SCOTTISH HOSPITALS INQUIRY

Paper in response to Closing Statements of Core Participants following Glasgow IV hearings

1. At the conclusion of the Glasgow IV series of hearings Counsel to the Inquiry ['CTI'] issued a Closing Statement, to which Core Participants responded with corresponding Closing Statements in the period to 22 December 2025.

2. We are grateful to Core Participants for those Statements. It is our intention to respond primarily by means of oral submissions scheduled to be delivered on 20 January 2026, to which Core Participants will then have an opportunity to respond.

3. There are a number of possibly less significant matters raised in those Statements, to which a response is also merited. In light of the limited time available to all during the diet of hearings fixed for the week of 19 January, it is considered more appropriate to address these matters in written form, such that Core Participants are made aware of our position, and are in a position to respond appropriately if thought necessary.

4. This Paper is intended to set out such observations in convenient form. Each Statement is addressed in turn.

1. NHS NATIONAL SERVICES SCOTLAND ("NHS NSS")

5. CTI welcomes the comments made in NHS NSS' Closing Statement. In particular, we appreciate the points of clarification set out in paragraph 21[1]. They give further helpful context to the Inquiry's understanding of the extent of NHS NSS' involvement in the refurbishment of Wards 2A and 2B during 2021 and 2022. However, they do not change our conclusion that NHS GGC decided not to seek support on any issues arising from the Ward 2A and 2B refurbishment project from NHS ASSURE. The consequence of NHS GGC's failure to seek support was that there was very little that NHS ASSURE could

[1] NSS Closing Statement, Para 21 (i) to (iii), Pages 337 to 339.

do to intervene to ensure any issues were picked up[2].

6. We are grateful to NHS NSS for their suggested change to paragraph 1828 of our Closing Statement concerning Mr Baxter's reference to CEL 19 (2009)[3]. We accept this change.

7. We acknowledge NHS NSS' suggested changes to paragraphs 385 and 1833 of CTI's Closing Statement which clarify that the steps taken to remedy issues with the water system were in fact put in place by the IMT subgroup supported by both HPS and Health Facilities Scotland[4]. These changes are accepted by CTI.

8. We are also thankful for NHS NSS' contribution in relation to the Edinburgh recommendation (b) at paragraph 1875 of CTI's Closing Statement. We agree that the recommendation would be more effective if broadened out beyond mid-project changes in the funding model or procurement route. We further agree with NHS NSS that the recommendation should apply to significant changes in the user requirements project brief or developed technical solution in order to ensure that the design and specification reflect such a change[5].

9. We are grateful for NHS NSS' comments on the proposed recommendation at paragraph 1885 of CTI's Closing Statement[6]. The update on SHFN currently being planned by NHS NSS and engagement with relevant NHS Scotland stakeholders is very much welcomed by CTI. In particular, an important additional point made by NHS NSS is that the Scottish Government will have to support health boards' recruitment and training of IPC specialists to achieve the objective of fully resolving issues around gaps in the IPCT workforce. We fully endorse NHS NSS' comments on this issue.

10. We also appreciate the comments made by NHS NSS on the proposed recommendation at paragraph 1886 of our Closing Statement[7]. We agree that all SHTM guidance including SHTM 03-01 should be widened.

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[2] CTI Closing Statement, Para 1718, Page 531.
[3] NSS Closing Statement, Para 32, Page 13.
[4] NSS Closing Statement, Para 33, Page 13.
[5] NSS Closing Statement, Para 34, Page 13.
[6] NSS Closing Statement, Para 46, Page 20.
[7] NSS Closing Statement, Paragraph 47, Page 20.

11. We are grateful for the comments made by NHS NSS on the proposed recommendation at paragraph 1899 of CTI's Closing Statement. However, we wish to highlight that our proposal is that only five people would be allowed in a ward bedroom would only apply until a risk assessment is undertaken[8].

2. MULTIPLEX

12. CTI thanks Multiplex for its Closing Statement. It is not considered that any matter arises such as requires to be addressed in this paper.

3. SCOTTISH MINISTERS

13. We welcome the comments made by the Scottish Ministers concerning paragraph 1865 of our Closing Statement and recognition of its role in promoting good working culture[9]. We note that a widescale review of the culture of NHS GGC and all other health boards in Scotland was envisaged by the Scottish Ministers but was interrupted by the pandemic. Given the concerns that have arisen in relation to the culture of NHS GGC[10], We invite the Scottish Ministers to explain whether there is now any intention of carrying out such widescale review of the culture of NHS GGC and all other health boards in Scotland and what the timescale might be.

14. We acknowledge the comments made by the Scottish Ministers in relation to the recommendations set out in paragraphs 1879 to 1884[11]. We acknowledge that the matters set out in those paragraphs are not directly for the Scottish Ministers to address, but would repeat the observation that the Scottish Ministers do have a general responsibility both in statute and in the eyes of the public for the NHS in Scotland as a whole and for the proper and effective use of public funds and considers that paragraphs 1882 and 1883 could be subject to specific provisions in the SCIM and the Policy on Design Quality for NHS Scotland.

