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 6

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Scottish Hospitals Inquiry
Witness Statement of
Thomas Rodger

Qualifications and Professional Background

1. I am Thomas Rodger. I currently hold the post of Head of Engineering at NHS Scotland Assure, NHS National Services Scotland ("NSS"), which I have held since September 2022.

2. I have previously provided a Witness Statement **(Hearing Commencing 26 February 2024 – Witness statements – Volume 1, Document 17, Page 444)** and Oral Evidence (**Transcript, Thomas Rodger, Page 51**) to the Scottish Hospital Inquiry as part of the Edinburgh III Hearing.

3. This statement is provided in response to a request made by Counsel to the Scottish Hospitals Inquiry. NSS submitted a closing statement (**Core Participants Closing Submissions Bundle, Document 8, Page 147**) following the Glasgow III Hearing. Counsel to the Inquiry has invited NSS to provide information relating to a number of areas covered within that closing statement. In preparing this supplementary witness statement I have been supported by NHSScotland Assure colleagues who specialise in ventilation and domestic water services/ above ground drainage, as well as colleagues from Antimicrobial Resistance and Healthcare Associated Infection Scotland ("ARHAI Scotland") and Property, Sustainability & Capital Planning. Both teams sit within NHSScotland Assure.

Positive Pressure Ventilated Lobby (PPVL) rooms

4. As referenced in paragraphs 212 and 213 (page 584) of the Closing Statement by Counsel to the Inquiry for Glasgow III (**A51312578 – Glasgow III Counsel Closing Statement**), the Inquiry has heard evidence in relation to the

application of PPVL rooms for certain patient cohorts. NHS England has recently published an updated HBN 4 Supplement 1 document (Available at: https://www.england.nhs.uk/publication/adult-in-patient-facilities-planning-and-design-hbn-04-01/). NHSScotland Assure initially planned to engage with wider NHSScotland stakeholders in 2025 on its applicability, or otherwise, in Scotland. However NHS England has indicated that, following receipt of other stakeholder feedback, there may be further revisions to the document in the near future. NHSScotland Assure is currently reviewing proposed amendments which NHS England has suggested. We will revisit how (and when) engagement with wider NHSScotland stakeholders will be progressed following this process to ensure this is done in the most efficient way possible.

Thermal Wheels

5. In light of evidence heard during the Glasgow III hearings in relation to the use of thermal wheels (referenced in paragraph 230 of chapter 7, (page 589), of Counsel to the Inquiry's Closing statement for Glasgow III (**A51312578 – Glasgow III Counsel Closing Statement**), NSS completed a rapid literature review to identify whether there is any evidence to support a change to the current SHTM 03-01 guidance. The findings indicated that, whilst there is a theoretical risk of air leakage between sections of the thermal wheel, the risk of pathogen transfer remains low provided it is designed, installed and maintained correctly. However, the impact on patient outcomes remains extremely challenging to establish due to the barriers related to testing in "real world" conditions with live pathogens.

6. There are ethical challenges (for example potential exposure to harmful pathogens and agents) with respect to comparing ventilation system performance and the consequential impact on clinical and patient outcomes. This is particularly evident when considering, for example, dilution effects on live viruses (i.e. how air may be used to reduce the concentration of a particular pathogen or agent).

7. NSS plans to include revised text within the forthcoming 2025 edition of SHTM 03-01, noting that where thermal wheels are proposed, the usage of such devices should be reviewed by the NHS Board's Ventilation Safety Group and considered as part of clinical and HAI-SCRIBE risk assessments.

Key Stage Assurance Reviews (KSAR) and NHSScotland Design Assessment Process (NDAP) Processes

8. Both the KSAR process and the pre-existing NDAP are undertaken in a collaborative manner with an NHS Board. Whilst both the KSAR process and NDAP consider compliance with appropriate guidance and standards, both processes can also provide recommendations that may be considered "improvement activities" which an NHS Board may wish to consider. It should be noted that this would not necessarily lead to an unsupported status if they were not followed. For example, a "Category 5" observation in a KSAR would be classed as an "observation and improvement activity". Therefore, the suggestion noted within Paragraph 19 of chapter 9, (page 759), of Counsel to the Inquiry submission for Glasgow III that, "If a Board did not want to follow the advice, the project would be labelled 'unsupported' and would not progress" is an oversimplification. (**A51312578 – Glasgow III Counsel Closing Statement**).

9. Should such a situation as noted in paragraph 8 arise during an KSAR or NDAP, NHSScotland Assure would engage with the NHS Board and the Scottish Government to discuss the issues, consider associated risks and potential pathways. Ultimately the decision as to whether a project will progress will be that of the NHS Board and/or the Scottish Government.

a) I have been asked in my opinion had these processes been in place in 2009 and throughout the period of the build would they have ensured that Ward 2A (The Schiehallion Unit) was built with 10 air changes per hour, Hepa filters and positive pressure differential to the rest of the hospital?

The KSAR and NDAP processes are complementary, independent review processes and are not a replacement for the responsibilities of the health board.

If the KSAR and NDAP had been undertaken on the Queen Elizabeth University Hospital (QUEH), there is a high probability that these processes would have raised observations around the design, construction, commissioning, validation and handover of Ward 2A. The ultimate decision, however, as to what solutions were implemented would have remained that of NHSGGC.

b) I have been asked in my opinion had these processes been in place in 2009 and throughout the period of the build would they have ensured that Ward 4B (Adult Bone Marrow Transplant Unit) was built 10 air changes per hour, Hepa filters and positive pressure differential to the rest of the hospital?
The KSAR and NDAP processes are complementary independent review processes and not a replacement for the responsibilities of the health board. If the KSAR and NDAP had been undertaken on the QUEH, there is a high probability that these processes would have raised observations around the design, construction, commissioning, validation and handover of Ward 4B. The ultimate decision, however, as to what solutions were implemented would have remained that of NHSGGC.

A Template for Healthcare Buildings

10. There are difficulties with the suggestion that NHSScotland Assure could provide a template for building healthcare buildings as noted in paragraph 21 of chapter 9, (page 759) of Counsel to the Inquiry's Closing Statement (**A51312578 – Glasgow III Counsel Closing Statement**). This is due to the typically unique clinical requirements of each project and the subsequent interdependencies of guidance and their application to projects throughout the period of briefing, design, development and operation. It is challenging to provide a 'one size fits all' template, however, the activity database (ADB) and the NHSScotland Assure Repeatable Rooms guidance provide a starting point for a departments/rooms 'template'.

