Bundle of documents for Oral hearings commencing from 20 January 2026 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow

Core Participants' Closing Statements following the Glasgow 4 Hearings from 13 May to 10 October 2025

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SCOTTISH HOSPITALS INQUIRY
CLOSING STATEMENT
on behalf of the
SCOTTISH MINISTERS
in respect of the 'Glasgow IV' hearings

A) Introduction

1. The Scottish Ministers are grateful to the Chair for his invitation to submit this closing statement. The Scottish Ministers are also grateful to the Chair, to Counsel to the Inquiry and to all other members of the Inquiry team for their hard work throughout. Most importantly, the Scottish Ministers pay tribute to all the patients, their families, and the staff affected by the issues that arose at QEUH and thank them for reliving those events in this Inquiry in order to provide their insights and assistance. The Scottish Ministers continue to be committed to patients being provided with the best possible patient-centred health care by the NHS in Scotland.

2. In that regard, the Scottish Ministers highlight NHS Scotland's Healthcare Quality Strategy and its three Quality Ambitions, designed to make NHS Scotland a 'world leader in Healthcare Quality'. These are 'Person Centred', 'Safe' and 'Effective'. Safe is defined: 'There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.' (**Bundle 52, Volume 1, Document 13, page 147**). The concept of 'avoidable' injury or harm is key. The Scottish Ministers are committed to, and emphasise, the fundamental importance of avoidable injury or harm and support and recognise the constant work that is carried out across the health service to identify, understand and mitigate against all potential harms. Without in any way undermining the fundamental concept of avoidable injury or harm, the concept itself recognises that little (if anything) is 100% safe. It is in this context that a thorough risk assessment and management process is implemented and followed, such as is set out in the UK Government Orange Book, Management of Risk, as recorded in the closing statement of Counsel to the Inquiry at paragraph 162. Risk assessment is 'not optional' (paragraph 185 of Counsel to the Inquiry's closing statement).

3. The Scottish Ministers would endorse the statement at paragraph 184 of Counsel to the Inquiry's closing statement:

> *In most spheres of human activity, some degree of risk is likely to be unavoidable or, if avoidable, avoidable only by virtue of expenditure of cost and effort which may be disproportionate to the magnitude of the risk which is sought to be avoided. Risk falls to be assessed (and then managed) by reference to a combination of the possibility or probability of harm eventuating, and the severity of the consequences if it does. The higher the probability and the greater the severity, the more material the risk; the lower the probability and the lesser the severity, the less material the risk. Safety does not require an absence of risk. Rather, it requires a level of risk, which, having regard to the level of its materiality, is acceptable to the decision maker.*

4. In that context, a risk can be assessed as high (even after appropriate mitigation) but nonetheless unavoidable. In other words, the presence of risk does not mean that a system is 'unsafe'. It is for the decision maker, exercising skill and judgement, to assess what risk is acceptable by taking account of the materiality and impact of the risk and the likelihood of it occurring and then to manage that risk accordingly. The Scottish Ministers respectfully submit that a consideration of the Terms of Reference addressing the adverse impact on patient safety and harm should be viewed through the lens of risk assessment.

i. Scottish Public Inquiries

5. Section 28(2) of the Inquiries Act 2005 provides that:

> *The terms of reference of the inquiry must not require it to determine any fact or to* ***make any recommendation*** *that is not* ***wholly or primarily concerned with a Scottish matter****.*

6. A *'*Scottish matter*'* is defined in subsection. (5) as:

> *a matter that relates to Scotland and is not a reserved matter (within the meaning of the Scotland Act 1998).*

7. The Scottish Ministers draw attention to s. 28 insofar as some of the recommendations may impinge upon reserved matters. In that regard, the Scottish Ministers have no employment functions under the National Health Service (Scotland) Act 1978, those being a function of the relevant Health Board. The Scottish Ministers may employ only 'civil servants'. Further examples of reserved matters within the Scotland Act 1998 include the Regulation of health professions (Sch. 5, Part II (G2), which includes professions regulated by the Medical Act 1983 (Sch. 5, Part II (G2), under exception of ss 21 and 25 of the 1978 Act, regulation of the profession of Auditor (re healthcare) (Sch. 5, Part II (G3)), the Health and Safety Commission, the Health and Safety Executive and the Employment Medical Advisory Service (Sch. 5, Part II (H2)).

ii. Scope of closing statement

8. In terms of Direction 12, paragraph 5.1, the Scottish Ministers (in the exercise of their duties under sections 1 and 1A of the National Health Service (Scotland) Act 1978) have an interest in the whole of the work of the Inquiry, however, they confine their observations in this closing submission (in their capacity as Core Participant) primarily to matters arising in respect of the following Terms of Reference:

(1) Term of Reference 1 ('To examine the issues in relation to adequacy of ventilation, water contamination and other matters adversely impacting on patient safety and care which arose in the construction and delivery of the QEUH and RHCYP/DCN; and to identify whether and to what extent these issues were contributed to by key building systems which were defective in the sense of: A. Not achieving the outcomes or being capable of the function or purpose for which they were intended; B. Not conforming to relevant statutory regulation and other applicable recommendations, guidance, and good practice.');

(2) Term of Reference 5 ('To examine whether, based on the governance arrangements in place, national oversight and support of such large-scale infrastructure projects was adequate and effective and whether there was effective communication between the organisations involved.');

(3) Term of reference 6 ('To examine, during the life cycle of the QEUH and RHCYP/DCN projects, how the Boards of NHS Greater Glasgow and Clyde and

NHS Lothian secured assurance and supporting evidence that: A. All necessary inspection and testing had taken place; B. All key building systems had been completed and functioned in accordance with contractual specifications and other applicable regulations, recommendations, guidance, and good practice and; C. Adequate information and training were provided to allow end-users effectively to operate and maintain key building systems.')

(Terms of reference 5 and 6 may overlap under the general heading of 'governance' and will be taken together.);

(4) Term of Reference 8 ('To examine the physical, emotional and other effects of the issues identified on patients and their families (in particular in respect of environmental organisms linked to infections at the QEUH) and to determine whether communication with patients and their families supported and respected their rights to be informed and to participate in respect of matters bearing on this treatment.');

(5) Term of Reference 9 ('To examine the processes and practices of reporting healthcare associated infections within QEUH and determine what lessons have been or should be learned'); and

(6) Term of Reference 11 ('To examine whether there are systematic knowledge transfer arrangements in place to learn lessons from healthcare construction projects and whether they are adequate and effective.').

9. The Scottish Ministers address these Terms of Reference in turn before addressing Counsel to the Inquiry's proposed recommendations so far as addressed to them.

B) Term of Reference 1

10. Reference is made to paragraphs 2 to 4 above in relation to the appropriate context within which to consider "matters adversely impacting on patient safety and care". The Scottish Ministers maintain the submissions made by them at the conclusion of the RHCYP/DCN session in this regard.

C) Terms of Reference 5 and 6

11. The Scottish Ministers respectfully endorse what was said by Counsel to the Inquiry at paragraphs 27–44 of Provisional Position Paper 15 as necessary context.

12. They would supplement that with the following observations as to the steps that have been taken to improve, so far as it is within the remit of the Scottish Ministers, the standard of governance of NHS boards in Scotland and to ensure that those standards are maintained.

i. Healthcare Improvement Scotland

13. As paragraph 36 of Provisional Position Paper 15 acknowledges, Healthcare Improvement Scotland has been established under section 108 of the Public Services Reform (Scotland) Act 2010 with the statutory duty, embodied in s. 10A(1)(b) of the National Health Service (Scotland) Act 1978, to improve the quality of health care in Scotland.

14. Healthcare Improvement Scotland inspects NHS hospitals in Scotland to establish whether standards of care are being met and whether there are areas for improvement in this regard. These inspections involve physical inspections of clinical areas as well as discussions with staff. The NHS Board concerned is then required to create an 'improvement plan' to ensure its hospitals meet national standards. Both the inspection report and improvement plan are published on the Healthcare Improvement Scotland website.

15. Concerns regarding NHS services can be raised with Healthcare Improvement Scotland and, in the first instance, an initial assessment of the concern will be carried out by its Internal Assessment Group. If the Group are of the view that the matter does fall within Healthcare Improvement Scotland's remit, the relevant NHS Board will be contacted and Healthcare Improvement Scotland will engage accordingly. Healthcare Improvement Scotland can escalate the matter to the Scottish Ministers if improvements have been identified as needed yet not made, or if there is a serious patient safety concern that requires immediate action.

16. Healthcare Improvement Scotland is ultimately accountable, via its Board Chair, to the Scottish Ministers for delivery of its strategic objectives.

ii. The Blueprint for Good Governance in NHS Scotland

17. The Scottish Ministers have, since 2019, required NHS Boards to adhere to the Blueprint for Good Governance in NHS Scotland: see e.g. NHS GGC's Board paper 21/58, for its meeting of 21 September 2021, which acknowledges this (**Bundle 42, Volume 5, document 1, p. 5**), as well as the evidence of Professor John Brown (**WS vol. 2, p. 5, paragraphs 10–11; and p.113, p.29)**.

18. The first edition of the Blueprint for Good Governance is at **Bundle 52, Volume 1, Document 12, p. 109** (with the enclosing 'Director's Letter' DL (2019) 02 dated 1 February 2019, by which it was sent to all NHS Board Chairs, Chief Executives and Secretaries, at **p. 106**), and the current, second, edition is at **Bundle 52, Volume 1, Document 14, p. 194** (sent by a further Director's Letter, DL (2022) 38).

19. The current edition sets out ten principles of good governance that NHS Boards are required to follow:

    (1) the Board should 'set strategic direction, hold executives to account for delivery, manage risk, engage stakeholders and influence organisational culture';

    (2) the Board should 'consist[] of a diverse group of people with the necessary skills, experience, values, behaviours, and relationships';

    (3) 'roles, responsibilities and accountabilities at Board and executive level [should be] clearly defined and widely communicated';

    (4) 'an assurance framework [should align] strategic planning and change implementation with the organisation's purpose, aims, values, corporate objectives and operational priorities';

    (5) 'an integrated governance system [should co-ordinate and link] the delivery of strategic planning and commissioning, risk management, assurance information flows, audit and sponsor oversight';

(6) ‘operating guidance [should be] agreed, documented, widely communicated, and reviewed by the Board on a regular basis’;

(7) ‘governance arrangements [should be regularly evaluated] to ensure [they are] proportionate, flexible and subject to continuous improvement’;

(8) ‘an active approach [should anticipate and respond] to risks and opportunities which could have a significant impact on the delivery of corporate objectives, the Board’s relationships with stakeholders and the management of the organisation’s reputation’;

(9) ‘a collaborative approach [should ensure] the organisation’s systems are integrated or aligned with the governance arrangements of key external stakeholders’; and

(10) ‘governance arrangements [should be] incorporated in the organisation’s approach to the management of day-to-day operations and the implementation of change’.

20. It is respectfully submitted that these principles provide a solid foundation for the adequate and effective oversight and support of large-scale infrastructure projects; and for effective communication between all those involved at all stages of such projects. Adoption of these principles should avoid the various issues identified by Counsel to the Inquiry in their discussion of Terms of Reference 3A-E and 6. At the very least, those issues would have been identified at an appropriate time and addressed accordingly.

21. By a further Director’s Letter (DL (2024) 08), the Scottish Ministers required, among others, the Chairs and Chief Executives of NHS Boards to comply with a Framework Document issued for the purposes of the Accountability section of the Scottish Public Finance Manual. The Framework Document:

(1) at paragraphs 6–10 records the different responsibilities of NHS Boards and the Scottish Ministers for the delivery of healthcare and for the development of policy, respectively;

(2) at paragraph 13, reinforces the need to comply with the Blueprint for Good Governance; and

(3) thereafter sets out further detailed requirements, including (at paragraphs 17–19) as to staff and clinical governance.

iii. Policy on Design Quality

22. The Scottish Ministers acknowledge the point, at paragraph 1828 of Counsel to the Inquiry's submissions, that the Policy's requirement to comply with SHTMs, including therefore SHTM 03-01, is capable of being misunderstood because SHTMs are by themselves (i.e. absent that requirement) not mandatory. They will consider how best to clarify the requirements.

D) Term of Reference 8

23. The Scottish Ministers adopt what they said at paragraphs 5–10 and 20 of their Closing Submission in respect of the Glasgow III Hearing.

E) Term of Reference 9

24. The Scottish Ministers note Counsel to the Inquiry's observations at paragraph 1865 as to their role in promoting good working culture. They would invite the Inquiry to recall the evidence of Ms Freeman within which she explained that the Scottish Ministers had envisaged undertaking a widescale review of the culture of NHS GGC and all other health boards in Scotland (at **Page 56, columns 107–8 and Page 66, Column 128**), which was interrupted by the pandemic and has, in substance, now been superseded by this Inquiry. This indicates the seriousness with which the Scottish Ministers take the issues of satisfactory working culture and governance in Scotland's health boards. It should also be recalled that the wider escalation of NHS GCC later, on 24 January 2020, as explained by Ms Freeman and Ms McQueen in their evidence, included issues of culture (Transcript, Jeane Freeman, 10 October 2025, **Page 58, Column 112**; Transcript, Fiona McQueen, 2 October 2025, **Page 69, Column 133**).

25. By way of minor correction, it is recorded at paragraph 997 of Counsel to the Inquiry's closing statement that Fiona McQueen invoked "stage 2" of the NHS Support and Intervention Framework on 26 March 2018. This is not an accurate reflection of Ms McQueen's evidence. As is recorded in the timeline appended to Ms McQueen's statement (Bundle 52, volume 1, document 37, p616), Ms McQueen invoked the Chief Nursing Officer's Framework on that date, not the Support and Intervention Framework.

F) Term of Reference 11

26. The Scottish Ministers note the acknowledgment, at paragraph 1871, of the work undertaken by NHS Scotland Assure, and address the proposed recommendations referred to in paragraph 1872 below.

G) Proposed recommendations

i. Procurement processes (§10.2.1)

27. The Scottish Ministers respectfully disagree, for a number of reasons, that it would be helpful for them to obtain the proposed specialist legal advice before approving the outline business case for large healthcare building projects:

(1) As emphasised above in respect of Term of Reference 5, it is for NHS Boards to deliver health care within their statutorily defined area. The Scottish Ministers do not have and may not assume a role (or, as put in paragraph 1872, 'a voice in the actual negotiations') that would entail, in extremis, that they require a Board to rewrite contractual or working relationships with its chosen contractors. If that is not what is ultimately envisaged, then it is difficult to understand the use to which the Scottish Ministers would be required to put any specialist legal advice received as to potential defects in the contractual arrangements.

(2) Relatedly, it is not clear what Counsel to the Inquiry envisage should happen if the Board's and Scottish Ministers' respective legal advisers should give conflicting advice. It may be that it is assumed that the Scottish Ministers would be entitled to, and even should, require the Board to comply with the effect of the

Scottish Ministers' specialist legal advice; but that would undercut the division of responsibilities set out above in the Blueprint for Good Governance (to the point, as this illustrates, of making the Board's own legal advice otiose).

(3) It is unclear what it is that lawyers for any party could have detected in relation to the Glasgow (or Edinburgh) project if their clients had not alerted them to the underlying technical issues. It may be that there are individual lawyers who might have sufficient technical expertise to assess spontaneously whether technical requirements have been complied with; however that cannot be counted upon and, even then, it would depend upon the lawyer's having been engaged to consider the project at large rather than (as would be more usual) advising on discrete contractual issues. Thus it is extremely unlikely that a lawyer, even one who is highly specialised, would be alert to the mischief identified at paragraph 1877 by Counsel to the Inquiry: 'the most significant issue with the building systems of the QEUH/RHC, arose from a decision, made in the final weeks before contract signature, by a Project Team that did not understand the implications of its decision'.

(4) Even if the advice were restricted to discrete issues identified by the client (in which case the proposed recommendation seems to be of little benefit) the cost to public funds is likely to be significant.

28. Consistently with the division of responsibilities emphasised above, the Scottish Ministers defer to other Core Participants on the desirability of the recommendation at paragraph 1878.

29. The Scottish Ministers have no specific objection to the recommendations at paragraphs 1879–84, though these do not in substance seem to be matters primarily for the Scottish Ministers to address. That is particularly so as regards the content of construction contracts, which it is not for the Scottish Ministers to dictate (it may be that Counsel to the Inquiry have misapprehended that the Scottish Ministers have any responsibility for the creation of, for example, the NEC3 form of contract). Again, for the avoidance of doubt, paragraph 1883 is not understood as being directed towards the Key Stage Review process but rather to the obligations of the Board and its contractors under the agreements between them; however, in so far as it was intended to refer to the Key

Stage Review process, that is what the Key Stage Review process already seeks to achieve as between the Scottish Ministers and the submitting NHS Board. The Inquiry will recall the detailed workbooks developed for each Key Stage Review: an example is to be found in the oral evidence of Ms Critchley (**columns 128–30**), which set out a detailed process of scrutiny and assurance.

ii. HAI-SCRIBE (§10.2.2)

30. The Scottish Ministers have no objection to the recommendations proposed at paragraphs 1885–86, though it must be left to NHS NSS to assess whether enough qualified staff could be found to do the additional work.

iii. Safe operation of water and ventilation systems of new hospitals (§10.2.3)

31. The Scottish Ministers agree with the recommendation proposed at paragraph 1887, though they have some hesitation (to which NHS GGC may be well placed to speak) about the alignment between the recommendation proposed at paragraph 1888, which may envisage some form of "ring-fencing", and how NHS Boards require to produce and set budgets and then allocate funds.

32. The Scottish Ministers are not in a position to comment on the recommendations proposed at paragraphs 1889–90 (which do not in fact appear to be addressed to them).

iv. Training (§10.2.4)

33. The Scottish Ministers agree with the recommendation proposed at paragraph 1891 and will consider how best to reflect it in forthcoming governance requirements issued to NHS Board leadership.

v. HAI reporting and investigation (§10.2.5)

34. The Scottish Ministers support the recommendations proposed at paragraphs 1893–94.

35. They endorse the aim of the recommendation proposed at paragraph 1892, however would be concerned that conferring such a power on NHS NSS would be inimical to its expressly supportive role which approach has, according to the evidence, been both constructive and effective. The aim might best be achieved by, for example, a DL or a

letter from the Cabinet Secretary, without the need for legislation. As the Inquiry has heard, failure to act as instructed by a DL or letter from the Cabinet Secretary is likely to have consequences for a Board.

vi. Communications (§10.2.6)

36. The Scottish Ministers would agree in principle with the recommendation made at paragraph 1895, noting that they have confirmed in the past months that such communication strategies now already exist in all NHS Boards in Scotland.

vii. Healthcare governance (§10.2.7)

37. The recommendations at paragraph 1896 raise difficult issues to which the Scottish Ministers require to give serious consideration, both as to principle and as to how it would be within their powers to take the action suggested. The present situation is, however, as follows:

(1) There is no legal requirement for Executive Members of territorial Boards to be appointed as Board Members (cf The Health Board (Membership and Procedure) (Scotland) Regulations 2001).

(2) A Chief Executive's position has up to three aspects: employment, delegated accountable officer status from the Permanent Secretary, and (as the case may be) appointment by the Scottish Ministers to the Board. The latter two are within the Scottish Ministers' control:

(a) Regulation 5(2) of 2001 Regulations permits the Scottish Ministers to terminate the appointment of a Board member, and

(b) under section 15 of the Public Finance and Accountability (Scotland) Act 2000, the Permanent Secretary can revoke a Chief Executive's Accountable Officer Status. Further information is provided in paragraphs 6-10 of the Framework annexed to the Director's Letter (DL (2024) 08). If Accountable Officer Status is removed, Annex 3 of the Scottish Public Finance Manual contains guidance about any disciplinary action that may be taken by the Health Board.

(3) The Scottish Ministers are unable to affect the employment status of an individual officer of a Board; nor is it clearly appropriate that they should be able to do so.

(4) As to the suggested power to introduce Commissioners to operate alongside the Board, the Scottish Ministers hesitate as to the wisdom or, indeed, utility of a mechanism that could lead to simultaneous, parallel governance structures.

38. The Scottish Ministers will undertake the review suggested in paragraph 1897 and would welcome more detail as to what Counsel to the Inquiry consider the desirable features of such a regulator would be and how it would add distinctly to the existing regulatory scheme.

18 December 2025

The Scottish Government
Caroline Lamb, Director-General Health and Social Care

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Scottish Government
Riaghaltas na h-Alba
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Dear Colleague

FRAMEWORK DOCUMENT FOR NHS BOARDS

Summary

1. This Framework document sets out how the Scottish Government and territorial NHS Boards work together.
2. As Director-General Health and Social Care and Chief Executive of NHS Scotland, I am required, as Portfolio Accountable Officer, to put a Framework document in place as set out in the Accountability section of the Scottish Public Finance Manual.
3. I would like to thank NHS Scotland Board Chairs and Chief Executives for the valuable and important contributions received in developing this framework. These have helped identify where further improvements could be made and help better understand how the Framework would work in practice.
4. The Framework document will be hosted on the NHS Board Governance website: www.nhs.scot and will be subject to continuous review.

Action

5. Chief Executives of territorial NHS Boards are asked to take forward this Framework with immediate effect.

Your sincerely

Caroline Lamb
Director-General Health and Social Care

From the Director-General Health and Social Care

Caroline Lamb

4th April 2024

DL (2024) 08

Addresses

For action

Chief Executives, NHS Boards

For information

Chairs, NHS Boards;
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Framework Document for NHS Boards

April 2024

Introduction and context

1. This Framework document (hereafter referred to as the *Framework)* sets out how the Scottish Government and NHS Boards work together. The Director-General Health and Social Care (who is also the Chief Executive of NHS Scotland) is required, as Portfolio Accountable Officer, to put a framework in place for each public body she sponsors, as set out in the Accountability section of the Scottish Public Finance Manual. This is to ensure there is clear understanding of the respective responsibilities of the Portfolio Accountable Officer and the appointed Accountable Officer (Chief Executive) of the NHS Board, and the relationship between the Scottish Ministers / Scottish Government and the NHS Board.

2. The NHS Boards covered by the *Framework* are: NHS Ayrshire & Arran; NHS Borders; NHS Dumfries & Galloway; NHS Fife; NHS Forth Valley; NHS Grampian; NHS Greater Glasgow & Clyde; NHS Highland; NHS Lanarkshire; NHS Lothian; NHS Orkney; NHS Shetland; NHS Tayside; and NHS Western Isles.

3. NHS Boards and the Scottish Government will collaborate and co-operate to deliver safe, person-centred and effective care to the people of Scotland. As described in the Scottish Government's Policy Prospectus in April 2023, this collaboration and co-operation should drive progress towards delivery of the Government's core Missions to 2026 of: *Equality*, *Opportunity* and *Community*.

4. The *Framework* will be subject to continuous review. Any proposal to amend the *Framework*, either by the Scottish Government or a territorial NHS Health Board, will be taken forward collaboratively, taking account of latest priorities and policy aims. The law takes precedence over any part of the *Framework*.

5. The *Framework* will support:

    - clear two-way communication between the organisations, supported by working arrangements that allow both parties to identify and alert the other to risks and potential areas of tension at an early stage;
    - a robust system for aligning the Scottish Government's priorities and the NHS Board's planning processes, which includes a view of the priorities and resources for the future;
    - improving the involvement of NHS Boards in the formulation of Scottish Government policy and decision-making, drawing from the NHS Boards' intelligence and evidence of the needs of the population they serve and the functions and services they are carrying out; and
    - the further strengthening of relationships based on openness, honesty, learning support and constructive challenge.

Relationship between the Scottish Ministers, Scottish Government and NHS Boards

6. NHS Boards exercise, on behalf of Scottish Ministers, responsibilities in relation to planning, commissioning and delivering healthcare services, and take overall responsibility for the health and wellbeing of the populations they serve. This is underpinned by the Functions of the Health Boards (Scotland) Order 1991 (as amended), and other legislation. NHS Boards are discrete legal entities and legally accountable and responsible for how they carry out their functions, services, duties and responsibilities.

7. Scottish Ministers determine policy and are accountable to Parliament for policy decisions and actions of the Scottish Administration (which includes the Scottish Government). Scottish Ministers determine and approve Scottish Government policy. NHS Boards and Accountable Officers have a key role in the development and delivery of Scottish Government policy through carrying out their functions and services; and discharging their duties and responsibilities.

8. The Cabinet Secretary for NHS Recovery, Health and Social Care is accountable to the Scottish Parliament for the degree of independence that NHS Boards have. The Cabinet Secretary creates NHS boards, appoints board members, etc and is ultimately accountable for the performance of NHS Boards and the use of resources as agreed through the annual Budget (Scotland Act).

9. The Scottish Government's role is to carry out the Scottish Ministers' priorities. The Permanent Secretary is the most senior civil servant, and the "Principal Accountable Officer" under the Public Finance & Accountability (Scotland) Act 2000. The Permanent Secretary designates the Director-General Health & Social Care / Chief Executive of NHS Scotland as "Portfolio Accountable Officer", and designates NHS Board chief executives as the "Accountable Officer" for their NHS Boards. Accountable Officers at all levels have personal responsibilities for the propriety and regularity of public finances, and ensuring resources are used economically, efficiently and effectively. Accountable Officers are to serve their NHS Boards. The NHS Board in turn is responsible to Parliament in respect of its actions and conduct. Accountable Officers may be called to give evidence before the Public Audit Committee. Board decisions should always comply with the law, including Ministerial directions (where provided for in statute), and Ministerial guidance and the objectives of the Scottish Government's Health & Social Care Directorates. Section 2(5) of the National Health Service (Scotland) Act 1978 gives Ministers the general power of direction to direct Boards on any function conferred on them under the Act. Given the different but related responsibilities that individuals and organisations have within the whole system, it is essential that the Scottish Government, Accountable Officers and the whole of NHS Scotland work together effectively.

10. NHS Board Chief Executives should assure themselves, that there are adequate and effective systems in place within the NHS Board, to discharge

their general and specific responsibilities as Accountable Officer, as described in the Memorandum to Accountable Officers. Chief Executives should use those systems to inform the work of the Executive Leadership Team and the Board, to ensure that the Board has the right information, advice and support to facilitate the Board carrying out its role, as described in the Blueprint for Good Governance. Doing so will facilitate organisational success, and properly inform the ongoing relationship between the Chief Executive and other NHS Chief Executives and the Scottish Government. Those systems will also inform any engagement that NHS Board Chairs may have with other Board Chairs and the Cabinet Secretary.

Scottish Government Strategic Ambition – equality, opportunity and community

11. Annex A summarises key legal reporting duties which are particularly important for NHS Boards in delivering the Scottish Government's 2026 missions:

- *equality* - tackling poverty and protecting people from harm;
- *opportunity* – a fair, green and growing economy;
- *community* – prioritising our public services.

12. These duties lead to Boards publishing information for the public. Chief Executives should ensure that these duties are carried out, and the information is easily accessible on their Board's website, and inform the Scottish Government where it can be found. If Chief Executives consider that any publication is particularly relevant to the application of the Framework and system-wide learning, they can inform the Health Sponsorship Unit (HealthSponsorship@gov.scot).

Governance and Accountability

13. The Scottish Government published the second edition of The Blueprint for Good Governance in NHS Scotland on 23 December 2022 (through DL (2022) 38). The *Blueprint* sets out what good governance is and how it operates in the NHS in Scotland; including the respective roles of Boards, Board members, the Executive Leadership Team, and the Scottish Government. Rather than repeat the contents, Boards should refer to the *Blueprint*, as required and where highlighted.

14. The *Blueprint* highlights the need for NHS Boards to adopt both active and collaborative approaches to governance. Ownership of the *Blueprint for Good Governance* rests with the Scottish Government, and accountability for reviewing and refreshing the healthcare model sits with the Director of Health and Social Care Finance, Digital and Governance.

15. To ensure that good governance is being delivered across NHS Scotland in a consistent manner, the Directorate for Health and Social Care Finance, Digital and Governance works with NHS Boards to achieve continuous improvement in their governance arrangements. This includes commissioning and approving

the national induction and other training and development material on governance in healthcare that is delivered by NHS Education for Scotland and other training providers.

16. The Scottish Government also supports this continuous improvement approach by providing advice and guidance to NHS Boards on specific governance issues. The Scottish Government Board Governance website contains valuable information to support Board Members in delivering their roles and responsibilities.

Staff Governance

17. Section 12I of the National Service (Scotland) Act 1978 requires NHS Boards to carry out a duty in relation to the governance of staff. In practice, this means implementing the requirements of the Staff Governance Standard. Section 5 of the standard summarises the roles and responsibilities of Scottish Government partnership forums and NHS Boards in implementing the standard. Information from a range of sources informs this work and NHS Boards have the flexibility to agree and set their own priorities. The Scottish Workforce and Staff Governance Committee (SWAG) reviews performance on behalf of the Scottish Partnership Forum (SPF).

18. The following websites contain key information to support good staff governance:

- Home — NHS Scotland Staff Governance
- NHS Workforce Policies | NHS Scotland
- MSG | Management Steering Group (scot.nhs.uk)

Clinical Governance

19. NHS Boards have a duty to put and keep in place arrangements to monitor and improve the quality of care they provide to individuals. All boards will have established a clinical (or healthcare) governance committee to oversee clinical governance, rather than deliver it. NHS Management Executive Letter (2000) 29 set out four roles explaining how clinical governance is carried out in practice:

Overseeing Role	Clinical Governance Committee
Delivering Role	The responsibility for the delivery of clinical governance, and safe, person-centred, effective care, rests with the Chief Executive.
Supporting Role	Staff employed in roles underpinning clinical governance, such as those involved in clinical effectiveness, audit, complaints handling, and risk management.
Practising Role	Clinical and support staff.

20. Ensuring that the voices of people who use healthcare services are heard and can influence the design and delivery of healthcare services is a priority for the Scottish Government. Meaningful engagement matters as it leads to high quality, safe services that are person-centred. Each NHS Board is committed to improving the services it provides, and Scottish Government expects NHS Boards to listen to, and take account of, feedback from people about their experience of care.

21. The topic of clinical governance and quality improvement has evolved significantly since clinical governance committees were introduced into NHS Scotland. Further information is available at:
    - Health and Social Care
    - Improvement and implementation support

Information Governance & Management

22. NHS Boards are required to prepare a 'records management plan' and present it to the Keeper of the Records of Scotland. The benefits include:

    - increase efficiency and effectiveness, delivering savings in administration costs;
    - improve and develop service delivery;
    - achieve business objectives and targets;
    - ensure compliance with the Public Records (Scotland) Act 2011 and other legislative requirements, standards and codes of conduct;
    - support transparency and open government;
    - underpin business resilience.

23. NHS Boards should at all times adhere to their obligations under the NHS Scotland Code of Practice – Protecting Patients Confidentiality and Records Management Health and Social Care Code of Practice (Scotland) 2020.

24. NHS Boards are required to comply with the Freedom of Information (Scotland) Act 2002 and the Environmental Information (Scotland) Regulations 2004. These are key to the principles of openness and transparency. The Scottish Government has published two Codes of Practice relevant to this law:

    - Section 60 Code of Practice: Best Practice Guidance on Discharging Functions under the FOI Act and Environmental Information Regulations.
    - Section 61 Code of Practice: Records Management

25. Further information is available on the Scottish Information Commissioner's website:
    - Duties under Freedom of Information law

26. The NHS Board should ensure that it has a clear understanding of the key risks, threats and hazards it may face in the personnel, physical and cyber domains,

and take action to ensure appropriate organisational resilience. The approach should be in line with the guidance in "Business Continuity: Strategic Guidance for NHS Health Boards in Scotland" (November 2023), which should be used alongside "Preparing for Emergencies: Guidance for Health Boards in Scotland (November 2023)".

27. All NHS Boards are considered to be Operators of Essential Services and must comply with the 'Network and Information Systems Regulations 2018'. These regulations cover managing security risk, defending systems against cyber-attack, detecting cyber security events and minimising the impact of cyber security incidents. Compliance includes reporting improvements to resilience and capabilities to the Scottish Health Competent Authority (SHCA) through Network and Information (NIS) regulatory audits. In doing so, the SHCA is able to monitor continual improvements by Boards against the Scottish Public Sector Cyber Resilience Framework.

28. A range of useful resources setting out the requirements and guidance for information assurance and cybersecurity are available on the Digital Healthcare Scotland website: About Us - Digital Healthcare Scotland (digihealthcare.scot).

29. NHS Board Chief Executives should demonstrate leadership and commitment with respect to information security management by ensuring that the Board-level information security policy, security objectives and Information Security Management System (ISMS) are established and are compatible with the strategic direction of both the organisation and NHS Scotland as a whole. This includes assigning the role of Senior Information Risk Owner (SIRO) at executive level to ensure measures in the frameworks described are undertaken and performance on the ISMS is reported to the management board at regular intervals. The responsibilities of the SIRO are established in the SIRO Manual: Introduction-to-Risk-Management-for-SIROs-and-IAOs-Workbook

Sponsorship management

30. The NHS Scotland Chief Operating Officer and Deputy Chief Operating Officers have responsibility for overseeing and ensuring effective sponsorship management between Scottish Government and NHS Boards. The Chief Operating Officer is answerable to the Director-General Health & Social Care / Chief Executive of NHS Scotland. The Chief Operating Officer and Deputy Chief Operating Officers will be responsible for maintaining and developing positive relationships characterised by openness, trust, respect and mutual support.

31. The Chief Operating Officer and Deputy Chief Operating Officers will work closely with NHS Board Chief Executives to promote the co-operation of NHS Boards in order to plan and provide services to secure and advance the health of the people of Scotland. The Chief Operating Officer can create groups to facilitate this goal.

32. The Chief Operating Officer has established a Health Sponsorship Unit who will support the effective sponsorship management between Scottish Government and NHS Boards. The specific responsibilities of the Health Sponsorship Unit are:

- develop, maintain and strengthen relationships and communications with NHS Boards to support progress towards delivery of the Government's core Missions to 2026;
- provide support to the Deputy Chief Operating Officers and Chief Operating Officer by providing timely and relevant information to enable them to carry out their role;
- management of the Ministerial Annual Review process as a focal point for public accountability, including formally writing to the NHS Board setting out the key areas covered and agreed actions;
- utilising data and intelligence gathered via the Creating Insights from Data programme, including the Whole System & Winter Dashboard, to provide advice and briefing for the Chief Operating Officer on NHS Board performance.

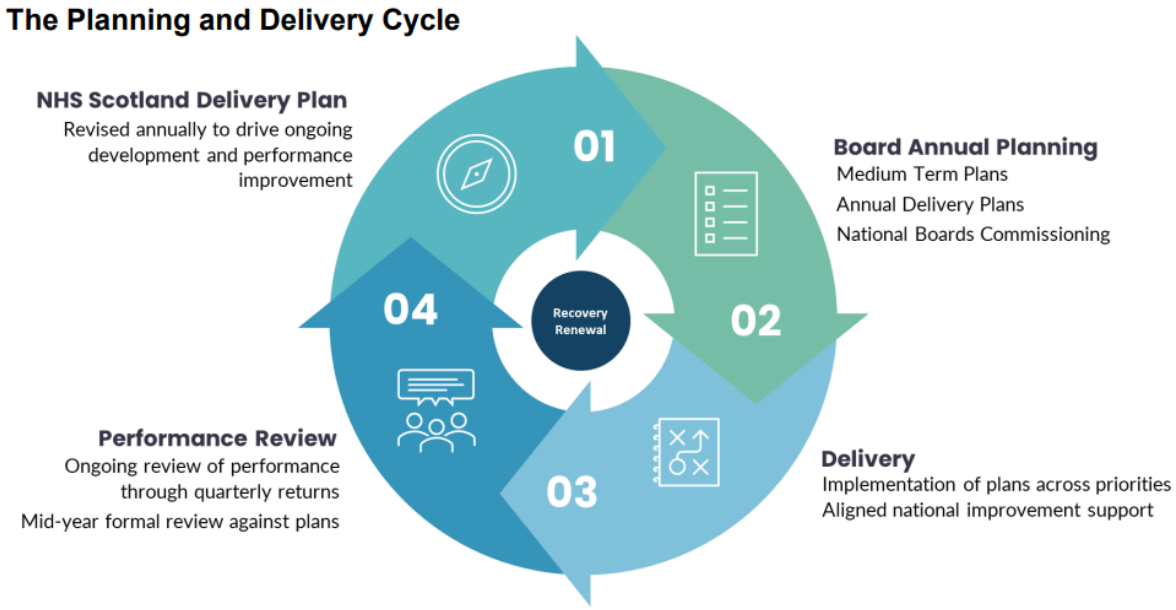
33. If you require access to the Whole System & Winter Dashboard, please send a request to: nss.neartimedata@nhs.scot

34. As part of the overall sponsorship relationship with NHS Boards, other Scottish Government Health and Social Care Policy leads and budget holders may have direct relationships with NHS Boards in relation to specific programmes of work, projects and policy areas. This includes meetings of the Chief Executives' Group, Directors of Finance, HR Directors, Directors of Planning, etc. The primary sponsorship mechanism will be the day to day working relationship between the Health Sponsorship Unit and NHS Boards. In addition to the work of the Health Sponsorship Unit, there will be scheduled Mid-Year and Annual Reviews.

35. The Chief Operating Officer will ensure Scottish Government Health and Social Care Policy Leads and budget holders will liaise with the Health Sponsorship Unit and NHS Boards early on in any legislation or policy development cycle in order that any implications for all parties can be understood and next steps mutually agreed. The relevant Scottish Government Health and Social Care Policy Leads will advise NHS Boards colleagues on how best to engage with the policy development process.

Planning and Delivery

36. The Planning and Delivery Cycle, outlined in the visual below, summarises the ongoing collaborative process between Scottish Government and NHS Boards to support planning and delivery of priorities:



Scottish Government Delivery Planning Guidance issues to Boards	End of November
Health Boards submit draft plans to Scottish Government for Review	End of February
Scottish Government confirms to Boards they are content with Delivery Plans	April
Quarterly review of performance	July; October; January; April (approx.)

37. This responsive planning and delivery cycle supports NHS Boards to develop their planning assumptions and intelligence, based on whole-system capacity and capability insight. Annually updated Delivery Plans are a key component of NHS Board annual planning and form the basis of the working relationship between Scottish Government and the NHS Board. The NHS Board should set out in detail through the Delivery Plans what the Board will achieve with regard expected levels of operational performance, particularly in relation to patient waiting times.

Delivering Planned Services

38. NHS Boards carry out functions and services on behalf of Scottish Ministers. The law does not specifically identify which health care services each Board directly delivers in practice. In this context it won't be practical for every Board to directly deliver the same services. Issues such as geography, physical location, availability of workforce and facilities, and the need to access specialist expertise, may lead to arrangements where one Board is delivering services on behalf of other Boards to ensure there is a sustainable solution in place. For clinical services, this will be most relevant in areas of secondary and tertiary care. NHS Boards also carry-out non-clinical / support functions for other Boards, for example, payroll, recruitment, etc.

39. Health care services could be delivered in a number of ways, for example:
    - On a cross-boundary basis. This can mean services provided by one health board to more than one health board area.

- For integration functions, services provided over several local authority areas to carry out the strategic plans of more than one integration authority.
- Nationally commissioned services, such as liver transplantation and paediatric heart transplants.

40. Regardless of why a Board is carrying out a particular service, the Accountable Officer of the delivering Board has to apply their duties to those services as summarised in the Memorandum to Accountable Officers. This will ensure that there is a single point of accountability for the delivery of such services.

41. If you have any queries regarding NHS Board Planning and Delivery, please contact: healthplanning@gov.scot.

Service Change

42. NHS Boards have a statutory duty to involve people and communities in the planning and development of care services, and in decisions that will significantly affect how services are run. The Scottish Government and COSLA have produced national guidance which sets out the process that NHS Boards and Integration Joint Boards should follow when they are involving people in decisions about local services.

43. When an NHS Board proposes *any* service change, it should work with Healthcare Improvement Scotland (HIS), to ensure that people and communities potentially affected have the information and support they need to play a full part in the consultation process. Where appropriate, they should collaborate in the delivery of these duties. NHS Boards will continue to make most decisions about the services that should be delivered locally. The outcome of community engagement and other relevant information must inform these decisions. HIS provides a range of information and support to NHS Boards on public engagement elements of all service change; as noted, the vast majority is non-major, so does not directly involve Scottish Ministers.

Major Service Change

44. There is an established process for proposed major service change in the NHS, as set out in sections 5.3 and 5.4 of the *Planning with People* guidance. All proposals for major service change must be subject to at least three months of formal public consultation; and, ultimately, to Ministerial approval.

45. HIS play a key role in working with Boards to identify potential major change (template on their site here). NHS Boards should contact HIS at the outset for preliminary discussions on the approach. NHS Boards can categorise proposals as major service change themselves and then follow the established process. HIS will offer the Board a view based on the completed template and associated discussions. In the absence of an agreed consensus between the NHS Board and HIS on whether specific proposals constitute major change, the NHS Board should seek a final decision from the Scottish Government.

46. In confirmed cases of major change, NHS Boards should not move to consultation until HIS has agreed that the engagement up to that point has been in accordance with the national guidance. HIS is required to quality assure the public consultation aspects of the major change process and so can provide advice on the nature and extent of the process being considered.

47. Following the public consultation, a full meeting of the NHS Board will consider the proposal/s and reach a decision. A range of information, including responses to the consultation and a report from HIS on the consultation process, will help inform the Board's decision. For information, HIS reports for previous major change examples can be found here. Following the Board's decision, the major service change proposal must be submitted to Scottish Ministers for final approval. Ministers will take all the available information and representations into account, including the HIS report. The proposals may be approved or rejected by Scottish Ministers. Where appropriate, Ministers may also instruct the relevant NHS Board to conduct further engagement activity. Once Scottish Ministers have concluded their considerations, they will write to the Board to set this out and Parliament will also be notified. The Board can then be formally assured on the outcome of Ministers' considerations and agree the next steps. Any further advice on Scottish Ministers' role in this process can be sought via: healthsponsorship@gov.scot.

Performance management

48. In order to ensure high quality, continuously improving health and social care in Scotland, it is important to strike the right balance between improvement, performance management and scrutiny. The NHS Board Delivery Framework sets out the indicators for 2024/25 that NHS Boards should monitor when assessing impacts of their Delivery Plans to improve services for patients. Using this framework, quarterly progress reporting against NHS Board Delivery Plans will support ministerial and executive level discussions with Boards on performance. These discussions will take place through at least two whole-system planning and delivery meetings per year with the Chief Operating Officer and Deputy Chief Operating Officers.

49. The NHS Scotland Support and Intervention Framework is one of the key elements of the Scottish Government's evidence-based approach to monitoring performance across NHS Scotland. A copy of the Framework is available on the Board Governance website. Please refer to the section of the Framework: *Stages of Support and Intervention in practice,* which will be helpful in explaining what escalation means in practice for NHS Boards who are escalated at stages 2 or above on the Framework. A listing of NHS Boards who are escalated to stage 3 or above on the Framework is here: NHS Scotland: support and intervention framework - gov.scot (www.gov.scot)

50. NHS Boards should provide data as required to Public Health Scotland as the official statistics producer of statistics across Health and Social Care.

Integration of Health & Social Care: Strategic Planning and Performance

51. Public Bodies (Joint Working) (Scotland) Act 2014 requires NHS Boards, and the local authorities in their area, to develop an integration scheme for each local authority area. The scheme creates an "integration authority" for the local authority area.

52. The NHS Boards and local authorities are primarily responsible in law for their functions and services, but the 2014 Act requires them to 'delegate' some of their functions to integration authorities. Regulations set out which functions the bodies 'must' delegate, and those which they may delegate. The delegated functions are the 'integration functions' for the integration authority.

53. The 2014 Act gives NHS Boards and local authorities a choice regarding the type of integration authority they may use. The integration authority can also cover more than one local authority area. The two types of integration authority are:

    1. A lead agency model.
    2. Integration Joint Board (IJB). This involves creating a new distinct legal entity, which is established by order under section 9 of the Public Bodies (Joint Working) (Scotland) Act 2014.

54. Once an integration authority is established, its role is to carry out the strategic planning of those integration functions, and issue directions to the NHS Board and local authority to carry them out.

55. The 2014 Act gives the NHS Boards and local authorities certain duties and powers:
    - in certain circumstances, where an integration joint board exists, the NHS Board and local authority can jointly direct the integration joint board to prepare a replacement strategic plan.
    - they are required to periodically review the integration schemes, and either party may request a review of the scheme at any time.
    - the NHS Board and local authority revising the integration model as part of a review. This means an integration joint board could be replaced with a form of a lead agency, or vice versa.

56. The 2014 Act gives the NHS Board choices, and the NHS Board is ultimately accountable to Scottish Ministers as to how it exercises those choices. If the integration arrangements are not having the desired impact on the relevant functions & services and outcomes, then NHS Boards should take appropriate action.

57. The NHS Board's system of governance should provide it assurance that the system of integration is operating effectively. This includes getting assurance through the Board's system of governance that:

- the NHS Board provides information that the integration authority requires to prepare its strategic plan and any subsequent directions.
- the NHS Board receives a copy of the strategic plan.
- the NHS Board receives the integration authority's annual financial statement (which it must publish under Section 39 of the 2014 Act), which sets out the amount that the integration authority intends to spend to implement the strategic plan. The NHS Board should incorporate the annual financial statement into its own financial planning processes.
- the NHS Board has a system to receive and account for all directions from integration authorities, and assure itself that the Board is implementing those directions.
- the NHS Board's performance management system allows it to monitor the impact of the directions on the performance of the relevant integration functions, and the NHS Board's overall performance.
- the NHS Board is providing information that the integration authority may require for its own performance management requirements, and for the integration authority to prepare its annual performance report (Section 42 of the 2014 Act).
- the NHS Board receives a copy of the integration authority's annual performance report, and uses this within its own systems for planning and performance management.

58. NHS Boards and integration authorities are required to produce annual accounts. NHS Boards should provide integration authorities with the information they require for this purpose, and follow the NHS Board Annual Accounts Manual which is published by the Scottish Government Health & Social Care Directorates.

Financial Management

59. Annex B identifies the relevant guidance NHS Boards are required to follow to apply the Scottish Public Finance Manual (SPFM) in the NHS. The Scottish Government translates the application of the SPFM to the NHS through specific Government circulars and detailed guidance/ frameworks/ instructions.

Risk management

60. Risk management is an integral part of the active and collaborative approaches to delivering good governance in the NHS. This is set out in Annex B of the Blueprint for Good Governance

Communications

61. Clear and effective communication channels between NHS Boards and Scottish Government on emerging risks/issues are integral to effective sponsorship relationships. The general approach in determining such interactions should be a local judgement of the most senior Board staff whilst respecting Boards' own operational space and governance arrangements.

62. The following schedule details the communication channel on emerging risks / issues between NHS Boards and Scottish Government:

- in the first instance, all key *routine* subject matter and reporting from NHS Boards should be in line with any instruction or guidance from the Scottish Government.
- Reporting of urgent local issues/risks that the NHS Board wish to raise should be done via SBAR wherever possible to relevant SG policy contacts, and signed off at Board Director level; copied to the Health Sponsorship Unit mailbox (HealthSponsorship@gov.scot). The Health Sponsorship Unit will maintain an up-to-date list of policy contacts – please see Annex C for the latest list.
- Emergency or major incidents (e.g. power failure or flooding which impact the delivery of services) should be considered against established Scottish Government Emergency Preparedness, Resilience and Response (EPRR) processes.
- Board Chief Executives and Directors can of course still raise the most urgent and/or sensitive issues directly via their Scottish Government senior/accountable officer counterparts, e.g. DG Health and Social Care /Chief Executive NHS Scotland, Chief Operating Officer NHS Scotland, etc. but must ensure the appropriate process noted above is pursued in parallel.

This document has three supporting annexes:

Annex A - Key legal reporting requirements

Annex B - Financial Management

Annex C – List of policy contacts

This document will next be reviewed in April 2025.