15. We are pleased that the Scottish Ministers have no objection to the recommendations proposed at paragraphs 1885 and 1886 of CTI's Closing

[8] CTI Closing Statement, Para 1183, Page 368.
[9] Scottish Ministers Closing Statement, Para 24, Page 8.
[10] CTI Closing Statement, Paras 1786 to 1787, Pages 552 to 553.
[11] Scottish Ministers Closing Statement, Para 29, Page 10.

Statement[12]. In order to achieve the required number of qualified staff CTI considers there will be a need for provision of additional resources from the Scottish Ministers.

16. We also welcome the Scottish Ministers' view that they agree with the recommendation proposed at paragraph 1887 of CTI's Closing Statement[13] that the SCIM should contain a requirement that, from at least the OBC stage and continuing until handover, the team developing a new hospital procurement project receive substantive and regular input from Estates personnel who will be involved in post-handover estates management. CTI considers that there will be a need for provision of additional resources from the Scottish Ministers.

17. Paragraphs 1889 and 1890 should be considered to be addressed to both Scottish Ministers and NHS NSS[14].

18. We welcome the Scottish Ministers' agreement with the recommendation proposed at paragraph 1891 of our Closing Statement[15]. Inevitably in order to achieve the goal of board officials being trained to scrutinise a large health procurement contract, we consider that additional resources will require to be allocated.

19. Paragraph 1897 of the our Closing Statement[16] arises because of our conclusion that if the Scottish Government procurement system fails to stop a health board building a large hospital using funds provided by Scottish Minister that does not comply with Scottish government guidance and then subsequently that board fails to properly respond to concerns by staff and patients and their families about growing numbers of infections amongst vulnerable patients there needs to be means to rapidly force change. As discussed in our submissions the Scottish Government response of taking NHS GGC to Stage 4 was arguably unable to forcing change. No doubt this was partly because of the impact of the Covid 19 pandemic, but it is the case

[12] Scottish Ministers Closing Statement Para 30, Page 11.
[13] Scottish Ministers Closing Statement Para 31, Page 11.
[14] Scottish Ministers Closing Statement Para 32, Page 11.
[15] Scottish Ministers Closing Statement Para 33, Page 11.
[16] AS commented on in Scottish Ministers Closing Statement Para 38, Page 13.

that the Oversight Board failed to force the changes to NHS GGC that were ultimately begun by Professor Gardner on 9 October 2025.

20. We quite understand that were the Scottish Ministers to take direct control over a large health board such as NHS GGC under Stage 5 of the National Framework this would cause significant issues, but the decision in December 2019 not to go to Stage 5 suggests that in reality no useable mechanism exists by which the Scottish Government can directly intervene at a point of significant failure of delivery by a large health board In respect of a significant aspect of its services. Without a review and serious consideration there is a real risk that health boards will feel able to act with impunity because at the end of the day they will know the Cabinet Secretary and Director General will not take over. We acknowledge that our proposal that Commissioners be able to be appointed or that Scottish ministers be able to replace significant parts or indeed the whole board would amount to an extreme outcome. However, if the public are to have confidence that the Scottish Ministers and the Scottish Parliament are truly responsible for the NHS in Scotland such a mechanism is arguably needed. The contrast with a local authority is significant. The people of Glasgow can change their City Council through elections every five years. The people of Glasgow and Clyde cannot change their health board. That power lies with the Scottish Ministers. Hence our respectful proposal that the Scottish Parliament and the Scottish Ministers consider introducing a practical mechanism of last resort by which in the gravest and most extreme circumstances a proper intervention could be made.

4. THE CUDDIHY & MACKAY FAMILIES

21. We are grateful for the observation at the foot of page 7 of the Core Participants' Closing Statement that water sampling was carried out in Ward 2A in April 2019, yielding positive results for Mycobacterium Chelonae around 10 months after Molly Cuddihy had contracted that micro-organism, and around two months prior to another case of infection, in contrast to NICPM guidance that targeted testing should be carried out upon such organisms being detected. This appears to be a significant addition to the timeline of actions taken post-opening.

5. ADULT PATIENTS AND FAMILIES, AND PATIENTS AND REPRESENTATIVES OF CHILD PATIENTS

22. We are grateful for the assistance provided by the 'Executive Summary' section of the Closing Statement at pages 7-11. It is noted in particular that in this section the Core Participants have drawn together three distinct stages of the Inquiry's investigations – being the procurement phase, the opening of the hospital, and the action required and taken following opening – into a single narrative. We would commend this for the attention of the Chair when it comes to a framework for analysing the Report stage of the Inquiry.

23. At paragraph 4.14 the Core Participants note that duration of exposure may be a possible factor in considering the higher rate of paediatric stenotrophomonas infections, when compared to the adult rates of infection. We would observe that this is an illuminating counterpart to the observations in our own closing statement that the two cohorts are in materially different positions – in short, that paediatric patients tend to evince more serious conditions, meaning that longer exposure and increased vulnerability go hand-in-hand ["*It may simply be that, due to the nature of their treatment, the paediatric patients in the Schiehallion Unit were more vulnerable and were accommodated in their ward for longer periods of time than the adults*" – para 399(d) of CTI's Closing Statement].

