Scottish Hospitals Inquiry
Glasgow 4 Part 3
Witness Statement of
Jeane Freeman OBE

Introduction

1. I am Jeane Tennent Freeman OBE. I am the former Cabinet Secretary for Health and Sport.

2. I provided Witness Statements to the Inquiry on 18 December 2023 and 23 February 2024. I provided oral testimony to the Inquiry on 12 March 2024.

3. I address the following in this statement:

- Background;
- Role of the Cabinet Secretary for Health and Sport;
- Awareness of water and ventilation system issues at QEUH/RHC after appointment as Cabinet Secretary for Health and Sport
- Retro-fit work at QEUH/RHC
- NHS Scotland Assure
- Whistleblowing
- Stage 4 of the Performance Escalation Framework and the Oversight Board
- Independent Review
- Case Notes Review
- Substantive Concerns about the procurement of the QEUH/RHC
- Conclusions

Background

4. I confirm that I was the Cabinet Secretary for Health and Sport from June 2018 to May 2021. I further confirm to the Inquiry that I had no involvement with the Queen Elizabeth University Hospital ("QEUH") or Royal Hospital for Children ("RHC") prior to my appointment, including as to whether any aspect of the water or ventilation system of the QEUH/RHC met relevant standards.

5. I pay sincere tribute to the patients, family members and dedicated NHS staff who supported every patient's journey and have been affected by the events being examined by this Inquiry, whether or not they have provided evidence to the Inquiry.

Role of the Cabinet Secretary for Health and Sport

6. I have previously provided evidence to this Inquiry as to the role of the Cabinet Secretary for Health and Sport and how I operated when I held that role. I refer the Inquiry to paragraphs 9 to 26 of my witness statement dated 18 December 2023, within which I set out the duties of Ministers, the Scottish Government and Health Boards in relation to the delivery of healthcare in Scotland. I do not repeat that evidence in full here but confirm that it applies equally to this section of the Inquiry's investigations. I will summarise the position as being that the Cabinet Secretary for Health is responsible and accountable to the Scottish Parliament for the safe and effective delivery of all health services across Scotland. Through that accountability, the Cabinet Secretary for Health is also responsible to the people who live and work in Scotland. The operation of the National Health Service in Scotland ("NHSS") is delegated to the Chief Executive of the NHS who is also the Director General for Health and Social Care ("DGHSC") in the Scottish Government.

7. I should make clear from the outset that, as Cabinet Secretary - a politician with responsibility for a Governmental portfolio - I asked questions of and relied heavily upon the expertise of my advisers, Directors and others within the Scottish Government and its agencies, through our regular meetings and their

briefings to me, on all matters related to the QEUH/RCN. This included technical issues that I have been asked to address within this witness statement, such as the standards set out in documents such as SHTM 03-01. I am not personally equipped with a background in engineering or building standards or possess specialist knowledge of Infection Prevention and Control. My evidence to this Inquiry should be read in that context. I was and remain hugely grateful to all Scottish Government colleagues and others who advised, supported and took leadership roles in addressing the situation that emerged in relation to the QEUH/RHC during my time as Cabinet Secretary.

8. The day-to-day operation of the safety of NHSS is delegated through the DGHSC/ Chief Executive of NHSS to individual health boards, including agencies such as National Services Scotland ("NSS") and Health Improvement Scotland ("HIS"), which are the two main agencies in terms of safe delivery of healthcare in Scotland.

9. The Cabinet Secretary for Health is also assisted by advice from clinical advisors including the Chief Medical Officer ("CMO"), Chief Nursing Officer ("CNO") and the National Clinical Director ("NCD").

10. I met regularly with the DGHSC, who is the strategic lead across the whole of NHSS, as well as the various Directors who operate within the Scottish Government's health directorates.

11. In relation to the QEUH/RHC, the CNO was the lead Director with responsibility for Infection Prevention and Control ("IPC") and that is because that role sits within the remit of the CNO.

12. I agree with the proposition that the Cabinet Secretary for Health and Sport is, in the eyes of the public of Scotland and the Scottish Parliament, responsible for the safe and effective delivery of hospital services within Scotland.

13. As will be clear, I was not the Cabinet Secretary when the QEUH was commissioned, procured and built. Prior to my appointment as Cabinet Secretary for Health and Sport, I had no role or knowledge in relation to any matter regarding the procurement and build of the QEUH (originally referred to as the "New South Glasgow Hospital" ("SGH")) nor can I comment on whether any previous Cabinet Secretary for Health and Sport had such responsibility or knowledge.

14. I refer back to evidence already before this Inquiry as to the role of the Scottish Government in the procurement of new largescale hospital building projects. The Scottish Government's role is to agree (or not) that the funding being asked for by a Health Board for a new hospital infrastructure project represents good value for money, in accordance with Scottish Public Finance Manual ("SPFM") and Scottish Capital Investment Manual ("SCIM") rules. I am aware that Mike Baxter (former Deputy Director (Capital Planning and Asset Management) within the Scottish Government Health and Social Care Directorate ("SGHSCD")) has already provided the Inquiry with evidence on this and would refer the Inquiry to him if any further questions in that respect arise.

15. Meeting those relevant standards is the responsibility of a Health Board's Chief Executive and Chair. Health Board Chief Executives are accountable to the DGHSC/ Chief Executive of NHSS. The Chair of the Health Board is responsible for ensuring that the Chief Executive of the Health Board is doing everything necessary to comply with the relevant rules that apply to any activity of that Health Board. The Chief Executive is the Accountable Officer. They are responsible for ensuring compliance with all health and safety regulations, safety standards in the delivery of healthcare, rules around public finance and how you spend it and account for it (per SPFM and SCIM, referred to above). The role of the Health Board Chair is to ensure that the Chief Executive is doing all of that. The Chair should make use of the Health Board's committees, internal/external auditors and their clinical advisory committee and medical director to ensure that all rules and regulations and standards are being met.

16. Similarly, prior to my appointment as Cabinet Secretary for Health and Sport, I had no formal or implied responsibility to ensure that new build hospitals funded by Scottish Government capital funding were built in a process that complied with HAI-SCRIBE procedures mandated by Scottish Health Facilities Note 30, nor can I comment upon whether any previous Cabinet Secretary for Health and Sport had such responsibility. At this distance removed, I cannot recall the specifics but, within the process of approval of finance for a healthcare infrastructure project, the Scottish Government would have had a reasonable expectation that HAI-SCRIBE was being met. I cannot recall how the Scottish Government assured themselves of that at the time. NHS Scotland Assure ("NHSSA") would have a role in relation to new-build hospitals now.

17. As I have said, I was not the Cabinet Secretary for Health & Sport when the QEUH was commissioned, procured and built, however, what I can say is that if it came to my attention, as Cabinet Secretary for Health & Sport, that the build of a hospital did not meet standards, then it was my responsibility to ensure that it became compliant in so far as possible. That was my rationale for not opening RHYCP/DCN, as set out in my previous evidence to this Inquiry. The QEUH/RHC, however, was different from the RHYCP/DCN because by the time the issues came to my attention, the QEUH was functioning with staff and patients and there was no alternative hospital facility to utilise in its place (as had been the case at RYCYP/DCN). In that case, as Cabinet Secretary for Health & Sport, if a hospital is not in compliance you have to seek information and take advice from the skilled advisers around you (CNO, CMO, CND and others) in order to understand in what way is it not complying, what (if any) risks are presented for patients and then work out how it can be retrofitted to make it compliant, in so far as possible. What is possible through retrofitting in an occupied hospital may be different from what is possible in a hospital that is not yet occupied.

