SCOTTISH HOSPITALS INQUIRY

Bundle of documents for Oral hearings commencing from 16 September 2025 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow

Bundle 51 Volume 2
Substantive Core Participants Direction 5 Responses to Sir Robert Francis Whistle-blowing Report

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SCOTTISH HOSPITALS INQUIRY

RESPONSE SUBMITTED ON BEHALF OF DR TERESA INKSTER, DR PENELOPE REDDING, AND DR CHRISTINE PETERS ("THE MDDUS MEMBERS")

TO

THE EXPERT REPORT OF SIR ROBERT FRANCIS KC

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1. INTRODUCTION

1.1 On behalf of the MDDUS members, and in accordance with the procedure set out in Direction 5 and the email sent by the Scottish Hospitals Inquiry Team dated 21 July 2025, this response is submitted in relation to the Expert Report of Sir Robert Francis KC dated 14 July 2025 regarding the standards to be expected in the treatment of whistle-blowers and the concerns they raise in the context of a newly built hospital or a hospital department in Scotland (the "Whistle-blowing Expert Report").

1.2 At the outset, the MDDUS members wish to express their thanks to the Inquiry for commissioning the report as it demonstrates a commitment to fulfilling the fourth Term of Reference, which is critical in ensuring that the Inquiry actually serves a purpose in improving patient safety in the NHS in Scotland.

2. RESPONSE

2.1. It is noted that, as per paragraph 1.4 of the Whistle-blowing Expert Report, Sir Robert Francis was asked to assist the Chair in reaching conclusions on whether:

> *"disclosures of evidence relating to the impact of features of the water and ventilation systems of the hospital on patient care and patient outcomes was encouraged as a practical reality."*

2.2 In view of this instruction, and based on the scenario set out in appendix 1 of the Whistle-blowing Expert Report, the MDDUS members request that Sir Robert directly answer the question as to whether whistleblowing was encouraged as a practical reality by NHS GGC at the Queen Elizabeth University Hospital between 2015 and 2019.

2.3 The MDDUS members also request that Sir Robert answer the related question as to whether NHS GGC followed the relevant whistle-blowing policies which were in place at the relevant times.

2.4 The MDDUS members further submit that it would be of assistance if Sir Robert could provide his overall comments on the way in which the whistle-blowers were treated by NHS GGC. For the avoidance of doubt, the MDDUS members are not asking Sir Robert to offer any comments on the merits or otherwise of the safety concerns which were being raised or on whether the MDDUS members "*should be praised for their commitment*" (per paragraph 2.2, final bullet point). Rather, the focus of the question is on the mechanics of the whistle-blowing process in this case to ensure that the fourth Term of Reference which specifically asks whether "disclosures…were encouraged" is answered to the fullest extent possible.

2.5 In addition to the above overarching questions, the MDDUS members have the following more specific questions which arise from the terms of the Whistle-blowing Expert Report:

(a) In relation to "Principle 12: Support to find alternative employment" which is dealt with at paragraph 4.6.1.12 of the report, would Sir Robert accept that it is unfortunate that a whistle-blower may feel required to move job whilst the individual(s) whose actions have prompted the whistle-blow remain in their posts? Would Sir Robert accept that in such a situation the whistle-blower is effectively being penalised? How can whistle-blowers be supported to remain in their job? Is there not an obligation to rectify any injustice or detriment experienced by the whistle-blower such as by seeking to implement concrete change and improvements in the workplace?

(b) Please can Sir Robert offer some observations on how the issue of power imbalance and the misuse of hierarchy in the whistle-blowing process can be addressed. For example, would Sir Robert accept that in his experience there can be an instinctive response of investigators to believe those who occupy more senior positions than a whistle-blower? How can this problem be solved?

(c) Please can Sir Robert offer any advice on how the focus is maintained during the whistle-blowing process on patient safety issues and how to properly handle

any attempts by organisations/employers to re-frame such concerns as "personal grievances".

2.6 In view of the recent publication of the independent research report by Grant Thornton UK LLP for the Department for Business and Trade titled "Understanding the Effectiveness of the Whistleblowing Framework in Great Britain" (available at https://www.gov.uk/government/publications/review-of-the-whistleblowing-framework-in-great-britain), please can Sir Robert advise whether he agrees with recommendations contained in the section "Summary of Suggestions for Change" and which (if any) of them he thinks could be usefully implemented in NHS GGC.

2.7 Finally, the following specific questions are submitted by Dr Peters:

(a) As regards paragraph 4.15, and in terms of the various recommendations, would Sir Robert accept that what is missing is a clear role for previous whistle-blowers to manage and support other whistle-blowers? Dr Peters invites Sir Robert to offer his opinion on such a role and whether he can see any advantages and/or disadvantages.

(b) Building on the foregoing, in relation to paragraph 6.11 which deals with training, would Sir Robert accept that a useful source of information when training INWO investigators is whistle-blowers and, thus, that they should be actively involved in such training?

3. CONCLUSION

3.1 In relation to the above comments, the MDDUS members would be happy to provide further input, information and/or clarification as required.

Helen Watts KC and Leigh Lawrie, Advocate

On behalf of Dr Teresa Inkster, Dr Penelope Redding, Dr Christine Peters

11 August 2025

SCOTTISH HOSPITALS INQUIRY

GLASGOW IV HEARINGS

RESPONSE ON BEHALF OF

NHSGGC

TO

REPORT OF SIR ROBERT FRANCIS KC

[1] The report from Sir Robert Francis KC is welcomed by NHSGGC, particularly given its invaluable insights into those three matters upon which the Inquiry sought comment, namely:

(i) how organisational issues relative to the reporting of patient safety concerns by staff of an NHS Board might be identified by an external observer or investigator;

(ii) the principles to be followed by an NHS Board in creating an effective system in which such concerns can be raised; and

(iii) the most effective changes which might be made by an NHS Board to create such an effective system in which such concerns can be raised.