24. On page 26 of the Closing Statement of the Patients and Families, there is reference to Dr Hood and Mr Powrie looking at the pressure differences across the door leading to the entrance to Ward 4B opposite the entrance to Ward 4C. It was observed that when the Ward 4C entrance door was opened then this resulted in the 4 Pa positive pressure becoming 1.5 negative pressure and 'dirty' corridor air being pulled into Ward 4B. This issue is summarised in the Minutes of the QEUH Cryptococcus IMT Expert Advisory Subgroup as Ward 4C having positive pressure in the corridor which is pushing air out and that is at times going into Ward 4B[17]. We are aware that the lack of HEPA filtered corridor air was a concern for Mr Poplett who identified that there was a risk of contaminants getting into a room when the

[17] Bundle 9, Document 32, Page 282.

door to a patient's room was opened[18] due to the drop in room pressure[19]. Moreover, he stated that increasing the pressure differential can introduce operational problems by getting doors to close and stay closed or 'back eddies' are created[20]. If a door is opened, then that can change the pressure resulting in a fluctuation of pressures in either one of the bedrooms and an inconsistent pressure cascade[21]. We note that Mr Bennett shared the same view and stated that, specifically in relation to isolation rooms, the pressure differential across the door needed to be maintained at a high enough level to protect against reversals in pressure[22]. A further point to consider is explored by Mr Hoffman in his evidence that bedroom doors between the corridor and the patient bedroom will inevitably have gaps resulting in an air exchange (with any contaminants) from the bedroom if there is slight positive pressure and into the bedroom if there is slight negative pressure[23]. This is a useful addition to the timeline of actions taken post-opening.

25. On page 29 of the Closing Statement of the Patients and Families, there is reference to Aspergillus being found in Ward 4B rooms and a higher percentage of counts of Aspergillus being found in the Ward 4B corridors[24]. CTI considers that this data is not inconsistent with the pressure differences concerns noted by Dr Hood and Mr Powrie between Ward 4C and Ward 4B. This is a useful addition to the timeline of actions taken post-opening

26. On page 32 of the Closing Statement of the Patients and Families, it is submitted that the risk assessment for Ward 4C was fundamentally flawed[25]. The Closing Statement also highlights[26] that CTI acknowledged the severe consequences of immunocompromised patients contracting infections such as Aspergillus and Cryptococcus, pointed to a connection between the infections and Ward 4C, and concluded that rooms in general wards were unsafe for

[18] Patients and Families Closing Statement Page 26.
[19] Bundle 21, Volume 1, Document 7, Paras 6.12 and 6.17, Page 503.
[20] Transcript, Andrew Poplett, 7 November 2024, Pages 43-44.
[21] Transcript, Andrew Poplett, 7 November 2024, Page 127.
[22] Bundle 21, Volume 1, Document 7, Para 7.11, Page 639.
[23] Transcript, Peter Hoffman, 26 September 2024, Pages 13 to 14.
[24] Patients and Families Closing Statement, Page 29.
[25] Patients and Families Closing Statement Closing Statement, Page 32.
[26] Patients and Families Closing Statement, Page 32.

immunocompromised patients[27]. We also concluded that the ventilation system for Ward 4C at handover was clearly high risk for that patient cohort[28]. The interventions subsequently introduced[29] did not change that risk level because it does not have the environment required by the Adult Haemato-oncology COS and any risk reduction may be due to anti-microbial prophylaxis that cannot be tolerated by all patients[30]. Accordingly, we agree with the Core Participants that the risk assessment of 'Medium' for Ward 4C was fundamentally flawed for patients unable to be prescribed

anti-microbial prophylaxis.

27. The Core Participants have raised a concern at page 54 of their Closing Statement that we are downplaying the events in Ward 4B and its ongoing failure to meet expected ventilation standards[31]. We do not agree with the assessment that the deficiencies in Ward 4B have been downplayed. The factual narrative of the events occurring within Ward 4B have been set out based on the available evidence. These facts have been presented by the Inquiry to independent experts who have given their views on whether Ward 4B meets expected ventilation standards and these views have been adopted by CTI. The deficiencies in Ward 4B at handover are narrated between paragraphs 1392 and 1406. The remediation measures taken by NHS GGC are narrated between paragraphs 1407 and 1414. We are of the view that potentially deficient features remain in respect of the ACH[32], the lack of a backup AHU[33] and the non-compliant isolation rooms[34]. It is difficult to reconcile the claim of downplaying with the fact that the chronology of Ward 4B and its deficiencies have been set out comprehensively and pragmatically in the CTI Closing Statement which concludes that it remains deficient in certain respects.

28. We are concerned that there may be a misapprehension at paragraph 11.6 of

[27] CTI Closing Statement Para 1749, Page 542.
[28] CTI Closing Statement, Para 1761, Page 545.
[29] Bundle 20, Document 62, Page 1429.
[30] CTI Closing Statement, Paras 1841 and 1842, Pages 570 to 571.
[31] Patients and Families Closing Statement, Page 54.
[32] CTI Closing Statement, Para 1415, Page 435.
[33] CTI Closing Statement, Para 1415, Page 435.
[34] CTI Closing Statement, Para 1606 and 1622, Pages 494 and 500.

the Closing Statement at page 67, where it is stated that we had proposed a recommendation for routine antimicrobial prophylaxis for high-risk patients[35]. For the avoidance of doubt, that was not a recommendation – rather, it was the recording of a suggestion made within an NHS GGC risk assessment in February 2020[36]. It will further be clear from the paragraphs following that we did not repeat that recommendation, those being confined to a submission that the Ward 4C ventilation had at that time made a material contribution to a higher infection risk[37].

