SCOTTISH HOSPITALS INQUIRY

**Hearings Commencing**
**12 June 2023**

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Melanie Hutton

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**10:20**

**THE CHAIR:** Good morning. I think we are able to continue, Mr Duncan, with Melanie Hutton.

**MR DUNCAN:** Yes. Ms Arnott will be questioning Ms Hutton.

**THE CHAIR:** Oh, right. Yes, I had not picked up on the significance of the change of seats. Ms Arnott, yes.

**MS ARNOTT:** Yes, thank you, my Lord, it's Ms Hutton.

**THE CHAIR:** Good morning. If you could bring in Ms Hutton. Good morning, Ms Hutton. As you understand, you are about to be asked some questions by Ms Arnott, who is on my right. First of all, you are willing to take the oath, are you not?

**A** That's correct.

**Melanie Hutton**
**Sworn**

**Questioned by Ms Arnott**

**THE CHAIR:** Ms Arnott.

**MS ARNOTT:** Thank you, my Lord. Ms Hutton, I am going to begin by taking you through a few formal questions. Could you please confirm your full name?

**A** Yeah, it's Melanie Hutton.



**Q** Thank you. You are currently the General Manager for Paediatrics and Neonates at the Royal Hospital for Children in Glasgow. Is that right?

**A** Yes, that's correct.

**Q** You have provided a statement to the Inquiry and, as I understand it, you are happy for that statement to form part of your evidence to the Inquiry. Is that correct?

**A** Yes.

**Q** Thank you. Do you have a hard copy of your statement in front of you?

**A** Yes, I do.

**Q** Please do just look at your statement any time you want to if you need to refresh your memory. Ms Hutton, before we go on to talk about the issues at the hospital, I want to ask you a few questions about your career. You qualified as a registered general nurse in 1991. Is that right?

**A** That's correct.

**Q** A registered sick children's nurse, I think, a couple of years later?

**A** Yeah, 1994.

**Q** At that point, you started working in Yorkhill Hospital?

**A** I did, yes.

**Q** Thank you. Could you just give us an outline of your career and roles since that point?

**A** Yes. So, in 1994, I qualified as a registered children's nurse, and I commenced my children's nursing career within what was then the Accident & Emergency at Yorkhill Hospital. That evolved over the years to be known as the Emergency Department, and I had a number of various roles through that period of time, from being a staff nurse to a senior staff nurse to then going on to be what was called an advanced emergency nurse practitioner where I worked for a number of years before then taking on nurse manager role in 2006. I continued in that role until 2014, and when I was appointed into a secondment role which was for maternity leave cover for a lead nurse still within Yorkhill Hospital. At that point, the areas that that covered were some of the inpatient areas, so I moved away from emergency care at that point in my career. I remained as a lead nurse within Yorkhill and was part of the transition over to the new hospital in 2015, and through that time, just because of the reconfiguration from Yorkhill to the new children's hospital, the remit within that position did change over the next couple of



years. By that, I mean the areas that I worked and were responsible for as a lead nurse. In July 2018, I changed roles from a nursing role into what's called a clinical service manager. At that point, you do not require to be a nurse to undertake that position. So, I remained in that role from July 2018 until November 2021, at which point I was appointed into my current role, which is General Manager.

**Q** Okay, thank you. So, would I be right in thinking that you now hold quite a senior managerial role within the organisation as General Manager?

**A** That's correct, yes.

**Q** Just to clarify, when you were clinical services manager, you reported into Mr Redfern. Is that right?

**A** That's correct, yes.

**Q** And you continue to report into Mr Redfern in his new role as Director?

**A** Yes, that's correct.

**Q** Okay, thank you. Now, just to clarify some of what you have said, because I know you have had quite a few different roles within the organisation. I just want to ask you a few more questions about your roles, specifically between 2015 and now, to help us understand your involvement in the relevant events. So, between

October 2015 and June 2018 you were lead nurse for Wards 2A, 2B and some other wards in the RHC. Is that right?

**A** Yes, that's correct.

**Q** Could you tell us what those other wards were?

**A** Yeah, so I had responsibility for Ward 1E, which is a 14-bedded cardiac ward, and I also had responsibility for the third floor. Within the third floor, at that point, the configuration was three wards. There was Ward 3A, which remains the same, which is a ward that looks after children with neurodisabilities, neurosurgery, long-term ventilation and complex airways. I also had Ward 3B, which is known as a general surgical ward, and that has children with childhood surgery issues as well as gastroenterology, cleft palate, ENT etc. Then Ward 3, at that point, was a combined ward that had both renal and orthopaedics and respiratory. That has subsequently been split into two wards now, but when I was lead nurse, it was a combined ward. Also, as part of my remit at that time, was the clinical nurse specialists, of which there was just under 100 nurses, and they were divided into teams, and the team leads for each of those specialties reported directly into myself.



**Q** Okay, thank you. I think you have just touched on it, but I just wanted to ask you what your role-- If you could outline your responsibilities as lead nurse. I think you indicate in your statement that you were not involved directly in clinical care at that time. So, could you tell us what your role involved?

**A** Yeah, so the lead nurse role is more of a leadership role. So, each ward has a senior charge nurse, and they are overall responsible for the management of their own ward. The senior charge nurses report up into a lead nurse. As such, the lead nurse then provides that overall leadership and guidance for that senior charge nurse in the role. So, we don't, therefore, work clinically. What I mean by that is we don't provide direct patient care to the patients in the ward, but we do give support into that ward. That would involve doing daily visits to your ward, ensuring that staff are supported at that time and, obviously, carrying out what we call "observation" – visits to ensure that we were happy with the standard of the ward and the environment.

**Q** So, you would have worked closely with the two senior charge nurses for Wards 2A and 2B at that time. Is that right?

**A** That's correct, yes.

**Q** Okay. Moving on now to think about your role between June 2018 and November 2021. I think, at that time, you were the clinical services manager for hospital paediatrics and neonates. Could you, first of all, explain what areas you covered in that role?

**A** Yeah. So, just for clarity, it was July 2018 that I took up the post, and the areas that I had as clinical service manager were ED, so Emergency Department, Clinical Decision Unit, Ward 2A/2B, which is Acute Receiving-- Sorry, Ward 2C, which is Acute Receiving. Ward 2A/2B, which is Haematology/Oncology and Day Care. I had the third floor, which was 3A, 3B, 3C, at this point. The ward has now split, and it's called 3C Ortho and 3C Renal. I had PICU theatres, and the three Neonatal units based at the Royal Hospital for Children, the Royal Alexander Hospital in Paisley and the Princess Royal Maternity in Glasgow Royal. I think that was all.

**Q** Okay, thank you. Could you outline your role and responsibilities as clinical services manager in comparison to your role as lead nurse?



**A** So, as I alluded to earlier, as-- Being a clinical service manager, you do not require to have a clinical background as such, so you-- Although it's a career progression for a number of nurses, it is also a role that doesn't need to be a nurse to undertake. So, I think it's important to note, at that time, I no longer required to be registered as a nurse to undertake this role. So, the responsibility is more of what we call an "operational" role, and we're responsible for operational delivery across all of the services. So, the lead nurses still report in from a line management structure to the clinical service manager, but we also had other direct reports as well that would report in that would maybe be waiting list managers, business managers etc. would also report into you as a clinical service manager.

**Q** Okay, thank you. After July 2018 – so when you have taken up your post as clinical services manager – I take it from what you said you would still have been aware of events on Wards 2A and 2B and then over into 6A and 4B. Is that correct?

**A** Yes, that's correct.

**Q** Finally, you were appointed as general manager in November 2021. Is that correct?

**A** Yeah, that's correct.

**Q** Could you outline your role now?

**A** Yeah. So, as general manager, I have more overall responsibility for all of the Royal Hospital of Children and the three neonatal units from a service delivery. So, my role is to ensure that the service is delivered, to ensure that we achieve targets that were set either locally by our own board or by Scottish Government, and by that I mean ED performance targets, our waiting list targets, and so that's part of the role. We have financial responsibility to ensure that we adhere to our financial budget and that we ensure that our budgets are met, and I also have responsibility for both a non-pay budget and a pay budget and, generally, I'm responsible-- I line manage both of the clinical service managers.

**Q** I think you say in your statement that part of your role is "delivery of a range of high quality, safe and efficient patient-centred services." Is that right?

**A** Yes, that's correct.

**Q** Okay. In terms of monitoring infection and responding to concerns around that, what responsibility do you have now?



**A** So, I would be notified in the same way as the chief nurse would be notified. If there is a IMT – an Incident Management Team meeting – called, then I would equally be invited along with the clinical team, the nursing team and also the clinical service manager for that area.

**Q** So, you would be aware of any concerns----

**A** Yes, I would.

**Q** -- about the safety of the environment or infection now? Okay, thank you. Now, moving on, we have heard a lot of evidence over the last couple of weeks about Wards 2A and 2B in the RHC. You have mentioned involvement in some of the other wards, so I am going to ask you a couple of questions about those other areas. Now, you mentioned Wards 3A, B and C as well as 1E. Do any of these wards house immunocompromised patients?

**A** They can at times. The normal pathway would be into Haematology/Oncology but, at times, children who have these underlying conditions may also have another condition that requires admission into a ward that's not necessarily for that specialty at that time and, therefore, the children could be nursed. So, for instance, if they were coming in for a

procedure that was non-related to their treatment that they were undertaking, then they would be managed correctly in that ward for that environment. There is also, at times, when Ward 2A/2B might be at full capacity and, therefore, we have to ensure that the children are admitted elsewhere in the hospital, and we would ensure that we had what we call "satellite support" from the Haematology/Oncology clinical team as well as the nursing team, and measures are put in place to ensure that nurses would be there to support the ward nurses of that area to support them at that time but, yes, they could come into other areas.

**Q** Okay, I think you have just touched on what my next question was going to be, which was how the risk of infection to Schiehallian unit patients is managed when they are housed outwith that unit.

