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

Witness Statements – Volume 1

Table of Contents

Scottish Hospitals Inquiry
Witness Statement of
Michael ("Mike") Baxter

Introduction

1. My name is Michael (Mike) Baxter. My details are known to the Inquiry. I have already provided the Inquiry with witness statements dated 20 April 2022, 14 February 2023 and 4 April 2023 and gave a full day of oral evidence at a hearing on 16 May 2022. I am providing this further statement in order to assist the Inquiry with its understanding of the Scottish Government's role in relation to the procurement and construction of the QEUH/RHC (referred to throughout my statement as "the Glasgow Project").

2. In this statement I shall cover:
    a. Role within the Scottish Government
    b. Outline Business Case and Funding
    c. Procurement
    d. The Capital Investment Group ("CIG")
    e. Design and compliance with SHTMs
    f. Feedback or follow-up issues with the OBC and FBC for the QEUH/RHC
    g. Role on NHSGGC's committees
    h. Building Research Establishment Environmental Assessment Method (BREEAM)
    i. Miscellaneous

Role within the Scottish Government

3. As I have outlined in my previous statements, I have been a qualified accountant since 1992, having qualified through the Chartered Institute of Public Finance and Accountancy (CIPFA). I also hold a BA (Hons) degree in business studies.

4. The detail as to my historical employment by the Scottish Government in a number of finance related roles is already a matter of public record, so I do not repeat it here in detail. In summary, between August 2002 and 15 February 2009, I was employed as the Head of the Private Finance and Capital Unit within the Scottish Government Health and Social Care Directorate ("SGHSCD"). As I explained in my witness statement dated 20 April 2022, in this role I was responsible for the capital budget for the NHS and private finance policy. I reported to David Hastie, who was then Deputy Director (Capital Planning and Asset Management) within the SGHSCD. As part of this role, I was also a member of the Capital Investment Group ("CIG"), the remit and workings of which, again, I have already provided detailed explanation in my witness statement dated 20 April 2022 and in the full day of oral evidence I gave to the Inquiry on 22 May 2022. For convenience, I would reiterate that my key responsibilities included:
   - Preparing, allocating and monitoring the capital budget for the Health Directorates and NHSScotland.
   - Leading on the development of Spending Review capital investment strategy input for health.
   - Reviewing and approving capital investment plans within Local Delivery Plans.
   - Development of appropriate procurement methodologies to support capital investment.
   - Providing direct advice to Ministers and Senior Officers on capital and Public Private Partnerships ("PPP") related matters as they affect Health.
   - Providing advice and support to NHSScotland in their development of infrastructure investment proposals and procurement in accordance with the Scottish Capital Investment Manual ("SCIM") https://www.pcpd.scot.nhs.uk/Capital/scimpilot.htm **(Bundle 3, Volume 2, Document 33, Page120).**
   - Developing and updating appropriate guidance in support of infrastructure investment.
   - Reviewing Business Cases for Infrastructure investment and providing advice to the CIG on capital related matters.

5. I was subsequently appointed to the role of Deputy Director (Capital Planning and Asset Management) within the SGHSCD and held this position between 16 February 2009 until the end of December 2014. The Capital Planning and Asset Management team were responsible for Health, Infrastructure, Investment, and Public Private Partnerships, as they applied to the National Health Service for Scotland ("NHSS"). As Deputy Director, I was responsible for the Scottish Government's infrastructure investment policy for the area of health and social care. Further detail on the specific responsibilities of that role is detailed in my previous statement dated 20 April 2022. Of most relevance is that, as Deputy Director, I was Chair of the CIG. The Director at that time was John Matheson, who was Director of Finance and Information within SGHSCD.

6. My involvement in relation to matters relevant to this Inquiry ended in December 2014.

7. At the point in time when I joined the SGHSCD in 2002, discussions were ongoing around the Acute Services Review ("ASR") that had been undertaken by the then Health Board, NHS Greater Glasgow ("NHSGG") between 1998 and 2001. The ASR had identified that there were significant challenges to the sustainability of the then configuration of healthcare services across Glasgow **(Bundle 48, Document 5, Page 297).** It recognised the need to improve, create more efficient and effective patient pathways and modernise aspects of the healthcare estate. The ASR was, essentially, the rationalisation of the hospital estate and configuration of healthcare services in Glasgow. The ASR culminated in NHSGGC's Acute Services Strategy ("ASS"), which was approved by the Scottish Government's then Minister for Health and Community Care, Malcolm Chisolm, in 2002.

8. I was not directly involved in any of the discussions about the ASR in 2002, but I understand that the discussions were focused on the high-level configuration and delivery of healthcare services in Glasgow rather than the finer details of matters, such as any new building design or procurement in relation to that.

9. As I also explained in my witness statement of 20 April 2022, my former colleague, Norman Kinnear, was heavily involved at the earlier stages of the QEUH project. He was the Scottish Government's PPP Facilitator and Major Capital Projects Advisor. He left Scottish Government in around December 2011 and sadly passed away a number of years ago. Norman used to attend Project Board meetings for all major investment projects, including the QEUH. When Norman became ill, I started attending those in an observer capacity, however, cannot recollect specific dates. Scottish Government representatives attended project board meetings in an observer capacity given their roles in the approval of projects as members of the CIG.

The Capital Investment Group

10. As I explained in my earlier statements, and as has been noted within the Inquiry's Interim Report in relation to the RHCYP/DCN at Chapter 10, the Scottish Ministers' oversight of healthcare infrastructure projects was conducted via the business case review process undertaken by the CIG. That process is an iterative one and involves regular dialogue between those within the Scottish Government Health Directorates ("SGHD") the health board, Scottish Futures Trust ("SFT") (for revenue funded projects), Health Facilities Scotland ("HFS"), Health Protection Scotland ("HPS") and others. As I explained in my statement dated 20 April 2022, the CIG received advice and support on planning, procurement, construction and facilities management issues from NHS National Services for Scotland ("NHS NSS") and the SFT. The CIG also obtained advice from relevant clinical and policy colleagues, as appropriate depending on the nature of the services to be provided from the facilities in question. As I explained in my oral testimony, I was also supported by some of my staff within my division, particularly on Finance and by Norman Kinnear. Norman was originally brought in from the NHS and had experience of delivering healthcare infrastructure projects. We had clinical input; we had analytical input in terms of the option appraisals that were done as part of the business cases; we had representation from Finance because the implications of these projects weren't simply about capital but about revenue and cost; and

we had representation from performance management who had an overview of the performance of NHS boards and their operation. We also had representation from the Chief Medical Officer's Office and Chief Nursing Officer, depending on the nature of the issues being discussed at any given time. As such, there was a very wide-ranging degree of input, providing a holistic view on business cases rather than simply concentrating on the finance. There was no engineering or architectural expertise on the CIG, however the CIG, through me or my Team, would have sought advice from Health Facilities Scotland on any queries raised by an NHS Board or from the content of a business case where an issue required clarification or advice.

11. The ultimate role of the CIG is to provide advice to the Director General that the conditions of the Scottish Capital Investment Manual ("SCIM") have been complied with **(Bundle 48, Document 3, Page 136).**

12. Standing the passage of time, I am reliant upon documentary evidence to refresh my memory as to what was discussed, with whom and when. I am, therefore, not, at this distance, able to recall detail beyond what is stated in the Minutes to relevant meetings of the CIG. I have not repeated the wording of Minutes of the CIG within this statement, as they speak for themselves.

Outline Business Case and Funding

13. My first direct involvement in the Glasgow Project began in around 2007 with the provision, through the CIG, of review and support of NHS Greater Glasgow and Clyde ("NHSGGC") in the development of their Outline Business Case ("OBC").

14. As I have explained in my earlier statements and oral testimony, health is devolved in Scotland and SGHSCD is responsible for the delivery of health and social care, through NHS Scotland's delivery arm, which is formed of 22 Scottish Health Boards. The Scottish Government's Health Finance Directorate (now the Health and Social Care Finance Directorate) is responsible for administering the capital healthcare budget for all 22 Health Boards in Scotland,

which includes financial approval of large healthcare projects over the Health Board's delegated financial limit. At that time, the delegated limit was £5m (see Hearing commencing 9 May 2022 – Bundle 4 – Single Bed Derogation, Document 11, Page 146) I can't recall the earlier version extant in 2007 but can recall that £5m was the limit for all boards; there was no differentiation based on size of NHS Board). The ultimate responsibility for the delivery of these projects lies with the relevant NHS Health Board.

15. I have explained the operation of the CIG at paragraphs 10 to 50 of my statement dated 20 April 2022 and expanded upon this in my oral testimony given on 16 May 2022. As I have explained, business cases for projects above Health Board delegated financial limits are reviewed by CIG at different stages of a project's lifetime to ensure, amongst other things, that health needs are appropriately met by the development proposed by the Health Board and that the development is affordable. This process is conducted in accordance with the SCIM.

16. The OBC was finalised by NHSGGC in February 2008. It represented phase 2 of the ASR. The purpose of the OBC was to set out the preferred proposed option for the new integrated Children and Adult Hospital and a new laboratory built on the site of the then Southern General Hospital. As with the discussions around the ASR, the OBC did not go into extensive detail about the proposed design of the building, or exact procurement model that would be used. Instead, the OBC set out a shortlist of service options alongside the cost, risk and benefit of each, in order to assist in the identification and validation of the preferred service option and how that would be delivered.

17. There would have been discussions between NHSGGC and the Scottish Government prior to and during the submission of the OBC as part of regular engagement on the capital programme and development of the OBC. I have no recollection of specifics except in relation to the consideration of the financing route, in relation to which I had a number of discussions with Douglas Griffin, the then Director of Finance for NHSGGC. This was in connection with the modelling of a PPP against a public capital option and the impacts on

NHSGGC's financial plans and affordability. I cannot recollect any dates or exchanges specifically.

18. NHSGGC's OBC for the Glasgow Project was appraised by the CIG on 14 March 2008. Prior to the OBC reaching the CIG, it had been assessed and approved by NHSGGC through its internal governance processes. Additionally, the OBC was subject to a Gateway Review, which was an independent review commissioned by the Scottish Government. I can't recall the detail save to say that the Gateway Review process was overseen by the Scottish Government Programme and Project Team and that, under Gateway Review, the reports are prepared for the Project Senior Responsible Officer (Robert Calderwood NHSGGC's Chief Executive) and shared with the DG Health and Social Care.

19. The CIG plays a vital role in providing assurance to the Scottish Ministers and the SGHSC Management Board, that proposals from Health Boards are robust, affordable and deliverable. The CIG is the vehicle through which that assessment is made prior to it being considered by the Scottish Cabinet (if necessary). The CIG recommended that the Scottish Cabinet should approve NHSGGC's OBC.

20. Following consideration by the CIG, the OBC was submitted to Cabinet of the Scottish Government with a recommendation for approval in April 2008. There was an oddity about this OBC because it should have been presented to Cabinet by the then Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon, but instead went to the then Minister for Public Health, Shona Robinson, due to the proposed Glasgow Project being built in Nicola Sturgeon's constituency, Glasgow Govan.

21. I prepared, with input from SGHD colleagues, a briefing paper for Cabinet, which provided a summary and explanation of the content of NHSGGC's OBC **(Bundle 48, Document 7, Page 308).** At this time, there was quite a lot of discussion around the proposed procurement and funding model for the Glasgow Project due to a number of challenges and changes to the financial

environment. These challenges, as detailed in my earlier evidence to this Inquiry, were related to the 2007-2008 financial crisis and the ensuing 36.5% real term reduction in capital funding available to the Scottish Government arising from the UK Government's Comprehensive Spending Review ("UKCSR"). Additionally, as explained to the Inquiry before, there was also a change to the balance sheet classification of Non-Profit Distributing ("NPD") model funding as a result of the guidance on Managing Government Deficit and Debt ("MGDD") associated with the application of the European System of Accounts 95 ("ESA95"). The changes to these accounting rules meant that, if the Glasgow Project were to proceed with public funding, then it would need to be through public capital funding.

22. The then challenges and changes to the financial environment were key considerations in the decision that the Glasgow Project would need to proceed with public capital funding. As the Inquiry has already heard, independent advice was obtained by NHSGGC from EY (previously known as Ernst & Young), which assessed various models for proceeding. NHSGGC selected and took forward the option recommended by EY[1].

23. The briefing prepared for Cabinet took account of a value for money and affordability analysis comparing the public capital funding option against a non-profit distributing model option. Overall, the public capital funding option was calculated as providing best value to the public purse, per the Scottish Public Finance Manual, because the additional revenue cost of the public capital funding option stood at £53.4m per year as compared to £76m per year for the non-profit distributing option. On that basis, the briefing paper to Cabinet recommended that it approve the CIGs recommendation of NHSGGC's OBC, with the consequence of an additional net capital funding of £108m over six years being provided by the Scottish Government; and for NHSGGC to proceed to procurement.

[1] Inquiry document reference for EY report not found, however, EY report referred to and summarised in Bundle 17 page 1811-1813

24. On 8 April 2008, the Scottish Cabinet accepted the CIGs recommendation and approved NHSGGC's OBC. The only stipulation that the Scottish Government had in relation to the OBC was that any movement in anticipated costs of more than 10% would require the Health Board to prepare an updated OBC. The Scottish Government provided the Glasgow Project with priority for capital funding despite the change in the allocation of funding to the Scottish Government as a consequence of the UKCSR. The cost of the Glasgow Project was more than a third of the total capital budget for the NHS in Scotland over several years, so was a significant investment. The Scottish Government was nonetheless satisfied that the Glasgow Project was affordable based on the assumptions set out in the OBC.

25. The Scottish Government's approval of the OBC permitted NHSGGC to proceed to procurement and develop a full business case ("FBC").

Procurement

26. Following the OBC being approved by Cabinet in April 2008, NHSGGC proceeded to procurement and continued its development work of the preferred service option for the Glasgow Project.

27. The Glasgow Project proceeded as a design and build project under the National Engineering Contract Three ("NEC 3"). This was entered into between NHSGGC and Brookfield Construction (UK) Limited ("Brookfield") on 18 December 2009.

28. I understand that NEC 3 was the contractual model of choice for the Glasgow Project because of its mechanism for sharing risk between the contracting authority and the contractor. I had limited direct involvement in the procurement or contractual arrangements in relation to the Glasgow Project. Norman Kinnear would have been the lead Scottish Government interface on the project at the time that those discussions/ decisions would have taken place. NHSGGC were the contracting authority for the Glasgow Project and retained responsibility throughout. Decisions for NHSGGC were made through their

Performance Review Group ("PRG") through delegated authority from the Board (see **Bundle 34** for PRG papers). HFS might provide the Inquiry with any further technical input it requires in relation to NEC 3 as the body responsible for overseeing Framework Scotland, which was the national framework for agreements surrounding public capital projects within the NHS in Scotland.

29. NHSGGC provided the Scottish Government with periodic updates on their progress of work, the selection of bidders and the progression of the contract. As part of my then role as Deputy Director, I would hold fairly regular meetings with Douglas Griffin, the then Director of Finance at NHSGGC, to review NHSGGC's financial and capital position. These meetings with Mr Griffin formed part of the wider duties of my role as Deputy Director in terms of oversight of the financial position of NHS Health Boards in Scotland in relation to their capital budgets, as opposed to any responsibility specifically related to my role as Chair of the CIG.

30. I was part of the New South Glasgow Hospitals and Laboratory Project Executive Board ("NSGHLPEB") for the Glasgow Project in an observer capacity only. The NSGHLPEB was set up by the NHSGGC Performance Review Group (an internal NHSGGC group that I was not party to) on 19 May 2009 **(Bundle 34, Document 21, page 145 at page 153)**. That decision is recorded at Item 32 of the Minutes of 19 May 2009 **(Bundle 34, Document 20, page 134)** and the Paper (Report of NHSGG's Director of Acute Services Strategy, Implementation and Planning – Paper No. 09/21) referred to therein at Item para 2.3-2.5 **(Bundle 34, Document 20, Page 147).** That Paper included Terms of Reference for the NSGHLPEB together with the proposed membership **(Bundle 34, Document 20, Page 147 at Appendix 2, Page 152).** I was listed in this document as a voting member of that group. I do not recall seeing the Terms of Reference for the NSGHLPEB or having been consulted on the text of this. I was not present at the meeting of the NSGHLPEB on 1 June 2009, which was attended by Norman Kinnear and I cannot recall seeing papers in advance of that meeting. Given my role as Chair of CIG and consequent involvement in a number of projects at the time, it was not

appropriate that I should be a voting member of the NSGHLPEB. This was addressed on 7 December 2009, when I attended the NSGHLPEB, having raised the issue in advance as a result of having had sight of the draft papers (**Bundle 42, Volume 2, Document 17, Page 85 at Pages 86-91**). As such, my attendance at the NSGHLPEB was always as an observer. My role was to track the development of the project in terms of cost to the Scottish Government and published timescales to ensure that it remained within the tolerance that had been set by the Scottish Government in terms of the overall capital budget for the NHS in Scotland. I did not have any professional expertise beyond that limited finance remit or any decision-making role on the Project Board.

Site Selection

31. The plan for the Glasgow Project was for the triple co-location of adult, children and maternity services. My direct knowledge of the discussions that NHSGGC had in relation to the site selection are limited to the information that would have been contained in the OBC and, latterly, the full business case ("FBC"). From memory, the Scottish Government's involvement in any discussions around site selection would likely have been handled by their Performance Manager who, at the time, was Carmel Sheriff or other colleagues within the Scottish Government's Performance Management Division as well as by David Hastie the then Deputy Director (Property and Capital Planning).

32. From the high-level knowledge that I do have, I recall there being a natural gravitation from NHSGGC towards the Southern General site because a maternity hospital had recently been built there and another hospital in the vicinity within Govan was due to be replaced through the ASR. The reconfiguration of services in Glasgow, especially with the reduction in standalone hospital sites, also led to discussions about the appropriate split of healthcare services between the north and south of Glasgow. This site offered triple co-location of maternity, children's and adult care. These factors, together with the availability of space on the Southern General site, seemed to be the rationale for building the Glasgow Project there.

33. I recall reading a discussion paper addressing the sewage works in the vicinity of the Southern General site. I do not recall any of the finer details around this and was certainly not involved in any discussions or decision making concerning this.

Design

34. The design team for the Glasgow Project was appointed in March 2009. The design for the Glasgow Project was prepared by Nightingale Associates, with construction carried out by Multiplex, who had previously undertaken major infrastructure construction projects, such as Wembley Stadium.

35. I was part of programme board meetings where NHSGGC provided progress updates on design. My role was that of observer. There was no basis for me to engage in this role upon matters of technical design given my remit. I would refer the Inquiry again to my professional qualifications and particular governmental interest in finance. Other witnesses from NHSGGC/NSS would be better placed than I to provide information on design.

36. I understand that the Inquiry may be interested in the content of certain Chief Executive Letters ("CEL"). I have already provided evidence to the Inquiry as to certain CEL's that I am named within. My name is on CEL 19 (2010) because it relates to capital investment and I was policy lead in relation to that, however those CELS were developed by colleagues in the hospital acquired infection teams in the Chief Nursing Officer's Directorate. I had no direct involvement in the development of that guidance.

37. I understand that the Inquiry is interested in the selection and installation of taps within the QEUH. As an accountant, I cannot speak to that. I understand that the Inquiry has or is seeking evidence on this from those with relevant expertise within Health Facilities Scotland.

38. As far as I was aware at the relevant time, the design processes were followed as intended and the Glasgow Project was delivered on time and within budget.

There were no issues flagged by NHSGGC to the Scottish Government during the business case process. As I have mentioned, I left my post as Deputy Director in December 2014, so the first time that I was aware of issues raised with the built environment of the Glasgow Project was through what was reported publicly within the press.

Full Business Case

39. NHSGGC's FBC **(Bundle 37, Document 42, Page 562)** was considered by the CIG on 9 November 2010 **(Bundle 48, Document 10, Page 332).** As with the OBC, this represented the final stages of review following consideration of the FBC through NHSGGC's internal governance structures and external Gateway Reviews. The Scottish Government's approval of the FBC was an essential stage in allowing the Glasgow Project to proceed to construction.

40. The FBC is a detailed document that sets out the agreed commercial arrangements for a project. The FBC was developed within the final procurement stage. The role of the CIG was to examine the extent to which the FBC matched national, regional and local priorities set out in Local Delivery Plans and associated Property and Asset Management Strategies; and to provide assurance to the Scottish Government that all aspects of the business case were appropriate, affordable and achievable.

41. My recollection is that, whilst the FBC would have been formally submitted by NHSGGC to the CIG on 22 October 2010 and comments were expected and provided from the CIG by 3 November 2010, there had been prior engagement with the CIG on the FBC development through presentations given by NHSGGC colleagues, including Helen Byrne (from memory). I cannot recall the specifics of this given the passage of time but it would have been typical for draft documents to have been provided by a health board and reviewed by the CIG's members prior to finalisation of the document. I would also add that a timetable for business cases was submitted to the CIG so that there was awareness of when business cases were due for submission and review, so that appropriate work could be planned by CIG members **(Bundle 48,**

Document 9, Page 330, Bundle 52, Volume 1, Document 20, Page 278 and Bundle 48, Document 10, Page 332).

42. I am asked whether NHSGGC disclosed the ventilation derogation recorded in the M&E Clarification Log **(Bundle 16, Document 23, at the foot of Page 1664)** and proposed in the ZBP Ventilation Strategy Paper dated on or around 15 December 2009 **(Bundle 16, Document 21, Page 1657)** within the FBC or to the CIG in any other way; and had they disclosed it would it have been discussed, considered, approved or challenged by the CIG at that time. I can confirm that there was no such disclosure. Had any such disclosure been made, technical advice would have been sought from HFS on the implications of any such derogation and, on the basis of that advice, issues raised with NHSGGC prior to any approval.

43. It is recorded in the meeting minutes of 9 November 2010 **(Bundle 48, Document 10, Page 332)** that I recommended that the project be considered via expedited procedures once the outstanding issues were resolved. I believe that there was a further check required on the financials in the FBC but cannot recall the specifics. Expedited procedures meant that when there were outstanding issues these would be recorded and dealt with via correspondence with the relevant CIG members. This allowed consideration to be closed out without having to wait for the next formal CIG meeting. Any such issues should have been minuted at the following meeting as either being resolved or not.

44. Norman Kinnear prepared a briefing paper for the Minister for Public Health and Sport dated 9 December 2010, within which it was recommended that the FBC be approved **(Bundle 52, Volume 1, Document 21, Page 284).** I cannot recall any issues being raised by the Minister. Had there been any these would have been in written form from the Minister's private office.

45. Similar to the process for the OBC, the FBC was submitted to Cabinet for Scottish Government approval, together with the briefing paper. The purpose of this briefing paper was to, amongst other things, confirm that the proposals set out in the FBC were in line with the phased construction contract signed

between NHSGGC and Brookfield in December 2009. It was recommended that Cabinet approve the FBC. This was subsequently supported by Cabinet **(Bundle 48, Document 12, Page 341).**

Design and compliance with SHTMs

46. I understand that the Inquiry is considering derogations from standards within the contract for the Glasgow Project. There were no derogations from standards referred to within the OBC or FBC. I do not recall any derogations being proposed/ sought or forming any part of any discussions at the CIG or taking part in any decision-making about any proposed derogations. Any derogation from technical standards would have required input from HFS and appropriate input from the Chief Medical Officer's Directorate. I do not recall any instances when HFS were consulted on this during the business case process. I cannot comment on the engagement between NHSGGC and HFS on these issues in the development of the project.

47. As I was not sighted on any discussions around derogations from standards, I cannot add anything materially to the Inquiry's understanding of them. What I can say is that any request to the Scottish Government for derogation from air change standards set out within SHTM03-01 would likely have to have been considered and, if appropriate, signed off by the Chief Medical Officer ("CMO"). The CMO would likely have to take advice from HFS, who the Scottish Government would refer to for matters of technical expertise. The standards set within SHTM03-01 are informed by expert clinical and technical input (which is outwith my field of expertise), but my understanding is that the SHTM stipulates the standard that the Scottish Government expects to be delivered for patients in new build hospitals, so if a health board has any intention to derogate from the standard (i.e. not to provide this for its patients) the Scottish Government would expect to be informed of this through the final business case process in order that it can consider whether the derogation sought is acceptable. Mandatory requirement 7 of CEL 2010 19 and the narrative on page 38 of that document covering the Activity Database ("ADB") and that the application of the tool would mean design would be compliant with guidance.

The Scottish Government was not made aware of any derogation from the standard set out for air changes within SHTM03-01 being sought by NHSGGC in relation to the QEUH. No information was presented to me personally or through the NSGHLPEB or CIG. The evidence that I have already given to the Inquiry in relation to my expectations (flowing from the mandatory application of ADB in the design quality policy CEL 2010 19, referred to above) that derogations from standards should be pro-actively brought to the attention of the Scottish Government by the health board as part of the FBC apply equally to the Glasgow Project. NHSGGC did not bring the derogation to the attention of the Scottish Government (either directly to me or by raising it at the NSGHLPEB or CIG) and, as such, the Scottish Government did not have the opportunity to consider it. Agreement from the Scottish Government to any derogation sought would be subject to taking and receiving appropriate technical advice.

48. In my witness statement for the hearing commencing 9 May 2022 **(Hearing Commencing 9 May 2022 - Witness Statement Bundle, Document 5, Page 83)** I discuss at paragraph 111 onwards the issues around compliance with SHTM. I am asked what the consequences would be if an NHS Board failed to comply with a CEL, SHTM or any other legalisation, regulation or guidance in a project that required approval by the CIG. In short, a business case would not have been approved until such matters had been satisfactorily resolved, assuming any such issues had been properly disclosed.

49. I am asked to what extent the Policy on Design Quality for NHS Scotland applied to either of the OBC or the FBC for the QEUH/RHC; did the 2006 Edition apply **(Bundle 3, Volume 1, Document 4, Page 113)**; and what impact did it have on compliance with guidance such as SHTM. The mandatory requirements set out in the 2006 policy would have applied to the OBC and the 2010 requirements to the FBC. The mandatory requirements set out in the 2006 and 2010 policies with regard to use of the Activity Database (and through that design to be compliant with SHTM's) were consistent.

50. I am asked what the relationship was between either of the 2006 or 2010 versions of the Policy on Design Quality for NHS Scotland at the OBC or the FBC for the QEUH/RHC; and whether the Glasgow project underwent the NHS Scotland Design Assessment Process ("NDAP") process either based on the 2006 version **(Bundle 3, Volume 1, Document 4, Page 113)** or 2010 version. As above, the mandatory requirements of the 2006 and 2010 policies were consistent. There is explicit reference in section 6.7 of the OBC to the requirements of the 2006 Design Quality policy and in section 6.9.7 to entering an agreement with Architecture and Design Scotland to deliver on design quality ambitions. I cannot recall whether the NDAP process was applied to the FBC (it would not have applied to the OBC as the OBC predated this requirement).

51. A design derogation from standard policy (such as single room configuration) should have been flagged at OBC stage. Detailed design on ventilation would not have been undertaken at this point, so that was not relevant at OBC stage. It was, however, absolutely relevant that this should have been flagged and tested prior to finalising of the FBC. The ventilation derogation was not recorded in the FBC. In my view, it should have been. My expectation is that an OBC and FBC should record whether a project complies with all legislation and guidance and if not, highlight and bring to the attention of the CIG that it does not. I say this because I would have expected FBC to be compliant with Design Quality Policy.

52. In my view, it would have made a difference to the outcome of the FBC if the derogation had been recorded. An assessment of any derogation sought would have been undertaken and a view taken following receipt of appropriate technical or medical advice. If the request for a derogation had been refused and confirmation was not received from the relevant health board that this refusal had been reflected within a revised business case and the decision complied with, approval could not have been recommended to Ministers.

53. I am asked to what extent I would agree with a group of linked propositions: that the specification of a ventilation system for a hospital will have a direct

bearing on the nature and scale, and therefore the cost, of a large variety of construction features; suitably technical members of the CIG should be able to notice at OBC or FBC stage that a hospital is to have a smaller and cheaper ventilation system than might be expected for a hospital of that size and start asking questions about the long term sustainability and effectiveness of the ventilation system. I would agree only to the extent that any element of the specification will have an impact on cost. I would disagree that CIG members would have had sufficient detail on the specification and costing to form the judgement set out. What I can state is that the expectations on costs were that the building would have been compliant with guidance and at no stage was any suggestion made by myself on behalf of the Scottish Government to take steps to reduce costs of any underlying systems. I would have expected NHSGGC, in conjunction with their Technical and Financial advisers, to have sufficient detail on the costing and requirement for compliant ventilation systems.

