SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
20 January 2026

Day 2
Wednesday, 21 January 2026

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10:02

Questions from The Chair, Continued

THE CHAIR: Good morning, and good morning, Mr Gray. (After a pause) Mr Gray, yesterday you, in your opening statement, emphasised that Greater Glasgow Health Board is a changed organisation. Would it be fair of me or rational of me to look at the various written positions that have been taken from time to time during the course of the Inquiry, in your written closing statements and positioning papers as indications of a process of change, or at least snapshots in time as to the position of the organisation and the nature of the organisation?

MR GRAY: Yes, my Lord.

THE CHAIR: Now, can I ask you some questions about the position of GGC in relation to the three doctors, Drs Redding, Peters and Inkster? Now, at-- I think it's paragraph 4.5, we see that:

> "[The Health Board] accepts that its previous criticisms of Dr Inkster and the 'whistleblowers' [and I take it that's a reference to Dr Peters and Dr Redding] were neither helpful nor fair."

Now, I think it would be fair to say that the criticisms as expressed in Position Paper 1 of 14 December 2022 are quite severe in their nature. It's an allegation of behaviour which is very clearly unprofessional and also malevolent. Now, the Health Board now accepts that these criticisms were "neither helpful nor fair." Now, first of all, the phrase "not helpful": why do you say they were not helpful?

MR GRAY: My Lord, they were not helpful because what was submitted in Positioning Paper 1 was not borne out by the evidence led before for the Inquiry. My Lord, what was advanced in Positioning Paper 1 was put forward on the basis of instructions and with an apparent evidential basis to underpin those instructions.

What became clear in the evidence led in the course of the Inquiry was that the evidence in support of the position, as set out in support of Positioning Paper 1, did not emerge as anticipated. My Lord will no doubt have noticed in the course of the evidential hearings that in a number of instances witnesses departed from the terms of their witness statement in relation to matters relevant to that issue.

THE CHAIR: Well, would you accept that, the Board having set out its position on the matter – and when I say "on the matter", in relation to the reliability and goodwill of these three

doctors and the relationship which their conduct may have had on the Board effectively responding to what were seen as problems subsequent to 2015 – would you accept that the Inquiry was obliged to follow that indication to see if there was a basis for it?

MR GRAY: Indeed, my Lord, and the purpose of Positioning Paper 1 was to provide Counsel to the Inquiry, at its request, information which had been provided by NHSGGC as to witnesses from whom the Inquiry may have benefitted from hearing in fully exploring its terms of reference.

Positioning Paper 1 did not advance conclusions, but rather information to assist the Inquiry in so doing, and all information was provided candidly. The information was not intended to be regarded as a submission, let alone a conclusive submission. It was a positioning paper based on instructions and information understood then to be available. But as is made clear, I hope, in the written submission, the previously stated position on the credibility, reliability and good faith of Drs Peters, Redding and Inkster is no longer maintained.

THE CHAIR: Right. That is helpful, but, in relation to the point I made about the Inquiry having to follow the lead, you have in the past been

critical – and, indeed, may still be critical – of Counsel to the Inquiry having spent so much time looking at the conduct of the whistleblowers and their experience. In the context of the expression "unhelpful", do you at least accept that the time spent by the Inquiry was a reasonable response to the position taken by the Board?

MR GRAY: Yes, I don't have a difficulty with that, my Lord.

THE CHAIR: Now, the other expression you use is "not fair". Why do you say the Board's position was not fair?

MR GRAY: Because it was not supported by the evidence that was led before the Inquiry, my Lord.

THE CHAIR: So the words "neither helpful nor fair" do not have a distinct meaning one from the other?

MR GRAY: No.

THE CHAIR: Right. Now, it may be that you have already dealt with this question in your answers to my previous questions, but is there any suggestion remaining that the concerns and issues raised by the doctors were, in any particular, wrong or misguided to the extent that they were not justified in raising them?

MR GRAY: No, my Lord. No.

THE CHAIR: Now, can I move to another topic that has been discussed by

Mr Connal yesterday, and that is the attribution of personal responsibility, as opposed to institutional responsibility. In the course of the exchanges yesterday, I drew attention – I think I did, anyway – to two statements that we see in the Health Board's most recent closing statement which might demonstrate a degree of tension as between one and the other. Now, the first one is found at paragraph 3.7, where the Board say:

> "It is critical that the public can see, through the work of the Inquiry, that people have been held to account. Where criticism is due, it is right that it [should] be made robustly."

That's one statement. At paragraph 7.1, we see that:

> "It is submitted that personal or professional criticism should not be made of any of these individuals for how they reacted to the expression extreme pressure they were under."

Now, I would value your comment on the appropriateness of attribution of personal responsibility in, eventually, the report of the Inquiry.

MR GRAY: Yes, my Lord. My Lord, NHSGGC's position on the governance of the project is set out at paragraph 5.12 of the written

submission, where it is acknowledged that there were a number of failings in relation to the management of the project. In relation to this aspect of the Inquiry, my Lord----

THE CHAIR: Sorry, just so that we're clear, we're speaking at the moment about the construction project.

MR GRAY: Yes, my Lord.

THE CHAIR: Yes. Sorry for interrupting.

MR GRAY: In relation to that aspect of the Inquiry, my Lord, namely the construction project, NHSGGC maintains its position as set out in paragraph 3.7 that, where criticism is due of individuals, that "it is right that it be made robustly." However, my Lord, I would draw a distinction between the acts or omissions or conduct of those managing the project and those addressing the unprecedented circumstances which they faced after handover.

My Lord, insofar as paragraph 7.1 of NHSGGC's submission is concerned, the Inquiry is invited to note that this submission was made in relation to the circumstances which existed following completion of the project, and the hospital having been handed over, and the extreme pressure under which all personnel were operating. In other words, my Lord, when it is submitted at

paragraph 7.1 that personal or professional criticism should not be made of any of these individuals for how they reacted to the extreme pressure they were under, I have in mind those who were having to deal, post the opening of the hospital, with a very complex and pressurised situation.

Ultimately, of course, my Lord, it is a matter for my Lord as to whether he considers such a distinction to be helpful or not.

THE CHAIR: So, in some cases, personal responsibility should be attributed if the evidence supports that; in some, not. Now, what's the test, the criterion, to distinguish one situation from the other?

MR GRAY: I would suggest, my Lord, that the distinction is to be made between those who were acting under extreme pressure in an unprecedented situation following the handover of the hospital-- In respect of those personnel, in my submission, personal professional criticism should not be made of any of those individuals, having regard to the extreme pressure under which they were working. Whereas, by contrast, I would accept that, in relation to the management of the project, where the Inquiry considers that there have been failings, that individuals should be held to account where appropriate. Where

criticism is due, it is accepted that it should be made robustly. That is the distinction I seek to draw, my Lord.

THE CHAIR: Sounds to me rather like one should have regard to such mitigating factors as are present, but in fact it's a judgment on the seriousness of the degree of failure.

MR GRAY: It's also, I would respectfully agree with my Lord, as to whether-- as to putting the failings in the appropriate context and where there are mitigating features or not.

THE CHAIR: Now, by way of example, the Board now makes a fairly unqualified admission of failure to listen in circumstances which are broadly described as whistleblowing. The reason I use the word "broadly" is, as I think we are agreed, "whistleblowing" can be used in a general-- in a wider sense of drawing attention to senior management matters which those in an inferior position think are worth drawing attention to.

Now, going back to my question, the Board accepts institutional failure there. Is that a situation where it would be appropriate to attach personal responsibility?

MR GRAY: My Lord, in my submission, it would not be, and certainly NHSGGC would not wish to attribute responsibility – for failing to adequately

listen or act in a timely manner to respond to those raising concerns – to any particular individual.

My Lord, the failure to listen was, in my submission, an organisational failure, and it was one which was based on a culture which, it is accepted, did not place appropriate emphasis on listening to staff and encouraging the raising of concerns. It's in recognition of that failing that changes have been made across the organisation as a whole, and the focus is on addressing the fundamental failings in culture, as opposed to the failings by any individual.

THE CHAIR: So, would it follow from that that you would not consider it appropriate for me to ask on whose behalf the apology is offered, because such apology as has been offered by the Board is not an apology for the acts or omissions of individuals, but for a culture?

MR GRAY: A culture and an organisational failure which resulted in acts and omissions being made by individuals.

THE CHAIR: Now, a matter of detail is: I am right in thinking that the Board has had a formal whistleblowing policy in place since at least 2013?

MR GRAY: Yes, that is correct, my Lord.

THE CHAIR: Moving to-- I'm

sorry.

MR GRAY: I apologise, my Lord. I perhaps should add that, whilst there was a policy in place from 2013, it is one which has been very substantially revised. In 2013, it was created at a time that there was no national guidance or standards available to those considering the terms of any policy when creating it, and, in my submission, it's clear from the evidence of Professor Gardner that much benefit has been derived from the creation of national standards in-- I think it was 2021.

THE CHAIR: Is work being done in relation to identifying specific weaknesses of the 2013 policy or----?

MR GRAY: Well, certainly, my Lord, very significant changes have been made to the entire approach to whistleblowing. My Lord, I had anticipated that my Lord may have questions about changes, if any, made in relation to whistleblowing, which I have put in writing, and I wonder-- I'm entirely in my Lord's hands, but because there have been a number of changes which I think it would be important for my Lord to hear, I wonder if that might be most conveniently dealt with by me simply providing to my Lord orally what the position is, but with an undertaking to provide in writing what I am saying to save my Lord having to make a detailed

note just now.

THE CHAIR: I think it may go beyond-- I think that's a good idea and I'm grateful for your suggestion, Mr Gray, but I think it perhaps might go beyond simply my notetaking. I mean, you're quite right; the fact that I'm taking a note slows down the process. I think you've accepted that your communications with the Inquiry been and are couched at a fairly high level. It may be that by providing something in writing – which, of course, would be shared with other----

MR GRAY: Of course, my Lord.

THE CHAIR: -- core participants – you might be able to provide a granularity, the same granularity I was looking for in March of last year, which might address any suggestion that-- The Board is assuring the Inquiry that there has been change, there has been action, there has been redirection.

MR GRAY: Yes, my Lord.

THE CHAIR: But it might be said that-- We've still got to hear the detail of that, and it appears to me that providing a written document might be a more effective way of doing that, and I'm grateful to you for the offer.

Can I move to, again, the Board's position on the effectiveness of the operation of the Incident Management meetings? Now, in response to my request on 11 March of last year, as

we've already dealt with yesterday, the Board provided an additional closing statement. Now, I think I'm right in saying that, at paragraph 32 of that, it is stated that the Incident Management team meetings worked satisfactorily until 2019. Now, have I understood that correctly?

MR GRAY: Yes, my Lord.

THE CHAIR: So, does that go the distance of the Board in relation to the Incident Management team meetings which this Inquiry is concerned with-- because I imagine there will have been others which we have heard nothing about because they did not concern the infections with which we're concerned. Would it be right to take from that that the Board's position is that, until 2019, there was nothing wrong about the operation of the meetings?

MR GRAY: Yes, I would entirely accept that, my Lord. Indeed, in my submission, the evidence led before the Inquiry suggested that the IMTs worked effectively in what were clearly extremely challenging circumstances, and the assessments and recommendations made by them were, in my submission, entirely appropriate.

THE CHAIR: Right. Are you able to offer a more precise date than 2019? In other words, at what point in 2019 did they stop being satisfactory?

MR GRAY: My Lord, I couldn't provide a precise date, but it would appear, in my submission, on the evidence that the IMT in 2019 which resulted in Dr Inkster no longer being the chair of the IMT-- that it was in the course of that IMT that IMTs did not work in the way that they had done previously.

In my submission, the evidence led before the Inquiry would indicate that a number of members of that IMT were concerned that that particular IMT was not functioning as it should and, as a result, was unable to fulfil its terms satisfactorily. I would invite my Lord to have regard in particular to the evidence of those members of the IMT at the relevant time as to the considerable tensions that appeared to exist at that IMT.

THE CHAIR: When you say "at that IMT", is that the IMT of-- is it 24 August?

MR GRAY: I think so, my Lord.

THE CHAIR: So it's the tensions at the IMT of 24 August, as opposed to anything that happened before 24 August?

MR GRAY: Well, my Lord, it was throughout the currency of that IMT, which clearly didn't last for a day----

THE CHAIR: Well----

MR GRAY: -- and the submission which I make is that the evidence led

from those who participated in that IMT was to the effect that that IMT was not working in the positive, constructive way in which previous IMTs had operated.

THE CHAIR: So – and I will do this – in going back to evidence, the period I should be focusing on is no more extensive than the month of August in 2019?

MR GRAY: Indeed, my Lord. That appeared-- My Lord, the interpretation of the evidence is entirely a matter for my Lord, but my interpretation of it was that it was that specific IMT which gave rise to particular concerns.

THE CHAIR: Maybe I should just check my use of language because I rather think that we use the expression "IMT" for a number of purposes. Probably, strictly, an IMT can comprehend a number of meetings, but when you say, "that IMT", you mean the meeting on the 24th?

MR GRAY: No, my Lord. I mean the meetings that were part of that Incident Management team process.

THE CHAIR: Right.

MR GRAY: My Lord, it's----

THE CHAIR: When was the first meeting?

MR GRAY: I'm afraid I can't assist, my Lord, in relation to that, but my Lord may feel, having regard to the evidence, that whilst that IMT process – as

opposed to a particular meeting of the IMT – was subject to considerable tensions, my Lord may feel that such tensions had been growing during 2019. But my recollection of the evidence, my Lord, and it's the evidence of witnesses such as Professor Steele, was that it was in the currency of the IMT process which resulted in Dr Inkster being removed as chair, which was the IMT that did not work as satisfactorily as ones had done before.

THE CHAIR: Can I turn to another topic, Mr Gray? That is the Board's reception of the Case Note Review report. The report, I think, is dated 21 March 2021. I think it was published on the 21st, and if I'm wrong about that, it was the 22nd.

Now, the Inquiry heard rather different-- or it might be thought that the Inquiry heard rather different accounts of the reception of the CNR report – and in particular the reception of its conclusions in relation to the 84 individual cases – on the one hand, from Professor Brown, and on the other hand, from a Ms Grant. Now, do you have any comment or submissions to make on what might be said to be a difference in the evidence?

MR GRAY: No, my Lord. There clearly was a difference in the evidence---

THE CHAIR: Mm-hmm.

MR GRAY: -- and there clearly was a difference in recollection of the position on the part of Professor Brown, on the one hand, and Ms Grant on the other. I would merely invite my Lord to find that, whilst there clearly was a difference in recollection or understanding of the position, there is no reason to consider, in my submission, that each recollection was anything other than honestly held. But, ultimately, it will be a matter for my Lord to reach a view as to whether the two positions can be reconciled.

THE CHAIR: My understanding is we have no Board minute of a decision of the Board as to how it should receive the conclusions on the individual cases. Am I right about that?

MR GRAY: Yes, that's my recollection of the evidence as well, my Lord.

THE CHAIR: Would you accept that the subsequent behaviour of the Board is more consistent with Ms Grant's understanding of the Board's position than Professor Brown's?

MR GRAY: Yes, my Lord.

THE CHAIR: (After a pause) Two perhaps rather free-standing questions, Mr Gray, first in relation to the written report by Professor Hawkey and his colleagues. Now, in the Board's position paper after the Glasgow III hearing – I

think it's at paragraph 26 – there is a statement broadly to the effect that the report by Professor Hawkey and his colleagues takes a multifactorial approach. Now, could you help me understand that as to how it is distinct in that quality?

MR GRAY: My Lord, in a sense, what is set out at paragraph 26 has been superseded by the conclusion of all the expert evidence, including Dr Hawkey and his colleagues, that there was an exceedance in bloodstream infections over the relevant period.

But in answer to my Lord's question, in their report, when taking a multifactorial approach, the instruction of the authors of, if I may call it, the HAD report was to consider whether there was objective evidence to suggest that there was an increased rate of infection in relation to bloodstream infections which was greater than that which might be expected in any hospital where there is not an entirely sterile environment. Taking a multifactorial approach, the authors of the HAD report examined, by carrying out comparators with other hospitals, whether there was an increased rate of infection and also considered, in terms of the management of that risk, the multifactorial approach that there would be to the control----

THE CHAIR: It's this multifactorial

approach you must help me with, Mr Gray. I frankly don't understand what it is.

MR GRAY: Well, my Lord, infection can be controlled in a number of ways.

THE CHAIR: Yes.

MR GRAY: It can be controlled by adequate cleaning. It can be controlled by prophylaxis.

THE CHAIR: Yes.

MR GRAY: All the various ways that my Lord has heard in evidence. That is all that is meant, or that is what is meant.

THE CHAIR: I mean, with great respect to the authors, that doesn't seem to be a unique insight. I mean, the suggestion is that there is something in what you described as "the HAD report" which is distinctive, and you use the word "multifactorial", and I'm just struggling to keep up.

MR GRAY: I think, my Lord, the distinction to be drawn is perhaps with the approach that was taken in the Case Note Review, of which I make no criticism, but the Case Note Review was looking at particular cases of infection, as my Lord is aware, and whether there was a basis to find that they were causally connected to the hospital environment.