11. NSS supports the views offered by Mr Leiper, which promote engagement with technical personnel and other key stakeholders throughout all stages of a

project's design and build cycle **(Transcript – Jim Leiper, columns 107 and 111)** and **(Hearing Commencing 19 August 2024 – Witness Bundle – Week Commencing 21 October 2024, Volume 10, Document 4, Page 315, Paragraph 269**). By engaging with technical experts and other stakeholders early, this helps to ensure that project teams have the opportunity to fully consider the needs of the facility and to ensure priorities are clearly outlined. It also helps to ensure that project briefs are well developed and representative of all stakeholder requirements and dependencies.

Standard Derogations Process

12. NHSScotland Assure has commenced work on a "once for Scotland" derogation standard process. The document is currently being drafted by NHSScotland Assure subject matter experts, with the drafting process expected to continue into late summer 2025. Thereafter, the document will go to NHSScotland and colleagues from NHS England, Wales, and Northern Ireland for consultation prior to publication later in 2025. The document will look to consider key principals such as how derogations are defined, how they are documented and how any associated risks are assessed and addressed by NHS Boards and their project teams throughout all stages of a healthcare project.

Guidance on Taps

13. Regarding paragraph 60 of chapter 4, (page 191) (**A51312578 – Glasgow III Counsel Closing Statement**), NSS suggests caution in any future recommendations associated with taps containing flow straighteners. The construction of taps is complex, where many variables need to be considered, not least the maintenance and cleaning of outlets. Steps taken to eliminate one risk may introduce others. The current position in guidance across the UK (Scotland, England, Wales, and Northern Ireland) is consistent in that, for existing installations, removal of flow straighteners should be considered, subject to a risk assessment. For new installations, their use is discouraged.

Further work is planned on sanitaryware through a review of SHTM 64 (2009) (**Bundle 15, Document 2, Page 100**). Selected guidance references include:

- SHTM 04-01 Part A (2014) (page 65, paragraph 9.51, note 15) (**Bundle 15, Document 4, Page 317**)

- SHTM 04-01 Part G (2015) (page 61, paragraph 17.4) (**Bundle 15, Document 6, Page 522**)

- HTM 04-01 Addendum (2013) (pages 2, 5 and 14-15, paragraphs 2.6, 3.9, and 4.49b-c) (**Available at: Health Technical Memorandum 04-01 Addendum: Pseudomonas aeruginosa – advice for augmented care units**)

- HTM 04-01 Part B (2016) (page 71, paragraph D22)

- HTM 04-01 Part C (2016) (page 3, paragraph 2.9)

Declaration

I believe that the facts stated in this witness statement are true. I understand that this statement may form part of the evidence before the Inquiry and be published on the Inquiry's website.

The witness was provided with the following Scottish Hospital Inquiry documents

for reference when they completed their questionnaire statement.

Appendix A

A44565997 - Hearing Commencing 26 February 2024 – Witness statements – Volume 1

A50625965 - Hearing Commencing 19 August 2024 – Witness Bundle – Volume 10

A47782389 – Transcript, Thomas Rodger

A50762612 - Transcript – Jim Leiper

A51651537 – NSS Closing Statement – Core Participants Closing Submissions Bundle

A51312578 – Glasgow III Counsel Closing Statement

A47664054 – Hearing commencing 19 August 2024 – Bundle 15 - Water PPP

Scottish Hospitals Inquiry
Witness Statement of
Andrew Rough

Introduction

1. My full name is Andrew Donald McCallum Rough. Date of birth was [redacted] so I'm 57 years old. I'm a chartered accountant. I am now CEO of ACS Clothing Limited.

2. Dr Sarah Jenkins and I met post-university in London. We were housemates, that was back in 1992, and then we started a relationship, lived together from 1997 and we got married on [redacted] 2005. Therefore, I was in a relationship with Sarah for quite some time and, in that period, I watched her become a consultant, a very passionate doctor, working for NHS Greater Glasgow and Clyde from the early 90s through to her death this year. We have a son who is [redacted] years old now.

3. It has been explained to me that the remit of the Inquiry is limited to the planning, design, construction, commissioning and maintenance of the Queen Elizabeth University Hospital (QEUH) and whether in that context any individual or body deliberately concealed or failed to disclose evidence of wrongdoing or failures in performance or inadequacies of systems whether during the life of the projects or following handover, including evidence relating to the impact of such matters on patient care and patient outcomes; and whether disclosures of such evidence was encouraged, including through implementation of whistleblowing policies, within the organisations involved.

4. I have produced this statement to address that final point as I believe that the implementation of NHS GGC whistleblowing policies does not encourage disclosures of evidence relating to the impact of such matters on patient care and patient outcomes. It has been explained to me that given the terms of reference of the Inquiry I cannot provide details of the actual issues that Sarah

raised with NHS GGC management as the original issues were unrelated to the planning, design, construction, commissioning and maintenance of the QUEH, but I have provided a brief summary of what she raised without naming persons involved other than Sarah and the current chair of NHS GGC.

Professional History

5. Sarah started working with NHS Greater Glasgow and Clyde in the early 90s. She became a consultant neurointerventional radiologist in April 2004, when she was 35 years old. This was a very specialised field. From my understanding, Sarah was one of two women in the whole of the UK that became a neuro interventional radiologist, and across the whole of the UK, I think there were 60 consultants, of which there was only four in Scotland. So it was a very specialised field.

6. Sarah did all the usual qualifications. She qualified from Edinburgh University with Medicine in 1991. Then she did her MRCP, and then she became a fellow of radiologists. She did all the various qualifications that people did. She did them at a very young age. She passed them all very quickly. I don't know if the NHS still do this, but when Sarah was a consultant they awarded certain consultants who they regarded as being excellent, doing above the norm, with discretionary points, and between the years of 2007 and 2013, Sarah received five discretionary points. So that, to me, was a sign of Sarah being highly respected as a Consultant.

7. Sarah was one of the pioneers that established the Scotland-wide service for the treatment of brain aneurysms across Scotland, and, to this day, I still believe, you can only receive this treatment in Glasgow and Edinburgh. That came with its challenges. As with any new specialism, they have to try and fight for funding, especially if you're a very small team, and also you have to basically try and get appropriate staffing to help you, whether that's anaesthetists' time or whether that is appropriately specialised nurses. The specialism of intervention which Sarah did, which was treating brain

aneurysms, was basically inserting a platinum coil through a puncture in the groin and then working that platinum coil up through the blood system and then deploying it in the brain. An aneurysm is a bit like a blister on a blood vessel, and the blood would naturally go into that blister because it's an easy way of travel, and what the coil, the platinum coil, does is it packs the blister so the blood will then go through its normal route.