54. I am asked what chief executive letters, if any, applied to or referenced the ventilation systems in the QEUH/RHC project; when were they issued; and were any derogations sought. Again, I would reference the Design Quality policy and mandatory requirement 7 regarding use of ADB, which would have demonstrated compliance with standards. No derogations were sought to my knowledge or recollection. The mandatory requirement for use of the Activity Database (ADB) was the same in the 2006 and 2010 policy documents. No derogations were sought.

Feedback or follow-up issues with the OBC and FBC for the QEUH/RH

55. There were financial checks required on the FBC, which I believe were minuted. Approval could not be recommended to DG Health and Social Care until all such issues had been satisfactorily addressed.

56. The SCIM gives guidance which applies to the process of project development from inception to post project evaluation. The guidance would have been per the extant SCIM at that time. The OBC and FBC would have been expected to

set out the approach to Post Project Evaluation, but clearly this would not have been conducted at the point of the FBC approval.

57. There is a requirement within the SCIM for NHS Boards to conduct Post Occupancy Evaluations and Post Project Evaluations. The requirement would have applied as per the SCIM. I cannot recall whether these were carried out. A post occupancy evaluation (from memory) would have been conducted 6 months after occupation with a post project evaluation 12-18 months after completion. There were separate manuals within the SCIM covering these requirements. The delivery of large healthcare projects is the responsibility of NHS health boards. In my view, the purpose of the oversight provided by my directorate and the Scottish Government during the design, procurement, construction and post evaluation phases of a major capital project was essentially about timescales and finance. Compliance with SCIM would have been assessed though the OBC and FBC to the extent that all relevant matters, including deviation from standards, was contained within these documents. It is also important to note that the OBC and FBC were the basis of an NHS Board approving the project before submission to the Scottish Government and, therefore, the clear expectation was that a relevant NHS Board should satisfy itself that all requirements had been satisfied prior to submission to the Scottish Government.

Role on NHSGGC's committees

58. I am asked about my membership of three groups:
    i. The Procurement and Finance Group - I don't recall being a member of this group; I note from the minute in the pack from 19 Feb 2010 that Stephen Gallagher, the then Deputy Director for Performance Management, was in attendance. Given our respective roles, we would not have substituted for each other;
    ii. New South Glasgow Hospitals and Laboratory Project Executive Board - I do not believe I was a member of this Board, which was internal to NHSGGC;
    iii. Acute Services Strategy Board - I attended as an observer, as recorded in the terms of reference. My role was to receive updates on progress and

financial matters and, in respect of business case development, to provide advice as necessary. I have no recollection of ever receiving information or being requested to provide advice on the same in relation to derogation from SHTM's.

59. I do not recall attending any other NHSGGC groups/ committees/ boards (other than the NSGHLPEB, as discussed above).

60. I was not involved in decisions in respect of site selection for the new SGH, procurement structure and funding and choice of contract model. Norman Kinnear would have attended any relevant meetings to which the Scottish Government was invited in that regard, therefore I cannot comment on the nature of those meetings. I may have been present at meetings when selection of preferred bidder was discussed but cannot recall specifically. If I was in attendance, it would have been as an observer and not part of the decision-making process.

61. I do not recall seeing any reports in respect of removal of the maximum temperature variant in May/June 2009 **(Bundle 17, Document 26, Page 1063 and Bundle 26, Document 3, Page 168)**; approval of changes in the respect of ventilation systems that were not consistent with the terms of SHTM 03-01 (2009) draft; the decision to use chilled beams; the detailed specification of the ventilation systems of what became Ward 2A (RHC), Wards 4B, 4C, 5C and 5D of the QUEH; or design of the ventilation systems of isolation rooms.

62. I have been asked to review items 4 and 5 of the Minutes of the NSGHLPEB of 7 December 2009 **(Bundle 42, Volume 2, Document 18, Page 86)** which I attended as an observer. I am asked whether there was any report that the Brookfield Europe bid remained (at that time) non-compliant with an aspect of the Employer's Requirements in that the proposed ventilation solution would not have been compliant with SHTM 03-01 2009 draft, in that the air change rate for single rooms was proposed to supply air at half the rate than that was called for. Given the passage of time, I am largely reliant on the Minutes to remind me of what was discussed at this meeting, however, I have no

recollection of any reference to the bid having been non-compliant at that time and, should such an issue have been discussed, would have expected that to have been appropriately recorded in the Minute, which it is not.

Building Research Establishment Environmental Assessment Method (BREEAM)

63. BREEAM is a tool/ methodology relating to environmental accreditation for buildings. The Design Quality Policy issued under cover of CEL 2010 19 sets out the requirements for BREEAM compliance in mandatory requirement 6. Technical advice in relation to BREEAM would have been available to NHSGGC through HFS.

Miscellaneous

64. By reference to a document **(Bundle 42, Volume 2, Document 24, Page 113)** it is put to me that I had advised NHSGGC that any support from HFS would require to be funded by the Board. I am asked the following questions: What was the discussion around this? Did NHSGGC go ahead with specialist equipment support from HFS? The minutes record that you had also enquired whether NHSGGC were considering project cashflow and forward purchase as this had been raised with you by HM Treasury. What were you asked by HM Treasury, how did you communicate this to NHSGGC and what was the outcome? I am inferring the response here, as I was not present at the meeting referred to. Given the scale of the project, HFS was not funded specifically to provide the level of support indicated and, as a result the costs of this support would need to be met from within overall project funding, which included a range of contingencies. I cannot recall what level of support was provided by HFS - representatives of HFS would be best placed to answer. From memory the issue of timing will have related to the drawing down of funding from the Scottish Government to NHSGGC to align with its equipping programme and, in particular, whether large pieces of equipment, such as scanners, needed to be installed during the construction process due to logistics. I cannot see where

the references to HM Treasury and timing are in the documents I have available to me and am unable to recall the detail.

65. By reference to a document **(Bundle 42, Volume 2, Document 25, Page 116)** it is put to me that I confirmed to NHSGGC that all provision of services by HFS (Equipping section) will be chargeable to the project and will not be subject to reimbursement. This is the same issue as above; given the significant capacity required within HFS, this was additional costs that would need to be funded from within the overall project budget, which contained a degree of contingency.

66. I am advised that the Inquiry has heard much evidence "over how it is that in the construction of new buildings it is much cheaper to get things right first time than to have to correct them later" and have been asked if any such consideration formed part of discussions at the NSGHLPEB. From memory I would say that it was only discussed in general terms, (again from memory) through reporting on design development and construction progress once that had commenced.

67. I am asked whether I should have had an element of oversight on the NSGHLPEB "and other NHS GGC committees that [I] attended", given my SG position and, in particular, whether I should have checked that change procedures, which might have had cost implications, were in place and operating. The governance arrangements were established and overseen by NHSGGC and delegation and reporting arrangements flowed from that. The only oversight possible was on the basis of actual information provided to NHSGHLPEB and, subsequently, through business cases or relevant correspondence submitted to the CIG, which had been through NHSGGC governance prior to formal submission to SG. I have already indicated my view that it was NHSGGC's responsibility to raise the derogation with the CIG, but did not do so. On the basis that there was a deviation from standard, I consider that oversight by NHSGGC to disclose derogations represents a significant gap in compliance with mandatory design quality policies and governance expectations. Any proposed derogation should have been advised by NHSGGC to the Scottish Government in order to allow for consideration prior

to approval and implementation, but this was not done. In my view, NHSGGC should also have raised the derogation at the NHSGHLPEB and the governance structure in NHSGGC would have allowed for escalation of significant issues, which in my view would have included any such derogation. I cannot comment on what discussions on this matter may have taken place within other parts of the governance structure to which I was not party.

68. I have been asked whether I have a view as to whether lack of transparency by NHSGGC prevented the necessary evaluation and risk assessment that might have been critical to ensuring patient safety, compliance with standards, and informed decision-making throughout the project lifecycle. I cannot comment on the reasons for the omission of such information but any disclosed proposed deviation from standard would have required evaluation and risk assessment.

69. I have been asked "Is it the case that PFI/PPP ceased to be a realistic option following the change of government from May 2007?" The short answer to this question is "No". The reasons for public procurement were based upon value for money and affordability grounds given changes in accounting standards/ budgeting rules at the time and how these impacted on the Scottish Government and NHSGGC budgets.

70. I confirm that I visited the site of QEUH/RHC to attend Programme Board meetings held in the project accommodation on site and had a couple of tours of the site during construction to see progress. I attended the opening.

71. I am asked for my impression of the QEUH/RHC project's budget pre and post-handover. I have no recollection of any issues on variation to project budget beyond those recorded in the FBC.

72. In relation to whether there is anything further that I want to add that could be of assistance to the Inquiry, I have endeavoured to answer the Inquiry's questions to the best of my ability (recognising the significant passage of time), both in this statement and my previous three statements and day of oral evidence to the Inquiry. There is nothing else I feel I can add at this time.

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.

Appendix A

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

A37215538 – Bundle 3, Volume 1 – Governance
A35761409 - Bundle 16 – Ventilation PPP
A32993814 - Bundle 16 – Ventilation PPP
A33010775 - Bundle 17 – Procurement History and Building Contract PPP
A49286669 – Bundle 26 – Provisional Position Papers
A51853180 - Bundle 42, Volume 2 – Previously Omitted Miscellaneous Meeting Minutes and Papers
A35422498 - Bundle 42, Volume 2 – Previously Omitted Miscellaneous Meeting Minutes and Papers
A37217037 - Bundle 42, Volume 2 – Previously Omitted Miscellaneous Meeting Minutes and Papers

Appendix B

The witness provided or referred to the following documents when they completed their questionnaire statement.

A51258946 – Bundle 34 – Performance Review Group and Quality and Performance Committee Minutes and Relevant Papers
A51258908 - Bundle 34 – Performance Review Group and Quality and Performance Committee Minutes and Relevant Papers
A34871325 – Bundle 37 – Board Minutes and Relevant Papers
A51853186 - Bundle 42, Volume 2 – Previously Omitted Miscellaneous Meeting Minutes and Papers
A32551720 – Bundle 48 - Provisional Position Paper 15 – Governance and Supporting Documents
A35289380 – Bundle 48 – Provisional Position Paper 15 – Governance and Supporting Documents
A35178847 - Bundle 48 – Provisional Position Paper 15 – Governance and Supporting Documents
A35072360 - Bundle 48 – Provisional Position Paper 15 – Governance and Supporting Documents
A35178847 – Bundle 48 - Provisional Position Paper 15 – Governance and Supporting Documents
A35100870 – Bundle 48 - Provisional Position Paper 15 – Governance and Supporting Documents
A35187175 – Bundle 52, Volume 1 – Miscellaneous Documents
A35072376 - Bundle 52, Volume 1 – Miscellaneous Documents
A37609211 - Hearing Commencing 9 May 2022 - Witness Statement Bundle
A37410080 - Hearing commencing 9 May 2022 – Bundle 4 – Single Bed Derogation

Scottish Hospitals Inquiry
Witness Statement of
Peter Gallagher

1. My name is Peter Gallagher and I retired as Director of Finance of Acute Services with NHS Greater Glasgow and Clyde in January 2015. I am qualified as FCCA (Fellow Chartered and Certified Accountant) and I am now a life member of the Chartered Association of Certified Accountants, and that was in the June ’78 diet, 1978.

2. When I left school, I was working in the South of Scotland Electricity Board as an administration assistant. I moved from there to Collins, the publishers, 1974 to 1976, then from 1976 to 1984 I worked at Neil and Spencer, who manufactured industrial laundry machinery, predominantly for hotels, but also hospitals, interestingly enough.

3. Between 1985 to 1987 I joined Argyll and Clyde Health Board as the chief accountant. I was then promoted to the unit finance officer in 1987 to 1992. So, I was with Argyll and Clyde Health Board from 1985 to 1992.

4. From 1992 to 1999, I was with Lanarkshire Health Board. I was in the Hairmyres and Stonehouse Trust as Director of Finance. I rebalanced the finances there, reestablished the Trust, and I became the Director of Finance and the Project Director for the PFI Hospital, Hairmyres.

5. In April 1999, I joined Glasgow and remained there until I retired but was there in various iterations. From 1999 to 2004, I was the Director of Finance for the South Glasgow University Hospitals NHS Trust, which was the Victoria and the Southern General Hospitals. Previously, they had been individual hospitals. John Connaghan was CEO in Victoria, and Robert Calderwood was CEO in Southern General.

6. In 2004, the numerous individual Glasgow hospital trusts, the North, the South and Yorkhill, were dissolved. I became the Director of Finance for the South Division.

7. In 2005 there was a re-structuring process in NHS Glasgow, quite a stressful one actually and from a finance point of view, NHS Glasgow ended up with two directors of finance. I became Director of Finance (Acute) with responsibility for the acute hospitals and an annual revenue budget of £1.5 billion at my retirement date.

8. NHS Glasgow also created a primary care Finance Director, which was all the GP's, *et al*. The primary care director was also the Board's Director of Finance. So, the Board's Director of Finance also oversaw primary care. I oversaw the acute hospitals.

9. Albeit I left in January 2015, when I came back from the October 2014 school week, I put my notice in, then worked from the October to the January on four days a week/three days a week etc wind down. So, largely, I had a lot less input from October 2014 to January 2015, when I retired.

10. When I joined NHS Glasgow in 1999, Robert Calderwood was the Chief Executive of the South Glasgow University Hospitals Trust, and that's really where NHS Glasgow launched the whole acute services review process. Then when Tom Divers, who was the Chief Executive for NHS Greater Glasgow, restructured in 2006, he introduced a Chief Executive for the non-acute side and a Chief Operating Officer for the acute hospitals.

11. Robert Calderwood became the Chief Operating Officer for the acute hospitals. A Director of Acute Services Planning post was also created.

12. The Director of Acute Planning's job was to oversee the rebuild of Glasgow Hospitals for the bits that had not been done, including bed models and running the project. So, the whole project team sat under here. I was responsible to ensure the capital plan and the revenue plan broke even. I was responsible to the Chief Operating Officer for that.

13. So, the Chief Operating Officer (now referred to herewith as C.O.O.) was then in charge of the £1.5 billion revenue budget, but he had different directorates delivering that. He had a Surgical directorate, a medical directorate, a radiology directorate, which would include labs, a Women and Children's directorate, etc., etc.

14. Each of those directorates had a Director. They also each had a Head of Finance who was responsible to that director. So, the Head of Finance in, say, Women and Children's, was directly responsible to the Director of Women and Children's directorate. I had no line responsibility to that individual, but only a professional link.

15. If there was a financial issue, I would report that back to the C.O.O. It was a financial monitoring role. Then if the C.O.O felt he had to see the Director, he would get the Director in, the Head of Finance in, myself under him, and then he could instruct the Director for whichever directorate to change tack if required. I could not instruct that directorate Head of Finance to change. I was more making sure the division broke even and performance managing the individual directorate's finance.

16. When the Director of Acute Planning left in February 2010, there was a new project structure introduced and that is referenced in your files. The C.O.O then took over the running both of the project and the Acute hospitals. That continued through until I retired in January 2015.

17. Together with being responsible directly to the Chief Operating Officer, I had a strong professional link to the NHS Board Director of Finance.

18. To explain this, had the Chief Operating Officer said, “I want you to do X,” and I thought, “No, I do not think that’s financially correct,” then I could have gone straight to the Board Director of Finance on a professional link, as the Board Director of Finance together with the Board CEO had ultimate say in all Board financial issues.

19. All financial decisions that were taken by the Board would have been approved by the Board Director of Finance.

20. I was not a Board member. I may have on occasion attended the Board meetings because they might want clarity. I suppose it’s a bit like the captain of the ship is the main guy, but he does not run the engine room. You need somebody down there doing the day to day work.

21. The problem with titles is when we were a Trust, we had a Trust Board. I saw this when I went through some of your papers (Bundles). They have an Acute Services Strategy Board, but that is different from the NHSGGC Board.

22. The Acute Services Planning Director was directly responsible to the Board Chief Executive. But the C.O.O and Director of Acute Planning clearly had to work together because one is delivering the project whilst the other is running the hospitals, so they need to talk to each other to manage the whole change process.

23. So, when the C.O.O would run acute divisional meetings, he would performance manage the individual directors. If the Board picked up various issues, the C.O.O would be the one who would be in attendance at the Board to discuss the issue.

24. I recall attending the Board on the ACADs (Ambulatory Care and Diagnostics) project because when we built the Ambulatory Care Hospitals, they were built under PFI process. I attended the Board to discuss it because by then I had a fair bit of PFI experience.

25. In 2006 onwards when we were progressing the Ambulatory Care Hospitals, my assistant in this process was a Head of Finance (now referred to herewith as H.O.F) who attended Gateway 1 interviews in 2008.

26. Over the period the H.O.F's changed and it was a different H.O.F who attended Gateway 3 in 2010.

27. It is difficult to recall all the various meeting group titles mentioned in your files, all at different levels, as so many are still called boards. I was not on the Acute Services Strategy Board **(Bundle 30, Document 6, at Page 38).** Referring to the organogram, the C.O.O is the chair, the Head of Finance for Capital is a member and Douglas Griffin as the Board Director of Finance is also a member.

28. Then you come to the committee below that, which is the Executive Sub-Group. The H.O.F is there, and I am also a member. You will see the whole structure is overseen by a Performance Review Group.

29. The Performance Review Group is almost exclusively non-Executive directors of the NHS Board. This structure chart shows you a good governance arrangement because Board non-Executives with wide experience are represented here.

30. So, when you look and see the Performance Review Group membership, Eleanor Smith who had been the chair of the South Glasgow University Hospital Trust, is the vice chair. Andrew Robertson is the chair of the Board. Donald Sime is a staff representative. Ken Winters was a non-Executive member. Ronnie Cleland was a non-Executive member. Ian Lee was a non-Executive member with a financial background. This is almost exclusively non-Executive members of the Board.

31. Looking at that structure, what you're really seeing is the governance from the various groups feeding back up, feeding into an Executive Sub-Group, feeding into Acute Services Strategy Board, and all the way to the non-Executives, so that when it finally gets to the NHS GGC Board, the Board members and non-Executive members are not blindsided in any way. They have sat in meetings and had any detail they have wanted to ask.

32. Regarding your question about reporting lines and decisions in respect of the procurement of the hospital, how that worked and where the decision-making sat in relation to procurement and appointment, that sat under Director of Acute Planning, who was responsible for the procurement of the new Hospital directly to the Board C.E.O.

33. In 1999 when I joined South Glasgow University Hospitals Trust, Mr Calderwood had previously been responsible for building other parts of Glasgow Health Care. The Board needed to do something about the Victoria Infirmary and the Southern General and needed a site to build a new hospital in South Glasgow.

34. After the 2006 restructuring, day-to-day responsibility for rebuilding went over to Director of Acute Planning and the C.O.O had responsibility for running Acute Hospitals.

35. NHS Glasgow is a big organisation. The acute revenue budget alone was £1.5 billion. So that meant the C.O.O and the Director of Acute Planning (now referred to herewith as D.O.A.P.) had to work together. In terms of launching the procurement and business case, the OBC and the FBC and the project team, all sat very clearly under the D.O.A.P.

36. In terms of final decisions, all final decisions were taken by the NHS GGC Board, including appointments of personnel and final preferred contractors.

37. When we met to evaluate bidders leading to the appointment of Multiplex, there could have been twenty or even thirty people at these meetings. There were members of the Board there. There were advisors there. There were Acute Services people there. We had presentations, and the advisors took us through it, but eventually it was a Board appointment. Neither the Acute Services Planning nor the Acute Services division had the power to appoint someone to build the new Hospital, then keeping the Board out of it all, or not knowing what was going on. These appointments were made entirely by the Board. Board representatives were at the selection panel working through the scoring.

38. In terms of water and ventilation systems, the responsibility for that would have sat with the Director of Facilities and Project Director, on a day-to-day basis. The Project Director and his team would be the ones who would be interfacing with Multiplex. I did not have any involvement as a finance manager for ventilation.

39. The main people who would understand ventilation issues, aside from our design advisors would have been the C.O.O, the Project Director and the Director of Facilities in the Acute Division.

40. When NHS Glasgow completed the organisational staff restructure in April 2006, Argyll and Clyde was then disbanded, and staff in Argyll and Clyde were subsumed into NHS Greater Glasgow and Clyde.

41. The Chief Executive at that time had just overseen that major restructuring programme and appointment to posts. At that time, ACHB had a Director of Facilities and there was also a Director of Facilities in Glasgow (Acute).

42. Mr Seabourne then came into NHS Glasgow from Argyll and Clyde understanding facilities and was appointed as the Project Director for the new hospital.

43. As project Director, he took over the project team and was responsible to the D.O.A.P.

44. In terms of the responsibilities for the management and reduction of risk to patient safety, or from the environment, I would have thought, again, that would have to sit under the Director of Acute Planning and her team through linkages to Infection Control. We should note that the Director of Acute Planning left in February 2010 and thereafter the Project Team reported to the C.O.O.

45. An issue might then eventually come to one of those senior committees where the change would be discussed and ratified because the decision would require to instruct a change control.

46. If the original bid assumed one design which has then changed, there would eventually be a change control and a need to pay an extra amount for the revised work. That is when I would be aware, under change control.

47. Overall, the responsibility for ensuring the health and safety and patient safety sat under the Director of Acute Services Planning and latterly the C.O.O. As mentioned, the D.O.A.P left February 2010, and I think we only appointed Brookfield towards the end of 2009, as per reading The Inquiry papers.

48. So, from February 2010 onwards, the C.O.O is now in the chair responsible for the new hospital project direct to the Board C.E.O.

49. In answer to the question about where the decision-making would sit for the works to improve or remedy any deficiencies in the water and ventilation systems after the handover, I left before the handover, so I do not know what happened after that.

50. The Director of Facilities retired late 2013 I think, and I believe the Project Director also retired, I think in 2013 as well, and a new director, David Loudon, replaced both posts. So, he would have been the responsible person direct to the C.O.O.

51. In terms of any understanding I might have of any formal/informal meetings that met outside the structures, beyond these groups that we've discussed, the committees etc., I am not aware of any such formal/informal meetings that made any such decisions.

52. I would keep in touch with the Head of Finance to understand what was happening. But I could not decide anything outside of that structure because when you see it in that chart from February 2010, any change would have to come up through the various groups reporting upwards. Outwith this I am not aware of any informal committees that made project decisions. Certainly, before January 2015 I am not aware of any.

53. In terms of how it was decided which issues, decisions and reports would be escalated to the full Health Board per se, I refer to the structure of the chart **(Bundle 30, Document 6, at Page 38)**. because it all worked a similar way. This was from 2010, but before 2010 there would be different names to boards and committees. When we were building the new Maternity, then Women and Children's would have a group, and if we were building labs, laboratories would have a group in here. But, in principle, if a group had a big issue, I would expect that group and the minutes of that group to find a way back up to this Executive Sub-Group.

54. Now, if there was a change to ventilation requirements, I would expect that the Director of Facilities, the Project Director and the C.O.O would know about it. They were the people who understood technical issues along with advisors but it then would come to the Executive Sub-Group if after February 2010 where it would be discussed and minuted. This group above the Executive Sub-Group, the ASSB, would then get the minutes of that Executive Sub-Group. If before 2010, a similar process was in place.

55. That is how it would escalate. We would not discuss a large issue at one group and then not inform the Committee above about that. The minutes go up as a matter of routine, so I really do not see how that can happen in relation to any major issue.

56. If we were discussing finance and where we were financially in the project, then I would expect the Board Director of Finance to know. Frankly, I would tell him the position, but I would expect him to see that from the minutes, if discussed.

57. In terms of the Health Board, and being aware of what procedures they had in place to ensure that issues that had been raised with them were being monitored, actioned, resolved, I never sat at Health Board level so I cannot comment on specific Board monitoring procedures for this.

58. I could only talk about the Acute Division level. I know when audit issues came to the Acute Division level, then our non-Executives made sure if there was an audit issue about anything, it went on to a list and we made sure the issues were actioned before the next audit committee. That way, the non-Executives made sure issues were progressing. I would imagine those same non-Executives, and particularly Eleanor Smith when she was on the Board, would have ensured that if any issues had been made known to them, that they would have been focused on receiving updates on these and getting clarification on how their resolution was progressing..

59. But I can only talk to that up to January 2015 in terms of what happened in the Acute Division. The Board's internal procedures I cannot comment on.

60. You referred me to Dr Redding's witness statement, her comments regarding the SMT and Clinical Governance Committee taking decisions on the information discussed at the full Board, etc., I believe this was all after I had left.

61. At that time, the senior management team would have been involved in clinical governance, but the timescale reads to me about 2017 or 2018 and the whistle blower etc; I really cannot comment.

62. But if you look at the structure **(Bundle 30, Document 6, Page 36 at Page 38)** how it all worked, certainly up to 2015, it is very difficult to progress issues without any form of oversight.

63. I have been asked about my role as Director of Finance (Acute) what were the circumstances of my appointment, what the length of my tenure, my key roles and responsibilities and who I reported to and who reported to me? Looking at my role as Director of Finance (Acute) my key role was the financial support to the Chief Operating Officer for all financial targets. I was responsible for finance. The Chief Operating Officer was responsible for all divisional targets. Waiting times, for example, I was not responsible for that, but I would sit at meetings, and the Director of Medicine would update whether we've met the target or not. If the Acute Division was not meeting its targets, the responsible officer was the Chief Operating Officer, and he/she was responsible to the Chief Executive and the Board.

64. In terms of my support, it was really basically making sure there was financial breakeven within the division overall. If surgery was well overspent because of waiting times or something, I could not instruct anybody there to spend less money. I could only say there was a need to escalate this to the Chief Operating Officer. I would sit in with the Chief Operating Officer, with the director of medicine or surgery and their Head of Finance and the C.O.O could instruct them to carry out certain agreed actions. . But I could say to the C.O.O, that I did not think they are going to financially recover in Surgery or Medicine, and they forecast £100,000 overspend. However, elsewhere, we've got underspending, so if we can keep that underspending, we'll deliver a breakeven overall within the division.

65. Largely, I was monitoring and making sure that Acute Services was delivering breakeven to let the Chief Operating Officer to meet the financial targets that he was accountable for, to the Chief Executive.

66. I had a Management Accounts Division and was line manager for them. We would be running the spend profiles and such for acute services overall, and the individual acute services departments' spend. That Management Accounting team reported directly to me.

67. I have been asked upon commencing my role what stage the New South Glasgow University Hospital Project was at, what was my understanding in respect of funding for the new hospital and if any concerns were brought to my attention in respect of any financial aspects of the new hospital. I joined SGUHT in 1999 and I moved to D.O.F (Acute) in 2006, I had been involved in the building of ACADs, the 210-bed unit, and the decision to build the additional Maternity onto the existing Maternity in the Southern General site and close the Queen Mother's at Yorkhill. So, if it's from 2006, we had appointed builders for ACADs, I think, but overall, I had been in since 1999.

68. When the Acute Services Review was first launched in 1999, there was a clinical forum led by the doctors at the Victoria Infirmary and doctors at the Southern General, etc. It was clinically led at that point.

69. I think the ACADs finished about 2009, so if we're talking about a two-year build, we'd probably appointed the builder around about '06/'07. The next stage was then to progress to the new South Glasgow Hospital, and that would be about OBC stage, or the launch of OBC stage. But that also coincided with a new Scottish Government in 2007 and a change of how they were going to fund capital projects.

70. There was no mid- project change of funding from PFI to public funding. It launched under public funding.

71. Prior to this, the only way you could get new hospitals was PFI, that had been the only game in town since about 1996, possibly even earlier.

72. When SNP were elected to form a new government, it quickly became clear that they did not favour the PFI model. We were not at OBC stage at this point. You cannot launch the OBC, FBC and talk to bidders if you do not know what your funding model is going to be so, there was question on what way we were going to go. The decision to move to public funding was taken early because it's mentioned in the Gateway 1 document **(Bundle 43, Volume 2, Document 3, Page 34)**.

73. I was not involved in any way in the decision to move to public funding. This was a Scottish Government decision. We met the Capital Investment Group (now referred to herewith as C.I.G) representative Mike Baxter and I had several meetings with Mr Baxter. So, I knew that the Scottish Government was considering going the public funding route.

74. Once it was confirmed public funding, this became a great big capital project from a funding point of view. However, if we overspend, then Scotland's capital programme has a problem. Other health boards probably can't deal with the knock on from that. If we underspend, can C.I.G. move the NHS capital funding to another project and bring it forward? So, we had to have discussions, I do not know how often, maybe four times a year, with Scottish Government colleagues.

75. I was involved in these discussions. The first budget we had I think was £770 million and we progressed to £843 million because we then knew the timeframe and we knew what building inflation would be.

76. The responsibility for monitoring that spend was myself assisted by the Head of Finance Capital Planning. Over the years, because of my involvement in ACADs, I had a relationship with members of CIG, particularly Mike Baxter. So, in those meetings, I went with the Head of Finance.