Framework Document for NHS Boards

Document Annexes

ANNEX A – Key legal reporting requirements

April 2024

Annex A – Key legal reporting requirements for NHS Boards, Framework Document

Equality: Tackling Poverty and Protecting People from Harm				
No.	Purpose	Legal Reference	Relevant Guidance	Date of Last review
1.	**Tackling Poverty** When making a 'strategic decision' health boards must actively consider how they can reduce inequalities of outcome caused by socio-economic inequalities. This should happen well before a decision is made and it should influence that decision. The health board is required to publish the assessment for each strategic assessment, or a statement explaining that the decision is not 'strategic' and assessment isn't required.	Part 1 of the Equality Act 2010.	Fairer Scotland Duty: statutory guidance for public bodies (last update 19 August 2022) Fairer Scotland Duty Guidance - Improvement Service	19/12/23
2.	**Tackling Child Poverty** A local authority and each relevant health board must annually after the end of each reporting year, jointly prepare and publish a local child poverty action report.	Section 13 of the Child Poverty (Scotland) Act 2017	Child poverty - Poverty and social justice - gov.scot (www.gov.scot) Developing a local child poverty action report: guidance (6 December 2022)	19/12/23
3.	**Community Planning for a local authority area** Health boards are community planning partners, and are required to carry out community planning with local authorities and other community planning partners. Section 5 of the Act says that a community planning partnership must act with a view to reducing inequalities of outcome which result from socio-economic disadvantage, unless the partnership agrees that it would be inappropriate to do so. Community Planning Partnerships will have a Local Outcome Improvement Plan and at least one locality plan**.** **Note:** Community Planning is also relevant to the mission "Community: Prioritising Our Public Services'.	Part 2 of Community Empowerment (Scotland) Act 2015	Community planning - Improving public services - gov.scot (www.gov.scot)	19/12/23
4.	**Advancing Equality through carrying out the Public Sector Equality Duty** The Public Sector Equality Duty exists to address these needs:	Part 11 of the Equality Act 2010	Guidance for Scottish public authorities | Equality and Human Rights Commission (equalityhumanrights.com)	19/12/23

Equality: Tackling Poverty and Protecting People from Harm				
No.	Purpose	Legal Reference	Relevant Guidance	Date of Last review
	• Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act. • Advance equality of opportunity between people who share a protected characteristic and those who do not. • Foster good relations between people who share a protected characteristic and those who do not. The 'specific duties' regulations require health boards to publish a wide range of information.	The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 as amended	Technical Guidance on the Public Sector Equality Duty in Scotland	
5.	**Children's rights reporting** Part 1 (section 2) of the Children and Young People (Scotland) Act 2014 ("the 2014 Act") places a duty on a range of public authorities (including all local authorities and health boards) to report, "as soon as practicable" after the end of each 3 year period, on the steps they have taken to secure better or further effect of the requirements of the United Nations Convention on the Rights of the Child (UNCRC). The United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Act 2024 commences on 16 July 2024. This will repeal the UNCRC reporting duties set out in the 2014 Act. Scottish Government will publish statutory guidance in relation to these UNCRC reporting duties and will continue to provide support to ensure Health Boards are able to prepare and publish their children's rights reports. Once commenced, the UNCRC Act will enhance the level of reporting required by Health Boards. As set out in Part 3, Section 18 of the UNCRC Act, Health Boards will be required to report on the following: ○ Actions taken and planned to ensure compliance with the UNCRC requirements, as set out in Section 6 of the UNCRC Act ○ Actions taken and planned to give further or better effect to children's rights.	Children and Young People (Scotland) Act 2014 (legislation.gov.uk) United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Act 2024	Guidance on Part 1, Section 2 (Duties of Public Authorities in relation to the UNCRC) of the Children and Young People (Scotland) Act 2014 Further note The draft guidance for Part 3, Section 18 of the UNCRC Act is currently out for public consultation.	25/3/24

Equality: Tackling Poverty and Protecting People from Harm				
No.	Purpose	Legal Reference	Relevant Guidance	Date of Last review
	Listed authorities will also be required to present a copy of the report to Scottish Ministers and to produce a child friendly version of the report.			
6.	**British Sign Language** Health boards are to publish an 'Authority Plan' on the use of British Sign Language under section 2 of the 2015 Act.	British Sign Language (Scotland) Act 2015 British Sign Language Act 2022	British Sign Language - Languages - gov.scot (www.gov.scot) The Scottish Ministers also produced a British Sign Language National Plan 2017-23: British Sign Language (BSL): National Plan 2017 to 2023 - gov.scot (www.gov.scot) British Sign Language - national plan: progress report - gov.scot (www.gov.scot)	20/12/23
7.	**Gaelic Language** Bòrd na Gàidhlig may give notice to any relevant public authority requiring the authority to prepare a Gaelic Language Plan. Once the Bòrd has approved the Plan, it may monitor its implementation.The public authority is required to periodically review the plan. Currently NHS Highland and NHS Western Isles are the only territorial NHS Boards required to have a Gaelic Language Plan. The Scottish Ambulance Service also must have a plan.	Gaelic Language (Scotland) Act 2005	Gaelic Language Plans – Bòrd na Gàidhlig (gaidhlig.scot)	7/3/24

Opportunity: A Fair, Green, Growing Economy				
No.	Purpose	Legal Reference	Relevant Guidance	Date of Last review
1.	**Promoting and Increasing Sustainable Economic Growth** Public bodies (listed in the Act) must publish a statement of the steps it has taken during the financial year to promote and increase sustainable economic growth through the exercise of its functions. The statement should be published as soon as is reasonably practical after the end of the financial year.	Section 32 (1) (a) of the Public Services Reform (Scotland) Act 2010	Duties on public bodies to provide information: guidance - gov.scot (www.gov.scot)	19/12/23
2.	**Furthering the Conservation of Biodiversity** All public bodies have to produce a report every three years setting out their compliance with their duty to further the conservation of biodiversity.	Section 2A of the Nature Conservation (Scotland) Act 2004	Biodiversity Duty | NatureScot	19/12/23
3.	**Reducing Emissions** Health boards are to report their progress in delivering their emissions reduction targets.	Climate Change (Scotland) Act 2009 The Climate Change (Duties of Public Bodies: Reporting Requirements) (Scotland) Amendment Order 2020 The Climate Change (Duties of Public Bodies: Reporting Requirements) (Scotland) Order 2015 (as amended)	Public bodies climate change duties: putting them into practice, guidance required by part four of the Climate Change (Scotland) Act 2009 - gov.scot (www.gov.scot)	19/12/23
4.	**Good Procurement Practice** All health boards are required to follow the 2014 Act and associated regulations. This includes having a procurement strategy to produce an annual report on regulated procurement activity after the end of the financial year.	Procurement Reform (Scotland) Act 2014. The Public Contracts (Scotland) Regulations 2015	Procurement Reform (Scotland) Act 2014: statutory guidance - gov.scot (www.gov.scot)	19/12/23
5.	**Improving Efficiency, Effectiveness and Economy** Health boards must publish a statement of the steps it has taken during the financial year to improve efficiency,	Section 32 (1) (b) of the Public Services Reform (Scotland) Act 2010	Duties on public bodies to provide information: guidance - gov.scot (www.gov.scot)	19/12/23

Opportunity: A Fair, Green, Growing Economy				
No.	Purpose	Legal Reference	Relevant Guidance	Date of Last review
	effectiveness, and economy in the exercise of its functions. The statement should be published as soon as is reasonably practical after the end of the financial year.			
6.	**Gender Representation on Public Boards** Health boards are required to produce a report every 2 years setting out activities to encourage women to apply for non-executive Board positions, and to achieve the gender representation objective.	The Gender Representation on Public Boards (Scotland) Act 2018 (Reports) Regulations 2020	Gender Representation on Public Boards (Scotland) Act 2018: statutory guidance (19 April 2022)	19/12/23

Community: Prioritising our Public Services				
No.	Purpose	Legal Reference	Relevant Guidance	Date of Last review
1.	**Protecting Public Health: Managing Public Health Incidents** Each health board is to make provision for the protection of public health in its area.	Section 2 of the Public Health etc (Scotland) Act 2008	Management of Public Health Incidents: Guidance on the Roles and Responsibilities of NHS led incident management teams (version 12.1, July 2020)	19/12/23
2.	**Protecting Public Health: Designating Competent Persons** Each health board is to designate competent persons relating to the protection of public health.	Section 3 of the Public Health etc (Scotland) Act 2008 The Public Health etc. (Scotland) Act 2008 Designation of Competent Persons Regulations 2009 (legislation.gov.uk	Management of Public Health Incidents: Guidance on the Roles and Responsibilities of NHS led incident management teams (version 12.1, July 2020)	19/12/23
3.	**Protecting Public Health: Joint Health Protection Plans** Each health board must prepare (after consulting relevant local authorities) and publish a joint health protection plan. The plan should cover a two-year period and be reviewed after two years.	Section 7 of the Public Health etc (Scotland) Act 2008	There is no extant guidance available on the web.	19/12/23
4.	**Preparing for Emergencies** Health boards are required to plan and prepare for emergencies.	Civil Contingencies Act 2004 The Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005, as amended.	Preparing for Emergencies Guidance - gov.scot (www.gov.scot)	04/03/24
5.	**Plan for Pharmaceutical Care Services in the area of a health board** Each health board must annually produce a 'pharmaceutical services care plan' comprising a summary of the pharmaceutical services provided in the area of the Board together with an analysis by the Board of where in its area it believes there is a lack of adequate provision of pharmaceutical services.	The National Health Service (Pharmaceutical Services) Regulations 2009 (as amended).	No guidance has been issued.	19/12/23

Community: Prioritising our Public Services				
No.	Purpose	Legal Reference	Relevant Guidance	Date of Last review
6.	**Effective Planning and Delivery of Children's Services** Health boards and local authorities have to produce children's services' plans so that those services: i) best safeguards, supports and promotes the wellbeing of children in the area concerned, (ii) ensures that any action to meet needs is taken at the earliest appropriate time and that, where appropriate, action is taken to prevent needs arising, (iii) is most integrated from the point of view of recipients, and (iv) constitutes the best use of available resources. Health boards and local authorities must also jointly produce an annual progress report on their children's services plan.	Part 3 of the Children and Young People (Scotland) Act 2014	Section 9: Aims of Children's Services Plans - Children's services planning: guidance - gov.scot (www.gov.scot)	19/12/23
7.	**Corporate Parenting** Health boards are corporate parents. Corporate parents are to produce reports setting out how they have carried out their corporate parenting responsibilities. This can be done as part of any other document.	Part 9 of the Children and Young People (Scotland) Act 2014	Corporate parenting - Looked after children	19/12/23
8.	**Developing a local strategy for carers** The health board and local authority are required to jointly develop a carer strategy which deals specifically with the exercise of all functions relating to carers. This will allow matters to be dealt with more comprehensively than can be the case in the integration strategic plan or children's services plan.	Carers (Scotland) Act 2016 Public Bodies (Joint Working) (Prescribed Local Authority Functions etc) (Scotland) Amendment (No 2.) Regulations 2017.	Carers (Scotland) Act 2016: statutory guidance - updated July 2021 - gov.scot (www.gov.scot) **Note**: Integration law obliges local authorities to delegate this responsibility for adult carers to the integration authority. Health boards may do so.	20/12//23
9.	**Community Justice Outcomes Improvement Plan** Health boards are 'community justice partners', along with other organisations. Community justice partners are required to produce a community justice outcome	Community Justice (Scotland) Act 2016	National Strategy for Community Justice - gov.scot (www.gov.scot) Community justice strategy: delivery plan - gov.scot (www.gov.scot)	20/12/23

Community: Prioritising our Public Services				
No.	Purpose	Legal Reference	Relevant Guidance	Date of Last review
	improvement plan, keep it under review and produce performance reports. The community justice partners are required to produce a participation statement, which they can do as part of the improvement plan.		What we do - Community Justice Scotland :Community Justice Scotland	
10.	**Integration Schemes** Health Boards and Local Authorities are required jointly to produce an Integration Scheme and periodically review. The Public Bodies (Joint Working) (Integration Scheme) (Scotland) Regulations 2014 prescribe matters, and information about those matters, that must be included in an integration scheme (a "scheme") prepared under section 1(2), 2(3) or 2(4) of the Public Bodies (Joint Working) (Scotland) Act 2014.	The Public Bodies (Joint Working) (Integration Scheme) (Scotland) Regulations 2014 (legislation.gov.uk)	No guidance has been issued.	02/04/24
11.	**Integration Authorities: Strategic Planning** This only applies if a health board is an 'integration authority' as a result of using the lead agency integration model. Where this applies, then the health board has to prepare a strategic plan for its 'integration functions' for the local authority area. Where the integration authority is not a health board, the health board is required to give the integration authority whatever information it may reasonably require to prepare the strategic plan.	Public Bodies (Joint Working) (Scotland) Act 2014	Public Bodies (Joint Working) (Scotland) Act 2014: statutory guidance - gov.scot (www.gov.scot)	19/12/23
12.	**Integration Authorities: Annual Financial Statement** If a health board is an integration authority, then it must produce an annual financial statement setting	Section 39 of Public Bodies (Joint Working) (Scotland) Act 2014	Health and social care - annual financial statement: advice note - gov.scot (www.gov.scot)	19/12/23

Community: Prioritising our Public Services				
No.	Purpose	Legal Reference	Relevant Guidance	Date of Last review
	out what it intends to spend to implement the integration authority's strategic plan.			
13.	**Integration Authorities: Annual Performance Report** If the health board is an integration authority, it is required to produce a performance report for the reporting year, relating to the planning and carrying out of 'integration functions' of the local authority area.	Section 42 of the Public Bodies (Joint Working) (Scotland) Act 2014.	Health and Social Care Integration Partnerships: reporting guidance - gov.scot (www.gov.scot)	19/12/23
14.	**Improving Community Participation in Improving Outcomes for Communities** Health boards are required to promote the use of participation requests by community participation bodies. When participation requests are made (and the request was accepted), and the associated outcome improvement process has been completed, then health boards are to produce a report. Health boards also are to produce annual reports on all participation requests.	Part 3 of the Community Empowerment (Scotland) Act 2015 The Participation Request (Scotland) Regulations 2017	Participation Requests under the Community Empowerment (Scotland) Act 2015 guidance (April 2017)	19/12/23
15.	**Health and Care Staffing** The 2019 Act places a duty on health boards to ensure appropriate staffing is in place, to enable high quality care and outcomes. Health boards will be required to submit annual reports to Scottish Ministers on their compliance with the Act.	Health and Care (Staffing) (Scotland) Act 2019	Roles in scope of the Act - Health and Care (Staffing) (Scotland) Act 2019: overview - gov.scot (www.gov.scot) Healthcare Staffing Programme (healthcareimprovementscotland.org) Health and Care (Staffing) (Scotland) Act 2019: Guidance Chapters Webinar 1 - YouTube	02/04/24
16.	**Delivering inpatient and day case service according to the treatment time guarantee**	Patients Rights (Scotland) Act 2011	About waiting times | NHS inform	19/12/23

Community: Prioritising our Public Services				
No.	Purpose	Legal Reference	Relevant Guidance	Date of Last review
	When a health board has not complied with the treatment time guarantee, it must provide the patient with an explanation as to why treatment did not start within the maximum waiting time, as well as other information. Health boards are required to receive a report on compliance with the guarantee at every public board meeting.	The Patients Rights (Treatment Time Guarantee) Regulations 2012 (as amended) Patients Rights (Treatment Time Guarantee) (Scotland) (No 2) Directions 2022	The regulations prescribe how waiting times are to be calculated for planned treatment on an inpatient or day case basis. The directions provide further detail on monitoring and recording waiting times, and communications with patients. Para 3 (2) also requires a report on compliance with the guarantee to be presented at every public Board meeting.	
17.	**Responding to and learning from feedback and complaints** Health boards are required to encourage patient feedback, and produce quarterly reports on complaints activity, and an annual report on action taken as a result of feedback, complaints or concerns.	Scottish Public Services Ombudsman Act 2002 Patients' Rights (Scotland) Act 2011 The Patients' Rights (Complaints Procedure and Consequential Provisions) (Scotland) Amendment Regulations 2016 The Patients' Rights (Feedback, Comments, Concerns and Complaints) (Scotland) Directions 2017	Section 16B of the 2002 Act allows the Ombudsman to publish model complaints handling procedures for public bodies. The SPSO's Complaints Standards Authority has taken this forward. NHS Boards adopted the model procedures with effect from 1 April 2017. The Model Complaints Handling Procedures | SPSO Section 14 (5) of the 2011 Act together with Directions issued through DL (2017) 6 requires relevant NHS bodies to produce quarterly reports on complaints activity, and an annual report on action taken as a result of feedback, complaints or concerns.	5 /1/24
18.	**Duty of Candour: Learning from Unexpected Events** The Duty of Candour relates to openness and accountability to the public when an unintended or unexpected event leads to certain outcomes defined in the Act (which relate to harm or death).	Part 2 of the Health (Tobacco, Nicotine etc and Care) Scotland Act 2016 The Duty of Candour Procedure (Scotland) Regulations 2018	Organisational duty of candour: guidance - gov.scot (www.gov.scot)	19/12/23

Community: Prioritising our Public Services				
No.	Purpose	Legal Reference	Relevant Guidance	Date of Last review
	A health board is a 'responsible person' as defined in the Act. The health board must produce an annual report on the Duty of Candour as soon as practicable after the end of the financial year.			
19.	**Responsiveness to staff concerns regarding patient safety or malpractice - whistleblowing** NHS Boards must publish an annual report setting out performance in handling whistleblowing concerns. This should summarise and build on the quarterly reports produced by the board, including performance against the requirements of the Standards, KPIs, the issues that have been raised and the actions that have been or will be taken to improve services as a result of concerns The information must cover all NHS services, and Boards must work with all service providers (inc. primary care, integration authorities) to get the information.	Scottish Public Services Ombudsman Act 2002	The National Whistleblowing Standards (April 2021)	20/12/23
20.	**Right for community bodies to request the transfer of land and buildings from a range of public bodies** The Act and the regulations require health boards to publish decision notices for each asset transfer request, as well as an annual report on asset transfer requests. Health boards must also maintain and publish a register of land (under Section 94 of the Act).	• Part 5 of the Community Empowerment (Scotland) Act 2015 • Asset transfer: legislative regulations • Community Empowerment (Registers of Land) (Scotland) Regulations 2016	Asset transfer - Community empowerment - gov.scot (www.gov.scot)	19/12/23
21.	**Reporting of Trade Union Facility Time** Health boards are to publish prescribed information on the amount of money spent on facility time for trade union work.	The Trade Union (Facility Time Publication Requirements) Regulations 2017	Report trade union facility time data - GOV.UK (www.gov.uk)	19/12/23

Community: Prioritising our Public Services				
No.	Purpose	Legal Reference	Relevant Guidance	Date of Last review
22.	**Disclosure of Certain Expenditure** Health boards are to publish as soon as is reasonably practicable after the end of each financial year a statement of any expenditure they have incurred during that financial year on or in connection with the following matters: • public relations • overseas travel • hospitality and entertainment • external consultancy	Section 31 (1) & (2) of the Public Services Reform (Scotland) Act 2010	Duties on public bodies to provide information: guidance - gov.scot (www.gov.scot)	19/12/23
23.	**Payments > £25,000** After the end of each financial year, publish a statement of any payments made during the year which are in excess of £25,000 (amount, date, payee, subject matter).	Section 31 (3) & (5) of the Public Services Reform (Scotland) Act 2010	Duties on public bodies to provide information: guidance - gov.scot (www.gov.scot)	20/12/23
24.	**Individuals who receive remuneration greater than £150,000** After the end of each financial year, health boards must publish a statement of the number of individuals who, during that year, received remuneration in excess of £150,000, in relation to be member of the body or one of its staff.	Section 31 (4) of the Public Services Reform (Scotland) Act 2010	Duties on public bodies to provide information: guidance - gov.scot (www.gov.scot)	19/12/23
25.	**Health Board Annual Accounts, including NHS endowment funds.** Health boards have to produce annual accounts which will be laid before the Scottish Parliament. The annual accounts include extensive information, including a Performance Report and an Accountability Report. Some Health Boards hold Endowment Funds which are registered charities. This requires Boards to	National Health Service (Scotland) Act 1978 Public Finance & Accountability (Scotland) Act 2000	The Scottish Government publishes a health board annual accounts manual every year. OSCR | Guidance and forms Governance of NHS endowment funds: review report (October 2021)- gov.scot (www.gov.scot)	20/12/23

Community: Prioritising our Public Services				
No.	Purpose	Legal Reference	Relevant Guidance	Date of Last review
	produce separate audited annual accounts and prescribed information to the Office of the Scottish Charity Regulator (OSCR).	Charities and Trustee Investment (Scotland) Act 2005		
26.	**Ethical Standards in Public Life (Scotland) Act 2000** All Board members are expected to observe standards of conduct in line with the key principles of public life, as set out in the Board's Code of Conduct. This includes maintaining a publicly accessible Register of Interests for board members.	Ethical Standards in Public Life etc (Scotland) Act 2000 Register of Interests Regulations 2003 (as amended)	Home | The Standards Commission for Scotland (standardscommissionscotland.org.uk)	20/12/23
27.	**Records Management Arrangements** Health boards are required to prepare a 'records management plan' and present it to the Keeper of the Records of Scotland. The benefits include: • Increase efficiency and effectiveness, delivering savings in administration costs • Improve and develop service delivery • Achieve business objectives and targets • Ensure compliance with the Public Records (Scotland) Act 2011 and other legislative requirements, standards and codes of conduct • Support transparency and open government • Underpin business resilience	Part 1 of the Public Records (Scotland) Act 2011	Model Records Management Plan | National Records of Scotland (nrscotland.gov.uk)	20/12/23
28.	**Notification of Public Sector Cyber Security Incidents and Personal Data Breaches** Health Boards are required to notify the Scottish Health Competent Authority of significant Network and	• Network and Information Systems Regulations 2018 (as amended) • Data Protection Act 2018 / UK General Data Protection Regulation	Significant Incident Reporting – Scottish Health Competent Authority (healthca.scot)	4/3/24

Community: Prioritising our Public Services				
No.	Purpose	Legal Reference	Relevant Guidance	Date of Last review
	Information System incidents within 72 hours of becoming aware. Health Boards are also required to notify the Scottish Government Digital Health and Care Division and the Information Commissioner's Office of certain personal data breaches within 72 hours of becoming aware of the incident.			
29.	**Due regard to preventing people from being drawn into terrorism** The key challenge for healthcare services is to ensure that, where there are signs that someone has been or is being drawn into terrorism, NHS staff are trained to recognise those signs correctly and are aware of and can locate available support, including making a referral, when necessary to Prevent Professional Concerns via their Health Boards Prevent Lead. Preventing someone from being drawn into terrorism is substantially comparable to child protection and the protection of vulnerable adults.	• Counter Terrorism and Security Act 2015 • The Counter-Terrorism and Security Act 2015 (Risk of Being Drawn into Terrorism) (Guidance) Regulations 2015 (legislation.gov.uk)	Prevent duty guidance: England, Scotland and Wales (2015) - GOV.UK (www.gov.uk)	20/12/23

Framework Document for NHS Boards

Document Annexes

ANNEX B – Financial Management

April 2024

Introduction

The table reviews key areas relating to finance which NHS Boards should be aware of, including sections of the Scottish Public Finance Manual, (SPFM) which applies to all NHS Boards. This is not intended to replace this guidance or cover every area of the SPFM, it simply sets out the main expectations of NHS Boards and how this should be used in day-to-day management. NHS Boards should be aware that there are periodic Finance Guidance Notes which can be either stand-alone guidance, or announcements of substantive updates to SPFM chapters (which will be reflected in the chapters). Not all Finance Guidance Notes are relevant to NHS Boards.

The table below summarises the relevant guidance or instructions that NHS Boards should follow relating to finance. The detailed content will be in the latest version of the guidance or instructions. If you have any queries, please contact NHSFinanceReturns@gov.scot

No.	Area	Relevant Guidance for NHS Boards	Date of Last review
1.	**Annual Accounts** **Governance Statement**	The NHS Scotland Technical Accounting Group updates the Annual Accounts Manual and Capital Accounting Manual for each financial year. Updated Manuals will be sent to Directors of Finance each year and copies can be obtained from nhsaccounts@gov.scot The Board Chief Executive, as Accountable Officer, has a personal responsibility to sign the annual accounts - and the associated governance statement - for the body, and in doing so accept personal responsibility for their proper presentation as prescribed in legislation and/or in the relevant Accounts Direction issued by the Scottish Ministers. NHS Board Chief Executives should receive certificates of assurance from their direct reports, and this should inform the preparation of their Governance Statement within the Board's annual accounts.	13/2/24

No.	Area	Relevant Guidance for NHS Boards	Date of Last review
	Certificates of Assurance	NHS Boards should always follow appropriate records management procedures for financial documents including Certificates of Assurance and Annual Accounts. Scottish Government Records Management: Health and Social Care Code of Practice (Scotland) 2020. Record keeping (VAT Notice 700/21)	
2.	**Annual Budgeting Process**	Scottish Government sets its budget annually, typically mid-December. This is the Stage 1 budget and is subject to further amendments before being passed by Parliament at Stage 3 by end February. The use of resources by the Scottish Administration and other bodies funded directly from the Scottish Consolidated Fund must be authorised on an annual basis by Budget Act. This includes the funding provided to NHS Boards and budgets delegated to Directorates. NHS Boards will be informed of their indicative budget at the announcement of Stage 1 which shows their National Resource Allocation Formula (NRAC) share of core budgets. It is important to note at this point it does not include in year allocations which will be additional to the amount set out in the published budget document. Page 32 of the published 2024-25 budget sets out detail for the NHS Recovery, Health and Social Care Portfolio. scottish-budget-2024-25.pdf (www.gov.scot)	13/2/24
3.	**Appraisal and Evaluation**	The Board Chief Executive, as Accountable Officer, has a personal responsibility to ensure that arrangements have been made to ensure that, in the consideration of policy proposals relating to the resources for which you have responsibilities as Accountable Officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and where appropriate brought to the attention of the body.	13/2/24

No.	Area	Relevant Guidance for NHS Boards	Date of Last review
		The Accountable Officer also has a personal responsibility to ensure that: • managers at all levels have a clear view of their objectives, and the means to assess and measure outputs, outcomes and performance in relation to those objective; • managers at all levels are assigned well defined responsibilities for making the best use of resources (both those consumed by their own commands and any made available to third parties) including a critical scrutiny of outputs, outcomes and value for money; and • managers at all levels have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.	
4.	**Audit Committees**	Audit Committee Chairs should notify the Scottish Government at the earliest opportunity if they have identified a significant issue which may have wider financial implications. Annex D of the NHS Scotland Blueprint for Good Governance (Second Edition)	13/2/24
5.	**Auditor-General for Scotland**	NHS Boards should provide any information the external auditor requires in a timely manner, to facilitate the efficient conduct of the audit of the annual accounts, or any other reviews which the external auditor or the Auditor-General may carry out as part of their duties. Annex D of the NHS Scotland Blueprint for Good Governance (Second Edition) Our work | Audit Scotland (audit-scotland.gov.uk)	13/2/24

No.	Area	Relevant Guidance for NHS Boards	Date of Last review
6.	**Best Value**	The Board Chief Executive, as Accountable Officer, has a personal responsibility to ensure that arrangements have been made to carry out the Duty of Best Value in Public Services Best value in public services: guidance for accountable officers - gov.scot (www.gov.scot)	13/2/24
7.	**Borrowing, Lending and Investments**	NHS Boards may not borrow from or lend money to another organisation. The Scottish Government Health & Social Care Directorates may provide an advance of funding ("brokerage") to an NHS Board. This is repayable funding given to ensure the NHS Board meets it statutory obligation to break even. A letter should be sent to Scottish Government in the final month of the financial year formally requesting brokerage. SG keeps a central tracker of brokerage amounts which will become repayable when the NHS Board returns to financial balance. NHS Boards should contact NHSFinanceReturns@gov.scot regarding any proposals for brokerage.	13/2/24
8.	**Checking Financial Instructions** **Expenditure and Funding** **Income Receivable and Receipts**	The Board Chief Executive, as Accountable Officer, has a personal responsibility to ensure that arrangements have been made to ensure that: • appropriate financial systems are in place and applied and that procedures and controls are reviewed from time to time to ensure their continuing relevance and reliability, especially at times of major changes; • proper financial procedures are followed and that accounting records are maintained in the form prescribed for published accounts; • the public funds for which the Accountable Officer is responsible are properly managed and safeguarded, including independent and effective checks of any cash balances in the hands of an official; and	13/2/24

No.	Area	Relevant Guidance for NHS Boards	Date of Last review
		• assets for which the Accountable Officer is responsible such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate. All NHS Boards are required to have Standing Financial Instructions and a Scheme of Delegation. The approval of these policies is a matter reserved to the Board within the Standing Orders, as set out in the model Standing Orders for NHS Boards issued through DL (2019) 24. These policies should be accessible on the Board's website. NHS Boards are also required, by the National Health Service (Financial Provisions) (Scotland) Regulations 1974 to appoint an officer as a "treasurer". The treasurer will be the Board's Director of Finance (or equivalent).	
9.	**Delegated Authority**	All NHS Boards are required to have Standing Financial Instructions and a Scheme of Delegation. The approval of these policies is a matter reserved to the Board within the Standing Orders, as set out in the model Standing Orders for NHS Boards issued through DL (2019) 24. These policies should be accessible on the Board's website. This has been a long-standing requirement, historically summarised in MEL (1994) 80: Corporate Governance in the NHS: Supplementary Guidance. They are a part of the suite of operating guidance that Boards should have, as described (from para 4.175) in the Blueprint of Good Governance. The SPFM sets out guidance on novel or contentious spend. This will require a degree of judgement to identify where spend is novel or contentious. Broadly speaking, if it is a financial transaction different to the type the Board normally enters into, if there is concern within the Board about the public or staff reaction to the spend, if it is materially out with budgets set and therefore is out with regularity	13/2/24

No.	Area	Relevant Guidance for NHS Boards	Date of Last review
		or assessment by the Accountable Officer deems this could be politically sensitive, further advice can be sought from SG. Please contact NHSFinanceReturns@gov.scot to discuss further.	
10.	**Expenditure without Parliamentary Authority** **Expenditure without Statutory Authority**	NHS Boards only have authority to commit expenditure which has been approved through Parliament, in other words, their communicated budget. It is understood this poses challenges with funding which is allocated in year rather than through the annual budget process through parliament. Anticipated allocations are included in financial plans. NHS Boards submit three-year financial plans to Scottish Government – see **section 11**. When this plan is approved, that is the expected delivery agreed, and any deviations from that plan must be notified to Scottish Government before expenditure is committed above the agreed plan. Simply put NHS Boards and the Scottish Government can only undertake particular activities if the law gives them the authority them to do so. All expenditure needs to arise from those activities.	13/2/24
11.	**Financial Planning**	NHS Boards submit three-year financial plans to Scottish Government setting out their anticipated revenue and capital resources, and performance against this. Where a Board submits a deficit plan, meaning it has not set out how it will be able to deliver services within its anticipated budget, a revised plan is requested by Scottish Government. Scottish Government may not approve the financial plan where the deficit is out with previously communicated expectations. Financial plans will then be tracked throughout the year to understand actual delivery, and any deviation from these plans.	13/2/24

No.	Area	Relevant Guidance for NHS Boards	Date of Last review
		The model Standing Orders for NHS Boards issued through DL (2019) 24, requires the Board to approve its financial plan for the forthcoming year, and the opening revenue and capital budgets.	
12.	**Fraud**	NHS Boards should work with NHS Counter Fraud Services Scotland, in line with the CFS Partnership Agreement (issued on 23 March 2022 through DL (2022) 06) to implement the Counter Fraud Standard and the NHS Scotland Counter Fraud Strategy 2023-26. Countering fraud | National Services Scotland	13/2/24
13.	**Insurance**	NHS Boards must participate in the Clinical Negligence and Other Risks Indemnity Scheme ('CNORIS'). Information on CNORIS is available here: Guide to the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) | National Services Scotland (nhs.scot) NHS Boards must take out commercial insurance where there is a legal obligation to do so. When NHS Boards are considering taking out any further commercial insurance, they should carry out a cost-benefit analysis, and that analysis should demonstrate a positive benefit before taking out the insurance. As with all expenditure, taking out insurance should meet the needs of the Duty of Best Value in Public Services.	13/2/24
14.	**Internal Audit**	The appointment of the Board's Chief Internal Auditor is a matter reserved to the Board, as set out in the model Standing Orders for NHS Boards issued through DL (2019) 24. The Board's internal auditors should operate in line with The Public Sector Internal Audit Standards.	13/2/24

No.	Area	Relevant Guidance for NHS Boards	Date of Last review
		See also Annex D of the NHS Scotland Blueprint for Good Governance (Second Edition)	
15.	**Losses and Special Payments**	Boards must follow the Losses and Special payments guidance which includes the forms Boards need to complete for any losses or special payments above their delegated thresholds. This guidance is subject to review. Delegated financial limits for gifts, losses and special payments can be found in the Chief Executive Letter, ref: CEL 10 (2010). For copies of special loss guidance contact nhsaccounts@gov.scot	13/2/24
16.	**Major Investment Projects**	Boards are required to submit a Capital Plan and a Property & Asset Management Strategy to the Scottish Government. The Scottish Capital Investment Manual sets out the processes and techniques to be applied in the development of all infrastructure and investment programmes and projects within NHS Scotland. The principles are to be applied to all developments by NHS bodies and IJBs requiring NHS investment support. If the project involves land and buildings transactions, then boards also have to comply with the Property Transactions Handbook concurrently with the business case process. Frameworks Scotland 3 provides a mechanism for health boards to select and contract with previously approved Principal Supply Chain Partners for major capital projects. This engagement happens after the project has been approved and funded, and avoids the need for boards to run a distinct procurement exercise.	13/2/24

<table>
<tr><th>No.</th><th>Area</th><th>Relevant Guidance for NHS Boards</th><th>Date of Last review</th></tr>
<tr><td></td><td></td><td>NHS Boards have delegated authority to approve capital business cases. They currently are:

<table><tr><th>Board</th><th>Limit</th></tr><tr><td>Grampian, Greater Glasgow & Clyde, and Lothian</td><td>£10m</td></tr><tr><td>Lanarkshire</td><td>£7.5m</td></tr><tr><td>Ayrshire & Arran, Fife, Forth Valley, Highland, and Tayside</td><td>£5m</td></tr><tr><td>Borders, Dumfries & Galloway, Orkney, Shetland, and Western Isles.</td><td>£3m</td></tr></table>
Source: DL (2019) 5 : Delegated Limits: Capital Investment Projects

For capital investment projects above the boards' delegated limits, the project has to be referred to the Scottish Government's Capital Investment Group.

Chief Executives must ensure that the above requirements are reflected in the Board's Standing Financial Instructions and Scheme of Delegation.

Please contact alan.morrison@gov.scot for further questions.</td><td></td></tr>
<tr><td>17.</td><td>Procurement</td><td>The Board's Accountable Officer has a specific responsibility to ensure that procurement activity is conducted in accordance with the requirements in the Procurement section of the Scottish Public Finance Manual. This has been translated into practice in the NHS in Scotland as follows:

National Procurement and Logistics | National Services Scotland (nhs.scot)

Procurement Reform (Scotland) Act 2014: statutory guidance - gov.scot (www.gov.scot)</td><td>13/2/24</td></tr>
</table>

No.	Area	Relevant Guidance for NHS Boards	Date of Last review
		CEL 05 (2012): Key Procurement Principles	
18.	**Property acquisition, disposal, and management.**	See section **on Major Investment Projects**. If a project involves land and buildings transactions, then NHS Boards have to comply with the Property Transactions Handbook concurrently with the business case process. NHS Boards must maintain a register of land and maintain it on its website: Community Empowerment (Registers of Land) (Scotland) Regulations 2016: amended version - gov.scot (www.gov.scot) Community Empowerment (Scotland) Act 2015: asset transfer guidance for authorities Please contact alan.morrison@gov.scot for further questions.	13/2/24
19.	**Risk Management**	All Boards are expected to maintain a risk register and it is likely finance risks will feature on this. Please refer to Annex B of the Blueprint for Good Governance.	13/2/24
20.	**Scottish Parliament Public Audit Committee**	The Board's Accountable Officer may be required to provide evidence to the committee or any of its sub committees relating to finance matters or financial performance. For any advice and support on this, please contact Robert.kirkwood@gov.scot	13/2/24
21.	**Settlement, severance, early retirement, redundancy**	Boards are to follow the NHS Scotland: guidance on settlement and severance arrangements (DL 2019 15).	13/2/24

Framework Document for NHS Boards

Document Annexes

ANNEX C – List of key policy contacts

April 2024

Section of the Framework Document	Contact Point
People, Governance and Appointments *(paragraphs 13-16)*	ocenhs@gov.scot
Staff Governance *(paragraph 17-18)*	directorofhealthworkforce@gov.scot
Digital policy *(paragraphs 22-29)*	alistair.hodgson@gov.scot
Health sponsorship *(paragraphs 30-35)*	HealthSponsorship@gov.scot
Whole system & winter dashboard *(paragraphs 32-33)*	nss.neartimedata@nhs.scot
Health planning *(paragraphs 36-41)*	healthplanning@gov.scot
Performance management (*paragraphs 48-50*)	Performanceanddeliveryhub@gov.scot
Emergency Preparedness, Resilience and Response (EPRR) *(paragraph 62)*	health.eprr@gov.scot

Framework Document, Annex B – Financial Management

Annual Accounts *(entry no. 1)* *Losses and Special Payments* *(entry no. 15)*	nhsaccounts@gov.scot
Borrowing, Lending and Investments *(entry no. 7)* *Delegated Authority* *(entry no. 9)*	NHSFinanceReturns@gov.scot
Major Investment Projects *(entry no. 16)* Property acquisition, disposal, and management. *(entry no. 18)*	Alan.morrison@gov.scot
Scottish Parliament Public Audit Committee *(entry no. 20)*	Robert.kirkwood@gov.scot

SCOTTISH HOSPITALS INQUIRY

FINAL CLOSING SUBMISSIONS

ON BEHALF OF

JOHN AND MOLLY CUDDIHY AND LISA AND EILIDH MACKAY

INTRODUCTION

These Closing Submissions on behalf of the Cuddihy and Mackay families are submitted in December 2025, following the hearing of evidence throughout the Scottish Hospitals Inquiry. These Closing Submissions are in addition and should be read alongside previous submissions made at earlier stages of the Inquiry.

Both families are grateful to Counsel to the Inquiry for their detailed and considered Closing Submissions. The extensive document that has been produced includes a detailed analysis of the evidence heard and the issues relevant to the Terms of Reference which were set by the Cabinet Secretary. We adopt Counsel to the Inquiry's submissions. Both Molly and Eilidh contracted ~~a~~ healthcare-associated infections. Molly contracted Mycobacterium Chelonae in 2018 through contaminated hospital water systems. Eilidh contracted Neuro -Aspergillus (the source being ventilation) and Pseudomonas Aeruginosa in 2016 (Pseudomonas Aeruginosa was identified in the hospital water supply in July 2016, although at that time water was not being routinely tested for this infection). The experience of both Molly and Eilidh, who were then children underscores the very real human cost of systemic failings.

The content of these Closing Submissions will focus on the experience of Molly Cuddihy and Eilidh Mackay who were both Schiehallion patients in the RHC. Both Molly and Eilidh contracted hospital acquired infections during their time as in-patients receiving treatment for cancer. It is the view of these patients and their families that those infections were linked to the hospital environment, and in particular the water and ventilation. Molly died on 26th August 2025 aged 23 years. Eilidh continues to live with the life impacting and life limiting effects of the infections she contracted.

It is a number of years since the Inquiry heard the oral evidence of many of the parents and some of the patients who were directly impacted by the deficiencies in water and ventilation in Ward 2A and elsewhere in the hospital estate. It is for the Chair to assess all of the evidence and to answer the Terms of Reference. We wish to highlight and focus on the impact of events including hospital acquired infection, decant of patients, communication and corporate governance, on the patients and families that we represent. This will be done through the optic of Getting it right for Every Child (GIRFEC) and the UN Convention on the Rights of the Child (UNCRC). These submissions seek, where possible, to capture the voices of the families that we represent.

These submissions will comprise the following sections:

1. REFLECTIONS
2. COUNSEL TO THE INQUIRY CLOSING SUBMISSIONS
3. GOVERNANCE FAILINGS
4. GIRFEC AND UNCRC
5. FULFILLMENT OF GIRFEC AND UNCRC BY NHS GGC
6. RECOMMENDATIONS

1. REFLECTIONS

To begin, we reflect on prior submissions/evidence that demonstrate that issues related to the safety of ventilation and water were highlighted prior to either Eilidh or Molly contracting their infections. The inaction that accompanied these events in the form of failure to investigate and failure to escalate are a central cause of the crisis that unfolded. A crisis that has at least contributed to the death of Molly and the life impacting and limiting consequences for Eilidh.

VENTILATION

> *"Ventilation concerns were being reported in 2014/15 with air sampling showing isolated microorganisms including Mucor (which has up to an 80% mortality rate in children and recording of 3 ACH rather than 6ACH in general wards. Concerns were reported to Aileen McLennan (by Dr Redding) but not escalated to the Medical Director Grant Archibald. This led to Dr Redding escalating to senior management and in 2017 to the outgoing and incumbent CEO. The inaction in response to her concerns led to Stage One Whistleblowing in September 2017…the finding of high particle counts (in the tens of thousands far exceeding the safe limit of 100 together with aspergillus being detected) on 30th June 2015 on Wards 4B and 2A, raised significant concerns about whether Ward 4B ventilation system provided a safe environment for patients. Testing established that even when increased to maximum, no more than 6 ACH could be achieved and the decant back to the Beatson took place. Significantly, the finding of the high particle counts and aspergillus led to the return of adult BMT patients to the Beatson but it did not trigger further investigation in ward 2A nor did it prevent the decant of immune compromised patients from Ward 2A to 4B. A full record of all of the deficiencies in Ward 2A was not put together until Mr Lambert's report in 2018. Whilst Ward 2A's non-compliance with SHTM 03-01 was recognised by NHS GGC in an internal document in March 2017, it should have been recognised in 2015 by the finding of high particle counts. If that finding been followed up and/or concerns around ward 4B had triggered detailed consideration of paediatric bone marrow transplant patients and the immune compromised patients being treated in Ward 2A, this should have led to*

preventative action. Evidence of the lack of reaction to the events in June 2015 is found in the evidence of Annette Rankin which is reflected upon in paragraphs 164 and 285 of Counsel to the Inquiry's submissions. (Glasgow 3 Submissions on behalf of the Cuddihy and Mackay Families at Page 19).

MYCOBACTERIUM CHELONAE

"13. On Wednesday 4 October 2017 I attended the Teaching and Learning Centre of the QEUH at 8am for the meeting instigated by Dr Armstrong. In attendance that morning were Dr Armstrong, David Loudon, Morag Gardner, Mrs Devine, Mr Powrie, Prof Jones, Mr Walsh, Anne Harkness, Jonathan Best, Gary Jenkins, Dr Redding, Dr Green, and Ann Lang as minute taker.

117. The first issued raised in the SBAR was patient placement. The SBAR highlighted not only the issues with the rooms but also the dates on which concerns had first been raised.

130. The next point to cover was water quality. We mentioned that all the taps were fitted with thermal mixing valves, but there was no cleaning and maintenance policy. We also mentioned that water on 4B had not been tested and that delays in water testing were being experienced by the ICDs.

131. Mr Powrie confirmed that water testing was carried out with only the exceptions (i.e. failures) being reported to the Infection Control Team. The minutes state that it was agreed that the Board were compliant with water testing protocol. However, I was in no position to agree or disagree without the evidence of the actual water testing history which had not been shared. It now transpires that the report from 2015 was in existence and DMA were on site and writing what became the 2017 report. It seems utterly astonishing to me now that the answers we were given at that time were so distant from the reality…

Ongoing infection concerns

137. On 13 October 2017 I grew Mycobacterium chelonae from a shower head in 7D, (a CF ward). I escalated this to Prof Jones, Jackie Balmonroy and Ms Joannidis on 13 October by email copying in the CF Consultants. Prof Jones replied to say that he and the ICNs would take it forward. I can provide a copy of this email if required.

138. On 19 October 2017 I became aware of an issue with air quality within the Teenage Cancer Trust with Dr Balfour writing an email to say that she had assessed previous air sampling results and although fungi had previously been cultured there, there was no obvious record of actions taken to investigate or remedy this. I have provided the Inquiry with Dr Balfour's email to me."

(Witness Statement of Dr Christine Peters - A48716888 August 2024

Pages 13, 42-43, 46-47, 48)

"7. No warning was shared with us or indeed ARHAI, about another paediatric patient in the same ward who was infected in 2016. Even as Molly's illness progressed, her infection was absent from official timelines and records, despite our repeated submissions to the oversight board by way of written reports. Our appeals for accuracy and acknowledgement went unanswered until we escalated issues to the highest levels. But even now the Scottish Government website continues to display the flawed timeline, which continues to omit details surrounding Molly's bacterial infection in 2018. This public display of an inaccurate timeline is a serious issue, especially for laypersons who are not connected to the case, because it obscures important facts and prevents full accountability and understanding of the tragedy.

8. We learned—too late—that Mycobacterium chelonae had been found in the very rooms occupied by Molly following decant in 2018, but we were not told at the time. Details of her bacterial infection were withheld from expert reviewers, including in the production of the HAD report by NHS GGC appointed experts, preventing thorough examination of her case." (Witness Statement Professor John Cuddihy - A54279169 pp 2-3, Witness Statements – Volume 6 – P34 at pp35-36)."

WATER /ENVIROMENTAL TESTING

CASE NOTE REVIEW P.67 (Bundle 6, for Oral hearings commencing from 12 June 2023, P.975 at P1041)

"5.5.2 Water testing at NHS GGC
We set out the summary of the policy above because, whilst the timing of the guidance issued in Scotland means that water systems in Haematology Oncology wards at NHS GGC were not required to be tested for P. aeruginosa contamination, there must have been professional and managerial awareness that such guidance was in place elsewhere in the UK. This ought to have further strengthened the need for regular, systematic sampling/testing of water given the emerging concerns over this timeframe about possible environmental sources for paediatric bacteraemias.

NHS GGC informed us that they had in fact implemented testing for P. aeruginosa in 2016 and we have confirmed this by reference to the risk assessment undertaken for that year. However, we found that their SOP for Minimising the risk of Pseudomonas aeruginosa infection from water is confusing: even the 2019 version is still headed 'Applicable in all adult and paediatric intensive care units and neonatal units' and makes no reference to other high risk areas such as transplant units. This is important as critical control of this issue is not just about water testing but also about flushing regimes and alert surveillance.

The investigation undertaken by HFS and the findings of the Independent Review have each confirmed that there were serious issues about the design and commissioning of the water system. The response of the organisation to the point at which additional whole system chlorination was introduced, suggests that these issues were accepted. Yet we have been told that there was a lack of a robust water testing strategy from the point at which the new hospital building was commissioned, including assurance that the system was fit for purpose.

From the information with which we have been provided, it has proved difficult to understand the rationale for how water sampling/testing took place, in particular to assure the organisation that water systems/sources were not related to the observed GNE bacteraemias in children. There did not appear to be a systematic water sampling process in place, or a consistent water system related response to clusters of infections caused by (often unusual/uncommon) GNE bacteria. We are not assured that there was adequate communication about what sampling and testing occurred and the results obtained. We have been told that some key staff involved in IPC at NHS GGC were denied access to water sampling/testing information despite multiple requests. As the concerns increased about whether the bacteraemias occurring in children on the Haematology Oncology wards at NHS GGC might be related to environmental/water contamination, the lack of a clear step change in the organisation's approach to water sampling, testing, reporting and strategy is of concern.

After repeated requests for information on what water system sampling testing took place, we were provided with data that frequently did not specify the precise location from where a sample was obtained, and/or precisely which bacteria were sought and identified in the laboratory. It is possible that water samples were examined to determine only the burdens (total numbers) of bacteria present, without formal identification of the bacteria present; conversely, samples may have been taken to look for specific bacteria (e.g. in relation to bacteraemias caused by uncommon microorganisms). Specific bacteria may have been sought in some samples, but this does not mean that all bacteria present were identified. Also, searching once or only occasionally for specific bacteria, and from only a limited number of sites, limits the confidence that a bacterium of concern was not contaminating a water point/system and thus could have been the source of one or more bacteraemias…

In summary, and crucially, without any other clear account of which water points/systems were/were not sampled, when and how often sampling occurred, and which bacteria were specifically sought, we frequently could not confidently exclude these as potential point sources for bacteraemias caused by GNE bacteria that are known to be associated with such environments."

"There were many inconsistencies in the provision and quality of data within the environmental sampling and water system sampling"
(Gaynor Evans Witness Statement, page 19; Hearing Commencing 19 August 2024 – Witness Statements – Week Commencing 28 October 2024 – Volume 11).

"…routine water testing did not commence until 2018…"
(Gaynor Evans Witness Statement, page 29; Hearing Commencing 19 August 2024 – Witness Statements – Week Commencing 28 October 2024 – Volume 11).

"the sampling of the potential environmental sources was not systematic…"
(Prof Mark Wilcox, Witness Statement, page 16; Hearing Commencing 19 August 2024 – Witness Statements – Week Commencing 28 October 2024 – Volume 11).

"we increasingly believed that there were sufficient grounds to be suspicious of the environment that a more robust scrutiny could have been set up" "the sampling of the potential environmental sources was not systematic…"
(Prof Michael Stevens Witness Statement, page 9; Hearing Commencing 19 August 2024 – Witness Statements – Week Commencing 28 October 2024 – Volume 11).

It is of note that National Scottish infection-control guidance on water testing in the built environment (NIPCM Chapter 4.1.7) requires Boards, via their Water Safety groups, to define both routine and as hoc microbiological testing and sets specific microbiological limits for Mycobacterium species in certain high-risk water uses, reflecting that targeted testing for mycobacteria should be undertaken when these organisms are suspected or detected. Water Samples from Ward 2A in April 2019, approximately 10 months after Molly contracted Mycobacterium Chelonae, yielded positive results from outlets in rooms she had occupied.

The testing in 2019 occurred two months prior to a further paediatric patient contracting Mycobacterium Chelonae in Ward 6A.

THE OVERSIGHT BOARD AND NHS GGC FAILURES

Q *I was now going to move, Professor Cuddihy, to think about your reflections on the Oversight Board and I think we understand that its final report was issued round about the same time, I think, as the independent case note review report. Would that be about right?*

A *The same day.*

Q *Yes. Now, I'll come to your reflections on it perhaps a little later but, first of all, I would be interested, as somebody who was a member of Oversight Board and had an active role on its work, I was wondering if you could tell us a little about or maybe picking up on where you were around about the time of the BBC programme, I wonder if you could tell us something about the Board's engagement, the Health Board's engagement, with the Oversight Board process during the remainder of its work up to the issuing of its final report?*

A *So from that point of the Disclosure Scotland programme, the Oversight Board, as were others, were impacted as a consequence of Covid, so the physical meetings had been replaced with online, so the communication with the Oversight Board to consider papers and the likes was through Teams or I presume one of those applications. And ahead of anything, the papers would be shared with you. You had the opportunity to consider those and make comment and I often did and challenge the detail within them. But specifically, Pricewaterhouse Cooper had been retained to develop an analytical process in terms of governance to produce various products in relation to this, a timeline of events from '15 through to 2020, to consider aspects of governance and the timeline; to consider and overlay aspects of infection; to consider and overlay aspects of communication, and specifically, when I reviewed the governance, and the large number of internal governance groups that applied to GG&C, I noted a number of things from my own investigations. First and foremost, there was pertinent detail missing from those timelines in that when it came to 2018 Molly Cuddihy didn't exist. She didn't appear on that timeline at all. Mycobacterium chelonae did not appear on that timeline. But also, importantly, certain documents that would be referred to that enabled compilation of this analytical document, those documents didn't appear. I had concern about that. But also what didn't appear, certain internal governance groups didn't seem to be reflected. That is no criticism of the individual that is engaged in the data acquisition, the data collation and the data analysis. You can only deal with that which you have. So I challenged this specifically and the Chair invited me to then prove the point. I proved the point and I submitted to them a 39-page report in relation to mycobacterium chelonae, involves the report as the process and procedure that NHS GGC should follow in relation to when mycobacterium chelonae is either suspected or identified, and that is you should take water samples. And, indeed, reflected in information from the Oversight Board and others, it was to canvas the rest of Scotland, all of the other Health Boards, "What do you do in relation to mycobacterium*

chelonae?" You sample the water. And yet Greater Glasgow and Clyde hadn't done so. So I had within this report reference to those guidance documents and recalling that Jennifer Armstrong, Medical Director, had told me in her letter to me in 2018 that they had followed all of the guidance and all of the protocols. Not here you haven't. Not here you haven't. And so I put this document together from an amalgam of sources that I had managed to gather and I presented that report to the Oversight Board, and it was accepted as a document to the Board, and as a consequence it influenced the final iteration of their oversight overview report. What also was within the timeline, highlighted who had access to what and when. Hugely important information is missing from those corporate documents and so I would contribute in relation to it, and the Oversight Board were accepting. Again, it demonstrates their transparency, it demonstrates their inclusiveness, that I provided this report, and also that times when I would challenge other aspects and they would come back and if they had a contra-view of it, fantastic. We wouldn't always agree. I could be wrong in my assumptions, I would be wrong in certain things. Fantastic. Tell me now. I need to know because it will help my head and it will allow me to make better informed decisions. So I found it, from my personal experience, to at that point do what it was intended within the faith of the terms of reference and to consider information that was presented to it. But could we have a collective confidence that that which they were reviewing was the sum of all its parts? And it goes back to the point that I had raised to the cabinet secretary, which Fiona McQueen, the Chair of the Oversight Board, was at, "Do you have confidence in the information that's been provided to you?"

Q *Thank you, Professor. Now, just two very brief points before lunch on that. Just on the general point that you've just made, and that you made before, about I think what you're saying is that provision of documents and information by GG&C to the Oversight Board, is that right?*

A *Yes, yes.*

Q *Did the Oversight Board have powers to compel the production of information or were they simply dependent on what GG&C considered was relevant to its terms of reference?*

A *Very much so, yes, it was.*

Q *And just one specific brief point, again just to help us when we come to consider your evidence, look, please, at paragraph 380 of your statement. That's where we see the reference to the report prepared by Pricewaterhouse Cooper. Is that right?*

A *Yes, that's so.*

Q *And are you indicating that among the concerns you had, even at this stage, was that the Oversight Board is not being provided with the totality of all infections, or even infection types? Is that right?*

A *Absolutely.*

(**Transcript of Professor Cuddihy's evidence – AM - 27 October 2021 Page numbers 48-50, columns 91-96)**

2. COUNSEL TO THE INQUIRY CLOSING SUBMISSIONS

Counsel to the Inquiry's Closing Submissions provide a comprehensive and evidence-based analysis of the governance, design, construction, commissioning, and operational issues affecting the QEUH and RHC. The clear evidentiary foundation for the report's findings and recommendations is welcomed, reflecting the depth and rigor of the Inquiry's investigative process.

We agree with the Recommendations addressing water safety governance, ventilation validation, infection surveillance, infection control culture, and risk management in NHS Greater Glasgow & Clyde (NHS GGC). The recommendations align with the fundamental systemic reforms that the Cuddihy family has sought since the onset of their daughter Molly's infection and treatment within the RHC and QEUH.

3. GOVERNANCE FAILINGS

We submit that the evidence as a whole reveals that from when the RHC and QEUH hospitals opened in 2015 there was an absence of effective governance.

Criticism of the governance and management of NHS GGC is not new. When Lord Maclean reported following the Vale of Leven Hospital Inquiry Report in 2014, he stated at page 2:

"Governance and management failures resulted in an environment where patient care was compromised and where infection prevention and control was inadequate. The important principle of Board to ward and ward to Board means that there must be an effective line of reporting, accountability, and assurance. This was lacking for the VOLH. There were failures by individuals but the overall responsibility has to rest ultimately with NHS Greater Glasgow and Clyde (NHSGGC)."

In respect of RHC/QEUH the Inquiry did not hear evidence that an effective line of reporting, accountability and assurance existed from Board to ward and ward to Board in the RHC/QEUH. Rather, there was evidence of whistleblowing being engaged, when evidenced concerns of IPC clinicians were ignored or discredited. We invite the Chair to reflect on the governance and management at GGC not only in respect of the construction project but the response or lack thereof, to the emerging problems with ventilation and water that caused or at least contributed to otherwise preventable infections being contracted by children with life ending or life limiting effects.

Professor John Brown, a former Chair of NHS GGC states at paragraph 3 of his statement to the Inquiry:

"3. Any deficiency in the technical and clinical knowledge of individual NHS Board Members is rectified by an integrated governance system that NHS Boards are required to have in place. The governance arrangements that provide the NHS Board with oversight of the service delivery are outlined in paragraphs 9 to 27 of this statement. These arrangements are expected to include providing Board members with information and assurance on the safety of the operating environment."

(Bundle Witness statements – 2 Hearing 16th September 2025, p.3)

Also, from paragraph 13 -

"13. The NHS GGC Board and the Standing Committees request, receive and consider information from the Corporate Management Team and other sources in writing or verbally at meetings. This information supports effective decision making and constructive debate and provides assurance to Board Members on the delivery of the organisation's purpose, aims and objectives.

14. The corporate governance system is designed to ensure that decisions by Board members are well informed, evidence based, and risk assessed. This not only includes the efficiency and effectiveness of the services delivered to patients and service users but also the safety and quality of the healthcare provided by NHSGGC. This would include the identification, management, mitigation, and reporting of risks to patient safety from the hospital environment, including the water and ventilation systems.

15. The Scheme of Delegation and the Terms of Reference of the Standing Committees describe the decision-making responsibilities within the NHSGGC governance system and from this it can be determined who would be required to confirm the need for and authorise works to improve or remedy deficiencies in the hospital environment, including the water and ventilation systems."

((Bundle Witness statements – 2 Hearing 16th September 2025, p.6)

The foregoing descriptions of effective governance in action do not square with the following adminicles of evidence, which are a few of many, that demonstrate that even in crisis those at the helm were not delivering effective governance:

- Ms Grant evidence was that she was not told that concerns had been raised by Dr Inkster and Dr Peters re ventilation in ward 2A RHC or 4B QEUH in 2015 (Grant Transcript, 23 September 2025, p.80 column 156);
- She was not told of any issues with the ventilation systems in the hospital prior to the 3rd October 2017 SBAR (Grant Transcript, 23 September 2025, p.80 column 156);
- Ms Grant accepted that the decision to decant ward 2A patients to wards 6A and 4B was made despite knowing the ventilation deficiencies and that it was the same water supply (Grant Transcript, 24 September 2025, Page 4 column 3 and Page 5 column 6).

- Ms Grant could not say what parents were told about the risks of Ward 6A. It was difficult to be clear on risks when it was not clear to NHS GGC what the risks were (Grant Transcript, 24 September 2025, Pages 5-6, Columns 6-8).
- Professor Brown said that the Board never got to the bottom of why the inaction over the DMA Canyon reports was never picked up (Transcript, John Brown, 3 October 2025, page 22, column 39);
- Both Professor Brown and Ms Grant expressed the view that NHS GGC priority was to focus on getting things sorted or resolved, not on finding out why they had got into that state (Brown, Transcript, 3 October 2025, pages 31 and 34, columns 58 and 63). Ms Grant emphasised a forward-looking approach rather than focussing on how the problems originated (Grant Transcript, 24 September 2025, Pages 4-5, Columns 4-5).
- Senior Managers ignored escalation protocols: Neither the 2015 nor 2017 DMA report were ever added to the risk registers or shared with clinicians.
- Executives prioritised optics over action: emails show executives discussing reputational damage control while children fell ill.
- Deflected blame: One Director dismissed infection clusters as "statistically insignificant," despite HPS linking them to water.
- Jane Freeman's comments re the attitude of Dr Armstrong and the NHS GGC Board during the meeting with the Scottish Government. Ms Freeman expressed her surprise at being asked by Dr Armstrong when she, along with the Chief Medical Officer for Scotland, the DG for Health and the CEO of NHS Scotland, attended the Board Offices:-

  Dr Armstrong - why are you here and what does the matter have to do with you?

  Ms Freeman - I am very sure that is what she said – some things do stick with you – and I explained that I was the Cabinet Secretary for health and I was responsible for and accountable to the public in Scotland on how our health service operated and delivered safe care, and that was why I was there… **I came away from that meeting with a general impression of surprise and concern about NHSGGC's guardedness and down-playing of the importance of the situation."** (*Jeane Freeman Friday, 10 October 2025 - Scottish Hospitals Inquiry Day 16* pages 24-26 of Jeane Freeman's transcript of evidence)
- Ms Freeman's provided evidence of the contempt in which patients and families were held and the failure of the NHS GGC Board to acknowledge the serious problem they faced, which she witnessed at a meeting with the GGC Board:

*"**A** There was a large number of them, and they were described to me as a situation-- they were described to me by the Board as a situation where the majority of patients and their families did not have concerns; this was a particular Facebook group that was troublesome.*

***Q** From where in the Board did that come?*

***A** It was actually said to me at one of the Board meetings I attended.*

***Q** The actual formal meetings?*

***A** Yes. It was also reported to me by the chief nursing officer and was something that was said to her by one of the executive Board members. So that was-- it's all part of this view that, "There isn't really a huge problem here and people are being difficult." I have rarely had-- in all the time that I have been Cabinet Secretary, I do not think I have had another meeting that had quite the impact that meeting with families had on me because they were asking questions for which they were perfectly entitled to the answers and were not being given those answers.*

***THE CHAIR:** Can I just take a step back because it's quite striking? At a Board meeting, which would be attended by the 30 or so members of the Health Board, somebody described the family group with whom you had met as a particular Facebook group which was troublesome?*

***A** Yes.*

***THE CHAIR:** So, whoever made that mistake, it was heard by every other Board member. Did you pick up any challenge from anybody in the room to that proposition?*

***A** The only challenge I recall is from me. "*

(Jeane Freeman Friday, 10 October 2025 - Scottish Hospitals Inquiry Day 16 pages 45-46 of Jeane Freeman's transcript of evidence).

- Communication with patients and families were described by many witnesses in Glasgow 1 as chaotic, opaque, and misleading. Communication failures included families being reassured water was "safe" despite contrary evidence.
- Governance failures included the absence of validation, tagging, PPM and testing. Critical reports (DMA Canyon, Intertek) withheld or "lost."
- Senior managers instructed staff to conceal infection incidents from parents.