8. In the days before interventional work, this was treated by neurosurgeons who would basically open up the skull and then they would clip the blood vessel. So that, as you imagine, was very intrusive. The interventional way of treating it through your groin was clearly shown as being a better way, had a better outcome for all patients because it removes significantly the risk of any impact of basically opening up someone's skull. As you would imagine, that is quite a delicate and stressful job because, if you make a mistake, the patient could have serious consequences and there could be fatalities, because you're trying to deploy a tiny platinum coil in someone's blood vessel within their brain.

9. Sarah became highly regarded in the UK. She was asked to speak at UK events and also European and worldwide events because it was a very small network.

10. Sarah worked at the Queen Elizabeth University Hospital (QEUH). She worked in the Institute of Neurosciences (sic), so INS, and she worked there through the period of training to be a consultant, and then also post-consultant from the point of 2004. Before that she worked at the Southern General Hospital. She never worked at the Royal Hospital in Edinburgh.

11. Sarah did not work in the new part of the QEUH, I think it was part of the retained estate. I believe that that all they simply did to the INS was put a new cladding on it. They didn't knock down the old building and replace it with a new building.

General

12. As I mentioned earlier during her career Sarah was awarded five discretionary points. She was a leading consultant in her field, not just in Glasgow, but in the UK. I remember that Sarah cut her maternity leave short and returned to work early. The day she returned to work, she was back in the operating theatre at 09:30am that morning treating an aneurysm. There was no “Return to Work”, there was no support of coming back after maternity leave.

Ventilation and Water Systems – Risks Posed to Patients

13. Sarah wasn’t involved at all with the water and ventilation system in the new hospital. From my understanding, she only really became aware of that after speaking to Dr Christine Peters. Sarah never raised any issues with me about the new building unless it was, “Oh, they’re miles behind construction and it’s just a mess, It’s just overrunning and people are getting frustrated” that kind of stuff rather than anything of patient care, certainly not to me.

Whistleblowing

14. I don’t know the specifics or the classifications that you have of Stage 1, Stage 2, or Stage 3 whistleblowing. I can just talk through my experiences of being the husband of a doctor who whistleblew.

15. First of all, to me, people that whistleblow are incredibly brave people. They put their head above the parapet and, sadly, I don’t think many people in society are willing to do that. As I mentioned earlier, Sarah was a highly regarded consultant. Actually, some people would laugh and call her, “TC” which was “Top Consultant”. That was the terminology used in social circles, and social events. Sarah became increasingly concerned about the governance of the department that she worked in.

16. It was a very, very small department in Glasgow. She worked in a small team. There was no distinguishing hierarchy; they were all at the same level. They all reported into the same person, which I believe was the Clinical Lead.

17. From what I've seen or what I observed, the reporting structure was completely messed up. Because it was such a new specialism, they didn't know where to report. Traditionally that procedure of treating brain aneurysms would have been completed by a neurosurgeon, but Sarah wasn't a neurosurgeon, she was a neuroradiologist, so the clinical lead that she was reporting to didn't actually do the procedure that she was doing, they would do primarily diagnostic work. They didn't actually know what was involved with what Sarah was doing. For someone like me who trained as a chartered accountant, your reporting line was to a partner within a firm. That partner had completed the work that you had done, that you were doing, so they would have known the difficulties that you face, the challenges that you had, how you had to deal with a client, what kind aspects you had in your role.

18. Sarah became increasingly concerned about the governance, about the lack of support for the department amongst other matters. The department of radiology which Sarah worked in was fundamentally diagnostic, so people would do limited procedures and report on scans, and those scans were all head and neck, and they were all completed at the Institute of Neurosciences. However, Sarah's specialism was taking that further and doing more extensive procedures, some of which would last several hours in an operating theatre with the patient being under general anaesthetic. As I understood it this was taking work away from what traditionally had been completed by neurosurgeons. I think that possibly caused unrest with the neurosurgeons, because the neurosurgeons were losing work that had traditionally gone to them, so therefore there was a risk of them losing funding.

19. Sarah had concerns regarding conflicts of interests within the department.

20. People started to find it uneasy with Sarah raising concerns. You could just tell. She came home from work a lot more disheartened, felt that people weren't listening to her, she felt that resource wasn't being properly allocated, she felt that there wasn't anaesthetists' time, there was clearly unrest with the neurosurgeons, and there was clearly unrest within her team.

21. I understand that Sarah raised concerns with her fellow consultants, and she raised them with the clinical lead. Sarah then started getting ostracised. As a result of that, that's where she took the decision to whistleblow because she felt that was the only way that she could take this further. She whistleblew in 2018.

22. That, to me, took incredible courage, because, for a long period of time, she just felt she was getting nowhere and felt she was getting more and more increasingly ostracised.

23. Sarah was accused of serious professional misconduct in 2013. A preliminary inquiry commissioned concluded that there was never any serious professional misconduct on Sarah's part. However, this damaging narrative was perpetuated and, again, repeated in a grievance panel in 2018 when Sarah's grievance was upheld (not associated with her whistleblowing) because she had been excluded from her position. During the period from 2013 to 2018, and I say 2013, that was when she had her last discretionary point, Sarah was removed and suspended, off and on, from the service. Not once, even after formal review, was Sarah found to have carried out any professional misconduct.

24. The circumstances surround Sarah's suspension were that she had concerns during an operating procedure in the theatre, and she sought to pause the procedure to raise matters with a senior nurse. Sarah was criticised for stepping out of the room, it was suggested that she had acted inappropriately. As I say this was not upheld.

25. When Sarah was trying to get back into her job after being suspended, she was instructed to go and retrain in London. They knew that she had a young child, they knew that she would have to spend over six months away from her family and home, and they did that to-- basically thinking that she wouldn't want to do it, but she did do it. They put up barriers to try and stop her getting back into her specialism. So, there's just a complete and utter disconnect between what they think is okay and what is not okay.

26. As I said earlier, when Sarah came back from maternity leave, there was no "Return to Work". There was nothing. She was just thrown in at the deep end then, when it suited them. Following her suspension they did not want her doing procedures, even though there was never any external review that found that Sarah had done anything wrong, they just put up barriers to stop her getting back into her specialism. How do I think that made her feel? She had the embarrassment of going down to London, working at Queen Square with colleagues that were less senior than her, or experienced, to be refreshed or retrained, and then the ironic thing is, when she was down there, they asked her if she wanted a job as a consultant there.