77. I did not have any concerns about finance, and when I retired, it was under spent. We had to deliver to capital phasing's, obviously, because it's an annual budget, and we also had the Maternity project running and the labs project running at the same time. Overspending on these and the new hospital could affect the national budget, but the project was under spent when I retired. Financially, it was never under any problem at all.

78. In terms of your question 10, and my understanding of the resource that would be required to deliver the new hospital, and what involvement did I have at the outset of the procurement phase in outlining the resource? I was heavily involved in that. I would meet with Mike Baxter along with the H.O.F, there may have been another member or so of CIG. I am not 100 per cent sure, but certainly we had regular discussions.

79. I think we had originally a bidding profile or a cost profile probably from the design advisors, and I do remember that was £770 million but that was based on current prices at the time. When we factored in building inflation and timeframe this moved from £770 million to £843 million and we had to phase it into 2010, 2011, 2012, 2013 etc.

80. I also had involvement with the Outline Business Case. The Head of Finance for Acute Services Planning wrote the finance section and I overviewed that. So, when you see the discussion in Gateway attendees, then you'll see that I am in attendance.

81. In terms of site selection, though, the site selection was before 2006. Site selection was probably under the South Glasgow University Hospital Trust timescale and we attended many public meetings. This was part of the acute services review.

82. I think the site selection was probably 2002/2003-ish because I know the Trust dissolved in April 2004, and there were only two sites identified as suitable: one was the Southern General site and one was Cowglen. Patient pathways and Flows became the key driver in site selection. With the future closing of the Western Infirmary all in patients would flow South of the river with outpatients moving to Gartnaval. So, the Southern General site would be a better pathway for patients in West of Glasgow as well as South Glasgow.

83. They hadn't built Silverburn at the time, and we had Cowglen Hospital, which wasn't a big enough site on its own, but NHSGGC had the ability to purchase the land that is now Silverburn and could have created a big enough site. Those were the two sites identified by the Board.

84. So, the Southern General site and Cowglen were the only options suitable. But you need to remember, in the Southern General there was a Neurosciences building, an Oral Maxillofacial building on top of that, a state-of-the-art Spinal Unit, and a Maternity. So, if you ended up going to a different site, you'd have to build the exact same in both sites plus those four buildings. So, in addition to a better patient pathway, in the Govan Site it was also a financially lower cost.

85. In answer to your questions regarding the changes in the ventilation system, I have read the documents provided and I confirm I had no direct involvement in ventilation changes.

86. When I retired, I left cupboardfuls of copious notes on every meeting I ever attended. But, when I retired they did away with post that I held. I think that the person who ran the Management Accounts would have taken over responsibility for the financial input into the new hospital project. I do not know what happened to the notes, but there was nothing that happened that was not left. There would have been nothing that they did not have access to.

87. But by then, the "building" was largely complete. We hadn't had the handover, nor commissioning, but it was not like you are halfway through a project. The project was, whatever the term is, almost complete.

88. The purpose of the acute services review was, to my understanding, that we had to rebuild acute services in Glasgow. We had a lot of old hospitals, particularly in the South. There was also the new Princess Royal Maternity being built in the North as well as other upgrades happening in the North. So, the strategy was to create one big site in South Glasgow and have the benefits of all of that in the South. The Victoria Hospital building was a Victorian building, and we had now signed up and were building a new Victoria ACAD.

89. To explain, ACAD's (ambulatory care) basically, if you went in and out in a day, whether it be for a scope, outpatient, x-ray or anything else, then you went to the Victoria ACAD. There were no inpatient beds in the Victoria ACAD.

90. So, inpatient services had to be rebuilt in South Glasgow, and that was the ASR launch and a decision on where it was going to be, but NHSGGC needed the two ambulatory care hospitals first. There were also issues with the Western and Gartnavel because, again, the Western was an old hospital. Although that was not situated in the South, the building of a new hospital in Govan would transfer patient flows to this hospital. Eventually the Western was sold, and the aim was to sell Yorkhill also. I think for a period Yorkhill was acting as an outpatient for adults in the West. I do not know what it is now.

91. I have noted alongside your question about ASR that I had a finance input into the ASR from the early clinical forum days. This is because from when I arrived in 1999, there were meetings with the Victoria Infirmary and Southern General staff.

92. Both John Connachen and Robert Calderwood had many a year working together because they were both based in the south of Glasgow. The Chief Executive in the Victoria Infirmary and the CEO in Southern General eventually became one CEO when John Connachen went to Scottish Government and Mr Calderwood took over the two Hospitals in 1998.

93. I have been asked about my role on the Acute Services Review (ASR) Programme Board, who else sat on the ASR Programme Board, how the membership was decided, what the remit of the ASR Programme Board, to whom did it report and what processes were in place in terms of decision making. I did sit on the Acute Services Review Programme Board. Referring to your Bundle 30, and the Programme Board meeting, Monday, 8 June 2009, as you can see, numerous senior individuals are involved in that meeting.

94. The Board Director of Finance is also a member. There's myself, the Chief Operating Officer and director of Acute Services Planning and numerous others. Director of Acute Planning was responsible for the progress in the project, and the C.O.O obviously is operational.

95. My role was to have the operational input into overall capital for the project so I would have been there talking about finance. So, you can see who else is there. We get an update from Director of Facilities on ambulatory care hospitals. Stobhill opens in four weeks, Victoria is about to open. They also talk about the Maternity strategy. So, that's the new Maternity coming into South Glasgow, so, Director of Women and Children is there. Also, the new Glasgow Hospital's laboratory. So, ASR programme board is bringing together the Maternity, the labs, where we are in the various projects, and that's why you have so many people here, including IT, including staff side, including communications. Basically, anybody who had anything to do with any of the new buildings going up in Glasgow at a senior level, if you look at attendees, would be in there.

96. As to how membership of this Board was decided I have no idea. I'd imagine it was D.O.A.P and the C.O.O, Mr Crombie, just to pick somebody from the names, was the director of Diagnostics. Diagnostics also took care of labs. He would have been there to say what was happening with the lab project. Ms Crocket was the Woman and Children's Director, so she is there updating on what was happening with the new Maternity and things like that. Sharon Adamson was the head of Planning. So, this included bed models and where we are going with targets and things like that. You have also got doctors' input. The medical director has apologised for that meeting, Audit Scotland is mentioned, director of HR from the Board has apologised. It's really Board members, Acute members, Planning members, all attended that group. So, it was really an update on where the various projects were.

97. In terms of decision making by this Board, recommendations from this Board would eventually go to the NHSGGC Board.

98. You will see that there are NHSGGC Board members there. As I say, the Director of Finance is a Board member. Mr Reid is the Board director of HR. So, there were Board members present. So, again, governance-wise, if a decision was made at this level, it is inconceivable that it would not find its way back to the NHSGGC Board.

99. I have been referred to **Bundle 30, Document 3, Page 26**, a minute of the ASR Programme Board Meeting of 8th June 2009. The minute notes that there was some discussion around the scoring system for the bidders and it was decided that A Seabourne and P Gallagher would require to have further discussion to clarify the criteria. I have been asked what was the scoring system in respect of the competitive dialogue and what was my involvement in the process.

100. You asked me if I can recall anything about that and what the scoring system was in respect of the competitive dialogue? I can as follows:

101. Firstly, in terms of a minute, it says little. “There was some discussion around the scoring system”.

102. So, the Head of Finance would have been the person on a day-to-day interface re finance with the Project Director. Before we go to meetings, any meetings, you get the previous minutes and you get the agenda. I’d read through the papers to see if there was an action for me and then look through the agenda.

103. I do remember that one because I remember sitting and thinking, “Why is that here? How am not sighted on it?”. I think the Project Director may have raised it under A.O.C.B., but it may have been an agenda item.

104. The reason it is such a short minute is I believe I suggested that the Project Director and I take that away and discuss it. I had been through ACADS and I had been through the Hairmyres Hospital, both of which were PFI, and been involved in previous scoring systems. Those mechanisms had been devised by professional advisors.

105. I met Mr Seabourne and we agreed to pass this to our advisors to produce the scoring system. We had financial advisors, design advisors and legal advisors and they created the scoring system that was then utilised.

106. The advisors had much more experience in creating a scoring system.

107. So, it was passed to the advisors to create this selection matrix and they led us through the selection process.

108. Currie and Brown were certainly one of the design advisors. I think there may have been another technical advisor, I can't remember. I believe the financial advisors were Ernst & Young. I was involved in ACADs and other PFIs and I am trying to remember which financial advisor was which. I am sure it was Ernst & Young who were financial advisors in the new hospital project.

109. I have been asked to refer to the Terms of Reference of the Acute Strategy Board Executive Sub-Group **(Bundle 30, Document 6, Page 36).** I have been asked what the purpose of this Group was and how was the membership agreed. I think you are referring to the Acute Services Strategy Board Executive Sub-Group **(Bundle 30, Document 6, at Page 41).**

110. This was basically the group who oversaw day-to-day delivery of the project. When you look at the Performance Review Group, the top Board that you're seeing on that chart, it's all non-Executives of NHSGGC. The next group A.S.S.B has some non-Executives, plus the C.O.O, the Project Director, the Board's Finance Director, the Head of Finance etc. So, that's a sort of higher-up group to the Executive Sub-Group.

111. So, the day-to-day interface between the project team and the builder would feed through some of these design groups and lab groups, etc. The C.O.O was the one who's now responsible for delivering the whole project because the Director of Acute Planning has now left. That Executive Sub-Group basically had to oversee various operational groups below. So, Women and Children's is there, the laboratory's in there. The new children's hospital is in there, and then there is design groups and a project team. The project team would be interfacing day-to-day with the builders, etc.

112. Basically, the Executive Sub-Group would allow decisions to be made to keep the project moving. However, if you look at the remit of the Strategy Board, which is the one above that, it was, "To ensure financial control is managed and kept within agreed parameters." It's the third bottom bullet point.

113. So, ASSB was responsible for overall financial control. Also, if you look at the fifth bullet point, "To approve change control in that any change that impacts upon the project must be authorised by this Board."

114. Albeit it says the Executive Sub-Group had delegated authority, the Terms of Reference state delegated authority within SFIs (Standard Financial Instructions). The Executive Sub-Group could not just go and commit another £30 million cost, because approved change, if it impacts on the project, must go to the ASSB above it.

115. So, this was largely the interface of all the groups coming together. If the C.O.O then had a problem with something slipping or whatever else, he/she was also on the ASSB above it. If Women and Children's had a problem, the Director of Women and Children is on the ASSB also above it. If it was labs, then it would feed in here, too.

116. Then it all fed up to the Acute Services Strategy Board. If you look at the remit of the ASSB, they are the ones who basically "monitor all aspects of performance and implementation, approve change control, ensure financial control, approve and monitor appropriate governance, and approve the full business case."

117. So ASSB was the board that gave the final approvals but below that somebody has to ensure the project was progressing.

118. Going back to the Acute Services Strategy Board Executive Sub-Group **(Bundle 30, Document 6, at Page 41)**, the Terms of Reference of this group says it has "delegated authority to make decisions on project issues to maintain the programme."

119. The Chief Operating Officer, who also sat on the ASSB above that, had the authority to say, "Yes, that is a decision". So, if the ASSB is not meeting above for a month, for the argument's sake, but actually the project needed the decision today, then the C.O.O had the ability to make that decision, within the Executive Sub-Group.

120. But because the C.O.O is on the ASSB above it, if it were a big issue, the C.O.O would clearly be reporting that back or talking to the Chief Executive about it.

121. But it might be something really small. So, it is a decision that can be made to maintain the programme. If anything was going to threaten the programme, the C.O.O had to make sure that was dealt with.

122. But if the C.O.O needed further assistance or approvals, the C.O.O is talking to the Chief Executive or he is talking to the members of the ASSB above that.

123. So, to answer your question about context, what sort of decisions were the Executive Sub-Group making? It was largely where the Chief Operating Officer thought it was within his/her delegation for these decisions to be taken and approved by the ASSBESG.

124. I do not think there were major financial issues here because finance was never really threatened in this project.

125. So, if there was something requiring attention or they had to move a door from here to there, the C.O.O would have had authority to make that decision. I can't recall in any of the meetings that we made a major decision that would not have then progressed to the ASSB.

126. And I think the Project Director would be describing the issue. So, the C.O.O and Project Director would know exactly what the issue is and both of those sat on the ASSB also. I do not recall any major changes which the Executive Sub-Group took that would not have progressed to ASSB also.

127. This was meeting weekly. The Executive Sub-Group was meeting weekly, and the Strategy Board was meeting bi-monthly.

128. With the executive sub-group, the Terms of Reference say that the executive sub-group could "exercise delegated authority to commit funding for new or additional works associated with the project."

129. And then the last bullet point says, "Within the Board's SFIs", which is an agreed delegated limit. So, the Executive Sub-Group could not bring in major change without ASSB approval.

130. Again, from a finance point of view, I do not recall many major issues, but if there was an issue coming up in the project team, they had access to this group to update what those issues were. If it was a large issue, then it clearly would go to the groups and Board above. But in between times, I would have expected the Chief Operating Officer to be talking to the Chief Executive or other seniors if there were a major issue affecting the programme. But I do not recall many major changes and any change control from a finance point, would have come to the Executive Sub-Group on a spreadsheet and that would have been approved either at Sub-Group or ASSB level, depending on the value.

131. So, albeit the Executive Sub-Group can make decisions, these must be within the Board's Standard Financial Instructions.

132. Regarding the ventilation derogation, I have reviewed the few pages sent to me, together with Mr Seabourne's email of the 23rd June 2016. I have also considered question 33 where Currie and Brown state to the Inquiry, that the project team had advised myself, Helen Byrne and Alex McIntyre of the agreed ventilation derogation.

133. Mr Seabourne's email notes that a key issue was that facilities specified the building could not rise in temperature above 26 degrees in the summer months (not usual). He also notes this had been problematic with the new ACADS.

134. The Ward ventilation design strategy paper from Currie and Brown in December 2009 starts with a Board requirement that the summertime temperature limit is "Not to exceed 26 degrees for more than 50 hours per year".

135. So, taking both documents into consideration it looks like a facilities specification on temperature requirements drove the change in the ventilation strategy to a Board requirement.

136. With regard to Currie and Brown's view that the project team advised myself, Helen Byrne and Alex McIntyre of the ventilation derogation, I have no papers here to review that. That said, I would expect Mr Seabourne to write to Helen Byrne (his Boss) Mr McIntyre as Director of Facilities who had apparently specified that change and myself to potentially expect an additional cost. I would confirm that I would have had no involvement in the ventilation derogation other than noting financial consequences.

137. Following on from this, any costs would go forward on the Change Control spreadsheet to the appropriate groups. Had it had a major finance input, I would have been involved in discussion, but I would need to see more papers on this particular topic. All I have really seen is what you have provided me.

138. This change looks to have preceded the Executive Sub-Group, where one of its Terms of Reference is, “Receiving reports from acute director and Project Director and changes being proposed with financial implications. The structure before 2010 would have been similar but I do not recall any reports or changes that threatened the project cost or timetable. However, any change that had a finance implication was kept in a spreadsheet by the Project Director and brought to the appropriate senior group at that time. So, I would expect ventilation derogation to have been raised and discussed.

139. So, as noted, when and where changes had been agreed or proposed, the Project Director would have brought to a senior group. There was a running spreadsheet detailing additional costs incurred. So, the Change Control spreadsheet that was maintained by the project team was updated for Executive Sub-Group’s approval, and the appropriate groups before 2010.

140. Next is question 19, Gateway Review process and any involvement I had with it. The Gateway Review was basically the Scottish Government’s governance arm. I think Gateway 1 was in January 2008. At that first one, I do not think we had launched OBC at that point. When the Board, the Health Board approves the OBC or FBC, they need to know good governance is in place. There is no point in the Board approving a project and the Gateway Review, then publishing next week stating that it had poor governance.

141. So, I think before the NHS Board approved the OBC/FBC, we had a few Gateway meetings, and then the fact that you get a good report, this fed back to the Board to say, from the Scottish Government point of view, governance is working well. Everything is in place. Financially, it is also within all the right levels so the NHS Board were able to approve OBC/FBC following good Gateway reviews.

142. It was really part of the governance process to go through, and also to let the Scottish Government know exactly where we were, what our timescales were and what our costs were.

143. I was one of the attendees at Gateway reviews. It all happened over a couple of days, and I recall discussions around the funding model, but what else we discussed there, I do not recall other than what they have written.

144. It was quite key that we got a decision following Gateway 1 on the procurement funding route. Had it been PFI, similar to ACAD's procurement, then we would have to have started and done whatever else was required. But if it is public funding, then it is a different route for the design group and the rest.

145. During the Gateway Review 1, I would have overseen the Head of Finance for Acute Planning for that interview. They would have written the finance section, and I would have overseen and been involved in that and have final review of it.

146. In general principle, my role would have been making sure the finance section was there. The Gateway 1 review input was led by the Director of Acute Planning.

147. The Director of Acute Planning would have been the person responsible for pulling that together, and within that, different parts of the group would be doing the finance section or the bed model or whatever else. We would all have been doing relevant sections and feeding back up through the D.O.A.P.

148. So, Gateway input goes up through the Acute Planning side. This included a finance section, and I was involved in that.

149. In terms of going to the NHSGGC Board for approval and then submitting it to the Capital Investment Group, firstly, it would have gone through Gateway because Gateway was the governance sign off that the project was in a fit state.

150. The principle is that would be your governance approval.

151. This allowed the Health Board to know that at committee level it is looking good, that the Government's governance arm is looking good and CIG would be feeding into that.

152. I interfaced with the Board's Director of Finance as required. He was the one who sat on all the NHS board meetings and, therefore, decision-making would have sat with, from a finance point, the Board's Director of Finance because ultimately it is at board level where approvals are made.

153. Regarding the extent of the dialogue with the Capital Investment Group and with the Scottish Government regarding the outline business case, I met with Mike Baxter and one or two members of CIG now and again, not about that *per se*, but largely about the funding model and how much we needed, but not the various sections in the business case.

154. You asked me about the Gateway Review, at 5.2. Gateway Review 1 states: "One major challenge to the project is the impact of the chosen procurement route. Early drafts of the OBC were predicated on a PFI procurement route. However, because of issues about affordability and a change of emphasis on alternative procurement options by the new government, a wider selection of procurement possibilities has been considered."

155. I agree that clarity on the funding route was required at that time. We had not started. We were at OBC stage. I am sure the SNP led government were elected, about June 2007. It was about then, and this was now January 2008. We have, somewhere around about that time, financially closed two ACADs, so we are moving on to the new hospital, but there are obviously sound bites that it might be going the public funding route. Well, we cannot do an OBC or an FBC without knowing the funding route.

156. The public funding route certainly cut down my involvement with lawyers quite a lot, because I do remember in the ACADs, and particularly the Hairmyres hospital, that there were acres of lawyers when you sat down, reading contractual changes. I did not see any of that in the public funding route. By going the public funding route, it is just a great big capital project, from a finance point.

157. I think it got easier, personally, but that is from a finance point of view. There were a lot less legal meetings regarding contract monitoring, second period pricing formula etc. But the funding route did not change during this project. That is the point I am making. PFI had been there for about 10 or 12 years or more. We had built other buildings in PFI in the South and assumed we were doing PFI in this project. So, in the early iterations we had thought because that was the funding route for the NHS, it would be remain the same. But we had not launched the project under PFI but rather, required clarity on the funding route before moving forward.

158. As to the next question, which is question 22 in respect of the Gateway Review 3, which was in October 2010, I am listed as one of the interviewees. I attended Gateway a couple times. It was just at this point the project team were in the final stages of completing the Full Business Case for Gateway Review 3.

159. The process lay, with the daily responsibility of the project team, under the Project Director. By then, the Chief Operating Officer, who took over after D.O.A.P left in February 2010, and this is October 2010, is leading the project. The process for leading that below the C.O.O would be with the Project Director and the project team.

160. The appropriate sections of the FBC were the responsibility of each directorate, where appropriate, so for example, the sections for Children and labs – I cannot remember if that is mentioned there – would have lain with them. The finance section was under my lead.

161. I had a similar role at the Outline Business Case as to when we did the Full Business Case.

162. It would be a similar process for gaining the full Board approval as with OBC, and then onwards to the Capital Investment Group.

163. So, again, from memory, gaining the NHS Board approval would've seen the FBC pass through the Acute Services Strategy Board, logically, to the Performance Review Group, because that is now the reporting structure.

164. From then, it would have gone up to the Board for approval, but I think after approval it would go to the CIG. But before that Board approval, I think, the Board need to know that the Scottish Government is happy with the FBC. .

165. In all, the final sign off on the Full Business Case would have been the NHSGGC Board. They are launching the project.

166. Regarding the Gateway Review 3 at paragraph 4.41, headed, "The Review of the Current Phase" where it states, third line down: "The review team found that both client and contractor staff acknowledged that the competitive dialogue period was shorter than typically found."

167. I have no real comment on the length of the CD (Competitive Dialogue) process. I suppose Gateway are seeing many projects and the Gateway teams will know how long they took, but this was a big project. Should it be longer? Have they done others? Or for the previous 10 years or so, Gateway has been reviewing PFI contracts, and whilst they are saying "typically", I do not know if that is a reasonable comparison.

168. I could not have told you whether it was 3 months, 9 months or 15 months or whatever. But I had no concerns about it at the time.

169. When you read on, you can see it was four months, and the Gateway team then say it is because of “contributing factors, a high quality of detail design, a high structured plan meeting and informing bidders.” It then says, “This project should capture the key points of procurement in a case study and share across the public sector.”

170. So, if you read the paragraph, you may ask, “why is it so short?”, but if you read the whole section, it states that “this approach has been highly effective and efficient”, so overall an excellent report.

171. When I was interviewed for Gateway Review 3, my input would have been the finance section and describing the affordability plan. That sort of thing. I do not specifically recall it, but I cannot see it can be anything other.

172. To bring it all together, as we were progressing OBC, we were really wondering which procurement route we would follow, but by the time we get to FBC and launch it, we know it is a public funding model.

173. I have been asked what impact, if any, did the change from the PFI model to public financing have on the overall delivery of services or the overall design and construction of the hospital. I have also been asked if there were any risks or resource implications as a result of the change from PFI to a public funding model, particularly in respect of commissioning, independent validation and resources. Again, please note it was public funded from the start. Early Gateway had mentioned this and there was no change to the funding model throughout the project.

174. I cannot comment on commissioning. I was not there. The impact of independent validation – again, I have no comment. I was not there. The affordability model was based on the public funding model, and we had already detailed the resources to manage and maintain affordability.

175. If you were closing, for argument's sake, the Victoria Infirmary, if we take facilities as an example, then there would be so many domestic staff, maintenance staff and whatever else. Equally, closing the labs in the Southern General and the Victoria Infirmary, then the appropriate directors came up with new staffing models, et al. as to what their new costs would be within the new hospital.

176. By adding that all up, we had an affordability model. We also knew what the capital charge would be, so there was no financial challenge based on the affordability plan.

177. In terms of all matters commissioning, I was away before the hospital was commissioned. At no point were any concerns brought to my attention in respect of funding. When I retired, the project was underspent. I do not know what other costs were incurred after that, but the building was nearing handover, so I suspect very few.

178. I have been asked about the process for requesting funding, who was responsible for submitting applications and who was responsible for approving them, and whether any specialist input was required to advise on application before they were submitted or approved.

179. When we commenced the QEUH project, the decision was made that some specialties were not included in the transfer to the Govan site.

180. We had agreed a bed model. We had agreed the number of consulting rooms, theatres, A&E spaces etc, and probably by 2013 that was it, it was all designed and was seen as a potential centre of excellence.

181. You could not put another floor on. The helipad was obviously going up there. So, by that point no major construction change was likely.

182. So, unless there were major changes for theatres for example, I would not have seen a significant finance cost in there, and I do not recall any of that, so I do

not know what question 27 paragraph 174 above means. My answer is once we had agreed the cost profile with Scottish Government, we knew how much money we had.

183. Where an internal cost arose that came back to the change control spreadsheet. The Project Director and his team would then have brought that as a cost, back up through the design group, to the Executive Sub-Group, to the ASSB all the way up. If it was a required change, then the Executive Sub-Group, largely led by people who knew whether it was appropriate, it would be discussed and approved at that group.

184. They would agree it. But, again, remember the Acute Services Strategy Board had to agree all major change control so governance was strong here.

185. The Acute Services Strategy Board also had the Performance Review Group above it. So, in theory, it would flow up through these groups.

186. If it was a much smaller change, then the Executive Sub-Group could just approve it and ratify this at the A.S.S.B later in order to keep the project moving.

187. Question 28 is about my role in ensuring the project remained on budget and on schedule. I had a role in looking at the reporting and the financial managing of the overall QUEH project and the Glasgow capital spend, because we had lots of other capital projects going on also within NHSGGC capital programme, so I would overview that.

188. The new hospital, if it was staying on spend profile, the likelihood is our other projects were going to be okay. However, if it was coming off profile then that could affect the whole NHS Scottish national programme due to the size of the project. However, we were never off programme.

189. If at the year-end we were going to have slippage, we were updating CIG. They would then consider how to move this and ensure we get that back next year. So, we had that interface, but I do not recall any large issues as such.

190. I have been asked about the Scottish Government oversight on the project, particularly the CIG in respect of financial decisions taken in respect of the project. The CIG approved the capital costs and their profile. This was required for the national programme.

191. We met regularly with the Scottish Government representative Mike Baxter on this group.

192. The other part of that question was who did I report to? I reported to the Chief Operating Officer.

193. The final bit of that question is what level of scrutiny was given by CIG in respect of financial decisions? The annual capital budget agreement on spend profiles was approved by CIG. Updates on actual spend went to CIG on a monthly basis. This included Glasgow capital spend on all projects, including the new hospital.

194. So, CIG are getting a monthly capital report for where Glasgow is as you progress. Invariably, there is slow spend at the start of the year and higher spends in March, but they need to see spend profiles.

195. So, there were interfaces and our Capital Accounting Head of Finance would update on spend profiles. So, CIG received monthly reports on all capital spend.

196. The capital accounting Head of Finance reported on all capital spend within Glasgow. He overviewed the capital programme in finance terms and reported to myself. I would take the HOF to all meetings with the CIG representative.

197. I have been asked if I had any involvement in respect of the appointment of Currie and Brown as technical advisors. From memory, I had no involvement in the appointment of Currie & Brown.

198. You asked me about my understanding and involvement in respect of the selection process whereby Multiplex was selected as the preferred bidder. As detailed earlier, once we had the scoring mechanism created by the advisors and once we had all presentations, I was a member of the group that recommended the NHS Board appointment of this builder.

199. I think we met in various places over the period. The group had Board representatives, Acute Division representatives, medical representatives etc. There were also advisors there who led us through the process.

200. My recollection is it was quite a detailed scoring mechanism and Currie & Brown, because you mentioned them, were the design advisors. I think there were other technical advisors on fixtures and fittings and pipework etc., but I am not quite sure.

201. The advisors created a Scoring Matrix that considered the quality of the building and the use of materials, the concrete or anything like that. The technical chaps took us through the technical side of things and then the finance advisors took us through the bids from the bidders. Then twenty, thirty or forty people, listened to that, scored the various bidders, and I think it was Ernst & Young financial advisors took ownership of it all, and presumably did minutes. The scoring sheets came up with a score and Multiplex were appointed by the NHS Board. That is as I recall it.

202. Multiplex would have then been awarded the contract by the NHS Board following the competitive dialogue process based on the scoring mechanisms,

203. I was a member of the evaluation group that included the scoring outcome. Multiplex were appointed following the outcome of that scoring profile.

204. The scoring outcomes were retained, I believe, by the financial advisors and that will detail the Multiplex scores against other bidders.

205. So, access to the scoring sheets will probably show that some of the bidders scored more for the non-technical side or the technical side and some scored less, and when you look at them all together Multiplex were recommended because they had the best score. That is how I would recall it.

206. The NHSGGC Board would need a scoring outcome to then appoint them, so there must be a minute somewhere because it was a Board appointment. There were Board members at the scoring event. I would not have seen other scoring sheets other than my own. I do not think we even left there with any papers. I am pretty sure they all went in. This would be late 2009. That is as I recollect it from about 15 years ago.

207. I have been asked about my understanding of the ventilation derogation at the Queen Elizabeth University Hospital. I have no specific recollection on major discussions on the issue but as noted I would have seen any financial cost implication.

208. I have read the paper on Ward Ventilation Design Strategy. Whilst I do not recall particular discussions around the paper at our usual committees, the footer notes it as a Currie & Brown document from December 2009. So, it is possible the design advisors brought this to the evaluation day to take members through any design issue. Other than that, I have nothing to offer on the ventilation issue.

209. I have been asked about changes made to the maximum temperature variant. As noted in paragraph 132 it would appear a facilities requirement due to ACAD temperature problems drove the change.