By contrast, what the authors of the

HAD report were looking at was whether there was an objective basis to say that there was an increased rate of infection over and above that which might be expected in a hospital. In looking at that question, they considered a number of factors, as set out in their very lengthy report, including the various ways in which infection is managed.

But perhaps the important point, my Lord, is that, having regard to the concession which has now been made by Dr Hawkey and others that, contrary to the position previously held in their original report, there was indeed a spike, an exceedance in bloodstream infections over the relevant period, then the point advanced accordingly, in my submission, may be disregarded and my Lord need not concern himself with it, as I do not seek to make any submission in relation to it.

THE CHAIR: Very well. Again, a free-standing point, although it may be covered by what you've just said. We talked about the litigation that the Board has initiated against various defenders----

MR GRAY: Yes, my Lord.

THE CHAIR: -- and one of these actions is the action that I referred to yesterday, the one that was raised in January, I think, of 2020. Now, I should say I have not had access to amended

pleadings, and indeed it may be that the pleadings in the case have not been developed because the process is sisted or stopped at the moment for alternative dispute resolution. That, in very broad terms, is my understanding of where it is procedurally. So, I suppose my first question is: am I right about that?

MR GRAY: I'm afraid, my Lord, I do not know the answer to that.

THE CHAIR: Right. Well, do you know the answer to this question? In Article 16 of the summons, there is reference to-- this is an allegation being made by the Board that the water system was contaminated, wholesale, at the point of handover. Now, is that, which is an assertion by the Board, something that the Inquiry should have any regard to or not?

MR GRAY: My Lord, I suppose, in relation to what is contained in the summons, they are nothing other than averments which provide a formal statement of NHSGGC's position in relation to those proceedings. However, my Lord, it is accepted that as, at handover in January 2015, water within the systems of both the Queen Elizabeth University Hospital and RHC were contaminated in the sense of containing a proliferation of potentially pathogenic microorganisms beyond the extent to be anticipated in a properly controlled

hospital water system.

THE CHAIR: And that was not a situation that was properly addressed until 2019-- sorry, well, until the end of 2018?

MR GRAY: Yes, my Lord.

THE CHAIR: Yes. Now, can I move on to another topic, Mr Gray, and that's the design and build contract?

MR GRAY: Yes, my Lord.

THE CHAIR: Now, in the most recent Board statement at paragraph 6.9, there are two sentences. I don't understand what they mean and would value your help. The sentences are:

> "A design and build form of contract is a design process requiring the appropriate responsive resources at the required time to iteratively develop the design."

Now, in a general sense, I suppose that's correct.

> "The failure to have adequate resources available at key stages meant not everything that was requested could be provided."

Now, it may be my fault in failing to understand what's being said, but I have failed to understand what's being said.

MR GRAY: I don't think it's my Lord's failing at all. On reflection, I think this sentence could have been better and more elegantly expressed.

THE CHAIR: This is your opportunity.

MR GRAY: Thank you, my Lord. My Lord, the design and build process obviously required input from staff at the NHSGGC throughout, and particularly where there were decisions on design that were required to be taken during that process. That's what is meant by the process having been an iterative one.

NHSGGC admits in its closing submissions that appropriate resource wasn't allocated to these phases where decisions were required to be made, in particular in the sense that the skill set of the project staff who were required to engage in these decisions was, in many respects, inadequate. That is one example of the inadequacies of the management of the project which are candidly accepted by NHSGGC. I hope that clarifies the position a little, my Lord.

THE CHAIR: Right. Thank you. Now, again, in the most recent statement – and I think Mr Connal touched on it yesterday, it's at paragraph 5.11 – there's a reference to Capita and an implication, but not, I think, really an explanation, an implication that perhaps they did not do what they might have done. Now, as, I think, discussed yesterday, Capita's position is that,

"Well, you didn't ask us to do it." So, can you help me with what I should take from paragraph 5.11 of the Board's most recent closing statement?

MR GRAY: My Lord, the position of NHSGGC remains that Capita was responsible for giving assurance to the Board that the building was handed over in terms of the contract and that it failed to do so, but I have to acknowledge that there was no evidence, as I recall, led before the Inquiry to refute the position that was taken by-- I think it was a Mr Redmond.

THE CHAIR: Yes. I think the only evidence we have on the topic is Mr Redmond's evidence, and he said, "Well, our arrangement with the Board was the Board required to call on us to carry out the function, and they did not call on us."

MR GRAY: I accept, my Lord, that there was no evidence led before the Inquiry, as I recall, to refute that. I can only invite my Lord to have regard to the totality of all the evidence and material that's been provided to the Inquiry when determining the merit of that submission, my Lord. But I can't point to witness evidence specifically led in the course of the Inquiry to refute what Mr Redmond said.

THE CHAIR: Thank you. Now, in relation to HAI-SCRIBE – that's the obligation imposed on health authorities

by-- I think it's-- is it SHFN 30? Now, my recollection of the evidence is that: there was a Stage 1 carried out, possibly by Ms Rankin; Ms Stewart filled in the form on Stage 2, although possibly without understanding what she was doing; but we've heard no evidence of any further implementation of the Board's HAI-SCRIBE obligations.

MR GRAY: That is my understanding as well, my Lord. I would invite my Lord to accept that these shortcomings were not deliberate and may at least in part be explained by the fact that, during this period, HAI-SCRIBE had only recently been introduced and the full extent of what was required, including clarity in respect of the roles within HAI-SCRIBE, was one which was being developed nationally.

My Lord, I don't put that forward as an excuse for any failing, but simply to provide my Lord with what I would invite my Lord to consider may be a reasonable and fair context for those failings.

THE CHAIR: Can I return to your, I think, very useful offer, Mr Gray, which we've already touched on? The Board recognises that there is a need for change. It has told the Inquiry, particularly through Professor Gardner, that change is underway but the journey is far from complete. As we have

previously discussed, if you are prepared to articulate that as fully as may be, I think that might be a better way of providing information to the Inquiry, if you're prepared to, to do that.

MR GRAY: To do so in writing, my Lord?

THE CHAIR: Yes.

MR GRAY: Yes, certainly, my Lord.

THE CHAIR: Right. I think the final thing I would say is that you will have read the closing statements of the other core participants. As I explained at the beginning of yesterday, this is the opportunity for all core participants to have their final word. Is there anything you wish to say from your perspective in relation to what has been said by other core participants, or are you content to leave things as they are at present?

MR GRAY: I am content to leave things as they are, my Lord.

THE CHAIR: Right. Well, thank you. Thank you Mr Gray.

MR GRAY: Thank you, my Lord.

THE CHAIR: (After a pause) Good morning, Ms McCafferty. You've anticipated my invitation. Now, as everyone in the room is aware, you represent Currie & Brown.

Closing submissions by Ms McCafferty

MS MCCAFFERTY: That's correct, my Lord, yes. Good morning. Thank you for the opportunity to address your Lordship this morning on behalf of Currie & Brown. Currie & Brown, as your Lordship knows, is a global organisation, but it has an office in Glasgow from which it serviced this project. Currie & Brown is a consultancy firm who provided cost management and project management services to NHSGGC during the project.

As I've stated in our closing statement, Currie & Brown has fully participated in the Inquiry process from the start. Representatives have attended the Glasgow hearings on almost every day of those hearings. Currie & Brown was deeply moved by the courage and fortitude which was shown by the patients and families who testified in the Glasgow I hearing in 2021. Currie & Brown believes it has discharged the pledge it made in the closing statement it made after the Glasgow I hearing to do all it can to assist and cooperate with the Inquiry. It's provided large amounts of documentation, factual evidence from

three witnesses, and detailed submissions, and it continues to stand ready to assist the Inquiry in whatever way it can.

My Lord, my submissions this morning will address some of the points that were raised by Counsel to the Inquiry in their written response to the core participants' closing statements and also yesterday in their oral submissions. The structure of my submissions is as follows. I will address three topics: the first is Currie & Brown's role in the project; the second is the ventilation derogation; and the third is the submissions that were raised orally by Counsel to the Inquiry yesterday about Currie & Brown having signed off certain design drawings.

So, starting with my first topic, Currie & Brown's role on the project, that's a topic which came up again yesterday in oral submissions, and some points were raised which I would like to take the opportunity to clarify. Now, I'm very conscious that, as your Lordship reminded counsel yesterday, the audience attending this hearing, both in person and remotely, includes people who are perhaps not as fully immersed in the written and oral evidence as some others are. I hope I will therefore be forgiven for repeating, for the benefit of those attendees, some points that Currie & Brown has previously made in written submissions and responses to the Inquiry.

THE CHAIR: I think that's a very good point, Ms McCafferty. You have a number of audiences.

MS MCCAFFERTY: I'm grateful, my Lord. Thank you. Now, the starting point, for the avoidance of doubt, is that Currie & Brown provide cost consultancy, programming and project management services. They are not engineers. They are not designers. They have no specialist technical expertise in-house. Currie & Brown was not responsible for the design, the construction, the commissioning, or the validation of either the water system or the ventilation system at the hospitals.

There was some discussion yesterday about Currie & Brown's role during comments that Counsel to the Inquiry made on paragraph 12.3 of GGC's closing statement. Counsel to the Inquiry noted that GGC stated there that, and I quote:

> "There was little expertise within the board to cope with a project of this magnitude. The board was accepting of what it was told during the design and construction phase. It was reliant on the technical team…"

The term “technical team” was in lowercase. Now, counsel for GGC was not asked what he meant by that term during his oral submissions, no doubt due to constraints of time. Counsel to the Inquiry correctly stated in their submissions yesterday that what we have referred to more commonly in this Inquiry as the “Technical Team”, often capitalised, of specialist subconsultants engaged by Currie & Brown during the initial pre-design phase of the project, which was known as Stage 1A, was stood down on GGC’s instruction after the award of the main contract to Multiplex on 18 December 2009. So that Technical Team was not in place during the design and construction phase.

There was some discussion between Counsel to the Inquiry and your Lordship about when precisely in 2010 Currie & Brown’s Technical Team was stood down. For your Lordship’s note, the confirmation of the change in Currie & Brown’s role and the instruction to stand down its Technical Team was set out in a letter from Peter Moir of GGC to Currie & Brown, dated 18 January 2010. The reference, for your Lordship’s note, is bundle 17, page 2870. Currie & Brown duly stood down the members of its Technical Team the following day by letters to those companies dated 19 January 2010.

It is, of course, only speculation on my part, but I would suggest that what GGC referred to in its submissions as “the Technical Team” in place during the design and construction phase must therefore refer to Multiplex, its design and build contractor, together with the Design team engaged by Multiplex to discharge its design responsibilities under the main contract as those were the only technical specialists engaged by GGC at the time.

In the context of a later discussion about Currie & Brown’s role, your Lordship asked whether, in December 2009, Currie & Brown was still providing the fuller service. Counsel to the Inquiry responded Currie & Brown was still providing that service beyond December 2009, just without the Technical Team.

Now, for clarity, that’s not correct. Currie & Brown’s role after the award of the contract to Multiplex changed very significantly. The full services which were listed in the invitation to tender which was issued to Currie & Brown in 2008 were not, in the event, required to be provided by Currie & Brown after the procurement strategy changed and the main contract was awarded to Multiplex in a different form from that envisaged, with GGC taking the role of project manager under the NEC3 terms. For your Lordship’s note, the invitation to

tender that I referred to is found in bundle 17, page 1814.

What instead happened is that, after the award of the contract to Multiplex, the more limited services identified in a schedule to Peter Moir's letter of 18 January 2010 were required to be provided by Currie & Brown. It was as a consequence of that change that GGC instructed Currie & Brown to stand down its technical team, but that was very far from being the only change to Currie & Brown's role.

Now, due to the constraints of time, I will not go through the detail of all the changes to the services to Currie & Brown's contractual remit that were instructed in January 2010. But, if I may, I would refer your Lordship on that point to section 1 of Currie & Brown's response to Provisional Position Paper 13, that response being dated 29 November 2024. It can be found in bundle 22, volume 3, document 3, at page 7. I would also refer your Lordship to paragraphs 84 to 86 of Currie & Brown's closing statement, which also deal with that point.

THE CHAIR: This is your most recent closing statement?

MS MCCAFFERTY: Correct, my Lord, yes. I turn now, my Lord, to my second topic, which is the ventilation derogation. By way of introduction, as in

Currie & Brown's written closing statement for this hearing, I'm going to break down this second topic into two parts, the same two parts as were used in that closing statement. By way of reminder, the first part referred to what Currie & Brown termed the assumption underlying Counsel to the Inquiry's submissions that the ventilation derogation in and of itself created a risk which rendered the bulk of the wards in the hospitals unsafe, and this is an issue concerning causation.

THE CHAIR: Right, paragraph 12?

MS MCCAFFERTY: Indeed, my Lord, yes. It's addressed in paragraphs 7 to 10 and 12 to 37 of Currie & Brown's closing statement. The second part of this second topic which I will discuss is the process by which the ventilation derogation came to be agreed and how it was recorded. This is addressed in paragraphs 38 to 80 of Currie & Brown's closing statement.

So, starting with the first part, which is the issue of causation, I would like to start by repeating the caveat at paragraphs 12 to 13 of Currie & Brown's closing statement that Currie & Brown has no expertise in the field of ventilation engineering or, indeed, the science behind it. In relation to ventilation, Currie & Brown relied upon the expertise of Wallace Whittle, the specialist M&E

engineer whom it appointed to its technical team in 2008-2009. Therefore, the submissions on this issue of causation in Currie & Brown's closing statement were made on behalf of Currie & Brown by its legal representatives purely on the evidence which has been led before the Inquiry. They are not the result of any specialist subject matter knowledge.

It is, of course, for ZBP, the M&E engineers who devised and proposed the alternative design solution which became the ventilation derogation, and who designed the ventilation system on behalf of Multiplex, to explain and defend that design solution. Indeed, TÜV SÜD has done so on behalf of ZB in its own written submissions. It's noted that TÜV SÜD has also adopted the bulk of Currie & Brown's submissions on this particular issue in their supplemental statement.

Currie & Brown's submissions on this issue were addressed by Counsel to the Inquiry in paragraphs 54 to 60 of their written response to the core participants' closing statements. In these paragraphs, Counsel to the Inquiry----

THE CHAIR: Sorry, my fault, Ms McCafferty. You're referring to Counsel to the Inquiry's-- which----

MS MCCAFFERTY: It's their written response to the core participants' closing statements, which was produced, I believe, last week----

THE CHAIR: Right.

MS MCCAFFERTY: -- and it's paragraphs 54 to 60.

THE CHAIR: -- I'm with you now. I've not seen that document, but that's not a problem. I think we identified it yesterday morning. This is Counsel to the Inquiry attempting to deal with matters of a more technical and detailed matter. Right.

MS MCCAFFERTY: Yes. Indeed.

THE CHAIR: I'm now with you.

MS MCCAFFERTY: I'm grateful, my Lord. Yes, there are lots of different documents flying around.

THE CHAIR: Yes, and, as I say, I have not yet seen this, but that's not a problem.

MS MCCAFFERTY: I'm grateful, my Lord. For your Lordship's note, it's paragraphs 54 to 60 of that document, where Counsel to the Inquiry address Currie & Brown's submissions on this issue. As your Lordship will see in due course, in those paragraphs, Counsel to the Inquiry limited its comments to the discussion of Professor Humphreys' written and oral evidence, which appear in Currie & Brown's closing statement.

In respect of part, although not all, of Professor Humphreys' evidence, Counsel to the Inquiry have a different

interpretation of what he said. That's a matter of textual interpretation. Currie & Brown stands by the interpretation it places on Professor Humphreys' evidence in paragraphs 17 to 23 of its closing statement. All that Currie & Brown would say on this point is that it's submitted that Counsel to the Inquiry's interpretation of Professor Humphreys' evidence is not consistent with his acceptance in oral evidence that the principal purpose of flow rate in general wards or non-isolation rooms is to ensure the comfort of patients, and that's opposed to the safety of patients, my Lord.

THE CHAIR: So your submission relates to what Professor Humphreys said, not what Mr Hoffman said?

MS MCCAFFERTY: I'm speaking specifically about Professor Humphreys at this point.

THE CHAIR: Right. Okay.

MS MCCAFFERTY: As your Lordship will have seen in our written closing statement, we do go on to draw some parallels between what Professor Humphreys says and what Peter Hoffman says on these points. That's not a matter which Counsel to the Inquiry addressed in either its written response or in its oral submissions yesterday, so there's nothing more for me to say on that point, but the point I made there

about Professor Humphreys' oral evidence is a point which we have set out in paragraph 21.5 of our written closing statement. That's where your Lordship will find the quotation that I read out from Professor Humphreys' evidence.

What it all boils down to, my Lord – the reason why we say this is important – is that, on the evidence available, it's submitted by Currie & Brown that it cannot be said that any or every reduction in air change rates will necessarily make a space less safe for patients to any material degree. That's the essential point which we make in our written closing statement in respect of this issue.

In that regard, I note that Counsel to the Inquiry state in paragraph 49 of their written response to the core participants' closing statements that they share GGC's view that a non-compliant ventilation system does not necessarily mean that the ventilation system is unsafe for all patients. That careful formulation of words is, in my submission, consistent with the submissions that Currie & Brown have made in respect of this issue.

