Note of Decision by the Chair of the Scottish Hospitals Inquiry in relation to the Procedural Hearing held on 11 March 2025

Introduction

1. I convened a procedural hearing on 11 March 2025 in order to obtain the assistance of Counsel to the Inquiry and the legal representatives of the Core Participants in addressing matters arising from the hearing of evidence in relation to the Queen Elizabeth University Hospital and Royal Hospital for Children which commenced on 19 August 2024 and concluded on 13 November 2024 (Glasgow III) and identifying how best to conduct what are intended to be the final hearings in the course of the Inquiry, which are currently scheduled for later in 2025 (Glasgow IV).

Agenda

2. The following items were listed as the agenda of the hearing
   - 2.1. Immediate publication of the closing statements of Counsel to the Inquiry and Core Participants following Glasgow III
   - 2.2. Witnesses and documents – further evidence required for Glasgow IV
   - 2.3. Application by NHS Greater Glasgow and Clyde Health Board (GGC) to admit into evidence report by Professor Hawkey, Dr Agrawal and Dr Drumwright (the HAD Report) and hear the authors as witnesses
   - 2.4. Practical implications of the outcome of the GGC application
   - 2.5. Matters rising from closing statements submitted after Glasgow III
   - 2.6. Requests to Core Participants by Counsel to the Inquiry

Participants

3. In addition to Counsel to the Inquiry (Fred Mackintosh KC and Craig Connal KC), the following legal representatives of Core Participants made representations at the hearing.
   - 3.1. Peter Gray KC on behalf of GGC

3.2. Ruth Crawford KC on behalf of Scottish Ministers

3.3. Una Doherty KC on behalf of NHS National Services Scotland

3.4. Helen Watts KC on behalf of Dr Teresa Inkster, Dr Christine Peters and Dr Penelope Redding

3.5. Clare Connelly, Advocate on behalf of Molly and John Cuddihy and Eilidh and Lisa Mackay

3.6. Steve Love KC on behalf of the affected Core Participants: patients, parents and representatives of adult and child patients affected by their treatment at the QEUH

4. Each of the legal representatives provided a written note setting out the respective positions of the Core Participants they represented in relation to the matters identified in the agenda in which they had an interest, in addition to what they submitted orally. I shall briefly summarise these positions but I refer to these notes, which accompany this Note of Decision, for fuller statements of what was put before me.

Summary of submissions

5. Counsel to the Inquiry (Craig Connal KC)

5.1. Mr Connal addressed the issue whether the HAD Report should be admitted into evidence and its authors led as witnesses.

5.2. Admission of the report would cause disruption, delay and additional expense. Notwithstanding the decision of Lady Wise in the petition for judicial review at the instance of *Greater Glasgow Health Board* [2025] CSOH 12, the Chair had no obligation to receive the report but the Chair should have regard to what was set out by Lady Wise in her opinion particularly at paragraphs 33, 34 and 36.

5.3. Mr Connal accepted that the authors of the report would appear to have relevant expertise but he made no concession beyond that. It was premature to come to any view as to the value of the report, notwithstanding the argument set out in the GGC note in support of its admission. He accepted that overall fairness might require admission of

the report and hearing from its authors. Moreover, its inclusion with the rest of the evidence available to the inquiry might make for more robust and defensible findings than would otherwise be the case. A timetable would be required for consideration of the report by Counsel to the Inquiry and Core Participants as had been foreshadowed in the GGC note but, should the HAD Report be admitted, the timetable adopted might differ from that proposed by GGC.

6. Peter Gray KC on behalf of GGC

6.1. Mr Gray invited me to admit the report and allow its authors to be led in evidence, for the reasons set out in his written note. The report was directly relevant, especially to the Inquiry's Term of Reference (TOR) 1, and by extension TOR 5. Each author was a recognised expert in their field and in a position to assist the Inquiry. So far as the conclusions reached by the authors were concerned, they are very different to the Inquiry's experts' conclusions. The provision of contradictory expert evidence should be regarded as a significant development. It was likely to be in the interest of promoting fairness and avoiding loss of balance. Mr Gray accepted that acceding to the application will lead to a delay in the progress of the Inquiry. This was unfortunate but the value of the report outweighed the consequences of it being received. A timetable was proposed for a procedure to allow Counsel to the Inquiry and Core Participants to review the report and the data on which it was based (it ran to 30 July 2025 with a hearing commencing on 19 August 2025).

6.2. Mr Gray confirmed that the data set informing the epidemiological element of the HAD Report had been provided to the Inquiry and could be provided to Core Participants subject to appropriate safeguards for confidentiality. The HAD Report authors' calculations and all the information which had been provided to the authors by GGC, would be provided to the Inquiry and to Core Participants who wished to have this material.

6.3. I raised with Mr Gray a matter which formed part of item 5 of the agenda but which in my opinion was also relevant to his application. That was the

importance of determining the facts relevant to the matters discussed in the HAD Report and the Terms of Reference more generally, and therefore the importance of my fully understanding core participants' respective positions on these facts.

6.4. Following Glasgow III I directed Counsel to the Inquiry and invited the legal representatives of Core Participants (CPs) to submit closing statements as are provided for by rule 10 of the Inquiries (Scotland) Rules 2007.

6.5. Closing statements are the means whereby Core Participants can communicate with the chair of an inquiry their view of the effect of the evidence which has been heard. As I said to Mr Gray, that meant my receiving in the closing statements a full analysis of the core participants' perspectives on the evidence heard, in the light of what was proposed by Counsel to the Inquiry in their closing statement. I had set out a request for such an analysis in paragraphs 2.1, 2.2 and 2.3 of Direction 9 which was issued prior to the commencement of Glasgow III. It did not appear to me that the closing statement submitted on behalf of GGC met the expectation set out in these paragraphs. I referred Mr Gray to the GGC closing statement and, in particular, paragraph 21 where it appeared to me that my request had effectively been declined. The result was that I did not have the benefit of the assistance that would be afforded by an explanation of the challenge to Counsel to the Inquiry's summary of the effect of the evidence heard at Glasgow III which informed some of the statements in the GGC closing statement. Neither did the legal representatives of the other Core Participants.

6.6. Mr Gray indicated that he understood my point and, at my invitation, agreed to provide a further closing statement, compliant with the request made at paragraphs 2.1, 2.2 and 2.3 of Direction 9, by the end of June 2025 (which I will take as Friday 27 June 2025).

7. Ruth Crawford KC on behalf of Scottish Ministers

7.1. Ministers adopt a neutral position on whether the HAD Report should be admitted but invited the Chair to direct himself by reference to section 17

(3) of the Inquiries Act 2005 and paragraphs 33,34 and 36 of the Opinion in *Greater Glasgow Health Board*.

7.2. In relation to how the evidence of the experts might be most efficiently led, Ms Crawford suggested that consideration might be given to a joint managed discussion with all relevant expert witnesses present, with a view to identifying the points on which the experts agree and the points on which they disagree. Ms Crawford explained that this is colloquially described as "hot-tubbing".

8. Una Doherty KC on behalf of NHS National Services Scotland

8.1. On behalf of NSS Ms Doherty maintained a neutral position on whether the HAD Report should be admitted, but in the event that it was admitted, proposed that it should be reviewed by NSS and statisticians instructed on its behalf. NSS had identified some matters on which further evidence was required. Laura Imrie and Shona Cairns were proposed as suitable witnesses to provide statements on these matters.

9. Helen Watts KC on behalf of Dr Teresa Inkster, Dr Christine Peters and Dr Penelope Redding

9.1. On behalf of her clients Ms Watts maintained opposition to receipt of the HAD Report. She and those she represented were not in a position meaningfully to consider chapter 7 of the report. They will likely need to apply for funding to instruct an expert epidemiologist. There is likely to be difficulty in meeting the projected timetable for the consideration and leading of this evidence.

10. Clare Connelly, Advocate on behalf of Molly and John Cuddihy and Eilidh and Lisa Mackay

10.1. Ms Connelly adopted a neutral attitude to receipt of the HAD Report but in the event of it being received would wish for confirmation through access to the data set, that the cases of Mycobacterium chelonae were included.

10.2. In her submission there was a lacuna in the evidence led to date which needed to be filled by leading an expert in governance, and that for the reasons set out in her written note. Her clients had identified a suitable candidate. However Counsel to the Inquiry had declined to agree to leading this evidence.