29. The Core Participants commented in their Closing Statement that they did not see the evidential basis on which CTI could propose that the risk of contracting Aspergillus or Cryptococcus infections was only a risk for a small group of patients[38]. The evidence for such a basis is that there is no statistically significant epidemiological evidence of increased Aspergillus infections among paediatric haemato-oncology patients in the RHC[39]. Furthermore, a risk only arises where immunocompromised patients are in isolation rooms that do not have correctly fitted HEPA filtration and positive pressure ventilation system. There was limited evidence on the risk of immunocompromised patients being accommodated within isolation rooms without HEPA filtration and a positive pressure ventilation system[40]. It follows that we were entitled to take the view that the likelihood of Aspergillus or Cryptococcus infections caused by non-compliant isolation rooms (or other rooms) would be on the 'low side'[41].

30. The Core Participants on page 71 of its Closing Statement questioned whether the use of the word 'impossible' was appropriate when referring to rectification of general ward rooms to the SHTM 03-01 standard. However, we actually stated that it '**may** be impossible' to rectify to SHTM 03-01 standard which is appropriate given the Cundall report issued in May 2022 concluded that the optimum solution would be the complete replacement of the existing

[35] CTI Closing Statement, Para 1758, Page 545.
[36] CTI Closing Statement, Para 1757, Pages 544 to 545.
[37] CTI Closing Statement, Paras 1759 to 1761, Page 545.
[38] Patients and Families Closing Statement, Page 69.
[39] CTI Closing Statement, Paras 222 and 406, Pages 73 and 138.
[40] Bundle 21, Vol 1, Pages 757 to 758.
[41] CTI Closing Statement, Paragraph 408, Page 137.

AHU which while not impossible is clearly an enormous undertaking which would require significant resources to achieve such that it may be practically impossible to rectify to SHTM 03-01 standard[42].

6. DR PETERS, DR INKSTER AND DR REDDING

31. We would draw attention to the observations made by the Core Participants at paragraphs 22-24, in which they make strong submissions against the characterisation by Ms Grant of the problems with the water and ventilation systems emerging from an iterative process. As we noted in our submissions following the Glasgow 3 hearings, "*it is important to note that in both letters of resignation and subsequently [Drs Peters and Inkster] were clear that deficiencies in the ventilation systems of both the adult and paediatric BMT and in respect of water quality and testing results (with specific reference to Legionella) formed a significant part of their reasons for resignation*[43]" in July 2015.

32. At paragraphs 34-36 the Core Participants identify a lack of curiosity, follow-up work, and proper scrutiny on the part of specialists dealing with the move of the Bone Marrow Transplant Unit to QEUH. It appears to us that the inferences drawn there are sound, and this section is specifically drawn to the Chair's attention.

33. At paragraph 43 the Core Participants make the point that actions which may be attributed to Professor Steele were in fact the work of others. This appears to us to be correct.

34. The Core Participants make certain criticisms of the HAD Report at paragraphs 45-47. It is important to observe that it was not the Inquiry which instructed the HAD Report, and that the Inquiry did not instruct a report on Aspergillus. Core Participants' observations may be accurate, but they do not directly pertain to work carried out by the Inquiry.

35. We accept the legitimate concerns raised by the Core Participants at pages

[42] Bundle 20, Document 63, Page 1466.
[43] Glasgow 3 CTI Closing Statement, Paragraph 175, Page 253.

50 and 51 of their Closing Submissions[44] in relation to the perception that there was no risk register or at least any such risk register was not being maintained until 2018. We concluded that prior to August 2018 the Board did not use its risk register system to address, understand or manage risks posed by the water or ventilation systems of the QEUH and the IPC Risk Register was not operated in a manner consistent with the way the VOLHI understood the commitments given to it by NHS GGC[45].

36. We would adopt the recommendation suggested at paragraph 133, regarding the addition of routine pseudomonas testing at the next SHTM update.

37. The recommendation then suggested by Core Participants at paragraph 147, regarding an annual reporting brief for independent experts on water, and on ventilation system safety, has considerable force. It is submitted that this should be incorporated within the Proposed Recommendation addressed to the Health, Social Care and Sport Committee of the Scottish Parliament at paragraph 1906 of our Closing Statement.

38. Dr Peters, one of the Core Participants, has listed a number of concerns in relation to Ward 2A in Annexe 1 of the Closing Submissions, namely between pages 58 and 63. We agree that the information about the state of the ventilation in Ward 2A after the 2019 upgrade works comes from the Sutton Services International Report[46]. This report was provided to one of the independent experts, Mr Bennett, who ultimately concluded that assuming filters testing and sealability testing has been undertaken these rooms on Ward 2A meet the specification set in all editions of HTM 03-01 and SHTM 03-01[47]. Although Mr Poplett did not have sight of the Sutton Services International Report, he did consider the extensive works undertaken between 2019 and 2022 on Ward 2A and concluded that the updated/revised design approach for Ward 2A was considered appropriate.