I would also suggest that the submissions that Currie & Brown make on this issue are consistent with the conclusions in your Lordship's interim

report in relation to the Edinburgh hospitals. Your Lordship concluded that more research is needed on this topic, that the scientific basis for the current recommendations as to particular ventilation parameters is limited and depends to a significant extent on work in the early 1970s, when hospital environments were very different. The reference is to page 13 of your Lordship's interim report, in the executive summary.

Some of the evidence that Currie & Brown has highlighted in paragraphs 7 to 10 and 12 to 37 of its written closing statement had not yet been heard at the time of your Lordship's interim report. This is why Currie & Brown would respectfully invite your Lordship to consider the evidence that we have summarised and to revisit the relevant parts of the interim report, if or where appropriate.

The crux of Currie & Brown's case on this issue is that the evidence now before the Inquiry is not sufficient to reliably found any conclusion that the agreed and mitigated reduction in air change rates from 6 to 2.5 air changes per hour in standard rooms in general wards had the effect of increasing the risk to any cohort of patients to any material degree.

THE CHAIR: Can I just take that

from you again, Ms McCafferty?

MS MCCAFFERTY: Yes.

THE CHAIR: On the basis of the evidence now led, the reduction in respect of general wards of an air change rate of 6 to an effective air change rate of 2.5, or 3 at the best-- Then if you would go on with your submission?

MS MCCAFFERTY: So, my submission is that the evidence now before the Inquiry is not sufficient to reliably found any conclusion that that reduction in air change rates from 6 to 2.5 air changes per hour in standard rooms in general wards had the effect of increasing the risk to any cohort of patients to any material degree.

THE CHAIR: Why do you introduce the reference to "any cohort of patients"?

MS MCCAFFERTY: The reason----

THE CHAIR: I mean, do you mean any sort of patient who might find themselves in a general ward?

MS MCCAFFERTY: Indeed, my Lord, yes----

THE CHAIR: Right. Okay.

MS MCCAFFERTY: -- a standard room in a general ward. That's an important qualification which your Lordship picked up on in questions to Counsel to the Inquiry yesterday. I'm

going to come on to look at one of those examples where your Lordship picked up on that distinction, which is, in my submission, important because the ambit of the ventilation derogation was limited to standard rooms in general wards.

Now, in oral submissions yesterday, Counsel to the Inquiry looked at paragraph 16.2 of Currie & Brown's written closing statement and, there, Counsel to the Inquiry took issue with Currie & Brown's statement that SHTM 03-01 is non-mandatory guidance. However, that statement is correct as a matter of fact, and paragraph 16.2 of Currie & Brown's closing statement provides a reference to where that appears in the text of the SHTM and also provides references to where this was confirmed by the experts. So it's correct that SHTM 03-01 is non-mandatory guidance. For the avoidance----

THE CHAIR: I don't think-- I mean, you're pushing at an open door if the point is, if you open the memorandum, that's what it says in terms, and you're about to tell me what follows from that.

MS MCCAFFERTY: Well, what I'm about to say is that it's also correct that the employer's requirements required the contractor to comply with the guidance in SHTM 03-01. Those two separate statements are distinct, and they are not mutually exclusive. Indeed, Currie & Brown has set out in its written evidence that it was an express requirement of the employer's requirements that the contractor comply with SHTM 03-01. For your Lordship's note, the best place where that's set out is in paragraph 50 of Mr David Hall's first statement for Currie & Brown, which appears in the Glasgow IV Part 1 witness statements bundle, volume 2, document 6, page 210.

It's important to be clear that the ventilation derogation was derogating from that requirement in the employer's requirements to comply with the guidance in SHTM 03-01. That derogation was then recorded and agreed in the relevant clarification logs, which then formed part of the main contract with Multiplex. I submit it's relevant, nevertheless, for Currie & Brown to note that SHTM 03-01 is non-mandatory when discussing whether it was reasonable and acceptable in the circumstances for the derogation that was proposed by Multiplex to be agreed and approved, but that's as far as that point goes.

Counsel to the Inquiry also commented on paragraph 37 of Currie & Brown's closing statement. During that discussion, your Lordship asked whether paragraph 37 of our closing statement proceeds on the basis that the ventilation

derogation had no application to specialist areas, and that's the point that I said, a few moments ago, I would come back to. In my submission, your Lordship is correct. Paragraph 37 of our closing statement does indeed proceed on the basis that the ventilation derogation had no application to specialist areas.

In that regard, Counsel to the Inquiry said that this raised a question, namely: were they all general wards? Now, the answer to that question is, of course, no, and it was for GGC's user groups, amongst others, to identify which areas of the hospital were to be specialist rooms, which were to be specialist wards, and it was for the designer, Multiplex and ZBP, to interpret those requirements accordingly. The obligation to comply with SHTM 03-01 in respect of those specialist areas continued and was not derogated from because the ventilation derogation, in terms, applied only to standard rooms in general wards.

I propose now to move on to the second part of my second topic, which is the process of agreeing and recording the ventilation derogation. Counsel to the Inquiry disagreed yesterday with the submission made in paragraph 7.1 of Currie & Brown's closing statement that it was clear which parts of the hospital

the ventilation derogation applied to. As I've just stated, and as stated in paragraph 7.1, it's Currie & Brown's position that it was clear that the ventilation derogation applied only to standard rooms in general wards.

It was stated in paragraph 7.1, and your Lordship picked up on this, that it was common ground that this was the case. It was my understanding that it was common ground amongst those witnesses who were asked about this in oral evidence that the ventilation derogation applied only to standard rooms in general wards – in other words, to those areas in which the guidance in SHTM 03-01 recommended that 6 air changes per hour be provided. I may be mistaken that it was common ground amongst those witnesses – there have certainly been a lot of witnesses – but I don't believe that Counsel to the Inquiry has identified any witness evidence given on behalf of any participants in the design and construction of the project which suggests that the ventilation derogation was intended or understood to have had wider effect.

THE CHAIR: Do you have a convenient note of the witnesses who you suggest demonstrate the common ground? If you don't, I'll just move on.

MS MCCAFFERTY: I'm afraid I don't, my Lord. No, I didn't set that out in

detail. What I did set out in paragraph 77 of Currie & Brown's closing statement is the references to the documents that we rely upon as setting out the scope of the ventilation derogation. Those are the two clarification logs where it was recorded and ZBP's ventilation design strategy. In paragraph 77, we have highlighted the wording that we rely upon.

THE CHAIR: Thank you.

MS MCCAFFERTY: Now, Counsel to the Inquiry suggested yesterday that it would have been easier if someone had just said where we're applying it, where we are not applying it, and written it down. However, the documents that I've referenced in paragraph 77 of Currie & Brown's closing statement show that there was indeed a written record of where the ventilation derogation was to be applied. As I've said, this was clear from the face of the relevant clarification logs and from ZBP's ventilation strategy, which evidenced the technical rationale for the derogation. It's my submission that, it being clear to all involved in the project to which areas the derogation did apply, there was no requirement to expressly record all the various areas to which it did not apply.

I come on now, my Lord, to a submission that Counsel to the Inquiry made yesterday that Currie & Brown should have communicated or escalated the ventilation derogation to somebody higher up in GGC's hierarchy than Mr Seaborne and Mr Moir. I make three points in response to that submission.

The first is that there was no need to escalate that issue, so far as Currie & Brown was concerned, because it was already appropriately and properly recorded in the clarification log and the M&E clarification log, which formed part of the contract with Multiplex. This is a point which is explained in some detail in paragraphs 53 to 61 of Currie & Brown's closing statement.

The key point explained there is that recording derogations from employer's requirements in clarification logs is standard procedure in construction projects of this nature, and it's a process that is well-known in the construction industry and to professionals working in that industry and to their legal representatives. I submit that Counsel to the Inquiry has not adduced any evidence to dispute that.

THE CHAIR: I'm entirely prepared to take that as correct, Ms McCafferty. You're going to come on to perhaps the more important point as to why Currie & Brown should have any obligation to go anywhere in the Board's chain of command beyond the Project team, but if

Counsel to the Inquiry was to leap that hurdle, I take it you would accept that no generalist in the management structure of the Board would know anything about logs or the way that construction contracts are documented?

MS MCCAFFERTY: I imagine there will be, as your Lordship has said, some generalists within the Board who are not au fait with construction projects and construction contracts, who may not have heard of clarification logs or, indeed, NEC3 contract terms, but those were not the people who were tasked with the day-to-day work of----

THE CHAIR: No.

MS MCCAFFERTY: -- applying derogations and clarifications within the logs and ensuring that they were complied with.

I wanted to pick up on a point that your Lordship queried yesterday. Your Lordship asked whether you would be entitled to say that the ventilation derogation should have been highlighted somewhere other than in the clarification logs, when Currie & Brown and TÜV SÜD have submitted that the derogation was recorded in precisely the place where someone experienced in construction contracts would expect it to be recorded. Currie & Brown has also provided witness evidence to that effect, as well as submissions, and that witness

evidence is referenced in the closing statement.

Currie & Brown would respectfully submit that your Lordship was correct to raise that point. To clarify, for the avoidance of doubt, it is our submission that it would not be open to your Lordship, on the evidence before the Inquiry, to say that the ventilation derogation should have been highlighted in some other way than in the clarification logs or that recording it in the clarification logs was not an appropriate way to record it. There's no evidence and no assistance from any independent construction specialist to support the assertions that were made by Counsel to the Inquiry in that regard.

So, my Lord, that was the first point that I made in response to Counsel to the Inquiry's submission that Currie & Brown should have communicated or escalated the ventilation derogation higher up within GGC.

THE CHAIR: My fault in notetaking. You referred to witness evidence on the matter; I just failed to get the reference to that.

MS MCCAFFERTY: My Lord, yes, the witness evidence-- I don't have the paragraph numbers immediately to hand, but it is addressed in Currie & Brown's closing statement, and we provide references to the witness statements

there. I believe it may be addressed in paragraphs 62 to 63----

THE CHAIR: Right, thank you.

MS MCCAFFERTY: -- and 107 to 108 of Currie & Brown's closing statement, but, in any event, the references to the witness statements that we rely upon are given in that section of Currie & Brown's closing statement. We cite extracts from Mr Hall's witness statement and from Mr Baird's witness statement there, which deal with this point.

The second point that I make in response to Counsel to the Inquiry's allegation that Currie & Brown should have escalated the derogation higher up is that – and I say this appreciating that Counsel to the Inquiry was operating under constraints of time yesterday, but nevertheless – I would suggest that this allegation was made in somewhat vague terms. It's not been identified either orally or in the written closing statement of Counsel to the Inquiry what precisely it's said Currie & Brown ought to have done, or to whom they ought to have spoken, or when, or in what forum.

That's important because we've seen countless times during the evidence in this Inquiry that there was quite a complicated system of governance and internal reporting obligations within GGC's structure –

multiple different committees and subcommittees and working groups and so on. It was certainly difficult for some of us in the room to follow the various committees, and who was on them, and who reported to whom, and the changes to those committees during the course of the project.

It would, in my submission, similarly, have been difficult for Currie & Brown to have followed all of that in the course of the project, but they certainly didn't have the information to do so. I would suggest that this allegation appears to be at odds with Counsel to the Inquiry's conclusion in paragraph 1663 of their closing statement that responsibility for escalation of changes to the employer's requirements must lie with GGC's Project team and not with Currie & Brown.

THE CHAIR: Did I get that paragraph correctly? Is it 1663?

MS MCCAFFERTY: Correct, my Lord, yes.

THE CHAIR: Thank you.

MS MCCAFFERTY: Currie & Brown have addressed this point in paragraphs 62 to 63 and 107 to 108 of its closing statement in more detail, but what is explained there is that Currie & Brown did not know to whom within GGC the ventilation derogation had or had not been communicated. It was not for

Currie & Brown to challenge those whom they were tasked with working, Mr Seaborne and Mr Moir, about whether they had followed any internal reporting or internal governance procedures which might apply. Those procedures, as I've said, were outside Currie & Brown's knowledge, in any event.

Currie & Brown had no authority to raise this with anyone else in GGC, even if they'd known who the appropriate person or forum might have been, which they did not. Currie & Brown was not part of or privy to GGC's internal governance arrangements. Currie & Brown was an external third-party corporate entity who could only act on its client's instructions, and its authority extended no further. If this allegation were to be pursued, then it would need to be explained with more specificity what exactly Currie & Brown ought to have done but did not do.

THE CHAIR: What I suppose this suggests to a legal observer is the problems associated with imposing general duties of care under reference to negligence within a contractual structure. I mean, to be less opaque, it becomes a bit complicated if you have a written contract and yet, in parallel to that, other obligations.

MS MCCAFFERTY: Absolutely, my Lord. That really brings me to the

third point which I was going to make, which your Lordship has already alluded to both yesterday and today, which is that-- and my submission is that this point is fatal to this allegation, and that's that Currie & Brown had no contractual obligation to communicate or escalate the ventilation derogation to anyone within GGC beyond agreeing it with the project director with whom they were working and recording it in the relevant clarification logs.

It's important to note that Counsel to the Inquiry have not cited any term in Currie & Brown's appointment document to support any suggestion that they had any contractual responsibility for escalation, for communicating matters up the hierarchy to the Board, or to anyone higher up than the project director and project manager they were working with. Currie & Brown made that point in paragraph 62 of its closing statement, and still no contractual obligation has been identified to support this.

What was instead said in oral submissions yesterday was: if Currie & Brown was assisting with project management, particularly under pressure of time, is it unreasonable for Currie & Brown to check that these things have been done? That comes back to the point your Lordship was making a few moments ago. With respect, that's not

the correct test or an appropriate test for whether Currie & Brown was under any obligation, or whether it was in breach of any such obligation. In any event, Counsel to the Inquiry has not pointed to any evidence to suggest that Currie & Brown had any reasonable grounds to believe that Mr Seaborne and Mr Moir were not discharging their internal reporting obligations appropriately, or to suggest that the relevant stakeholders had not been apprised of and approved the ventilation derogation.

My Lord, I'm going to come on now-- I'm still sticking with the ventilation derogation, but come on to another point. I wonder, looking at the time, whether that might be an appropriate moment to break.

THE CHAIR: Well, it certainly would be a break with tradition if we did not take a coffee break, but you've mentioned the expression "constraint of time" on a number of occasions, very correctly. If we take the usual 20 minutes, which would mean sitting again at 12, when would you anticipate finishing?

MS MCCAFFERTY: Well, my Lord, I would say that I am probably three-quarters of the way through what I wanted to say this morning. I have to say, I've not kept a close eye on what time I started, to be able to----

THE CHAIR: Well, my recollection is that Mr Gray finished-- I think you must have taken over from Mr Gray at about five to eleven.

MS MCCAFFERTY: Yes, I believe I've been going for 45 minutes. I think my slot was an hour, but I discussed with Counsel to the Inquiry I might go over that slightly because of some additional points that were made yesterday. I think I'm still on track to finish, perhaps, in another 15 to 20 minutes.

THE CHAIR: Right. Well, on that basis, we might try and aim for five to twelve.

MS MCCAFFERTY: I'm very grateful, my Lord. Thank you.

(<u>Short break</u>)

THE CHAIR: Ms McCafferty.

MS MCCAFFERTY: Thank you, my Lord. Before the mid-morning break, your Lordship asked for witness statement references in regards to the point that clarification logs, we say, are the appropriate place where derogations should be recorded. That appears in Mr Mark Baird's witness statement at paragraphs 80 and 84. The bundle reference is the Glasgow IV Part 1 witness statement bundle, volume 3, document 3, page 58 onwards. This is----

THE CHAIR: Thank you.

MS MCCAFFERTY: -- also covered in David Hall's witness statement, his first witness statement, at paragraph 68. That's in the Glasgow IV Part 1 witness statement bundle, volume 2, document 6, page 215. It was also confirmed by Emma White of IBI in her oral evidence, and an excerpt from that is quoted with the relevant references given in paragraph 54 of Currie & Brown's closing statement.

THE CHAIR: Thank you.

MS MCCAFFERTY: Thank you, my Lord. Returning to my submissions, as your Lordship will recall, I'm on the second part of my second topic, which is the process of agreeing and recording the ventilation derogation. We were looking, before the morning break, at the allegation by Counsel to the Inquiry that Currie & Brown ought to have escalated the ventilation derogation higher up the chain of command. In oral submissions yesterday, Counsel to the Inquiry also developed a similar allegation that Currie & Brown should have checked that GGC had obtained input from Infection Prevention and Control colleagues into the ventilation derogation before it was approved. This allegation is addressed in paragraph 66 of Currie & Brown's closing statement.

The same three points I made before the morning break apply equally to this allegation. I don't labour those, but I would simply repeat that, again, it has not been identified either orally or in written closing submissions what precisely Currie & Brown ought to have done that it did not. Again, no evidence has been adduced to suggest that Currie & Brown was ever aware that GGC had not obtained IPC input. The fact is that GGC approved the ventilation derogation. There was nothing to put Currie & Brown on notice that GGC had not gone through the proper channels or obtained appropriate input from all relevant stakeholders when it gave that approval.

In connection with this allegation, Counsel to the Inquiry said yesterday, and I quote:

> "… if you're under this pressure of time and someone has said 'IPC sign-off is required', is it not part of the project manager's job to say [whether this has been obtained]?"