- BBC Disclosure programme (2020) exposed failures; GG&C prepared media statements but did not inform families.
- Lack of proactive communication that compounded trauma for families and staff.
- Duty of candour breached amongst a culture of concealment and denial.
- Crisis management and contingency planning grossly inadequate for a flagship hospital.
- No Business Continuity Plans were in place.
- NHS GGC relied on Incident Management Teams (IMTs), Problem Assessment Groups (PAGs), and Infection Prevention and Control Teams (IPCTs) for infection outbreaks rather than explicitly invoking the gold-silver-bronze major incident structure. These groups handled Gram-negative/positive environmental (GNE/GPE) bacteraemia in paediatric haemato-oncology wards (e.g., 2A/2B RHC), involving environmental surveillance, patient decanting (e.g., to Ward 6A QEUH in 2018), and mitigation like point-of-use filters, but inquiries noted inconsistent processes, poor action tracking, and inadequate evolution despite repeated episodes from 2015-2019.
- NHS GGC should have had in place a Hospital Major Incident Co-ordination Team structure for crisis response, aligned with the gold-silver-bronze command model used in emergency services, though adapted for hospital operations without explicit tiered labelling in public documents. This is governed primarily by the Civil Contingencies Act 2004 and the Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005, which mandate Category 1 responders like NHS boards to assess risks, maintain emergency plans, and ensure coordinated responses to disruptions seriously obstructing functions or requiring resource redeployment.
- At all times the decision making around the care of children should have been informed by the principles of GIRFEC and UNCRC. There is no evidence of these principles being engaged at any time, including the decision to decant from Ward 2A was taken.
- Failure to follow the NHS Scotland Blueprint, of which the former Chair of NHS GGC was a co-author.

The NHS Scotland Blueprint mandates that boards “lead by example” and “take ownership of risks”. NHS GGC’s Executives and senior managers failed this standard. Their inaction normalised a culture of neglect, where risks to vulnerable patients were deemed acceptable collateral.

Any analysis of effective governance should consider: culture; organisational behaviour; leadership; decision making; compliance; communication - internal and external; resilience; business continuity; risk management; and responsibility and accountability.

In his statement provided for the hearing commencing 16th September 2025 (Witness Statements Vol 3, p.325) Professor Cuddihy stated:

> *“A Father’s Plea for Governance That Protects the Vulnerable*
> *When my child was diagnosed with cancer, I placed my faith in the NHS—an institution synonymous with compassion and care. But what unfolded was a harrowing lesson in how fractured governance can betray the very people it is meant to protect. This is not just my story; it is a warning.*
>
> *The Illusion of Safety*
> *Even before the water contamination crisis, Ward 2A was compromised. A 2011 ventilation strategy, designed to provide 40 litres per second of airflow, failed to comply with SHTM 03-01 standards. This meant immunocompromised children were breathing recirculated air laden with pathogens- an environment ripe for infection.*
> *Further compounding these risks, the hospital water system was filled in 2013 well before the ward was occupied. Public Inquiry evidence highlights that this premature filling, without appropriate flushing and microbiological testing as mandated by SHTM 04-01 guidance, created an environment conducive to bacterial colonisation. Experts testified that filling the system too early allowed water to stagnate in pipes and tanks, promoting biofilm formation and the growth of harmful organisms such as Pseudomonas and Mycobacterium species. This avoidable misstep exposed vulnerable patients to risk from the very moment the ward opened.*

Despite explicit warnings, in 2014, NHS Greater Glasgow and Clyde (NHSGGC) made a deliberate choice: to install Horne Optitherm taps in Schiehallion Ward. Sir Harry Burns' 2012 CLE03 report had already flagged the dangers of biofilm buildup in such systems, and the 2014 HPS SBAR warned these taps violated national safety standards. Yet, the Board accepted the risk.

They promised mitigation—quarterly maintenance, rigorous flushing, expert oversight. None of it happened. When my daughter's bloodstream infection was traced to Mycobacterium chelonae in the hospital's water, I learned the truth: cost-cutting had trumped safety. The taps became breeding grounds for bacteria, their flow straighteners clogged with stagnant water. My child, already fighting cancer, was poisoned by the place meant to heal her.

The Silence of Broken Systems

For years, NHSGGC's governance structures failed at every level. The 2015 DMA Canyon report— 'lost' by Estates—exposed debris in water tanks, faulty temperature controls, and flexi-hoses teeming with Cupriavidus. By 2017, the same risks remained, marked "URGENT." Still, no action. Frontline staff pleaded for repairs; clinicians documented infections. Their warnings evaporated into a void of accountability.

A critical failure revealed by the Public Inquiry was NHSGGC's profound lack of awareness regarding the interplay between resource allocation and the complex demand profile of high-risk clinical areas like Schiehallion Ward. This disconnect was compounded by significant reductions in both financial and human resources allocated to Estates and Facilities teams responsible for maintaining critical infrastructure. Inquiry evidence exposed that inadequate asset tagging and the absence of a robust action management system severely undermined the ability to schedule, track, and complete essential preplanned maintenance activities. Without accurate identification and monitoring of water system components—such as Horne Optitherm taps and thermostatic mixing valves—maintenance was sporadic or entirely omitted. This systemic neglect directly contributed to the persistence of biofilm and bacterial colonisation within the water system, exposing vulnerable immunocompromised patients to life- threatening infections. The Inquiry's findings underscore that these governance and operational failings were not isolated oversights but symptomatic of a

fragmented approach to risk management and resource stewardship, with devastating consequences for patient safety.

I sat helpless as my daughter endured toxic antibiotics; her body ravaged by treatments designed to treat leprosy. Her brother's kidney now sustains her—a brutal exchange forced by institutional neglect. When I asked, "Why?" the answer was evasion. The closure in 2018 of a specialised unit- for three long years- and transfer to a general ward, not fit for purpose as detailed in an SBAR, written by concerned clinicians. The Board's 2018 press release blamed "air quality," and stated the closure provided for "an opportunity to upgrade". Both untruths that haunt me, especially following the release of 2018 Innovated Design Solution report; 'the existing ventilation strategy would appear only likely to promote the risks associated with uncontrolled ingress of infectious aerosols into patient areas.' Transparency died where governance failed.

The Cost of Complacency

Corporate governance is not an abstract policy—it is the difference between life and death for vulnerable patients. NHSGGC's pre-2019 framework lacked teeth: life threatening risks to children were tolerated, not eliminated. The Board ignored the Blueprint for Good Governance, which demands "zero tolerance for preventable harm." Budgets were slashed, maintenance deprioritised, whistleblowers silenced.

The 2025 HIS Report confirms little has changed. Emergency departments still haemorrhage trust. Risk registers still omit critical threats. Executives still deflect blame, dismissing families' anguish as "a call to war." How many children must suffer before governance becomes more than a checklist?

A Demand for Accountability

Effective governance requires four pillars:

1. Transparency: No more 'lost' reports, no more sanitised updates. Families deserve truth, not platitudes.

2. Proactive Risk Mitigation: Boards must enforce preventative measures, not react when children suffer.

3. Cultural Courage: Reward whistleblowers. Hold to account leaders who prioritise reputation over safety.

4. Leadership Accountability: Hold Executives responsible for systematic failures to account.

The NHS Scotland Blueprint mandates this. Yet NHSGGC's "reforms" post-2019 remain half-measures. Centralised risk oversight? Incomplete. ISO 31000 principles? Partially adopted. My daughter's scars—physical and emotional—testify to the cost of half-hearted compliance.

Leadership Accountability: The Missing Link

The Public Inquiry has revealed a chilling truth: NHSGGC's leadership ignored risks they were legally and morally obligated to address. Despite clear SHTM statutory guidelines, CLE03 (2012) and DMA warnings, executives approved non-compliant taps then abandoned agreed mitigation. The 2014 decision to proceed with Horne Optithern taps- despite microbiologists' objections- exposed a leadership culture that dismissed safety as 'someone else's problem".

4. TERM OF REFERENCE 8 - GETTING IT RIGHT FOR EVERY CHILD (GIRFEC) and UNITED NATIONS CONVENTION FOR THE RIGHTS (UNCRC)

TERM OF REFERENCE 8 STATES:

"8. To examine the physical, emotional and other effects of the issues identified on patients and their families (in particular in respect of environmental organisms linked to infections at the QEUH) and to determine whether communication with patients and their families supported and respected their rights to be informed and to participate in respect of matters bearing on treatment."

We submit that any analysis of TOR 8 should also consider the extent to which the experience and treatment of children and families by NHS GGC met the obligations contained within GIRFEC and UNCRC. GIRFEC principles focus on putting children, young people, and families at the centre, working together, building on strengths, valuing diversity, and ensuring timely, appropriate support to help children reach their full potential, based on the United Nations Convention for the Rights of the Child (UNCRC). Article 3 of the UNCRC, 'Best Interests of the Child', states that the best interests of the child must be a top priority in all decisions that affect children. Article 24 of UNCRC relates to Health and Health Services and states "Every child has the right to the best possible health. Governments must provide good quality health care, clean water, nutritious food, and a clean environment and education on health and well-being so that children can stay healthy." Article 28 "Every child has the right to an education." Article 31 "Every child has the right to relax, play and take part in a wide range of cultural and artistic activities.". GIRFEC with, UNCRC as its foundation, is intended to be locally embedded and positively embraced by practitioners across children's services, changing culture, systems and practice for the benefit of children, young people and their families. Key values of GIRFEC include promoting well-being, safety, choice, fairness, resilience, and collaborative support, using the SHANARRI indicators (Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible, Included) to assess needs. GIRFEC isn't just a policy for Health Boards; it's embedded in law, making it a fundamental part of their responsibility for child welfare in Scotland.

The Inquiry has heard extensive evidence of the impact that issues with water and ventilation had on the Schiehallion patients and their families. The following extracts from closing submissions are included as a reminder of that impact.

In the Closing Submissions for Glasgow 1, Counsel to the Inquiry stated at pp.5-6:

> *"Theme 5: Impacts of environmental concerns on Wards 2A and 2B*
>
> *(vi) Quite apart from the impact of infection itself, concerns about key building systems caused a number of other serious disruptions to life on Wards 2A and 2B, which impacted on patients and families. Children were thought to have been placed in isolation more than would be usual. Cleaning appeared more extensive than usual. Of itself that was disruptive. Patients were decanted to other wards. That in turn presented a risk of children being placed in areas where infection control was not perceived to be at the level within the Schiehallion Unit and where there was a concern about receiving care not attuned to the particular needs of immunocompromised patients. Concerns about the building systems grew with time and undermined trust.*
>
> *Theme 6: The closure of Wards 2A and 2B*
>
> *(vii) The evidence suggests that communication around the decisions to close Wards 2A and 2B and to relocate to Ward 6A was perceived to be, at best, inconsistent and, at worst, non-existent. In many cases, this was the cause of significant distress to some witnesses. People tended to learn of the move via the media. The few witnesses who indicated prior notice of the decision to close the ward, indicated that they understood it to be a response to an infection outbreak. Such evidence as there was about official communication, indicated that GGC sought to explain the closure differently; they said they wished to undertake cleaning.*
>
> *(viii) Witness evidence suggested a perceived lack of risk assessment in the decision to relocate Schiehallion patients to Ward 6A in the adult hospital. While patients and families were relieved that in large part the Schiehallion teams had been relocated too, the unanimous view of witnesses was that Ward 6A was wholly unsuited to caring for paediatric cancer patients. At the time of writing, it is understood to remain the position that paediatric cancer patients are cared for on that ward.*

Theme 7: Impact of the move to Ward 6A

(ix) The evidence painted a bleak picture of Ward 6A. Patients were said to have become institutionalised; several described the ward as being like a prison. The arrangements for accessing the ward were a cause of some anxiety, given the need to take immunocompromised children through areas where smokers, adult patients and other members of the public tended to gather or be present. The distance from other paediatric services was also a cause of concern, as was the absence of many of the vital facilities that had enabled children to be children and teenagers to be teenagers; and had fostered a support network for families.

Theme 8 & 9: Concerns about environmental safety on Ward 6A; the impacts of those concerns

(x) Reassurances that Ward 6A would be free of environmental concerns proved unfounded in the opinion of patients and families. The use of preventative medicine continued; evidence of infections continued. In [redacted] *2018, a child died. GGC confirmed the presence of Cryptococcus, a bacterium linked to soil and pigeon droppings, on Ward 6A. For some parents, matters seemed only to deteriorate after that. In 2019, one patient was infected by the same extremely rare bacterium that had infected another patient in Ward 2A the year previously. Ward 6A itself was closed, wholly or partially, on at least two occasions due to infection concerns. On one of those occasions, patients were decanted back to the RHC, the very environment from which they had understood they had been removed due to the risk posed to their safety.*

(xi) Overall, the impression was of an increasingly fraught and anxious situation which brought some parents close to breaking point. Once again, communication from GGC was not considered acceptable. Attempted reassurance by GGC staff that the water was "wholesome" did not square with what patients experienced and witnessed. Nor did it square with what some took to be indications of concern from staff. In the case of two patients at least, staff were taken to indicate to patients that they might be safer at home.

Theme 10: Healthcare Associated Infections

…(at p.7)

xvi) The physical and emotional effects of a serious healthcare associated infection are therefore obvious. But parents are concerned that the price of avoiding an infection may also have been very high. Children were understood to have been given prophylactic medication to protect them against the hospital environment. Parents worry about the side-effects from these medications, and in some cases are concerned that some recognised side effects – for example hearing loss – have already arisen.

Theme 11: Communication

(xvii) One of the reasons that some parents appeared worried about the use of prophylactic medication was, as they saw it, an absence of communication. An absence of clear communication was also alleged in relation to individual cases of infection and in relation to concerns more broadly about the risk of infection.

(xviii) But overall, and beyond these two issues, concern about the approach taken by GGC and hospital management to communication was universal. Not a single witness identified a good example of communication by managers in relation to the perceived issues with the hospital building or infection risk. This contrasted with communication from doctors and nurses about clinical care. This was mostly considered to have been exemplary. But for many patients and families, communication about the building was communication about clinical care. Universally, it was considered to have been lacking. Responsibility for that was said to lie with management.

(xix) As concerns about the hospital environment and the risk of infection emerged, it seemed to patients that GGC had no communication strategy. The responsibility to explain what was going on appeared to have been pushed onto clinical staff, something many witnesses considered inappropriate. Communicating with patients did not appear to be the priority; the media was usually seen to be the first port of call. It was said that communication tended to put a positive spin on things; it did not accord with what patients said they had experienced on the ground.

(xx) Great concern was raised about the accuracy of GGC's communications to the media and, when it happened at all, to patients. Many if not all witnesses indicated a belief that GGC managers had not communicated with patients and with the public openly and in good faith. Evidence was said to exist that supported this view: a consistent disparity between what was said publicly by GGC and what patients and families saw with their

own eyes; a tendency on the part of GGC to put a positive spin on things in their communications; an allegation made by one father that a clinician had confessed that she had been instructed to lie to him; and evidence that GGC's actual awareness of issues (from contemporaneous expert reports on the safety of the water and ventilation systems within the hospital) was understood to conflict with what they had said publicly and to patients.

The foregoing submissions, and the evidence on which they are based, do not evidence that putting children, young people, and families at the centre, working together, building on strengths, valuing diversity, and ensuring timely, appropriate support to help children reach their full potential was evident either in the decisions that were made or the communication of those decisions. Communication, or the absence thereof, added so much additional stress to the families and patients in the Schiehallion.

THE PATIENT VIEW

In her evidence during Glasgow 1 (15/10/2021), Molly Cuddihy referred to:

HOSPITAL ENVIRONMENT AND SAFETY CONCERNS
Water contamination: Filters on taps, bottled water, portable sinks; patients told not to drink or shower with tap water.
Ward closures & relocation: Schiehallion Unit (Ward 2A) closed in Sept 2018; patients moved to Ward 6A at QEUH.

Ward 6A issues included the loss of Teenage Cancer Trust facilities and social spaces, no playroom, limited kitchen access, isolation for patients and, reports of mould, HPV cleaning, and poor communication about risks.

Molly also spoke of the Physical hazards she encountered when attending the hospital - Falling glass panels, cladding removal exposing fungal spores, smokers near entrances.

COMMUNICATION & TRUST

- **Clinical staff**: Praised for honesty, empathy, and adapting communication to patient needs. Molly never lost trust in her clinical team.

Hospital Management:

- Communication described as "dysfunctional" and "disjointed."
- Patients often learned about issues from the news before staff.
- Lack of candour on environmental risks and infection history.

- Oversight Board letters criticized for insensitivity (generic wording sent to bereaved families).

Personal Impact

- Emotional toll: Anxiety, psychological breakdown during transplant, ongoing therapy.
- Educational disruption: Scaled back Highers from six to three; sat exams during chemo and hospital stays.

Molly's evidence emphasised:

- Clinical care was "world-class," but the hospital environment was unsafe.
- Failures in communication and infrastructure caused avoidable harm.
- Duty of candour should apply to all staff, not just clinicians.
- Management underestimated the human impact of systemic failures.

The following submissions which formed part of Glasgow 4, evidence the impact of the decision to decant to 6A on the wellbeing of children and families affected.

> ***"Glasgow 4 COUNSEL TO THE INQUIRY SUBMISSIONS P. 575***
>
> *1853. The decant to Ward 6A had a profound effect on the mental wellbeing of many patients. The alternative ward was not designed for children and did not have the same range of facilities, such as a playroom. Patients and families felt isolated, and that they had lost the sense of community that the old Schiehallion ward had brought."*

Term of reference 8 invites the Chair to report on the impact of the "the physical, emotional and other effects of the issues identified on patients and their families (in particular in respect of environmental organisms linked to infections at the QEUH) and to determine whether communication with patients and their families supported and respected their rights to be informed and to participate in respect of matters bearing on treatment."

Response to this term of reference, we submit necessitates considering if the provisions of GIRFEC and the UNCRC informed and underpinned the response by NHS GGC to the water and ventilation issues that arose in the Schiehallion and elsewhere in the hospital estate. Were decisions made in the best interests of children? Was decision making based on the key values of GIRFEC including promoting well-being, safety, choice, fairness, resilience, and collaborative

support, using the SHANARRI indicators (Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible, Included) to assess needs. These are matters for the Chair to determine.

We submit that the response to TOR 8 and the answer to whether NHS GGC fulfilled its obligations under GIRFEC and UNCRC, should be informed primarily by those who experienced the emotional and physical and other effects of the issues identified and who should have been the recipients of communication. In recognition of that we submit the following:
We begin by referring to the "Impact" statements prepared by Molly and John Cuddihy and Eilidh and Lisa Mackay. We submit that these statements, along with the whole evidence before the Inquiry, evidence multiple failures including the failure of NHS GGC to fulfil its obligations under GIRFEC and UNCRC.

Lisa Mackay - IMPACT STATEMENT WITNESS STATEMENTS VOL 2 P.171 –HEARING BUNDLE FOR 16TH SEPTEMBER 2025

> *Impact - Essentially, it describes how something significantly alters or changes a person's life. In this instance the life is that of our daughter Eilidh's. Fundamentally her life has been affected, altered and changed forever and it is she who has had to learn to accept and live with this.*
>
> *Eilidh's diagnosis of ALL in 2016 at aged 14 was the start of a living nightmare for her and our family and nothing could have prepared us for the long bleak journey ahead filled with pain, uncertainty, worry and darkness. Light came however, in the form of all the wonderful medical professionals whom we have met along the way, and who with their expertise, professionalism, dedication and compassion have made it their life's mission to treat, guide, help and care for patients like Eilidh with the utmost love and respect.*
>
> *Her ALL diagnosis had brought us to the RHC Glasgow, a state of the art, multi-million-pound hospital of less than a year old, a place of safety and the place where she would be treated and cared for. We felt relief, we felt trust, but above all we felt safe!*

After diagnosis her treatment plan was arranged swiftly and efficiently and there was a clear plan moving forward. We all knew the plan, everyone stuck to the plan and the plan was implemented with trust, care and transparency.

Eilidh knew she had a fight on her hands but with the love and support of us, her family and the dedicated medical staff she was ready to fight her ALL.
What was certainly not in the plan was that her ALL diagnosis and treatment, the reason we were in the RHC, became secondary to unusual infections and that the treatment of these infections would take precedence and these infections would be what threatened to end her life.

At no time during our 2016/2017 hospital stay of 338 days was Eilidh, or us, her parents, advised that her infections were connected to the hospital environment, ventilation system or water supply. It was not until October 2019 when we received a letter from NHS Greater Glasgow & Clyde advising that they were investigating infections at the hospital, which then led me to find online, a newspaper article dated May 2019. This article spoke of a child (Eilidh) on the cancer ward at the RHC being infected with Aspergillus in 2016 and how it was suspected to have come from mould in a ceiling void, which developed following a leak. That we became aware that the hospital environment was the source and cause of the infections she had contracted, contributing to the ongoing health difficulties she continues to suffer from. The environment we trusted, the hospital where we had felt safe! It is very difficult to detail the impact on Eilidh. Her life has forever been altered. She has to work harder for everything she wants and will forever face barriers. She has had to learn to accept the far greater changes in her life, becoming a wheelchair user, being diagnosed with epilepsy, to name but a few. Her physical changes are evident, but the severe psychological effects caused by these debilitating infections run far deeper than her visible scars. More so than would have been the consequence of her cancer diagnosis.

Eilidh chooses not to revisit her dark days as it is a chapter of her life that she finds too traumatic. She prefers to concentrate on her recovery, moving forward with her life and

her plans for the future. Our family life has been impacted and changed forever. The shockwaves permeating from this have reeked devastation on us all and will reverberate for many, many years to come. We have been left in a state of stress, mistrust, disbelief, fear, worry and with an enormous sense of guilt. Guilty, for taking her to the RHC, in the first place, for treatment for her ALL diagnosis. A place that has become the vessel for the countless flaws, failings, consequences and misplaced actions. A place where she should have been made better, a place where she was meant to be safe, a place that has let her, us and countless others down.

I have accepted the baton on her behalf with an aim through the Scottish Hospital Inquiry to seek justice, accountability and clarity. Listening to the evidence of the Inquiry, the missed opportunities, the complete disregard, the countless flaws and failings, the monumental deficiencies, the negative culture, the mistrust and misgivings, the negativity and toxicity, feels like physical blows raining down on me. Our family will never recover from this and in our lifetime, we will never experience anything as traumatic again. But what we must all never lose sight of, is the reason why we are all here and doing what we are doing. The issue that is far bigger than all of us. The victims at the core of it all, the children. Our daughter Eilidh!
In this fight there are no winners, only victims seeking the truth!

John Cuddihy (Witness statement vol 6 – Hearing Commencing 16th September 2025)

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

2. *Yet, it is simply not possible to speak honestly about our experience without contrasting this standard of care with the corporate response. Here, it is important to note that information was deliberately withheld by the organisational entity*

responsible for the hospital, reflecting not only a lack of empathy and curiosity but also an intentional obfuscation that compounded our suffering. That lack of compassion and openness compounded the suffering endured by our daughter and our family.

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

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

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

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

7. *No warning was shared with us or indeed ARHAI, about another paediatric patient in the same ward who was infected in 2016. Even as Molly's illness progressed, her infection was absent from official timelines and records, despite our repeated submissions to the oversight board by way of written reports. Our appeals for accuracy and acknowledgement went unanswered until we escalated issues to the highest levels. But even now the Scottish Government website continues to display the flawed timeline, which continues to omit details surrounding Molly's bacterial infection in 2018. This public display of an inaccurate timeline is a serious issue, especially for laypersons who are not connected to the case, because it obscures important facts and prevents full accountability and understanding of the tragedy.*

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

9. The case note review was never provided with a copy of the reports submitted to the oversight board by my family, depriving the CNR of information that would assist their decision making. Only after, we, the family, provided a copy direct to the CNR and

pressed for its inclusion was it considered. The duty of candour, and even the principles of basic decency, were set aside.

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

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

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

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

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

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

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

17. The loss of Molly has had a profound and devastating impact on our entire family. For my wife and me, the grief is an ever-present shadow that colours every aspect of our lives, a daily reminder of the daughter and sister who was taken from us far too soon. Our son too bears this heavy burden, grappling with the absence of his beloved sister and the upheaval her passing has wrought on our family's life.

Beyond our immediate family, the grief extends deeply into our broader family, friends, and wider community—especially vulnerable children, their families, and the staff who worked alongside Molly—all of whom were touched in profound ways by her courage, kindness, and advocacy. Each of us mourns not only the loss of Molly's vibrant presence but also the dreams and future we had hoped to share with her. This immeasurable grief shapes our lives now, fuelling our resolve to seek justice and systemic change, so that no other family endures such heartache.

18. The ongoing criminal and civil investigations following Molly's death have brought additional trauma and heartache to our family. We were deeply affected by the fact that no death certificate would be issued, necessitating a two-doctor post mortem instructed by the Procurator Fiscal, which required Molly's body to be transferred from the Queen Elizabeth University Hospital to Edinburgh for examination. The additional distress of

having post mortem samples sent out of Glasgow for analysis compounded our grief. Our family endured the intrusion of CID officers visiting our home during initial investigations, adding to our emotional burden. Furthermore, procedural challenges delayed the issue of medical certificates required to register Molly's death, ultimately postponing her burial by five weeks. These bureaucratic obstacles were overwhelmingly traumatic, prolonging our heartbreak and making the unbearable reality of Molly's death even harder to endure. The profound emotional impact on our family from both her loss and the ongoing investigations is beyond measure.

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

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

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

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

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

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

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

Molly Cuddihy (Witness statement vol 3, p.248, Hearing Commencing 16th September 2025)

In October of 2021, I sat before the inquiry and gave evidence of my experience throughout my treatment. At that point I was in recovery from my first relapse of my original cancer diagnosis, as well as the two separate incidences of Mycobacterium chelonae infection. I was 18 years old and truly believed that I had at that point suffered enough for a lifetime.

However, I did not get that lucky and over the past four years my health has only further deteriorated, in no small part due to the intensive antibiotic treatment. I realise that my sarcoma was always a life-threatening condition, but there is a large difference between that and the life-limiting conditions that I now have to contend with. It's not just a difference of treatments and learning new medications and the like, but the sheer difference psychologically is immense. There is now no end in sight, there is no day to look forward to a cure, and I'm very likely to have a much more limited lifespan than the majority of my peers. I understand life isn't fair, that I had already been diagnosed with a rare, aggressive cancer that is more than likely to be terminal the majority of the time. But surely, at 22 years old, I should not be so resigned to such a future?

I'm under the regular care of renal, gastrointestinal, oncology, endocrinology, fertility and vascular specialists, with input often having to be given by pain teams and a whole host of others for my treatment. Many of my team are world-renowned in their own right, and every single one of them is incredible and are an exemplary show of our NHS. I'm so very grateful to them all, and in no way have I found the medical side of my healthcare treatment to be lacking.

The same cannot be said for the management of NHSGGC and I feel the evidence they have given only highlights that fact. Their utter contempt for the entire process has been clear and the total disregard they've shown for the patients and their families has been startling. I mention the physical impact, but it feels like there is no thought given to the psychological torment that patients have been and continue to be subjected to with this. In my own case, it's been the most challenging aspect of my care that has only compounded by my participation.

Now, do not misunderstand me, I have never once, nor will I ever regret participating in the Public Inquiry, but it continues to have an effect on my daily life and mental health, such that I've had to seek consistent help for over this time period. I've had to watch members of the management sit and not only contradict the immense amount of evidence to the contrary, but their very own written statements – they haven't even had the decency to check beforehand to match facts. It has never been any one individual's

fault, and nothing has ever been done with ill intent – of that, I am sure. However, when faults began to show, when they were asked for information, when they were simply asked 'why?' – their actions from that point on were done with the knowledge of what was wrong. But, of course, in some opinions, we were cancer patients anyway, weren't we? It's 'alright' for us to get sick, it was going to happen anyway! Why not just write us off when we get the initial diagnosis if that is your thinking? If that is your attitude? For that, I will never ever be able to forgive.

This past year, I was so incredibly fortunate to receive a kidney donated to me from my older brother Daragh. I cannot quite articulate how much I love and am grateful to him for that, for giving me a little of my life back. But it should never have had to be done, that risk should never have had to be taken. I should not have been terrified that not only was I risking myself staying in ward 4C, where whilst their care has been nothing short of exemplary, I knew fine well given the evidence on ward 4B, that the ventilation alone was not safe. I was also risking my big brother, my favourite person, when he was already giving up so much for me.

It's not just hospital stays though, its having showers, its staying on edge to make sure all my medications are always right, it's trying to simply sleep. It all terrifies me and is totally illogical and, in my opinion, frankly ridiculous because it's not exactly like I can avoid them, can I? Like I said before, the hospitals are such a huge part of my life.

The impact of it all has been so profound that it's even the little things that have changed, the big life decisions that have had to be made or have been completely taken away from me is remarkable. My priorities have entirely changed and the things I have been totally desensitised too genuinely frighten me. I am 22 years old, and I have totally lost count of the amount of times I've almost died, even accepted it as imminent at a few points. Like I said before – how is any of that fair?

I do however want to note that I am incredibly grateful to the professionalism, respect and genuine kindness that the inquiry team have shown throughout this process. I also want to note how delighted I am that we've progressed to the point of having a safe

environment for the children of the oncology/haematology department at RHC. After working with the Glasgow Children's Hospital Charity, I've been lucky enough to make a fair few visits to Schiehallion and cannot emphasise the sheer delight and relief I feel whenever I see the children back where they belong, as safe and as happy as they can be whilst they go through their already tumultuous journey.

Eilidh Mackay December 2025

"I will need to carry this for the rest of my life and where I want to get to in the future has been made harder for me due to this whole situation and what I have been forced to live with.

I am paying the price to basically live but I have so much to live for. I have had to battle through emotional and physical traumas to get here and I am lucky I have survived as I wasn't expected to. In this hospital I should have been safe but the building was killing me. My life is important and should never have been jeopardised the way it has been. I was just a teenager whose life was turned upside down with a cancer diagnosis. It should never have got to the extent it did with the infections I contracted and how ill they made me. Myself and my family should never have had to go through this nightmare. For us and for me this torment will never go away, our lives have been changed forever and we have to live with this horror for the rest of our lives. In hospital we are asked What Matters To Me? A question which relates to patient centred care and what is important to each child. Now when I think of this same question, my answer would be that the truth matters to me and I think it is the least that I, and my family deserve."

Lisa Mackay December 2025

"Finally we have reached the conclusion of the oral evidence heard by the Scottish Hospitals Inquiry in relation to the QEUH/RHC. This is a milestone in this Inquiry which was originally announced way back in September 2019.

We now stand at a crossroads reflecting on the evidence heard and admissions learnt. The fundamental question "What happened?" remains the same and the hope is that with the Inquiry and the passing of time, this question will finally be answered.

Getting it right for every child (GIRFEC) is Scotland's long standing, national commitment to provide all children, young people and their families with the right support at the right time. It is both an approach and framework used by services across Scotland to improve and uphold the wellbeing of children and their families. A commitment adopted and implemented by Eilidh every day of her working life within an educational setting for the children in her care. Can the same be said for her, and the countless other children and young people who were patients. Did they get it right for every child?

The QEUH/RHC Glasgow, a state of the art acute hospital integrating adult and children's services that we never once questioned. This flagship Hospital is now permanently tainted with serious operational issues. Hearing and learning so much about ventilation and water systems, prompts the memories to resurface. Rooms too hot to bear and requiring a fan to be on 24 hours a day, the build up of dried blood in mine and Eilidh's noses due to the dry air and in 2018 being told not to touch Eilidh with the water, are memories that are definitely abnormal.

'Moving forward' and 'lessons learned' are phrases widely considered overused clichés, that have lost their impact due to frequent use. Their overuse highlights a lack of genuine change, as organisations often repeat the same mistakes despite "learning" lessons. We can only hope and pray that this will not be the case here."

John Cuddihy December 2025

The absence of any acknowledgment or public apology from NHS GGC regarding what happened to Molly troubled her greatly. Sadly, she never lived to see the outcome of this Public Inquiry. However, we hold hope that the recognition of wrongdoing contained within this closing statement will bring some measure of comfort to our family.

Despite enduring severe illness and treatment burdens, the silence from NHS GGC, paired with the deeply hurtful comment from the Director of Communications that I (John Cuddihy) ***"may have won the battle but won't win the war,"*** *exemplifies the toxic culture referenced in the report and reveals an institutional failure to genuinely express accountability or remorse.*

Importantly, the Closing Submissions directly references that certain NHS GGC board members and officials challenged the conclusions of the Case Note Review (CNR) regarding infection links to the hospital environment. I welcome and fully support the voices of the then Health Secretary Jeane Freeman, former Director General for Health Malcolm Wright, Chair of the Oversight Board Professor Fiona McQueen, and other experts, as well as Molly and my own, who pressed for truthful recognition and accountability. The Inquiry confirms that scepticism delayed timely protective action for patients like Molly.

RECOMMENDATIONS

In furtherance to the Inquiry's recommendations, we respectfully request consideration of the following additional recommendations:

- We urge the Inquiry and NHS GGC to recognise in policy and practice that the pursuit of justice by families, such as ours, was wholly justified, anchored in the genuine desire for accountability and systemic reform.

- Establish dedicated surveillance and review processes specifically targeting rare waterborne opportunistic infections among immunocompromised patient groups.

- Mandate routine multidisciplinary clinical-environmental case reviews that dynamically connect patient infection data with environmental risk assessments.

- Implement formal, transparent, and timely communication protocols to ensure patients and families are informed promptly about infection risks and events.

- Conduct scheduled independent audits of hospital water and ventilation system safety, with public reporting and clear remedial plans.

- Enhance protections and clear escalation pathways for staff who raise concerns regarding infection risks or environmental hazards.

- Conduct a root and branch independent review of NHS GGC corporate communications department to confirm that the transparency, engagement, and positive culture promoted by new leadership is effectively operationalised and sustained.

- Require health boards to formally record in writing all offers of technical support, independent review, or assurance offered by NHS Assure (or equivalent national bodies), and require documented acceptance or refusal decisions with rationale signed off by leadership, submitted to Scottish Government, NHS Assure, appropriate oversight boards, and recorded in risk registers, to ensure transparency and accountability.

This final recommendation arises from the documented instance where NHS Assure offered to establish a short-life working group to provide review and assurance to NHS GGC prior to the reopening of Wards 2A and 2B, known as the Schiehallion Unit, which was declined by the Director, Tom Steele.

Given NHS Assure was created following previous QEUH/RHC failures to improve risk management and oversight in healthcare infrastructure, declining their expert, independent support in such a critical context demonstrates a governance failure that must be addressed through formal recording and transparency measures.

CONCLUSION

We wish to record our thanks for the opportunity to participate in the Public Inquiry and to render these final submissions. We acknowledge the dedication and hard work of the Inquiry legal team and the Chair in conducting the Inquiry.

We trust that all of our submissions, to date, and recommendations will be considered by the Chair in reaching his determination of the Terms of Reference. Implementation of our recommendations, will not only honour Molly's memory and Eilidh's ongoing journey, but guard against recurrence of such harm and catalyse genuine reform and restore public trust in NHS GGC services.

Clare Connelly, Advocate

Glasgow, 18th December 2025.

THE SCOTTISH HOSPITALS INQUIRY

CURRIE & BROWN UK LIMITED

CLOSING STATEMENT - GLASGOW IV HEARING

INTRODUCTION

1. This Closing Statement is served on behalf of Currie & Brown UK Limited ("**Currie & Brown**") following the Glasgow IV Inquiry Hearing on various dates between 13 May and 10 October 2025. It responds to the Closing Statement issued by Counsel to the Inquiry ("**CTI**") on 21 November 2025 where relevant to Currie & Brown's involvement.

2. Currie & Brown explained its role on the project for the procurement, design, and construction of the new Glasgow hospitals[1] for GGC ("**the Project**"), and the change to that role after the award of the Main Contract to Multiplex on 18 December 2009, in detail in its response to PPP 13.[2] That is not repeated here, but the Chair is respectfully invited to re-read Section 1 of Currie & Brown's response to PPP 13 when considering this Closing Statement.

3. Since its successful application to the Inquiry for Core Participant status on 9 December 2020, Currie & Brown has fully participated in and cooperated with the Inquiry process. It has provided substantial amounts of documentation and information in accordance with the Inquiry's requests; it has responded to the Inquiry's Provisional Position Papers and expert reports; it has provided written evidence from three factual witnesses (two of whom gave oral evidence during the Glasgow IV, Part 1 hearing); and its legal representatives have attended almost every day of the Glasgow hearings from 2021 to 2025 and the Edinburgh I hearing in May 2022. Currie & Brown continues to stand ready to provide any further assistance that may be required by the Inquiry.

4. The structure of this Closing Statement is as follows:

   4.1 **Section 1** discusses the evidence and submissions relating to what CTI have termed the Agreed Ventilation Derogation, which forms the focus of much of CTI's Closing Statement insofar as it is relevant to Currie & Brown's involvement on the Project.

[1] Namely, the Queen Elizabeth University Hospital ("**QEUH**") and the Royal Hospital for Children ("**RHC**"), referred to herein collectively as ("**the Hospitals**").
[2] Currie & Brown's Response to PPP 13 dated 29 November 2024 [Bundle 22, Volume 3, document 3, page 7].

4.2 **Section 2** and **Section 3** address other matters raised in Chapter 5 and Chapter 8 of CTI's Closing Statement respectively which require or may benefit from a response or clarification from Currie & Brown.

4.3 **Section 4** comments on CTI's proposed responses to the Inquiry's Terms of Reference in Chapter 9 of their Closing Statement where relevant to Currie & Brown's involvement.

4.4 **Section 5** comments on the potential recommendations developed in Chapter 10 of CTI's Closing Statement in which Currie & Brown has an interest.

5. In this Closing Statement, and unless otherwise stated:

5.1 The definitions and abbreviations used in CTI's Closing Statement are adopted herein for ease of reference.

5.2 References to paragraph numbers and Chapter numbers are to the numbered paragraphs and Chapters of CTI's Closing Statement.

5.3 References in square brackets to bundles are to the numbered bundles of evidence before the Inquiry for the Glasgow III and IV hearings.

5.4 In each case, any emphasis in a quotation has been added.

SECTION 1: THE VENTILATION DEROGATION

Introduction

6. This section discusses the evidence, and the submissions in CTI's Closing Statement, relating to what the Inquiry has defined in paragraph 540 as the Agreed Ventilation Derogation. The term "**Ventilation Derogation**" is instead used here for brevity.

7. The Ventilation Derogation forms the focus of much of CTI's Closing Statement. The Closing Statement goes so far as to say, in paragraph 1877, that "*the **most significant** issue with the building systems of the QEUH/RHC arose from a decision, made in the final weeks before contract signature*", i.e. the Ventilation Derogation. It is surprising that CTI's Closing Statement has singled out the Ventilation Derogation as the single most significant issue with the Hospitals in circumstances where:

7.1 The Ventilation Derogation was a limited agreement to derogate from the recommended air change rate of 6 ACH only in standard rooms in general wards. It is common ground, and a matter of record, that the Ventilation Derogation did not apply to isolation rooms or

specialist wards. It ought not to have been applied to specialist wards or isolation rooms when ZBP came to carry out the mechanical and electrical ("**M&E**") design.

7.2 The Inquiry and its experts have identified other potentially deficient features of the ventilation design and construction which are unrelated to the Ventilation Derogation, including the lack of HEPA filtration in some wards/rooms, omission of air lock double-door barriers, failure to achieve correct pressurisation, inadequately sealed ceilings, and lack of validation.

7.3 But, in any event and more importantly, **no causal link** has been established between the Ventilation Derogation and either: (a) any infection suffered by any individual patient; or (b) any impact on the rate or incidence of infection in either the QEUH or the RHC, as now agreed by many of the Inquiry's experts.

7.4 This is acknowledged in paragraphs 406 to 408 by CTI, who now put forward a broad and theoretical case that the ventilation system generally gave rise to "*sufficient risk*" to "*suggest*" an unsafe environment for immunocompromised patients.

7.5 By contrast, the Closing Statement concludes, with confidence, that "*there clearly was a link between patient infections and features of the water system in the hospital*" (paragraph 399) and that the contamination of the water system "*clearly*" had an impact on patient safety and care (paragraph 404).

8. In these circumstances, it is submitted that the conclusions in paragraph 1877 of CTI's Closing Statement as to the significance and effect of the Ventilation Derogation are erroneous and insufficiently substantiated.

9. However, there is an even more fundamental problem with the conclusions in CTI's Closing Statement as to the Ventilation Derogation.

10. CTI's Closing Statement starts from an assumption that the Ventilation Derogation in and of itself created a risk which rendered the bulk of the wards in the Hospitals unsafe. It is respectfully submitted that this assumption has not been established with sufficient forensic rigour, either in evidence or in the Closing Statement. This assumption is inconsistent with reliable and cogent evidence from multiple witnesses with relevant expertise (including some appointed as independent experts to the Inquiry). There is a substantial body of expert opinion which supports the conclusion that there was nothing inherently wrong in reducing air change rates from 6 ACH to 3 ACH in standard rooms in general wards, and that this would not have had any material effect on patient safety. Further, the risk said to be created by the Ventilation Derogation is identified

only vaguely and broadly, and the materiality of the risk has not been credibly established. Currie & Brown submits that this assumption is therefore unsafe and should be rejected.

11. This section is in **two parts**:

11.1 **Part 1** starts by examining the above assumption and issues with causation in the context of the evidence before the Inquiry.

11.2 **Part 2** considers (subject to the submissions in Part 1) CTI's narrative and submissions about the process by which the Ventilation Derogation came to be agreed and recorded (largely to be found in Chapters 5 and 8 of CTI's Closing Statement).

Part 1: The Assumption

12. First, an important **caveat**: Currie & Brown has no expertise in the field of ventilation engineering or the science behind it. This is why Currie & Brown relied on the expertise of specialist M&E engineers Wallace Whittle, whom it appointed to its Technical Team in 2008-2009; and why it sought the advice of Wallace Whittle on the alternative design solution for ventilation in standard rooms in general wards which was proposed by ZBP in December 2009 and ultimately agreed as the Ventilation Derogation.

13. Subject to this caveat, the following submissions are therefore made on behalf of Currie & Brown on the basis of the evidence before the Inquiry.

14. As noted in paragraph 146, the Scottish Ministers submitted in their response of 31 January 2025 to CTI's Glasgow III Closing Statement that:[3]

> "*In material respects (e.g. as regards general wards), Counsel to the Inquiry's submissions are based explicitly on an absence of evidence rather than on any assessment, expert or otherwise, that the risks arising from too few air changes per hour have not been satisfactorily mitigated…*"

15. Currie & Brown respectfully agrees with the Scottish Ministers and submits that, almost eleven months on, it remains the case that there is insufficient evidence to support a conclusion either that (a) any material risks to patient safety were created by the agreement in December 2009 to reduce air change rates in standard rooms in general wards; or (b) any such risks were not satisfactorily mitigated.

[3] [Glasgow III – Core Participants' Closing Submissions, Scottish Ministers, Document 5, page 64, para 17].

16. It is submitted that the Closing Statement has not analysed with sufficient forensic rigour whether, in light of the expert evidence summarised below, the Ventilation Derogation can safely be said to have been an unacceptable derogation from the guidance in SHTM 03-01:

16.1 The circumstances in which ZBP/Multiplex proposed, and GGC approved, an alternative design solution[4] for the ventilation in standard rooms in general wards are discussed in Section 1, Part 2 below. The proposal was intended to resolve the conundrum that GGC's required reduction in the maximum temperature variant could not be achieved if the recommendation in SHTM 03-01 for 6 ACH in single rooms in general wards[5] were to be followed.

16.2 SHTM 03-01 is non-mandatory guidance, as is clear from the preface to SHTM 00 (quoted in paragraph 1158).[6] Mr Andrew Poplett (an Authorising Engineer appointed by the Inquiry) confirmed in his witness statement for the Edinburgh I hearing that SHTMs have the status of "*guidance*" or an "*approved code of practice*", only "*elements*" of which should be deemed to be "*minimum standards*".[7] He confirmed that the guidance "*can be derogated from provided you record why and the reasons and this can be evidenced and supported*". The reasons for the Ventilation Derogation and the evidence in support were indeed recorded, as discussed in Part 2 below.

16.3 The solution which was agreed and approved to control the environment in the standard rooms in general wards was a mechanical ventilation system with an air change rate of 40 litres per second (approx. 2.5 to 3 ACH), a reduction from the recommended 6 ACH, together with chilled beams. This was recorded in the Clarification Log[8] and the M&E Clarification Log[9] which were formed part of the Main Contract.

17. The Closing Statement is premised upon an assumption that this was not an acceptable design solution. The assumption appears to be based to a large extent on the fact that the alternative design did not follow the (non-mandatory) recommendation for 6 ACH in SHTM 03-01, which it is said thereby created an avoidable risk. In that regard the Closing Statement relies (in paragraph 155) on what it describes as the "*important*" evidence of Professor Humphreys (the Inquiry's Clinical Microbiology expert) in the Edinburgh I hearing that "*the greater the air change is, the greater*

[4] ZBP's proposed alternative design solution was set out in an undated paper headed 'Ward Ventilation Design Strategy' [Bundle 16, Document 21, Page 1657].
[5] This recommendation is in Table A1, Appendix 1, Part A of SHTM 03-01 (Draft for Consultation, March 2009) [Bundle 16, Document 5, Page 483]. This is the edition applied on the Project, which later became SHTM 03-01 (2013).
[6] The preface to SHTM 00 describes the SHTM as "*comprehensive advice and guidance*" and "*best practice*" [Edinburgh II – Bundle 1, Document 1, Page 3].
[7] [Edinburgh I, Bundle 6, Document 4, page 129, paras 73-74].
[8] [Bundle 17, Document 21, Page 979, row 10.0]
[9] [Bundle 16, Document 23, Page 1664].

dilution you have, reducing the number of contaminants in the air and therefore the safer it is".[10] However, this line cannot bear the weight placed upon it: Professor Humphreys made this point when discussing air change rates as a generality, stating only that this was "*generally the principle upon which we work*". He was not suggesting there that any reduction to the air change rate in a space will necessarily make that space 'unsafe' for patients.

18. Likewise, paragraph 1283 relies upon Professor Humphreys' statement in oral evidence that there is a risk associated with reducing air change rates. However, he qualified that statement with the important proviso that "*I wouldn't be able to give you a judgment as to how significant that risk would be*".[11] Further, this statement was, again, made during a discussion about air change rates as a generality. The example Professor Humphreys gave during that discussion was a reduction in air change rates in an operating theatre from the recommended 25 ACH down to 15 or 16 ACH (at which point "*I think you're into territory where there may be significant risk*") as compared to a reduction only to 20 ACH (where "*the risk may not be so great*"). Whilst that example is not relevant here, the qualified and conditional language Professor Humphreys used ("*think*", "*may*") illustrates the difficulty of reliably identifying either when a risk has arisen or the materiality of that risk.

19. Consistent with Professor Humphreys' proviso, Mr Stephen Maddocks (the Inquiry's Building Services Engineering Expert) was similarly unable to say at what point any deviation from the recommended air change rates would get to a level that would render the relevant space unsafe for a patient.[12]

20. Therefore, on the basis of the evidence of Professor Humphreys and Mr Maddocks, it is not possible to say with any degree of reliability that any reduction (and, if so, what degree of reduction) in the recommended air change rates would give rise to a material risk that the space in question would be unsafe.

21. Further, CTI's Closing Statement does not address the highly pertinent evidence of Professor Humphreys that, in the case at least of standard rooms in general wards (to which the Ventilation Derogation was agreed to apply and ought only to have been applied) flow rate is not clinically important and is instead concerned with ensuring patient comfort, not safety:

[10] No document reference was cited in paragraph 155, but the reference is [Transcript, Prof. Hilary Humphreys, 12 May 2022, Page 27, Column 49].
[11] [Transcript, Prof. Hilary Humphreys, 12 May 2022, Page 26, Column 47].
[12] Mr Maddocks was discussing the equivalent recommended air change rates in the table in Appendix 2 to HTM 03-01 [Transcript, Stephen Maddocks, 12 May 2022, Page 58, Column 111].

21.1 Counsel to the Inquiry in respect of the Edinburgh hospitals, Mr John MacGregor KC, put paragraph 5.6 of SHTM 03-01, Part A (February 2022)[13] to Professor Humphreys, which states:

"*With natural ventilation, it is almost impossible to maintain consistent flow rates and ensure that minimum ventilation rates will be achieved all times. However, this variability is normally acceptable in non-clinical spaces such as office accommodation, staff areas, library/seminar rooms and dining rooms, and some clinical areas such as level 0 and 1 care spaces and waiting and consulting rooms where risk of airborne infections is likely to be low.*"

21.2 Professor Humphreys indicated that he agreed with paragraph 5.6. He was then asked the following:[14]

"***Q*** *So, is it fair to say that if a purpose of a particular room or ward is neither control of infection from an infectious patient or protection of a particularly vulnerable patient from infection, the flow rate is not clinically important?*

A *No, and if you look at, even in-- we talked earlier, I think, in terms of naturally ventilated areas in hospitals. Often, in general medical and surgical wards where we believe that we have low-risk patients for infection, often they would be naturally ventilated, even though patients would be there for a period of time.*"

21.3 It is submitted that it is clear from the context of his answer that Professor Humphreys was agreeing with the last part of the question put to him, i.e., that flow rate is not clinically important. His evidence therefore was that low-risk patients are often accommodated in rooms which are naturally ventilated where flow rates cannot reliably be controlled or achieved, and that this is not problematic as per paragraph 5.6 of SHTM 03-01, Part A (February 2022) because natural ventilation is permitted.

21.4 This is reflected in ZBP's paper titled 'Ward Ventilation Design Strategy',[15] which cited the equivalent passage in SHTM 03-01 (Draft for Consultation, March 2009) about the impossibility of maintaining consistent flow rates and ensuring that minimum ventilation rates will be achieved all times when using natural ventilation. The equivalent passage in SHTM 03-01 (Draft for Consultation, March 2009) says that "*[t]his variability is normally acceptable for general areas including…general wards*".[16]

[13] [Edinburgh I, Bundle 1, Document 10, page 837].
[14] [Transcript, Prof. Hilary Humphreys, 12 May 2022, Page 28, Column 51].
[15] [Bundle 16, Document 21, Page 1657].
[16] Paragraph 2.3 of Part A of SHTM 03-01 (Draft for Consultation, March 2009) [Bundle 16, Document 5, Page 366].

21.5 Drawing the threads together, Counsel to the Inquiry then asked: "*is the principal purpose of flow rate in general wards, or non-isolation rooms, to ensure the comfort of patients?*". Professor Humphreys responded: "*I think that's a fair comment, yes*".[17]

21.6 Professor Humphreys also explained that there was no "*precise science*" underlying the recommended air change rates in SHTM 03-01, and instead the objective is "*increasing the air changes according to where you think there is risk*".[18]

22. Therefore, Professor Humphreys (an Inquiry-appointed expert) does not take a "*different view*" from Peter Hoffman, as incorrectly suggested in paragraph 1283. On the contrary, their views on the relevant issues are broadly similar:

22.1 Mr Hoffman is a scientist who specialised in hospital infection control and, prior to his retirement, worked for the Health Protection Agency and then Public Health England (and in that capacity was consulted by GGC) during the period when the Hospitals were being designed and built. He gave written[19] and oral evidence for the Glasgow III hearing.

22.2 Mr Hoffman's oral evidence,[20] like Professor Humphreys', was that the recommended air change rates in HTMs and SHTMs are for patient comfort, not safety.[21] Mr Hoffman did not restrict those comments to general wards, although Professor Humphreys was not asked whether he would say the same for specialist wards.

22.3 Mr Hoffman also explained that the recommended air change rates are not relevant to the removal of bacteria,[22] they are relevant only to the dilution of contamination, and that HEPA filtration is required to remove contamination. Professor Humphreys likewise explained that higher air change rates will increase the dilution of contamination but, in order to prevent contamination coming into the room at all, high quality filtration is required.[23]

22.4 Mr Hoffman agreed that, in order to protect immunocompromised patients, the aim is to exclude contamination via HEPA filtration.[24] His view is that, in a ventilated space for protection of immunocompromised patients, air change rates do not impact on infection

[17] [Transcript, Prof. Hilary Humphreys, 12 May 2022, Page 28, Column 52].
[18] [Transcript, Prof. Hilary Humphreys, 12 May 2022, Page 25, Column 46].
[19] [Glasgow III – Witness Statements, Volume 6, Peter Hoffman, Document 4, Page 191].
[20] There is, unfortunately, no evidence about these issues in Mr Hoffman's witness statement because he was not asked any questions about them in the questionnaire issued to him by the Inquiry.
[21] [Transcript, Peter Hoffman, 26 September 2024, Page 18, Column 32 and Page 53, Column 102].
[22] [Transcript, Peter Hoffman, 26 September 2024, Pages 21-22, Columns 38-39].
[23] [Transcript, Peter Hoffman, 26 September 2024, Pages 18-19, Columns 31-34].
[24] Prof. Humphreys' evidence was that "*the more air changes you have, the more dilution of contamination you have*" but "*the better the quality of filters you have, the less likely you are to get contamination coming through*" [Transcript, Prof. Hilary Humphreys, 12 May 2022, Page 9, Columns 13-14].

risk.[25] He opined that there is no aerosol risk of infection to the patient from anyone entering the room; that risk is a contact risk.[26]

23. Mr Hoffman's oral evidence is consistent with the advice he gave to GGC, at its request, during the Project. See, e.g., the email from Dr John Hood on 25 October 2010 reporting that Mr Hoffman had advised in relation to the reduction in air change rates from 6 ACH to 2.5 ACH that "*the suggested 6 ACH is really for temperature control and not for any infection control issues (i.e. not dilution and removal*".[27]

24. Mr Hoffman's oral evidence is also consistent with the written advice he gave GGC after the completion of the Project, when he was consulted during the investigations into infections by the Incident Management Team ("**IMT**"), chaired by Dr Teresa Inkster. By email to Dr Inkster dated 16 September 2018, Mr Hoffman advised that:[28]

> "*(S)HTMs do not address the ventilation needed for highly immunocompromised patients. They need protecting against inhalation of fungal spores, typically originating from outdoor air. For their rooms, all air in them needs to have passed through a HEPA filter. The rooms should be at positive pressure so all gaps leak outwards, preventing the ingress of unfiltered air…**The air change rate is irrelevant**. You are not trying to dilute anything (just the patient's and staff normal flora – they will not give off fungal spores) but to exclude spores from outside. **Three or six air changes – doesn't matter**. Six air changes is the generally accepted level for temperature and odour control – no relevance to preventing infections.*"

25. Dr Inkster stated in oral evidence that she did not report this advice to the IMT because she did not agree with it.[29]

26. Despite that, Dr Inkster continued to consult Mr Hoffman. He gave further, similar, advice to Dr Inkster, again at her request, by email dated 8 January 2019 (copied to Dr Hood).[30] Mr Hoffman advised that, even for immunocompromised haematology patients requiring protection from fungal spores, the "*"recommended" air change rates*" in SHTM 03-01, Part A, Appendix 1 are "*not evidence based and the applications are poorly described*"; they are "*best treated as a starting point for a thought process, rather than definitive guidance in itself*". He continued:

> "*What is necessary for these specific isolation rooms is that 100% of the air the patient breathes has passed through a HEPA filter…Protection of these patient [sic] from airborne infection from other patients is a more minor consideration – most such infection will be in droplets which will fall rapidly out of the air in the room in which they are generated…**The air change rate is for patient comfort** – temperature control and dilution of odours. I do*

[25] [Transcript, Peter Hoffman, 26 September 2024, Pages 31-32, Columns 58-59].
[26] [Transcript, Peter Hoffman, 26 September 2024, Page 54, Column 104].
[27] [Bundle 17, Document 79, Page 3032].
[28] [Bundle 14, Volume 2, Document 91, Page 140].
[29] [Transcript, Dr Teresa Inkster, 1 October 2024, Page 102, Columns 199-200] and [Transcript, Dr Teresa Inkster, 2 October 2024, Page 6, Columns 7-8].
[30] [Bundle 14, Volume 1, Document 62, Page 647].