**A** So, we put in similar measures as they would have within the Haematology/Oncology ward. So, the configuration of our inpatient wards is still cubicles within our inpatient areas. We do have a four-bed bay in each of our wards which-- Ward 2A, being the inpatient ward, would be what I'm referring to here-- does not have in it single cubicles. So, we would ensure that a Haematology/



Oncology patient was nursed in a single cubicle. We do have what we call our-- Areas that have, like, our ante-cubicle. The same-- so your-- high-- Sorry, your-- Sorry.

**Q** That is all right. When you say "ante-cubicle," are you talking about the room that has got a lobby?

**A** Your cubicle before you go into the cubicle. We do have them. We have two of them in each of the third floor room. One is negative pressure is down in 2C, and the rest of the wards have these rooms. So, we would ensure that a Haematology/Oncology patient was in one of the areas and, if required, then we would also have a portable HEPA filter could be put into the rooms if the room doesn't have a HEPA filter in place, which the ante-cubicle rooms all do.

**Q** So, just to unpick some of that. So, some of the rooms that have the lobby rooms that go in, so that-- I think you have described them as "ante-cubicles." Those have specialist ventilation?

**A** They do, and they would have HEPA filters in place. So they would be the room----

**Q** Portable HEPA filters or built-in?

**A** No, they would be built-in, and so that would be your room of choice.

**Q** And if the room of choice is not available?

**A** Then it would have to be a normal cubicle, which is very rare. We would make measures to ensure that a room of that quality was available, maybe by having to move other patients that maybe don't require to be in that room because of their clinical needs, we would move that patient out to accommodate a Haematology/Oncology patient.

**Q** I think you also mentioned provision of satellite support. Is that in relation to the nursing care?

**A** Yes, as well as the medical team as well. So, the medical team would obviously still visit the child and undertake their ward rounds and give support to the staff within the ward but, from a nursing point of view, we would ensure-- So, at times, children who have got underlying Haematology/Oncology conditions will require drug therapy that maybe the ward nurses-- I refer to ward nurses as the nurses in the, maybe, generic surgical ward, for example, may not have skillsets in, so they wouldn't be used to delivering that, and they wouldn't be trained in that area. So, therefore, the nurse from 2A would be asked to be moved on-shift, and they would then provide direct patient care to the haematology/oncology patient and the ward if they were outwith their own environment. The same would be said if the patient was in their PICU; they would give support out as well.

**Q** We have heard some evidence about, I think, protocols that are in place for the Schiehallion patients, and I think those can be accessed by staff on the other wards. Is that right?

**A** Absolutely, yes.

**Q** We heard some evidence from patients and families that their impression, at least, was that those protocols were not always followed to the letter when their children were housed outwith the Schiehallion unit. Is that something you are aware of?

**A** Not that I'm aware of, no.

**Q** There is no possibility that there could ever be any slips from the protocols when patients are housed outwith that?

**A** That's something that has never been brought to my attention.

**Q** Okay. I am going to move on now and think about your first

impressions of the Royal Hospital for Children back in 2015. That is something you talked about in your statement. I would be quite interested to hear you describe your impressions of when it first opened.

**A** So, Yorkhill was a wonderful hospital. It had been a hospital that I had worked the majority of my career in, but it was an old building, and we had adapted as much as we could possibly adapt at that time. So, to have the opportunity to move to a brand-new hospital was very exciting. It also was built with children and young people in mind. So, the atrium when you entered the hospital was very bright. It was airy. It was very colourful and, at times, staff and patients have described as if they're walking into the Science Centre rather than coming into a hospital. Therefore, the environment just didn't feel as clinical as what I was anticipating when we arrived. So it was a very exciting time to move in. We also, as I alluded to earlier, had adopted a model of single cubicles on the whole within the ward areas, and this was something that we didn't have in Yorkhill. In Yorkhill, our wards only had eight cubicles. We, therefore, had parents having to share open space that was very constricted in space, and they were also all having to sleep beside their child and also within the eight-bed or six-bed area. So, for the parents to be able to stay with their child in a comfortable environment--

We did a lot of research on the parent beds. Previously, we had a, sort of, pull down Z bed-type bed, and we used to get a lot of comments that it wasn't very comfortable. It was very narrow. It was a camp bed as such. So we wanted to ensure that the parents had a facility that was as comfortable as we possibly could make it. They also, the rooms, all had en suite facilities. Again, that was something that the parents didn't have in Yorkhill; you used to arrive on shift in the morning, and there would be a couple of showers on each floor, and there would be a line of parents waiting to take a shower. That was just so lovely to be able to give the parents the opportunity that they had their own privacy within that area.

So, it was light. It was airy. It was bright. The facilities that we had with regards to the additional facilities that were in-- So, Ward 3A, as alluded to, has children with a lot of neurodisabilities, and we were able to build a Snoezelen, which was an area for children with special needs that enhances their recovery times. That

was something we didn't have in Yorkhill. Although we had a MediCinema in Yorkhill, it would be fair to say that this just blew us all away for what the MediCinema then looked like. It was like going to the cinema from the time that you entered the area, and that was exciting. It also had an area within the MediCinema where we could bring children in beds that we hadn't been able to do previously, so it had been carefully thought out of. Then we also had incorporated what we call "Zone 12," which was a teenage area, and that also had kitchen facilities so the young people could get together and make their own snacks and have that ability as well. So it was a lovely new shiny building that we got to go into. So it was very exciting to move.

**Q** Thank you. You also say in your statement that you felt that, in the comparison to Yorkhill, the medical equipment itself would be better in the new hospital. Is that right?

**A** Yeah, so, what I had alluded to in my statement from that was-- So, taking back a step to where I was in my career for the new hospital, I was still within the Emergency Department and, therefore, I was very involved in the design and the layout of the



Emergency Department. We had the ability to design what's called a "resuscitation area," and, therefore, we were able to get the same spec of equipment that was simulated in our Intensive Care Unit that we hadn't had at Yorkhill. So, there was a definite upgrade of a medical equipment within the areas. Also, within the ward areas, we used to, at times, have to split oxygen pipes because we didn't have enough oxygen and you had to put a splitter on. We had we had enough oxygen supply. We had suction supply that was just-- meant that it was much more assessable. We had equipment previously that, in the cubicles, you had to have your-- so a saturation monitor is where you're measuring the child saturation rate. They had to be collated outside the room, and the cable went through a hole in the wall so we could observe it. We moved to what's called "central monitoring system" in the new hospital. So that meant that we had-- That no longer required to have to be in place, which just felt a lot safer than it had done at Yorkhill.

**Q** Okay, thank you. The Inquiry has heard a lot of evidence about the sequence of events in the Royal Hospital for Children since 2015, and I do not need to go through all of

that with you. What I would like to do is take you through some key events and clarify a few points in your statement as we go along. After we have done that, I am going to pick up on some of the key themes that have arisen. Does that sound okay?

**A** Yeah.

**Q** Okay. So, thinking back to 2016 and 2017, we heard evidence yesterday from Ms Rogers about an increase in line infections and something called the CLABSI Quality Improvement Project. Now, is that something you recall?

**A** I do, yes.

**Q** Okay. You say in your statement that you witnessed an upsurge in positive central line cultures in Haemato-oncology patients, I think, since July 2016. Is that right?

**A** That's correct.

**Q** Okay, and, moving on from that, in March 2018 we have heard evidence that an IMT was established because of concerns about infections on Ward 2A and that the IMT's hypothesis came to be that the water supply may be contaminated. Do you recall that?

**A** I do.

**Q** Now, your statement contains some quite good detail about the control measures that were put in place in March 2018 due to the concerns about the water supply. Could you tell us more about those control measures?

**A** Is that referring to when we started to put in the filters onto the taps?

**Q** I think you mentioned in your statement there were filters on taps, but you also talk about a particular weekend where there were portable sinks brought in and bottled water was in use.

**A** So, our initial part was there was filters put on the sinks. Prior to that, there was-- and it was a decision that would be taken by the microbiologist leading the IMT at the time. That was felt that we should look to bring in what was called "portable hand washing facilities," and these were portable sinks, to speak, that were brought into Ward 2A. Initially, they were to be put in every cubicle. It would be fair to say that this was not normal practice for us. That was not something we had done previously. The actual collating of the equipment was challenging for the Facilities team. Therefore, we did get a supply in, and it did take over the weekend until we were able to put one in every area throughout the ward.

**Q** I think you say in your statement that, in fact, Facilities had to source the portable sinks from multiple different suppliers.

**A** That's correct. We had used them previously, or I had used them previously when we'd had, sort of, water supply issues, as in from business continuity planning point of view, and that was more in a trough-style sink. So, we did have that sort of facility within the Queen Elizabeth campus site but, due to the volume of sinks that we required, we had to outsource to other companies. So, it did take time to get the correct number of sinks in place.

**Q** Just picking up on what you just said there, what were the water supply issues that you'd had prior to that?

**A** No, that would just be for contingency business planning. If your water had to go off-- That hadn't happened. Well, I wasn't aware of it happening in the Queen Elizabeth campus site.

**Q** Okay, so it was a plan that was in place?

**A** Previously, in Yorkhill, we'd had a water shutdown where our water supply had stopped and we'd had to bring sinks in, so I had been aware of them when they'd come into



ED at that point, but that had been a number of years previously to the move.

**Q** I think you say in your statement that Facilities had to demonstrate to the nursing staff how to use the sinks, and the nursing staff then had to demonstrate to families how to use the sinks. Is that right?

**A** That's correct.

**Q** Okay. Before we move on, there is just part of your statement I would like to clarify, and it relates to the impacts of these control measures and, in particular what you have just told us about. Mr Castell, I wonder if we could turn up paragraphs 221 and 222 of the statement, please. If you can maybe enlarge that and, Ms Hutton, if you just take a moment just to familiarise yourself with those two paragraphs and let me know when you have done that.