210. I would not have been involved in specifying a change to the maximum temperature variant.

211. Overall, though, I am unable to comment on ventilation or BREEAM.

212. Overall, in terms of Question 36, the responsibility for approving the ventilation strategy would have started at the Project Team or Facilities level and worked its way through the appropriate groups.

213. I would not expect a change to an SHTM without discussion at a senior project group.

214. I think, given it was before new arrangements in February 2010, it would likely have had to come to Acute Services Review Program Board via the Director of Acute Planning or Director of Facilities. The way governance works, if there had been discussion it would have to have started its route in the project and then it would have had to have gone up through the appropriate groups.

215. I would have thought it would find its way to the Acute Services Program Board for discussion.

216. If this necessitated a large finance change, then it should have been discussed at an ASR Program Board. Equally if there is no finance change, or there is a small finance change, I would have been involved in a finance change control.

217. In response to your question about SHTM guidance, I knew there were standards to be met, but I do not recall specific discussions about the ventilation strategy paper.

218. In terms of there being a drive for cost efficiency during the build; we had an affordability profile. There is always a drive for cost efficiencies. But, when we launched FBC, we obviously could not launch without knowing that we could afford it.

219. We had the capital cost which was now public funded, and that brought a capital charge as opposed to being exposed to the market at completion on the volatility of interest rates.

220. Each director set their workforce profiles, so the director of nursing, for example, had detailed what the nursing profile would be in each ward within the new hospital, and the Director of Facilities had detailed how many porters, maintenance staff and domestics were required, and that built up against what we were saving in the other hospitals. Once we had that affordability profile, there was no further push required.

221. It would always be reviewed annually with new budgets etc, and then, getting nearer the hospital opening, you would need to then review it again. But the requirements were signed off. For example, the nurse director signed that she could manage with the agreed nursing profile.

222. In terms of energy efficiency, I think the Director of Facilities would be clear on what energy saving we would expect. A lot of the old Southern General infrastructure was energy inefficient. So, there was energy saving. There were other savings that created the affordability profile.

223. Just to clarify, when I say this was always being reviewed, what I mean is, for example, if we suddenly said we required more than £843 million, or the Treasury increased the capital charge percentage and, therefore, there was going to be an additional cost to the project, then we would need to consider what additional savings we could make. You would always keep an eye on it as you go through the project. We had an affordability profile and we had a capital budget that allowed us to build and run the hospital and, broadly, that was it.

224. Again, there was no drive for cost efficiency against the needs for patient safety. Certainly not in the models before 2014/15. There was no trade-off for cost efficiencies against patient safety. That just did not happen.

225. At the point I retired, I had no concerns about the financial profile for the hospital opening. As to the building itself, it would have been whoever was involved in commissioning and the technical individuals as to whether they were ready for opening.

226. I had absolutely no involvement in handover commissioning, validation, Infection Prevention Control, or commissioning validation. I wouldn't have been involved in any of the commissioning, completion certificates or contractual compliance.

227. Regarding Section J, the New South Glasgow Hospital Executive Board, question 52. This is May 2008. I do not see the document referred to in the papers I have been sent. I do not recall this Board without seeing the document. However, it is likely I was a member and this would have been an early iteration of the later Executive Sub-Group etc.

228. There are so many of these groups over the years. I do not recognise the name of the Hospitals Executive Board. I suspect the remit was not majorly different to where you end up later with another group, the Acute Services Strategy Board or the Executive Sub-Group.

229. In the ASR programme Board meeting in June 2009 there is listed myself and the Board D.O.F, and the members of that group at that time, including Brian Cowan. He is the Medical Director. Whereas, later on in February 2010, you have got the HOF and Board DOF in that Acute Services Strategy Board meeting. You have got Director of Women & Childrens so I suspect the NSGHEB in 2008 was an earlier version of the Acute Services Strategy Board or Executive Sub-Group from February 2010.

230. I believe that with the Director of Acute Planning leaving, that forced a review of the various groups and the creation of this structure because it was all coming back under the C.O.O. So, I think the remits would be broadly similar with the addition that the appointment of a builder required additional interfaces and governance approvals.

231. Regarding the Performance Review Group as detailed in the new governance structures in February 2010, you will find that all of those members are non-Executives of the Board. Therefore, I am not a member of this PRG. However, there could have been a Performance Review Group back in 2008, but again I do not have papers detailing this group or remit etc.

232. It is the titles that are difficult to recall. I sat on lots of groups over the years of the project. So, if it is the Performance Review Group as depicted in the 2010 February paper, then I was not a member. But if, in 2008, there was something else called a Performance Review Group, I may well have been a member. But the remits of these groups and the roles of these groups would have been created by the Director of Acute Planning. If it ran from 2006 to 2009, the D.O.A.P would have been the one that created the remits et al., and I would probably have sat on some of those groups.

233. A lot of groups are called “Board”, but this should not be confused with NHSGGC Board, who had ultimate authority on decisions and other appointments. But these other Boards are other operational groups.

234. I have been referred to **Bundle 30, Document 6, at Page 50**, regarding the Project Steering Group. I do not see this group in the new structures, but I suspect remit etc. would have been an earlier iteration of February 2010 structure.

235. Gateway reviewed all this in January 2008. I am not sure of the year for this Project Steering Group though I suspect it was overseeing the project until 2009.

236. Given this is before OBC, my role in this group would have been what is happening generally in the project, what are going to be the financial consequences etc.

237. I think the D.O.A.P joined in 2006 because that was the restructure period. She had a Head of Finance appointed to her, who worked for her for a period of about 18 months. That person would have been responsible for the early finance progress towards OBC and I would have overviewed this, but we didn't get there until 2008 and we have already picked up my involvement in the OBC.

238. Regarding the New South Glasgow Hospital's Laboratory Project Executive Group, I think this again is an early development, of how the structures worked between 2006 up to when we get to Gateway 1 in January 2008. This preceded the structures detailed in February 2010.

239. I think this was the structure for the build of a new laboratory so a project board to overview this build was required.

240. So, in addition to laboratory specialists there would be a need for a financial representative, facilities representative etc.

241. The likelihood is if it was covering the New South Glasgow Hospitals and Laboratory and I was at a senior level as the acute Director of Finance, I would have sat on that group. But it would have been the first go at a structure as the project develops. So that would be in about 2006 to 2009 or so.

242. In response to your final question on whether there is anything else I'd like to share with the Inquiry and whether I thought the project had been a success I'd offer the following.

243. I think in terms of the final output the Acute Services Review was a success. The ASR set out to replace old hospital facilities across Glasgow. We now have new Ambulatory Care Hospitals in Stobhill and Victoria, a new Beatson Cancer

hospital on the Gartnavel site, a new Children's Hospital and Maternity Unit on the QEUH site , transferred from Yorkhill, and a 1000 bed, single room , modern hospital in the shape of the QEUH. The old infrastructure of Western Infirmary, Yorkhill, Victoria Infirmary, Stobhill Hospital and the Southern General Hospital have all been replaced. So, the ASR achieved what it set out to do.

244. Wearing my finance hat, all of the above was achieved within financial budgets. Other major Scottish projects in Edinburgh Trams, Scottish Parliament and presently Ferries, have not delivered within the financial budgets allocated. So again a positive outcome here.

245. I think at times there were too many meetings, but that is largely what happens in a large project of this size. But the output is there in the shape of modern health facilities as detailed above.

246. Over the last few years, I have taken my 93 year old father to the QEUH, re his healthcare, on numerous occasions. The relevant departments are in close proximity and easily accessible for him.

247. Five of my grandchildren have been born in the new maternity facility since 2011. My children, grandchildren, my wife and I all access QEUH when required. So, from a personal healthcare interface I have found the QEUH to be an excellent hospital.

248. Overall, I do believe the project was a success and the ASR achieved what it set out to do. .

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.

Signature……. Date…….

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

Appendix A

A47390519 - Bundle 11 - Water Safety Group (External Version)
A47069198 - Bundle 12 - Estates Communications
A48890718 - Bundle 13 - Additional Minutes Bundle (AICC/BICC etc)
A47851278 - Bundle 16 - Ventilation PPP
A48235836 - Bundle 18, Volume 1 - Documents referred to in the expert report of Dr J.T. Walker
A51598597 - Bundle 30 - Acute Services Review Papers
A35503139 – Bundle 30 – Acute Services Review Papers
A33998289 – Bundle 43, Volume 2 – Miscellaneous Documents
A33998293 – Bundle 43, Volume 2 – Miscellaneous Documents
A35422674 – Bundle 52, Volume 2 – Miscellaneous Documents
A49847577 - Hearing Commencing 19 August 2024 - Witness Bundle, Volume 3
A47711392 - Hearing Commencing 19 August 2024 – Witness Bundle, Volume 7
A49223572 - Hearing Commencing 19 August 2024 – Witness Bundle, Volume 7

Scottish Hospitals Inquiry
Witness Statement of
Ken Winter

This statement was produced by the process of sending the witness a questionnaire with an introduction followed by a series of questions and spaces for answers. The introduction, questions and answers are produced within the statement.

Personal Details and Professional Background

1. Name, qualifications, chronological professional history, specialism etc. – please provide an up-to-date CV to assist with answering this question. Please include professional background and role within NHS GGC, including dates occupied, responsibilities and persons worked with/ reporting lines.

A. Kenneth Winter. Retired Managing Director of Balfour Beatty Construction. I was employed by Balfour Beatty for over 30 years during which time I progressed from a fairly junior level to eventually Managing Director, retiring aged 60 in December 2005. In the latter stages of this employment the Balfour Beatty Group became involved in the delivery of hospitals via the PFI procurement route and the company I managed was responsible for the delivery of the construction of these. For example, we successfully delivered major hospitals in Edinburgh, Durham, Blackburn, UCLH and Birmingham. Therefore, when GGCH advertised for a non-executive director with experience in hospital building I felt qualified to apply. I was subsequently interviewed by the chairman Andrew Robertson and two others [can't remember names]. It was explained that the Board was about to embark on major construction expenditure but the persons on the Board did not have any experience in construction. The Chair explained he wanted someone in place who could give an independent view of progress and costs, challenge the construction team if necessary and report to him. I fulfilled this role by visiting the construction site on monthly basis and meeting the Board's site team along with their appointed project managers and carrying out a site inspection.

[This was not dissimilar from what I would do during my working career]. The Chairman stressed that he did not want to find out 6 weeks from the end that the Project was a year late and millions over budget. I would review with the Board's own Project Manager any issues to be raised at Board meetings to hopefully ensure no surprises or contentious issues. I fulfilled this role from 2009 until the Project was handed over on time and on budget.

NHS GGC Board and Governance Structure

2. For the period where you sat on the NHS GGC Board, please explain the governance structure and reporting lines. Please discuss the reporting lines between the Board and its first line of subordinate committees. Please explain how the Board made and authorised decisions in respect of the new South Glasgow Hospital (that became the QEUH/RHC).

A. I have no knowledge off the reporting lines save that the project director reported to the chief executive.

3. What procedures were put in place by the NHS GGC Board to ensure monitoring, progress and resolution of issues that had been reported to the Board or one of its first line subordinate committees?

A. No knowledge.

4. What are your views on the effectiveness of the governance structure within NHS GGC in respect of procurement of the new SGH/QEUH/RHC or Infection Prevention and Control during your time on the Board?

A. No knowledge

The South Glasgow Hospital Project

5. Please detail your involvement if any in the following matters in respect of the QEUH. Where applicable please note where you expressed views and what they were:

a) Construction/design.
b) Commissioning and validation.
c) Finance.
d) Site selection.
e) Value for money in respect of the build.
f) Derogations; and
g) Procurement model

A. a. Gave an overview of construction to Boards project manager on a regular basis. These were generally of a positive nature.
b. Discussed progress in this regard with Boards project manager. Generally, all was on track from an overview aspect.
c. Review of any major financial issues with Boards project manager. No recollection of any major problems.
d. No involvement.
e. No involvement
f. No involvement
g. No involvement

6. Describe your understanding and the Board's involvement, if any, in respect of the selection process whereby Multiplex were selected as the preferred bidder.

A. No knowledge

7. Why were Multiplex awarded the contract following the competitive dialogue process? What distinguished Multiplex from the other bidders to make them the preferred bidder?

A. No knowledge

8. Describe the Gateway Review process and your involvement in it, if any.

A. No knowledge

9. At the NHS GGC Board meeting of 15th December 2009 **(Bundle 37, Document 40, Page 526)**, which you attended, at minute 118 ii) it discusses the tendering process and the preferred bidder. What can you tell us about

this process? What was your involvement in this process? Who made decisions on the outcome of the tender process and the preferred bidder? What advice was sought and from whom? Were the bids presented to the Board for a final decision?

A. The Board had in place a large team of advisers in all aspects of design and construction and they in conjunction with the Boards in house team had concluded that the Multiplex bid provided the best value for money bid. I can't remember the names of those parties.

10. At minute 119 iii) in respect of the same meeting, it states that Mr Calderwood alongside the Cabinet Secretary had hosted the launch of the preferred bidder, namely, Brookfield Europe LP., now Multiplex. What can you tell us in respect of the decision to choose Multiplex as the preferred bidder? What was your involvement in this decision, if any?

A. No involvement

Water Systems at the QEUH/RHC

11. Throughout your time on the NHS GGC Board and through your work with the project team were you aware of any concerns raised in respect of the water and ventilation systems of the QEUH/RHC during the build phase? If so, what were these concerns? Did you discuss these concerns with anyone? Were these concerns reported to the Board through the monthly progress reports or raised at the Quality Performance Committee?

A. None of these issues were ever brought to my attention.

12. Were you aware, i) during the build phase and ii) at the point of handover of the QEUH/RHC, of the requirement for a L8 Pre-occupation Risk Assessment? Are you aware of what steps were taken to ensure that one was carried out? What steps did you take to ensure that the water system of the QEUH/RHC was safe?

A. No involvement apart from asking in overview terms if all testing was progressing in accordance with the programme.

13. At what point did you first become aware of the issues with the water system of the QEUH/RHC that related to any risk that the water system might be contaminated or pose a risk of growth of a biofilm? What was your reaction upon learning of these issues?

A. No recollection

Beatson/Adult BMT

14. The Inquiry is aware the adult BMT service was to transfer from the Beatson to the QEUH as noted in the meeting minutes from the Quality Performance Committee dated 2 July 2013 **(Bundle 34, Document 62, Page 542).** This was confirmed in a change order request, issued by Jonathan Best in July 2013 **(Bundle 16, Document 29, Page 1699)**. Please provide details in respect of the following:

a) What risk assessments/ HAI Scribes were carried out prior to the change order request?

A. No involvement.

b) What were the technical and environmental requirements (in particular air change rates, pressure regimes and HEPA and air permeability requirements) to accommodate the BMT Unit at QEUH/RHC?

A. No knowledge

c) Your attendance and involvement in any design review meetings which were held to confirm with the user groups the requirements for the BMT Unit.

A. None

d) Discussion with Multiplex regarding the proposed change order and the impact on Air Change Rates and Pressure Differentials?

A. No involvement

e) Involvement with Infection Prevention and Control in respect of the proposed change order?

A. None

f) What ceiling types were specified and approved for use in Ward 4B? Who from the GGC Project Team approved this? Describe your involvement, if any? What was the impact, if any, of the choice of ceiling tiles? What concerns, if any did you have regarding the choice of ceiling tiles?

A. No knowledge.

g) What concerns, if any, did you have regarding the final design specification of Ward 4B, and what action, if any, did you take in respect of these concerns?

A. No involvement.

h) Whether at any time you were told by anyone that the ventilation system already planned for the hospital would not be able to provide 10 air changes per hour within the proposed adult BMT ward?

A. Never

15. To what extent did discussion of the proposed addition of an adult BMT ward in the QEUH consider the application of the specification for air change rate, pressure differentials and requirement for HEPA filtration set out for a 'Neutropenic Ward' in SHTM 03-01 ventilation for Healthcare Premises

A. No knowledge

16. The Inquiry is aware that the change order not only confirmed that the Bone Marrow Transplant (BMT) service would transfer to Ward 4B in the QEUH but also that the hematology patients that were originally planned to accommodate Ward 4B would move to Ward 4C.

a) Describe how this change was communicated to the project team and Multiplex and how this change was captured in the design and specification documentation.

A. No knowledge

b) To what extent was there discussion at this time as to whether the specification for air change rate, pressure differentials and requirement for HEPA filtration set out for a 'Neutropenic Ward' in SHTM 03-01 ventilation for Healthcare Premises might now apply to Ward 4C is accommodating Haematology patients who might well be neutropenic?

A. No knowledge

c) When did you first become aware of the issues identified within Ward 4B in June 2015?

A. No knowledge

17. Patients migrated to Ward 4B in June 2015 however less than one month later they returned to the Beatson. The issues identified were present at the point of handover in January 2015, please explain why the ward was signed off and handover accepted given the issues which arose shortly thereafter.

A. No knowledge

<u>Ventilation Systems at the QEUH/RHC</u>

18. At what point did you first become aware of other issues with the ventilation system within the QEUH/RHC? Specifically, when did you learn that Ward 2A RHC and the isolation rooms might not have been completed to the standard expected by the clinicians asked to treat patients in them or SHTM 03-01?

A. No knowledge

19. Was this something you were aware of through your work with the project team? Upon hearing of this decision, did you discuss this with anyone? Was advice sought in respect of this decision? Did you have concerns in respect of the consequences of this decision and patient safety? Was this decision discussed at the Quality Performance Committee? Was this decision included in the progress reports shared with the Boards?

A. No knowledge

Project Management Group

20. The Inquiry is aware you were involved with the Project Management Group. What was the remit of this group? To whom did it report? Who were the other members of the Project Management Group? Was there any infection control input into this group? Was there ever a requirement to seek external advice on areas of the project? If so, what advice was sought and from whom? Did any other Board members sit on this group? What were the decision making processes within this group?

A. The only 'group' I had involvement with was one consisting of the Board's own project manager and representatives from the appointed project managers. We would meet approximately once a month. It did not formally report to anyone, its purpose was to have an overview of construction issues primarily progress and through me give confidence to the Board that what was being reported to the Board was a true version of events. It was never the intent to probe into detail as on any project of this size there was bound to be at any point of time many issues of detail.

a) In your answer to question 20 in your March 2025 statement you refer to "the Board's own project manager". Was this Mr Alan Seabourne, Mr David Loudon or someone else?

A. It was Alan Seabourne and then David Loudon

b) The Inquiry heard evidence at its Glasgow 4, Part 1 hearing in May 2025 that although NHS GGC appointed Currie & Brown as technical advisors for the Stage 1 of the new SGH project in 2008 and that Currie & Brown had the support of technical subconsultants including Wallace Whittle as M&E Engineers with experience in ventilation systems during Stage 1 in 2009 they "stood down" their technical subconsultants in February 2010 following the reduction of the scope of their role.

With reference to the "group" discussed in your answer to Question 20 in your statement of March 2025 who did you think was providing technical

advice on ventilation systems at the new SGH to NHS GGC after February 2010?

A. I can't recall that issue but I don't think it would have been relevant to my role.

21. In the minute of 10th January 2012, it is noted at item 2 that the NHS Team required an updated inspection look-ahead programme for the forthcoming visit by yourself **(Bundle 31, Document 40, Page 247).** What is an inspection look-ahead programme? What did these visits/inspections entail? Did you ever come across anything concerning in respect of any aspect of the build/project? Who would provide assurances in respect of any recommended actions or steps that were required being undertaken

A. No recollection

Performance Review Group

22. The Inquiry understands you were a member of the Performance Review Group. What was the remit of this group? To whom did it report? Who were the other members of the Performance Review Group? Was there any infection control input into this group? Was there ever a requirement to seek external advice on areas of the project? If so, what advice was sought and from whom? Did any other Board members sit on this group? What were the decision making processes within this group?

A. No recollection

23. At the meeting of the Performance Review Group of 7th July 2009 **(Bundle 34, Document 22, Page 154),** in respect of an update relation to the New South Glasgow Hospital, it states that 3 companies have been shortlisted by the evaluation panel and issued with an Invitation to Participate in Dialogue (ITPD). What can you tell us about this process? What was your involvement in this? Was this a fair, open and honest process?

A. No knowledge of this

a) The contract between Brookfield Europe and NHS GGC contains in the M&E Clarification Log **(Bundle 16, Document 23, Page 1664)** an agreement that the single rooms of the new SGH would be built with a ventilation system that supplied air at half the rate than that called for by Scottish Government Guidance. Compliance with that piece of guidance had been a requirement of the Employer's Requirements. Whether that decision has increased risk to patients in the hospital is a key issue that faces this Inquiry.

The Inquiry has heard evidence about the operation of the Performance Review Group (PRG) and the New South Glasgow Hospitals and Laboratory Project Executive Board (NSGHLPEB) during Stage 1 of the new SGH project in 2009.

Based on the evidence the Inquiry has heard so far it appears to be the case that this decision was not reported to or made by the NSGHLPEB, the PRG or the NHS GGC Board proper.

At our Glasgow 3 hearing Professor Steele (then Director of Estates) gave evidence that no documentation other than the M&E Clarification Log itself exists to explain why the NHS GGC agreed to the derogation

You may wish to review Provisional Position Paper 15 - Governance Structure within the project to construct the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow which was issued by the Inquiry Team in June 2009.

You were a member of the PRG on 19 May 2009 when it approved the Terms of Reference and Membership of the NSGHLPEB **(Bundle 34, Documents 20 and 21, particularly at pages 134, 147, 152 and 153)**.

With your experience in the construction industry and in the light of the Terms of Reference of NSGHLPEB:

i) Would you have expected that a decision to build the new SGH with a ventilation system that did not meet the Employer's Requirements to have

been reported to any of the NSGHLPEB, the PRG or the NHS GGC Board proper?

A. Design was not in my remit but I would only comment that I would expect that any decisions made by the Project Team would have to go through appropriate approvals.

ii) Would you have expected that a decision to build the new SGH with a ventilation system that did not meet the Employer's Requirements to have been made by any of the NSGHLPEB, the PRG or the NHS GGC Board proper?

A. I would expect that at board level it would be a "sign off" with reliance placed upon the Project Team to have properly evaluated this. There could be any number of reasons why changes might be made to Employers' requirements.

Quality Performance Committee

24. The Inquiry understands that you were appointed to the Quality Performance Committee to monitor the building phase of the project. What was the remit of the Quality Performance Committee? For what purpose was it established? What role did it have in the procurement of the new SGH/QEUH/RHC In a manner consistent with good practice and particularly in the field of IPC? What can you tell us in respect of your role both within the project and when providing updates to the Committee? Who did you liaise with within the project team? To whom did you report?

A. At the Quality and Performance committee I was solely concerned with the issue of overall progress and cost. I reported to the Chairman.

25. In what way did the Quality Performance Committee receive updates from the project team? What meetings took place and who attended? What reports were produced and how often? What details were provided within these reports? Was an appropriate level of scrutiny given to the project team and the reports produced by the Quality Performance Committee? What would the reporting process from the Quality Performance Committee entail?

A. I have little recollection of the committee meetings. There was a regular meeting between myself and the Boards Project Manager and the Boards appointed Project Manager. There was no formal reporting from this save to assure the Board at monthly meetings that the reports they presented were aligned with my view of progress and finance. This was a high level overview.

a) The Inquiry Team has noted that Questions 24 and 25 asked you about your membership of "the Quality Performance Committee" when in fact you were a member the Quality and Performance Committee from its establishment in July 2011 until at least May 2015; **Bundle 34, Documents 44 to 89** are minutes and relevant papers from the Quality and Performance Committee. Please review your answer to Questions 24 and 25 in light of the contents of Bundle 34.

A. At the time of my original answer, I had no recollection of participation in the Quality and Performance Committee.

26. At the minutes of the Quality and Performance Committee of 18 March 2014 which you are noted to have attended **(Bundle 34, Document 72, Page 653)** at minute 49 in respect of the New South Glasgow Hospitals Progress Update Stages 2 and 3, you ask a question about technical inspections as a result of the pending expiry of the two year defects liability period for the hospital. What can you tell us in respect of the two year defects liability period? What was your view on the number/extent of defects required within for the new QEUH/RHC?

A. No recollection of this

27. In its most recent its Glasgow 4, Part 1 hearing in May 2025 in the Inquiry heard evidence about the absence of formal Validation of the ventilation systems of the new SGH prior to occupation of the hospital by patients. It appears that members of the NHS GGC Project Team may not have understood the difference between 'commissioning' a ventilation system to confirm it has been fitted in compliance with the contract and 'Validation' of a ventilation system to confirm that it operates as its users expect it to.

Do you have an understanding of the difference between commissioning' a ventilation system and 'Validation' of a ventilation system and can you assist the Inquiry in understanding why the ventilation system of the QEUH/RHC including specialist ventilation areas such as isolation rooms and haemato-oncology wards were not validated before patient occupation?

A. I am unable to shed any light on this issue

Conclusion

28. Is there anything further you wish to add that you think would assist the Inquiry?

A. In my opinion this project was well managed and controlled by the boards project manager, contractor and the team of advisors. There may well have been any number of detailed issues I was not aware of but this would not be unusual on project of this size and complexity. I would stress my sole focus as requested was monitoring overall progress and cost and ensuring these were as reported to the Board.

Declaration

29. 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

A47851278 - Bundle 16 – Ventilation PPP

A51662829 - Bundle 31 – Project Management Group

A51785179 - Bundle 34 – Performance Review Group and Quality and Performance Committee Minutes and Relevant Papers

A34872080 – Bundle 34 – Performance Review Group and Quality and Performance Committee Minutes and Relevant Papers

A34871048 – Bundle 34 – Performance Review Group and Quality and Performance Committee Minutes and Relevant Papers

A34872674 – Bundle 34 – Performance Review Group and Quality and

A51259159 – Bundle 37 – Board Minutes and Relevant Papers

Performance Committee Minutes and Relevant Papers

Scottish Hospitals Inquiry
Witness Statement of
Ian Lee

1. My name is Ian Lee. I have been asked to provide this statement to the Scottish Hospitals Inquiry. In terms of my career, I started as an apprentice accountant, thereafter I qualified as an accountant. I progressed through the ranks of a firm which was then called Arthur Young, McClelland, Moores & Co. It became Arthur Young, then it merged with Ernst & Whinney and became Ernst & Young, and it has now changed to EY. I had spent my whole full-time career with Ernst & Young, and upon leaving, within a month or so I managed to get a non-executive role as chair of the audit committee of an AIM listed company called Clyde Process Solutions plc.

2. In 2008 I joined the board of Ricardo plc, which is a Small Cap listed PLC, I sat on that board for nine years where I was chair of the audit committee, and then that same year I became a member of the NHS Greater Glasgow and Clyde board as a non-executive member.

3. Covering Ricardo first, I was the chair of the audit committee there and on various other committees. With NHS Greater Glasgow and Clyde, when I joined I was a member of the Performance Review Group and the audit committee. In 2011 I became chair of the newly formed Quality and Performance Committee and Vice-chair of the Board. I also had some other roles. I was chair of the charities forum, which was a forum with all the charities involved in the Children's Hospital. At the end of my time there, I was chair for a year of the East Renfrewshire Integrated Joint Board, which was a joint board with the local councillors for the social services and the NHS services, so I worked quite hard as a non-exec at the health board

4. I then in 2015 became a non-executive director and trustee of the Erskine Hospital, which is a charity for ex-servicemen and women and runs nursing dementia and respite care. I did that for eight years until 2023 and became chair

of the Audit Committee in 2016. I'm currently also a trustee of a small trust called the Endrick Trust, which is a Glasgow-based trust for the prevention of poverty and advancement of citizenship in the greater Glasgow area. I have also been a trustee of the Stroke Association since 2019, a charity raising awareness of stroke and supporting stroke survivors. I have been chair of the audit and risk committee, chair of the financial performance committee and I am currently senior independent director and vice-chair of the finance committee.

5. I was on the Student Loans Company for seven years from 2011as a member of the Audit committee there, but not as a director. I was the independent advisor on the committee as a non-board expert, because none of the board members, apart from the finance director, had accounting and finance experience.

6. I did have some involvement with the Institute of Chartered Accountants of Scotland, as convener of their Audit and Assurance Committee, as convener of the Summer Conference Committee and as a member of the Accounting Standards Committee.

7. I spent a year and a half in Dallas, Texas, which is why I've got my AICPA and Texas CPA qualification.

8. I have been asked to recount my understanding of the reporting lines within NHS GGC in relation to the Board and relevant subcommittees. We had a Board meeting every two months, and every alternative two months we had a Board seminar. The Board seminars were to cover specific subjects in depth, current issues that were significant to the board. The subcommittees also met in regular cycles. The Performance Review Group where I was member and Quality and Performance Committee and the Acute Services Committee which I chaired, met every two months. An agenda was agreed in advance by the chair of the committee and in the case of the Board, by the Board chair with the appropriate senior executives. The papers were prepared by the executives for each agenda item and these were circulated roughly two weeks in advance, although it may have been less on occasion.