> *not see patient protection as a valid reason to increase air supply rates in the ward in question*."

27. CTI are also somewhat dismissive of Mr Hoffman, commenting in paragraph 57, for example, that he "*lacks expertise in a clinical environment*"; and that he is not a clinician, a professor, or an academic, "*but an engineer*". In fact, Mr Hoffman is not an engineer: he attested in his witness statement that he has a B.Sc. in Microbiology and an Honorary Diploma in Hospital Infection Control; and he summarised his professional history as follows:[31]

> "*From 1977, a scientist in the Public Health Laboratory Service (1977-2003), Health Protection Agency (2003-2013), Public Health England (2013-2021) and the UK Health Security Agency (2021) in the department dealing with healthcare associated infections. Essentially the same role progressing through these successive organisations, becoming a Consultant Clinical Scientist. Retired in October 2021*
>
> *...My bachelor's degree in microbiology provided me with a broad context that facilitated build-up of expertise in infection prevention. My honorary diploma in hospital infection control was awarded as a "grandparent" diploma for my part formulating and delivering that qualification for the University of London.*"

28. This professional history would suggest that Mr Hoffman was eminently qualified to opine on the science and practice underlying recommended air change rates in ventilation systems in healthcare environments, contrary to the implication in paragraph 57.

29. Furthermore, the evidence of Professor Humphreys and Mr Hoffman on these issues has been largely borne out by the expert evidence heard during the Glasgow IV, Part 2 hearing in August 2025:[32]

29.1 **Dr Lydia Drumright** (Clinical Informatics expert) warned that more research is needed to understand what is required for ventilation in healthcare settings; current guidance does not meet that need and "*we know very little about ventilation*". The data she has analysed suggests that ventilation does not have any impact on rates of Aspergillus. She declined to answer the question whether hospitals should follow ventilation guidance, on the basis that she is not sure how good that guidance is.[33]

29.2 **Dr Samir Agrawal** (Consultant Haematologist):

29.2.1 In section 5.7 of his report dated 18 May 2021, Dr Agrawal opined that there is only a theoretical risk of increased airborne infection caused by the non-compliance of the ventilation system (in Ward 4C) with the recommended air change rates in SHTM 03-01. However, he said that this risk is not material because (amongst other

[31] [Glasgow III – Witness Statements, Volume 6, Peter Hoffman, Document 4, Page 191, paras 1-3].
[32] Dr Drumright, Dr Agrawal, and Professor Hawkey were initially appointed as experts by GGC but their appointments were, in effect, novated to the Inquiry later.
[33] [Transcript, Dr Lydia Drumright, 21 August 2025, Pages 89-91, Columns 174-178].

things) there is "*no clear evidence that a SHTM 03-01 compliant system is associated with decreased rates of (airborne) infection or mortality in haemato-oncology units*".[34]

29.2.2 Dr Agrawal expanded upon this in oral evidence, opining that the available data does not support an argument that following the ventilation guidance in SHTM 03-01 has any clinical impact, "*hence perhaps why so many guidelines do not specify that these ventilation systems are essential for managing patients*". He explained that there is no evidence available to prove that ventilation systems prevent infection.[35] He said he could see no evidence from the references provided in Dr Mumford and Ms Dempster's Glasgow III report that 'compliant' ventilation would prevent transmission of pathogens through airborne aerosols.[36]

29.2.3 Dr Agrawal also explained, echoing Mr Hoffman's views, that it was "*very unlikely*" that bacteria would be transmitted by airborne aerosols as a consequence of reduced air change rates:[37]

> "*So the suggestion is that environmental bacteria can become aerosolised and hence, if there's a problem with the ventilation system, that that risk is real, when the real concern around environmental bacteria is not there. It's endogenous in patients.*
>
> *The question I think we have to ask ourselves is even if they're aerosolised and even if they're not being cleared, how do they then get to cause infection in the patient? And that would be a question of transmission, of how does the pathogen get in its droplet form to the patient. And* ***the idea that they're being breathed in****, because we're talking about airborne routes of transmission,* ***seems very unlikely****. What's much more likely is the water droplets falling on surfaces. Those surfaces then have the organism on there and then transmitted almost certainly* ***by contact***."

29.2.4 Faced with the challenge that Dr Agrawal's views pose to CTI's case on the significance of the Ventilation Derogation, paragraphs 279 and 1747 rely very heavily upon Dr Agrawal's statement that he would not open a new ward without validating the ventilation system. However, he explained this was because it would be important to check that the air handling unit is filtering to the required level.[38] He said: "*the key thing I'd want to know is* ***not*** *the number of changes per hour and is not the positive pressure, it would be is the HEPA filtration working?*".[39]

[34] Dr Agrawal's report dated 18 May 2021 [Bundle 44, Volume 5, Document 3, Page 117, para 5.7].
[35] [Transcript, Dr Samir Agrawal, 22 August 2025, Page 65, Column 125].
[36] [Transcript, Dr Samir Agrawal, 22 August 2025, Pages 76-77, Columns 148-150].
[37] [Transcript, Dr Samir Agrawal, 22 August 2025, Pages 79-80, Columns 154-155].
[38] [Transcript, Dr Samir Agrawal, 22 August 2025, Page 63, Columns 121-122].
[39] [Transcript, Dr Samir Agrawal, 22 August 2025, Page 106, Column 208].

29.3 **Professor Mike Stevens** (Paediatric Oncologist and Case Note Review Panellist):

29.3.1 Professor Stevens clarified in oral evidence during the Glasgow IV, Part 2 hearing that the Case Note Review Panel's joint report dated 3 June 2025,[40] responding to the HAD Report,[41] said little about Chapter 6 of the HAD Report (Ventilation) because "*we agreed that we didn't believe that ventilation per se had a tremendous impact on gram-negative environmental infection*".

29.3.2 In a further echo of Mr Hoffman's evidence that there is no aerosol risk of infection from someone entering the patient's room,[42] Professor Stevens said that:[43]

"*…there's an argument that's been rehearsed, I think, about how much aerosolisation can be affected by adequate ventilation, but I think <u>everyone seems to agree, **if** it is affected, it's a **very small component**</u>*."

29.3.3 Therefore the scepticism about Mr Hoffman's evidence on aerosol risk which is implied in paragraph 1283 ("*he claimed that…*"), which cites the contrary views of Dr Inkster, would appear to be misplaced, according to both Professor Stevens and Dr Agrawal.

30. Faced with this weight of evidence, CTI's Closing Statement now instead pursues a hypothetical and theoretical case that the reduction in air change rates from those recommended in SHTM 03-01 gave rise to an avoidable risk. However, the risk is identified only vaguely and broadly in the Closing Statement. The principles of risk assessment and risk management were introduced only belatedly in the Inquiry process, and cursorily, in a nine-page report issued by the Inquiry's Microbiology expert, Dr Sara Mumford, on 20 July 2025.[44] Dr Mumford does not appear to have any recognised expertise in the field of risk assessment or risk management.

31. Dr Mumford was forced by the data in the HAD Report to downgrade the conclusion on ventilation in her earlier joint report with Ms Dempster dated 24 May 2024.[45] She accepted in oral evidence that she could no longer maintain her view that the cases of Aspergillosis in Schiehallion Unit patients were "*<u>strongly</u> associated*" with "*the inadequate ventilation system on wards 2A, 2B and*

[40] Joint report of Professor Stevens, Ms Evans, and Professor Wilcox dated 3 June 2025 [Bundle 44, Volume 2, Document 15, Page 120].
[41] Joint report of Professor Hawkey, Dr Agrawal, and Dr Drumright dated 24 July 2024 [Bundle 44, Volume 1, Document 1, Page 5].
[42] [Transcript, Peter Hoffman, 26 September 2024, Page 54, Column 104].
[43] [Transcript, Professor Mike Stevens, 28 August 2025, Page 40, Column 76].
[44] Dr Mumford, 'Report on the risk related to the current safety of the ventilation and water systems at QEUH/RHC' dated 20 July 2025 [Bundle 44, Volume 6, Document 1, Page 4]. This was supplemented by questions put to Dr Mumford during the Glasgow IV, Part 2 hearing on 29 August 2025.
[45] Joint report of Dr Mumford and Ms Dempster dated 24 May 2024 [Bundle 21, Volume 1, Document 4, Page 179, para 11.34].

6A".[46] She continued to insist that there was an association, as pointed out in paragraph 367(b); but she appeared to base this only on the existence of an 'unnecessary risk' of infection – i.e., it is only a theoretical association. When asked if there was ever a time when the adequacy of the ventilation adversely impacted patient safety and care, she could say little more than that it was "*very, very difficult to assess*", and again referred vaguely to "*increased risk*".[47]

32. It is submitted that a theoretical risk is not really an 'association' at all; the materiality of any such risk would have to be established to maintain credibly that there was an association. However, the highest Dr Mumford is able to put it in her new report dated 20 July 2025 is a generalised statement that failure to follow guidance "*carries with it an inherent risk of resulting in unsafe practice*" and that derogating from SHTMs is "*not without risk*".[48] Her report does not carry out any proper analysis of the materiality of the hypothetical risk that is only vaguely identified. Neither is there identification of any evidence that the Ventilation Derogation has resulted in an unsafe environment for patients, other than a brief reference to difficulties cleaning the chilled beams[49] (which is an issue of maintenance unrelated to the guidance on recommended air change rates).

33. It is submitted that the lack of evidential basis for these recently proffered opinions undermines Dr Mumford's credibility to opine on these particular matters.

34. Whereas CTI conclude with some confidence in Chapter 4 that "*there clearly was a link between patient infections and features of the water system in the hospital*" (paragraph 399), and that the contamination of the water system "*clearly*" had an impact on patient safety and care (paragraph 404), their conclusions in respect of the ventilation system are rather more circumspect. It is acknowledged in paragraph 408 (with, it is submitted, some understatement) that the likelihood of airborne infections such as Aspergillus or Cryptococcus in patients at the Hospitals "*may well be on the low side*", but paragraph 408 then relies solely upon the "*severe consequences*" of contracting such infections to support the surprising submission that "*notwithstanding Dr Agrawal's results…there is a sufficient risk for this small group of patients that suggests that the **bulk** of the rooms in the hospital are unsafe for them*".

35. It is submitted that this leap in logic cannot be supported by the "*severe consequences*" of contracting Aspergillus or Cryptococcus alone. No cause and effect has been established.

36. It is further submitted that there is insufficient evidence from which it could be concluded that the Ventilation Derogation has given rise to any material risk of creating an unsafe environment for

[46] [Transcript, Dr Mumford, 29 August 2025, Page 74, Column 144].
[47] [Transcript, Dr Mumford, 29 August 2025, Page 77, Column 149].
[48] Paragraphs 22-23 of Dr Mumford's report dated 20 July 2025 [Bundle 44, Volume 6, Document 1, Page 11].
[49] Paragraph 25 of Dr Mumford's report dated 20 July 2025 [Bundle 44, Volume 6, Document 1, Page 11].

patients (including immunocompromised patients in specialist wards, but certainly low-risk patients in standard rooms in general wards) given:

36.1 The evidence of Professor Humphreys and Mr Hoffman that the recommended air change rates in SHTM 03-01 are for patient comfort, not safety; and

36.2 The views of Dr Drumright and Dr Agrawal, with which Professor Stevens agreed, that there is no clear evidence that compliance with the recommended air change rates prevents airborne infection or is associated with any decreased rates of airborne infection.

37. For all the reasons set out above, it is submitted that the Ventilation Derogation has ultimately been revealed by the expert evidence to be something of a 'red herring'. The belated reliance upon vague and inadequately developed themes of risk management does not provide any credible or cogent basis for a finding that the Ventilation Derogation was an unacceptable design solution, or that it had any material impact on any patients or on the rate of infections, or that it has created any material risk to patient safety. Further and moreover, it does not provide a sound basis for any criticism of those who proposed, accepted, or approved the Ventilation Derogation in December 2009. The submissions that follow below must be viewed in that context.

Part 2: The process by which the Ventilation Derogation was agreed and recorded

38. This section turns next to discuss CTI's narrative and submissions about the process by which the Ventilation Derogation came to be agreed and how it was recorded. As stated above, this discussion is subject to the submissions in Part 1 above that there is no credible or cogent basis for a finding that the Ventilation Derogation was an unacceptable design solution, or that it had any material impact on any patients or on the rate of infections, or that it has created any material risk to patient safety.

39. CTI's narrative is largely to be found in Chapter 5 and their submissions in Chapter 8. The approach in this Section 1, Part 2 is to address both together thematically, rather than strictly following the order in which points were made in the Closing Statement.

The driver of the Ventilation Derogation

40. CTI's Closing Statement concludes in paragraph 1520 that the need to find an alternative design solution which led ultimately to the Ventilation Derogation was driven by the change in GGC's requirement for room temperatures in the Hospitals. The new requirement was set out in an instruction to bidders which required that room temperatures in the Hospitals "*should not go…higher than 26°C in summer for more that* [sic] *50 hours in total, but not on successive*

days",[50] a reduction from the maximum room temperature of 28 degrees which had been set out in the Employer's Requirements. This change has been referred to as the removal of the maximum temperature variant. ZBP established through thermal modelling that this new requirement could not be achieved with air change rates of 6 ACH (as set out in paragraph 1521).[51]

41. Currie & Brown's understanding is that one of the drivers behind the Ventilation Derogation was indeed the removal of the maximum temperature variant. This is reflected in the opening two paragraphs of ZBP's 'Ward Ventilation Design Strategy' paper.[52]

42. However, it is Currie & Brown's understanding that the requirement to meet GGC's energy efficiency and low carbon targets was also a factor in its decision-making at the time. This is set out in paragraph 14 of Currie & Brown's letter dated 25 July 2024 responding to Mr Poplett's 'Independent Expert Report Concerning Critical Healthcare Ventilation Systems' dated 10 June 2024 ("**Ventilation Report**"),[53] which paragraph the Chair is respectfully invited to read in full. Further sources of Currie & Brown's understanding include:

42.1 ZBP's 'Ward Ventilation Design Strategy' paper, which says:[54]

> "*Chilled beams are also an energy efficient solution and save some 9kg/m² of CO_2 over that of an all air system delivering 6ac/h, equivalent to about 10% of the hospitals' total emissions.*"

42.2 The comment on ZBP/Multiplex's proposal recorded in the M&E Clarification Log that:[55]

> "*Brookfield proposal as outlined within the bid submission is to incorporate chilled beams as a low energy solution to control the environment which do not rely on large volumes of treated air or variable natural ventilation. All accommodation is single bedrooms and therefore the need for dilution of airborne microbiological contamination should be reduced (rooms could also be at slightly negative pressure to corridor).*
>
> *Providing 6 air changes is energy intensive and not necessary.*"

43. However, Currie & Brown would defer to GGC on the factor(s) that drove, or were taken into consideration in, its decision to request an alternative design solution and approve the Ventilation Derogation.

[50] The instruction to bidders was headed 'Removal of Mandatory Maximum Temperature Variant' [Bundle 17, Document 26, Page 1063].
[51] This was reported in the fourth paragraph of ZBP's 'Ward Ventilation Design Strategy' paper [Bundle 16, Document 21, Page 1657].
[52] [Bundle 16, Document 21, Page 1657].
[53] [Bundle 21, Volume 5, Document 7, Page 34, Para 14].
[54] [Bundle 16, Document 21, Page 1658].
[55] [Bundle 16, Document 23, Page 1664].

The removal of the maximum temperature variant

44. Paragraph 527 states that the evidence of Alan Seabourne of GGC was that the removal of the maximum temperature variant was decided by GGC's Director of Facilities (Alex McIntyre) "*in discussion with Currie & Brown*".[56] For the avoidance of doubt, Currie & Brown had no involvement in GGC's decision to make this change to its requirements, save only that it was informed of and aware of this decision, as explained in paragraph 40 of the witness statement of David Hall of Currie & Brown:[57]

> "*Through facilitating Project meetings where technical matters were discussed, I was aware that Alex Macintyre, the Board Director of Facilities, had expressed concern about the maximum room temperature which was set at 28 degrees. I became aware from these same meetings that a new maximum room temperature of 26 degrees was then set, with a possible allowance of exceeding the maximum for up to 50 hours per year. I cannot recall a specific meeting where the decision to adopt this new maximum room temperature was approved, or who made the decision.*"

45. Currie & Brown understands, from Mr Hall's attendance at the meetings he referred to, that GGC's decision to remove the maximum temperature variant was due to GGC's experience of patients complaining about over-heating in a new build Ambulatory Care and Diagnostic Centre ("**ACAD**") at Stobhill Hospital, as explained in paragraph 41 of David Hall's witness statement:[58]

> "*I have been asked why Alex McIntyre was concerned about the maximum room temperature being set at 28 degrees. I recall that this was based on his experience of "lessons learned" in relation to patient comfort from previous projects such as ACADs at Victoria and Stobhill, i.e. that the rooms were found to be too warm and that this was also the rationale for reducing the maximum room temperature to 26 degrees.*"

46. The second sentence of paragraph 527 says that "*Ms [Helen] Byrne noted that escalation would have had to come from Mr Seabourne and his technical advisors*". If this is intended to refer to Currie & Brown (who was leading the Technical Team at the time), Currie & Brown was unaware of any need to escalate the decision over the head of Mr McIntyre (or indeed Mr Seabourne) and, in any event, had no responsibility or authority to do so. As Mr Hall explained in paragraph 40 of his witness statement as quoted above, he did not know who made the decision. Currie & Brown was not privy to the internal discussions between GGC's Project Team and the Board. Currie & Brown was not in a position to know whether this decision had been made and/or approved at Board level already, nor to whom it had or had not been communicated. That was a matter for Mr Seabourne as GGC's Project Director. It was not any part of Currie & Brown's role to assist GGC in the internal management of its own reporting lines or internal governance procedures (of which it had no detailed knowledge).

[56] [Transcript, Alan Seabourne, 29 May 2025, Page 23, Column 41].
[57] [Glasgow IV, Part 1 – Witness Statements, Volume 2, David Hall, Document 6, Page 207].
[58] [Glasgow IV, Part 1 – Witness Statements, Volume 2, David Hall, Document 6, Page 208].

47. The oral evidence of Peter Gallagher (GGC's Finance Director and a member of its Board) was that he was aware of the decision to remove the maximum temperature variant. He said that Alex McIntyre brought a paper to the Acute Services Review Programme Board or the Acute Divisional Senior Management Team in around September/October 2009 reporting that patients in the new Stobhill Hospital were complaining that the buildings were too hot. He said the paper was passed to Helen Byrne and the Project Team, who were charged with finding a solution.[59]

48. Paragraphs 1509 and 1512 say that the removal of the maximum temperature variant was not accompanied by "*any of the process which might be thought appropriate*" and that "*there is no record of the possible consequences of such a decision being debated or assessed*". Currie & Brown does not know what internal considerations were given by GGC to the technical issues, cost consequences, or risk assessment of its decision, and it was not asked to advise on such matters at the time. However, Mr Gallagher's evidence would appear to suggest that there was an internal process whereby this decision was discussed and approved at Board level.

ZBP's 'Ward Ventilation Design Strategy'

49. There is no mystery as to why ZBP produced its 'Ward Ventilation Design Strategy' paper in December 2009, contrary to the suggestion in paragraph 1525:

    49.1 The paper was provided to set out ZBP's proposed alternative design solution to meet GGC's recently-changed requirement as to room temperatures, ZBP having established through thermal modelling that this new requirement could not be achieved with air change rates of 6 ACH (as set out in paragraph 1521).

    49.2 The paper is not an "*expert presentation*". The paper was provided on behalf of the preferred bidder, Multiplex, by its M&E engineer during the tender clarifications and discussions, which is a normal part of the tender process.

    49.3 There is no evidence to support the speculation that "*someone has belatedly realised that the topic under discussion might be important, and there was nothing on paper to sit behind it*", and none has been cited.

50. Paragraph 1526 describes the comment attributed to ZBP in the M&E Clarification Log that 6 ACH was unnecessary as "*controversial*", and criticises ZBP for "*dismissing a requirement for air change rate in single rooms so summarily*". For the reasons set out in Section 1, Part 1 above, the analysis that the recommended (not 'required') air change rate of 6 ACH was unnecessary in standard rooms in general wards is not controversial – on the contrary, it would seem that Professor Humphreys, Mr Hoffman, Dr Drumright, Dr Agrawal, and Professor Stevens would agree with it.

[59] [Transcript, Peter Gallagher, 18 September 2025, Page 56-58, Columns 108-111].

Further, the criticism in paragraph 1526 ignores the fact that ZBP did not 'dismiss' the recommendation summarily but rather set out in its 'Ward Ventilation Design Strategy' a holistic solution to the challenge raised by the removal of the maximum temperature variant. The solution did not simply reduce the air change rate from 6 ACH to 3 ACH, it also incorporated chilled beams by way of mitigation to improve temperature control. Chilled beams were not, at that time, known to be problematic and they were permitted by SHTM 03-01.[60]

51. The suggestion in paragraph 1529 that "*No doubt there are other ways in which temperature could be reduced*" is not, so far as Currie & Brown is aware, based on any evidence and no source is given. That was not explored in oral evidence, so there is no basis to make this assertion with such certainty ("*no doubt*"). Nor is there any support for the assertion that "*Even a compromise over maximum temperature might have been available, if pursued*", and no such possible compromise has been identified.

How the Ventilation Derogation was agreed and recorded

52. The Closing Statement proceeds on the assumption that derogation from the (non-mandatory) guidance in SHTMs is inherently 'risky' and wrong. That is not the case: as Mr Poplett acknowledges in paragraph 9.107 of his Ventilation Report,[61] there can be many good reasons why building owners may seek to derogate from the guidance in SHTMs and other NHS standards. Provided the implications and risks of the derogation are considered and carefully balanced with the benefits, derogations can be sensible and safe, as Mr Poplett recognises in paragraph 9.108.[62]

53. The first sentence of paragraph 542 purports to summarise the oral evidence of Emma White of IBI in the following terms:

> "*Ms White stated that as a matter of good practice, the default assumption should be that there is no derogation from a mandatory piece of national guidance, unless this were made clear, with good practice being to record the change on a schedule for visibility*."

54. In fact, it was Counsel, not Ms White, who described SHTM 03-01 as "*an <u>obligatory</u> piece of national guidance*".[63] This is incorrect: SHTM 03-01 was non-mandatory guidance, as set out in paragraph 16.2 above. Further, Ms White did not say that there should be no derogation, and made no reference to any 'default' position. Rather, the exchange that paragraph 542 purported to summarise was as follows:[64]

[60] As set out in paragraphs 2 to 7 of Currie & Brown's response on 25 July 2014 to Mr Poplett's ventilation report dated 10 June 2024 [Bundle 21, Volume 5, Document 7, Page 31].
[61] [Bundle 21, Volume 1, Document 7, Page 557, para 9.107].
[62] [Bundle 21, Volume 1, Document 7, Page 558, para 9.108]. It is submitted that it is not unusual (let alone "*highly unusual*") for derogations from the relevant NHS standards to be sought and (if appropriate) approved on 'new build' projects, contrary to paragraph 9.108.
[63] [Transcript, Emma White, 13 May 2025, Page 51, Column 97].
[64] [Transcript, Emma White, 13 May 2025, Page 51, Columns 97-98].

> "***Q*** *...But as a matter of good practice, would I be right in assuming that one shouldn't find that any of that leads to a derogation from an obligatory piece of national guidance like SHTMO 301* [sic]*, unless somebody says that's what it is and it's been agreed by A, B and C and it covers X, Y and Z?*
>
> ***A*** *Yes, it would be normal that you would agree it before you changed something to demonstrate a derogation, yes.*
>
> ***Q*** *Rather than having to kind of work out in retrospect who said what at a workshop and what the output of the workshop was and who signed what document, I'm simply asking you whether as good practice it should have been recorded if it existed.*
>
> ***A*** *Yes, it's good practice to have recorded it on a schedule, so you could see it.*"

55. The Ventilation Derogation was recorded on a "*schedule*" in accordance with good practice. In fact, the decision and the rationale for the decision were recorded on two schedules: the M&E Clarification Log[65] and the Clarification Log.[66] In their final form, the Clarification Logs were incorporated into the Main Contract and took precedence over the relevant parts of the Employer's Requirements. This is standard procedure on construction projects of this nature and is a process that is well known to the construction industry, professionals, and their legal representatives.

56. As to the final sentence of paragraph 542, which refers to the oral evidence of David Wilson (Multiplex's Commissioning Manager),[67] it is easy to say with hindsight that there may have been a better way of recording the Ventilation Derogation which would have been easier for those outside the Project team to find. But that does not mean that the Ventilation Derogation was not recorded appropriately. The question put to Mr Wilson misunderstands the purpose and status of the logs: because the M&E Clarification Log and the Clarification Log were incorporated into the Main Contract which Multiplex was engaged and obliged to perform, they formed part of it. They were the very documents that the Project participants used to track and manage queries and issues that arose during the tender evaluation process "*to ensure that all questions, clarifications and responses were systematically documented to avoid any miscommunications or delays*", as explained by Mark Baird of Currie & Brown.[68] Mr Baird was responsible for producing and maintaining the logs.

57. Mr Baird further explained in paragraph 80 of his statement that the Clarification Logs were "*the agreed method of recording all issues which were under review and consideration by the Board and the Technical Team*" and that "*this is standard practice and was understood by all*

[65] [Bundle 16, Document 23, Page 1664].
[66] [Bundle 17, Document 21, Page 979, row 10.0].
[67] [Transcript, David Wilson, 20 May 2025, Page 38, Column 74].
[68] [Glasgow IV, Part 1 – Witness Statements, Volume 3, Mark Baird, Document 3, Page 58, para 80].

participants".[69] Mr Hall agreed that "*this is the standard practice on projects of this nature – this is not unusual at all*".[70]

58. Mr Baird also explained in paragraph 84 of his witness statement as follows:[71]

> "*I have been asked to explain what steps I took to bring the derogation to the attention of the Board, other than including it in the M&E Clarification Log. The logs were the agreed way to capture and share information which required consideration which was relevant to particular specialisms. It is standard practice to identify potential derogations when reviewing a bid submission and log those in a table. That is what took place here with the comments being added to the agreed log and being shared with the Board and Technical Team. Using an agreed log to capture and track the progression of issues avoided multiple channels of communication of such issues, and the associated risk that issues can be missed (e.g. multiple emails and conversations which are not recorded) or not fully closed out and was therefore the key step.*" [emphasis in the original]

59. It is therefore misconceived to say in paragraph 1534 that "*Neither NHS GGC nor the Inquiry has been able to trace any written record referring to the derogation (other than the M&E Clarification log.)*" The words in parenthesis are key (as correctly anticipated in paragraphs 1536 to 1537): the Ventilation Derogation was recorded precisely where it ought to have been recorded – in the Clarification Log and the M&E Clarification Log. The evidence to support the rationale for the Ventilation Derogation was also set out in ZBP's 'Ward Ventilation Design Strategy' which sets out the evidence in support of the derogation.

60. Returning to paragraph 542 and Mr Wilson, it was incumbent on Multiplex to ensure that all members of its team, including its Commissioning Manager, were aware of the design solution that Multiplex's specialist M&E engineer, ZBP, had proposed and which had been approved to enable Multiplex to deliver GGC's requirements. It is notable that Mr Wilson did not suggest during oral evidence that he or his commissioning team were unaware of the Ventilation Derogation.[72]

61. Paragraph 543 says (purporting to paraphrase his evidence) that Mr Hall accepted that recording derogations on the M&E Clarification Log "*did not equate to visibility for the wider Board*". What Mr Hall in fact said was slightly different; he said that the Ventilation Derogation is "*in the correct place in terms of the contract but whether it should have been somewhere else in terms of visibility within the wider Board is a different question*".[73] The understanding at least of Mr Baird (who produced and maintained the logs) was that the clarifications and derogations recorded in the logs

[69] [Glasgow IV, Part 1 – Witness Statements, Volume 3, Mark Baird, Document 3, Page 58, para 81].
[70] [Glasgow IV, Part 1 – Witness Statements, Volume 2, David Hall, Document 6, Page 215, para 68]. Mr Hall confirmed that in his oral evidence that "*the clarification log is the place where the changes to the contractor or where the exceptions occur and are recorded*" [Transcript, David Hall, 22 May 2025, Page 46, Column 88].
[71] [Glasgow IV, Part 1 – Witness Statements, Volume 3, Mark Baird, document 3, page 62, para 84].
[72] [Transcript, David Wilson, 20 May 2025, Pages 37-38, Columns 71-75].
[73] [Transcript, David Hall, 22 May 2025, Page 46, Columns 87-88].

would be reviewed and considered by GGC's wider Board, as he explained in paragraph 80 of his statement:

> "*My role was to make sure that anything relating to the M&E works which was or was perceived to be non-compliant with the ERs was captured within the M&E Clarification Log so that it could be reviewed by the Board and closed out.*"

62. As paragraph 543 correctly states, Mr Hall said that it was not part of his role to ensure that the wider Board was made aware of any derogations; he said this was because "*I reported into Peter Moir and Alan Seaborne, you know. I wouldn't have seen it as my responsibility to go to senior members of the NHS management and inform them*".[74] It is submitted that Mr Hall is correct; beyond recording derogations in the Clarification Log and (in the case of the Ventilation Derogation) in the M&E Clarification Log, any wider 'visibility' within the Board was an internal matter for GGC, not for their external third party consultants. It was not for Currie & Brown to go over the heads of those within GGC with whom they were instructed to work. Moreover, CTI has not cited any term in Currie & Brown's appointment to support any suggestion that it had any responsibility for escalating matters to the Board.

63. Currie & Brown was entitled to assume (and had no reason to doubt) that Mr Seabourne and Mr Moir complied with their own internal reporting obligations (which were outside Currie & Brown's knowledge). In any event, Mr Hall's understanding (albeit anecdotal) was that Mr Seabourne and Mr Moir had indeed advised senior members of the Board about the Ventilation Derogation.[75]

64. Paragraph 1507 questions whether those outside GGC's Project team would have understood that "*under the type of design and build contract envisaged, at any time prior to contract signature any of things* [sic] *described as 'requirements' could be altered or removed*". This could be interpreted as implying that such changes could be made easily, or at will, or on a whim. That was not the case. There was a formal process in place (the Competitive Dialogue stage) during which any alternative design solutions proposed, technical queries raised, or clarifications required by the bidders (and ultimately the preferred bidder, Multiplex), in respect of the Employer's Requirements were required to be (a) discussed and agreed between the relevant parties; and (b) recorded in the relevant clarification logs. This was explained in paragraphs 60 to 63 of Mr Baird's witness statement.[76] He explained there that the Competitive Dialogue process was "*a complex and significant tender process*" and that:

> "*The M&E Clarification Log was used to track and manage queries and tasks related to the mechanical and electrical systems. The Clarification Log was used to track and manage*

[74] [Transcript, David Hall, 22 May 2025, Pages 46-47, Columns 88-89].
[75] [Glasgow IV, Part 1 – Witness Statements, Volume 2, David Hall, Document 6, Page 224, para 96].
[76] [Glasgow IV, Part 1 – Witness Statements, Volume 3, Mark Baird, document 3, page 58, paras 60-63].

queries and issues that arose during the design and procurement phases. It was used to ensure that all questions, clarifications and responses were systematically documented to avoid any miscommunication or delays."

65. Paragraph 1523 says that there is a 'debate' about whether Currie & Brown was "*perhaps unintentionally*" downplaying the significance of its project management role in the agreement of the Ventilation Derogation, although it says that resolving this debate is not necessary for present purposes. Any suggestion that Currie & Brown was downplaying the significance of its role is strenuously denied:

65.1 In the oral evidence referenced in paragraph 1523, Currie & Brown's witnesses were not 'downplaying' their role but merely explaining that role in circumstances where the relevant questions in oral evidence proceeded on the incorrect premise that Currie & Brown had some kind of technical input into advising on that decision.

65.2 Currie & Brown did not have any such technical input – the technical advice on ZBP's design solution came from Wallace Whittle, who was part of Currie & Brown's Technical Team, on Currie & Brown's instructions.

66. As to paragraph 1528, responsibility for securing Infection Prevention & Control (**IPC**) sign-off of ZBP's proposal fell to GGC's Project Team, not to Currie & Brown. Currie & Brown had obtained technical advice on the proposal from Wallace Whittle; it was up to the Project Team to identify the appropriate people within IPC to review the proposal internally. Currie & Brown would not have known precisely who the appropriate individuals were, or who was authorised to review the proposal from an IPC perspective at that time.

67. It is unsurprising given the nature of the questions, and with the benefit of hindsight when sitting in a public inquiry hearing, that the witnesses accepted, when asked, that it would have been better to have made a minute of the meetings in mid-December 2009 at which the Ventilation Derogation was discussed as stated in paragraph 1535. However:

67.1 Taking the clarification logs together, they contained hundreds of items (clarifications, responses to queries, and derogations). It would not have been feasible or possible to have recorded in full detail the rationale behind every one of them. The focus in this Inquiry happens to have fallen on one particular derogation / clarification but there were many others.

67.2 A minute of meeting would perhaps have helped this Inquiry, but would not have formed part of the Main Contract, and thus would have had no contractual status. The criticism in paragraph 1535 misses the crucial point that it was (a) standard industry practice and (b)

specifically agreed and known by the Project participants, that derogations and clarifications would be recorded in the clarification logs, as explained above.

67.3 There is therefore no sound basis on which to criticise Currie & Brown for not minuting all of the discussions in mid-December 2009. As Mr Baird explained, the clarification logs recorded the decisions reached and the rationale for those decisions.

68. As to paragraphs 1535 to 1537 and 1539, it is submitted that it would not be appropriate or fair some 16 years later and with the benefit of hindsight to criticise professionals who were following standard practice in the industry at the time by recording derogations and clarifications in the clarifications logs. The fact that the decision to agree the Ventilation Derogation was debated and discussed in multiple calls and meetings, recorded in the clarification logs, supported by reasoned evidence (i.e., ZBP's 'Ward Ventilation Design Strategy'), and incorporated in the Main Contract is instead an indication of compliance with good practice. The Inquiry does not have the benefit of any independent construction expertise to reach a contrary conclusion.

69. The key is that those who needed to know about the Ventilation Derogation for the purposes of the Project knew about it, and none have denied that – neither the Director of the Project Team (who approved it), ZBP (who designed it), nor Multiplex (who was responsible for ensuring that ZBP applied the solution).

70. Reporting to the Board is an internal governance matter for the Project Team. It was not for David Hall or anyone else in Currie & Brown to go over Mr Seabourne's head and report on what was at the time a routine discussion to Mr Seabourne's superiors as suggested in paragraphs 1538 and 1540. As stated above, Currie & Brown did not have the detailed knowledge of the internal line of reporting or the governance procedures internally within GGC to have done so in any event. It was for Currie & Brown to provide project management support in managing the project, not in managing internal GGC governance or reporting procedures about which Currie & Brown had very limited visibility and no authority.

The role of Wallace Whittle

71. Paragraph 550 refers to the oral evidence of Ross Ballingall of Multiplex that ZBP's 'Ward Ventilation Design Strategy' was "*basically put together by Steve Pardy* [ZBP] *and Stewart McKechnie* [Wallace Whittle]*, so Stewart was commenting on it as it was being produced*".[77] Currie & Brown would defer to Wallace Whittle on this point as Currie & Brown (and, presumably, Multiplex) was not privy to all of the discussions between ZBP and Wallace Whittle about this. Subject to that, Currie & Brown's understanding is that ZBP alone wrote the 'Ward

[77] [Transcript, Ross Ballingall, 21 May 2025, Page 26, Column 47].

Ventilation Design Strategy', and that Wallace Whittle merely commented on it. Currie & Brown's understanding is consistent with the evidence of Steve Pardy of ZBP, who describes himself as the "*primary author of the ZBP Ventilation Strategy…supported by the ZBP team with relevant calculation data and QA reviewing, both inhouse and with MPX* [Multiplex]".[78] It is unclear why paragraph 550 refers to the evidence of Mr Ballingall of Multiplex rather than the evidence of the paper's primary author, Mr Pardy. Mr Pardy makes no mention in his statement of working together with Wallace Whittle on the paper.

72. In 2009, Wallace Whittle was part of Currie & Brown's Technical Team, not Multiplex's design team. Currie & Brown did not instruct Wallace Whittle to work on the alternative design solution with ZBP, it merely instructed Wallace Whittle to review ZBP's 'Ward Ventilation Design Strategy' and to advise on it.[79]

73. Similarly, Mr McKechnie was right to say that it was not part of Wallace Whittle's role in 2009 to 'come up with solutions', as recorded in paragraph 1524. Wallace Whittle was not part of Multiplex's design team;[80] it was ZBP's responsibility, as Multiplex's M&E engineer, to come up with the alternative design solution in response to the removal of the maximum temperature variant, and it did so.

74. Paragraph 553 states that Mr Calderwood's oral evidence was that he worked on the basis that "*the technical advisors would have approved*" the Ventilation Derogation. It was not for the "*technical advisors*" (whether Currie & Brown or Wallace Whittle) to "*approve*" any change or derogation; only GGC (as Employer) could do so. Currie & Brown (through its subconsultant, Wallace Whittle) was merely advising on the details of the change being proposed by Multiplex and ZBP to meet GGC's changed requirements. It was always up to GGC to decide not to reduce the maximum temperature variant and to revert to the original proposal if it did not accept that advice. That was a matter for GGC as the Employer.

The status of the Ventilation Derogation

75. Paragraphs 554 to 556 and 1531 refer to evidence given by Mr Hall and Mr Seabourne about whether the agreement of the Ventilation Derogation in 2009 should be regarded as a final agreement. It is respectfully suggested that CTI may have misunderstood this evidence:

    75.1 What Mr Hall was explaining in his oral evidence was merely that the stage in the Project at which the Ventilation Derogation was agreed and recorded in the clarification logs (Stage

[78] [Glasgow 4, Part 1 - Witness Statements, Volume 3, Steven Pardy, Document 1, Page 14, Para 46].
[79] As explained by Mr Baird in [Glasgow IV, Part 1 – Witness Statements, Volume 3, Mark Baird, Document 3, Page 63, paras 89 and 91-92].
[80] At least not until much later, in 2013, when Wallace Whittle acquired ZBP following its administration and took over its role on the Project.

1) was before the detailed design had yet got underway. That is correct as a matter of contract and chronology; the design phase (Stage 2) did not begin until 2010 (after the award of the Main Contract on 18 December 2009). As Mr Hall correctly explained, it was therefore only in 2010 that the alternative design solution that had been agreed in the Ventilation Derogation "*was then designed and developed and approved*" because "*that's when the design was completed*".[81]

75.2 Mr Hall's evidence is correct as a matter of contract: because the design phase (i.e., Stage 2) had not yet begun when the Ventilation Derogation was agreed in December 2009, it was open to GGC, Multiplex, and/or ZBP to revisit the design proposal if, for example, further information came to light or if there was any further change in requirements (albeit this would need to be managed through the change control process, as he explained). It was during the design phase that detailed design development would take place (as indeed is recognised in paragraph 570) – that is the same for **any** design and build contract. Mr Hall's evidence was factually and contractually correct.

75.3 Mr Hall's evidence is also consistent with Ms White's evidence that the Sustainability Log recorded an agreement to review the "*agreed Ventilation Strategy including reduced air changes to the Typical Wards*" and that this review would be carried out "*during Stage 2 as the design developed to a point where the whole building could be thermally modelled*".[82]

75.4 Therefore the suggestion in paragraph 1531 that there is "*not a hint of any such proposition in the contemporaneous documentation*" reflects a misunderstanding of Mr Hall's evidence, or perhaps a misunderstanding of the status of the design during Stage 1 of the Project when the Ventilation Derogation was agreed.

75.5 CTI seemed surprised by this evidence when it came up at the hearing (as acknowledged in paragraph 1530), but that evidence is consistent not only with Ms White's written evidence but also with Currie & Brown's earlier response to PPP 13 dated 29 November 2024 which said as follows:

"*Currie & Brown is not aware of any material lack of knowledge of the Agreed Ventilation Derogation on the part of GGC. In any event, the dialogue referred to in paragraph 38 above, and the engagement by GGC stakeholders during the design development stage described in paragraph 45 above, would suggest that there were opportunities for the Agreed Ventilation Derogation to be interrogated or questioned by GGC from late 2009 onwards*".

[81] [Transcript, David Hall, 22 May 2025, Page 36, Column 67].
[82] [Glasgow 4, Part 1 - Witness Statements, Volume 1, Emma White, Document 1, Page 57, Para 3.7].

76. For these reasons, the insinuation in paragraph 1533 that Mr Hall's "*explanation…has occurred ex post facto*", and may have been 'misleading', is strenuously rejected. It is made without any evidential basis and in circumstances where it appears that CTI may not have fully appreciated Mr Hall's evidence. The evidence that Mr Hall gave is contractually and legally correct; it is no more nor less than an explanation of the fact that when the Ventilation Derogation was agreed the design phase had not yet begun, so the design solution agreed in the Ventilation Derogation was not set in stone and could be revisited if desired, subject to the change control process. It is not clear what exactly is said to be inaccurate about that explanation.

The application of the Ventilation Derogation

77. Paragraph 1591 suggests that there was a "*lack of clarity about the areas to which the agreed ventilation derogation would apply*". It is submitted that there was no lack of clarity; ZBP and Multiplex (who were responsible for the application of the Ventilation Derogation to the design and construction) knew that the Ventilation Derogation applied to standard rooms in general wards (as noted in paragraphs 1584 and 1589), and this has not been disputed in the Inquiry process. The limited application of the Ventilation Derogation was clear from:

77.1 ZBP's 'Ward Ventilation Design Strategy', which says "*[t]he SHTM allows for the natural ventilation of areas including general wards*" and identifies that the recommendation from which derogation is sought is 6 ACH, i.e. the rate that applies to general wards).[83]

77.2 The Clarification Log (as incorporated into the Main Contract) which identified that the derogation applied to "*[a] typical ward in the tower*" and cross-referred to the M&E Clarification Log "*for typical single bed ward*";[84] and

77.3 The M&E Clarification Log (also incorporated into the Main Contract), which identified that Multiplex's proposal applied to areas where "*Ward Air change to be 6AC/HR*", i.e. general wards.[85]

78. For these reasons, the Deficient Features identified in sub-section 8.3.9 (the specialist wards) and sub-section 8.3.10 (the isolation rooms) of the Closing Statement (if they are Deficient Features, which is not accepted for the reasons set out in Section 1, Part 1 above) are unrelated to, and were not caused by, the Ventilation Derogation. The wards discussed in sub-sections 8.3.9 and 8.3.10 were specialist wards, some of them housing patients likely to be neutropenic, and it was always required that the ventilation in those wards would follow the guidance in SHTM 03-01 (which was for 10 ACH). There was never any derogation from that guidance in relation to those specialist

[83] [Bundle 16, Document 21, Page 1657].
[84] [Bundle 17, Document 21, Page 979, row 10.0]. The "*tower*" referred to the QEUH.
[85] [Bundle 16, Document 23, Page 1664].

wards. The fact that the design and construction of those specialist wards does not follow the guidance indicates that something went wrong during the design and/or construction phases, as noted in, e.g., paragraphs 1585, 1590, 1606, and 1616. It was for ZBP to ensure that its own alternative design solution was correctly applied in its design. Design was the responsibility of the design & build contractor (Multiplex) and M&E design was the responsibility of Multiplex's M&E subconsultant (ZBP).

79. It is therefore wrong for paragraphs 1542 to 1543 to dismiss the 'question' of which rooms the Ventilation Derogation applied to as "*largely an academic issue*". If the alternative design solution was acceptable (as the combined expertise of ZBP, Wallace Whittle and, at least later, Mr Hoffman concluded) the real question is how that solution come to be applied much more widely than intended and agreed. That issue does not appear to merit much discussion in the Closing Statement, perhaps because it is assumed and concluded (it is submitted, incorrectly and without proper forensic scrutiny, for the reasons set out in Section 1, Part 1 above) that the Ventilation Derogation was flawed whether it applied to standard rooms in general wards as intended or more widely.

80. Paragraph 1544 refers to the comment in David Loudon's (unapproved and unsigned) draft written statement that he did not recall being provided with information regarding the derogations in the M&E Clarification Log.[86] When Mr Loudon took over from Mr Seabourne as GGC's Project Director in June 2013, as a basic first step he ought to (and may well) have read and familiarised himself with the Main Contract, which included the M&E Clarification Log and the Clarification Log. This is where important technical detail is to be found, as anyone with experience of working in or with the construction industry would know. But in any event, paragraph 1544 proceeds on the assumption that there was something inherently wrong with the Ventilation Derogation. That assumption is unsafe for the reasons set out above. Therefore, even if it is the case that the Ventilation Derogation was not specifically flagged up to Mr Loudon, presumably that was because there was no need to do so, as the relevant parties reasonably believed they had reached an acceptable and appropriate technical solution (which was by then in the process of being constructed).

SECTION 2: RESPONSE TO CHAPTER 5 – NARRATIVE OF EVENTS

81. This section addresses matters (other than those relating to the Ventilation Derogation) raised in Chapter 5, the narrative section of CTI's Closing Statement, which require or may benefit from a response or clarification from Currie & Brown. The headings used in Chapter 5 are adopted for ease of reference.

[86] [Glasgow IV, Part 1 – Witness Statements, Volume 3, David Loudon, Document 8, Page 250, para 31(d)].

5.1.1. PPP 15 - Governance

82. Paragraph 410 refers to the Core Participants' responses to PPP 15, stating at paragraph 410(b) that: "*We note and accept the comments made on behalf of Currie & Brown that that company was not involved in the project before its appointment in February 2008*". However, Currie & Brown was not appointed to the Project until 2 September 2008,[87] as explained in paragraph 6 of its response to PPP 15.[88] It is noted that paragraphs 421 and 473 of CTI's Closing Statement correctly state that Currie & Brown was appointed by GGC on 2 September 2008.

83. Currie & Brown's response to PPP 15 had explained that it was not involved in the Project at the time it attended a market engagement workshop with GGC and others on 19 February 2008, and highlighted that this workshop preceded the appointment of Currie & Brown by over six months.[89]

5.1.2. Key Companies and Organisation

84. Currie & Brown is described in the table in sub-section 5.1.2 as "*lead consultant appointed by Greater Glasgow Health Board*", without any qualification as to the limited time period (2008-2009) or early Stage of the Project (Stage 1) during which Currie & Brown performed this role. Without such qualification this description is not entirely accurate, and may be apt to mislead, because, as explained in previous submissions,[90] Currie & Brown was not ultimately appointed to the role of Lead Consultant on the design and construction phase of the Project (Stages 2 to 4).

85. Currie & Brown does not repeat those previous submissions, but highlights this point again because the role of 'Lead Consultant' on a design and build project is a specific function which is usually fulfilled by the consultant who leads the main contractor's design team during the design and construction phase. On this Project, that consultant was Multiplex's architect, IBI.

86. In short, Currie & Brown was appointed by GGC on 2 September 2008 to provide consultancy services during the initial pre-design and pre-construction phase of the Project (Stage 1A) pursuant to an Invitation to Tender for the "*Agreement for the Appointment of a Lead Consultant and Technical Team*".[91] Currie & Brown discharged that function through the Technical Team it led from 2008 to 2009,[92] but the full services listed in the Invitation to Tender were not, in the event, required to be provided by Currie & Brown following the change in its role after the award of the

[87] By appointment letter from GGC to Currie & Brown dated 2 September 2008 [Bundle 17, document 38, page 1902].
[88] Paragraphs 6 and 7 of Currie & Brown's response to PPP 15 dated 10 July 2025 [Bundle 50, document 2, page 54].
[89] See paragraph 9 of Currie & Brown's response to PPP 15 dated 10 July 2025 [Bundle 50, document 2, page 55].
[90] In paragraphs 1 to 4 of Currie & Brown's letter dated 11 June 2024 [Bundle 21, Volume 2, page 23] responding to Dr Walker's Report dated 21 January 2024; and in paragraphs 7-10 and 16-19 of Currie & Brown's response to PPP 13 dated 29 November 2024 [Bundle 22, Volume 3, document 4, page 7].
[91] [Bundle 17, document 36, page 1814].
[92] Namely, AECOM, Buchan Associates, HLM Architects, and Wallace Whittle.

Main Contract to Multiplex on 18 December 2009, as correctly set out in paragraphs 613 to 615 of CTI's Closing Statement.

5.2.6. Change in funding model from PFI to traditional Design & Build

87. Paragraph 452 refers to a workshop held by GGC in February 2008, the purpose of which was to "*determine the most appropriate public finance procurement route that meets the Board's key objectives*".[93] Paragraph 452 says this workshop was attended by a "*wide range of key personnel*" including GGC, GGC's solicitors, and Currie & Brown, whom it describes as "*the technical team behind the Exemplar Design*". In the context of this workshop in February 2008 this description of Currie & Brown is inaccurate because, as previously explained in response to PPP 15:[94]

87.1 The Procurement Workshop on 19 February 2008 was a market engagement workshop for GGC to explore potential procurement routes for the Project. This workshop preceded Currie & Brown's appointment on the Project (on 2 September 2008) by over six months, as noted above.

87.2 Currie & Brown understands that it was invited to attend the workshop as an external participant because at the time it was engaged on a separate project for GGC, known as the ACAD project.[95] Other external participants in the workshop included Keppie Design (a healthcare architect) and Mott MacDonald (an engineering, management, and development consultancy).[96] The workshop was also attended by Davis Langdon LLP, who was GGC's technical adviser on the Project at the time.[97]

87.3 The "*exemplar design*" referred to in the materials issued for the Procurement Workshop[98] was <u>not</u> developed by or on behalf of Currie & Brown, who was not yet involved in the Project and so had not yet assembled its Technical Team.[99] After its appointment to the Project on 2 September 2008, Currie & Brown was involved in developing the final

[93] As stated in the evaluation form issued in advance of the workshop [Bundle 17, document 34, page 1807].
[94] See paragraph 9 of Currie & Brown's response to PPP 15 dated 10 July 2025 [Bundle 50, document 2, page 55].
[95] The ACAD project involved the design and construction of Ambulatory Care and Diagnostic Centres in the New Victoria Hospital and the New Stobhill Hospital by Balfour Beatty.
[96] The market participants are listed in item 3 of the Agenda for the Procurement Workshop [Bundle 17, document 34, page 1810].
[97] This can be seen from section 1.2 of the 'New South Glasgow Hospitals Design Solution Report' dated July 2007 which describes Davis Langon LLP as "*Project Managers and Lead Consultant*" [Bundle 17, document 32, page 1708].
[98] [Bundle 17, document 34, page 1809].
[99] It appears that this earlier exemplar design was developed by Davis Langdon LLP amongst others: see section 1.2 of the 'New South Glasgow Hospitals Design Solution Report' dated July 2007 [Bundle 17, document 32, page 1708].

Exemplar Design for the Project through its Technical Team; but this took place during the pre-design stage (Stage 1A) from September 2008 to April 2009.[100]

87.4 Therefore, any implication in paragraph 452 that, by the time of the Procurement Workshop on 19 February 2008, Currie & Brown had previously been involved in the Project or in developing any exemplar design is incorrect.

5.3.2 Appointment of Currie & Brown

88. Under the heading "*Appointment of Currie & Brown*", paragraph 474 states (without comment) that, when Multiplex responded to the proposed terms of the Main Contract in its tender documents in September 2008, the "*proposed project manager was identified as Currie & Brown*".[101] For the avoidance of doubt, Currie & Brown was not appointed as Project Manager on the Project. The role of Project Manager was a formal defined role under the NEC form of contract, and an important one, as Shepherd & Wedderburn LLP and Currie & Brown had advised in their joint 'Procurement Paper' to GGC dated 1 December 2008.[102] That role was carried out by GGC. GGC notified Currie & Brown of this by letter from Peter Moir dated 18 January 2010,[103] as noted in paragraph 614.

5.6.4 Changing the role of Currie & Brown

89. Paragraphs 615 to 620 discuss the perceptions or recollections of Currie & Brown's role on the Project held by some of those who gave oral evidence.[104] This was the subject of many questions during the Glasgow IV hearings. Whatever those witnesses believed, or may now recall, about Currie & Brown's role after the award of the Main Contract to Multiplex on 18 December 2009 does not, of course, change the fact of what Currie & Brown was engaged and paid to do, and actually did, on the Project, as CTI have rightly stated in paragraph 1565 of their Closing Statement.

90. Once Currie & Brown's role was changed and its Technical Team was stood down accordingly (on GGC's instructions on 18 January 2010), Currie & Brown ceased to be a 'technical advisor' and ceased to have a Technical Team to call upon for technical advice,[105] as acknowledged in

[100] See the table in paragraph 12 of Mark Baird's witness statement [Glasgow IV, Part 1 – Witness Statements, Volume 3, Mark Baird, document 3, page 45].
[101] [Bundle 43, volume 6, document 29, page 498].
[102] [Bundle 43, Volume 2, document 8, page 100]. The joint 'Procurement Paper' is cited in paragraphs 461 to 462.
[103] The letter stated, "*As the Board are undertaking the role of Project Manager…*" [Bundle 17, document 74, page 2871].
[104] There is also some discussion of this in paragraphs 597 to 599.
[105] Save on an ad hoc 'call off' basis if expressly requested by GGC, as explained in paragraphs 28 and 130-131 of Douglas Ross's witness statement [Glasgow IV, Part 1 – Witness Statements, Volume 3, Douglas Ross, document 10, page 316 and page 349].

paragraphs 1565 to 1566. Any reference to Currie & Brown as 'technical advisor' after that date is therefore mistaken and inaccurate.

91. It was for GGC to communicate the change it had instructed to Currie & Brown's role to (a) the relevant and appropriate people within its own Project team; and (b) its contractor, Multiplex. If and/or to the extent that GGC may have failed to do so, CTI have (in our submission, rightly) recognised in paragraph 1566 that any such failure of communication was on the part of GGC.

92. In any event, Currie & Brown was unaware that anyone in GGC, Multiplex, or its design team was under any misapprehension about the change in Currie & Brown's role, or the nature of that role, after the award of the Main Contract to Multiplex on 18 December 2009. On the contrary, Mr Hall explained in his oral evidence that he recalled and understood that this change had been communicated and was known, as follows:[106]

92.1 He believed there was a "*clear awareness*" on the part of GGC's Project team, and Multiplex and its design team, that Currie & Brown's Technical Team (i.e., "*the people that they had been talking to through competitive dialogue through the employer's requirements preparation*") were no longer around (having been stood down) because "*the team worked out of the one office*", i.e., the Project office in Hillington until around summer 2010 and thereafter the construction site office.