Awareness of water and ventilation system issues at QEUH/RHC after appointment as Cabinet Secretary for Health and Sport

18. I took up my role as Cabinet Secretary for Health and Sport on 26 June 2018, I received a Briefing Note from Scottish Government Health Finance Directorate on 27 July 2018 **(Bundle 52, Volume 4, Document 4, Page 18)** which outlined the issues at QEUH/RHC as understood at that time. The content of the briefing note speaks for itself, so I do not repeat its terms here. Upon considering the Briefing Note I liaised with the CNO, who was directly engaging both with NHSGGC and Health Protection Scotland ("HPS"). The CNO had written to HPS on 11 June 2918 to confirm that The National Support Framework should be updated to ensure that a board "would be supported with management of any/ all subsequent incident(s)/ outbreak(s)/ data exceedance within the same ward/ area that occur while the original incident(s)/ outbreak(s)/ data exceedance is still under investigation". The Deputy Chief Medical Officer ("DCMO") had also chaired a call on 15 June 2018 with NHSGGC to discuss the situation as known to the Scottish Government at that time. Fiona McQueen would be able to assist the Inquiry on the detail in relation to this.

19. I have been asked when NHSGGC first disclosed to Scottish Ministers that, in its own assessment, Ward 2A as built did not meet SHTM 03-01 **(Bundle 27, Volume 7, Document 6 at Page 172)** and when NHSGGC first disclosed to Scottish Ministers that the air change rate for the whole QEUH/RCH was less than 6 ACH, as described in the 26 May 2016 email from Mr Powrie to Dr Inkster **(Bundle 20, Document 68, Page 1495)**. I cannot give the Inquiry a definitive answer to these questions. I am not sure whether NHSGGC did actually make such disclosures to the Scottish Government: it may be that this information first came to the attention via other sources.

20. I am asked to refer to paragraph 29 of my witness statement to the Inquiry dated 18 December 2023 **(Hearing Commencing 26 February 2024 - Witness statements - Volume 1, Document 8, Page 160)**. I am noted as saying that by September 2018 "all Board CEOs had been kept up-to-date with the ventilation and water issues arising at QEUH" and asked "What was the

information that had been passed to the Chief Executives of "all Boards", what the basis for providing that information and when had that information been given to the Scottish Government or NHS NSS?" Upon re-reviewing the detail, I may have had in mind here a briefing given by the then DGHSC, Paul Gray, when he met with the Chief Executives and Directors of Estates of all Health Boards in Scotland on 22 January 2019 to update them on the emerging issues at the QEUH and RHC and to seek assurances, in conjunction with Health Facilities Scotland, about the maintenance and testing of water and ventilation systems, as well as plant rooms within their acute estate. **(Bundle 13, Volume 4, Document 1, Page 5)**. Malcolm Wright, the subsequent DGHSC, has provided evidence to the Inquiry in relation to this (including that the Health Boards required to respond to NHS National Services Scotland ("NHS NSS")) and I can do no better than refer the Inquiry to that evidence and suggest that any follow-up questions be directed to him.

21. I am asked by the Inquiry about my interactions with Dr Peters and Dr Redding in the first three months of 2019. I described my interactions with Dr Peters and Dr Redding in my Supplementary Witness Statement for the Edinburgh III hearing and gave further oral evidence in this respect at the hearing on 12 March 2024. There is little more I can add to that.

22. I agreed to meet with Dr Peters and Dr Redding at the request of Anas Sanwar. They told me their roles and concerns. Their primary concern, at that point, was that they were not being listened to and also that they were being sidelined because they were raising those concerns. My next step was to discuss the issues raised with the CNO and DGHSC in order to see what could be uncovered and corroborated regarding the substance of their concerns. I was mindful that one cannot ignore people's perceptions of being ignored, sidelined and bullied.

23. That initial meeting with Dr Peters and Dr Redding was an informal confidential meeting - just me and them with no civil servants or notetakers in attendance. That was the start of ongoing engagement, including further meetings, with Dr Peters and Dr Redding, which did involve me but primarily took place through

my office and the CNO. The Inquiry will have been provided with copies of email exchanges and notes, including the CNO advising me of the outcome of her engagement on the issue. I then met Dr Peters and Dr Redding again once, or possibly twice, as we moved forward and commissioned the Independent Review ("IR") and the Case Note Review ("CNR") to ensure that they were kept up to date and given the courtesy and respect of that insight before it became public knowledge.

24. My recollection, albeit quite some time has passed, is that issues raised by Dr Peters and Dr Redding included concerns about the way that the Infection Prevention and Control Team ("IPCT") at NHSGGC had been operating for some time, particularly in respect of access to water testing results and microbiologists being asked to sign off HAI-SCRIBEs for work on ventilation systems. Issues were raised in relation to the ventilation system of Wards 2A RHC, Wards 4B, 4C and Infectious Diseases and isolation rooms throughout the hospital not being in compliance with relevant standards. Healthcare Improvement Scotland ("HIS") was commissioned by the CNO to undertake work to investigate this. I would defer to the CNO in relation to the detail of this but would observe that the results produced by HIS were quite shocking. In general, the results of the commissioned work indicated that what Dr Peters and Dr Redding were saying required further investigation, which led me to commission further work to develop a fuller understanding of what was going on. The report was extensive and it is worth noting that the unannounced inspection followed on from two previous inspections, in respect of which not all of the recommendations had been implemented. With specific reference to this 2019 report, there are aspects of what I would consider basic infection prevention and control highlighted as unmet and aspects of assurance that necessary procedures were carried out as required are not provided sufficient for a board to be assured in this area. Infection prevention and control is basic to creating a safe environment in both the physical aspect of this and the daily practice. It will not always be possible to prevent every infection in a hospital but the prioritisation of work and practice to minimise that risk must be of the highest priority. The HIS report is clear that, even in the context of ongoing infection issues in QEUH, this was not consistently the case.

25. The Inquiry has indicated that it understands that in 2019, following awareness of concerns regarding cryptococcus at QEUH/RHC, I sought assurance regarding the RYCYP/DCN ventilation system and asks what assurance I sought. I did seek assurance and actioned this by instructing the DGHSC to write to all Health Boards, as referenced at paragraph [20] above.

26. Upon becoming aware of concerns regarding cryptococcus at QEUH/RHC I was party to a meeting at the QEUH along with the then CMO (Professor Calderwood) and DGHSC, along with the Chief Executive, Chair, and Medical Director of NHSGGC and NHSGGC's newly appointed Head of Estates, at which they briefed us on what they were doing in relation to identifying where this infection had come from, in other words, how had an infection that was rooted in pigeon droppings found its way into a hospital and the consequent connection to two patients.

27. I clearly recall from that meeting being surprised that NHSGGC's medical director asked me why I was there and what this matter had to do with me. I came away from that meeting with a general impression of surprise and concern about NHSGGC's guardedness and down-playing of the importance of the situation, particularly in light of the then known issues and concerns about water and ventilation. In the background, for fuller context, were also broader concerns being raised by that time about the location of the hospital being close to waste disposal facilities at Shield Hall. My impression, at that time, was that there was a general "nothing to see here" response from NHSGGC.

28. I recall that there was an opening within a ventilation unit at the top of the building in the QEUH, which pigeons had gained access through. There was a discussion about the new Head of Estates addressing this through general maintenance, undertaking maintenance checks and ensuring that the Board allocated appropriate resource to undertake regular checks in relation to this issue. The DGHSC followed up on this in writing (referenced above).

