones or about the review that we did in general?

Q Well, I don't want to go to the Vincent review, but a number of microbiologists did whistleblows about

the Queen Elizabeth Hospital, did they not? Did you learn lessons from these?

A Yeah, I think they did. I think one of the lessons that was learned from that is that it's important to be clear. If it's a whistleblow, it's a whistleblow. I mean, certainly one of the microbiologists, when she first raised through the whistleblowing, it wasn't identified, as you know, as being Stage 1 whistleblowing, and it was progressed. The concerns she had were progressed but not through that particular-- which it should have been. So that identification is one of the things that has been learned from it. As far as the rest of it then, Stage 2 reviews and then the Stage 3 reviews, I think were conducted in the appropriate fashion.

Q Were there any more substantive lessons or is it just a question of procedure that you've identified?

A I think there's a lesson about the need to ensure that what I was saying earlier about the value of whistleblowing continues to be promoted and continues to be upheld across the organisation, that whistleblowing is necessary and it's a good thing. It gives people the opportunity to raise things that they don't feel comfortable with, with the line management, and it gives people an opportunity to raise things that they don't feel have been properly resolved. So I

think there is, and certainly there's been some work done within GGC to try and promote that more and there was some good work done by Charles Vincent in that space as well.

Q Thank you. Now, the question has been put to me in the following form: how were risks relating to hospital infrastructure prioritised compared to clinical risks?

A Risks are prioritised through the risk management system by how they're assessed. So risk is identified and then the likelihood and the impact is assessed and then those risks that have got the highest score based on likelihood and impact, then they are prioritised in sense of how quickly you can actually get to them. You don't prioritise on the basis of what the risk itself is. You don't prioritise financial risk before-- So, it's not really how risk management works.

Q Possibly a follow up to that: various issues were identified with the ventilation and water system. Were any specific actions taken following the identification of ventilation and water system risks and how were these then tracked and reported?

A Well, there was the action plans around the risks and the waters, and these actions were reported and tracked through the standing committees. So the standing committees would get a report that would say, "This is what we're doing. This is when it needs to be done by," and then an update would come to them until it was closed.

Q Taking the matter generally, how did the Board ensure that recommendations from either risk assessments or external reviews were implemented effectively and promptly?

A Same answer as the previous question really. The actions were laid out. The board approved these actions. The board then got regular update reports on them and then when they were closed off, the Board then moved on to whatever other business that they had.

So we had the register of the 108 risks and they worked through-- that was worked through in the standing committees for those recommendations that had been allocated to whatever committee and then the Board get the overall report, which then culminated in being able to present to the Oversight board and the Cabinet Secretary that they had all been implemented. Then the Oversight board came back and looked to confirm that they had been implemented before they recommended that the Board was de-escalated. So it's quite a clear process to follow up in these actions.

Q You said in your evidence that the Board's appetite for risk relating to patient safety was very low. Is there any

process for reviewing and updating the appetite for risk in relation to patient safety?

THE CHAIR: Sorry, could you repeat that again? I mean, I've got the theme of risk appetite.

MR CONNAL: Yes.

THE CHAIR: And what's the----?

MR CONNAL: Was there any process for reviewing and updating the risk appetite relating to patient safety which was said to be very low?

A That's the lowest within the categories that-- and we follow the Scottish Government's risk management system and the Scottish Government's risk appetite scores, and it's reviewed every year.

Q So if you were to say, "Well, as of today, NHSGGC appetite for risk, topic board safety, patient safety is very low." That gets looked at again a year from now, whenever the appropriate date is. Is that right?

A Or it could be brought, for whatever reason – and I haven't seen this happen before the annual review – it could be brought to the Board to say, "We think you should increase your risk appetite, and I don't think that would ever happen in the case of patient risk, but it might be for technology risk or whatever. You might want to lower it because of cyber security threats or whatever. So it could change in there, but I haven't seen that happen.

Q Thank you. I have nothing further for this witness, my Lord.

THE CHAIR: All right. In the absence of indication to the contrary, I will proceed on the basis that Mr Connal has asked such questions as legal representatives want asked. (After a pause) Very well. Professor Brown, that's the end of your evidence and that means you're free to go but before you do, can I say thank you for your attendance and thank you for the preparatory work behind your evidence today. So, thank you very much, but you're now free to go.

THE WITNESS: Can I just thank you, Lord Brodie, and thank yourself for giving me the opportunity to actually provide you with a bit of insight and my perspective on what happened over the period, and I hope that's helpful.

I think everyone would like to see a resolution of some of these issues which have been with us for some time and continue to cause a lot of concern to patients, staff, to the population that Greater Glasgow and Clyde serves and to the leadership of Greater Glasgow and Clyde, and no doubt to the Scottish Government as well. So I look forward to seeing your report in due course. Thank you.

THE CHAIR: Thank you.

(The witness withdrew)

THE CHAIR: Well, we shall resume on Tuesday of next week and I can't immediately recollect who our first witness will be.

MR CONNAL: I'm afraid I just can't remember off the top of my head. I know it's not me. It'll be Mr Mackintosh on Tuesday.

THE CHAIR: All right.

MR CONNAL: I think I return on Wednesday.

THE CHAIR: Well, I wish everyone a good weekend, and we'll see each other, all being well, next week.

(Session ends)

16:20