11. Steve Love KC on behalf of the affected Core Participants: patients, parents and representatives of adult and child patients affected by their treatment at the QEUH

11.1. Mr Love too adopted a neutral position on receipt of the HAD Report. He had provided a written note where there was identified a need for funding to be provided to those he represented to allow the instruction of experts to advise on the report. He had nothing further to add.

12. Counsel to the Inquiry (Fred Mackintosh KC)

12.1. Mr Mackintosh confirmed that Directions 8 and 9 had set out deadlines for Core Participants to propose additional witnesses and identify additional documents. The responses to those and the closing statements from Core Participants to Glasgow III had been considered by Counsel to the Inquiry and that has resulted in the provisional witness lists for the balance of the Inquiry sent to Core Participants legal teams last week. However, discussions with legal representatives of Core Participants were continuing. Subject to the outcome of these discussions, I understood Mr Mackintosh to remain open to including additional witnesses.

12.2. Mr Mackintosh turned to address item 4 on the agenda, the practical implications of acceding to the GGC application and the consequent receipt of the HAD Report and leading its authors in evidence.

12.3. In the event of the HAD Report being received, there were six elements within that report which, in the light of evidence heard in GII and GIII, called for particular attention and therefore preparatory work, some of which had already been started.

12.4. It appears from its introduction, that the HAD Report (mainly in Chapters 3 and 4) is a critique of the Case Notes Review (CNR) Overview Report, which was commissioned by the then Cabinet Secretary for Health and Sport and published in March 2021, and, accordingly, the extent to which the CNR report can assist the Inquiry. Counsel to the Inquiry agreed with the Scottish Ministers that it is essential to hear the response to the HAD Report. by the three members of the CNR Expert Panel. Contact had been made with the three experts and while Mr Mackintosh could not commit to how their evidence would be captured, it was important that this be done effectively and in a manner that was fair to the large amount of work they and the rest of the CNR Team had done between 2020 and 2021.

12.5. The proposition is advanced in the HAD Report that if the water system had "widespread contamination" this would be seen in increased rates of infection in both adult haemato-oncology patients and paediatric haemato-oncology patients. Given that the Inquiry has proceeded on the basis that there was no noticeable increase in rates of infection in adult haemato-oncology patients during the period they were located at the QUEH, as compared to elsewhere, this proposition would need to be considered.

12.6. Chapter 7 of the HAD Report contains an analysis of infection rates amongst both adult haemato-oncology patients and paediatric haemato-oncology patients at the QUEH/RHC and elsewhere in Glasgow. It was necessary to understand and check these calculations.

12.7. The HAD Report reaches conclusions on the rate of environmentally relevant blood stream infections in the Schiehallion Unit at RHC that appear to suggest that the rate peaked at around 17 Blood Stream Infections (BSI) per 1,000 bed days in 2018 when HPS in their October 2019 report calculated a rate of environmental blood stream infections peaking at five or seven BSI per 1,000 bed days in 2018. This apparent inconsistency needed to be understood.

12.8. The HAD Report appears to reach the conclusion that the rate of environmentally relevant blood stream infections in the Schiehallion Unit at Yorkhill were higher than that at RHC. This does not appear to be

something put to clinical witnesses in Glasgow II and is apparently inconsistent with the general tenor of evidence indicating that rates of infections in Schiehallion Unit at RHC were unusual. This apparent inconsistency needs to be understood and will at the very least involve sending written questionnaires to a range of Glasgow II and III witnesses who have direct experience of Yorkhill.

12.9. The data in Chapter 8 is of a class, that is non Blood Stream Infection test results in respect of Aspergillus, not previously sought or available to the Inquiry and if the HAD Report were to be received it must be properly understood and scrutinised and the opportunity be taken to connect this data with the PAG, IMT and reports to HPS/ARHAI about which the Inquiry has already heard evidence.

12.10. Mr Mackintosh was grateful for proposals by GGC on how practically to deal with the process around this and agreed that the Direction 5 procedure should be used to ensure that all Core Participants can ask questions of the authors of the HAD Report. However, Mr Mackintosh would propose to start that process rather sooner than suggested. The Inquiry would accordingly open communication with a questionnaire directed to Professor Hawkey, Dr Agrawal and Dr Drumwright. Direct communication between them and the GGC and its legal advisers should now cease given the proposed change in status of these witnesses.

12.11. In addition to the members of the CNR Expert Panel Counsel to the Inquiry propose to obtain reports from Dr Mumford and Mr Mookerjee on the HAD Report. This will involving sharing the data sets, the reports and the response to that questionnaire from Professor Hawkey, Dr Agrawal and Dr Drumwright with Dr Mumford and Mr Mookerjee. Dr Mumford should be asked to prepare a Report for the Inquiry on the whole HAD Report, on the validity of its methodology and conclusions from an Microbiology and IPC perspective.

12.12. Mr Mookerjee should be asked to prepare a Report for the Inquiry reviewing the methodology and conclusions for Chapter 7 and to also consider if there are any points of comparison or connection between

Chapter 7 and other epidemiology studies known to the Inquiry, particularly those carried out by HPS and Dr Kennedy in 2018/2019 and by him for the Inquiry.

12.13. Dr Mumford and Mr Mookerjee should be asked to prepare a Report for the Inquiry reviewing the methodology and conclusions for Chapter 8 in respect of Aspergillus infections and see if there are any points of comparison or connection with the narrative of Aspergillus infections already analysed by Dr Mumford and Ms Dempster.

12.14. The authors of the HAD Report should have an opportunity to respond to any questions, clarifications or criticisms made by Dr Mumford and/or Mr Mookerjee. Equally the Direction 5 procedure should be used in order to allow Core Participants to direct questions to Professor Hawkey, Dr Agrawal, Dr Drumwright, Dr Mumford and Mr Mookerjee.

12.15. Counsel to the Inquiry welcomed the proposal from NSS that their data scientists comment on the HAD Report. Counsel to the Inquiry proposed to take up that suggestion and share relevant information with NSS

12.16. Given the lateness of the production of the HAD Report, some three months after Dr Inkster, Peters and Redding finalised their statements, Counsel to the Inquiry proposed that all the data and documents shared by GGC with the authors of the HAD Report should be made available to Drs Inkster, Peters and Redding so that they may properly instruct their counsel.

13. Counsel to the Inquiry (Craig Connal KC)

13.1. Mr Connal referred to the immediately next stage of the Inquiry; a three week hearing (to be known as Glasgow IV, Part 1) to be held in the three weeks beginning on 13 May 2025, with a primary focus on the evidence on the GGC Project Team for the construction of the hospitals, the contractors and consultants. Preparation remained underway. Mr Connal emphasised that this would be assisted by Core Participants with the relevant knowledge being forthcoming in sharing that with the Inquiry.

Decisions

14. Immediate publication of closing statements on the website

14.1. As already mentioned, following Glasgow III I directed Counsel to the Inquiry and invited the legal representatives of Core Participants to submit closing statements as are provided for by rule 10 of the Inquiries (Scotland) Rules 2007. Counsel to the Inquiry duly submitted a closing statement, as did legal representatives of Core Participants. These have been distributed among legal representatives, initially subject to a Restriction Order.

14.2. Section 18 (1) (a) of the Inquiries Act 2005 provides that the Chair must take such steps as he considers reasonable to secure that members of the public (including reporters) are able to obtain or to view a record of evidence and documents given, produced or provided to the inquiry. The Inquiry therefore intimated to Core Participants that I was minded to direct publication of all closing statements on the Inquiry website. No objection to that course of action was received and accordingly I direct that the closing statements should be so published. The Restriction Order is accordingly varied.

14.3. However, I must very strongly emphasise that nothing in the closing statements including the closing statement submitted by Counsel to the Inquiry represents my view on the matters discussed. The closing statements are simply submissions as to what I should make of the evidence heard at Glasgow III, taken together with previously heard evidence. Different views are expressed both on the effect of the evidence and the way in which relevant questions in relation to that evidence have to be addressed. I have yet to come to a conclusion on these points and in doing so I will have to take into account the other evidence I have heard and have yet to hear, as well as all of what all the core participants have to say about matters.