29. I do not have any recollection of you being informed by NHSGGC or Scottish Government staff in late 2018 or early 2019 that the rooms where the two patients who contracted cryptococcus had been accommodated in the QEUH did not benefit from HEPA filtration of their air supply.

30. In my previous witness statement to the Inquiry dated 18 December 2023, at paragraph 34, I stated: 'The focus was on maintenance of existing estate because, at least in part, the issues arising at QEUH appeared to have been exacerbated or contributed to by inadequate maintenance performance'. The relatively recently appointed Head of Estates for NHSGGC, who I met at the meeting referred to above, indicated that his initial view was that the maintenance routine and rota was not as he would want it to be. That was the first time that I was aware that there may be an issue regarding general maintenance at the QEUH. One needs to understand that the maintenance of a hospital includes matters of significantly higher importance than, for example, the changing of lightbulbs. The maintenance team need to know what they are looking for when they do regular water and waste testing and when looking at the fabric of the building. There should be a maintenance rota that provides regular checks of both the external façade and internal workings of the building to provide assurance that it complies with all relevant standards. The Health Board needs to ensure that the content and frequency of that maintenance schedule are appropriate to the nature of each healthcare facility. For example, you would check water on a higher frequency in an acute hospital than you would, for example, in a health centre. For me as Cabinet Secretary, my understanding and appreciation of complexity and criticality of maintenance was significantly increased following that meeting.

31. In my previous witness statement to the Inquiry dated 18 December 2023, at paragraphs 123 to 125, I referred to the NHS NSS Review of: Water, Ventilation, Drainage and Plumbing Systems of the RHCYP/DCN dated 9 September 2019. At that point, I understood the ventilation issues within different parts of the QEUH/RHC, where vulnerable and immune suppressed patients were being cared for, would be different. With respect to the cancer ward for children, that this was inadequate. I understood much better than before how infection could

enter a hospital. I would also have been aware then of many of the issues around water supply and the actions the Board was taking to improve filtration of water.

32. The Inquiry may find it helpful to refer to various of the Ministerial Briefings that were prepared by Scottish Government officials and which have been provided to the Inquiry. For example, the briefing dated 17 January 2020 includes a helpful timeline of key developments, as known to the Scottish Government between 14 November and that date **(Bundle 52, Volume 1, Document 5, Page 29)**.

Retro-fit work at QEUH/RHC

33. I recall there being two main areas of significant retrofit in the QEUH/RHC: i) wards 2A/2B which included changes to the ventilation system and frequency of Air Change Rates ("ACR"); and ii) individual room areas including changes to sinks and, where necessary, showers in order to improve the water filtration system. In both of those cases, the retrofit required the decant of patients to another area, which inevitably reduces the number of new patients that can be admitted due to a reduction in the number of available beds. Additionally, there is the risk that any new work will in and of itself produce dust and disturbance, which may leak into spaces/areas where there are patients, thereby producing potential Infection Prevention and Control ("IPC") risks, for example such as risk of respiratory infection. These retrofits can never be risk free when patients are there. Even with the best measures, you cannot eliminate all dust (as an example) in a retrofit situation. As such retrofitting is inherently risky because patients receiving healthcare in a hospital are vulnerable to infection simply by being there. That risk of infection is then compounded when these patients are immunosuppressed and vulnerable because of their specific condition. In those circumstances the risk of retrofitting can be substantial.

34. I did not receive, at that time, any explanation from NHSGGC as to why it had taken the length of time it did from the hospital opening to identify and put in hand changes to the patient environment in the Schiehallion Unit in general and specifically to its ventilation system.

35. In relation to the need to retrofit at the QEUH/RHC I had a range of concerns. I was concerned about the fact that these changes were needed in the first place. I was nervous about whether retrofitting would meet the standards given that these standards were not met initially. I was concerned about the impact upon patients and staff from the works being completed (from the inevitable upheaval and reduced available bedspace through to management of IPC and clinical risk). I was also concerned that appropriate steps would be taken to ensure that, even on a temporary basis, the intended location for decanted patients had the right level of ACR. My over-riding concern to be sure, with the benefit of advice from my experienced advisors, that every step was being taken to understand and minimise the risks.

36. I have been asked to expand on paragraph 177 of my Witness Statement to the Inquiry dated 18 December 2023, where I commented 'that retrofitting does not work for something as critical as ventilation. I had seen that on the QEUH project'. Retrofitting applies when patients are *in situ*. RHCYP/DCN had no patients *in situ*. What I learned from the QEUH/RHC situation was that you would not choose to admit patients (to what in the case of the RHCYP/DCN was then an empty hospital) and then retrofit. The QEUH was not in that situation because it was a major fully operational hospital. It was necessary to fix the problem, so the only way to do that was to retrofit and manage all of the additional factors that come with a retrofit situation. This is something that the NHS have extensive experience of managing across older parts of the NHS estate. But you would not choose to put patients into a new hospital and then retrofit when the option was available of ensuring that such a major system as ventilation met the appropriate standards when that new hospital was still empty. The retrofit situation in the QEUH/RCN led to the situation where not only were some patients decanted, but also some patients were admitted to other parts of NHS estate in other health board facilities for their treatment.

That is clearly not a situation that was in any way desirable or acceptable in the context of a new multi-million pound 'state of the art' hospital.

37. I made inquiries, through my own staff, of NHS NSS, the Oversight Board ("OB"), NHS GGC as to the extent to which it would be possible to carry out works to the ventilation systems of the QEUH/RHC to bring them up to the required standards for a new build hospital (which I understand to be those described in SHTM 03-01 at the relevant point in time). I should make clear that, as Cabinet Secretary - a politician with responsibility for a Governmental portfolio - I asked questions of and relied heavily upon the expertise of my advisers through our regular meetings and their briefings to me, including upon technical issues such as the standards set out in documents such as SHTM 03-01. I am not personally equipped with a background in engineering or building standards. My evidence to this Inquiry should be read in that context. I was regularly speaking with and seeking advice from the CNO and also seeking advice from HIS and NHS NSS on their assessment of the adequacy of the works planned or undertaken by NHSGGC. I also received advice from the OB once that had been set up. The OB was set up as a result of concern as to the seriousness of the issues and the escalation of NHSGGC to Stage 4 of the NHS Board Performance Framework ("the Framework"), discussed further below. The OB gave me a direct channel of advice and direction I wouldn't otherwise have. I was able to get additional input from the OB once it had been established; up until that point my primary advisors were NHSNSS, HIS, and the CNO. The OB and NHSGGC's Board had to take a view on what to prioritise in relation to works to be carried out – air change rates not meeting the standard across the hospital is not unimportant, but the priority had to be the wards and rooms housing the most vulnerable patients, whether adults or children. Consideration had to be given to the order of that and is reflected within the TOR of the OB.

38. I am asked why, before leaving office as Cabinet Secretary, did I not order retrofit or remedial work to the ventilation system or an investigation into how such a step could be taken at the QEUH/RHC to ensure that, as was then the case at the Edinburgh hospital, the ventilation system throughout this hospital

was in compliance with the relevant statutory regulation and other applicable recommendations, guidance and good practice? I think that when Wards 2A and 2B were retrofitted, and maybe Ward 4A too, they went beyond the requirement of the standard in place when the hospital was built. From memory, Jane Grant told me that they were going beyond the standard in place when QEUH was built but I cannot recall whether that applied anywhere else or not (I would need to see what was being said at the time, as well as what the OB was saying). The general point is, though, that the situations in Edinburgh and Glasgow were very different, because the issues at RHCYP/DCN were discovered before the hospital became occupied with patients and staff, whereas the issues at the QEUH/RHC did not come to light until the hospital was fully functioning and occupied. This meant that the course of action available at RHCYP/DCN, i.e. delay the opening of the hospital and fix all the problems while the hospital was unoccupied, was not available in relation to the QEUH/RHC.

