SCOTTISH HOSPITALS INQUIRY

Bundle of documents for Oral hearings commencing from 16 September 2025 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow

Witness Statements – Volume 8

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Scottish Hospitals Inquiry

Supplementary Statement of

Heather Griffin

29 October 2025

1. Response to the Scottish Inquiry's supplemental questions dated 24th September 2025.

2. Please find below my responses to the supplemental questions, please also refer to my earlier statement.

3. The 5 or 6 Haemato-oncology User meetings which took place at Hillington were to develop the Schedule of Accommodation and then, post market, the 1:200 drawing which showed the layout of Ward 4B. At that point the QEUH Ward 4B was a 10 bedded Haemato-oncology ward. I recall that during these meetings the pentamidine room was highlighted as being negative pressure but I do not recall any detailed discussions about M&E aspects (such as pressure gradients, 10-12 ACH etc) other than the suggestion to contact the microbiologist Dr Hood who had specialist knowledge on requirements for the ward. Dr Hood was contacted and the information given by Dr Hood regarding ventilation was included in the Clinical Output Specification (this was 2009). The Clinical Output Specification was signed off by the respective Directorate Director.

4. Some of the 5 to 6 meetings held in the Hillington Project Offices were to develop the 1:200 ward drawing, once the User Group was happy with the 1:200 Ward 4B layout the 1:200 Ward 4B drawing was signed off on the 7th May 2010 by Gary Jenkins as Lead for the User Group and also by myself, Heather Griffin, Project Manager, the Project Infection Control Nurse (Jackie Stewart) and the Project Team FM representative (Karen Connelly). The 1:200 drawing did not contain any information about ventilation, air exchanges, pressure gradients etc. I enclose a copy of the signed drawing.

5. As previously stated in my earlier statement, the User Group meetings were not technical meetings.

6. The 5 or 6 meetings in Hillington were completed in 2010 with the 1:200 Ward 4B drawing signed at the final meeting.

   In the latter half of 2010 the Project Team moved out of the Hillington Project Offices into office accommodation on the Southern General site (now QEUH site).

7. There were no meetings taking place Hillington in 2013 as we vacated the Hillington offices at the end of 2010.

8. I do not recall Ian Powrie at any of the Ward 4B User meetings I chaired/attended.

9. Mairi MacLeod was not involved in the Ward 4B User group meetings, Mairi was the Project Manager for the Children's Hospital.

10. I do not recall signing any other Ward 4B drawing other than the 1:200 drawing described above, as stated this did not contain any information about ventilation, air exchanges, pressure gradients etc.

11. I think the reason why Gary Jenkins refers to 5 or 6 meetings and I describe 2 meetings (with regard to BMT) is that we are describing different sets of meetings which I presume were held in different time periods. The two BMT meetings I refer to took place in 2013, I reference these meetings in my earlier statement.

12. All of these events are 10 to 16 years ago but I am very clear at no time in any of the Ward 4B User group meetings that I chaired or attended, including the two BMT meetings, were there any in depth discussions talking about ventilation pressure gradients, air exchanges etc. I am also very clear that there were no discussions highlighting that BMT had different M&E requirements from Haemato-oncology.

13. I do not recognise the information in Mr Jenkins statement; the only way I can make sense of this is if Mr Jenkins is recalling events which took place after May 2015, during the rectification of Ward 4B.

14. As previously stated in my earlier statement I left the project around late spring 2015.

Declaration

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

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

Appendix A

A47851278 – Bundle 16 – Ventilation PPP

Scottish Hospitals Inquiry
Supplementary Statement of
Christine Ward

The following statement is a response to further questions from SHI.

1. The SHI would like to know "*what work was done to reach the conclusions set out in para 18 of the AARG statement, including who did the work to review the update of NHSGGC Estate & Management System and how the conclusion that this included "making maintenance activities more accessible and available to the wider team and the water sampling process was also reviewed and enhanced, with data returns from NHSGGC's water management contractor strengthened". The team working on this response should have Mr Poplett's AE Audit (Water) in mind to understand the level of detail that exists in the current Site Water Safety Plan in respect of Planned Preventative Maintenance and the extent of the water sampling process. It is appreciated this work was not done by AARG Team civil servants, but by colleagues in HFS/Assure and Capital & Finance, but it important to understand who did the work and what was actually reported*".

2. Paragraph 18 is part of a response to a question posed by the Inquiry relating to a recommendation made in the Case Note Review Overview Report. The question is noted in paragraph 16 of the witness statement:

> *The Inquiry has asked whether AARG was satisfied that NHSGGC addressed the adequacy of the organisation's data systems, for example in the microbiological surveillance of the hospital environment and the extent of building, repair and maintenance work that took place in clinical areas.*

3. The relevant recommendation is reproduced in NHSGGC's "Action Plan" **(Bundle 27, Volume 14, Document 5, Page 31)** (see paragraph 4 of the corporate witness statement - **Hearing Commencing 16 September 2025, Witness Statements, Volume 5, Document 2, Page 42**) as:

***Recommendation/Action**: The precise location of any swab or water sample taken for microbiological surveillance, and the date on which it was obtained, must be recorded and the results made accessible to inform the IPC process, including the investigation of clusters and outbreaks.*

4. Paragraph 17 of the witness statement explains:

AARG recognised that the data systems used by NHSGGC to document facilities maintenance activities in clinical areas needed to consistently capture the exact location of the work done; the date which the work took place; the frequency activities occurred and be accessible to inform the IPC process. It was understood that the need to record precise locations and dates taken from any swabs or water sample for microbiological surveillance which should also be shared to inform the IPC process. NHSGGC demonstrated to AARG that they had updated the NHSGGC Estate and Management System to meet these requirements.

5. NHSGGC's progress against the "Action Plan" was discussed at meetings of AARG. In advance of the meeting of AARG on 19 August 2021, NHSGGC updated its action plan inter alia as follows:

***Recommendation/Action**: The precise location of any swab or water sample taken for microbiological surveillance, and the date on which it was obtained, must be recorded and the results made accessible to inform the IPC process, including the investigation of clusters and outbreaks.*

***Progress and evidence of completion**: The water sampling request process has been reviewed. Enhanced data returns from the Board water management contractor, has been enhanced and strengthened, with evidence now supporting retrospective review, via a new water sampling database.*

The process for environmental swabs has been updated. All requests for environmental testing must come through the Infection Control

Microbiologist Consultant. Requests include sample type and investigation required for specific locations. Results are available to the IC Team. In addition, NHSGGC has the functionality for specific results relevant to a patient are scanned and uploaded to the clinical record in Clinical Portal.

Furthermore, improvements have been identified in addition to the new request form [sic] system. These include how results from Specialist Service Providers are reported, a summary of the result as part of the incident report and the need for the result to be searchable in the Telepath Laboratory system. Following analysis and improvements of data recorded in Facilities, Infection Control and Laboratory systems the precise location of the sample and also the result is recorded within the relevant forms and also within the Telepath Laboratory system. This information is now extracted to the new database system and available to the IC Team. the water sampling requests are now also recorded in the FM First system where previously this had been reliant on email communication. This suite of work has significantly enhanced and strengthened the Board integrated reporting mechanisms.

6. This update, as well as NHSGGC Estate's and Facilities' progress against the "Action Plan" generally, was discussed at AARG's meeting on 19 August 2021 **(Bundle 27, Volume 12, Document 38, Page 390)**. In so far as is relevant, the minute of that meeting records:

The Group discussed progress against the recommendations affecting Estates and Facilities within the Board action plan, which brought together common themes across the Reviews, particularly regarding the management of water systems and ventilation, the planned re-opening dates of Wards 2A and 2B and data collection and assurance processes. The work that the Board has undertaken on Estates and Facilities has been impressive, with the appropriate use of experts to help them identify, address and continue to manage the substantial work that was required to be undertaken. The Board's Water Safety Group, along with an independent Authorising Engineer were charged with confirming all work, which was

noted to be another exemplar of good practice. This has been used to bring them to a place where Wards 2A and 2B will be due to reopen.

7. AARG were assured that NHSGGC had undertaken work to improve the management of its estate and that when making these process improvements, experts and an independent authorising engineer had been engaged. The Scottish Government Health Finance Directorate did not oversee this work given its technical nature. The technical maintenance of health facilities is the responsibility of health boards who may, if required, draw on the support of NHS NSS. Mr Morrison was aware that NHSS Assure were providing NHSGGC with technical support in relation to management of the QEUH estate, particularly related to domestic water systems, at the relevant time.

8. NHSGGC had principal responsibility to deliver the recommendations in the "Action Plan" and to provide evidence/assurance of their having done so.

9. The SHI would like to know "*Can the Scottish Government provide further detail of when and to what extent the various parts of NSS (Assure, ARHAI and HFS) were involved in scrutinising the refurbishment and reopening of Ward 2A from the establishment of the AARG to re-opening of the ward and what specifically was reported to the AARG Team, the AARG and the HSC Management Board*."

10. The Scottish Government are unable to add to the evidence of Julie Critchley of NHSS Assure in relation to the work undertaken by NHSS Assure in relation to Wards 2A and 2B.

11. The Scottish Government received a briefing from NHSS Assure, dated 22 February 2022, concerning the support provided to NHSGGC in relation to the domestic water supply for Wards 2A and 2B. That briefing confirms:

Therefore, NHS S Assure based on the comprehensive information presented to us, are able to support the reopening of wards 2A and 2B at QEUH, subject to NHSGGC confirmation (received in the joint meeting on

24th February) of their action plan and commitment to address the issues identified.

12. The reopening of wards 2A was discussed at a meeting of AARG on 28 February **(Bundle 49, Document 22, Page 170)**. An excerpt from the minute of that meeting is noted below.

> ***CNO** invited **JG** to provide an update on their current position regarding the sign off of wards 2A/2B*
>
> ***JG** reported that NHS Greater Glasgow and Clyde met with NSS several times recently in order to develop an acceptable position. There were a number of areas where information and/or action was requested. The position of NHS Assure is that they are content for the wards to open provided NHS Greater Glasgow and Clyde complete the few outstanding actions.*
>
> ***TS** highlighted that they have received an extensive briefing statement from NSS with 7 Actions to be taken; 4 have already closed and the remaining 3 will be responded to by Wednesday. There is a need for internal logistics around visibility regarding the Water Testing Group; the fortnightly Infection Control Committee (who have already met last week); and across the Acute Clinical Governance Forum. A Risk Assessment around the drainage request will be considered a reduced risk in comparison to the rest of the estate and will be subject to a sanitisation process. Beyond that, NHS Greater Glasgow and Clyde have worked through the 14-page spreadsheet. Although not required to feedback to NSS, the team will continue to do so. TS is confident NHS Greater Glasgow and Clyde can complete their actions.*
>
> ***LI** queried if the Pre-flush samples would be done prior to opening. **TS** confirmed samples have been taken, Legionella is confirmed as zero, await Clostridium difficile results on 1 March.*

***CNO** noted this position regarding the engineering and Risk Management structures in place, invited NHS Greater Glasgow and Clyde colleagues to provide an update on the pathway towards a date of the opening as well as the proposed communications that they will issue to patients and families.*

***JG** confirmed NHS Greater Glasgow and Clyde had a meeting today with the planning team. The clinical team have agreed to the opening of the wards on the 9 March.*

***SB** confirmed there is a plan of action after this meeting today following agreement. A number of communications would be made on Tuesday 1 March; including inpatients and parents, outpatients, the Board whilst issuing Government communications and media lines.*

The clinical staff have also produced an orientation video that will be shared with patients/parents later in the afternoon (1 March) as well as shared on their Facebook page alongside frequently asked questions. **SB** also confirmed elected representatives will be informed through the weekly updates already established by the Board. **SB** to make the orientation video available to politicians and to send a copy to **CNO**.

CNO agreed that with Comms commencing tomorrow, CNOD will brief Cabinet Secretary and First Minister on the 28 February regarding the opening date of 9 March. **CH** to provide this briefing.

13. The Inquiry asked the Scottish Government to *"Provide a letter setting out to what extent [Mr Morrison] and his team was told by NHS GGC that there was, to any extent, an issue with microbial proliferation in Ward 2A during the period before re-opening that required to be addressed before opening."*

14. Mr Morrison does not recollect receiving correspondence from NHSGGC relating to "microbial proliferation" in Ward 2A. Mr Morrison would not expect to engage in correspondence with NHSGGC on such technical matters. Mr Morrison had frequent discussions with Professor Steele during the

refurbishment of Wards 2A and 2B. These discussions did not concern the technical details related to the refurbishment. Rather, the discussions related to, at a high level, the scope of the works being undertaken, cost and timescales for delivery. Mr Morrison was aware that NHSS Assure were supporting NHSGGC in relation to delivery of a safe domestic water supply on Wards 2A and 2B (as per NHSS Assure's briefing dated 24 February 2022). NHSS Assure is the body with the expertise to check anything done by NHS Boards; the Scottish Government does not have the expertise to make an informed assessment of work carried out of this nature. Mr Morrison was also aware that NHSGGC could approach NHSS Assure for any further technical support as and when required and that, during this time, discussions and meetings were taking place directly between NHSGGC and NHSS Assure to discuss these issues.

Clarification of Evidence provided by Christine Ward

15. In addition to the above, Ms Ward and the Scottish Government wish to clarify two matters that arose during Ms Ward's oral testimony of 16 November 2024.

16. Clarification 1: The following exchange between Ms Ward and Mr Mackintosh KC, in relation to Ms Barkby's role on AARG, is recorded at column 15 of the transcript of Ms Ward's evidence:

> *Q And Irene Barkby, what role does she hold?*
>
> *CHRISTINE WARD: So, Irene Barkby was the professional adviser on IPC and HAI, acting on behalf of the Scottish Government.*

Ms Barkby was, at the relevant time, a member of the HCAI Policy Unit within CNOD, providing professional leadership, advice and guidance within and beyond the Policy Unit, having previously held the role of Board Executive Nurse Director and HAI Exec Lead in NHS Lanarkshire.

17. Clarification 2: The following exchange between Ms Ward and Mr Mackintosh KC, relating to NHSGGC's Incident Management Process Framework ("IMPF"), is recorded at columns 23 and 24 of the transcript of Ms Ward's evidence:

> *Q Right. If we go back to it, this one is described as draft 1.3 and we don't know what Version 1 is. We know that Version 2 comes into force in April, comes into force in 2023 and comes to our attention in the evidence of Professor Wallace at the Inquiry last year and then to the attention of ARHAI, who intervene and have concerns about it and it is withdrawn and replaced by Version 3 and now Version 4 is being revised. To what extent did AARG approve a version of this framework in that August process?*
>
> *CHRISTINE WARD: So, the framework would have been reviewed and agreed to by Irene Barkby as part of her review*

A version of this document was requested by, and provided to, the Scottish Government. Ms Barkby, however, advises that she did not personally review the IMPF referred to in Counsel to the Inquiry's question. The IMPF was approved by NHSGGC. This approval was recorded by NHSGGC as an update to the "Action Plan". The IMPF was referred to within a presentation to the AARG by Angela Wallace on how NHSGGC had made progress against various action points. The copy of the IMPF was requested by the Scottish Government and provided by NHSGGC as an illustrative piece of evidence to support/corroborate the presentation update provided by Ms Wallace.

