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

Hearing commencing on 26 February 2024 covering the period from financial close to the Opening of the Hospital

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. Following the previous hearings in 2023 we set out our comments about the fact that a fundamental error by one individual in the design process was never picked up by anyone involved in the procurement, design and construction of the new RHCYP. The responsible parties were the health board NHSL, their technical advisers Mott MacDonald Limited MML and the main contractors IHSL. We were very critical of the failure by NHSL to make clear the requirements for the ventilation system, an essential feature for the safety of the young patients to be treated there. The guidance documents for the Health Board were straightforward for them to apply in relation to the critical care rooms. We reiterate following the further hearings that we continue to find it "astonishing" that patient safety was dealt with "in such a slack and haphazard fashion" without any proper system of review in place by the health board or their technical advisors. The evidence at the latest hearings continues with the theme of failures by the Health Board and their technical advisors along with what

appears to be failures by the Scottish Government to question what was happening with the hospital until it was almost too late.

3. The fact that there were major problems with the ventilation system at the new QEUH in Glasgow were well known to the Scottish Government and the fact that the same main contractors were involved ought to have resulted in far closer scrutiny by the government during the period prior to intervention by the Health Minister, which was only a matter of weeks before the hospital was due to open in July 2019.

4. In our previous statement we asked how such an obvious error was allowed to occur and be missed in a high cost project involving significant public expense and the key safety of young patients. The further evidence we heard has failed to explain why that happened and has made it plain that there were further failures and errors made by many of those involved. As we described in our previous submission these failures continue to be "both remarkable and inexcusable". In addition, there appears to have been a complete lack of acceptance of responsibility by any of the main parties involved.

5. Perhaps the worst example of this is the fact that the Health Board failed to follow their own procedure by not carrying out something called stage 4 of HAI- SCRIBE before they accepted the hospital as complete from the contractors, IHSL. In addition, they failed to consult with their own Infection Prevention Control (IPC) specialists. **This resulted in the Health Board accepting and paying for a hospital that it could not use**.

6. The Health Board accepted practical completion and handover of the hospital when it was incomplete. This triggered the Health Board's obligation to start paying for a hospital, which it was unable to use. The core participants and members of the public are no doubt going to question this quite remarkable decision of a public body, which has led to a significant waste of public money and delays in treatment.

7. The HAI- SCRIBE procedure stands for "Healthcare Associated Infection System (for) Controlling Risk in the Built Environment". The procedure was developed to

identify, manage and mitigate issues in the built environment impacting on infection and prevention control risks. The stage 4 check referred to above requires to be completed before a hospital is handed over to a Health Board. As we have said this was not done. When the Health Board eventually proceeded with stage 4 of the HAI-SCRIBE assessment with the assistance of the Board's own Infection Prevention Control specialists the problems and deficiencies in the ventilation system were identified. They identified that certain parts of the new hospital ventilation system were potentially unsafe - this new hospital that the Health Board had previously accepted as completed without following standard safety procedures and without involving their own IPC staff. The actions and failures of the Health Board in this regard were frankly irresponsible. The seemingly cavalier disregard for patient safety in a hospital for the treatment of children, often those who are most vulnerable, seems hard to comprehend. We shall return later to the issue of what the Scottish Government ought to have done and failed to do at this stage.

8. The Health Board's IPC team were heavily involved at the early stages of the project. For reasons which were not clear the Health Board involved the IPC team less and less as the project progressed. Reasons for this from the Board witnesses remained rather opaque. In any event, the IPC team were not consulted on the final technical solution for the multibed rooms or the other ventilation solutions in the settlement agreement. This failure to use their own specialist IPC team remains a mystery and one that should simply not have happened in any Health Board involved in detailed technical discussions about ventilation and patient safety.

