SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
13 May 2025

Day 10

29 May 2025
Alan Seabourne

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10.03

THE CHAIR: Good morning to those in the Edinburgh hearing room and those who are following us online. We're ready to resume, I think, with Mr Seabourne.

MR CONNAL: That's correct, my Lord.

MR SEABOURNE: Good morning.

THE CHAIR: Good morning, Mr Seabourne. Now, as you understand, you're about to be asked questions by Mr Connal, who is sitting opposite, but before that, I understand you're prepared to take the oath.

MR SEABOURNE: Yes, sir.

Mr Alan Seabourne
Sworn

THE CHAIR: Thank you, Mr Seabourne. Now, your evidence is scheduled for the day. We will take our lunch break at about one o'clock. We'll take a coffee break in the morning at about half past eleven, but if at any time you want to take a break, just give me an indication and we can take a break.

THE WITNESS: Thanks.

THE CHAIR: Right. As I would say to any witness, it's helpful if you keep your voice at a level perhaps a little above that that you would use in conversation and maybe speak a little more slowly. My hearing is not what it was.

THE WITNESS: I think you'll find I'm loud enough. You'll need to rein me in for speed.

THE CHAIR: Right. That strikes me as a good volume. Right, Mr Connal.

Questioned by Mr Connal

Q Good morning, Mr Seabourne. Just to start your evidence, I'm going to ask you the formal question that I ask all witnesses and, in asking this question, can I just make it clear I know there is one small change you want to make to your statement and I suggest we pick it up as we go through. Subject to that, are you prepared to adopt your state a witness statement as part of your evidence for this Inquiry?

A Yes, I am.

Q Thank you. Now, you were the project director, the director of the Project team, whichever way around you want to put it, for what I'll just call the new hospital----

A Yes.

Q -- just because it's easier than using its full title at different stages. The function of the Project team, would I be correct, was essentially to deliver that project to the Health Board that they wanted?

A The function of Project team was to support the construction and design people in order that they could fulfill their contract to the Health Board.

Q So far as one understands that Multiplex – I'll just call them Multiplex----

A That's fine, yeah.

Q -- just so we're using the one name – that they obviously had a team of people, subcontractors and so on, and on the Board side, the Project team was leading. Is that right?

A Yeah, yeah.

Q Okay. Now, I'm going to use your witness statement just to guide us through your evidence, although I may digress from it at various points. We'll put it up on the screen, and you'll find that there are numbers at the top of each page, which are the electronic numbers that make it easier for the operator. So, if I say to the operator, "Go to page 20," they will go to an electronic number. If there's any issues, then please just let me know.

A Sure.

Q Now, in your witness statement at page 118, so this is fairly early on, you're explaining that your direct reporting line was to Helen Byrne. Is that right?

A Yes, it was.

Q Now, we're going to hear from Ms Byrne hopefully tomorrow, and in fact you set out in your witness statement that you were a somewhat reluctant recruit to this post.

A Yeah.

Q You would have preferred a different role. Is that right?

A Yeah. I'd spent-- Since 1980, I'd spent the first part of my career in the health service mostly on the technical side and then going into general management and then taking over at Yorkhill, the old children's hospital. I was the director for IM&T. And so, in 2000, I wanted to move on and actually manage the clinical services, and you can see from my CV I managed acute services, mental health services, and led re-provision programmes, etc. So, I was more interested in doing that and then, as policy moved on with the government, we merged with the local authority more. I was a key component in joining up the health service and local authorities, particularly regarding social care within East Renfrewshire, Renfrewshire and Inverclyde, and that was the job-- When I-- before I just met-- before I left to come to this role, I was the chief officer for Inverclyde Royal and the chief officer for the Health and Care Social Partnership, and I left that job.

Q Just so we have it on record, when you say in the earlier part of your career you were involved on the technical

side----

A Yeah.

Q -- what kind of technical side were you involved in?

A Well, you've heard a comment here about estate management, so looking after the estate, capital projects, all that type-- responsible for capital projects, so that type of work.

Q But were you an engineer by training? Is that----?

A I was an engineer by training, yes, but I was not a building services engineer.

Q Not a building----

A And not a design engineer.

Q No. Thank you. So, eventually you did take up your role. Now, can I just say, and I'll say this now to save us picking it up repeatedly, the Inquiry recognises that the new hospital project was an enormous project of considerable complexity, and we're only asking people about what, in a sense, are very small parts of it. May be important parts, but only small parts, so take it as read that we understand that.

A Okay.

Q What you've described your role as on page 120, you'll see about two thirds of the way down your page you say it was an administrative role. So, an administrative role rather than a technical role. Is that right?

A Yeah, because the set up was, as you know now, Peter Moir, who was an architect, and he was the professional that had the-- that was holding the technical part of it, and I was the person above Peter, not to say-- we'll come onto that, fully involved in that bit, but I was the person above that who was going to manage all the different phases of work and manage the programmes of work within those phases of work. So, I had the overview of the process and the programme.

Q I think what you were probably telling me there is that that didn't mean you were completely hands-off. You didn't just----

A Oh, no.

Q -- sit in a room and allow things to happen. You----

A No, no, I think you'll find, through this process, I was totally hands-on.

Q Then you helpfully-- I'm not going to go through everything in your witness statement----

A That's okay.

Q -- because obviously it's part of your evidence anyway and it would keep us here for longer than we need to be. But you set out, so everybody knows, on that page and on the next page, a lot of the things that you were actually involved in doing. Then you touch on one topic,

and I just want to get that clear from you. On page 121, you talk about having had indications that you'd to avoid an adversarial relationship with the contractor.

A Yeah. Yeah.

Q Where did that come from?

A It came from the government. It came from the Board's-- what I call the Board's senior advisors, Ernst & Young, Shepherd and Wedderburn, Partnership UK, and that was all-- We had hundreds of meetings and conversations and telephone calls, and that was a key theme because the health service has had projects, the government have had projects that have turned out very adversarial. And because of what you said earlier – this was going be an enormous project – we certainly didn't want to go along that line of, you know, "This contract, you can only do that and you're only allowed to do that." They were trying to build a partnership that merged both organisations to the same goal. I'm not saying they achieved it, but that's what they were-- that's what they're talking about.

Q That's what you were told----

A Yeah.

Q -- to try to facilitate. Is that right?

A 100 per cent.

Q Yes. The particular form of contract that was ultimately used, NEC3 Design and Build, were you familiar with that?

A No.

Q You hadn't come across it before?

A No, I hadn't even heard about it before.

Q Do you know if Mr Moir had come across it before?

A Yeah, Peter knew-- Peter was-- had done a lot of projects. Peter knew about NEC3, but Peter didn't have any experience of NEC3. And we'll come onto this: when we knew we were going to do NEC3, then Peter and I organised for my whole team to do a couple of day sessions with an expert, Stuart Kings I think his name was, and we organised that to get as much knowledge as possible. And I think Douglas Ross of Currie & Brown gave us a day seminar as well, or half a day. I can't remember.

Q So, just so his Lordship has this, because you spoke quite quickly.

A Oh, right. I'm sorry.

Q No, no. It's our job to spot when you're going too fast. What you're saying is that you weren't personally familiar with NEC3, but you arranged for-- is that the Project team to get a couple of days' seminars on it?

A Yeah, yeah, two full days.

Q Also, you said Douglas Ross

of Currie & Brown gave you maybe one day. Is that right?

A Yeah. As we were going through the process to arrive at NEC3, you could see it coming. Douglas, who did have some experience-- I don't know that any of them have actually done projects. They know of NEC3, but Douglas set up a one-day or a half-day – I can't remember – seminar for people on my Project team.

Q Now, at the foot of that page, you talk about receiving some-- I don't want to use the word "direction" as if it was a strict instruction, but an indication that-- how you were to deal with the question of risk in that project. Now, who was telling you this again? Do you remember?

A Yeah, absolutely. Yeah, just for information, you know, all the conversations leading up to signing that contract, which started for me in 2006, were between the government, government advisors, Partnership UK, the Board, Board's advisors, the Board's senior officers. And lots of the senior officers at Glasgow Health Board have done many, many projects, probably more than anybody else in Scotland. So, we had a lot-- There'd obviously been lots of problems, and what they were saying was, in this new world, this new design and build world, stepping-- probably stepping beyond PFI, you let the contractor take the strain, let the contractor take the risk, let the contractor innovate, and in fact, in your bundle you sent me-- I forgot the name of the department. Department of Expertise at Scottish Government, they were very much on, "Do not tell a contractor what to do," right? So, that's not something I've heard here before, but that was the ethos from my-- to my direction from My Health Board senior officers and the government.

Q And just, it may or may not help: when you say the Board's senior officers, can you tell us who?

A Well, the people I would be dealing with would be-- and the chief exec changed. Obviously, Tom Divers passed away sadly. So, chief executive, Helen Byrne, strategy, Douglas Griffin, finance – I'm trying to think who else – medical director would always be involved. All these people would be involved in the planning of this major operation and part of the communications and conversations that are going on daily.

Q So, if you're being told, "Do not tell them what to do. Let them take the risk," does that create a risk for the project if you just let them get on with it?

A If I'm describing it as just, "Let them go on with it," that's probably not really what I mean, but they were saying,

if we entered a contract with a contractor and we ask them what to do, at that time, around 2006 to 2010, the ethos was-- and it's from the PFI world. The ethos was, "The contractor knows what he's doing better than you do." I've heard you say in here, you know, "What does NHS people know about design?", for example, right? So let them do it, and we'll set it up accordingly.

And the Board's advisors, particularly Ernst & Young – I haven't heard their name mentioned much here – they did a-- It's in my statement. They did a market sounding exercise, and I was part of that. From that, they were clearly getting the message from the contractor, "We can do this. You don't really need to take our hand," right? And that was the ethos that we worked from.

Q Thank you. Now, if we go onto the next page of your witness statement, the NEC3 contract crops up again. I've already asked you about that. Near the top of that page, you're saying that there was going to be:

> "… a competitive dialogue process and that there would be a Professional Services Contract Supervisor role… and hence, no shadow design team as previously planned."

So, the original idea we were being told, at least by Currie & Brown, was that they thought that what was going to happen was that they and the subconsultants that they had, a whole range of consultants, would become the sort of shadow design team once the contract was let. When was it decided not to do that?

A Well, right up to a point-- Well, it was PFI originally, as you know, and then it was going to be capital funded by the government. And right up to a certain point, we all thought it would be a JCT contract, right? And then, as we met the market, as we talked about Ernst & Young running this market sounding exercise, it started to flip into being advised that NEC would be the best way to go. At that point, Peter and I had set it up in a JCT manner.

So, we just-- we thought we'd have-- And you can see from some of the paperwork that I've seen in the past, we had fees-- we had fees from the start right up to the end of the project, having the design team running along with us, and then-- I don't know the date. Was it March 2009? I'm not sure. When they decided to go NEC3, then, as I've just said, I didn't even know what NEC3 was. In that particular type of contract, you had a supervisor. So, were the Board going to give me a supervisor, a shadow design team, and a project team? Well, the answer is no.

But I would like to add, having listened to some of the evidence, that I just wonder, if I had a shadow design team-- because I heard evidence the other day that my design team technical advisors were giving me advice, but at the end of the day, I had to select-- it was me who chose that advice. So, if I had a shadow design team who were getting information from Multiplex's team, and they said that's okay, I could still be sitting here today with that shadow design team saying, "Yeah, we told Mr Seabourne it was okay," right? So, I'm not-- I would rather have had a shadow design team but, bearing in mind I wasn't doing design then, why would I have needed one? So it's complex. It's not simple. There was pros and cons to it.

Q Well, I'm going to come back, when we come to the design process, to discuss----

A Yeah, look forward to that. Yeah.

Q -- how it worked, as you can probably imagine, but one of the issues that's cropped up in the evidence is that a decision was taken basically to stand down Currie & Brown from their full role and----

A Yes.

Q -- use them in a more limited role, and they then stood down the range of subconsultants. Now, can I just take this generally? First of all, a lot of witnesses, including members of the Project team, seemed to have thought that there was still, you know, what was described as "the technical team", which is how they were described before they were stood down. Do you know how the change was communicated at all?

A Well, firstly, you probably see in my statement I've used the term "technical team", right? Technical advisor, sorry. And it has just rolled on. I'll answer your question in a second, but when I was recruiting Capita, or Peter was recruiting Capita and both of us were doing it, you know, I was feeding to everybody why I was recruiting Capita. Nobody in my team-- I met my project teammate every Friday. Even when I was on holiday, I phoned in. So, my project team met every Friday, never missed a Friday for, whatever, five years. And in those meetings, I was clear about what I was doing. That's because I was-- I always communicate.

In terms of Multiplex, I told Ross Ballingall, Paul Serkis – he was a bid manager – Mike Sharples – sadly he's passed away as well – John Ballantyne. Every one of them, I'd explained in great detail before we started and after we started what Currie & Brown were doing. And what brought that to the fore? Because I was saying to them--

Remember, I don't have a shadow design team, or whatever you want to call it, advisors anymore. So, I had loads of those conversations.

And Peter Moir, whatever Peter Moir is, he's meticulous. Peter Moir would have written something to people. I don't have access to any of my own information, which is a real problem. So Peter would have dealt with that absolutely, 100 per cent. But it's just the nuance of just having the same people running past a deadline and being involved. I could see why some of them think that nothing's changed here, right? Did that explain that?

Q What we're keen to do is get what you understand, Mr Seabourne. There is an extent to which, as you'll find as you go through your evidence, that there's a bit of reference to what other people said or didn't say, but what I'm keen to do is to get your understanding of----

A Sure.

Q -- the position, whether it's the same or different. In the same paragraph on page 122, you do mention keeping Wallace Whittle on as M&E advisors. Now, the evidence we had from Wallace Whittle was that they were asked to stay on on a kind of time and line basis, but that didn't suit them so they said no, and they only really came back to do one specific job. So they didn't come back as M&E designers. Would that accord with your recollection?

A Partly. The Health Board, as I said, weren't going to run D teams. And what Peter and I knew from our long, long experience in doing capital projects, we knew that we needed some M&E input. As much as we have got lots of experience ourselves, we're not design engineers, but we can run programmes that work. And it was Peter and I-- I think it was Peter that said to me, "Look, we need to retain some of this," and we retained Wallace Whittle, and I think we also retained health planners, Buchan + Associates, and we agreed with Currie & Brown we would do that. I'm staggered that Wallace Whittle think we didn't come to that agreement.

And in that year – and you've seen it yourself in the evidence – Wallace Whittle reported on the M&E design and, more importantly for this Inquiry, reviewed the environmental matrix in great detail. Because, as you've probably got the information, and I know this anyway, you know, the cost of reviewing that environmental matrix was over £30,000. So, it wasn't a glance. So, the invoice for that and for all their work is there.

So, they were there to help us with M&E design, to comment on the designs, and particularly to deal with the

environmental matrix. I think you've mentioned it before. That was a double loop check. So, for me, ZBP are 100 per cent was responsible for the environmental matrix, but we brought in this double loop in order to say, "How is that looking?" And then, again, they'll probably come back and say it's me that approved it, but----

Q Well, I think probably it may be easier to deal with some of that when we come onto the design----

A Okay, that's fair. Yeah.

Q -- the actual design process, but your evidence is that Wallace Whittle were reviewing designs?

A Yeah, parts of it, yeah, yeah.

Q Okay. Now, in the next section of your witness statement, you're essentially being asked about personnel, who you were reporting to and so on, and you were reporting to Helen Byrne, and you were asked were there any issues. I'm just keeping firmly in mind that your retirement date was July 2013. Is that right?

A Yes.

Q So, we can take you up to that position. As we move through your witness statement, you're explaining how you worked and, on page 125, you confirm that you worked most closely with Helen Byrne and with Peter Moir, and also with a finance manager which, for our purposes, we'll leave aside. Then you say you had communications and meetings with Board directors, some non-executive directors and so on. Now, was this a sort of formal process or an informal process or what?

A The Board had Ken Winter, who used to be a managing director of Balfour Beatty Europe. The government appointed him to the Board. So I had lots of informal conversations with Ken. He came onsite and we explained what we were doing. He was very, very experienced in the construction industry. Other Board members, for example Barry Williamson was a surgeon that used to work for me, and Barry and I had a good rapport and we would talk about things. So lots of informal stuff and formal stuff at the Board meeting but, to be fair, I don't think I went to more than two Board meetings. It would always be a subcommittee of the Board like the performance review group or something like that but, at that Board, the chairman of the Board was chairman of the performance review group, so it wasn't a much lesser group, if you see what I mean. So formal and informal with all those people.

Q Yes, I think we may or may not hear from Mr Winter later. I think his evidence is that he made some informal visits and basically had a chat with a

variety of people, no doubt one of them being you.

A Yeah, and when I say he-- I'm not for a minute saying he approved anything. I'm saying Ken came over and he was there to hold my hand. If I said, "How should I do this? How should I do that?", he would have freely given me-- easily given me his advice. So, yeah, it was just a wee bit of a buddying exercise.

Q Right. Thank you. Now, one of the topics that's cropped up in the Inquiry is the issue of site selection. The big picture issue of site selection, I'm not going to ask you about because that predates your involvement, but I did want to ask you about one topic that you just touch on, 127 of your witness statement. You were asked, "Well, do you remember any discussion about being beside the sewage works?" and you describe it as, "not a big issue". Is that your recollection?

A Yeah. Absolutely.

Q You say that:

> "... the Board senior officers informed us that the process at Shieldhall Sewage Works had changed or was going to change from a sewage treatment plant to a transfer station reducing the potential for odours..."

Is that what you were being told?

A Yeah. I think you'll see in the-- Susan Logan, who was a BREEAM advisor, I think she wrote an initial design solution report and she mentioned the perceived odour, and she also mentions that it's getting better and it'll probably negate itself because of the work that Scottish Water were doing. So, yeah, that was the general story. I did lots and lots of public meetings. I was the face of the project and, you know what the public's like, they had lots of comments to make, and very, very few had that comment to make. Also, in our general discussions, and this is just anecdotal, "The hospital's been here for a hundred years. It's never affected it yet," and that was the conversation.

Q Can you remember who among the Board senior officers told you about this proposed change on the part of Scottish Water?

A Yeah, I think it was Robert. Robert Calderwood, yeah. I think it was Robert who told me, who was somebody who would be very connected to Scottish Water and every other government agency because that's the role he played and that's who he was. So, yeah, Robert generally told us that it had changed or was changing from a sewage work to a kind of transfer station where sewage only really got mixed twice a year, maybe, or that was the story. He didn't go into any more detail than that.

Q Do you know from your conversation with Mr Calderwood whether anyone was carrying out any kind of, you know, risk assessment of putting the hospital beside this sewage work?

A I don't know, but in my conversations with ICDs, i.e. microbiological doctors or Infection Control, prior to setting all this up, it was never ever raised as an issue to me. I mean, I think the Southern General maybe had about 10,000 staff. You did get the odd person that, you know, was going to complain. In fact, I think-- and it's maybe in the evidence, I think somebody wrote to the minister to say, "The smell here is terrible," right? I don't know what they were-- I was there. I was on the site for seven years. I don't really know what they're talking about, so.

Q So, other than having this conversation and being reassured it wasn't an issue, this is not a topic that really got your attention?

A It didn't take up-- It didn't take up any of my time, no.

Q Thank you. Now, the next topic that's covered in your witness statement is described as "procurement". There are a couple of things I need to ask you about there so that we can understand, perhaps, things that a number of witnesses have said about the consequences. Now, we know that this was originally intended to be a PFI-type contract. Were you familiar with the concept of PFI contracts?

A Yeah, I served the second PFI in Scotland, Yorkhill Hospital. It was an energy project but it did give me some insight to it. I think Fraserburgh set up the very first PFI in Scotland so-- Obviously, through discussion, learning, going to seminars, I had a reasonable knowledge of what PFI was trying to do.

Q So, in terms of PFI for a hospital, at the risk of being criticised by somebody elsewhere for oversimplifying, the usual pattern is that a company builds the building and then hands it onto a-- let me call it a facilities management company, who then runs it----

A An operator, yeah.

Q -- who then runs it and then the Health Board put the patient in and do all the clinical stuff but the facilities management company runs that building for them. That's the general picture. Did that accord with your understanding?

A 100 per cent.

Q The effect of that then is that, if you like, the maintenance, the general today-- what the Health Board tend to call "Estates" issues are actually run by the facilities management company.

A Yeah.

Q Now, one of the questions you

were asked to see if you could help us on this topic was – and I think you know why it's being asked – when the switch came from PFI to not PFI, which you've set out why that was, that's fine, when that switch came, can you recall what steps were being taken to arrange for sufficient-- let me call them "Estates resources", to cope with the fact that there wasn't going to be a facilities management company running the hospital?

A Well, that would be down to – and it was down to – The Facilities Management team, and there's a number of directors of finance. There's a director of finance for acute services and a director of finance for the Health Board. They would be having conversations about affordability, right? In the affordability envelope, they would need to be considering how much money they would need to put in in terms of to keep this building going in its lifecycle for-- well, they'd be looking at 10 years but it's obviously going to go 30 years, and a building's got a life of 60 years. So that would be part of their planning process, to say, "We're going to close five hospitals and we're going to open this new hospital and we're now going to maintain it, so let's make sure we put in the right resources." So they would be working that through, and that would go through a lot of machines before it came out at the number that they wanted to run with.

Q Were you involved in these discussions at all?