NHS Scotland Assure ("NHSSA")

39. I have previously provided the Inquiry with evidence in relation to the reasoning for creation of NHSSA, with the intention that it would provide additional assurance that NHS infrastructure projects would be built in compliance with relevant statutory regulation and other applicable recommendations, guidance and good practice. I set out to the Scottish Parliament why it was needed, it then went into the Scottish Government's manifesto and then it was set up. I was not involved in the setting up of NHSSA. Civil servants carried out work to scope this out, along with its possible responsibilities and powers, in anticipation of the 2021 Scottish Parliament election results, in order to brief a future Cabinet Secretary and Government on this body. This work would have been carried out by Civil Servants because all parties were in agreement about the need for this body, so it would likely have been established regardless of government being elected. I am not able to comment upon any steps taken since I left office by the Scottish Government or NHSSA to provide the greater scrutiny and assurance I thought should be in place.

40. The Inquiry has asked “If as set out in the Inquiry’s Provisional Position Paper 13 **(Bundle 26, Document 3, Page 168)** it is the case that a decision was made a few days before contract close in 2009 that the QEUH/RHC would be built with ventilation that was not in compliance with SHTM 03-01 in respect of air change rates, that this derogation was not subject to a risk assessment in the manner envisaged in SHTM and that this derogation was not disclosed to Scottish Minsters in the Business Case or at remaining Gateway stages to what extent do you think that the new NHS Assure system would be able to stop a similar event happening in a future hospital procurement?”. I would hope that this would be the case; this was the intention when I set out the proposal in the Scottish Parliament for the creation of the new body, but I am not in a position to comment on how NHSSA operates in practice. Before I left office, I stated publicly that a body like NHSSA should be established for reasons I already explained.

Whistleblowing

41. I described my interactions with Dr Peters and Dr Redding in my Supplementary Statement from the Edinburgh III hearing and my evidence to that hearing on 12 March 2024. In my Supplementary Statement I set out how the information from Dr Peters and Dr Redding and others impacted upon decision-making regarding RHCYP/DCN. The information I received from Dr Peters and Dr Redding from January to June 2019 had a significant impact on the actions I took in respect of the QEUH/RHC: firstly, in seeking to verify the extent and degree of concerns expressed to me; and then in pursuing the various decisions and actions that I did take to try to ensure that the necessary improvements for patient safety were taken timeously and also that the Health Board’s governance and communications were significantly improved.

42. The meetings I attended with the whistle-blowers and the meetings I held with families had the biggest impact on me. I also separately met some of the families who didn’t want to be in the larger group meeting. As I discussed in my previous evidence to the Inquiry, putting Professor White in place was intended to improve transparency and communication of the NHSGGC Board,

including two-way transparent communication with families and full compliance with the statutory duty of candour, in light of NHSGGC's continued apparent "nothing to see here" attitude together with their expressed view that relatives were not up in arms and bothered, and that it was simply the FB group that was causing bother.

43. I also met with staff who cared for these patients. One of the striking things about meeting families was that they had no criticism of staff because these staff had no knowledge of what was going on. So, the families were doubly cross about not being told what was happening, but also that trusted clinicians and other hospital staff who cared for patients could not answer their questions. The meetings highlighted to me that the Board was failing in their organisational duty of candour; and individual clinicians were being hampered in the exercise of their individual duty of candour as a result of not being provided with relevant information.

44. It was equally clear that the Board did not accept a failure of their statutory duty of candour and did not have the necessary approach and historical practice to have open and transparent communications with patients and families, which I firmly believed was absolutely critical. That is why I decided to ask Professor Craig White to act, because of his previous roles and experience in the Scottish Government and experience in relation to duty of candour, because he is an expert in this area. Professor White is well-versed in open and transparent communication, which is why I asked him to take this role on in terms of dealing directly between the Board and families. I am aware that there has been some criticism made by other witnesses to the effect that my involvement and intervention in relation to communications caused delay and indeed prevented the NGHGGC Board from effectively communicating with patients, families and staff. I don't believe that it caused any delay or prevented communication. It required the Board, with Professor White's assistance, to communicate frequently and with transparency; and it provided the Board with the tools to do so.

45. Around this point in time I also appointed Professor Marion Bain as a new Medical Director to deal with IPC. I understand that she is providing evidence to the Inquiry about what she did. I also appointed Calum Campbell to assist NHSGGC in response to the situation at the QEUH. He was brought into the role of Turnaround Director in NHSGGC, to directly manage operational delivery (see my letter to Lewis Macdonald MSP dated 24 January 2020 – **Bundle 52, Volume 6, Document 1, Page 3**). He reported to the Chief Executive of NHSGGC from a governance perspective and also reported to the DGHSC (through the NHS National Performance Oversight Group) on all matters pertaining to the recovery plan. He brought many years of relevant experience to the situation, having begun his career as a nurse before moving to management and senior leadership roles - he had held Director posts in Wales and Scotland before serving as Chief Executive at NHS Borders and then NHS Lanarkshire. He became Chief Executive at NHS Lothian in June 2020 (and retired in June 2024). I was clear in that letter that the arrangements I put in place (which also included the establishment of a Performance Oversight Group chaired by NHS Scotland's Chief Performance Officer, with a focus on performance recovery) were intended to allow the Chief Executive of NHSGG to focus on the strategic direction of the board and provide the visible leadership required to address the infection control at the QEUH and RHC and related issues. I was clear that this approach did not involve the exercise of any statutory power by Ministers and the Board of NHSGGC would retain oversight of all business of the Health Board.

46. In summary, having heard the concerns of patients, families and staff, I took steps to ensure that the best resource available was made available to NHSGGC and also to provide me with advice and assurance. I discuss this further below in relation to escalation and the OB.

Stage 4 of the Performance Escalation Framework and the Oversight Board (OB)

47. NHSGGC was escalated from Stage 2 in the Framework to Stage 4 on 2 November 2019. The Inquiry has already received detailed evidence on the purpose and operation of the Framework from Malcolm Wright and Fiona McQueen, so I do not duplicate that here. In short, the Scottish Ministers are responsible for NHS Scotland in accordance with the National Health Service (Scotland) Act 1978 ("the 1978 Act"). The Framework is a performance management tool used by the Scottish Ministers to meet their statutory duties under the 1978 Act.

48. At Stages 1 and 2 of the Framework, the relevant policy lead within the Health and Social Care Directorates is responsible for deciding whether a health board should be escalated and, if so, to what Stage. At Stages 3 and 4, the decision is taken by the DGHSC. Any decision to escalate to Stage 5 of the Framework is made by the Cabinet Secretary for Health. Any decision to escalate or de-escalate a health board to a different Stage on the Framework is made with the advice of officials from different Health and Social Care Directorates. In relation to stages 3, 4 and 5, the decision maker's principal adviser is the Health and Social Care Management Board ("HSCMB"), as explained by Malcolm Wright at paragraphs 15 and 16 of his statement dated 18 December 2023.