9. Turning now to the roles and relationship of the Health Board and Mott MacDonald Limited, who were the Board's technical advisers. The confused state of the nature of the relationship and responsibilities between the two of them ought to be embarrassing for both of them, as neither appeared to know what the other one was doing. This was much more than a lack of clarity as described by Counsel to the Inquiry. The Health Board considered that it was getting technical advice and assurance from MML whereas MML considered that it was not providing any such assurance. Quite how that has transpired was not explained properly by any of the witnesses and neither party appeared to accept any responsibility for the confusion,

which contributed significantly to the problems and why the original error was not rectified until shortly before the hospital was due to open.

10. An example of the failures by the Health Board and Mott MacDonald is that after the contractors IHSL issued a letter on 31 January 2019 stating, incorrectly as it turned out, that the ventilation system was compliant with the guidance in SHTM 03-01, neither of them checked or verified whether that statement was accurate. Firstly, no adequate explanation was provided by any of the witnesses for either the Health Board or for Mott MacDonald as to why that statement was not checked for its accuracy. Secondly, if it was not possible to check or verify the statement, which seems to us unlikely, they could have instructed an independent company to do the check as happened later with IOM Limited. IOM carried out testing of the ventilation system in critical care rooms shortly before the hospital was due to open and found that the ventilation in some of the rooms did not meet the required standard for the safety of the patients. Again, none of the witnesses appeared to take responsibility for this failure, which was a common theme throughout the hearings.

11. The Scottish Government provided the finance for the hospital project. They provided significant further funds to complete the project when it started to go off the rails. What sort of oversight was being carried out by the Government during the project and particularly in late 2018 and early 2019? The answer appears to be very little based on the evidence we have heard. The Government were aware of the major problems with the new Queen Elizabeth hospital in Glasgow in 2018. The same contractors were responsible for building both hospitals. Surely it should have occurred to someone in the Government that a major problem was developing at the new children's hospital in Edinburgh? Yet nothing appears to have been done until the very last minute.

12. The Health Minister was asked about the additional funding provided by the Scottish Government for the settlement agreement in January 2019 at a time when the stage 4 HAI-SCRIBE procedure had not been completed. It was clear that the Scottish Government had failed to check whether this obvious procedure had been complied with before they handed over the money for a hospital, which could not

be used. The public are entitled to ask how on earth could that happen? When questioned the Health Minister failed accept any responsibility for this clear and obvious oversight and placed all the blame onto the Health Board. The general theme of the Scottish Government's evidence was that the Health Board were solely responsible for all errors that occurred along with their advisors. In our view this amounts to an abrogation of responsibility by the Scottish Government. They paid for a hospital which could not be used and failed to ensure that the required safety checks had been carried out by the Health Board before they handed over the money.

13. There has been little evidence of any substance about term of reference 12, which was for the Inquiry: "To examine whether NHS Lothian had an opportunity to learn lessons from the experience of issues relating to ventilation, water and drainage systems at the QEUH and to what extent they took advantage of that opportunity." It appears that NHS Lothian had the opportunity, but failed yet again to act. Indeed Tracey Gilles, provided an example of a "formal meeting" that was held between individuals at the QEUH and RHC to try and learn lessons from the QEUH project, where it appears to have been deemed that no meeting minutes would need to be kept. Equally the Scottish Government were aware of the problems with the ventilation system at QEUH when they wrote to all the Health Boards in January 2019 asking them to inspect all critical ventilation systems for compliance with the guidance: SHTM03-01. Did this result in greater scrutiny of what was happening at the new children's hospital by the Scottish Government? The answer to that appears to no. No proper explanation was given as to why the Government appeared unaware of what was happening until 2 July. In our view this failure lies at the door of the Scottish Government, again, for which no responsibility was accepted.

14. The evidence as to whether this will not happen again in the future was unconvincing. A new body called NHS Assure has been created by the Scottish Government, no doubt at significant cost, to assist with new construction projects. If there had been proper scrutiny, checks and oversight by the Health Board, their advisors and the Scottish Government this whole series of events would not have happened. Significant additional public funds have been used to rectify the problems, which should never have occurred in the first place. It appeared to us

from the evidence we heard that NHS Assure would probably not have prevented the mistake from being identified.