A On the periphery. They'd maybe want me to play in my view or get views on what it would cost in terms of running it, but that, for me, might just come down to me saying, "Well, I've spoke to cost advisors and they're saying, 'Oh, it's £X,000 per screen meter per week/per month'" or whatever. It would be a higher level thing like that. The facilities director would have much more knowledge and experience of what he needed to cover. I just remember at that point, not quite in terms of estate but in terms of cleaning, I always remember the estate director saying, "We've went from open wards to single rooms. That stretches the building from A to A-plus, and that'll need more cleaning staff." So he would be building that into his facilities management cost.

Q I just wanted to ask you about this because there have been a few comments on it. We're moving to 129 of your witness statement and following, just so we're following it through. The reason I want to ask you about it is the way you've explained some of this, which has been quite helpful. Near the foot of page 129, you talk about one of the things that was investigated, which was the

possibility of getting a seven-year period, and you say, instead of the normal one-year period:

> "… in order to try and mitigate life cycle risk (as the client would get in a PFI) after handover."

You touch on that again on page 130, if we just go to it. It's about a quarter of the way down the page, you say:

> "... there could be a seven year's insurance/resourcing cover period by the contractor where the contractor was taking all the building structure and building services risks with obvious benefits to the Board."

Which sounds a bit like, as you say, a bit like you get in PFI.

A Many PFI, yeah.

Q So that's not just a question of, you know, defects liability and the standard JCT understanding of a defects liability, that's something different that they're looking at.

A It's a concept. I mean, the people I'm dealing with here are all very well-versed and know how a hospital runs or gets ran and, as much as people say PFI is a very expensive model, I only need to look at the Victoria and the Stobhill in Glasgow, and if you go in them, you'll see just how well-maintained they are. And we knew that having that envelope of cash tied into a 30-year concession period was a good way to take some risk out of building life cycle. So, in those conversations, which would generally be with both senior officers, people I spoke to, the government, Partnership UK, Ernst & Young and Shepherd and Wedderburn, with those people, we had many, many meetings, not one meeting. We talked about these concepts. Indeed, I think that Michael McVeigh of Ernst & Young took this concept, when we were doing the market sounding exercise, to the contractors we spoke to, and they all went, "Not for us."

Q Well, let me ask you a couple of things more about that. Near the foot of page 130, you say:

> "... the Board would use this as an incentive to the contractor to drive higher quality in construction..."

So, why would that kind of arrangement whereby they were going to maintain it for seven years drive higher quality in construction, just for those of us who are not experts in this field?

A Just like PFI, that made it theirs for seven years. So, you know, the first five years of a building is when you're starting to see some of the things-- use the word "come apart", break down, and so they would maybe have to-- whatever element of the building they were putting in, they'd maybe have to buy a bit more

expensive to make it last a bit longer, to make it have less maintenance, less maintenance being the key word. So, and it's a bit like a liability period. They build for a year. We ended up saying, "Let's do two years." I hadn't been involved in a contract that'd done two years, and that was the quid pro quo we ended up with. That was the middle ground, but they had no interest in having a seven-year liability hanging over their heads, but it might have drove quality.

Q The reason I'm asking you this – so let's be quite open about it – is that one of our witnesses says he was told by David Loudon that the high-ups, the CEO and so on, thought that Multiplex were going to completely maintain the building for the first two years. Could that have come from these discussions, do you think?

A No.

Q No?

A Multiplex were never maintaining the building.

Q Well, we know that, but I just wonder whether because of this exploration of an extended mini-PFI, as you've described it, those who were not particularly steeped in construction might have thought that what the two years was they were getting was a period of maintenance.

A Well, possibly, but I think the discussions that I'm talking about were in a kind of small cohort of people. They weren't a secret, but we weren't going and singing and dancing about it. So I'm not sure that anybody-- I'm not sure that that would fall into anybody else's environment, you know?

Q Mr Calderwood's, possibly?

A Well, if it's Mr Calderwood that said it, yeah, he was part of the core team but, no, I don't-- I'm just saying that anybody outside the people that were in the planning regime for this hospital, it was just a concept. We dealt with it. We moved away from it, and I don't think it went anywhere else. So, I don't think anybody else picked it up is what I'm really saying to you.

Q Okay. The next section of your witness statement moves onto a topic that we have been discussing with a number of witnesses, which is this thing called the employer's requirements.

A Mm.

Q So, we're 131 in your witness statement now. This was designed to be an expression of-- I think one party has said it's what you want. Not how to build it, but what you want. Is that a reasonable summary?

A Yeah, an output specification, yeah.

Q Your position in your witness statement is that the employer's

requirements were a responsibility of the technical advisors. Now, of course, at that point you've got Currie & Brown and a whole troupe of technical advisors.

A Yes.

Q Did that mean that the Project team were leading it or they were leading it? How was this being done?

A No, the Project team, when I had three excellent people working for me, in terms of administrative duties, they would organise the meetings, the venues, schedule all the meetings for all the people. We met many-- it might not appear now we met many people, but we certainly met more people than I'd ever met before. So, they would organise that.

Currie & Brown were the experts in taking this forward. I was a follower, not a leader on that, because I had never done an employer's requirement before. It was generally much more detailed specification types for projects I'd been involved in. So, this was a kind of new way and Currie & Brown had a-- if not a framework, a process that they'd used before, and we would follow that process and we would make sure the people arrived in order to give them the information to pull the ERs together, which, to be fair, it's substantial documents.

Q Can I just make sure I understand your answer? Are you telling us that you hadn't previously been involved in this type of design and build idea where instead of saying to a contractor, "This is your building. Here's your details. Get on with it," you have the employer's requirements process? You hadn't been through that before?

A No, to different levels, we would have specifications and commentary running. This employer requirement process was quite lazy on design. There wasn't a lot of design detail. It was mostly all output. I know we had an exemplar and we'd done some 1:200s, however many-- 11 or something like that. I can't remember. So, for me, this was a very low level of information, even though those books are-- you know, in terms of being specific.

Q Do you know if Mr Moir was familiar with doing this process?

A He probably was, but Mr Moir was a-- Mr Moir wanted to do – and we'll maybe come onto this – much more detailed design work-- well, maybe not much more, but more detailed design work in the procurement process.

Q But that was something that wasn't being done in this process. Is that right?

A No, not really, other than what you've heard to the past about the exemplar drawing, the massing, the 1:500s, the layouts, some 1:50s, etc. So,

that was-- it was base information-- and adjacencies, clinical adjacencies. It was base information along with a lot of information. I think you heard Jim Leiper saying, you know, we just describe and make sure you comply with all this guidance, and not actually tell them how to comply with the guidance. So, that's the nuance of it.

Q Right. Is this quite a big exercise?

A Oh, yeah, yeah, yeah.

Q Just while we're on the employer's requirements, can I ask you this? Obviously, you're somebody who's been involved in a lot of capital works and so on, that you say, but not this type of exercise before. You described yourself as a follower rather than leader during the employer's requirements----

A On this bit, yeah.

Q What we know happened, and we'll come to the detail of that in a minute, is that the employer's requirements could be changed or departed from in the negotiations leading up to signing of the contract. Now, do you think that was understood among the people who were working on these things?

A Well, I know I've heard this-- I've heard this, and I know what you're going to ask me about it. The employer's requirements, the technical bit is put together by Currie & Brown. So, when you've got a mandatory and a non-mandatory field of information, they just-- that wasn't me for the Board saying, "We need this." That was them telling us, "You should have this. This is the best way forward." So, when they then-- I'm not going to use the word derogation. I know you use it. When they then come up with an alternative solution, you know, it was their judgment to say it doesn't need to be in that field because the solution that is being presented is okay.

So, it was their set of rules which, as far as I'm aware, they had the right to deviate from, or change, because they were our advisors.

THE CHAIR: Mr Seabourne, just to check that I've noted you correctly, because you do speak quite quickly----

A Oh, I'm sorry, my Lord.

THE CHAIR: You're describing the level of detail being provided in the employer's requirements, and you made the point that Mr Moir wanted the detail to be dealt with during the procurement phase. Now, did I note you correctly as you seeing the employment requirements as giving them – in other words, the potential bidders – the guidance, but not how to apply it?

A Well, yes, yeah.

THE CHAIR: Right. Thank you.

MR CONNAL: Now, part of the

employer's requirements were things called clinical output specifications.

A Sure.

Q Were you involved in that process?

A No, my team were involved in that process and my involvement was to get it done, right? Okay, so I had two people who led that process. Heather Griffin for the Adult, Mairi Mcleod-- I'm going to try and slow my voice down. Mairi Mcleod for the Children's, and their role was to go-- We had clinical output specs and non-clinical output specs, but you're interested in clinical. They were to go through the clinical specialties. I think the Children's have got 39 clinical specialties. I think the Adult's, around about 30, I think, and it's maybe changed now.

So, let's call it 80 clinical outcome specs, and they met the users. We had user groups set up then, all detailed by the Health Board. Who would be in these groups? Consultants, nurses, other people that were in the clinical environment, and through that process Mairi and Heather were to lead them through with our health planners, who was Iain Buchan-- was to lead them through what you might need to tell us in order to get your department right. Yeah.

So, that was general high-level brief, and they would feed in things that they needed, be it relationship things, be it equipment things, or whatever it was. They would tell my two staff, who also had some other support from my team, tell them what they thought they needed, with the health planner saying-- well, that's-- he was supposed to be keeping them right. I'm not saying he wasn't keeping them right, but his role was to keep them right, and I've heard you say in the past, "Well these are all different," and they are, and maybe there should just be a standard format, and quite easily-- I could write it myself, I think, just to say, "You must touch on all these things," but at that point that's not quite how it was.

And you've raised it, and I've seen it on your bundles on the net. I looked at – and I haven't looked at it for 16 years – the Ward 2A, the Schiehallion Ward, and I looked at Ward 4B, and I have to say they're night and day.

Q It's very helpful you've mentioned that because what I was wondering, and bear in mind we're coming at it even further away from it----

A Oh, yeah, I know, yeah.

Q -- than you are, was that I can see the process that you've explained, but when you look at 2A and 4B, as you say, they're very, very different documents. I wondered whether at least the intention had been that there should

be some kind of moderation system, so that somebody was saying, “Okay, have you covered everything you need to cover? Can we check that before we put this into the employer’s requirement?”

A Well, two things. I would say that was our health planners-- I mean, the nurses and the doctors didn’t do this every day. They done nursing and doctoring. The health planner was the planner. I would have expected him to have balanced this up.

That said, the other thing I was going to say is that in both organisations, from my memory, there was a process to go through which was all clinicians also-- to say, “Does this describe your department?” I think in Children’s, excuse me, there’s an advisory committee, and then there was a senior management committee because the senior management committee – and this is how they work – wouldn’t let anything go through to us without looking at it, because that’s-- that was the operation that they were doing.

So, they were there and, also, remember I had two medical directors, and for Children I had Morgan Jamieson, you know, an eminent cardiac surgeon. I mean, Morgan must have that clinical outcome spec. He’s also been the chief executive. I hold him in high regard, and I looked at it last night and I thought, “It’s not too good.”

THE CHAIR: Could I just look for your help as to who actually drafted the clinical output specifications? Because, as you rightly say, if you look at the clinical output specification for Schiehallion on the one hand and for 4B on the other, they are different documents. The format is different and the degree of specification is different. Now, I, looking at these documents, have assumed that a clinician or one or two clinicians in these respective departments had drafted the document as opposed to, for example, Buchan.

A Yeah, they did, yeah, yeah, but Buchan reviews it, right, and I’m actually-- My Lord, it’s-- I’m going back a long time. My two colleagues, Heather and Mairi, might have actually drafted-- actually drafted them from notes given by the clinicians. I’m not too sure. It’s just too long ago.

THE CHAIR: Well, I hear what you say. If it had been Mairi Mcleod and Heather who drafted it, might you not have expected a sort of standard format, in other words, two documents dealing with two different departments but set out in the same way?

A I would just answer that by saying I absolutely expected that, yeah, but in the environment I was working, with very senior people, very

knowledgeable people, unfortunately, when get told that, “Those 39 are done. Everybody’s signed them off,” you know, you can say to me, “Well, maybe you should’ve reviewed them,” but I’m afraid I’d have to work 24 hours a day to do that. So, there’s a bit of trust involved. People get delegated authority, etc., etc. So, I mean, I was actually quite surprised when I read it last night. It’s probably the poorest one I’ve read for a children’s cancer unit.

THE CHAIR: Am I right in thinking that the clinical output specifications are essentially the only piece of information which is being provided to the contractor to describe the particular service which is to be delivered in a particular part of the hospital?

A Yes.

THE CHAIR: Right.

A And that-- sorry, my Lord, that’s when I’m saying I think, although the ERs are bulking, lots of information on them, that’s where I think it’s a bit light.

THE CHAIR: Sorry, that’s----

A That’s where-- Sorry, that’s where I think it’s a bit light when I said the information’s light.

THE CHAIR: Thank you.

MR CONNAL: So, when the contractor gets a clinical output specification, the idea is that they should try at least to work out what they need to provide, both in terms of, you know, layout and equipment, everything, what’s likely to have to go in there and what kind of facilities it’s going to need? That’s the idea anyway. Is that right?

A Well, Mr Connal, I would say, if you read the forewords of all these big documents to tell you just how good these people are, right, and we had user groups up and running, so when they see these pieces of information, and their health planner, which I think was Tribal, and they don’t think they’re up to scratch, all they need to do is come back to us and ask-- and say to us, “We need a bit more information on that.”

I mean, we heard from Mr Pardy, extensive healthcare design experience, but he wasn’t sure how a children’s cancer unit worked, and I have to say, he has to make himself aware of how it worked, and even though he’s sitting with that one piece of-- that one document that isn’t very good, that’s when I would expect him to go back through the process and say, “I need more information,” but he clearly didn’t think he did.

Q I think, in fairness, in your witness statement, at the time it was written, you say you don’t remember the details of them, but you have looked at these two for the purposes of your

evidence. Thank you for doing.

A Yeah, fortunately, you've put them up and I can see them now.

Q You're also asked a question, well, who was responsible for deciding what NHS guidance went in and which bits were compulsory and which were not, and you say that was the technical advisors.

A Advising us, yeah.

Q Is that not the Project team? The technical advisors, is that right?

A No, technical advisors.

Q And you were also asked-- and it's partly because this has been a topic that sort of was thought to be a prominent issue and then may have drifted away a little bit. Page 132, you were asked about how sustainability and energy targets impacted on the design, and you say, well, not very much other than making the whole process a bit more expensive.

A Yeah, a bit more detailed, yeah. Well, I'm all for the carbon-- I mean, I'm all for the carbon reduction, and you heard Emma White saying they're going for zero now. I think we were going for 80 kilograms of carbon per metre squared, which at the time was a very tight target. So, a target handed down, I'm sure, by the government.

Q Can we go to 133, where another topic crops up, which is the-- what we've been calling the maximum temperature variant. Were you involved in this discussion, the change in the maximum temperature?

A No, I think I said in my statement I think I was told that that was changing, right? And was I in the room at the time? I don't really know, because I'm sure it was David Hall, Currie & Brown, they told me they've had an instruction to change-- to bring the maximum temperature in compliance with HTM from 28 degrees down to 26.

Now, I'm only going to tell you my assumption of that, and that would be-- I think it's to do with ACADs, as we call them, Victoria and Stobhill had opened. Hadn't opened long, to be fair. I think they only moved in in June 2009, and they were clearly-- they were clearly-- when I say "they", I'll be talking about the chief operating officer and the chief exec. They were clearly getting maybe press or pressure saying, "These rooms are all overheated," right? And they said this about a range of things. "Make sure that big hospital doesn't have this problem as well," and that-- I'm just assuming that's the conversation, so that's not factual.

And so, from the director of facilities who would be in that conversation or they would contact, he then came and told Currie & Brown that that was a change. For me, if you talk about derogations,

that's the first derogation. For me, that's the only derogation, but that's the derogation to making that change.

Q Yes. Well, we know that the SHTM figure is 28 and the instruction was 26. I think, because we're rather short of people who seem to accept that they were involved in that discussion-- Do you know from your discussion with Douglas Hall who was involved in any discussions about this decision? Or was it just handed down?

A No, I think the discussion came from the director of facilities to Currie & Brown. I think it was David Hall. I'm saying that because I dealt with David and Douglas all the time. So, the director of facilities made the change.

Q Are you aware whether there were any other technical advisors involved in discussing that change?

A No, but I think Currie & Brown also were also the technical advisors on the two hospitals in question that we're talking about, or at least one of them, and so they were having that-- they were having conversations anyway, and they were having some problems with, I think, a heating plant and stuff like that. So there was another conversation happening over on this side and filtering into the job that I'm doing, or trying to do.

Q Yes. What we're trying to understand with some difficulty, because we don't have people who seem to remember it, is whether anyone looked at, you know, could this have knock-on effects on other issues? Are there risks we should be assessing? What about bringing IPC in in case it impacts on something they're interested in? Do you know any of that information?

A No, I don't think-- no. No. That is just-- that's just the way it happened, and things like that did happen, do and did happen, in the health service.

What they were doing was-- of course, you know, they're dealing with patients every day of every week and, having been a patient myself, I have to say to you I'd rather the room was comfortable than actually worry about infection control. I know that might sound ridiculous, but it's actually quite true. These guys know that keeping patients happy in rooms is part of the process of getting them better. So it would come from a good act and maybe the repercussions of it, as you're asking me now, I don't think any of us-- I think Emma said that: none of us knew what that was going to drive in the end.

Q Well, if you take a ridiculous example, if somebody says, "We need to reduce the temperature in this room when we're designing it," that might mean somebody designed Venetian blinds on

the windows or fewer windows, all kinds of possible knock-ons. I just wondered whether you had any indication that any of these issues had been considered?

A No, the key thing for the hospital, right from day one when they changed from open wards to single rooms, the key thing is that the single rooms are the optimum in stopping the transfer of infection. That's the one-- it's multifactorial, but that's the one thing that we all thought was the thing.

We spent-- because of the Vale of Leven Inquiry, we spent years trying to separate beds. In the Glasgow Royal, the beds were only separated by the cabinet, the locker, right? And we spent-- and there was a-- they've got 3.7 metres. I might be wrong with that. We spent years trying to make beds further a pitch from each other, and then we come into single rooms. And I have to say, all through this, the single rooms, from everybody's perspective, was the key thing, the saviour. "This will help everything. This will be better than anything else," and that's in our minds.

Q Thank you. Can we move on to another topic? Chilled beams, which come into our discussion that we're going to get to in due course about what you don't want to call the derogation, but the-- --

A Sorry, excuse me. Can I go back just to the temperature thing?

Q Yes.

A You're going to come on and talk about logs, I'm quite sure, but you'll see that change you call that derogation in temperature has actually got-- was actually written and drafted out in the ERs, which I don't think any other one was.

Q Right. It was during the process, was it?

A Yeah, it was during the-- yeah, around about June, I think, June/July. I think it was written in July 2009, but as you're talking about the log-- everything else was in the logs, but this thing's actually written down. In fact, when I reviewed it for this process, I thought that must have been in there already, but it wasn't. It was inserted in there. So, I only give you that for your information. I'm not making a point.

Q No, no. Let's just get that up on screen. Bundle 17, 1063. 1063. Thank you.

A Yeah, that's it. Yeah. I think all I'm saying to you is I don't think any other action got that level of input.

Q No. So your point is that somebody actually wrote it all down, given some of the discussions about what was or was not to be written down.

A Yes.

Q Okay, thank you. Only really

the one question I wanted to ask you about chilled beams, because we now know, to our cost, what chilled beams are and what they do and don't do and what some of the issues are with them. You say on page 134 of your witness statement, if we can go back there, that you:

> "… never heard anyone… raise any issues with chilled beams although [you] had no experience [with] them… and [you] took [your] advice from the experts…"

Which is what you've been explaining. Were you made aware of feedback from unsuccessful bidders in the competition?

A In terms of unsuccessful bidders, during the process dialogue and evaluation, our lawyers, Shepherd and Wedderburn, clearly telling us, "Do not take one from the other. Don't take a good thing from that bidder and put it in that." So, we were-- and it maybe doesn't apply to the time you're talking about, but we were kind of entrenched in, "Do not take something from Bidder A and put it into the successful Bidder B's process," because that's not allowed. That's not what you're supposed to be doing.

So, I wasn't aware of it, but even if I had been aware of it, I might have shied away from it because-- and that was explained to us rigidly, "Do not do this or you'll be breaking the European Union procurement rules." So, that's maybe an issue, but in saying that, when you come on to talk to me about carbon filters, I'm going to play something different back to you.

Q I'd be happy to give you that opportunity, Mr Seabourne.

A Good.

Q The only reason I ask is that we happen to know now that one of the unsuccessful bidders basically said, "Look, if you're going with chilled beams, you're not going to meet your air change rate target." So, the suggestion is that someone somewhere in the Board structure should have been aware of that before you got into all these debates about them.

A Well, having been in the evaluation process and having remembered the people meeting, for instance, Multiplex's bid which had come up in two vans of-- that's the size of the information that we were working with, and looking through all the bids to come out with, "What's the best bid?" You know it's like any bidding process, pros and cons. There's good and bad in every bid, and what you've got to do is to pick as many good ones in order to get the best bid.

That bid you're talking about might have been the bidder-- might have been,

and I'm not saying any names, might have been the bidder that didn't have any internal stairs in their bid. No, so marked down for that, and I'm just trying to say it's a process of, you know, iteration and compromise and consideration, and you come out with the best example and, yeah, have bidders who have lost got better ideas-- some better ideas, and bidders who have won? Every time, every process.