Declaration

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

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

Appendix A

A54071466 - Witness Bundle – Hearing Commencing 16 September 2025 - Volume 5

A50491351 - Bundle 27 – Miscellaneous Documents - Volume 12

A50611329 - Bundle 27 – Miscellaneous Documents - Volume 14

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

Scottish Hospitals Inquiry
Witness Statement of
Ross Anderson

BACKGROUND

1. My name is Ross Anderson, and I am a partner in Jones Whyte solicitors. My date of birth is [redacted]. I live with my wife, [redacted] a teacher, and our daughter [redacted] Anderson. [redacted] is five years old and was born on [redacted]. [redacted] is an only child and has no siblings.

2. On the 11 November 2023 when [redacted] was three and a half years old, [redacted] was diagnosed with acute lymphoblastic leukaemia. [redacted] had an intensive six-week course of chemotherapy as an inpatient at the Queen Elizabeth University Hospital. [redacted] then had six months of chemotherapy as a mixture of inpatient and outpatient. [redacted] is now in an 18-month maintenance phase of treatment which is low dose chemotherapy to make sure [redacted] does not relapse.

3. When [redacted] was first admitted [redacted] was taken in at A&E and then [redacted] was moved to ward 2A, the Schiehallion Ward. [redacted] remained in there for the initial induction six weeks phase. Because of the length of the treatment- it is a two-year treatment protocol- [redacted] has been in various wards including all the two's, 2A, 2B and 2C. We have also been in ward 3C, we have been down in the cardiac ward, but I cannot remember what number that is, and [redacted] has also been in Clinic 1, which is an outpatient clinic down by reception. [redacted] has also been in Day Surgery which is 1A and 1B. Now we only have three months to go.

4. Throughout [redacted] treatment, if [redacted] ever has a temperature of 38° or more, [redacted] has to be admitted for I.V. antibiotics as a precaution because of [redacted] central line. [redacted] has been in the maintenance phase of [redacted] treatment since July 2025, so I think we have been in six times since that has happened.

5. My wife and I have been aware of the problems at the QEUH, but you live in naivety, and you think, “well that won’t happen to us.” I only knew about the problems through tabloid media, so you do always take it with a slight pinch of salt.

6. My first impression of Queen Elizabeth Hospital, was that the building itself looked very dated, considering, it is only about 10 years old. My immediate impression entering A&E was it is a bit grubby, scuffed floors, a bit dark, dated machinery. It might not be, but it looks like that to the layperson.

7. However, in terms of the practices and procedures, that initial trip to A&E, we could not have faulted it because we were admitted very quickly. We had been referred by out of hours, they thought it was some sort of virus, so we went there. We went through an immediate triage where they applied plasters so that they could take bloods later down the line. We then went through to the next room where there was a minor and a major category. We noted that [redacted] had been put in the major category. We still did not really know what was going on at that point, but we then were moved to a sort of cubicle. The doctor came in, took blood. We were left for maybe two hours or so, just while they were figuring out what was going on, and then we were attended by the Haematology team, by Dr Sarah Clark and Dr Jacob Emkem and they both attended to tell us ultimately what the diagnosis was at that point.

8. So, from getting to the hospital and being told what the diagnosis was, was three hours or so. We were very quickly thereafter moved to 2A for a blood transfusion and a platelet transfusion.

9. We were just trying to take it all in. We couldn’t really fault anything at that point because everyone who came in, when you’re admitted at that level, it’s all of the senior, very experienced staff who are with you, which is a shame, actually,

because you then have a level of expectation as to what you expect the rest of the journey to be like.

10. We had very senior nurses who had been on the ward for many, many years. The chief consultant, Sarah Clark, was constantly attending us. So, we did not really have any concerns at that point, what was happening was the right thing to be happening.

11. But, about 10 days into the first stay, during that induction period is when things started to change. The waters had been steadied; we had had the chat about the treatment plan; we knew we were going to be there for some time, and we just had an ability to be more perceptive. The first major concern was the norovirus outbreak.

PART 2- CONTRACTION OF NOROVIRUS

12. The first major cause of concern was the norovirus outbreak. This would be about 21st November 2023, and we were still in ward 2A.

13. The shock was, “Well, how did we manage to catch norovirus? We have been in hospital for 10 days.” It was quite apparent that the ward was suffering from an outbreak because, just anecdotally, the nurses would comment that other patients in other rooms were suffering the same experience.

14. I recollect that about 50 per cent of the ward, was affected. The reason I would say that is, when you are in source, which is you are not allowed to leave the room, they put a sticker on the window. It does not say, “These people are infectious. Stay away.” It says, “Please speak to a nurse before you enter the room,” but every second room when you were entering and exiting the ward had one of those labels on them. So, it obviously could have been other infections, but certainly at that time there seemed to be a heightened level of infection in the ward.

15. There are around twenty-six rooms in that ward, so probably about ten to thirteen of the rooms had these signs on them.

16. We never got out of source because of the chemotherapy treatment. [redacted] immune system was massively reduced, which meant that the norovirus, even after [redacted] symptoms improved, it was still present in [redacted] system when they tested [redacted] If you test positive for norovirus, you are not permitted into the kind of communal areas, like the playroom and things like that.

17. So, I am not actually sure when the rest of the ward got back to normal, but I would say within about a week to 10 days the coming and going seemed to increase.

18. [redacted] was testing positive for Norovirus all the way to Boxing Day, which was 26 December 2023. But it is not unusual for children with this chemotherapy to test positive for months afterwards, and the reason they were still testing at that point is because we were still an inpatient. We were discharged on Boxing Day, 2023, to go home and from then on there was no more testing for the norovirus, so I could not honestly say when [redacted] was finally clear, testing negative.

19. We were never told what the source of the norovirus was. Whilst in 2A that first time, I remember that there was not any sort of immediate jump to, “Right, we’ll all wear masks, and we’ll all wear gloves, and we’ll all do what we’re supposed to do.” This is a theme that we have seen consistently, that when there is an infection, infection control always seems to come too late. These things did happen eventually, but only after we had exhibited initial symptoms for a few days. It was 48hours before we saw any infection control measures begin. This was certainly at least 48 hours after [redacted] had tested positive [redacted]

20. I never got formally tested or anything, but I did not feel very well for a few days, but I got over it quickly, as you would expect somebody with a normal immune system to do.

21. My wife also contracted it. We were both in the hospital together. She had gone home one evening and had taken unwell. She then was not permitted back into the ward until not displaying symptoms for 48 hours. I was unwell, but I was in the ward, so I just had to stay in the room because otherwise no one would have been with [redacted]

22. They later moved us into a different room; they were moving people around. They would clean an empty room, move someone there, clean that vacated room, then move someone there, trying to eradicate the virus, I would assume.

23. We were not moved into any of the double doored rooms, they are at the bottom of the ward for transplant patients, though we were later in those because of [redacted] RSV and flu.

24. In terms of treatment for the norovirus, other than fluids, you do not tend to get anything for viral infections, so [redacted] just got fluids. That said, whenever [redacted] had a temperature above 38, which the norovirus caused, too, and just [redacted] initial illness caused a temperature, then they would treat [redacted] with various antibiotics. [redacted] was on Tazocin and Gentamicin, and those are the two prophylactics that [redacted] always receives when [redacted] is admitted with a temperature. It was explained to us that they are given only on the basis that, “We give these just in case it’s something more serious.” So, we have always understood that.

25. But having norovirus did not have any impact on [redacted] leukaemia treatment. At that stage, it is full steam ahead. Nothing really gets in the way of the chemotherapy treatment. It just meant that [redacted] could not leave the room, so [redacted] was in a room isolated for about six weeks.

26. It did not have a negative effect on the underlying condition; it just made things a lot more unpleasant than they needed to be.

27. This goes without saying: the actual illness, the leukaemia and the treatment, has all been very successful. It’s done exactly what it was supposed to do. It is

simply things that have got in the way that made it so much more difficult than it needed to be.

28. As an example, with the norovirus, testing positive for six weeks and being isolated for those six weeks, that then led to a kind of deterioration in [redacted] leg muscles, which meant that when [redacted] left hospital [redacted] could not walk. Being a four-year-old or three-and-a-half-year-old at that point, [redacted] bounced back very quickly; in two weeks [redacted] was back on her feet, but you only know that when you get to that point. As you can imagine, when you leave hospital and your [redacted] cannot walk when [redacted] was fine six weeks ago, it is very difficult to deal with.

PART 3 - CLEANLINESS AND HYGIENE

29. I would have to describe the cleaning as lacklustre, although it very much depended on who was doing it. We often had a young guy named Adam, who we thought was great. He came in and he would be there for 10 or15 minutes, and every inch of the room would be cleaned. The tops of the whiteboards, door handles, the beds, the sort of signs that come up, the bathroom. It became a bit of a running joke that I used to say, “I’m going to hire this guy when we leave here,” because he was so efficient.

30. But you would then have someone else who would come in and, honestly, it would be like they would damp the cloth, wipe the sides of the bed. They were more interested in chatting for 10 minutes. They would give the floors a quick sort of swish and then out you go.

31. It was so poor that we even started to bring our own cleaning supplies, bleach and wipes and give the room a proper clean ourselves, just to try and keep on top of things.

32. Even though the rooms were cleaned daily, often it was little more than a quick wipe, empty the bins, and that was it. This included Ward 2A, but I would say

it is a theme across all the wards that we visited. You either have the people who come in and they are thorough or there's people who come in and it is very lacklustre, as I said.

33. The cleaning staff would be quite open about the fact that there was not enough staff to do it all. In addition to this the management were not efficient at making sure everyone worked the same way. The good people became demotivated by the not so good people. We never saw any cleaning audits, nor did we ever see any cleaning supervisors coming round to inspect their staff or their work.

34. It really was about attitude, from the supervisors, down to the staff; no supervisors were ever named directly to us, though.

35. In terms of other hygiene procedures, not everyone who came into the room washed their hands, although at the very least everyone who came in used the hand sanitiser before leaving. There were some nurses and doctors who, after every visit, would wash their hands, use the hand sanitiser, and there were others who would do one or the other.

36. We also attended wards 1A and 1B, which are Day Surgery, because the children who are going through this treatment every sort of three to six weeks, need lumbar punctures for chemotherapy. At the very start of the treatment process, we were told, "You will be safe. When people come to this ward, it is only children who are receiving this treatment. If anyone has any signs of coughs, colds, anything at all, they will be isolated, their treatment will not go ahead and ultimately it will be a clean, safe environment." But often that was not the case, and very often we would be in a communal waiting room or the play area where children would be coughing, running noses, sneezing. We would be in with patients who had tonsils removed, arms broken. What we were told would happen was not the reality.

37. I believe that most if not all of the viruses and bugs that [redacted] picked up were picked up in the hospital environment rather than elsewhere. This is because

at home we were virtually in isolation. We did not have many visitors and did not go anywhere unless it was necessary. We also did what we could to ensure that anyone did interact with had to be in excellent health before they came near us. So, the only places we were where there was this sort of infection was the hospital.

PART 4- LINE CARE

38. In Ward 2A the mantra was "protect the line." I now know that is because of the previous issues that had arisen, which is why they had to change the protocol.

39. There are all different kinds of central lines. [redacted] has one called a port-a-cath. If patients require multiple medications, there is a device called a "spider", which fits on the end and different prongs. For example, one might be used for IV fluids, one might be for antibiotics, one might be for a blood transfusion etc. However, the bit that connects to [redacted] is never broken, never changed and it is always a different line used for different treatment; they are very strict with that. I do not have any issues with how the line was treated in 2A or 2B, but we did have concerns in other wards that we been in.

40. In January 2024, when we were in 1A and 1B, (Day Surgery) we noticed [redacted] wound, where [redacted] port was inserted, was very inflamed and red and a bit angry looking. Everyone looked at it and said it looks fine. [redacted] was then admitted to the ward, 2A, with a temperature.

41. Because it is drilled into you, "Line safety, bacterial infections, be very careful", we asked staff to check [redacted] wound because it was quite red, angry, and inflamed looking. Somebody looked at it and said, "No, it looks fine. We will just do blood tests, etc." But, because we had been around the mill a few times at this point, we asked if they could swab it and test it. But the reply was, "No, we will not be doing that because there is no fluid. It is dry." We had to accept that.

42. By this stage we had started to believe that [redacted] might have an allergy to the plasters because it was on and off, on and off, on and off; it was agitating the skin. When the plaster was removed, we asked again if they would swab it before another plaster was put on, to save taking that plaster off, too, to swab the wound. Again, they said “No, no, it’ll be fine.”

43. Eventually a doctor whose name I cannot recall came along [redacted] and , we tell him all this and he asks, “did they swab it?” We told him that we were told there was no need to. He looked surprised and asked, “Why would they not swab it? You have said it is red because [redacted] has a fever. We have to eliminate everything.” At that point they then took the plaster off, swabbed it, put the plaster back on. They then lost the swab. One of the nurses said, “I’m really sorry, we’re going to have to do this again”.

44. This time, when it was removed, there was then some leakage from the wound, probably because the plaster had been removed and applied so often. A nurse was sent to look at it, and it turned out she had only been qualified for about six weeks. She started to dab at it, but I stopped her and asked her to get someone more experienced to look at it.

45. Another nurse came, looked at it and said, “Sometimes you get this fluid discharge from where the gripper needle is inserted. I do not want to take the needle out to check the wound.” We agreed, asking her to keep it in and the nurse simply said that they would keep an eye on it.

46. [redacted] temperature subsided and we were discharged; however, when we got home there was some minor leakage from the wound. We made sure it was clean, and they had given us dressings to put over it.

47. We then attended the Day Surgery where we spoke with a nurse. At this point, [redacted] has to get the gripper needle back in because [redacted] is going for chemotherapy treatment. We asked, “Can we just stop a minute because this

is leaking? We are really worried about it." At that point, we were not concerned about the wound opening because we did not even think that would be a thing. We were concerned about infection at that stage.

48. She looked at it and said, "Oh, it will be fine. It will just heal." She then inserted the gripper needle, but I am still not certain about all this, putting another plaster on. She had got the big plaster, and I asked, "Can you just stop?" but before I had finished the word, she had quickly applied this plaster over the top of it, and the wound was still open underneath. She told me "Oh, these plasters are breathable so the air will get in, the wound will heal up and it will be fine."

49. And she might have been right, that could have happened in another version of it, but the problem was I was actively saying, "Please stop, please listen, please think,".

50. Again, none of that affected [redacted] treatment. [redacted] had [redacted] treatment, and [redacted] got better. The main core medical need was addressed, but this peripheral stuff is what then obviously caused the issue. This all developed and developed and developed over a couple of weeks to the point that [redacted] had to have the port removed because the wound opened. But, if we had learned lessons from the two weeks prior, we could have saved all this.

51. Thankfully there actually was not an infection. We later found out, it has a name, but it is a mild allergy to the adhesive in the plaster, which was causing the issue. The surgeon that fitted the new port said that the constant on and off, tugging and pulling, would have exacerbated that.