27. Sarah came back from Queen Square which, from my understanding, is the best centre in the UK, with a glowing report. However, when she came back to work at the Institute where she felt that nothing had changed. None of the recommendations had been followed and she just felt that, if anything went wrong in a procedure, which will happen, she would be victimised and referred to the GMC. She just felt unprotected and unsupported, and therefore she took the difficult decision to say, "I can't do interventional work," and then it just became a huge war with BMA representation to negotiate a diagnostic role within NHSGGC, and a diagnostic role is just reviewing scans.

28. Sarah raised a whistleblow about the culture within the Interventional Neurological Service, and there were recommendations as a result of that whistleblow. Unfortunately, as I don't work there, I don't know them in detail. But there must be something on file what those recommendations were, and

Sarah was concerned that none of those recommendations were implemented by management.

29. I get lost with the timeline because there was so much going on. I suppose what I'm trying to say to you is that, if you whistleblow, from what I saw is you get hounded, you get systematically bullied, and people make up things about you.

30. Sarah sent an email, in 2023, to an [redacted] of GGC NHS Scotland raising her concerns that none of the recommendations of the whistleblow were taken forward **(Bundle 52, Volume 8, Document 4, Page 47)**. In addition, there was a Charles Vincent who was appointed by the NHSGGC Interim Board to review all whistleblows.

31. Sarah's whistleblow was never part of that review. Sarah asked why it wasn't, and Charles Vincent, from my understanding, said there was no record of her whistleblow. She was totally gobsmacked, to be honest. It felt like another example of how she was being victimised and no one was listening to her when she knew that there had been a whistleblow, they knew there'd been a review, they knew that there'd been review recommendations, none of which had been followed, and then the actual whistleblow itself didn't fall part of the remit that Charles Vincent was looking at. So she just felt, "What is the integrity of the management?" And, for her personally, it's just another blow.

32. I understand that Sarah whistleblew and following investigation various recommendations were made, none of which were acted upon, and then the record of the actual whistleblow itself was lost. When NHSGGC engaged Charles Vincent, he was an independent person brought in by NHSGGC to review whistleblows, and there wasn't even a whistleblow to examine. So, if Sarah's whistleblow wasn't there, how many other whistleblows weren't there? So, I suppose, from my perspective as a layman, it brings into serious concerns about the integrity of NHSGGC management at that time.

33. It appears to me that staff are raising whistleblower concerns. Yes, actions are taken, i.e. a review is conducted, but none of the recommendations are implemented, and then, when a review of whistleblows is completed, not all the whistleblows that were raised by staff are actually part of the review. It makes me wonder what else has gone missing.

34. I can understand how this is coming into concerns over the ventilation because, from my understanding, there was a whistleblow about this. So, if management of Greater Glasgow and Clyde were not acting on whistleblows previously, what kind of systems and procedures and processes do they have in place to ensure that all whistleblows are actually reviewed and followed through and someone independently engaged is actually making sure that the actions from the whistleblower reviews are being completed correctly? From this example, they aren't. What's really quite interesting as well, if you think about it, is that Sarah, by her very nature, just couldn't let this go.

35. Sarah kept on going on, and she sent emails to various people saying, "I'm concerned about this. Why wasn't there anything done?" and she just got fobbed off. That, to me, is the most disheartening thing, because I saw Sarah turn from a passionate, engaged doctor to someone that felt that there was no hope. If you're an individual and you're feeling you're doing the right thing and you've been doing the right thing for years, and no one in authority listens to you, you are bound to get completely disheartened. And that's what happened to Sarah. And I don't think this is right.

36. I was shown an email from Sarah, (**Bundle 52, Volume 5, Document 18, Page 94**). Towards the bottom of the email it sets out some of Sarah's concerns. In the final paragraph of that page, it says that her 2018 whistleblow was upheld, but then it was excluded by mistake from the report. This is what I was talking about earlier when I referred to her whistleblow not being included.

37. In the report she goes on to say that she'll be making a further whistleblow with two colleagues, but I am unable to tell you anything about that.

38. I do know that Sarah became a restorative facilitator. This focused on adopting a restorative approach to issues. Sarah had done a lot of research into how this would work in practice and looked to other heath boards for inspiration, including NHS Merseyside. Sarah felt that this was a different way of trying to learn about ways and to actually try and change culture into a positive way to actually openly say, “There’s been a mistake here. How do we change the systems to try and rectify that?”

39. Sarah was having regular meetings with the recent chair of NHSGGC, Lesley Thomson. She built up a rapport with Sarah and recognised the concerns that Sarah had, and also, from my understanding, recognised that there was a toxic culture and, from my understanding, is trying to make a difference.

40. I suppose from my perspective, it isn’t necessarily the Board that is present now, it is the previous Board members. But I suppose, what kind of procedures and processes were in place at that time to let something like this fall through the net? And I think that is really, really concerning. I’ve got no idea how many people whistleblow in NHSGGC on an annual basis, but I do know that, for a doctor to do it, or any medical staff member, they’re really putting themselves out there, and I suspect there probably isn’t that many on an annual basis, and therefore for it to be mistakenly lost just sums up the incompetence. Was that incompetence deliberate or was it just negligent?

41. It got to a level where her colleagues at the same level as her were really distant. Sarah was ostracised. She was made to feel like a leper and people just distanced themselves. She was asked to move out of the Institute. In 2020 she ended up working at Glasgow Royal Infirmary (GRI) and Stobhill.

42. When she was an interventionalist, she probably did, I don’t know, maybe for argument’s sake, 20 per cent diagnostic work, 80 per cent interventional work. So she was still a credible diagnostic radiologist who had a specialism in the head and neck, but because of all the unrest within the department at the INS, other consultants wrote a letter to management to say that they felt that Sarah was “Ms Governance”, I think that was title that they gave her. So she

actually got ostracised for being high on audit, wanting to report, wanting to review cases, and people felt that, if Sarah sort of said, “Well, look at that case there, do we feel we’ve caught everything there, was there anything missed?” and people just didn’t like that.

