SCOTTISH HOSPITALS INQUIRY

CL.OSING STATEMENT RELATIVE TO HEARING COMMENCING 26TH FEBRUARY 2024 CONCERNING RHCYP/DCN

ON BEHALF OF JOHN AND MOLLY CUDDIHY AND LISA AND EILIDH MACKAY

INTRODUCTION

Direction 6 outlines the expectations of the Chair of the Inquiry in relation to Closing submissions. These directions and the oral direction provided by the Chair at the conclusion of the February hearing emphasised his expectation that any written submissions made should relate only to the RHCYP/DCN. It is, of course, for the Chair to determine the Terms of Reference of the Inquiry. It is worthy of a reminder that the overarching aim of the Inquiry is to consider the planning, design, construction, commissioning and where appropriate maintenance of both the QEUH/RHC and the RHCYP/DCN. The remit of the Inquiry was to "determine how issues relating to adequacy of ventilation, water contamination and other matters adversely impacted on patient safety and care occurred; if these issues could have been prevented; the impacts of these issues on patients and their families; and whether the buildings provide a suitable environment for the delivery of safe, effective person-centred care. The Inquiry will make recommendations to ensure that any past mistakes are not repeated in future NHS infrastructure projects."

Given the Remit of the Inquiry and the Terms of Reference, which are described as applying to both hospitals, it is disappointing to note that the conduct of the February 2024 was approached by both Counsel and the Chair to the Inquiry as only dealing with matters that related to the Edinburgh Hospital. This approach stymied the opportunity to consider the influence and impact of GGC and the staff of QEUH/RHC and the crisis they were facing in 2018 and 2019 on the decision making in respect of the Edinburgh project. Core Participants legal representatives were prohibited from asking questions of key witnesses such as the past cabinet Secretary for Health Jeane Freeman and representatives of NHS Assure - specifically Julie Critchley (Director) and Thomas Rodger (Head of Engineering). No undertaking was provided that they would be called to give evidence at later hearings dealing with the Glasgow hospitals.

The approach taken - of ring fencing the examination of each of the hospitals - sets the Inquiry on a path to fail to effectively identify past mistakes and ensure they are not repeated in future. The design and build of these types of infrastructure projects was described by a number of witnesses as “a once in a career opportunity”. This was tacitly given as an explanation why there appeared to be a lack of personnel with actual experience of delivering such projects. Clearly, in a country of approximately 5.454 million people, hospital infrastructure projects are not a regular occurrence. However, the Inquiry was established to consider fundamental errors and problems that arose in respect of two projects that overlapped and were designed to provide healthcare to the majority of the Scottish population. By “ring fencing” (as the Inquiry has done) the focus is on the individual projects rather than the systemic issues of governance and accountability. A clear example of this was the refusal by Counsel to the Inquiry to ask Julie Critchley about the refusal by GGC to allow NHS Asssure to inspect the Schehallion Unit at the RHC in Glasgow prior to its re-opening after an extensive multi-million pound refurbishment. The Core Participants we represent were given no reassurance that this witness would be recalled in autumn 2024 when the Glasgow Hospitals were the focus of the Inquiry. The best offer we had was that another witness would be asked this important question. We were not told who. It is notable that the scope of the evidence was to consider decision making and governance around the decision to open the Edinburgh Hospital. NHS Assure was not in place at the time the opening of the Edinburgh Hospitals was delayed but was in place when the refurbished Schiehallion re-opened without any external check or validation that the hospital environment was now safe. We submit that the issue of validation (or the lack thereof) should properly be explored as a systematic failure which is evidenced in both the Edinburgh and Glasgow Hopspital projects. In terms of addressing this systemic issue in the future, it should be noted that the creation of ASSURE was designed to “improve how we manage risk in the healthcare built environment across Scotland. Managing risk in the right way gives those involved in maintaining NHS buildings, facilities and equipment confidence and reassurance.” Evidence is available (but which the Inquiry refused to explore with the Assure witnesses) to suggest that Assure is and will be prevented from fulfilling their remit whilst health boards such as GGC can refuse them access to examine and validate healthcare facilities as was seen in 2022.

MATTERS TO BE ADDRESSED BY LEGAL REPRESENTATIVES

In Direction 6 the Chair requested that Core participants' representatives address the following issues:

3.4.1 In so far as they differ with Counsel to the Inquiry, what themes they submit have emerged from the evidence which are relevant to the Terms of Reference of the Inquiry

A. We agree with the themes identified by Counsel to the Inquiry at Section 2 of the closing submissions.
B. We accept Counsel's proposed explanations of and, where framed as questions, proposed answers to, each of the topics listed in the List of topics;
C. We accept Counsel's proposed answers to the questions which are posed in Terms of Reference 1 to 12.
D. We agree as appropriate Counsel's proposed recommendations and, propose some additional recommendations.
E. We accept Counsel's proposed material findings of fact.

The Key issues arising from the themes and recommendations are explored below:

1. The error in the environmental matrix, relating to air changes per hour in critical care rooms, was identified by one of the tenderers. Despite the failure of the environmental matrix to comply with SHTM-03-01 being highlighted at this stage, not only was the matrix revised to correct the highlighted error but the sole tenderer who had highlighted the issue was ultimately unsuccessful. It is unclear the extent to which the contract deviated from the 'exemplar' design that involved Robert Menzies in liaison with clinicians.