[2] Sir Robert has been asked to consider a scenario put to him by Counsel to the Inquiry relating to the concerns raised by Drs Peters, Inkster and Redding following the opening of the QEUH/ RHC and thereafter. It is noted that Sir Robert, quite properly, does not propose any factual findings or offer comment on what was or might have been done in relation to those concerns.

[3] In relation to the scenario put forward, NHSGGC observes that its substance is drawn from the submissions of Counsel to the Inquiry, following the

conclusion of the evidence in the Glasgow III hearings. As before, NHSGGC accepts the factual narrative as set out to the extent that it provides a summary of some events which occurred and a timeline of those events but does not accept Counsel to the Inquiry's commentary on that narrative or Counsel to the Inquiry's position on, and criticism of, the NHSGGC witnesses.

[4] It is wholly accepted, as has been made clear in NHSGGC's closing submissions following the evidence in Glasgow III, that the concerns raised by Drs Peters, Inkster and Redding were relevant to the safety of patients and the use of the relevant hospital for that purpose. As ought to be clear from the evidence led during Glasgow III, these concerns and, importantly, their potential bearing upon patient safety, were concerns which were shared by all other NHSGGC staff and its board, without exception.

Peter Gray KC,

Emma Toner, Advocate

and

Andrew McWhirter, Advocate

11th August 2025

From: [redacted]
Sent: 11 August 2025 17:06
To: [redacted]; Hospitals Inquiry Information Requests; Hospitals Inquiry Legal Enquiries
Cc: Brandon Nolan; [redacted]; David Anderson; [redacted]; NSS.CLO-TeamC-SHI@nhs.scot
Subject: Scottish Hospitals Inquiry - Bundle 51 - Response by NSS - NHS S Assure

Dear [redacted],

In response to your email below seeking responses to Sir Robert Francis's Whistle-blowing Expert Report, I can advise that my client NSS NHS S Assure only wishes to clarify one issue, as follows:-

> " At para 240, the second last sentence says that Laura Imrie emailed Jason Birch NHS GGC. Laura did email Jason Birch, but he was part of CNOD in SG and not employed by NHS GCC."

Many thanks.

Kind regards

[redacted]

[redacted]

Law Society of Scotland Accredited specialist medical negligence law

Central**Legal**Office
Gyle Square, 1 South Gyle Crescent, Edinburgh. EH12 9EB

NHS National Services Scotland
Tel: [redacted] | [redacted]

From: [redacted]
Sent: 21 July 2025 16:08
To: demt[redacted]; legal[redacted]
Cc: brandon.nolan ; [redacted] scot;
David.Anderson[redacted] ; [redacted]
Subject: Scottish Hospitals Inquiry - Bundle 51

Good afternoon,

Glasgow 4 Part 3 hearings:

Please note that **Bundle 51; Sir Robert Francis Whistle-blowing Expert Report** will be uploaded to the Connect Workspace today. Please be advised that Bundle 51 comprises the Report prepared by Sir Robert Francis and the supporting documentation.

The period for response to the **Sir Robert Francis Whistle-blowing Expert Report** commences today, Monday 21 July 2025 with the deadline for response being no later than 11 August 2025.

Please note that all the information contained within this email and any released evidence is subject to Restriction Order No. 1.

Please do not hesitate to contact the Inquiry team should you have any questions or queries.

Kind regards,
[redacted]

[redacted] | Assistant Solicitor to the Public Inquiry into QEUH & RHCYP/DCN
[redacted] l www.hospitalsinquiry.scot
@ScotHospInquiry l Scottish Hospitals Facebook l Scottish Hospitals Inquiry

SCOTTISH HOSPITALS INQUIRY

Core Participants: the parents and representatives of the children and adults affected by their treatment at QEUH

Response to Sir Robert Francis Whistle-blowing Report

The patients and families welcome the observations made by Sir Robert Francis in his report. His comments and observations resonate with the evidence provided by the patients and families at the hearings.

We refer to the Closing Statement submitted following the Glasgow 1 hearings and adopt what was said in that Statement. Since this, further families have also joined the inquiry bringing forward important evidence in relation to adult cases.

The report has highlighted issues which the patients and families agree with, namely:

- Failures in the communications with patients and families
- Failures to act on staff concerns
- Defensiveness as opposed to being proactive
- Poor culture of management and staff relationships

The report flags up common themes from previous reviews, such as the reference to the Vale of Leven Inquiry. Patients and families have expressed the view that there is a continuing problematic culture at the hospital that prevents people, staff and patients and families alike, from speaking up if there a problem or concern.

The patients and families feel that the Hospital Board and Management must be open and honest with them about the risks to the patients and create a culture for staff and patients and families to have open, transparent conversations that will establish trust. This in turn will lead to the patients and families having a better understanding and being better informed.

Concerns have been expressed about the continuing culture at the hospital. Examples include David Campbell trying to seek reassurance that the hospital is safe today in terms of the water and the responses leaving him with a feeling that he is being dismissed. Some families have referred to a culture of fear amongst the staff which they have personally witnessed. They talk of feeling dismissed

and one mother talks of feeling separated from other patients and staff not engaging with them.

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Bundle 51 Volume 2

Substantive Core Participants Direction 5 Responses to Sir Robert Francis Whistle-blowing Report