Whistleblow – Stage 3

43. Regarding the context for Stage 3, I can’t think of anything specific. Apart from just the continual thought of, “No one is listening to me, no one is”. There was a company set up by the University of Glasgow and NHS, from my understanding, and various consultants within the Institute of Neurosurgeons--Neuroservices in Glasgow, all invested in that company (Aurum Biosciences), which was to do with device checking. Devices being surgical implements as from my understanding these Platinum Coils are four-figure sums. Sarah had real concerns because she felt there was a total conflict of interest there.

44. Sarah had further concerns about staff conflicts of interest which she raised, but these concerns fell on deaf ears. I don’t know whether she specifically raised this concern within her whistleblow.

45. I am not aware that Sarah had any knowledge of Dr Penelope Redding’s Stage 3 whistleblow. If she did, I was not aware of this.

46. As well as the email sent to [redacted] in 2023, Sarah was also speaking to the head of HR for Diagnostics and Regional Services. These were all people that she raised her concerns with but she felt that she just didn’t get anywhere, she felt that people didn’t want to know. People know who the whistleblowers are. Let’s be honest here, people know who the whistleblowers are and people don’t like it. It’s the society we’re in.

47. In my view of the effectiveness of the whistleblowers’ system, it’s ineffective, it doesn’t exist. In regard to the culture, I think, certainly when Sarah was there, it was toxic. I think one positive I would say about younger women, is that they

feel that they can talk out more now than they ever have, and I think that is a great step forward for society. But when Sarah was a trainee in the late 90's and earl 2000's, it was truly misogynistic.

48. Sarah wasn't alone in these feelings. She was in her 50s. When I speak to friends and colleagues of hers who are of a similar age, they all share similar experiences.

49. Following the issues at work, Sarah took more and more time off with stress and depression. Up until that point, Sarah had worked all the time. We nearly didn't have a child because she was so focused on her job. She used to work weekends when she didn't need to. But then, when the things started to go wrong and all the accusations, that had a huge impact on her health, and that's when she started having periods of long-term sickness. There was none of that when she was getting discretionary points and it was going well. It was only after raising concerns that it started having a negative impact on her health. So, certainly from what I've seen, the culture is toxic within NHSGGC, and I hope it is changing, but I suspect that they need to remove a lot of the bullies that must still exist within that organisation.

Declaration

50. I believe that the facts stated in this witness statement are true to the best of my knowledge, information, and belief. I understand that this statement may form part of the evidence before the Inquiry and be published on the Inquiry's website.

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

Appendix A

A53995861 – Bundle 52, Volume 5 – Miscellaneous Documents

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

Appendix B

A54067378 – Bundle 52 – Volume 8 – Miscellaneous Documents
A54067376 – Bundle 52 - Volume 8 – Miscellaneous Documents
A54067377 – Bundle 52 – Volume 8 – Miscellaneous Documents

Scottish Hospitals Inquiry
Supplementary Statement of
Fiona McCluskey

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.

The Inquiry already has your evidence from Glasgow 4, Part 1 in the form of a witness statement Witness Statement - Fiona McCluskey - 15.05.2025 | Hospitals Inquiry and transcript (Transcript - Fiona McCluskey - 15.05.2025 | Hospitals Inquiry). The Inquiry is now hearing evidence in at the Glasgow 4, Part 3 hearings. Matters now arise from evidence of Gary Jenkins in the form of witness statement and oral evidence of 17 September 2025 in respect of your involvement in respect of Ward 4B following the Change Order dated issued in July 2013 (**Bundle 16, Document 29, page 1699**):

S1: Mr Jenkins has given evidence that after the issuing of the change order (**Bundle 16, Document 29, page 1699**) he and his team usually including Consultant Clinical Hematologist Dr Anne Parker and Clinical Service Manager Ms Myra Campbell attended five or six meetings at the Project Team offices in Hillington. They gave detailed instructions on the requirements of ventilation system that would be needed in the new Adult BMT Ward in Ward 4B in order to replicate what they had at the Beatson.

Mr Jenkins was clear that those present from the Project Team included Heather Griffin who chaired the meetings, Mairi MacLeod, Ian Powrie (occasionally) and Fiona McCluskey. He said they reviewed drawings of the layout of the wards in the QEUH, at one point down to 1:50 drawings. Detailed information on ventilation requirements was given including the need for 10-12 ACH, pressure gradients, sealed rooms, for some rooms to be positive pressure, and others negative with an airlock. Specific reference was made to

the needs of the Pentamidine Room. He explained that he and his colleagues reviewed drawings on which they marked up and signed. He insists that neither at the meetings or at any time thereafter did anyone in the Project Team indicate any difficulty with what they were suggesting. While he recalled mentioning SHTM 03-01 he also stressed that this was not the same as a haemato-oncology ward because the BMT requirements were different. One suggestion was that contact might be made with Dr John Hood as he had been involved in issues over the move to Beatson's present location.

In respect of the period between PMI 228 on 2 July 2013 and the and the NEC Compensation Event CE 051 on 23 October 2013 inclusive and the decision to move the BMT service to QEUH:

a) What was your involvement in defining the specification of the works to be carried out following the Change Order in 2013 (**Bundle 16, Document 29, page 1699**) between PMI 228 on 2 July 2013 and the and the NEC Compensation Event CE 051 on 23 October 2013 inclusive in respect of the planning and design of Ward 4B?

A. I had no involvement in defining the specification of the works to be carried out.

b) Confirm your understanding of the specification of Ward 4B following the Change Order.

A. I did not have any involvement in the specification of Wards.

c) At Q17 you previously statement you were asked about this and responded: Following the Change order request, what actions did the GGC Project Team take to confirm the technical and environment requirements (in particular air change rates, pressure regimes and HEPA and air permeability requirements) for the BMT Unit?

A. I was aware of the change order request from Jonathon Best but was not involved in any aspect of this

Further at Q19 you statement in respect of Ward 4B following the 2013 Change Order you state: *I did not have any involvement in the design and specification documentation*
Having regard to Mr Jenkins' evidence do you wish to add anything further to your earlier evidence?

A. As previously stated I was not involved. I was not involved in any technical matters during my tenure as Senior Nurse Adviser on the Project as I do not have the qualifications or knowledge. My role was to give nursing advice.

My recollection is that Heather Griffin Adult Hospital Project Manager and Peter Moir Deputy Project Director were the Project team members who were involved with the change order request.

d) What took place at these meetings at Hillington between PMI 228 on 2 July 2013 and the and the NEC Compensation Event CE 051 on 23 October 2013 inclusive, which were in respect of the planning and design of Ward 4B, and any other matters in respect of the move of the BMT service to QEUH, with other Project Team members, possibly including Heather Griffin and Mairi MacLeod?