52. But we then move to much further down the line until just recently in June of this year. [redacted] was admitted again with a fever, and it turned out to be chickenpox. When you have chickenpox, you cannot be in 2A because it is highly infectious, so they moved us to 2C. That was just a total disaster, being in 2C, because they were not trained to provide any infection or line control in the way that they are in Schiehallion.

53. To give you some examples, I have obviously said about the line being sacred. What they did at the start was they disconnected the line, they hung it over one of these hooks that they have the IV fluids on, pushed the antibiotic medication into it and then reattached it. I had never seen it done like that before and said that they should not be doing that.

54. When it is your child, you pay close attention to the things that are happening, but the nurse said "No, no, it is fine. This is just how we do it on this ward." Anyway, we let that go, but then she had a lot of problems with the gripper needle on that admission.

55. It had to be replaced eight times during [redacted] stay because it was not working properly. The inside port was blocked. No one could figure out what it was. We eventually had one of the very good Advanced Nurse Practitioners (ANPs), Caitlin, who managed to get the bottom of it.

56. Once it fell out in the middle of the night and we waited about an hour and half for somebody to come and help us. I was at home that night, because only one parent could stay over at a time, but my wife called me in a frenzied panic and she had been up and down the ward trying to find somebody to come and help, but there was no one there.

57. Eventually, one of the nurses, Diane, from Schiehallion came across, and when she saw the way, the lines were being treated she said, "Oh my goodness, what is happening here? This is not acceptable."

58. At this stage [redacted] had zero neutrophils, so [redacted] was at the highest risk of infection, and they were leaving open lines hanging over a hook which were then being reconnected to [redacted] Obviously, the risk is that while it is dangling there, a bug gets into it, it is then reattached and that bug goes straight to [redacted] heart.

59. The line is never supposed to be detached. What is supposed to happen is that that line constantly runs and then an extra bung is added to the line for any new things that is to go in so that there is always a sterile access point.

60. We did not have any line care issues in other parts of the hospital that I can think of, just in that ward there. I would add that the level of experience with Ports in CDU is minimal and there have been instances were multiple attempts at access have been required, which is very distressing. We had all sorts of issues with the wrong medication being prescribed, which made the infection much worse. There was a lack of staff in that ward 2C, too. When you are on Schiehallion, it is usually two nurses to one patient whereas at one point in 2C there were, I think, two nurses to fourteen patients.

61. We had to be vigilant at all times, even to the point that every time the line is accessed it gets locked with something called TauroLock. We now know the reason is because of all the issues with patients who have died in the Queen Elizabeth because their line was infected. So, we now know that this lock is in the line to stop that from happening. It was not explained at the beginning. It was just put across as, “It’s to stop infections.” It was not explained as “because we’ve had this bad experience.”

62. Eventually, we had the nurse in charge coming because we had lost all faith in the other nurses that were in the ward 2C. They had also changed from TauroLock to TauroHep, which is a sort of stronger anticoagulant and that was to stop the line being blocked. They always come with everything in a little blue tray, and everything is lined up and the TauroLock’s usually quite a small container of fluid. So, the nurse did all her stuff, gave [redacted] her medication, clamped it, put the cap on, and I asked, “Have you used your TauroLock there, your TauroHep?” The nurse replied “Yep, absolutely.” I asked, “Are you sure?” and she replied “Yes, of course.” I said, “It’s still in your tray in the syringe.” She looked down and she said, “Oh my goodness, I’m so sorry.” And to be fair, she said, “I am sorry, I can’t believe that’s happened. I’ll fix it. It’s not a problem,”

but that was almost example twelve of something that had gone wrong in that ward, which is why, as a one-off, we probably wouldn't have really thought of it as such a big deal but at the end of a two-week saga it was just ridiculous.

63. My wife has, well, she is religious with this, so she has a day-by-day breakdown of everything. Anything that you need that I have not be able to give you I can get from her, and we can put that in.

64. PART 5- OTHER ISSUES IMPACTING HEALTH AND SAFETY

65. In terms of the hospital building itself, I cannot recall seeing any sort of water leaks, but they were obviously taking precautions because all of the taps have filters on them now and at least two or three times when we've been in, we've seen people in, cleaning the vents. They have some sort of thing that goes up into the vents, I do not know what it does, but it was always put across the wards cleaning the vents. So, obviously, they are doing some good things to try and manage infection control there.

66. Quite often they had builders above one of the entrances to the children's hospital. At the top, I think there's a sort of outside garden being built on the roof, so, for most of the time that we were there you couldn't access that because they were effectively building and dragging ballast and sand and whatever else up to do that. We were told they were making a garden, like an outside garden that the patients could use if they were in the hospital.

67. There were never any issues with water quality when we were there. Quite often, when we were in the wards, there were guys in black T-shirts, and I do not think they worked for the NHS. I think they are a private contractor, but I would say at least once a week they came in and tested the water quality.

68. In terms of the room ventilation, all the rooms in Schiehallion, above the doors, have these vents that flap back and forward. It was always put across to us as,

"It's to maintain pressure in the rooms," because people are having treatment, but I think it is also to make sure that there is a constant flow of fresh air and that things are clean, etc.

69. But quite often they would be broken, so you would close your door, and they would just swing back and forward all night long. The nurses would say, "Listen, I'm really not supposed to tell you this, but if you stick this tape up there and tape it over, it'll stop that from happening" which when you don't know, you don't know. You just think, "Oh goodness, I'll just do that, and we'll get to sleep because it's gone on for 12 hours so far." But there were problems with that type of equipment. All the rooms that we have ever been in have those vents.

70. In June 2025 in Ward 2C, [redacted] had to have a blood transfusion, and it was quite clear that the nurse who was in charge of giving that was not properly trained to do it because she could not get the machine to work. When you have a blood transfusion, you have the bag of blood and then you have a little sort of vial that it drips into and that drip is what keeps it constantly flowing. That vial is usually half full, half empty. For reasons known only to that nurse, she squeezed the bag so that the vial filled up to the top which then means it is not dripping so, therefore, it is not flowing.

71. She then flipped the bag upside down, squeezed some of it back in, turned it back over. She was there about 10 minutes, and there's a little sort of magnet thing that you attach to the little vial which makes the drip happen, which makes the flow happen, and I had said to my wife, "That's the issue. She has not put that on, so it is not happening."

72. The nurse said, "I am really sorry. I will get something to fix it," but I went over, moved this little black clip, put it on and it was sorted. Now, obviously my [redacted] had quite a few blood transfusions, so I've seen it happening, so I don't profess to be a sort of expert on anything, but when you see that happening and it's your child, you do pay close attention to it.

73. So, my view is, the person that is coming in to administer a blood transfusion should have known how that process works and not tried to figure it out.

74. In addition, whenever you are admitted and you have to have IV antibiotics, you have to have your line accessed. Because [redacted] has a port, [redacted] has the gripper needle put in and, as I said, it just was not working. But the staff in 2C and CDU had no ability to troubleshoot that. At one point, the nurse who was doing it was being monitored by someone who was wearing a badge that said "Senior." I asked that nurse if she could take over, "Could you please do this? Because it is clearly not working. My [redacted] distressed. You are the senior person here. Could you take over?" But she replied, "Although I'm the senior nurse, this person actually has more experience doing these than I do."

75. We then had to get somebody down from Schiehallion. Again, it was someone quite junior. They were not very experienced in doing it, and it was not until three hours later that we had an experienced ANP attend, and she was able to troubleshoot. She was able to say, "Use this, this, this," and she got it working. But, by this point we were on needle number five or something like that.

76. But that's just one aspect of this; the distress caused is one thing, but the whole policy is that we're supposed to have IV antibiotics within an hour of the temperature spike because with sepsis, which it could well be – every time there's a temperature, they treat it as suspected sepsis – three hours can make a life or death difference.

77. There just seemed to be a lot of hesitancy by people who didn't really know what they were doing and more than once we had heard the words, "I can give it a go, if you would like," which just is unacceptable for anyone to say, "I'll just give it a go."

78. It was all said with the best of intentions, and the staff were genuinely trying to help, but they should not be in a position where they are having to say, “I’m trying to help you by giving it a go.” There should be someone there who can do the things that they are supposed to do.

79. There is a common theme through our whole experience, which is that there has been a lack of active listening. Whenever there is a problem, parents often have an opinion on that. My wife and I do not shout and scream. We are quite sensible and level-headed. We try and explain things, but it very often seemed as if we were being told “Well, we are the doctors, we are the nurses. We know best, so we will just do this.” In many cases if there had been just a little bit more stopping and listening, we would not have had the difficulties that we then had, or we would have been better informed about how to deal with the thing that had arisen.

80. In November 2024, [redacted] was admitted to QEUH with Respiratory Syncytial Virus (RSV). We were not put into a negative pressure room from the outset. [redacted] was exhibiting all the symptoms, coughing, shortness of breath etc but they did not move us into a negative pressure room until around forty-two hours after admission, then they discharged us at hour forty-eight. I would have expected [redacted] to be put straight into one of those rooms if there was one are available. It seemed to us that that they wait until you test positive for an infection and only at that stage do they involve infection control, as opposed to taking precautionary measures at the start.

PART 6 -ATTITUDES TO COMPLAINTS/ RAISING OF CONCERNS

81. [redacted] was admitted on 3rd June this year and was discharged on 15th June. It was during this admission that we decided to complain to Caitlin, who is one of the ANPs in Schiehallion. She is fantastic, and when we were having all the difficulties, she had taken it upon herself to really get all the nursing staff together, the senior nurses in that ward, and tell them what needed to happen.

It was Caitlin that identified that [redacted] had been given the wrong dose of antiviral medication for the chickenpox, and she then brought the consultant along who had to explain that to us. We only complained verbally, not in writing. We asked for a meeting with Dr Srah Clark, who is the lead consultant in the Haematology treatment ward. Caitlin said, “Well, actually, parents don’t often get told the outcome of these reports, so we’ll submit.”

82. Our complaint was about our whole two-week stay in Wards 2A and 2C at that point because the wrong medication started in 2A. Then in 2C we had the issues with the poor line care, understaffing, the incorrect insertion of needles, not using Tauro Lock, the line being left blocked for an hour, no one coming back. So, there was just a whole host of things.

83. However, this was several weeks ago, and we have yet to hear back from anyone about the complaint. We are deeply unhappy with the ancillary medical support and, really, just what we have always wanted through this is to use our experience, for them to learn, so that other children do not have the same experience as [redacted]

84. The point really is, if you are a Schiehallion patient on any other ward, you should receive the same level of care as a Schiehallion patient on 2A, but that just was not possible. The staff are not able to deliver that level of care, not through any fault of their own, but through issues with the management and the resources there.

85. We have only spoken with Caitlin, the Advanced Nurse Practitioner, who was taking it forward. We have not heard anything more about any of this and that is what led us to contacting The Scottish Hospitals Inquiry, looking to contribute, because it was another example of not listening and not acting.

86. My wife has a fear that if we speak up and say something, that this will affect [redacted] treatment, which I keep assuring her it would not; in fact, if anything, it should make them sit up. It should not affect [redacted] treatment, but nevertheless that is the fear that [redacted] has. So, we agreed that, as [redacted] only has three months left of [redacted] treatment, we would wait until it finishes in November. My wife has been keeping a note of everything that has happened over the past two years, and we will therefore put in a formal written complaint and hopefully we will get a response.

87. We know that they have already done that to some extent because when [redacted] had the issues with [redacted] first line, we had a very good nurse who was in the tissue viability team. She pulled everyone together, the surgeons, the consultants, the doctors and said "This is the problem. This is how it has happened, and these are the changes that we need to make."

88. It had happened to two other children around about the same time, there was a bit of a theme So, we have seen good examples of them adopting change now. That nurse happened to be the aunt of one of the personal injury lawyers in this firm, so, maybe she knew that I worked here, and she thought, "We'd better do something about this before it becomes a bigger deal," but who knows?

PART 7: COMMUNICATION

89. In my opinion communication is a huge issue at QEUH. There is very rarely a time when we meet someone new where they know everything that they are supposed to know about [redacted] medical history. Very often we have to start from the beginning, go through the whole process, the whole thing and reiterate everything that has come before, because there does not appear to be a decent note keeping system, recording from someone who knows what has happened before.

90. For example, when we were in the most recent stay, the nurse said to us , “You guys seem really anxious about this. It is as if you have had some sort of septic treatment before or something that, or like septic exposure.” We said that nurse, “Yes, [redacted] was in last year with sepsis.” She had no clue that that had happened; I found it bizarre that they would not know that, as this will all be documented in [redacted] medical records.

91. Again, very often we had to say to nurses, that we want you to ask somebody this question and come straight back and tell us the answer to that question. Otherwise, it would be, “Yes, yes, I’ll be back, no problem at all,” and it just would not happen. So, yes, there is a concern with communication, even between departments.

92. When [redacted] was having [redacted] PICC line inserted, the nurse, , said, “Oh, so [redacted] here for [redacted] port removal?” and she had also written that down on [redacted] surgical form.

93. So, the form that is going to be theatre form, she had written down “port removal.” We told her that [redacted] was in to have a PICC line inserted, and she was, like, “Oh, right, I’ll get a new form.” Obviously, she’s just trying to be prepared or whatever, but our concern, actually, one of my wife’s concerns, is because my wife’s a teacher in a school where there are a lot of children where English is not their first language, our concern always has been that if there was a family in our position where English was not their first language, things could go seriously wrong because you have to be vigilant at all times. Otherwise, as you see, from the experiences we have had, we have had quite a few near misses that have not been accidents because we have noticed it, like the TauroLock not being inserted.

94. We have identified this in a couple of wards; there is a change in tone when people are speaking to people where English is not their first language. It is frustration. It’s very much a case of, “Oh my goodness, you can’t understand what I’m saying, I’m too busy, I don’t have time for this,” so, they just say the

thing again louder and move on to the next person, and that isn't fair for those families because they're then not knowing what's happening.

95. We have other concerns about how the hospital addresses the various infections [redacted] has had. When [redacted] had sepsis, it was put across as, "Well, this is just a thing that happens when you are in this treatment. It is unfortunate and it is serious, and we will treat it," and they did, and [redacted] was much better. But it was very much, "This is just a thing that happens."

96. The RSV and the chickenpox, again, it was just, "Listen, [redacted] a four-year-old, these things get picked up and then we deal with them," But, even with the RSV, we didn't know what it was, and this is maybe 40 hours into it and a nurse comes into [redacted] room wearing a mask. I commented, "Oh you're wearing a mask now," and she replied "Yes, we have to with RSV." I asked "So, [redacted] has RSV?" The nurse then replied "Yes, did nobody tell you? Did nobody tell you that?" "No," I told her "We didn't know that."

97. So, again, she should have come in and said, "I'm wearing a mask because we've read the notes and [redacted] has RSV," and that would have been a totally different experience for us in those situations, as opposed to it being another example of where we're not really talking to each other.

98. [redacted] was admitted for two weeks in May 2024 when [redacted] contracted sepsis, and I think, part of that, I think, was because of the decisions that had been made about the treatment at that stage, which left [redacted] in a much more vulnerable position than [redacted] should have been.