The important point to stress is that Currie & Brown was not the project manager either before or after the award of the main contract award to Multiplex. As your Lordship has heard, the role of project manager, which is usually capitalised, is a specific role which is defined in the NEC3 standard terms of

contract. It's a defined role.

GGC was the designated NEC3 project manager named in the main contract with Multiplex, not Currie & Brown. GGC informed Currie & Brown that GGC was taking that formal role in its letter to Currie & Brown dated 18 January 2010, to which I have previously referred. Before the contract award to Multiplex, Currie & Brown was providing advisory services to GGC, but it was not part of Currie & Brown's role to be the project manager or to supervise or micromanage the discharging by GGC of its own responsibilities.

Now, finally on this second topic, I want to deal very quickly with one further point that emerged in this regard during this same discussion. Counsel to the Inquiry said that both Currie & Brown and TÜV SÜD had relied upon things said by Mr Calderwood of GGC. I want to clarify that Currie & Brown did not rely upon Mr Calderwood's evidence. On the contrary, there is only one reference to Mr Calderwood in Currie & Brown's closing statement. That's in paragraph 74, where Currie & Brown in fact corrected something that Mr Calderwood had said and which had been quoted, without comment, in paragraph 553 of Counsel to the Inquiry's written closing statement.

I turn now, my Lord, to my third and

final topic, which is an oral submission that was made by Counsel to the Inquiry yesterday that Currie & Brown did not address in its closing statement the issue that David Hall of Currie & Brown had signed off design drawings on behalf of GGC for clinical functionality. Now, the reason that Currie & Brown did not address this in its written closing statement was because it appeared that no criticism of Currie & Brown was made in this regard in Counsel to the Inquiry's written closing statement. It was therefore understood that Counsel to the Inquiry had accepted, or at least did not challenge, the evidence of Mr Hall on this point, evidence which Counsel to the Inquiry quoted extensively in its own closing statement.

I've gone back over Counsel to the Inquiry's closing statement overnight and searched for the references to clinical functionality. You'll be pleased to hear, my Lord, I won't go through all of them but, for your Lordship's note, I'm going to pick up on some of the key ones, some of them briefly, some in a little bit more detail, but I'll try to take this quickly.

Paragraph 735 of Counsel to the Inquiry's closing statement and paragraph 1467 cite Mr Hall's evidence in relation to his signing off of drawings for clinical functionality. There is no disagreement with that evidence in those

paragraphs, or any criticism of Currie & Brown.

In paragraph 1476, under the heading, “Clinical Functionality”, there is a citation of the contractual definition of the term “clinical functionality”. The following paragraph, paragraph 1477, then says that this definition is “generally consistent” with the evidence, “particularly by Mr Hall”, about the ambit of GGC’s responsibility to review the design drawings for clinical functionality. So there’s no suggestion that Mr Hall’s evidence is incorrect and no criticism there of Currie & Brown.

Paragraph 1559 again cites Mr Hall’s evidence. It is suggested there generally that the contractual definition of “clinical functionality” may not be as clear as it might be, or as clear as Mr Hall and others understood it to be, but the point is not taken any further than that. Again, no criticism of Currie & Brown.

Similarly, paragraph 1562 again cites Mr Hall’s evidence and suggests on a general level that there seems to be a “lack of consensus”. But, again, the point is not taken any further, and no criticism is made of either Mr Hall or Currie & Brown.

Now, importantly, a few paragraphs later, from paragraph 1565 onwards, Counsel to the Inquiry then accepts that it was not Currie & Brown’s role to review the M&E design or to advise GGC on the M&E design during the design and construction phase. That’s important because it appears, therefore, to be accepted that, as Mr Hall said, he was merely reviewing clinical functionality on behalf of GGC and had no obligation--there was no obligation on Currie & Brown to review the technical detail of the M&E design.

There’s a couple of other references. Paragraph 1567 and 1777----

THE CHAIR: Could you give me--There’s 1777.

MS MCCAFFERTY: Yes.

THE CHAIR: The previous paragraph?

MS MCCAFFERTY: 1576.

THE CHAIR: Thank you.

MS MCCAFFERTY: I mention those just for completeness. There’s, again, nothing there that takes the point forward. So, the upshot of my review of Counsel to the Inquiry’s closing statement, again, is that I can’t identify any specific criticism of Currie & Brown with reference to this issue or any material disagreement with Mr Hall’s evidence. Listening back again to the recording of yesterday’s oral submissions, again, I could not discern any specific criticism then. What Counsel to the Inquiry said yesterday

was-- he said:

> "Mr Hall says that he told everybody … that the only thing they were signing off was clinical functionality [but] his signature appeared on [some drawings] … if he signs them, they have a contractual effect … he signs them [status] A, B or C."

Now, this latter point is incorrect. It was the design and build contractor, Multiplex, not Currie & Brown, who signed off design drawings status A, B or C. Mr Hall explained this in his second witness statement, which was produced to respond to a supplemental questionnaire provided to him by the Inquiry a few months ago. The reference is paragraphs 23, 24, 28, 42 and 43 of that statement. This is in the Glasgow IV Part 3 witness statement bundle. It's volume 7, document 3.

Now, the key point here is that Mr Hall has explained very clearly in his written and oral evidence that he signed certain drawings on behalf of GGC under delegated authority from GGC, but that, in accordance with that authority, he was reviewing and signing those drawings only for clinical functionality as defined in the relevant terms of the main contract. His review of those drawings was not for technical detail of the design.

There is no case put in Counsel to the Inquiry's closing statement to suggest now that his actions or that Currie & Brown's responsibility went any further than that. The key paragraphs to note in Mr Hall's first witness statement where he makes this point are paragraphs 15, 101 to 103, 105, 120, 124 and 153. That statement can be found in the Glasgow IV Part 1 witness statement bundle, volume 2, document 6. Currie & Brown respectfully submits that Mr Hall's evidence on this point, which has been extensively cited in Counsel to the Inquiry's closing statement, should be accepted.

My Lord, I've come to the end of my oral closing submissions, unless your Lordship has any further questions for me.

THE CHAIR: No. No, I don't think I have, Ms McCafferty. I'm very grateful for your written statement and your oral supplement.

MS MCCAFFERTY: Thank you very much indeed, my Lord. I'm very grateful for the opportunity to address your Lordship.

THE CHAIR: Good afternoon, Mr MacLeod. You appear for IBI.

Closing submissions by Mr MacLeod

MR MACLEOD: I do, my Lord.

Thank you. My Lord, it is sometimes difficult to believe that four and a half years have passed since the Glasgow I hearings, but the accounts of those who spoke with such dignity at that and subsequent hearings, notably the deeply moving and courageous account of Molly Cuddihy, remain fresh in the memory, and IBI wishes to express its sympathy to all those affected.

My Lord, IBI's primary objective, made clear from the outset, has been to assist this Inquiry in fulfilling its remit. To that end, Ms Emma White provided a very comprehensive statement, running to 247 pages. She also provided a whole day's evidence on 13 May last year. In my submission, her testimony was provided in a clear, comprehensive, and helpful manner. In these circumstances, my Lord, it is perhaps unsurprising that, at paragraph 1548 of their submission, Counsel to the Inquiry submit that Ms White "went out of her way to assist the Inquiry…" These words were echoed yesterday in the comments of Mr Connal KC. It is hoped that your Lordship takes a similar view of her contribution.

THE CHAIR: I do.

MR MACLEOD: A written submission has been lodged on behalf of IBI, and I formally adopt that. As I understand it from reading the document

that Ms McCafferty KC mentioned earlier, which is a Counsel to the Inquiry response to submissions by all core participants that your Lordship has not yet had the chance to read, no issue is taken with anything stated within IBI's submission. However, there is an issue canvassed yesterday upon which your Lordship suggested that some more detail might be helpful. In particular, paragraph 11.1.3 of IBI's submission draws the Inquiry's attention, and no more than that, to the principles of the "golden thread" of fire and safety design in higher-risk buildings introduced under the Building Safety Act 2022.

Now, it should be said at the outset, my Lord, that the golden thread is entirely a creature of statute. The Building Safety Act, as I said, of 2022 and subsequent regulations that apply to so-called higher-risk buildings in England-- the Act does not impose a corresponding duty in Scotland. The suggestion, however, is driven by Ms White's experience in England, where most of her work is conducted, but it is a concept that she and IBI are familiar with, and it is their view that the Inquiry may derive some benefit in considering whether parts of it are worthy of incorporation into a Scottish setting.

Central to that golden thread is a requirement for a digital and secure

chain of information about higher-risk buildings from design and construction, potentially through to the occupation stages. That ensures accurate and accessible records for identifying and managing structural safety risks, potentially throughout the whole lifecycle of the building, all as a means of ensuring that the right people have the right information about the building when they need it. Put shortly, my Lord, information about a building must be stored and managed in such a way that it is: first, kept digitally; secondly, secure from unauthorised access; thirdly, so that it is available when someone needs the information; fourthly, presented in a way that someone can use; fifthly, and this is the phrase used in the Government's explanatory note, that it is a "single source of truth for that building"; and, finally, that it is accessible by providing the information in a simple format that is easy to understand and written in plain English.

Whilst the Act was principally a response to the Grenfell Tower tragedy, its subsequent regulations, notably The Higher-Risk Buildings (Descriptions and Supplementary Provisions) Regulations from 2023, confirm that healthcare facilities – and there is no doubt that this hospital would have fallen into this category – also need to comply with the

stringent high-risk building regime in England during the design and construction phases of the project.

In Scotland, building safety, as I say, is a devolved matter and regulated through the Building (Scotland) Act 2003, its associated regulations, guidance and enforcement mechanisms. Since that time in 2003, these regulations have introduced several reforms focusing strongly on information assurance, regulatory strengthening, as it were, and, post-Grenfell, the safety of cladding. The Scottish Government has introduced a compliance plan approach, a CPA, that is a quality assurance system aimed at improving transparency and accountability in higher-risk building projects and, consequent to that, a new role of the Compliance Plan Manager, or CPM. Voluntary adoption of that approach is to start in March of this year, ahead of a future mandatory regime and potentially legislation at some time in the future, although I've looked to see when that is likely to come in and I can't find it.

THE CHAIR: Just so I'm following, Mr MacLeod----

MR MACLEOD: Yes.

THE CHAIR: -- the Scottish-- well, they are more than proposals.

MR MACLEOD: Yes.

THE CHAIR: Well, they may, strictly speaking, be no more than

recommendations at the moment. Where do I find them articulated?

MR MACLEOD: They are readily available on the internet.

THE CHAIR: Right. As a Scottish Government policy document?

MR MACLEOD: As a-- Well, the way I looked at it in the short time available to me was actually information provided to end users, to builders and the like.

THE CHAIR: Okay.

MR MACLEOD: But one of your Lordship's team could doubtless find it----

THE CHAIR: Yes, we can pursue that.

MR MACLEOD: Yes, much more quickly than I could. I think, importantly, if I may say so, my Lord, the scheme in Scotland will categorically refer to hospitals, and the compliance manager, the plan manager, acts as the coordinator of compliance and will be required – that's the CPM will be required – to do three things that are relevant: firstly, to demonstrate that the building complies with the primary legislation as it presently stands in the 2003 Act; secondly, to reduce the risk of non-compliant work during the design and construction phase; and, thirdly, to provide coordination, oversight and information management across the

project, ensuring that all compliance processes are in place and followed.

But, my Lord, and stressing that IBI is simply providing food for thought for your Lordship, the Inquiry might consider that some elements of the English golden thread regime could be imported into Scotland's building standards system and particularly into this, as it appears to be, emerging CPA model in Scotland. I say that because, as I read them and as IBI read them, the anticipated proposals in Scotland, whilst focusing on oversight of the compliance processes, do not require a digital recordkeeping or a lifecycle information assurance comparable to the golden thread system, all these matters that I referred to earlier, albeit that there is some documented compliance evidence that will still be required.

If Scotland embedded the requirements of digital, durable and accessible records throughout the design, construction and occupation stages into those duties in Scotland, it is possible at least that this could strengthen compliance processes on buildings such as the Queen Elizabeth Hospital and go some way to ensuring that it can be made easier for everyone involved to understand the technical detail. Your Lordship will remember the requirement for plain English and,

indeed, keeping documents in the one place, not least as it relates to ventilation and water systems.

One thinks, hearing Counsel to the Inquiry speaking yesterday about the derogations, and looking as I did at the evidence of Ms White from May of last year, he focused at that time with her on the whereabouts of information about the derogation. If I can quote him, my Lord. This is Mr Connal KC to Emma White:

> "I ask you that [he says], because one of the questions that we debated long and hard at the last session … was, if you're going to derogate from something like that, please try and make it clear who's agreed it and record it somewhere. I just wondered where that one might be."

Ms White completely agreed with him and said it was normal to have, for example, "a derogation schedule that is more transparent [as she put it], that you can see all of the decisions". There are other instances, I think, in the course of the evidence, such as who signed off the Room Data Sheets and the like, where there is perhaps – and it's entirely a matter for your Lordship – a degree of uncertainty as to where and when that was done and by whom. Of course, it might have made your Lordship's job a little bit easier too, during the course of this Inquiry, although that would not be a basis, of course, for suggesting this, but I submit that this is worthy of some consideration, at least, by the Inquiry.

If your Lordship wishes more information about it – because this was mentioned in IBI's submission but not in any great detail, and your Lordship, yesterday, asked for further clarification – the simplest thing to do, if your Lordship desired more information from, as it were, this side, would be for the provision of a supplementary witness statement by Ms White. Mr Gray KC earlier suggested, from his perspective, that sort of additional submission, but of course here we're talking about Ms White's opinion, and I suppose that would be evidence rather than a submission from me, if your Lordship----

THE CHAIR: Well, essentially it's provision of information.

MR MACLEOD: Yes.

THE CHAIR: I mean, I suppose that's evidence of a sort. I would welcome that and, as with everything else, it would be disclosed to others, and if something arose out of it, no doubt we could deal with that. So I would welcome that, Mr MacLeod.

MR MACLEOD: That is all that I propose to say by way of submission at this point, unless there are any questions upon which I can assist your Lordship.

THE CHAIR: No. I was very interested in the reference to the golden thread. However, having taken the fairly modest step of having looked at the Building Safety Act and seeing that it's a very substantial piece of legislation, I appreciate further guidance, and I'm going to get further guidance beyond that. So, if there's nothing else that you wish to add, Mr MacLeod----

MR MACLEOD: Nothing from me.

THE CHAIR: -- thank you very much. (After a pause) Thank you. Good afternoon, Ms Doherty. Now, you represent NSS.

Closing submissions by Ms Doherty

MS DOHERTY: Yes, my Lord. I appear for NSS along with Mr Gardiner. Your Lordship has NSS's written closing statement, which I formally adopt. I do not propose to repeat it, but I will use this opportunity to give short oral submissions to address three matters: first, I'll briefly set out a forthcoming change to NSS's name; secondly, I'd like to comment on a number of points that may assist the Inquiry; and, thirdly, I will respond to some points raised by other core participants' closing statements.

So, first, my Lord, the change to NSS's name. So, we represent NHS National Services Scotland, who we're calling "NSS", the common name for the Common Services Agency. NHS Scotland Assure was created in June 2021, and it is a directorate of NSS. Three parts of NHS Scotland Assure have been involved in this Inquiry: (1) the Antimicrobial Resistance and Healthcare Associated Infection – that's ARHAI; (2) Engineering; and (3) Property Sustainability and Capital Planning.

There has also been mention of Health Facilities Scotland and Health Protection Scotland. Health Facilities Scotland was a division of NSS, which was wholly subsumed into NHS Scotland Assure when it was created. Health Protection Scotland was also a division of NSS and included ARHAI. In April 2020, much of the function of Health Protection Scotland, excluding ARHAI, became part of the new Public Health Scotland, a separate health board. In June 2025, it was announced by the Scottish Government that, as part of the Health and Social Care Service Renewal Framework, NSS is to merge with NHS National Education Scotland. It's known as NES.

Now, this is unlikely to have a major effect on the delivery of services by NHS Scotland Assure and its departments. It does, however, mean that the name "NSS" is likely to disappear. It is

expected that the Common Services Agency will continue to exist as an entity, but it will encompass the services of NHS National Education Scotland, and it is likely to have the new common name "NHS Delivery".

Now, my Lord, that was just setting that out because, by the time my Lord's report comes out, NSS----

THE CHAIR: No, it's very helpful. I have to say that at various stages in the Inquiry I've had to go back and re-educate myself as to what is a changing environment----

MS DOHERTY: Yes.

THE CHAIR: -- and quite a complicated environment.

MS DOHERTY: Yes, my Lord.

THE CHAIR: I suspect I'll go to the transcript of what you've just said to reassure myself, but you make important points.

MS DOHERTY: Thank you, my Lord. So, if I turn to the second area which I'd like to address, which is points which we hope may assist the Inquiry. My Lord yesterday asked counsel for NHSGGC to comment on the relevance and utility of various policies, standards, statutes and reports of other public inquiries, and NSS has also been invited to comment on these for an understanding of what is envisaged by the terms of reference as a suitable

environment for the delivery of safe, effective, person-centred care in contemporary Scotland.

NSS considers the policies, standards, statutes and reports of other public inquiries to be relevant and useful, but does note that they're not exhaustive, and technical standards and guidance may also be relevant and useful – for example, SHTMs and British standards.