Q On the next page, you make some comment about the environmental data and what data was in what documents and so on, and I think we're probably easier to look at that in more detail when we come on to look at the design process----

A Yeah.

Q -- that went on, but in that same page, 135, when we'd been talking about environmental data, air change rates, pressure differentials, that kind of stuff, you say the project team were involved in the employer's requirements and then in the design process:

> "The project team were involved in [employer's requirements] and [then in the design] process to endeavour to provide as much information and support to the contractor and their team to advise them of the functional requirements of the ER's. But we were very much led by our TA's and Capita… and the Brookfield and ZBP on all technical issues."

Now, just pausing there. By the time you get to the design process, you've not got your technical team. Is that not right?

A No, I've not got the technical team as it was, yeah, but it's been discussed in these hearings that we don't have design people, and we don't. I just told you at the beginning I'm not a designer, but myself, Peter Moir, Frances Wrath, David Hall – take that as the core – we're more than capable, more than capable of looking at designs and giving our opinion. Now, we'll probably come onto this. That's not an opinion where I'm saying, "This is how you design a vent," but it's an opinion where I'm saying, using my 33 years' health service experience, "You should think of this."

So, we're going to come on to discuss our involvement in design, and myself, Peter Moir and others were involved in design-- involved in design every day of every week, and that was the role we played. But the Health Board-- the health service didn't put us there to be designers, but they knew we knew generally what we were talking about.

I mean, if I can give an example, my

Lord, we've got a 33,000-volt substation there, and we must have had, I don't know, many conversations about setting that up. That's a big deal. I've never dealt with that size before, and we went to Scottish Power and at Scottish Power I've got all the designers, Multiplex people and Scottish Power people. I would say I was the person saying more about what the requirements were than anybody else knew.

So, I'm just trying to express that although none of us are designers, our experience allows us to participate, and if we don't know the answer – hence the Wallace Whittle contract – we know, or we think we know-- I thought we knew where to get it. So, it's a bit of a misdemeanour thinking that we, as a project team, are not involved in design, are not capable more or less of being involved in design. We certainly are.

Up and down the country-- I'm going on a bit, but I think the more evidence I can give you the better. Up and down the country, every health board in the UK at that point and before – maybe changed now because the world's changed – has got estates teams that are doing capital projects, right, who are not designers, but quite easily-- not easily, quite competently getting designs developed and concluded in hospitals, or bits of hospitals, built. So, that's what we do.

Q In the same paragraph, you mentioned Capita, so let's just deal with Capita. In your statement at various places, you talk about Capita dealing with, as other witnesses have also said, contract compliance.

A Yeah.

Q Now, the Capita evidence essentially is that, with two minor exceptions, one about some switchgear and one about a piece of ducting. They weren't asked to review any design, and they were simply doing this inspection supervising role. They weren't asked to do an exercise of-- that would have allowed them to say whether somebody was complying with the contract. Can you help us at all?

A In the design stage, we're talking about, Peter Moir, and that's really unfortunate. I don't really have access to Peter. I do keep in touch, but I don't have access. Peter Moir asked Capita and gave them a conversation event to do some design review on the information we were getting fed by Multiplex's designers. And he actually done that for two reasons, because Capita didn't come on board till June 2010, to give them experience of what-- the project and some of the designs in the project, and also – and it's a bit later on – to look at some-- because they're chartered

engineers, to look at some specialist-- and I'm sure we'll come on to talk about it, some specialist areas, your double loop thing. A final check, and final check on the PPVL rooms in Ward 2A.

And I think I heard yesterday that Capita say they didn't do that, but I think you'll see on the stamp of the drawing it's Allan Follett's name. So Peter asked them, and it was a bit of the project Peter dealt with. So, unfortunately, he would give you it in detail. I've only got it at high-level. We asked Capita to support us in the design process. And just for clarity, I'm not saying that's them signing it off because the only people who can sign off the design is ZBP and Multiplex, nobody else.

Q I need to ask you about it because, as emerged yesterday, when Capita were given their contract, it contained a clause which said something like, "Review all the contract documents, design requirements…" which is the material you would need in order to determine whether someone was complying with the contract as opposed to complying with a contract drawing produced by the contractor, which might or might not be correct. Now, when Capita were challenged on that and said, "Well, everybody's talking about you doing contract compliance. You've not answered that question," they say, "Well,

look at the top of the page," and it says, "If asked".

A Yeah.

Q They said they weren't asked.

A Well, Peter did ask them. Peter gave them additional funds in order to do additional work. I'll repeat – I'll probably repeat this often – I don't have access to all my files, notes, emails. I wish I had, I really wish I had. Peter had asked Capita and paid Capita to do additional works, and that must be there on record somewhere.

Q Well, let me take your example, if I can. When we had Mr Pardy here, we showed Mr Pardy a record that indicated that a non-isolation room in Ward 2A was recorded as having 40 litres per second, which is the-- what we're calling the derogated figure, the 2 and a half air changes, not 6, not 10.

A I think it's 3 actually, but yeah-- --

Q Okay, well, take it from me. We're not going quibble between 2 and a half and 3.

A Let's hope not.

Q That figure was also shown to various other people, Ross Ballingall and so on, and they all went, "Well, that doesn't seem right." Now, that's what Mr Pardy said. Well, maybe I haven't interpreted this correctly. Maybe I've just been assuming that it's not an isolation

room, it's just an ordinary room. Are you telling us that Capita checked the ventilation specification for Ward 2A?

A No, I'm telling you Capita checked the ventilation for the eight PPVL rooms, positive pressure ventilated lobbies, and signed the stamp on the drawing.

Q Okay. Okay.

A I would like to come onto 2A, so hopefully we will come onto 2A at some point to express what I feel about what I think went wrong.

Q Okay. Well, I'll certainly allow you an opportunity to deal with 2A because we want to ask you about it as well.

A Thanks.

THE CHAIR: Right, just clarifying for my note, Mr Seabourne-----

A Sure.

THE CHAIR: -- your evidence is that Peter Moir asked Capita to do a particular piece of work. Now, it's the scope of the piece of work to review the design of the positive pressure----

A Ventilated lobbies, yeah. Excuse me, yeah.

THE CHAIR: Right, so specific to these lobbied isolation rooms?

A No, my Lord. He asked them to do some general design review work during the period of 2010, the Appendix K period, and on top of that he asked them to do some work, and I think David Hall used the term "to review things" where Multiplex designers were saying, "We're not quite compliant but here's an alternative solution," and you've had that discussion with Steve Pardy. Happy to have it again.

So, when the contractor was saying, "This isn't quite in line with ERs," Peter asked Capita in this particular instance. I don't know many instances-- he asked them to run their eye over it with their chartered engineer, Allan Follett, and he paid them for that extra work.

THE CHAIR: Right.

A But that's actually into 2012. So, just so that everyone knows, the RDD process ran right up to-- it didn't finish. It's a design and build. It continues to move. So, I just thought I'd add that in.

MR CONNAL: I think what his Lordship is keen to do is make sure he notes correctly what your evidence is about instructions to Capita. Now, as I heard you give your evidence – and I would like you to make absolutely sure that we're getting this right – it probably splits into two. He'd asked them to do possibly a couple of bits of work where somebody was saying, "This isn't quite in accordance with the ER. Can you check it?" We did hear about a couple of items from them. But also you say that they were specifically asked to review the

ventilation arrangements for the PPVL rooms in Ward 2A. Is that right?

A Yeah. I've seen the stamp. Allan Follett's name's on the stamp. Well, I'll just leave it at that. His name's on the stamp.

Q Thank you. Let me ask you a completely different question just because it's next on the-- happens to crop up next on your witness statement. You were asked who was responsible for HAI-SCRIBE assessment, and you say, "Annette Rankin led on this and subsequently Jackie Stewart…" Jackie Barmanroy. Now, I just wanted to ask you one thing. According to Jackie Barmanroy, you told her that HAI 1, the first of these, had been signed off by the Project team. Do you have any recollection of that?

A I just recollect-- I don't know. I can't remember how many HAI-SCRIBES should be in a project. I'm sure you might tell me. But there's a first one, the planning one, and I think it deals with some of the stuff you've asked me about: "Is this the right site? Is it near anything hazardous or dangerous, etc.? Are we doing it-- Is there buildings, health buildings local to us, that could be affected?" I'm not an expert on HAI-SCRIBE. I think Annette did do that one, and I think the next one was-- I think there's four, and I think we've only got

two done. I think Jackie done the second one. So, yeah, I think Annette did do the first one. That would be my evidence. That's my memory of it.

Q So you think Annette did the first one, but did the Project team sign off on that?

A Yeah, it was for us. If we were coming up to say she did it and she went, "Oh, no, you can't build that here," then, obviously, I'd need to raise that with the chief executive, so--but we weren't getting that feedback. So, yeah, it was an internal-- I don't-- It was internally being addressed and, as it was a positive, then move on, next issue.

Q Can I ask you about Infection Prevention and Control involvement in the project? You point out in your witness statement that, according to your experience, it hadn't been customary to have any IPC person sort of embedded in the team, whereas you did.

A Yeah.

Q Therefore you say, well, that's a positive for the team that you were leading. The person embedded tended to be an Infection Control nurse. Is that right?

A Yeah.

Q Now, let me just ask you this question. I can understand that if somebody turns up at a team meeting which has got the IPC member and says,

"Oh my God, we've got this problem. Here's this complex IPC issue," the nurse can go, "Well, I've no idea, but I'll go and find out where I can get that information." The other side of the coin, I have to suggest to you, is that if you're discussing topics, issues, as you might do in a large group, how does the nurse know if there's something in that discussion that's flagging a question that they need to take further?

A Just the same as me and any other member of the team, we use our initiative, we use our experience, our knowledge, and we generally challenge it or not as the case may be. That's how it's set up, and if I take IT in the new hospital-- I mean, IT in the new hospital-- Well, bearing in mind, 2009, we didn't even have iPads, right? So we were trying to look ahead. IT in a new hospital was very, very complex, and I'm not an IT person, but the IT person doing that same role-- we produced an excellent IT system, very complex system, in the new hospital, and that's what they were doing. I heard Fiona say the hub and spoke, going back and forward, back and forward.

If Jackie Stewart or Annette hadn't been there, then Peter and I would have to have done that job, and maybe we would have done it differently with our long experience, but that's what we had

and we used that. And if it's a flaw, then-- If you think it's a flaw, it's a flaw. But if you go back to the-- if you go back to the two ACADs, they didn't have anything like that. The medical director----

Q If you go back to where?

A Sorry, the two new hospitals. The Victoria and Stobhill just completed, so being built for the previous three or four years, they didn't have anything like that, and the medical director-- In fact, the project director, who was Alec McIntyre, told me-- I didn't really deal with that. Anything that was coming through that might have been about, you know, cancer unit, air rates or whatever, funnelled itself through the medical director, seemingly.

So, we thought we had a more-- not a perfect solid line, but we thought we had a more solid line. And having travelled wide in the UK to look at a whole range of processes to build hospitals in the short period of time I had to learn about it, I didn't come across any other organisation that had that. So we thought we were really doing very well, innovative, and that's not for me, I want to make it clear-- for me to say this is Jackie or Annette's responsibility. It was just a process we had we thought would improve things, and maybe it didn't.

Q I suspect the question is probably more nuanced than that

because I'm not putting a question to you saying this was good, bad or indifferent. I'm simply seeking information from you.

A Sure.

Q But one of the topics that we've heard discussed, particularly at the earlier stages of the Inquiry, is the extent to which even people who do lots of IPC work know about, for instance, ventilation arrangements. They may be focused on other issues, but they're not necessarily experts in ventilation. So, I suppose the question then becomes, if you want to ask-- you know, something crops up about safe disposal of clinical waste or something, you might think the nurse will go, "Well, I know a wee bit about that, but I know another nurse who knows more," but it might be challenging, would you agree, if you're starting to get into ventilation issues, for them to spot where the issues are?

A I don't expect them to-- I expect them to maybe spot the potential outcome rather than the system being designed to produce the outcome. If we carry on a wee bit in the design process, you'll see the renal user group-- and you've had this discussion, although it's not quite correct, the way it was discussed, from what I gather. In the renal discussion user group, Jackie then goes to-- I think she goes Craig Williams, who's the head ICD, and he tells her to go to Peter Hoffman, right? So, I'm not going into detail with that. I'm just telling you that's the link made.

So, they want to reduce the air changes. Jackie recognises from a clinical perspective that that could be an issue. She sees her-- the senior, and the senior says, "Go and ask an expert." So, that's it working perfectly. Now, I'm not saying it worked perfectly in every case, but that was the reason for the user groups, that was the reason for the Project team, that was the reason for Jackie being there, and that was the reason for her seeking advice and getting advice back. And that advice that he gave us **–** if we want to talk about it, sure – made us all feel, "All right, we're fine with some of the decisions we've made here."

Q As I explained to you, Mr Seabourne, we're trying to look with the benefit of hindsight at things that may or may not have worked well to see whether things could be made to work better. That's all we're doing. We're not looking to say you were responsible for the performance of the ICN system.

A Sure.

Q So please understand that.

A No, and I'm new to this process, so please forgive me if I'm misunderstanding.

Q The topic of BREEAM has

cropped up repeatedly, and I'm not going to take up your time debating that, but that's where your correction to your witness statement comes in.

A Yeah.

Q So, if we can go to page 138 of the electronic bundle, and it's at the foot, where the sentence makes no sense as it's said at the moment. The sentence says:

> "… at no time can I recall myself or anyone else associated with the project ever prioritising safety over BREEAM."

That's clearly intended to be "BREEAM over safety". Is that correct?

A Yeah, you must have thought that was a godsend when you saw that.

Q No, I actually had that noted as an error.

A Oh, thank you. Cheers.

Q In any event, you've intimated to us that the two words have been transposed and your position is, as I suspect a number of other witnesses have already said, "We did not prioritise BREEAM over safety."

A No, never.

Q That's your position?

A Never, yeah.

Q My Lord, I was about to move onto what we're calling the "ventilation derogation" but I wonder whether it might therefore be sensible to pause now.

THE CHAIR: Mr Seabourne, as I indicated, we take a coffee break. So could I ask you to be back for quarter to twelve?

THE WITNESS: Certainly, my Lord.

(<u>Short break</u>)

THE CHAIR: Mr Connal.

MR CONNAL: Thank you. We're going to move on to what we're calling the ventilation derogation, although I know you don't accept that description, Mr Seabourne. You're aware that there was something called an M&E clarification log that----

A Yes.

Q -- was at the heart of a lot of the exchanges here, and let's just get that out so we can see it. That will be the 2009 version, which is bundle 17, 824. Now, I put that up simply and solely, Mr Seabourne, because-- and I can tell you the first column with writing in it is, "Board Comment". The first thing that's said at the end of that narrative there is:

> "Ward Air change to be 6AC/HR, currently shown as 2.5AC/HR which is not in compliance with SHTM 03-01."

So, at least at that point, the Board position is relatively straightforward: this is not in compliance. Would you agree?

A Yes, yeah.

Q I'll ask you about one particular aspect. In the course of these exchanges, one commentator – and it was said to be Mr Bushfield, whether it was or was not doesn't matter – in response to the suggestion of using a lower air change rate said, "Not accepted. Requires IPC sign-off." Are you aware of that?

A Yeah, you sent me a bundle with that in it, yeah, and I thought that bundle was an inter-contractual thing with the design teams, but yeah, I do. The answer is yes.

Q It suggests, at least, that someone on the client side had to get IPC sign-off. Can you help us as to whether that was done?

A I'd need to go through the whole process. At that point in time, you can clearly see-- say-- see, sorry, that we're saying not for us, right? But we weren't saying not for us in terms of infection control. We were saying not for us in terms of we were thinking heating and cooling the environment in terms of the patient, and nobody was-- that I can remember was switched on to, "This is an infection control issue." However, as it runs through the process, and I'm sure we'll get there, up to 2010, there's lots of discussions led by Mark Baird. Mark Baird led this process.

That's what we employed him to do from start to finish, and as we went through this process, we are persuaded-- I mean, I say, "me". I mean the team. We are persuaded that this is worth considering. I'm going back-- I can't detail it exactly because it's a long time ago, and you can see at some point we are persuaded to change that view.

And in that part of the process, Currie & Brown, and I'm not sure Wallace Whittle are in the room with them, but are speaking to my team who's got an IPC person. This is us going back to the link again, right, and they're having a conversation about, "Well, we can't have the six air changes because of the maximum temperature, but how can we maximise how much air can go across these chilled beams?" and we come up with this figure. I think Fiona McCluskey told you that we come up with the figure of, well, we must have 8 litres per second per person, right, and that was 40 litres per second.

So, at that, was there any-- to answer your question, "Was there any IPC involvement?" Now, when I done my statement, I actually thought there was. I thought it was Annette Rankin, and it might still have been, but it's only through listening to some of these that your memory comes back. Annette left, and I'm not sure when Annette left, right? But I would still expect my team, you know, of

Frances Wrath, Heather, Mairi, Fiona, me, David, I'd still expect one of them to go and have a touch base. Not a whole review, a touch base – because it might say "review" but it means a discussion – with Infection Control.

Now, at that point in time, I can't say whether that happened or not, but I want to say at that point in time, for me, that wasn't the most important thing in the world, right? And that's really because we were going into a year of design, if we were going to sign this off, and in that design process – I know we are going to talk about this – we had the user groups with their own Infection folk, and we had the user groups with our Infection folk. So, it wasn't a big deal for me to-- in the end for somebody to say, "We'll run with this," and we'll get to that point, I'm sure, when we talk about some of the correspondence.

So, to answer your question, I'm not sure if Infection Control were involved then, considering all that was going on. So, you've showed me a part of a log here that's got thousands of things in it, right, and it's just the volume of work. I didn't have any concerns. Nobody was raising a concern, and then we heard Mr McKechnie, and actually I'm glad I sat and listened to that process because he told me what he was saying to us-- right, I know he ended up saying, "Oh, but you need to do a health check on this, really." So, he told us that in terms of regulation this was fine. He said to you that this is way past the minimum, so that's good. We'll have patients in it themselves. They'll have 40 litres per second to themselves.

The one key thing I keep coming back to is single room, and through my statement and others we really wanted natural ventilation, and in a natural ventilation situation there could be zero air changes. And so for the general room treating general patients with my 33 years' experience in health, I'm just going to be honest with you: I didn't think that was a risk.

Now, there's the next bit of that I'm sure we'll come onto, but that's how we got the-- that is in the final bit in December I'm sure you want to ask about, but that was the thought process from me and people on my team at that time, and we were-- you keep asking, why did we change our mind? We were persuaded to change our mind by the people we were employing to tell us how to design a hospital.

MR CONNAL: Okay. I have two questions that follow from that – at least two. One is, as you quite rightly say, I'm focusing on the period during which a decision was made to put into the contract that 2.5 air changes with chilled

beams could be provided instead of the original intention of 6, and can you tell me at all at what point the decision changed from, “No, that’s not on. That doesn’t comply with guidance,” to, “Okay, we’re being persuaded”? Do you know when that happened?

A Well, the bit I’m talking about, the 40 litres bit, is part of that. That’s us being persuaded and we can get the maximum flow at 40 litres, because I think Stuart McKechnie said-- bearing in mind it was 2 and a half at 30 litres, and he’s saying-- I don’t know why he’s asking, “How did you get to 40?” because we sat down with our nurse and the medical people on my team and we said, “What do we need to get to?” and we got to 40.

So, that part of the decision was there, but the final part of the decision about how did you get it in the contract, that’s the very last week of-- before the contract’s signed, and you guys are all the lawyers in here. You know that most things-- most contracts that you sign, at the very, very end, lots of the key decisions are made.

If I could do an analogy, my Lord? The biggest thing you ever do in life is buy a house. I think I’ve bought about 10 in my life, and the process goes I never see my lawyer and then, two days before I’m going to buy the house, everything

happens. You’ve given this, you’ve asked this, and don’t do what-- So, contract-- I think somebody’s already said to you, contracting’s like that, the very last minute. And at the very last minute Currie & Brown are saying to me, “We’ve got a solution,” and I think you asked me in my statement when I saw the strategy. I think that was in the new year because, again, I would say all that was was a point in time where we said, Put that in the contract.”

Now, the corollary of that is, if they’d said, “We don’t have an agreement,” I would just have went to Shepherd and Wedderburn and said, “So what am I doing here on the 18th? Am I just going to sign the contract with that amendment to be resolved, or will we leave it for a month?” That was my next-- I’m always thinking what’s next, but when they feed to me that they’ve got a solution, and I’m just going, “I’m fine with that.”

At that time, my Lord, just to be clear, I’m just about to start on site with a 75-- well, actually, call it a £125 million laboratory project, and at that point in time-- and this isn’t me dodging my responsibilities because other people are dealing with it on my behalf. At that point in time, that’s my focus. 7 January, this project started. In fact, they were on site before they even signed the contract, and that’s my focus. But in that focus I can

say, “I’m not bothered about this decision the now because I can go back and readdress that,” and that’s just the honest answer of what it was.

THE CHAIR: Okay.

A Sorry, is that too much? I’m happy to break it down. Sorry, my apologies.

THE CHAIR: Certainly, it’s quite a lot, Mr Seabourne. This process of being persuaded is a process that’s going on in 2009.

A Yes, sir.

THE CHAIR: Right. Is there any particular forum for that?

A Well, the particular forum is that we have got a big, huge, open plan office, and in Currie & Brown I used to actually say, “I’ll need to charge you rent.” We worked together as a cohesive team. They were in the office as often as I was in the office, and so you interacted with people as you need. So it wasn’t a formal meeting, “Let’s go and--” It was just happening all the time. They’re dealing with these logs. You see how many things are on these logs, and this was one outstanding thing.