**A** Is it 221 and-- what was the other one?

**Q** 221, and then Mr Castell will move the page forward to 222. Mr Castell, if you just move the page down, that would be great. Thank you.

**A** Yeah, so this was regards the installation of the portable sinks.

**Q** Yes. You say at paragraph 221 that the effect of the

portable hand basins-- I think it resulted in some staff anxiety. At paragraph 222, you say the measures also "had an impact for the patients." Then you go on to say – it is about halfway down that paragraph:

> "I am not aware of any family member raising this as a concern and nobody raised it as a concern with me directly. I think that was the perception of staff."

Could you just explain what you mean by that?

**A** Yep. So, I was aware that the staff were anxious about how they were going to, sort of, explain to the families why we were using them and also how to use them. It would be fair to say that these came in various sizes, and they came in various ways that they worked. So, there was foot pumps. There was other handles that you used. Some of the sinks were smaller than the others, and each sink didn't look the same. So, there was anxiety with the staff on how you would wash your hands, how you would ensure that there was correct hand hygiene taking place. There was concern that-- how would we be able to control the water? With the water, normally, you've got a valve so you control hot water and cold water.



Would the water be too hot? Would the water be too cold? So there was that anxiety amongst the staff on how that would work. What I mean by this comment was I wasn't-- I think I must have been asked, "Was I aware of a family member raising a concern?" and I wasn't. Nobody directly raised that to me myself, but I was aware that the staff felt that the parents would be concerned about having to use portable sinks.

**Q** Okay. Mr Castell, could you turn up paragraph 150 of the statement, please? There is just something I just want to clarify, Ms Hutton, on that. Now, I think, at this point in your statement, you are talking about communication around this time. So, the events in March 2018. You say here that you do recall one incident where you met with a parent, along with Mr Redfern, and the parent asked why portable sinks were brought in and why they were to drink bottled water. Is that right?

**A** That's correct. So, that was after the parent had contacted the senior charge nurse, and they had asked to speak to what they referred to as the "senior management team," of which that would have been Mr Redfern. He asked me to accompany him to speak to the parent, so that was

the first time that I was aware there had been a parental concern but, as I said earlier in my statement, it wasn't directed to me at that time by the parent. It was more that the parent then asked to meet with us after.

**Q** Okay, so just to clarify, there were concerns being raised by parents, or was at least this one concern that was raised?

**A** This one parent in particular, yes, did raise a concern and----

**Q** And it was escalated.

**A** Yes.

**Q** Just thinking back to that meeting, do you recall what you and Mr Redfern said to the parent about why these measures have been put in place?

**A** No, I don't, sorry.

**Q** Thinking, then, about what your awareness at the time was about why they were put in place, what are you likely to have said?

**A** We were likely to, at the time of the sinks going in-- I don't recall the conversation, so it would be hard for me to give a correct interpretation of what was or wasn't said, but I'm assuming we would have given assurance as to why we put the sinks in and that there was concerns at that point with the water supply, and



therefore we were looking at this as an alternative measure until we undertook further investigations.

**Q** Okay, thank you. I want to ask you a few questions now about water control measures outwith Wards 2A and 2B and I wonder if we might turn up, Mr Castell, paragraphs 151 to 153 of the statement. Thank you. Miss Hutton, if you just take a moment, we will just scroll through these just to refresh your memory on what you have said here.

**A** Yeah, so this was noted through the minutes of an IMT and, as I said previously, the role is, as a lead nurse, we would visit all our clinical areas on a daily basis, and it had just so happened on this day I had been in 3A prior to going to the IMT meeting. When I was in the four-bed bay of that ward, I noted that one of the taps did not have a filter in place so, therefore, at the meeting-- because I took the opportunity to discuss with the head of Estates, at that time, that I had visibly noticed that that wasn't in place and asked that it be rectified immediately and which it was done. In fact, I do remember, we communicated very frequently with our colleagues using DECT phones – we still do – and I remember at that time that, when I raised it, it was actually going into the

meeting that he automatically used his phone to phone his staff and ask for them to ensure that they went up to 3A and fitted a filter.

**Q** Okay, thank you. So, just to backtrack slightly on that. I think the minute you referred to is an IMT minute dated 21 March 2018. We do not need to pull that up. We have looked at it before in the context of this hearing. Would I be right in thinking, by that point in time, the control measures included installation of filters in other areas?

**A** Yes, that's correct.

**Q** So in what other areas were they installed?

**A** We fitted it on every area at that point.

**Q** So throughout the hospital?

**A** They were throughout the hospital on every tap except the-- I'm unclear of whether they were fitted in the Neonatal Unit at that stage. It had a different water supply, but I'm aware throughout the Royal Hospital for Children every tap had a filter fitted.

**Q** Okay, thank you. That is helpful, and I think you have said there that on a walk round you noticed that one had not been, you raised it, and it was very swiftly dealt with.

**A** It was.

**Q** Can you recall whether there was concern on the other wards about the issues to do with the water supply?

**A** I think there wasn't-- I think it'd be fair to say there wasn't the same awareness as what there was of the staff in 2A and 2B and that's mainly because they were the people-- they were the staff group that were involved in the IMTs but also were getting involved in the communication, but there was an awareness amongst the other staff that there was a concern of the water at that time.

**Q** How was the concern about the water supply communicated to staff on the other wards?

**A** So, in the same format of the communication with 2A/2B, we would update them through myself as lead nurse speaking to the senior charge nurses. It was also updated through different formats of meetings that we had within the hospital. So, we had an inpatient operational group that met, so it would be raised through that format. It would be raised through the senior charge nurse meetings, heads of service meetings. It would just be noted through these formats.

**Q** We have heard some evidence over the last couple of weeks about the cascading of information. Is that really what you are referring to,

information being cascaded through various meetings?

**A** Yeah, absolutely, and equally if there was any information that would come out through an email cascade and then it would be cascaded down through. It's always cascaded to your heads of departments, senior charge nurses.

**Q** And do you know what was communicated to patients and families on these other wards about the water supply?

**A** I don't, sorry.

**Q** Okay, moving onto May and June 2018. We have heard evidence that another IMT was established, and I think this time the hypothesis was related to problems with the drains. More control measures were put in place, and in your statement you provide a good description of the HPV cleaning process. I would like to look at that in a little more detail if I may. Mr Castell, could we turn up paragraphs 168 to 169, please? Miss Hutton, if you just take a moment just to refresh your memory of those. Thank you.

Mr Castell, I wonder if we could go back up to paragraph 168. Thank you. I am sorry, it is split across the page which is a bit awkward. Now, in this paragraph you talk about the



process of HPV cleaning on the ward, and I think you talk here about the process of having to move families from room to room. Could you tell us a bit more about that please?

**A** Yeah. So, at that point of the HPV cleaning being carried out, this was the first time that we'd undertaken this cleaning method. It has evolved over the years and the process now is different to this process. So, in order for the room to be cleaned the room had to be empty, and therefore that involved the patients having to be moved from their existing cubicle into what we called a clean cubicle. So, we had empty rooms on the ward. We prioritised them to be cleaned first, and therefore we meant that if a patient was moved, they were moved into a clean room rather than-- I wouldn't call it a dirty room, but a room that hadn't undertaken HPV cleaning. So that did involve a move for the families and the parents. At times, some of the families were fine to remain in the room they were moved to, and others were requested to return to the room that they had been in previously. So we then had to then clean the room and then, once it was deemed the process had completed, we then moved the family back which then resulted in the room that we had

then vacated requiring to be further cleaned.

**Q** Okay, it sounds like quite a disruptive process potentially for the families. Is that right?

**A** It was a disruptive process.

**Q** We do not need to turn it up, but you do talk about that issue of families wanting to go back to their original room further on in your statement, and the reference for that is 181, but we do not need to look at it. Why do you think it was some patients and families wanted to go back to their original rooms?

**A** I think they just-- So, when a lot of these families come into the ward, especially within Haematology/Oncology, their length of stay can be quite a long period of stay and some of these families can be with us for a number of months. Therefore, their room becomes their home, and they become comfortable in the room that they're in. It might be that they like where it's positioned in the ward. It might be that they like what their outlook is from the window, etc. I suppose, I can only surmise, but I assume they're comforted by the room that they were in, so therefore we looked to accommodate that to ensure they went back to the room that they wished to return to.



**Q** We heard evidence yesterday from Ms Rodgers that June 2018, when this particular procedure was happening, was a very difficult time, I think, for staff and patients and families. Does that accord with your recollection?

**A** Yeah, that's correct.

**Q** Mr Castell, there is just one last paragraph I would like to look at on the statement on this topic and it is paragraph 171. Thank you. Miss Hutton, if you just take a moment to look at that. Thank you. I just want to clarify the timeframe that you are talking about here. You are still talking here about HPV cleaning?

**A** I am, but this isn't June '18. This is now much further down the journey that, since undertaking HPV cleaning in 2A/2B, we have now-- it's now standard practice within what we call all our high-risk areas. So, we have a rolling programme now with Estates and Facilities where all our high-risk areas undergo HPV cleaning, and we also use that timeframe to allow for what we call our vent cleaning to be done at the same time because that also can be disruptive because you have to close the room off to do it. So we do it as a scheduled, sort of, process together and we undertake that every 6 months

in 2A/2B, our PICU and our three neonatal units.

**Q** Okay, and we will come back just to touch on the ventilation cleaning towards the end of your evidence, but I just want to clarify then that, at paragraph 171, when you talk about a decision to apply HPV cleaning to the PICU and the NICU, that is at a later point in time. I think you mentioned it is after the chair of the IMT changed from Dr Inkster so that would place us later on in 2019.

**A** That's correct. Sorry, yes, that is referring to that time.

**Q** No, that is helpful, thank you. So, just moving forward in time, by September 2018, you are the clinical services manager, I think.