39. It is unfortunate that the Sutton Services International Report was not

[44] Dr Teresa Inkser, Dr Christine Peters, and Dr Penelope Redding Closing Statement – Pages 50 and 51.
[45] CTI Closing Statement, Para 1695, Page 524.
[46] Bundle 52, Vol 10, Document 45.
[47] Bundle 21, Vol 1, Document 8, Page 685.

discussed with Mr Bennett in his oral evidence since many of the alleged discrepancies within the body of the report such as retained ductwork and leakage could have then been brought to his attention. We are grateful to Dr Peters for raising these discrepancies and highlighting the oddity of 78 air changes per hour (Bed 24 PPVL En-Suite Extract)[48] which is remarkable but, in our view, must be a typo. The concerns listed in Annex 1 are welcomed by Counsel to the Inquiry and prompt us to propose a recommendation that a new validation report from a different independent contractor be obtained as soon as reasonably practicable for the ventilation system of Ward 2A.

7. NHS GGC

40. We welcome the statement in paragraph 1.3 that save as provided for in its Closing Statement NHS GGC agrees with our assessment of the evidence. This is a significant change. The impression is given that this change of position took place after the close of evidence, but in our submission the Inquiry should be given a more precise explanation of when and why the position of the Board changed.

41. The evidence of Prof. Gardner on 9 October 2025 has the potential to be seen as representing a significant change of approach by NHS GGC, but such a change was not reflected in Prof. Gardner's statement to the Inquiry which was submitted on 25 August 2025. That statement was submitted to the Inquiry the day before Prof. Gardner wrote to the DG Health and Social Care of 26 August 2025 (Bundle 52, Volume 5, Document 32, Page 146) attaching a SBAR from the IPC Senior Management Team about which she later stated "I don't think the tone or, indeed, the nature of them should have been articulated, certainly not in a formal SBAR." (Transcript, 9 October 2025, Col. 101). When did Prof. Gardner and NHS GGC decide to take the position that was set out in her evidence and is now followed in its Closing Statement, and why was the decision made then and not earlier?

42. In light of how Prof. Gardner explained on 9 October 2025 that the apologies she proferred were personal to her as Chief Executive and Accountable

[48] Bundle 52, Vol 10, Document 45, Page 309.

Officer (Transcript, 9 October 2025, Col. 162) we have looked at recent public minutes of NHS GGC for evidence of the change of position being reported to and approved by the NHS GGC Board at its public meetings. The minutes of the meeting of the board held on 30 October 2025 at 09:30am state at page 4 that "Prof Gardner had also attended the Scottish Hospital Inquiry on 9 October 2025 to provide evidence, which had concluded the following day". We noted an earlier NHS GGC ACF Minute from 9 October 2025 which states at page 3 "Professor Wallace also provided an update on the Scottish Hospitals Inquiry, with oral evidence sessions currently underway.". In our submission these limited public records prompt the question as to the extent to which the full Board of NHS GGC has approved the position now taken by NHS GGC in its closing statement and acknowledges the significant change that represents.

43. We have some concern with the reference made by NHS GGC at paragraph 4.3 about it being "*broadly acknowledged that there is no definite link between infections and the water system*"[49]. This is to miss the point, in the whole context of the Inquiry, that there is insufficient information to allow a 'definite' connection to be established, due to lapse of time, the absence of data, the complexity of the water system, and so forth. The degree to which the link can be established must not be taken to minimise the point that the water system was linked to infections, as NHS GGC go on to accept in the sentences following.

44. We note that at paragraph 4.2 the NHS GGC position is now that it "accepts that there was an exceedance in the rate of environmentally relevant blood stream infections (BSI) amongst paediatric haemato-oncology patients in the RHC in the period 2016-2020, with a decrease when remedial measures, including those pertaining to the water system, began to be put in place in 2018". This is consistent with Figure 2.F.3. from the HAD Response Document (Bundle 44, Volume 5, Document 2, Page 50) where Dr Drumright and the other HAD Authors were clear that it took until the end of 2020 for infections to return to the long term trend line.

[49] NHS GGC Closing Statement, Para 4.3, Page 6.