9. In respect of both the Board and the subcommittees, there were presentations made at each meeting by the relevant executive, and these would be focused on the key issues that were in the papers. There was then an opportunity for the Board or the subcommittees to ask questions to the executives involved. If it was a matter which required a decision there were opportunities to discuss it amongst themselves to allow them to come to a decision. For the eight years that I was on the Board, I only recall one Board meeting where we actually had a show of hands and a vote on an issue, because usually the Board would come to consensus, as happens with a lot of boards. The matter put to vote was in relation to a contract to Network Hire Taxis.

10. Every meeting had an "any other business" item too, which would allow for any other competent business to be raised.

11. The Board's subcommittee meetings were always included in the papers for the Board and they'd be on the agenda so that the Board members could raise issues on what had happened in the subcommittee. If there was a big issue in the Quality and Performance Committee, Board members who were not on that committee could raise the matters on that. I felt that this was an effective way to ensure that all Board members knew what was going on. As the organisation was very large – we had about 40,000 employees and our revenues were about [redacted], it was always significant issues that were raised.

12. Some of the papers were voluminous, I can recall papers being 450 pages for a board meeting and 400 pages for a Quality and Performance Committee meeting. As an accountant I read through all these pages as I believe most members did. Although we would focus on the key issues at the meetings, there was a lot of information provided in the papers.

13. In respect of decision making at board level and within the subcommittees, there were terms of reference which made clear what the responsibilities and the delegated authority were of the subcommittees. For instance, capital projects were approved by the Quality and Performance Committee (previously the Performance Review Group), as that was one of their roles. I cannot recall

whether in respect of big decisions there was a limit as to what the committee could cover. As an example, the approval of the contract for the New South Glasgow Hospitals, is a decision which I believe was taken by the Board on the recommendation of the Performance Review Group, but I'd have to have looked at the terms of reference of committees and the delegated authorities and the Standing Financial Instruments (SFIs) at the time to be certain. There are SFIs, which would cover what the delegated authorities are, which I don't have a copy of, so I cannot be certain.

14. I have been asked about my recollection of the procurement contract for the New South Glasgow Hospitals. When I was in charge of the Quality and Performance Committee, the procurement contract had already been awarded. I do not recall precisely when it was awarded, but I do remember that around 2008, before I joined the board, the outline business case had been prepared and had gone to the Scottish Government, who had approved it. I think that happened not long before I joined the board, but I can't be certain.

15. When I sat on the Board and the Performance Review Group, all Scottish Government contracts followed a detailed gateway process with multiple stages and various external reviews. Approval was required, although I cannot recall whether that came from the Performance Review Group or the Board – likely both, but I cannot remember.

16. There were decisions taken about how we would go ahead with this contract because there were various options, and what was decided on was a design and build contract. Following this, there was a process which ended up to my recollection, with a preferred bidder. The preferred bidder had to move forward, and we also had to appoint the advisor for us. I can't remember the name of the advisor, but I think that they were Currie & Brown who as far as I recall were the independent professional advisors helping us with the project management of the whole contract, including the tender process.

17. There was a similar process for all major capital works. For instance, during the period I was in charge of the Quality and Performance Committee, we built

various health and social care centres. For example there's one in Maryhill and there's one in East Renfrewshire, and these all had to go through the same process of outline business case, full business case, gateway processes, etc. So, it was quite a busy time with the Board approving these procurements.

18. The other thing I did want to say about procurement was there are internal controls in place which would be recorded, as I recollect, in the SFIs. The Audit Committee would have had a role, and I was on the Audit Committee, for reviewing the internal controls. The main process for reviewing internal controls was internal audit. That was what the Audit Committee would be focusing on. The Audit Committee at the time was led by Ken Winter and then by Ross Finnie, I can't remember who led it before Ken but there was scrutiny from a governance standpoint on the process.

19. I recall a woman with the surname Smith was the chair of the Audit Committee before Ken Winter. Ken eventually decided that, because he was a builder rather than an accountant, he would prefer not to chair the Audit Committee.

20. The concept for appointment of Ken was that although normally an audit committee would be chaired by an accountant it would be equally good to have someone chairing the Audit Committee who had wider business experience and was not an accountant, because the business of the audit committee was also to cover risk, internal control processes and business processes, not just accounting. Ken was succeeded as chair by Ross Finnie who is an accountant.

21. Each year, we had a governance report which went to the Board. These can be seen in the Board papers. They would cover how the Board would be gaining assurance in governance, including things like the internal audit, the external audit, the various committees, subcommittees, the various management committees, and how the Board was governed.

22. I have been asked to detail my recollection of the Gateway Review. I think there was an outline business case and then a full business case, but I don't

remember how many stages there were. There are several gateways and, at each gateway, an external person came in to check that we had met all the requirements of the gateway, rather than the fact that we've taken the right decisions or the decisions taken were right. It was a process check that was carried out, as I understood it, and the results of this check would go to the Scottish Government. The Scottish Government had a very a tight handle on this. I'm sure the government department would have known exactly what was going on with all these decisions.

23. I was not personally involved in the gateway review. My only involvement was from the perspective of reviewing the results of the review. Having it reported to us that the gateway had happened, but not the gateway review as such. It will be on the public record because it's a Scottish Government process, as far as I'm aware.

24. The project team would be involved in the gateway review. Also the Director of Facilities would have been involved and I'm sure the CEO and his executive team would have been involved because these were big decisions. Even things like the health and social care centres were costly and these were big decisions as well. Another big decision I recall was the sale of the Western Infirmary site, which went eventually to the University of Glasgow. These were big decisions which would be covered by Quality and Performance Committee but would also go to the board.

25. Infection Prevention and Control concerns were reported to the Board Clinical Governance Forum (a committee), which was chaired by the Medical Director and composed of senior management and clinicians. This committee reviewed clinical governance matters and decided whether to escalate concerns to the Quality and Performance Committee.

26. The Quality and Performance Committee had a comprehensive integrated report on patient safety, quality of delivery of service and infection control. All of this was in one report and went to the Quality and Performance Committee at each

meeting with information as to how we were doing against targets, with comments on issues arising and how they were being dealt with.

27. Before going to the Quality and Performance Committee, the report would go to the Board Clinical Governance Forum, and it was reviewed by them first. As far as I can recall, they would then decide what items would go up to the board members, but the Quality and Performance Committee got a copy of their minutes at each meeting that would be more detailed because there'd be much more discussion at these meetings. If there was something specific that came up that was not in the comprehensive report, as it was quite a long report, there was an opportunity to raise questions on that. Of course, the Quality and Performance Committee always had the Medical Director and the CEO there, and we usually had the Finance Director there also because it covered finance matters too. So, they were all attending the meeting.

28. Infection control matters would come up regularly, and there were measures on these and reports on how we were doing against these. We would discuss various clinical matters and whether they were doing something about it, but it was also patient safety and delivery of targets. For instance, the Quality and Performance Committee were very concerned about performance with child and adult mental health services because there were long delays in people being seen, and there was action taken, and as the committee kept hammering away at it, staff were brought in to sort it out and we got that done. So, there was scrutiny and there were demands for action.

29. I have been asked about the effectiveness of the governance structure within NHSGGC. To my mind, the governance structure was good, and it was designed to surface any significant issues to the board and its committees. Board members got copies of all the Quality and Performance Committee minutes, so they had an opportunity to ask any questions on anything that was being considered in the Quality and Performance Committee. I think that there were 12 non-executive members of the board on the Quality and Performance Committee, so it was a big committee, although I can't remember exactly how many members. There was a large number of members on the committee, but

those board members that were not on the committee could attend, so on occasion there were up to four other non-executive members of the Board attending, because they all got a copy of the agenda and the papers so if there was something they particularly wanted to hear about, they could attend.

30. When I was chairing the Quality and Performance Committee, if one of the non-committee members wanted to raise a matter, I would allow that. When I say they could attend, they could actively participate, they could raise matters and sometimes did but in general it was the committee members. To my mind, that worked well. I think the Audit Committee did a reasonable job of ensuring the internal controls were operating effectively, and my memory is that the governance structure appeared to operate effectively as planned in regard to both infection prevention and control and procurement.

31. I have been asked about the remit of the Quality and Performance Committee. The committee was set up in 2011 and the general remit was to provide assurance to the Board on performance in critical areas. From memory, its remit was to cover the quality of the services provided, patient safety, clinical governance matters, the delivery of corporate objectives against government plans and targets, financial planning and management, staff matters and patient-focused public involvement.

32. The staff matters I mentioned there were delegated to a staff committee, which was a subcommittee of the Quality and Performance Committee, so their minutes were included in the Quality and Performance Committee. There was a member of staff who was a full-time representative of the staff on the Board, Donald Sime. He chaired the Staff Committee and he also sat on the Quality and Performance Committee so that he could report on anything that related to staff matters. In general, staff matters were covered elsewhere. I would say half of the focus of the Quality and Performance Committee meetings would be on the quality and patient safety and clinical governance and targets, and slightly less than half on financial planning and management, because the financial planning and management was monitoring, approving budgets, and getting reports on financial matters. There was also review and approval of major

capital projects which took quite a lot of time because there were many of them. Apart from the New South Glasgow Hospitals, we had a series of new health and social care centres being built, and these tended to be being built by the NHS, even although they were jointly NHS and social care services. As far as I'm aware, I can't remember anything being built by the council as such. I think they were all built by the NHS.

33. The Quality and Performance Committee met every two months and we received a report in each meeting from the Director of Facilities, who was also the Project Director for the New South Glasgow Hospitals. I mentioned already we had 12 non-executive members and that it was attended by the senior executive directors, and sometimes there were reports as well.

34. For example, the Director of Facilities was a senior executive director, and I think reported directly to the CEO. The Quality and Performance Committee was established to integrate the reporting of connected areas, because prior to 2011, we had several committees. We had a Performance Review Group, which looked at the performance side and the financial side and we had a Clinical Governance Committee. There were several committees which were merged into the one, and the idea of that was that all these things are interrelated, and it was felt that by having separate committees, it was really working in silos, and it was better to integrate both the reporting and the discussions and the scrutiny across all these areas.

35. From my recollection, the Quality and Performance Committee meetings had very large agendas. These meetings would start at about 9.30 and sometimes not finish till about 1.30. We'd have a break at one point, but there was a lot of agenda management required in advance by myself and the executives to make sure we were covering everything, we were giving due time for each item on the agenda but we didn't overdo it. In 2015, the Integrated Joint Boards (IJBs) for Community Health and Care Partnerships, were established, and that area was then being handled by the IJBs, and we had different non-executives chairing different IJBs.

36. I mentioned I was chairing East Renfrewshire IJB, and other people were chairing each IJB, because there were six IJBs, East Renfrewshire, East Dunbartonshire, Inverclyde, Renfrew, West Dunbartonshire, Glasgow. There was a different person chairing each of these. Sometimes it would be a councillor chairing, sometimes it would be an NHS member chairing, the idea was to take turns between the councillors and the NHS members.

37. After the setting up of the IJBs in 2015, we had the Acute Services Committee which took on the remit of the Quality and Performance Committee for acute services, although there may have been slight differences in the remit. From memory, the membership of the Quality and Performance Committee and the membership of Acute Services Committee was pretty similar, these committees almost merged into each other.

38. I have been asked about the Director of Facilities. Throughout the time that I was there, there were two people involved. When I first joined the board, it was Alan Seabourne, and then he retired and David Loudon was recruited. I can't recall exactly how many years it was Alan Seabourne and how many years it was David Loudon, but it was probably roughly half and half in a short period. We're talking about 2008 to 2016, so maybe three or four years with Alan Seabourne and then maybe three or four years with David Loudon.

39. The senior executive directors who attended the Quality and Performance Committee meetings would be the CEO, Robert Calderwood, the Medical Director, Jennifer Armstrong, although she had a predecessor called Brian, I do not recall his surname, but I think he retired a couple of years into that timeframe. Catriona Renfrew who I think was the Director of Strategy and the Finance Director would attend. I think we had three Finance Directors while I was there.

40. Mark White was the most recent, before him I think was Paul James, and Douglas Griffin was the Finance Director when I joined. So they would attend, the Nursing Director would attend, and the nursing director was Ros Crockett, and then when she retired, it was Margaret McGuire.

41. They would attend, because of the governance of patient safety. They may not have been able to attend sometimes but for most meetings they would all be there. Sometimes they would not be able to attend because it was a two-monthly schedule, but I would say the Chief Executive, in particular, would always be there who always demonstrated a very wide knowledge of the organisation.

42. I have been asked if the Executive Director and the Director of Facilities participated in the meetings. As the chair, I would invite input, for instance, in the capital side of things, Robert Calderwood, the Chief Executive, would quite often ask if he could make a comment, and he definitely participated on the clinical governance side, and we'd often ask Jennifer Armstrong to comment, or she would quite often answer questions on that, because she was responsible for that whole area - patient safety and infection control. Their participation was a key part of the scrutiny. Whilst they were not on the committee, which was of non-executive members, they were attending and they would certainly participate.

43. I wouldn't say they were asking questions, because the papers presented by either themselves or their subordinates, they would know about, but they certainly answered questions. If the Director of Facilities came up with an answer and the Chief Executive knew something further he would add it, because he was the main link with the Scottish Government and therefore he might have had discussions with the Scottish Government on, for example the New South Glasgow Hospitals project. They were definitely not observing, they were definitely very actively participating. Their participation involved presenting papers, presenting information, and answering questions.

44. I have been asked about the role of the Quality and Performance Committee in respect of procurement. For the capital projects we got the reports and we would quiz the Director of Facilities on various matters. The reports we got from each meeting would cover how the project was progressing. Thinking about the New South Glasgow Hospitals project specifically, it would cover detailed design, and if there was any new design changes or whatever, which weren't many,

because we had a design and build contract and if you change the design, you'd have to pay more, as with any contract.

45. There were not that many "compensation events". They were called this because for example, if there was extremely bad weather and there was a delay, the contract specified just how that was handled. Delays could reflect something the contractor could actually get in addition to what was specified, for example the contractor could get additional money for it if it was outside their control. I can't remember exactly how it worked, because it was designed so that it wasn't just bad weather, but maybe something like the recent storm we had might have been a compensating event.

46. I can't remember the exact detail of the reports. There was discussion about how the building work was going, any issues they'd encountered and how they were resolved, and very much the financial aspects, including any extra amounts agreed for changes. There was a risk assessment carried out, and there would be a report, and how risks have changed, because there was an assessment of risk and there was a financial value put on the assessment of risk; it was pretty detailed.

47. As you go through the contract, some of these risks would no longer apply, because, if the risk had been, for instance, difficult ground conditions when you're making the foundations, and once you've got the foundations in, you either needed the amount that had been set aside for that risk, or it was no longer required. That's an example of how the risk assessment would be changing throughout and the quantity of money allocated for that risk would be changing. So that would come up too, and this would come up every two months. There were usually photos of progress too and from time to time there would be visits offered to the site to see what was going on and to the site offices.

48. Site visits were fairly infrequent, but I had wanted to walk around various areas at various stages, and we had occasional meetings at the site office. There was a lot of reporting of the key issues, but this was not huge. I can't remember how

long these reports would be, it might be two or three pages, but it covered the key issues that were arising.

49. I have been asked who from the project team would attend the Quality and Performance Committee meetings. The Director of Facilities would attend pretty much every time. Occasionally, I recall Currie and Brown attended too, but I think that might have been fairly early on when it was the Performance Review Group. This may have been when the group was talking about the way the contract and the process for tendering went, but I can't really remember that because it was back in 2009.

a) I have been asked who did I think was providing technical advice on ventilation systems at the new SGH to NHS GGC after February 2010. I do not know who was providing technical advice on ventilation systems at the new SGH to NHSGGC.

Having now had an opportunity to see Inquiry Bundle 34, I see that Mr Douglas Ross, a Director of Currie and Brown, attended nearly every meeting of the PRG from July 2010 to May 2011 and then the Q&PC from September 2011 until November 2014 to report on the change control process, potential compensation events and an overall budget update. There are no minutes in the bundle for the PRG May 2010 meeting, so he may also have attended that meeting. As one of ten non-executive members of PRG from September 2008, not its chair and also as Convener of Q&PC from its formation in July 2011, my recollection now, having seen the bundle, is that Currie and Brown's main technical input from the standpoint of PRG and Q&PC from 2010 was as cost adviser.

50. I don't think these reports that the Quality and Performance Committee were getting would be passed on to the Board. However, the Board would get the papers for the Quality and Performance Committee, so every board member would be able to see them. The board would get the minutes of the Quality and Performance Committee with the Board papers, which would cover issues arising. These reports would also cover things like the transport links to the hospital, the parking and the negotiation going on with the Glasgow City Council about the number of car parking spaces, things that were not actually with the

main contract but were allied to the whole New South Glasgow Hospitals project, they would be included in that report. For instance, there was a lot of debate with the council about the number of parking spaces, because originally it was very restrictive because the council in Glasgow are very much for the use of public transport.

51. I have been asked if I can recall any specific changes that were made to the design. I cannot because it was a design and build contract. Before I joined the board in 2008, the outline business case had been approved. The clinicians were heavily involved in the design. I had a particular interest in the new children's hospital because I was a member and chaired a charities forum for the children's hospital, and therefore I attended several meetings where we had management people along from the old children's hospital, and for example they would tell us about how they and clinicians went to Toronto Children's Hospital to see how things were done there, how things were laid out and designed and how they operated.

52. There was a lot of work done by the clinicians and a lot of input into the design of certainly the children's hospital. I can't speak to the adults' hospital, but my understanding was that it was the same. I think pretty much all of that was done before the final design stage. There were very few design changes from memory.

53. The major design change was the car parking, because originally it was going to be quite a small car park. I think from memory about half the parking that's now available. My understanding was the City Council had prohibited any further parking, and there was a huge negotiation which succeeded in getting more spaces, but then it had to be paid for. It was quite late in the day when it was clear that the contract was running under budget and that there would be surplus funds, which could partly pay for extra parking. Some came out of the capital budget of the board itself, I can't remember exactly, and perhaps the Scottish Government paid something. So that was a major, major change. The new lab was part of this project too, and I recall there might have been some minor changes in the lab as well, but I don't remember what this was.

54. I have been asked about the process and reporting in respect of changes. I think it would depend how significant it was, but I think if it had a financial or safety impact, it would have been reported to the Quality and Performance Committee. I'm not absolutely sure, but I do not think that there were many major changes, but I can't remember.

55. In terms of the progress that was made with the new hospital throughout the building phase, I think it was very good progress, because throughout the project they were really ahead of timetable, and they were well within the budget, and our budget included this risk assessment too. As I have already said, many of these risks did not materialise which was good. From the financial standpoint, I was really delighted, because so many public sector contracts go over budget and are delayed.

56. I think it was partly due to the work that was put into the tender process and getting a design and build contract, which I think makes all the difference, and tying down that design early on and then sticking to it. I think that progress went well, and on completion, to a non-builder, a non-construction person, to an accountant, the building looked pretty good. When it was finished, I had various tours around it and I thought it was looking really good. That is superficial and I don't remember any major issues during the build. Like any building contract things come up, but these were all dealt with at the time.

57. I have been asked if I had any concerns in respect of the design, the built environment or the water and ventilation systems. I don't recall any issues in the ventilation or water before completion. On the ventilation, after the bone marrow transplant unit was moved into the adult hospital. there was an issue about the air circulation there. I think it was to do with the number of times the air circulated in a minute, I can't remember the exact detail. But from my recollection, that was identified very quickly, as soon as they moved in and they were monitoring it.

58. There's a lot of monitoring which goes on for that type of thing, particularly for vulnerable patients with cancer, bone marrow transfer, and it was discovered and reported, I think, within days and the patients were moved back to the Beatson. This was certainly reported to the Quality and Performance Committee, I think it would have been at the next meeting which would be September, because I think this all arose shortly after the hospital had opened, which would be the end of June, beginning of July.

59. There was a paper produced that was presented, and it explained what was happening, which was basically the action they'd taken to move the patients, what they were going to do with the clinicians to look at what was required. To consider whether the spec, in the first place, was right, in terms of the ventilation, and did it need changing or was the problem that the builder hadn't built according to the spec. Obviously, if that was the case, the builder then had to come back and change it.

60. I remember there was a question, also, about the sealant round light fittings and the doors and things to make sure that the air wasn't getting in. From memory, I think it was agreed that the patients would not go back there until this was all sorted out. I can't recall exactly how long it took to sort it out, but I would guess it would be a few months. So yes, I knew about the ventilation issue there in the adult hospital. I don't know whether they also looked at the cancer wards in the Children's Hospital at the time, or not. I think they probably did look at the specs, but I don't know. I can't remember. But certainly the problem was in the bone marrow transplant unit in the adult hospital, which, if you're having bone marrow transfer, you're particularly vulnerable, it's very high vulnerability.

a) As I was a member of the PRG on 19 May 2009 when it approved the Terms of Reference and Membership of the NSGHLPEB **(Bundle 34, Documents 20 and 21, particularly at pages 134, 147, 152 and 153)** and in light of the Terms of Reference of NSGHLPEB: I have been asked would I have expected that a decision to build the new SGH with a ventilation system that did not meet the

Employer's Requirements to have been reported to any of the NSGHLPEB, the PRG or the NHS GGC Board proper.

In my view, the design of the ventilation systems would have been a matter to be considered by the NSGHLPEB as a technical matter. I had no knowledge of the technical detail of the ventilation systems. I also had no knowledge of ventilation matters during my eight years on the Board, except in 2013 when the Q&PC approved the transfer of the Bone Marrow Transplant Unit from the Beatson to the NSGH to be co-located with an intensive care unit, increasing the number of haematology beds with HEPA filtration and in 2015, shortly after the hospital opened, the air circulation issue explained at sections 57 and 58 of my witness statement.

Given that the decision on the ventilation systems did not wholly comply with Scottish Government Guidance and therefore the Employer's Requirements, I would have expected this matter together with the rationale for not following the guidance to have been reported to the NSGHLPEB for their decision, and if they had endorsed that view, to then have been reported in due course to the ASRB for their approval.

Although PRG's remit was on organisational performance, resource allocation and utilisation, implementation of agreed NHS Board strategies and property matters**,** rather than patient safety, which was brought into Q&PC's remit when it was formed in July 2011, I would have expected a matter of this significance to have been reported to the PRG or the main Board. I consider that the decision making around such technical matters would not normally be made by the PRG nor the main Board.

61. I don't remember anything about the water, and the first time I heard about anything about the Children's Hospital was when it hit the press in 2018, when there was press comment about ventilation. I think it was ventilation, I cannot recall if it was water as well in 2018. I can't remember as I'd left the board in 2016.

62. I have been asked about Ken Winter, who was appointed to the Quality and Performance Committee to monitor the building phase of the project. I understand he was actually appointed to the board because

he had expertise there. He then sat on the Quality and Performance Committee, but I don't remember when Ken joined the Board. I think he probably joined before the Quality and Performance Committee was formed, but I could be wrong in that, because I think the chairman wanted a Board member who had expertise in building and construction, and I think he encouraged the recruitment of someone with that experience. Ken was appointed as he was a former managing director of the building division of Balfour Beatty, so he had a lot of experience, and as I understand it, when he joined the board, he was really there to scrutinise the building phase and the progress.

63. He worked with the Project Management Team and as I recall, he had monthly meetings with the Project Management Team, the Project Team and also probably the project managers. He was a member of the Quality and Performance Committee, so he, like everyone else, received the reports on progress from the Director of Facilities, and he would usually be asked by myself to give his view on progress at the meeting and he was available for questioning by the committee. He always would tell the Board if he had any concerns at the Quality and Performance Committee, certainly, and he would attend the Board meetings too.

64. I don't remember precisely who he liaised with in the Project Team, but I think it was the Director of Facilities, NHSGGC's own Project Team and the external project managers. Like all non-execs, his reporting line would be to the chair of the Board, who at that time was Andrew Robertson. Andrew Robertson was the chair from 2008. I do not recall when he sat as chair until. I do recall that he was still the chair when the hospital opened in 2015, because it was Andrew Robertson who greeted the Queen and took her around the hospital. I recall that he introduced her at the opening ceremony. John Brown took over from him as chair. Andrew Robertson was the chair for almost all of the period when I was there.

65. I have been asked about the process for raising concerns and how they would be raised with the Board. In respect of infection control and patient safety concerns, these would come through in that integrated report I mentioned that goes to Quality and Performance Committee. In the first case it would go to the Clinical Governance Forum, if it was really serious, it would be escalated to the Board. I found one of the Board Clinical Governance Forum minutes attached to an email I still had, and there was a specific item on that agenda to review what items we were taking to the Quality and Performance Committee and report it to them as a matter. So, as I recall, anything serious would certainly come up to the Board or its subcommittees. Things did come up from time to time. There were issues with outbreaks and serious incidents and all of these matters would come up to the Board and through the Quality and Performance Committee.

66. I think I became aware of the issues with the water in 2018 when I read it in the media after leaving the Board in 2016. I have also been asked about the L8 risk assessment of the water system. I do not know what that is, and I have no recollection of that at all.

67. I have been asked if I was aware of the guidance around air circulation rates and if I recall any conversations about the standards expected for the wards. No, but my point earlier was that, when there was this concern in 2015, the action was first to say, “Well, was the spec right, was it in accordance with the guidance?” So, I think it might have been mentioned how many times per minute or second, I don’t know how you measure these things, but how many times per minute the air should change but I wasn’t aware of the standards as such apart from the fact that they existed.

68. From memory, I think relations were very good with the builders Brookfield at that time. I gather things have been less good recently but throughout the build, there was very good relations and, from memory, the builders got involved with everything. There were one or two things

during the build where the clinicians were not happy and the builders would change things as the clinicians had tours around the hospital at various times and could comment on things.

Declaration

69. 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 background information for assistance when completing their questionnaire/statement, with no formal expectation for the witness to read through all of these documents

Appendix A

A48890718 - Bundle 13 – Additional Minutes Bundle (AICC/BICC)
A49142433 – Bundle 21, Volume 1 – Expert Reports
A49615172 – Bundle 26 – Provisional Position Papers

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

Appendix B

A51642380 – Ian Lee - CV

Ian Lee - CV

Addresses: [redacted]
Phone: [redacted]
Email: [redacted]

Profile

Strong leader with expertise in corporate governance, business strategy, financial reporting, accounting and mentoring. Seventeen years' experience as audit committee chair, financial performance committee chair, vice chair and non-executive director. Former EY senior audit partner and member of the EY UK governing council.

2007 to date Portfolio of non-executive directorships – Listed, AIM, public sector and charity sectors.
1979 to 2007 Partner in EY with a portfolio of national and international listed, public and private company clients in industrial and commercial industry sectors.

Knowledge and experience

- Sixteen years' experience as a strong and well organised chair of audit committees, and nine years' experience of chairing quality, performance and financial performance committees.
- Corporate governance, risk management, internal audit, financial diligence and whistleblowing expertise from audit committee and NED experience and as an EY audit partner advising listed companies.
- Financial reporting and accounting expertise from experience as an EY partner.
- Strategic development and acquisition and disposals expertise from NED and EY experience.
- International and industrial and commercial experience from portfolio of NED roles, EY client portfolio and secondment to Dallas, Texas with EY.

- Leadership skills and experience from chairing audit committees and vice chair and chair roles at NHS bodies and charities with diverse membership, EY management roles and leading international audit teams.
- People skills, mentoring and involvement in recruiting finance and other executive and non-executive directors, and counselling partners and staff at EY.
- Good working relationships with fellow board members both executive and non-executive and formerly with clients and colleagues at EY, challenging but supportive.

Non-executive director experience

Current

- **Non-executive director and trustee – The Stroke Association (2019 to date)**
  - Charity raising awareness of stroke and supporting stroke survivors.
  - Chair of the audit and risk committee then chair of the financial performance committee. Member of governance and remuneration committee.
- **Non-executive director and trustee - Erskine Hospital (2015 to 2023)**
  - Veterans' charity. Nursing, dementia and respite care to ex-servicemen and women.
  - Chair of audit committee and member of chairman's and remuneration committees.
- **Trustee of the Endrick Trust (2014 to present)**
  - Charity supporting the prevention of poverty and advancement of citizenship and community development in the Glasgow area.
  - Chair of audit committee.

Previous

- **Member of audit committee – Student Loans Company (2011 to 2018)**
  - Non-profit making Government owned organisation. Provides loans and grants to students at universities and colleges across the UK.
  - Independent external member of audit committee.
- **Non-executive director – Ricardo plc (2008 – 2017)**

- FTSE small cap. Then market capitalisation c. [redacted]. Global engineering and strategic, technical and environmental consultancy business including niche manufacture and assembly of high-performance products.
- Chair of audit committee. Member of remuneration, nomination and pensions committees.