**A** Yes.

**Q** Okay, and I think you say in your statement you are actually on annual leave when the decant happens.

**A** That is correct.

**Q** Now, you say there was no indication of the decant before you went off. You are off for two and a half weeks and, by the time you come back, it has happened.

**A** That's correct. They had moved the day prior to my return.

**Q** How did you feel about that when you came back?



**A** I was a bit-- not-- shocked is maybe a bit strong, but I was a little bit like-- I wasn't expecting it. I wasn't expecting to return and the ward not to be where the ward was.

**Q** Moving forward again in time, we have heard evidence about events on Ward 6A and 4B during 2019 and their impact. I do not propose to go over that in detail with you, but I might just ask you this: did the events in 2019 cause you any concerns or pose any challenges, thinking about your role as clinical services manager?

**A** Can I ask for clarification on what events you're alluding to in 2019?

**Q** So, we know that in early 2019 there were concerns about air quality and fungal growth discovered. We know there was a decant to CDU, I think, at the end of January 2019 and into February. We know there was a further concern about gram-negative bacteria in the summer of 2019. We know that Ward 6A was closed to new admissions come, I think, about August 2019. Then, eventually, the ward reopens in November 2019. So, in terms of your role as clinical services manager during that time, did that pose any challenge to you?

**A** It did in the fact that, during

that time, as well we had the-- So, I was the clinical service manager for the inpatient areas. I think my colleague was still there at that point, but I had taken-- when the decant had started, we had obviously commenced the work to undertake a refurbishment of Ward 2A and 2B, and therefore the decision had been taken that, due to the fact that I undertook an operational role and Mr Redfern also had a service operational role as well, that he would continue with the IMT aspect and continue with what we refer to as the decant work, and that I would focus purely on the move back for the refurbishment in 2A. So I was still aware of it and still involved in supporting the team, but I was much more distant than I had been previously.

**Q** Okay. Were you aware of any staffing or resourcing issues during that period as a result of the ward being split over two different areas?

**A** I was aware of the challenges that we had with regards to that we had to make sure that we uplifted our staff, but I was aware that-- working closely with the lead nurses at that point, because somebody had subsequently took my role, as such, as a lead nurse, but I still directly



managed that person, that the mitigations of risk that they had taken along with the support of the chief nurse, Ms Rodgers at that time, to ensure that the numbers of staffing were adequate for the split across the area and especially with the ward being split between 4B and 6A and subsequently during the time of the decant from 6A to CDU and then from CDU back to 6A. So, I am aware that the measures were put in place to mitigate that risk.

**Q** So, just to sum up, and we heard evidence about this from Ms Rodgers yesterday, the staffing and resourcing issues was identified as a risk at that point, but mitigations were put in place.

**A** That’s correct.

**Q** Okay. We will come on to talk about your involvement in the Project Board, which you have mentioned but, in order just to finish off the chronology, am I right in thinking you were promoted to general manager in November 2021, patients moved back to the refurbished ward in March 2022.

**A** That’s correct.

**Q** Okay. We will come on to talk about that, but first there are a couple of standalone matters in your statement that I would like to explore

further with you. You set out some useful evidence about the monitoring of infections in your statement. I want to clarify a few things about that. I think it might be helpful just to turn up the part of your statement where you talk about that. Mr Castell, could we turn up paragraphs 99 to 102, please. Thank you. If you just leave it there. Miss Hutton, if you just have a look at that and remind yourself. Okay, thank you. Mr Castell, if you take it back up to paragraph 99, please. Now, looking at this paragraph, you start by describing the process that follows if a clinician suspects a child may have an infection. Now, you say if there is a concern about an infection, a blood sample is sent to the lab. Is that correct?

**A** That's correct.

**Q** Okay. Is that the laboratory on the campus or is it elsewhere?

**A** No, it's on the campus site.

**Q** Separate building?

**A** Separate building. It's adjacent to the children's hospital.

**Q** Okay. The lab analyses the result and sends it back. Is that right?

**A** That's correct. Well, they would analyse the result of the blood sample and then they would produce



the result of the findings.

**Q** Is the work in the laboratory done by microbiologists or clinical scientists?

**A** I'm unclear. I would assume it's microbiologists but there's also-- I would be unfair to the profession to comment on what all the titles are, but there's a number of different professionals who would review depending on what the sample was for.

**Q** You say in that paragraph, I think, that clinicians receive an automatic notification that the result is back. How does the automatic notification work?

**A** So, the result is uploaded onto Track Care, which is a portal platform. It's an IT process and the clinician would then basically log into Track Care, go onto the child's case note record and then a part of that process-- There is a, sort of, icon to click on that would give you all the blood results and that would be where the results would be found.

**Q** Okay, sorry, that is called Track Care?

**A** It's the NHS IT system that we use, and then there's also a portal element that the results would be uploaded onto, a portal as well which is clinical portal.

**Q** So, the portal is separate from Track Care?

**A** They're both linked but they are a separate process. You could go in via either area but Track Care is probably the easiest format to use.

**Q** Okay, and would that rely on the clinician actively going and logging into that system to find out what the result was?

**A** It would, but if there any cause for concern from the labs, as I've alluded to in my statement, it would be an automatic trigger for, usually, the microbiologist or the lead nurse for Infection Control to contact the clinician direct.

**Q** You talk about this at paragraph 100 of your statement, and I wonder actually, Mr Castell, if you could just put that paragraph up, please. That is helpful, thank you. I think you say here-- you talk about an abnormal result. I wonder if you could just explain what you mean by that.

**A** So, abnormal would be anything that would cause any concern. So, the result shows anything that has maybe grown, any bacteria that has grown in the sample, that there would be any concern regarding.

**Q** So, effectively what you are referring to here, do you mean a



positive culture of any kind?

**A** Yes.

**Q** Not infections of particular concern, just a positive result?

**A** I think what I'm referring to here is anything that there would be a particular concern about and there are samples that would come back that would be, probably, what would be expected to come back so that might just be automatically triggered, but I'm not the correct person to talk about this in that much detail. It's not my area of expertise, but what I'm alluding to in my statement is, if there was anything that was causing immediate concern from the microbiologist, that would be raised immediately.

**Q** Just from your experience in nursing, what is the sort of thing that might cause concern above and beyond the normal?

**A** So, any bacteria that they wouldn't normally be expecting to be triggered.

**Q** Okay, we have heard some evidence in the Inquiry about a system called ICNet. Do you know what that is?

**A** No, I don't.

**Q** So, that is a separate system to the portal and to Track Care.

**A** Okay.

**Q** Okay. When you say in

here that the information is triggered to the lead nurse, what do you mean by "triggered"?

**A** So, it would just be alerted by the lab so the lead nurse would be notified of it, so it was usually by a phone call.

**Q** Then I think, actually, you go on to talk about this in paragraph 101 and I wonder if we could just scroll onto that. I think we have probably got most, if not all, of it there. You say the information, if there is a trigger about something of concern, it is then cascaded to the appropriate people. I think you mentioned here clinical lead, clinical director, the lead nurse, and the senior charge nurse for the area. Is that right?

**A** Yeah, and I should have also stated the child's own consultant would also be notified.

**Q** What would the clinical director do with that sort of information?

**A** It's just more for awareness that they would be notified and aware of it as well.

**Q** Okay, thank you, that is helpful. Then you say in your statement, I think, that from there a PAG may be triggered, and from there an IMT might be triggered, depending on the circumstances.



On the subject of IMTs, there is one aspect of the IMT that we have not heard much about yet, but you reference in your statement, and I just wonder if you can help us understand it a bit better. Mr Castell, could you turn up paragraph 135, please? Miss Hutton, if you just read through that paragraph to remind yourself of it. Thank you. Now, I anticipate that you may not be the best person to tell us about the HIIAT scoring system, but you have mentioned it in your statement. I just want to ask you a couple of questions about it. Can you tell us what its purpose is?

**A** So, the HIIAT, it's an instant assessment tool and its purpose is to what we call "RAG score" the situation or the incident. By RAG, I mean that it's either scored as red, amber, or green, and that would trigger it to be a minor, moderate or-- I think it's major is the third category. Within that we score on different topics, so it's on patient condition-- sorry, I'll probably need to reference it.

**Q** I can probably help you with that. I was going to ask Mr Castell to turn up just an example of an IMT minute, and it is the minute of 1 August 2019. It should be at-- if we turn firstly to-- it is bundle 1, page 334, just so we can see what the document

is. I think this is an IMT that, if you look at the attendees, you were actually at, but this is just an example. Then, Mr Castell, if you could turn to page 336, please. If you scroll down, we will see reference to the HIIAT, and is that the four things you are talking about?

**A** Thank you, that is helpful. Yes, so we would score it on the severity of the illness and that's with regard to the patient, the impact that it would have on the service, the risk of transmission, and that's across the patient group. Then we also score on public anxiety, and what that's demonstrating there was the elements of each component of that in the HIIAT and how it was scored. It's an automatic trigger to be a red if any of the four components score a major.

**Q** Okay. So, just to be clear about what you have just said, there are four components to that which are set out there. So, severity of illness, services, risk of transmission, public anxiety. Each of those can be scored as minor, moderate, or major.

**A** That's correct.

**Q** Then you look at the overall, and you get to a red, amber, or green rating, but I think what you have just indicated is that, if there is any major within those four, it is an



automatic red.

**A** It is an automatic to be scored at red.

**Q** That is very helpful, and I am sure we will hear more evidence about that from others. The thing that you do talk about in your statement is how that process of scoring actually works practically in the context of an IMT meeting. I wonder if you could just tell us about that.