49. In the period leading to the decision to escalate NHSGGC to Stage 4, I was receiving updates on the situation from the DGHSC, CNO and other advisers. I also met the NHSGGC Chair, Chief Executive and Board, although I cannot recall the date of that. The decision to escalate to Stage 4 was formally made in terms of the Framework by the DGHSC, Malcolm Wright. The DGHSC's decision to escalate NHSGGC was informed by the HSCMB, which met to discuss the potential for escalation on 22 November 2019. At that meeting the HSCMB considered a paper prepared by the CNO, Fiona McQueen, entitled "Consideration of Escalation", dated 21 November 2019 **(Bundle 52, Volume 1, Document 6, Page 34)**. The paper sets out the CNO's concerns in relation to Hospital Acquired Infections ("HAI") and IPC at QEUH and her recommendation for escalation. In particular, it says:

> "Based on the most recent discussion at the National Performance Oversight Board there is no evidence to suggest a systemic issue at NHSGGC which would require whole system escalation beyond stage 2. However given the concerns about the delivery of a safe and effective service for paediatric haemato/oncology in-patients, and the significant risks to public confidence in the delivery of the wider service, the recommendation is that NHSGGC is escalated to level 4 for IPC issues, and as such, external, expert support is sought (IPC, as well as communications and engagement) and an oversight board is established, chaired by the CNO".

The CNO prepared this paper as the concerns raised fell within the "policy" areas of the CNO Directorate.

50. The DGHSC consulted me on the intention to escalate NHSGGC to Stage 4. I wanted to go to Stage 5 because NHSGGC appeared to be refusing to accept the idea that there was an issue; and I remember asking the DGHSC why he would not escalate to Stage 5. His view was that escalation to Stage 5 would mean the dismantling of the Board and the level of disruption and uncertainty of the wholesale dismantling of a Board the size of NHSGGC would carry significant risk for effective operation of health services well beyond the QEUH/RHC (i.e. across the whole of the estate and services operated by NHSGGC). I ultimately accepted the recommendation that Stage 4 was sufficient for the DGHSC and the Scottish Government to do what was required in order to provide support to and receive assurance in relation to steps to be taken by NHSGGC specifically in relation to the QEUH/RHC.

51. I am asked by the Inquiry whether it might assist a future Cabinet Secretary if legislation gave Scottish Ministers to remove only the executive board members of a Health Board and leave the non-executive board members in place. I don't see how that would assist. Executive members of health boards are employed by the Health Board and, even if there were to be a move to one single NHS employer, that would not be Scottish Ministers.

52. On 22 November 2019, the DGHSC escalated NHSGGC to Stage 4 of the Framework. A copy of the DGHSC's letter to the Chair and Chief Executive of NHSGGC is produced at **(Bundle 52, Volume 1, Document 23, Page 310)** It sets out:

> "In light of the on-going issues around the systems, processes and governance in relation to infection prevention, management and control at the QEUH and the RHC and the associated communication and public engagement issues, I have concluded that further action is necessary to support the Board to ensure appropriate governance is in place to increase public confidence in these matters and therefore that for this specific issue the Board will be escalated to Stage 4 of our performance framework."

53. I am asked why the escalation had not taken place earlier. That would primarily be a question for Malcolm Wright, as the person appointed in terms of the Framework to make a decision to escalate to Stage 4 on the Framework. I would observe, however, that escalation is a serious matter with a number of significant implications that require to be fully considered. It is wise to take a measured approach to deciding what is required and, in the process of making that decision, to give the Board time to come to the view that they need to take specific actions. The level of escalation is a balance between the seriousness of the issue against the measured assessment of what the Board needs most, be that support or direction. In all but the most extreme circumstances, it is not a decision to be reached quickly.

54. I still saw resistance from NHSGGC following escalation to Stage 4 and a sense that they were being unfairly dealt with; and I did not see their attitude changing when the OB were in place. That made the interventions set in train, both in terms of the work of the OB and other steps taken to provide support to the NHSGGC Board and assurance to the DGHSC and me, more challenging.

55. The remit and authority of the OB was set out in its Terms of Reference ("TOR") **(Bundle 52, Volume 1, Document 4, Page 24).** The OB was formally convened at the direction of the DGHSC/Chief Executive of NHSScotland, further to his letter of 22 November 2019 to the Chairman and Chief Executive of NHSGGC. The Oversight Board first met on 27 November 2019, when it considered and finalised its draft terms of reference, which were then approved by the DGHSC following discussion with me. I agreed that the CNO should be appointed to chair the OB because in her role as CNO she was one of my most experienced and senior advisers and, in particular, she had significant experience in relation to IPC and HAI, which were within her policy brief.

56. The purpose of the OB was to support NHSGGC in determining what steps were necessary to ensure the delivery of and increase public confidence in safe, accessible, high-quality, person-centred care at the QEUH/RHC and to advise the Director General that such steps had been taken. In particular, the OB was tasked with seeking to:

a. ensure appropriate governance was in place in relation to infection prevention, management and control;
b. strengthen practice to mitigate avoidable harms, particularly with respect to infection prevention, management and control;
c. improve how families with children being cared for or monitored by the haemato-oncology service had received relevant information and been engaged with;
d. confirm that relevant environments at the QEUH and RHC were and continue to be safe;
e. oversee and consider recommendations for action further to the review of relevant cases, including cases of infection;
f. provide oversight on connected issues that emerge;
g. consider the lessons learned that could be shared across NHS Scotland; and
h. provide advice to the Director General about potential de-escalation of the NHSGGC Board from Stage 4.

57. The OB was to agree a programme of work to pursue the objectives described above. In doing so, the OB was expected to establish sub-groups with necessary experts and other participants, with remits set by the chair of the OB, in consultation with OB members. The OB was to receive reports and consider recommendations from the sub-groups.

58. In line with the NHSScotland escalation process, NHSGGC was expected to work with the OB to construct required plans and to take responsibility for delivery. The NHSGGC Chief Executive, as Accountable Officer, continued to be responsible for matters of resource allocation connected to delivering actions agreed by the OB. NHSGGC representatives were invited and expected to attend OB meetings in order to provide the OB with any information it required and also, importantly, to listen and learn from the support and guidance the OB was able to offer.

59. The OB members were expected to adopt the National Performance Framework ("NPF") and NHSScotland values in their delivery of their work and in their interaction with all stakeholders. The OB's work was also to be informed by engagement work undertaken with other stakeholder groups, in particular family members/patient representatives and also NHS GGC staff.

60. The TOR made clear that the work of the OB was to be focused on improvement, with OB/sub-group members ensuring that a lessons-learned approach underpinned their work in order that learning would be captured and shared both locally and nationally.

61. The TOR set out various objectives for the OB:

- improve the provision of responses, information and support to patients and their families;
- if identified, support any improvements in the delivery of effective clinical governance and assurance within the Directorates identified;
- provide specific support for infection prevention and control, if required;
- provide specific support for communications and engagement; and

- oversee progress on the refurbishment of Wards 2A/B and any related estates and facilities issues as they pertain to haemato-oncology services.

Matters unrelated to the issues that gave rise to escalation were assumed not to be in scope, unless OB work established a significant link to the issues set out above.

62. In order to meet these objectives, the OB was tasked with retrospectively assessing issues around the systems, processes and governance in relation to infection prevention, management and control at the QEUH/RHC and the associated communication and public engagement; having identified these issues, it was to produce a gap analysis and work with NHSGGC to seek assurance that issues had already been resolved or that action was being taken to resolve them; compare systems, processes and governance with national standards and make recommendations for improvement and how to share lessons learned across NHSScotland. The issues were to be assessed with regard to the information available at the particular point in time and relevant standards that were extant at that point in time. Consideration was also to be given to any subsequent information or knowledge gained from further investigations and the lessons learned reported.