14.4. When the reader is considering what is said in the closing statements about the water and ventilation systems in particular parts of the hospitals being or not being in an unsafe condition at various points in time, regard

must be had to the context in which Counsel to the Inquiry had invited witnesses to approach the concept of "unsafe condition", by reference to whether particular features of the systems, taken in isolation, presented an additional risk of avoidable infection to patients, whereas the legal representative for GGC submitted that there were severe shortcomings in that approach and that Counsel to the Inquiry's submissions were made on insufficient and sometimes plainly flawed evidence. It is the GGC position that infection management and control is multifactorial. Accordingly, regard must be had to the steps taken to mitigate specific risks. The conclusion that GGC consider that the Inquiry should reach is that the hospital is safe and that there is no need for public concern as to any risk posed by the hospital.

14.5. As I have said, when I come to make my determination I shall have to have regard to these and all other submissions and not only the evidence I have heard but the evidence I have yet to hear.

15. Witnesses and Documents

15.1. Provision is made in Direction 9 at paragraphs 2.4 to 2.5, 4 and 5 for core participants to notify which witnesses and documents they consider it is still necessary to lead or produce.

15.2. Counsel to the Inquiry have considered these notifications and issued provisional lists of the witnesses they propose to call in Glasgow IV.

15.3. Substantial agreement has been reached among Counsel to the Inquiry and the legal representatives of Core Participants as to who are relevant witnesses to the Inquiry. This agreement is not however complete and is potentially contingent on whether the HAD Report is to be received and its contents be part of the evidence heard by the Inquiry. I was not asked to make any decisions under this head of the agenda. In the immediate future at least it is appropriate to leave choice of witnesses in the hands of the Counsel to the Inquiry in consultation with the legal representatives of the Core Participants.

16. The GGC application

16.1. GGC has submitted an application "that the Inquiry receive the evidence of Professor Hawkey, Dr Agrawal and Dr Drumwright in respect of their report on the evidence of risk of infection from the water and ventilation systems at the QEUH/RHC, how that might be accomplished and what steps would require to be taken to ensure that the procedure to be adopted will be fair".

16.2. I heard a similar application in respect on 30 July 2024 with the difference that it was to receive the HAD Report with a view to it being considered as part of the evidence and its authors being led at Glasgow III, which was due to commence on 19 August 2024. I refused its admission then on the basis that to accept an report of this nature commissioned by one core participant was incompatible with the investigative nature of a public inquiry, but also because, on the basis to the submissions I had heard from core participants, if the report was to be received and its authors led, it would not have been possible to conduct a Glasgow III hearing beginning on 19 August 2024 which met the requirements of procedural fairness. In her decision in *Greater Glasgow Health Board* Lady Wise determined that I was in error in respect of the first of my reasons; the chair of an inquiry must listen fairly to any relevant evidence and rational argument that a person represented at the inquiry and whose interest may be adversely affected by its findings may wish to place before him.

16.3. Given the court's decision and the change of circumstances in that the application is no longer being made three weeks before the hearing at which it is proposed to lead the relevant evidence, I can and do consider GGC's application afresh, having regard to Lady Wise's opinion in *Greater Glasgow Health Board* and in particular the passages to which I was referred during the Procedural Hearing.

16.4. Only Ms Watts maintained opposition to the admission of the HAD Report, with other of the legal representatives and Counsel to the Inquiry maintaining neutral positions, but she and they were agreed that the decision was a matter for the discretion of the Chair, having proper regard

to the terms of section 17(3) of the Inquiries Act 2005. That subsection is in these terms: “In making any decision as to the procedure or conduct of an inquiry the chairman must act with fairness and with regard also to the need to avoid any unnecessary cost (whether to public funds or to witnesses or others)”.

16.5. Part of the framing context of this application is that the HAD Report comes late, and that notwithstanding that it will be for Counsel to the Inquiry to lead the necessary associated evidence it is not yet clear that they have been provided with all the material necessary for them fully to understand the basis upon which the authors were instructed, or to assess, in particular, the epidemiological element within the HAD Report. The supporting calculations are promised but not yet available.

16.6. What is now very clear, and explicitly acknowledged by GGC by the proposed timetable included as part of the written statement submitted in support of the application, receiving the report, considering it and hearing the evidence of its authors will, of necessity, involve a considerable amount of work by Counsel to the Inquiry and the Inquiry Team as well as by Core Participants. That will take time and inevitably result in cost and in delay. If it had been implicit in GGC’s earlier application heard on 30 July 2024 that this evidence could simply be accommodated at the end of a previously scheduled hearing without very significant preparation, that is no longer the case in relation to the present application. Counsel to the Inquiry has set out in Direction 10 his proposed timetable for dealing with the HAD Report evidence. Ms Watts, however, was sceptical as to whether it was realistic.

16.7. Mr Mackintosh’s outline of the particular matters to be addressed, as summarised above, gives an indication of not only what needs to be done but is a reminder that in anticipation of consideration of this application and with a view properly analysing its implications Counsel to the Inquiry has already had to carry out a not inconsiderable amount of work in time that might have been devoted to other business of the Inquiry.

16.8. As mentioned by Mr Mackintosh, the fact that Professor Hawkey, Dr Agrawal and Dr Drumwright were commissioned by GGC means that if they are to be led by Counsel to the Inquiry, that has consequences for the work that needs to be done and how long it will take. It will, for example, be necessary to ascertain exactly what information they were provided with. It will also be necessary to terminate their status as experts instructed by GGC.

16.9. It is not of course only Counsel to the Inquiry who need to understand this evidence, it is also the Core Participants. That will also require preparation and take time.

16.10. In deciding whether to receive this evidence, I have had regard to everything put before me, including the terms of the HAD Report. It is relevant to the Inquiry's Terms of Reference. It is, on its face (although this would be a matter for further consideration) supportive of the position that GGC consider to be the correct position and contradictory of other evidence that the Inquiry has heard. I can therefore see that fairness might be said to require the other side of the argument to be heard. The HAD Report is critical of the CNR report on which the Inquiry might put weight. Overall, these considerations point to receiving the HAD Report notwithstanding the consequent cost and delay. What I would see as important is that, insofar as possible, the Inquiry should endeavour to put itself into a position to reach decisions which are based on all the available relevant evidence and in which the public can therefore have confidence. As Mr Connal submitted, the findings of the Inquiry should be robust and defensible. A consideration of the HAD Report, irrespective of the outcome of that, should assist in achieving that objective.

16.11. I shall therefore grant the application to receive the evidence of Professor Hawkey, Dr Agrawal and Dr Drumwright in respect of their report on the evidence of risk of infection from the water and ventilation systems at the QEUH/RHC. How that is achieved will initially be for Counsel to the Inquiry to determine subject to any further applications as may be made.

17. Matters rising from closing statements submitted after Glasgow III

17.1. Two matters arise from the closing statements submitted to the Inquiry following Glasgow III. They may be sufficiently identified by referring to relevant paragraphs in Directions issued by the Inquiry.

17.2. The first reference is to Direction 9 paragraph 2.1 to 2.3:

> "2. Whereas Core Participants may include in their written closing statements such references to evidence and submissions as they consider relevant to the Inquiry's Terms of Reference, the Chair would wish that:
>
> "2.1 Where a Core Participant disputes the accuracy of the narrative or proposed findings set out in Counsel to the Inquiry's written closing statement, they identify the relevant passage or passages, and explain the basis of and reason for the dispute under specific reference to such documents and witnesses' transcripts or statements on which they rely
>
> "2.2 Where a Core Participant proposes that the Chair should adopt a narrative or make findings additional to what is proposed by Counsel to the Inquiry, they set out such narrative or findings under specific reference to the documents and witnesses' transcripts or statements on which they rely
>
> "2.3 Where it is proposed that the Chair should disregard any evidence heard or considered by the Inquiry in the three Glasgow hearings or within PPPs 5, 11, 12 and 14 a Core Participant set out clearly and explicitly which evidence should be disregarded and why the Chair should do so by reference to that evidence and any other evidence that is relied on"

17.3. I understand that Mr Gray accepted that the GGC closing statement did not comply with what was requested Direction 9 paragraph 2.1 to 2.3 and the result was that it did not afford the assistance to the Chair that was looked for. I am very grateful to him for agreeing to submit a further closing statement which will meet what is requested in the paragraph. He further agreed that this will be done by 27 June 2025. It will then be distributed to other Core Participants and published on the website.