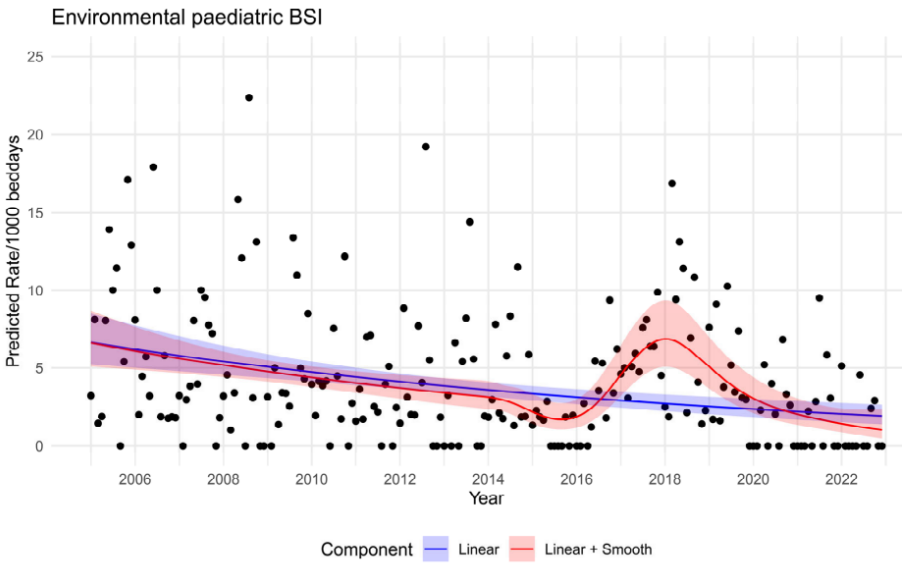

Figure 2.F.3: GAM fit for linear (blue line) and smooth (red line) components against incidence rates (black dots) for BSI incidence rates attributed to environmental microorganisms among paediatric haematology-oncology patients in Yorkhill (Jan 2005-April 2015) and RHC at QEUH (May 2015-Dec 2025) - year tick marks are placed at Jan of that year)

45. We note that the period of the accepted link between the water system and infections set out in the paragraph 4.3 is different from the preceding paragraph. The position is stated there is that "NHSGGC accepts, having regard to the evidence led, that it is more likely than not that a material proportion of the additional environmentally relevant BSI in the paediatric haemato-oncology population between 2016 and 2018 had a connection to the state of the hospital water system".

46. Does NHS GGC not accept that it is more likely than not that a material proportion of the additional environmentally relevant BSI in the paediatric haemato-oncology population in 2019 and 2020 had a connection to the state of the hospital water system? If that is the position, what is the reason for that distinction being drawn from the evidence of Dr Drumright and others? If this is a deliberate restriction in the concession it appears material.

47. NHS GGC has submitted that there is an inherent unlikelihood that professionals who have dedicated their lives to patient care would engage in a 'cover up'. Unfortunately, the past offers up many examples of failures of NHS organisations to respond to concerns about patient safety issues raised by their own staff. Sir Robert Francis listed some of the following examples in his

Expert Report on Whistleblowing[50]:

(i) Bristol Royal Infirmary (1984-1995)

(ii) Mid Staffordshire NHS Foundation Trust Inquiries (2005 – 2009)

(iii) The Vale of Leven Hospital Inquiry (2009-2014)

(iv) The Freedom to Speak Up Review (2015)

(v) The Infected Blood Inquiry (2017-2022)

(vi) The Ockenden Review (2022)

(vii) Thirlwall Inquiry (currently underway)[51]

48. Thus, we consider that given the list of scandals that have arisen in the past with NHS organisations, that there is no basis for a presumption against finding that healthcare professionals putting their own interests or organisational interests ahead of patient safety.

49. NHS GGC, at paragraphs 11.2 and 11.3 of its Closing Statement, addresses the safety of the ventilation system in the QEUH/RHC. Counsel to the Inquiry wish to clarify that, for the avoidance of doubt, we share the NHS GGC's view that a non-compliant ventilation system does not necessarily mean that the ventilation system is unsafe for all patients and have carefully set out our position on this in Chapter 10 of our Closing Statement that it can be considered unsafe for some patients in certain circumstances. However, NHS GGC have yet to explain why there has not been a risk assessment of the ventilation system of the general wards covered by the Agreed Ventilation Derogation.

50. Whilst paragraph 11.5 appears to suggest that the Integrated Performance and Quality Report will now be used to pick up and action any increase in infections at the earliest opportunity it does appear to be the case that NHS GGC has yet to provide a clear explanation why its IPC Management Team and HAI Lead did not action this over the past decade and what lessons have

[50] Bundle 51, Document 1, Pages 195 to 201.
[51] CTI Closing Statement, Para 59, Page 17.

been learned by the IPC professionals in its organisation.

8. IBI (UK) LTD

51. IBI have provided additional narrative at paragraphs 6.1 and 6.2 with reference to paragraph 425 of the Counsel to the Inquiry's Closing Statement. We would accept this additional narrative.

52. At paragraph 6.4 IBI have set out an account of the development of ADB room codes, and the process by which IBI and NHS GGC did not identify the absence of a dedicated or bespoke room code for a single room for immunocompromised patients. We would accept this premise.

53. At paragraphs 6.5 to 6.7 IBI make some footnote corrections. Those are accepted to be accurate, and hence:

    a. Footnote 953 in CTI's Closing Submission should read "Transcript, Emma White, 13 May 2025, Pages 9-10, Columns 13-16.";

    b. Footnote 1107 in CTI's Closing Submission should read "Glasgow 4, Part 1 - Witness Statements, Volume 1, Emma White, Document 1, Page 136."; and

    c. Footnote 2696 in CTI's Closing Submission should read "Transcript, Emma White, 13 May 2025, Page 69, Column 133.".