- **Non-executive director – NHS Greater Glasgow and Clyde (2008 to 2016)**
- Integrated health board. Delivering primary and secondary healthcare to the west of Scotland. 40,000 employees and annual revenue of [redacted].
- Vice chair of board and chair of quality and performance committee and acute services committee. Member of audit, remuneration and endowments committees. Chair of the Charities Forum for the new Royal Hospital for Children.
- Chair of East Renfrewshire Integrated Joint Board of the Health and Care Partnership and vice chair of predecessor Community Health and Care Partnership.

- **Non- executive director - Clyde Process Solutions plc (2007 to 2011)**
- AIM listed. International provider of technology-driven solutions for material handling and air quality management for process-based manufacturing environments. Acquired by Schenck Process.
- Chair of audit and AIM compliance committees. Member of remuneration committee.

Advisory and executive experience

- **Partner Ernst & Young (1979 to 2007)**
- Client service roles – service delivery, co-ordination of international audits, financial and audit reporting, accounting advice, investigations, due diligence and internal audit services. Worked with listed companies, large private companies and universities.
- Management roles – head of audit, staff partner, practice development partner, industrial products sector leader and International Financial Reporting Standards conversion leader.
- Member of EY UK governing council 1998 to 2004 and EY UK audit committee.

- Secondment to EY US in Dallas, Texas 1979-80 in technical accounting and auditing roles.
- Team leader for EY international quality reviews of India, Sweden and Ireland and participant in EY international audit innovation project.

Academic and professional qualifications and experience

- **Member of Institute of Chartered Accountants of Scotland**
  - Convener of audit and assurance committee
  - Convenor of Summer Conference committee
  - Member of accounting standards committee.
- **Member of American Institute of Certified Public Accountants and Texas CPA**
- **BA (Honours) 2(1) in politics and economics from University of Durham**

Languages

French – fluent – Diplome d'études en langue française

Interests

Skiing, walking and opera

Scottish Hospitals Inquiry
Witness Statement of
Douglas Griffin

This statement was produced by the process of sending the witness a questionnaire with an introduction followed by a series of questions and spaces for answers. The introduction, questions and answers are produced within the statement.

Personal Details and Professional Background

1. Name, qualifications, chronological professional history, specialism etc – please provide an up-to-date CV to assist with answering this question. Please include professional background and role within NHS GGC, including dates occupied, responsibilities and persons worked with/ reporting lines.

A. David Douglas Griffin, M.A C.A. Trained as Chartered Accountant with Peat Marwick Mitchell and Co, qualifying C.A. in 1982. Left to join Barr and Stroud Ltd in 1984 as Assistant Accountant. Was appointed Chief Accountant in 1988 and worked in this role until I left in 1993 to take up position of Director of Finance Monklands and Bellshill NHS Hospitals Trust. In 1998 I moved to take the position of Director of Finance Greater Glasgow Primary Care NHS Trust, which became the Primary Care Division of Greater Glasgow NHS Board when NHS Trusts were dissolved. Was appointed Director of Finance Corporate and Partnerships NHS Greater Glasgow in 2005/06. NHS Greater Glasgow subsequently became NHS Greater Glasgow and Clyde. I remained in the position of Director of Finance Corporate and Partnerships NHS Greater Glasgow and Clyde until leaving in June 2011.

` My primary responsibility in NHS Greater Glasgow and Clyde was for the provision of financial reporting and accounting services. This included coordinating the preparation of the Board's corporate annual financial plan and ensuring that the combined total of the financial plans prepared by each of the Board's Divisions and Partnerships and Corporate Departments remained within the total resources made available to it by Scottish

Government ie its capital and revenue funding limits. It was my responsibility to report to the NHS Board on progress with the development of the annual financial plan and to report on the actual financial outturn versus plan at NHS Board meetings. My job remit included responsibility for the preparation and completion of the NHS Board's audited annual accounts. It also included responsibility for the provision of monthly financial reports to the various NHS partnerships which existed at the time. This embraced in essence all areas of the Board's partnerships activities with the exception of its Acute Division. In terms of reporting lines, I reported to the Chief Executive of NHS Greater Glasgow and Clyde. There were 4 managers who reported to me These were the Head of Financial Services (Financial Accounting, Ledgers, Payroll etc), the Head of Corporate Financial Planning, the Head of Corporate Financial Reporting, and the Head of Management Accounting Services for NHS Partnerships. I retired from full time working in June 2011, resigning from the position of Director of Finance Corporate and Partnerships at this time, so as to free up time to do voluntary work.

Governance Reporting Structures within NHS GGC

2. During your time at NHS GGC please explain how the governance structure and reporting lines to the NHS GGC Board and its first line of subordinate committees received information and made and authorised decisions in respect of (a) the procurement of the new Southern General Hospital (that became the QEUH/RHC), (b) the safe and efficient operation of the water and ventilation systems of the QEUH/RHC, (c) the management and reduction of risks to patient safety from infections that had the potential to be connected to the environment (particularly the water and ventilation systems) of the QEUH/RHC, (d) the need for and authorisation of works to improve or remedy deficiencies in the water and ventilation systems of the QEUH/RHC and (e) the processes put in place to ensure that disclosure by staff of evidence of wrongdoing, failures in performance or inadequacies of systems was encouraged and reacted to by the Board to ensure that the safety of patients and the best value use of public funds were protected.

You should be aware that Hearing Bundle 13 contains minutes of the Board Infection Control Committee and the Acute Infection Control Committee, and that Hearing Bundle 11 contains minutes of the Board Water Safety Group.

A. Overall governance of the activities of NHSGGC was provided by the NHS Board of which I was a member until June 2011. The Board received regular reports from its subordinate committees which would probably have included information on the progress of the procurement of the new Southern General Hospital, however given the time that has elapsed I have no specific recollection of this.

3. Please explain what informal and formal meetings or groups met outside the structures you have described in the previous question that made decisions about the issues listed in Question 2.

A. As my area of responsibility excluded the Acute Division, I have no knowledge of this.

4. How is it decided which issues, decisions and reports would be escalated to the full Board or one of the first line of subordinate committees?

A. Responsibility for this rested with the Chief Executive and Directors regarding their areas of responsibility.

5. What procedures were put in to ensure all significant questions about the issues listed in Question 2 were being taken to the Board or one of first line of subordinate committees, discussed and actioned?

A. These areas were all out-with my area of involvement at NHSGGC and so I have no knowledge which I can draw upon to give an answer.

6. What procedures were put in place by the Board to ensure monitoring, progress and resolution of issues related to the list in Question 2 that had been reported to the Board or one of first line of subordinate committees?

A. These areas were all out-with my area of involvement at NHSGGC and so I have no knowledge which I can draw upon to give an answer.

7. Please refer to Dr Redding's witness statement at paragraph 186 **(Witness Bundle - Week commencing 2 September 2024 - Volume 3, Document 2, Page 63).** Dr Redding says that "The SMT and Clinical Governance Committees take decisions on what information is discussed at meetings of the full board." Is this statement correct? What is your understanding of how this process works?

A. The Board received the minutes of meetings of its subordinate committees as part of the Board papers. The Committee Chairs would highlight key issues that the Committees believed should be brought to the attention of the Board.

a. Explain the oversight the Board had over issues escalated from the standing committees until they were resolved.

A. Items discussed at Board meetings including decisions and actions would be reflected in the Board minutes.

b. Explain the types of decisions that were made at standing committee level and what decisions were made by the Board. What were the delegations to the Standing Committees?

A. This was set out in the Board's standing orders.

8. Please refer to **Bundle 29, Documents 13 and 14, Pages 485 to 523.** What led to the changes in the Board's governance structure in 2016/17, specifically the establishment of new committees and the subsequent requirement for the Chairs of the standing committees to update on discussions and decisions made at their respective committees (see audit report 2017/18)? Was the Board satisfied that the implementation of these changes enhanced and strengthened governance at GGC?

A. This event took place after I had left NHS Greater Glasgow and Clyde.

Director of Finance

9. Tell us about your role as Director of Finance at GGC?

A. My primary responsibility in NHS Greater Glasgow and Clyde was for the provision of financial reporting and accounting services. This included coordinating the preparation of the Board's corporate annual financial plan and ensuring that the combined total of the financial plans prepared by each of the Board's Divisions and Partnerships and Corporate Departments remained within the total resources made available to it by Scottish Government ie its capital and revenue funding limits. It was my responsibility to report to the NHS Board on progress with the development of the annual financial plan and to report on the actual financial outturn versus plan at NHS Board meetings. My job remit included responsibility for the preparation and completion of the NHS Board's audited annual accounts. It also included responsibility for the provision of monthly financial reports to the various NHS partnerships which existed at the time. This embraced in essence all areas of the Board's partnerships activities with the exception of its Acute Division.

10. What was the scope of your role?

A. See answer to Question 9. The scope of my role embraced corporate financial services (ie financial accounting, ledgers, payroll) on behalf of all of NHSGGC, monthly and annual corporate financial reporting to the NHS Board and to the Scottish Government Health Dept, and management accounting services to NHS Partnerships ie those NHS services (mental health and primary and community care) which were managed within partnership arrangements with Local Authorities.

11. When you left your position as Director of Finance within NHS GGC, what information or hand over did you provide to your successor?

A. I gave informal notice of my intention to leave my position as Director of Finance Corporate and Partnerships in April 2011, in the Spring of 2010. As my successor was appointed in first quarter of 2011, I was asked and agreed to delay my leaving date until June 2011. There was therefore a period of 3-4 months when my successor was able to shadow me. During this period, he

attended every meeting/group which I was a member of and we were able to meet frequently as required/requested to pass across information/ explanations which he was seeking. Following the end of June, it was agreed he could access me as required to ask any remaining questions however by that time he seemed to have settled into his new role.

12. Describe your understanding, if any, of the resource required to deliver the QEUH/ RHC build. What involvement, if any, did you have at the outset of the procurement phase in outlining the resource required to delivery the QEUH/RHC build.

A. As my job responsibilities did not include the Board's Acute Division, I was not involved in the procurement process. However, my role carried responsibility for the NHS Board's corporate financial plan, and so I would have been regularly made aware/updated on the capital and revenue consequences of the project as these unfolded. My remit in this regard was to be satisfied that the project was affordable within the context of the financial resources available to the NHS Board. I cannot remember the precise amount of the capital funding required however I remember it to be substantial and I also remember the revenue consequences as being significant on account of the range and complexity of service changes and relocations required to deliver the project.

NHS GGC Board and Structure

13. Describe your understanding of the NHS GGC Board Structure.

A. My understanding relates to the position as I recall it from 2011. If my memory serves me right, there were five Executive Board members who were statutory appointments. These were the Chief Executive, Medical Director, Nurse Director, Director of Public Health and Director of Finance. In addition, there were further Executive members of the Board who were not statutory appointments.

Again, if my memory serves me right, these included the Chief Operations Officer for Acute Services, the Lead Director for NHS Partnerships, The Corporate Director of Planning and Performance, the Director of Human Resources, and the Director of Communications. Each main Board division/function was represented on the Board. There was a Board Chairman supported by the Head of Board Administration and a number of independent non-executive Board members and each Local Authority which had a partnership relationship with NHS GGC had a Councillor representative on the Board. The Board also had an Employee Director member who represented the staff groups on the Board. There were a number of sub committees which supported the work of the Board in specific areas such as Clinical Governance, Audit and Staff Governance.

14. Describe the role of executive Board members.

A. Each Executive Board member was in essence responsible for the operational management of the services that sat within their area of management responsibility. The role of positions such as the Medical Director, Nurse Director and Employee Director was slightly different being more focussed on clinical/staff group leadership, policy and advisory matters.

15. Describe the difference in role between executive and non-executive Board members.

A. The primary role of the non-executive Board members was to hold the executive members to account for the exercise of their responsibilities.

16. Describe how the transfer of knowledge and information from sub-committees and committees was delivered to the Board. Which committees and sub-committees fed in to the Board, by what means and how frequently?

A. My recollection relates to the operation of the Board Audit Committee as I had direct experience of this. I cannot remember how frequently the committee met but believe it met 3-4 times per annum. As I recall, feedback was made via meeting minutes which were included with the Board meeting papers. The Audit Committee Chair who was a non-Executive member would speak to

these highlighting key points. I believe that a similar process was followed by the other Committees.

17. The Inquiry understand that you sat as an executive Board member (please refer to **Bundle 52, Volume 2, Document 4, Page 67**) in your opinion, how if at all, did the executive Board ensure that it oversaw 'the overall process of the project and to co-ordinate the work streams of the two groups'?

A. As Director of Finance Corporate and Partnerships, my role and reason for being on this group was to be kept informed on the overall project costs and their affordability in the context of the NHS Board's available capital and revenue funds. Ultimately a full business case incorporating the capital and revenue cost impact of the project would require to be submitted to the NHS Board and thereafter to the Scottish Government Health Dept for approval. In my role as Director of Finance I would be expected to give an opinion on the affordability of what was being proposed. Being aware of the outputs of the work of the two groups would therefore have been necessary to understanding the capital and revenue cost plans as they developed, however I have no recollection of the detail of discussions that took place at the meetings and am unable to offer an opinion on how effectively this Board co-ordinated the two streams of work.

18. The Inquiry understands that schemes of delegation were in place, delegating roles and responsibilities from the Board to the likes of the Project Team. Describe your understanding, if any, of the schemes of delegation in place, to whom and what responsibilities and decision making powers were delegated and why. Explain what decisions, if any, were taken by the Board, and what was the basis for a decision being referred to the Board.

A. I was not involved in the design of the schemes of delegation that were established to manage the different strands of work encompassed by the project. Ultimately, the NHS Board would be required to approve the full business case before this was able to be submitted to the Scottish Government Health Dept.

Funding model for QEUH/RHC

19. Upon commencing your role, what was your understanding regarding the funding of the new QEUH and RHC? What did you understand the reasons behind the change in the funding model from PFI to capital to be?

A. Again, my primary focus was always on the affordability of the project in terms of capital and revenue costs, rather than whether it would be funded by PFI or by capital funding. I remember both funding options being under consideration and remember being made aware that capital funding had been selected as the preferred option and so this was presented as the preferred funding method in the full business case which was submitted for SGHD approval. My understanding is that capital funding was selected as the preferred funding model on the basis that it was affordable and offered better overall value for money.

a) With reference to your answer to Question 19 in your statement; in terms of the funding for this project, how important was “value for money” compared to, for example, the extent to which any new building complied with Scottish Government Guidance?

A. Whichever funding approach had been taken with regard to the project, it would have been necessary to demonstrate that it was not only affordable in terms of capital and revenue funding but also provided value for money in terms of the benefits which the project sought to deliver. These benefits would include clinical and other service benefits associated with providing services from new custom built hospital facilities, and not simply financial benefits. As I recall, the requirements to demonstrate affordability and value for money were set out in guidance provided by Scottish Government for the development of Business Cases, and related to the preferred solution which was being presented in a Full Business Case, this being the submission which required to be made to Scottish Government to source capital funding. I do not recall being made aware of any areas of non-compliance with Scottish Government Guidance with regard to the building specification which was the subject of the preferred solution being presented within the Full Business Case.

b) Given that after the opening of the QEUH NHS GGC has had to spend large sums of money retrofitting improved ventilation systems into Wards 2A and 2B RHC, Ward 4B QEUH and a number of isolation rooms can it be said to be "value for money" to build a hospital does not comply with Scottish Government Guidance on the ventilation systems for hospitals?

A. I have no knowledge of the circumstances which gave rise to the requirement to spend these funds after the hospital was opened so am unable to provide a comment on this. In my answer to S1 I outlined the range of benefits which the new hospital facilities were expected to provide in terms of delivering value for money. As I recall, these would have been articulated in the Business Case. This was the outcome of a significant amount of work over a considerable time period, led by the Project Team supported by professional advisers, and colleagues within the Board's Acute Division, to ensure that to the best of their ability and in good faith the proposed new hospitals were compliant with extant guidance and fit for purpose.

20. What impact, if any, did the change from the PFI model to public financing have on the delivery of services or the overall design and construction of QEUH?

A. This is out-with my area of involvement and knowledge and so I am unable to comment.

21. Were any risks and any resource implications as a result of changing the procurement model from PFI to public funding adequately assessed, if so, how so, in particular:

(i) The impact, if any, on commissioning?

(ii) The impact, if any, on independent validation?

(iii) Ensuring sufficient resources to manage and maintain the hospital post-handover?

A. This is out-with my area of involvement; however I believe based on my experience during my time at the Board that appropriate processes would

have been put in place to manage resources and risks related to either funding approach.

a) With reference to your answer to Question 21 in your statement please explain what you mean by “based on my experience during my time at the Board that appropriate processes would have been put in place to manage resources and risks related to either funding approach”. Please describe your experience and the processes which would have been put in place.

A What I meant by my answer was that during my period of employment in NHS Greater Glasgow I had observed capital projects being taken forward that were funded by both NHS provided capital funding and Private Finance. For NHS provided capital funded projects, the NHS was procuring a building which it would own and operate itself. For projects funded by Private Finance, the NHS was procuring a service where the building was owned and operated by a third party. On account of the differences between the two approaches, the processes required to manage the procurements and the skillsets required were different, and the NHS Board would take account of this in putting in place arrangements for project management, including managing procurement and developing the necessary Business Case. The NHS Board had experience of doing both so would fully understand the differences between the two.

22. What concerns, if any, were brought to your attention in respect of funding or any other financial aspect of the QEUH/RHC hospital campus?

A. The scale of the project including the service redesign and location changes were many and complex and required a great deal of work to be done over a prolonged period of time within the Acute Division to arrive at a solution which was deliverable and affordable. There were no concerns of which I was made aware in the period up until June 2011 that the proposed solution was not capable of being delivered.

a) With reference to your answer to Question 22 in your statement:

(i) Who was involved in this process?

A. As the project was taken forward within the Board's Acute Services Division, the process would have involved a wide range of colleagues from within the Division. The Acute Director of Finance and the Acute Division finance function would have overseen and coordinated this process, working with Clinical Services Managers, Operational Services Managers, Facilities and Human Resources managers, who had budget responsibility for their respective functions. It would also have involved the project team and their professional advisers, led by the Project Director, who were responsible for preparing the Business Case. Any concerns arising regarding funding or any other financial aspects could have been raised out of this process.

(ii) Who made you aware that the proposed solution was not capable of being delivered and what reason was given? Please detail your recollection of this discussion.

A. In my answer to Question 22, I explained that I do not recall being made aware of any concerns in the period up until June 2011, when I left my employment with NHSGGC, that the proposed solution was not capable of being delivered, or was not affordable. I have no recollection of having had any discussion to the contrary.

23. What was the process for requesting funding? Who was responsible for submitting applications and who was responsible for approving them? What specialist input, if any, was required for such applications or to advise the board before applications were submitted and/or approved?

A. The process for requesting funding would have been the submission of a full business case to the Scottish Government Health Dept, setting out the case for the QUEH/RHC and the proposed funding approach. The primary purpose of the full business case which would have been prepared by the project

Director and his team was to demonstrate affordability and value for money. The business case would have required NHS Board approval before being submitted to SGHD for approval. The business case was the culmination of a considerable amount of work carried out by the NHSGGC Project team, with specialist input from a range of professional advisers.

a) With reference to your answer to Question 23 in your statement;

(i) Please detail your involvement in the production of the Full Business Case (**Bundle 18, Volume 1, Document 10, Page 629 and Bundle 17, Document 30, Page 1453**). Who had ultimately responsibility for preparing the final version that went to the NHS GGC Board for approval?

A. My recollection is that the Full Business Case was produced by the Project Team, with the support of professional advisers, and that they prepared the final version that went to the NHS GGC Board for approval. I had no direct involvement in the production of the Business Case, but was aware of progress with its development through updates provided by the Project Director and his team.

(ii) Would you accept that the Scottish Government would expect a health board to make it clear in a FBC that it was proposed to construct a building in a manner that did not conform to Scottish Government Guidance?

A. I do not believe that a health board would knowingly propose to construct a building that did not conform or was in conflict with extant Scottish Government Guidance. As buildings' construction and related guidance are out-with my area of experience and knowledge, I am not qualified to offer any further comment.

24. How did you manage the financial transition, and what was your role, if any, in ensuring the project remained both on budget and on schedule?

A. This took place after I had left NHS GGC.

Tender and Preferred Bidder Selection

25. Describe the Gateway Review process and your involvement in it, if any,

A. I recall that it would have been required to follow a Gateway Review Process but am unable to describe it and had no involvement in the process.

26. Describe your involvement, if any, in respect of the appointment of Currie and Brown as technical advisors. Confirming the selection process, why they were selected, setting out their role and responsibilities.

A. I was aware that Currie and Brown had been selected as technical advisors however I had no involvement in the process of their selection.

27. Describe your understanding and involvement, and the Board's involvement, if any, in respect of the selection process whereby Multiplex were selected as the preferred bidder.

A. I had no involvement in this process so am unable to offer any comment.

a) Why were Multiplex awarded the contract following the competitive dialogue process? What distinguished Multiplex from the other bidders to make them the preferred bidder? Include details of the tender process and explain how Multiplex engaged and became distinguished as the preferred bidder.

A. I had no involvement in this process so am unable to offer any comment.

b) Describe the scoring for value for money within the tender process, including your role, if any. How did Multiplex score relative to other bidders?

A. I had no involvement in this process so am unable to offer any comment.

Ventilation Derogation

28. Explain your understanding of the ventilation design strategy contained in the Contractor's Tender Return Submission (11 September 2009). Please refer to **Bundle 18, Volume 1, Document 8, Page 205**. Was the ventilation system to be a mixed mode ventilation system (dependent on a non-sealed building) or a mechanical ventilation system (dependent on a sealed building)?

A. This area is out-with my area of involvement or knowledge in my time at NHSGGC and so I have no understanding or knowledge that I can draw upon to give an answer.

29. The Inquiry is aware of the agreed ventilation derogation recorded in the M&E Clarification Log. Please refer to **Bundle 16, Document 23, Page 1664.**

a) When, if at all, were you and the Board first made aware of this, and how were you made aware of this?

A. This area is out-with my area of involvement or knowledge in my time at NHSGGC and so I have no knowledge or understanding that I can draw upon to give an answer.

b) Who else from the GGC project Team and Board were aware of the Ventilation derogation?

A. This area is out-with my area of involvement at NHSGGC and so I have no knowledge or understanding which I can draw upon to give an answer.

c) What action, if any, was taken and by whom to escalate knowledge and understanding of the ventilation derogation to the Board?

A. This area is out-with my area of involvement at NHSGGC and so I have no knowledge or understanding which I can draw upon to give an answer.

d) How was the agreed ventilation derogation signed off by the Board? The Inquiry understands from the response from Currie and Brown to PPP13 that the GGC Project Team had advised Helen Byrne of the Agreed Ventilation Derogation, alongside Alex McIntyre (Director of Facilities) & Peter Gallagher (Director of Finance). Please confirm your position and involvement, if any. Who from the Board signed off the derogation?

A. This area is out-with my area of involvement or knowledge in my time at NHSGGC and so I have no knowledge or understanding which I can draw upon to give an answer.

e) What was your understanding, if any, at the time of the potential impact of the proposed ventilation derogation? Did you understand the proposed derogation to comply with SHTM/HTM guidance? If not, how did this come to be signed off the Board?

A. This area is out-with my area of involvement or knowledge at NHSGGC and so I have no knowledge or understanding which I can draw upon to give an answer.

30. When did you and the Board first become aware of the ZBP Ventilation Strategy Paper dated on or around 15 December 2009? Please refer to **Bundle 16, Document 21, Page 1657**

A. I have no recollection of this paper, given the time that has elapsed.

a) What concerns if any did you have on reading this document?

A. AS explained above, I have no recollection of this paper.

31. What risk assessments (if any), whether in compliance with the standards in HAI Scribe or otherwise, did GGC carry out or have carried out in respect of the change in the ventilation strategy that appears to follow the ZBP Ventilation Strategy Paper dated 15 December 2009? Please refer to **Bundle 16, Document 21, Page 1657**

A. This area is out-with my area of involvement or knowledge at NHSGGC and so I have no knowledge or understanding which I can draw upon to give an answer.

32. Was the Ventilation Derogation recorded in the Full Business Case? Who was responsible for doing this? If not, why not? If you were aware that it had not been recorded in the Full Business Case please explain what action, if any, you took.

A. I have no recollection of the detail within the Full Business Case and whether this contained any information regarding the Ventilation Derogation.

B. Acute Services Strategy Board

33. The Inquiry understands you were a member of the Acute Services Strategy Board.

Please provide details of:

a) The purpose of the Acute Services Strategy Board

b) Your role in the Acute Services Strategy Board

c) Describe your understanding and involvement, if any, in any decisions made by the Acute Services Strategy Board in respect of site selection, procurement, funding, contract, ventilation derogation, decision to use chilled beams.

A. a) My understanding of the purpose of the Acute Services Strategy Board was to oversee implementation of the Acute Services Review, including the implementation of the New South Glasgow Hospitals Development.

b) My role was to monitor project capital and revenue expenditure levels as they varied compared to plan to understand how they might impact on the Board's overall financial plan.

c) While I was a member of the Acute Services Strategy Board, my role was focussed on the overall affordability of the project and I do not recall being involved in decision making in these areas.

34. Refer to **Bundle 52, Volume 2, Document 5, Page 68.** A role of the Acute Services Strategy Board 'is to Approve change control in that any change which impacts upon the project must be authorised by this Board before it can be implemented.'
Describe any changes which impacted upon the project which were authorised by the Board during your time on the Board.

A. In the period up until I left NHSGGC in June 2011 it is possible that there could have been such changes however I do not recall any. As I have explained my role on this Board was to focus on capital and revenue costs and changes which could have had a potentially material impact on the NHS Board's financial plan. I do not remember any such changes arising in that time period.

35. Refer to **Bundle 52, Volume 2, Document 5, Page 68.** A role of the Acute Services Strategy Board 'is to Approve change control in that any change which impacts upon the project must be authorised by this Board before it can be implemented.'
Describe your involvement, and the Board's involvement, if any, in Details of any relevant substantive decisions made by the Acute Services Strategy Board in respect of site selection, procurement, funding, contract, ventilation derogation, decision to use chilled beams.

A. See answer to 29 c above.

36. Refer to **Bundle 52, Volume 2, Document 5, Page 68.** A role of the Acute Services Strategy Board 'is to Approve change control in that any change which impacts upon the project must be authorised by this Board before it can be implemented.'
Describe the working relationship between the Performance Review Group and the Acute Services Strategy Board. How was information shared and on what basis?

A. I have no recollection of the working relationship which existed between the Performance Review Group and the Acute Services Strategy Board and so am unable to offer any insight into the manner in which information may have been shared.

C. Project Executive Group

37. The Inquiry understands that you were a member of the Project Executive Group (PEG).

a) What was the purpose and remit of the PEG?

b) What was your role in the PEG?

c) What matters, if any, did the PEG take decisions on?

A. I have no recollection of being a member of the "Project Executive Group" and wonder if this might have been formed after I had left NHSGGC in June 2011

38. Was there a drive for cost efficiency during the build of QEUH/RHC? If so, how did you ensure that the drive for cost-efficiency was balanced against the need for patient safety and healthcare guidance (such as SHTM) compliance during the construction of the QEUH/RHC?

A. This postdated my leaving NHSGGC in June 2011.

39. What concerns, if any were you aware of regarding the construction materials, ventilation systems, or other safety-related aspects of the QEUH during the Acute Services Review process? If so, how were these issues addressed?

A. This postdated my leaving NHSGGC in June 2011.

40. Were there any concerns regarding the hospital's readiness and safety to open? If so, how were these concerns managed? At the time what concerns, if any, did you have regarding the deadline for opening the hospital?

A. This postdated my leaving NHS GGC in June 2011.

Post handover

41. What do you recall regarding the request for funding and subsequent approval of the various remedial works required for:

i) Wards 2A/2B
ii) Wards 4A/4B/BMT
iii) Wards 5C/5D/IDU
iv) Wards 6A/6B
v) Replacement of taps/sinks
vi) Dosing of Water System
vii) Ventilation upgrades

A. This all postdated my leaving NHSGGC in June 2011.

42. Given the significant remedial works required and the associated requests for funding to you and the Board, did this raise concerns with you? If so, please describe these concerns and any reassurances sought.

A. This postdated my leaving NHSGGC in June 2011.

43. Were there any budgetary constraints which affected the ongoing safety of the QEUH, such as maintenance, upgrades, or safety checks?

A. This postdated my leaving NHSGGC in June 2011.

44. What role did you play in the decision-making process in respect of allocation of funding to problems as they arose?

A. This postdated my leaving NHSGGC in June 2011.

45. Were you involved in discussions about whether to take immediate action to fix the problems or to phase resolutions over a prolonged period to spread out the financial impact?