There was another outstanding thing which actually might not have been in the logs, which is the total square meterage that you’re buying, which is a very expensive issue to get sorted. So, we are dealing with that in an iterative-type process, and at the end of the day we are persuaded by our experts, Wallace Whittle and Currie & Brown, that this is a reasonable way forward to meet all the challenges you’ve got, taking account of what I said the first delegation is, the change from 28 to 26, right? So, in order to meet that and meet everything else, we then said, “Okay, let’s go.”

THE CHAIR: My other question is: at the end of what you previously said, you said you weren’t particularly bothered about this going into 2010, because----?

A Because we were going into the design process, okay, which had-- I’m sure we’ll talk about this, which had the users, which had Infection Control, which had architects and-- Multiplex’s architects, Multiplex’s designers, etc. So it would get dealt with in there. I’m sure we’ll come on to talk about that precise bit, but at that point, just before Christmas, to me it didn’t matter.

If I was going to sign the contract with that in it, it would still get revisited. If I wasn’t going to sign it, if that wasn’t concluded, then I would be asking my legal advisors, “What do I do next?” and they would have said one of two things to me: “We’ll make an amendment and deal with it,” or, “We’ll hold off signing the contract for, say, another month.” So, that’s the logistics of working on a very complex project with millions of bits of

information, but that's how it all distilled out.

THE CHAIR: And so part of your thinking was that it could be revisited in the course of the reviewable design?

A Well, it was getting revisited in reviewable design because these logs are very high level. These are only concluding the ERs basically.

THE CHAIR: But if it was to be revisited, there would be cost implications?

A There may or there may not be cost implications. It depends in the design what solution we might have come up with, and you've already heard me saying natural ventilation – don't think that would have cost us anything. Mixed mode ventilation may have cost us money, and we might-- I'm surprised we've not been asked the question. We might have went back and went, "We need to go back and change this from 26 to 28," although that would have made it really uncomfortable in Glasgow for the patients. So, that's the kind of thought processes that were going on.

THE CHAIR: Thank you.

MR CONNAL: Can I just ask a follow-up question? The sequence that we see, and that's all we can see, on the logs and in the emails suggests a process of working towards a conclusion, an answer. Nowhere in that documentation do we see any suggestion, hint or comment suggesting that this is provisional or you're thinking about changing it in the future. Are you actually telling us that that was actually being considered at the time, the possibility of moving away from the 2.5 air changes in due course?

A No, I'm just telling you at that point in time that's where we are with all the thousand items, or how many thousand items there are on that, is to get us to a point where we say, "Can we sign the contract? Yeah, we're quite comfortable, but we've still got--" I mean, part of the-- we were signing for the laboratory that I spoke about, Stage 1, and we were signing for the design period, Stage 2, and I think you asked Ross Ballingall, "What happened if you didn't get Stage 2 and it stopped. Would you get a big bonus?" No, he was getting nothing, right? It was-- if we didn't get to the end point in design, we were probably going back to the beginning again, right? So, I sit and I listen to people thinking – and I mean everybody – that this is just a straight-line process. It is nothing like a straight-line process. It is so complicated, convoluted, very, very difficult. So it's important that you understand that context.

Q Well, we have your evidence on the context. I have an additional

question to that, and that's this: at this point, you've got your technical team working for you. You've got Wallace Whittle. You've got any other of the consultants that you need on any particular topic. You're just about to move into a process where they're out the door because of the change that we've been talking about. Now, somebody might suggest that it's illogical to think that you're about to revisit a ventilation debate reliant on technical advice at the same time as you're dispensing with your technical advice. Is that a fair point?

A To some extent, but we weren't-- I've maybe not come across properly here. We weren't consciously saying, "We're going to revisit that." We were consciously saying, "We're at a point in time where we've agreed something and we've still got a lot of design to do." Whether we revisited it or not, it would come out in the wash. So, we just got to that point and then we said, "We're going to go in and redesign things."

In terms of the technical team, as I said, we had a technical team that were capable of challenging the analysis of whatever the contractors' design team was coming up with, and we had a call-out contract that we set up for Wallace Whittle to give us advice on, right? I'm

not quite sure how that would work because what I heard from Mr McKechnie's evidence was that he gave me advice but it was my decision, right? So, in a shadow design team, would that just have been the same? He'd have gave me advice but it would still have been my decision? So, I thought we had enough people with experience and knowledge to help the designers through the process and give the users, the clinical people, what they wanted.

Q Those people are what, you, Peter Moir, Frances Wrath?

A Frances Wrath had done more projects than me. Frances Wrath was given to me as my building services person. Frances Wrath was a person that I tasked with doing the ADB sheets along with Emma, and the RDS sheets. So, my expectation of Frances Wrath and yours is clearly totally different.

Q We've heard from her that her technical abilities were quite restricted.

A (Inaudible 12:09:28).

THE CHAIR: Just maybe before we lose this point, Mr Seabourne, you used the expression, "We had a technical team," and then you went on describe a call-out arrangement----

A Yes. Sorry, my Lord.

THE CHAIR: -- with Wallace Whittle. I actually noted that as Currie & Brown, but my memory is that you said,

what, call-out----

A Well, Currie & Brown were going to do the project management and cost management in the new world, and Wallace Whittle were going to be on a call-out basis that we could ask their advice on.

THE CHAIR: My question is: who did you have in mind when you used the expression, "We had a technical team"?

A So, I was talking about the internal team.

THE CHAIR: Right, so that's yourself, Peter Moir and Frances Wrath?

A Yeah, yeah.

THE CHAIR: Thank you.

A And we had-- sorry, my Lord, we had people in that-- in my project team were the Estates people, FM people, etc., etc., and obviously we had links to a range of folk in Estates and Facilities that we could challenge ourselves with if we needed to challenge ourselves with, or challenge the design work.

MR CONNAL: Can I next try to get as clear as I can, focusing on the December period, particularly the tail end of December when, as you quite rightly say, this was all happening? We've had quite a lot of evidence from other people as to who was or was not involved in this decision-making process. Now, what's your version of who was involved in the discussions on the ventilation derogation?

A Right. Well, first of all, if you look at the email trail, right, you'll see I'm not even in it, okay? Neither's Peter because we are so-- And this is not an excuse. This is a practical way that we're working. We're focused on getting this lab up and running, which is a far, far more detailed stage of design than the hospitals were at that stage. Currie & Brown, led by Mark Baird, was taking this forward, liaising all the time with Ross Ballingall, Multiplex, and his team, and ZBP, and Wallace Whittle. That's my total explanation.

So, when they talk about having a meeting in my office that week, you couldn't have got me that week for a start. There was no meeting, right, that I know of. I wasn't at a meeting, and when-- I can't remember if it was the day of the contract or the day before, I get a conversation because they're all on my office to say, "That's fine. We're going ahead with that-- sorry, that stuff." That's closed out as far as the air change issue is concerned, and that's at a point in time. So, I wasn't party to all that, and that's not me saying-- It's my responsibility. I'm not saying it's not, but I was doing something different and they were trying to conclude this. And they didn't need to conclude it, but they concluded it in that

way.

Q We can look at the email chains if you want, but----

A No, I'm not necessarily on them.

Q The email chains that we have involve-- first of all, Mr Hall is copied in, but he tells us he wasn't really involved; he was just being sent that for information. We know Mark Baird is involved, and he says he's basically just organising the meetings, and there's Mr McKechnie. Now, that appears to be all we have involved in these discussions. Mr Baird says, "Well, I'm just a project manager. I don't know anything about detailed ventilation, so I was just organising this." Was anyone else involved that you're aware of?

A No, they're the key people leading us forward. The other involvement, as I said, when they spoke to my team in order to maximise the airflow, right, the 40 litre-- So, we went from 30 litres to 40 litres per second. My team were involved in that part of the process.

Q Who in your team?

A Well, in my team would be me, Peter, Frances, Fiona. Fiona was particularly getting involved because they were asking her about what patients-- what patients need, how many people would be in a room, etc., etc. So, that was them trying to get-- And I don't know if Annette Rankin was there then or she'd left, and she's the IPC. So, that was them trying to get a handle on this functionality bit, that I'm sure we'll come on to talk about, of what you needed in a single bedroom. And they took that back to Wallace Whittle because I don't think Wallace Whittle were actually in the conversation, and they agreed or they advised us then that that was the best way forward, after having spoken to ZBP about that final strategy document, which I think was a final iteration of work that was getting done. I'm sure it was.

Q Okay. So, some of your team are involved in a discussion which leads to this figure of one patient and four other people that appears on the log. In terms of discussing the rights or wrongs of the proposal, it's just Mr McKechnie then? Is that what you're saying?

A Mr McKechnie's team. Well, Mr McKechnie, in discussion with ZBP, yeah, on behalf of me.

Q Right, but ZBP are sitting on the other side of the fence. They're the contractor making the proposal. I'm very keen to understand your----

A Yes.

Q -- side of the fence, which is McKechnie-- You say Baird had a role? I mean, he just says he organises meetings.

A Well, that's his evidence. I can't-- I'm telling you what I thought he done for me. He led the process of the logs to conclusion, and his role was to get them concluded, and he got them concluded through discussion with Wallace Whittle and ZBP. So----

Q Well, who then provides the final word, if you like, "Agreed"? There's a proposal. There's some discussion. Somebody then has to say, "Agreed".

A Well, there can only be one person who does that; that's me.

Q Right. So, at some point, you or Peter Moir, I suppose, possibly?

A Well, it might have been, but I'm his senior. So, at some point, they tell me, "The logs are clear. We can go ahead," right? And no major conversation because we all know that we're going into a design phase. So I personally didn't have any particular worries about it at that stage.

Q So, when you say in your witness statement – and go back to that, please, at 141 just near the top:

> "It was then concluded by the TA team that this was the best and most reasonable solution to meet the Boards requirements and included in… logs…"

I have been asked specifically to ask you this question: when you say "the TA team", is that then basically just Mr McKechnie's view being relayed to you by Mark Baird, as far as you can remember?

A Yes, that was-- Yeah, yeah. Mr McKechnie leads-- on behalf of the technical team, he leads the M&E design. Iain Buchan, in terms of health planning, leads the health planners. Harry Smith, in terms of ATLM, leads the architectural. That's their team. But Currie & Brown pulls them together. I'm not quite sure of the contractual arrangement with consultant and subconsultant, but yeah-- So, I would just referred to "the TAs", but what I'm saying is, in terms of engineering, Wallace Whittle.

Q Yes. Okay. Now, you go on to make a reference to Mr Hoffman addressing another similar issue. Now, do you remember what the issue was that they were addressing that you mention here?

A Yeah, it's what I mentioned-- excuse me, it's what mentioned before the break.

Q You said it was an idea of IPC, your hub and spoke, working well. Do you remember what the actual substantive topic was?

A Yeah, I think the substantive topic was, again, in the two new hospitals that had been built, that the Renal Unit was getting draughts through the

ventilation systems. It's not unheard of, by the way, and I'll maybe come on to talk about that. They were getting draughts. I think they were getting-- Whatever unit they were in, they were getting 10 air changes per hour and they wanted it reduced to – I think it was the same – 2 and a half. It was maybe 6. I'm not quite sure, but they wanted it reduced, and in that process they spoke to-- In that process, sorry, Jackie Stewart took up that lead and spoke to-- I'm not sure if it was John Hood. I said Craig Williams, John or Craig Williams, and they passed Jackie-- or they related to Professor Hoffman on her behalf to have this discussion, and you can see the outcome-- You've had Professor Hoffman here to see the outcome of the discussion.

Q Can we just look at this, bundle 17, 3032? Now, this was an outpatient renal dialysis area where a specific question had been raised about ventilation in 2010. As you quite rightly say, Mr Hoffman was spoken to. The way you put it in your witness statement is that-- "while addressing another similar issue". Well, this is not really a similar issue, is it, to whether you're going to put 2.5 air changes in almost all the rooms in the hospital?

A I think it is similar. The similar part to it is that reducing air changes is

not affecting or diminishing the dilution of air contaminants. And I think, as Mr Hoffman said, it's more important to be keeping things out than dealing with them when they're in. So, I think it's-- I think it is, and everybody in the team thought it was, and anybody that's now saying it's not, I would be in disagreement with. So, that was something that we thought, "Well, that's in line with the thinking, you know, our own thinking." So, yeah, I think it's similar, yeah.

Q It's not similar in scale.

A No.

Q One small room.

A No.

Q Correct?

A It's not similar in scale in terms of whether it is 300 rooms, but it's still 300 of the same rooms.

Q Where does 300 rooms come from?

A Well, no, it was just a number for single rooms. I hadn't calculated the number of single rooms, sorry. I was just----

Q Right, so that's single rooms in the hospital overall?

A Yeah. On both hospitals, yeah.

Q Yes. The other question, I suppose, is, just thinking from your experience as a manager, one can perhaps see that if you have a query

about a particular small location, it's maybe fine to ring somebody up and say, "What do you think, Peter?" or whatever. There's no formal instruction. There's no contract. He's not being paid. It's only being recorded in an email. You wouldn't want to do that for any major decision, would you?

A We do do it. Hindsight, as you said earlier on, is a great thing. So, I'm afraid we do do that. At the end of the day, Peter Hoffman, what was the-- in charge of Health Protection England. And that's what we would have done with John Hood, who-- the Board would have just asked him, "What do you think?" I'm not saying we would not have went through a big process, but I've got to sit here and take your point, yeah.

Q Thank you. Just bear with me a moment. After January 2010, when the Currie & Brown technical team was stood down, who was responsible for providing technical advice to GGC on ventilation and water issues?

A Depends what you mean by providing advice, or what I've talked about earlier on, providing comment, right? So, providing advice----

Q Let's leave aside for the moment-- We've got your evidence on the abilities of the in-house team.

A Okay.

Q Let's think of someone other than you, Peter Moir, Frances Wrath. Who's the technical advisors after the standing down of the Currie & Brown team?

A If we need-- if we think we need technical advice, we would ask Currie & Brown to ask Wallace Whittle.

Q So, unless they're specifically asked, you don't have anyone in the team on ventilation. Is that right?

A We don't have a designer on the team, no.

Q What about water?

A In terms of a designer?

Q Well, did you have anyone with any particular technical expertise in water?

A No, we'd lots of contacts with people in the NHS who had done lots of stuff for water. But, again, I repeat, we're commenting. We're not designing. The design belongs to the contractor.

Q I will get to that just in a moment. Are you now aware that-- well, first of all, there are differing views on whether the ventilation requirements in SHTM are only to do with comfort?

A I'm sure there are, yeah.

Q If you're dealing with air change rates in a critical ward, they may have very important benefits to safety of patients.

A Absolutely.

Q Presumably, you're also aware

that, although you rely on the single rooms concept, the guidance, rightly or wrongly, still says 6 air changes for a single room.

A And I think the guidance was written for multi-occupancy wards that had-- like Yorkhill, that's got 24 beds, eight of which are single rooms, and I think it's written for that type of scenario, I think. I'm not an expert, but I think it was. And the hospital-- the first hospital I ever experienced – and I've been in a few – that had all single rooms, apart from a couple of four-bedded rooms in the Children's Hospital, and we are all thinking this is the panacea for health.

Q Yes. The other question I just wanted to ask you, while we've been talking about these exchanges and Mr Baird and so on, is that Mr Baird seemed to think that you were not only decision making but you were feeding back to somewhere in the Board structure about what was going on on this discussion. Were you doing that?

A No, I was-- As we said earlier on, my superior was Helen Byrne, and Helen likes progress and she likes detail in terms of, "Is it getting done?" And I've fed back to Helen on a number of occasions what the outstanding issues are, and I fed to Helen that we had this one closed out, because it was one of the ones that was hanging out. So, just to be

clear, how much information did I give her? Just what's on the logs, basically. Her response always would be to me, "What's our expert saying?" "They're saying this is fine." "Let's go. Acceptable." So that's my-- more than one communication with Helen.

Q So your evidence is that you discussed this topic with her?

A In a way that I was sitting with about 500 notes, taking her through it. So, just for total clarity, she-- Let's take the ZBP paper. I never showed her the ZBP paper, right? I just told Helen that we closed this situation out, or our advisors had.

Q So you told her that after the decision had been made?

A I told her that before the decision had been made. We had an outstanding issue and I told her after, which was probably-- I can't remember when, but I told her after that we had no outstanding issues, it was done.

Q Earlier in your witness statement, you described Helen Byrne as being a detail person.

A She is.

Q At least according to her witness statement, she doesn't seem to recollect being told about this by you.

A I honestly can't comment on that. Anybody that's seen Helen and I's relationship knew that I fed Helen all the

information I had. I think there's an action plan – again I don't have it – from a Project team meeting that says I'm going to speak to Helen. In fact, I think it says I'm going to speak to Helen and I'm going to speak to Helen, Peter Gallacher and Alec McIntyre, but Helen and I were in communication all the time and Helen was not going to approach-- come to the point where we're approaching contract signed for the Board and she's not onto me every day saying, "Where is this issue?", and I'm saying, "It's getting sorted." So, that's it.

I mean, sitting in this sterile environment, to go, "Oh, you should have had a big seminar about it," well, I'm sorry, that's not how it is. It's a contract with hundreds of thousands of bits of information, and it might seem critical now; we're in a different place from where we were then.

Q The reason I wanted to pause for a moment on that point is that you've probably picked up by now that, apart from the log itself, which says what it says, no one has been able to trace-- and that's "no one" being this Inquiry or GGC at their instance, has been able to trace any record anywhere in the many structures of the Board recording the agreement of this ventilation derogation, which we'll call it that for the moment. Now, can you help us at all as to why that is?

A Just because that's the-- There isn't one, and just because that's the process we were in and, as Mark Baird said, that was the process that they had agreed to go through. Yes, now I wish I'd put a banner up and put it in Argyle Street, but we never did because there was an awful lot going on at that particular time. That's not an excuse. That's just a fact of working in this project.

Q Again, the reason I wanted to ask that specifically was that, if you're talking to a detail person and you've warned them that there's this issue that you're trying to sort out, and then you tell them, "Great, we've sorted it. This is the solution," you might expect it to appear in the next minutes of the meeting, next meeting she goes to, or somewhere else.

A I'm quite a detail person myself. It's not there. We had the discussion. No point in saying anything else. That's what happened. It was seen as a point in time, wasn't-- and we need to go through that-- we'll continue to talk about HTM and all the guidance that's in it but, you know, I could be sitting-- I can sit and design that room with no air changes, as you heard from Mr McKechnie, in a naturally ventilated room, which as you'll see from my statement-- which is what people were

promoting, and I was certainly a promotor of. So, just like Yorkhill current, opening windows, fresh air. So I've got to gauge my decisions against things like that.

Well, I'm not at the moment asking you about, if you like, the quality of the decision, Mr Seabourne. I'm just asking about the communication of it because----

A I accept that.

Q I think you'll probably understand that----

A Yeah.

Q -- whatever the position is about agreeing what to do about the renal outpatient room, this was a decision which was going to affect a great many rooms, and I'm just about to come to ask you about, but certainly a great many rooms in the new hospital.

A Yeah, but that----

Q You would agree with that?

A I'm going far-- I'm going a long way, but just-- I think I said in my statement, that discussion on renal, as you say, minimal versus maximum, in that discussion was Infection Control nurses, Craig Williams, head of Microbiology, John Hood, ventilation expert for the Scottish NHS, Professor Hoffman, and it's not about the Renal Unit. It's about them saying, "These rooms don't need 6 air changes." If I can take anything out of that email, that's what it's throwing at me. That, for me

and my team, was, "That's fine. We're happy. We've made a right decision further back down the road." So that's what I take from that.

Q We can take that document off the screen, thanks. Go back to the witness statement. We go to 143. There's been a bit of a debate about what this agreement actually covered, in other words, what rooms it covered. Partly because, as you correctly point out, if you go to the clarification log, not the M&E clarification log, the clarification log, it talks about tower rooms, which is only adult rooms. When you're asked about this, you say, "general single rooms only". Now, why do you say that, just so we're clear?

A Every general room, in Adult or Children's, and we did refer to the tower, and everybody knows what the tower-- everybody in the project knows what the tower means. That, when we went to general rooms, we meant all rooms that were designated for single patients with overnight stay, which had 6 air changes, now going to become 40 litres per second.

Q If you're coming to this from outside, trying to find out what the position is, can we find a discussion of that anywhere?

A Right, I don't know. The answer to that is I don't know. I think,

when we come on to talk about design, you might see where the discussion is happening.

Q The ZBP document, you say you may not have seen it until in the new year.

A I don't think I seen it till in the new year, yeah.

Q But, again, one of the questions we've been asking other witnesses is, you know, if you're going to produce some kind of expert report to support your argument, you would expect it to come a bit earlier in the process than a couple of days before contract----

A It'd have been great if it came in September but it didn't, and we signed it, as I say-- I'm quite happy to go to Shepherd and Wedderburn's office and say, "This is still hanging out, this issue. What will I do?" They would have told me exactly what to do, and so I didn't really have any particular worries about that.

Q Just to ask you another question about communications, just thinking of the practicalities of it, the M&E clarification log is on a list of contract documents in the contract bundle, which is a huge----

A Project bundle, yeah. Massive.

Q -- massive thing. If you want to find this point, as you quite rightly say, it's one of a huge number of clarifications, what are called "clarifications" in that log. So you need to find the log, then go through all of the clarifications until you find this one, correct?