63. I am asked by the Inquiry, in particular, whether the OB had the authority to direct NHSGGC to act or prevent it from acting or to act on behalf of NHSGGC and, if such powers of action were not given to the OB, why not. I think it is clear from the TOR, as noted above, that the role of the OB was to work with NHSGGC to seek assurance that issues identified in the OB's GAP analysis had been resolved or that action was being taken by NHSGGC to resolve them. It was not the role of the OB to stand in place of NHSGGC or control it to make it act or prevent it from acting in a certain way. At Stage 4 of the Escalation Framework, as I mentioned above, NHSGGC's Board was still in place and its Chief Executive was still it's Accountable Officer. NHSGGC was still responsible for the delivery of healthcare. As I have already mentioned, the TOR made clear that NHSGGC representatives should attended the OB

meetings as observers, but were not members of the Oversight Board; they attended for purposes of providing information and receiving the support available to them through the expertise of the OB. The appointment of, for example, Marion Bain as NHSGGC's Director of IPC, provided further additional support directly to NHSGGC and also provided the OB and me with the assurances we sought. Had NHSGGC not co-operated with the OB and failed to provide it with the assurances it sought then, depending on the nature of the failure, consideration might have had to be given to escalating NHSGGC further on the Framework. As I have already mentioned, Stage 5 of the Framework, which would be invoked only in the most extreme circumstances, results in the responsibility for the provision of healthcare being removed entirely from a territorial health board and assumed by the Scottish Ministers. Very serious as the situation was at the QEUH/RCH, it was not considered necessary or proportionate to move NHSGGC as a whole to Stage 5, with all that would entail, in order to deal with the issues at the QEUH/RHC.

64. Once the OB had been established, I had regular update meetings with the CNO as chair of the OB - at least weekly but more frequently if there was something that she wanted to discuss with me. From time to time, I would also receive written briefings from CNO, the purpose of which was also to keep me up to date. The CNO was also regularly reporting to the DGHSC, with whom I also regularly met. I was satisfied that the OB was fulfilling its TOR, so had no cause to raise any concerns in that respect with either the CNO or DGHSC.

65. I did have concerns as to what I saw as a continued reluctance of NHSGGC to act in a way consistent with its organisational duty of candour and co-operate fully with the work of Professor Craig White in that respect. I discussed that with the CNO and also with the Chair and Chief Executive of NHSGGC directly. Ultimately these discussions with NHSGGC led to a satisfactory outcome, but the issue with NHSGGC was that, in those discussions, almost without exception, the Chair would seek to reassure and convince, and the CE would rarely say anything. We'd reach an agreement about what they were going to do, but that would not necessarily be what they did. By way of example: NHSGGC's whole attitude in dealing with relatives of children was that they

maintained a view or approach that there was nothing of substance to parents' concerns that they were not being communicated with effectively; that it was simply a small number of parents causing trouble. In my view, this attitude did not leave that Board at any point. I think that we probably got to a place where they suppressed it and grudgingly did what we were asking them to do. That was their view for other things like whistle-blowers too. The approach was one of "nothing to see here and no need for all of this".

66. As I should be clear to the Inquiry, the OB was not responsible for the operations of NHSGGC. At all times, NHSGGC remained responsible for its operations. The OB was responsible for the actions it required to take to meet its TOR. As explained above, the OB had clear set of terms in the TOR, with knowledge of which its members agreed to be members. In carrying out those TOR, individual members may be independent of the Scottish Government but still working to a set of TOR agreed by a Cabinet Secretary. So, in that respect, you could equate it to the Scottish Hospitals Inquiry itself – the Inquiry is established by a Scottish Minister, but Inquiry Chair is independent and reports to the Scottish Parliament. It may be important to say that the CNO, like her colleagues the CMO and NCD, are senior officers within the Scottish Government, but also have a set of professional standards that they are required to meet independent of any requirements of the Scottish Government. For example, if I ask the CNO/CMO to do something, it must be in conformity with the professional standards from their professional regulators like (Nursing and Midwifery Council, General Medical Council, etc.). These professional advisors are unlike Civil Servants in that regard. Professional advisors such as the CNO/CMO must meet their own professional standards at the same time as what you are asking them to do; they advise and report to you and are accountable to you, but they are one step removed from you, which makes their role quite unique and special.

67. The TOR of the OB make clear that the OB was accountable to the DGHSC. As already explained, the role of the OB was to seek and obtain assurance from NHSGGC. It did not have the power to direct NHSGGC to do or prevent it from doing things. I did not have the power to direct NHSGGC to act in a particular manner through the OB. The Cabinet Secretary has no power to direct the NHS Board or its Chief Executive because they are accountable to the DGHSC/Chief Executive of NHSS. A Cabinet Secretary can appoint or otherwise require actions of a Board Chair. In that sense, I had no power to direct NHSGGC to take particular actions. This is one of the reasons why, when the Covid pandemic occurred, I triggered emergency powers under the 1978 Act, which allowed me to direct the health boards – without these emergency powers the Cabinet Secretary cannot direct health boards. My role was to ensure that the OB was meeting its TOR and, if there was anything additional that I wanted the OB to do in fulfilment of its TOR, to ask the OB to do it; but I cannot direct either the OB or NHSGGC.

68. I am asked to what extent I "would accept that, by December 2019, the Scottish Government knew that at that time (a) the question of whether the PPVL isolation rooms in the QEUH/RHC were suitable for immunocompromised patients remained a live issue, (b) that it remained unclear the extent to which the ventilation systems of the QUEH/RHC had been validated, (c) that the ventilation of the general wards of the QUEH/RHC did not provide 6 ACH as stated in SHTM 03-01, (d) no risk assessment had been carried out in respect of the air change rate for the general wards of the QUEH/RHC, (e) no HAI-Scribe had been completed for the construction of the QUEH/RHC and (f) the ventilation system Ward 4C did not meet the air change rate, pressure differentials and requirement for HEPA filtration set out for a 'Neutropenic Ward' in SHTM 03-01". In so far as the question relates to the Scottish Government's state of knowledge, I can only speak to my knowledge as Cabinet Secretary. As I have indicated previously, by December 2019 I was aware of a number of concerns related to the construction and maintenance of the hospital. By that time, through the actions of the DGHSC (with my support as Cabinet Secretary), NHSGGC had been escalated to Stage 4 of the Framework and the OB was appointed, primarily, to provide governance support in relation to the

delivery of IPC at the QEUH/RHC. The Scottish Government relied upon information provided to it by NHSGGC and others. I asked questions of NHSGGC, HPS, NHS NSS, the OB and others in order to have as full information as possible available both to me and to the patients/families, staff, wider public. It was neither the responsibility of the Scottish Government, nor within the remit of the OB, to directly undertake the type of investigations/technical reviews necessary to obtain the information lists in this question – factual information was sought and obtained from NHSGGC together with specialist input from others with relevant expertise. The Final Report of the Oversight Board, dated 22 March 2021, **(Bundle 6, Document 36, Pages 795-921)** contains a very detailed timeline detailing "incidents" of infection, what was done to investigate those incidents and the measures taken to mitigate harmful consequences. A timeline describing the actions of the different organisations involved in responding to those incidents was also prepared by the Scottish Government and provided to the Inquiry as part of its May 2023 s21 Notice response **(Bundle 6, Document 37, Page 922)**.