92.2 Mr Hall said that:

> "*From the point of January 2010, those people* [Currie & Brown's Technical Team] *were no longer there, so it was very quickly evident-- would have been very quickly evident to anyone that was engaged in the project that there was, indeed, a change in the way that the project was being designed. The design responsibility had moved over to Multiplex entirely*".

92.3 The change in Currie & Brown's role was communicated at the internal project team meetings led by Alan Seabourne. Mr Hall said that this change, from engaging with Currie & Brown and its Technical Team to engaging with Multiplex and its design team, was communicated after contract award: "*that was part of the discussions around that time about how we moved forward*".

5.6.6 Detailed Design Development Process

93. Similarly, there are a number of references in sub-section 5.6.6 to misperceptions or mistaken recollections of Currie & Brown's role during the detailed design development phase of the Project (Stage 2) on the part of some individuals working for GGC, Multiplex, and its design team.[107] It

[106] [Transcript, David Hall, 22 May 2025, from Page 6, Column 8 to Page 8, Column 12.]
[107] In particular, in paragraphs 636, 650, 653, 654, 656, 663, and 664.

is, however, a matter of record that (following the change in its role after the Main Contract was awarded to Multiplex) Currie & Brown had no design responsibility and was neither qualified nor contractually obliged to review or approve the technical content of the Room Data Sheets or the M&E design, nor did it do so, as CTI have (in our submission, rightly) concluded in paragraphs 1565 and 1566. Under the contractual framework, it was for the design and build contractor (Multiplex) and its specialist M&E designer (ZBP) to design the M&E systems, including the ventilation system, and to seek any clarification or further information that was required. Whilst paragraph 1492 rightly identifies that "*it is not a part of the Inquiry's role to determine issues of contractual liability*", it nevertheless remains relevant to have regard to who was contractually responsible for doing what.

5.7.5 Isolation Rooms

94. Paragraph 723 is not entirely clear but it appears from the context and from footnotes 1185 to 1188 that "*they*" refers to ZBP and "*he*" refers to Steve Pardy of ZBP (not David Hall of Currie & Brown, who is the subject of the preceding paragraph 722). This appears from the context because the matters set out in paragraph 723 were ZBP's responsibility as the specialist designer engaged by Multiplex to design the M&E systems.

5.7.17 Commissioning

95. Paragraph 850 states that H&V's commissioning of the ventilation and water systems was witnessed by, amongst others, "*Wallace Whittle, NHS GGC technical advisors*". This description of Wallace Whittle's role at the time of commissioning is inaccurate because Wallace Whittle was by that time working for and engaged directly by Multiplex. Wallace Whittle acquired ZBP after ZBP went into administration on 28 January 2013, and took over ZBP's role as specialist M&E engineer on the Project under a direct contract with Multiplex dated 7 March 2013,[108] as explained in paragraph 629. Wallace Whittle had therefore belatedly become part of Multiplex's design team by that stage and witnessed commissioning on that basis.

96. Wallace Whittle had ceased to be a 'GGC technical advisor' after being stood down by Currie & Brown in January 2010 and following the final ad hoc work it carried out on a 'call off' basis in 2010 for Currie & Brown at GGC's request.[109]

[108] See paragraphs 9 and 10 of the witness statement of Stewart McKechnie of TÜV SÜD Ltd (formerly Wallace Whittle) [Glasgow IV, Part 1 – Witness Statements, Volume 3, Stewart McKechnie, document 2, page 34].
[109] David Hall explained in paragraph 147 of his first statement that there was only "*very limited*" engagement with Wallace Whittle during the design and construction phase [Glasgow IV, Part 1 – Witness Statements, Volume 2, David Hall, document 6, page 241]. See also paragraphs 28 and 130-131 of Douglas Ross's witness statement [Glasgow IV, Part 1 – Witness Statements, Volume 3, Douglas Ross, document 10, page 316 and page 349].

5.8.2 The first year after handover

97. Paragraph 865 states that David Loudon of GGC and Douglas Ross of Currie & Brown told Mary Ann Kane of GGC that Multiplex's document management system, Zutec, was fully populated following handover. This was not put to Mr Ross (who was not called to give oral evidence). Currie & Brown had no licence to access Zutec for the Project because it had no involvement in or responsibility for technical commissioning.[110] Therefore, even if Mr Ross did say this to Ms Kane, it is highly unlikely that he was speaking from direct personal knowledge; he may have been merely reporting what others had told him.

98. Paragraph 888 refers to the answers that David Hall gave when specifically asked during oral evidence why GGC did not carry out any validation. As was clear from his written statement and his oral answers (although perhaps not so clear from the face of paragraph 888), Mr Hall was speculating about the reasons (as the line of questioning invited him to do) because neither he nor anyone else from Currie & Brown was involved in validation,[111] and he did not know at the time that GGC had not discharged its responsibility to carry out validation.[112]

SECTION 3: CHAPTER 8 - WHY CERTAIN EVENTS OCCURRED AS THEY DID

99. This section addresses matters (other than those relating to the Ventilation Derogation) raised in Chapter 8, the discursive section of CTI's Closing Statement, which require or may benefit from a response or clarification from Currie & Brown. The headings used in Chapter 8 are adopted for ease of reference.

8.3.2 The form of contract between GGC and Multiplex

100. Paragraph 1508 says that Alan Seabourne "*felt the ERs were 'light on design and information' generally*", referring to his oral evidence.[113] It is submitted that this is not a fair comment; and, further, Mr Seabourne's criticism of the level of design detail suggests a misunderstanding of the function and purpose of Employer's Requirements in the context of a design and build project of this nature.

[110] As explained in paragraph 157 of David Hall's first statement [Glasgow IV, Part 1 – Witness Statements, Volume 2, David Hall, document 6, page 243].
[111] As explained in paragraphs 15, 139, and 143-146 to David Hall's first statement [Glasgow IV, Part 1 – Witness Statements, Volume 2, David Hall, document 6, pages 199, 239, and 240]. Mr Hall explained there that Currie & Brown did not provide any advice or support to GGC in relation to technical commissioning or validation as these activities fell within the remit of the NEC Project Supervisor (i.e., Capita).
[112] Mr Hall said at paragraph 146 of his first statement that "*I was unaware of the lack of validation of any areas prior to occupation*" [Glasgow IV, Part 1 – Witness Statements, Volume 2, David Hall, document 6, page 240].
[113] The citation given for this in paragraph 1508 is [Transcript, Alan Seabourne, 29 May 2025, Pages 17-18, Columns 29-32] although this appears to be a summary by CTI of the overall effect of the evidence given over several pages of the transcript rather than a quotation or paraphrase.

101. The Employer's Requirements (which Mr Seabourne accepted were "*substantial documents*")[114] were, by their nature, not intended to be fully prescriptive and detailed design specifications; it was for the design and build contractor (Multiplex) to develop the detailed design after the award of the Main Contract in order to meet GGC's requirements.

102. Mr Baird explained in his witness statement the collaborative and detailed process by which GGC's requirements and objectives were captured in the Employer's Requirements (a process which was led and facilitated by Currie & Brown):

102.1 The Employer's Requirements (which Mr Baird said included "*written information, tables, designs on 1:500 scale, room layouts*") "*set out NHS GGC's objectives, expectations, specifications and performance requirements for the Project*".[115] They were not intended to set out a design; on a design and build project it is for the design and build contractor and its design team to carry out the detailed design development. Rather, as Mr Baird explained, the Employer's Requirements "*identify (through written narrative and drawings) what the employer…wishes to buy*" and capture requirements including "*for example, departmental adjacencies, travel times, lines of sight (bedrooms) and facilities management*".[116]

102.2 Mr Baird further explained that:

> "*The information was captured by Currie & Brown's Technical Team via consultation with the Board as the client. This was obtained through meetings with clinical user groups, discussions with NHS Estates team members and discussions with the Board's Project Team*".[117]

102.3 Thereafter, the contractor's design is required to meet the performance requirements in the Employer's Requirements but, where there are various different ways to achieve those requirements, the contractor has an element of choice. This is intended to allow contractors to draw upon the expertise in their design team to bring forward the most appropriate design solutions and up-to-date methods and technology, and to facilitate innovation (as recognised in paragraph 1497).

103. Further, Mr Seabourne's comment needs to be seen in the context that he acknowledged that "*I had never done an employer's requirement before*".[118] It is understood that Mr Seabourne worked full-time on this Project before retiring in July 2013 whilst the Project was still ongoing. It would therefore seem likely that the Employer's Requirements on this Project were the only employer's requirements that Mr Seabourne has ever had any direct experience of. It is submitted that Mr

[114] [Transcript, Alan Seabourne, 29 May 2025, Page 17, Columns 29,]
[115] [Glasgow IV, Part 1 – Witness Statements, Volume 3, Mark Baird, document 3, page 49, para 23].
[116] [Glasgow IV, Part 1 – Witness Statements, Volume 3, Mark Baird, document 3, page 50, paras 28-29].
[117] [Glasgow IV, Part 1 – Witness Statements, Volume 3, Mark Baird, document 3, page 50, para 30].
[118] [Transcript, Alan Seabourne, 29 May 2025, Page 17, Column 29, line 20].

Seabourne is not, therefore, in a position to reliably comment upon the relative level of design detail and information in the Employer's Requirements on this Project. His comments on the subject should therefore be disregarded.

8.3.8 Who was available to deal with M&E design for NHS GGC?

104. Paragraph 1566 states that, when Heather Griffin of GGC was "*sent off to 'collate' information on the design and sign off process for the BMT Unit in January 2016*", David Hall is "*recorded as confirming that the room designs were compliant 'with relevant SHTMs and SHBN04 Supp 1'.*". This refers to a comment attributed to David Hall in a table[119] produced by David Loudon on 27 January 2016 and circulated by him to various people by email on the same date.[120] This matter was not put to Mr Hall in oral evidence. It is submitted that it should be recalled that Mr Hall explained generally that, in his role providing project management support, he was often the conduit between GGC's Project team and Multiplex:[121]

> "*I was the conduit for M&E matters. So, for example, if there was a question mark over M&E, quite often I would be asked the question and I would then communicate with the appropriate people. Post-2010, of course, that was Multiplex.*
>
> *So there will be emails from me, for example, where people have raised questions. I have actually taken their question, put that into the design management process, and asked Multiplex to come back with their responses, because they were responsible for the design. So I was, I was acting in that role of coordination, but I was not, you know, I'm not qualified, you know, to do M&E.*"

105. It is therefore submitted that, given his lack of M&E expertise, it was likely that Mr Hall was acting as a conduit in January 2016 as opposed to giving his own personal opinion.

106. As to paragraph 1568, the Environmental Matrix was produced by ZBP in November 2010,[122] not in November 2009. Currie & Brown arranged for Wallace Whittle to comment upon ZBP's Environmental Matrix in around November 2010, at GGC's request, on a 'call off' basis.[123]

8.3.19 Governance Arrangements for the new SGH Project

107. Paragraph 1663 refers to a conflict of evidence between Alan Seabourne of GGC and David Hall of Currie & Brown about whose responsibility it was to escalate changes to NSGHLPEB or the PAG and to obtain approval, concluding that:

[119] [Bundle 27, Volume 8, document 73, page 302].
[120] [Bundle 27, Volume 8, document 73, page 300].
[121] [Transcript, David Hall, 22 May 2025, Pages 9-10, Columns 14-15].
[122] NSGH Environmental Matrix, November 2010 [Bundle 43, Volume 5, Document 96, Page 782].
[123] [Glasgow IV, Part 1 – Witness Statements, Volume 3, Douglas Ross, document 10, page 349, para 131].

"*Whilst Currie & Brown were clearly an important part of the process and might have been the communication vehicle for escalation if so instructed, the ultimate responsibility for escalation of changes to the ERs must lie with the Project Team and Mr Seabourne*".

108. As to this conflict, Currie & Brown respectfully submit that:

108.1 CTI is correct to conclude that responsibility for escalation of changes to the Employer's Requirements lay with GGC's Project Team and, consequently, Mr Seabourne as GGC's Project Director.

108.2 However, Currie & Brown had neither the responsibility nor (importantly) the authority nor the knowledge required to escalate such matters to whatever the appropriate governance channel within GGC might have been at the material time. Currie & Brown was generally aware that there were complex reporting requirements and governance structures within GGC's organisational framework, and Currie & Brown was invited to attend meetings of some of these committees on occasion, but Currie & Brown did not have the detailed knowledge required to understand the reporting channels; it had no authority or standing to table any matters for discussion at any of these forums; and it only attended such meetings when invited by GGC to do so in order to deliver presentations for particular purposes.

108.3 Currie & Brown was not part of, or privy to, these internal governance arrangements. Currie & Brown was an external third party corporate entity who could only act on its client's instructions; its authority extended no further.

108.4 For all these reasons, Currie & Brown disagrees with the conclusion in paragraph 1663 that it was "*clearly an important part of the process*" and "*might have been the communication vehicle for escalation if so instructed*".

SECTION 4: CHAPTER 9 - THE INQUIRY'S TERMS OF REFERENCE

109. In accordance with paragraph 5.1 of Direction 12, Currie & Brown addresses below those Terms of Reference in respect of which it has an interest.

Terms of Reference 1: impact of potentially deficient features of ventilation system on patient safety

110. It is accepted that, as stated in paragraph 1741, elements of the ventilation system in the specialist wards and isolation rooms did not follow the guidance in SHTM 03-01 (2009) Draft. To that limited extent only, it is accepted that those parts of the ventilation, as built, did not follow the guidance. However:

110.1 That non-conformance was <u>not</u> due to the Ventilation Derogation, which was clearly limited (and known by all relevant parties to be limited) to standard rooms in general wards.

110.2 The Ventilation Derogation did not amount to non-conformance, and did not give rise to any Deficient Feature, because - for the reasons set out in Section 1, Part 2 above - it was a considered, agreed, and approved derogation from (non-mandatory) guidance and recorded in the Main Contract as such.

110.3 For all the reasons set out in Section 1 above, the Ventilation Derogation was an acceptable design solution to meet the conflict between GGC's reasonable requirement for a reduced maximum temperature variant on the one hand and the recommended air change rates in the guidance on the other hand.

111. Further and in any event, it is clear from the expert evidence discussed in Section 1, Part 1 above that, even in the case of the specialist wards and the isolation rooms, there is no credible or cogent evidence to suggest that any non-conformance with the guidance in SHTM 03-01, whether in the limited respect noted above or at all, had any material adverse impact on any patient or on the safety of the environment, or gave rise to any material risk to patient safety.

112. Paragraph 1745 quotes the conclusion in paragraph 5.32 of the Interim Report that "*a numerically significant reduction of air change rate (4 ac/h rather than 10 ac/h, for example) will bring with it an increase in the risk of infection to relevant patients*". It is respectfully submitted that this conclusion requires to be revisited, and should now be rejected, in light of the expert evidence which has been adduced since the Interim Report was issued, as discussed in Section 1, Part 1 above.

113. The suggestion in paragraph 1754 that, whilst it is "*not possible to know whether the ventilation system in the Schiehallion Unit directly caused infections*", it would be "*unreasonable to conclude that it did not impact on patient safety and care*" is neither explained nor substantiated. In the absence of any credible or cogent evidence of any impact on patient safety and care caused by the ventilation system, it is submitted that it would be inappropriate and unreasonable to do anything other than conclude that this has not been established.

Terms of Reference 2: Arrangements for procurement, supply chain, and contractual structure

114. It is submitted that the processes for agreeing and recording the removal of the maximum temperature variant and the Ventilation Derogation were satisfactory and accorded with both standard industry practice and good practice for the reasons set out in Section 1, Part 2 above.

SECTION 5: CHAPTER 10 - CTI's PROPOSED RECOMMENDATIONS

115. Paragraph 1876(b) says that "*health boards must have in place <u>mechanical and engineering support</u> to mirror that available to the contractor, including architects, structural engineers, M&E*

engineers and other such experts". Architects and structural engineers do not come under the umbrella of "*mechanical and engineering support*"; only M&E engineers do. It is suggested that this recommendation should be reworded to: "*health boards must have in place technical design expertise to mirror that available to the contractor, including…*"

116. The conclusion in paragraph 1877 that "*the most significant issue with the building systems of the QEUH/RHC, arose from a decision, made in the final weeks before contract signature, by a Project Team that did not understand the implications of its decision*" is erroneous and cannot be sustained or substantiated for the reasons set out specifically in paragraph 7 above and generally in Section 1 above. There is a mismatch between the focus on the Ventilation Derogation on the one hand, and the conclusions about the water contamination (which the Closing Statement acknowledges is a more established link with a higher incidence of infections) on the other hand.

117. It is submitted that, for the reasons set out in Section 1 above, there is no credible or cogent basis for a finding that the Ventilation Derogation was an unacceptable design solution, or that it had any material impact on any patients or on the rate of infections, or that it has created any material risk to patient safety. Further and moreover, there is no sound evidential basis for any criticism of those who proposed, accepted, or approved the Ventilation Derogation in December 2009.

LYNNE McCAFFERTY KC

19 December 2025

4 Pump Court, Temple, London, EC4Y 7AN

The Scottish Hospitals Inquiry

The Queen Elizabeth University Hospital and Royal Hospital for Children

Hearing Date: 13 May to 10 October 2025 (Glasgow IV Hearing) – Closing Statement by IBI UK Limited (IBI)

1. INTRODUCTION

1.1 This closing statement is submitted by IBI in response to the closing statement by Counsel to the Inquiry (CTI), distributed to Core Participants on 21 November 2025.

1.2 From the outset of its involvement in this Inquiry, IBI has sought to provide assistance to the fullest extent possible having regard to its role in the issues falling within the Terms of Reference. It remains the intention of IBI to continue to assist the Inquiry in that fashion. That approach is recognised in the closing submission by Counsel to the Inquiry, where it is stated that, "*Ms White went out of her way to assist the Inquiry by formulating her own analysis of how problems might have arisen.*"[1]

1.3 IBI has limited its closing statement only to matters upon which it considers itself able to offer material assistance to the Inquiry. In this regard, IBI would draw the Inquiry's attention to its own remit within the QEUH Project which did not extend to the design of the MEP systems. IBI understands that the ventilation system was designed by TUV SUD, the MEP consultant. Mercury Engineering, the MEP subcontractor, also bore design responsibilities.[2]

1.4 Furthermore, IBI understands that the water system was designed by TUV SUD, who took over that role from ZBP with Mercury Engineering, the MEP subcontractor, also bearing design responsibilities. IBI's understanding is that WSP UK Limited, the Civil Structural subcontractor, was responsible for below ground drainage. IBI's involvement in relation

[1] *Closing Statement of Glasgow IV by Counsel to the Inquiry, Page 474, P*aragraph 1548.
[2] *IBI bases this understanding on the Consultant Coordination Matrix annexed to its own appointment. See Part Two of Schedule 2 of NEC Professional Services Contract between Brookfield Construction (UK) Limited and Nightingale Architects Limited dated 18 June 2010*

to the water and drainage systems was limited to the specification of materials in areas of sanitary ware.

1.5 Due to IBI's relatively limited involvement, and in line with paragraph 5.1 of Direction 12, this closing statement is accordingly restricted to the issues identified in TOR1. However, it is also considered necessary to respond to certain observations made within CTI's closing statement and, for ease of reference, these are now addressed in turn.

2. CHAPTER 1

2.1 IBI has no observations on this section of CTI's Closing Statement.

3. CHAPTER 2

3.1 As above.

4. CHAPTER 3

4.1 As above.

5. CHAPTER 4

5.1 As above.

6. CHAPTER 5 – NARRATIVE OF EVENTS

Paragraph 425 of the Closing Statement

6.1 Paragraph 425 of CTI's Closing Statement records that an email of 22 August 2008 (from Dr John Hood to Ms Myra Campbell) "specified that no chilled beams were to be installed in the haemato-oncology wards". Despite this, they became a feature of the Schiehallion Unit. CTI suggests that Emma White of IBI "could not explain" why chilled beams were installed.[3]

6.2 Albeit there is no evidence that this email was ever brought to Ms White's attention, in her evidence to the Inquiry she confirmed that she had reviewed the documentation, and

[3] *Closing Statement of Glasgow IV by Counsel to the Inquiry, Page 143, Paragraph 425.*

her assumption was that the M&E team had understood that the rest of the Schiehallion Ward, beyond the isolation rooms, was to be treated as a standard ward.[4] She did not know the reason for this assumption, but she explained that the design was reviewed in M&E workshops (involving ZBP and the client).[5]

6.3 Within the same paragraph, CTI summarises Emma White's evidence that chilled beams were not prohibited in healthcare premises, "but the emphasis being now placed more on research before installation."[6] It is submitted that Ms White's evidence on the point was more nuanced than that. She stated to the Inquiry that chilled beams were still used in hospital designs, including the current project in which she was working.[7] She considered that the latest guidance on chilled beams, from 2021, was much more detailed than before, and that the onus was now on everybody to understand the implications, and assess the risk, of their use.[8]

Paragraph 535 of the Closing Statement

6.4 Paragraph 535 of CTI's Closing Statement summarises Emma White's evidence that there were no specific single rooms in the ADB which identified immunocompromised patients. For context, it may assist the Inquiry to consider the evidence given by Emma White in her statement (confirmed in her evidence to the Inquiry) in relation to the process by which ADB room codes were developed into Room Data Sheets.[9] The draft RDS batches were developed by Tribal (the healthcare planner) with the GGC NHS project team using the SoA version provided by the NHS which allocated their suggested ADB briefing code. Later in her statement Ms White states that the responsibility for populating information/data into the RDS lay with the NHS initially, assigning ADB Brief/room codes to each room via their SoA, confirming their required brief.[10] Tribal reviewed and ensured the latest version of ADB was used and prepared the draft template RDS. The Clinical Brief/Actively Data was exported into excel and issued to the NHS to review and

[4] Transcript, Emma White, 13 May 2025, Page 91.
[5] Ibid, Pages 91-92.
[6] Closing Statement of Glasgow IV by Counsel to the Inquiry, Page 143, Paragraph 425.
[7] Transcript, Emma White, 13 May 2025, Page 71, Column 138.
[8] Bundle 2, Document 5, Page 360.
[9] Glasgow IV – Bundle of documents for Oral hearings commencing from 13 May 2025 – Witness Statements Volume 1, Page 203, question 30A.
[10] Glasgow IV – Bundle of documents for Oral hearings commencing from 13 May 2025 – Witness Statements Volume 1, Page 205, question 34A.

validate/check that the clinical briefing information data was correct. The environmental data was exported and issued to ZBP (M&E) for reviewing, checking and populating as required. IBI would have reviewed the finishes page and the equipment data with input from ZBP for the mechanical and electrical equipment. Ms White also confirmed that the M&E Engineers ZBP were responsible for populating the environmental information and data into the RDS.[11]

Paragraph 616 of the Closing Statement

6.5 The correct footnote reference for footnote 953 should be pages 9 -10 and columns 13 - 16.

Paragraph 690 of the Closing Statement

6.6 IBI submits that, whilst the content of this paragraph is correct, the footnote 1107 does not appear to accord with the contents of the paragraph; this appears to be due to an error in the footnoting.

Paragraph 1512 of the Closing Statement

6.7 Footnote 2696 is incorrect, it should be instead page 69 and column 133.

7. CHAPTER 6 – STATUTORY REGULATION AND GUIDANCE

7.1 IBI has no observations on this part of CTI's Closing Statement.

8. CHAPTER 7

8.1 The Inquiry's determination of issues raised in this chapter will be dependent upon its assessment of the evidence and, when necessary, resolving inconsistencies in the evidence. IBI has no observations which it believes would assist the Inquiry in that task.

[11] Glasgow IV – Bundle of documents for Oral hearings commencing from 13 May 2025 – Witness Statements Volume 1, Page 205, question 35A.

9. CHAPTER 8

9.1 The Inquiry's determination of issues raised in this Chapter will be dependent upon its assessment of the evidence and, where necessary, resolving inconsistencies in the evidence. IBI has no observations which it believes would assist the Inquiry in that task.

10. CHAPTER 9

10.1 IBI offers no observations in relation to this part of CTI's Closing Submissions. It is for the Inquiry to be satisfied that it has received sufficient evidence, in the form of witness statements and oral testimony, in order to meet its Terms of Reference.

11. CHAPTER 10

11.1 The following observations are made by IBI in an effort to assist the Inquiry in its task of making recommendations.

11.1.1 Ventilation Design

The recommendations contained within the current HTM03-01 **Specialised ventilation,** published in 2021,[12] address many of the ventilation design issues of interest to the Inquiry. It should be noted that the implications of the Covid-19 pandemic are still being assessed, although the updated HBN 04-01 supplement 1[13] appears to have been amended to incorporate the lessons learnt, and there is now clarity on the differences in the design of isolation rooms required specifically for immune-compromised patients.

11.1.2 Water Safety/Design

NHS England have released updated design requirements which apply to all healthcare settings, **NHS Estates Technical Bulletin (NETB) No.2024/3.**[14] IBI invites the Inquiry to acknowledge the updated technical requirements mandated in England with a view to those requirements being implemented in Scotland.

[12] *Bundle 2, Document 5*
[13] *Bundle 2, Document 11*
[14] *NHS Estates Technical Bulletin (NETB) No.2024/3, available here: https://www.england.nhs.uk/publication/nhs-estates-technical-bulletin-netb-no-2024-3/*

11.1.3 Expanded Health and Life Safety Impacts in Healthcare Design

IBI draws the Inquiry's attention to the principles of the "*golden thread*" of fire and safety design in high-risk buildings introduced under the Building Safety Act 2022. The Inquiry might consider there to be some benefit in adopting similar principles in relation to water safety and ventilation design in healthcare construction projects.

11.1.4 Derogations

The Inquiry may benefit from considering NHS England's processes for managing and reporting derogations from estates technical standards and guidance. The NHS England process is designed to ensure that any derogation is appropriately reviewed from a risk assessment perspective by all parties. Design risks should be added to the project design risk register and appropriately managed through the design and construction stages of any project through to handover and beyond.

Dated this 19 day of December 2025

Murdo MacLeod KC

Womble Bond Dickinson (UK) LLP, Solicitors for IBI (UK) Limited

Scottish Hospitals Inquiry

Closing Statement by NHS National Services Scotland

following the conclusion of the Glasgow IV hearings from 13 May to 10 October 2025 in respect of the Queen Elizabeth University Hospital/Royal Hospital for Children, Glasgow

1. This closing statement is prepared pursuant to the Chair's Direction 12. NHS National Services Scotland ("NSS") responds to the closing statement prepared by Counsel to the Inquiry ("CTI"), with reference to paragraphs 4 to 6 of Direction 12.

Matters of clarification in respect of CTI's closing statement Chapters 1- 8

Section 4.2 The consideration of the HAD Report by the Inquiry

2. Section 4.2 addresses the Inquiry's consideration of the Hawkey, Agrawal and Drumright ("HAD") Report. NSS considers that it would be useful to set out its position on this topic.

3. NSS has already produced detailed responses to the epidemiological analyses, including those by Sid Mookerjee and the HAD authors. It stands by those responses and does not repeat them here. Particular reference is made to NSS' closing submission to the Glasgow III hearings at paragraphs 26 to 35 (Core Participants' Closing Submissions Bundle, pages 155 to 159).

4. With regards to the HAD report, NSS notes that the original report dated 24 July 2024 concluded that the data did not support the hypotheses that the water or ventilation systems were in an unsafe condition (Bundle 44, Volume 1, Document 1, page 10). It concluded that the data did not demonstrate a link between the water or ventilation systems and patient infections (Bundle 44, Volume 1, Document 1, page 11).

5. NSS' position on the original report remains unchanged (Bundle 44, Volume 2, Document 45, pages 687-688 at paragraph 1.5).

6. The position of the HAD authors evolved during the Glasgow IV hearings. Dr Drumwright acknowledged in her evidence that the environment could have contributed to infections (Transcript, 21 August 2025, pages 78-79, columns 152-153). Professor Hawkey accepted that the data was consistent with some of the infections being caused by exposure to the hospital water system (Transcript, 27 August 2025, page 80, column 155). Dr Agrawal confirmed that his initial impression that there was no "signal" of increased infection rates changed following further analysis (Transcript, 22 August 2025, page 44, column 83).

7. NSS welcomes this evolution, which resolves a number of its earlier concerns. The main outstanding limitation is the absence of clinical or environmental context. This may be due to the restrictions on the HAD authors' remit (see, for example, Bundle 44, Volume 5, Document 1, page 18 at the answers to questions 49 and 50). NSS considers, however, that such context is essential to proper interpretation of the data. For example, if infection rates have fallen it is contextually relevant that environmental controls have been implemented. Similarly, if infection rates have increased it is contextually relevant that there are known issues with contamination of the water system. This approach of the HAD authors contrasts with other analyses, including that produced by Antimicrobial Resistance and Healthcare Associated Infection Scotland ("ARHAI")/Health Protection Scotland ("HPS"), that was discussed at the interdisciplinary Incident Management Team ("IMT") and was informed by all the context available at that time.

8. A further limitation of the HAD report is the exclusion of *Mycobacterium spp.* from the list of environmental organisms. This exclusion removes non-tuberculous *Mycobacteria*, which have been implicated in hospital outbreaks related to water sources (see NSS' discussion of this issue in Bundle 44, Volume 2, Document 45, page 690 at paragraph 3.1.3). Further, *Mycobacterium chelonae* was one of the few organisms where a potential link was made between the patient and environment in NHS Greater Glasgow and Clyde ("NHS GGC") using whole genome sequencing. This investigation was published by NHS GGC in an academic journal and was included in evidence in Bundle 18, Volume 1, Document 52, page 3550.

Section 4.3.3 Patient groups considered by the HAD Authors

9. Paragraph 221 on pages 71-72 states that Ms Cairns suggested that: "While 'South Sector' patients (4C) would be a better comparator, however, using 'before' and 'after' figures for them would raise the problem of trying to directly compare Queen Elizabeth University Hospital ("QEUH") and Yorkhill." In fact, she was suggesting that the comparison would have similar issues to comparing Royal Hospital for Children ("RHC") and Yorkhill (Transcript, 20 August 2025, page 24, column 44).

10. Paragraph 221 on pages 71-72 also states that Ms Cairns suggested that "the best way to run a comparison would be by using QEUH itself as the control, and by comparing Blood Stream Infection ("BSI") incidence rate figures from 'before' and 'after' interventions." Ms Cairns did not say that using QEUH and comparing before and after interventions is the best way to compare but did acknowledge that such analyses were commonly used epidemiological studies (Transcript, 20 August 2025, page 25, column 45).

Section 4.3.4 Dr Lydia Drumright

11. Paragraph 226 on page 73 notes Dr Drumright's surprise that Ms Cairns had been able to work from Healthcare Scotland bed day data. In fact, Ms Cairns' evidence was that the bed days data used by NSS is a national activity dataset held by Public Health Scotland (not Healthcare Scotland) (Transcript, 20 August 2025, page 27, column 50).

12. Paragraph 233 on page 77 states that "in around March 2014 the incidence rate begins to drop lower than the overall trend, but then begins to turn upward in around September 2015, and steadily increases to well above the trend until around January 2018 after which it changes (at a point which is approximate)." All dates when the trend in rates changed in the Generalised Additive ("GAM") models should be considered approximate. The GAM models are simple. They are not an exact measure of when the rate changed (Ms Cairns Transcript, 20 August 2025, page 36, column 67).

Section 4.3.6 Dr Samir Agrawal

13. Paragraph 282 on page 92 notes that Dr Agrawal's view is that "despite the views of NHS NSS, a formal de-duplication exercise for Aspergillus could not be done for those infections, given the nature of this invasive fungal disease and how (unlike with BSIs) a successful treatment does not necessarily mean a patient becomes free of Aspergillus." In fact, NSS was also concerned regarding the lack of information available to assess the impact on the final interpretation of either conducting or not conducting a de-duplication exercise. There was no information regarding patients with multiple samples or who were counted more than once in the case numbers. This would have greatly assisted in interpretation of the final conclusions (Bundle 42, Volume 2, Document 45, page 702, paragraph 4.2).

Section 4.4.2 Ms Shona Cairns

14. Paragraph 310 on page 100 states that "Ms Cairns concluded that the Environmental and Enteric Group used by HPS358 came closest to – and was broadly comparable with – the environmentally relevant group used by the HAD Authors." While the two groups were broadly similar, there was one important difference: Atypical *Mycobacteria* were included in the HPS analysis but were put in a non-environmentally relevant list by the HAD authors (Bundle 7, Document 6, page 219).

Section 4.4.6 Mr Mookerjee

15. Paragraph 344 on page 113 notes that "the degree of correlation between the two sets of peaks and dips would be of value, which it so proved, giving a p-value of about 0.7". The figure quoted is a correlation coefficient and not a p-value.

16. Paragraph 348 on page 114 refers to Ms Cairns' concern in relation to confounding in the comparison between the NHSGGC patients and the comparator hospitals. It notes that, in his response to NSS criticism, Mr Mookerjee "drew attention to the graph charting the rate of infections per 1000 admissions provided by NSS agreeing that it largely aligns with the analysis done by him and other authors." For clarity, the graph only features NHSGGC data. Therefore, it is not affected by the type of

confounding introduced when making comparisons between patient populations so does not support Mr Mookerjee's defence of the challenge.

17. Following Mr Mookerjee's oral evidence, NSS commented on further comparator analyses undertaken by Mr Mookerjee at the request of CTI (Bundle 44, Volume 9, Document 4, page 46). NSS concluded that it is not valid to calculate and interpret the rate ratio comparing the NHS GGC rate with the comparator organisations. Mr Mookerjee responded to the NSS report stating that the criticisms noted by Ms Cairns "make no material difference to the validity of the conclusions drawn in my report" (Bundle 44, Volume 9, Document 6, page 58). The response from Mr Mookerjee did not change the NSS position regarding the validity of the comparison. It remains that making unadjusted external comparisons with other institutions is significantly limited and directs focus away from considering the epidemiological situation within NHS GGC and the impact on patients during that time.

18. Following conclusion of the oral evidence a further report by Mr Mookerjee entitled "Response to the following two documents - Dr Dominique Chaput additional statement 2025-09-26 final and 20251109 NSS Mookerjee IRR response Final" was circulated to core participants through Objective Connect on 17 November 2025. (Bundle 44, Volume 9, page 58). NSS wishes to make the following observations about specific paragraphs of this adminicle of evidence:

    i. With regard to Paragraph 2 (d) (iii to iv), NSS does not criticise the rate ratio calculations and methodologies. The limitations noted by Ms Cairns in her evidence were specifically in relation to lack of comparability due to inconsistency in deduplication; lack of adjustment for confounding to adjust for likely significant differences in the groups being compared, and possible remaining data errors. These points were not made in the relation to the methodology itself, rather the appropriateness of the application by Mr Mookerjee to this specific scenario and the patient groups involved.

    ii. With regard to Paragraph 2 (d)(v), "Incidence rate ratio" is a more specific description of a "rate ratio". Given that the ratio is of two

incidence rates, the term “rate ratio” is interchangeable with “incidence rate ratio”. It is not possible to “mix up” incidence rate ratios and rate ratios as they are the same measure when comparing incidence rates. Rate ratios are also reported as <1 and >1. In Paragraph 2(d)(vi) Mr Mookerjee asks for scientific references when the points made are specifically in relation to his analysis. Understanding the effects of confounding in this analysis is the role of the person undertaking the analysis- the answer to this question will not be found in scientific literature. Mr Mookerjee may not have had access to data required to adjust for confounding. His conclusions should have acknowledged this limitation when interpreting the data.

Section 4.5 CTI Submission to Key Question 4

19. Paragraph 391 on page 129 states that “there is an area of inconsistency that does require to be addressed. That is that Dr Drumright concludes there was a long-term reducing trend of environmentally relevant BSIs at Yorkhill from 2005 to 2015. That is not the view of Ms Cairns, who did not think there was such a trend”. Ms Cairns' view is based on the analysis in Figure 2.4 where Dr Drumright describes the trend in environmental BSI in Yorkhill Hospital between 2008 and 2015. Dr Drumright states that this trend “did not quite reach statistical significance”. Accordingly, it should not be interpreted as a long-term reducing trend (Bundle 44, Volume 7, page 57, paragraph 2.3.2).

20. Further, taken together, the epidemiological analyses presented by the HAD authors and others have used different organism lists, case definitions, denominators, and statistical techniques. NSS has at times disagreed with these methodological choices. Nevertheless, when viewed together, the analyses show consistent patterns: an increase in bloodstream infections caused by environmental organisms following the move to QEUH/RHC, and a subsequent decrease after control measures were implemented. NSS considers that the consistency of this pattern across independent analyses strengthens confidence in the overall epidemiological picture. The consistency across multiple epidemiological reports is referred to in CTI’s Closing Statement at paragraph 399b in support of CTI’s conclusions regarding a link

between patient infections and features of the water system in the hospital. NSS maintains the position as noted in Key Question 4 of its Glasgow III Closing Submission that the evidence presented is consistent with a link.

Section 5.12.3 The Perspective of NHS Scotland Assure on the Ward 2A and 2B refit

21. Section 5.12.3 on pages 337-339 discusses the perspective of NHS Scotland Assure on the Ward 2A and 2B refit. NSS would like to make the following points in clarification:

    i. There was evidence at the hearings about the involvement of NHS Scotland Assure in the refurbishment of Wards 2A and 2B. NSS wishes to make clear that it was willing to assist with the issue of ventilation, but its help was not sought on that issue. As explained in Ms Critchley's witness statement (Witness Statements Bundle, Volume 4, pages 225-227), in June 2021 NHS GGC approached NHS Scotland Assure for support for the ongoing refurbishment project at Wards 2A and 2B. The support sought and therefore provided by NHS Scotland Assure was limited to the domestic water installation. The scope of support was outlined in Terms of Reference agreed between NHS Scotland Assure and NHS GGC (Bundle 52, Volume 2, Document 7, page 72). The agreed scope of support given by NHS Scotland Assure did not include any final "sign off" site inspections or review of handover documentation. In her oral evidence, Ms Critchley confirmed that NHS Scotland Assure did not attend NHS GGC meetings about the refurbishment works, as it was not asked to attend (Transcript, 8 October 2025, page 10, column 15). She explained that NHS GGC had technical support from AECOM (Transcript, page 10, column 16). Mr Beattie had been the technical advisor at AECOM but then joined NHS Scotland Assure, and NHS GGC had wanted some continuity around support. Mr Beattie attended site on numerous occasions when asked by NHS GGC and provided observation reports and photographs (Transcript, page 10-11, column 16-18). He had site visits on 22 July, 5 August and 8 October 2021 (Transcript, page 12, column 19). He was not signing off or handing over, that would be for the technical adviser of NHS GGC (Transcript, page 12, column 20).

ii. In her oral evidence Ms Critchley updated the Inquiry on events of December 2021. On 6 December 2021, NHS Scotland Assure employees Ian Storrar and Annette Rankin attended a NHS GGC water group meeting, having been asked to attend as 'critical friends' i.e. they were there in an advisory capacity (Transcript, 8 October 2025, page 13, column 21- 22). There were emails between NHS GGC and NHS Scotland Assure (Transcript, page 14, column 23-24). These are now found at [A54531933]. These include an email from Ian Storrar and Annette Rankin dated 7 December 2021 to NHS GGC's Sandra Devine and Tom Steele, referring to the previous day's meeting to review water sampling results, and posing a number of questions about Wards 2A and 2B, in relation to both water and ventilation systems. This email included an offer to provide ARHAI/HFS support if requested into Wards 2A and B. This support offered was in relation to both water and ventilation. A later email from Annette Rankin dated 21 January 2022 to NHS GGC's Tom Steele and Sandra Devine referred to a meeting which took place on 17 January 2022. It summarised NHS GGC's requests, and noted that validation for ventilation was being undertaken and no ARHAI/HFS support was requested for this. In this email, ARHAI/HFS offered to establish a Short Life Working Group ("SLWG") to support NHS GGC's repatriation of children back to Wards 2A and 2B (as referred to in Ms Critchley's witness statement at paragraph 28: Witness Statements Bundle, Volume 4, pages 233). By email response dated 28 January 2022 to Annette Rankin, Tom Steele posed a number of questions on which NHS GGC required guidance to enable completion of the project, but did not accept the offer of a SLWG as "even a SLWG may delay the project significantly with the resultant patient harm" (as referred to in Ms Critchley's witness statement at paragraphs 26 and 29: Witness Statements Bundle, Volume 4, page 233).

iii. In her oral evidence Ms Critchley confirmed that in February 2022, the Chief Nursing Officer ("CNO") requested that NHS Scotland Assure,

NHS GGC and the CNO's team meet to review the position as to the opening of Wards 2A and 2B (Transcript, 8 October 2025, page 15, column 25-26). Ms Critchley re-iterated that NHS Scotland Assure was not asked to provide support about ventilation, rather it was asked to help support NHS GGC and give some assurance that the water was safe within the unit. NHS Scotland Assure worked on a pathway provision, a framework to show what needs to be done, for NHS GGC, to mitigate the risks based on the principles of a Key Stage Assurance Review ("KSAR"). The responsibilities still lay with NHS GGC (Transcript, page 16 and 18, column 27-28, and 32). She explained that there was not a KSAR process in place. The refurbishment project was quite far along by the time NHS Scotland Assure was established in June 2021 (Transcript, page 18, column 31). In terms of the criteria for a KSAR, something like rebuilding the ventilation system of Ward 2A would not qualify as it would not exceed the health board's delegated authority level, but the health board could still request support outwith the healthcare build KSAR (Transcript, page 17, column 30).

Section 5.13 HAI Reporting in compliance with the NIPCM

22. Paragraph 1122 on page 349 states, "However, Ms Imrie when the meetings with Ms Devine had stopped, there was a change in who was reporting in incidents. It was more ICNs than ICDs. They were not seeing the same incidents." For clarity, Ms Imrie meant that they were not seeing the same number of issues around reporting – not that fewer incidents were being reported (Transcript, 25 September 2025, page 41, columns 77-78).

23. In regard to paragraph 1124 on page 349 and for clarity, NSS notes that in Ms Imrie's evidence when she used the word "we" she was not suggesting that ARHAI lacked the requisite understanding. She was referring to the NHS GGC/NSS Senior Management Group established by NHS GGC/NSS Chief Executives (Transcript, 25 September 2025, page 43, columns 78 and 81-82).

24. Further, NSS considers that it would be useful to set out its position on HAI reporting in compliance with the National Infection Prevention and Control Manual ("NIPCM") this topic.

25. NSS confirms that there have been longstanding issues over NHS GGC's reporting of infections to ARHAI. In her oral evidence, Ms Imrie was asked about the NHS GGC Standard Operating Procedure (SOP) on HAI reporting with an effective date of December 2023, which she had not seen prior to it being provided to the Inquiry by NHS GGC (now in Bundle 27, Volume 17, Document 28, page 315; Transcript, 26 September 2025, page 9, column 13-14). She explained her concern that, according to this SOP, a Problem Assessment Group ("PAG") could be stood down if NHS GGC decided that there was no significant risk to public health and/or patients, without there being any definition or criteria for that risk having been assessed. The lack of reporting to ARHAI as a result could lead to national intelligence being missed. Also, when separate assessments are introduced, this affects the quality of the data which ARHAI has (Transcript, page 10-11, column 15-17). When referred to Version 3 of the SOP, with an effective date of April 2025, Ms Imrie confirmed that, given the changes in it, it was compliant with the NIPCM but ARHAI had not been made aware that NHS GGC had changed to Version 3 in April 2025 (Transcript, pages 12 and 15-16, column 19-20 and 26-27).

26. In her oral evidence, Ms Imrie confirmed that her weekly meetings with Ms Devine stopped in around November 2024. Ms Devine stopped the meetings saying they had served a purpose (Transcript, 26 September 2025, page 39, column 73). The meetings had started in the beginning of 2023, in relation to NHS GGC's reporting of incidents and sharing of information. After that, ARHAI had done some training sessions with the Infection Control Nurses ("ICN") in NHS GGC around the outbreak reporting template (Transcript, 26 September 2025, page 39-40, column 74-76). Ms Imrie explained in her evidence that there is still an issue that needs to be addressed in relation to reporting in terms of Chapter 3 of NIPCM and the role of ARHAI when it asks questions. Facilitated development sessions with the wider team have been suggested (Transcript, 26 September 2025, page 41, column 77-78). She was referred to the Situation, Background Assessment, Recommendation ("SBAR") document

"NSS and GGC collaborative working re IPC reporting" dated 19 September 2025 (Bundle 52, Volume 7, Document 60, page 483). She explained that now if NHS GGC are following the SOP Version 3 they should be reporting per the NIPCM, but she is aware that there may be more subjective views about how cases fit into the criteria and some work may need to be done in development sessions around that (Transcript, 26 September 2025, page 43, column 81-82). She confirmed that there have not been equivalent or similar difficulties with HAI reporting with any other health board (Transcript, 26 September 2025, pages 46-47, column 88-89). For NHS GGC, Professor Gardner spoke about the loss of trust between the NHS GGC Infection Prevention and Control team ("IPCT") and ARHAI in their working relationships (Transcript, 9 October 2025, page 54, column 103) and the processes now in place with weekly meetings, Version 4 of the SOP and development work (Transcript, 9 October 2025, page 59, column 113-114). NSS welcomes these recent developments.

27. There was evidence about the issue of *Cryptococcus* cases, and the delay in NHS GGC providing information sought by ARHAI. NSS want to emphasise that the context for ARHAI seeking information was the request to it by the Scottish Government to review the details of cases identified at the QEUH (see Ms Imrie's witness statement, Witness Statements Bundle 4, document 3, paragraphs 20-30). In her oral evidence, Ms Imrie confirmed that the final information sought by ARHAI was produced by NHS GGC on 20 July 2025 (Transcript, 26 September 2025, page 23, columns 41-42). In her oral evidence, Professor Gardner explained that she had become aware in July 2025 that there was a request for information, she had queried why it had taken so long to respond, and she had asked for it to be expedited (Transcript, 9 October 2025, page 40, column 75). She was then referred to a letter of 20 August 2025 from Caroline Lamb (Bundle 52, Volume 5, Document 31, page 144) in which there was a request for information to be provided to the Scottish Government. Professor Gardner commented "I also think it's of concern that, from July, no one had come back…. to say "We need further information" but I think what we can see throughout this, and we'll continue to come back to that, is there is clearly a tension in the relationship between the NHS GGC Infection Control team and ARHAI". NSS notes that the request for more information was a direct request from

Caroline Lamb, for the information deemed necessary to be provided to the Scottish Government. ARHAI had no role in this follow up request by the Scottish Government. This follow up request cannot reasonably be regarded as evidence of any tension in the relationship between the NHS GGC IPCT and ARHAI.

28. Evidence was heard from Ms Critchley and Ms Imrie on the challenges to NHS Scotland Assure's national role in monitoring incidents, when health boards do not comply with Chapter 3 of the NIPCM. (Transcript, 23 September 2025, pages 10 and 16, columns 15-16 and 27-28; Transcript, 16 September 2025, page 45, columns 85-86). In her supplementary witness statement produced for Glasgow IV Part 2 (Witness Statements Bundle Volume 3, Document 2, page 14, paragraph 4), Sandra Devine states that reporting all triggers may benefit national intelligence but risks undermining the clinical judgment of health board IPCTs. NSS notes that there has been no evidence produced in support of that claimed risk. Ms Imrie's evidence was that: "Triggers are what should alert you to start an investigation. It doesn't necessarily mean that you have an incident because you have a trigger" (Transcript, 25 September 2025, page 5, column 6). In other words, triggers are what should alert the local IPCT to investigate. It is during such investigation that the criteria for reporting should be considered in line with the NIPCM.

Section 6.3.2 Guidance: Ventilation

29. NSS notes that the exclusions referred to in paragraph 1195 on page 372 have now been removed from HBN 04-01 Supplement 1 (July 2025 version). That guidance now makes provision for other types of isolation facilities. Consequently, SHPN Note 04 Supp 1 was withdrawn in September 2025.

Response to CTI's Chapter 9 - the Inquiry's Terms of Reference

30. NSS has an interest in all of the Inquiry's Terms of Reference except Term of Reference 8, which relates to matters out with NSS's knowledge and expertise, where NSS considers that other Core Participants will be better able to assist the Inquiry. In addressing all remaining Terms of Reference, as required by Direction 12, NSS

agrees with CTI's proposed responses in Chapter 9, under exception of the specific points set out in paragraphs 32 and 33 below.

31. Specifically, in relation to Term of Reference 1, given the additional evidence heard during Glasgow 4 since NSS' closing statement following the Glasgow 3 hearings, NSS now agrees with CTI's proposed response to this Term of Reference. As regards Term of Reference 4, NSS agrees and considers that not disclosing the DMA Canyon reports impacted risk management and potentially patient outcomes. Dr Inkster's evidence was that "This would have enabled a much clearer understanding of the issues and more rapid implementation of control measures, which would in turn have led to a reduction in the risk of infections and a reduction in the resultant harm to patients" (Witness Statement of Teresa Inkster, 1 October 2024, page 26, paragraph 61). NSS, in supporting the incident, would also have benefited from having all the available relevant information.

32. Regarding the discussion relating to Term of Reference 5 at paragraph 1828 on pages 566-567, for the purpose of clarification, NSS considers that Mr Baxter's reference to CEL 19 (2009) ("Capital Investment Manual for NHS Scotland") should be made to CEL (2010) 19 (Policy on Design "Quality for NHS Scotland").

33. Regarding Term of Reference 7, paragraphs 385 and 1833 lists steps taken "under the leadership of Professor Steele" to remedy issues with the water system. NSS notes however that these actions were put in place by the IMT subgroup that was supported by both HPS and Health Facilities Scotland ("HFS") (Bundle 10, Document 1, page 7).

Response to CTI's Chapter 10-Recommendations

34. NSS agrees with the Edinburgh recommendation at paragraph 1875.b). However, the recommendation would be more effective if broadened out beyond mid-project changes in the funding model or procurement route. It should also apply to significant changes in the user requirements project brief or developed technical solution in order to ensure that the design and specification reflect such a change.

35. NSS agrees with the Edinburgh recommendation at paragraph 1875.d). NSS previously advised that it was working on producing a standard derogation process (Closing Submission Bundle Edinburgh 3, February 2024, Document 7, page 360, paragraph 8). By way of update, NSS has now produced the draft SHTN 00-06: Derogation Identification and Management Guidance. As Ms Critchley gave evidence on, this is currently undergoing a formal consultation process and is expected to be published in the first quarter of 2026. (Transcript, 8 October 2025, columns 56-57).

36. The Edinburgh recommendation at paragraph 1875.f) includes that NHS Scotland Assure should consider whether and how to provide health boards with more detailed information about common errors and issues experienced with projects than is currently provided. NSS notes that this may require an obligation on the part of health boards to share detailed information about common errors and issues experienced with projects. There is currently no proposed recommendation to that effect and therefore to enhance the effectiveness of this recommendation, NSS suggests that an obligation to share such information with NSS is included in this recommendation.

37. NSS agrees with the Edinburgh recommendation at paragraph 1875.g). However, NSS suggests that this recommendation should apply to all hospital projects as opposed to being limited to revenue funded projects. The method of funding is ultimately irrelevant as SHTM 03-01 does not, and should not, differentiate between contract types. NSS notes that there are no immediate plans to undertake any revenue funded projects; these procurement routes were discontinued several years ago. With regard to independent validation, NSS also suggests replacing ‘on behalf of’ with ‘by direct appointment by’ to ensure consistency with the terminology used in SHTM 03-01.

38. NSS agrees with the Edinburgh recommendation at paragraph 1875.i) but suggests that it be broadened. There were gaps in the knowledge of clinical, technical, and project management professionals. Accordingly, it would be useful for the proposed

basic training to be provided not just to IPC professionals and clinicians but to all project roles.

39. Regarding the proposed recommendation at paragraph 1876, NSS has a number of suggestions:

    i. As it currently stands, the recommendation would cover every single new large healthcare project. This seems unnecessarily broad. If the recommendation as drafted is applied, in some situations it would require a further legal review of over-arching New Engineering Contract ("NEC") templates that have already been drafted and reviewed by legal experts, for example, 'Frameworks Scotland' and 'Hub' contracts (this commonly refers to Scotland's national Hub Programme, managed by the Scottish Futures Trust). NSS notes that the Frameworks Scotland example uses standardised NEC contract templates incorporating standardised processes and structure, which are then applied to individual healthcare project call-offs by NHS Scotland. Framework Guidance via the Advisory Team within NHS Scotland Assure is available to provide direction on specific queries related to the NEC contract templates, including when legal advice is required. Therefore, NSS suggests that the proposed requirement for legal advice could be restricted to: (i) significant amendment to NHS Scotland agreed templates, (ii) bespoke procurement, (iii) any new and untested contracts, (iv) or when non-standard forms/non-industry standard contracts are being proposed for use.

    ii. If a legal review is required, this should be done at the outset of a project to ensure any issues with the potential procurement and delivery routes are identified prior to entering into contract. NSS notes that doing so mid-project, for example during the outline business case ("OBC") development phase, may be too late.

    iii. Regarding paragraph 1876.a), NSS disagrees with the recommendation as it is currently worded. The NEC suite of contracts

(including NEC3 and NEC4) is an industry standard for public sector procurement across the UK. The 'obligation of co-operation' is an NEC contract condition and is integral to the ongoing management of the contract. The specific detail of how both parties intend to operate this is typically a project governance matter which can be set out in the appropriate section of the contract and associated documents, as required. NSS would also note that not all NEC projects are 'design and build' and the design team may be directly appointed by the client in some projects delivered under an NEC contract.

iv. NSS welcomes the intent behind paragraph 1876.b). However, the phrase "mirror" could be construed as requiring a replicated design team (sometimes referred to as a "shadow design team"). Whilst this may be appropriate under certain circumstances, it would not be appropriate in all circumstances. For example, in a design and build contract it could be appropriate, where client appointed technical advisors or a shadow team could provide assurance for the contractor's design proposals. But in a project using a traditional procurement approach, where the design team is directly appointed by the client, it may not be necessary to have a full shadow team. NSS further notes that not all NEC projects are design and build, and the design team can be directly appointed by the client in some projects delivered under an NEC contract. A full shadow design team could potentially even be counterproductive in certain contract arrangements, and NSS is particularly concerned about the risk of confusion regarding demarcation of liabilities and responsibilities for the design. "Shadow" teams of designers/technical advisors can also lead to additional time, cost and complexity on projects that is not necessary or proportionate. NSS suggests a less prescriptive proposed recommendation, such as that health boards should implement an appropriate level of independent technical due diligence on all projects. The exact form of this will be dependent on the size and complexity of the project, as well as the contract type and

procurement approach (e.g. design and build, traditional, and alliance) being implemented.

v. As regards 1876.b), health boards should also ensure that there is a full design and construction quality assurance plan in place for all projects which clearly identifies roles and responsibilities, as well as tasks to be undertaken, such as key milestone design reviews.

vi. NSS is concerned about the workability of paragraph 1876.c). In particular, the proposed role is beyond the professional capacity of one individual. For example, to carry out its own role NHS Scotland Assure deploy a team with a range of professional disciplines to undertake reviews and assurance. A similar multi-disciplinary team response would be required by health boards in order to carry out the proposed requirement. NSS refers to its comments in relation to 1876.b) above regarding technical advisors and due diligence and suggest that these activities at 1876.b) and c) be combined.