A. I cannot recall attending any meetings at Hillington on those dates in 2013. There was no Project Office base at Hillington in 2013 as at that time the team were located in offices adjacent to the new build (see below)

<u>For information:</u>

When I started in post in 2009 the Project team were located in an office base in St Andrews House, Hillington. In early 2010 when the adult User group meetings were established they were held at 1 Jubilee Court, Hillington Park,

Glasgow G52 as they had a meeting room that could accommodate large groups.

In 2010 the project team were relocated to the top floor of portacabin office accommodation adjacent to the new build on the Southern General site. The Project team were based alongside the Multiplex team who occupied the floors below. As this was 15 years ago I cannot recall the exact date.

Following the project office move in 2010, meetings were held in the Project Office meeting room situated on the top floor of the office base on the Southern General site.

My recollection of Project Team members at the adult user group meetings I attended were as follows: Heather Griffin, Project Manager, Infection Control Nurse Jackie Barmanroy, Project Medical Director Dr Stephen Gallacher, Senior Nurse Adviser Fiona McCluskey , Project Technical Manager Frances Wrath, Technical Adviser David Hall from Currie and Brown, Architect from Nightingale Associates. The architects from Nightingale Associates were responsible for the design of the hospital including all wards and departments and led the users through the meetings. My role in the meetings was to provide expert nursing advice.

All communication with the architect and Multiplex was done via the Project Manager Heather Griffin.

I do not recall Mairi McLeod being present at any adult user group meetings I attended. Ms McLeod was the Project Manager for the New Children's Hospital and did not attend adult user group meetings.

I do not recollect Ian Powrie being present at any user group meetings that I attended.

In early 2013 I was asked by the Project Director Alan Seabourne to work with the Project Medical Director Dr Stephen Gallacher to develop a Clinical Migration Plan for the transfer of clinical services into the new hospitals. This included patient transfers from the Western Infirmary, Victoria Infirmary, Mansionhouse Unit, Gartnavel General Hospital and the Royal Hospital for Sick Children.

The Clinical Migration Plan was first discussed in mid 2013 with the Chief Operating Officer and the Acute Directors. Several iterations of the plan were considered and following a number of meetings an overarching plan was agreed. A Clinical Migration Logistics group was established in August 2014 chaired by the Acute Medical Director to develop and execute the final plan. I was the project manager for this plan from 2013 which involved numerous meetings with NHSGGC Directors, NHSGGC clinical teams, the Scottish Ambulance Service, Police Scotland and colleagues in other NHS Boards.

This was ultimately the largest hospital migration programme undertaken in the United Kingdom. It was an immensely complex and difficult programme to construct and was delivered with no adverse clinical incidents, or harm coming to any of the 700 patients who were moved during the migration period from 24/4/15 - 14/6/15

This project was my main responsibility from 2013 until I left the project team on 30/6/15.

e) Mr Jenkins gave evidence that he was not aware of any other meetings, save for the ones referred to in S1 that would have discussed the specifications of Ward 4B following the change order in 2013. Is Mr Jenkins correct?

A. I cannot recall attending any meetings referred to in S1 or any other meetings to discuss the technical specifications following the change order.

f) Mr Jenkins recalls signing plans providing detail of the specific requirements (such as pressure differentials) of Ward 4B, and that all attendees at these meetings, including you, signed these plans. Is Mr Jenkins correct?

A. As Senior Nurse Advisor it was not part of my role to sign the drawings at user group meetings. I do not recall ever signing any drawings presented at user group meetings , nor ever being requested to do so.

In all adult user group meetings that I attended the meetings were chaired by Heather Griffin, the adult hospital Project Manager who organised the meetings and communicated with the users and architects outwith the meetings. The architects from Nightingale Associates were responsible for the design of the hospital including all wards and departments and led the users through these meetings. The architect would mark up the drawings based on the discussions / any points raised by the users during the meeting. At the end of the meeting the drawings were signed by the service user group lead who was either a manager or a lead clinician. The Project Infection Control Nurse Jackie Barmanroy and the Project Technical Lead Frances Wrath signed the drawings on behalf of the Board. The drawings used at the meetings I attended focused on the Ward/ department 1:200 layout or 1:50 room layouts.

I do not recall any technical drawings being presented or used during any user group meetings I attended.

g) Mr Jenkins gave evidence that in 2015 he was told by members of the Project Team that the records of these meetings had been destroyed due to lack of storage space. Is he correct? What knowledge do you have of destruction of project records for any reason in 2014 or 2015?

A. I left the Project on 30/6/15. I have no knowledge about the destruction of records.

h) Why was the specification that Mr Jenkins says was provided to the Project Team not what was ultimately built by Multiplex?

A. I am unable to comment. My recollection is that any information or instructions regarding the adult hospital were communicated via the Project Manager Heather Griffin to either the Project Director David Loudon or Deputy Project Director Peter Moir and they communicated to Multiplex through formal meetings or electronic communication.

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.

A47851278 - Bundle 16 - Ventilation PPP

Scottish Hospitals Inquiry
Supplementary Statement of
Mairi MacLeod

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.

The Inquiry already has your evidence from Glasgow 4, Part 1 in the form of a witness statement Witness Statement - Mairi Macleod - 14.05.2025 | Hospitals Inquiry and transcript (Transcript - Mairi Macleod - 14.05.2025 | Hospitals Inquiry). The Inquiry is now hearing evidence in the Glasgow 4, Part 3 hearings. Matters now arise from the evidence of Gary Jenkins in the form his of witness statement and his oral evidence of 17 September 2025. These relate to your possible involvement during the period between PMI 228 on 2 July 2013 and the and the NEC Compensation Event CE 051 on 23 October 2013 inclusive (these documents can be found in Bundle 16, documents 27 & 30) in respect of the decision to transfer the BMT service from the Beatson to QEUH:

S1: Mr Jenkins has given evidence that after the issuing of the change order (**Bundle 16, Document 29, page 1699**) he and his team usually including Consultant Clinical Haematologist Dr Anne Parker and Clinical Service Manager Ms Myra Campbell attended five or six meetings at the Project Team offices in Hillington. They gave detailed instructions on the requirements of ventilation system that would be needed in the new Adult BMT Ward in Ward 4B in order to replicate what they had at the Beatson.