9. CURRIE & BROWN UK LTD

54. Currie & Brown have submitted at paragraph 17 of their Closing Statement that Professor Humphreys was not suggesting in his evidence that any reduction in air change rate in a space would necessarily make that space 'unsafe' for patients[52]. We accept that he considered this to be a general principle. However, in the context of his oral evidence, he had given an example of trying to reduce infection of SARS-CoV-2 by increasing air changes which alongside direction of air and filters he considered important. It follows that if air changes reduce the risk of infection, then it makes the space safer for patients and the corollary is that if air changes are reduced then that

[52] Transcript, Prof. Hilary Humphreys, 12 May 2022, Page 27, Column 49.

makes the space less safe for patients.

55. Currie & Brown highlighted at paragraph 18 of its Closing Statement that Professor Humphreys had qualified his statement that there is a risk associated with reducing air change rates with a proviso that he was unable to say how significant that risk would be[53]. We acknowledge that qualification, but the fact remains that there is a risk with reducing air change rates and the conditional language used by Mr Humphreys related to the extent of the risk rather than the risk itself.

56. Currie & Brown have submitted at paragraph 19 of the Closing Statement that Mr Stephen Maddocks' view was consistent with Professor Humphreys as he also could not say at what point any reduction in air changes would give rise to a material risk that a space was unsafe. However, Mr Maddocks ultimately conceded that whether a space is unsafe or safe was a matter for clinical judgment[54].

57. At paragraph 21.3 of their Closing Statement, Currie & Brown have sought to rely upon excerpts[55] from Professor Humphreys to advance a submission that he agreed that flow rate is not clinically important. We do not accept this submission. Professor Humphreys explicitly responded 'no' to the question concerning whether it was fair to say that flow rate was not clinically important. He then went on to say that:

> "…the difficulty we're now facing is that within that category are a cohort of what we call 'general medical or surgical patients'. We often have patients who are at some risk of infection because of advances in medical care, including the use of drugs that affect the immune system[56]."

58. Professor Humphreys then went on to conclude that:

[53] Transcript, Prof. Hilary Humphreys, 12 May 2022, Page 26, Column 47.
[54] Transcript, Stephen Maddocks, 13 March 2024, Page 32, Column 59.
[55] Transcript, Prof. Hilary Humphreys, 12 May 2022, Page 28, Column 51.
[56] Transcript, Prof. Hilary Humphreys, 12 May 2022, Page 28, Column 51.

> "…if you have patients in hospital who are in those areas for whatever reason – so for example, they have to move through the hospital to radiology or whatever – then they are highly immunosuppressed, **then it does represent a risk**[57].
>
> [our emphasis added]

59. Our view is that the essential point being made by Professor Humphreys, when the context is fully considered, is that immunocompromised patients will be using standard rooms and wards, so the flow rate is clinically important.

60. Currie & Brown stated at paragraph 22 of their Closing Statement that we incorrectly suggested that Professor Humphreys takes a different view from Peter Hoffman. We do not accept that we were incorrect to state that there was a different view because Professor Humphreys did consider there to be a risk when air changes are reduced[58] whereas Mr Hoffman's view was that there is no risk with a reduction in air changes[59].

10. TUV SUD LTD

61. We thank TUV SUD for its Closing Statement. The matters contained therein are not addressed as part of this Paper. We plan to cover this Closing Statement in some detail during oral submissions.

11. OTHER CORRECTIONS

62. There is an error at paragraph 667 of our Closing Statement where we referred to a Construction Interface Group that took place on 24 March 2011 as having taken place on 24 March 2021 (Bundle 40, Document 42, Page 153).

63. In paragraph 1261 the reference to Bundle 27, Volume 1, Document 1 should be a reference to Bundle 27, Volume 2, Document 1.

64. In paragraph 1695 the reference to September 2018 should be a reference to August 2018.

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[57] Transcript, Prof. Hilary Humphreys, 12 May 2022, Page 28, Column 52.
[58] Transcript, Prof. Hilary Humphreys, 12 May 2022, Page 26, Column 47.
[59] Transcript, Peter Hoffman, 26 September 2024, Pages 53 to 54, Columns 102 to 103.

65. There are some typographical errors in CTI's Closing Statement which have now been amended, including but not limited to: updating missing bundle references and witness bundle references within footnotes; infections such as Cryptococcus, Legionella and Stenotrophomonas have been italicised within the body of the text where they were not previously; Ms Freeman and Kathleen Harvey-Wood's names have had typographical errors removed; and the font size of footnotes within the body of the text has been standardised.

12. NOTE OF WHISTLEBLOWS

66. In December 2025 the Chair asked us to identify what are the particular communications by staff at the QEUH/RHC that we say amount, in any sense, to 'whistleblowing' in the period from the handover of the new hospital on 26 January 2015 until NHS GGC was escalated to Stage 4 of the National Framework. What follows is that note.

67. During this period there were two NHS GGC whistleblowing policies in force, one from June 2013[60] and the second from 2018[61]. In the first policy, NHS GGC defined "whistleblowing" as "the disclosure internally or externally by staff who have concerns about patient safety, malpractice, as well as illegal acts or omissions at work". This note is not limited to communications recognised by NHS GGC as "whistleblows" and is generally limited to communication touched on in our Closing Statements following Glasgow 3 ("CTICS G3") or Glasgow 4 ("CTICS G4"). We do not list the various communications by Dr Redding in respect of her Stage 3 Whistleblow. They are described in some detail in her statement with relevant communications largely to be found in Bundle 14, Volume 2.