THE CHAIR: What I had in mind, in trying to understand – well, really as you've just said – what is meant by a suitable environment for the delivery of safe, effective, person-centred care-- I take your point that anything that I may have put forward is not necessarily comprehensive.

MS DOHERTY: Thank you, my Lord. Another point arises in relation to the CLABSI QI project. Now, as regards whether the CLABSI QI project is a paradigm for how one achieves a safe environment, NSS notes that the CLABSI project focused on a single, well-defined process. It was a project about safe practice rather than about safe environment, and achieving an overall safe environment is far more complex, involving a broad systems approach that addresses diverse risks, cultural and behavioural change, infrastructure, and continuous learning.

Moving on, in its----

THE CHAIR: I take that point. One might immediately take the point that the CLABSI project, as spoken to by Ms Roger, is-- it's fairly narrow objectives and possibly dealing with much more limited parameters than safety in the context of physical-- well, delivery of care within a particular infrastructure. But what one might take from Ms Roger's evidence is the objective of pursuing greater safety. I mean, what she described was, first of all, not being satisfied with the 3 per cent per thousand infection days and pushing to achieve 1 and then pushing beyond that. In other words, the notion of safety as a commitment to improvement. Now, one might see in that an insight into safety, or one might argue that.

MS DOHERTY: I think that's right, my Lord. I think achieving an overall safe environment is complex, but it's something that one would keep striving for----

THE CHAIR: Yes.

MS DOHERTY: -- and not think, "Well, that's good enough," and I think that can certainly be taken from that project.

Moving on now, my Lord, in its closing statement, NHSGGC at paragraph 2.2 states that:

> "Infection prevention and control is multifactorial. It goes well beyond the physical systems within a building. It includes culture, communication and attitude."

NSS just wants to point out that it does agree with that statement. Given that, the question arises whether any determination on the safety or otherwise of a hospital requires a view to be taken on the culture and attitude of those managing the hospital and the effectiveness of their communications. NSS agrees that, when assessing whether a building is safe, human factors such as leadership, communication and risk management must be considered, and this assessment should be anchored in clinical working practices and methodologies for healthcare built environment use to ensure infection prevention and control measures are effectively applied.

So, in simple terms, the approach should mirror fire safety, emphasising awareness and responsibility across all levels. However, competency is equally critical. Beyond awareness, those involved must possess the necessary knowledge, skills, qualifications and experience to implement and maintain appropriate control measures.

Now, reference has been made to the Standards for Healthcare Associated Infections issued by HIS in February

2015, which include the statement, “The prevention and control of infection is everybody’s responsibility”, and NSS agrees with this and agrees that it has an application as to how a health board should respond to expressions of concern by staff in relation to infection prevention and control. Effective infection prevention and control requires constant action at all levels of the health system, including policymakers, facility managers, health workers and those who access health services. This principle that prevention and control of infection is everybody’s responsibility means that safety is not only about systems and infrastructures, but also about how concerns are managed.

Expressions of concern from staff should be treated seriously, acknowledged promptly, and escalated through clear reporting pathways. Responses should be transparent, supportive and solution-focused, ensuring staff feel heard and confident that issues will be addressed. This approach reinforces a culture of safety, accountability and continuous improvement. NSS agrees that an institutional willingness to listen to expressions of concern on possible adverse impact on patients is a factor in ensuring the safety of a hospital.

So, NSS has been asked if it

agrees with the proposed recommendation by Dr Peters, Dr Redding and Dr Inkster that IMTs should only be chaired by someone who is appropriately qualified. NSS agrees with that proposed recommendation. The individual should have strong expertise in infectious disease control and outbreak management. The individual should have proven leadership and decision-making skills and experience of coordinating multidisciplinary teams.

The National Infection Prevention and Control Manual provides at paragraph 3.2.2 – that’s “Investigation, management and communication” – that:

> “In the NHS hospital setting the [infection control doctor] will usually chair the IMT and lead the investigation of healthcare incidents.”

My Lord, the last note that we have of providing the Inquiry with a version of this manual was in bundle 19 for the Glasgow III hearings, which started on 19 August 2024. It was document 24, page 459. As has been said in evidence, it is a live document, so there may be an updated version online, but that was the last version we think we provided to the Inquiry.

THE CHAIR: That was in bundle 13?

MS DOHERTY: Sorry, bundle 19

for Glasgow III, document 24, page 459.

THE CHAIR: Thank you.

MS DOHERTY: NSS also say that, where there are implications for the wider community, for example with tuberculosis or measles or rare events such as hepatitis B or HIV lookback, or where there's an actual or potential conflict of interest with the hospital service, then the consultant in public health medicine may chair the IMT. NSS does not consider that, where the chair is not appropriately qualified, it is sufficient to have a deputy who is. The chair requires to have the appropriate qualifications.

Now, turning to the Case Note Review, there was evidence that in April 2021 the Board of NHSGGC accepted both the recommendations and the conclusions of the Case Note Review. But there was also separate evidence, which was alluded to earlier today, that while accepting the recommendations of the Case Note Review, the Board, or at least the Executive team, was more uncertain about the conclusions. I think it was said that they wanted to get their own view.

NSS considers that this apparent inconsistency does raise issues to be resolved, but considers that other core participants will be better placed to assist the Inquiry with these issues. Counsel

on behalf of NHSGGC this morning, I think, left it to my Lord to determine on the evidence. I'm afraid NSS can't help any more than that but does agree that there is an inconsistency in the evidence on this. NSS does agree with Counsel to the Inquiry's approach regarding the use of the Case Note Review conclusions.

Now, something that arose earlier this morning, my Lord: counsel on behalf of NHSGGC was asked about the completion of the HAI-SCRIBE documents.

THE CHAIR: Yes.

MS DOHERTY: I think my Lord mentioned that Stage 1 of the HAI-SCRIBE was completed possibly by Annette Rankin.

THE CHAIR: Yes, that is what I said. Am I wrong?

MS DOHERTY: Well, I've been asked to remind your Lordship that, in her evidence, Annette Rankin made it clear that she did not undertake such a process and, in fact, she's never undertaken any HAI-SCRIBEs.

THE CHAIR: Right.

MS DOHERTY: So, I can refer your Lordship to Annette Rankin's evidence, her transcript on 19 August 2025. It was columns 129 and 130 where there's that discussion about her involvement or not in the HAI-SCRIBE.

THE CHAIR: Can I just take that

again?

MS DOHERTY: Yes.

THE CHAIR: 19 August----

MS DOHERTY: 19 August ’25, columns 129 and 130.

THE CHAIR: Right. Right, did I simply just make that up, or was----

MS DOHERTY: It was put to her because I think there’s some-- her signature is in some documentation and----

THE CHAIR: Right, yes.

MS DOHERTY: -- it was put to her in evidence, and she was-- as I say, it’s clear from that part of the transcript she was adamant she’s never been involved in HAI-SCRIBEs.

THE CHAIR: Right.

MS DOHERTY: The only other thing about the HAI-SCRIBE: I think counsel on behalf of NHSGGC said something this morning about it being a relatively new process at the time. I think that’s right and that’s accepted, and it is something that evolved over time, but NSS’s position is that boards were always expected to work together to identify and manage the infection control risks in the built environment. So, even though the HAI-SCRIBE was a relatively new process, there were other things in place.

THE CHAIR: Yes, like the evolution of NSS, I have to keep going back to these foundation documents. My possibly imperfect memory is that it’s a 2007, is it, SHF-- 30?

MS DOHERTY: SHFN 30? Yes.

THE CHAIR: Yes, in a 2007 version, which perhaps follows on an earlier document which did not have the HAI-SCRIBE process, I think, but I may be wrong.

MS DOHERTY: I think you may be right about that, my Lord----

THE CHAIR: Right.

MS DOHERTY: -- but certainly I think the SHFN 30 guidance evolved over time, I think, and HAI-SCRIBE came in as part of that. I think all that was being said is that there was always an expectation-- although the guidance evolved over time, there was an expectation to work together to identify and manage infection control risks. I can’t take that any further, my Lord. It’s really just to make that point.

A matter that NSS has been asked to clarify at paragraph 56 of its closing statement: NSS refers to Gary Jenkins’ evidence on 16 September 2025.

THE CHAIR: Yes.

MS DOHERTY: Now, with apologies, that’s an incorrect reference, my Lord. The reference should have been to evidence by Jonathan Best on 19 September 2025. The page and column references are the same, but the

witness and the date was inaccurate.

THE CHAIR: Right. So it should have been Jonathan Best on the----

MS DOHERTY: 19 September 2025.

THE CHAIR: Right. So, if I go to that reference, I might----

MS DOHERTY: It might make more sense.

THE CHAIR: -- understand your point rather better.

MS DOHERTY: Yes.

THE CHAIR: I was a little confused.

MS DOHERTY: In that witness' evidence, there was reference to, I think, possible supervision by NSD, the National Services Division. So the point made in our written statement is that there's not a supervisory role, and it was really to flag up that.

THE CHAIR: Now, I have also to make the confession that I didn't recognise the acronym "NSD".

MS DOHERTY: **"**National Services Division" is what it stands for. I think it came up rather unexpectedly in that witness' evidence, my Lord.

THE CHAIR: Remind me what the National Services Division is, if you have that readily to hand.

MS DOHERTY: I can find it, or help to find it. Yes, I think that just really is as it says-- Actually, I don't think I

can, my Lord. All we say at paragraph 55 of our closing statement is that the National Services Division-- My Lord, yes, we do refer to it in 55.

THE CHAIR: (After a pause) Ms Doherty, it may be that your junior can do the necessary research over lunch----

MS DOHERTY: Yes.

THE CHAIR: -- and communicate to a member of the Inquiry team. It's just that I don't recognise that.

MS DOHERTY: Yes. Moving on, my Lord, there's an issue regarding the extent to which responsibility falls on the contractor and on subcontractors to draw areas of doubt to the attention of the client and to seek to obtain clear instructions. All NSS would do in this connection is draw attention to the relevant provisions in the NEC3 Engineering and Construction Contract. Clause 17 is titled, "Ambiguities and Inconsistencies", and 17.1 states that:

> "The Project Manager or the Contractor notifies the other as soon as either becomes aware of an ambiguity or inconsistency in or between the documents which are part of this contract. The Project Manager gives an instruction resolving the ambiguity or inconsistency."

THE CHAIR: Right.

MS DOHERTY: Clause 18 is titled,

"Illegal and Impossible Requirements", and 18.1 states:

> "The Contractor notifies the Project Manager as soon as he considers the Works Information requires him to do anything which is illegal or impossible. If the Project Manager agrees, he gives an instruction to change the Works Information appropriately."

In addition, my Lord, NSS observes that some subcontractors may have professional obligations specified in their institute or registration body's codes of conduct to raise matters they're aware of which are not in accordance with the contract or the law.

Now, moving on, my Lord, to the SBAR of November 2024, which was discussed in evidence. As regards the terms of that SBAR, which was in the name of NHSGGC IPCT, NSS has not seen or heard any evidence to support the accusations made in this SBAR against ARHAI, expert witnesses or whistleblowers, nor has NSS heard any explanation of the evidence on which NHSGGC based its assessment of the patient cases.

THE CHAIR: Yes, that's not a point I raised with-- or rather-- Well, it's not a point I raised with Mr Gray. So, we have the-- I mean, this was canvassed with Professor Gardner, but we have the assertions by the Infection Prevention and Control Team and on behalf of NSS. In relation to those parties who you represent, you're not aware of any basis for the assertions?

MS DOHERTY: That's correct. Following on from that, my Lord, NSS considers that it is fair to draw an analogy between the opinions expressed in the SBAR of November 2024 and the approach to the conclusions of the Case Notes Review spoken to in the oral evidence of Ms Grant. Both show a lack of acknowledgement of external expertise. Although not mentioned in its written closing statement, NSS wants to confirm that it agrees with Counsel to the Inquiry's proposed recommendations at paragraphs 1889 and 1890 of his closing statement.

THE CHAIR: Can you find that for me? Yes, I'm asking that to be identified for me. So that's 1889?

MS DOHERTY: 1889 and 1890.

THE CHAIR: Right. It's in relation to-- it's a proposed recommendation which-- and I'm reading, with a view to everyone following what we're talking about----

MS DOHERTY: Yes.

THE CHAIR: -- from Counsel to the Inquiry's closing statement in relation to Glasgow IV, paragraph 1889:

> "During the construction

phase, where there is a time gap between pressure testing and commissioning, a healthcare facility domestic water system must either (a) not be pre-filled, with all pressure testing of the water distribution system being carried out with air/inert gases (pneumatic testing), or (b) if the water system is pre-filled, then it must be managed from that point in compliance with SHTM 04-01…"

And you confirm your agreement with that recommendation?

MS DOHERTY: Yes, my Lord. My Lord, I can move on to the third chapter of my submission, which relates to responding to some points raised by other participants' closing statements, but I think I'll probably be 15 minutes or so, so perhaps this is a good time to stop?

THE CHAIR: Well, what we could do is break now and try and sit again at five to----

MS DOHERTY: Yes, my Lord.

THE CHAIR: -- five to two? I think we're on time. You were originally allocated to the afternoon.

MS DOHERTY: To the afternoon. So, yes, we're ahead of time, yes.

THE CHAIR: Very much on time. Right. Well, we'll take lunch now and try for five to two.

MS DOHERTY: Thank you.

(<u>Adjourned for a short time</u>)

THE CHAIR: Ms Doherty, I understand that I-- I think I failed to hear you completely. You were drawing my attention to the recommendation by Counsel to the Inquiry contained in paragraph 1889 and 1890. Now, I have to confess, I failed to hear the 1890. If I can just take us to that, the proposed recommendation for the Inquiry is:

"All major healthcare construction contracts must contain provisions mandating that all the requirements for an effective Planned Preventative Maintenance regime are in place, to the entire satisfaction of the Board and its Water Safety Group and Ventilation Safety Group, before the Board is required to accept handover."

NSS would endorse that?

MS DOHERTY: Yes, my Lord.

THE CHAIR: I suppose one should bear in mind that I think the Ventilation Safety Group is a concept which is first set out in the 2022 version of SHTM 03-01 and therefore wouldn't be applicable to the Glasgow contract.

MS DOHERTY: I think----

THE CHAIR: I think that-- Well,

we can always go and look at the document. Right. Now, you were moving on to----

MS DOHERTY: Yes, well----

THE CHAIR: -- your third topic.

MS DOHERTY: Just before I do that, my Lord, if I could just clarify the National Services' position, which-- I'd been clarifying or correcting what's at paragraph 56 of NSS's closing statement when there was an incorrect reference to evidence. I explained that it should have been a reference to the evidence of Jonathan Best on 19 September. In the written closing statement at paragraph 56, NSS seeks to clarify the role of the National Services Division, which is NSD, and my Lord asked me more about that division.

It's a division which supports the provision of specialist medical services, so it's involved in planning, commissioning and coordinating high-quality medical specialist services. An example would be screening programmes. It is not responsible for capital infrastructure, for building commissioning, for environmental systems such as water or ventilation. So, as set out at paragraph 56 of NSS's written closing statement, the Health Board remains responsible for ensuring that facilities and buildings are fit for purpose, and the reason that this

reference was made in paragraph 56 of the written closing statement to the witness evidence was there was a suggestion in the witness evidence-- well, there is a reference to NSD in the witness evidence, and that there was a concern that it might be misunderstood that National Services Division had more of an oversight of the service than I've indicated.

It wasn't something that was expected in the evidence. It wasn't picked up in questions to the witness. It was just to make sure everybody's aware that National Service Division's role would not have had a different role to what I have set out, and in the context this witness's evidence was in relation to, the move of the Bone Marrow Transplant Unit. That is a service that the National Services Division would have oversight of, but to the extent I've indicated, my Lord.

THE CHAIR: Thank you.

MS DOHERTY: Now, moving on, my Lord, to the third chapter of my submissions, which deals with points raised in other core participants' written closing statements. So, turning first to the written closing statement of NHSGGC. At paragraph 10.1, NHSGGC states that relationships between its:

"… IPCT and ARHAI became challenging over an extended period

of time. This ought not to have occurred. NHSGGC has engaged in work to rebuild relationships with ARHAI."

NSS wishes to make clear that ARHAI has always maintained a professional relationship with the NHSGGC IPCT. In its written closing statement at paragraphs 25 to 26, NSS referred to longstanding issues over NHSGGC's reporting of infections and to recent developments in collaborative working with NHSGGC, and NSS welcomes this collaborative approach.

THE CHAIR: A difficult thing with a statement such as we find at 10.1 is that when one finds a word like "challenging", one doesn't really find any content or meaning whatsoever. Do you know what is referred to as "challenging"?

MS DOHERTY: Well, it's in NHSGGC's statement, my Lord, not----

THE CHAIR: That's what I----

MS DOHERTY: -- not----

THE CHAIR: That is absolutely true, but you're the person in the-- you're the only person who I could ask the question at the moment.

MS DOHERTY: Well, I think as I've said, my Lord, in the written closing statement, NSS has explained problems with the reporting of infections and that situation, I suppose, could be described as challenging, and what it required to do as a result of that. Then the recent developments-- I don't have any more information, my Lord, to explain why NHSGGC have chosen that particular description.