99. I cannot remember exactly what the organism was; it has a long Latin name which I cannot remember. It was a bacterium that exists in everyone's intestines, but because of [redacted] severe immunocompromised state, it passed into [redacted] bloodstream, which caused the sepsis.

100. What we were told at the time, they call it febrile neutropenia, was that it was just an infection caused by being neutropenic, which meant [redacted] had zero

immune system. But the reason [redacted] was so severely neutropenic is because [redacted] had just been in a hospital the week before for a chemotherapy called doxorubicin. When [redacted] was given doxorubicin, the protocol, as we understood it, said that you were supposed to be 0.5 or have 0.5 neutrophils as a minimum and have haemoglobin above 80 and platelets above 30. [redacted] however, had neutrophils of 0.1 and [redacted] had haemoglobin of sixty-seven and platelets of thirty-three. So, [redacted] was just above the platelet threshold, and [redacted] was below the haemoglobin threshold and below the neutrophil threshold.

101. But the decision was taken by the ANP, the advanced nurse practitioner, I believe in conjunction with the consultants, to go ahead with that treatment because the protocol allowed for consultant discretion at that stage. They felt that it should go ahead, because [redacted] was in otherwise good health, [redacted] was presenting well at that point and what they would do is, do the treatment and do a blood transfusion immediately afterwards to bring [redacted] haemoglobin back up.

102. But where we were let down there is we were sent home with platelets of 33 and then given very, very, very strong chemotherapy. What happened was that by the time we were admitted to hospital, and [redacted] was on the ward, [redacted] platelets had dropped to seven.

103. Now, to put it in perspective, [redacted] now sits at 200-odd as a level. [redacted] was left with absolutely nothing to fight any form of infection and we genuinely believe that [redacted] should not have been discharged without some sort of platelet follow-up. When we then were admitted to the hospital, we went through CDU at that point, which is the sort of clinical decision unit. We asked many, many times if they would check [redacted] blood levels, because [redacted] was only 33, [redacted] has had chemotherapy, and you would think that [redacted] would be much lower. It was 36 hours later before someone said, "[redacted] is sitting at seven. This needs to happen now."

104. The thing is that the test was done when we were admitted. So, they took bloods when we were admitted into CDU, but no one came and spoke to us about the results until 36 hours later, despite us asking four or five times, “Can you go and check the bloods? Can you find out what is happening? Can you find out what the numbers are?”

105. This is what I mean about there being poor communication – nobody was listening to our concerns. It’s two extremes: there are some fabulous staff at the QEUH who went well above and beyond, but then there are other staff – and it’s probably through sheer business, I accept that- who seem to listen but don’t hear what you’re saying and don’t kind of act as you’d want it. We asked the ANP at the time, “Is it okay to go ahead on this basis or do you think we should wait until the numbers come up a bit?” and it was put across that, “No, this will be fine. “You know, it is not unusual for children in this treatment course to catch sepsis, so it was almost put across as, “This is just a necessary evil of the treatment.”

106. There is one other issue, which relates to communication, to do with antibiotic prophylaxis, which is something that happens religiously. Whenever [redacted] has a temperature, [redacted] will be admitted and then [redacted] receives them. I am still not, to this day, sure whether that is treatment that is universal in these circumstances or whether it’s something that happens because of the issues that have happened with the hospitals before because, other than the septic issue, every other time has been a viral infection.

107. Even when [redacted] had the flu at one point, and we knew it was the flu because [redacted] tested positive for the flu, but they still gave [redacted] the antibiotics, which obviously do not do anything for flu. The antibiotics are very strong, like they are very serious antibiotics. They cause an awful lot of stomach upset and bone damage and things like that, so they are very strong.

108. Obviously, we would always rather err on the side of caution, but I just do not know, are we being cautious because of the illness and the treatment or are we being cautious because of other things in the hospital that mean we have to be cautious?

109. [redacted] also received weekly anti-fungal medication when [redacted] was an inpatient. But, again, that was never put across as, "We do this because there have been instances before where children have picked up fungal infections." We asked, "Why does [redacted] get this?" One of the nurses said, "Oh, it's just that when people are in hospital for a prolonged period of time, they can develop fungal infections."

110. But the way it was put across was as though it is because [redacted] is in bed and not moving and has chemo. It wasn't, which we now know, because there have been issues with cleanliness in the past which have led to people picking up fungal conditions, so we have to prophylactically treat that, which I am not even sure the nursing staff would know to explain that properly.

111. We have dealt with fantastic staff during all of this, and the consultant team, have cured [redacted] illness, so I cannot take any of that away. I cannot fault the medical treatment that [redacted] has received, but the reason I contacted you is because it is these peripheral things that make the core treatment so much more difficult to deal with than it needs to be.

112. When I was reading your terms of reference, I thought that that is the part that I can contribute to. Having parents two or three years down the line is a helpful thing because we can see the things that should have changed, that have not changed, and which will be nasty if it repeats itself and if these issues do not get resolved.

Scottish Hospitals Inquiry
Supplementary Statement of
Alan Seabourne

1. In early 2024, I was approached by the Scottish Hospitals Inquiry and requested to participate as a witness to the Inquiry. In April 2025, I submitted a final statement to the Inquiry **(Witness Statement - Alan Seabourne - 29.05.2025 Hospitals Inquiry)** and on Thursday 29th May 2025, I provided oral evidence at the Inquiry **(Transcript - Alan Seabourne - 29.05.2025 | Hospitals Inquiry).**

2. Both pre and post these events, I have taken regular interest in the Inquiry and in particular the evidence of witnesses during the hearings.

3. I have been watching some of the current Glasgow 4 Part 3 hearing and I want to make comment on some of the evidence I have heard.

4. I listened to some of Mike Baxter and Peter Gallagher's oral evidence **(Transcript - Mike Baxter - 16.09.2025 | Hospitals Inquiry** and **Transcript - Peter Gallagher - 18.09.2025 | Hospitals Inquiry)** just for interest and I normally would not comment, however, when I hear statements that for me are not a true reflection of events and, when such statements may be considered detrimental to me and my colleagues, then I feel I must raise it with the Scottish Hospitals Inquiry Team.

NEC 3 Building Contract

5. The choosing of this option for a building contract type had absolutely nothing to do with myself or the project team. The NEC3 contract was decided upon with advice from the Board's three main advisors Ernst Young, Shepherd and Wedderburn, Currie and Brown in conjunction with Partnership UK (PUK)

(consultants to Mr Baxter's team and employed by the Scottish Government and seconded to NHSGGC) in developing the procurement strategy. This information is important in understanding future decisions on the project because this decision led to the commissioning of Capita as NEC3 Supervisors and subsequently changed Currie and Brown's original role as Technical Advisors (TA's) from providing a full technical service including design elements to providing Cost Management, Programme Management and Project Management, these changes are contained in papers submitted to Performance Review Group one of the Board's most senior committees. Please see Reference Note 1

6. My involvement along with Peter Moir's was only to action the decision made by those mentioned above. I stated in my evidence that I personally had never heard of this type of contract and my deputy Peter Moir a professional architect for many years who had led many health projects, was unfamiliar with it and indeed he had never used it in the past, therefore, neither of us promoted this change to the building contract type.

7. In his evidence, Mr Baxter was asked by Mr Mackintosh KC, if the major change to the building contract from PFI to public funded capital had an impact on staff delivering the project as they were obviously unfamiliar with NEC3. Mr Baxter said that in his opinion this was just another standard form of building contract (in my opinion it is totally different from all other contract forms used prior to this including the most commonly used JCT) and that the health community who generally manage such contracts (I assume he meant staff like the project team) would view it in a similar way. In support of his answer he said that the project team could go to Health Facilities Scotland (HFS) for NEC3 training if required. Both of these comments are incorrect, firstly, if you read my CV in my statement you will see that I was in a totally different role(s) previous to being Project Director on the QEUH and hadn't undertaken any capital building works for some 7 or 8 years, therefore at that time I could not be considered part of the capital funded building community whom Mr Baxter refers**,** hence, it is not accurate to state that project people

could just adapt**.** With regard to Mr Baxter's other comment on getting NEC3 training from HFS, I did go to HFS for training, however, as they didn't have the knowledge, capability or capacity to provide NEC3 training their response was this was not possible. I contacted Stuart Kings a building contracts consultant recommended to me to provide the training and subsequently my whole team received two days of NEC3 contract training, as stated in my evidence**.** I also asked Currie & Brown to provide some training on NEC3. Therefore, again Mr Baxter's evidence is not accurate. For clarity, the project team (including myself) did not make the decision to change the form of building contract to NEC3 and hence, had no say in the decision to appoint NEC3 Supervisors with a subsequent change to the original TA's role.

Standing Down of the Design Team

8. Firstly, the design element of the TA was never totally stood down and this term or phrase that has been used by Counsel to the Inquiry. It does not reflect what actually happened. The role of the TA was changed but it is very important to note that it was still called the TA throughout the duration of the project and people knew and referred to it as the TA which is why I think there is confusion with some of the witnesses.

9. Mr Connal KC discussed the stand down of the design team with Mr Peter Gallagher in his evidence. My evidence was paraphrased as me saying that the technical team was stood down because nobody was going to pay for it. For the avoidance of doubt I did not make this decision on cost or at all. The decision wasn't made with regard to cost or affordability it was made in regard to requirements of NEC3 building contract and the project requirements.

10. Mr Connal KC relayed this position when questioning Mr Peter Gallagher about the project finances to which Mr Peter Gallagher responded there was no problem with finances on this project and pressed further by Mr Connal KC, Mr Peter Gallagher said that the TA design team wouldn't have been

stood down because of finances on this project, hence, trying to make the point I was wrong about not being able to afford to keep the full TA on board. With regard to Mr Peter Gallagher's evidence on project finance, it is important to note that it was my responsibility to manage the finances on this project and no matter what Mr Peter Gallagher or anyone else has stated the reality was that there was absolutely no excess or flexibility in the budget to pay for any additional services, therefore, it wasn't affordable to duplicate this service by having both the TA designers and NEC3 Supervisors doing very similar roles, although as stated above finance was never considered on deciding this strategy, it was down to the type of contract.

11. On the QEUH project every pound was accounted for and contained within Brookfield's contract, within the Board's priced risk register, within the enabling works budget or it was required to fund the necessary infrastructure to support overall project (i.e. the provision of car parks, offices etc.) which even at this late stage i.e. around the beginning of 2010 had no approved budget allocation. The Board and project team also had to contend with Scottish Government and Scottish Futures Trust trying their best to remove money from the overall project budget, therefore, there wasn't any flexibility or additional funding to support anything other than the project planned activities, which was the point I tried to make during my evidence and as Mr Peter Gallagher was involved in project finance, I was very surprised to hear that he thinks finance would not have been an issue in any decision regarding this project. For the record, on a number of occasions I was severely challenged and censured by my senior officers within the Board on project expenditure including the PRG (May 2010) for requesting additional expenditure for professional advisor fees and other project costs.

12. In both Mr Baxter and Mr Peter Gallagher's oral evidence they said that they had no knowledge of the design team being stood down, again using the term created by the Inquiry, the question to them should have been, *"were you aware of any change in role of elements of the TA team because of the addition of the NEC3 supervisor role",* which may have produced a different

answer from them because they were involved in the discussions regarding this change.

13. When the decision to choose NEC3 was being discussed and taken the change in TA role was central to the discussions on procurement, which both Mr Baxter and Mr Peter Gallagher had knowledge of or were involved in mainly because the type of procurement strategy/route selected would have a direct impact on the overall project budget, but more importantly, impact on cash flows which were a critical element of financing a project of this scale, so it was very important the finance personnel from the Board and the Scottish Government were involved or aware in such decisions. There were many meetings where this was discussed along with all other aspects of the procurement strategy held at range of venues (Shepherd and Wedderburn offices, Ernst & Young offices, Currie & Brown Offices, Board premises), including briefings to Mr Baxter's team at the Scottish Government Health Department. Everyone involved was made aware that a different structure was required for an NEC3 contract which required an NEC3 Supervisor role, not the TA's design team role as envisaged and planned from the outset. In fact, Currie & Brown during these discussions expressed that if the Board were now changing elements of their TA team service, could they be considered for fulfilling the new NEC3 Supervisor role, an offer they put in writing to Pete Moir. They were subsequently refused because the procurement of the NEC3 Supervisor was being procured via the governments national framework contracts as agreed by Mr Baxter's team and Currie & Brown were not on the governments framework for this type of role. There were many discussions on this hence, my surprise that two very senior finance people say they didn't know about this issue.

14. Furthermore, and this is very important with regard to this issue, because of the scale and technical complexity of the project, myself and Peter Moir (not anyone else) asked senior management, which would have included Mr Peter Gallagher because of the cost implications, if they would give approval to retain some elements of the original TA team on a draw down basis to help

with the design process (in my statement and oral evidence). The request was for Wallace Whittle building services engineers and Buchanan Associates health planners because Peter Moir and I knew from many past experiences that we may need such a resource at critical times and this was agreed by the Board's senior officers, probably at the ASSB (Acute Services Strategy Board) Sub Group, the ASSB itself or indeed the PRG. The cost to approve this was circa £60,000 (I think my statement stated £40.000) a cost well over my delegated authority of £10,000, therefore, it had to be agreed by my seniors and again the senior finance officers would be aware and involved in this as members of the approval process. The draw down sum was part of an overall package of costs for the Laboratory and Hospitals projects of £1,105,601 to be proposed for approval to the PRG., There is absolutely no way I could propose or approve this amount without the support and direction from my seniors. In 2010 expenditure of £1,105,601 was approved by the PRG (no one else had the authority to approve this amount of funding) and this included £60,000 to retain elements of the original Currie and Brown TA service at the request of Peter Moir and myself. The drawdown funding was required to support the design development during stage 2 (App. K) of the project. For context, at the time (2010) this would pay for around 100 professional technical consultant days, more than adequate to support the project through the main design development process. The proposal was approved by senior management including senior finance officers and the PRG.

15. At the point when I would have to draw down this funding to pay Wallace Whittle or Buchan's for their additional design input (around Q4 2009 as I stated in my oral evidence) I had to go through an approval process and this would be reported to relevant group(s). Finance on this project was very strictly controlled and rigorously reported, the project team had two independent and very effective senior financial officers supporting and advising us, both of whom reported directly to Mr Peter Gallagher. I do not understand how anyone in a senior role, not to mention a financial role, who had any involvement in this project would not know about this change or

funding this change.

Derogation (Alternate Design Solution)

16. Mr Baxter was asked if the Scottish Government had a policy on derogation reporting. The answer, although he never actually said it, is that they didn't and neither did the Board. Mr Baxter's comment to excuse this lack of policy requirement by the government was to suggest that staff working on capital projects would understand all about derogation requirements because his department held workshops and from those workshops project staff would be aware of how to address derogations. I totally disagree, neither myself nor any member of the project team to my knowledge were invited or participated in any such workshops where derogation process was discussed, it did not happen. I don't recall ever attending a workshop run by Mr Baxter's team.