17.4. The second reference is Direction 10 paragraph 6 (issued subsequent to Glasgow III) to which I would draw attention:

> “Core participants are reminded that any question relating to whether witnesses are being asked questions to which they object or are not being asked questions that it is believed they should be asked, or any other issue about the conduct of the hearing must be drawn to the Chair's attention at the time the issue arises or made the subject of a formal Rule 9 application”.

17.5. My objective is that hearings be conducted fairly, relevantly and courteously. If legal representatives consider that that objective is not being achieved, I wish the matter be raised at the time in order that appropriate action be taken.

The Right Honourable Lord Brodie KC PC
Chair of the Scottish Hospitals Inquiry
12 March 2025

Annex 1 : Responses by Core Participants to "Direction 10 – in respect of the hearings relating to Glasgow III & IV and further procedure"

1. Pursuant to paragraph 1 of Direction 10, NHS GGC prepared a written statement in support of its renewed application that the Inquiry receive the expert report by Professor Hawkey and Drs Agrawal and Drumright.
2. Paragraph 2 of Direction 10 invited Core Participants who wished to make submissions to the Chair in response to the application by NHS GGC or to propose that the Inquiry should hear any other identified witness on the issues likely to be the subject of such evidence, to set out that response in a written statement to the Solicitor to the Inquiry.
3. Both NHS GGC's written statement and the Direction 10 responses of other Core Participants may be found in the following pages in this order:
    a. NHS GGC
    b. Scottish Ministers
    c. NSS
    d. Cuddihy & Mackay
    e. Patients & Families
    f. Drs Inkster, Redding and Peters

SCOTTISH HOSPITALS INQUIRY

GREATER GLASGOW HEALTH BOARD

WRITTEN STATEMENT IN SUPPORT OF APPLICATION THAT THE INQUIRY RECEIVE THE EXPERT REPORT OF PROF HAWKEY, DR AGRAWAL AND DR DRUMWRIGHT DATED 24 JULY 2024

1. INTRODUCTION

1.1. In terms of Inquiry Direction 10 dated 17 February 2025, Greater Glasgow Health Board ("**NHSGGC**") is invited to provide a written statement in support of its application "*that the Inquiry receive the evidence of Professor Hawkey, Dr Agrawal and Dr Drumwright in respect of their report on the evidence of risk of infection from the water and ventilation systems at the QEUH/RHC, how that might be accomplished and what steps would require to be taken to ensure that the procedure to be adopted will be fair.*" This document is NHSGGC's written statement in response to that request.

1.2. NHSGGC invites the Chair to allow the report of Professor Peter Hawkey, Dr Samir Agrawal, and Dr Lydia Drumwright titled *"Expert Report for the Scottish Hospitals Inquiry on the evidence of risk of infection from the water and ventilation systems at the Queen Elizabeth University Hospital and Royal Hospital for Children, Glasgow"* dated 24 July 2024 (the "**Report**") to be received into evidence, for its authors to be called to give oral evidence and for regard to be had to their conclusions in making any findings and recommendations in respect of the Inquiry's Terms of Reference.

1.3. This application is made in terms of section 17(3) of the Inquiries Act 2005, and paragraphs 2 and 4 of Inquiry Direction 9. The Report is of direct relevance to the Inquiry's Terms of Reference. It is submitted that it will assist the Chair in making findings and recommendations as to the safety of the hospital. It accordingly ought to be admitted into evidence and its authors ought to be called to give oral evidence to the Inquiry.

1.4. NHSGGC notes that, in accordance with Direction 10, the hearing fixed to commence on 11 March 2025 will take the form of a procedural hearing and that a two-week hearing (to be known as Glasgow IV, Part 2) has been fixed to begin on 19 August 2025 to hear any evidence that arises from decisions made at the Procedural Hearing. NHSGGC invites the Inquiry to hear the oral evidence of the authors of the Report at Glasgow IV, Part 2.

2. THE REPORT

2.1. It is submitted that the Report directly addresses the question, did/does the built environment of the QEUH/RHC expose patients to an increased risk of infection. The Report therefore directly addresses the issues in Term of Reference 1.

2.2. All of the authors of the Report are recognised experts in their respective fields. Professor Peter Hawkey is Professor Emeritus of Clinical & Public Bacteriology and Consultant Clinical Microbiologist, Grampian Health Board. Dr Samir Agrawal is Consultant Haematologist, St Bartholomew's Hospital and Senior Lecturer Queen Mary University of London. Dr Lydia Drumwright is Research Assistant Professor, University of Washington. The authors are independent and skilled witnesses. It is submitted that the authors satisfy the requirements of skilled witnesses as set out by the Supreme Court in *Kennedy v Cordia,* in particular at paragraph 44.

2.3. The Report concludes, following detailed data analysis, that there were no excess infections at the QEUH/RHC when compared with other hospitals. It provides the following analysis:

2.3.1. The types of bacteria identified in the CNR are common in the environment as a whole and in patients' own flora and therefore cannot simply be attributed to the hospital built environment. Establishing a link requires consideration to be given to alternative sources of infection, such as the patient themselves. The report addresses how an infection can be linked to a particular source. This is not done by the Inquiry's experts.

2.3.2. As it is common for infections to occur and for bacteria to be present in the environment as a whole, before it can be said that there is an abnormal (increased) level of risk, it must first be determined what is the normal level of risk. It is appropriate that this is done by conducting a robust comparison with infection rates in comparable hospitals. It is submitted that the Report provides such a robust comparison.

2.3.3. Infection control is multifactorial. Steps taken to manage risk within the QEUH include, but are not limited to: use of single en-suite rooms, prophylaxis, PPE, air filtration, air pressure differential, limiting access to patients, staff vaccination, cleaning regime, screening, testing and monitoring. The combined impact of these features in a hospital environment, particularly one used to treat neutropenic patients, must be understood in order to determine what is "safe" or "unsafe". The Report takes into account steps taken to mitigate risk. The Inquiry's experts do not

engage with overall infection risk management. Many of the Inquiry's experts do not have clinical expertise and so are unable to comment on clinical matters such as use of prophylaxis to mitigate infection risk. Instead, they focus on water and ventilation in isolation. It is submitted that this is the incorrect approach.

2.4. The Report therefore represents crucial evidence by addressing multiple potential sources of infection, providing a robust comparative exercise with other hospitals and taking into account wider mitigation of risk. It is submitted that this evidence is required to fully address the terms of reference. At the very least, the Report, and its conclusions, are a contradictory view to those of the Inquiry Experts and ought to be considered by the Inquiry.

3. BASIS FOR APPLICATION

3.1. NHSGGC notes that, in terms of Direction 10, a Procedural Hearing will be held on 11 and 12 March 2025. It is anticipated at that hearing that the Chair will be invited to make a decision on receipt of the report, consider how that may be done and hear from other core participants on whether the report should be received and how it should be addressed. NHSGGC sets out below the basis for its application and how it considers the Inquiry could lead evidence from the authors of the Report. It is recognised that the appropriate procedure is ultimately a matter for the Chair in terms of s17 of the Act.

3.2. The Inquiry has led evidence from 6 experts. The tenor of all six experts was to the effect that the ventilation and water systems at QEUH posed an increased risk of avoidable infections to patients and accordingly were "unsafe". Such a conclusion will undermine public trust in the QEUH. The conclusion that Scotland's largest hospital and a nationally important paediatric cancer centre is "unsafe" and exposes patients to an increased risk of infection is a serious one.

3.3. None of the Inquiry's experts recognise that infection risk in hospitals is multifactorial. They instead look at each system in isolation and determine whether that system is or was unsafe. This does not, in NHSGGC's submission, address the question posed. The question posed requires consideration of "additional" risk of "avoidable" infection. It is submitted that the questions of whether a feature presents an additional risk, and whether any infection is "avoidable," require a holistic approach to the safety of the QEUH/RHC. It is not appropriate to consider one factor alone.

3.4. It is submitted that the application ought to be allowed on the basis of s17(3) of the 2005 Act. Section 17(3) provides that the Chair is obliged to act with fairness. In acting fairly, it is respectfully submitted that the Chair must listen fairly to any relevant evidence and rational

argument that a person represented at the Inquiry and whose interest may be adversely affected by its findings may wish to place before him [*Mahon v Air NZ* [1984] A.C. 808 at 820]. For the reasons outlined above, it is submitted that the Report provides relevant evidence and rational argument.