A Yes.

Q Now, we've been told that if you're a construction expert, professional contractor, whatever, you know that that's where these things are to be found and so you go there straight away. I just wanted to ask one question. You were asked, "Well, how did you bring this to the Board's attention?" You say, "Well, I told Helen Byrne because she was my superior," and, at the foot of 144, you say:

> "… it was contained in the main contract documents available to senior Board officers."

Would you agree it wouldn't exactly jump out at you?

A No, but my senior Board officers did read most of the stuff that was produced. It was that type of organisation, quite hierarchical. So, yes, it might be difficult to find, but if I was doing leases and missives and all the rest of it, they would go through it with a fine-tooth comb. I'm just telling you-- I'm just answering the question. That's where it is, and if they needed to get it, that's where it was.

Q Among the documents that's in the contract is employer's requirements, and they include a list of guidance notes

to be complied with, including SHTM 03-01.

A Yeah.

Q That's still there, so if somebody found that list, they would still find SHTM 03-01, not, "SHTM 03-01. Please note: go to the log." There's nothing in there to direct you, is there?

A No, but they would have us, the Project team.

Q Now, you were asked a number of questions about this, and you were obviously getting slightly fed up with being asked similar questions more than once.

A Yeah, I was confused.

Q Perfectly understandable reaction if you perceive you're being asked the same question more than once, and you were asked, "Well, where do we find this document if you're on the Board and you're looking for it?" You say, "Well, there's nothing specific to the Board, but there's nothing that tells you that you have to tell the Board about it." That's your position.

A Well, yeah. I suppose so, yeah. Yeah.

Q I rather took it from what you said at the top of 145 that you were saying, "Well, if it had to go to the Board in some other form than just me telling Helen Byrne, then the Board's TAs," by which I suspect you mean here Currie & Brown----

A Yeah.

Q -- "should have done that." If they're really working for you, would they be expected to sort of say, "Well, Peter's only told Helen. Nothing's been written down anywhere. We need to go and report to somewhere or other"? Is that the kind of thing you would expect them to do?

A Yeah, I'm expecting them-- You're here at a high level 20 years on, or 15 years on. I'm expecting them to guide me through this in detail, and when they say, "This is a final decision, right, that's not with HTM but it has got this and it's not got that. We suggest you go to the Board"-- and they would have done it with other things, right? So I wasn't getting that feeling from them because Mr McKechnie had totally minimised us. I mean that in terms of acceptance, and nobody was flagging this was an issue. Now, looking at it today, would you have done something different? Probably, yeah, but when we were dealing with this and 10,000 other things, I'm afraid we looked at it slightly different.

Q Now, the other thing you say in the same paragraph, you say:

> "The contract documents contain the logs which were available to the Board's senior managers, it was recorded the logs.

It was also discussed and agreed via the RDD/RDS process."

Now, we'll come to the design process to work our way through it, but if I can just take it short for the moment. The information we have, which is reasonably consistent, is that the design process had user groups looking at stuff, you know, what kit they needed, where the rooms should be, what furniture should be in rooms, things of that kind, but they were not looking at ventilation, nor were they provided with, for instance, air change rates on which they might have accidentally spotted it. Now, that wouldn't discuss and agree anything about the derogation in that part of the process, correct?

A Well, I would really like to talk to you about that part of the process, yeah, if you want me to do that now.

Q Well, what were then-- I mean, are you saying that the user groups were discussing the ventilation rates?

A You know, I've got a fundamental difference from you on what the user groups were doing, okay, and as far as I'm concerned David Hall is absolutely right. We were responsible for functionality. That was our role to parallel with the contractor and tell them, basically, how a hospital worked. If we just want to condense it to that. David Hall told you functionality. You know, we said, "Where's the bed going? What colour are the curtains?" I'm afraid it's a wee bit more detailed than that. The first part of functionality is: what is the room used for, okay?

So, in those user group meetings which were-- and it doesn't come out in this process, were meticulously managed by three people that worked for me, Shona, Allyson and Carol, right? Those-- and had the right membership in it, from consultant and other clinical staff, ZBP, Nightingale's, Multiplex, Project team. I would be saying to you today, that's a heck of a cost sitting in a room, and if they're not talking about the room use, I don't know what they were talking about, and I'll take that forward as an example.

So, if we're doing-- let's do Cancer Ward. Let's do Ward 2A. So, my expectation-- no, my instruction was that they would sit, user group meeting 1, 2, 3 and whatever, so they would go through the 1:500s, where they are in the building. Got that. 1:200s, here's how your room-- here's how your department, sorry, is going to be laid out, and 1:50, here's what's in the room.

And, as part of that process, our part of the process, functionality, you have to tell them-- you have to tell them what the room is, or ZBP sitting there, or Nightingale sitting there saying, "What is

that room used for?" I mean, a perfect analogy was, if I was sitting talking to an architect and I said, "Will you build me a house?" and he says, "Yeah, what do you want in it?" "Just six rooms." "Okay, just six rooms." No, they've got to tell them, "We've got eight--" This is Ward 2. "We've got eight PPVL rooms," and the contractor doesn't say, "Well, I'm going to tell you the rates, the pressure, etc." The contractor is going to say, "I'll do them to HTM," right? Or, "I'll tell you I'm not."

We then go into single rooms. The Children's single rooms in the Cancer Unit are a wee bit different, but just say it is an ordinary single room. My expectation, because my team know this, ZBP have promoted this to say to the architect, "These rooms are single rooms, overnight stay accommodation, and they're not to HTM. They're to half HTM, let's call it." That's the conversation I'm instructing, and that's the conversation I'm paying a fortune to Nightingale's and ZBP to have.

Now, if you just want to stick with 2A and let's go back to the clinical outcome spec. I mean, as bad as it is, there's only one piece of information in it, and that is it should have an airlock, and you've spoke to Emma sitting here, you've spoke to Steven Pardy sitting here, and ward-- I think Emma-- I don't know how Emma missed it, bearing in mind she's an

architect. I don't mean her personally, her team. And Mr Pardy, who's got extensive healthcare design, he said the architect never told him. Just look at these clinical outcome specs, which I agree with you are different. Just interpret it. It's got an airlock. The first thing that tells you is it's got a different ventilation system.

So, bearing in mind the users have written that, and bearing in mind the designers are designing that, I would think the users should say, "Where's our airlock?" and I'd expect the contractor to say, "What about this airlock?" and that airlock is quite important. It's very important because the single rooms, with them, you would know then if you're putting an airlock in that these single rooms weren't sitting at 2 and a half, and they weren't sitting with chilled beams. They're probably sitting at 10 air changes, and you don't have to go into the rates and the pressures, pressure differences with the user.

But there's another thing I want to say. The user isn't as daft as people seem to think they are. I was the project director in the Cancer Unit at Yorkhill, so-- and I know the users. I know Brenda Gibson well. I've known her 20 years, 30 maybe. They are very intelligent users, and they might not know air rates, but they know what these rooms house in

terms of patients, and they must know what they are asking for when speaking to these professional designers, and they had a whole series of meetings. I'm sitting listening to this Inquiry and I'm aghast that they never had that conversation.

That conversation gets fed up, we'll come on to talk about, to M&E, workshops, presentations, call it what you will, when drawings get made, and nobody's saying to me-- I'm saying, "So, everything's okay with ventilation?" Just generally. "Yep, no problem, move on," and it shouldn't be that way. Mr Pardy, in terms of ZBP, and Emma White's team, she's responsible for ADB sheets and, by the way, Frances Wrath is responsible for agreeing the ADB sheets with Emma White. So, all that process that we're paying a fortune for clearly hasn't happened. Sorry if that's a long, long explanation. I hope it's helpful.

THE CHAIR: I suspect when we pick through it, it will helpful, but can I----

A Was I too fast for----

THE CHAIR: -- with Mr Connal's help, see if we've got the main points?

A Okay.

THE CHAIR: Can I start with the-- and I think this is the point I will take, the notion of operational functionality?

A Sure.

THE CHAIR: Now, we see a definition of operational functionality in the contract documents but, when one interrogates it, it's still not absolutely clear what it covers. From your perspective and your expectation as the project director, what did you think that operational functionality covered?

A Simply how a room works, and to know how it works, you need to know what the room's doing, so----

THE CHAIR: Could I ask you----

A Sorry, I beg your pardon, my Lord----

THE CHAIR: -- to keep your voice up----

A -- I usually speak loud, as you know.

THE CHAIR: -- because I'm keen to sort of get this evidence.

A How a room is used, for me, it would be the first bit on the agenda of the clinicians meeting the experts. So, we've got 50 rooms in this department, and the first thing we're going to tell you is what they all are. In the 1:50 process, they should be labelled what they all are, and then everything else is about: what does that room need then? So, if it's a special room, it needs ventilation, and the users aren't interested in whether it's 10 or 510 litres per second or whatever. They just need to know that that's a special room and you're going to put in special ventilation to cover the needs of that

room. That's the first bit of the design process. So, that's my expectation, Lord Brodie.

THE CHAIR: Your expectation is that those people attending the user group meetings, who are, by definition, presumably those who are going to be using the room, would ask sufficient questions to cover, for example, how the special ventilation needs are being accommodated?

A Absolutely. I mean, I think-- I'll give you-- I'll try-- maybe not a good analogy. I'll take it out of Ward 2A. Let's talk about theatres.

THE CHAIR: Talk about?

A Theatres. Theatre.

THE CHAIR: Yes.

A Surgical theatre. Right. The person who'd usually be in-- would be (inaudible 02:55:42), usually. It's usually, in my lifetime, been the theatre sister. That theatre sister in a suite of theatre or one theatre would know every detail of what that theatre needs. She might not know the air rate. She probably did actually, but she might not know the air rate. She knows what the surgeon needs in terms of his equipment, what the information systems, the data is on the surgeon's panel. She knows it's got to be sterile. She knows the floor's got to be anti-static. She knows it needs a theatre table right in the middle, probably a

mobile one that goes from one room to-- transitions from one room to another, etc., etc.

She knows everything, and if I flip back to Schiehallion and Schiehallion at Yorkhill, their people know exactly what they're looking for, even though they don't know the air rate. And, as I say, I'm getting a PPVL room, and all they need to know is, "Is that to standard?" "Yes." "Fine. Move on." And that's got to be part of the conversation-- I demand this part of the conversation.

THE CHAIR: So, the process which we've had described to us whereby data relating to each room type and, I suppose, each department, including Room Data Sheets and 1:50 documents being looked at by user groups, perhaps on three occasions, in exceptional circumstances, five occasions, was, from your perspective, designed to pick up, for example, whether or not the design being offered by ZBP made provision for the special ventilation of special rooms?

A Mm-hmm.

THE CHAIR: Right, we may have got a different impression from other evidence.

A And that-- Do you mind if I just add a wee bit to that?

THE CHAIR: Please.

A That's why, and you've discussed it, the information from those

meetings feeds into the environmental matrix already populated by ZBP in a kind of first stage attempt and then populated when they're talking to the users about what they need. So, forgive me if I forget the guidance number for PPVL rooms. So, they would say, "it's a PPVL room." Then we'll discuss all the bits and then-- but it's a PPVL room. It's to HTM XYZ. Everybody's agreed, "Yeah, that's fine," and then the environmental matrix, it will log that. And there's a document, and I think it's a Multiplex document, that actually says, "Nightingale's to update ZBP on room extract rates," or, "room inlet rates." So, that should all be getting captured quite easily in this process where I've got 20 people sitting, most of whom are experts. It's the first thing I'd expect them to do.

THE CHAIR: On this question of the environmental matrix, which you mentioned before coffee, you were referring to a document. As I understand it, it's an Excel----

A Yes.

THE CHAIR: -- sheet populated by ZBP in the course of 2010.

A Yes. I had some-- They would have a starter of, "Here's how we think-- what should be in the hospital, what the rooms should be there, and here's what we think the rates are," and they would then enter this discussion with users and either leave them where they thought they might be or, if somebody makes a change, they would change it.

THE CHAIR: And you told us before coffee that Wallace Whittle was specifically instructed to review that environmental matrix as a piece of work.

A Yes, yeah.

THE CHAIR: Can you recollect at what stage you say that happened?

A Well, you'd have your user groups, and by the way user groups actually continued into next year, but for this part we'll stick with this. We had the user groups. We had a range of M&E meetings, one lasted two days, and Wallace Whittle probably around the end of that bit of process, say maybe August, early September, would get the environmental matrix and they would go through it, and then come back to Currie & Brown, to me to say-- me and my team to say, "We're happy with that."

THE CHAIR: Right, so----

A So, that was our double check.

THE CHAIR: A specific piece of work instructing Wallace Whittle, presumably as part of this call down arrangement, perhaps in about August of 2009?

A I'm picking the date because I think I know----

THE CHAIR: 2010, sorry.

A Sorry, yeah. I'm picking the

date because I think I know where the design process has gone at that point, but yeah. I think the invoice for them was round about the end of the year, November time, so it must have happened September/October probably.

THE CHAIR: Before instruction to proceed?

A Oh, yeah, yeah. Aye, to proceed with Stage 3, yeah, definitely, yeah.

THE CHAIR: Thank you, Mr Seabourne. Sorry for interrupting, Mr Connal.

MR CONNAL: We're jumping slightly out of the order----

THE CHAIR: There may be other matters of detail you want to pick up?

MR CONNAL: Well, we're jumping slightly out of the order of the witness statement, but no matter. Let's come at this from the other end. These user groups involved lots of people from all over the intended hospital user cohorts, different wards, different specialities. The evidence the Inquiry had pretty early on is that when the hospital opened – that's after your time----

A That's right. No problem.

Q -- nobody knew about the change to 2.5 or 3 air changes from 6 as a standard usage. Some investigations were eventually made and eventually somebody came up with some

exchanges about it. Now, that might suggest that when this part of the Inquiry is told that the user groups didn't discuss ventilation issues at all, that's likely to be correct because otherwise one person in one of these groups would have gone, "What? I thought it was supposed to be 6," and it would have got out from there.

A I don't think it happens like that, but I'll say one thing. So, we finished the project in January '15. Obviously, I wasn't there, but I'll give you my view on it, and at that point in time we've got practical completion, which I know you've discussed. We then move into what we call operational commissioning, okay? That's the point between practical completion and service day one. In that area, and I'm not going to go on about it, but you've talked about validation or the lack of it or whatever, but in that process, Infection Control or Microbiology, whoever, should be checking these rooms for what they've got.

Now, these single rooms, because they're kind of natural ventilation, etc., etc., and they're only for general patients, probably don't have validation, but somebody should at least be checking if they're okay. And if we manage to move on to 2016, where you're going to come on to my letter, that's exactly what Dr Inkster's done, and I've never met Dr

Inkster in my life, by the way, just to be clear. That's exactly what she's done. She's done an SBAR in 2016. Personally, I think she should have done it in 2015, but to address your point directly, I don't know anybody that didn't know it was 2.5 air changes for general rooms, and Darren Pike told you that we all knew.

I mean, it just gob smacks me that people are saying they don't know this. Well, they don't know it if what I'm saying about user group meetings are not saying to the users, "By the way, these aren't 6 air changes, they're only 3." If that's not happening, then I'm with you, but that should be happening. Am I complicating this for you?

Q No. You're just giving us your evidence, and we'll work out what to do with all of the evidence in due course, and there's a lot of it. But I suppose if we just come to that, the impression we have been given by other witnesses is that the user group meetings, first of all, did not discuss ventilation rate at all and, secondly, none of the information that they were given had on it 2.5 or 6, which were the kind of figures that people might have spotted, even though they weren't supposed to be----

A There's drawings with 2.5 on it for the technical folk.

Q Sorry?

A There's drawings with 2.5 ACHs on it.

Q But these were not discussed in the user groups?

A No, no, no. That's after the user groups. No, that's after the user groups. So, can I just clarify one thing? It's really important. I've never said that the user groups were talking about ventilation rates – nuance there. What I'm saying is the user groups and the designers agreed what the room usage was, and it's the designers' responsibility to fulfill that. That's what I'm saying. Nothing more.

Q No. Well, my point is this: that if you were an experienced clinician and you turned up at a user group, and perhaps you had a wee bit of knowledge about ventilation rates, it's not your area, but you know a little bit.

A They've got more than you think, but anyway, yeah.

Q And you're expecting to see, for instance, 10, and you see somebody's written on a piece of paper which happens to be in the room 2.5. You might think, "I don't think I'm here to do this but, hey, what's that about?" Then a discussion would ensue. So, the information we have suggests that, first of all, they weren't discussing ventilation and, secondly, there was nothing given to them in these groups which would have

caused them to discuss it. The issue of ventilation was quite a separate matter dealt with through Mr Hall.

A I'm going a long way-- part of the way. I honestly don't know why ZBP are sitting at that user group meeting. ZBP whose strategy is 40 litres per second, ZBP who promoted 40 litres per second – just let's call it half the HTM rate – is sitting in that room, just a normal ward and saying to them, "By the way, I need to tell you you've only got half the rate, but it's fine because we think it's okay." "Oh really? Do you? Whatever." I'm sorry, if ZBP haven't done that, they haven't done their job. There'd be no other reason for them to be there.

Q The other point, this is a purely technical one, but we have been told by some witnesses that unless you're pretty adept in understanding this stuff, even if you saw the words "40 litres a second", you wouldn't necessarily be able to translate that in your head into "air changes per hour", which might be what you were familiar with.

A The 40 litres per second to calculate the ACH is a very simple calculation, right, but I'm not saying that. What I'm saying is ZBP are not mentioning any rates. They're saying, "This is a standard bedroom and it should have HTM compliance. This is a standard bedroom that we've changed,"

right? So that's the information that had to go, and the clinicians who I've worked with for 30 years would go, "Right, why has it changed then? Oh, well, all right. Oh no, we don't like that. Let's go back and see Seabourne," or whatever, right?

That's the process that always works, always works, and the only thing that's missing from that is if ZBP and the architects – because they know as well – if they're not telling the users that piece of info-- that very critical piece of information. And that's the point when I'm saying to you in December '09, that's the test I'm giving it. As I go to the meetings that bring all that information together, I'm getting no feedback that this is a problem. In fact, I'm saying, "Is everything okay?" "Yeah." "Right." So, that's where that-- I'm just trying to practically explain the process to you and hopefully I'm helping.

Q The answer may be in your last point, I might suggest to you, this: that if among these user groups and continued user groups and all these series of meetings, all these people had spotted an issue over air change rates, exactly what you've just described would have happened, that they'd have come knocking on your door and going, "What's going on here? I was expecting X and I'm getting Y," and that didn't happen.

A No, and I can tell you it's

happened many, many times, but I also want to say, you know, Nightingale's architects, who Emma said, "This is a change. It's got obvious knock-on effect," I mean, Emma and her team weren't kicking my door down either saying, "You need to rethink this, Alan," right? On the contrary. So, I think there's a-- well, I'll leave it at that.

Q Let me just try and finish with one point, and we'll see whether we can get it short and, if not, we'll continue later. The explanation that we got from Mr Hall, who was leading the Currie & Brown team, reduced as it was, was that there were some discussions in which air change rates may have been mentioned, not the user groups, but he constantly banged the drum to say, "I am signing off nothing about air change rates. I'm only signing for clinical functionality. That's my role. Everything else is for ZBP." Now, is that a correct reflection of what you understood the position to be?

A Nearly.

Q Nearly?

A Nearly, because he missed that one point that we started this conversation with: you need to tell-- you need to agree what the room use is, otherwise you're going nowhere. You talked-- I think the other day you talked about-- you were talking about what were they doing in the user groups, where the bed was and all that. Really? And then you mentioned medical gases. So, here we are with life support systems, oxygen, vacuum, potentially nitrous oxide.

The users are commenting on that all the time because they're very well aware of what the requirements are in every single room, and that's why when I've listened to some of this I've thought, "That's not the job I was on." So, I mean, we really do do the users down if we're saying all they were doing is just going, you know, "We'll paint it, or, "We'll put the bed there," or whatever. The users are very, very knowledgeable in what they need. And you hit it on the head, and if they're not getting what they think they want, trust me, my door's the first place they're coming to it.

Q The only logical follow-up question to that is this: that Mr Pardy, when asked about what he did when he got, say, a clinical output specification, he tried to interpret it to see if he had got it right. What he thought was happening was it was he was taking his stab at what was needed. Let's say 2A, because that was a tricky one. He takes a stab at it. He puts that into the system, and then he's expecting someone with expertise in that area to look at it and go, "Got it down right," or alternatively, "No, you're not in the right area at all," or something, but that doesn't happen because you don't

have technical advisors anymore and Mr Hall is saying, "I'm only doing clinical functionality."

A No. We don't have technical advisors, but we've got Frances Wrath, Heather Griffin, Fiona McCluskey, and Mairi Mcleod in that room, who are all experienced health managers. And I would like to go into Mr-- So, Mr Pardy has given evidence to say, yeah, he identified the PPVL rooms. They're special, and the rest of the ward was supposed to have an airlock. Mr Pardy with extensive healthcare design, right, didn't either recognise or didn't ask, "Were these other rooms the same or different in a cancer unit?" I have to be very clear here: that is very naive because I'm not a designer and it's the first question I would ask.

So, let's flip over to 4B, which used to be haematology, and again the same mistake roles out. We've got-- I don't know how many because it's a long time since I've looked at it. We've got PPVL rooms and we've got the rest of the ward, and Mr Pardy says, "Oh, I thought it was just the PPVL rooms." And can I flip back to the clinical outcome spec? Only one piece of reasonable information on that and it's we need an airlock, and Mr Pardy doesn't take that into consideration-- Why were they sitting at the meetings? I honestly don't know. So, that's my

expectation. Maybe my expectations are too high, but I'm saying this is the basics of healthcare design.