17. With regard to alternate design solutions, I would like to add that it is my understanding that it was agreed that Brookfield was responsible for providing an alternate design solution list (derogation list as counsel describe it) at Practical Completion of the contract as part of the handover documentation to the Board. This was an action given to Mr Darren Smith, Brookfield's Senior Design Manager although obviously I don't know if this was completed as I retired before the completion of the contract. If the list was compiled at handover, then everyone would have been aware of any changes before occupancy. I have not seen Mr Smith give oral evidence which I find surprising as this topic has been a thread all through the Inquiry.

Activity Data Base ('ADB') Use

18. From Mr Baxter's session it seemed to be intimated that ADB wasn't used on the project. This is wrong it was used by the project team to do the initial planning and preparing of the Employer's Requirements ('ER's'), Exemplar,

procurement and tender process. Subsequently, the designers, Nightingales wanted to use codebook which was allowed by the Board. There are very few technical differences between the two systems as discussed by Emma White in her evidence on the first day of the Glasgow 4 Part 1 hearings.

Mr Calderwood's Evidence

19. After hearing some of the evidence from Mr Calderwood I have some further comments to add to this supplemental statement. In questioning Mr Calderwood, Mr Connal KC indicated that evidence from Capita personnel stated that they did not refer to the ER's to provide assurance that they complied with the Board's requirements This is not true. Peter Moir arranged for the ER's in disc format to be sent to Capita for them to use as their reference to ensure all works primarily met the Board's requirements. This will be recorded somewhere in Project Board files. The ER's were used as the primary document for Capita to ensure conformance, for example, when Brookfield team designed something and then built and/or installed it, it was up to Capita to check the build/install was correct against Brookfield's drawings but more importantly it was their role to check it was in compliance with the ER's. Another example would be system commissioning, where it was Capita's role to witness test the outcomes of commissioning and ensure that they complied with the ER's. This is called assurance and for Capita to suggest the Board never asked them to do this is not true.

20. When it was further put to Mr Calderwood by Mr Connal KC that Capita did not provide the compliance and assurance service although others had stated they did, Mr Calderwood rightly did not agree and responded "what were we paying them for then" my thoughts exactly. Capita were employed to provide inspection and compliance of the works with regards to the Boards ER's giving the project team and the Board the assurance needed on all stages of the project i.e. stages I,2,3 and 3 a). Additionally, they were requested to review elements of stage 2 design specification produced by Brookfield team

in the run up to the completion of the FBC in October 2010 and they were also requested by Peter Moir to continue to provide additional elements of design review beyond 2010. (Reference: PRG Paper on 18th MAY 2010, Paper number 10/25) **(A51758411 - Scottish Hospitals Inquiry – Hearing Commencing 13 May 2025 – Document 29, Bundle 34 – Performance Review Group and Quality and Performance Committee Minutes and Relevant Papers)**

21. An example of Capita's input to design development can be seen in relation to the design of Ward 2A ventilation systems (specifically the BMT PPVL rooms) an area seemingly of considerable importance to the Inquiry. Capita staff signed off the A status in the RDD process of the change to the PPVL room design in conjunction with Brookfield and their designers ZBP. I mentioned this in my evidence although signing off A status drawings was disputed by John Redmond of Capita in his oral evidence. However, the drawing record will show Mr Follett, Capita's Associate Director of Building Services was the person who signed the drawing off as status A in 2012. It is therefore somewhat surprising to me that considering the attention the ventilation system in Ward 2A including the BMT rooms has been given by the Inquiry, Mr Follett has not given oral evidence to the Inquiry to clarify why he signed this off. Capita, from my memory had 6 personnel on the project in my time, two of them, William Roxburgh and John Redmond who were overseeing the structure and building works respectively and four others, Alan Follett, Graeme Bruce, Douglas Wilson and David Ramsey on the engineering side and yet the Inquiry has only heard from John Redmond a builder who isn't an engineer to give oral evidence on engineering systems.

Further Points

22. As the final session of the Inquiry is over, I wanted to raise a couple of issues of concern about the Inquiry process and in particular a number of things I heard or more importantly didn't hear from the Inquiry.

23. My concerns are about people who worked on critical areas of design and construction of the hospital, for example, water and ventilation systems and as far as I can see have not given written or oral evidence to the Inquiry. I have already mentioned Mr D. Smith, Brookfield and Mr A. Follett and other members of the Capita team but there are others whom I think are important for the Inquiry to hear from.

24. The Inquiry is focussed on the design, construction, commissioning and maintenance of the new hospital and yet as far as I can see there are people who worked on the project with significant responsibilities in the key areas the Inquiry has been investigating and have not been called to give evidence, those areas being primarily water and ventilation. This is in direct contrast to nearly every member of the project team being called to give evidence apart from those not medically fit to do so. From my perspective it appears that the Inquiry counsel think that the project team were the designers and constructors of the hospitals when in fact the only people responsible for design, construction and commissioning of the building and its services were Brookfield, their sub-contractors and their consultants.

25. The water and ventilation systems were designed by ZBP and the Inquiry only heard from one witness from ZBP i.e. Steve Pardy their most senior person on the project. ZBP, the hospital designers, had others such as Andrew Percival and Neil Ross and others who may have more detail about systems design in the roles they fulfilled, I question why they haven't been called to give evidence on issues such as the ventilation strategy design, the reduced air changes in general single rooms, the lack of an air lock and the reduced air changes in Ward 2A single rooms etc.

26. ZBP received significant input from Mercury Engineering in the design process and who's staff also installed, tested and commissioned those systems. Key staff from Mercury Engineering have not given evidence, the Inquiry heard from one person, Robert O'Donovan. The key people with significant involvement were Ed McIntyre, the Director responsible for all

mechanical and electrical systems, Siobhan Rogan, engineer responsible for ventilation systems and Ciaran Kelleher engineer responsible for the water system, therefore, from my perspective it is astonishing that none of these people have appeared to give evidence bearing in mind the significance the Inquiry has given to these specific services.

27. For example, I was asked during my oral evidence, as were others, about when the water system was filled, a very pertinent issue for the Inquiry and to my knowledge no one seemed to know the answer, surely the lead water engineer i.e. Ciaran Kelleher would have been the most appropriate person to ask to obtain an answer and not someone like me who wasn't even there at the time?

28. Mercury Engineering had a quality department, responsible for checking all system installs, why hasn't anyone from that department been asked to give evidence to discuss the engineering quality of the building systems bearing in mind some of the evidence heard and concerns about ventilation, water systems and issues with filtration. For example, considering the significant number of faults/defects highlighted in the DMA Canyon report in 2015 and 2017, surely this should have had a high level of importance to the Inquiry as it is a basis for the quality of workmanship on building services. I recognise the DM Canyon report was not provided to Brookfield or its sub-contractors at the time it was completed and presented to the Board back in 2015 but in terms of potential impact on contamination subsequently, why hasn't the Inquiry taken that report and asked members of Mercury Engineering or their quality team how those defects occurred in the first place. Why have Capita not been asked to explain why they didn't identify any of these numerous significant defects. Again, I find this unbelievable because clearly these defects could have increased the rate of contamination in the water system if it was contaminated at handover, or at any time in the future, they certainly wouldn't have helped.

29. During the oral evidence sessions, including my own, counsel to the Inquiry seemed to be very concerned that they couldn't find information on the building services design input and how it was carried out and progressed. In my oral evidence I explained that the architects (Nightingales) led the User Group Meetings (UGM's) to determine the layouts for each department and the individual rooms within the departments. I gave an example of how this would/should have worked, i.e. the architects would have a number of people at the UGM's including, users, project team, quantity surveyors, health planners, Brookfield staff and a building services designer from ZBP. The users would inform them of the type of rooms needed and how they were arranged within a floor layout to suit the patient groups they would be treating. From this information, ZBP's role (working in unison with the architects) was to take this information and design the required systems for all the relevant rooms in accordance with the ER's and national guidance, it's called Design & Build. For the avoidance of doubt, I am not suggesting the users were asked to specify the building services requirements, they weren't, all they had to do was identify the room type and what they were used for (clinical functionality) and ZBP would design the required building systems. For clarity, users would however, be asked to comment on their requirements for services such as medical gases and power outlets etc.

30. During Emma White's evidence (the most senior consultant on Brookfield's team) this issue was discussed and as I recall Emma did allude to a similar explanation although when pushed about the input of the building services engineers she wasn't sure because she did not attend any of the UGM's. Therefore, in order to get a definitive answer to this, I am again confused why the Inquiry didn't ask the architects who were leading these UGM's to give evidence or ask the ZBP engineer(s) who attended the UGM's and get an accurate answer to this point. From my memory the names of those architects who attended the UGM's were Graham Harris (I think he was the lead on UGM's), Terry Lane, Liane Edwards, Jason Truscott, John Wigget, all Nightingales architects and a couple of others who inputted but I don't recall their names.

31. In my opinion the Inquiry thus far has not done enough to take evidence from people who participated in the delivery of the QEUH project and to hear evidence from those who had some of the most significant roles in the project process.

Note 1

32. There were two papers to the PRG on the issue of TA and NEC3 Supervisor changes. These were in May 2010 providing a report on the commissioning of the NEC3 Supervisor and January 2011, confirming the re-evaluation of the TA requirement. The January paper sets out the new role of the TA including the following with no mention of any design requirement.

    Monthly payment assessment – validation of costs.
    Monthly valuations – up to circa £ 200M per annum.
    Programme Management.
    Project Management support.

Declaration

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

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

Appendix A

A51758411 - Bundle 34 – Performance Review Group and Quality and Performance Committee Minutes and Relevant Papers

Glasgow 4 Hearings
Supplementary Witness Statement
Louise Slorance

1. Reaching the end of oral evidence is a momentous step for all involved both past and present. For myself, I hoped for an end to the regular trauma as information is revealed.

2. It is nearly 5 years since I lost my husband, and our children lost their dad. Though the repercussions of his loss can be seen in every aspect of our lives, the unanswered questions sit uncomfortably, silently with us all. As the reality of his untimely death broke into my consciousness during the lockdown of early 2021, I made myself and our family a promise – losing Andrew would not be vain, we would continue his work in life and prevent harm to future patients of the QEUH.

3. It seemed so simple at that time, highlight issues that contributed to Andrew's death, make these known to those who could action change, urgent rectification would follow, and patient safety would be ensured both now and for the future. Little did I know that the unsafe features had been known and raised, as early as 5 years before Andrew's admission, with the only action to silence those that dared to question this 'world class' facility.

4. The substandard ventilation features of the BMT ward, 4B, had been in the hands of Scottish Government, NHS GGC and the public since the publication of the Independent Review (IR) in June 2020 **(Bundle 27, Vol 9, Document 11, Page 145)** several months before Andrew was admitted for one of the highest risk treatments. The IR clearly states the deficiencies of these wards. My naivety in thinking it was a simple task to elicit change started to dawn as the details of this report became clear.

5. As further evidence unfolded, the exposure of Dr Peters emails raising the ventilation issues as far back as 2015, and to both NHS GGC executive team and Scottish Government, provoked pain that is hard to describe. Lives lost, lives changed forever – not only those of patients and families but of staff that doggedly advocated for the safety of the patients they cared for and those that they were yet to meet. Unnecessary harm, pain and trauma, that could easily have been avoided so long ago if individuals had taken their roles and responsibilities seriously.

6. The 2017 Options Appraisal paper for 4B shone a spotlight on the safety of4B from 2018 to the present day that shocks me to the core.

7. On the 4th April 2017 a version of the Bone Marrow Transplant: Options Appraisal **(Bundle 20, Document 51, Page 968)** went to the Finance and

Planning Committee to agree “the temporary relocation of BMT services to 4B QEUH”. The recommendation of the paper also talks about delivery of a longer-term sustainable option to meet both service and environmental considerations. Jann Gardner, current Chief Executive of NHS GGC, has, in October 2025 told us that she is not aware of plans to upgrade this ward. As the options appraisal makes clear, to achieve the SHTM 03-01 standards of ventilation in the BMT ward, substantial building works are required with large funding implications. It is improbable to suggest that this could occur without the knowledge of the chief executive.

8. The options appraisal asserts that the option should be agreed on the basis of prioritisation of service delivery over, IPC concerns on meeting national standards and HPS recommendations. In para 8 it states, “committee is therefore, asked to consider option two as an interim solution and support the relocation of BMT services to 4B QEUH.” Another crushing blow. This 2017 short-term option and its substandard ventilation system was what my husband was told was the only service that had the ability to safely provide his life prolonging allogenic transplant, in late 2020.

9. The importance placed on identifying any risk of infection and safety of patients dwindles yet further when the options appraisal documents presented to both the Acute Services Committee and the Finance and Planning Committee, in spring 2017, are considered. These documents contain notable differences that raise questions on the governance process followed in returning BMT patients to 4B, and whether the committees actually both agreed to one, and the same, proposal.

10. Of more concern to myself, is the reference to air sampling recommended prior to the patients return “to assess the environmental suitability of transferring the BMT service to the QEUH” **(Bundle 36, Document 18, Page 164).**

11. Despite the different proposals to the two committees, only limited air sampling took place with fungal counts report, the recommended active sampling and follow up sampling a month later apparently ignored (**HPS SBAR, Bundle 27, Vol 7, Document 6, Page 197)**. Therefore, this critical monitoring did not take place appropriately to ensure patient safety on the national BMT unit. This signifies, again, the complete lack of value placed on identifying or otherwise, risks to one of the most vulnerable patient groups on the QEUH site. Patients were relocated without the safety of their environment being confirmed and remain there to this day.

12. Importantly, the committee paper also describes the burst phenomenon associated with the release of fungal spores, in particular aspergillus **(Appendix 4, Bundle 20, Document 51, Page 992**), which was not discussed either in regard to the findings of the HAD report or other expert evidence looking at the

rates of fungal infection. How was this phenomenon accounted for in the methodology of air sampling used in expert reports?

13. In considering the options for 4B, a group was identified to establish the benefits criteria and weighting. This group included BMT clinicians, **(Bundle 20, Document 51, Page 986)**. Gary Jenkins evidence is that these clinicians did not see complying with IPC standards outweighing that of the adjacency to other specialities. As no BMT clinicians provided statements to the inquiry, it is unknown whether this is indeed their view, and if it was, their reasons for this position. Equally were they aware of all the recommendations made to both committees and, which of these seeking committee agreement were they supportive of? Was the recommendation on air sampling, either 4-6 weeks or 6 months, a condition to their clinical choice of a return to the QEUH?

14. The clinical input to the options appraisal process also provides further insight to the candour of communications to patients and families. At para 14 of my own statement **(Hearing Commencing 19 August 2024, Witness Bundle Volume 10, Page 5)**, I described asking when BMT moved to the QEUH and the limited information in response - only, in 2018. It has made me sick to the stomach that nearly 6 years after this meeting, only through evidence to a Public Inquiry am I aware of the knowledge of 4B environmental deficiencies among BMT clinicians. Transparency required this information to be imparted back in January 2020. Without this disclosure Andrew was unaware of the decision to gamble with patients' lives, a gamble that with the additional risk presented by the COVID pandemic, resulted in the loss of his life.