**A** So, the meeting is chaired by the chair who is the microbiologist and, when we come to the HIIAT, the HIIAT scoring occurs at the end of the meeting. So, because of the size of the team that was involved in these IMTs, we had printed out cards, so that was just the scoring system of the HIAT, and they would be on the table, and that's what I refer to as being laminated on the table. So, each individual was then given one of these cards as an aide-mémoire. Then each element of the scoring, so the severity of the illness on the patient, that was led usually by the child's consultant or the clinician that was in the IMT. Then the impact of service would be discussed, and then the risk of transmission would be discussed, and then we would also discuss what that would be for public anxiety.

At that point, the consensus of

the membership of the meeting is taken and that can result in discussion amongst the group. Some may think that it's a moderate versus a major and others, and everybody would be allowed their voice and their opinion on that matter and then a consensus of the overall of the management team-- I mean the incident management team group would then be agreed. The chair would then say that we are agreeing, for instance, the severity of illness, in this case, is major and at that point they ask for the consensus of the whole team that they are in agreement with that scoring. Then, from that, we agree as a team what the end score will be. There is further clarification once it has scored the outcome whether it's red, amber, or green that the incident management team, as in the group, is all happy with what is scored. Then, once that's agreed, that's when it's finally agreed that that will be the score that we will end that meeting on.

**Q** Okay, thank you. I just wanted to ask a couple of things about what you have said. I think you indicate in your statement when you talk about the laminated cards that there were-- are you indicating there are coloured cards that are held up?

**A** No, so that was a copy of the HIIAT tool, so they just laminated the tool. So, it was for ease of reference and so that we were all sighted on the same document at the same time.

**Q** So you can see the categories of scoring?

**A** Yeah, so it's a sort of tool, aide-mémoire, and it's got your scoring down one side and your four categories along the other and then you score what it should be. So it's a sort of risk assessment tool, I suppose, would be the way to describe it.

**Q** Just thinking about that meeting that we have looked at, I counted 23 people in the attendees at that, and I think you do say in your statement that, as IMTs progressed, the membership grew. Is that right?

**A** That's correct, yes.

**Q** And thinking about, you know, you have got 23 people around a table, presumably, at that point.

**A** We were.

**Q** Would each person be asked to score each part of the HIIAT tool?

**A** They would be welcomed their opinion on it at times. So, for instance, with regards to severity of illness within that forum, you would have Estate colleagues and Facility colleagues. So, they wouldn't have a

clinical opinion on the child so they may not vocally say what their feeling was. We were very much guided by the clinical team on that element, but if they did have an opinion then, yes, they would be able to put that forward and they would be listened to, but normally they wouldn't speak on that kind of element as well as risk of transmission.

**Q** So, it is not a case of going round every single person four times. The questions would be put to those who have particular expertise depending on the category, but I think I understood you to indicate that, when it came to the overall red, amber, green score, there would be a vote of some kind.

**A** So, there's a sense check, so what happens is the chair will go through the four elements and then, from that, they would say, "That would take our HIIAT score to be, in this instance, a red. Is there any objections to this being scored as a red?" At that point, everybody had an opportunity to object or agree with what was scored.

**Q** And what happened if there was disagreement?

**A** I'm not really aware of an incident where we completely disagreed, but we would have the



opportunity for further discussion and for people to have if they had-- I'm assuming, if they disagreed with what the final score was, they would be looking for more questions and answers to their questions, so they'd be given the opportunity to ask further questions and get further clarification, but I'm not aware-- I'm aware of discussion taking place and, at times, we had lengthy debates regarding, particularly, maybe, the impact it would have on service or whether this public anxiety-- where it would be scoring at that level, but I was never aware of a time where we all disagreed with the outcome.

**Q** Okay. What happens once there is a score reached?

**A** So, that forms the report. At that point, that's over to the Infection Control team, and they then complete the HIIAT-- I assume it's paperwork. Then that's sent onto your Chair for accuracy. At that point, we also sent a copy to HPS as an outcome of the meeting, and then that would go on record that that was what the HIIAT was scored at for that meeting.

**Q** When you say "the Chair," that is the Chair of the IMT. So the paperwork is sent to the Chair of

the IMT, and then that is forwarded on externally.

**A** Yeah.

**Q** Okay, thank you. That is very helpful. I want to move on just to clarify briefly some observations you make about communication during this period, so that is really 2018 and 2019. Mr Castell, could we turn up paragraphs 213 and 214, please? Thank you. If you just take a moment to look at those two paragraphs.

**A** Sorry, could you remind me of the numbers again? Sorry.

**Q** Sorry, it is 213 and 214.

**A** Thank you.

**Q** Okay?

**A** Yeah.

**Q** Right. So, at paragraph 213 you start off by saying that you thought "communication was managed very well." You say you felt decisions from these meetings – and I think you are referring to the IMT meetings there----

**A** I am.

**Q** -- were cascaded immediately. "There was both written and verbal communication." Then, "The General Manager and Chief Nurse were in the wards more than once a week to pass communications on to parents." Could you confirm



what timeframe you are describing here?

**A** Do you mean what--

**Q** Are you talking about 2018 in Wards 2A and 2B, or the period in 6A and 4B in 2019?

**A** I would probably be referring to both timeframes here. I felt the communication was well. I was more heavily involved in 2018 in the IMTs than I was in 2019, but I would think I would be referring to the whole process that the communication was managed well.

**Q** Okay. So, in your view, communication was managed well right from the beginning in March 2018?

**A** I feel that, yeah, the communication was cascaded.

**Q** If we look at paragraph 214, you say:

> "At Board level, Jennifer Armstrong, our Director of Medicine, Jane Grant, our Chief Executive, and Professor Margaret McGuire, our Nurse Director, had an open question session with families and parents, and that they were available to speak to them if they required."

Again, can you remember what timeframe you are talking about there?

**A** I can't remember definitively when it was. I'm just aware that there was a meeting scheduled and that the families were invited to meet with them.

**Q** There is currently no evidence before the Inquiry of a meeting between those individuals and parents in 2019, so I wonder if you are thinking about a time in 2019 (sic). Is that possible?

**A** It's possible, yes.

**Q** Okay, Mr Castell, could you turn up paragraphs 205 and 206, please? Thank you, and Ms Hutton, if you just take a moment to look at them. Now, these paragraphs come under the heading, "COMMUNICATION RELATING TO WATER CONCERNS," so I take you to be talking, here, about March 2018 and, indeed, at paragraph 205 you say you are talking about the very beginning stage. Okay?

**A** Yep.

**Q** So, you say here:

> "Because the IMT was not aware of whether there was or was not an issue with the water, it was not sure what the communication to families should be."

Then, at 206, you say:

> "As the IMTs evolved, communications were routinely issued to families either verbally or in written format, and holding statements were regularly created for the press."

So, just to clarify these paragraphs, is it your position that communication changed as the IMTs evolved?

**A** Yes, I do believe it did. So, in referring to what I spoke about previously, I felt that the communication to staff at that point was very good. To families, I think it would be fair to say, in March 2018, we were unsure of what information we were going to give because I think it'd be fair to say we were unsure of what was actually the issue, if there was an issue, with the water at that time. Then, as it evolved, the communication, I would think, got better to the families as we had more information to give.

**Q** Just to help you, the evidence of Mr Redfern was that communication improved somewhat when the wards moved over to 6A and 4B. His position was that the organisation learned from challenges it had faced in 2018 and altered its approach to communication in 2019. Would you agree with that?

**A** Yeah, I would agree with that.

**Q** Ms Hutton, I want to turn now and ask you some questions about the refurbishment of Wards 2A and 2B – sorry, Mr Castell, you can take that statement down now – in particular your involvement in the project board for the refurbishment. Now, the Inquiry knows there are others who will come along later who would be better placed to speak about, I think, the more technical aspects of that, but you do mention it in your statement, and I just want to ask you about what you know at this stage. If there is anything that I ask you that is outwith your knowledge, please just say so. Could you start by describing the process that led up to the establishment of the project board for the refurbishment of Wards 2A and 2B?

**A** So, whenever a capital project is commissioned, then there is a project board established. That board is set to look at the journey of the project, and we meet before the project starts, and we would meet routinely during the timeline of the project. So it wasn't abnormal for a project board to be commissioned. At that point, I was the Clinical Service Manager. So, as alluded to earlier, a



big part of my role is operational responsibility, and Capital Planning sits under that. So it would be normal for me to be a member of that board, along with representation from the clinical team as well-- as part of that board as well. So, the board was commissioned when it was identified that the works were going to be undertaken.

**Q** Can you remember, even roughly, when that was set up?

**A** Our first meeting would have-- Well, I returned from leave, and the ward had decanted and the work was to commence. So, our first meeting would have been at the very beginning of when the works was about to start with regards to the access etc to the ward. So it would be at the very beginning of the process.

**Q** Okay. We might be able to just drill down on some of the detail on that. If we turn up, Mr Castell, paragraph 225, please, of the statement. Again, Ms Hutton, if you just take a moment to look at that and let me know when you have done that.

**A** Yeah, sorry.

**Q** No, that is okay, thank you. I should have been watching. Now, you indicate here that your first awareness of the issues that led to establishment of the project board was

knowledge that the Estates team were looking at a program relating to ventilation as part of the IMT process----

**A** Sorry, so, this was not in relation to 2A/2B. This was as part of the Estates work that was ongoing-- This was paediatric ICU. So, without looking at minutes, I can't remember the definitive timeline of this, but this was not anything to do with the project board work for 2A/2B. This was two completely different meetings, and this was around the positioning of patients within our ICU unit with regard to-- We have cardiac patients in that area post-surgery as well as-- We take what we call "unscheduled admissions," so, children who come in through front door or from other district general hospitals with infections that are common infections in children, and that's what I've referred to with Respiratory Syncytial Virus and, therefore, there was decision taken that the air changes within the ventilation should be different for the children that were having surgery versus the children that were-- had the virus, and this was the purpose of that group that was set up.

**Q** So, at this time, in relation to that group that you are talking about, there was a concern about the ventilation provision in the PICU. Is that right?