Q I'm just keen to understand the structure because we thought we were beginning to get towards an understanding of what was happening.

A That's why I'm glad I'm here this morning.

Q Mr Pardy-- Let's call it ZBP, depersonalise it for a minute.

A Yeah, okay. Fine.

Q ZBP produce a design for ventilation for a particular room or a particular ward and they feed it into the design system. Now, what we've been hearing so far is that Mr Hall doesn't think that he or for that matter Frances Wrath have the job of analysing, reviewing, commenting on the ventilation design, because Mr Hall says, "That's their job. I'm doing functionality, nothing else." Frances Wrath arguably doesn't have the expertise to review a ventilation design and comment on it and knock it back if it's hopeless. So, what we seemed to be getting to was a situation where there was nobody on the team who had the expertise to consider, review, revise a ventilation design produced by ZBP. Now, do you disagree with that proposition?

A Totally.

Q Who do you say had that

expertise?

A Us.

Q When you say "us", who do you mean?

A The Project team.

Q The Project team. Who in the Project team?

A Frances Wrath, David Hall, Peter Moir, myself. We've got one-- you keep talking about the ventilation design. There's only one person-- set of people doing the ventilation design, and that's ZBP. Mairi Macleod, who done the clinical outcome spec, back to Ward 2A, right, knows that she has to get all these rooms detailed, what they are, what they do, and what they need, right? And that's the bit-- So, it needs ventilation. It's a general single room. It's only getting 3 air changes, supposed to be 6 but only getting 3 – ZBP's plan, not ours, ZBP's plan.

All I'm saying is that's got to be communicated to the user. What else would you tell them? And then they would say, "Well, I'm not happy with that." That's the communication that-- In the hundreds of projects I've done, that's the communication that always, always happens, and that's the-- So, nobody's designing it.

But I want to move on a wee bit to then all that information comes together, and we're still not designers, but we're also not stupid. So, when I'm sitting at that meeting and somebody's saying, "This special room" – this is in a design meeting – "it's only got this or that," we'll go, "Well, is that right?" So, we're challenging it. That's the kind of-- that's it all coming together, that they've done it at user groups, we've taken it up to the next stage, and everybody's saying to me, "Perfectly happy." Well, they're obviously perfectly happy if they're not actually telling them what they're getting in the room. There's absolutely no way that you'd have a theatre complex without telling them that the air in the theatre complex is the HTM XYZ. And that's what should have been-- that's what should have been happening, and I thought that's what was happening. And I'm not sure that that didn't happen.

THE CHAIR: Can I say something back to you that I think you've just said to me?

A Yeah, yeah. Please do.

THE CHAIR: With the utmost of respect, there appears to me to be a difference between the design of a ventilation system – in other words, sizing of the air handling unit, sizing of the ductwork, the positioning of elements which are not visible within in the room, perhaps in contrast with positioning of outlet and inlet-- the design which, again, subject to anything else I'm told, I can

see is the sole business of the designer, and what you've described as "what they are getting", in other words, the output----

A Yes.

THE CHAIR: -- as discerned by the user of that ventilation design. Now, all I'm doing at the moment is just asking you whether I've understood one of the points that you have just made.

A You have.

THE CHAIR: Right. Well, on that note, I think we'll take our lunch break. As far as timing is concerned, Mr Connal, I'd be inclined to resume at ten past two, unless you feel there's a time constraint. Right. Could I ask you to be back at ten past two?

THE WITNESS: Certainly you can.

THE CHAIR: Thank you.

(Adjourned for a short time)

THE CHAIR: Good afternoon, Mr Seabourne.

THE WITNESS: Hi.

THE CHAIR: Mr Connal.

MR CONNAL: Thank you, my Lord. I just want to, if I can, Mr Seabourne, get to the end of this exercise about the design process. You've told us what you thought the user groups should have been doing, or could have been doing, and we've discussed that, and I'm not going to go back over that part of the evidence.

We then moved onto the suggestion that, well, assuming ventilation and design-- and let me be clear when I ask this question, I'm talking about things like air change rates, pressure gradients, absence of chilled beams, the kind of things we saw in the 4B clinical output specification, although they didn't put ACH in it, but that kind of thing. The prospect that these were capable of being reviewed or discussed other than in the user groups. Now, I think you'd started to tell us that the people who had the expertise to do that were, as you put it, you. I just want to go through this. David Hall told the Inquiry that he had neither the expertise to do this and nor was it his role. Now, is he right about that?

A I'm not sure what you mean, "do this", right? That's the bit I don't understand what you're asking me.

Q Okay. Look at a design which had air change rates and pressures and things on it and say, "There is something not right with this. I am going to change it." Would you agree?

A Yes.

Q In fairness to you, I think what you have in mind may be that someone in your team spots there's something that doesn't look right and then takes it off to talk to users. Is that right?

A Yeah.

Q Now, the other possible person mentioned, or one of the other possible people mentioned, was Frances Wrath. Now, Frances Wrath, I think, would-- she's already given evidence and I don't think she had accepted that she had the expertise to spot that there was something not right about that kind of information. Would you agree?

A She may not have the expertise to spot the actual detailed design of that vent, that single vent system, but, like me, she's got the expertise to look at a drawing or a set of information to say, "I'm going to comment on that. That doesn't quite look as if it's right," and she might miss that as well, but she would use her NHS----

Q So you think she would have the ability to spot things like incorrect air change rates or incorrect pressures?

A No, but-- Yeah, when we've already been to a meeting and we've been told, "This is the iterative process," we've been told, "That's what that unit's getting," so then we have that conversation, drawings are updated and it comes back to us and we go, "Well, they said there was going to be 10 but there's only 5 here." So she's not picking what it should be. We're commenting on things that we now see that we didn't hear before. So that's why we keep using the word "comment". So we're not checking the design. We're just checking that what they told us has actually happened. That's generally what we're doing.

Q Okay. Well, I'm not sure I entirely follow that. I can see if somebody says in a meeting, "You're going to get 10 air change rates in this room," and then they give you a drawing showing 5, then you're going to go, "What? You just told me yesterday it was 10," but if you're in a user group which has focused on things like the medical gases, for instance, the more technical needs of a child cancer patient or whatever, but not air changes or pressures in the room, and then you're given a drawing which has these on it, would Frances Wrath have the skills to say, "Whoa, this is not right"?

A She's got the skills to say, "This isn't what you told me."

Q That would assume that someone had told her beforehand.

A Yeah, sorry, we've moved on a bit. We're doing user group meetings, and you talked about previously – not today, before – the parallel universe, right? The parallel universe is the other bit, the M&E design actually getting done, which should match what's happening in the user group meetings, and then there's a coming together of the designers who--

Let's just take water. So, the designers don't need me or anybody else to say, "We need a water system. It needs tanks. It needs a distribution system, and it needs an outlet system," right?

So, they'll be busily doing that whilst we're all at user group meetings, and then we move onto the next bit. So we've had the user group meetings. We know it's a 28-bedded ward. You've got 28 taps or whatever it is, and we come to the more technical meeting, and they tell us technical stuff about the water, right? "You've got all the taps. We've not picked the valves yet, etc., etc., but here's what we're giving you," and she can see every room's got water, every ensuite's got water, etc., basins, all that stuff. She's generally checking all that, and that's the stuff that she has seen fed into this meeting.

Then, after this meeting, which is a kind of general meeting, they then move onto a more detailed meeting where they're telling us their intended design solution. What they're asking us is, "How does that look? Does that look reasonable?" That's maybe the best word for it. We're saying, "That looks reasonable, yes."

We even get further than that, as I've said in my statement. We get to Status A. Status A means, "Go and construct it," but Status A does not mean,

absolutely does not mean, that we've just said we approve that drawing. We're saying, "We've got no further comment to make on that drawing and it looks like what you were expressing to us at the previous M&E meetings."

Now, if I follow that through, and maybe come off water and go onto vent, when something special comes in, and I've just said to you that's when we would maybe bring in a specialist, and we brought in Capita for the PPVL rooms, and they looked at it in detail. So I've got a team of folk who are competent enough to look at what they've been told is actually getting played out, and if it's not, we'll comment. You could even miss it but, at the end of the day, I'll go back to the first principles. It's still ZBP that's responsible for designing a design that's compliant for healthcare.

Q Let me see if I can understand this.

A I'm not there then, right?

Q Sorry?

A I'm saying I've not got you there, no? No?

Q No. No, you haven't, I'm afraid.

A Right, okay. All right. Let's go for it.

Q You've done your user group meetings, stop. You're in more detailed M&E discussions, okay?

THE CHAIR: Right, I mean-- Sorry, just so that I'm keeping up. This scenario assumes maybe three user group meetings.

MR CONNAL: Yes, so it's not a-- The question oversimplifies it because it assumes there's a user group meeting followed by something else, which we know because in a number of cases there were more than one user group meeting about a particular area. What I'm trying to do is to move the witness away from the user group meetings into meetings that were not titled user group meetings. This witness, my Lord, has said that he expected certain things to happen in the user group meetings which didn't, it would appear, happen, from what we've been told. So I'm moving into a different area now.

THE CHAIR: Right.

MR CONNAL: So, let's stick to ventilation for the moment.

A Okay.

Q Let's stick to things like air changes per hour and pressure gradients. A bit like the point you made about the airlock which, infers, in fact, it's said to be for positive pressure. I accept your point. If Frances Wrath was told, "You're getting an airlock to keep the positive pressure in," and then she's shown something that doesn't show that, she puts her hand up and says, "Where's it gone?" If Frances Wrath is shown information about Ward 2A, which shows ordinary bedrooms with chilled beams and 2.5 air changes an hour, are you saying she has the skills to say, "Stop, this can't be right," or does that alert her? Because I suspect she would say she doesn't, so I just want your view on it.

A Well, it alerts her because, as I said previously, Frances Wrath sat with Emma or Emma's team and agreed the ADB sheets which has got some of this information on it. Frances Wrath, for me, for my team, was the holder of the RDSs, the Room Data Sheets. So, Frances Wrath would have information to say to them, "You said 40 litres per second here but you've actually only got 4, right," and they go, "Oh, right. So, okay." So, that's a comment. Now, that does not put Frances Wrath in frame for, "I've changed that design." It only puts Frances Wrath in the frame for, "I've advised them they've got this wrong." That's what-- that's what my team were doing.

Q Mr Hall says he didn't do it. Frances Wrath doesn't seem to recognise doing it, although you feel she could have done it. Anyone else that could have done that job?

A Peter Moir, clearly.

Q Peter Moir?

A Yeah, yeah.

Q Did you tell Frances Wrath that

the ventilation system was compliant with guidance?

A No, I-- What ventilation system? The----

Q Well, the----

A -- single rooms? The single rooms?

Q Yes.

A No, Frances Wrath knew the same as me that it was 40 litres per second.

Q Well, that's not quite the same question.

A Oh, sorry. Well, what is-- Sorry, my apologies. What is the question? Sorry.

Q She seems to think that you told her that the hospital's ventilation system was compliant with guidance.

A When? No. Don't think so.

Q I don't have a date. No?

A Don't think so.

Q Well, let's just, so we don't leave this----

A Hanging.

Q -- hanging any more than we need to, just make sure we go through what you've said in your witness statement about this topic. Now, that really starts on page 152, so we'll go back to the bits we haven't touched on. 152 for the moment. There's various comments, and then on 153 you say that your "main involvement was with some of the initial" discussions, and then the process continued:

> "… with the overall programme overseen by Peter Moir and David Hall with the technical detail managed by Frances Wrath…"

So, you really have Frances down as the person in charge of technical detail. Is that right?

A In 2007 the chief executive, or Helen Byrne, maybe it wasn't the chief executive, gave me Frances Wrath, who, for me, was the capital project leader on the Southern General site who had done many, many projects. I think she's a building surveyor to profession and was given to me to be my building services-- not expert because she's not an expert, my building services person for this project.

Q In that paragraph there, you produce a list of people:

> "… supported [by] Mairi McLeod, Heather Griffin, Jackie Stewart and Fiona McCluskey, Eleanor McColl, John McGarrity…"

And you say they were "reviewing design and compliance". Now, of ventilation systems or not?

A A whole range of systems. So, if you take Eleanor McColl, she's IT, massive IT. So she would be getting-- she would definitely be getting her IT

guys, who are experts, to say this is compliant.

Q Are any of them reviewing ventilation, air change rates and pressures?

A Well, not in terms of rate. In terms of what they expect. So, as we've talked, Frances Wrath would know that single rooms get 40 litres per second, yeah. In terms of that, nodding to that, "Yeah, that's what's in the drawing and that's what I'm expecting to see," yeah.

Q Does she know what 40 litres a second is in air changes?

A I can't answer for her, but she knows 40 litres per second is what we've agreed. So, as long as she sees it's on the RDS, it's on the ADB sheet, it's in the environmental matrix. I can't be the only one who's reading these, surely.

Q Now, if we go to 155, this is just to make sure that we get the distinction you're making correctly because this is where Mr Hall was very keen to make a distinction for us. You say about halfway down that page:

> "The project team's role was limited to clinical and operational functionality i.e. the end user requirements and this did not include approving technical specifications or technical compliance which was always the responsibility of Brookfield and no one else..."

Now, that seems reasonably clear. So, if you want to build a ward which complies for cancer patients with what SHTM says for cancer patients, you're saying the team were not reviewing that? That was for Brookfield?

A That's for Brookfield for the technical design, yeah.

Q Then you go on to say:

> "...it was the contractor, as in the building contract, no one else, who had full responsibility to ensure all compliance technically was achieved which would finally be confirmed at testing/commissioning/validation prior to acceptance..."

I'll just pause there just to see if we can get rid of validation as an issue. You obviously know-- Do you know what validation is?

A Yeah.

Q Can you just give us a thumbnail of what validation is as opposed to, say, commissioning?

A Well, I would expect-- I would expect the validation of any system that's been designed, has been built, is getting tested and commissioned, right? And the performance of that is logged, and then I would expect that the client, and I know

it's done different in different contracts, the client on-- let's call it critical systems, so that's medical gas, water, ventilation, the client would do an independent validation process of what that's delivering, and that's us.

Just let's step into the PPVL room. Differential pressures: a simple smoke test with a smoke stick will show you the flow of air going from the anteroom – that's the lobby – to the bedroom, to the ensuite. So, quite simple. You may also-- microbiologists may also want to put plates down to check contaminants in the air. They may actually want to take a specimen of the air through one of the anemometers or whatever. That's speed. That's not the right word. So, validation is carried out by the client in the period called operational commissioning, and that's the period between practical completion and service day one.

Q Right, and you use the phrase in your witness statement, "prior to acceptance"?

A Yeah.

Q That's because, presumably, you validate to see whether you can accept it?

A After practical completion though.

Q Right.

A All right? So, it's actually-- so, actually, practical complete-- it may be

partial, but it's happened and then you're doing validation, and before-- it's actually-- I call it something else. I call it pre-occupancy testing, right?

Q Right.

A Because that's the important thing. So, validation, you would do a validation. The DMA report, for example. Excellent idea. Super idea. Done the validation. Nobody-- I'm not going to-- nobody running with that, but that was a perfect example, and in that report it clearly said-- it didn't say, "Don't move in," but it did say, "Fix these things reasonably urgently."

However, in a job I'm connected with at the minute, big job, similar size, validation actually starts before the-- Let's talk air handling units. Air handling unit arrives. The validator comes in to see that it's there, it's got all its bits. Air handling unit's connected up. He comes back to see that. Air handling unit commissioned. He comes back. So, he's actually doing a trail of validation and then, finally, he'll go to the room it's serving to make sure it's providing the performance parameters that it's supposed to provide.

Q Well, let's go back to where we got to before we became slightly diverted into the approval processes. Go back to 145, please, and we'll just see if there's anything else we need to pick up. To

some extent, on 145, we're still talking about the ventilation derogation because we'd asked you about the ZBP paper and when you first saw that, so I won't go back into there. Then we continue on to the question of, well, who did you tell? Your position is you told Helen Byrne and that was all you needed to do. Is that right?

A Yeah, (inaudible 14:32:07).

Q You've already been asked about Infection Control involvement, so we won't ask you about that again. Just in terms of one practical point, because you emphasised it earlier. On page 148, you take the view that if somebody's going to do a risk assessment, that's for the technical advisors to do before they give you the advice on the topic. That's your position on that, and then you say, "Well, and by the way, before any patients go in here, somebody's going to check it anyway."

Now, if you were checking whether, you know, the bed was a type X or a type Y to suit a particular patient, orthopaedic or whatever it was, that's fine because if you go in before occupation and say, "Wrong type, get me the right one." We've had quite a lot of evidence which basically says you need to get your ventilation right at the start because fixing it later becomes a complete nightmare because it affects the built structures in a whole variety of ways. Would you agree?

A Well, that's-- yeah, and that's what I've just described in this other job I'm connected to at the minute, where the ventilation engineer comes in all through the design-- not the design, the install process, and he gets a-- I've read his reports. He gets a great idea on just how good this system is right up until after practical completion, before patient occupancy, and then he does his performance testing and says, "Well, I've checked all that. All the bits are there. I'm going to check it performance wise. Should be okay" "Oh, it is okay," or, "It isn't okay." So, that's the complete process of validation.

Q I just wondered what you thought of this idea. One of the other witnesses when asked, you know, "Can you think of anything that might help?" suggested that one possibility might be that you have whatever discussions you have about the design of your ward, including ventilation and everything else, but then when you finish the design process, before you start, as it were, pouring the concrete, you'll loop back through some official process to the users and bring in lots of advisors and say, "Just before we go, are we all okay with this?"

A Yeah.

Q What do you think of that idea?

A I think that's an excellent idea. I think there's another way of achieving it, and that's by traditional-- excuse me, traditional design, like Monklands currently is designed to the Nth degree, so you've actually done every single thing. But even then, before they say go, they'll go, "Is that still okay?" So, in terms of your point, I totally agree.

Q Yes. So, am I understanding from your answer that, in Monklands, it's not a design and build----

A No.

Q -- contract? It's a traditional client does the design, gives it to the contractor and says, "Build it"?

A Yeah.

Q Is that right?

A Well, the only-- the only difference I think – I don't want to get this wrong – the builder is with them doing the design as well. Okay? So, it's a-- there's a buildability issue. So, the builder's there, the designer's there, and the client's there, and they've taken it to, I don't know, stage five or six in the RIBA process. I'm not quite sure, but they've done a lot of design on it before they ever go and start to build it. But the clients-- sorry, the contractor's already picked, right?

Q Okay.

THE CHAIR: As Mr Connal has flagged, we are interested in suggestions from appropriately skilled people such as yourself. So, Mr Connal put to you the possibility of you go through the design process but you then return to the result and you have a formal process that reviews it. As I understand your answer, you said that's a good idea.

A Absolutely.

THE CHAIR: Then you said, "But another good idea is to follow the model which is in course of being adopted in Monklands," or has been?

A Yeah, yeah, but obviously-- There's some downsides to that, my Lord. You know, Monklands has been designing the hospital for about 10 years, so there's a long lead to get there. Now, it's not all about design, before they start phoning me up, but that means when you're trying fit in government in terms of, say, cashflows and stuff like that, that's a long, long lead and that's why design and build came out, but normally, before design and build, we would have done traditional designs, and that would design everything, power quantities, every nut and bolt. Nobody would be in any doubt of what we had actually asked for until the users change, of course, but there you go.

THE CHAIR: Right. Well, it's just so that I have followed, as it were, the Monklands model, which you are commending?

A Yeah, it's got its downsides but, yeah. Now, considering where I am now, it's the only model I would probably do, yeah.

THE CHAIR: So what are the key features of what I'll describe as the "Monkland model"?

A Everybody's agreeing the detail, and I mean everybody, the contractor, the designer and the client, as you go along. So there's no doubt about what's-- no doubt about information, no doubt about communication, no doubt about what you're designing.

THE CHAIR: And how do you achieve that?

A By working together and getting into the very nitty-gritty of every single design, every room, every system, so nothing's left to chance. That doesn't mean it will all go right, but that's the philosophy behind it.

MR CONNAL: Am I right in understanding that one of the issues with the traditional model, where the client works out exactly, in every detail, what he wants and tells the builder to build it, is the point you made about lead time, particularly in the context of healthcare where, by the time you go into next week, somebody's come up with some new machine or new device----

A Yeah.

Q -- or new process or whatever. The healthcare moves rapidly and the construction process may struggle to keep up.

A Yeah, absolutely.

Q Is that one of the issues over that----

A Absolutely, it is, yeah, yeah, yeah. One of the other things is, in these very long processes, so start procurement, do some design, construct and finish it, four/five/six years, a lot of the personnel, particularly on the user side, have changed and got different views, and that's where change comes in. So-- and nobody really wants change. You've seen change in 4B. So change in a contract is always-- apart from being expensive, always difficult.

Q Can I ask you about another topic, the Full Business Case? Now, we asked somebody to dig their way through the entire massive document.

A No luck.

Q Exactly. I don't know what they did to deserve that, but we asked somebody to do it anyway. The information we have is this-- and I just need to know because you were involved in the Full Business Case and putting that up to Scottish Government, weren't you?

A Yes, sorry, yes. Yes, I was.

Q It is that if you read the Full Business Case, you would not know that guidance like SHTM was not going to be

filled. Is that probably correct?

A Yeah. Absolutely.