15. This failure to inform Andrew and myself of the substandard environment of 4B must be seen in the context of Dr Agrawal's oral evidence to the inquiry:

16. "Plus, with my position that there are effective ways of mitigating that risk so the only proviso I have around this is knowing that the system is not making things worse, so that would be my one big caveat. If I don't know the system is not making things worse then I wouldn't proceed with high risk procedures in that environment. I come back to what I said, I would need to know something to convince me that there wasn't aspergillus spores being pushed into the space, I would need some reassurance. If I had that reassurance then I think consent would be… complicated."

17. JACIE accreditation proves to be another consideration in the options appraisal. The committee paper contains an apparent direction for account to be taken of JACIE accreditation over and above either national standards or HPS recommendations, noting that the Beatson BMT ward would not receive accreditation. This has led me to conclude that the board's reputation took precedent over patient safety.

18. The behaviours described towards the whistleblowers have been shown as disgusting attempts to bully, intimidate and undermine these individuals in an attempt to end the raising of legitimate concerns, behaviours not limited to GGC staff. It became apparent that this could be expanded to anyone who raised concerns of Scotland's flagship hospital in public view . Using public funds to monitor the social media of a deceased patient, their widow and a number of politicians **(Hearing Commencing 19 August 2024, Witness Bundle Volume 10, Page 50)** may only be seen in the context of the seven principals of public life. The suggestion by the current Chief Executive of NHS GGC, Jann Gardner, that conversations at Executive level around communications is sufficient to address this as well as the attitude it was only "troublesome families" who asked difficult questions, "he may have won the battle but he will not win the war" comment about Prof Cuddihy is plainly falling far short of the necessary action. Every patient and family has the right to open, honest and transparent communication, something that has eluded GGC communications in their determination to deny failures and uphold their perceived reputation. As was identified by Sir Robert Francis in his report to the inquiry **(Bundle 51, Vol 1, Document 1, Page 3)**, a culture is determined by its leadership, consequently there is only one appropriate action.

19. The numerous references to 'an acceptable level of infection' in the haem oncology patient cohort by members of NHS GGC is one that burns a hole in my heart. Losing someone with cancer in the COVID pandemic, has led to the unacceptable position that I expect the question of whether it was 'with' or 'from' COVID from some individuals. Specifying one of these 2 words is in reality a conclusion on whether the infection itself matters. 'With' insinuates a number of conclusions – they would have died anyway, their suffering was to be expected, they lost nothing. 'From' is to indicate a causation of death, an additional harm, a shortened life. None of this fully reflects the impact an additional or avoidable infection has on any person. The impacts are vast, from treatment through to the emotional and physical effects for both the patient and their loved ones. My experience during the COVID pandemic can be used to infer the feelings stirred during evidence of this type but it is what this revealed about the Health Board's attitude to avoidable infection that causes huge concern.

20. If you accept a negative consequence, you can be said to have accepted that occurrence as expected and not preventable. This in turn will decrease, or even stop, any ambition to minimise the associated risks. The absence of the motivation to minimise infections, will inevitably erode expectations over time, patient safety will deteriorate yet further and outcomes seen will fall far below the ability of Scotland's health service. Everyone in healthcare should be aspiring to improvement, whatever their role.

21. While a wide range of ventilation deficiencies have been identified by the inquiry across the QEUH campus, from PPVL rooms, 4B and C, ICU, 2A and B and, in its entirety the general adult wards, the timing of acquisition of this knowledge by different organisations is unclear. The AECOM ventilation report remains unpublished for undisclosed reasons. However, from references made to this report in conjunction with other evidence certain questions emerge. What was the scope of the report? When was the report commissioned and received? Who was it shared with and when? Is the rectification committee at GGC using the AECOM report as the basis of this group to carry out works? Does this group have or plan to obtain clinical risk assessments, including risk of infections, associated with each and every defect requiring rectification, in line with patient safety standards? The confirmation of this would provide assurance that the current Medical Director's comments around risk assessments being unnecessary is not the pervading view within the health board.

22. As a bereaved wife and mother, waiting and watching as information pertinent to the circumstances that led to Andrew's death is finally revealed, has controlled our lives both practically and emotionally ever since, with no part left unaffected. It would seem to me, that in return I should be allowed to expect all lines of information to be fully explored. With the unanswered questions outlined, I am disappointed to say that this point is yet to be reached. More critically, unanswered questions limit the opportunities to ensure patient safety for the people the QEUH campus serves.

Appendix A

Scottish Hospitals Inquiry - Hearing Commencing 19 August 2024 - Witness Bundle - Week Commencing 21 October 2024 - Volume 10

Scottish Hospitals Inquiry - Hearing Commencing 19 August 2024 - Bundle 20 - Documents referred to in the Expert Reports by Andrew Poplett and Allan Bennett

Scottish Hospitals Inquiry - Hearing Commencing 19 August 2024 - Bundle 27 - Miscellaneous Documents - Volume 7

Scottish Hospitals Inquiry - Hearing Commencing 19 August 2024 - Bundle 27 - Miscellaneous Documents - Volume 9

Scottish Hospitals Inquiry - Hearing Commencing 13 May 2025 - Bundle 36 - Acute Services Committee Minutes and Relevant Papers

Scottish Hospitals Inquiry - Hearing Commencing 16 September 2025 - Bundle 51 - Volume 1 - Sir Robert Francis Whistle-blowing Expert Report and supporting documents

Signed Name: Louise Slorance **Date:** 12th October 2025

Scottish Hospitals Inquiry
Supplementary Hearing Statement of
Jacqueline Barmanroy

Ventilation Email 18 August 2011

1. Please look at the email from you to Tom Walsh, Sandra McNamee, Craig Williams and Pamela Joannidis that appears to have been sent on 18 August 2011. It is to be found in **Bundle 14, Volume 1, Document 2 at pages 21 to 23**.

a) Did you send this email?

A. Yes

b) Did the meeting with "the M&E chaps" take place?

A. In the email the term meeting actually referred to go and see to ask for the details which were given to me verbally and I transcribed them into the attachment referred to in question 1-part d.

c) Who were the "the M&E chaps" with whom you met?

A. So whilst working in the project team I was expected to go through either Francis Wrath or David Hall who liaised directly with Brookfield. Therefore, I cannot name the who they spoke with.

d) Are you the author of the attachment that can be found **Bundle 14, Volume 1, Document 2 at page 23?**

A. Yes this is the feedback requested by Sandra Devine and Tom Walsh. I was just a conduit for information.

e) What was your source for the information in the attachment on **Bundle 14, Volume 1, Document 2 at page 23?**

A. After this length of time I could not say whether it was David Hall or Francis Wrath.

f) Could your source be the specification contained in the Minute of the meeting of 18 May 2009 **(Bundle 14, Volume 1, Document 3, Page 75)?**

A. I would agree that this information has been used at this meeting.

g) Does the attachment address only the proposed adult hospital or the whole new SGH?

A. Reviewing the information in the bundle provided, it pertains to the adult hospital.

h) When you sent this email, and the attachment, were you aware of the Project Manager's Instruction to remove HEPA Filters from the proposed Adult Haematology Ward in the new SGH dated 23 June 2010 **(Bundle 16, Document 24, Page 1674)?**

A. No.

i) When you met the "the M&E chaps" did they give you any indication that the ventilation was not to be as set out this email and its attachment?

A. As mentioned earlier, there was no meeting as such. I was not given any feedback regarding ventilation. Perhaps how the decision was reached can be found in ventilation meeting minutes?

j) If they did, to whom did you report that?

A. I cannot answer this due to the reasons above.

<u>Meeting on 17 September 2012</u>

2. Please look at the email thread of 23 to 24 August 2012 **(Bundle 14, Volume 1, Document 2 at pages 25 to 26)** which appears to involve you arranging a meeting between Professor Williams and "the technical guys" in September 2012 about "water and ventilation system in generic format".

a) Did you send this email?

A. Yes, I can't remember who asked me to contact Craig and unsure why Craig wasn't contacted directly.

b) Did the meeting Professor Williams and “the technical guys” take place on 17 September 2012 or any other date?

A. I don’t know.

c) Did you attend?

A. No, not my area of expertise and made this clear to David Hall that Professor Williams should be contacted for advice for water and ventilation.

d) Did Dr Inkster attend?

A. I don’t know, should be in the minutes or notes of the meeting.

e) Who were “the technical guys” who wished to arrange the meeting?

A. I cannot recall a name, but as I said before most requests came via David Hall or Francis Wrath. Very occasionally Alan Seaborne, project director would ask me to contact Craig.

f) Who else attended?

A. I can’t tell you that, the minutes should be able to help.

g) Did the meeting cover any of the following and what was said about these matters:

i) The amount of air changes in bedrooms?

A. I can’t tell you that, the minutes should be able to help.

ii) The amount of air changes in treatment rooms?

A. I can’t tell you that, the minutes should be able to help.

iii) TB isolation rooms?

A. I can’t tell you that, the minutes should be able to help.

iv) Controlled ventilation rooms, including isolation rooms?

A. I can’t tell you that, the minutes should be able to help.

h) What else was said at the meeting?

A. I can't tell you that, the minutes should be able to help.

Meetings in respect of ventilation matters

3. How many other meetings with "the M&E chaps" and "the technical guys" did you attend during your secondment to the new SGH in addition to those mentioned in the emails of 18 August 2011 **(Bundle 14, Volume 1, Document 2 at pages 21 to 23)** and 23 August 2012 **(Bundle 14, Volume 1, Document 2 at pages 25 to 26)?**

A. No. The 'we' that is referred to may possibly be Professor Williams and Dr Inkster. As you will notice from the email on page 27, Professor Williams sent an email to me informing me of a decision made, which would not have been necessary if I had been in attendance. The minutes from the meeting will confirm who attended.

Declaration

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

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

Appendix A

A50091048 – Bundle 14, Volume 1 – Further Communications

A47851278 – Bundle 16 – Ventilation PPP

Scottish Hospitals Inquiry
Witness Statement of
Elaine Vanhegan

Introduction

You have not previously been asked to give evidence to the Inquiry.
The Inquiry is now hearing evidence in at the Glasgow 4, Part 3 hearings which largely relates to the procurement, design and construction of the QEUH/ RHC.

Matters now arise questions regarding whistleblowing and the Charles Vincent review **(Bundle 27, Volume 4, Document 14)** arising from the written statement of Mr Andrew Rough **(Witness Bundle Volume 6 in respect of Hearings Commencing September 2025, Document 2)** the husband of the late Dr Sarah Jenkins. In his statement Mr Rough states:

*'Sarah sent an email, in 2023, to an Elaine Van Hagen of GGC NHS Scotland raising her concerns that none of the recommendations of the whistleblow were taken forward **(A54067378)**. In addition, there was a Charles Vincent who was appointed by the NHSGGC Interim Board to review all whistleblows.*

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

The Inquiry also has a written statement from Dr Christine Peters (**Witness Bundle Volume 4 in respect of Hearings Commencing September 2025, Document 5)** which states:

'My understanding is that Dr Jenkins whistle blow was not included in the whistleblowing report produced by Charles Vincent. I have emails from Dr Jenkins which she sent to me before she died highlighting the fact that her whistle blow had been omitted.'

Q1. Please refer **Bundle 52 Volume 8 Page 47.** This is an email from Dr Jenkins to you. In that email Dr Jenkins asks for information regarding how the recommendations of her whistleblow were taken forwards. She further explains that *she had been in contact with Charles Vincent, in his role as whistleblowing champion, and thus far he has been unable to provide me with any evidence that any of the recommendations were acted upon or the justification for them being put to one side. This is a serious concern to me. Another serious concern is that my stage 3 whistleblow was not included in the Whistleblow review that was commissioned by the Interim Board.*

a) Please explain and set out exactly what you told Dr Jenkins about whether her case was included in the Vincent review.

A On reviewing my diary, I see I met with Dr Jenkins twice on Teams, once on the 23rd April 2023 and then again on the 5th May 2023. I did not reply directly to her email, rather the above meetings were set up by my Corporate Services Manager – Governance to discuss matters with Dr Jenkins. I was keen to ensure I was as supportive as possible and wanted to understand her position in person.

From memory, the main content of the discussion was allowing Dr Jenkins to describe what she had been through in the preceding 10 years and the processes that had been undertaken. I joined NHSGGC in May 2018 so was unaware of the detail of her journey and had not been involved in her whistleblowing investigation, although I obviously knew she had gone through the process. I was very much in 'listening mode' to let Dr Jenkins talk over her

issues in her own time. I tried to ascertain what would help moving forward e.g. a further whistleblow / HR process to bring some closure. However, it was hard to pin point exactly what Dr Jenkins was looking for and this seemed difficult for her to articulate. I remember being keen to ensure she had the correct occupational health/pastoral support and she advised me she did have support. Dr Jenkins emailed me on 19th May 2023 stating that, on reflection, she would make a monitored referral via the INWO. I do not know if this was taken forward by Dr Jenkins; NHSGGC did not have any engagement with the INWO in this respect.

At the second meeting, I think the main focus was her being keen to engage with an expert in restorative culture. I highlighted this to the Director of HR at the time, as this was not my area of expertise. She advised that I ask Dr Jenkins to discuss with her own HR support. I think she was keen for me to be involved since I had recently been a listening ear. I indicated this was not within my remit and I could not commit to taking forward the approach, hence my reference to HR. I am not aware of the next steps undertaken.

Despite Dr Jenkins' mention in her email of the inclusion of her whistleblow in Mr Charles Vincent's whistleblowing review, I am sorry but I have no recollection of any specific discussion with Dr Jenkins about this.

b) Why did Mr Rough understand that Dr Jenkins was told that there was no record of her whistleblow? Did you tell her this?

A No, I did not tell her this, as noted above. I am sorry, but I cannot identify how this information was provided. In terms of the record of her whistleblow, this remains within the GGC system.

c) What would lead Dr Jenkins and Dr Peters to believe that Dr Jenkins review had not been included in the review?

A As the Inquiry now knows, Dr Jenkins case was included in the Whistleblowing review. Again, I am sorry I do not know what could have led Drs Jenkins and Peters to believe that.

d) In his statement Mr Rough tells the Inquiry that following a review of the recommendations in respect of Dr Jenkins whistleblow, that none of the recommendations had been carried out. What do you say to this?

A I note in my letter of 28th September 2018, that I advised recommendations would be taken forward. At that time, the respective services were responsible for doing this and I therefore cannot comment in detail.

I am aware however that there was an external review of interventional neuroradiology undertaken in summer 2018, examining services in both Glasgow and Edinburgh. This considered some of the themes within the recommendations made in the whistleblow, however I do not know that this, in itself, was a direct result of the whistleblow, but does indicate action was taken in relation to some of these matters. Subsequent changes have been made to departmental staffing, structure and development.

It is important to note that present day whistleblowing practice has evolved significantly in NHSGGC and further supported by the introduction of the INWO Standards with full adherence to same. This now ensures all recommendations made from a whistleblow are followed up and reported.

Scottish Hospitals Inquiry

Third Witness Statement of

Louise Slorance

Introduction

1. My name is Louise Slorance. My date of birth and details are known to the Inquiry. I have previously provided the Inquiry with two statements and gave oral evidence on 22 October 2024.Due to events outwith my control directly before my oral evidence and having reviewed this evidence, I have reflected that there was further information to the answers I provided that would assist the inquiry with their investigations. As such I wish to provide a third statement to the Inquiry.