Mr Jenkins was clear that those present from the Project Team included Heather Griffin who chaired the meetings, Mairi MacLeod, Ian Powrie (occasionally) and Fiona McCluskey. He said they reviewed drawings of the layout of the wards in the QEUH, at one point down to 1:50 drawings. Detailed information on ventilation requirements was given including the need for 10-12

ACH, pressure gradients, sealed rooms, for some rooms to be positive pressure, and others negative with an airlock. Specific reference was made to the needs of the Pentamidine Room. He explained that he and his colleagues reviewed drawings on which they marked up and signed. He insists that neither at the meetings or at any time thereafter did anyone in the Project Team indicate any difficulty with what they were suggesting. While he recalled mentioning SHTM 03-01 he also stressed that this was not the same as a haemato-oncology ward because the BMT requirements were different. One suggestion was that contact might be made with Dr John Hood as he had been involved in issues over the move to Beatson's present location.

In respect of the period between PMI 228 on 2 July 2013 and the and the NEC Compensation Event CE 051 on 23 October 2013 inclusive and the decision to move the BMT service to QEUH:

a) What was your involvement in defining the specification of the works to be carried out following the Change Order in 2013 **(Bundle 16, Document 29, page 1699)** between PMI 228 on 2 July 2013 and the and the NEC Compensation Event CE 051 on 23 October 2013 inclusive in respect of the planning and design of Ward 4B

A. I was not involved in this part of the process.

b) Please also confirm your understanding of the specification of Ward 4B following the Change Order.

A. Not applicable- I was not involved in this part of the process

c) What took place at these meetings at Hillington between PMI 228 on 2 July 2013 and the and the NEC Compensation Event CE 051 on 23 October 2013 inclusive, which were in respect of the planning and design of Ward 4B, and any other matters in respect of the move of the BMT service to QEUH, with other Project Team members possibly including, Heather Griffin and Fiona McCluskey?

A. Not applicable- I was not involved in this part of the process

d) Mr Jenkins gave evidence that he was not aware of any other meetings, save for the ones referred to in S1 that would have discussed the specifications of Ward 4B following the change order in 2013. Is Mr Jenkins correct?

A. I do not know the answer to this question as I was not involved in this part of the process

e) Mr Jenkins recalls signing plans providing detail of the specific requirements (such as pressure differentials) of Ward 4B, and that all attendees at these meetings, including you, signed these plans. Is Mr Jenkins correct?

A. I did not attend any meetings about Ward 4B in the adult hospital. I was not involved in the Adult Hospital design and did not attend any meetings

f) Mr Jenkins recalls signing plans providing detail of the specific requirements (such as pressure differentials) of Ward 4B, and that all attendees at these meetings, including you, signed these plans. Is Mr Jenkins correct?

A. I was not involved in the Adult Hospital design and did not attend any meetings

g) Mr Jenkins gave evidence that in 2015 he was told by members of the Project Team that the records of these meetings had been destroyed due to lack of storage space. Is he correct? What knowledge do you have of destruction of project records for any reason in 2014 or 2015?

A. I have no knowledge about the storage/destruction of the records of the Adult Hospital design meetings

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.
A47851278 - Bundle 16 - Ventilation PPP

Scottish Hospitals Inquiry
Witness Statement of
Professor John Cuddihy FRSA

1. Throughout my daughter Molly's illness, our family witnessed the very best of clinical care. Molly herself had the utmost respect for the clinicians who treated her—professionals who demonstrated not only exceptional expertise but also deep kindness and humanity in the most difficult of circumstances. For their skill, empathy, and unfailing dedication, we remain forever grateful.

2. Yet, it is simply not possible to speak honestly about our experience without contrasting this standard of care with the corporate response. Here, it is important to note that information was deliberately withheld by the organisational entity responsible for the hospital, reflecting not only a lack of empathy and curiosity but also an intentional obfuscation that compounded our suffering. That lack of compassion and openness compounded the suffering endured by our daughter and our family.

3. I want to remind everyone that Molly died in that hospital, a direct consequence of the multiple issues that arose during her treatment. Central to this tragedy was the hospital-acquired bacterial infection—Mycobacterium chelonae—that infected her treatment line, leading to septic shock and a cascade of complications that ultimately contributed to her death on 26 August 2025. This was not just a coincidence or an unfortunate event; it was a preventable harm rooted in systemic failings that this Inquiry seeks to uncover and rectify. The unimaginable loss of Molly is compounded by the erosion of her quality of life from the time of her diagnosis in January 2018 through to her death. Over those years, she battled not only cancer and its related conditions but also endured the debilitating effects of the hospital-acquired infection and the side effects of prolonged intensive treatments, including an overdose of chemotherapy.

4. It was not the cancer, nor chronic liver disease, transplant failure kidney failure, osteoporosis, or other health conditions caused by years of continuous use of intravenous and oral antibiotics—often three different types administered simultaneously—that ultimately took her life. Instead, there had been no recurrence of cancer, the kidney donated to Molly by her brother was functioning as well as it could have done and following that transplant her liver function was showing improvement. The cause of the deterioration in Molly's health and her death in August remains under investigation by pathologists and COPFS, however, we were told by the doctors treating Molly that she was once again suffering from the effects of bacterial infection with Mycobacterium chelonae, the infection that she contracted from the water supply in the QEUH in 2018 under consideration. It is this that led to Molly's death being reported to COPFS by her treating consultant.

5. Despite all she endured, Molly remained a source of inspiration, a passionate patient advocate, and someone profoundly loved. Her loss is a devastating reminder of the urgent necessity to ensure safe, compassionate, and accountable healthcare for all patients.

6. Listening to the evidence given to this Inquiry, especially this latest chapter (Glasgow 4), has been both devastating and illuminating. The facts now disclosed show a series of grave and inexcusable failures — failures to act, to communicate honestly, and to learn. It is now clear that the organisation failed to act on two statutory legionella reports that highlighted significant risks to patient safety. Nor did they test the hospital water after Molly contracted Mycobacterium chelonae, contrary to their own guidance at that time.

7. No warning was shared with us or indeed ARHAI, about another paediatric patient in the same ward who was infected in 2016. Even as Molly's illness progressed, her infection was absent from official timelines and records, despite our repeated submissions to the oversight board by way of written reports. Our appeals for accuracy and acknowledgement went unanswered until we escalated issues to the

highest levels. But even now the Scottish Government website continues to display the flawed timeline, which continues to omit details surrounding Molly's bacterial infection in 2018. This public display of an inaccurate timeline is a serious issue, especially for laypersons who are not connected to the case, because it obscures important facts and prevents full accountability and understanding of the tragedy.