**A** There was-- I would say it wasn't a concern; there was a meeting to discuss what the air change should be for the different patient categories within the unit and, therefore, where the patient should be placed in the unit with regards to them having the different conditions that the children had.

**Q** Do you know if any work was ultimately done in the PICU in relation to that?

**A** Yes. Again, this was led by the microbiologists and Infection Control team and Estates, and when it was agreed by them what the levels of air changes should be in each particular cubical area, then the Estates adjusted that accordingly.

**Q** Mr Castell, I wonder if we could skip down to paragraph 226, please. Ms Hutton, I-- Oh, sorry. Thank you. I think this is where you indicate the first concerns about the ventilation system on Wards 2A and 2B. Is that right?

**A** That's correct.

**Q** You say here you think this-- You became aware of this after patients had been decanted, which is what you already indicated, and after the contractors had come onsite.

Which contractors? I do not mean the name of the contractors, but why would contractors be onsite at that point?

**A** So, I think what I'm referring to there is that-- once the works commenced, so that would be what I mean by "the contractors." So, this work wasn't carried out by our local Estates team. There was a team commissioned to come in to do it. It would be that, once the work started, is what I'm referring to is we were aware that-- We knew that the ventilation system was to be updated or adjusted but, at that point, we weren't aware of the extent of the ventilation system changes.

**Q** So, when you say "works" there, are you talking about works in relation to the ventilation system or are you talking about the investigatory works that were to be done towards 2A and 2B?

**A** I'm probably talking about the whole aspect of the work commencing and the fact that the external contractor's come onsite to then start to look at the ward, and that process, as you're aware, evolved over time, and additional works were carried out than what we initially thought were going to be carried out.



**Q** Okay. I think you come on to talk about that, so I wonder-- If we just scroll down, we have got 227 on the screen there. You say here:

> "At that point we thought it was just going to require a few adjustments to the existing ventilation system to allow the contractors to achieve the pressures that the Estates team felt they should be achieving."

Then you say you:

> "…were subsequently informed, via the Capital Planning Team, that the whole ventilation system required to be replaced, which would delay the decant time."

Is that right?

**A** Yeah. That was my understanding at the time was that we were going to require-- Well, I was maybe-- I assumed that we were only going to have to do some changes to the system, and then, subsequently, we were found that the whole system required to be replaced.

**Q** What was your understanding of why it required to be replaced?

**A** My understanding was it was a-- So, I think what I'm-- From memory, what I'm alluding to here is at that point we were going to be

changing the ventilation system to some areas in 2A but not all of them. There was felt that the ventilation system that had been installed within the bone marrow transplant suites would not require to be undertaken, but then it was decided that we would have to. I'm not sure why. That isn't my area of expertise of why that decision was taken, but I was made aware that the ventilation within the BMT rooms was also going to be changed, which required-- which was one of the factors that resulted in the delay of the decant time. That's what I'm alluding to in that paragraph.

**Q** Just in general terms, I take it from what you have said that there was a requirement to replace the ventilation system, that there was some concern about the safety of the ventilation system?

**A** I wouldn't have the expertise to comment on that. That would be something for the Estates team.

**Q** You are clear that it was required to be replaced at this time?

**A** Yeah. At that point, I was clear it was required. Sorry, I misunderstood you. I was----

**Q** No, I am sure it was my question.



**A** What I meant from that is I couldn't give clarification of why that was thought to be the case, but I was aware of it.

**Q** Okay. Now, there has been evidence this week from Mr Redfern which, at least on the face of it, suggests that, in fact, the ventilation system in 2A posed a potential risk to patients, and that is why it required to be replaced. Is that your understanding?

**A** Yes, that's correct.

**Q** Okay. I want to move on now and think about the project board itself and the work that it did. Mr Castell, I wonder if you could turn up paragraph 126, please. Thank you. Ms Hutton, if you just take a moment to look at that. Now, I think you have mentioned already your role on the project board, but I wonder if you could just to expand a bit on what you were doing on it, and that might help us understand the limitations of your expertise on it.

**A** Yeah, no, so, I attended-- So, we had monthly project board meetings initially. They evolved more frequently as the duration of the works continued. So, I was what would be called the "service attendee" at the meeting. So, I was the liaison between James Huddleston, who was

the Project Team Lead at that point in time. So, he led the Project team from a Capital Planning component, and I was his key link from a service point of view, which meant that, with regards to any disturbance of operational issues – access to the building, timeframes of works that would be done – it would be myself that he liaised directly with and, as part of that, I became a member of the project board.

**Q** When you say you were a link, were you a link to the clinical and nursing teams or-- What were the link between?

**A** More between myself and the Capital Planning team, rather than the-- There would be membership at these meetings of the clinical team and the nursing team, so they would be at the same meeting as me, but when there was direct communication outwith the meetings that required-- It tended to be about the scheduling of the works, access to the works, anything that would involve disturbance to the rest of the hospital etc., it would be myself that would be the key link to the Capital team.

**Q** So you are looking at it from the operational angle and the impact on the hospital and what might have to happen to facilitate the works? Okay.



**A** Exactly.

**Q** You also say in paragraph 126 that the initial plan was for a redesign, I think, of the wards, "As matters evolved, it went on to be a complete rebuild of Ward 2A/2B." Can you tell us more about that process? So, how you came to understand it moved from a redesign to a rebuild?

**A** So, I meant, from the redesign, we knew that the ventilation was being changed but, as I alluded to, we felt previously that the BMT-- the bone marrow transplant rooms wouldn't require to be removed. As the project evolved, there was a number of things that were discovered. So, we knew that we'd previously had an issue with the flow, within the showers, of drainage. Then, when the works were being undertaken, it was felt that what-- Again, I would allude more down to the Capital Planning and Estates team to correct me on this, but my understanding of it was that it was felt, in order to correct it, the works that would require to be undertaken were more extensive than what they first envisaged, and I'm aware that it then required flooring to be uplifted. That was quite problematic in the fact that they had to drill out the existing floor. Then, when they were removing elements, it was, maybe, the walls had

to be more stripped back than what, maybe, was first anticipated.

We also used it as an opportunity to redesign the ward. There had been lessons learned from the structure of the ward when we had been in previously, and what I'm really alluding to that is where the staff base was in the ward was in the middle component, and behind that-- the ward had been designed with two cubicles directly behind a staff base. When working in a hospital, a staff base can be the hub for the staff, but it can also be where your telephones are. There's a lot of communication happens around that desk and, therefore, it can be deemed as quite a noisy area. We had reflected on comments that we'd had from parents previously, who occupied their rooms, that they felt the rooms were noisy to be in as an inpatient. So, we took that onboard, and we felt that we wouldn't recommission them as inpatient areas. So that then required further works that were really to enhance the ward rather than part of the project team, and with that, we-- and due to the fundraising of two of our young patients, we were able to redesign a room into a tween room, which has been a massive success and a beautiful room. We also were able to



bring our Pharmacy team more into the hub of the ward which, again, had been an issue previously that they felt the Pharmacy team didn't have an area that was a hub within the exact clinical area, so we redesigned the room into a Pharmacy hub as well.

We also changed some areas to have additional storage in the ward that we felt we didn't have previously, and we also used it as an opportunity to increase electrical points that-- A lot of these children are on multiple machines for their drug therapy, and we felt that some of our rooms didn't have enough sockets. We also used it as an opportunity to listen to our young people and enhance our teenage cancer rest area/zone that they have by updating that area for them as well.

**Q** Thank you. That is all very helpful. Thinking about all of that and what you have just said, how would you describe the size and scale of this project?

**A** It was massive. It was a huge impact. It was a huge piece of work. It would be fair to say, during this period of time, this evolved my whole working week so much so that, during the process, the head of the project board actually relocated himself to be beside me so that we could work much more closely

together because we met on a daily basis with the works. It had a hospital-wide impact that, probably, I wasn't expecting, personally, prior to the project and the impact it did have on the rest of the hospital with regards to noise, with regards to inconvenience.

So, in order to get up into the fourth floor, we had to close off a large store area that we had on the third floor that housed a lot of equipment for the third-floor patients, and that had to be re-handed over to the project board to allow them access, so we had to find additional storage supplies. We had impacts when-- especially when they were removing the shower floors, with the noise. Again, I had a very good communication relationship with Mr Huddleston, so we did noise impact assessments with myself down in one ward and him in another listening to the impact of that, and we put measures in place. The ward affected was 1A/1B, which is predominantly a Monday to Friday ward. So, we scheduled as much activity as we could at weekends to minimise that impact, and we also worked creatively with our play team to see how we could minimise the impact for the patient. So, we purchased noise-cancelling headphones for the patients to have, and we tried to make the



experience of them having this noise as a more enjoyable experience and turn it into play with them to try and minimise the impact on them.

We also, as part of the ventilation works, had to erect scaffolding in our main atrium which, again, impacted on the flow into one of our clinics in outpatient area, as well as-- It was very intrusive of that space as well. We then had to creatively think of how we brought supplies in and out of the area, and we worked as much as we could into the evening when outpatients would be closed and, again, as much work as we could to bring supplies in and out at weekend times.

**Q** Thank you. What was the initial timeframe for the project?

**A** So, initially, if I remember correctly, it was 12 weeks. That then evolved. It'd be fair to say, though, we had a number of things throughout this period of time. The pandemic and COVID being one of the main effects that obviously had a huge impact on all of NHS, but it also had an impact on this project with regards to Scottish Government guidance at that time for construction staff to be furloughed, and then that subsequently led to a delay with the supply chain of construction works, and material supplies were

impacted due to the pandemic as well. So we had delays in getting supplies to the project as well as-- When the contractors were able to come back onsite, we then obviously had to introduce social distancing measures, so we couldn't have the same levels of contractoral (sic) persons onsite because they had to social distance, so therefore we had to re-look at our hours of work, our-- Move to a seven-day week, but also we had to minimise the amount of contractors that were onsite at the same time, which fundamentally led to further delays as well.