Still with NHSGGC's closing statement, my Lord, at paragraphs 11.6 and 16.3, they propose a recommendation for standardised reporting of incidents of infection across health boards. NSS notes that there is already standardised reporting, as set out in the National Infection Prevention and Control Manual, and it is unclear to NSS exactly what further standardisation is being proposed.

Comparing hospital infection rates is complex, and it is not always a robust way to improve local outcomes. Rates do not account for differences in patient risk, deprivation, staffing levels or service complexity, making comparisons potentially misleading. Careful consideration of these caveats is essential when designing any comparison system, and NSS would urge your Lordship to be cautious about making any recommendations about further standardised reporting.

THE CHAIR: Well, I suppose it's my fault for not exploring this further with Mr Gray, but I wonder if-- There's a possibility of speaking at cross purposes. As I understand it, a recommendation

that Glasgow do make is about internal reporting. I think I used the word "template". I don't think anyone else did, and that is what I had taken as being described by Professor Gardner, that the Board has adopted a more comprehensive, effective way of reporting to the Health Board.

Now, that's what I understood, and because it seemed to me that in order for me to understand that I needed something a bit more tangible, that is why I asked Professor Gardner to provide us with a document. I think – I'll be corrected if I'm wrong – I raised with Mr Gray, because I think he referred to it in his opening statement, that I had understood that.

Now, at 16.4 of the Board's submission, there's reference to something else called, "The strengthening of national surveillance", and that's:

> "All NHS boards report incidents of infection electronically and through the same system. NHSGGC supports the implementation of a national electronic surveillance system … This will facilitate oversight and scrutiny of such infections nationally…"

With great respect to everyone, that seemed so banal or broad as not to

invite challenge. Now, have I misunderstood, first of all, what GGC are recommending and maybe, secondly, what you are saying?

MS DOHERTY: Well, NSS don't understand exactly what it is that GGC are suggesting as further standardisation, and that's----

THE CHAIR: Which paragraph in----

MS DOHERTY: Paragraph 11.6.

THE CHAIR: Sorry, I'm----

MS DOHERTY: 11.6, when they talk about monitoring and testing.

THE CHAIR: Sorry, have I got the right document? 11.6 of what?

MS DOHERTY: Of GCC's closing statement. Oh.

THE CHAIR: We don't have an-- At least in my text, we don't have an 11.6, and it was because I couldn't find that that I went to their recommendations at 16.

MS DOHERTY: Yes. We have an 11.6.

THE CHAIR: So you've got more than we've got.

MS DOHERTY: Well, I can't explain that, my Lord.

THE CHAIR: Okay.

MS DOHERTY: I have this. This is a document which is 29 pages.

THE CHAIR: Yes. Well, it may be sufficient for present purposes.

MS DOHERTY: Well, I suppose, my Lord, they're still saying the same thing. At 11.6, it's suggested at the end-- it's the same point that I'm looking at, but I have it as 11.6, whereas on this document it's 11.5. They're suggesting that it would:

> "… be appropriate … to make a recommendation to standardise this reporting so that comparisons can be made across different health boards."

Now, it's unclear exactly what further standardisation is being proposed. That's what NSS have said to me, because there's already standardised reporting required per the manual. So what is it that they're suggesting? That's the first question. We don't understand it.

Then there's also a concern that what's said there is, "… so that comparisons can be made against different health boards." There's a concern about that, as I've explained, that there are a number of different factors which could explain different infection rates, including patient risk, deprivation, staffing levels, service complexity. So you can't just look at one health board and another like that, and that's why NSS say that your Lordship should be cautious about making any recommendation about further

standardised reporting. First of all, we do not know what they mean and, secondly, they seem to want to do this to look at comparisons, and NSS say it's not as easy as that.

THE CHAIR: Right. Well, I think, first of all, I have to apologise for introducing the internal reporting point because I was looking at the wrong part of the Glasgow statement. So we can leave that aside. Perhaps, for present purposes, I can listen to your point that, insofar as GGC are making a recommendation or suggesting a recommendation the Inquiry might make, it is not sufficiently precise----

MS DOHERTY: Yes.

THE CHAIR: -- for at least NSS to understand. I have to say, it's not sufficiently precise for me to understand either. This reflects the high level at which GGC have chosen to communicate. Right, it may be that we can't----

MS DOHERTY: No, and that's-- So, paragraph 11.6, that seems to be 11.5 in the document that was on screen. That's what they're suggesting, and then they follow that through into their proposed recommendation at 16.3. So, that's what we-- for the reasons you've said, my Lord, we don't understand what they're asking for. We say it's not as easy as that. You don't

just compare infection rates at health boards, which is what they seem to suggest would be useful.

THE CHAIR: Yes.

MS DOHERTY: Now, at 16.4, they support a:

> "… national electronic surveillance system for Healthcare Acquired Infections, with all data [that's the way they worded it] on infections flowing to ARHAI."

Now, NSS welcomes this support for a national electronic surveillance system, save for a concern about GGC's reference to all data going to ARHAI. NSS say it may not be appropriate for all laboratory data to go to ARHAI, and the exact scope of the data to be included is a matter requiring further consideration when the system is established. NSS has said more about the proposed electronic surveillance system in its own written closing statement at paragraph 54, my Lord.

Now, moving on to the written closing statement by the Scottish Government. At paragraph 35, in relation to infection reporting, the Scottish Government notes that the proposed recommendation----

THE CHAIR: Sorry, just give me a moment, Ms Doherty. Now, paragraph 35?

MS DOHERTY: Paragraph 35.

They refer to the proposed recommendation that NSS report to the chair of the Health Board if there is a failure to comply with reporting. That's the proposed recommendation at paragraph 1892 of Counsel to the Inquiry's closing statement. The Scottish Government notes that this might be "inimical" to NSS's "expressly supportive role". It suggests that a better way might be to escalate within the Board by, for example, a director's letter, a DL, or a letter from the Cabinet Secretary, rather than conferring a power on NSS to report, that power being by legislation. NSS supports the approach proposed by the Scottish Government in this connection.

(After a pause) Now, turning to the submissions of Drs Peters, Redding and Inkster. My Lord, do you want me to wait while you get those before you?

THE CHAIR: That would be very kind of you. I've now got it.

MS DOHERTY: Thank you. At paragraph 133----

THE CHAIR: Yes.

MS DOHERTY: -- paragraph 133, the doctors endorse Tom Makin's recommendation that routine testing for pseudonomas should be added to the SHTM. We note that Counsel to the Inquiry has recently indicated his agreement with an adoption of this

recommendation. NSS's position is that the approach in Scotland and England about testing for pseudonomas is substantially the same, although there are some differences in how the approach is worded in the current guidance. In England, predominantly, there is monitoring in high-risk areas only, and this is consistent with the approach in Scotland.

In any event, as part of the work ongoing in relation to SHTM 04-01 and the English equivalent, language is being aligned across the devolved administrations. NSS considers that a much fuller analysis of the merits of extending routine pseudomonas testing beyond high-risk areas should be undertaken before any recommendation is made by the Inquiry.

(After a pause) Now, the next paragraph I'd like to look at in these submissions is paragraph 134, which considers the role of the authorising engineer. The doctors asked the Inquiry to consider making recommendations to improve the effectiveness of this role in the future. NSS would like to assure my Lord that SHTM 00, which is "Healthcare engineering – Policies and principles of best practice guidance", is being updated in 2026-2027, and the intention is to further clarify the role of the authorising engineer.

NSS would be cautious about any recommendation being made without adequate review and input from experts. For example, it has encountered situations where the expansion of the authorising engineer's role has made the role of other parties more ambiguous, which has led to gaps in decision-making.

Now, paragraphs 136 and 137 of the doctors' submissions suggest that the Inquiry should consider whether the SHTM 04-01 provisions regarding water safety risk assessments can be improved and/or more effectively enforced. It's difficult for NSS to comment without knowing what the new provisions would be, and it would again be cautious about any recommendation being made without adequate review and input from experts. At paragraph 137, there's mention of effective enforcement, and NSS note it would not be appropriate for NSS to have an enforcement role in relation to risk assessments.

NSS also notes that recommendations regarding water risk assessments could cover matters dealt with in British Standards, which the SHTM and HTM are derived from, and examples of British Standards where this might be an issue include BS 8580-1.

THE CHAIR: Sorry, could you give

me that again?

MS DOHERTY: BS 8580-1, which deals with, “Water Quality – Risk assessments for Legionella control – Code of Practice”, and also BS 8580-2, which is entitled, “Water quality – Risk assessments for Pseudomonas aeruginosa and other waterborne pathogens – Code of practice”.

If my Lord is happy, I’ll move on to paragraph 144. There’s reference in these submissions to the “Rectification Board”, and proposing that the Rectification Board should be supervised by ARHAI and NHS Scotland Assure. NSS does not know what body is being referred to by the term “Rectification Board”. In any event, it would not be appropriate for NSS to have a supervisory role; NSS operates and is effective in a supportive role.

Finally, my Lord, I turn to the written submissions on behalf of IBI. Again, if my Lord wants to have them available, first paragraph is 11.1.2.

THE CHAIR: Yes, I got there.

MS DOHERTY: You’ve got that, my Lord. Well, at paragraph 11.1.2, IBI refers to NHS England’s NHS Estates Technical Bulletin No.2024/3, and it invites the Inquiry to acknowledge the updated technical requirements mandated in England with a view to those requirements being implemented

in Scotland.

NSS urges caution here. This NHS Estates Technical Bulletin has led to some concerns across stakeholder groups since its publication. NSS is currently in discussions with colleagues in the devolved nations around how these concerns can be addressed. The current intention is to move to our harmonised SHTM 04-01 and an equivalent HTM 04-01 suite of documents across England, Wales, Scotland and Northern Ireland. That would see key themes from the NHS Estates Technical Bulletin absorbed, where appropriate, into a single place of truth, namely the updated SHTM 04-01 and HTM 04-01 documents. A UK-wide consultation on this document is underway, with plans for a 2026 publication.

THE CHAIR: Now, I don’t think we’ve really heard anything about the Technical Bulletin series. Is there a Scottish equivalent to that sort of document?

MS DOHERTY: “I don’t know” is the answer. I don’t know, my Lord. I’m sorry.

THE CHAIR: The project for moving towards a uniform-- Now, is it a document or a series of documents?

MS DOHERTY: They described it as a suite of documents.

THE CHAIR: Suite of documents.

MS DOHERTY: Yes, that would absorb themes from this NHS Estates Technical Bulletin where appropriate.

THE CHAIR: Right.

MS DOHERTY: That's how it's been described.

THE CHAIR: This is something different from the technical memoranda.

MS DOHERTY: I understand so, my Lord.

THE CHAIR: Right, okay. Maybe the key point is that this is currently under consideration.

MS DOHERTY: It is, and there's a UK-wide consultation, and with plans for a 2026 publication.

Finally, my Lord, at paragraph 11.1.3, IBI refers to the principles of the golden thread of fire and safety design introduced under the Building Safety Act 2022. Yesterday, Counsel to the Inquiry suggested that if other core participants think this reference is helpful, they should say so. Your Lordship yesterday indicated that you would welcome assistance on this point.

NSS fully supports the concept of the golden thread. In fact, NSS's witness Thomas Roger referred to this concept in his witness statement for the Edinburgh III hearings, which commenced on 26 April 2024. His witness statement is in volume 1 of the

witness statements for those hearings, document 17, page 444, and at paragraph 37 he refers to and quotes this golden thread principle. If NSS does have further comments which it considers may assist my Lord, then its intention would be to submit them in writing in early course. My Lord, that's the end of my submissions, unless there's anything else I can help with.

THE CHAIR: Thank you very much, Ms Doherty.

MS DOHERTY: Thank you.

THE CHAIR: Good afternoon, Ms Crawford. You are appearing for the Scottish Ministers?

Closing submissions by Ms Crawford

MS CRAWFORD: Indeed, yes, my Lord, and thank you. I should, of course, at the outset, express the gratitude, on behalf of the Ministers, to the Inquiry for the opportunity to make these oral submissions on their behalf. In that regard, I adopt the closing statement already submitted to the Inquiry following Glasgow IV session.

The Inquiry has, of course, received and heard a very large amount of evidence in order to inform itself and to fulfil the terms of reference. It perhaps goes without saying, but is worth

emphasising, that a number of critically important issues have been raised, both in relation to the Queen Elizabeth University Hospital, but also the Edinburgh Royal Infirmary project. Recognising those critically important issues, of course, the Ministers established this Inquiry and have participated with it, but it is obviously for the Inquiry, and only the Inquiry, to assess the evidence and thereafter address and fulfil the terms of reference. In that regard, the Ministers repeat their gratitude to the Chair, to Counsel to the Inquiry and to all other members of the Inquiry team for their undoubted hard work and diligence.

Recognising and respecting the proper role of the Inquiry, the submissions for the Ministers will be at a high level, or perhaps also described as at a strategic level. Before I turn to address those high-level issues, I should, again echoing what is said in paragraph 1 of the closing statement, frame those submissions with the following remarks. In my submission, they are important remarks.

First of all, the Ministers pay tribute to all the patients, their families, and all staff affected by the issues which arose at the Queen Elizabeth University Hospital and thank them for reliving those events in this Inquiry and for their

insight and assistance. Just pausing there, my Lord, as with other core participants, no one could fail to be moved by the at times harrowing testimony provided by some of the witnesses to this Inquiry. It's, again, important to acknowledge that.

Secondly, by way of opening remarks, the Ministers continue to be committed to provide patients with the best possible patient-centred healthcare. I will have more to say on that very shortly, but for present purposes it is to be noted that the Ministers are, of course, collectively responsible and accountable to ensure that patient-centred healthcare is delivered by NHS Scotland to the highest possible standard.

Turning, if I may, to look at the responsibilities of the Ministers, and indeed how it is that they deliver patient-centred healthcare in Scotland, it may assist my Lord, perhaps repeating myself from the closing statement I made in the Edinburgh session, to remind my Lord of some provisions of the National Health Service (Scotland) Act 1978. With apologies for adding to my Lord's paper, I have had printed off a few sections of that Act, and indeed of other statutes, which hopefully will save the writing.

The first provision in the bundle is section 1 of the 1978 Act, which provides

for the general duty of the Secretary of State – now, of course, the Ministers – to:

> "… promote in Scotland a comprehensive and integrated health service designed to secure–
>
> "(a) improvement in the physical and mental health of the people of Scotland, and,
>
> "(b) the prevention, diagnosis and treatment of illness,
>
> "and for that purpose to provide or secure the effective provision of services in accordance with the provisions of this Act."

Reading on in the bundle, securing that provision is achieved by the establishment of health boards, which we see in section 2, subsection (1):

> "(1) The Secretary of State
>
> "(a) shall by order constitute in accordance with Part I of Schedule 1 boards for such areas as he may by order determine, for the purpose of exercising such of his functions relating to the health service as he may so determine [etc., and these bodies will] be called Health Boards."

Then there's provision for special health boards, which I needn't trouble my Lord with for present purposes.

Reading on in the bundle – it's about three or four pages on – we then come to section 2A, which makes provision for the duty of a health board. Section 2A, subsection (1):

> "(1) It is the duty of every Health Board and Special Health Board and of HIS [Health Improvement Scotland] and the Agency [the Common Services Agency] …"

I'll come to HIS and the Agency in a moment.

> "It is the duty of [those organisations] to promote the improvement of the physical and mental health of the people of Scotland."

Subsection (2) is an enabling power to do that which is likely to assist in discharging the duty. Then, turning over a couple of pages, we come to section 2C, which sets out the functions of health boards. 2C, subsection (1):

> "(1) Every Health Board–
>
> "(a) must, to the extent that they consider necessary to meet all reasonable requirements, provide or secure the provision of primary medical services as respects their area; and
>
> "(b) [they may also do so] as respects the area of another Health Board."

Subsection (2):

"(2) For the purpose of securing the provision of primary medical services under subsection (1), a Health Board may make such arrangements for the provision of the services as they think fit."

Then reading on, if I may, to section 10, which addresses the Common Services Agency, now NSS-- well, currently known as NSS Scotland. Section 10, subsection (1):

"(1) There shall be constituted a body, to be called the Common Services Agency for the Scottish Health Service (hereafter in this Act referred to as 'the Agency') …"

My Lord will note its functions are at subsection (1A). Schedule 5 I needn't trouble my Lord with, but that's just to the composition of the Agency. Subsection (3):

"The Secretary of State may by order delegate to the Agency such of its functions relating to the health service as he considers appropriate."

My Lord has heard a lot of evidence relative to NSS Scotland and what it does, and there are a number of further detailed provisions, again, by way of delegation at subsection (4). Subsection (6), over the page:

"(6) The Agency shall provide such services and carry out such tasks for bodies associated with the health service as the Secretary of State and those bodies may agree, and on such terms and conditions as may be agreed."

And:

"… the Agency shall act subject to, and in accordance with, such directions as may be given by the Secretary of State."

That's subsection (7). Then we turn, if we may, to section 10A and the creation of the body, Healthcare Improvement Scotland:

"(1) There is established a body to be known as Healthcare Improvement Scotland (in this Act referred to as 'HIS') which–

"(a) is to exercise the functions conferred on it by virtue of this Act and any other enactment (including the 2021 Act); and

"(b) has the general duty of furthering improvement in the quality of health care and of services provided under the 2021 Act."