3.5. As noted by Lady Wise at para [33] of her opinion (2025 CSOH 12), the application is presented by a core participant for whom the risks, including loss of public confidence, are incalculable in a situation where the expert evidence adduced to date has all been to the same effect. It is submitted that the existence of contradictory expert evidence should be regarded as a significant development when considering the need for balance. Accordingly, it is respectfully submitted that section 17(3) and the duty to act with fairness requires the Report to be admitted into evidence.

3.6. Inquiry Direction 9 provides two further routes for this application:

3.6.1. At paragraph 2.4, the Chair invites core participants to state what additional evidence must be heard or considered by the Chair in order to answer each question, and explain why that is so. NHSGGC considers, for the reasons outlined above, that the Report addresses the questions in respect of the safety of the hospital. It is submitted that it ought to be considered by the Chair.

3.6.2. At paragraph 4, the Chair confirms that the object of Glasgow IV is to hear all the remaining evidence which is necessary for the Inquiry to address its Terms of Reference. Core participants are invited to identify all witnesses known to them from whom they consider it essential that the Inquiry hear evidence. It is submitted, for the reasons outlined above, that it is essential for the Inquiry to admit the Report and hear oral evidence from its authors in order to address the Terms of Reference.

3.7. In the circumstances, it is submitted that it is appropriate for the Report to be admitted into evidence and for its authors to be called to give evidence in Glasgow IV, Part 2.

4. TIMETABLE

4.1. The following proposed timetable is provided in terms of Direction 10 and in order to assist the Chair. It is recognised that the timetable is ultimately a matter for the Chair in terms of s17(1) of the Act.

4.2. Should the Inquiry admit the Report into evidence and call its authors to give evidence, it is submitted that it is appropriate that Counsel to the Inquiry question the authors. Counsel to

the Inquiry will require to familiarise themselves with the content of the Report, the underlying data, and will likely wish to consult with the Inquiry's existing expert witnesses. Core Participants also require sufficient time to consider the Report and address any questions to its authors. NHSGGC is mindful that the Report raises complex issues and has taken that into account in the suggested timetable. NHSGGC considers that the following indicative timetable is fair to all core participants and provides sufficient time for Counsel to the Inquiry to be in a position to examine the authors of the Report at Glasgow IV, Part 2:

4.2.1. Counsel to the Inquiry, together with the existing Inquiry expert panel if considered necessary, be allowed 8 weeks from the Procedural Hearing to consider the Report and underlying data. By the end of that period, being 7 May 2025, Counsel to the Inquiry would submit any questions to the authors of the Report, in a similar manner to the approach adopted by Core Participants in terms of Direction 5. Counsel to the Inquiry's questions would be made available to all core participants;

4.2.2. The authors of the Report be allowed 4 weeks to respond to those questions, being 4 June 2025. Their responses would be made available to all core participants;

4.2.3. Core Participants then be allowed 4 weeks to submit their own questions to the authors of the Report, in a similar manner to Direction 5. This would require to be done by 2 July 2025. The questions would be made available to all core participants;

4.2.4. The authors of the Report be allowed 4 weeks to respond, being 30 July 2025. Their responses would be made available to all core participants;

4.2.5. At Glasgow IV, Part 2, commencing on 19 August 2025, the authors of the Report would be called to give evidence. They would be questioned by Counsel to the Inquiry, with core participants able to utilise the Rule 9 process to put additional questions to them. Once the authors have given evidence, Counsel to the Inquiry may call, or recall, any witness who they consider appropriate in respect of the issues addressed in the Report. Counsel to the Inquiry may take into account the submissions of core participants in deciding which additional witnesses to call.

5. CONCLUSION

5.1. Having regard to s17(3) of the 2005 Act, and paragraphs 2 and 4 of Inquiry Direction 9, it is submitted that the Report ought to be admitted into evidence. NHSGGC invites the Chair to receive the Report into evidence, call its authors to give oral evidence and have regard to the conclusions of the authors in addressing the Terms and Reference and making recommendations.

Peter Gray KC

Emma Toner, Advocate
Andrew McWhirter, Advocate

20 February 2025

SCOTTISH HOSPITALS INQUIRY

WRITTEN STATEMENT

in terms of Direction 10

on behalf of the

SCOTTISH MINISTERS

1. This written statement is submitted on behalf of the Scottish Ministers in the following respects:

   1.1. in terms of paragraph 2 of Direction 10, in response to the application by NHS GGC;

   1.2. in response to the invitation in the Solicitor to the Inquiry's email of 3 March 2025, as regards publication of Counsel's and Core Participants' Closing Submissions on the Inquiry's website; and

   1.3. to note a further matter arising from the Closing Submissions of Core Participants, which have now been circulated.

Application by NHS GGC

2. The Scottish Ministers are neutral as to the outcome of the application.

3. They agree that the appropriate basis for the Chair's decision as to whether to accede to NHS GGC's application is ultimately section 17(3) of the Act, noting that that provision also requires express attention to the need to avoid unnecessary cost to public funds.

4. They also note, however, the observations of Lady Wise in her Opinion at [33] to [34], leading to her observation at [36] that the Inquiry must be enabled to make 'robust and defensible findings'. Those observations, of course, being made in the context of the Inquiry's Terms of Reference and the safety of the QEUH being matters of significant public concern.

5. If the Chair were minded to accede to the application, the Scottish Ministers would respectfully submit that the evidence should be heard in such a way and on such terms as to be fair to NHS GGC as well as other Core Participants, bearing in mind the stage that the Inquiry has reached and the potential impact on public funds.

6. With that in mind, the Scottish Ministers wish to canvass the possibility of NHS GGC's experts giving (at least part of) their evidence concurrently with other relevant skilled witnesses (that is, as it is colloquially known, by 'hot tubbing'), among whom the most directly relevant would appear to

be the Case Note Review panel (whose methodology, reasoning, and conclusions are criticised by NHS GGC's experts). In that regard, the Scottish Ministers note the Inquiry intends to obtain supplementary written statements from the Case Note Review panel but not necessarily lead further oral evidence from them. The Scottish Ministers would invite the Inquiry to keep that intention under review, noting that the extent to which there may be differences between the NHS GCC experts and the Case Note Review panel has yet to be ascertained.

7. While "hot-tubbing" would require re-calling the relevant witnesses, it might allow for more immediate identification and potentially reconciliation of points of difference among these skilled witnesses than sequential evidence would; and it would be consistent with the non-adversarial approach of the Inquiry.

8. It is right to note that there may be other practical issues such as the possibility that the Case Note Review panel would need to be given access to the necessary data platforms; the Scottish Ministers have yet to speak to the panel, but do not envisage any practical issues as being meaningful obstacles to such a course.

Publication of Closing Submissions

9. The Scottish Ministers consider in principle that publication would be appropriate bearing in mind the need for transparency. If minded to order publication, it is important to note that the Closing Submissions are just that. That being so, the Chair may wish to indicate (or reiterate) prominently that, for example, there remains a significant amount of evidence still to be heard as to the Inquiry's Terms of Reference, particularly as regards the Queen Elizabeth University Hospital, Glasgow (and perhaps including the expert evidence sought to be adduced by NHS GGC), which the Inquiry will consider fully before reaching a decision on what aspects of the Closing Submissions to accept.

Other matters arising from Closing Submissions

10. It is noted that NHS National Services Scotland suggests within its Closing Submission at paragraph 15 (pdf p.151) that more evidence will be needed if the topic of ongoing reporting of infections by NHSGGC is a matter of interest to the Inquiry. The Scottish Ministers respectfully associate themselves with this suggestion, adding only that this matter would appear to be directly relevant to the Inquiry's Term of Reference 9.

Ruth Crawford KC
Stephen Donnelly, Advocate
Harper Macleod LLP

7 March 2025

Scottish Hospitals Inquiry

WRITTEN STATEMENT
TO THE SOLICITOR TO THE INQUIRY

ON BEHALF OF NHS NSS

in response to GGC's application and in relation to additional witnesses for Glasgow IV hearings
(per Direction 10 at paragraph 2)

1. GGC is applying to have its report received into evidence ("the Report"). On 3 March 2025, NHS NSS ("NSS") received a Provisional Witness List for the Glasgow IV hearings. Direction 10 at paragraph 2 instructs Core Participants to set out, in a written statement, any (i) submissions in response to the application by GGC, and/or (ii) proposal that the Inquiry should hear from additional witnesses.