Q And you wouldn't find, at least as far as we've been able to find, the-- let's call it the ventilation derogation for the moment.

A Sure.

Q The ventilation change mentioned in the Full Business Case?

A No, you wouldn't find that, no.

Q And the decision to change the nature of the advice available to the Project team, i.e. the stepping down of the Currie & Brown team, probably not there either?

A Definitely not there.

Q Right. Why are none of these things in it? Can you help us at all?

A The business case is about selling something to the government who's buying something. So I'm not quite sure whether-- I'm not quite sure whether the Currie & Brown change would enhance that or whatever, and the derogation has become a normal part of what we are buying, and we've not-- and we're not saying-- Well, remember, it's your word, the "derogation". My word's the "alternative design". We're not saying, "This is a problem." We're just saying, "We're moving through with this," so it's just simple, practical steps.

Q I've been asked, for reasons that are not primarily directed at you, just to check something. We had some discussion in another session of the Inquiry in which Appendix K to the Full Business Case was mentioned. Can I just ask for bundle 17 at 1453, please? (After a pause) Well, it's come up and disappeared again. It purely-- somebody raised the question of, "What on earth is Appendix K to the Full Business Case? Is everybody clear as to what that is?" And it is the design statement, the design statement about buildings and there's a design statement about other parts, landscape and so on, and that's what Appendix K is. So we're all clear about that. Do you remember this being put together as part of the package?

A Yeah, it's part of the-- it's the outcome of the work in 2010.

Q Right. Thank you. Well, we can take that down. Thanks very much. Now, in the next page of your witness statement, you're talking about the role of IPC. We've already dealt with that, and then you go on to the appointment of the main contractor, and then we come back to design again. So, let's not go there again, but let's move on to page 156 of your witness statement. Actually, let me ask you about another topic just while I have it in my head.

A Okay.

Q We understand that the Board keeps a risk register. Now, we don't

actually have it in our published documents yet, but was there also a project risk register?

A Yeah, there was. Excuse me. We had a project risk register, and the Board had a risk register, and we had a corporate risk register, and as we went through our gateway review process-- which is something that might be built into this design process because it doesn't actually deal with design, even though you think it should. In the gateway process, they were very anti us having three risk registers and said that the Board had to move forward with one, which is really impractical. So we really ended up with two, a kind of corporate one with the top five risks for the Board to look at for every service they provide, and then we had one for the project and the wider aspects of the project, i.e. the Southern General. So, yeah.

Q Okay.

A So that takes it to-- it doesn't go into finite detail because it's up at this kind of level.

Q Right. Okay. Just so we know what we're looking at for people that are not familiar with it, can I have bundle 43, volume 6 at document 37, please? So, this is the kind of thing that you see. This is the project risk register at June 2010. Now, if we can scroll down and find Risk 24, please. (After a pause) Right, I suppose that the question I have: am I right in thinking that you talk about people owning risks and, as project director, do you own the risks on the risk register that we're looking at?

A Most of them, yeah, aye. So I see, yeah.

Q So we see, for instance, at Risk 24, "RISK": "Inadequate [Full Business Case] Design", and then, "CONTROLS IN PLACE". and so on. So is that-- that was one of your risks? Now, there's nothing in there about the derogation at all.

A There wouldn't be. It's dealing with all the design as one component.

Q Could we also look at bundle 43, volume 7? This is really just so we get the information in. Can we have document 48 and then Risk 11? We're not getting the document. Well, the reference is obviously incorrect. Let's leave that one. It doesn't matter for my purposes. Let me ask you another random question just while we're off your witness statement just for a moment, arising from something that someone else told the Inquiry. In this case, it's Mary Anne Kane, and she came into a position of head of Estates, and that turned out to have responsibilities for water that she hadn't quite understood.

A Sure.

Q As she explained to us that

she had, and she recalls speaking to you at or around that time. Now, according to her evidence, you told her something along the lines of, "The new hospital would have the best water and ventilation systems in Europe, given all the work on compliance." Do you remember telling her that?

A Not really, but I would say it was true. It's certainly how I would feel at the time.

Q So, what would be your basis for saying that?

A It's a conversation.

Q Of course.

A Mary Anne came into the project at certain times to do certain things, particularly in an area we call "cause and effect", which is the cause and effect of all the systems integrated together coming out with the right results. So fire, particularly, so Mary Anne was the nominated fire officer, I think, at that point, and we would have conversations and I don't really-- I'll answer that-- I don't really know why she would say that, because she was maybe having problems with water or vents somewhere else, and I would say it because why would I expect any less?

Q Now, I just want to ask you one question, going back to your witness statement for the moment. You've been asked a number of questions about the

specialised wards. Now, 2A's the one we've been looking at. 4B might be another. There are obviously other special areas such as theatres and so on and so forth. What did you understand the guidance to be in relation to these? Was that covered by your derogation or not?

A No, no. No, no. Only 6 air changes to 3.

Q So anything that might be in guidance as requiring more than that, not touched?

A Absolutely not confused.

Q Thank you. You make some comments about Capita's role, but we've already dealt with that. Now, I'm waiting for the surprise because on page 158 you are asked about – it's a mistype – carbon filters. What we know is that odour was an issue which was raised at the time the project was being discussed and that the response, initial response, was, "Not a problem, we'll put carbon filters in." Now, you, I think in your witness statement, say you don't really remember much about the carbon filters. Are you now about to tell me something that isn't in your witness statement?

A I'm about to give-- well, having listened and read what I can----

Q Yes.

A -- not wanting to come here and, you know, not be able to answer the

question, I know a bit more about it and, reflecting on the beginning of the project, I referred to earlier on Susan Logan's design statement solution said, "the perceived odour." It also said, "Make sure when you're doing something like carbon filters, you don't restrict the air flow." Move it on a bit, in terms of people speaking to me, me living and walking the site. I pass the site every day of the week of my life now. I don't think there's an issue with odour. A couple people, some people might.

Multiplex clearly didn't think there was an issue with odour, and they said, "Why don't we remove the carbon filters?" and one of the key issues behind it was that they might slow up the airflow because of-- I think you've seen that we're not brilliant at maintenance. If the maintenance of these filters isn't done promptly and every time it should be done, then we'll have less air in the building. So that was part of it. Then, getting back to the bit that I said to you at the very beginning, two bidders of the three bidders said, "We're not putting carbon filters in."

Q Right.

A But at that point in time, I could consider that because it was well out of the procurement process. So that was a general range of stuff that I can remember.

Q Okay. So, initially they were there, and then you say it was Multiplex's idea to take them out?

A Yeah. It was part of the-- what do you call it? The VE process, the value engineering process which every project has.

Q And it saves you money why?

A Save you money----

Q Because we see-- Sorry, just pause a second. This is my fault. I cut across the start of your answer. I was just saying to you value engineering's about saving money on a project. You were about to give me an answer, but I'm afraid I spoke and you spoke, so I need you now to return to the start of your answer, if you don't mind.

A In terms of carbon filters, you'd be using more energy, more cost. You would have-- So, yeah, in terms of energy and cost, you would definitely have gone lesser cost and better energy use going forward without them, right? Do they do a job? Yes, they do do a job, but you've got to keep up with them, no doubt about it.

Q Was it at that point influenced by any view as to whether there was or was not an odour problem? Because there's been different views on it.

A I think that's what brought it to the table, yeah.

Q Now, on page 159, one of the

issues that you're asked about is how the decision-making was structured, who was responsible for what, how it all worked. So, I wonder if you can just bear with me while we look at one or two documents just to help us with this. If we look at-- Sorry, let me start with a question. There's something called a performance review group. You know what that is?

A Yeah, subgroup of the Board, yeah.

Q Subgroup of the Board, yes. Now, what we're just going to work through is one of the decisions made by the performance review group. So, could we have bundle 34, please? I think I'm told it's page 147. Now, what we're going to here is a review group meeting on 19 May 2009 – just take that date from me if you mind for the moment – at which point the decision was made to amalgamate two bodies so that you could get on with the project. If you see in 2.3 on that page, I'll just read it to you:

> "In considering how best to take this forward, it has been agreed that the new South Glasgow Hospitals and Laboratories Project Executive Board [lovely mouthful] and the procurement and finance group should manage to become one group, the new South Glasgow Hospitals and Laboratories Project Executive Board."

Which I might just call the Executive Board from now on.

A Sure.

Q So, and then it said 2.4:

> "… amended terms of reference are attached together with proposed membership."

And then 2.5, "director of acute services [etc.] will chair." So, if we then go onto 152. Do you remember all this happening?

A Yeah. Well, bits of it, yeah, bits of it.

Q As you can see, this is then headed "terms of reference" for this new renamed sort of body, the Executive Board. What it says there is that, you see at the start, that that body will have delegated authority to make executive decisions on critical points in the project programme. So that, at least at that stage, seems to be where the responsibility sits with the Executive Board.

A Mm-hmm.

Q Would you agree?

A Yeah, generally, yeah.

Q And, well----

A No, I do agree, yeah.

Q Yes, okay. Thank you. About halfway, maybe a little more than that, down the page:

> "The Executive Board, will oversee the management of change

control procedures, and any change which impacts upon the project must be authorised by this board before it can be implemented."

You see that?

A Mm-hmm.

Q Now, do you remember that ever being done, changes being brought to that Board----

A Yeah.

Q -- for agreement?

A You asked me did I remember it; the reason I remember is because I probably wrote it and wrote the change, and the change is about change in service, and the change is about change in cost and change in programme. It's generally not about technical issues.

Q All right.

A So, if you take an example, 4B change to BMT, the concern from government, the concern from the Board, the concern from everybody always says that the service makes a change during the project, and so we talked about projects with great longevity. That was always happening, and we can see here 4B was a change, not very successful in the end, but that's a fact. So, that was about cost and programme. The two most-- the two criteria you've really got to control because programme-- extensions of time, half a million quid a week, are very expensive, etc., etc. So, that's what that's about, service change.

Q Okay, and the reference to having delegated authority in the middle of the page "to conduct and conclude negotiations at project critical moments", from one view, that might include signing the contract.

A Yeah, yeah. It's just-- it's after that but-- I can't say it's not.

Q Okay. Well, can we then-- I'm just trying to-- we're trying to understand how this all works. Were you a member of this group, the Executive Board?

A Yeah, well, I reported to it so I suppose I was an attendee.

Q Okay. Let's just scroll on and see if it tells us anything else about membership.

A There was that many groups. I might have been, but I think I reported to this one. I'm not sure.

Q Can we go on to the next page please? It says "voting members". So, Helen Byrne's on this, Mr Calderwood, and then we see you----

A Yes, so I-- sorry, I am on it.

Q -- Mr McIntyre, and so on and so forth, Jane Grant in her then position, Mike Baxter from the Scottish Government, and then non-voting members, which include technical team members and Peter Moir. So this, of course, is May, so this is before any of the changes. So, you appear to be a

member of this?

A Yeah, so I see.

Q Yes, okay, this group that has the job of conducting and concluding negotiations. Can we go to another document then? Bundle 42, volume 2, page 87, please. This is a minute of a meeting of the Executive Board, if you take that for me. We can go back to the start if you want, but----

A No, it's fine.

Q -- just take it from me that that's what that is, on 7 December 2009. So, before all these last few days, discussions about contract details, but getting close to that. You remember from the last document, it appeared that the Executive Board had the job of concluding negotiations on critical points. But what we see here, it appears, is that they're not doing that because the Project team are doing that. If you look at 5, "Key Actions":

> "AS [that's presumably you] reported that the project team were now in the process of carrying out due diligence… reviewing the Boards Employers Requirements against Brookfield's tender offer to conclude the formal contract document."

A Yeah.

Q So, can you help us as to why the issue of doing these critical negotiations went from the Executive Board down to the Project team?

A Well, I just think they obviously thought we were the best people to do it. So, that would be a bit of work that fitted into another bit of work that they were probably doing. So we're all doing bits to try and get the whole thing together, I think. I don't really have anything other to say than that. I'm just trying to read on to see if it gives me a clue, but.

Q If there's something else you want to look at, then I'm happy for you to do that.

A No.

Q But what you say in your witness statement is that, apart from the general rules that the Board had about how much people at a particular level could authorise in money terms, and perhaps apart from what we see in these minutes, there weren't any particular rules put in place as to what had to be reported and where it had to be reported?

A Generally, that would-- I know this becomes a headline, but generally we would report compensation events that had an effect on the target price.

Q That's the kind of thing that you would anticipate reporting up to the Executive Board?

A Aye. That's critical, yeah.

Q Okay, and it'd be nice to ask

you about that because some participants in the Inquiry are particularly interested in the Horne taps saga.

A Yeah.

Q Now, in your witness statement at page 161, if we could go back there, please. Thank you. What you're doing in this section of your evidence is you're saying, "Well, I'm trying to explain to you how we decided what we needed to go to the Executive Board on and what we didn't. Technical things didn't."

A Not generally, no.

Q And then you say a good example of something technical that doesn't need to go get reported to the Executive Board is the issue about the selection of the Horne taps. Now, I suppose that the question that I need to ask you about, just because of the background to that decision, is that I think I'm right in saying that even in 2012 when this was being discussed – because 2014, Horne taps, you were gone – 2012, was there not an issue about people dying in Northern Ireland due to flow straighteners or something of that kind?

A I think it was a special care baby unit in Belfast. Yeah, there was an issue with-- don't really recall the detail, but flagged up to us by Health Facilities Scotland, and I think Fiona McCluskey, not sure about Jackie Stewart, probably

both of them had a conversation with HFS and Belfast to make sure any decision we were going to make kind of took account of that. It was Pseudomonas, wasn't it? So, I thought we'd actually taken account of what was flagged to us, yeah.

Q Yes. I mean, the question, put simply, is this: if you're dealing with a topic which has possible serious health implications and having to make a decision as to what to do against that background, would that not be the kind of matter that should be reported up for discussion at the Executive Board?

A You can maybe say that now, but at that point in time I would have taken it to the Executive Board if I couldn't pick a tap. If you read all the stuff leading to that, it was very time-pressured, and that's not an excuse; it was. So, if I couldn't have found a result for that, then probably I'd have took it up because it would have affected the programme, which would have had potential costs on it.

But generally, as long as we had done a reasonable risk assessment, and I'm sure anybody-- and I think we did. I'm sure if anybody thinks we could have done more, then that's always the case, but we'd done a reasonable risk assessment. We spoke to the right people. We had Infection Control and

nursing involved, and we come up with a solution, and we thought that was a good solution.

Then, in 2014, Health Services Scotland gets everybody together to review that decision. The taps are bought, I agree with that, and they decide, "No, fine, we can run with these." So I felt my decision was ratified.

Q At the time you made the decision in 2012, after the investigations that you've explained to us, were you aware that in order to protect against the issues that had been identified, there would need to be a pretty stringent maintenance regime for the taps?

A Mm-hmm.

Q And did you take any steps to make sure that that was clear to everybody?

A I think, as you'll see in my statement, I spoke to Mr Powrie for ongoing maintenance of this particular tap, but in terms of this particular tap, which would be in theatres, intensive care, coronary care, special care-- not special care, that's maternity, PICU, paediatric intensive care, etc., this tap could be taken off and put on for maintenance at the drop of a hat without disturbing anybody, and hence not having to take panels off, potential risk, etc., etc. So, I think we account of just about everything in order to say, "This is the best solution considering all that we know."

Q Thank you. We have a few more. What we need to do, the way we operate here, Mr Seabourne, as you may have noticed if you've been watching any of the full sessions, is that I ask you as many questions as I can immediately think of, and then we kind of take a short pause to see whether-- well, first of all, I suddenly realise I've not asked you something, or anybody else has a burning question they want you to answer.

But can we to go to 162 in your witness statement there? In fairness, the questioner is asking you about something which took place, ultimately, after you had left, because you left in July 2013. Can I ask you, generally, the original Ward 4B, which was haemato-oncology, do you agree that that was a specialised area not covered by the ventilation derogation?

A 100 per cent, yeah.

Q Now, I think you indicate that you were aware this was-- well, I'll put words in your mouth a little bit, this was a Jennifer Armstrong project or Jennifer Armstrong idea. You mention her specifically in the middle of page 162.

A Yeah.

Q Do you know what was going to happen to the-- Sorry, let me start that

question again. When the original 4B output specification was produced----

A Yeah.

Q -- flaws or not, the clinical output specification indicated a significant range of protective measures to protect the immunocompromised people in that ward. Do you remember that?

A Yeah, it was a reasonable COS, yeah.

Q Yes. Under the proposal to bring the BMT unit in, do you know what was going to happen to the people who were currently scheduled to occupy 4B, the 4B occupants before that decision? Because we haven't been able to trace at the moment any discussion about what was happening about moving their protective environment to somewhere else. Do you know anything about that?

A No. As you know, I just left at that point, and I maybe did take the odd paper to the Board. I think there is a paper appended-- When I say "the Board", the performance review group, just to be clear. I think there's a paper appended from Jennifer and Jane Grant which comes with my paper, just because it slots into the agenda at that particular time. "Will we do this project? What are the needs to do this project?" But I never actually seen the bit where the patients who were going in there, where they were going. And I think I say in my statement

to you I think Ward 1C is just a general ward; that's because I didn't have any knowledge of that.

Q No, the reason I ask – and this is in case you can help us any further at all – is this: that if you assume for the moment you've got 4B, which is haemato-oncology, you've got 4C as the general ward, you're going to move the people from 4B into 4C, on the face of it, that requires you to reproduce the protective environment in 4C. Is that correct?

A Yeah, it does. Yeah, I would say so, yeah.

Q Yes. Now, 2A, let's come to 2A. We've touched on this to some extent, and I think you've accepted that 2A was another specialist area not covered by the ventilation derogation.

A Cancer unit, yeah.

Q When you answer the questions on this, you, I think, say in the middle of 164-- So, we get that up on the screen for you. That's page 48 of your hardcopy, if you need it.

A Yeah, I've got it.

Q You're asked, "Well, did they get what they wanted in 2A?" You say, "I'm gone by then, sorry." Then you say you would assume that all tests including validation were carried out. So you would be assuming, back in 2013, as a project manager, that validation of an area like

that would be carried out before occupancy?

A Oh, absolutely, yeah.

Q Now, the reason-- I just want to pause a second. We have talked about validation. You're saying, "Oh, absolutely," but yet no one-- well, first of all, no one on the contractor side seems to have had in mind that there was going to be a period during which somebody was running checks which might come back with an answer saying, "Not acceptable", and validation wasn't carried out at all. Is this something you would have discussed with Mr Loudon, the need for validation, or would you just assume he would know about it?

A No, I wouldn't discuss that with Mr Loudon at all, no. Not in 2013, absolutely not.

Q Why is that? It's just you've----

A It's just too far away at that stage. I would expect him to take over from me and get to-- That's another stage in the job. It's another critical stage, commission, test, validate, and for him to put the plans in place in order to carry out the validations that are required.

Q 2A we've been using as an example when we've been discussing the design process----

A Yeah.

Q -- and you've been asked a few more questions about that. It's

probably quite a good example just to pause on just for a second while we have you here. 2A, you say, "Absolutely clear, not covered by the derogation." We asked Mr Pardy, "Well, here's an ordinary room in 2A with 2.5 air changes or 40 litres a second. How did that happen?" He says, "Well, maybe we didn't interpret it correctly." He thinks the user groups might have removed the airlock. You think that's likely?

A I don't know how. Well, I wasn't there in the first place.

Q No, no.

A I don't know how they could remove it. And, as I say, go back to the COS, it's the one outstanding thing in the COS that says we need an airlock. And ZBP, our hospital designers, they've at least got to ask the question, "Are we keeping that airlock? Are we not? Do we need it?" Right? Even bearing in mind we're only putting 2 and a half air change-- I mean, it should just have been a flag to say, "Let's check this out."

Q Because, as you quite rightly said, the logical reason for the airlock is to keep the pressure in.

A Absolutely, yeah.

Q Let me just double check that to see whether it's mentioned.

A You could have had one or two things. You could have had-- You could have had the rooms at 10 air changes

and high pressure going into a corridor that wasn't covered by an airlock, or you could have had-- and that might not have been perfect, but it would've been a lot better than what they've got. Or you could have had the 10 air changes going into a lobby that's probably kept at about 4 or 5 pascals, and that would be a whole system. So, it's kind of a partial system versus a whole system, but they actually kind of ended up with the worst. They had no airlock and the wrong air changes.

Q Yes. Well, I'm just checking, given I'd slightly unfairly been asking about this without showing you the document. So, take it from me that what it actually says: the ward should be accessed by entry through a double door barrier system which allows the entire ward area the benefit of low positive pressure ventilation. So the existence of or reason for the airlock-- and I'm calling it an airlock. It's not----

A So am I. I've----

Q It's just what people call it rather than a technical description. From your understanding of the people in the user group, is it likely, in your view, that user group members would have said, "Now, take that airlock out"? Does this seem to fit with your understanding of how they----

A Somebody-- I don't

remember. I've had a lot of conversations. No, not swapping the evidence, just having conversations for the past six months to come here, and somebody said that the clinicians at Yorkhill wanted the same as I'd built them at Yorkhill, right, and I don't think that had an airlock. So, I'm not saying they did, but it's the only piece of rational evidence that I can think of that might have caused this to happen from a user perspective as opposed to a design perspective.

Q So, am I right in understanding from your last answer that you were a participant in the building of the Schiehallion Unit ventilation system in Yorkhill?

A Yeah, I was the project director, yeah.

Q Am I right in understanding that advice was taken on that from various sources, including overseas?