There is a definition of "healthcare" in subsection (2):

"… [it] means services for or in connection with the prevention, diagnosis or treatment of illness

provided–

"(a) under the health service; or

"(b) by persons providing independent health care services."

Subsection (3):

"… HIS is to act subject to and in accordance with such directions as may be given by the … Ministers."

Section 10C makes provision for health service functions to be exercised by HIS. Subsection (1):

"(1) HIS is to exercise the following functions of the Scottish Ministers–

"(a) functions in relation to supporting, ensuring and monitoring the quality of health care …"

My Lord may recollect Ms Doherty mentioning a moment or two ago the use of the word "support", which has an echo in section 10C:

"(a) … to supporting, ensuring and monitoring the quality of health care provided or secured by the health service including, without prejudice to the foregoing generality, providing quality assurance and accreditation;

"(b) functions in relation to supporting, ensuring and monitoring the discharge of the duty under section 2B [which we looked at a moment or two ago]…"

Sorry, we haven't looked at section 2B, but each body to whom that section applies-- Section 2B is a provision about involving the public in relation to the provision of healthcare services, and (c) makes reference to section 2D, which is an equal opportunities duty.

If I may invite my Lord to turn over the page. These list a number of functions which HIS is to perform, and my Lord can read these for himself, but I might invite my Lord just to read with me subsection (d), which provides that HIS is to have:

"(d) … the duties of the Scottish Ministers under section 47 [of the Act, which is]—

"(i) to make available such facilities as appear to HIS to be reasonably required for undergraduate and post-graduate clinical teaching and research and for the education and training of persons providing or intending to provide services under this Act…"

Just pausing there, my Lord, my Lord will recollect we've had some evidence about the provision of education and training, not least in relation to infection prevention and control and – with apologies for the management speak – mention of workforce strategies being developed in

relation to that particular discipline. We also invite my Lord----

THE CHAIR: Just so I'm picking you up correctly, "workforce strategies", and I don't mean to trivialise this when I say-- mechanisms for people-- well, working better together and----

MS CRAWFORD: No, I was actually meaning more----

THE CHAIR: -- or relating-- or is it something else?

MS CRAWFORD: No, I was actually meaning this is the provision of proper-- "proper training"; I don't mean "proper". It's the provision of education for healthcare professionals, which will include, for example, IPC. I think we heard evidence, I think from Professor McMahon in the Edinburgh session, for example, relative to ongoing work in relation to-- I think it was IPC nurses particularly he was talking about. So that was what I was meaning by----

THE CHAIR: Right, okay. My fault entirely, I hadn't followed you.

MS CRAWFORD: No.

THE CHAIR: Yes. I now recollect Professor McMahon's evidence about, as I understood it, an initiative to apply further resource to IPC.

MS CRAWFORD: Indeed. The point I'm making, my Lord, is just to set the statutory framework under which the delivery of healthcare is provided in

Scotland, and here we have specific provision relative to education. Obviously, there's a lot of detail underneath all that.

Then section 2A:

> "HIS is to exercise …
>
> "(a) a duty of supporting, ensuring and monitoring the quality of services provided by the Health Boards … [reading short] including … quality assurance and accreditation."

And similar provision in relation to the duties under 2A(b) and 2A(d).

Then over the page at subsection (3), if I may, there is provision for HIS at (c) whereby HIS, if requested by the Ministers, has a duty to provide them with advice "relevant to the health service functions of HIS"; a function to-- and "a power to provide such advice to Scottish Ministers at any time". Also, at (e), general advice provisions, including to health boards. My Lord will know that, at times, GGC requested advice from HIS.

Then, at (f), there is a general:

> "… power to disseminate … as HIS considers relevant of general or specific application arising out of or in connection with the exercise of its health service functions."

That provision, again, may be relevant to at least one of the terms of

reference in relation to information sharing. There is provision in the Act for dissemination by HIS.

Moving forward in the bundle, if I may, so about three or four pages on, we come to section 10Z14. I simply highlight this provision to, again, provide this Inquiry with information about the monitoring, supervision delivery of healthcare services in Scotland. So, we have in 10Z14:

> "For the purposes of its functions as they relate to the provision of independent health care services … a Health Board … must take into account the matters mentioned in subsection (3)."

Those matters include, in subsection (3), reports prepared, etc., by HIS. So that's a dissemination provision, again, in relation to independent healthcare services.

THE CHAIR: I think I've forgotten if I ever knew what an independent healthcare service is. I think I rather assume it's outwith the NHS, but I may be wrong about that.

MS CRAWFORD: There is a definition, my Lord. I may have to come back to my Lord on that, because otherwise I'm going to have to crawl through a very lengthy statute.

THE CHAIR: It will be defined somewhere.

MS CRAWFORD: It is. It's not in the interpretation section. It's probably in section 1 or section-- It is somewhere, my Lord. If my Lord would allow me, I can----

THE CHAIR: I can find it.

MS CRAWFORD: Yes. My Lord, if I could then invite my Lord, perhaps moving forward two pages in the offprint to section 12H. My Lord will note that it is:

> "… the duty of each Health Board … and of the Agency to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care which it provides to individuals."

Then a couple of pages on, section 12I, headed up "Duty in relation to governance of staff":

> "It shall be the duty of every Health Board … and the Agency to put and keep in place arrangements for the purposes of—
>
> "(a) improving the management of the officers employed by it;
>
> "(b) monitoring such management; and
>
> "(c) workforce planning."

I simply draw that provision to my Lord's attention because it may be of some relevance to whether there is in existence provision to enable, to use of

the words of the section, governance of the healthcare staff employed by the Health Board.

Then, in section 12J, there is a duty to cooperate between health boards, and also in section 13, a few pages on, a duty between health boards, local authorities and education authorities to cooperate with one another to "secure and advance the health of the people of Scotland".

How that operates in practice, my Lord may recollect, was explained by Ms Freeman, the former Cabinet Secretary, in her statement for Glasgow IV, dated 10 October 2025, at paragraph 6, which in turn cross-referred to her statement for Edinburgh, dated 18 December 2023. The relevant paragraphs in the December '23 statement are paragraphs 9 through to 26.

THE CHAIR: My fault. I've got the Edinburgh reference. The reference to the Glasgow statement?

MS CRAWFORD: Paragraph 6, and my Lord might also want to look at paragraphs 8 through to 15.

THE CHAIR: Right. Ms Freeman has just provided one witness statement in relation to Glasgow?

MS CRAWFORD: IV, yes.

THE CHAIR: What?

MS CRAWFORD: I think-- Yes.

THE CHAIR: Right. Yes.

MS CRAWFORD: I've been helpfully told by those sitting behind me that, insofar as "independent healthcare service" is concerned, my Lord will find the definition in section 10F.

THE CHAIR: Electronic communication is----

MS CRAWFORD: Sometimes good, sometimes bad.

THE CHAIR: -- sometimes useful.

MS CRAWFORD: Yes, indeed. I was aware when I heard something happening that somebody might be giving me the answer to my Lord's question, and I'm grateful.

THE CHAIR: So it's defined in section 10?

MS CRAWFORD: 10F.

THE CHAIR: 10 capital----

MS CRAWFORD: F. F for Freddie.

THE CHAIR: Right, thank you.

MS CRAWFORD: Turning to the operation of the respective powers and functions of the Ministers and how they deliver healthcare in Scotland through health boards, my Lord may also derive assistance from the statement of Mr Wright, both his Edinburgh statement of 15 March 2024 – and the paragraphs which address this matter are paragraphs 15, 16, 20, 25, 79 through to 84, and 101 to 103 – and he provided similar evidence in his statement to

Glasgow IV, that statement being dated 26 September 2025, at paragraphs 4 to 6, 24, 58, 71 and 72.

Picking up, if I may, on Mr Wright's evidence and also the closing statement of the Ministers at paragraph 6 and the question of who is responsible for the employment of the workforce in NHS Scotland. Paragraph 6, my Lord may recollect, refers to section 28 of the Inquiries Act and the constraint on my Lord relative to what are described as "Scottish matters".

THE CHAIR: Yes, I would particularly value your guidance on that.

MS CRAWFORD: Thank you, my Lord. Well, again, if my Lord goes back to his bundle of offprints of statutes, in the first tab, just going back again to what-- the quick excursion through the 1978 Act, we saw from that that it is the health boards who are delegated the function of employing staff sufficient to deliver healthcare in their respective health board areas.

Turning, if I may, to the Scotland Act and section 51. Section 51 is headed up, "The Civil Service":

> "The Scottish Ministers may appoint persons to be members of the staff of the Scottish Administration."

Subsection 2, reading short, provides that that service shall be

service in the civil service of the state. Now, the point I make from section 51, my Lord, is that the only power the Ministers have to employ people is through section 51, and those people, in the language of 51(1), are members of the staff of the Scottish Administration, commonly known, as we see in subsection 2, as "civil servants". They do not have a power to employ staff in the NHS.

Payment of the staff of the Scottish Administration is from the Scottish Consolidated Fund. My Lord sees that from section 51(8). My Lord will find a bit more information about the Scottish Consolidated Fund in section 64, which is over the page. Subsection (1):

> "There shall be a Scottish Consolidated Fund.
>
> "(2) The Secretary of State shall from time to time make payments into the Fund out of money provided by Parliament [that's the UK Parliament] of such amounts as he may determine."

That takes me on to reserved matters, if I may. A page or two on into the bundle, my Lord will find, first of all, an offprint from Schedule 5, "Reserved matters". Paragraph 8 is in Part 1 of Schedule 5, which relates to-- The heading of that, I should have provided

for my Lord. The heading of that is "General Reservations", and paragraph 8 provides, subparagraph (1), that, "The Civil Service of the State is a reserved matter." My Lord will recollect from section 51 that members of staff of the Scottish Administration are civil servants of the state paid out of the Scottish Consolidated Fund.

The short submission made on behalf of the Ministers, my Lord, is that there is no power for them to employ anyone in the health service. If there were to be power, that would obviously require legislation by the UK Parliament.

So, if we look to chief executives and the like of health boards, as my Lord knows from Mr Wright's evidence, they are employed by health boards and may be dismissed by health boards. The Ministers may, as Mr Wright said, "make noises" if they are dissatisfied with the performance of the chief executive, but ultimately the Ministers cannot dismiss a chief executive or, indeed, any other member of staff of the NHS in Scotland.

They can, the Ministers being "they", remove accountable officer status from a chief executive, which no doubt-- I say, "no doubt"; I strongly suspect would have consequences for that person's ongoing employment by the Health Board. Mr Wright provides an explanation of that in his statement of

September 2025 in more detail.

Moving, if I may, my Lord, to more specific reserved matters, which are to be found in Part 2 of Schedule 5. The first one, which may be of relevance to Scottish matters in terms of the Inquiries Act, is that provided by G2, headed up, "Health professions". The regulation of the health professions is a reserved matter, with an exception relative inter alia to Section 21 of the 1978 Act and suitable experience for medical practitioners. My Lord will note the number of professions who are encapsulated by the phrase "health professions". I don't think I need read those out, but they encompass more or less every health profession you could conceive.

The next reserved matter which may be of some relevance is the auditor, and that's in G3. That may be of some relevance to general auditing of the health service.

Finally, my Lord may also pause to note that there are certain provisions which may not be directly relevant, but I thought for completeness my Lord should have, at H3 and "Job search and support"-- Sorry, actually, my Lord has H3. My Lord should have had H2, and I'm sorry my Lord doesn't have it, but I can read out H2, which is headed, "Health and safety". It comprises:

"The subject-matter of Part I of the Health and Safety at Work etc. Act 1974

"[and] The Health and Safety Commission, the Health and Safety Executive and the Employment Medical Advisory Service"

So, rather than H3, it was H2, my Lord. The failing is mine in printing off the wrong reserved matter. But, again, that may be relevant to any recommendations which my Lord considers appropriate, just to flag up that health and safety is also a reserved matter.

THE CHAIR: That might have most obvious reference to the matters that are picked up by SHTM 04-01.

MS CRAWFORD: It may do as well, which maybe-- Well, my Lord has heard the reference to NSS Assure working with and collaborating with their English colleagues as well. But, again, one would have to drill down-- Apologies, my Lord, I haven't drilled down to look at exactly what Part 1 of the Health and Safety at Work Act says, nor indeed looked at the remit of the Health and Safety Commission, the Health and Safety Executive, or indeed the Employment Medical Advisory Service. I've not drilled down into detail and, again, it'd be a bit difficult to do that in the abstract, not knowing precisely what might be envisaged or be thought of by my Lord eventually, but simply to draw that to my Lord's attention, if I may.

My Lord, having again addressed the functions and duties of the Ministers and of the health boards, having looked at Scottish matters/reserved matters under the Inquiries Act, I now move on, if I may, to say a word or two about the Ministers' oversight of health boards. At this stage, before my Lord puts his bundle of legislation to one side, if I could invite my Lord to return to that and look at tab 2, which contains the 1978 Act. Working from the back of that might be easier. About five pages, six pages from the back, my Lord will first find section 77, which makes provision for, the heading, "Default powers":

"(1) Where the Secretary of State is of the opinion, on representations made to him or otherwise, that— [reading short]

"(a) any Health Board …

"… have failed to carry out any functions conferred or imposed on them by or under this Act … or have in carrying out those functions failed to comply with any regulations, schemes, proposals or directions relating to those functions, he may after holding an inquiry make an order declaring them to be in default

"(2) When such an order is made, the members of the body shall forthwith vacate their office…"

Now, obviously, my Lord, I've drawn my Lord's attention to the reserved matter under Section 51 of the Scotland Act, but my Lord will note that rather than a dismissal power, there is, following an Inquiry and an order being made, a requirement of the members of the relevant body to vacate their office. Again, I draw that provision to my Lord's attention just so my Lord has hopefully as complete a picture about how it is that the Ministers ensure oversight of the health boards to whom healthcare provision has been delegated.

There are further powers, first of all in section 78. "Emergency powers", as they're described:

"If the Secretary of State is of the opinion that an emergency exists, and thinks it necessary in order to secure the effective continuance of any service under this Act, he shall have power to direct that any function conferred by or under this Act on any body or person shall, during the period of the emergency, be performed by such other body or person as he may specify in the direction."

Over the page, Section 78A makes provision in case of service failure:

"(1) This section applies where—

"(a) it is a function of a body or person under or by virtue of this Act to provide, or secure the provision of, a service, and

"(b) the Scottish Ministers consider that the body or person has failed, is failing or is likely to fail—

"(i) to provide the service, or

"(ii) to provide it to a standard which they regard as acceptable.

"(2) The Scottish Ministers may, where they consider it necessary for the purpose of ensuring the provision of the service in question to a standard which they regard as acceptable, direct that specified functions of the body or person under or by virtue of this Act be performed, for a specified period and to a specified extent, by—

"(a) a body falling within subsection (4), or

"(b) one or more persons falling within subsection (5)."

The bodies are listed in subsection (4) and the persons in subsection (5). My Lord may pause to note that the persons (a) can be an employee of a health board, and (b) a member of the staff of the Scottish Administration. So,

in case of service failure, there is a provision within Section 78A for a member of the staff of the Scottish Administration, a civil servant, to perform such functions as the Ministers may direct.

Now, those provisions to which I've drawn my Lord's attention are reflected to a certain extent by the escalation framework which my Lord may recall seeing, and in particular by Level 5. As Mr Wright explained in paragraph 29 of his 26 September 2025 statement, and I just quote him here:

> "Stage 5 escalation would only be used in the most exceptional circumstances when the Scottish Ministers are of the view that a Health Board as a whole requires direct statutory intervention because of the view that the Board are unable to deliver safe and effective healthcare…"

And he then quotes from Level 5 itself in the escalation framework. which is to the following effect:

> "('The level of risk and organisational dysfunction is so significant that the NHS Board requires direct intervention using statutory powers of direction')."

Those statutory powers of direction are found in section 78A. Now, it is of course a matter for the Inquiry but, in my submission, I would suggest to the Inquiry that the powers to which I've just made reference do provide a proper and appropriate mechanism for intervention, if the circumstances require that, for the proper provision of patient-centred healthcare in Scotland.

I respectfully submit to the Inquiry that no further statutory or regulatory mechanism is required for intervention in the event of service failure. Of course, the Ministers are and will continue to be accountable to Parliament and to the people of Scotland for the exercise or indeed the non-exercise of those intervention powers, but the mechanism is already in place for intervention.

THE CHAIR: The context of what you're directing me to at present, Ms Crawford, is Counsel to the Inquiry's submissions in relation to sufficiency of powers of intervention?

MS CRAWFORD: Indeed.

THE CHAIR: Yes.

MS CRAWFORD: Indeed. A related point arises relative to the manner in which health boards deliver their functions, or should deliver their functions, as set out by the Scottish Ministers. There are a number of mechanisms and, indeed, oversight. For present purposes, it perhaps suffices to note, again under reference to the closing statement to this session of the

Inquiry, paragraph 17 to 19, the reference to the Blueprint for Governance, and also, at paragraph 13, the reference to the director's letter of 2024/08-- sorry, paragraph 21, and the framework document, detailed documents setting out how the Ministers require health boards to deliver the functions delegated to them to provide patient-centred healthcare in Scotland.

THE CHAIR: I've got your reference to paragraph 17 to 19. I think you mentioned another paragraph.