I. Submissions in response to the application by GGC

2. If GGC's application is successful, NSS considers that it would assist the Inquiry to receive a commentary from NSS on the Report. NSS would be happy to provide such a commentary ("the Commentary").

3. The Commentary would be on the epidemiological content of the Report. It would be similar in nature to the responses that NSS provided to Mr Mookerjee's report, and would be prepared by Shona Cairns, NSS Consultant Healthcare Scientist.

4. For the avoidance of doubt, the Commentary would not address microbiology or whole genome sequencing. Nor would it attempt to redo – rather than merely commenting on – the analysis in the Report.

5. In order for the Commentary to be as meaningful as possible, NSS would need access to the data (both raw and final) used by the Report's authors when preparing it. In addition, it would need support from an external statistician, who would assist by

providing specialist input in respect of the methodology used in the Report (there are several statisticians who collaborate with NSS).

6. NSS notes the suggested timetable in GGC's application. With regard to how long it would take to produce the Commentary, NSS notes that it has not yet seen the data referred to above. But, on the assumption that the data is broadly as expected, NSS should be able to provide the Inquiry with its Commentary within 8 weeks of receiving that data.

7. In the event that Shona Cairns is provided with the data to enable her to provide the Commentary on the Report, she should be listed as an additional witness for Glasgow IV Part 2.

II. Additional witnesses

8. On 31 January 2025, following the Glasgow III hearings and receipt of the Closing Statement by Counsel to the Inquiry, NSS submitted a Closing Statement. NSS's Closing Statement referred to some matters on which evidence has not yet been heard. It was thought that these matters would assist the Inquiry.

9. NSS proposes two additional witnesses who will be able to speak to these matters in written statements:
    a. Laura Imrie, Clinical Lead at NHS Scotland Assure; and
    b. Shona Cairns, NSS Consultant Healthcare Scientist.

10. With reference to NSS's Closing Statement, Ms Imrie can speak to paragraphs 16 to 17, 37 and 40. Ms Cairns can speak to paragraphs 26 to 31, and 34 to 35.

11. NSS notes that Thomas Rodger, already a witness in the Provisional Witness List for Glasgow IV, Part 3 (see below), will speak to new matters raised in other paragraphs of NSS's Closing Statement.

III. Miscellaneous matters

12. In the section of the Provisional Witness List on Glasgow IV, Part 3, one of the witnesses listed is Jim McMenamin. He is described as "Head of Infections Service,

NHS NSS". In fact, Dr McMenamin is employed by Public Health Scotland rather than NSS.

13. In the same section, one of the witnesses listed is "Roger Thomas" (the Head of Engineering at NSS). This should be "Thomas Rodger".

7 March 2025

SCOTTISH HOSPITALS INQUIRY

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

IN RESPECT OF
(A) THE APPLICATION THAT THE INQUIRY RECEIVE THE EXPERT REPORT OF PROF HAWKEY, DR AGRAWAL AND DR DRUMWRIGHT DATED 24 JULY 2024
(B) ADDITIONAL EVIDENCE THAT THE INQUIRY SHOULD CONSIDER IN THE COURSE OF GLASGOW IV

1. INTRODUCTION

Direction 10 was issued by the Public Inquiry in respect of Glasgow III and IV Further Procedure. Direction 10 states at paragraph 2:

2. Core Participants who wish to participate in the Glasgow IV hearing who wish to make submissions to the Chair in response to the application by NHS GGC or to propose that the Inquiry should hear any other identified witness on the issues likely to be the subject of such evidence should set out that response in a written statement to the Solicitor to the Inquiry by noon on 7 March 2025.

This submission has been prepared on behalf of the Cuddihy and MacKay families in response to paragraph 2 above.

(A) THE APPLICATION THAT THE INQUIRY RECEIVE THE EXPERT REPORT OF PROF HAWKEY, DR AGRAWAL AND DR DRUMWRIGHT DATED 24 JULY 2024.

The Cuddihy and Mackay families maintain a neutral position in respect of the application by NHS GGC to have their Expert Report Received. However, in the event that the Report is allowed, we request that copies of the letters of instruction and all documents that were furnished to said experts in respect of their instruction to prepare said Report, be made available to all Core Participants at the same time as the Report itself.

(B) ADDITIONAL EVIDENCE THAT THE INQUIRY SHOULD CONSIDER IN THE COURSE OF GLASGOW IV.

(i) As noted in the written submissions for Glasgow III, we submit that the Inquiry would benefit from hearing from Mrs Lisa MacKay, Prof John Cuddihy and Molly Cuddihy. In the interests of fairness we believe that oral evidence in addition to Inquiry statements should be taken from each of these witnesses to facilitate Core Participants making Rule 9 applications.

(ii) In addition, we submit that the Inquiry witnesses to date and the proposed witnesses will result in their being a lacuna in the evidence around the issue of Governance.

It is respectfully submitted that, to date, a substantial body of evidence had been led of individual failures, including, failure to action the 2015 and 2017 DMA Canyon Reports timeously; failure to respond to early alerts of non-compliance with existing guidance on ventilation (email exchanges involving Dr Peters from the period 19th June 2015 to 1st July 2015 where she provides a checklist of the required specification for ventilation, the current state and action required, including access to the commissioning and validation data (Bundle 14, Vol 1, Document 15 pp327-328)), and failure to appoint appropriate personnel (AP and CP) in respect of ventilation and water and have appropriate testing regimes by qualified individuals in place.

Whilst there has been evidence of multiple individual instances of failure there has not been an exploration of how failures in NHSGGC Corporate

Governance may have materially contributed to an increased risk of infection for vulnerable patients. This governance failure represents a critical enabler that likely heightened the risk of harm.

To illustrate this point we refer to the systematic governance issues that arose in the response by NHSGGC to both Mycobacterium Chelonae and Aspergillus bacterial infections between 2015 and 2020. Key issues include, but are not limited to:

Delayed and Insufficient Response: NHSGGC identified mycobacterium chelonae in 2016, 2017 and 2018 but failed to formally report these to the Board or conduct water testing, despite its presence in patients being treated in the Schiehallion Unit and in ward areas such as showers. This lack of immediate investigation and testing contravened established infection, prevention practices.[1] [2]

Failure to Implement Immediate Identification and Testing: NHSGGC failed to collect water samples from outlets, storage tanks and mains supply for testing. They also failed to timeously use culture methods and molecular techniques like Whole-Genome Sequencing (WGS) following identification of bacterial infection, to link environmental and clinical isolates to determine nosocomial transmission.[3] [4] [5]

Non-Compliance with Standards: The 2015 Healthcare Associated Infection (HAI) Standards, which emphasise leadership, surveillance and robust infection control policies, were not fully adhered to. NHSGGC did not

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[1] https://www.gov.scot/publications/queen-elizabeth-university-hospital-nhs-greater-glasgow-clyde-oversight-board-final-report/pages/4/

[2] https://hospitalsinquiry.scot/sites/default/files/2024-08/Scottish%20Hospitals%20Inquiry%20-%20Hearing%20Commencing%2019%20August%202024%20-%20Bundle%2021%20-%20Substantive%20Core%20Participants%20responses%20to%20Dr%20Walker%20Report%20-%20Volume%202%20(External%20Version)_0.pdf?utm

[3] https://pubmed.ncbi.nlm.nih.gov/33945838/

[4] https://research-repository.st-andrews.ac.uk/bitstream/handle/10023/25265/Inkster_2021_Investigation_of_two_cases_JHI_AAM.pdf;jsessionid=2A2B35E92DF1A8E9EC836945E4EBB81D?sequence=1

[5] https://journals.plos.org/plosone/article?id=10.1371%2Fjournal.pone.0236533&utm

implement timely measures to identify and mitigate risks, as required by these standards. [6] [7]

Governance Failures: The absence of a coordinated organisational response, including water testing and risk management, highlights governance lapses. This undermines compliance with frameworks like National Infection Prevention and Control Manual (NIPCM)[8] and the Scottish Governments Blueprint for Good Governance.[9]

Delayed Recognition: The Case Note Review identified instances of Gram-negative bacterial infections in 2015 (Aspergillus is a GNB) that were not investigated at the time, suggesting potential gaps in early detection systems.[10]

Building and Design Issues: Concerns about ventilation systems and water quality were raised before and after the hospital opened, indicating potential oversights in the construction and commissioning process.[11]