A Not so sure about overseas. It was a big refurb as opposed to a new build, so you had to compromise and adapt to get to things that you thought were the best, you know, environments for the patients. I can't remember what those were, but it didn't have a-- I just know it didn't have a corridor which was airlocked, positive it didn't.

Q Well, it just raises a slightly----

THE CHAIR: Sorry, just give me that again. It didn't have a corridor that

was----

A I don't think it had an airlocked corridor that we're thinking should be here, you know, in terms of the barrier door. So, we think there's going to be a corridor that's controlled. I don't think that Schiehallion's got that. I'm sure it's not got that in Yorkhill, but, for me, that's 25 years ago. And in terms of your reference point about overseas, don't remember that but Professor Gibson, worldwide known, so she-- and didn't do a project without Brenda throwing her heart and soul into it. So, she may have asked somebody a view, and that's maybe where that comment comes from. I'm kind of guessing.

MR CONNAL: But it wouldn't be an area with what you might describe as standard ventilation----

A No.

Q -- at that time.

A No.

Q It does raise a question, I suppose, just, as it were, by the back door of how a design for Ward 2A's air changes and chilled beams and all these other issues got to where it was when, among other things, the person who built the Schiehallion's refurbed version was on the team.

A Well, yeah, but it would have been 6 air changes as opposed to 10, so it still wouldn't have been right. It might

have been a little bit better, right? So.

THE CHAIR: Sorry, entirely my fault. I don't quite understand that last answer. It would have been 6 air changes rather than 10.

A I think Mr Connal was saying to me that if it hadn't changed to 3-- just call it 3. If it hadn't changed to 3 air changes, then the mistake would have been carried into Schiehallion as 6, i.e. a normal bedroom because that's where the 3 comes from. Am I explaining that well enough?

THE CHAIR: I'm sure it's my fault.

A A single room would've normally had 6.

THE CHAIR: Yes.

A And in this design process, they thought that was a single room.

THE CHAIR: Right.

A Right? So it would have got 6 air changes, but our derogation changed 6 to 3----

THE CHAIR: Right, okay.

A -- and that's why you get 3 air changes. Well, I wasn't-- I'm surmising all this, but I think it's a good summary of what's happened.

MR CONNAL: Okay, and the reason it still wasn't right was the figure ought to have been 10.

A Yeah, I think it was 10. I think it should have been 10, yeah. Yeah. I think, unfortunately, the description in the

RDSs and the description in the matrix just terms it as a single room with overnight stay, and it's nearly-- although it's not a lobby PPVL room, it is a kind of isolation room, and it might have been better-- it might have been better if that's how it had been designated.

Q I just want to ask you about the-- one or two issues about isolation rooms, if I can.

A Sure.

Q Can I just divert off that for a moment and ask you-- Now, you left in July 2013. One of the issues that the Inquiry has been considering-- it's nothing to do with ventilation; it's to do with the water system. One of the questions that has arisen is about the filling of the water system before occupancy, perhaps a long time before occupancy. Now, by the time you left, were you aware whether the water system had been filled?

A No, I don't think it had been filled, and if I go back to-- If I left in July, if I go back to just-- July '13, sorry. If I go back to '12, November/December, in the Adult Hospital, we had completed in terms of structure and fit out critical-- not critical, intensive care, high dependency and critical-- and CCU. So, that was the there as a-- Everybody we came to take-- to see the hospital, we showed them this pristine ward, and it was impressive.

And there was a discussion about, "Will we put the services on in it?" Right, just a-- we had thousands of discussions. And I think it was Darren Pike and me that was having the discussion, and we both agreed, "No, no, we'll leave the-- We're not ready to do that yet." So, if I roll onto-- I roll onto July, as I was leaving – and you've got to remember I'm trying to close down things and people are taking things forward – there was discussion about, "Can we start testing pipework?" But I thought that discussion would be about testing pipework with nitrogen as opposed to wet media, because that's normally what you would do and nitrogen would be a very clean agent. So, my simple-- Sorry, it's a long way to say, "No, sorry, I wasn't."

Q The point in the witness statement that I've reached, which is about 172, we're talking about handover. I have another question about handover. By the time you left, had you given any thought to what pre-occupation testing was needed on the water that you would need to discuss with David Loudon before, as it were, you went and he took over?

A No, I never had that discussion with David. I was only with David for, I think, four weeks, two of which he took two weeks' holiday, so I had limited time with David. I just decided in my head David would need to deal with that but, in

terms of-- I'm going to move the clock on. In terms of what they did, and done that DMA pre-occupation report, you couldn't have done anything-- that's gold standard. It's just, when it was done, something else should have happened. So David obviously got there, or David's team got there, and did it. I can't comment on what happened after that.

Q Nor am I asking you to do that.

A No, I know. I know.

Q Thank you. Just while we're on that page, 172, you are asked the question, "What did you tell David Loudon about the ventilation derogation and the log?" and you say derogation wasn't mentioned, as you remember.

A Yeah. Yeah.

Q So, if he needed to work out what he was trying to build, what his output was going to be, he would have needed to find that himself among the papers that he had?

A Well, my deputy and everybody else in the team was a conduit to advise David anything he needed to know. So Peter Moir, I think I said in my statement, that was one of the key linkages. The Board didn't do an official induction process. We kind of made up the process as best we could, and Peter was a key part of that process. So, of all the things I had to tell David, no, we'd already built some of the systems. We'd already agreed to move forward. I didn't see that as a risk, but I did know that, when it came to testing, people would know what they were testing.

Q Now, in many ways, the most prominent thing that was attributed to Alan Seabourne in a lot of the exchanges we've seen is the email you sent years after the event, in 2016.

A Yeah. Feels like an affidavit but, no, it wasn't.

Q Well, let's just get hold of that because I need to put it in front of you. Bundle 12, page 813, please. I need to put it to you in part because you now try to give some context to some of the statements you make there. Probably the most prominent one is in the third line, where you say:

> "Whatever the infection control people say, they were involved in every aspect of the design, and the member of my team responsible for infection control, Annette Rankin, was the person responsible at design, dialogue and evaluation for ensuring appropriate liaison communication was carried out effectively. To this end, infection control and microbiology, along with Annette, were party to the sign-off of all design matters that had an impact on patients, including the environment."

Now, am I right in understanding from your witness statement that the inference that that might give, just read on its own, which is that you had IPC people signing things off, is not what you were meaning to say? Is that right?

A No, I think you see in my statement that I've kind of clarified that, you know? Sometimes you think you'd done a good job here and somebody's just knocking it down, and I remember that day well. I was just going to play golf and I wrote that down, and then you showed me it back and I condensed or I described what it actually meant, which was: Infection Control and many others were party to most of the discussions, which I absolutely believe.

Q So, let's just go through what you do say because Annette Rankin says, "I didn't sign off anything."

A No, she didn't. I said that in my statement.

Q You say on page 173-- Hang onto the document if you don't mind. Page 173, which is 57 of your hardcopy, you say at the foot:

> "What I mean is that we were all involved, including infection control, Annette, then Jackie Stewart…"

Can I just pause and ask: was there a gap when you didn't have somebody there? When one had gone and the other hadn't arrived?

A Yeah, Annette went, and I don't know-- that's why, when we talked about 3 air changes, I'm not quite sure when Annette went but she went quite fast. She was in the Project team and then she had another, better job and she left. So there was no intention to recruit anybody but, the minute she left, we would then recruit somebody, and we would recruit somebody internally but they've still got a job to leave and then they've got a job to go to. So there is a gap, yeah. Yeah.

Q Yes. So, what you say in your witness statement is that the process was set up as a hub and spoke, which is the one, in fact-- and you say it's:

> "… not set up by me by the Board whereby people in the project team and the wider evaluation group etc. had a responsibility to connect with their own departments/functions and share information…"

That's what we've discussed. So you're not actually saying that either of these individuals signed off on anything, it's just that they were party to the Project team's way of working. Is that right?

A Yeah. Yeah. Just like us, they weren't approving anything, they were just party to all the correspondence, information, meetings, etc, etc.

Q You've provided various names and so on in your email, and then you make the point that we've already covered, that one of the key issues was this 26 degrees point, because that was a key issue. So, that's in your email, second paragraph from the bottom.

A Yeah. I see it.

Q Then you say, "Well, you were telling me the general rooms are not at negative pressure," and you say, "Well, I thought that's what they were contracted to provide, negative pressure. So how was this tested?" and so on. I wanted to ask you about how some of these things worked because there's another issue that links into that a little bit. The inference of IPC being involved in everything that you might take from your email, the isolation rooms for the hospital, they were specified in the employer's requirements----

A I think so, yeah.

Q -- as PPVL rooms designed in accordance with HTM supplement four or----

A 04, supplement one or something. Yeah.

Q Yes. Yes. Now, my understanding is that those requirements were completed and put into the necessary form in April 2009. If we're talking about isolation rooms and who's involved in what, I wonder if we could look at bundle 14, volume 1, page 75. Now, the reason that I've put this in is largely to look at the timing because the ERs are finished in April. Here we are in May, a meeting being held, no doubt for convenience, in the project office, because that's where there's a nice big room, you were telling us, and it's the Infection Control meeting and it includes Annette Rankin and various others whose names you'll be familiar with. It says:

> "This meeting is to review the advice given to date by infection control and agree a final position on the new hospital with regard to [and then various topics, first one being]: isolation rooms…"

What the meeting then did was to review a paper that Drs Redding and Hood had produced with Annette Rankin and said, "Fine, this is the position." Isolation rooms, haemato-oncology, sealed ward, HEPA filtration positive to the hospital, respiratory, three negative pressure rooms. If we just go onto the next page. Renal inpatient, two positively pressured rooms, A&E, two negative pressure rooms, critical care, 10 isolation rooms and so on. Then they go onto other topics.

Now, the point is simply to try and understand the process because, when we asked ZBP about this, which essentially discusses different types of

rooms in different locations, depending on the different needs, ZBP go, “We know nothing about that. We just got the employer’s requirements, which said PPVL rooms, so that’s what we built.” Well, subject to a debate about how they built them, but that’s essentially what they built. So, is there a kind of disconnect here? Here, you’ve got the IPC people saying, “Oh, we’ve been talking about this. Let’s just finalise it, write it all down. Here it is,” but you’ve already basically agreed something else. Can you help us as to how that might have happened?

A The PPVL rooms, the number of them, location of them and the type of them can only come from the users and the clinicians. I’ve seen this question asked before. There is an issue about PPVL rooms in that environment, and stuff I’ve read said that PPVL rooms can do positive and negative pressure in the bedroom and, if it can positive and negative pressure in the bedroom, then it’s got source and protective isolation. So, from an engineering background, my background, I would say they look fine. I think that’s what Steve Pardy was generally alluding to.

Other folk, I think HFS, came in and said you, “No, you could have other types of rooms,” and, again, that’s opinion but, getting back to your point, the PPVL rooms could only be asked for by the users with Infection Control, and then when the schedules of accommodation are signed off later in 2010 by the directors, including the medical directors, then, for me, that’s just information that I’ve got to deal with. So, I don’t know if that answers your question, but I don’t know who chose the PPVL rooms. However, the job I’m connected with at the minute, in the same paediatric cancer unit, we’ve got 10 PPVL rooms, so it’s all opinion.

Q Yes. We know that the guidance has changed since we were dealing with it there because one of the issues that we had to take up with ZBP is that the guidance, which is referenced in the employer’s requirements, says, “Not for immunocompromised”, and, “Not for infectious diseases units”. So we said to them, “Well, does that mean you had to think of something else?” and there was a discussion about that. I’m just trying to understand-- I can understand you say, “Well, the information must have come from the users,” but here we have, it would appear, quite a wide group, people concerned with infection prevention and control, talking about different types of protective environments for different patients.

A Yeah, but, going back to my point, you know, that’s the point that I’m trying to get across in the user group

meetings with the architect, the design engineer and the user. Take my team out. My team were there but this is going above their knowledge, and them saying, "This is what we want. So, we've got eight of them, and they're all the same or they're all different, and it should be three of these--" I mean, that's a discussion that should have occurred, and it doesn't actually mean that that discussion didn't occur and that the users said, "We'll have eight PPVL rooms, thank you."

Q It may raise questions, I suppose, as to whether there was specific IPC involvement, because if we go back to page 75, the membership of that discussion, you know, you've got a fair group there. You've got Mr Walsh. You've got your project manager, Heather Griffin. You've got Fiona McCluskey, Annette Rankin, both people connected to your team in various ways. Sandra McNamee, now Devine, Pamela Joannidis. So, you know, this is not, you know, a couple of doctors having a chat. This is a pretty wide group.

A Top team, yeah. There's one missing.

Q Okay.

A Penny Redding? Is she missing? Is she-- It mentions her there but is she in it?

Q She's not in that list, no.

A Right. So, Penny, in 2008, was really taking the lead on the isolation rooms throughout the hospitals. It's strange to see why she's not part of this communication.

Q I suppose the other question might be-- Heather Griffin's there. She's one of your assistant project managers. Question as to what skills she had, but we're not getting to hear from her, unfortunately. So, your team is at this meeting, and at least we haven't been able to find a record of someone coming to the Project team and saying, "Whoa, hang on a minute, there's an issue about isolation rooms because I've just been at a meeting where IPC have agreed we should have a whole variety of things and we've just put it in as one."

A Don't know.

Q You can't help us with that?

A Don't think so, no.

Q Thank you. Now, for the moment at least, I just wanted to take you to the end of your witness statement because, as is practice, what the Inquiry has tended to do, given that the questioning can arise from a variety of information, some of which may or may not be accurate, may not cover all the grounds, may not hit on the sweet spot of the witness's expertise----

A Sure.

Q -- or any other such thing, so the Inquiry usually says, "What else could

you tell that might help?" So, you've then set out quite a long narrative over the next few pages from 179. It's in answer to question 56. Are there any points in what you set out there that, knowing now what you do, you think you should emphasise to the chair?

A Let's just take ventilation then. I don't know if you've done-- I know you wrote a summary for Edinburgh, but I can't recall what it said because I'm just back from holiday. Brain's not kicked in yet. I think ventilation, like water, for any of these refurbs, rebuilds, whatever, should have a ventilation group that oversees anything or any decision on ventilation regarding any particular patient group. I think if they get the right people on that, and I'll say that-- I'll caution that to say it's not often I've seen two ICD doctors agreeing at the same time, but never mind. That's just a personal comment from me. So, I think that would be very, very helpful indeed to have a group. I'm sure I've read it somewhere and the same for water. You've already got that.

You've already talked about the stop points, the gateway review, which would say, "Let's see what we're planning here. We're all agreed. Any disagreement? No, move on." I think that's clearly another thing, and in that process, the Scottish Government or the UK

Government's process of gateway review, which I've done five of, and generally get five gold stars, right? Good for me. But they never really touched on the technical aspects of the job. In fact, Tom Steele was in one of my reviews. I've every highest regard for Tom, and it wasn't his remit to even ask me about derogations or whatever.

So, that process is there. It could be a bit-- made a bit more robust. Internal processes for each board, or take it up a level, but I'd keep it board level, to say, "All this design has been considered and we're happy with it," whether it's water, whether it's ventilation, and that kind of applies to medical-- In medical gas terms, you install all the medical gases and, guess what, the pharmacy comes out and checks them all that they're all right. So, that's kind of in line with that, but medical gases are seen-- they're not, but they're seen more critical than water and ventilation systems generally.

Q The only question I need to ask, because I should have asked you about it when you touched on this earlier, is that I think it was Mr Fernie of Multiplex – I may be about that – who made this suggestion. He made the idea, then he said, of course, that would introduce an element of delay because in effect you'd be saying, "Stop a minute. Let's make

sure we know what we're doing. Check it for the users." Would that be a reason to do it or not do it? Would that affect it?

A That would not be a reason not to do it. Definitely not. If we've ended up where we are today, then you need to do it. I think-- and I'm not connected now but-- certainly in this country, but I think you've got a group called Assure who do a kind of high-level version of that. So, on the right tracks I would say but, yeah, each health board should have the decision point.

Q Thank you. My Lord, this might be an appropriate point to take a short pause.

THE CHAIR: Well, Mr Seabourne, as I think has been explained by Mr Connal, we need to check if there's any other questions in the room, as it were.

THE WITNESS: Oh, right.

THE CHAIR: So, it might take us about 10 minutes. So, if I could ask you to return to the witness room?

THE WITNESS: Yeah, my Lord. Thank you.

(<u>Short break</u>)

MR CONNAL: I think, my Lord, I have about half a dozen. The questions are short-ish. We'll see whether the answers are.

THE CHAIR: (After a pause) I understand there's a few more questions.

THE WITNESS: Thanks, I'm glad of that.

THE CHAIR: Mr Connal.

MR CONNAL: Thank you. Mr Seabourne, these are questions which do not have a single theme. They inevitably come from a variety of sources, so please bear with me. I'm jumping around a bit. In your evidence you were asked about the design of Ward 2A, and then you were taken to the fact that you had a connection with Yorkhill because you were the project manager on a major refurbishment of the Schiehallion Unit at Yorkhill. You remember that?

A Yes.

Q Am I right in understanding that your recollection is that Yorkhill Schiehallion Unit did not have an airlock?

A I don't think it had an air corridor, no.

Q Because the information I've subsequently been given is that it did have the benefit of an airlock. Would that simply be your recollection?

A Certainly would, but it would make it more that we should have one now, so yeah.

Q In the process that was being undertaken in the context of design, a lot of the materials were being recorded on a contractor system called Aconnex.

A Aconnex.

Q Aconnex, my apologies, and each drawing was supposed to be stamped A, B, C or D.

A Mm-hmm.

Q Now, your evidence is that your team were reviewing things for clinical functionality; design liability lay with ZBP. I think the point I've been asked to put to you is this: if you stamp something under Aconnex with an A, does that just not mean, "This is fine. Get on and build it"?

A No, it means, "We've got no further comment to make on it and it's in line with what you told us at the previous workshop."

Q The issue of the Full Business Case was discussed with you and you accepted that the derogation, if that's the right word, wasn't reported. Now, the Inquiry, I'm told, has had some at an earlier session, which I was not involved, from a Mike Baxter of the Scottish Government who expressed a view that you should report non-compliance with Scottish Government guidance as part of a Full Business Case presentation. Do you remember being told that?

A Told me that?

Q Well, no, told that that was what you should do.

A No, I don't ever remember having that level of detail on the discussion about FBCs, and to add a wee bit – I know that I won't, but I will – you know, Currie & Brown and myself actually took the FBC process and turned it into a kind of logic map for them, which they thought was extremely helpful, and even then I don't remember being asked to address that issue.

Q A couple of things about conversations which you may or may not recall. If so, just tell me.

A Okay.

Q There'd been some indication in the evidence, particularly from Frances Wrath and Fiona McCluskey, that you had actually told them, "Don't look at the environmental data. That's going to be dealt with in these separate discussions." Do you remember doing that?

A No. What I said to them was, "You're not responsible for design," which was a key concern of most of my team, right? And that's what I said to them. "You can participate in this process. You're not responsible for design. You're supporting and helping out."

Q Again, I'm going back to an earlier discussion. Remember I asked you about a conversation with Mary Anne Kane when you said that, "It would be the best water ventilation system in Europe because of the work we're putting in with compliance," and you said you couldn't remember it but you might have said that,

or you would have said that if somebody had asked. I think you may have said to me that it was just a casual conversation, because I'm being asked, well, what was your basis for saying it would be the best water system?

A Because that's what I was planning and hoping for. No other reason than that.

Q The final question I have for you is really a point of clarification. Could we have the witness statement back, please? It's 153 in the electronic version. If you want your hard copy, it's 37.

A 37?

Q 37, 3-7, at the foot of the page, if that's easier to work with. Relatively simple question: you state at the bottom of that page:

> "… there had been problems in the past with such user groups and hence, the service directors were instructed to ensure the membership was appropriate and controlled by them."

Can you tell us what these problems were?

A Yeah, been to lots and lots of user groups, particularly the clinical people, and many, many times in the past user groups would be sometimes I'd see three doctors and then another three would come in, and there was absolute no control over it. And I'll just say as I've seen it: the clinical staff thought they could come and go to these meetings whenever they wanted and, when they came to a meeting and didn't like something they saw, they changed-- they potentially changed what people had been planning.

So the senior officers of the Health Board told the directors of the services, the director of surgery, director of medicine, etc., etc., that they had to make sure they were comfortable with the people that were going to be in the user groups, and that's right from the beginning right through to the end, and that they didn't change those people. They weren't allowed to change unless the service director agreed. So it was a control point.

Q And the control that you've just talked about, is that what you put in place?

A Yeah, that was general-- yeah, probably the best I've seen, yeah.

Q I have no further questions, my Lord.

THE CHAIR: Thank you, Mr Seabourne, for your attendance here today. I mean, you've had quite a long day but, behind that, I appreciate there's a lot of the preparation in responding to our questionnaire and reading the material we asked you to read. So, in thanking you, I'm not simply recognising

your attendance today, I'm recognising the work that went behind it. You're now free to go. Thank you.

THE WITNESS: Thank you very much. Cheers. Thank you.

(The witness withdrew)

THE CHAIR: Now, as the legal representatives will remember, we're hoping to begin at nine o'clock tomorrow morning with Mr O'Donovan.

MR CONNAL: Mr O'Donovan is appearing remotely. We have tested the system. It did appear to work, so we're hoping to be able to deal with his evidence reasonably promptly and then move on to Ms Byrne later.

THE CHAIR: Well, I wish you a pleasant afternoon, and we'll see each other at nine o'clock tomorrow.

(Session ends)

15.59