MS CRAWFORD: Paragraph 21. I'm sorry, my Lord.

THE CHAIR: No, it's my fault.

MS CRAWFORD: Hopefully-- If I can just check the reference so I've not misdirected my Lord. Yes, paragraph 21 refers to the director's letter, which the Inquiry kindly gave us leave to lodge, and reference to the framework document. It may bear some reading, indicating the manner in which health boards and Ministers are to deliver their respective functions, and reinforcing the need to comply with the Blueprint for Good Governance.

While I remember, my Lord, there's a point of detail. I think this arose in submissions for Counsel to the Inquiry yesterday morning. The first edition of the Blueprint for Governance was January 2019.

THE CHAIR: I misremembered.

MS CRAWFORD: The second edition was 23 December 2022. One can also, in relation to this question of expectations, recall the oversight-- the supervision delegated to HIS to which I made reference when looking at the provisions of the 1978 Act. The submission here, my Lord, is that, again, we can see in practice that there are proper checks to ensure that health boards do deliver that which they are required to do under the 1978 Act.

In terms of delivery and effectiveness of delivery and checks and balances of health boards, one can perhaps note how that operated-- and learning lessons, indeed-- how that operated by reference to the events for the Edinburgh Royal Infirmary. My Lord may recollect that, as soon as the problem was discovered by the Senior Executive team, immediate steps were taken to inform the Ministers, firstly through the Director General and immediately escalated up to the Cabinet Secretary, and that the Ministers very, very quickly intervened to suspend the opening of the relevant department. So, again, that's an example I would suggest to my Lord----

THE CHAIR: Sorry. Again, I have to apologise. Take me back to the beginning of the instance you're referring

me to.

MS CRAWFORD: Yes, I was saying that when one looks to the escalation framework, and the section 78(8) powers, and the oversight, and checks and balances, and if one-- following the Blueprint for Governance appropriately, or its predecessor, one can see that operating in practice by the Edinburgh Royal Infirmary and the events which led----

THE CHAIR: Right.

MS CRAWFORD: -- to the Cabinet Secretary----

THE CHAIR: Yes.

MS CRAWFORD: -- the Ministers deciding that the opening should be delayed. The submission I'm trying to make to my Lord, perhaps inelegantly----

THE CHAIR: Not at all.

MS CRAWFORD: -- is that there are processes, proper processes, in place which do enable prompt and effective action to be taken if something has gone wrong.

THE CHAIR: Within a matter of days, if even that.

MS CRAWFORD: Within a matter of days, yes. Now, of course, mistakes will happen. The point I'm making, my Lord, is that there is a mechanism in place. What that leads me to submit to my Lord is that those checks and balances, mechanisms – and indeed there are others to which I'll come to in a moment or two – are, I would respectfully submit to this Inquiry, an appropriate way to secure provision of healthcare, rather than an overly-centralised system run and managed operationally by the Ministers.

Now, I remember having a discussion with my Lord in the Edinburgh closing submission session relative to that, if the Inquiry, my Lord, comes to the view that there should be more hands on operational control on the part of the Ministers, that would raise a number of complex issues, touching – and, indeed, not just touching, grabbing perhaps – issues of a highly sensitive political nature which would require to be addressed by the Parliament, Scottish Parliament, but would also require, I would suggest, prior to that, a detailed consultation exercise across Scotland about-- on the topic of how the delivery of healthcare in Scotland is best managed.

I note in the submissions for Counsel to the Inquiry an acknowledgement that some of their suggested recommendations will increase the resource burden, both on health boards and also on the Ministers, and on agencies. So far as resource is concerned, allocation of resource, by which I mean financial resource, is, I

would respectfully submit, the paradigm of a political decision exercised by the Scottish Parliament through its approval of the budget each year. That allocation of financial resource, budget allocation, is carried out by the Parliament in the public interest. So, the submission I make, my Lord, is while of course the Inquiry can make recommendations which may be resource intensive, allocation of budget to meet those intense resource requirements will ultimately be a matter for Parliament. I say that with all due respect, of course, to the Inquiry.

THE CHAIR: The Inquiry can only recommend.

MS CRAWFORD: Indeed. My Lord, I wonder if I might make a few further general observations. This really relates to how the Ministers deliver or seek, through delegation to health boards, delivery of healthcare in Scotland. There is – my Lord may have come across this – the World Health Organisation Global Patient Safety Action Plan of '21 to 2030. It should be noted that Scotland is not recognised as an independent member of the World Health Organisation. However, the Ministers take full account of the principles set out in that Global Patient Safety Action Plan. A reflection of that might be found in the document noted at

paragraph 2 of the Ministers' closing statement, namely the NHS Scotland Healthcare Quality Strategy and the three quality parameters set out in that.

In terms of reducing avoidable harm in healthcare and strengthening patient safety, which is the overarching theme of the Global Patient Safety Action Plan, that is delivered-- I've made reference to the quality strategy, but one can add to that at either general or granular detail depending upon which particular programme is being discussed, but there are a number of national improvement programmes, clinical governance arrangements, HIS itself, the Scottish Patient Safety Programme, the duty of candour – to which I'll come in a moment or two and say a few more words about that – a systematic adverse events review process----

THE CHAIR: I wonder if you should give me these----

MS CRAWFORD: In writing. I can do, my Lord.

THE CHAIR: -- at dictation speed.

MS CRAWFORD: Oh, at dictation speed. Right.

THE CHAIR: Or either at dictation-----

MS CRAWFORD: No, I'll give it at dictation speed. I'm not sure how far my Lord got when he was trying to catch up.

THE CHAIR: Not very far.

MS CRAWFORD: Right. National improvement programmes.

THE CHAIR: Yes.

MS CRAWFORD: Clinical governance arrangements, and that's primarily a reference to the Blueprint for Governance. HIS. (After a pause) The Scottish Patient Safety Programme. Duty of candour, and I will come back and address that in a bit more detail, if I may.

THE CHAIR: Maybe just to give me a heads up, as expressed in statute or----

MS CRAWFORD: As expressed in statute, but there are also----

THE CHAIR: Okay, I think you've given me the heads up. Statute plus.

MS CRAWFORD: Plus, yes. Adverse event review processes. Health and social care standards. Education and training of the healthcare workforce, and the body known as NHS Education for Scotland. Infection prevention and control measures, and again I'll have something to say about that in a moment or two.

I'm aware, my Lord, I've given very general headings here, but it's just to present a general view, overall view, about how it is, through these various programmes and arrangements, that the Ministers ensure, or have the ability to ensure, that patient-centred healthcare is

delivered to the highest standards possible. Proper account is taken of the principles set out in the WHO document.

My Lord, I mentioned IPC, infection prevention and control, a moment ago. My Lord may care to note – and this may be of some relevance-- relevant to submissions about the IPCT workforce – that there is or has been established by the Ministers an "Infection Prevention Services Workforce: Strategic Plan". This goes back to the point I was making earlier, my Lord, which is focused on health boards identifying and reviewing the current specialist IPC roles.

THE CHAIR: This, again, is a reference to the work that Professor McMahon referred to. Yes.

MS CRAWFORD: Indeed, indeed. Again, I think, reflecting back on what Professor McMahon said, my Lord may also recollect his evidence to the effect – I'm summarising it at a very general level – that some recommendations were being made in respect of training and education for the IPC workforce. I should advise my Lord that that workforce strategic plan will be reviewed this year, and further consideration will be given at that time about the continuing recruitment and training needs for the IPC workforce.

My Lord, I now, if I may, make a few submissions in relation to-- and I

mean no disrespect, but just by way of a useful shorthand for my purposes, make a few submissions relative to whistleblowers. As I said, I mean no disrespect to the relevant doctors when using that collective term. So far as the communications by them in their evidence are concerned, the Ministers regard those as disclosures which would be protected under the Public Interest Disclosure Act 1998. They, in the Ministers' submission, should also be regarded as disclosures protected under the NHS Scotland PIN whistleblower policy of 2011.

THE CHAIR: NHS----

MS CRAWFORD: Scotland P-I-N, PIN----

THE CHAIR: PIN----

MS CRAWFORD: -- whistleblowing policy of 2011. That policy, my Lord----

THE CHAIR: That's a national policy.

MS CRAWFORD: It's a national policy, yes, my Lord. I can summarise it to this effect: it requires health boards to ensure staff can safely raise concerns about risk, malpractice or wrongdoing, and to investigate, act and provide feedback. That policy also enables-- concerns can be raised outside the relevant health board where the internal whistleblowing processes have proved to

be ineffective or unsafe. It follows, in the Ministers' submission, that the whistleblowers were and are fully entitled to raise the concerns that they did, and I venture to suggest were, I suspect, under a professional obligation to do so anyhow.

THE CHAIR: You make that submission under reference to the specific evidence that we've heard, as opposed to just general principle?

MS CRAWFORD: The specific evidence we've heard.

THE CHAIR: Right.

MS CRAWFORD: Yes, my Lord. (After a pause) If I may now, having flagged it up a moment or two ago, turn to look at the duty of candour and, with apologies, invite my Lord to return to his folder of papers. The duty of candour – the statutory duty of candour – arises under the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016.

THE CHAIR: Before we do that, just----

MS CRAWFORD: Certainly, my Lord.

THE CHAIR: -- really for my assistance, the Public Service Disclosure Act 1998-- Am I remembering correctly? It sort of fits within the employment----

MS CRAWFORD: Indeed it does.

THE CHAIR: -- legislation, and it gives protective status to those persons.

It's not at all specific to healthcare----

MS CRAWFORD: It's not.

THE CHAIR: -- who raise concerns. The point you were making was that, in terms of that Act, which has consequences within the general structure of employment law, the three doctors would have the status of protected-- I think the term is "protected"----

MS CRAWFORD: It's "protected disclosure", indeed.

THE CHAIR: Yes.

MS CRAWFORD: But that's built on-- as I've mentioned, by reference to the policy----

THE CHAIR: Yes.

MS CRAWFORD: -- which requires-- or should enable staff to be able to report their concerns.

THE CHAIR: Mm-hmm.

MS CRAWFORD: But the root of that, I suspect, is in the 1998 Act.

THE CHAIR: Duty of candour?

MS CRAWFORD: Duty of candour, yes. I'm obliged, my Lord. The section which I printed from the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 is section 24, and my purpose in drawing that to my Lord's attention is, again, to inform my Lord, hopefully, of an ability-- a statutory mechanism by which the monitoring of the compliance with the duty of candour is or should be carried out. My Lord can see in section 24 that:

> "(1) A responsible person who provides a health service [reading short] must prepare an annual report on the duty of candour as soon as reasonably practicable after the end of that financial year."

Subsection (2) sets out what that report must provide. Subsection (3) indicates, obviously, that there should not be any identification of any individual. Subsection (5), the responsible person is to notify HIS, the Ministers and the Social Care and Social Work Improvement Scotland, relative to a care service or a social work service.

Subsection (6):

> "A person mentioned in subsection (7) may, for the purpose of monitoring compliance with the provisions of this Part, serve a notice on a responsible person requiring —
>
> "(a) the responsible person to provide the person serving the notice with information about any matter mentioned in subsection (2) as specified in the notice, and
>
> "(b) that information to be provided within the time specified in the notice."

Those persons are set out in subsection (7), including HIS and the

Scottish Ministers. Then there's provision in subsection (8) for the Ministers and HIS, whereby they may publish a report on compliance.

So, the point I'm seeking to make here by reference to the duty of candour, my Lord, is to say that there is built into the Act itself a mechanism to require reporting and to check that the duty of candour, as set out in the Act, is being properly complied with.

I should add for the sake of completion that, to date, the Ministers have not exercised its power under subsection (8) of section 24, but that power does exist in the legislation, reflecting my theme that there are mechanisms, processes, to enable checks to be made if necessary.

If I may, my Lord, I now propose to say a few words about NSS Assure, as I will still call them, which, in my submission, is a body which provides a further check across a number of areas relative to the provision of healthcare. As my Lord knows, NSS Assure was created in 2021 following the concerns raised by both the Queen Elizabeth and the Royal Hospital for Sick Children and Young Persons in Edinburgh. In my submission, again, that may be an example of the Ministers reacting in an appropriate way to issues which had arisen.

I shan't rehearse the evidence, but my Lord has heard detailed evidence from NSS Assure regarding what it does across a number of areas – a considerable number of areas – including rolling reviews of guidance and the collaborative nature of its engagement with health boards.

My Lord may also recollect the evidence about the KSAR process for building projects and the detailed workbooks which require to be completed at each and every stage going up to the final business case. If, my Lord, as I'm sure he will, looks at those detailed workbooks, my Lord may accede to my submission that the questions and the areas which are addressed and covered in those workbooks are very far removed from a simple tick-box exercise.

The workbooks, in my submission, ask probing questions, over very many pages, on very many issues, which the health board requires to address, answer and vouch. That KSAR process, in my submission, provides a robust oversight of capital building projects and their procurement. As this Inquiry may recall, a health board will not be permitted to progress with a project if NSS Assure is not satisfied with the responses to the KSARs.

My Lord, in my respectful

submission, would be entitled to have confidence in the work of NSS Assure across all the areas falling within its remit. My Lord has heard, detailed, careful and considered evidence from Ms Critchley and others, and, in my submission, my Lord would be entitled to place confidence and reliance on that body and its work.

My Lord, turning briefly, if I may, again on the topic of oversight of the delivery of healthcare in Scotland. On the question of HAI reporting, my Lord may care to note that the Scottish Government – Scottish Ministers – have commissioned ARHAI Scotland to review Chapter 3 and Appendices 14 and 15 of the National Infection Prevention and Control Manual in the Healthcare Associated Infection Strategy of ’23 to ’25. The intention, my Lord, is that that should ensure – noting, of course, the submissions made by Ms Doherty shortly after lunch – that there will be consistency in approach across NHS boards on the reporting of incidents or outbreaks of infection, and it is hoped that an updated outbreak reporting tool will be piloted this year.

Finally, on the question of ongoing delivery of healthcare, mention has been made of an e-surveillance system, and my Lord has already heard evidence to this effect, but there is work ongoing

currently to deliver and secure such a system.

THE CHAIR: Perhaps you might just give me that again. The ongoing work is----?

MS CRAWFORD: To deliver and secure an e-surveillance system.

THE CHAIR: E-surveillance.

MS CRAWFORD: Yes. My Lord may recall it was one of the recommendations by Counsel to the Inquiry, and I think supported by NSS Assure, and simply to advise my Lord that there is work ongoing relative to that.

THE CHAIR: The three chapters of the National Infection Prevention and Control Manual, 14 and 15-- Is the third one Chapter 3?

MS CRAWFORD: Chapter 3, yes. I’m sorry, my Lord.

THE CHAIR: Right.

MS CRAWFORD: Chapter 3 and Appendices 14 and 15.

THE CHAIR: Did you say, “Appendices”?

MS CRAWFORD: Appendices, yes.

THE CHAIR: Right, yes. That’s it.

MS CRAWFORD: Now, my Lord, having made those submissions, I go back to what I said at the outset under reference to those submissions to the effect that the Ministers remain

committed to the provision of the best possible patient-centred healthcare, and the existing arrangements to secure that are, in my respectful submission, in place. One can see from a number of-- in short, from the areas briefly discussed by me, how they operate in practice. But part of that commitment to the provision of the best possible patient-centred healthcare will, of course, be listening to the lessons to be learned from the output of this Inquiry, to which, again, the Ministers extend their thanks to the Chair, Counsel and the team.

My Lord, that concludes the submissions on behalf of the Ministers, but I'm aware that my Lord may have questions for me.

THE CHAIR: No, I don't think I have. As I indicated, I was particularly interested in what you had to say about straying beyond involved matters, but I think that's the only matter that hadn't been otherwise addressed.

MS CRAWFORD: Thank you, my Lord. I was just checking that nothing had arrived in my inbox to say I may have missed out something, but there doesn't seem to be either on my part.

THE CHAIR: Right. Thank you very much, Ms Crawford.

MS CRAWFORD: Thank you, my Lord.

THE CHAIR: Well, I think we have heard from the parties scheduled for today.

MR MACKINTOSH: Yes, my Lord.

THE CHAIR: Looking at the timetable for tomorrow, I think we begin with Ms Watts on behalf of the three doctors.

MR MACKINTOSH: Yes, indeed, followed by Ms Connolly on behalf of the Cuddihy/Mackay families, and then, in the afternoon, Mr Love in respect of the larger patients and families group.

THE CHAIR: Well, thank you very much for attendance today, and I look forward to seeing you tomorrow morning at ten.

(Session ends)

15:54

Appendix 1

1. Scotland Act 1998 - ss 51, 64, Sch 5 Part 1 Para 8, Sch 5 Part 2 heads G2, G3, H3
2. National Health Service (Scotland) Act 1978 - ss 1, 2, 2A, 2C, 10, 10A, 10C, 10Z14, 12H, 12I, 12J, 13, 77, 78, 78A
3. Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 Section 24
4. Scotland Act 1998 - ss 51, 64, Sch 5 Part 1 Para 8, Sch 5 Part 2 heads G2, G3, H3
5. National Health Service (Scotland) Act 1978 - ss 1, 2, 2A, 2C, 10, 10A, 10C, 10Z14, 12H, 12I, 12J, 13, 77, 78, 78A
6. Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 - Section 24