Consistency in Outbreak Management: There were inconsistencies in how cases were defined, identified and reported during outbreaks, which could impact effective management and analysis.[12]

Whilst the Inquiry has focused on specific incidents and technical deficiencies, broader system issues, such as the lack of robust 'Board to Ward' accountability framework have not been sufficiently explored. This

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[6] https://hub.careinspectorate.com/media/1211/healthcare-associated-infection-hai-standards.pdf?utm
[7] https://www.nipcm.scot.nhs.uk/?utm
[8] https://www.gov.scot/publications/queen-elizabeth-university-hospital-nhs-greater-glasgow-clyde-oversight-board-final-report/pages/4/
[9] https://www.publications.scot.nhs.uk/files/dl-2019-02.pdf
[10] Provisional Position Paper 5 – History of Infections Concerns

[11] Provisional Position Paper 5 – History of Infections Concerns

[12] https://www.nipcm.hps.scot.nhs.uk/media/2261/2024-02-08-healthcare-infection-incidents-and-outbreaks-in-scotland-v-21.pdf

was a critical finding in previous Inquiries, e.g., Vale of Levan Hospital Inquiry, which highlighted how governance lapses compromise patient care environments.[13] It is of note that Professor Angela Wallace, during her evidence to the Public Inquiry, repeatedly referred to the NHSGGC 'system', with an assertion that it was effective[14]. We believe that it would assist the Chair to the Inquiry to hear the evidence of an expert as to the effectiveness of the systemic governance of infection prevention and control practices in QEUH/RHC. This should involve consideration of the organisational; transparency and responsiveness of NHSGGC to the crisis as it developed. We believe that addressing these systemic governance issues is crucial to fulfil the Terms of Reference and, if appropriate, to identify recommendations to ensure sustainable improvements in patient safety.

For the sake of clarity, we regard effective governance within NHS GGC as applying across several key areas (listed below) to ensure the delivery of safe, effective, and person-centred healthcare. These areas align with the principles outlined in the Healthcare Quality Strategy (2010), the Blueprint for Good Governance (2019), and other statutory frameworks.

Key Areas for Effective Governance

1. Clinical Governance
   - Ensures the quality and safety of patient care by embedding continuous improvement in clinical practices.
   - Includes monitoring clinical performance, addressing risks, and ensuring compliance with national standards.
2. Financial Governance-
   - Focuses on the responsible management of public funds, ensuring transparency, accountability, and value for money. *(with regards to the decision around the Horne Optithern Taps, was finance a factor?)*

[13] https://hub.careinspectorate.com/media/1415/vale-of-leven-hospital-inquiry-report.pdf

[14] Professor Angela Wallace - Witness Statement

- NHS Boards must regularly evaluate financial performance and align spending with strategic priorities. (*aligning financial performance and the decision not to increase the resource allocation model within Facilities Management & Estates and ensuring appropriate funds used to upskill and train staff thus safeguarding patients and staff - ultimately at what cost to patient & staff safety)*

3. Staff Governance
    - Promotes a culture where staff are well-supported, valued, and empowered to raise concerns safely. (*evidence provided that this has not been the case in relation to IPC and Communication and Engagement*)
    - Includes adherence to policies such as whistleblowing and workforce development initiatives. (*reference can be made to the independent review by WB Commissioner in her report into GGC)*
4. Information Governance
    - Ensures the secure and ethical management of patient data and information systems.
    - Aligns with legal requirements like GDPR to protect confidentiality and data integrity.
5. Integrated Governance
    - Combines clinical, financial, staff, and information governance into a cohesive framework that supports decision-making and accountability.
    - Encourages collaboration across NHS GGC Board and Integration Joint Boards (IJBs) to meet health and social care integration goals.
6. Governance of Change
    - Guides NHS GGC Board in managing reforms or service redesigns effectively while ensuring stakeholder engagement.
    - Emphasises adaptability in response to evolving healthcare needs, such as move from Schiehallion Wards to Ward 6A and thereafter to CDU.
7. Assurance Framework
    - Provides mechanisms for NHS Boards to evaluate risks, monitor performance, and ensure compliance with Scottish Government policies.

- Includes regular self-assessments and external audits to identify areas for improvement.

8. Community Engagement
    - Ensures that local needs and expectations are reflected in healthcare planning and delivery.
    - Promotes transparency by involving patients and communities in decision-making processes.

By exploring whether NHSGGC employed robust governance across these areas, the Chair of the Inquiry will be in a position to establish if NHS GGC upheld its commitment to deliver high-quality care while maintaining accountability to Scottish Ministers and the public. In the event that the expert report highlights systemic failures in corporate governance, it should shed light on how each contributed, individually and collectively to increased risks from infections thereby impacting patient safety.

Ineffective governance, such as inadequate oversight by hospital boards, poor interpretation of infection control data, or a lack of accountable mechanisms, can lead to systemic issues that exacerbate infection risks. Additionally, governance gaps such as insufficient risk assessments, delays in reporting on such, and poor communication between key stakeholders have been linked to preventable harm and adverse outcomes in patients.

CONCLUSION

We respectfully invite the Public Inquiry to instruct an expert report on Governance to fill a current and future lacuna in evidence. We have identified a suitable expert with whom we have no connection and can provide details of same to the Inquiry.

Clare Connelly, Advocate

6th March 2025

THE SCOTTISH HOSPITALS INQUIRY

NOTE on Direction 10

from the affected Core Participants: patients and the parents and representatives of the adult and child patients affected by their treatment at QEUH

1.1 We have been invited in Direction 10 to indicate whether we wish to make submissions to the chair in response to the application by NHS GGC to receive the evidence of their experts or to propose that the inquiry should hear any other identified witness on the issues likely to be the subject of such evidence.

1.2 We are disappointed albeit not surprised by the decision of Lady Wise, particularly given the likely consequences for the elongation of this Inquiry. We offer no view on the receipt of the joint report of the experts instructed by NHS GGC on the evidence of risk of infection from the water and ventilation systems. Receipt at this desperately late stage, with all its consequences, remains a matter entirely for the Chair's discretion.

1.3 We would observe that the report came very late and without explanation for its lateness. At the hearing in July 2024 on the question of receipt of this report, we asked: why a report of this nature, likely funded by the Scottish tax payer, did not materialise years ago when patients and families were being affected by the ongoing problems and infection issues at the hospital; where this report was when medical practitioners were giving evidence at the Glasgow II hearings about the QEUH when they were highlighting what they considered to be high infection rates; why the report did not materialise after the 2021 Case Note Review and why that review was not challenged at the time (or certainly long before it was). It remains the case that none of these questions have been acknowledged or answered.

1.4 It should be obvious that it is simply not possible for us to indicate at this stage whether we would like the Inquiry to hear from further witnesses, if so whom on what matters and when it might be available.

1.5 We have not been provided with access to the supporting data and evidence referred to in the NHS GGC expert report.

1.6 The issues that are engaged are complex and intertwined. The supporting data and evidence is voluminous.

1.7 We have previously been granted authority to obtain expert input from various expert witnesses on the water and ventilation issues set out in the detailed reports by the experts instructed on behalf of the inquiry. We do not have permission to obtain comment from the experts instructed by us on the NHS GGC expert report and its content. Without reasonable remuneration being provided to allow us to obtain comment from our own experts, we are simply not in a position to advise the inquiry whether we would like them to hear from further witnesses.

1.8 If the Chair grants the application of NHS GGC then we will require to seek funding from the Inquiry to allow our instructed experts time to consider and advise on the NHS GGC expert report and its findings.

1.9 It will be accepted that if the NHS GGC report is received into evidence, issues that ought properly and fairly to have been put to witness who have already given evidence were not put. In connection with paediatric oncology, for example, Professor Gibson was not asked to comment on the question of whether, as the NHS GGC expert report offers, infection rates at Yorkhill Hospital were higher than those encountered at QEUH/RHC. At the very least, Professor Gibson should be recalled to give further evidence in that regard. It will be a matter for the Chair to determine whether the approach to infection rates taken by the expert panel instructed on behalf of NHS GGC is borne out by the oral and documentary evidence in that regard. There are material inconsistencies between the content of the NHS GGC report and other sources of evidence that will require to be scrutinised and evaluated by this Inquiry.