40. NSS does not support the proposed recommendation in paragraph 1877 as it currently stands:

i. Additional scrutiny after OBC may be too late as by this point health boards are often in contract, and key decisions about project structure, governance and roles and responsibilities have already been taken and may be difficult to influence.

ii. NSS does not consider that additional legal advice alone would necessarily identify some of the construction specific and technical points that this recommendation likely seeks to address.

iii. NSS considers that if additional scrutiny is being recommended, it is important to consider the technical nature of the issues likely to be problematic and therefore technical advice would be required.

iv. Health boards are individual legal entities and are accountable for the delivery of their projects. It may therefore be appropriate for any advice to be commissioned directly by the health board rather than by the Scottish Government to maintain this separation of responsibilities and avoid any conflict or duplication. It may be more appropriate for the Scottish Government to require health boards to commission such advice and to receive a report from a health board detailing this at key milestones.

v. NSS would further note that it is important for health boards to seek suitable legal advice, where appropriate, and technical advice throughout the life of a project. For clarity, NSS is supportive in principle of the proposal for additional scrutiny on projects, however it is important to consider the above factors in relation to any recommendations.

vi. With respect to the observation made by CTI, as described in paragraph 1877, "it seems unlikely that systems now introduced by NHS Scotland Assure would have been able to influence the decision, had they been in place", NSS notes that both KSAR and NHS Scotland Design Assessment Process ("NDAP") processes require health boards to demonstrate that technical designs are appropriately developed and governed, including approval of briefing requirements and derogations. These processes would have provided opportunities at earlier stages to identify concerns - such as reduced air change rates and their impact on compliance with SHTM 03-01 and the Scottish Non-Domestic Technical Handbook well before contract signing. As Scottish Government funding approval currently depends on a supported status from KSAR and NDAP, this would also have allowed escalation to key stakeholders and resolution of issues.

vii. NSS acknowledges that the KSAR/NDAP process assumes no major changes to key technical strategies after milestone approval and before contract signing. In practice, this depends on health board transparency

i.e. sharing information in relation to any changes after milestone approval.

41. On the proposed recommendation in paragraph 1878 regarding Project Managers, NSS suggests that this recommendation is updated and use of the word "external" in relation to Project Managers is deleted. NSS notes that whilst most large projects do appoint external Project Managers, this is often due to capacity as opposed to capability reasons. There is a finite number of experienced and competent external Project Managers for healthcare project delivery in Scotland and there are a number of highly competent, skilled and experienced health board Project Managers who would be excluded if the recommendation was implemented as it stands. The Project Management structure is already part of the management case forming part of the OBC and full business case ("FBC"), reviewed by the Capital Investment Group ("CIG") as part of the Scottish Capital Investment Manual ("SCIM") process. This recommendation could seek enhanced scrutiny of this element.

42. NSS supports the recommendation at paragraph 1879. NSS notes that a commission from the Scottish Government would be required to take forward this work. It would also require partnership working across NHS Scotland in which the Scottish Government takes a leading role on ensuring that its implementation is fully costed and resourced, noting that this could be a significant undertaking.

43. Regarding the proposed recommendation at paragraph 1880, NSS opposes referring to selected and/or abridged elements of the guidance, including adding headlines or key points. There is a risk that adding sections or key points from guidance may result in other parts of the guidance being overlooked or omitted. The correct approach to use of the NHS Scotland Assure guidance is to consider it holistically.

44. The proposed recommendation at paragraph 1882 applies to contracts for "major" projects. NSS suggests that rather than 'major' this should be replaced with 'all projects with ventilation systems classified as "critical" under SHTM 03-01 Part A'.

45. NSS agrees with the proposed recommendation at paragraph 1883. However, it notes that due to the volume and complexity of information requiring review, and in order to be effective, the exercise should be an iterative process completed through a series of workshops, which would require significant resource (internal and/or external technical alongside technical participation). NSS would therefore suggest that this recommendation is expanded to note that the project programme should be extended to accommodate this and that this is considered as protected time within the programme.

46. Regarding the proposed recommendation at paragraph 1885:

    i. NSS notes that, in relation to NSS producing "a specific volume and process for use in larger scale projects," NSS is planning an update to SHFN 30. NSS will engage with relevant stakeholders across NHS Scotland on how HAI-SCRIBE process flows can be developed for projects of all sizes and complexities. This will help to ensure that HAI-SCRIBE remains effective for all projects, including large, complex new builds, major refurbishments, minor ad hoc projects, routine lifecycle activities, and preventative maintenance.

    ii. NSS considers that changes to HAI-SCRIBE will not fully resolve the issues around gaps in the IPCT workforce. To achieve that objective, the Scottish Government will have to support health boards' recruitment and training of IPC specialists. A long-term national recruitment and retention plan will be required.

47. NSS proposes that the recommendation in paragraph 1886 should be widened. Stage 4 of HAI-SCRIBE should include a requirement to confirm that all appointments are in place for Responsible, Designated and Authorised Persons and Authorising Engineers as required under SHTM guidance, including SHTM 03-01 and SHTM 04-01.

48. Regarding the proposed recommendation at paragraph 1897, NSS notes that the recommended review as to whether there is a need for a regulator should take into

account possible unintended consequences from such a change. In particular, NSS is concerned that such a regulator, which would need staff, would put further strain on health board IPC capacity. A comprehensive cost-benefit analysis would be required.

49. The proposed recommendation at paragraph 1898 gives NHS Scotland Assure a role in agreeing when the noted risk can come off the NHS GGC corporate risk register. It is unlikely that NHS Scotland Assure would ever be comfortable agreeing that the risk of another organisation can come off. This could require assessing individual patient notes alongside any controls put in place. NHS Scotland Assure is not an inspector. NHS GGC is responsible for its own risks, issues, controls, and mitigation monitoring.

50. Below are some broader submissions that may be of assistance when considering any broadening of NHS Scotland Assure's role:

    i. The role of NHS Scotland Assure is prescribed by the Scottish Government, so any extension of its role to include a regulatory role would require legislation. NSS considers that there would be challenges if NHS Scotland Assure is required not only to provide support but also to regulate or intervene. As Ms Critchley said in her oral evidence, NHS Scotland Assure's relationship with the health boards is built on collaboration and trust, and it is approached for help regularly by health boards. Health boards may not be so keen if they thought NHS Scotland Assure would "mark their homework instead of working collaboratively" (Transcript, 8 October 2025, page 59-60, column 114-115). Ms Imrie in her oral evidence said ARHAI functions very well as a support to health boards, it works in collaboration with them to provide an IPC service. If ARHAI was turned into a scrutiny organisation, it would lose the support it has (Transcript, 26 September 2025, page 30, column 55).

    ii. NSS acknowledges the evidence given by Fiona McQueen, Jeane Freeman and others around this matter, and it would be keen to be an active participant in any future discussions around roles regarding support and regulation, and the remit of national organisations.

51. Regarding paragraph 1899 of CTI's Closing Statement, NSS supports the recommendation for risk assessment of ventilation provision and would suggest that this needs to also consider patient placement and assessment of occupancy to ensure that adequate ventilation is provided. NSS understands that the single bedrooms at the QUEH rely on mechanical ventilation to provide fresh air as per the recommendations of the Scottish Non-Domestic Technical Handbook Clause 3.14.5c, and as noted in paragraph 1182 of CTI's Closing Statement. NSS suggests that the recommendation is amended to make it clear that the risk assessment should demonstrate how the mechanical ventilation systems are meeting these requirements and that, if deficiencies are identified, appropriate mitigations are implemented, which may include limiting the number of sedentary occupants. This amendment would also allow a fuller assessment of current provision where the number and type of occupants and/or mechanical ventilation volumes may vary.

52. NSS suggests the following wording for recommendation 1899: "As part of a risk assessment of the mechanical ventilation of the single patient bedrooms in the QEUH that solely receive fresh air supply (from mechanical ventilation), NHS GGC should demonstrate that the minimum fresh air provisions as detailed within Scottish Non-Domestic Technical Handbook Section 3.14 are achieved. Where compliance cannot be demonstrated, NHS GGC, with immediate effect, should implement appropriate contingency measures which could include limiting the maximum sedentary occupants within the rooms relative to the amount of fresh air being provided to the space through the mechanical ventilation system."

53. As regards the proposed recommended training in paragraph 1902, NSS suggests that this recommendation is expanded to consider the wider estates and facilities workforce across NHS Scotland. A revised recommendation should include establishing a national multi-agency programme with key stakeholders (NHS Education for Scotland ("NES") and the Scottish Government) to develop the estates and facilities workforce. This will help directly address the current system gap for these staff groups and will ensure that training and workforce resource is appropriately supported across NHS Scotland.

Recommendations Proposed by NSS

54. NSS proposes a new recommendation that work on a national IPC electronic surveillance solution should be completed through to implementation. The Scottish Government has developed an OBC but funding has not yet been secured (Glasgow IV Witness Statements, Volume 1, pages 18-19, paragraph 28). NSS suggests the solution should be centrally funded and rolled out across Scotland. The business case is for a system that includes local and national functionality. The system would support local surveillance and IPC case management alongside the development of national intelligence on HAIs, including unusual organisms presenting environmental risk. The benefits of such a system were raised in NSS's Glasgow III closing submission (Core Participants' Closing Submissions, page 152, paragraph 17) and reinforced in Ms Imrie's supplementary statement (Glasgow IV Witness Statements, Volume 4, page 191, paragraph 13). Sandra Devine of NHS GGC also noted the scoping work being undertaken by the Scottish Government in her statement (Glasgow III Witness Statements, Volume 7, page 432, paragraph 123) in the context of the importance of electronic surveillance to support IPC efforts locally.

55. NSS proposes a new recommendation in relation to developing an environmental sampling methodology and infrastructure in NHS Scotland. There are gaps with defined sampling strategies and capacity to undertake reactive testing and typing or whole genome sequencing in response to environmental incidents or outbreaks. NSS, in collaboration with Public Health Scotland ("PHS"), is exploring options for provision of an environmental testing and reference laboratory service (Bundle 44, Volume 3, page 214). Any future national reference laboratory service would require to be costed and such services are commissioned by PHS in partnership with NHS National Services Division ("NSD"). A national laboratory service that provides environmental testing support and capacity to all health boards would support them in this priority area.

Another issue arising out of the Glasgow IV Part 3 hearings

56. There was some discussion of the role of NSD in Gary Jenkins' evidence (Transcript, 16 September 2025, pages 74-75, columns 144 -145). For the avoidance of doubt, NSD's role is limited to commissioning, funding, and oversight of the specialist clinical service. It is not responsible for clinical governance, infrastructure commissioning, or operational management of service moves. The health board remains solely responsible for ensuring that facilities and buildings are fit for purpose and meet required build and operational standards. NSD has no role in this regard.

NHS National Services Scotland

19 December 2025

Scottish Hospitals Inquiry

Closing Submissions on behalf of Dr Teresa Inkster, Dr Christine Peters, and Dr Penelope Redding

Helen Watts KC and Leigh Lawrie KC

December 2025

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Introduction

1. Dr Inkster, Dr Peters, and Dr Redding (the "Whistleblowers")[1] are substantially in agreement with the position taken by Counsel to the Inquiry ("CTI") on all material matters. Attempts have therefore been made to avoid simply repeating points already made by CTI in this document. Instead, the focus has been on additional matters and on clarifications which the Whistleblowers wish to highlight for the Chair in considering the way forward. For the avoidance of doubt, the submissions previously made on behalf of the Whistleblowers at the conclusion of the Glasgow III hearings are adopted.

2. The Whistleblowers' profound concerns about the organisational culture of the IPCT within GGC, both past and present, have only grown throughout the lifespan of this Inquiry. The attitude that GGC has taken to the Inquiry is set out by Professor Cuddihy who has told the Chair about his concern "*about the reluctance of the board to accept expert scrutiny*" which he believes "*reflect[s] a broader cultural problem in governance and accountability.*"[2] The fact that Professor Cuddihy felt compelled to take the time to record this view, in the immediate aftermath of the tragic loss of his daughter, should not be lost sight of. In her own final statement to the Inquiry, Molly Cuddihy was keen to emphasise her gratitude to the medical teams caring for her for their enormous skill and care, but to note that "*the same cannot be said for the management of NHS GGC and I feel the evidence they have given only highlights that fact. Their utter contempt for the entire process has been clear and the total disregard they've shown for the patients and their families has been startling[3]".*

3. The Whistleblowers are gravely concerned that, as matters stand, clinicians working in GGC and beyond are likely to be less, rather than more, inclined to raise concerns standing the treatment which the Whistleblowers have so publicly been subjected to by GGC for

[1] Dr Inkster, Dr Peters, and Dr Redding are referred to as "the Whistleblowers" in this submission for the sake of brevity, although Dr Inkster was never technically a whistleblower.
[2] Second Supplementary Statement of Professor John Cuddihy, 1 July 2025, para. 19.
[3] Supplementary Statement of Molly Cuddy, 1 July 2025, Page 2.

raising concerns in good faith, that have been consistently demonstrated to have been well founded.

4. It is enormously comforting to the Whistleblowers to have their position so comprehensively vindicated by the overwhelming evidence before the Chair, as set out in CTI's submissions. The recommendation that they receive apologies is very much appreciated by the Whistleblowers and is welcomed in the spirit in which it was no doubt intended by CTI. However, should the Chair be minded to accept this recommendation, the Whistleblowers would wish to highlight that an apology given many years after events, at the behest of a public inquiry, offers little, if any, evidence of any genuine contrition.

5. The Whistleblowers have no confidence at all that the current personnel in the IPCT at the RHC and QEUH, and the management team of Director for Infection Prevention and Control (Sandra Devine), and the Lead ICD (Dr Linda Bagrade[4]) are capable of, or indeed desirous of, implementing the sort of fundamental cultural change that is required, despite Professor Gardner's somewhat nebulous attempts to reassure the Inquiry of steps that might be taken in the future. The Inquiry should not be persuaded by a last-minute attempt by the current Chief Executive to turn around the tidal wave of criticism, disrespect, and ill will that has characterised the GGC approach to the Whistleblowers for the last decade.

6. The Inquiry should remember that Dr Peters remains in the full-time employment of GGC. Professor Gardner gave evidence over two months ago. Nothing has changed. No one in Dr Peters' chain of line management has ever offered any support or encouragement of any sort to Dr Peters, much less an apology, although she continues to be well supported by clinicians and other colleagues, many of whom have thanked her privately for her courage in taking their shared concerns forward. They recognise that she has paid a heavy price for doing so. No contact has been made or even attempted by Professor Gardner who Dr Peters has still never met or spoken to. In fact, she has never met any CEO or Chair

[4] Dr Linda Bagrade has not been called to give evidence to the Inquiry, despite several requests from the Whistleblowers that she should do so.

of GGC. With the exception of being at two meetings that Dr Armstrong attended (the 2017 SBAR meeting and a single meeting in 2014) she has never met a medical director of GGC either. Dr Peters experience is that the organisational culture in which she works, which causes her profound concern and which caused or contributed to many of the events that the Inquiry has had to consider, is entirely unchanged.

7. This failure to change is perhaps unsurprising, given that many of the individuals involved in the events considered by the Inquiry remain in very senior positions; indeed, some have been promoted so that they now have even more power and influence. For example:

8. **Professor Tom Steele** is the current Director of Estates and Facilities for GGC. His attitude to the raising of patient safety concerns by the Whistleblowers is exemplified by the following closing remarks which he made in response to the question *"[i]s there anything further that you feel could be of assistance to the Inquiry?*":

> "Since joining NHS GGC I have experienced the most demanding and paradoxically rewarding challenges of my career, and in particular throughout 2019/20. In hindsight some of this has undoubtedly been detrimental to my overall wellbeing and that of my family. **The deliberate actions of others to systematically undermine the efforts of those charged with managing these complex issues was extremely challenging and stressful for many**. They did nothing other than to **fuel the unfounded concerns** of already anxious patients, relatives and staff. In essence, **these cynical actions**, allied to intense media scrutiny created a working environment that was in effect under siege.[5]"

In relation to this passage, Professor Steele was asked only three questions. Was he referring to Dr Peters? Was he referring to Dr Redding? Was he referring to Dr Inkster? He responded "no" to each question.[6] This answer was simply not credible. When set against all the evidence before the Chair regarding his attitude and approach to Drs

[5] Statement of Professor Tom Steele, Para. 216 (emphasis added).
[6] Transcript of Professor Tom Steele, 4 October 2024, Columns 119-120.

Peters and Inkster in particular, Professor Steele's evidence on this point should be rejected. It is abundantly clear that, at a minimum, he was criticising both of these doctors, there being no sensible alternative explanation and certainly none offered by him. As the Whistleblowers have previously submitted, his unwillingness to commit to that position during his evidence demonstrates an ill-fated attempt at self-preservation at the expense of giving honest evidence to the Inquiry. However, what is perhaps more important to note in this closing stage of the Inquiry is that Professor Steele is still in a senior leadership position in GGC. He is one of those tasked with setting the tone and culture of the organisation. The implications of this, in view of the necessity for drastic change, are extremely worrying. There is no evidence to allow the Inquiry to conclude that Professor Steele would deal any differently with any whistleblower in the future.

9. **Professor Angela Wallace** is a member of the GGC Board and holds the position of Nurse Director. Professor Wallace's statement to the Inquiry included the following passage which was rightly described by CTI as containing "*pretty hefty criticism…of Drs Peters and Inkster*":[7]

> "On taking up my role, I remained as the HAI exec lead in NHS FV and within only a few weeks the Covid-19 pandemic began and all NHS Scotland systems moved into the gold command structures to face these unprecedented times. I assessed the style and tone of leadership and relationships akin to any other system including my home board, NHS FV. **The behaviours of colleagues who have raised concerns, Dr Peters and Dr Inkster, were however something I had not experienced before despite almost 40 years continuous NHS experience.** The overarching desire of all colleagues appeared to be in the service of patient care and provision of quality services. However, as I began to lead in my role, I began to create new conditions in which colleagues could move forward or reset and the largest part of this was the impact and consequences of the behaviours. The scale of trauma or moral injury I

[7] Transcript of Professor Angela Wallace, 25 October 2024, Column 67.

witnessed was significant. The OD plans, including individual coaching appointments and OD support in the Buzz meetings, did not have the impact I had hoped for and **Dr Peters continued to challenge IPC decisions regarding the management of infection incidents in QE and RHC. This hampered new ways of working that were tentatively building. Unfortunately the pattern prevails today.**"[8]

When challenged by CTI to explain the above comments, Professor Wallace said "*"behaviours" are not always bad behaviours*" and, despite only naming Dr Inkster and Dr Peters, tried to retrospectively argue that "the behaviours/that experience were across a range of colleagues".[9] Again, the lack of candour and, indeed, of ownership of the serious criticisms which were committed to writing in her formal statement to the Inquiry provide a concerning insight into the attitude and approach of a senior leader within GGC to the raising of patient safety concerns and the organisation's failure to effectively respond to them. In addition, the statement reflects the fact that Ms Wallace still regards Dr Peters' actions in "*continuing to challenge*" as being, essentially, troublemaking, rather than rightly pointing out serious patient safety issues that were not being adequately dealt with. There is no evidence to allow the Inquiry to conclude that Ms Wallace would deal any differently with any whistleblower in the future.

10. **Dr Emilia Crighton** is also a member of the GGC Board and is the Director of Public Health for GGC. Based on her evidence to the Inquiry, Dr Crighton's credibility and reliability was seriously impugned in the closing submissions of CTI at the end of the 'Glasgow 3' hearings.[10] It is to be borne in mind that leaders in public bodies should promote the seven principles of public life, often referred to as the Nolan principles.[11] Two of those are integrity (the obligation to be truthful) and leadership (which includes the obligation to actively promote and robustly support the Nolan principles and to challenge poor

[8] Statement of Professor Angela Wallace, Para. 185 (emphasis added).
[9] Transcript of Professor Angela Wallace, 25 October 2024, Columns 67-68.
[10] Closing Statement by Counsel to the Inquiry following 'Glasgow 3' hearings, Pages 104-106.
[11] Bundle 51, Volume 1, Page 19, Para. 4.1.

behaviour wherever it occurs).[12] At the conclusion of this Inquiry it is far from clear that Dr Crighton has discharged these important obligations and there is no evidence to suggest that she can be trusted with helping the organisation to undertake the fundamental overhaul of its unhealthy culture towards the raising of patient safety concerns. There is no evidence to allow the Inquiry to conclude that Dr Crighton would deal any differently with any whistleblower in the future.

11. **Sandra Devine** is the Director of Infection Prevention and Control for GGC. She has been a constant presence in the IPCT at the QEUH from 2015 to date. As CTI observed in their closing submissions following the 'Glasgow 3' hearings, she "*participated in many of the events on which the Inquiry has heard evidence*".[13] Indeed, as a then Infection Control Nurse Consultant for GGC, she was also part of the IPCT which was the subject of the Vale of Leven Inquiry.[14] Ms Devine's position was that she had had no substantive involvement with the new build. Analysis of the available minutes makes it clear that this is not correct[15]. Ms Devine misled ARHAI about the unacceptable circumstances in which Dr Inkster was removed from the chairmanship of the IMT. While Ms Devine described her explanation to ARHAI as an "*overstatement*" on her part, she did not offer any explanation about why or how that "*overstatement*" came to be made on such a critical matter at such a sensitive time.[16] Second, she cancelled the weekly meetings between herself and ARHAI.[17] Given the fraught current relationship between ARHAI and GGC, it is to be queried whether cancelling this meeting demonstrated a constructive attitude to addressing the problems. Third, she was in post as Director of Infection Prevention and Control for GGC when ARHAI raised concerns that GGC was not reporting HAIs in compliance with Chapter 3 of NIPCM. As highlighted by CTI in their submissions, Ms Devine's evidence when asked about this issue was concerning in terms of its "deflection" and its failure to tell the Inquiry that GGC had, by the time of her statement, changed its SOP or Framework on HAI Reporting in April 2025 to a version clearly in compliance with

[12] Bundle 51, Volume 1, Page 20, Para. 4.1.
[13] Closing Statement by Counsel to the Inquiry following 'Glasgow 3' hearings, Page 54, Para. 120.
[14] See e.g., Bundle 51, Volume 1, Page 499.
[15] Bundle 13, Page 486.
[16] Transcript of Sandra Devine, 3 October 2024, Columns 143–144.
[17] Closing Statement by Counsel to the Inquiry following 'Glasgow 3' hearings, Page 79, Para. 221.

Chapter 3 of NIPCM.[18] Further, her grasp of the requirements set down in Chapter 3 of the NIPCM is also of concern, given her position. Fourth, Ms Devine is Director of the current IPCT which prepared and submitted the November 2024 SBAR titled "NHS GGC IPCT response to the public criticism of our approach to case management and reporting of *Cryptococcus* sp. Cases to ARHAI".[19] This document is discussed later in these submissions but it contains serious, baseless, allegations challenging the professional integrity of "*whistleblowers, ARHAI colleagues and experts appointed to the Public Inquiry"*.[20] The Chief Executive – in her evidence to the Inquiry at least – appears to disavow this document.[21] However, Ms Devine (and indeed Dr Bagrade) must accept responsibility for this SBAR. There is no evidence to allow the Inquiry to conclude that Ms Devine would deal any differently with any whistleblower in the future.

12. Dr Peters has, on a number of occasions, become aware of serious HAIs resulting in the deaths of patients not being reported to ARHAI in a timely manner by the GGC IPCT. That continues to the present day, and includes a report which Dr Peters felt compelled to make in the week of CTI's closing submission being received. One might assume, given the recent history of the IPCT in the QEUH, that the team would simply err on the side of caution and report any cases to ARHAI where there was even arguably a requirement to report, even if they were not convinced that there was a requirement to do so. This does not appear to be the approach that they are taking.

13. The above observations are made to alert the Chair of the landscape into which the Inquiry's recommendations will be made. After the considerable time, effort and money which has been invested into this Inquiry and given the importance of the issues which the Inquiry has been asked to determine, the recommendations which emerge must effect real change. The Whistleblowers submit that change can only be made if the deeply entrenched negative attitudes to the raising of patient safety concerns, and indeed, GGC's whole organisational culture, is completely swept away. The Whistleblowers recognise

[18] Closing Statement by Counsel to the Inquiry following 'Glasgow 4' hearings, Para. 1113.
[19] Bundle 52, Volume 5, Pages 148-150.
[20] Bundle 52, Volume 5, Page 150.
[21] See, e.g., Transcript, Professor Jann Gardner, 10 October 2025, Page 53, Column 101.

the magnitude of the task ahead for the Chair. The following submissions are intended to assist the Chair with that task.

Clarifications and Additional Points relating to the Evidence of Specific Factual Witnesses

Jonathan Best

14. There were passages of Mr Best's evidence in which he clearly failed to adhere to the Nolan Principles of integrity, objectivity, accountability, openness and leadership. It was clear from his questionnaire that he had made little, if any, effort to meaningfully engage with a significant proportion of the questions which the Inquiry had put to him. He was critical of the Whistleblowers for the step one whistleblow in 2017 on the basis that it was too soon. He wilfully disregarded the fact that at this point they had been raising the same concerns, repeatedly, without success, for over two years. He repeatedly obfuscated during his evidence when he was asked whether the concerns which were raised were valid, for example in the following exchange:

    Mr Connal KC: "The question put to you [in your statement was] in your view, were Dr Peters, Dr Redding, and other microbiologists raising valid concerns? Answer "in my personal opinion if the issues were raised and escalated via the agreed internal managerial and professional structure many of the concerns would have been dealt with at the time". Well firstly you haven't answered the question, were these valid concerns?"

    Mr Best: "well, I wasn't involved in the original raising of their concerns, so I wouldn't know if they were valid or not, but I think – as I've said, I'm a firm believer in exhausting the agreed management professional processes before we get to whistleblowing or complaints…[22]"

15. At no point was Mr Best ever able to actually identify a failure in process by the Whistleblowers. His evidence amounts to a criticism of the Whistleblowers for proceeding with a whistleblow at too early a stage, when the whistleblowers in question had been

[22] Transcript of Jonathan Best, 19 September 2025, Page 100, Columns 194 – 195.

raising serious concerns, without success, for over two years. This is exemplary of the attitude that the Whistleblowers were confronted with.

Dr Scott Davidson

16. The Inquiry should not be reassured by Scott Davidson's evidence. His statement that GGC are already doing "*everything we can*[23]" to ensure that its organisational culture encourages whistleblowing is plainly wrong. His inability to provide a straight answer to the question of whether the whistleblowers deserved an apology takes up almost 7 columns of transcript[24]. One might have thought that this was an issue he might have applied his mind to before he gave evidence, such that he would know what his clear response would be if asked about it.

Professor Brenda Gibson

17. It might be worth adding to the end of CTI Closing Submission paragraph 291 that Professor Gibson specifically stated that (in relation to environmental organisms) "*You know, we're not seeing them since we've had a refurbished unit and we probably didn't see them maybe from 2019 onwards. I know there's quite a lot in the statements about a decline in 2018. I think I would personally put it at 2019. So* ***we had a period from 2017 to 2019 when I think most of us thought there was an increased incidence of positive blood cultures***". When asked whether this had been an issue since the unit had been refurbished, she replied "*no, absolutely not*"[25].

Jan Gardner

18. Much like the new Medical Director, Dr Davidson, the Whistleblowers submit that the Inquiry should not be reassured at all by the evidence given by the new CEO Professor Gardner. A great deal of her evidence was difficult to follow due to its sheer verbosity.

[23] Transcript of Scott Davidson, 9 October 2025, Page 22, Column 40.
[24] Transcript of Scott Davidson, 9 October 2025, Columns 41, 44, 45, 46, 47, 48 and 49.
[25] Transcript of Professor Gibson, 19 August 2025, Page 7, Column 9 (emphasis added).

The decision to attach the SBAR to her letter to the Scottish Government,[26] and therefore simply to repeat the unacceptable and baseless allegations contained within it, represents a grave error of judgement. Her evidence that she "*meant no disrespect to anyone within it*"[27] is not plausible. The content of the SBAR and the allegations contained within it can scarcely be described as anything other than disrespectful. The SBAR, as framed, accuses individuals (including, it would appear, Dr Peters – one of her employees) of actions which would clearly amount to professional misconduct if proven, without ever discussing those allegations with the individuals in question or asking for their perspective. This is precisely the sort of failure that arose at an earlier stage (see, for example, events relating to Dr de Caestacker's report[28]) and confirms that nothing has changed. It also reflects the unacceptable approach taken by GGC in its first Positioning Paper (discussed below). She had to concede that she didn't even know whether the Rectification Board existed or not[29].

19. Her evidence about her ability to deliver the necessary program of change was essentially just a series of "management speak" platitudes about "*hackathons*", "*getting out and about*", "*unpacking*" information and seeing and hearing "*under the hood*"[30], and falls far short of the reassurance that the Inquiry should require at this stage.

Jane Grant

20. Jane Grant's evidence was unsatisfactory in a number of respects. Particular attention should be paid to the following passages:

21. When asked when she became aware of defects with the water and ventilation systems, she was unwilling to provide a clear answer. Instead, she stated that *"I think it was an iterative process and I still think that there are some questions today as to what the exact*

[26] Bundle 52, Volume 5, Page 146 *et seq*.
[27] Transcript of Professor Gardner, 9 October 2025, Page 62, Column 120.
[28] Bundle of documents for oral hearings commencing from 19 August 2024, Core participants' closing submissions, Page 95.
[29] Transcript of Professor Gardner, 9 October 2025, Page 32 – 33, Columns 58 to 59.
[30] Transcript of Professor Gardner, 9 October 2025, Page 90, Column 176.

situation was[31]*".* The first part of this sentence is an attempt to abdicate responsibility for a total failure to respond to concerns that were raised directly by the Whistleblowers and in relation to which there was a total failure to mount an adequate response for which she must bear substantial responsibility as Chief Executive. The second part of the sentence appears to be a continued failure to accept that in fact the Whistleblowers were substantially right about the concerns they were raising and an ongoing attempt to cast doubt and muddy the waters. Neither reflects well on Mrs Grant and neither should be looked upon favourably by this Inquiry.

22. In any event, Mrs Grant's evidence on the *"iterative"* nature of events is simply wrong. On 20 June 2015, Dr Peters prepared a "gap analysis" table that highlighted the numerous problems with the ventilation systems. She sent this gap analysis to Tom Walsh by email[32]. Tom Walsh specifically undertook (in an email to Dr Peters dated 26 June 2015) that he would escalate her concerns to the Medical Director and the then COO, Grant Archibald.[33] In relation to water, in June 2015, Dr Peters highlighted various outstanding matters in an email to the then members of the IPCT including Tom Walsh and Professor Williams.[34]

23. On 26 June 2015, Dr Peters sent Tom Walsh an email which identified many of the key issues. In this email:

    - She highlighted that she had repeatedly requested the written legionella testing, in order to enable clinical risk assessment. She also noted that she needed "full reports" to ensure that legionella was not in any outlets. This was a request for the DMA Canyon report.
    - She noted that she was "awaiting full documentation on current accommodation specs and validation".
    - She noted that HEPA filters needed to be in place in areas where immunosuppressed adults would be staying.

[31] Transcript of Jane Grant, 24 September 2025, Page 6, Column 8.
[32] See Statement of Dr Peters, Para. 41, and Gap Analysis document, Bundle 14, Volume 1, Page 395 to 397 (ventilation).
[33] Bundle 12, Page 227.
[34] Bundle 14, Volume 1, Page 387.

- She highlighted that she still needed validation and leak testing data for the lobbied isolation rooms.
- She requested validation data for the theatres.

24. There was a total failure to act on the contents of this email. By 16 December 2015, Dr Peters emailed Anne Cruickshank, in terms that made clear her utter despair at the wider situation:

> "*I cannot express strongly enough how compromised I feel my professional practice is becoming within the current set up in GGC infection control*"[35].

25. If Mr Walsh had been competent, and if GGC had implemented the recommendations of the Vale of Leven Inquiry report properly, then Mr Walsh would have been reporting directly to the Chief Executive, which failing to an executive board member, and this information would have made its way immediately to the then CEO, Mr Calderwood[36]. Mrs Grant may prefer to adopt the position, a decade later, that there was a gradual appreciation of the seriousness of the situation over an extended period and that it was simply not possible for her, her predecessor, and their senior colleagues to grasp the gravity of the problems at an earlier stage. In fact, the serious and very pressing nature of the problems was raised, and raised forcefully, at a very early stage, and there was an abject failure to respond adequately to the Whistleblowers who were raising these concerns.

26. Mrs Grant's entirely unacceptable approach is probably best encapsulated by the passage of her evidence in which she declined to apologise to the Whistleblowers on the basis that she had nothing to apologise for, and instead took the opportunity to make further unsubstantiated allegations against them by saying ***"some of them have been incredibly***

[35] Bundle 27, Volume 11, page 70.
[36] See Bundle 51, Volume 1, Page 644, Vale of Leven Report recommendation 47 "Health Boards should ensure that the infection control manager reports direct to the Chief Executive, or at least to an executive board member".

challenging *to try and work with in a constructive way.* ***We do require to have people to be team players*** *and so on….*[37]*".*

27. It is worth coming back to this passage when considering the practical effect of the suggested recommendation by CTI that the Whistleblowers receive apologies. Dr Peters would wish to record that it is abundantly clear from her experience of working as a full time microbiologist throughout the inquiry and its aftermath that the key personnel currently leading the IPCT in Glasgow take the same position as Mrs Grant; they are not sorry for what happened to her or for any part that they played in it, because they do not believe that they did anything wrong. They do not agree that she was substantially right about the concerns that she raised, they do not believe that the environment was likely to have been responsible for any of the infections, and they have not modified any aspect of their professional practice or the tone of their interactions with her as a result of what the Inquiry has uncovered. As Mrs Grant said herself, people who whistleblow are not regarded as "team players" in NHS GGC. The November 2024 SBAR appended to Professor Gardner's August 2025 letter perfectly demonstrates this attitude.[38] Unfortunately, Dr Peters does not believe that an apology issued on behalf of the Board will change any of that, welcome though it would be.

Kevin Hill

28. Mr Hill provided yet another example of Dr Peters and Dr Inkster's expertise and views being diminished and belittled, by a man with no qualifications or training in their field. Numerous references have been made to Dr Inkster's mention of *Elizabethkingia Miricola* at an IMT meeting. This organism is very rare, and (as is well known by those who are experts in microbiology), was isolated from condensation on a Space Station. The "*Mir"* in the organism's name comes from the name of the "Mir" Space Station. All of this was obviously unknown to Mr Hill and a number of his colleagues. Because of their unwillingness to listen to colleagues who were experts in the relevant field, they regarded

[37] Transcript of Jane Grant, 24 September 2025, Page 78, Column 152 (emphasis added).
[38] Bundle 52, Volume 5, Pages 148-150.

what was being said by them as outlandish and obviously wrong[39]. Mr Hill's evidence on this is demonstrative of the attitude that Dr Peters and Dr Inkster regularly faced:

> *"We were originally told at one time that the infection that was arising was only discovered previously on Mars on the spaceship right? That was a quote from someone at a meeting, at an IMT meeting. At that point, of course, me like any other, would say "well if it's only been discovered there how come we're now dealing with it on Earth". So, there's some ridiculous comments made, I would say, in my opinion, which clearly needed to be, if you like, challenged, and therefore not entertained any further".*

29. Despite the many years that have passed, and all that has been learned since, it was clear from Mr Hill's evidence that he still thinks that he was right about this, and Dr Peters and Dr Inkster were being so "*ridiculous*" that it was therefore incumbent on him to ensure that they were "*not entertained any further*". Mr Hill has since retired but other staff who essentially took the same position as him (such as Tom Steele[40]) remain in post. Ironically, Dr Chaput's paper specifically refers to organisms such as Cupriavidus having been found on the International Space Station[41].

Fiona McQueen

30. Fiona McQueen stated that "*you cannot learn and improve and provide as safe care as you want to if there is a culture of blame*".[42] The Whistleblowers emphatically agree with this statement, but wish to emphasise that a culture of blame still very much prevails in the senior IPCT in GGC. This is made completely clear in the November 2024 SBAR where, in relation to evidence led before the Inquiry about a number of historical *Cryptococcus* cases at the QEUH, the current IPCT assert "*[a]ll these opinions have been based on incomplete information biased by people's personal beliefs and interests trying to sensationalise the fact that if there is a case of Cryptococcus sp., it most likely will be found*

[39] See, for example, the evidence of Professor Thomas Steele, 4 October 2024, Column 93.
[40] See transcript of Tom Steele, 4 October 2004, Pages 48 – 49, Columns 91 – 93.
[41] Paper by Chaput et al, Bundle 44, Volume 8, page 152.
[42] Transcript of Fiona McQueen, 2 October 2025, Page 12, Column 20.

in a patient hospitalised in, or linked to QEUH. These statements have been made without providing any evidence or facing any consequences for giving misleading information."[43] Allegations of "sensationalising", which for the avoidance of doubt are false, are incredibly serious and demonstrative of a total lack of willingness to learn, and to change on the part of the authors. No explanation has been provided for the contents of this SBAR.

31. It is also worth noting that Ms McQueen was asked what she thought of GGC's approach of challenging the behaviour of those raising concerns (rather than addressing the substance of the concerns). Her response was that such an approach would: *"compound the harm that has been experienced …..when people do speak out and there is an investigation in a way it's almost turned on that person…..* ***they become the problem rather than the truth teller who needs to be listened to…..whistleblowing is a protective policy for the organisation. It keeps you safe, if you listen to it***[44]*"*.

32. Whatever its aspirations, the Oversight Board did nothing to practically improve the position for the whistleblowers.

[43] Bundle 52, Volume 5, Page 150.
[44] Transcript of Fiona McQueen, 2 October 2025, Page 86, Columns 167 to 168 (emphasis added).

Clarifications and Additional Points for Chapter 5 – Narrative of Events

CTI Closing Submission Paragraph 413

33. This passage comes from CTI's submissions relating to the 2002 to 2008 phase. It is worth highlighting that although the infectious diseases unit move has been described as a late addition to the QEUH project, in fact a proposal to move this unit to the new hospital was made in 2005, and this proposal was referred to and discussed at the Acute Services Strategy Implementation and Planning Director ASR Program Board Executive Group meeting on 26 July 2006[45].

CTI Closing Submission Paragraph 611

34. In terms of IPC involvement in the commissioning of the facilities at the new hospital, of importance are the series of AICC minutes from mid-2014 going into autumn. Starting with the minutes for the 7 July 2014 meeting, under the heading "Bone Marrow Transplant", these minutes record: "*Mr Walsh advised that there had been discussion around the planned move of the Bone Marrow Transplant to the new SGH and in particular the potential suitability of the rooms and the environment/ventilation. Professor Williams will bring a paper/ update to the next meeting*."[46] However, no update was provided at the next meeting which was held on 8 September 2014.[47] Instead, under the heading "Bone Marrow Transplant", it is recorded that "*Prof Williams and Ms McNamee advised that they were meeting with the Design Team for the new South General Hospital to go over outstanding issues, and an update would be provided at the next meeting*."[48] Mr Walsh chaired the next meeting on 3 November 2014, and Ms Devine attended it. No such update was provided[49].

[45] Bundle 42, Volume 2, page 7.
[46] Bundle 42, Volume 1, Page 154.
[47] Bundle 42, Volume 1 Page 156, Para. 3(c).
[48] Bundle 42, Volume 1 Page 156, Para. 3(c).
[49] See AICC Minutes, 3 November 2014, Bundle 13, page 10

35. In the context of responding to an Inquiry questionnaire, Professor Williams was asked about: (i) the minutes of 7 July and 8 September 2014; (ii) his involvement in the environment/ventilation of the Bone Marrow Transplant unit; and (iii) the production of a paper on this topic. His evidence is that he was not asked to provide such a paper, nor was there any discussion around the adult BMT unit at that time.[50] He states "*[a]t no time during my email exchanges with the project team, Director of Estates or specialist engineers working on the new build, were any concerns raised with me about the ventilation/environment of the adult Bone Marrow Transplant unit.*"[51]

36. Taking this evidence at face value, what it demonstrates is an incredible lack of curiosity on the part of the IPCT team about matters central to their purported speciality coupled with a retrospective attempt to avoid any responsibility for what in fact happened. There appears to be no probing of, or follow up on, important matters such as the suitability of rooms and the built environment for an extremely vulnerable group of patients. The appearance is of incredibly superficial scrutiny.

37. It is also important to note, in relation to the same paragraph, that Dr Armstrong and some members of the IPCT were aware of the issues from an early stage.[52]

CTI Closing Submission Paragraph 859

38. As already stated elsewhere in this submission, Dr Peters would observe that Fiona McQueen's evidence about the deep-seated behaviour that was preventing change in 2015, could equally be used to describe her experience working for GGC in 2025.

CTI Closing Submission Paragraphs 925 – 926

[50] Bundle of Documents for Oral Hearings commencing from 19 August 2025, Witness Statements – Volume 3, Supplementary Consequential Questionnaire for Professor Craig Williams, Page 26.
[51] Bundle of Documents for Oral Hearings commencing from 19 August 2025, Witness Statements – Volume 3, Supplementary Consequential Questionnaire for Professor Craig Williams, Page 27.
[52] Bundle 35, Page 350.

39. On 30 October 2015 Dr Inkster was copied into an email from Craig Williams to Melanie McColgan, General Manager for Specialist Oncology and Clinical Haematology[53]. In this email, Professor Williams advised Ms McColgan that Dr Inkster was "leading" on handover of the wards with a view to moving back to QEUH. In fact, Dr Inkster knew nothing about the work and had no involvement in it at all. This was known to Craig Williams when he sent the email above. She emailed Brian Jones to express how concerned she was to be described as "*leading*" something that she had no knowledge of.

40. This email thread demonstrates that, as at 30 October 2015, no effort had been made to seek any input from Dr Inkster on the return to the QEUH. Dr Inkster first attended a meeting to discuss the return of the patients to QEUH on 12 November 2015. The minutes of this meeting record her attendance and her desire to contact HPS and Peter Hoffman to ensure that the specification was suitable[54]. David Wilson gave evidence to the effect that Dr Inkster was involved in this work in summer 2015[55]. The contemporaneous documents make it clear that he was simply not correct about that. From June 2015 until 30 October 2015, Craig Williams appears to have been the sole source of ICD input for this work.

CTI Closing Submission Paragraph 968

41. Dr Inkster wishes to highlight that she does not believe that Mr Hill placed a block on Mr Redfern telling Professor Cuddihy about the second infection in a genuine attempt to protect patient confidentiality. The decision had been taken at the IMT to tell Professor Cuddihy that there was a second case.[56] Dr Inkster would never have told Professor Cuddihy any specific details about the patient, merely that there was another case. No genuine issue of confidentiality arose. If Mr Hill had a genuine concern about confidentiality, he could have raised that with Dr Inkster in advance of the meeting. He

[53] See email thread at Bundle 27, Volume 7, Page 395.
[54] See minutes at Bundle 13, Page 845.
[55] Transcript, David Wilson, 20 May 2025, Pages 33 – 35, Columns 63 – 67.
[56] Bundle 1, Page 328.

did not do so. Dr Inkster believes that this information was deliberately withheld from Professor Cuddihy by GGC senior management.

CTI Closing Submission Paragraphs 1357 to 1358

42. Dr Peters remains concerned about the current ventilation arrangements for Ward 2A. Detail of this has been provided at Annexe 1 to this Submission.

CTI Closing Submission Paragraph 1833[57]

43. The CTI Closing Submission states that real steps have been taken under the leadership of Professor Steele to remedy issues with the water system. It is important to clarify that many of the steps referred to were actually put in place by Dr Inkster, prior to the arrival of Tom Steele. Some action was also taken by Mary Anne Kane under the auspices of the Water Technical Group. The Inquiry should not be falsely reassured by the continued presence of Tom Steele by reference to work that was in fact done by others. Examples include:

    43.1. The installation of point of use filters to all of the taps in Wards 2A, 2B, 3C, and PICU[58],

    43.2. Discussion of the introduction of low dosing of chlorine dioxide to the water supply[59],

    43.3. Water sampling from random outlets in RHC in PICU, 2A, and theatres, and from QEUH in wards 4A-D, 7A_D, 8C, 9D, 10A, 11C, Critical care, CCU and theatres[60],

    43.4. The fitting of tap and shower filters in RHC wards 2A, 2B, 3C and QEUH ward 4B, and in NICU with sampling in PICU[61],

[57] See also CTI Closing Submissions, Paragraph 385.
[58] See IMT minutes Bundle 1, Page 68.
[59] See IMT minutes Bundle 1, Page 72.
[60] See IMT minutes Bundle 1, Page 77.
[61] See IMT minutes Bundle 1, Page 78.

43.5. Consideration of replacement of all Horne taps in high-risk areas and low dosing of chlorine dioxide[62],

43.6. Installation of water filters including quality checking throughout RHC site (PICU/NICU, wards 2A 2B, and 3C, and further rooms housing immunosuppressed patients, plus in the QEUH in Level 4, Level 7, 8C, 9D, 10A and 11C[63]),

43.7. An invitation to Suzanne Lee to assist with the incident and recommend any other measures especially for BMT patients including new taps and dosing[64],

43.8. Arrangements for a visit from Tom Makin to consider (amongst other things) chlorine dioxide and silver solution[65],

43.9. A plan prepared by Ian Powrie and discussed at the Water Treatment Group in July 2018[66],

43.10. Mr Makin and Mr Wafer attending the Water Treatment Group to discuss control measures in July 2017[67], and

43.11. Appointment of a bidder for the implementation of control measures at the Water Treatment Group in August 2018[68].

[62] See IMT minutes Bundle 1, Page 79.
[63] See IMT minutes Bundle 1, Page 83.
[64] See IMT minutes Bundle 1, Page 84.
[65] See WTG minutes Bundle 10, Page 19.
[66] See WTG minutes Bundle 10, Page 56.
[67] See WTG minutes Bundle 10, Page 68.
[68] See WTG minutes Bundle 10, Page 75.

Clarifications and Additional Points relating to Expert Evidence

The HAD report – general comments

44. The CTI Closing Submission identifies many of the significant shortcomings with the HAD report. We will not rehearse all of that here. The Whistleblowers are gravely concerned that the authors analysed the data and reached conclusions without assessing all of the available evidence, and as a result their conclusions are of no real assistance to the Inquiry.

The HAD report – Aspergillus

45. The HAD Report states as follows:

> *"32. From 2013 to 2023, there is no indication of increased cases of infections with [aspergillus] in the Adult BMT service, including after the permanent move to QEUH from the Beatson unit in June 2018.*
> *33. From 2013 to 2023, there is no indication of increased cases of infections with [aspergillus] in the Adult Haematology South service, including after the permanent move to QEUH May 2015[69]".*

46. This conclusion is not correct and demonstrates one of the many limitations in the approach taken by the HAD report authors. Dr Peters is aware of the clinical journey of these patients from her own clinical practice, and in fact, there were five cases of Aspergillus in patients who were all resident in Ward 4B in the month of October 2020. This clear link in time, place and person is not picked up in figures 23 and 24 in the HAD report[70].

[69] HAD Report, Bundle 44, Volume 1, Page 10, Paras 32 and 33.
[70] Fig. 23, HAD Report, Bundle 44, Volume 1, Page 125, and Fig. 24, HAD Report, Bundle 44, Volume 1, Page 128.

47. This link is omitted from the HAD analysis because the patients were on different wards at the time of their Aspergillus diagnosis. Considering links in time, place and person for a cluster is good practice. It should be noted that it is possible for a single case of infection to be hospital acquired and a well functioning IPCT should not wait for a cluster to develop to identify the issue, to commence interventions, or to report nationally. A cluster is epidemiological evidence of acquisition in a place and time, but it is not the definition of hospital acquired. A large epidemiological study which is blind to the details of patient movement and instead looks for statistically significant differences between diverse populations over decades fails to detect such links because it is not possible to define the periods of environmental fungal exposure in order to differentiate exposed from non-exposed patients. This example illustrates that any approach to IPCT that relies solely on statistical significance being achieved with rare infections is inherently flawed and likely to miss opportunities to learn and put in place evidenced based preventative measures. Dr Peters believes that this is still the approach being taken by GCC.

Andrew Poplett

48. Mr Poplett has spent a considerable amount of time with the current IPCT senior management. Critically, this does not include any clinician who was a whistleblower or who openly supported those raising concerns, but it does include a number of people who have been involved in marginalising and disparaging the Whistleblowers over many years. This limited perspective is obvious from his evidence about the purported existence of "*very effective close working relationships and lines of communication*[71]". Regrettably, this is not Dr Peters' experience of working with those colleagues, either historically or at the present time.

49. It was striking that he had not been made aware by the same members of the current IPCT senior management team that there are a number of significant ongoing rectification projects[72]. These include, for example, the issues raised in Dr Peters' second

[71] Transcript of Andrew Poplett, 19 September 2025, Page 26, Column 47.
[72] Transcript of Andrew Poplett, 19 September 2025, Page 42, Column 80.

supplementary statement including the replacement of toilets in ward 4B because of persistent water leaks around shower flooring leading to damp[73].

Clarifications and Additional Points - Terms of Reference

Term of Reference 1

50. At paragraph 1754 of the Closing Submission, CTI make an observation about the JACIE ventilation standards. The Whistleblowers agree with the observations made by CTI. They also note that, as explained by Professor Gibson, there are good reasons why JACIE guidance is framed as it is and, therefore, why GGC had set the standards higher. Professor Gibson explained that JACIE recommendations are:

> *"…written as a guidance to accreditation to existing units and they're particularly careful about their wording. You know, what they do not want to do is make them so rigid that countries of lower income or middle income can't afford to transplant because they can't meet those requirements, so they're deliberately geared towards making almost everybody eligible."*[74]

51. The short point is that GGC ought not to be allowed to hide behind the proposition that something is not important if it is not required by the JACIE guidelines. These guidelines are intended to set absolute minimum standards and to apply internationally including across the developing world in which standards of water quality and ventilation simply cannot the match standards which can and, indeed, should be achieved in a state-of-the-art facility in the UK. The minimum required by JACIE guidelines were not what was aspired to in the QEUH, nor should it have been. Robert Calderwood confirmed that what they were trying to achieve was a "*gold standard*"[75]. Despite that evidence, he then made a deeply unsatisfactory attempt (during an exchange with the Chair) to justify a statement to the effect that he was aware of a number of other hospitals with less than 6 air changes

[73] Second Supplementary statement of Dr Peters, 13 June 2005, Paragraphs 19 and 20.
[74] Transcript of Professor Brenda Gibson, 19 August 2025, Column 66.
[75] Transcript of Robert Calderwood, 30 September 2025, Page 35, Column 66.

per hour. It became clear that in fact he was not aware of any such examples and the basis upon which he had made that statement remained unsatisfactorily unclear[76].

Term of Reference 4

Introduction to Term of Reference 4 and the report of Sir Robert Francis

52. The clear answer to Term of Reference 4, in so far as it relates to whistleblowing,[77] is that GGC did not encourage disclosure of "*failures in performance or inadequacies of systems…following handover [of the QEUH/RHC]…, including through implementation of whistleblowing policies".*[78]

53. As the evidence before this Inquiry overwhelmingly shows, the failure to create and promote an appropriately open and safe culture in which patient safety concerns could be raised and addressed had catastrophic consequences on a myriad of fronts, but most directly on patients and their families. That said, the financial implications on a chronically under-funded NHS of GGC's approach must also be recognised - implications which continue to this day when one considers that the failure to listen led to this Inquiry and the attitude which has continued throughout it has significantly increased the cost and duration for GGC, the Inquiry itself, and all of the other participants.

54. Against this background, ensuring that there is "a change in culture" within GGC which "make[s] speaking up part of the normal business of healthcare rather than a dangerous activity resulting in little action other than detrimental treatment for the member of staff brave enough to raise the concern"[79] is the key aim of this Inquiry for the Whistleblowers.

[76] Transcript of Robert Calderwood, 30 September 2025, Pages 44 - 45, Columns 82 – 83.
[77] Closing Statement by Counsel to the Inquiry following 'Glasgow 4' hearings, Para. 1791.
[78] Term of Reference 4 requires the Inquiry: "To consider whether any individual or body deliberately concealed or failed to disclose evidence of wrongdoing or failures in performance or inadequacies of systems whether during the life of the projects or following handover, including evidence relating to the impact of such matters on patient care and patient outcomes; and whether disclosures of such evidence was encouraged, including through implementation of whistleblowing policies, within the organisations involved."
[79] Bundle 51, Volume 1, Document1, Appendix 8, Page 207, Para. 10.

55. Given all of their experiences, and, critically, Dr Peters' continuing experience as a full-time employee of GGC, recommendations which will ensure that past mistakes are not repeated in future are desperately required.

GGC's failure to encourage staff to raise safety concerns with the QEUH/RHC

56. Support for the conclusion that GGC did not encourage clinicians to raise patient safety concerns about the built environment at the QEUH/RHC following handover, can be found in the Expert Report of Sir Robert Francis KC dated 14 July 2025.[80]

57. In his report, Sir Robert considers the question "How can an external observer or investigator tell if an NHS Board or Trust has a problem within its organisation related to the encouragement of reporting by staff or patient safety concerns?"[81] To answer this question, he suggests that the health of an organisation's culture can be assessed by reference to a number of factors, none of which would be sufficient on their own.[82]

58. The factors Sir Robert identifies are discussed in the following paragraphs by reference to the experience of the Whistleblowers. On no measure can GGC be given anything other than a woeful bill of health in relation to its approach to whistleblowing and its treatment of the Whistleblowers.

Policies and procedures

59. Sir Robert stresses that the existence of whistleblowing policies and procedures alone is not sufficient to discharge an organisation's responsibilities to help patients and staff to raise safety concerns.[83] Rather, "*[i]n the end a culture can only be judged by the behaviours over a period of the people working within it and not by formal compliance with policies, let alone the bureaucratic processes associated with them.*"[84]

[80] Bundle 51, Volume 1, Document1.
[81] Bundle 51, Volume 1, Document1, Chapter 5, Page 47 *et seq*.
[82] Bundle 51, Volume 1, Document1, Chapter 5, Page 47.
[83] Bundle 51, Volume 1, Document1, Chapter 5, Page 47, Para. 5.1.
[84] Bundle 51, Volume 1, Document1, Chapter 5, Page 47, Para. 5.1.

60. None of this is particularly controversial. However, it is a useful reminder of the importance of looking beyond words and seeking out concrete actions for two reasons. First, despite the availability of the then applicable GGC whistleblowing policies to Dr Redding and Dr Peters, their treatment as whistleblowers (as discussed below) shows that a culture in which staff were encouraged to raise patient safety concerns did not exist.

61. Second, in assessing whether the recent change in senior leadership at GGC has resulted in any demonstrable change (a topic discussed below), it is noteworthy that such action which has been taken (i.e. the November 2024 SBAR)[85] combined with the failure to take any other meaningful steps to create change, all point towards the conclusion that the culture desired by Sir Robert still does not exist. Nor is there any prospect that it will come to exist without clear recommendations from this Inquiry, compliance with which can be robustly scrutinised to ensure that change can be achieved.