68. For each communication set out in the following table we have recorded:

    a. The date of the communication

    b. A bundle reference

    c. Who sent the communication

[60] Bundle 27, Volume 4, Document 3, Page 25.
[61] Bundle 27, Volume 4, Document 4, Page 53.

d. To whom it was sent

e. Subject

f. Where it is referred in our Closing Statements

Date	Bundle Reference	Sender	Recipient	Subject	Reference
8/7/15	Bundle 14, Volume 1, Document 26, Pages 414-415	CP	Prof. Jones	Demit role as Sector ICD out of concern for safety and culture within the IPC Team	CTICS G3. Page 252, Paras 173-198
9/7/15	Bundle 14, Volume 1, Document 27, Pages 416-420	TI	Prof. Jones	Demit role as Sector ICD out of concern for safety and culture within the IPC Team	CTICS G3. Page 252, Paras 173-198
16/9/15	Bundle 14, Volume 1, Page 463	PR	Dr Stewart & Mr Archibald	Issues about isolation rooms across the QEUH site	CTICS G3. Page 58, Para 134
9/11/15	Bundle 14, Volume 1, Document 47 at Page 478	CP	Dr Stewart	Patient safety issues raised in July 2015 still not addressed	CTICS G3. Page 260, Paras 199-203
Feb 2017	PR Statement Para. 94 (G3 Vol 3, Page 93)	PR	Mr Calderwood	Meeting about ventilation	CTICS G3. Page 279, Para 265
23/8/17	Bundle 14, Document 69, Pages 696 to 700	CP	Dr Armstrong	HAI-Scribe Signoff	CTICS G3. Page 302, Paas 341-346
5/9/17	Bundle 14, Volume 1, Document 73, Page 722	PR	Dr Armstrong	Issues that became SBAR of 3 October 2017	CTICS G3. Page 58, Para 136
3/10/17	Bundle 4, Document 19, page.104.	PR, CP, W7	Dr Armstrong	SBAR 3 October 2017: Issues with building systems and the IPC Team	CTICS G3. Page 65, Para 166 and Page 305, Paras 350-368 and 388-404 and CTICS G4,

					Page 285, Paras 935-940
24/1/18	Bundle 14, Volume 2, Document 85, Page 10	TI	Mr Walsh and Prof. Jones	Concern over the restructuring of the role of Lead IDC	CTICS G3. Page 323, Paras 405-410
8/2/18	Bundle 14, Volume 2, Document 87, page 72.	PR	Dr de Caestecker	Stage 2 Whistleblow	CTICS G3. Page 324, Paras 411-436 and CTICS G4, Page 289, Paras 945-947
21/2/18	[CP Statement para 156, V4 P153]	CP	Dr Inkster and Mr Powrie	Concerns over PPVL Rooms	CTICS G3. Page 64, Para 162
October 2018 and January 2019	Dr Peters witness statement para 189-191	CP, PR	Anas Sarwar MSP		CTICS G3. Page 417, Para 709 and CTICS G4, Page 311, Para 1012
January 2019	Bundle 14, Volume 2, Page 346 -347	CP, PR	Jean Freeman MSP		CTICS G4, Page 311, Para 1012
29-31 January 2019	Bundle 18, Volume 2, Document 128, Page 1490	TI	HIS Inspectors	Concerns about communication by Professor Steele	CTICS G3. Page 434, Paras 765-774
1/2/19	Bundle 14, Volume 2, Document 115, Page 350	PR	Scottish Parliament Health and Sport Committee	Health Hazards in the Healthcare Environment	
21/3/19	Bundle 14, Volume 2, Document 122, Page 410	CP	Ms Freeman		
1/4/19	Bundle 14, Volume 2, Document 123, Page 410	CP	Scottish Parliament Health and Sport Committee	Health Hazards in the Healthcare Environment	
1/4/19	Bundle 14, Volume 2, Document 124, Page 419	TI	Scottish Parliament Health and Sport Committee	Health Hazards in the Healthcare Environment	

2/5/19	Bundle 14, Volume 2, Document 127, Page 489	PR	Ms Freeman		
16/8/19	Bundle 27, Volume 4, Document 17, Page 209	CP	HPS	Concerns about the way TI as IMT Chair was being treated	CTICS G3. Page 460, Paras 852-853
25/8/19	Bundle 4, Documents 41 and 42 from page 165 and Bundle 14, Volume 2, Document 149, Page 574	All consultant microbiologists at QEUH	Dr Crighton as Chair of the IMT	Concerns about infections in Ward 6A	CTICS G3. Page 479, Paras 908-909
7/10/19	Bundle 4, Document 44, Page 180	CP, TI	Dr Crighton as Chair of the IMT	Concerns about infections in Ward 6A	CTICS G3. Page 487, Paras 931-936
2/12/19	Bundle 14, Volume 2, Page 633	TI	Ms Freeman		