2. Whilst it is agreed that NHSL had a governance structure in place, it cannot be said to have been effective. Evidence led at the hearing in February together with the extensive written evidence available expose a lack of effective

governance in respect of the project. It remains unclear to the core participants who was in charge. The role of Mott Macdonald (MML) appears to be very vague and they robustly denied being involved in providing design advice. However, it is clear (as recognised by Counsel to the Inquiry) that they should have provided technical advice. Whilst they were not design reviewers, they were lead technical advisors. They should have provided advice to ensure that the clinical requirement of each room (including critical care) was met. The approval of SA1 is a clear example of MML failing to discharge their duties. There is no record of the technical solution being approved by subject specialists and this resulted in SA1 being approved by the Finance and Resources Committee and Board of NHSL based on false reassurance.

3. Many witnesses referred to Ronnie Henderson have a key leadership role. His evidence was that he had good knowledge - but not expertise - in respect of SHTM-03-01. This witness stated that if there were questions around SHTM-03-01, then he would pose these to colleagues or, if more complex, to HFS. Despite Mr Henderson being relatively low in terms of seniority, oral evidence of witnesses repeatedly placed responsibility at his door. This was notwithstanding a lack of objective evidence that he had the expertise or seniority to take on the lead governance role that others repeatedly attributed to him. At the end of this chapter of evidence the following question remained unanswered:- “Who was in control and who owned the risk?”

4. Despite the numerous individuals and organisations involved in the Edinburgh project, no one appears (except the one body at the tender stage) to have identified that the proposed air changes in critical care rooms in the environmental matrix did not meet the 10 AC/PH required by SHTM-03-01.It should be noted that on 17th October 2016, Mott MacDonald emailed Multiplex (A46440425) stating “…the Board reminds Project Co that unless the Board has already accepted a derogation, it is Project Co’s obligation to comply with the BCR’s/SHTMS etc, and the Board not commenting does not remove that obligation on Project Co.”

5. Taking the evidence as a totality, it remains unclear who was responsible for the critical aspects of the project that resulted in the delayed opening. For effective governance, those responsible for risk assessment, quality assurance and delivery must be clearly identified and be aware that responsibility lies with them. This infrastructure project provides support for external assessors to be mandatory to "sign off" on all aspects from design to settlement agreements. In the present case the expected internal scrutiny from the stage of the environmental matrix to SA1 was absent or ineffective.

6. The agreement of derogations and SA1 appear to have been primarily driven by a desire to save face, save IHSL and to avoid the expense and complications should IHSL cease to operate. These failures apply to both NHSL and the Scottish Government.

7. The absence of governing guidance on derogation added to the problems. It is noted that SHTM guidance now requires the VSG to be involved in any decision to depart from guidance.

8. The failure to identify the omissions around critical care areas was compounded by the response to the delayed project - namely entering SA1. It is of particular concern that SA1 was signed off without stage 4 HAI-SCRIBE procedure being completed. The effect of this is that SA1 took place without consultation or "sign off" by IPC and in the absence of external independent scrutiny having taken place. This lack of validation is inconsistent with patient safety being prioritised as is the failure to engage IPC in critical decisions such as signing off SA1.

9. The question raised in para 424 regarding the current model for Assure is important. So long as Assure is neither an inspector nor a regulator, its ability to provide key stage assurance review on refurbishment projects will be seriously restricted. This is demonstrated by the refusal of their offer to inspect the Schiehallion Unit. The letter from Richard McCallum, Director of Health, Finance and Governance which was co-signed by the Chief Nursing Officer, Professor Amanda Croft, dated 27 May 2021, states "NHS Scotland Assure has been co-designed with users to deliver a co-ordinated approach to the

improvement of risk management in new builds and refurbishment projects across NHS Scotland… From the 1 June 2021, all NHS Board projects that require review and approval from the NHS Capital Investment Group (CIG), will need to engage with NHS Scotland Assure to undertake key stage assurance reviews (KSARs).” The question that should have been asked of NHS Assure is whether health boards are inhibiting or preventing them fulfilling their remit.

10. The full extent to which NHSL and, in particular, IPC staff had opportunities to learn lessons from the experiences at the QEUH has not yet been fully explored. Witnesses called, including Dr Inverarity, were asked very limited questions around this issue and no evidence was obtained on what was discussed when meetings between GGC and NHSL took place. The evidence of IPC professionals, including Dr Inkster is an opportunity to gather a clearer picture on the opportunities that arose.

11. Following the Innovated Design Solution Report and NSS HFS Report in respect of the Glasgow Hospitals, the then Director General of Health and Social Care wrote to Scotland’s Health Boards on 29th January 2019 seeking confirmation that all critical ventilation systems were inspected and maintained in line with SHTM-03-01. This prompted Multiplex to state to IHSL that critical ventilation systems were compliant. IHSL thereafter wrote to NHSL in similar terms. This was not the case.

12. It appears that various points throughout the project pressure to prevent further delay and fiscal concerns/interests were prioritised over patient safety.

Clare Connelly, Advocate