Leadership

62. The importance of leadership including the need for leaders to "*promote and exemplify the desired behaviours in their own work and interactions with others*" is underlined by Sir Robert.[86] In his report, he identifies ways in which leaders can lead by example in whistleblowing including, *inter alia*, by:

- Being seen to listen to and welcome staff concerns;
- Ensuring that concerns are investigated thoroughly and authoritatively focusing on the events rather than the personalities involved;
- Taking relevant remedial action where concerns are found to be justified;
- Accepting personal and corporate responsibility where appropriate.[87]

[85] Bundle 52, Volume 5, Page 150.
[86] Bundle 51, Volume 1, Document1, Chapter 5, Page 47, Para. 5.2.
[87] Bundle 51, Volume 1, Document1, Chapter 5, Page 47, Para. 5.2.

63. As highlighted in the CTI Closing Submission, the evidential record is replete with examples of situations where individuals in senior management and senior leadership roles within GGC did not exemplify the qualities listed above when dealing with the concerns raised by the Whistleblowers. In order not to unduly add to the considerable volume of material already before the Chair and, given that Sir Robert recommends that leadership "*at all levels*" demonstrate that the raising of concerns by staff should be welcomed,[88] the following examples of those at the top of GGC failing to lead by example and, indeed, displaying a staggering lack of curiosity and initiative are highlighted:

Example One

64. First, in September 2015, a few months after the opening of the QEUH/RHC, Dr Redding met with Dr Stewart (then Deputy Medical Director) and Grant Archibald (then Chief Operating Officer) to try to alert them to the various concerns about the new hospital which others were raising but without success[89]. Dr Stewart and Mr Archibald failed to respond adequately (if at all) to the concerns raised.

65. In keeping with the reporting lines then in place, Dr Redding had already tried to report these same concerns to the Director of Diagnostics, Aileen McLennan, but her response was to ask Dr Redding if "*she really wanted to end her career like this?*"[90].

66. An email sent by Dr Redding on 16 September 2015 shows that one of the issues discussed with Dr Stewart and Mr Archibald was the "*complete lack of clarity about the isolation rooms across the QEUH site*".[91] She noted that "*clinicians are still asking questions*".[92] She also told them about the issues with the working culture in IPC, and said that this was leading to a loss of expertise because people did not want to continue as ICDs[93]. There was a continued failure to respond adequately (if at all) to the concerns raised.

[88] Bundle 51, Volume 1, Document1, Appendix 7, Page 200, Para. 4.
[89] Transcript, Dr Penelope Redding, 4 September 2024, Pages 83-89.
[90] Statement, Dr Penelope Redding, Para. 78.
[91] Bundle 14, Vol. 1, Page 463.
[92] Bundle 14, Vol. 1, Page 463.
[93] Statement, Dr Penelope Redding, Para. 81.

67. At the meeting, Dr Redding recalls that Mr Archibald said that the ventilation concerns were merely her "*opinion*". This wholly unacceptable response is striking for a number of reasons, not least because (i) Dr Redding was not the only microbiologist with concerns, and, thus, the opinion being expressed was not only held by Dr Redding, and (ii) Dr Redding was, unlike Mr Archibald, professionally qualified to offer an opinion on the matters in issue[94]. To be constructive, Dr Redding agreed that the concerns were "*her opinion*" but suggested that an external expert should be asked to evaluate the differences in opinion. She said she would accept any evidence-based opinion if she was wrong.[95] It is worth noting that Dr Redding's suggestion of an external investigator is in line with one of the principles later advanced by Sir Robert in his Freedom to Speak Up Review.[96] Dr Redding's suggestion was ignored.

68. Dr Redding received no feedback from senior management addressing the issues."[97] The failure to listen to Dr Redding (and the others on whose behalf she was speaking) at this early stage is one of many opportunities missed by those who could have effected real change at key stages. These failures continued and indeed still continue to the present day, but the missed opportunities particularly at this very early stage are worthy of particular attention. The provision of PPVL rooms throughout the hospital is now recognised as a defect and one which only started to be remediated in 2018.[98] Indeed, given the problems NHS GGC has experienced with time bar arguments about some of its civil claims, it is also worth noting that Dr Redding asked Dr Stewart and Mr Archibald if there was a warranty with the contractors to address the concerns, but she did not receive an answer.[99]

<u>Example Two</u>

[94] Statement, Dr Penelope Redding, Para. 81.
[95] Statement, Dr Penelope Redding, Para. 81.
[96] Bundle 51, Volume 1, Document1, Appendix 7, Page 201, Para. 8(a).
[97] Statement, Dr Penelope Redding, Para. 82.
[98] See e.g., Closing Statement by Counsel to the Inquiry following 'Glasgow 4' hearings, para. 898 *et seq*.
[99] Statement, Dr Penelope Redding, Para. 81.

69. A second example of a failure in leadership occurred in February 2017 when Dr Redding raised her ongoing concerns about the ventilation system and the IPC service with the then CEO Robert Calderwood. He told her that she could not expect to reach a "*gold standard*" with everything (despite his express evidence to the contrary to this Inquiry) and also added "*that Peters woman is creating problems"*.[100]

Example Three

70. Further evidence of the disdain and lack of respect which was afforded to Dr Peters came in the meeting of 4 October 2017 to discuss the 3 October 2017 SBAR. This is a third example of GGC leaders failing to demonstrate the qualities described by Sir Robert. When Dr Peters introduced herself as Clinical Lead for Microbiology at the QEUH, Dr Armstrong responded that she was '*head of nothing*'.[101]

71. Dr Armstrong now denies saying this. However, Dr Peters is not the only person to have been on the receiving end of this sort of utter rudeness. Echoes of this attitude were observed by Jeanne Freeman. In 2019, Ms Freeman attended a meeting held at the QEUH to discuss the cryptococcus cases and the hospital's ventilation system. Also in attendance were the Chief Medical Officer and the Director General for Health and Social Care, along with the Chief Executive, Chair, Medical Director (then Dr Armstrong) and the Head of Estates for GGC. Dr Armstrong asked Ms Freeman why she was there and what the matter had to do with her.[102] Ms Freeman told the Inquiry that she was taken aback by such questions.[103] She said she came away from the meeting "***with a general impression of surprise and concern about NHSGGC's guardedness and down-playing of the importance of the situation, particularly in light of the then known issues and concerns about water and ventilation***."[104]

Example Four

[100] Dr Redding, Statement, Para. 94, Hearing Bundle, Page 93.
[101] Transcript, Dr Christine Peters, 12 September 2024, Page 21, Column 37.
[102] Witness Statements, Volume 5, Statement, Jeane Freeman, Page 104, Paras. 25-27.
[103] Transcript, Jeane Freeman, 10 October 2025, Page 23, Column 42.
[104] Witness Statements, Volume 5, Statement, Jeane Freeman, Page 104, Para. 27 (emphasis added).

72. A fourth example of a failure in leadership to address the concerns being raised by the Whistleblowers is the contact between Dr Redding and Jane Grant in November 2017. By this point, there had been a stage 1 whistleblow as encapsulated in the October 2017 SBAR. In the face of years of little, if any, action, Dr Redding, a senior clinician, contacted Jane Grant (then Chief Executive) to try to make progress with the concerns she had been raising since 2015. Ms Grant's response displays very little interest in any of the serious matters Dr Redding was raising, and simply asked her to continue to work via meetings with colleagues, including Dr Green, Dr Armstrong and Professor Jones as the interim Lead ICD.[105] The fact that Dr Redding clearly felt this process was not working and that she may have to go to stage 2 of the whistleblowing process was ignored. As Dr Redding told the Inquiry, "*No one from Senior Management ever meaningfully engaged with us after the meeting in October 2017. Our emails were either ignored altogether or we were criticised for sending them. Where we did get a response, it was unsatisfactory*."[106]

Bullying, how raising concerns is treated and the need for supportive teamwork

73. The third (bullying), fourth (how raising concerns is treated) and fifth (supportive teamwork) factors identified by Sir Robert to assess the health of an organisation's culture can be dealt with together for the purposes of this submission.[107] Again, only a select number of examples relevant to these factors are highlighted below but the evidential record contains a great many more.

74. From the very outset of the process of raising concerns about the built environment at the QEUH/RHC, it is clear that those who did so (or who wished to do so) felt scared, vulnerable to negative reactions (including bullying), and also felt that they would not be supported if they raised concerns. This is encapsulated by the fact that Dr Redding had to speak up when others were too frightened to do so. She felt able to do so because of her considerable experience and because she was near the end of her career. Nevertheless,

[105] Bundle 52, Vol. 9, Pages 18-20.
[106] Statement, Dr Penelope Redding, Para. 146.
[107] Bundle 51, Volume 1, Document1, Page 48, Paras. 5.3-5.5.

the stress and subsequent toll on her health which she experienced as a result of becoming a whistleblower should not be underestimated[108].

75. In 2015, at around the time when Dr Peters was expressing her concerns about the building, and the infection control set up within GGC, Professor Leanord asked her, "*why would you raise your head above the parapet*?". He also encouraged her to "*pipe down*" as otherwise she would find things hard.[109] While Dr Peters understood the advice to be "constructive" rather than threatening, it is clear evidence that raising concerns about patient safety was not something that a senior clinician such as Professor Leanord thought would be welcomed by the organisation.

76. A further neat encapsulation of the way in which those trying to raise patient safety concerns were treated is contained in the email exchange between Dr Peters and Mary Anne Kane (then Interim Director of Estates & Facilities for NHS GGC) on 30 June 2015. Having "*been informed by Ian Powrie*" that there had "*been positive legionella samples in the new build water supply*", Dr Peters asked for, *inter alia*, "*details of the testing that has taken place, the locations that have had positive results…and a copy of the risk assessment along with actions taken*."[110]

77. Ms Kane's response was:

> *"Christine,*
> *I am not sure why you would write to myself and Heather about this.*
> *Ian Powrie is the sector estates manager with responsibility for this. We have to date shared this data via the Sector Water Groups and have involved Pamela and Craig in discussions on newSGUH (sic).*
> *The Board has a Water Safety Policy which describes the governance arrangements in place. I am sure that Ian and Pamela would be more than happy to take you through the details of the arrangements in place.*

[108] Statement, Dr Penelope Redding, Paras. 211-214.
[109] Statement, Dr Christine Peters, Para. 56.
[110] Bundle 14, Vol. 1, Page 215.

Mary Anne"[111]

78. In essence, Dr Peters was asking for the provision of the DMA Canyon report. The significance of the request at this time in 2015 and the failure of anyone to either realise that, or to constructively respond to it, will not be lost on the Chair.

79. In fairness to Ms Kane, on being shown this email exchange by Counsel to the Inquiry, she acknowledged that it was a "*really cheeky email*", accepted that she should not have responded in that way and apologised.[112] Ms Kane's willingness to apologise is welcomed by Dr Peters but stands in stark contrast to other witnesses who have appeared before the Inquiry. In fact, the apology offered by Ms Kane on this matter during her evidence is the only apology Dr Peters has ever received from anyone at GGC.

80. In relation to the question of "How raising concerns is treated", two examples stand out in terms of demonstrating GGC's willingness to divert and deflect by investigating matters secondary to the patient safety concerns at issue.

81. The first is the review carried out by Dr Stewart (then Deputy Medical Director) in August and September 2015 into the "main issues surrounding the resignation of Infection Control Doctors in June 2015 and to determine what, if any, further actions might be required."[113] Rather than address the specific patient safety issues raised by Dr Inkster and Dr Peters in their resignation letters, this review only focused on the working relationships within the IPCT.[114] While Dr Stewart's report following his review was not provided to Dr Inkster or Dr Peters, a letter was sent by him to a range of microbiologists and members of the IPCT on 30 October 2015.[115] In Dr Inkster's view, the letter labelled her and Dr Peters as being difficult and risk averse.[116] As Counsel to the Inquiry acknowledge, the result of this process was that "[i]n essence, there were personality

[111] Bundle 14, Vol. 1, Page 214.
[112] Transcript, Mary Anne Kane, 16 May 2025, Page 79, Column 154.
[113] Bundle 14, Vol. 1, Page 464.
[114] Transcript, Dr David Stewart, 19 September 2024, Pages 34-35.
[115] Bundle 14, Vol. 1, Pages 472-473.
[116] Transcript, Dr Teresa Inkster, 1 October 2024**,** Day 1, Page 63.

issues and little if any genuine concern for the patient safety issues that both her and Dr Peters had raised."[117]

82. The second example is the Stage 2 whistleblow report produced by Dr Linda de Caestecker in 2018. The evidence before the Inquiry concerning the Stage 2 whistleblow including this report are addressed in detail in Chapter 5 of Counsel to the Inquiry's Closing Submissions following the 'Glasgow 3' hearings and need not be rehearsed here. Suffice to say that, as CTI observe, *"[n]o good reason was given for the decision to include a detailed critique of Dr Peters within a report that was supposed to be about whether there was merit in the specific issues raised by Dr Redding…Dr Redding's concerns in her Stage 2 whistleblow were substantially correct and Dr de Caestecker did not investigate the main point, but she did find the time – just as she had in her statement – to repeat criticism of Dr Peters and avoid giving Dr Peters any indication that she was going to do that*."[118]

83. Before leaving the matter of Dr de Caestecker's report, it is recalled that one of the criticisms of Dr Peters which featured in this report and, indeed, throughout the Inquiry is that she sent too many emails.[119] It is important to understand that, save in one respect, Dr Peters does not accept this criticism. The one exception is in relation to the email communications between Dr Peters and Dr Inkster during a particularly stressful IMT when Dr Peters wished more communication from Dr Inkster and Dr Inkster felt Dr Peters' emails were diverting her from the task in hand. However, this issue was resolved following a discussion between them when both acknowledged each other's concerns.[120] Any criticism of Dr Peters relating to the sending of emails was made without reference to evidence and should be rejected.

Recognition of successes, staff morale and well-being

[117] Closing Statement by Counsel to the Inquiry following 'Glasgow 3' hearings, Para. 190.
[118] Closing Statement by Counsel to the Inquiry following 'Glasgow 3' hearings, Page 535, Para. 45.
[119] Bundle 27, Vol. 4, Doc 6, Page 84.
[120] Transcript, Dr Christine Peters, 12 September 2024, Day 2, Pages 81-83.

84. The final two factors (Recognition of successes and Staff morale and well-being) identified by Sir Robert to measure whether an organisation has a problem related to encouraging staff to report safety concerns are interrelated and can also be dealt with together for the purposes of this submission.[121]

85. When set against what happened to the Whistleblowers in the present case, including how Dr Peters and Dr Inkster in particular have been described in GGC's formal submissions to this Inquiry, it is clear that Sir Robert's recommendation that *"[w]here a concern has resulted in a safety improvement, the individual raising it should be recognised and thanked*",[122] has not been met in GGC. It is no exaggeration to say that GGC have taken the polar opposite approach throughout. That approach continues, with the description of those raising concerns as "sensationalists".

86. As Counsel to the Inquiry has submitted, there is little if any substance to the criticisms levelled against Dr Inkster and Dr Peters. Instead, as CTI have observed "[*t]he reality was that these were experienced clinicians raising patient safety concerns about the built environment of the QEUH/RHC and these concerns were ultimately vindicated…Rather than being valued, acknowledged and assisted for using their initiative, they were castigated for essentially being difficult and risk averse."*[123]

87. The first GGC Positioning Paper, produced in December 2022, in which GGC states, with apparent "regret":

> *…that the extraordinary challenges faced by the Board in the period post 2015 were significantly exacerbated by the conduct of "whistleblowers" whose various actions appeared to have been designed to undermine their colleagues, and the steps being taken collectively to ensure the safety and welfare of patients and, in consequence, undermined the crucial bond of trust between the hospital and its patients….*[124]

[121] Bundle 51, Volume 1, Document1, Page 48, Paras. 5.6-5.7.
[122] Bundle 51, Volume 1, Document1, Page 48, Para. 5.6.
[123] Closing Statement by Counsel to the Inquiry following 'Glasgow 3' hearings, Page 776, Para. 28.
[124] Bundle 25, Page 1264, Para. 11.

88. The paper then concludes with a long list of complaints about the conduct of the whistleblowers.[125] Of concern is the fact that this paper was originally submitted by GGC confidentially and at a time when none of the Whistleblowers were core participants. The Inquiry will recall that the criticisms included (but are not limited to) the following:

    - Making excessive and unnecessary demands of the IPCT and Estates teams, and of IMTs;
    - A failure to "recognise and respect professional boundaries";
    - Engaging in conduct which "was designed to undermine or intimidate professional colleagues";
    - Failing to "apply basic principles of risk management in infection control";
    - Providing inaccurate information to patients and families;
    - Breaching patient confidentiality;
    - Making false allegations; and
    - Deliberately failing to follow proper processes in airing concerns.

89. These criticisms are incredibly serious. They were made behind the Whistleblowers' backs and when they had no means of challenge or defence. As all three are now core participants, the position has thankfully changed. Moreover, the overwhelming evidence before the Chair now clearly exposes these complaints as being completely without merit and fundamentally misconceived. Indeed, their inaccuracy is evidenced by the fact that at no time has any action ever been taken by GGC to bring such serious allegations to the attention of the GMC, despite their duty to do so had they believed that any of allegations were well founded. GGC's practice of making unfounded allegations of the utmost severity, without giving anyone the opportunity to challenge what is said or correct the record, continues in the November 2024 SBAR.

90. On at least one occasion, the state of their mental health was queried in an effort to undermine their concerns. In a statement to the Inquiry, the journalist, Hannah Rodger, describes a discussion she had with a member of the GGC communications team in which

[125] Bundle 25, Page 1282, Para. 69.

it was suggested by the GGC employee that *"they knew [she] had three sources and made a derogatory comment about the mental health of these supposed three sources".*[126] Ms Rodger states that it was not lost on her *"that there are three whistleblowers giving evidence to the Inquiry."*[127]

Whistleblowing and GGC more widely

91. GGC's position now appears to be that the Whistleblowers are not entirely credible and reliable because they are all individuals with grievances.[128] However, that narrative does not withstand scrutiny when the wider context is considered. First, it was abundantly clear from the witness statements and oral evidence given by many senior GGC employees that they too felt very "aggrieved" by events at the QEUH. Any suggestion that feeling "aggrieved" taints the evidence of the Whistleblowers but not of those who disagree with them is self-evidently without merit.

92. In any event, the Whistleblowers are not alone in terms of the problems they have persistently faced when trying to raise patient safety concerns within GGC. This is evidenced by the March 2025 report produced by Health Improvement Scotland (HIS) titled "*NHS Greater Glasgow and Clyde Emergency Department Review*".[129] The review was triggered by emergency medicine consultants who did not have confidence in the current processes within GGC to escalate their concerns via the established whistleblowing policy and, therefore, approached HIS.[130]

93. The report was damning, finding that:

> *"The significant and sustained deterioration in relationships over several years both between teams in the emergency department in the Queen Elizabeth University Hospital, and between staff in the department and senior leadership/management in*

[126] Witness Statements – Volume 3, Week commencing 26 May 2025, Statement of Hannah Roger, Page 525.
[127] Witness Statements – Volume 3, Week commencing 26 May 2025, Statement of Hannah Roger, Page 526.
[128] Core Participants' Closing Submissions, Page 212, Para 55.
[129] Bundle 51, Volume 1, Document 7, Page 904.
[130] Bundle 51, Volume 1, Document 7, Page 1061, Para. 7.85.

NHS Greater Glasgow and Clyde is evidenced by disrespectful behaviours, poor teamwork and incivility."[131]

94. In relation to whistleblowing, HIS found:

*"**The emergency medicine consultants at Queen Elizabeth University Hospital lacked confidence in the existing whistleblowing mechanisms**. Similarly, concerns were not escalated through the professional advisory or staff partnership structures. **It is essential to ensure that the clinical voice is consistently heard, especially on safety-related matters, and that individuals feel confident their concerns will be addressed, and they will be protected**."*[132]

95. The similarity in the experiences of the Whistleblowers and the emergency medicine consultants is striking. There are clearly deeply engrained and systemic problems in GGC in relation to the ability of staff to raise patient safety concerns. These problems are persisting. As explored below, it seems unlikely that, absent a radical overhaul in culture and personnel, these problems will be overcome.

96. In relation to the wider whistleblowing context at GGC, the Inquiry has also received evidence about Dr Sarah Jenkins who was a stage 3 whistleblower.[133] It is acknowledged that the substantive reasons behind Dr Jenkins' 2018 whistleblow are not directly relevant to the present Inquiry, albeit it is noted that her whistleblow was upheld. Dr Jenkins' case is still important because it is further evidence that the problems in GGC are not confined to the Whistleblowers in this Inquiry.

There has been no demonstrable change in attitude to whistleblowing

[131] Bundle 51, Volume 1, Document 7, Page 913.
[132] Bundle 51, Volume 1, Document 7, Page 1061 (emphasis added).
[133] See Statement of Andrew Rough and Second Supplementary Statement of Dr Christine Peters, Pages 449-450.

97. There has been a change in leadership at GGC. A new Chair, Dr Lesley Thomson KC, was appointed on 9 November 2023 and a new Chief Executive, Professor Gardner, was appointed on 1 February 2025. There has also been a change in Medical Director with Dr Scott Davidson being appointed in October 2024.

98. However, it must also be recalled that several key individuals involved in IPC and whistleblowing matters before this Inquiry are not only still working within GGC but have been promoted (Sandra Devine is now Director of Infection Prevention and Control for NHS GGC), and some even sit on the Board (e.g., Professor Angela Wallace and Dr Emilia Crighton).

99. The question which therefore arises is whether, as a result of this 'regime change', there has been any demonstrable change in approach and attitude to the raising of patient safety concerns within GGC? Regrettably, the answer must be no for the following four reasons.

100. First, the clearest and most recent reason for this conclusion is the HIS report into the emergency department mentioned above. The report dates from March 2025. It is acknowledged that at this point Professor Gardner had only been in post for a month. However, there is no reason why the other senior leaders should not be thought responsible for the report's findings and recommendations as the serious problems occurred on 'their watch'.

101. A second clear example that there has been no change is Professor Gardner's handling of the November 2024 SBAR. As discussed above, on 26 August 2025, in the context of a request from ARHAI for information regarding a number of historical *Cryptococcus* cases at the QEUH, Professor Gardner appended an SBAR dated 20 November 2024 to a letter to Caroline Lamb, Director General, Health and Social Care.[134] The SBAR authored by the "NHS GGC Infection Prevention and Control Team", already referred to elsewhere in this submission, contained the following paragraph:

[134] Bundle 52, Volume 5, Page 146 *et seq*.

"There have been multiple statements recently made by the whistleblowers, ARHAI colleagues and experts appointed to Public Inquiry criticising NHS GGC compliance with NIPCM and requirements for reporting infection episodes to ARHAI. All these opinions have been based on incomplete information biased by people's personal beliefs and interests trying to sensationalise the fact that if there is a case of Cryptococcus sp., it most likely will be found in a patient hospitalised in, or linked to QEUH. These statements have been made without providing any evidence or facing any consequences for giving misleading information."[135]

102. As with the contents of GGC Positioning Paper One, discussed above, these are incredibly serious and totally unfounded allegations. Professor Gardner accepted that the SBAR made serious allegations. She also told the Chair, "*I don't think the tone or, indeed, the nature of them should have been articulated, certainly not in a formal SBAR. I think they raise a number of concerning points"*.[136] Yet she appended the SBAR in a formal letter to the Scottish Government with no explanation that she viewed these allegations in this way. By appending the SBAR to her letter absent any explanation, the straightforward interpretation is that she supports its contents. To have simply appended the SBAR without instigating a full investigation of its contents, standing the advanced stage that the work of this Inquiry had reached by that point, represents a grave error of judgement on Professor Gardner's part and casts significant doubt on her ability to oversee the significant changes that are required.

103. Professor Gardner's position before the Chair was that she sent the SBAR – prepared before she was Chief Executive – for "*complete transparency*".[137] She explained, "*What I regret, in hindsight, is I should have put an additional sentence into this piece to say, "I do not support the tone or the content of this and we're exploring this as part of our internal work*." *So, there is a piece that could have added to that element but it's not me endorsing*

[135] Buncle 52, Volume 5, Page 150.
[136] Transcript, Professor Jann Gardner, 10 October 2025, Page 53, Column 101.
[137] Transcript, Professor Jann Gardner, 10 October 2025, Page 51, Column 97.

it."[138] It is submitted that this *ex post facto* explanation should not be accepted. It is self-serving and lacks any basis in common sense. On reading the SBAR, it is plain it contains serious allegations. It is also plain that, given their seriousness, if the document is to be included in formal correspondence with government officials an explanation of the sender's position on those allegations is required if the intention is not simply to adopt them. A more appropriate response would have been for Professor Gardner to summon the authors of the SBAR to explain why they had committed such serious and unsubstantiated allegations to writing.

104. In addition to Professor Gardner's less than straightforward conduct in this matter, is the fact that the SBAR was written by the present IPCT at QEUH. In this regard, it provides a litmus test for the current attitude to the raising of patient safety concerns within that team. It shows there has been no positive change. Instead, the following observations of Sir Robert (adjusted to fit the present discussion) on the historical position to raising concerns apply with equal force to the concerns raised about the recent *Cryptococcus* cases:

- The concerns raised were relevant to the safety of patients and the use of the relevant hospital premises for that purpose.
- There would appear to have been at best a reluctance to accept these concerns or the right of the doctors to raise them.
- It is not clear that all such concerns were investigated rigorously or at all.
- Dr Peters, ARHAI colleagues and experts appointed to Public Inquiry were resented for raising these concerns or at least persisting in doing so.
- The fact that allegations of the type made in SBAR have been made at all suggests a complete breakdown of trust between Dr Peters and ARHAI colleagues on the one hand and the NHS GGC senior IPCT staff on the other in relation to serious issues regarding patient safety.[139]

[138] Transcript, Professor Jann Gardner, 10 October 2025, Page 51, Column 97.
[139] Bundle 51, Volume 1, Page 13, Paras. 2.3.1-2.3.5.

105. Sir Robert concludes by stating that the above are typical of the sorts of issues which in his experience not only arise but persist when an appropriately open and "*safe*" culture is not being consistently maintained.[140] The SBAR is, therefore, a significant piece of evidence that there is no open and "*safe*" culture within the current IPCT. One explanation for this may be that Ms. Devine is the Director of Infection Prevention and Control for NHS GGC. She is one of the constants in GGC IPC throughout the period under the Inquiry's scrutiny. Indeed, she worked in IPC at the time of the Vale of Leven Inquiry.

106. The third reason for submitting that there has been no change in approach and attitude to the raising of patient safety concerns within GGC is the INWO decision dated 20 November 2024. In response to a complaint raised by Dr Peters, the INWO determined that NHS GGC "*has failed to create and maintain a culture that values and acts on concerns raised by staff*."[141] To improve GGC's speak up culture, a number of recommendations were made by INWO.[142] However, as Dr Peters has told the Inquiry in her Second Supplementary Statement dated June 2025, "*I have received no communication whatsoever regarding this from anyone within GGC [*regarding the upholding of my INWO complaint*] and there has been no follow up by the INWO to check on progress and how my situation has been affected*."[143]

107. Finally, and building on Sir Robert's recommendation that employers should show that they value staff who raise concerns and celebrate the benefits made in response to the issues identified, two points are noteworthy.

108. First, at no point has any of the new senior leaders in GGC made any attempt to contact the Whistleblowers, including Dr Peters who still remains within the employment of GGC. Second, the present attitude of GGC's senior leaders to the whistleblowers is apparent by their inability to offer an apology, despite being repeatedly offered the

[140] Bundle 51, Volume 1, Page 13, Para. 2.3.6.
[141] Report of the Independent National Whistleblowing Officer, Case Ref: 202106845, Executive Summary, Para. 3.1 (report available at: 20.11.2024 INWO 202106845 Greater Glasgow and Clyde NHS Board .pdf).
[142] Report of the Independent National Whistleblowing Officer, Case Ref: 202106845, Recommendations, Page 13 *et seq*.
[143] Second Supplementary Statement of Dr Christine Peters, June 2025, Para. 16.

opportunity before the Inquiry to do so. Dr Davidson was asked a simple question – do you feel the same public acknowledgement and apology which was afforded to A&E consultants following publication of the HIS report should be given to the whistleblowers? His inability to answer that question was tortured and his answer remains unclear.[144]

109. Professor Gardner fared no better. She was asked a question which invites a yes or no answer: "*do you consider that in any way Dr Redding is owed an apology by NHS Greater Glasgow and Clyde*?" It is unclear what the answer to that question was. Of possible relevance is the following passage taken from Professor Gardner's response:

> *"Again, I think it is-- I-- I am sorry that-- that individuals did not feel listened to by the organisation, were not treated in a way that allowed them to feel empowered and to be able to be harnessed onto a solution and were not afforded that opportunity.*
> *I think it's a complex landscape where it is our responsibility to understand different perspectives and to take time to really unpack, but also to help colleagues come together to find the best way forward, and I don't think-- I don't think from my observation that, while some efforts were made, that that was fully afforded to those individuals.*
> *So on that basis, I am sorry that they were not-- that she and others were not afforded that opportunity…"*[145]

110. It is a matter for the Chair what any of the above means. It appears to the Whistleblowers to be another example of Professor Gardner deploying "management speak" in preference to simply stating a clear position when asked a straightforward question. It is clearly not a demonstration of any of the principles advocated for by Sir Robert to show that an organisation has an effective system in which patient safety concerns can be raised, including a culture of visible leadership.

Recommendations on Whistleblowing

[144] Transcript, Dr Scott Davidson, 10 October 2025, Page 22, Column 40 to Page 27, Column 49.
[145] Transcript, Professor Jann Gardner, 10 October 2025, Page 82, Columns 159-160.

111. Dr Redding, Dr Peters and Dr Inkster endorse the recommendations proposed by Counsel to the Inquiry in relation to the raising of patient safety concerns and whistleblowing subject to the following additional observations.[146]

112. If the Inquiry's recommendations on whistleblowing are to have any meaningful and lasting effect, they must be rooted in ensuring that there is a complete cultural shift within GGC to the raising of patient safety concerns by staff. As Malcolm Wright, with his considerable experience in healthcare management including as a board chief executive, observed:

> *"…culture…has to be a part of the diagnosis of whatever problem the Board is facing."*[147]

113. While Dr Redding, Dr Peters and Dr Inkster, wholeheartedly endorse Mr Wright's assessment, what they wish to underline is that the answer to achieving the necessary cultural change is not to be found in organisational development and/or mediation. Not only have these types of initiative been tried in the past (without success) but they divert attention away from addressing the content of the safety concern and they risk creating the impression that the problem is really with the person raising the concern. For example, that the person needs to learn to be a better "team player".

114. These types of initiative also do not reach all of the individuals who need to bring about the cultural change, as they do not normally extend to the most senior levels of an organisation. As both Mr Wright and Sir Robert recognise, culture is influenced by those at the top of an organisation.

115. Mr Wright told this Inquiry:

[146] Closing Statement by Counsel to the Inquiry following 'Glasgow 4' hearings, paras. 1900-1901.
[147] Transcript, Malcolm Wright, 25 September 2025, Page 72, Column 139.

"…I've always felt that one of the most important parts of a chief executive role is to lead and manage the culture of the organisation, and you do that by example. You do that by how you chair your management team meetings, how you walk about, how you interact with clinicians, the things that you value and the things that you don't value."

116. Mr Wright's approach finds support in the principles proposed by Sir Robert as a result of his Freedom to Speak Up Review which included the following:

"Culture of visible leadership: All employers of NHS staff should demonstrate, through visible leadership at all levels in the organisation, that they welcome and encourage the raising of concerns by staff."[148]

117. As evident from the discussion above, at no point can it be fairly said that the type of leadership described above was ever demonstrated by any of those occupying senior roles – indeed the most senior roles – within GGC during the period considered by the Inquiry. That conclusion is demoralising because the people occupying those roles did change over the years, but the culture and attitude did not. It appears to be entrenched. Patient safety demands that this not be allowed to continue.

118. When formulating recommendations around whistleblowing, it may be of assistance for the Chair to understand the limitations of the INWO process in terms of providing a further safeguard. It is acknowledged that the INWO and its function do not fall directly within the Inquiry's Terms of Reference. However, Dr Peters escalated her ongoing patient safety concerns about Ward 4B at the QEUH to the INWO and their response was entirely unsatisfactory, finding that: "*due to the passage of time and the progress of the Hospitals Inquiry in the interim, it was no longer in the public interest to continue to investigate the points of complaint that involved overlap with the Hospitals Inquiry's terms of reference.*" It is to be borne in mind that, as already noted above, part of Dr Peters' same INWO complaint was upheld, namely that GGC has failed to create and maintain a culture that

[148] Bundle 51, Volume 1, Document 1, Appendix 7, Page 200, Para. 4.

values and acts on concerns raised by staff. This INWO finding reveals a gap in the process. Underlying GGC's deficient "speak up" culture are real-life patient safety concerns, in this case the concerns about ward 4B. But, given that INWO will not deal with them due to a purported overlap with the work of this Inquiry, and GGC's speak up culture is deficient, it would appear there is no effective process or mechanism through which to raise these safety concerns and have them addressed.

Conclusions on Term of Reference 4

119. Malcolm Wright provides a positive example of how senior management within the NHS can foster a culture of openness; where clinicians are encouraged to raise concerns about patient safety without fear of consequences. Mr Wright explained:

> *"So, in the Glasgow situation, I would value clinicians, I would value clinical voices, I would value clinicians who were whistleblowing, who were not happy. And just because people are whistleblowing and that is a threat to the organisation, my sense has always been to surround myself with people who are very bright and who will tell me things sometimes I don't want to hear. So, I think it's about having a culture that encourages people coming to you and saying, "Look…that's not right, and while you're at it, you need to understand that, that, that, and that." And having a culture that doesn't punish people for giving you bad news, I think that is absolutely essential."*[149]

120. Had the senior management within GGC from 2015 onwards approached the concerns raised by the whistleblowers with the same openness, the question which is begged is to what extent would all that have followed been different? The answer must be that it would have been significantly different, most poignantly for the patients and families who suffered the consequences of concerns not being properly dealt with as soon as they were raised.

[149] Transcript, Malcolm Wright, 25 September 2025, Page 71, Column 137.

121. Whistleblowing plays a vital role in the NHS. It must be encouraged and supported. The Whistleblowers in this case look forward to receiving the Chair's recommendations on whistleblowing with a view to these aims being achieved not simply on paper but in practice.

Term of Reference 8

122. In the CTI closing submissions, certain observations are made about the impact on patients and families of the GGC approach to the CNR during the Inquiry[150]. In particular, reference is made to Professor Cuddihy's observations about what might have happened if GGC had indicated at the time when the CNR issued its conclusions that they did not accept its findings. The Whistleblowers did not have a chance to give evidence about this matter during the hearings because the GGC position on this had not been clearly stated at that time. For the avoidance of doubt, it was always clear to Dr Peters from her interactions with the senior leadership of the GGC IPCT that they never accepted that there had ever been any link between the infections and the built environment, and never would do, and that is what prompted her to escalate her whistleblow to the INWO.

123. In considering the communications between GGC and patients and their families it is worth highlighting events relating to the death of Andrew Slorance. Dr Peters explained to the Inquiry that she expected to meet with Mrs Slorance:

> "*and have a frank, open discussion about whatever I knew, whatever she wanted to ask about what I knew, and if there was something I didn't know the answer to I could go away and find it out from a microbiology perspective because that was my remit. She'd obviously been told quite conflicting things, but there was agreement in the team from the clinicians involved that it would be a good idea for us to get together, openly…….. it's very difficult when things go in a sad direction*

[150] CTI Closing Submission, Page 589, Para. 1858.

and you know it's the right of the family to have questions answered openly, transparently, explaining uncertainty[151]*"*

124. Dr Peters then went on to explain that she was told that Mrs Slorance had complained. Dr Peters, therefore, agreed that she should not attend a meeting with Mrs Slorance. In fact, Dr Peters now understands that no such complaint was made, and so the premise upon which she was dissuaded from meeting Mrs Slorance was incorrect.

Term of Reference 9

125. The Whistleblowers' position on this can again be stated in very brief terms: **the necessary lessons have not been learned**. It is worth returning to the evidence of Fiona McQueen whose evidence was that she was "*incredibly disappointed*" that

"*in 2015 we had an open dialogue about reporting of infections. We had a series of issues within Infection Prevention and Control within Greater Glasgow & Clyde over the following five, six years, the Board were escalated to Level 4 for problems with Infection Prevention and Control, and yet things have still not been resolved. That bothers me because I worry about the quality of care that is being delivered if safe and effective infection prevention and control mechanisms are not in place in one of our biggest boards in Scotland*[152]*"*.

126. Evidence from Laura Imrie of ARHAI confirmed that GGC's attitude is unique within Scotland and that she has never experienced equivalent or similar difficulties with another health board since 2019[153].

127. It should be noted that GGC have apparently failed to learn many of the lessons, and to implement many of the recommendations, arising from the Vale of Leven Inquiry

[151] Transcript of Dr Christine Peters, 12 September 2024, Columns 161 – 162.
[152] Transcript of Fiona McQueen, 2 October 2025, page 25, column 45.
[153] Transcript of Laura Imrie, 25 September 2025, Page 46, Column 88

(which cost over £10,000,000).[154] While not the subject of a specific recommendation, of note is that the maintenance of risk registers was a matter which was explored in some detail by the Vale of Leven Inquiry.[155] This Inquiry has also explored risk registers. It appears that it was the understanding of the Chair of the Vale of Leven Inquiry that a risk register for IPC was in place by 3 December 2008.[156] However, based on evidence before this Inquiry it is to be queried whether this register was actually put in place, or at least maintained.

128. Of relevance in this regard is that in June 2018, Tom Walsh told the AICC that he had "*generated a separate risk register where primary risks relating to IPCT are held. It allows people to see what is currently on it and see how we monitor these risks moving forward."*[157] It appears that this is the same register which was discussed in the Vale of Leven report. Mr Walsh was said to be leading on monitoring the implementation of the recommendations of the Vale of Leven Report[158].

129. It also appears that the emergence of this register may have been as a direct result of the Stage 2 whistleblow. As can be seen from Dr de Caestaker's letter of 4 May 2018, one of her recommendations was that "*[t]he issues raised in this [stage 2 whistleblow] complaint should be appropriately entered onto risk registers."*[159]

130. Therefore, the following questions are begged. If Tom Walsh's register is the same register as mentioned in the Vale of Leven Report, what happened between 2008 and 2018? Further, why did no one notice it had either disappeared or was not being maintained? These are the types of issue, alongside the other serious concerns detailed in these submissions, which mean that this Inquiry should be highly sceptical of any

[154] See Bundle 51, Volume 1, Page 644, Vale of Leven Report, Recommendation 47 "Health Boards should ensure that the infection control manager reports direct to the Chief Executive, or at least to an executive board member" and Recommendation 51 "Health Boards should ensure that any Infection Control Team functions as a team, with clear lines of communication and regular meetings."
[155] Bundle 51, Volume 1, Vale of Leven Inquiry Report, Chapter 15.19 (Risk Registers), Pages 574-577.
[156] Bundle 51, Volume 1, Vale of Leven Inquiry Report, Chapter 15.19 (Risk Registers), Page 576.
[157] Bundle 13, Page 127.
[158] Bundle 13, Page 241.
[159] Bundle 14, Volume 2, Page 224. See also Statement of Dr Penelope Redding, Paras. 162 and 163.

assurances from GGC that it will implement the required changes without taking radical steps given their failure to do so in the past.

List of Suggested Recommendations

Clarifications on recommendations proposed by CTI

CTI Closing Submission Paragraph 1894

131. It is important to understand that this recommendation will only work if an outbreak is properly identified in accordance with the criteria set out in the NIPCM.

CTI Closing Submission Paragraph 1903

132. To ensure the effectiveness of this recommendation the annual review should be performed by an independent third party.

Proposed recommendations submitted at the conclusion of the Glasgow III hearings

Pseudomonas testing

133. Tom Makin indicated that routine testing for pseudomonas should be added when the SHTM is updated.[160] The Whistleblowers endorse this recommendation.

Designated roles

134. Role of authorising engineer: The Inquiry should consider making recommendations to improve the effectiveness of this role in the future.

[160] Transcript, Tom Makin, 27 August 2024, Columns 25 – 27. See also Statement of Dr Surman-Lee, Pages 18-20 Legionella is not the greatest risk for high-risk patients such as haemato-oncology patients, whether adult or paediatric. As Dr Surman-Lee points out, "[b]ecause of their immunocompromised state they are at risk from a whole range of waterborne pathogens particularly Pseudomonas aeruginosa and other gram-negative bacteria as well as from non-tuberculous mycobacteria, and fungal infections".)

POUFS

135. In his evidence in the Glasgow III hearings, Dennis Kelly stated he was in favour of the permanent use of point of use filters in high-risk areas, which is contrary to the current approach taken by GGC.[161] The Inquiry should consider recommendations about future revisions to the SHTM on this point.

Water system design

136. Dr Surman-Lee gave evidence to the Inquiry about the necessity for "a risk assessment for water safety [to be undertaken] at the design stage, to ensure the systems were designed to maintain water quality targets which would ensure safety for all intended users who may be exposed to water and wastewater as well as sprays and aerosols derived from water sources".[162]

137. While the draft SHTM 04-01 does state that a risk assessment should be completed at each stage of a project, the Whistleblowers submit that the Inquiry should consider whether that can be improved and/or more effectively enforced.

IMT Chairs

138. The Whistleblowers submit that a key recommendation must be that IMTs should only be chaired by appropriately qualified individuals.

IPCT members qualifications

139. The Whistleblowers submit that the qualifications and job descriptions of all those who make up the IPCT requires serious scrutiny and is an area which would benefit from recommendations by the Inquiry.

[161] Transcript, Dennis Kelly, 27 August 2024, Columns 208 – 209.
[162] Statement of Dr Surman-Lee, Pages 6-7.

140. Of relevance to this area is the evidence of Dr Sara Mumford who explained the role of Director of Infection Prevention and Control (DIPC) in England and Wales. She noted that it was a statutory role and that no background or experience in infection prevention and control was necessary to hold it. However, Dr Mumford advised that, in her opinion, a non-subject matter DIPC should be supported in the role by a strong subject matter deputy.[163]

Additional proposed recommendations

Environmental testing

141. Consideration needs to be given to enhancing the capacity and resource required to undertake environmental testing in NHS Scotland. The Whistleblowers submit that NHS Scotland would benefit from its own national environmental laboratory similar to the UKHSA laboratories. Work should also include expanding the availability of WGS and introducing and exploring the role of newer methods such as metagenomics.

Education

142. The Royal College of Pathologists should ensure that built environment aspects of IPC are a core and examinable component of the medical microbiology curriculum. In this regard, consideration could be given to an IPC specific qualification.

Workforce planning

143. The Scottish Government should consider the creation/release of more training posts to ensure adequate numbers of infection control doctors. The government needs to take into account the changes in training to combined microbiology/infectious diseases which mean that newly appointed Consultants have a clinical ID remit which may conflict with

[163] Transcript, Dr Sara Mumford, 12 November 2024, Columns 31 – 32.

the reactive response required from the ICD role. A proportion of training posts could be single specialty microbiology which would facilitate specialisation in IPC.

Rectification Board

144. The Inquiry should consider ensuring that the Rectification Board outputs are supervised by ARHAI and ASSURE in order to ensure that mitigations appropriate to the clinical risks arising from the defects being rectified are put in place.

Giving effect to recommendations of this Inquiry

145. Given the time, effort and resources (human and financial) that have been invested in the Inquiry, it is imperative that its recommendations are implemented. The Whistleblowers note the proposed recommendations of CTI which it is understood are aimed at ensuring this outcome[164]. The Whistleblowers would propose the following further measures. To ensure the effectiveness of this Inquiry and in line with the approach taken by the Chair of the UK Infected Blood Inquiry, Sir Brian Langstaff, the Whistleblowers submit that within 12 months of the issuance of this Inquiry's recommendations, the Scottish Government and/or GGC (as appropriate) should consider and either commit to implementing the recommendations made, or give sufficient reason, in sufficient detail for others to understand, why it is not considered appropriate to implement any one or more of them.

146. During that period, and within a timescale set by the Chair, the Scottish Government and/or GGC should report back to the Scottish Parliament as to the progress made on considering and implementing this Inquiry's recommendations.

147. Consideration should also be given to recommending that independent experts with the appropriate skills and experience are appointed to audit and report on each of the following three functions at QEUH and the RHC on an annual basis for 5 years following

[164] CTI Closing Submissions paras 1904 – 1906.

the publication of the Inquiry's recommendations so that the Scottish Government and the public can be reassured that the problems identified in this Inquiry have been adequately remediated:

147.1. Water systems,

147.2. Ventilation systems, and

147.3. The performance of the IPCT.

Conclusions

148. Dr Inkster, Dr Peters and Dr Redding would like to express their sincere thanks to the entire Inquiry team. At times the team faced considerable headwinds in completing the Glasgow 3 and 4 hearings. The fact that the hearings were concluded as timetabled and such comprehensive submissions have been produced, again as timetabled, is to the credit of the entire Inquiry team and their efforts are greatly appreciated.

149. Finally, but most importantly, they express their sincere condolences to those families who lost loved ones due to infections at QEUH, and send their best wishes to those patients who suffered additional harm in the form of infections when already seriously ill.

Helen Watts KC and Leigh Lawrie KC
Lyn Beattie, Solicitor
Caitlin Perring, Solicitor
19 December 2025

On behalf of Dr Inkster, Dr Peters, and Dr Redding.

Annexe 1

Concerns of Dr Peters in relation to current state of Ward 2A

1. CTI state in their Closing Submission that *"the 2019 upgrade works brought Ward 2A in line with SHTM 03-01 (draft 2009) and the 2022 version". They further state that "accordingly there are currently no potentially deficient features in Ward 2A".*[165]

2. Dr Peters respectfully disagrees with the CTI on this matter and wishes to highlight some particular issues causing her concern in this Annexe. The information which the Inquiry has about the state ventilation in Ward 2A after the 2019 upgrade works comes from the Sutton Services International Report[166].

3. Some of the retained ductwork is noted in this report to be non-compliant. Sutton Services refer to a file note titled "RHC Ward 2A Ventilation Operating Tolerances". This document states as follows: *"Some existing distribution ductwork is being retained, and it is known that much of the existing ductwork has an air leakage rate considerable higher than that permitted by SHTM 03-01 (although endeavours are being made to repair as much as possible*[167]*".*

4. It does not appear that such repairs as have been undertaken have been sufficient. The table contained within the Sutton Services Report shows that in Ward 2A, there were five separate locations where the engineer has noted *"System shows significant amount of leakage between main test points and terminals",* and one location in which it was also noted that there was *"Leakage on AHU compartments and no filter magnehelic pressure gauges installed*[168]*".* The significance of this should not be

[165] CTI Closing Submissions paragraph 1357 and 1358.
[166] Bundle 52, Vol 10, Document 45.
[167] Bundle 52, Vol 10, Page 231.
[168] Ref Bundle 52, Vol 10, Page 234.

underestimated – it means that air is leaking in an uncontrolled and undefined manner from the ducting out with the standard allowances.

5. There is a paucity of data on some parameters due to what is said to be an absence of *"safe access to measure"* on at least 25 occasions throughout the Sutton Services report, and on at least 30 occasions it is noted that the required suction test hole could not be found.

6. The Sutton Services report identifies extreme excesses in air changes per hour in some rooms and ensuites. For example, Bed 17 on Ward 2A is noted to have 20 air changes per hour which is double that of the design intent of 10 that the validation is intended to confirm[169].

7. One en-suite is reported as being 78 air changes per hour. This is remarkable and represents 780% of what was designed[170]. The intended design cannot have been implemented in this room, otherwise the air change rate would not be so high. It should be clearly understood that it is not desirable to have this many air changes in an hour. An hourly air change rate of 78 gives rise to a risk of turbulence and lack of air control for infection prevention purposes and is likely to be very drafty and therefore uncomfortable for the patient. It is also highly energy inefficient and will expedite system wearing and aging such that normal expected routine maintenance schedules might be insufficient. It appears that the IPCT input in this work erroneously proceeded on the footing that more air changes will always be better, and therefore no upper limit is required. The report notes that *"Infection Control have confirmed that higher air change rates are a betterment of the room dilution and it is therefore not considered problematic if they were to exceed the recommended rates[171]".*

8. Dr Peters respectfully disagrees with the advice that the IPCT appear to have provided to Sutton Services. Excessively high air change rates (for example, the 78 air changes

[169] Bundle 52 Vol 10 page 243.
[170] Bundle 52 vol 10 page 309
[171] Ref Bundle 52, vol 10, page 232.

per hour mentioned above), are not "betterment" and can give rise to significant problems.

9. The Inquiry has evidence from Ross Anderson, a partner in Jones Whyte solicitors, who has had recent experience of Ward 2A as a father whose daughter was being treated for acute lymphoblastic leukaemia. Mr Anderson describes his experience of the ventilation the ward which is consistent with the effects of excessive air changes:

> *"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.*
>
> *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 take 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 its 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[172]".*

10. If measures (such as the taping described by Mr Anderson) are taken to block the blades of the pressure sensors, then the system is rendered non-compliant.

11. The validation report for bed 17 omits the total design volume for the system – that section of the table is simply blank[173].

[172] Statement of Ross Anderson, 23 September 2025, paras 68 – 69.

[173] Ref Bundle 52, Volume 10, page 240.

12. It appears that in some cases the pressures in the rooms are meeting the requirements of SHPN-04 but the air change rates and the noise levels are meeting the design requirements, the implication being that these are not the same as the requirements of SHPN-04.

13. Many parts of the system are working at above 100% of the system design volume to achieve the outputs (in particular the pressure cascade[174]).

14. The variation in air changes per hour across the rooms and ensuites is so marked as to suggest a potential issue with the methodology. Most of the rooms are intended to have 10 air changes per hour according to the summary table[175], but the air changes per hour achieved vary between 7 and 78. A staff room has been supplied with the levels of air changes per hour expected in a theatre. This suggests a misconceived approach to the design of the ventilation system.

15. There is a similarly vast variation in the pressures achieved. Some of the ensuites are said to have a pressure of negative 32 pascals[176]. This is so outwith standard design parameters that it suggests a problem with the overall ventilation strategy and installation.

16. The Sutton Solutions validation report is from 2022. There is no further evidence available regarding annual verification.

17. CTI correctly note in their Closing Submission that *"Given the validation of the Scottish equivalent of HBN 04-01 and the provision of HEPA filtered air, then it cannot be clearly stated that the PPVL rooms are deficient subject to air permeability and filters testing*

[174] Air handling units and extract fans are described as working up to 150% of the design volume on pages 234 and 235 (Bundle 52, vol 10). This means that there is no scope for increases over time as the systems age, and no redundancy built in.
[175] Bundle 52, Volume 10, pages 326 to 328.
[176] Bundle 52, Volume 10, page 431.

being passed[177]*".* However, there does not appear to be any data on leakage, or the HEPA integrity.

18. The PPVL rooms are not validated to the specifications in SHBN 04- 01 and the validation should not refer to this design as justification for the parameters measured. The validation information demonstrates that these rooms differ entirely from the PPVL design due to:

    a. The layout is different when comparison is made between the layout in HBN 04-01[178] and the two entirely different layouts actually installed in the RHC and shown in the Sutton Solutions report[179].
    b. There are bedrooms at a positive pressure to the corridor when they should be neutral[180].
    c. There is no gauge or acceptable parameters for this pressure cascade so it is unclear what the validation, design intent and acceptable tolerance is given there is a 3.5 fold difference between the rooms. In contrast the gauges for the positively pressure isolation rooms measure the bedroom to corridor in the region of 20 pascals with a clear acceptance limit of +18 to +22[181].

19. If these PPVL rooms are being used for non-infectious neutropenic patients then they are a novel design with airflow the reverse of a positively pressured isolation room, i.e. from lobby to room rather than 20 pascals in the room and airflow from the room to the lobby. It is unclear why this approach was taken or how air mixing in the room layout has been validated.

20. Dr Peters is aware from working in the hospital that the door lock in place at one end of the corridor incorporates toilets, office space and a sluice area. This invalidates the

[177] CTI Closing Submission Para 1358.
[178] Bundle 43 Volume 5 Page 187.
[179] Bundle 52, Volume 10, Pages 289 and 311.
[180] The Sutton Solutions report shows that bedroom 22 is 3.2 Pascals [Bundle 52, Volume 10, Page 288], bedroom 24 is at 11.3 pascals to the corridor [Bundle 52, Volume 10, Page 310] and bedroom 25 is 10.2 Pascals positive to the corridor [Bundle 52, Volume 10, Page 321].
[181] Bundle 52, Volume 10, Page 277.

concept of double door lock as keeping non HEPA filtered air out of the unit. This is not recorded or considered in the evidence provided by NHS GGC and is a potential deficient feature.

21. The four Teenage Cancer Trust rooms have a shared lobby which renders them different from the positively pressured isolation rooms provided to the rest of the patients. Mr Poplett specifically said that he thought shared lobbies were inappropriate[182].

[182] Transcript of Andrew Poplett, 7 November 2024, Page 66, Column 127.

ARC(M) 25/04
Minutes 55–72

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Audit and Risk Committee held on Thursday 18 September 2025 at 9.30am hybrid at JB Russell House/Microsoft Teams

PRESENT

Ms Michelle Wailes (in the Chair)

Mr Brian Auld	Dr Rebecca Metcalfe
Cllr Jacqueline Cameron	Mr Colin Neil
Ms Margaret Kerr	Mr Charles Vincent

IN ATTENDANCE

Ms Denise Brown		Director of Digital Services
Mr Euan Cronin		Assistant Head of Financial Services
Mr William Edwards		Deputy Chief Executive
Mr Martin Gill		BDO
Ms Katrina Heenan		Chief Risk Officer
Mr Paul Kelly		Internal Auditor, Azets
Ms Rachel King		Internal Auditor, Azets
Ms Louise Russell		Secretariat Manager (Minutes)
Mr Michael Sheils		Head of Financial Services
Dr Lesley Thomson KC		NHSGGC Chair
Mr John Thomson		Assistant Director of Finance
Ms Elaine Vanhegan		Director of Corporate Services and Governance
Ms Rachel Wynne		External Auditor, EY
Ms Elizabeth Young		Internal Auditor, Azets

			ACTION BY
55.	**Welcome and Apologies**		
	The Chair welcomed those present to the September meeting of the Audit and Risk Committee. Apologies were noted on behalf of Dr Scott Davidson, Professor Jann Gardner and Professor Tom Steele. **NOTED**		

			ACTION BY
56.	**Declaration(s) of Interest(s)**		
	The Chair invited members to declare any interests in any of the matters being discussed. There were no declarations made. **NOTED**		
57.	**Minutes of Previous Meeting**		
	The Committee considered the minute of the Audit and Risk Committee meeting held on 17 June 2025 [ARC(M)25/03] and on the motion of Ms Margaret Kerr and Dr Becky Metcalfe the Committee were content to accept the minutes of the meeting as a complete and accurate record. **APPROVED**		
58.	**Matters Arising**		
	a) Rolling Action List The Committee considered the Rolling Action List [Paper No. 25/36] and were content to accept that 4 items were closed. There were no other matters arising and the Committee were content to approve the Rolling Action List. **APPROVED**		
59.	**Urgent Items of Business**		
	The Chair invited members to raise any urgent items of business. There were no issues raised. **NOTED**		
60.	**Fraud Report and Counter Fraud Services Update**		
	The Committee considered the Fraud Report and Counter Fraud Services Update [Paper 25/37] presented by Mr Euan Cronin, Assistant Head of Financial Services, for assurance. Mr Cronin advised that the paper provided an update on current fraud cases and the actions undertaken to prevent, detect and investigate fraud in the period 1 April 2025 to 31 August 2025. There were 38 allegations reported during the period which was broadly in line with the same period in the previous year.		