69. I am asked by the Inquiry about what steps were taken by the Scottish Government during the Stage 4 process variously to ensure that the water and ventilation systems of the QEUH were then in compliance with relevant statutory regulation and other applicable recommendations, guidance and good practice; ensure that the operation of the IPCT within the QEUH/RHC was being carried out both in compliance with the National Infection Prevention and Control Manual and to the satisfaction of both myself and HPS/ARHAI. NHS NSS and HIS were commissioned to check and report on the water and ventilation systems, which they did. As explained previously, I met regularly with the CNO as Chair of the OB throughout the period of NHSGGC being at Stage 4 of the escalation process and was satisfied with the work of the OB. Professor Marion Bain was appointed to be NHSGGC's Director of IPC as part of the Stage 4 supports in order to provide senior-level support to NHSGGC and assurance to the OB and me in that respect.

70. The OB produced an Interim Report and Final Report **(Bundle 6, Documents 35 and 36, from Page 700)** containing local recommendations in respect of

Governance and Risk Management, and Communications and Engagement. I was content, in the circumstances, with these recommendations and thought they adequately addressed the issues that caused the Oversight Board to be established. By "the circumstances" I refer, in no small measure, to the fact that by the time the OB reported we were in the Covid-19 pandemic. The Oversight Board met on 19 February 2020, but then did not meet again in person until 4 September 2020. During this period, Covid-19 spread to mainland Europe and then our shores, so the whole NHS in Scotland had to adapt and re-focus to meet the threat, which became the pandemic. The UK Covid-19 Inquiry has ingathered a large body of evidence on what required to be done, including from me, the CNO, CMO and others, on what had to be prioritised during this time. Suffice to say that, to very significant extent, those responsible for the safe delivery or IPC across Scotland (a number of whom were members of, or attended, the OB) had to dedicate their time to the Covid-19 response. Whilst the OB did not meet in person, it did continue with work on a remote basis and I did receive updates. A Peer Review was established and the findings were compiled into a report. A copy of that report is produced at **Bundle 52, Volume 1, Document 7, Page 45**. On 13 May 2020 officials provided me with an update on the progress of the Oversight Board being undertaken remotely. A copy of that update is produced at **Bundle 52, Volume 1, Document 8, Page 75**. On 4 September 2020 the Oversight Board held its first meeting since February 2020. A copy of the minute of that meeting is produced at **Bundle 49, Document 9, Page 38**. As has been said on many occasions, the Covid-19 pandemic was unprecedented and its impact, including upon available specialist government healthcare and NHS resource, was wide-reaching. One impact was that the OB did not progress its work in the traditional way that might have been anticipated, through regular in person meetings, however, other ways of working were adopted to adapt to the circumstances that presented.

71. I am not aware of what steps NHSGGC have taken to implement each of the separate recommendations of the 'Local Recommendations' of the OB. As the Inquiry is aware, I left the office of Cabinet Secretary and the Scottish Government in May 2021.

Independent Review

72. As the Inquiry is aware, I commissioned the Independent Review in response to the concerns arising from the QEUH/RHC. I established the Independent Review because I thought the situation sufficiently serious and the concerns sufficiently considerable such that it was in the public interest to seek an Independent Review, with the view to understanding what had happened and what was required to be done, both then and, importantly, in the future. Everyone was saying that the QEUH has not been right since it was built and there was nothing to do but tear it down to fix it. It seemed to me that the only way to take this forward was to have the whole situation independently reviewed - from design, through procurement, to build - to try to understand (and get us past the "he said she said" situation, which was not going to resolve anything). That is what they were asked to do. The issues being raised were so serious that you couldn't dismiss them; and at the same time you are dealing with evidence of infection and work needing to be done to improve the build because it did not meet standards, so taking all of that together, in a major public hospital (the largest hospital in Europe), it was clearly in public interest to have that looked at, which is why I commissioned the Review.

73. I consider that the Independent Review had sufficient authority to carry out its work. Likewise, I am satisfied the Independent Review adequately dealt with the concerns arising from QEUH. It dealt with the concerns it was asked to address: design, procurement and build. It was not asked to address individual cases where patients had died or been harmed where relevance of infection required to be considered; that is why I commissioned the independent Case Note Review ("CNR"). In my view, the authors fully met the remit they were given and reasonably, in my view, expressed a view on the basis of that work with respect to the impact on infection prevention and control. They did not consider or comment on, specific cases.

74. The Independent Review was a non-statutory review and reported (see para. 1.6.6 of their Report- **Bundle 27, Volume 9, Document 11, Page 145**) that there were documents it could not obtain. I had given consideration to

establishing the Independent Review using powers under section 76 and Schedule 12 of the National Health Service (Scotland) Act 1978 but, on balance, took the view that I wanted the work to begin as soon as possible. I had every expectation that all material they wanted to look at would be made available to them, especially from public bodies, and could see no good reason why that would not happen. This comes back to the Organisational Duty of Candour. In considering the question of whether to have a statutory or non-statutory review, the difference is the power to compel, but downside of setting it up on a statutory basis is the length of time it can take to establish. I wanted the review to begin quickly and had no reason to think they required power to compel when they were looking for material from bodies who had an Organisational Duty of Candour. An Inquiry under section 76 might have produced a more complete report than that of Independent Review and might well have produced a faster response than this Inquiry, but if that was the route to be chosen it might be that the TOR of the section 76 Inquiry would have been broader, so it is hard to say with certainty what the outcome of that hypothetical would have been.

75. When the Independent Review produced its report, the whole of the health service and Scottish Government was dealing with a global pandemic, so I do not believe that there were other actions that could practically be taken at that point.

Case Notes Review

76. I established the CNR because I considered it necessary and appropriate for individual cases to be looked at. The purpose of the Case Note Review was to investigate how many children and young people with cancer, leukaemia and other serious conditions were affected by infection caused by Gram-negative environmental bacteria at the QEUH and RHC between 2015 and 2019. In relation to those children found to have been affected, the Case Note Review was to determine, as far as is possible, whether those incidences of infection were linked to the hospital environment. The Case Note Review was also tasked with characterising the impact of the infections on the care and outcome

of the patients concerned. I wanted the Case Note Review to provide patients and families with a professional and independent view as to the cause of the infection(s) that they or their family member(s) had been affected by.

77. The decision was made by the Chair of the CNR to have the CNR established in such a way that the individual reports, explaining why the Overview Report reached the conclusion it did on infection link, are confidential to the patients and their families and were not made available to NHSGGC. My understanding is that the data set used by the expert panel was provided by NHSGGC. The approach and methodology adopted by the Case Note Review expert panel is set out in the Overview Report.

78. I am asked "To what extent would you accept that the decision to ensure that individual reports that explain why the Overview Report reached the conclusion it did on infection link were confidential to the patients and their families and were not made available to NHSGGC has now made it possible NHSGGC to reject the conclusion of the Case Notes Review and attempt to persuade the Inquiry, the patients and the families that there was no link between all but two of the infections in the Schiehallion patient cohort and the hospital environment?". Firstly, it is my recollection that NHSGGC did accept the findings of the Overview Report when it was first produced, so I suggest that it is for NHSGGC to explain why they could accept findings of Report without sight of individual cases but now feel unable to do so. Secondly, I would mention that the person who chaired the CNR and wrote the report, Professor Mike Stevens, had significant credentials both in terms of his qualifications and experience. He undertook the Morcombe Bay Inquiry and other inquiries into situations where children/babies have been harmed as a result of action or inaction in a hospital environment. My role was to have him appointed and agree what he would look at, i.e. the TOR. Having done that, it was then for Professor Stevens to decide who would assist him, how he would do so and who to share results with. I don't think that not "seeing the workings" justifies NHSGGC's change of heart. The standing of Professor Stevens is such that we should be prepared to accept his findings.