A. This postdated my leaving NHSGGC in June 2011.

DMA Canyon Report

46. Were you aware of the requirement for a L8 Pre-Occupation Risk Assessment before NHS GGC took responsibility for the QEUH/RHC building in January 2015? What steps were taken to ensure that one was carried out? What steps were taken to ensure the water system of the QEUH/RHC was safe and not subject to widespread contamination before patients moved in?

A. This postdated my leaving NHSGGC in June 2011.

47. When did you first become aware of the recommendations of the DMA Canyon Report 2015 L8 Risk Assessment **(Bundle 6, Document 29, Page 122)** and why?

A. This postdated my leaving NHSGGC in June 2011.

Decision to decant wards 2A and 2B

48. To what extent were you aware of the issues which arose in ward 2A/B at the RHC? What discussions, if any, were had at Board level regarding the decision to decant wards 2A and 2B in 2018? What is your understanding as to why a decant was necessary?

A. This postdated my leaving NHSGGC in June 2011.

49. What remedial works were carried out on wards 2A and 2B? How long did these remedial works take? What was the financial impact of the remedial work? Following completion of the remedial works, were any additional risk assessments put in place?

A. This postdated my leaving NHSGGC in June 2011.

50. In hindsight, how might the remedial works required to wards 2A and 2B have been avoided?

A. This postdated my leaving NHSGGC in June 2011.

D. Ventilation System in Ward 4C

51. To what extent were the Board aware that the ventilation system in ward 4C was not compliant with SHTM 03-01? When did the Board become aware of this?

A. This postdated my leaving NHSGGC in June 2011.

52. What discussions were had at Board level surrounding the ventilation system? What remedial works were carried out to rectify the ventilation system in Ward 4C and throughout the hospital? What was the financial impact of the remedial works?

A. This postdated my leaving NHSGGC in June 2011.

53. In hindsight, how might the remedial works required to the ventilation system within ward 4C and other wards have been avoided?

A. This postdated my leaving NHSGGC in June 2011.

E New South Glasgow Hospitals and Laboratory Project Executive Board

54. Please refer to **Bundle 34, Document 21, Page 152**. This document sets out the Terms of Reference and the Membership of the New South Glasgow Hospitals and Laboratory Project Executive Board. It says, "The NSGHLPEB will be accountable for the planning and delivery of all procurement financial and technical measures required to deliver the identified investment and services that fall within the scope of the whole project." You are listed as a voting member. Please explain:

(a) What was the purpose and remit of the NSGHLPEB?

(b) What was your role in the NSGHLPEB?

(c) What matters did the NSGHLPEB take decisions on?

A. I have no recollection of discussions or decisions being taken by this group in the period up until I left the employment of the Board in June 2011 and am unsure if it was actually established. Having read the remit, it would appear that the intention behind setting it up was to oversee the implementation of the project to establish the New South Glasgow Hospitals and Laboratories going forward. This would have included receiving reports from the project team on project progress, considering and approving recommendations from the project team, for example related to stages reached in the procurement process or the appointment of professional advisers. As Director of Finance for Corporate and Partnerships, my role would have been to keep appraised on the progress of work on the development of the financial plans which would underpin the service changes required within the Acute Division, also the development of the capital plan to construct the hospitals and associated facilities, to be assured that these remained within the capacity of the Board to afford them.

55. According to its terms of reference the NSGHLPEB had delegated authority to conduct and conclude negotiations at project critical moments and was required to "oversee the management of change control processes" so that "any change which impacted on the project must be authorised by [it] before it can be implemented (see remit at **Bundle 34, Document 21, Page 152**).

The Inquiry has heard evidence from Mr Seabourne and Ms Byrne that no such change control system existed.

Please review the meeting of the NSGHLPEB on 7 December 2009, shortly before the contract was concluded on 18 December 2009, (**Bundle 42, Volume 2, Document 18, Page 86**), that suggests the NSGHLPEB did not "conduct and conclude negotiations" but rather this was left to the Project Team (see item 5). This was also Mr Seabourne's evidence.

a) Why was there no change control process in place for the Stage 1 of the new SGH project?

A. Although there is a remit, I do not recall the NSGHLPEB meeting and/or making decisions and wonder whether it was actually established in practice. This would resonate with Mr Seabourne and Ms Byrne's evidence.

b) Considering the above, how did the contract come to be signed on 18 December 2009 despite the PRG not being asked to authorise any changes and the NSGHLPEB not conducting and concluding the negotiations?

A. As I was not directly involved in the procurement process, I am not able to offer any comment. Having said this, I believe that those who were involved in this process at the time were entirely knowledgeable of the different stages and requirements of the procurement process applicable to this project and would have ensured that the Board complied with applicable procurement legislation and the Board's own established procedures.

56. What responsibility does a board staff member who is a voting member of a committee or executive board created under terms of reference or a remit approved by a Board subcommittee or group have for the work of that committee or executive board?

A. Ultimately each Board officer is responsible for carrying out the requirements of their role as set out in their job description in good faith to the best of their ability. This would include the exercise of responsibilities within the context of committees on which they serve.

Conclusion

54. Is there anything further you would like to add which you think would assist the Inquiry?

A. I have nothing further to add except that I have attempted to honestly answer the questions asked to the best of my ability and remembered knowledge given that I left the employment of the Board in June 2011.]

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.

Name Date

Appendix A

The witness was provided access to the following Scottish Hospital Inquiry bundles/documents for reference when they completed their statement.

A43293438 - Bundle 6 - Miscellaneous documents
A47390519 - Bundle 11 - Water Safety Group (External Version)
A48890718 - Bundle 13 - Additional Minutes Bundle (AICC/BICC etc)
A47851278 - Bundle 16 - Ventilation PPP
A49342285 - Bundle 17 - Procurement History and Building Contract PPP
A48235836 - Bundle 18 - Documents referred to in the expert report of Dr J.T. Walker - Volume 1 (of 2)
A49847577 - Witness Bundle - Week Commencing 2 September 2024 - Volume 3
A51483446 - Bundle 29 - NHS Greater Glasgow and Clyde Audit Reports
A51785179 – Bundle 34 – Performance Review Group and Quality and Performance Committee Minutes and Relevant Papers
A52498034 – Bundle 42 – Volume 2 – Previously omitted miscellaneous meeting minutes and papers
A53671356 – Bundle 52 – Volume 2 – Miscellaneous Documents

Scottish Hospitals Inquiry
Witness Statement of
Jonathan Best

This statement was produced by the process of sending the witness a questionnaire with an introduction followed by a series of questions and spaces for answers. The introduction, questions and answers are produced within the statement.

Personal Details and Professional Background

1. Name, qualifications, chronological professional history, specialism etc – please provide an up-to-date CV to assist with answering this question. Please include professional background and role within NHS GGC, including dates occupied, responsibilities and persons worked with/ reporting lines.

A. Jonathan Best retired March 2022. In my final post I reported directly to the Board Chief Executive. The posts I held within GGC are as follows:
Chief Operating Officer January 2019 to 31st March 2022. Direct report to Board Chief Executive.
Interim Chief Operating Officer 2016 to December 2019. Direct report to Board Chief Executive.
Director North Sector April 2015 to December 2016. Direct report to Chief Operating Officer.
Director of Regional Services 2014 to April 2015. Direct report to Chief Operating Officer.
Chief Executive Yorkhill NHS Trust February 2000 to April 2014. Direct report to Trust Chair and Trust Board.

2. Please explain how your roles and responsibilities in NHS GGC related to the delivery of adult services, paediatric services and the IPC Team.

A. In my last role I was responsible for the delivery of all Acute Services within NHS GGC. The Chief Operating Officer has 5 Directors with teams running all the acute hospitals providing acute care 24/7. It is an operational role running

all acute clinical services across GGC. The COO reports directly to the Board Chief Executive and is part of the Strategic Management Team and the NHS Board and its various sub committees. The IPC team did not report to me. Clinical staff within Acute Services worked alongside IPC colleagues as they provided specialist advice on a day to day basis.

Governance Reporting Structures within NHS GGC

3. During your time at NHS GGC please explain how the governance structure and reporting lines to the NHS GGC Board and its first line of subordinate committees received information and made and authorised decisions in respect of (a) the procurement of the new Southern General Hospital (that became the QEUH/RHC), (b) the safe and efficient operation of the water and ventilation systems of the QEUH/RHC, (c) the management and reduction of risks to patient safety from infections that had the potential to be connected to the environment (particularly the water and ventilation systems) of the QEUH/RHC, (d) the need for and authorisation of works to improve or remedy deficiencies in the water and ventilation systems of the QEUH/RHC and (e) the processes put in place to ensure that disclosure by staff of evidence of wrongdoing, failures in performance or inadequacies of systems was encouraged and reacted to by the Board to ensure that the safety of patients and the best value use of public funds were protected.
You should be aware that Hearing Bundle 13 contains minutes of the Board Infection Control Committee and the Acute Infection Control Committee, and that Hearing Bundle 11 contains minutes of the Board Water Safety Group.

A. I was not involved in the procurement process for the new hospitals and therefore cannot provide an explanation of the governance structures and reporting lines to the Board in respect of this process. Project Management Team members along with technical staff were responsible for water and ventilation system procurement following national guidance at the time. Any changes or issues would be taken through the appropriate governance group as noted in the published structure.

4. Please explain what informal and formal meetings or groups met outside the structures you have described in the previous question that made decisions about the issues listed in Question 2.

A. The new hospital Project Team established a governance/meeting structure, which reported into the Board Governance structure as published. I am not aware of any informal groups involved in decision making.

5. How is it decided which issues, decisions and reports would be escalated to the full Board or one of the first line of subordinate committees?

A. I was not involved in deciding which issues, decisions and reports were escalated regarding the procurement. A progress and reporting process was established to review progress and deal with issues and changes. Governance arrangements to escalate any issues through the agreed governance structures would be in place. As far as I am aware regular reporting to the NHS Board or relevant sub committees would be in place.

6. What procedures were put in to ensure all significant questions about the issues listed in Question 2 were being taken to the Board or one of first line of subordinate committees, discussed and actioned?

A. I refer to my answer to question 5. Alongside the Project governance process the management structure within Acute Services remained in place as well as the clinical professional reporting lines.

7. What procedures were put in place by the Board to ensure monitoring, progress and resolution of issues related to the list in Question 2 that had been reported to the Board or one of first line of subordinate committees?

A. All progress was reported through the agreed, established Board governance structure.

a) At any time prior to your appointment as Director of Regional Services were you informed that a decision has been made to procure the new SGH with a ventilation system that supplied air at half the rate than that called for by Scottish Government Guidance?

A. No, I was not involved in the procurement process.

Handover, Commissioning and Validation

8. Describe the Infection Prevention and Control (IPC) input, if any, in respect of critical ventilation. What was the process for obtaining input, who from IPC was involved. Describe the IPC involvement of signing off on critical ventilation. What was the process, who from IPC signed off on critical ventilation, when, and by whom. Was there an audit trail of IPC involvement and sign off, if so, where would this have been kept?

A. I was not involved in this issue during procurement and so do not have requisite knowledge of this matter.

9. In respect of commissioning and validation how were you satisfied the appropriate commission and validation in respect of the water and ventilation system had been carried out? Who provided you with these assurances and when? What concerns, if any, did you have regarding commissioning and validation being carried out prior to handover?

A. I am not able to answer this question, as I was not involved in the commissioning and validation process.

a) Was the energy centre commissioned prior to NHS GGC taking occupation of QEUH? If so, describe what you know about the commissioning of the energy centre. Provide details of the intricacies in relation to its completion/

A. This was not my remit or area of responsibility.

b) The Inquiry understands that NHS GCC decided to forgo the requirement to have an independent commissioning engineer. Who made this decision? What was the impact, if any, of this decision? In hindsight, do you think that it was the correct decision?

A. I was not involved in this decision as it was not part of my remit or responsibilities. This issue would have been within the remit of the Project Team.

c) The Inquiry understand that no validation was carried out in respect of the ventilation system. When did you become aware of this? How did handover come to be accepted without the ventilation system being validated? Who was responsible for this and who signed off on this?

A. I was not involved in this issue and it was not part of my remit.

10. Describe your role in the lead up to accepting handover.

a) At the point of handover, how satisfied were you that all areas of QEUH/RHC accepted by NHS GGC, were designed to the intended specification and suitable for the intended patient cohort, meeting all the relevant guidance requirements?

A. The Project Management Team along with relevant clinical and technical staff worked with operational staff to ensure areas being handed over were ready for occupation.

b) How were you assured that the wards met the requirements of the specific patient cohorts?

A. See answer 10a.

c) Were any wards not handed over, or only partially handed over, please confirm. If so, why they were they held back? Was there any financial consequence to both Multiplex and NHS GGC of the ward(s) being held back? What works were carried out in order to allow this ward(s) to be handed over to the NHS GGC?

A. This was not in my remit.

11. Was an HAI-SCRIBE assessment carried out at any point regarding the proposed site development, design and planning and new construction of the new SGH (including at the time of completion)? If not, why not?

A. This would be the responsibility of ICT colleagues working with the new hospital Project Team.

Beatson/Adult BMT

12. The Inquiry is aware the adult BMT service was to transfer from the Beatson to the QEUH as noted in the meeting minutes from the Quality and Performance Committee dated 2 July 2013 (**Bundle 34, Document 62, Page 542**). This was confirmed in a change order request, issued by you in July 2013 (**Bundle 16, Document 29, Page 1699)**. Please provide details in respect of the following:

a) What risk assessments/ HAI Scribes were carried out prior to the change order request?

A. Risk assessments and HAI Scribes would have been provided by ICT, nursing and local operation managers working with the new hospital Project Team.

b) What were the technical and environmental requirements (in particular air change rates, pressure regimes and HEPA and air permeability requirements) to accommodate the BMT Unit at QEUH/RHC?

A. This information would have been provided by technical, clinical and ICT colleagues.

c) Your attendance and involvement in any design review meetings which were held to confirm with the user groups the requirements for the BMT Unit.

A. I would have attended meetings within the Board Governance structure. In general terms there were multiple meetings and I, along with other senior leaders attended to receive updates and progress reports as well as contribute to any discussions and debates. I do not recall any involvement in detailed design review meetings.

d) Discussion with Multiplex regarding the proposed change order and the impact on Air Change Rates and Pressure Differentials?

A. I was not involved in discussions with Multiplex on this issue

e) Involvement with Infection Prevention and Control in respect of the proposed change order?

A. I was not involved in technical discussions as this was not in my remit.

f) What ceiling types were specified and approved for use in Ward 4B? Who from the GGC Project Team approved this? Describe your involvement, if any? What was the impact, if any, of the choice of ceiling tiles? What concerns, if any did you have regarding the choice of ceiling tiles?

A. I was not involved in the choice of ceiling tiles.

g) What concerns, if any, did you have regarding the final design specification of Ward 4B, and what action, if any, did you take in respect of these concerns?

A. Any concerns would have been raised through relevant groups and via the operational line management structure.

h) Whether at any time you were told by anyone that the ventilation system already planned for the hospital would not be able to provide 10 air changes per hour within the proposed adult BMT ward?

A. Any issues would have been raised through the Project Management structure and discussed at relevant governance meetings.

13. To what extent did discussion of the proposed addition of an adult BMT ward in the QEUH consider the application of the specification for air change rate, pressure differentials and requirement for HEPA filtration set out for a 'Neutropenic Ward' in SHTM 03-01 ventilation for Healthcare Premises?

A. Any technical requirements would be dealt with through the appropriate new hospital Project Team working with local operational teams, which would then inform any proposals for discussion at the appropriate management group.

14. The Inquiry is aware that the change order not only confirmed that the Bone Marrow Transplant (BMT) service would transfer to Ward 4B in the QEUH but also that the haematology patients that were originally planned to accommodate Ward 4B would move to Ward 4C.

a) Describe how this change was communicated to the project team and Multiplex and how this change was captured in the design and specification documentation.

A. I am unable to answer this question.

b) To what extent was there discussion at this time as to whether the specification for air change rate, pressure differentials and requirement for HEPA filtration set out for a 'Neutropenic Ward' in SHTM 03-01 ventilation for Healthcare Premises might now apply to Ward 4C is accommodating haematology patients who might well be neutropenic?

A. I was not involved in the technical discussions as this was out with my remit.

c) When did you first become aware of the issues identified within Ward 4B in June 2015?

A. I am unable to recall as I was working in the North Sector at that time.

15. Patients migrated to Ward 4B in June 2015 however less than one month later they returned to the Beatson. The issues identified were present at the point of handover in January 2015, please explain why the ward was signed off and handover accepted given the issues which arose shortly thereafter.

A. I was not involved in signing off the ward nor was I involved in the handover.

16. At a BICC meeting on 27th July 2015 Professor Craig Williams states that in respect of ward 4B "*the unit was not built to the correct specification and Brookfield have agreed to fund the rebuild for this area and the timeframe for this is 12 weeks*". Please discuss this statement.

A. I am unable to comment on this statement as I was not involved in the specification work referred to.

a) Were the issues with Ward 4B discussed with the Board?

A. I assume any issues would be raised through the new hospital Project Management governance structure then through the appropriate Board governance structure.

b) What concerns did the Board have in respect of these issues?

A. I am unable to answer this question.

c) What steps were taken by the Board to address these?

A. I am unable to answer this question.

d) What steps did you/the Board take to ensure these were sufficiently addressed?

A. I am unable to answer this question.

e) With reference to your answer to question 9 in your May 2025 draft statement and, in its most recent Glasgow 4, Part 1 hearing in May 2025, the Inquiry heard evidence about the absence of formal Validation of the ventilation systems of the new SGH prior to occupation of the hospital by patients. It appears that members of the NHS GGC Project Team may not have understood the difference between 'commissioning' a ventilation system to confirm it has been fitted in compliance with the contract and 'Validation' of a ventilation system to confirm that it operates as its users expect it to. Do you have an understanding of the difference between 'commissioning' a ventilation system and 'Validation' of a ventilation system and can you assist the Inquiry in understanding why the ventilation system of the RHC including specialist ventilation areas such as isolation rooms and haemato-oncology wards were not validated before patient occupation?

A. I understand the difference as stated in the question. I was not involved in the commissioning or validation of the ventilation system. This was not part of my remit.

f) With reference to your answer to Question 10(a) of your statement of May 2025 how did you ensure that on the arrival of transplant patients in Ward 4B on 6 June 2025 that ventilation system for both the ward as a whole and the BMT isolation rooms in particular was operating on accordance with the standards then set down in SHTM 03-01 or that there was a derogation in place if it was not?

A. I assume the date in question S3 regarding 4B is an error. Before any move of patients to new wards or departments a range of assurances would be provided by the Project Team, along with clinical, estates, ICT colleagues working with the operation team moving into the new facilities.

g) In question 12 if your statement, the Change Order Request for the Adult BMT is discussed (**Bundle 16, Document 29, Page 1699**).

(i) What do you recall in respect of this change order request?

A. The change order came about as a result of national work to centralise Adult BMT services. A plan was produced to demonstrate the need for the change in service.

(ii) As this change order was issued in your name? Do you accept responsibility for it?

A. It was my responsibility to sign the change order along with the Chief Executive due to the Standing Financial Instructions. The decision to create a centralised Adult BMT Service was a collective decision by the Board Chief Executives.

(iii) What advice did you take in advance of issuing it?

A. As stated, a planning proposal including clinical arguments was produced to argue the case for the service.

h) From whom did you seek advice this advice?

A. See previous answers to question 12.

(i) What assurances were you given that this information on technical and environmental requirements was being provided by technical, clinical and ICT colleagues?

A. I am unable to recall if assurances were given.

(ii) What interactions did you have with Multiplex during this time? Did you seek assurances from them in advance of issuing the change order?

A. I had very limited interaction with Multiplex. The Project Team dealt with contractors on a day to day basis, and through the agreed governance arrangements.

(iii) Given you were responsible for issuing the change order what do you recall in respect of communicating these significant changes to Multiplex and the Project Team? If you did not, then who did?

A. The changes would be issued as part of the agreed governance process. The Project Team would be responsible for communicating agreed changes to the contractor given any financial changes would require agreement. I am not aware of any assurances sought from Multiplex. This would be through the interaction between the Project Team and Multiplex.

i) With reference to question 13 of your statement, were you made aware of the technical requirements set out in SHTM 03-01 for air change rates in a neutropenic ward?

A. I do not recall being made aware of the technical requirements set out in SHTM 03-01. This would be the responsibility of the technical team.

Water Incident in 2018 and DMA Canyon Reports

17. Before NHS GGC took responsibility for the QEUH/RHC building in January 2009 were you aware of the requirement for a L8 Pre-occupation Risk Assessment? When did you first become aware of the recommendations of the DMA Canyon Report 2015 L8 Risk Assessment, see **(Bundle 6, Document 29, Page 122**) and why?

A. I was not aware of the DMA Report until 2017/18.

18. The QUEH/RHC uses large numbers of Horne Optitherm Taps. Following neonate deaths at hospitals in Northern Ireland and Western Australia a meeting was held with representatives of HPS, HFS and others on 5th June 2014 (**Bundle 15, Document 9, Page 692 and the HPS SBAR of 2014 Bundle 3, Document 1, Page 5)**. What is your understanding of the decision that then faced NHS GGC in respect of the use of Horne taps within the new SGH? Given these Horne taps were used in the new SGH what was reported to you as Chair of NHS GGC about this issue and specifically what steps were being taken after handover to ensure that these taps were being used safely and without build-up of biofilm?

A. This question is directed to the then Chair of GGC.

19. Please refer to **Bundle 13, Document 132, Page 921**. The Inquiry understands you were involved in a Short Life Working Group known as the "external review" following the discovery of the DMA Canyon Reports. When and by whom was this review established, who was involved in this review, what was your role in this review, what investigations were undertaken and what were the relevant outcomes following this review? What actions, if any, were taken following the outcomes of the review?

A. I was asked by the Board Chief Executive to oversee the implementation of an action plan to ensure the recommendations of the DMA Report were fully implemented. My role was to ensure the recommendations were implemented at pace and I chaired a small group which met frequently to monitor progress. I recall that separate investigations into the reasons why the reports were not implemented were commissioned by the Chief Executive.

20. The Inquiry understands you were also involved in the Executive Water Group which was set up to include yourself, Mary Anne Kane and Jane Grant. What can you tell us about the role of this group, who was involved, what was the extent of your role in the group and details of any relevant outcomes from its work?

A. I refer to my answer to question 19. The main outcome was the monitoring of progress to ensure the actions were fully implemented and a Responsible Person/engineer was identified for water, which was a key recommendation.

21. What was your role in communicating with patients and families in respect of the issues which arose with the water system at the QEUH?

A. I received daily updates from the Director of Women and Children's Services along with his senior colleagues – the General Manager and Chief Nurse for Women and Children's Services. I visited the wards and departments and spoke to clinicians and nursing staff and also parents where possible. The Women and Children's senior team made sure they were available to speak to parents and staff and undertook daily visits to the ward. This was also undertaken in the evenings and at weekends to accommodate families.

22. What was your role in respect of communicating with the Scottish Government in respect of the issues which arose with the water system at the QEUH?

A. Regular updates were provided to SG via the Board Chief Executive.

a) How did you first become aware of the DMA Canyon Reports? As Director of Acute Services what steps did you take to address the concerns raised and to ensure patient safety?

A. I was made aware by the Chief Executive. The actions to address concerns were not within my remit.

b) At question 19 of your statement the “external review” is discussed following the discovery of the DMA Canyon Reports.

(i) Is the “external review” you refer to that conducted by Mr Leiper (**Bundle 8, Documents 34-40, Pages 150-206**)?

(ii) What can you recall about progress made in terms of ensuring the recommendations from the DMA Report were implemented?

A. Yes, the external review was the report conducted by Mr Leiper. The report stated that many of the recommendations had been actioned.

(iii) In undertaking this work what insight did you gain into the reasons behind why these recommendations were missed in the original report?

A. The DMA Report was the responsibility of the Estates and Facilities Directorate. I am not in a position to comment on the details of why the recommendations were missed.

(iv) What is your view on who was responsible for implementing the recommendations of the DMA Canyon Report?

A. See above answer

Decant of Wards 2A/B

23. What involvement did you have in the decision to decant Ward 2A/B to Ward 4B/6A in September 2018? What was your understanding as to why a decant was necessary?

A. In my role as Interim Chief Operating Officer I was involved in assessing the proposed decant options along with other senior leaders. Any proposals would have been developed by the local team, including advice from ICT colleagues and clinical staff managing the patients, all of which would be based on clinical risk and patient safety. Advice from technical estates staff would be part of the process.

24. The Inquiry has the minutes of a meeting from Tuesday 18 September 2018 of what was called the Water Review Meeting of which you attended that appears to have made the decision to decant the patients from Ward 2A (**Bundle 19, Document 35, Page 614**). What was the Water Review Meeting? What was its remit and membership and how often did it meet? Who chaired that meeting of the Water Review Group on 18 September 2018?

A. As I recall, the meeting was called by the Board Medical Director and the aim was to agree what actions were required, taking clinical, ICT and technical estates advise to ensure the safety of our patients.

25. The Inquiry has an SBAR that we understand was used to brief the Chair of NHS GGC, Mr Brown, on or about 13 November 2018 (**Bundle 4, Document 32, Page 133**). Why was it necessary to decant the Ward 2A/2B of the RHC to Ward 4B/6A of the QEUH in September 2018 and what role did concerns that the domestic water system posed a risk to the safety of patients play in that decision?

A. My understanding of the SBAR was to provide a situation report and proposed actions to ensure the safety of the patient cohort. The SBAR was used to assess the situation and inform decision making.

26. What involvement did you have on or about 18 January 2019 in the decision to decant Ward 6A to the CDU? What was your understanding as to why a decant was necessary?

A. As Chief Operating Officer, I would have received regular communication and updates from the Women and Children's Directorate team, and along with Deputy Medical Director – Acute and Deputy Director of Nursing – Acute review the options presented to us. We would also take advice from ICT and technical colleagues on the best course of action to maintain patient care in a safe environment. It is important to note that we all worked closely together to agree the way forward in challenging circumstances. I am unable to recall my exact involvement in the decision without reference to relevant papers from that period.

27. The Inquiry understands that ward 6A was closed to new admissions at the start of August 2019. Patients were diverted to other centres, including Aberdeen and Edinburgh (**Hearing Commencing 12 June 2023, Bundle of witness statements, James Redfern, Document 7, Page 396, para. 118**). Some were sent further afield (**see Hearing Commencing 12 June 2023, Bundle of witness statements, Dr Jairam Sastry, Document 4, Page 219, para. 127**). The Minutes of the IMT of 1 August 2019 (**Bundle 1, Document 75 at page 336**) imply that a decision was previously to close Ward 6A to new admissions and patients requiring higher risk chemotherapy. What knowledge did you have of that decision at the time. Why was it made, who made it and who approved it?

A. Any decision to divert patients to other centres would be taken after careful consideration and based on clinical advice. I was involved in the discussions given the magnitude of the decision for patients and their families.

28. The Inquiry understands that at an IMT meeting on 8 August 2019 there was a discussion of a potential further decant of patients from Ward 6A and that whilst the IMT might make a recommendation the "final decision will be endorsed by the Chief Executive" see **(Bundle 1, Document 76 at page 340**). To what extent would be correct to say that a decision to decant patients from one ward to another would not be made by the IMT, but by the Chief

Executive or a group of senior managers and executive Board members given the wider service impact of such a move?

A. I was not present at the meeting, however I do not think it is fair to assume that ward decants were decided by the Chief Executive. I am not sure what a group of senior managers refers to. In the case of ward 6A, IMT members, senior clinicians and senior nurses along with Estates colleagues worked together to look at all options for the ward and to deal with any work required to ensure the facility was safe for patients. Given the impact on the hospital and ongoing review of the environment it was appropriate to seek senior sign off by the Chief Executive.

29. What steps were taken to ensure that ward 6A was safe to reopen for admissions before the decision was made to re-open the ward for admissions?

A. A number of steps are required before a ward can reopen for patients. Estates, cleaning and microbiology work are key requirements, along with staffing. Daily updates would be provided to senior clinicians and managers. Infection Control will recommend a ward can reopen.

30. Dr Gibson alongside other clinicians wrote to both Jane Grant and Dr Armstrong on 30 August 2019 highlighting their concerns about infection and environment issues which had affected the unit for the past 18 month and sought an external review, (**Bundle 6, Document 43, Page 1416**) to which they responded September 2019 (**Bundle 8, Document 17, Page 85**). The Inquiry understands that on 2nd September 2019 you, alongside Dr Scott Davidson, met with the clinicians. What do you recall in respect of this meeting? Who attended? What was discussed? What was the outcome of this meeting?