**Q** Okay. I think you indicated earlier that the move back took place in March 2022. So that is, I think, three and a half years after the original decant. Now, I think you have indicated that you were involved in the planning and logistics of the move back toward 2A and 2B. Could you tell us a bit about that?

**A** Yep. So, I think Ms Jennifer Rodgers yesterday outlined the decant over. So, we had a very robust operational decant log that was created by my colleague who did the original decant from 2A/2B to 6A/4B. So, it became very-- That had been very successful. It had worked exceptionally well, so we decided that



we would just revert that and use the exact same document but revert it back the way. So we followed the same operational log that we'd used to move over and, rather than it going from 2A to 6A, it became 6A to 2A: vice versa. We followed the same sequence of events back. There was elements of it that we didn't require to do. So, we had done a lot of work with regards to our hospital at night allocation, our time between PICU and 6A, our time between theatre etc. The fact we were moving back, we didn't have to redo they scenarios that we'd done. Apart from that, we followed the same decant process and the same paperwork.

**Q** Okay, thank you. My Lord, I am conscious of the time. I think that brings me to the end of that chapter of Ms Hutton's evidence. I wonder if we were to take the coffee break now.

**THE CHAIR:** That seems appropriate. We usually take a coffee break about this time, so we will try and sit again at quarter two.

**MS ARNOTT:** Thank you, my Lord.

**THE CHAIR:** Right. Please take Ms Hutton to the witness room.

(Short break)

**THE CHAIR:** Ms Arnott.

**Q** Thank you, my Lord. Ms Hutton, before the break, you told us about the Project Board and the refurbishment of Wards 2A and 2B and you have given us quite a lot of detail about the changes made to the layout of the ward. I think you indicated that some of the criticisms that had been made of the layout and the space allocation have been addressed, but we know the ward was also refurbished for other reasons to do with, I think, the ventilation system and possibly some other matters that you have mentioned. So, just thinking about the overall safety of the built environment on the new refurbished Ward 2A and 2B, what is your assessment of that now?

**A** So, with regards to the ventilation, I'm very assured that the spec of the ventilation is adequate, and we have been given assurance that, you know, we are of an exceptionally high standard and one of the best units now, if not in the UK, across Europe. With regards to the water, we have good assurance, and ongoing assurance, with regards to the water sampling that's undertaken, that our water is good, if not better, than we would have ever hoped it to be.



**Q** In relation to the assurance that you have received in relation to the ventilation system, what form has that assurance taken?

**A** So, with regards to prior to the move back, there was an independent inspection of the ventilation system that was undertaken as part of the project. So, that gave the assurance for the move back. With regards to the water, the sampling process went through a rigorous process with regards to the involvement with microbiologists, also HPS as-- or Health Assure, and also with Estates colleagues. The sampling remains ongoing, and they routinely sample the water.

**Q** Thank you. I wonder if we can just split up the ventilation and water systems for the moment. Now, you said there was an independent inspection carried out in relation to the ventilation system. Are you aware if a report was produced?

**A** I would assume so, and that would have been signed off by the capital planning----

**Q** Did you see it? I am just wondering if it was shown to the group at a meeting.

**A** I've not been sighted of it, no.

**Q** Okay. Mr Castell, I wonder

if we could turn up paragraph 230 of the witness's statement, please. Now, you say here, Ms Hutton, that you "now have a very good maintenance programme arranged and also for ventilation cleaning on a six monthly basis, at the same time." Now, when you say you "now" have a very good maintenance programme arranged, has that programme changed from what the ventilation maintenance programme was before?

**A** The ventilation cleaning process? No, that has not changed. That was ongoing prior to the move but what has changed is the way that we undertake the process. So, the disturbance of the cycling of it, as such, is now a more joined up approach. So, we ensure that the ventilation of the ceiling vent cleaning and the HPV clean happens coherently so that we do the vent cleaning, and then we follow that up with the HPV clean. As alluded to previously, the area needs to be empty and the equipment put into the area to allow the HPV to be cleaned. So, when the vent cleaning is undertaken from the ceiling vents, the patient would have to be decanted from the room in order for that to be undertaken. So, rather than that being a sort of double process, we now have



it as a one process that it all happens at the same time.

**Q** So, when you talk about a maintenance programme for ventilation you are talking about the HPV cleaning and ventilation cleaning?

**A** Yes, the actual cleaning of the ceiling vents is what I'm referring to.

**Q** So, when you say there is now a good maintenance programme, you are talking about a maintenance programme that was instituted, I think, probably in around about mid-2018 when you told us about HPV cleaning.

**A** Yes, so with regards to that, so the HPV clean in 2018 was done as a one-off in Ward 2A but we didn't have what I would refer to as a maintenance programme, as in a scheduled programme moving forward which we now do have across all our high-risk areas, which is every 6 months. Not all areas done in the same month. It's staggered, but each area is cleaned every 6 months.

**Q** And I think you mentioned earlier that those areas would include the PICU and the NICU.

**A** That's correct.

**Q** Okay, and just to clarify, you said it was done as a one-off in 2018. So, as far as you are aware,

prior to 2018, was there any programme like this for ventilation maintenance?

**A** For ventilation, with regards to the maintenance, that would be Estates to comment on that, but with regard to the vent cleaning, then that did occur within all areas, but we didn't at that point undertake HPV cleaning.

**Q** Okay. So HPV cleaning is the new aspect to the programme?

**A** It is, and that has evolved. The process of undertaking that has evolved during this time as well.

**Q** Okay, thank you. Mr Castell, I wonder if we could go back to paragraph 201, please, and, Miss Hutton, I am just going to ask you now about the situation in relation to the water maintenance programme. So, you say here that your understanding of the situation now is that we have a good maintenance programme in place, and I think you are talking about the water supply here.

**A** Yeah, so that has evolved since 2018. We obviously had our filters in place and from that we had a change system put in place of when the filters are dated-- of when they need to be changed and the sampling is undertaken by the Estates team through an external company and that has maintained and has remained



since 2018.

**Q** And were you aware if there was a similar programme prior to 2018?

**A** I'm not aware of one prior to then, no.

**Q** You say here, at the end of this paragraph, that there are results fed back from the sampling by the external company through the Estates team, and the results are cascaded down to the clinical team. Is that right, that water sampling results are passed to the clinical team?

**A** So, the water sampling results fundamentally come through Estates. Estates will ensure that the Microbiologist and Infection Control team are sighted on them and then they're also then-- from a management point of view, we are sighted on the results of the sampling. Then it would be my action now, in my current position, to forward them onto the clinical service manager who would be expected to cascade them down so the clinical staff are sighted on the results.

**Q** So, clinical staff are now sighted on water sampling results?

**A** That's correct.

**Q** Presumably they would not be expected to take any action?

**A** No, they're not expected to

take action. It's just for awareness. Any action required would be within the Infection Control team and Estates team.

**Q** Now, are there any ongoing infection control measures in the new Wards 2A and 2B?

**A** None that I'm aware of currently.

**Q** I am talking about control measures, so point-of-use filters, that kind of thing?

**A** Yeah, so currently-- I'm not sure actually if the filters are still in place since the move back or not.

**Q** I think we have heard evidence that they are still in place.

**A** I have no reason to believe they are not in place, but I would have to get further clarification, but I'm not aware over the last few weeks that they've been removed as such.

**Q** Okay. You have also talked about the fact that the HPV programme is still in place, but you have said it is a different process now and it is less disruptive. Is that right?

**A** That's correct. It's just that-- when we first commenced this, it was very large machines that were brought into the room and the actual undertaking of the procedure was much more time-consuming. It also was much more disruptive and the fact that the vents had to all be sealed and the room had to be sealed off, and it was much more time labouring. That process has evolved over the years, and it is now a much less intrusive process and it's also a much quicker process in carrying that out.

**Q** Do families still have to be moved room?

**A** Yes, no, they do.

**Q** And do they get to go back to their original rooms, or are they still displaced?

**A** It would be a personal choice of the family member.

**Q** Are you aware of this HPV cleaning process as something that is unique to the RHC or is it used at other centres?

**A** I'm not aware of anywhere else across GGC that uses it and, sorry, I'm unable to comment if it's used elsewhere.

**Q** Now, just thinking about communication about the refurbishment process – it obviously took 3½ years for the various reasons that you have explained – how did you go about keeping staff and patients and families informed about the progress of the project?

**A** Well, as I alluded to earlier, part of the project team would be the clinical team, both medical and

nursing, would be part of that group and we met monthly. So, they would be members and actively at the meeting, and then sighted on the minutes from the meeting. So, we would expect that they would then cascade that to their colleagues. So, the clinical lead from medical and your senior charge nurses would be present. With regards to the patients and family, they were updated via the local clinical team on any sort of delays as such. I'm not aware that they were given definitive timelines because it would be fair to say, at that stage, we weren't sure how long the delays would result in, so we never gave a definitive timeline for the move back until that had been agreed when the date would be, and at that point was when we gave more formal communication to the families with regards to the move back.

**Q** And by more formal do you mean written or----?

**A** Yeah, so we had time to move back which we maybe didn't have at the decant period. So we were able to work very closely with our Comms colleagues and we worked with our families and young people to determine what questions they had and what they would like us to answer. So we put together two booklets: one aimed at the parents, and one aimed more at the young people. These were published in a sort of format that was given to all inpatients and also our patients that attended Day Care at the time, and then we subsequently posted a copy to any child who was under Haematology/Oncology services that was just currently receiving treatment within the hospital but might not be actively in treatment.

We followed that up with a virtual walk around, and we filmed, we used an external company to come in and do a very in-depth virtual walk around of showing what the ward looked like, what the place-- the areas we walked around at. It was a narrated by Mr Huddleston, who'd been the project lead. We uploaded that and gave the families a link, and the link was contained in the booklet as well. We also uploaded that on the parent and young people Facebook page that had been established as part of this process.