Scottish Hospitals Inquiry

Note by MDDUS on behalf of Dr Teresa Inkster, Dr Christine Peters, and Dr Penelope Redding for the Procedural Hearing on 11 March 2025

5 March 2025

Introduction

1. This Note is produced to comply with Paragraph 2 of Direction 5. In addition, the Note has been prepared to convey the position of TI, CP and PR to the Inquiry in advance of the Procedural Hearing due to take place on 11 March 2025, and in particular to set out our position on the matters set out in the Agenda circulated on 3 March 2025.

Agenda Item 1 - Publication of Closing Statements

2. Given the large amount of work which went into these documents and the significant public expense which was incurred in their production, we respectfully submit that the Chair should direct that all closing statements relative to the Glasgow III hearing submitted by Counsel to the Inquiry and all Core Participants should be published on the SHI website and, thus, made available to the public. We note that the Chair is already minded to do this (Agenda for the Procedural hearing on 11 March 2025, para 1.2).

3. Such a direction would ensure that the closing statements for Glasgow III are treated in the same way as all the closing statements submitted for all the other hearings held by this Inquiry and would give effect to the statutory obligation which requires that, subject to certain limited exceptions, the public be given access to Inquiry evidence.

4. Section 18 of the Inquiries Act 2005 provides that the Chair is required to take such steps as he considers reasonable to “secure” that members of the public are able to

obtain or view a record of evidence and documents given, produced or provided to the Inquiry. This obligation is limited only by a restriction notice or order imposed under section 19 of the Act. Other than the restriction order issued for witness 7 and redactions which would be required to protect the privacy of some patients and their family members, no other notice or order has been issued under section 19 which would prevent publication of the closing statements. Indeed, the closing statements are all based on evidence which was led in public.

5. Given the importance of the subject matter of the closing statements and the fact that any report by the Chair is likely to be well over a year away, publication of the Glasgow III closing statements should take place as soon as possible. This will allow the public to follow the progress of the Inquiry and to understand what it is doing to discharge its remit and to fulfil its terms of reference, all of which are being funded by the public purse.

Agenda Item 2 – Witnesses and Documents

6. We provided lists of witnesses and documents in January of this year. We note that whilst some of the witnesses that we suggested do now appear on the Provisional Witness List for Glasgow IV, many do not.

7. In particular, we would wish to note that we regard it as absolutely essential that Laura Imrie (Clinical Lead at ARHAI) be recalled during Glasgow IV (either during part 2 or part 3). We are disappointed that she does not appear on the provisional list. The need to recall her arises, at least in part, from the evidence which emerged after she was called at Glasgow III about recent cases of Cryptococcus at QEUH which have not been reported to ARHAI, and other recent concerns about reporting culture within the IPCT at QEUH.

Agenda Item 3 – NHS GGC Application, and

Agenda Item 4 – Practical Implications of the outcome of the NHS GGC Application

8. We consider that these two agenda items are inextricably linked. Accordingly, we deal with them together below.

9. TI, CP and PR maintain their previously stated opposition to the receipt of the evidence of Professor Hawkey, Dr Agrawal and Dr Drumwright in respect of their Report ("the Report"). Their position, as outlined in July 2024, was that the report came too late. Since then, more than 7 months have passed and the Glasgow III hearing has been completed. The claim that the report "represents crucial evidence" (application, para. 2.4) is belied by NHS GGC's inexplicably dilatory approach to seeking its admission into evidence. At no point has NHS GGC sought to expedite matters. They did not seek urgent disposal of their Judicial Review, nor did they seek to delay the holding of the Glasgow III hearing. The report, which was already "late" in July 2024, is now even more "late" given the passage of time and the procedure which has taken place in the Inquiry in the interim.

10. We have been provided with a copy of the Report, but not with any of the underlying data which inform its conclusions. Without this data, there is little that can usefully be done to interrogate the findings of the Report or to respond meaningfully to it. Without knowing the nature and extent of the data that has been considered by the Report it is also not possible to state a final position on what input would be required to allow us to respond. All that can be said at this stage is that it is likely that we will require to make an application for funding for the instruction of an expert epidemiologist. It is possible other expertise will also be required – it will depend on the data. If an explanation has ever been provided by NHS GGC for the fact that the data was withheld from the Inquiry until February of this year, then such explanation has not been shared with us.

11. TI, CP and PR have considerable expertise in their own right and we therefore might be thought to be better placed to respond to the Report without the need for separate

input than some other Core Participants. There are two problems with that assumption. First, CP and TI both have full time jobs and have already had considerable burdens placed upon them by the Inquiry, with which they have cooperated fully and frankly over many years. PR, who has also expended considerable efforts in her full and frank cooperation with the Inquiry over many years, has retired but has significant family commitments, and her own health to consider.

12. Secondly, NHS GGC state in their closing statement for the Glasgow III hearing (at para 24) that TI, CP, and PR all feel "*deeply personally aggrieved*" and that all evidence given by them has to be seen in that light.

13. It is, therefore, reasonable to expect that if we attempted to make a submission about the significant shortcomings with the Report without the benefit of access to an independent expert to support our position, then NHS GGC will simply submit that such a submission should be afforded little or no weight because TI, CP, and PR's expertise is somehow nullified by their "aggrieved" state. The position adopted by NHS GGC, therefore, increases the likelihood of us requiring to make an application for funding to instruct our own expert.

14. This aspect of the closing submission by NHS GGC of course ignores the fact that many of their staff who don't share the views of TI, CP and PR, are likely to feel similarly "aggrieved" by the events giving rise to the Inquiry, and indeed concerned about their own personal and professional positions, including in relation to the ongoing police investigation. Despite this, it appears to be said on behalf of NHS GGC that only TI, CP and PR's evidence should be regarded by the Inquiry as being somehow tainted. All of this will require to be dealt with on another occasion.

15. We have carefully considered the timetable which NHS GGC have set out in their application. We doubt whether the timescales set out are realistic. However, we cannot provide a clear position on any proposed timetable at this stage given that we do not have the data and, therefore, cannot determine what, if any, external input will

be required to meaningfully respond to the Report. We have no idea how long it might take to identify and instruct any experts that are required, or how long it might take the Inquiry to consider the necessary applications for funding once expert(s) are identified.

16. Whilst the lack of the data gives rise to some uncertainty at this stage, two things do appear to be clear. First, the receipt of the GGC Report is likely to delay the final conclusion of this Inquiry by a year, and quite possibly longer. Secondly, the receipt of the Report will considerably add to the expense of the Inquiry. Both of these are significant considerations in the context of an Inquiry which was announced 5 and a half years ago and which had already cost over £23.5m as at the end of September 2024.

Agenda Item 5 – Matters arising from closing statements

17. We are specifically directed to consider two matters arising from the Inquiry's previously issued Directions:

Direction 9 paragraphs 2.1 – 2.3

18. Direction 9 provides as follows –

2.1. Where a Core Participant disputes the accuracy of the narrative or proposed findings set out in Counsel to the Inquiry's written closing statement, they identify the relevant passage or passages, and explain the basis of and reason for the dispute under specific reference to such documents and witnesses' transcripts or statements on which they rely;

2.2. Where a Core Participant proposes that the Chair should adopt a narrative or make findings additional to what is proposed by Counsel to the Inquiry, they set out such narrative or findings under specific reference to the documents and witnesses' transcripts or statements on which they rely;

2.3. Where it is proposed that the Chair should disregard any evidence heard or considered by the Inquiry in the three Glasgow hearings or within PPPs 5, 11, 12 and 14 a Core Participant set out clearly and explicitly which evidence should be disregarded and why the Chair should do so by reference to that evidence and any other evidence that is relied on;

19. We set out a detailed position on these matters, insofar as applicable, in our closing statement for Glasgow III. We have nothing to add at this point.

Direction 10 paragraph 6

20. Direction 10 paragraph 6 provides as follows –

> 6. For the avoidance of doubt a Core Participant granted leave to appear at Glasgow IV are granted leave to appear at all three parts of the hearing.

21. TI, CP and PR have been granted leave to appear at Glasgow IV. We note that this will now apply to all of the Glasgow IV hearing and we are grateful to the Inquiry for that clarification. We have nothing further to add on this matter.

Agenda Item 6 – Requests of CPs by CTI in relation to Glasgow IV

22. Should any assistance be required by the Inquiry in relation to the Glasgow IV hearings, TI, CP and PR would be very pleased to provide it.

Helen Watts KC

Leigh Lawrie, Advocate

Medical and Dental Defence Union of Scotland