8. We learned—too late—that Mycobacterium chelonae had been found in the very rooms occupied by Molly following decant in 2018, but we were not told at the time. Details of her bacterial infection were withheld from expert reviewers, including in the production of the HAD report by NHS GGC appointed experts, preventing thorough examination of her case.

9. The case note review was never provided with a copy of the reports submitted to the oversight board by my family, depriving the CNR of information that would assist their decision making. Only after, we, the family, provided a copy direct to the CNR and pressed for its inclusion was it considered. The duty of candour, and even the principles of basic decency, were set aside.

10. Additionally, I was astonished to learn through recent disclosures that certain witnesses from NHS Greater Glasgow and Clyde challenged the recommendations of the Case Note Review—information that was previously unknown not only to us but also to the Chair of the Oversight Board and other senior officials at the time. Had these challenges been known then, they likely would have been vigorously contested by the Chair, the Director General for Health, and Scottish Ministers. Such scrutiny may have influenced the critical decision to de-escalate NHSGGC from Level 4 to Level 2 within the NHS escalation framework and might even have warranted escalation to Level 5. This revelation casts further doubt on the transparency and accountability of the response to the serious failings identified, underscoring the urgent need for open governance and steadfast oversight.

11. One of the most distressing moments was hearing in this Inquiry that a senior corporate communications director had been investigated for aggressive and inappropriate remarks, saying he (Professor Cuddihy) ***"may have won the battle but won't win the war."***

12. Molly, I and my family found this comment deeply troubling and offensive. It highlighted a disturbing readiness by some within the organisation to deliberately mislead and protect the institution's reputation ahead of protecting Scotland's children. Such institutional self-protection, at the expense of children's safety and truth, is something that must be confronted openly.

13. For our family, and especially for Molly, the failure to acknowledge her suffering and the reality of her infection feels irreconcilable. It sent a message that her life, her pain, and her ultimate loss, were to be minimised and overlooked as if Molly herself was irrelevant.

14. The existence of an agreed single point of contact, and assurances about ongoing communication, offered only the appearance of inclusion. In practice, essential details about Molly's infection and the hospital's conditions were withheld, even when the circumstances had direct, material impact on her safety and treatment.

15. Despite the duty of candour and meetings where our right to information was acknowledged, facts that would NOT have compromised patient confidentiality, but would have honoured our daughter's truth, were not shared.

16. The impact upon Molly—a young woman defined by courage, hope, and trust in those around her—was immeasurable. The cost to our family, living with the reality of both her suffering and her erasure from institutional records, is incalculable.

17. The loss of Molly has had a profound and devastating impact on our entire family. For my wife and me, the grief is an ever-present shadow that colors every aspect of our lives, a daily reminder of the daughter and sister who was taken from us far too soon. Our son too bears this heavy burden, grappling with the absence of his beloved sister and the upheaval her passing has wrought on our family's life. Beyond our immediate family, the grief extends deeply into our broader family, friends, and wider community—especially vulnerable children, their families, and the staff who worked alongside Molly—all of whom were touched in profound ways by her courage, kindness, and advocacy. Each of us mourns not only the loss of Molly's vibrant presence but also the dreams and future we had hoped to share with her. This immeasurable grief shapes our lives now, fueling our resolve to seek justice and systemic change, so that no other family endures such heartache.

18. The ongoing criminal and civil investigations following Molly's death have brought additional trauma and heartache to our family. We were deeply affected by the fact that no death certificate would be issued, necessitating a two-doctor post mortem instructed by the Procurator Fiscal, which required Molly's body to be transferred from the Queen Elizabeth University Hospital to Edinburgh for examination. The additional distress of having post mortem samples sent out of Glasgow for analysis compounded our grief. Our family endured the intrusion of CID officers visiting our home during initial investigations, adding to our emotional burden. Furthermore, procedural challenges delayed the issue of medical certificates required to register Molly's death, ultimately postponing her burial by five weeks. These bureaucratic obstacles were overwhelmingly traumatic, prolonging our heartbreak and making the unbearable reality of Molly's death even harder to endure. The profound emotional impact on our family from both her loss and the ongoing investigations is beyond measure.

19. We noted with interest the comments from Malcolm Wright, former Director General for Health and former CEO of a health board, who stated that the Case Note Review (CNR) was a robust and commendable expert review. He emphasised that if the board wished to challenge its findings, there would need to be a high threshold for such a challenge, especially given the praise from the Chief Nursing Officer, Chair of the Review, and Chief Medical Officer. He further suggested that a board's inappropriate challenge or refusal to accept such a review may reveal a deeper cultural issue within the board itself—an issue demanding examination. This assertion reinforces my family's concerns about the reluctance of the board to accept expert scrutiny, reflecting a broader cultural problem in governance and accountability.

20. Furthermore, the former Director General highlights that a safe hospital environment inherently involves not only clinical skill but also effective management of services. It requires genuine listening to clinicians within the management structure, open internal communications with patients, families, and staff and a culture that fosters confidence in the organisation's effectiveness. Crucially, the culture must allow for the transparent escalation of concerns and bad news without fear of reprisal or punishment for those who bring such issues forward.

21. It is my family's strong belief that such a culture was not present in NHS GGC, which resulted in our lack of confidence in the safety and integrity of the hospital environment which was inevitably undermined by NHS GGC.

22. The failure to protect Molly and other vulnerable children in this case indeed has broader resonance. Across Scotland, such failures often arise from systemic issues in communication, entrenched culture problems, and the prioritisation of institutional protection over the welfare and safety of children. This is a tragedy not only specific to our family but indicative of a wider, urgent need for reform.

23. We continue to believe that Molly's voice, and every family's experience, must echo beyond these hearings. Her story is a powerful testament not only to the human cost of systemic failings but also to the urgent need for cultural transformation within healthcare governance.

24. The reflections shared here underscore that true progress demands more than expert reviews and reports; it requires a board and organisational culture willing to embrace robust scrutiny with humility and openness, fostering an environment where bad news is escalated without fear of reprisal, and where clinicians, patients, and families are genuinely heard. Only through sustained commitment to transparency, empathy, and accountability at all levels can confidence be restored, and safe hospital environments be realised.

25. It is too late now for our wee Molly, but her legacy should inspire unrelenting curiosity, meaningful compassion, and decisive action—not merely to prevent future harm, but to honor the truth and dignity of Molly and every patient and family impacted by the NHSGGC water and ventilation crisis.

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 6