A. I am unable to recall the precise details of the meeting. Senior clinicians attended along with members of the Women and Children's Directorate senior leadership team. We met to listen to the clinicians concerns and to ensure that actions were underway to resolve any issues. We discussed all the issues and

also wanted to ensure that ongoing communications were in place for clinicians and staff.

31. What role did you have in the preparation and approval of the NHS GGC response to a list of issues raised by the families of children in the Schiehallion Unit published on 30 October 2019 (**Bundle 6, Document 25, Page 77**) and do you consider it accurate in all respects?

A. I was involved in the final draft. The issues were wide ranging and required information from a number of sources. I believe the response was detailed and accurate.

a) With reference to question 24 of your statement, what were the proposed decant options? Which option did you proceed with and why? You may wish to refer to Mr Redfern's Options Appraisal of 17 September 2018 (**Bundle 6, Document 13, Page 38**).

A. Mr Redfern along with clinical, nursing and operational colleagues prepared a detailed options appraisal proposal for the decant of wards 2A/B for the Director of Women and Children's Services. Advice from a range of experts including estates, technical, microbiology and ICT was sought to inform the options. Following debate and discussions with senior colleagues the decant option was agreed based on patient safety and service continuation.

b) With reference to question 24 of your statement, what was your role in the Water Review Group? What responsibilities sat with you?

A. I was invited to the meeting in my management role. I do not recall having any actions from this meeting.

c) With reference to question 24 of your statement was there any member of the Water Review Group who had professional expertise in IPC or microbiology? If not, who was providing you, as Chair of the group, with advice on the microbiological impacts of decisions in response to the water incident and potential environmentally related infections in the Schiehallion Unit?

A. I was not the chair of the Water Review Group, the Board Medical Director chaired the group. I attended the meeting in my role as interim Chief Operating Officer given the implications of maintaining a safe service for patients. I understand that Infection Control were present at the meeting.

d) With reference to question 25 of your statement, did you agree with the conclusions and recommendations of this SBAR?

A. The SBAR was produced to provide details of the current situation and is commonly used within the NHS in Scotland. I am not qualified to comment on technical or clinical aspects but in general the SBAR is a fair reflection of the situation.

e) From everything that YOU are aware of relating to the water incident, was it the right decision to decant patients from Wards 2A and 2B to Wards 6A and 4B?

A. At the time of the water incident everyone was working tirelessly to ensure patients remained safe. Clinician concerns and IPC/microbiology work indicated that action was required to ensure patient safety and maintain services. Multiple discussions took place with many clinicians and managers to consider the way forward. The consensus was that a decant was the best option.

f) What was wrong with Ward 2A and 2B when the decision was made to decant the patients to Wards 6A and 4B in September 2018?

A. I am not qualified to answer this question.

g) What was wrong with Ward 6A when the decision was made to decant the patients to the CDU in January 2019?

A. I am not qualified to answer this question.

h) What was wrong with Ward 6A when the decision was made to stop receiving new admissions in August 2019?

A. I am not qualified to answer this question. Any decision to stop receiving admissions would be carefully considered by the senior clinicians treating the patient cohort with advice from Infection control and Microbiology colleagues.

Cryptococcus

32. What was your role in respect of communicating with i) patients and families in respect of cryptococcus infections and ii) the Scottish Government?

A. As Chief Operating Officer I was involved in responding to complaints or queries, also any meetings with relatives. Communication with SG would in general go through the Chief Executives Office.

33. Please refer to **Bundle 27, Volume 13, Documents 5, Document 6, Document 7 and Document 8, from Page 26**. The Inquiry understands a meeting took place on 30th September 2020 with Beth and Sandie Armstrong, which you attended, in respect of the Significant Clinical Incident Report of 28 April 2020 following their mother's death. What do you recall in respect of this meeting? What concerns were raised? At Document 6, page 34 they state, "confidence in the management of QEUH is now so damaged it has become very distressing to engage with it". Is this an accurate statement in terms of the management of the QEUH? If not, why not? Were the concerns raised by the Armstrong's valid?

A. I recall the meeting with Beth and Sandie Armstrong. Meetings with relatives are sensitive, especially following the death of a loved one. The Armstrong family raised a number of issues, which we tried to respond to and in particular Dr Hart was present as the Consultant who cared for their mother. I recall he was able to describe in detail the illness and the clinical aspects of their late mothers infection. It was particularly difficult at the time due to the many hypotheses regarding potential sources of infection surrounding the hospital.

34. In your letter of 13th October 2020, you write to Ms Armstrong acknowledging her concerns and apologise? On reflection how might this have been dealt with differently?

A. I believe it is important to meet families who have concerns and I also think it is important to apologise to relatives who raise concerns. In hindsight I am sure some aspects of the interaction with Ms Armstrong could have been handled differently. It was important to provide accurate information to Ms Armstrong and I hope the meeting helped explain the clinical issues regarding their late mother.

35. What is your understanding of the role (if any) that the fact that both patients who died in the QEUH/RHC after contracting Cryptococcus neoformans were accommodated in rooms without HEPA filtration whilst unable to be prescribed prophylactic anti-fungal medication played in them contracting that infection?

A. I am not qualified to comment on this question.

36. Why and how was the Cryptococcus Subgroup set up and who was chosen to serve on it and why? How were you and the Board provided with updates from the work of the Cryptococcus IMT and the Cryptococcus Subgroup?

A. I am unable to recall who established this group.

37. How was it that the decisions of the work of the subgroup at the Board (including on 25 February 2020) appear to have included the reporting that certain hypotheses had been discounted in advance of the final report (**Bundle 14, Volume 2, Document 125, page 455**)?

A. I was unable to open or download Bundle 14.

38. Were the Board seeking to rule out hypotheses and force a conclusion on the likely cause being reactivation before full investigations had been completed?

A. I do not believe this to be the case.

a) With reference to your answer to Question 33 do you accept the criticism made by Beth and Sandie Armstrong on 30th September 2020 that,

"confidence in the management of the QEUH is now so damaged it has become very distressing to engage with it" is accurate?

A. I fully understand the criticism from Beth and Sandie Armstrong about the management of the QEUH. It was particularly distressing for the family dealing with their mother's illness and the press speculation about the hospital. I felt it was important to meet with the family along with senior clinicians to listen to their concerns and try to explain the issues relating to their mother's illness. The family had a good relationship with Dr Hart the consultant in charge of Mrs Armstrongs care, and he was able to answer questions about their mother's illness

b) With reference to question 35 in your questionnaire why was it that severely immunocompromised patients who later died in the QEUH/RHC after contracting Cryptococcus neoformans were accommodated in rooms without HEPA filtration whilst unable to be prescribed prophylactic anti-fungal medication?

A. I am not qualified to answer this question.

c) You have not answered question 35 of your questionnaire. You should be able to source the bundle from our website at **Bundle 14 - Further Communications - Volume 2 of 3 | Hospitals Inquiry**. Once downloaded can you please answer this question.

Question 35: How was it that the decisions of the work of the subgroup at the Board (including on 25 February 2020) appear to have included the reporting that certain hypotheses had been discounted in advance of the final report (**Bundle 14, Volume 2, Document 125, page 455**)?

A. I am not able to answer this question. However, I would think that many hypotheses would be considered and narrowed down using the expertise available.

<u>Concerns Raised by Infection Prevention Control Colleagues</u>

39. When did you first become aware of concerns raised by IPC colleagues in respect of the increase of infections in paediatric haemato-oncology patients and risk of the built environment within the QEUH?

A. I am not able to recall when this issue occurred.

40. What awareness did you have of the resignation of Dr Inkster and Dr Peters from their ICD sessions in July 2015 and their concerns about the safety of the water and ventilation systems of the hospital (**Bundle 14, Volume 1, Document 26, Page 414; Bundle 14, Volume 1, Document 27, Page 416-420; and Bundle 14, Volume 1, Document 45, Page 472**)?

A. I was Director for the North Sector at the time and did not have responsibility for QEUH.

41. In November 2015, Dr Peters wrote to Dr Stewart regarding the discovery of Mucor in the paediatric BMT despite ongoing transplants and expressing doubts about the functionality of the PPVL (**Bundle 8, Document 24, Page 121**). What do you recall about this incident? What steps did you take, if any, to address these concerns? Were Dr Peters concerns in respect of the environment justified?

A. I was not responsible for Paediatrics in 2015.

42. What is your understanding of the whistleblowing process within NHS GGC in 2017 and the extent to which it was designed and operated to ensure that disclosure by staff of evidence of wrongdoing, failures in performance or inadequacies of systems was encouraged and reacted to by the Board to ensure that the safety of patients and the best value use of public funds were protected?

A. NHS GGC like all other NHS Boards in Scotland developed a Board wide whistleblowing policy and promoted the policy via internal communications. Appropriate governance arrangements were established to implement the policy and report to the appropriate Board governance group.

43. Dr Redding and others made a stage 1 whistle blow to Dr Armstrong for which they produced an SBAR (**Bundle 14, Volume 1, Document 75.1, Page 732**)

and a meeting on 4 October 2017 (**see minute at Bundle 14, Volume 1, Document 83.1, Page 753**) which you attended. What do you recall about this meeting? Why did you attend? What action points from that meeting became your responsibility? Was this Stage 1 whistle blow discussed and reported on at Board meetings? What actions were taken in respect of the concerns raised in the whistle blow? How did the 27-point action plan (**Bundle 20, Document 48, Page 792**) come about?

A. I am unable to open or download bundles 14 or 20. I do recall the meeting and it was called by the Board Medical Director as a genuine attempt to bring all parties together to agree a way forward and develop an action plan. An action plan was developed as agreed at the meeting.

44. To what extent is it fair to say that the 27 point action plan come about as a direct consequence of the Stage 1 whistleblow raised by Dr Redding and others?

A. This statement is a matter of opinion. Personally I believe that staff should raise issues through the agreed line management processes within the NHS Board general management and professional management structures. Line management and professional line management processes need to be followed to ensure resolution or not before other avenues are explored including using the Whistleblowing Policy. In this case I would need to see any relevant papers or emails from Dr Redding and others as evidence that the agreed processes were followed prior to making a decision to invoke the Whistleblowing Policy.

45. What steps were taken by the Board to ensure that the issues raised by Dr Redding and in the Stage 1 whistleblow were addressed by NHS GGC?

A. I was not involved in the Stage 1 process.

46. What was your understanding and involvement, if any, in any subsequent whistleblow during your time at NHS GGC?

A. I was involved in some discussions to try to establish suitable working arrangements within the Laboratory management structure to accommodate all parties.

47. In your view were Dr Peters, Dr Redding and other microbiologists raising valid concerns?

A. In my personal opinion if the issues were raised and escalated via the agreed internal managerial and professional structure many of the concerns would have been dealt with at the time.

48. Please refer to **Bundle 6, Document 22, Page 70**, a meeting took place on 20th August 2019 in which the decision was taken to change the chair of the Gram Negative Bacteraemia IMT. What do you recall in respect of this meeting? What was your understanding as to why this meeting was being called? Why were you invited? Were you aware of concerns in respect of the running of the IMT in advance of this meeting? What is your view on the outcome? Do you think it was fair to make such a decision in Dr Inkster's absence?

A. I attended the meeting and the discussion considered the need to ensure that complex IMTs had the correct membership and admin support to make decisions. The minute clearly details the concerns of some staff attending IMTs and the huge burden on the chair. It was important to ensure that all IMTs were run on an agreed basis with appropriate membership. I was invited in my role as Chief Operating Officer for Acute Services.

49. Whilst you were in post what steps did the Board of NHSGGC take to encourage staff to raise concerns and highlight issues, including by whistleblowing policies and processes. If it were suggested that raising concerns and highlighting issues, including by whistleblowing policies and procedures, was not encouraged between 2017 and 2019, what would your response be? What evidence can you point to which supports your position?

A. I do not believe this to be the case. I am happy to review any correspondence regarding any claims that raising issues was not encouraged. In my senior leadership roles I regularly met staff groups, worked with staff side organisations, visited acute sites and ensured communications with staff were a priority. Also, as previously stated a clear general and professional management structure was in place across GGC. As I recall the Board

promoted the Whistleblowing Policy through various forms of communication internally and a senior leader was identified as the lead for Whistleblowing.

a) You have not answered question 37 of your questionnaire. You should be able to source the bundles from our website at **Bundle 14 - Further Communications - Volume 1 of 3 | Hospitals Inquiry** and **Bundle 20 - Documents referred to in the Expert Reports by Andrew Poplett and Andrew Bennett | Hospitals Inquiry.** Once downloaded can you please answer this question

Question 37: Dr Redding and others made a stage 1 whistle blow to Dr Armstrong for which they produced an SBAR (**Bundle 14, Volume 1, Document 75.1, Page 732**) and a meeting on 4 October 2017 (**see minute at Bundle 14, Volume 1, Document 83.1, Page 753**) which you attended. What do you recall about this meeting? Why did you attend? What action points from that meeting became your responsibility? Was this Stage 1 whistle blow discussed and reported on at Board meetings? What actions were taken in respect of the concerns raised in the whistle blow? How did the 27-point action plan (**Bundle 20, Document 48, Page 792**) come about?

A. I was invited to attend the meeting by the Board Medical Director. The purpose of the meeting was to consider all the issues raised by Dr Redding and agree actions to be taken by the various attendees. I don't think I had any actions from the meeting. I understand the action plan was developed from the meeting. I

cannot recall if the Stage 1 Whistleblowing was reported at a Board meeting.

b) With reference to your answer to question 47 of your statement are you aware the principal point being made by Dr Peters, Dr Redding and other microbiologists is that they raised issues in 2017 as earlier attempts to raise the same or similar issues had not succeeded.?

A. I was not aware of any previous issues raised as I was in a different role.

c) Were the concerns raised by Dr Peters and Dr Redding in October 2017 invalid?

A. I am not able to comment on any clinical issues which may have been raised. My focus was in attempting to ensure that all parties involved worked through the agreed Directorate General Management structure and the professional reporting structure.

d) With reference to your answer question 48 of your statement:

(i) In advance of the meeting of 20th August 2019 were you aware the meeting had been called to discuss the removal of Dr Inkster as chair of the IMT?

A. No, I was invited to the meeting to discuss how to support the IMT due to the complexity of the issues and the membership to ensure consistency of attendance.

(ii) Why were the clinicians who were responsible for the care of the patients in Ward 6A led by Professor Gibson not informed of the meeting of 20 August 2019 or asked to attend?

A. I was not the organiser of the meeting therefore I cannot comment on who was or was not invited to the meeting.

Procurement of What Became the QEUH/RHC

50. What role and responsibilities did you in respect of the procurement, design and construction of the new SGH that became QEUH/RHC?

A. At the time I was in a different role within GGC. My involvement was in terms of the centralisation of Renal Services to the new hospital following an interim centralisation in the Western Infirmary prior to transfer to QEUH. Also, I chaired a working Group to plan outpatients within QEUH. Latterly I attended governance groups preparing for the migration to the new facilities.

51. Refer to **Bundle 52, Volume 1, Document 22, Page 308** where you approved changes to reduce haemato-oncology beds from 14 inpatient beds and a day

area to 10 patient beds and no day area. What ward was affected? What was the intended patient group? What was the rationale behind this decision, who was involved and what advice if any, was sought in reaching this decision?

A. I have reviewed the Change Control Sign Off but without back up papers I cannot recall the rationale for this decision. Any decision would have been carefully considered with evidence and proposals based on options involving the clinical team at the time.

52. The Inquiry understands that you then later approved the increase of the number of beds to 24. What was the rationale behind this decision, who was involved and what advice, if any, was sought in reaching this decision?

A. Please see my answer to question 50.

53. Did you have any role in the site selection process in respect of QEUH/RHC and if so what was it? Were any risk assessments carried out in respect of the selection of the site and its proximity to Shieldhall Sewage Treatment Works? What consideration, if any, was there in respect of the Shieldhall Recycling Centre? What concerns, if any, did you have regarding site selection? What action, if any, did you take in respect of such concerns and what was the outcome?

A. I was not involved in selecting the site for the new hospital.

54. Did you have involvement in the preparation of the Employer's Requirements (ERs) for any part of the new SGH project and if so which parts?

A. No.

a) Who was responsible for providing the requirements for the Clinical Output Specifications and who approved the COS for inclusion in the ERs?

A. I am unable to answer this question. I assume a process following the published national guidance at the time was put in place.

b) Who was responsible for confirming what the relevant NHS Guidance was for the project?

A. I was not involved in this part of the project.

c) How was the impact of sustainability and energy targets on the ER and the project as a whole defined by NHS GGC?

A. This was not in my remit.

55. How was the Clinical Output Specification (COS) for the design of each of the Wards confirmed and signed off. What system was put in place to define the technical requirements of the ventilation system (air change rates, pressure differentials and filter requirements) for the rooms in the hospital?

A. Local teams were involved in the design of wards working alongside project architects. Any technical requirements would be provided by technical/ ICT/Microbiology experts following the appropriate national guidance available at the time. This would lead to a collective decision on design and layout of wards.

56. During the period of procurement (including construction) what guidance was considered in the design of wards to accommodate immunosuppressed patients, what processes were in place to ensure guidance compliance? Were there any changes to the specification of the ventilation systems for the hospital after the start of the competitive dialogue, if so, please describe any such changes, describe the impact, if any, on compliance guidance with SHTM 03-01, and describe the sign off process for any such changes, your involvement and how any changes were communicated to the Board?

A. I was not involved in the specification of the ventilation system.

57. What member of the NHS GGC IPC Team was responsible for confirming the acceptability of filtration and HEPA requirements, air change rates and pressure differentials for wards in the new SGH before construction commenced? What was the Board's awareness at the time, if any, of such a process and responsibility?

A. I am unable to answer this question.

58. Describe your involvement and understanding, if any, in the removal of the maximum temperature variant in May/June 2009? **(Bundle 17, Document 26, Page 1063 and Bundle 26, Document 3, Page 247)** When did you first

become aware of this decision? Why was the decision taken and by whom? What was the Board level knowledge/ input into this decision? What risk assessments, if any, were taken prior to making this decision? What was the impact, if any, in removing the maximum temperature variant?

A. I was not involved in this issue.

a) Describe your involvement and understanding, if any, in the decision to use chilled beams. Why was the decision taken and by whom? What was the Board level knowledge/ input into this decision? What risk assessments, if any, were taken prior to making this decision? What was the impact, if any, in using chilled beams?

A. I was not involved in the decision to use chilled beams.

b) Who provided the specification for environmental data relating to air change rates, pressure differentials and filter requirements?

A. See answer to 57a.

59. Explain your understanding of the ventilation design strategy contained in the Contractor's Tender Return Submission (11 September 2009) **(Bundle 18 Volume 1, Document 8, Page 205)**. Was the ventilation system to be a mixed mode ventilation system (dependent on a non-sealed building) or a mechanical ventilation system (dependent on a sealed building)?

A. This was not in my remit. I was not involved in the choice of ventilation system.

60. Was the design and/or specification of the ventilation system as recorded in the Building Contract, in particular in the M&E Clarification Log **(Bundle 16, Document 23, Page 1664**) compliant with NHS Guidance?

A. See answers to questions 57 and 58 above.

a) If not, please explain:

(i) Why this design was proposed;

(ii) Why this design was accepted, and who advised the Board regarding acceptance; and

(iii) What role, if any, BREEAM played in the acceptance of this design.

A. See answers to questions 57 and 58.

b) If you are of the view that it was compliant, please explain why, with reference to SHTM 03-01 2009 (Ventilation Design) **(Bundle 16, Document 5, Page 342).**

A. See answers to questions 57 and 58 above.

61. The Inquiry is aware of the agreed ventilation derogation recorded in the M&E Clarification Log. **(Bundle 16, Document 23, Page 1664).**

a) What was your understanding and awareness, if any, the scope of the agreed ventilation derogation recorded in the M&E Clarification Log?

A. I was not involved in this technical issue.

b) When did you first become aware of it and how?

A. See answer to question 60A.

c) Was the agreed ventilation derogation restricted to general wards only?

A. See answer to question 60A.

d) If so, how is this interpretation evidenced within the documentation (such as the M&E Clarification Log) and where is the specification located for areas that required specialist ventilation and isolation rooms?

A. See answer to question 60A.

e) Who else from the GGC Project Team and Board were aware of the Ventilation derogation?

A. I am unable to answer this question.

f) How was the agreed ventilation derogation signed off by the Board? The Inquiry understands from the response from Currie and Brown to PPP13 that the GGC Project Team had advised Helen Byrne of the Agreed Ventilation Derogation, alongside Alex McIntyre (Director of Facilities) & Peter Gallagher (Director of Finance). Please also confirm how this was discussed with the Board having regard to the paper Helen Byrne drafted alongside Alan

Seabourne; Drafted Acute Services Review paper in 2010 which stated the Acute Services Strategy Board will "*Approve change control in that any change which impacts upon the project must be authorised by this Board before it can be implemented".* **(Bundle 30, Document 6, Page 36)**

A. I was not involved in this issue at the time.

62. When did you first become aware of the ZBP Ventilation Strategy Paper dated on or around 15 December 2009? **(Bundle 16, Document 21, Page 1657)**

A. I was not involved in this issue at the time.

a) What action, if any, did you take when you became aware of this document and why? If you did not take any action, please explain why not.

A. See answer above.

b) What concerns if any did you have on reading this document?

A. See answer above.

63. What risk assessments, if any, whether in compliance with the standards in HAI Scribe or otherwise, did NHS GGC carry out or have carried out in respect of the change in the ventilation strategy that appears to follow the ZBP Ventilation Strategy Paper dated 15 December 2009? **(Bundle 16, Document 21, Page 1657)**

A. See answer to question 61.

64. Was the Ventilation Derogation recorded in the Full Business Case? Who was responsible for doing this? If not, why not? If you were aware that it had not been recorded in the Full Business Case please explain what action, if any, you took.

A. I was not involved in this issue.

65. Describe your involvement and understanding, if any, of the decision to remove carbon filters from the ventilation system of the QUEH/RHC? What was the rationale behind this decision, who was involved and what advice, if any, was sought in reaching this decision?

A. I was not involved in this issue.

Ward 2A – The Schiehallion Unit

66. The Inquiry understands that Ward 2A/2B is the paediatric-oncology Unit and includes the Teenage Cancer Trust and the paediatric Bone Marrow Transplant (BMT) Unit - the department is known as the Schiehallion Unit.

a) What is your understanding of the intended use and purpose of the Ward 2A/ 2B?

A. The intended use and purpose of ward 2A/2B was to transfer the extant Schiehallion Unit on the Yorkhill Hospital campus to brand new facilities in the new RHC. The Shiehallion team led by the senior clinicians were involved in the design of the ward and facilities to ensure children could receive the best treatment in modern facilities'.

b) What guidance was considered in the design of these wards?

A. I assume the latest available guidance was used along with visits to other new units in the UK. Also, research into current facilities in similar units across the globe would have been considered.

c) What processes were in place to ensure guidance compliance?

A. The Project Team were responsible for ensuring guidance was followed in developing the final design for sign off.

d) Were there any changes to the design during the design and build? If so, please describe any such changes, describe the impact, if any, on guidance compliance, and described the sign off process for any such changes, your involvement and how any changes were communicated to the Board. Was external advice ever sought in respect of design changes?

A. I am unable to recall the detail of any proposed changes. Any changes would be subject to approval through the agreed governance process established by the NHS Board.

e) Describe the IPC involvement in the design of Wards 2A and 2B, who was involved and who signed off the final design and when.

A. I am aware of IPC involvement but cannot recall the detail and who signed off the final design.

f) What concerns, if any, did you have regarding the final design specification of Wards 2A and 2B, and what action, if any, did you take in respect of these concerns?

A. I cannot recall any specific concerns, however the process to reach sign off of design specifications involved the multi-disciplinary team from Schiehallion along with advice from IPC and technical colleagues.

Isolation Rooms

67. Describe how was the number and location of isolation rooms agreed? Who approved the final number and locations in the QEUH and RHC?

A. I am unable to answer this question.

68. Who was responsible for producing the drawings and the specification for isolation Rooms; who approved these from the GGC Project Team?

A. I am unable to answer this question. The Project Team would have been responsible for this area.

69. What concerns, if any, did you have regarding isolation rooms and compliance with SHTM/HTM? What action, if any, did you take in respect of any such concerns?

A. I am unable to answer this question.

70. The Inquiry has reviewed the RDS in excel format and note there is an entry under ‘Design Notes’ relating to Ward 2A isolation rooms; the entry states:

WARNING NOTICE: This room is based on a theoretical design model; which has not been validated (see paragraph 1.8 of HBN 4 Supplement 1). Specialist advice should be sought on its design. The lamp repeat call from the bedroom is situated over the door outside the room.

a) Was this note entered on the RDS? If so, why and by whom?

A. I am unable to answer this question. The Project Team was responsible for the technical design issues.

b) What specialist advice was sought relating to the design of these rooms?

A. See answer to question 69A.

c) What was the final agreed design for isolation rooms and who approved this?

A. See answer to question 69A.

71. What ceiling types were specified and approved for use in isolation rooms? Who from the GGC Project Team approved this? Describe your involvement, if any? What was the impact, if any, of the choice of ceiling tiles? What concerns, if any did you have regarding the choice of ceiling tiles?

A. I was not involved in this issue.

<u>Case Note Review</u>

72. Please describe the process involved for the Case Note Review from the point of view of NHS GGC. Please include how this was established, who established it, who from NHS GGC was involved, what work was done by NHS GGC to support it, what access NHS GGC had to its reports and conclusions and any relevant outcomes? What was your role in the Case Note Review, if any?

A. I was involved in liaison with the Review team to ensure access to any information on a day to day basis. I am unable to recall how the case note review was established, my role was minor, ensuring the review team were supported during their work.

73. Referring to the Case Note Review Overview Report March 2021 (**Bundle 6, Document 38, Page 975**) what was the conclusions of the Case Note Review in respect of the role of the hospital environment as a source of infection?

A. I am unable to answer this question.

74. Did NHS GGC make any public statement after the publication of the Case Note Review Overview Report? What was that statement and why was it made?

A. I am unable to recall if any statement was made.

Conclusion

75. Is there anything else you would like to add which you think would assist the Inquiry?

A. I worked in the NHS in Scotland for 41 years and at all times I was committed to putting patients and their families first, closely followed by our staff providing services at all levels. Some of the questions relate to a period some time ago and it is difficult to recall the detail. I have tried as best I can to answer the questions, however I have neither clinical nor technical/estates qualifications. During my career I have always tried to build a team approach to managing complex services to the population we serve. This has to be done through professional and general management accountability structures within the Boards governance arrangements. It is also important that all staff recognise that they are part of a team providing health care and respect each other and their contributions.

a) When you learned that the BBC was to air the Disclosure Scotland Programme about the patients at the Schiehallion Unit: Did you email staff in NHSGGC prior to the programme being aired?

A. I am unable to recall if I emailed staff regarding the BBC Programme, however any email will be available to the Inquiry on the NHSGGC server.

c) Did you take any steps to warn current patients and families at the Schiehallion Unit prior to the programme being aired?

A. A system of regular visits and engagement with patients and families in the Schiehallion Unit was in place and I visited the ward to meet staff and patients and families.

The Women and Children's team visited regularly including evenings and weekends to be available for patients and families. The team would have advised the patients, families and staff of the programme.

Declaration

76. 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

A43255563 - Bundle 1 – Incident Management Team Meeting Minutes (IMT Minutes)
A43273121 - Bundle 3 – NHS National Services Scotland Situation: SBAR documentation
A43299519 - Bundle 4 – NHS Greater Glasgow and Clyde: SBAR documentation
A43293438 - Bundle 6 – Miscellaneous Documents
A43955371 - Bundle 8 – Supplementary Documents for the Oral hearing commencing on 12 June
A47390519 - Bundle 11 - Water Safety Group
A48890718 - Bundle 13 – Additional Minutes Bundle (AICC/BICC)
A49525252 - Bundle 14, Volume 1 - Further Communications
A48541141 - Bundle 14, Volume 2 – Further Communications

A47664054 - Bundle 15 – Water PPP

A47851278 - Bundle 16 – Ventilation PPP

A49342285 – Bundle 17 - Procurement History and Building Contract PPP

A48235836 - Bundle 18, Volume 1 – Documents referred to in the expert report of Dr J.T. Walker

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

A49615172 - Bundle 26 – Provisional Position Papers

A50527456 - Bundle 27, Volume 13 – Miscellaneous Documents

A35560136 – Bundle 30 – Acute Services Review Papers

A51785179 - Bundle 34 – Performance Review Group and Quality and Performance Committee

A53674650- Bundle 52 – Volume 1 – Miscellaneous Documents

A43501437 - Bundle of witness statements for the Oral hearing commencing 12 June 2023

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

Witness Statements – Volume 1

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