Consent

2. During my oral evidence I was asked about paragraph 13 of my witness statement and if I would have 'liked' to have known everything in relation to my husband Andrew Slorance's treatment in relation to the hospital environment. In my answer I advised that I believe we should have been informed. I would further like to add that it was not a case that we would have liked to have known, we had a right to know. Information on the safety of treatment is the basis of informed consent.

Wrong telephone number

3. During my oral evidence I was asked about paragraph 45 of my witness statement in relation to the wrong telephone number that the QEUH held for me. I advised that this was subsequently corrected. I would further add that the timing of the wrong telephone noted on Andrew's admission highlights the lack of consideration for Andrew's needs when delivering the news he was covid positive. It also demonstrates that there was no intention to provide information as to the potential that this was HAI COVID nor any information on the implications of this development. When Andrew phoned me straight after

the doctors visit, he knew no more than a second COVID PCR would be carried out.

Asymptomatic at the point of the second COVID test.

4. During my oral evidence I was asked about paragraph 21 of my witness statement in relation to a pre-admission meeting in October 2020 where I was advised that other patients in Andrew's position had been asymptomatic. The reassurance this offered us was not only in respect of Andrew's clinical status but also that the information we had been given at the pre admission meeting on 13th October was correct and would be the case for Andrew, i.e. COVID would not cause additional problems.

5. The line used by [redacted] at the pre admission meeting has more recently been entirely contradicted with a statement in the FAI determination for [redacted], that was likely received from QEUH clinicians stating that "COVID in patients with haematological malignancies did not have positive outcomes."

Discussion around 4A and COVID ward

6. During my oral evidence I was asked about paragraph 41 of my witness statement where there was a discussion about moving him out of the Transplant Ward to Infectious Diseases or the Renal Ward. As raised in previous evidence heard at the inquiry a predetermined patient pathway for a BMT patient with an Infectious disease should have been in place, which identified appropriate rooms available for this specific situation. As I recall, John hood provided that the QEUH did not have rooms for this specific instance. With that being the case, whether due to availability or an absence of the appropriate accommodation entirely, consideration should have been given to transferring Andrew to another hospital. It is possible that this could have resulted in Andrew being closer to home which would have had a number of benefits not only for him but also for our family going forward.

Specialist ventilation on 4A

7. I have come to understand there was no specialist ventilation and no HEPA filtration in Ward 4A at the point of Andrew's admission. My source of

information on this is the NHS GGC patient placement standard operating policy which has not been contested by anyone at GGC. It is worthy of comment that there are several versions of this SOP containing interesting differences. This incudes the addition of en suites and HEPA filtration to ICU rooms during the COVID pandemic. I would be like to know if there are associated documentation and specifically HAI scribes for this work. It feels questionable that building work would be carried out in ICU during the pandemic.

8. The Patient Placement SOP also is the basis for the fact that HDU 7, where the NHS GGC review identified that Andrew was located had no protective ventilation and would be of a general ward specification.

Use of medical records in my statement

9. During my oral evidence I was asked about the information contained in Andrew's medical records. The information I have regarding the accommodation he was housed in and his care has been limited not only by the visiting restrictions in place at the time but following his death, by the refusal of GGC to meet with me, answer my questions or provide all information they hold (or held) for him. In the circumstances I found myself in, I have had to accept that the full truth is now out of my reach.

Obtaining medical records

10. I also spoke about the difficulties I experienced in recovering the records. Following the receipt of 5 batches of medical records and the final letter from legal aspects saying they had met their legal obligations, I have received a 6th batch of medical records from COPFS in January of this year.

11. As I explained there are still missing notes – A clinical note of 28 October records that a bug has been found in his Hickman line, yet I do not have an associated laboratory result.

Missed dose

12. During my oral evidence I was asked about paragraph 53 of my witness statement and the lack of communication about this missed dose. Further to the answer I provided, the other notable point about this was the recording by the nurse of a lack of knowledge about how to use of Andrew's Hickman line, the very reason given for moving him to ward 4A following diagnosis of COVID.

Medical errors

13. During my oral evidence I was asked about paragraph 56 of my witness statement in relation to an overdose of gliclazide. The severity of this situation was demonstrated by the requirement of increased monitoring of Andrew, that was initially every 15 minutes.

14. Another serious episode was the misplacement of a line during Andrew's ventilation which led to a second procedure occurring later that night, which I was not informed of. There are risks associated with these invasive procedures, not least the increased infection risk in a immunosuppressed patient.

Second source of infection

15. During my oral evidence I was asked about paragraph 57 of my witness statement where I found in Andrew's medical records that a second source of infection was being suggested yet not investigation was conducted into what that was. Additional investigation or tests to identify infection is a key part in being able to prescribe the appropriate and specific medicine for the infection you are treating as well as determining the length of time treatment that is required. Without this information, these decisions are being made blind.

16. Andrew's medical records show a lot of medicines being prescribed, some that he remains on until the end of his life, without reason or explanation for this.

Communication with doctors

17. During my oral evidence I was asked about the communication difficulties with the clinicians. While this was during pandemic times, this was the early stages of COVID wave 2 and certainly in December ICU was not full as I observed empty beds throughout 4 and 5th December .

Bloods

18. During my oral evidence I was asked about Andrew's reaction to the blood products. I advised that he had to be given high doses of antihistamines and the products needed to come from Edinburgh because they needed to be washed. This only affected the use of Convalescent plasma.

Post death telephone calls

19. During my oral evidence I discussed the phone calls I had with a clinician after Andrew passed away. On these calls COVID was not described as HAI or Nosocomial but I knew though work that this was probable HAI by definition. As a result I asked about establishing how he had contracted COVID in a protected environment. The email referral to PF has the subject as Nosocomial COVID19.

20. The potential for an additional infection was not mentioned in either of these calls either and was in fact, only mentioned on the one occasion when Andrew was alive.

21. Understanding how Andrew contracted COVID in a high risk ward, should have been a priority. To identify the source of COVID I was expecting whole genome sequencing to have occurred and asked about this on a number of occasions. I never got a response.

Dr McGuire letter

22. During my oral evidence I discussed a letter from NHSGGC's Director Dr McGuire where it was stated that Andrew's two infections could not be seen as adverse events. While the explanation for the lack of any adverse event procedure at the time of Andrew's death was said to be as they did not see a failure in care, Dr Maguire chaired the development of the framework for adverse events in Scotland and as such has a deep understanding of when processes should be invoked. For this reason I can only assume the decision not to proceed with any such process was to ensure secrecy around Andrew having Invasive Aspergillus and avoid highlighting the circumstances leading up to his death.

Angela Wallace email

23. During my oral evidence I discussed a letter that Angela Wallace sent me which ultimately referred me to the NHSGGC complaints process. I have been unable to identify what actions, if any, Prof Wallace took following receipt of Dr Peters email. It certainly does not appear that this information was used in the GGC case review of Andrew or to inform any GGC media statements.

NHS Lothian Case review

24. The review of Andrew's case found that the placement was appropriate despite the content on shielding patients found in NHS GGC Pathways and cohorting guidance for patients with confirmed or possible COVID-19 or who require shielding SOP. It is clear a clinical assessment for the level of protection required for Andrew should have been carried out and if there was a lack of availability of the specific room, consideration given to his transfer. There is no record of this taking place.

Attendees to meetings

25. During my oral evidence I discussed the difficulties I encountered when attempting to arrange a meeting with NHSGGC. Further to my answer, Also contributing to my decision on my own attendees was the level of the

proposed attendees for the boards and the Scottish Government. These attendees were not Andrew's treating clinicians, they were senior clinical management, including board members.

Spying

26. During my oral evidence I discussed the Scottish Government and HIS monitoring my social media. The suggestion was made that monitoring could be done to enable the Board to react quickly to what is being said on social media. This contradicts the statement made by Sandra Bustillo in her letter to me where she says "we erroneously reviewed your public individual posts." Even this suggestion of an error by Ms Bustillo goes no where in reasoning why mentions of my deceased husband were also identified for monitoring.

27. The first occurrence of the flagging of my social media posts happened while Andrew was still alive, during his admission to the QEUH by Scottish Government. Monitoring of this nature breaches my right to privacy and a family life, and only goes to enforce my view that Scottish Government and NHS GGC were desperate to restore the reputation of the QEUH. [redacted]

28. The wider question for a health board utilising a paid monitoring service for surveillance of named individuals boils down to whether it is an appropriate use of limited NHS funds than would otherwise be used on improving care and treatment.

Complaints

29. It was actually the case that not only was it never explained that raising concerns, as I did on 7th December 2020, could be treated as a complaint, that no other reference was made to complaints than that of referral by Angela Wallace in August 2022. In the event that GGC did not progress in any way with this suggestion, it must be assumed that this was an addition to the letter

to distract from a complete closure of the prospect of a meeting between myself and the health board within which my husband lost his life.

HIS report

30. During my oral evidence I discussed the HIS inspection reports. The instigation of the two 2022 reports was outwith any involvement of myself. HIS took the decision to downgrade the initial visit in March 2022 due to the pressures on services from the COVID pandemic. The second visit, and subsequent report, therefore required to be conducted in line with the instruction from Scottish Government.

31. While the paragraph identifies consideration of aspergillus, the report is limited to reference to only 2 cases of aspergillus without providing the timeframe within which these took place. There are no other references to cases of aspergillus in the QEUH.

32. The lack of UK guidance on aspergillus does represent a gap in having a consistent approach to the prevention, diagnosis and treatment of aspergillus. However it must be noted that outbreak definitions are provided in the NIPCM and HPS guidance and, there is widespread knowledge within clinical specialities of the risk it poses to severely immunosuppressed patients. It would be wrong to say that the omission of guidance has resulted in BMT patients being at higher risk. Comparisons of the numbers of patients developing Invasive Aspergillus, and an outcome analysis, during BMT within similar units should have be carried out by HIS in this report.

33. The effect of a derogation of ventilation in both BMT and general wards is a high risk of infection to immunosuppressed patients. The door closure policy was introduced as one mitigation to address the ventilation derogation. Without HIS exploring these issues, assessing staff awareness and ensuring implementation of the door closure policy, HIS have failed to answer the question of risk from aspergillus in the QEUH.

34. As a response to the concerns I raised in regard of Andrew developing aspergillus during his admission to the QEUH for BMT, the HIS report did not provide any reassurance that the same events could or would take place in the future.

Conclusion

35. Myself and Andrew approached his treatment with NHS GGC with absolute trust that he would receive the right care, in an environment suitable for his needs. The journey I have been through over the last 4 years, has eroded every ounce of the initial trust we placed in them. Information hidden, mistruths told and the public misled. Trust comes from openness, honesty and transparency – Glasgow have shown none of these.

J

36. The number of cases linked to Ward 4B is potentially 3 in late 2020. As the NIPCM states investigation should take place in the event of 1 case in a high risk area (IPC, BMT ward), I question how GGC missed the need for further investigation and whether this was an attempt to secure the hidden risk of aspergillus at the QEUH.

Declaration

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

NOTE

FOR

TÜV SÜD LIMITED

RE

GLASGOW IV SECTION OF THE SCOTTISH HOSPITAL INQUIRY

Introduction

1. This document is provided on behalf of TÜV SÜD Limited ("TÜV"). It is produced in relation to certain additional issues which might be considered of potential relevance for the Chair's purposes. It will also cover the points raised by the inquiry team in their email to TÜV's solicitors, BTO Solicitors LLP, sent on 17 December 2025 at 15:51. It will also make some very brief comments on the other parties' submissions so as to make TÜV's position clear for the Chair. This is considered appropriate as TÜV do not intend to make oral submissions at the hearings scheduled to begin on 20 January 2026. In what follows, defined terms will, unless indicated otherwise, be used as per TÜV's written submission dated 19 December 2025 (the "TÜV Submission").

2. The undernoted structure will be adopted in this document.

   (I) The additional issues.

   (II) TÜV's response to the inquiry team email of 17 December 2025.

   (III) Brief comments on the submissions of other core participants.

(I) The additional issues

The two questions

3. The first additional issue which might be thought to be of potential relevance for the Chair can be posed in the form of the following question:

> "What is the extent (if any) to which it is considered that a party had any responsibility after contract signature to point out respects in which the M&E Clarification Log, the Employers Requirements or the Clinical Output Specifications were unclear or to ask questions designed to clarify areas of uncertainty in contractual documents that described what was to be built?"

This will be referred to hereinafter as "Issue 1".

4. The second additional issue can be put in the following terms:

> "To what extent does any responsibility fall on the contractor and/or sub-contractors to draw areas of doubt to the attention of their client and seek to obtain clear instructions?"

This will be referred to as "Issue 2".

TÜV's position in relation to Issue 1 – initial points

5. TÜV makes nine initial points in response to Issue 1.

6. First, if it is suggested that NHSGGC did not get the hospital which it expected it would receive then, as will be obvious from the TÜV Submission, TÜV does not accept that premise. TÜV's position is that NHSGGC did receive what they had asked for in relation to the design and construction of the QEUH and the RHC. Indeed, this has been acknowledged by representatives of NHSGGC, such as Mr Calderwood. Reference is made to the detailed submissions contained in the TÜV Submission.

7. To the extent that it is now considered in hindsight that what was delivered was in some way contrary to NHSGGC's expectations, that arose from a failure on their part properly to specify their requirements in the applicable contract documents. This has also been acknowledged by representatives of NHSGGC, such as Mr Calderwood: see, again, the TÜV Submission.

8. Second, Issue 1 refers to the possibility of there having been a responsibility to point out respects in which the documents referred to in Issue 1 were "unclear" or to ask questions designed to clarify "areas of uncertainty" in contractual documents. In what follows, TÜV will address this issue from the perspective of ZBP. As the Chair is well aware, ZBP were the M&E engineers employed as a sub-consultant to MPX and who undertook the detailed design of the ventilation systems on the project.

9. Third, even if (which is not admitted) there was actually such a responsibility on ZBP of the type contemplated in Issue 1 (as to which, see paras 10-16 below), it would be one which fell to be discharged, vis-à-vis NHSGGC, by MPX, as the latter entity was the party in contract with the health board.

10. Fourth, and in any event, whether in that context or even if the issue is viewed as one between MPX and its design consultant, ZBP, in order to allow the Chair to make a finding – on a valid basis – of the sort contemplated by Issue 1, there would require to be a proper and sufficiently specific foundation in the evidence for it.

11. Fifth, and related, whether there was such a responsibility incumbent on the M&E sub-consultant here, and, if so, the extent and nature of such a duty, must depend on the particular facts. It is submitted that in a project as complex as the present one, these issues cannot sensibly and properly be approached in the generality. Put another way, it is impossible to formulate a general duty in this connection. The matter is fact sensitive.