We then invited all staff, as well as parents and patients if they wished to come, for an actual face-to-face visit, and we facilitated them throughout weekends, evenings, and during the day. That was a voluntary aspect if staff or family members wish to uptake, and that was to let them see

the unit prior to the move back.

We also then, when the date was agreed, put out formal communication so that they were aware of the date. We then, as I alluded to earlier, did the same process of moving the patients back as we did when we moved over, and the way that that was undertaken was input by the clinical team for them to decide who should move at what time and who should come first, etc. The parents were then given a note of the time of when they would likely move on the day, as well as what team would be escorting them on the day as well. So, we had an exit team, we had a transfer team – that was who was with the child during the journey over – and we had an arrival team as well.

**Q** Okay, thank you. Ms Hutton, I just want to pause here and think about all of the events over this period, and I want to give you an opportunity to comment on the impact on patients and families and on staff. Now, is there anything you would like to say, firstly, about the impacts on patients and families?

**A** I think I didn't have personal involvement with the period the patients and families as much as my other colleagues did, however, it would be-- and so this would be my impression of the impact that's had on



them. I can't imagine the impact that this has had for these families. To have a child have to come to hospital is very distressing, but to have a child who's suffering from a cancer condition is life-changing for that family and, therefore, to have this added anxiety and uncertainty that this has caused to this family, I can only imagine what these parents have had to go through, as well as the young people involved in this.

With regards to staff, I could speak more closely to relationships with them. This has had huge impact on staff members, and throughout the journey of the last few years there has been ups and downs. It would be fair to say that media coverage, at times, has been very challenging for staff. Especially when the coverage is out in the media, it's as if the staff have to continually relive this experience.

Equally to that, we have a number of families who were not with us in part of this journey in 2018 and their children have come new to this environment. So, every time that there is media attention, then that adds additional anxiety for these new families as well, as the staff having to go over the situation again and again with them. I would hope, at one point, we can move on from this and that we

can celebrate the hospital that we are. The Royal Hospital for Children in Glasgow is an exceptional hospital. It's a privilege to work with these staff and the families. It's a privilege to be able to direct patient and family-centred care, and I hope one day that we can move on from this.

**Q** Okay, thank you. Now, as we approach the end of your evidence I want to move on to think about any changes you have implemented in your tenure as general manager. Now, we heard evidence from Mr Redfern that Greater Glasgow and Clyde Health Board is a learning organisation with a culture of safety. Would you agree with that assessment?

**A** Absolutely.

**Q** Can you tell us what lessons you think have been learned as a result of these events?

**A** So, for us, communication. I think it would be fair to say that, along the journey, we have got better at communicating. A good example of that was the move back. Now, you could argue that back that we had time to prepare for that move, but I felt we have learned how to engage with our Comms team, how to use social media platforms, how to make sure that we have the correct communication out,



that we engage with our families and young people to ensure that the information that we are sharing is of value to them and it is what they would want.

We have introduced-- we have our PACE group, which is our patient and children's forum where we have representation of both parents and young people attend that forum. That's the platform that we use to try and improve on our communication as well as acknowledging the worth that we get from our patients. We have engaged fully in our patient feedback platforms.

We look really well into our care opinion. We get some exceptionally good reports on care opinion platform, but we also learn from comments that are made on that and we will use that opportunity to outreach to the families to allow us to learn to improve for the future.

We also have implemented the change across the hospital from our iPads and these are all at each bedside and, as part of that, we use that platform as well to try and encourage our parents to give feedback through that so that we can learn.

**Q** Just to pick up on that, is there a process for providing feedback

that is accessible? Is it just via the website?

**A** Yeah, so it's via the website. There is also a platform on the iPad that they can leave a feedback. We also have an opportunity that, if anybody wished to speak to a member of the senior management team, that we're available, and we outreach a lot to families that we have a very good cascading of communication. If the nursing team wants to speak to the lead nurse, that the lead nurse has an opportunity to come and speak to myself and the existing chief nurse and that we will then go to the patient bedside and meet with the families if that is what they wish, so that we can learn, and try and-- Sometimes, what is a situation, you would rather that we have an opportunity to try and fix it there and then, rather than allow this to evolve for this family, so we have a very open access to family if required.

**Q** Okay, thank you. If problems were to re-emerge on the sort of scale that you were dealing with in 2018-2019, is there a specific plan in place for communication with patients and families, and by that I include outpatients and Day Care patients in that?

**A** Yes. So, now we have a



very good cascading implication of how we get our information out, but we work very closely with our Comms team, so therefore we would put together a statement and we have a process in place where we can ensure that all families receive it both verbally, if they're an inpatient, but we would always follow that up with the same written communication. We have a database where all our patients are recorded on that we make sure-- So, for instance, when the booklet was being sent out, we ensured that-- it was a huge under task (sic) for our admin team, but we ensured that all parents were lettered on the same day and they received a copy of the booklet, so that it was sent by mail in the same day as well.

**Q** So, you have indicated that there is a plan in place for the handling communication in that sort of situation. Is there a written document that the Inquiry might be able to see setting out that plan?

**A** Not that I'm aware of. There's not a written document as such.

**Q** Okay. Again, thinking about were something of a similar scale to happen again, is there a contingency plan now in place for the movement of these patients?

**A** So, the contingency would be-- yeah, we have. Each area has their own business continuity plan of where your designated area would be to move to. Again, evolving back to-- it would depend on what the incident was, what the nature of the incident is, what the length, the potential decant time would require to be, and also what areas would be available for part of that. So, I would assume we would go through the same process as we did before: that we would put together an options paper and decide on what was the best option from both clinical and all those that required to be involved in that process.

**Q** Just so I am clear about that, there will be a written document that is a business continuity plan for the patients in 2A and 2B.

**A** Each area, 2A and 2B, if that's specifically what you're asking here, hold their own business continuity plans.

**Q** Thank you. That is very helpful. Now, we are now approaching the end of your evidence and I just want-- you have touched on this already, but I just want to give you an opportunity to talk about your hopes for the future of the hospital and the new chapter for the Schiehallion Unit.

**A** So, firstly, it's exciting that it's now identified as Schiehallion Unit, and we all call it Schiehallion now and it's lovely that the ward has got its identity back. The hopes for the future, as I said before, is that we can draw a line under this. We have learnt a lot from this incident but are hopeful that this isn't what we're reminded of and that's not what the hospital is looked at being reminded of. I would hope that we'll get good media coverage moving forward and that we can celebrate our success. We are a hospital that strives in innovation, and we have excellent clinicians and staff that work within the hospital, and I would hope that the good news stories is what we can move forward with.

**Q** Okay, thank you. My Lord, I do not have any further questions for Ms Hutton.

**THE CHAIR:** Thank you, Ms Arnott. Ms Hutton, I am going to give the legal representatives an opportunity to consider whether there is anything they wish to raise. So, I will ask that you be taken back to the witness room for maybe 10 or 15 minutes.

**A** Thank you.

**THE CHAIR:** If anyone could indicate to Mr Duncan and Ms Arnott whether there are additional questions that have to be raised, or it may be

that you have anticipated this.

**MS ARNOTT:** My Lord, I believe there may be a couple of queries to deal with with the core participants.

**THE CHAIR:** Right. Well, if we rise for about 15 minutes.

(Short break)

**THE CHAIR:** Ms Arnott.

**MS ARNOTT:** My Lord, I have been asked to clarify one short point with Ms Hutton, which I think I can do.

**THE CHAIR:** You are content to do that?

**MS ARNOTT:** I am, yes, my Lord.

**THE CHAIR:** Can you ask Ms Hutton to re-join us. (After a pause) There may just be one matter which Ms Arnott wants to clarify. Ms Arnott.

**Q** Ms Hutton, I have been asked to clarify just one short point with you and it relates to your evidence in relation to the fitting of filters across the hospital in March 2018. Now, we looked at a paragraph of your statement which, in turn, referred to an IMT minute and we did not turn the minute up itself. I am going to ask Mr Castell to put that up on the screen now. It is bundle 1, page 75. Thank you, and we can see the attendees of the minute there. I think you are



present. If we skip forward to page 78, please, Mr Castell. Ms Hutton, I wonder if you could just take a moment to look at the first two paragraphs under the heading, "Water Control Measures"?

**A** Sorry.

**Q** That is okay. Now, in your evidence earlier we were talking about the reference later in that minute to your concerns about a filter not having been fitted in a four-bed bay in Ward 3A, and you indicated that you thought filters had been fitted everywhere in the hospital. Now, looking at these two paragraphs, it appears as though filters had not yet been fitted in all areas of the hospital.

**A** Yeah, and that looks accurate. From memory, that's correct. We put it in a rolling process, so apologies for that error.

**Q** No, I am sure it is my fault. So, at that point in time, 21 March, filters were not yet fitted in all areas of the hospital. Is that correct?

**A** That would be correct, yes.

**Q** Okay, thank you. My Lord, I am hoping that addresses the question that was raised. My Lord, I have got no further questions for Ms Hutton.

**THE CHAIR:** Thank you, Ms Arnott, and thank you, Ms Hutton.

Thank you for your attendance, but also thank you for all the preparatory work that you must have done. I appreciate you have other important duties to fulfil, and this can only have diverted you from them, so thank you but you are now free to go.

**A** Thank you.

**THE CHAIR:** While addressing myself to the legal representatives, as I think was emailed to you in the course of the week, counsel to the Inquiry will provide his closing statement for circulation by 21 July. There then will be a period of two weeks for core participants to exchange draft concluding statements on their own behalf, or rather on behalf of-- yes, legal representatives will have the opportunity of exchanging drafts on behalf of their respective clients, the core participants, with a view to the submission of final statements by 18 August of this year. Thank you very much for your attendance during this hearing and I look forward to the closing statements. Thank you.

(Session ends)

**12:15**