THE SCOTTISH HOSPITALS INQUIRY

ROYAL HOSPITAL FOR CHILDREN AND YOUNG PEOPLE/ DEPARTMENT OF CLINICAL NEUROSCIENCES

Closing Statement for the affected Core Participants: the parents and representatives of the children affected by their treatment at QEUH

Hearings covering the period from the commencement of the Project to Financial Close

1. The Core Participants represented before this Inquiry by Messrs Thompsons, Solicitors are patients, family members of patients and parents of child patients who were, or are still being, treated on the children cancer ward, the neo-natal unit and the adult wards at the Queen Elizabeth University Hospital in Glasgow ('QEUH') and at the Royal Hospital for Children and Young People in Edinburgh ('RHCYP').

2. In July 2019 the RHYCP was ready to welcome its first patients. Prior to opening, safety concerns relating to the ventilation system were identified.

3. This Inquiry has already heard evidence about the devastating impact of infections on patients and families in the QEUH. We have heard evidence about the additional suffering caused by infection. Infection has devastating effects. The evidence heard in that regard has been distressing and shocking in equal measure. Patients died as a result of infections acquired at QEUH.

4. The risk posed by infection is well known. When the new RHCYP was being designed, one of the fundamental aims of the design of that hospital was, or ought

to have been, securing the safety and wellbeing of its patients. Central to that objective was, or ought to have been, the prevention and reduction of the risk of infection to patients, particularly those who were immunosuppressed or critically ill. We have heard evidence that those patients are especially vulnerable to infection and its consequences.

5. Accordingly, the suitability and sufficiency of the ventilation system at the new hospital was or ought to have been at the heart of the design process for all patient rooms and internal areas.

6. It was clear from the evidence that we have heard that NHSL failed to make the key requirements for the ventilation system clear to those who were bidding for the construction contract. Not surprisingly, NHSL's failure led to confusion among all involved parties. It is utterly astonishing that patient safety was dealt with in such a slack and haphazard fashion. There can be no doubt that it was for NHSL to specify, with absolute clarity and accuracy, the ventilation requirements for the patient rooms within their hospital. They failed to do so.

7. It was also for the NHSL, and their expert advisors, to consider, assess and have regard to the readily available technical guidance for the ventilation requirements for different types of rooms within the hospital. If guidance specified that certain types of room should have a specific number of air changes per hour then that should have been abundantly clear to those designing and bidding to build the hospital. It was, or ought to have been, obvious that any failure to follow guidance could give rise to a real danger to the health and wellbeing of patients attending the hospital, principally an increased risk of infection.

8. Human error in any manual design process is a high and obvious risk. That being so, a robust process for review of key documents, and the data contained within those documents, ought to have been in place. It was not. Such a robust process ought to have been applied by those seeking the new hospital (NHSL) and those

bidding to construct it. It appears from the evidence that NHSL did not have any competent review system in place for checking the accuracy of the designs that were put forward by bidders. They lacked expertise and experience. If NHSL were unable to review the design, and the data for key features such as room air changes for the ventilation, then surely it is not unreasonable to propose that their technical advisers ought to have done it for them (or been required to do so). The fact that the review process was so weak and failed to pick up what was, or ought to have been, an obvious human error in the ventilation system design for critical care rooms is bewildering. Surely that is something that ought never to happen in the design and construction of a public hospital being constructed at significant public expense.

9. The fact that an error occurred is accepted. How such an obvious error was allowed to occur/missed in a high cost project involving significant public expense has not been explained by any witness, whether from NHSL or any of their advisers. That is both remarkable and inexcusable.

10. We are committed and look forward to working with the Inquiry Team in further substantive hearings going forward.