79. I am asked "To what extent would you accept the criticism that this structure of the CNR that was selected in January 2019 has had the effect of resulting in a situation where around 30% of the patients who received a report from the CNR indicating that a link between their infection and the hospital environment was "probable" might well have anticipated receiving an appropriate duty of candour acknowledgement from NHSGGC for that connection, but now have not done so as a consequence of the position of NHSGGC?" I do not accept this proposition. There is a statutory duty of candour and that should be exercised in all instances.

80. The CNR report was published in March 2021. I would not expect NHSGGC to reject the conclusions of the CNR. I would expect them to accept the conclusions of the CNR and take whatever actions were required, both in relation to patients and families of those individual cases and to ensure that they are or have taken all steps to ensure no repetition of the circumstances that led to the situation in those individual cases. Sadly, given the overall approach of NHSGGC, I am not the least bit surprised that they have taken this stance now.

81. I am not aware of whether, by the time I left office, NHSGGC had completed actioning the recommendations of the CNR, although, to re-state, I am aware that they accepted the conclusions of the CNR in full at the time. I expect that they accepted them all because they didn't want to have a row with me. I find it genuinely shocking that the findings of Professor Mike Stevens are in question given his high standing in relation to child healthcare.

Substantive Concerns about the procurement of the QEUH/RHC

82. I am asked "What impact do you consider the change of funding model change from private-partnership procurement model to a standard procurement model had on the management of estates and facilities within the new hospital, particularly as it effected the safe operation of the water system? How can such an impact be prevented or the risk of any such impacted be prevented in future

projects?". I'm afraid that I am not an expert in procurement, so cannot assist the Inquiry in this respect.

83. I am asked "Had the Scottish Government known of the ventilation derogation proposed in the ZBP Ventilation Strategy Paper dated on or around 15 December 2009? (Please refer to **Bundle 16, Document 21, Page 1657**) and recorded as agreed in the M&E Clarification Log. (Please refer to **Bundle 16, Document 23**, **at the foot of Page 1664**) should and would the Scottish Government had required compliance with SHTM 03-01 in the design and construction of the proposed hospital before approving the final business case?" Again, I don't know the answer to the first question and in relation to the second, I would assume so. In approving the final business case, the Scottish Government assumes that what is about to be built will meet all legislative and other standards required. The purpose of NHS Scotland Assure is to avoid assumptions and provide assurances.

84. I am asked by the Inquiry "aware that NHSGGC declined an offer by NHS Assure to visit wards 2A and 2B after refurbishment? If so, would this approach restrict the ability of NHS Assure to achieve the aim you mention? Would it suggest to you the continuation of a 'nothing to see here' approach?" I have not been in government since May 2021 and therefore am not aware whether NHSGGC refused an offer from NHS Assure as described. I am also not aware of any reasons that may have been offered for that refusal.

85. I am asked "At paragraph 4.6.6 of the Independent Review, it states 'In turn, the balance shifted toward achieving the "BREEAM Excellence" target instead of air change rates that met NHS guidance standards.' What action, if any, has been taken to avoid such issues in future builds?" I'm not equipped with the technical detail, but I think the setting up of NHSSA would be part of the action taken - less presumption and greater evidence-based assurance.

86. I am asked “During the period you were Cabinet Secretary what consideration was given to seeking mandatory compliance with SHTM in respect of new healthcare projects?” I don’t know the answer to this. If it was considered, it would have been considered by NHSNSS and perhaps officials in Scottish Government Health Finance.

Conclusions

87. I think that, as Cabinet Secretary, I took all reasonable steps at the time to ensure that all concerns raised in respect of QEUH/RHC were addressed. The Inquiry has asked “what prevented me from removing or replacing the appointed NHSGGC Board members to ‘ensure a fresh start’”. The Cabinet Secretary can only appoint or remove non-executive board members. An NHS territorial board will also have local authority appointments and may also, depending on the Board, have a senior Director within its membership. I did give consideration to the non-executive Board members and whether or not I felt, during my time, that they were undertaking their roles with the level of scrutiny and challenge that I required. I met the Board and made it clear to them what my expectations were, but I was also conscious that many of the issues had a historic component pre-dating their terms of office. There was nothing in their actions that indicated to me that they as individual non-executive Board members were unwilling to undertake the steps that I required of them. I therefore did not consider it reasonable at that point in time to create instability and uncertainty by removing them and replacing them. Taking such a step would not be an action that would be completed quickly. A couple of them didn’t like what I had to say to them to the extent that they said that they would resign. I said I’d be happy to accept their resignations but they didn’t tender any.

88. As to the Inquiry’s follow-up question as to whether removal/replacement of the Board members “would this have ensured clearer lines of accountability for issues with QEUH/RHC at Board level” – I don’t think so. Lines of responsibility are clear regardless of which health board it is or what issues they are dealing with.

89. Finally, I am asked by the Inquiry whether I consider that there are now appropriate measures and check points in place to prevent the issues seen in QEUH/RHC from happening with future health care projects and, if so, why. I consider that the creation of NHSSA goes someway to provide that assurance, but I cannot comment on performance or behaviour of individual health boards at this point. NHSSA could be doing everything that I'd hope but if you have a health board that has a poor, non-challenging, non-scrutinising, culture then you could be faced with similar problems again.

Declaration

I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

The witness was provided the following Scottish Hospital Inquiry documents for reference when they completed their questionnaire statement.

Appendix A

A43293438 - Bundle 6 - Miscellaneous documents

A47193110 – Bundle 13 – Miscellaneous Documents – Volume 4

A47851278 - Bundle 16 - Ventilation PPP

A48408984 - Bundle 19 - Documents referred to in the Quantitative and Qualitative Infection Link expert reports of Sid Mookerjee, Sara Mumford and Linda Dempster

A48946859 - Bundle 20 - Documents referred to in the Expert Reports by Andrew Poplett and Allan Bennett

A49585984 - Bundle 25 - Case Note Review Expert Panel, Additional Reports, and DMA Canyon

A49615172 - Bundle 26 - Provisional Position Papers

A50002331 - Bundle 27 - Miscellaneous Documents - Volume 7

A50125560 - Bundle 27 - Miscellaneous Documents - Volume 9

A53429115 - Bundle 49 - Oversight Board, Advice and Assurance Review Group (AARG) and Healthcare Improvement Scotland (HIS)

A34216901 – Bundle 52, Volume 1 – Miscellaneous Documents

A47231435 - Scottish Hospitals Inquiry - Hearing Commencing 26 February 2024 - Witness Statements - Volume 1

The witness provided the following documents to the Scottish Hospital Inquiry for reference when they completed their questionnaire statement.

Appendix B:

A34216901 – Bundle 52, Volume 1 – Miscellaneous Documents

A50967356 – Bundle 52, Volume 1 – Miscellaneous Documents

A41416821 – Bundle 52, Volume 1 – Miscellaneous Documents

A34264952 – Bundle 52, Volume 1 – Miscellaneous Documents

A44685543 – Bundle 52, Volume 4 – Miscellaneous Documents

A54051182 – Bundle 52, Volume 6 – Miscellaneous Documents