12. Sixth, the evidence required in order to allow the Chair to decide whether there was a responsibility on a party like ZBP to point out a respect in which a particular document was "unclear" or to ask questions about "areas of uncertainty" concerning particular contractual documents, and whether that responsibility was adequately discharged, would require evidence: (a) regarding the specific respect in which a particular document was unclear or uncertain; (b) that the relevant element of the document in question was recognised, at the material time, by a particular person within ZBP as being unclear (or uncertain) or that it ought reasonably to have been recognised by an ordinarily competent engineer, at the material time, as something which was unclear (or uncertain); (c) that an ordinarily competent M&E engineer exercising ordinary care would, in the circumstances, have raised the issue; and (d) as to how that should have been done, when and with whom.

13. Seventh, there is no such evidence before the inquiry. Hence there is no proper basis for a finding of the type contemplated as a possibility by Issue 1.

14. Eighth, there is also a fairness issue. For the Chair to make a finding – on a valid basis – of the sort contemplated by Issue 1, the type of issue now being raised would have had to have been put to the relevant witness directly and in a specific way in relation to

a particular aspect of a particular document. That was never done. Such matters were also not raised with the relevant expert witnesses.

15. It would be very unfair to individual witnesses to subject them to criticism for failing to have complied with what might now be asserted – after the close of the evidence – as being a responsibility incumbent on them in circumstances where that line was never put to the witness for his/her comment when giving evidence.

16. Ninth, even supposing that there was any lack of clarity or uncertainty relative to any particular document (which is not admitted), the position of a party like MPX or ZBP cannot be viewed in isolation. In order eventually to get built, the buildings being designed and constructed here had to go through a number of different checks, including those applied by NHSGGC user and technical groups, such that there was ultimately a form of 'sign-off' from NHSGGC at various different stages in relation to what was being proposed by way of design and construction by MPX. Accordingly, if there was any lack of clarity or uncertainty relative to any particular document (which is not admitted), such that there was a responsibility on the contractor side to raise points or ask questions (which, as submitted above, are issues which would require to be examined very carefully and specifically), the Chair would, if acting on a proper basis, also have to factor the aforementioned client side checking process into the circumstances relevant to the overall assessment. The reason why that would be relevant is that there could equally be a responsibility on NHSGGC to seek to clarify its requirements if presented with a design and/or construction proposal which, on this hypothesis, did not apparently meet those requirements[1]. That might be thought especially to be the case because the premise of Issue 1 is that it relates to a post-contract situation. In other words, in this context there could be two sides to the responsibility coin. As previously noted, however, the evidence required to reach proper conclusions in this connection is wholly lacking.

Mr Ballingall's evidence

17. In the context of Issue 1, TÜV will, for completeness, address the evidence of MPX's Mr Ballingall in which he suggested that he did not "think" that the agreed ventilation derogation/clarification applied to the RHC.

[1] TÜV of course denies that this was the case.

18. The evidence in question is found in the transcript for 13 May 2025, p 33, column 61, and is as set out below. It is important to note that at this stage of his evidence Mr Ballingall was being asked questions not about the M&E Clarification Log[2] which was incorporated into the main contract, but instead about another, different document[3] which referred to the clarification and the "tower". Indeed, it is also significant that Mr Ballingall was not even sure whether the document put to him was properly characterised as a RFI-type document or as a log (see his evidence in the transcript for 13 May 2025, p 32, column 59). That obviously calls into serious question the reliability of his evidence in this connection.

19. The relevant passage of Mr Ballingall's evidence is as follows.

> "**Q:** Because one possible question here is that this version of this row, as opposed to the M&E clarification log itself, it restricts the issue in some way, depending on how you interpret it, to the tower and the other one doesn't. The tower includes all adult wards. There's no children's wards in the tower.
>
> **A:** Yes, that's correct, yeah.
>
> **Q:** So why do you think that the agreed ventilation derogation, as we refer to it, only applies to places either above the fifth floor or in the tower? Why do you think that?
>
> **A:** Because it applied to general wards, and from memory the general wards were Level 5 up in the tower…
>
> **Q:** But were there not general wards in the children's hospital?
>
> **A:** Sorry?
>
> **Q:** Were there not general wards in the children's hospital?
>
> **A:** I don't think it applied to the children's hospital"[4].

20. First of all, it is important to note that counsel was **not** speaking here about the M&E Clarification Log which formed part of the main contract. Counsel's questions related to a different document. That is made clear by counsel's opening question in the passage

[2] Bundle 43, volume 5, document 47, pp 431-442.
[3] Bundle 43, volume 6, document 64, p 1120.
[4] Emphasis added.

reproduced above. Mr Ballingall's evidence must be viewed with that point firmly in mind.

21. In any event, and critically, Mr Ballingall provided **no** basis whatsoever to justify his assertion that the agreed ventilation derogation/clarification relative to the ACH rate in the general wards was restricted to the QEUH and did not apply to the RHC. In terms of the quality of the evidence given, what Mr Ballingall said plainly fell well short of the type of reasoned evidence which would justify a conclusion that the agreed ventilation derogation/clarification did not apply to the RHC. Such an important conclusion should not depend on what essentially was an aside by Mr Ballingall – especially one for which he provided no basis or explanation and which was not thereafter explored with him.

22. An examination of the relevant documents also makes it clear that Mr Ballingall's evidence in this connection was ill-founded.

23. In the ZBP ventilation strategy document[5], there was no suggestion that the proposed reduction in the ACH rate (from that referred to in the draft SHTM 03-01 guidance) was intended only to apply relative to the QEUH, and not to the RHC. Had the intention been to restrict the proposed reduction to the QEUH, it would have been remarkable for such a restriction not to be mentioned in the ZBP document.

24. Even more importantly, in the M&E Clarification Log – which was incorporated into the main contract and thus formed part of its terms – there is again no indication whatsoever that the reduction to 2.5 ACH applied only to the QEUH, but not to the RHC. Rather, the reduction in ACH rate was presented as a general proposal, and was agreed as such. In the absence of any indication to the contrary in the key document recording what was agreed (i.e., the M&E Clarification Log), the entry in respect of the agreed reduction of the relevant rate to 2.5 ACH was plainly a general one intended to be applicable to both the QEUH and the RHC. That is how it was, and should be, regarded.

25. Three final, related points should be noted. The first is that Mr Ballingall provided no rationale which would explain why the proposed reduction in the ACH rate was supposedly applicable only to the QEUH, but not the RHC. The reason why he did not

[5] Bundle 17, document 71, pp 2859-2860.

proffer any such rationale is that there was none. The second point is that there is no support in the rest of the evidence justifying the notion that there was a restriction of the type mentioned by Mr Ballingall. In particular, there is nothing in the evidence which indicates that, in the run-up to the conclusion of the main contract in late 2009, there was any agreement that the ventilation derogation/clarification was to apply only to the QEUH, but not to the RHC. Indeed, there is no evidence of any discussion of such a restriction at all, never mind an agreement in relation to it. Third, there is nothing in the evidence to suggest that the reduction in the ACH rate, as aforesaid, was understood by others at the time as only applying to the QEUH.

26. The correct conclusion, it is submitted, is that Mr Ballingall's evidence in this regard had no proper foundation. His evidence was nothing more than a groundless assertion. The Chair should reject this evidence.

The specific documents referred to in Issue 1

27. Subject always to the foregoing points, TÜV make the following additional observations relative to each of the documents mentioned in Issue 1.

The M&E Clarification Log

28. There was no lack of clarity in this log as regards the ventilation derogation/clarification which was proposed by MPX/ZBP, and which was agreed to by NHSGGC and eventually incorporated into (and which thus formed part of) the main contract. Reference is made to paras 30 to 77 of the TÜV Submission – in particular, paras 46 to 61 thereof. As submitted above, the reduction in ACH rate was presented as a general proposal applicable to the QEUH and the RHC, and was agreed as such.

The Employer's Requirements

29. CTI appear to have accepted (correctly, it is submitted) the evidence of Mr Baird[6] of C&B that the Employer's Requirements and the COSs were "two halves making a whole" – the whole being the specification of what NHSGGC actually wanted in relation to a given part of the hospital, such as a ward.

30. According to the evidence of C&B's Mr Baird, the Employer's Requirements were intended to "set out NHSGGC's objectives, expectations, specifications and

[6] See CTI Submission, para 1545.

performance requirements for the Project"[7]. As he later put it, the Employer's Requirements identified what the employer wished to buy[8]. His evidence was a reasonable description of the Employer's Requirements.

31. As noted above, for the Chair to make a finding – on a valid basis – of the sort contemplated by Issue 1, there would require to be a proper foundation in the evidence for it. The sort of evidence which would have been required is set out at para 12 above. But such evidence is completely lacking. The relevant line of argument was simply not canvassed at all before the inquiry, never mind in the detail and with the specificity which would have been required to allow proper findings to be made – in relation to, for example, particular areas of the Employer's Requirements which, it is perhaps only now to be alleged, were unclear or uncertain at the time (such that a particular responsibility supposedly became incumbent on a specific person/entity at a particular point in the project). Such issues cannot be analysed and determined in the generality. Whether there was such a responsibility incumbent on any particular person or entity (and, if so, the extent and nature of such a duty and when it arose) must depend on the particular facts and must therefore be founded on a proper body of evidence – which is entirely absent here.

<u>The COSs</u>

32. The same points made relative to the Employer's Requirements at para 31 above apply equally in connection with any suggestion that a particular party should have queried a COS document.

33. Three further points are made on behalf of TÜV.

34. First, neither ZBP nor WW played any part in the compilation of the COS documents in relation to the project. There has been no suggestion that either entity had any such involvement.

35. Second, the COSs were supposed to be documents of a clinical and technical nature. Such documents were intended to be one of the means by which the employer, NHSGGC, would stipulate what they wanted by way of their requirements. It was not

[7] See Mr Baird's witness statement, found at volume 3 of the witness statements for w/c 26 May 2025, document 3, p 49, para 23.
[8] See Mr Baird's witness statement, found at volume 3 of the witness statements for the w/c 26 May 2025, document 3, p 50, para 28.

for parties like ZBP[9] to second guess what was provided for in this type of document. They did not have the clinical expertise to do so. There is no basis in evidence which would allow a valid finding that a party in the position of ZBP should have queried what was contained in a COS document.

36. Third, it is submitted that, if there was an absence of ventilation requirements identified in a particular COS, then it was on the face of it (especially in the absence of any evidence suggesting otherwise) reasonable for a party in a position of a consultant like ZBP to conclude that NHSGGC did not have any specific ventilation requirements in the particular context covered by the COS[10]. There is no proper basis in evidence which would allow a valid finding to the contrary. Indeed, to expect a designer in the position of a party like ZBP to challenge the absence of specified requirements in documents like the COSs would, on the face of it, impose an extremely onerous burden on the designer – in the sense that if there was to be such a responsibility the designer would, in order to discharge it, have to query in every case, and in considerable detail, the absence of specification of requirements by the employer in the COS. If that were the case (and it is submitted that there is no basis in evidence justifying such a conclusion), the nature of the COS documents would be fundamentally altered. They would cease to be one of the contractual documents by which NHSGGC specified their requirements, and would instead simply become a prompt for further discussion or exploration.

TÜV's position in relation to Issue 2

37. TÜV adopt the same position vis-à-vis Issue 2 as they have taken relative to Issue 1.

(II) TÜV's response to the inquiry team email of 17 December 2025

38. As noted in the context of the TÜV Submission (see para 314 thereof), in the ZBP Engineering Services Specification, August 2012[11], it was said:

> "Isolation rooms supply air terminals shall be capable of having terminal HEPA filters fitted at some future date. The air handling unit fan shall be capable of

[9] Or WW – who were not, of course, involved in the detailed design in any event.
[10] The same observation could be made in relation to the Employer's Requirements.
[11] Bundle 23, Document 11, p 77.

overcoming the additional resistance imposed by the HEPA filter by a simple speed change on the motor inverter"[12].

39. Thus, ZBP noted that what was going to be provided in this context was a terminal which would be capable of having a HEPA filter fitted in the future. The proposal did not go any further than that. This is what ZBP proposed and what NHSGGC agreed to, as Mr Pardy confirmed in his evidence[13].

40. The inquiry team have asked in their email of 17 December 2025 how it came to be that this proposal was put forward by ZBP's Mr Pardy.

41. Mr Pardy has confirmed that in this connection he was proceeding under reference to the guidance contained in SHPN 04: Supplement 1 and, in particular, para 4.20 thereof[14] which noted that:

> "…The lobby air supply terminal should be of a type into which a HEPA filter can be fitted. While it is not envisaged that a HEPA filter will be routinely required, this arrangement will allow for subsequent fitting when appropriate with the least disturbance…"[15]

42. It is accordingly clear that the available guidance at the time only indicated that the design should provide for a lobby air supply terminal of a type into which a HEPA filter could be fitted at a future date (if that was thought necessary by the health board). The guidance does not indicate that a HEPA filter had to be installed or that the design had to stipulate its installation. Instead, all that had to be provided for was a terminal which might accommodate a HEPA filter unit being installed in the future. That having been done, it was a matter for NHSGGC whether they wished to have such a HEPA filter unit installed in due course.

43. Consequently, what was included by Mr Pardy in the relevant part of the ZBP Engineering Services Specification, August 2012, was exactly in line with the available guidance provided in the form of SHPN 04: Supplement 1, para 4.20. Furthermore, what was said by Mr Pardy in the document was unambiguous. Isolation room supply

[12] Emphasis added.
[13] Transcript, Steve Pardy, 27 May 2025, pp 47-48, columns 89-91.
[14] Produced at Bundle 23, document 94, pp 963-964.
[15] Emphasis added.

air terminals shall, he said, "be capable of having terminal HEPA filters fitted at some future date"[16]. The specification was therefore clear.

44. As to the other issue raised by the inquiry team – namely, the impact which this proposal might have had on the validation exercise – ZBP were not involved in the validation process as they had ceased trading in early 2013. This was well before the validation exercise was undertaken (which was much later in the project).

45. Further, and in any event, Mr Pardy has added that he would regard the question of validation as being a matter between the contractor's commissioning team/manager and the health board's acceptance specialist.

(III) Brief comments on the submissions of other core participants

46. Having read the submissions of the other core participants, TÜV hold to the position set out in their written submission.

47. There are only three supplementary points which require to be made on behalf of TÜV. They all relate to the written submission lodged on behalf of C&B (the "C&B Submission").

48. First, TÜV align themselves with, and adopt, the submissions made by C&B at paras 8, 9, 10, 14 to 20, 21.1 to 21.6, 22 to 38 and 110 to 117 of the C&B Submission.

49. Second, what is set out at paras 40 to 42 and 44 to 76 of the C&B Submission is consistent with, and provides additional support for, the written submissions of TÜV relative to the ventilation clarification issue.

50. The third point is a very specific one, and it relates to para 71 of the C&B Submission. C&B are correct to say, for the reasons which they have set out at para 71, that:

    (i) it was Mr Pardy of ZBP who alone drafted the ZBP ventilation strategy document[17]; and

[16] Emphasis added.
[17] Bundle 17, document 71, pp 2859-2860.

(ii) Mr McKechnie of WW merely commented on it[18] (around mid-December 2009).

GARRY BORLAND, K.C.

Senior counsel for TÜV

16 January 2026

[18] Refer to paras 65 to 73 of the TÜV Submission.

SCOTTISH HOSPITALS INQUIRY

Bundle of documents for Oral hearings commencing from 16 September 2025 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow

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