			ACTION BY
	There was one new case of fraud recorded during the reporting period. This related to a successful bank mandate fraud perpetrated by an individual posing as an individual at a foreign supplier. Attempts to recover the funds were being pursued with the bank, with an outcome expected in September 2025. Mr Cronin reported that a case was raised with Counter Fraud Services as the fraud was discovered, after which an alert was disseminated to the Boards. The Committee received assurance that a review of internal controls within Accounts Payable had been undertaken to prevent reoccurrence. As at 31 August 2025, there were 10 open fraud cases on the Fraud Register and 26 open allegations on the Enquiries Register. The Committee noted the CFS Quarter 1 report and the 2025/26 annual action plan attached for information. The Committee discussed common themes for fraud, including undisclosed secondary employment, which accounted for a significant portion of referrals to Counter Fraud Services. The Committee noted that currently any cases raised of secondary employment were referred to the Board. Further detail would be brought back to the Committee in relation to secondary employment and how awareness was being raised about the requirement for all staff to disclose any form of secondary employment. The Committee noted that International Fraud Awareness week would take place from 16 to 25 November 2025 which would provide an opportunity to promote themes. The Committee reviewed statistics related to fraud awareness training and observed a decline in participation in recent years. It was noted that while the fraud awareness training module was currently optional, it would become mandatory in 2026 and would be implemented across the Board. The Committee noted however that this was for Agenda for Change staff only. In response to a question about the training matrix, including its timeline and intended recipients, the Committee noted that the training matrix was currently under consultation. Consideration would be given to determining the appropriate level, and the target rollout was by the end of the calendar year. Further detail would be provided at a future meeting in relation to the training matrix and training related to core contractors. In relation to Economic Crime and Corporate Transparency Act (ECCTA) which came into force on 1 September 2025, the Committee noted that the risk for the Health Board was low, however the Risk Assessment Toolkit would be brought to the		Mr Cronin Mr Cronin Mr Cronin

			ACTION BY
	Committee at a future meeting to provide assurance that NHSGCC were complying with the Act. Operation Milton was progressing well, with regular meetings taking place with CFS and greater clarity expected by the end of the month. The Committee noted a counter fraud meeting with the Fiscal to nominate a KC for case review had taken place, with further feedback expected on 23 September 2025. The internal HR review concerning one staff member's conduct hearing was set to conclude by the end of the month, with the next steps pending its outcome. A meeting with Committee members and Counter Fraud Services would be set up, with a written update to be provided. The Committee were content to note the update. **NOTED**		Mr Neil
61.	**Patient Private Funds Annual Report**		
	The Committee considered the Patient Private Funds Annual Report [Paper 25/38] introduced by Mr John Thomson, Assistant Director of Finance, and presented by Mr Martin Gill, BDO. Mr Gill provided an overview of the key elements of the Patient Private Funds Annual Accounts and audit report from BDO for the financial year ended 31 March 2025. Mr Gill highlighted that BDO had identified that £72,250 of interest was recorded as cash at year end. However, this had not been received into the bank until April 2025 and should have been separately disclosed in the accounts as accrued interest. Therefore, this had been adjusted for. A sample of 17-month end bank reconciliations, spread across all hospitals was obtained, to test the control that the reconciliation should be signed as prepared and reviewed each month. Eight Hospitals were visited to complete controls testing. Mr Gill advised that there were no significant changes to the planned audit approach, and it was anticipated that an unmodified audit opinion on the annual accounts would be issued. In response to a query regarding the difference between Patient Private Funds and Health Board accounts, Mr Gill explained that Patient Private Funds sat separately from the Board accounts due to interest. The Committee agreed that the naming conventions of the accounts was required to be clarified.		Mr Gill

			ACTION BY
	The Committee were content to approve the PPF annual accounts. **APPROVED**		
62.	**External Audit Debrief and Action Tracker**		
	The Committee considered the External Audit Debrief and Action Tracker [Paper 25/39] presented by Mr John Thomson, Assistant Director of Finance, for assurance. Mr Thomson advised that the Audit Debrief was completed with EY on 25 August 2025 to consider improvements and update actions going forward. Four new recommendations were made in their Annual Audit Report for 2024-25. Mr Thomson advised that of the 17 outstanding audit actions from previous years, 11 had been completed and 6 remained. Progress against the 10 outstanding audit actions was monitored to completion. The Committee discussed concerns about the timeline for the external review of the Blueprint for Good Governance self-assessment, noting recent governance changes including, for example, the formation of the People Committee and the Inquiries Oversight Sub Committee. Ms Rachel Wynne, EY, suggested the deadline could be adjusted if necessary. EY were invited to attend any Committee meetings to observe regular discussions regarding governance at Board Committee level. An update would be added to the paper to note why the due date had been extended. The Committee were content to note the paper. **NOTED**		Mr Thomson
63.	**Business Continuity Planning Overview**		
	The Committee considered the Business Continuity Planning Overview [Paper 25/40] presented by Dr Emilia Crighton, Director of Public Health, for assurance. Dr Crighton said that the paper provided an update on business continuing planning across NHSGGC noting that this was critical in ensuring that essential services could be maintained during disruptive events and was in line with statutory duties under the Civil Contingencies Act 2004 and associated Scottish Government regulations. Dr Crighton set out the key developments including the restructuring of the Strategic Resilience Group to strengthen oversight and embed local accountability and the implantation of a programme of training and scenario-based exercises.		

			ACTION BY
	The Committee were content to note the paper. **NOTED**		
64.	**Corporate Risk Register**		
	The Committee considered the Corporate Risk Register [Paper 25/41] presented by Ms Katrina Heenan, Chief Risk Officer, for approval. Ms Heenan provided an overview of the current Corporate Risk Register and changes that had been made since the last meeting. She noted that 96%-100% of the risks had been reviewed since the last meeting. There were 20 new actions, 22 had been completed and 35 were overdue. Actions continued to be progressed with the risk owners and monitored by the Corporate Management Team. Mr Heenan highlighted that the risk score for Risk 3036 – Financial Sustainability Revenue, had been increased to 25 in July 2025. A deep dive of the Corporate Risk Register had been carried out and 4 of the actions in relation to Risk 3052 – Regulatory Body Compliance had been closed following agreement to report the status in a compliance report rather than tracking through this action. The score had not changed. In response to a question regarding risk scoring, the Committee noted that a new policy for the whole risk register had been proposed. The scoring matrix was included in the proposal and there would be updated to reflect different impacts. The work on this was starting through the Director's Group and updates would be provided in due course. The Committee were content to note the update provided. **NOTED**		Ms Heenan
65.	**Risk Management**		
	The Committee considered the Risk Management Policy, Strategy and Procedure presented by Mr Colin Neil, Director of Finance, for endorsement and approval. Ms Heenan advised that, to align with the new NHSGGC Policy Framework and Template, the Risk Management Policy and Guidance for Managers document along with the Risk Management Strategy had now been revised into three documents – the Risk Management Policy, Risk Management Strategy and Risk Management Procedure. To align with the NHSGGC Policy Framework, the guidance information had been		

			ACTION BY
	removed from the Policy and incorporated into a separate procedure. The procedure provided a step-by-step approach to risk management and incorporated the new NHS Scotland Risk Scoring Matrix which would require risks to be re-scored to this new matrix. This would then allow the Boards Risk Appetite and Tolerance levels to be applied to risks. The Committee were content to approve the Risk Management Procedure and to endorse the Risk Management Policy and Strategy which would now be presented to the Board for onward approval. **ENDORSED AND APPROVED**		
66.	**Freedom of Information Quarter 1 Report**		
	The Committee considered the Freedom of Information Quarter 1 Report [Paper 25/43] presented by Mr Iain Paterson, Corporate Services Manager – Compliance, for assurance. Mr Paterson advised that between 1 April and 30 June 2025, NHSGGC received 395 FOI/EIR requests which was comparable to the demand recorded in the previous quarter and an increase of 15% on Quarter 1 in 2024/25. 88% of requests were responded to within statutory timescales during the quarter which was comparable to the 89% recorded in the previous quarter and a significant improvement on the 39% recorded at the same stage last year. Only 5 requests for review were received during the quarter and all reviews upheld the original decision on the information disclosed. The Committee were content to note the report. **NOTED**		
67.	**Whistleblowing Quarter 1 Report**		
	The Committee considered the Whistleblowing Quarter 1 Report [Paper 25/44] presented by Ms Elaine Vanhegan, Director of Corporate Services and Governance. Ms Vanhegan advised that there was one Stage 2 case taken forward in the quarter and there were no Stage 1 cases closed in the quarter. Stage 2 performance was 50% against the target of 20 working days to respond. The Speak Up 2025/26 Action Plan had been included in the paper to provide assurance of the ongoing work around implementing the Standards and increasing colleague confidence in the process. The Committee were content to note the report.		

			ACTION BY
	NOTED		
68.	**Information Governance Steering Group Update**		
	The Committee considered the Information Governance Steering Group Update [Paper 25/45] presented by Mr Colin Neil, Director of Finance, for assurance. Mr Neil provided a high level summary of the key discussions and decisions from the Information Governance Steering Group (IGSG) that had been held on 27 August 2025. The IGSG had considered the standard performance reports in relation to Information Governance and IT Cyber Security and had also considered other business including the review and endorsement of new NHSGGC AI guidance; approval of a new AI section for the NHSGGC Privacy Notice; proposals for the review period for the new Once for Scotland Safe Information Handling mandatory training module; an update on the new NHSGGC Information Asset Register; and proposals for a Core Brief to remind staff of the process to follow if an NHSGGC device is lost or stolen. The Committee were content to note the update. **NOTED**		
69.	**Committee Annual Cycle of Business 2025/26**		
	The Committee considered the Committee Annual Cycle of Business 2025/26 [Paper 25/46] presented by Ms Elaine Vanhegan, Director of Corporate Services and Governance, for approval. Ms Vanhegan said that the paper was presented to ensure awareness of the Committee's Annual Cycle of Business which was aligned to NHSGGC's Corporate Aims and Corporate Objectives. It was important to note that this was a dynamic process and if items required to be added or moved this would be notified to the Committee and the Annual Cycle of Business annotated to ensure transparency. The Committee were content to approve the Annual Cycle of Business. **APPROVED**		
70.	**Internal Audit Reports**		

			ACTION BY
	The Committee considered the paper Internal Audit Reports [Paper 25/47] presented by Azets for assurance. **a) <u>Internal Audit Progress Report</u>** The paper provided a summary of internal audit activity since the last meeting and there were no issues highlighted. The draft audit of whistleblowing had been issued to management for comment. The reviews of risk management and waiting list management were in progress, with the remaining audits at planning stages. Discussions were taking place with senior management to ensure the audit plan remained relevant and aligned to priorities noting that any proposed amendments would be agreed with the Committee prior to going forward. A number of changes had been made to the timing of audits in the year and these changes and the rationale for each were documented within the paper. **b) <u>Environmental Sustainability</u>** The Committee were advised that NHSGGC had developed a Climate Emergency and Sustainability Strategy which closely aligned with the NHS Scotland Strategy Climate Emergency and Sustainability Strategy 2022-26. However, while it was clear that there was considerable work being undertaken in environmental sustainability and there was a particular focus on the Annual Delivery Plan targets, there was a need to improve tracking of progress against the aims set out in the Strategy to be able to better evidence progress. Risks related to the achievement of the Strategy had not been fully identified, documented and monitored at an operational level and, additionally, environmental sustainability risks to NHSGGC more generally had not been identified or appropriately overseen through the Directorate level risk management processes. The recommendations made in the report would support a more robust control framework. The Committee were content to note the report. **c) <u>Freedom of Information (FOI)</u>** The Committee were advised that NHSGGC had responded to being placed into Level 3 intervention by the Scottish Information Commissioner in June 2024 and noted that there was regular dialogue with Commissioner staff to report on progress. It was noted that while performance had improved significantly since June 2024, the 90% compliance rate set by the Commissioner had not yet been met and it would be important to review options on how responses could be processed more efficiently to meet this target which may		

			ACTION BY
	include allocating time and resources within the FOI team to continuous improvement activity and reduce the risk of negative impact on performance. The current systems to support the management of FOI requests were not suitable for the volume and complexity of requests received and it was recommended that as a medium to longer term objective a case management system should be implemented to enable better recording, tracking and management of FOI requests. **d) <u>Property Transaction Monitoring</u>** The Committee were advised that generally there were robust arrangements in place to ensure that property transactions were managed in line with the requirements of the NHS Scotland Property Transaction Handbook. These procedures had been consistently applied for the two property transactions concluded in the financial year 2024/25. Three minor improvement actions were identified which would provide the opportunity to strengthen existing controls and processes in this area, **e) <u>Management Action Follow Up – Q2 2025/26</u>** The Committee noted that in the period to August 2025 there had been 45 total actions to follow-up which were 32 actions that had been added to the tracker and 13 open actions that had been brought forward. 8 actions had been closed and there was a total of 37 open actions carried forward. The Committee noted that none of the actions were high risk. A summary of the status of actions was included in the report. The Committee were content to note the reports. **<u>NOTED</u>**		
71.	**Closing Remarks and Key Messages for the Board**		
	The Chair thanked colleagues for attending and closed the meeting. A report on the key items of discussion would be prepared for the next meeting of the NHS Board. **<u>NOTED</u>**		
72.	**Date and Time of Next Scheduled Meeting**		
	The next meeting would be held on Tuesday 2 December 2025 at 9.30 am via MS Teams.		

NHS Greater Glasgow and Clyde	**Paper No. 25/83**
Meeting:	**NHSGGC Board Meeting**
Meeting Date:	**24 June 2025**
Title:	**Whistleblowing Annual Report**
Sponsoring Director/Manager:	**Ms Elaine Vanhegan, Director of Corporate Services and Governance**
Report Author:	**Ms Kim Donald, Corporate Services Manager (Governance)**

1 Purpose

1.1 The purpose of the accompanying paper is to give the Board an overview of whistleblowing activity across the annual review period from 1st April 2024-31st March 2025. This is to provide assurance that whistleblowing investigations are taking place in line with the National Whistleblowing Standards (the Standards).

2 Executive Summary

2.1 The paper can be summarised as follows:

- There were 8 concerns received in the reporting period and taken forward as a whistleblow:
  - 3 x Stage 1s
  - 5 x Stage 2s

- **Stage 1 performance was 100%** against the target of 5 working days with an option of extension of 10 working days to respond;
- **Stage 2 performance was 60%** against the target of 20 working days.
- **Stage 3:** There were 3 Stage 3 cases closed by the INWO during the period. Recommendations made by the INWO are monitored by the Corporate Services Manager – Governance who is responsible for collating evidence of completed actions and facilitating feedback to the INWO for their final decision.

3 Recommendations

3.1 The committee is asked to consider the following recommendations:

- To note the performance across the year.
- To note the improvement work undertaken throughout the reporting period as a result of whistleblowing cases received.

4 Response Required

4.1 This paper is presented for **assurance**.

5 Impact Assessment

5.1 The impact of this paper on NHS Greater Glasgow and Clyde's corporate aims, approach to equality and diversity and environmental impact are assessed as follows:

- **Better Health** **Positive impact**
- **Better Care** **Positive impact**
- **Better Value** **Positive impact**
- **Better Workplace** **Positive impact**
- **Equality & Diversity** **Positive impact**
- **Environment** **Positive impact**

6 Engagement & Communications

6.1 The issues addressed in this paper were subject to the following engagement and communications activity:

- The Whistleblowing process is communicated via Core Briefs and promoted through the Speak Up! Campaign.

7 Governance Route

7.1 This paper has been previously considered by the following groups as part of its development:

- Audit and Risk Committee.

8 Date Prepared & Issued

Date Prepared: June 2025
Date Issued: 16 June 2025

WHISTLEBLOWING ANNUAL REPORT 2024/25

NHS Greater Glasgow and Clyde

Kim Donald (Corporate Services Manager – Governance)
kim.donald@ggc.scot.nhs.uk

Executive Summary

- There were 11 concerns received in the reporting period:
  - 3 x Stage 1s
  - 5 x Stage 2s

- **Stage 1 performance was 100%** against the target of 5 working days with an option of extension of 10 working days to respond;
- **Stage 2 performance was 60%** against the target of 20 working days.

1. Introduction

The National Whistleblowing Standards (the Standards) set out how all NHS service providers in Scotland must handle concerns that have been raised with them about risks to patient safety and effective service delivery. A staged process has been developed by the INWO.

• Stage 1: Early resolution – for simple and straightforward concerns that involve little or no investigation and can be handled by providing an explanation or taking limited action – 5 working days.

• Stage 2: Investigation – for concerns which tend to be serious or complex and need a detailed examination before the organisation can provide a response – 20 working days.

There are 10 Key Performance Indicator Requirements:

1. Statement outlining learning, changes or improvements to services or procedures as a result of consideration of whistleblowing concerns
2. Statement to report the experiences of all those involved in the whistleblowing procedure
3. Statement to report on levels of staff perceptions, awareness and training
4. Total number of concerns received
5. Concerns closed at stage 1 and stage 2 of the whistleblowing procedure as a percentage of all concerns closed
6. Concerns upheld, partially upheld, and not upheld at each stage of the whistleblowing procedure as a percentage of all concerns closed in full at each stage
7. Average time in working days for a full response to concerns at each stage of the whistleblowing procedure
8. Number and percentage of concerns at each stage which were closed in full within the set timescales of 5 and 20 working day

9. Number of concerns at stage 1 where an extension was authorised as a percentage of all concerns at stage 1
10. Number of concerns at stage 2 where an extension was authorised as a percentage of all concerns at stage 2

The report indicates which KPI is being met throughout each of the reporting sections.

More information on how NHSGGC handles whistleblowing can be found on the website: https://www.nhsggc.org.uk/working-with-us/hr-connect/policies-and-staff-governance/policies/whistleblowing-policy/

Learning (KPI 1)

Learning from whistleblowing is crucial for several reasons. It helps NHSGGC identify and address issues, ensuring that risks to patient safety and effective service delivery are mitigated. After a case is closed, monitoring continues until all recommendations are completed. This ongoing oversight ensures that actions are taken seriously and that improvements are sustained over time. The responsibility of actions sits with the Director and Chief Nurse of the service; however, an action tracker is monitored and overseen by the Director of Corporate Services and Governance.

By learning from whistleblowing, the Board can continuously improve and ensure the safety and well-being of patients and staff and maintain a culture of openness and accountability.

The following table outlines a high-level summary of the concerns received to maintain confidentiality, and the recommendations made following investigation. Some are noted as ongoing in recognition that the actions would require to be filtered through to business-as-usual practices.

Table 1: Recommendations and learning from closed cases:

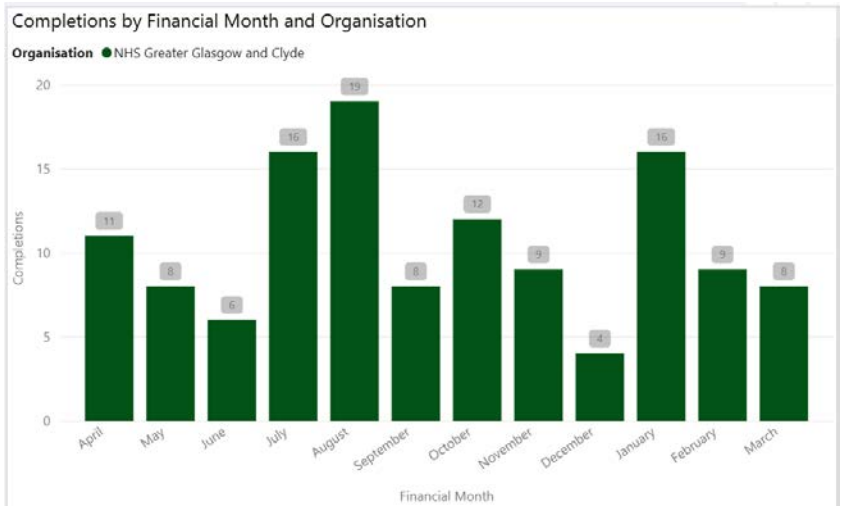
Issues Raised	Outcome	Action / Recommendations	Status
Concern raised regarding discrimination of both staff and patients impacting on the service	Not upheld	• To continue to make improvements to MDT communication, ensuring all professional voices are heard. • To continue to raise awareness in relation to Equality & Diversity and BME, to break down barriers and ensure a fair and equal work environment. • To continue to support the whole team to work better together in a truly integrated service.	Ongoing
Concern regarding delays experienced by patients accessing unplanned care	Not upheld	• Data to be regularly reviewed and scrutinised by the management team and included in sector governance reports	Ongoing

Issues Raised	Outcome	Action / Recommendations	Status
pathways as a result of national reporting targets		• Development of a standing operating procedure clearly demonstrating responsibility of performance monitoring and escalation throughout the day • Immediate review and implementation of medical leadership input and management across unplanned care	
Concern raised about conduct of manager and risk to patient safety	Not upheld	N/A	N/A
Concern regarding unequal access to bank shifts	Not upheld	N/A	N/A
Concern regarding nepotism and bullying culture impacting on staffing on Ward	Not upheld	N/A	N/A
Concerns regarding staff doing private practice during period of leave	Not upheld	Taken forward by Counter Fraud Services.	N/A
Concerns about staffing level on ward and impact on patient care	Partially upheld	• Ensure staffing is monitored through HCSSA • Ensure clinical guidelines are up to date and circulated • Review of OOH rota to be undertaken	Ongoing
Concerns about impact of Continuous Flow during winter	Partially upheld	• Risk assessments to be undertaken in real time	N/A

Issues Raised	Outcome	Action / Recommendations	Status
		• Communication and escalation to be further embedded during periods of extremis	

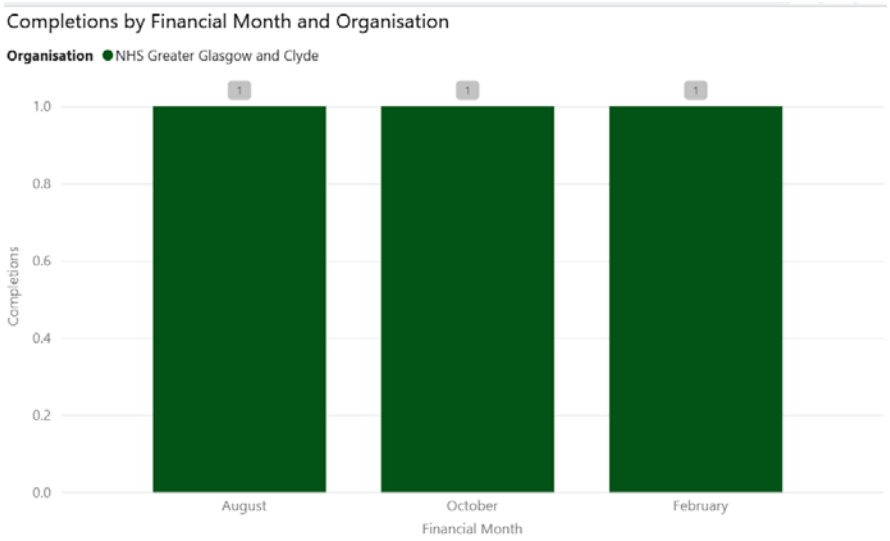
TURAS Whistleblow Module

1) Whistleblowing: An Overview



2) Whistleblowing: For Line Managers

2) Whistleblowing: For Senior Managers



The data highlights that there is a lack of engagement from the wider management team with regards to module completion. Management engagement and training is part of the wider Speak Up action plan and will be monitored throughout the course of the year.

Feedback Survey (KPI 2)

An anonymous survey is circulated to everyone involved in a whistleblow, whether they are the whistleblower or assisting with the investigation, to establish their thoughts on the process, access to support as well as offering them the opportunity to feedback to the Board on what we should be doing to assist colleagues through the whistleblowing procedure, which we recognise can be daunting. Unfortunately, engagement with the user feedback forms remains low. We have amended the feedback from an anonymous survey via email to an anonymous online form hosted on MS Teams in the hope that an easier user experience may drive up response rates. This has been a challenge nationally and we are working with colleagues as part of the wider Speak Up campaign on how to encourage wider engagement and demonstrate our commitment to learning and improving with feedback received.

Speak Up! (KPI 3)

Work continues with HR and Comms colleagues regarding the ongoing publicising of Speak Up! and the methods available to colleagues to raise their concerns. Confidential Contacts meet quarterly and feedback any key trends or themes and are encouraged to undertake localised projects within their area to ensure ongoing engagement with colleagues throughout the year.

The Whistleblowing Champion is overseeing a programme of work in this regard, including information sessions for colleagues at induction, increasing our pool of confidential contacts and working with key stakeholders to widen understanding and knowledge of the processes and protection in place.

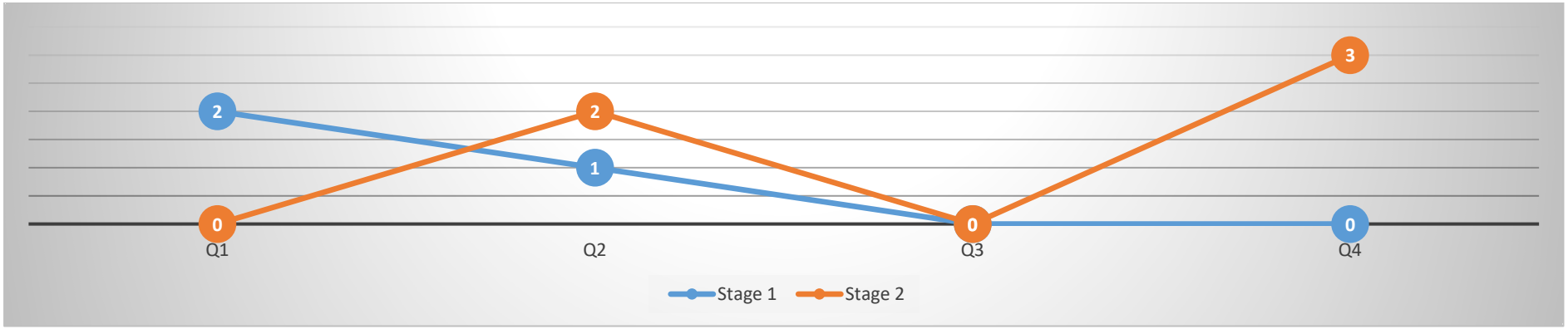
Cases Received (KPI 4)

Table 2: Cases Received and Accepted as Whistleblowing

	Acute	Corporate	HSCP/Prisons	TOTAL
Stage 1	0	1	2	3
Stage 2	3	0	2	5
TOTAL	3	1	4	8

The above table gives the figures for cases that were received, and which met the criteria for whistleblowing, and were therefore taken forward via the Whistleblowing Policy. The graph below details the number of cases received over the quarters:

Graph 1: Whistleblowing Cases Received



The number of cases received has reduced from 2023-24 where 16 cases had been received. The overall reduction in the number of cases has been discussed nationally and further work is being undertaken by the Corporate Services Manager – Governance, with the support of the Whistleblowing Champion and HR colleagues, to further embed speaking up across the organisation.

Cases Closed (KPI 5)

The information in this section relates to the performance for whistleblowing cases that were closed in the reporting period. More detailed information regarding the nature and learning from the cases is contained in Section 2.

Table 3: Closed Cases by Outcome **(KPI 6)**

	Acute	Corporate	HSCP / Prisons	Total
Upheld	-	-	-	0
Partially Upheld	2	-	-	2
Not Upheld	1	1	4	6
TOTAL	3	1	4	8

Table 4: Average Time to Respond (in working days) **(KPI 7)**

	Acute (working days)	Corporate (working days)	HSCP / Prisons (working days)	Total Average (working days)

Stage 1	-	1	5	4
Stage 2	64	-	35	39

Table 5: Closed Cases by Stage **(KPI 8)**

	Acute	Corporate	HSCP / Prisons	Total
Stage 1	-	1	2	3
Stage 2	3	-	2	5
TOTAL	3	1	4	8

It is recognised that the average number of days to respond to whistleblowing concerns at Stage 2 is longer than we would like. This number has been impacted by the complex cases received, alongside challenges with diary conflicts including annual leave across the holiday periods. The focus remains on a thorough and high-quality investigation. The individuals involved remain fully informed of progress and offered support **(KPI 9 and 10)**.

Stage 3 – INWO Investigations

	Acute	Corporate	HSCP/Prisons	TOTAL
Stage 3	1	1	1	3

Throughout the year we received 3 decision notices from the INWO. All outcome reports are published and can be found here:- Our findings | INWO (spso.org.uk). Recommendations made by the INWO are monitored by the Director of Corporate Services and Governance and the Corporate Services Manager – Governance who is responsible for collating evidence of completed actions and facilitating feedback to the INWO for their final decision.

Conclusion

As well as continuing to manage the case load of whistleblowing cases, there should be a consistent message across the Board regarding the Standards and our employees' rights to access the process, should it be required. We continue to support staff via line management, Confidential Contacts, the Whistleblowing Champion and the Whistleblowing Lead.

Kim Donald
Corporate Services Manager for Governance

SCOTTISH HOSPITALS INQUIRY

Closing Statement on behalf of Multiplex Construction Europe Limited in respect of The Queen Elizabeth University Hospital and Royal Hospital for Children

Hearing Diet: 13 May to 10 October 2025 ("Glasgow 4 Hearing")

1 Introduction

1.1 This closing statement on behalf of Multiplex Construction Europe Limited ("Multiplex") is produced following consideration of the Closing Statement by Counsel to the Inquiry, dated 21 November 2025.

1.2 At the outset of this submission, Multiplex wishes to take the opportunity to acknowledge the bravery of the patients, families of patients and front-line members of the NHS staff who provided evidence to the Inquiry. Many of these individuals have required to revisit extremely challenging times in their lives to assist the Inquiry. This cannot have been easy, and Multiplex believes that the strength of character required to do so should be recorded.

2 Multiplex remarks

2.1 At its own request, Multiplex was appointed as a core participant to the Inquiry on 10 December 2020. It sought that designation as Multiplex acknowledges, and always has acknowledged, that the purpose of the Inquiry – in seeking answers on behalf of patients and families to questions surrounding the quality of care received at The Queen Elizabeth University Hospital and Royal Hospital for Children (the “Hospital”) – was an important one.

2.2 With that in mind, Multiplex has sought to fully engage with the Inquiry at all times. It has met with solicitors to the Inquiry, answered both formal and informal information requests, provided clarification in respect of the responses to those requests to ensure that all information which the Inquiry wished to see was provided and made sure that its staff have been available to engage with the Inquiry, provided witness statements and attend various hearings across the years that the Inquiry has run. It trusts that the input which it has provided has been useful to the Inquiry.

2.3 Multiplex has considered the Closing Statement by Counsel to the Inquiry, dated 21 November 2025. It considers that Statement provides a fair summary of the evidence led to

the Inquiry in respect of the issues which Multiplex has knowledge. It does not consider that there are any further points which it can usefully make at this juncture.

2.4 Multiplex is grateful for the opportunity to have been a core participant to the Inquiry and looks forward to receiving and considering the Chair's Report in due course.

CLOSING SUBMISSION

FOR

TÜV SÜD LIMITED

RE

GLASGOW IV SECTION OF THE SCOTTISH HOSPITAL INQUIRY

Introduction

1. This written submission is provided on behalf of TÜV SÜD Limited ("TÜV"). Given TÜV's corporate ownership, in the period material to this inquiry, of Wallace Whittle Limited ("WW"), the submission will cover WW's position before the inquiry. For the reasons explained below, it will also address, where appropriate, the position of Zisman Bowyer & Partners LLP ("ZBP"). It is produced in response to the closing submission by counsel to the inquiry (referred to, respectively, as the "CTI Submission" and "CTI"). The approach taken in this submission is to concentrate on what TÜV consider are the key points relative to their position and in relation to which they can provide useful input for the purposes of the Chair producing his final report. The objective is to do so in a document of manageable length.

2. The submissions herein will in the main be directed at addressing item 1 of the inquiry's terms of reference ("TOR"). TÜV will, however, also provide brief comments relevant to item 2 of the TOR.

3. In what follows defined terms will, unless indicated otherwise, be used as per the CTI Submission.

4. In this submission, the undernoted structure will be adopted.

   (I) Overview of WW's involvement in the project.

   (II) A summary of TÜV's basic position before the inquiry.

(III) Observations in relation to the proper approach by the Chair to the evidence and core participants' submissions.

(IV) QEUH General wards – ventilation.

(V) RHC Ward 2A – ventilation.

(VI) RHC Ward 2B – ventilation.

(VII) RHC PICU – ventilation.

(VIII) QEUH Ward 6A – ventilation.

(IX) QEUH Ward 4B – ventilation.

(X) QEUH Ward 4C – ventilation.

(XI) PPVL isolation rooms – ventilation.

(XII) The water system.

(XIII) The issue of infections.

(XIV) Overall conclusions and final observations.

5. For completeness, it should be noted that TÜV do not depart from their position in any of their responses to the PPPs produced by CTI earlier in the inquiry process, albeit TÜV's finalised position is that set out in the present written submission.

(I) Overview of WW's involvement in the project

WW' s role as part of the technical advisory team

6. WW was involved at an early stage of the project as part of the technical advisory team. The lead of the technical advisory team was Currie & Brown UK Limited ("C&B"). C&B reported to NHS Greater Glasgow & Clyde ("NHSGGC"). As the lead of the advisory team, C&B appointed WW to assist with building services aspects of the project at the stage before the main contract documents were executed[1]. In this context, WW only interacted with C&B. It had no direct contact with or access to NHSGGC. WW's role as part of the technical advisory team ended in January 2010. It is accepted

[1] The appointment agreement was between C&B and WW. Produced at Bundle 17, Document 41, pp 1973-2066.

– correctly – at para 1565 of the CTI Submission that WW were stood down from their role as part of the technical advisory team as at January 2010.

7. In this connection, the evidence of NHSGGC's Mr Seabourne should also be noted. He was of course the manager of the NHSGGC project team. His evidence was that he was relaxed about the technical advisory team being stood down. According to Mr Seabourne, he and his team were "more than capable"[2] of assessing designs and design information and giving their opinions on those matters – which would, of course, include stipulating what NHSGGC was asking for in terms of specifications and requirements. Thus, the NHSGGC project team considered and presented itself as a highly informed client in relation to the project with its own technical capability.

WW's role after being brought back in 2013

8. The building services design on the project was originally carried out by ZBP. They were appointed by the main contractor, Multiplex ("MPX")[3]. ZBP ceased trading in 2013.

9. By means of an appointment dated 7 March 2013, MPX appointed WW to assist in completing certain elements of the project[4]. Importantly, however, the detailed design phase had been completed (and reviewed by NHSGGC) by the time WW were appointed by MPX. Indeed, the design was already being implemented at the stage WW was brought back into the project by MPX in 2013. Notwithstanding that, as WW's involvement followed on from ZBP's, aspects of the latter's design and approach will be addressed in these submissions.

Important points for the Chair to bear in mind

10. Five points require to be made at this stage.

11. First, Mr McKechnie's very clear evidence was that, after WW's role had concluded in late 2009/early 2010, WW had not participated in the design of the ventilation systems: see CTI Submission, para 1567. CTI appear to accept that evidence. They are right to do so. Had WW been involved in the design process – which they were not – one would

[2] Mr Seabourne's evidence in this regard can be found at Transcript, Alan Seabourne, 29 May 2025, p 26, column 48.
[3] The appointment agreement was between Brookfield Construction (UK) Limited and ZBP. Produced at Bundle 17, Document 62, pp 2359-2516.
[4] The appointment agreement was between Brookfield Multiplex Construction Europe Limited and TÜV SÜD Limited, trading as WW. Produced at Bundle 17, Document 63, pp 2517-2650.

have expected to see correspondence demonstrating their involvement, and indeed evidence of them being paid for detailed design work. There is no such evidence before the inquiry. There is no substantive basis whatsoever which would indicate any involvement by WW in the design of the ventilation systems after they had been stood down in late 2009/early 2010. The Chair should therefore find that WW did **not** participate in the design of the ventilation systems.

12. Second, CTI are also correct in what is said at para 1568 of the CTI Submission – namely, that there is **no** basis for concluding that WW played any role on behalf of NHSGGC in reviewing the design produced by ZBP. The Chair should also make a finding to that effect.

13. Third, neither WW nor ZBP 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.

14. Fourth, given the foregoing, it will be important for the Chair to maintain a rigorous distinction in relation to which role WW was undertaking, what it was doing, for whom and when. In addition, it is of the highest importance that the Chair bears in mind what WW were not doing on the project (i.e., they had no involvement in the design of the ventilation systems or in reviewing the design).

15. Fifth, and as noted above, as a result of WW becoming involved in the project again in 2013 (after the design had been completed), it will however be necessary in this submission for TÜV to comment – where they are able to do so – on what ZBP had already done by way of design.

(II) A summary of TÜV's basic position before the inquiry

16. If the role and conduct of WW are carefully examined (and the limitations thereof properly factored in), and the relevant evidence dealt with in a comprehensive, considered and objective manner, it is respectfully submitted that the Chair should make no adverse finding or any material criticism in relation to WW or any of its employees.

17. To the extent relevant to TÜV (or WW), they adopt the same position in relation to the role and conduct of ZBP.

(III) <u>Observations in relation to the proper approach by the Chair to the evidence and core participants' submissions</u>

18. Six points are made at this juncture. They are points of general application for the inquiry's purposes.

19. First, it is respectfully submitted that it is vital for the Chair to keep in mind, and seek to answer, the following questions.

    (a) Who was involved in the design and specification of the project, and what did they each do?

    (b) What was in fact designed and specified, and why was it designed and specified in the way it was?

    (c) Was the final design and specification in accordance with contemporaneous applicable guidance or practice or what NHSGGC had stipulated that they wanted; if not, why not; and was any non-compliance with contemporaneous applicable guidance or practice or what NHSGGC had said they wanted appropriately communicated to the relevant party?

    In this connection, it will be very important for the Chair to determine whether NHSGGC received what it wanted and/or had agreed to, in terms of the design and construction delivered.

    (d) Did what was in fact built and commissioned conform to the final design and specification?

    (e) Were there any features of the completed buildings, as at handover in January 2015, which were inadequate and, if so, in what ways were they inadequate?

    Again, in this context it will be very important for the Chair to determine whether NHSGGC received what it wanted or had agreed to, in terms of the design and construction delivered. Put another way, the Chair will have to determine whether any inadequacy is being identified with the benefit of hindsight notwithstanding that the relevant element of the design or construction delivered was in fact what NHSGGC wanted or had agreed to.

    (f) Did any inadequate features in fact adversely impact on patient safety and, if so, in what ways?

The submissions of TÜV are intended to facilitate the Chair answering these questions, at least insofar as they concern WW (and, as necessary, ZBP).

20. Second, given the seriousness of the inquiry for all the core participants, the patients, their families and indeed the wider public, the Chair will of course need a clear, cogent and robust basis in evidence when giving his answers to the above-noted questions. It is only by having a reliable basis for his findings that the Chair's report will command the confidence of core participants, patients, their families and the wider public.

21. Third, when the Chair comes to judge the adequacy or otherwise of a particular feature of the design or construction of the buildings, he should ask himself what is the relevant benchmark which he is applying in that regard. In a proper analysis, if one is to conclude that something is inadequate in some way one requires (a) to identify the applicable contemporaneous standard which is being used and under reference to which a building feature or a party's conduct is adjudged to have fallen short of it and (b) ascertain whether that standard was in fact being imposed at the relevant time or whether something else had been stipulated or agreed to by NHSGGC.

22. Fourth, and related, in this connection it is submitted that when it comes to considering the adequacy or otherwise of a particular feature of the buildings, the relevant feature should be assessed against the outcome which it was requested, or could reasonably be taken to be required, to achieve, rather than against the expectations or opinions of individuals who were not involved in the design and construction process at the time (and who often spoke without proper knowledge of the process and frequently in hindsight). In this context, it will be critical to understand what NHSGGC asked for, stipulated and agreed to in relation to the buildings, and what in turn they received. It will also be important to understand what NHSGGC did not stipulated by way of requirements.

23. Fifth, and again related, a critical element of the analysis of the adequacy of the features of the buildings at issue will of course also be what was contractually required of a particular party.

24. Unless these points are properly factored into the Chair's report, there is a material risk that his findings will be taken out of context and interpreted wrongly.

25. Sixth, it will be vital that, if there are any features of the buildings which the Chair finds were inadequate, there is a proper analysis of causation in relation to what, if any, effect those deficiencies actually had on patients. More specifically, before a finding could be made in this context, there would need to be a proper causal link established (and thus one based on reliable evidence) between a deficient feature and a particular patient effect, such as an infection.

(IV) QEUH General wards – ventilation

Introduction

26. There are three issues raised here relating to the ventilation.

27. First, there is the rate of ACH provided by the ventilation system in the general wards (CTI Submission, para 1303).

28. Second, an issue has been raised in relation to the use of CBUs (CTI Submission, para 1304).

29. Third, it has been said that whilst, as at handover in 2015, commissioning of the ventilation system in the general wards had been carried out, there was no validation of the system (CTI Submission, para 1306).

(i) The rate of ACH in the general wards

Prefatory points

30. At handover, the ventilation system delivered 2.5 ACH in relation to the general wards.

31. In both Appendix 2 of HTM 03-01 Part A (2007)[5] and Appendix 1 of the Draft for Consultation SHTM 03-01 Part A (2009)[6], the rate of ACH for general wards is stated to be 6 ACH.

32. Four things should be noted in this connection.

33. The first is that, strictly speaking, the current and applicable guidance for Scottish hospitals at the time of the design being undertaken was SHTM 2025[7].

[5] Hearing commencing 9 May 2022, Bundle 2 – Health Technical Memoranda, Document 9, p 794.
[6] Bundle 16, Document 5, p 483.
[7] Hearing Commencing 9 May 2022, Bundle 1 – Scottish Health Technical Memoranda, Documents 1-4, pp 4-251.

34. The draft SHTM 03-01 document from 2009 was just that: a draft. It was not a finalised document. At the time of design, no-one knew what the finalised version of the draft SHTM 03-01 document might provide by way of guidance.

35. The second is that, in any event, what is contained in a finalised version of such documents is guidance, nothing more.

36. The third is that the draft 2009 SHTM 03-01 guidance contemplated the use of natural ventilation. That type of ventilation inherently means that it is impossible (a) to maintain consistent flow rates and (b) to ensure that minimum ventilation rates are achieved. At para 2.3 of the draft SHTM 03-01, these features of natural ventilation are nonetheless deemed acceptable for general wards:

> "As the motivating influences of natural ventilation are variable, it is almost impossible to maintain consistent flow rates and ensure that minimum ventilation rates will be achieved at all times. This variability is normally acceptable for…general wards…"[8]

The additional observation to be made in this connection is that if this inherent variability is deemed acceptable for general wards by the draft SHTM 03-01, it indicates that any supposed 'requirement' for 6 ACH in the general wards cannot properly be taken as being mandatory.

37. The fourth thing is that what was stated in these documents in relation to the rate of ACH was subject, of course, to what NHSGGC indicated that they wanted and what they eventually agreed to.

The ZBP ventilation strategy document

38. With regard to what NHSGGC wanted, the ZBP ventilation strategy document is a vital document[9]. The ZBP ventilation strategy document was issued on 15 December 2009 by MPX's Mr Ballingall to Messrs Hall and Baird of C&B[10]. It recorded that NHSGGC's requirement was that the summertime temperature limit should be no more than 26°C. Thus, NHSGGC had set a design parameter. That was of course a matter for NHSGGC.

[8] Bundle 16, Document 5, p 366, emphasis added.
[9] Bundle 17, Document 71, pp 2859-2860.
[10] Bundle 17, Document 70, p 2855.

39. In the ZBP ventilation strategy document, ZBP made it clear that this temperature limit was stricter than the guidance provided within the draft SHTM 03-01 document (in which the summertime temperature limit was 28°C).

40. ZBP also noted in their strategy document that the figure for ACH for single rooms in the draft SHTM 03-01 guidance (Appendix 1) was 6 ACH. In the strategy document, ZBP then noted that:

> "Modelling was carried out based on this recommendation, but it was found that the requirement of 26°C could not be met. To try to achieve this, the ventilation rate was further increased, but became excessive and likely to cause draughts to the occupants, poor temperature control and increased energy consumption."

41. Later in the strategy document, ZBP noted the use of CBUs would provide individual room control and fresh air "albeit **less than** the recommendation of **SHTM 03-01**"[11]. Rather obviously, this point is of particular significance for present purposes. ZBP were specifically flagging that the proposed ventilation provision to the rooms would not comply with the draft SHTM 03-01 guidance.

42. The document also noted, however, that CBUs provided "an energy efficient solution" which would result in a material saving when it came to the buildings' total carbon dioxide emissions.

43. With all this having been explained, ZBP concluded in the strategy document by stating:

> "The recommended air change rate of 6 ac/h in the SHTM is considered to relate to the ability to achieve an acceptable internal environment, i.e. 50 hours exceedance above 28°C. This could be achieved with 6 ac/h of cooled air.
>
> However, the Board's requirement for a reduced temperature [i.e., the 26°C limit] makes this solution impractical and the use of chilled beams is the only viable solution, using a reduced quantity of primary air.

[11] Bundle 17, Document 71, p 2860, emphasis added.

> Whilst the air change rate is **less than the SHTM**…it is in compliance with Scottish Building Regulations and also CIBSE codes…"[12]

44. Thus, the ZBP ventilation strategy document made it crystal clear to NHSGGC that: (a) the latter's decision to insist on a summertime temperature limit of 26° rendered the achievement of 6 ACH in the wards impractical; (b) given NHSGGC's drive for energy efficiency, the use of CBUs was to be the adopted solution; and (c) the ACH rate would be less than the guidance indicated the draft SHTM 03-01 document in circulation at the time (a point mentioned more than once in the document).

45. Given NHSGGC's decision relative to the summertime temperature limit, what was said by ZBP in their ventilation strategy document was within the parameters and engineering judgment of an ordinarily competent building services engineer operating in this context at the time. Indeed, it is not understood that there has been any substantive challenge to ZBP's position that NHSGGC's decision to lower the temperature limit to 26°C rendered the achievement of 6 ACH impractical.

The M&E Clarification Log

46. The final position was crystallised in the M&E Clarification Log[13].

47. In this connection, it should be remembered that the term "Employer's Requirements" in the construction contract context (see clause 11.2(39) of the applicable conditions, as amended) was defined as NHSGGC's technical requirements for the works, as supplemented and amended by logs (cross-refer to the CTI Submission, at para 1457).

48. The obvious purpose of the M&E Clarification Log was to capture what was being proposed in relation to the relevant elements of the design and to record, if appropriate, NHSGGC's understanding of, and agreement to, the relevant proposal. It seems reasonable to refer to the log as the "output" of the discussions (CTI Submission, para 1536). Indeed, that would be consistent with the definition of Employer's Requirements noted above, in the sense that logs should on the face of it seek to amend the employer's technical requirements – i.e., what it wants – rather than seeking to record all discussions around a particular issue. The contents of the log would very readily be considered, at least by those in the construction field, to be critical in terms of what

[12] Bundle 17, Document 71, p 2860, emphasis added.
[13] Bundle 43, Volume 5, Document 47, pp 431-442.

NHSGGC had agreed to in relation to their requirements (cf CTI Submission, para 1537).

49. In the final version of the M&E Clarification Log, it was recorded in the "Board comment" section that:

> "Ward Air change to be 6 AC/HR, currently shown as 2.5 AC/HR which is not in compliance with SHTM 03-01"[14].

50. Pausing here, this demonstrates beyond any doubt that NHSGGC were well aware that what was being proposed was a 2.5 ACH rate, and this rate was below what was indicated in the guidance.

51. In the "Brookfield Comment" section of the log, it was noted that:

> "Brookfield proposal as outlined within the bid submission is to incorporate chilled beams as a low energy solution to control the environment which do not rely on large volumes of treated air or variable natural ventilation. All accommodation is single bedrooms and therefore the need for dilution of microbiological contamination should be reduced (rooms could also be at slightly negative pressure to corridor).
>
> Providing 6 air changes is energy intensive and not necessary"[15].

52. By means of this passage, four points were made very clear to NHSGGC.

53. First, the proposal was to use CBUs.

54. Second, the contractor was proceeding on the basis that all the accommodation comprised single bedrooms and therefore the need for dilution of microbiological contamination was being taken as reduced.

55. Third, rooms would also be configured such as to be at a slightly negative pressure to the corridor.

56. Fourth, the contractor did not consider that a 6 ACH rate was necessary. The contractor's position was therefore laid out to NHSGGC in the plainest of terms. There was no scope for misunderstanding. It was then up to NHSGGC to assess whether what

[14] Bundle 43, Volume 5, Document 47, p 433, emphasis added.
[15] Bundle 43, Volume 5, Document 47, p 433, emphasis added.

was being proposed satisfied their requirements from a clinical perspective. That assessment was not for the designer of the building services or the contractor to undertake. Neither had the medical expertise to do so. It was for NHSGGC to make that assessment.

57. Critically, the M&E Clarification Log (2010 ItP version) records the agreed position between the parties in the column headed "Agreed Position 2009 Contract", as follows:

> "**Agreed**.
>
> The proposal is **accepted** on the basis of 40 litres per second per single room (8 litres per second per second) **for one patient and four others**…
>
> Negative pressure to be created in the design solution."

58. Accordingly, it was made crystal clear that the ventilation proposal would accommodate five people in the room. By way of aside, this is of particular importance given the recommendation at para 1899 of the CTI Submission that NHSGCC should implement a limit of no more than four persons, plus the patient, in any bedroom (except where urgently required for clinical reasons). This recommendation is simply a recognition of what NHSGGC asked for, and what they agreed to in terms of the M&E Clarification Log. According to the evidence of the NHSGGC project manager, Mr Seabourne, it was NHSGGC which stipulated the figure of 40 litres per second per single room (being eight litres per second for five persons)[16].

59. In the "2010 ItP Comments" section of the M&E Clarification Log, it is recorded that:

> "All items in this Section as per 'Agreed Position 2009 Contract' i.e. no change in status for 2010 ItP."

60. In the "Agreed Position 2010 ItP" section, the entry was simply:

> "**Agreed.**"

61. As noted above, there is no doubt that NHSGGC agreed to the proposal that a rate of 2.5 ACH would be delivered, and that no more than five people could be accommodated in a room from a ventilation perspective.

[16] Produced at Transcript, Alan Seabourne, 29 May 2025, p 34, column 64.

The absence of any involvement of the IPC team

62. The proposal having been made by MPX/ZBP, it was for NHSGGC to assess it from a clinical perspective. There is, however, no evidence that the NHSGGC project team raised the proposal with the IPC team with a view to obtaining the latter's sign off.

63. Indeed, as CTI have noted, there is no significant evidence of the involvement of the IPC team in **any** of the detail of the design process regarding the hospital **as a whole**: see CTI Submission, paras 1478 and 1577.

64. It was not for MPX or ZBP to prompt the NHSGGC project team to engage with the IPC team.

WW's involvement

65. At para 1765 of the CTI Submission, responsibility for the ventilation clarification (or derogation, as the case may be) is said to:

> "fall on the senior members of the Project Team for accepting it, on Mr McKechnie for advising them to accept it, and on those who approved the removal of the maximum temperature variant without considering the implications".

66. TÜV do not understand why Mr McKechnie is singled out here as the only named individual in this context. That is unfair and unjustified. If responsibility is being allocated individually in this connection, this should apply equally to the others who are the subject of the comment at para 1765 of the CTI Submission. Who are they? Why are they not named? If there is to be any reference included here, it would be more appropriate to refer to WW.

67. In any event, the sweeping generalisation in para 1765 that Mr McKechnie 'advised' NHSGGC to accept the MPX/ZBP proposal is unwarranted and, in particular, ignores in a vital respect what Mr McKechnie actually said when the MPX/ZBP proposal was raised with him.

68. What CTI say at para 1765 of the CTI Submission suggests that Mr McKechnie endorsed the MPX/ZBP proposal without any qualification. That is completely wrong. Whilst Mr McKechnie said the proposal was a solution (given NHSGGC's decision to lower the maximum temperature parameter which was to be allowed), he specifically

noted that what ZBP had proposed did **not** comply with the SHTM guidance. Refer to Mr McKechnie's email[17] to C&B's Mr Baird sent on 15 December 2009 at 10:04.

69. Furthermore, Mr McKechnie had no direct contact with NHSGGC. His contact was with C&B. He made the non-compliance point to C&B, and did so clearly. This is another reason why what is said at para 1765 of the CTI Submission is inaccurate. It gives the impression that (i) Mr McKechnie was advising the NHSGGC project team directly and (ii) he advised without qualification that the MPX/ZBP proposal was acceptable. Both these things would be wrong. The Chair should not lapse into error in such an important area. TÜV remain confident that he will not do so.

70. At the risk of stating the obvious (albeit the CTI submission at para 1765 appears not to recognise this), Mr McKechnie's statement in his 15 December 2009 email constituted a critical qualification to what he was saying – namely, he made it clear that what was being proposed by MPX/ZBP in terms of the ventilation was **not** compliant with the guidance. If the significance of Mr McKechnie's critical qualification is not recognised by the Chair, the inquiry will risk making a finding which does not properly reflect the clear evidence of what Mr McKechnie actually said at the time in writing. That would be inappropriate, wrong and unfair.

71. The result is that what is said at para 1765 of the CTI Submission should not be adopted by the Chair.

72. The same criticisms are made by TÜV in relation to what is said at para 1524 of the CTI Submission where Mr McKechnie's role around mid-December 2009 is considered. This culminates with CTI saying that, "Ultimately, Mr McKechnie's recorded view was that the ZBP proposal was a 'sensible practical solution'". Again, this omits the critical qualification which Mr McKechnie very clearly stated in his 15 December 2009 email – i.e., that what was being proposed by ZBP in terms of the ventilation was **not** compliant with the guidance. For the reasons set out above, what is said at para 1524 of the CTI Submission is apt to mislead (no doubt unintentionally) unless the full content of what Mr McKechnie actually said is properly reflected.

73. Consequently, the Chair should not adopt what is said at para 1524 of the CTI Submission.

[17] Produced at Bundle 17, Document 72, p 2863.

Conclusions relative to ACH rate issue

74. In the draft SHTM 03-01 guidance, at para 2.3, natural ventilation is recognised as one of the acceptable ventilation methods. In that connection, it is said to be "impossible" (a) to maintain consistent flow rates and (b) to ensure that minimum ventilation rates are achieved. Notwithstanding the inherent variability of natural ventilation, the draft SHTM 03-01 document expressly stated that this method of ventilation was acceptable for general wards. As previously noted, this indicates that any supposed 'requirement' for 6 ACH in the general wards cannot properly be regarded as mandatory.

75. In any event, NHSGGC set a design parameter in relation to the maximum summertime temperature in the rooms. This meant that achieving an ACH rate of 6 ACH was not practical, especially given NHSGGC's drive for energy efficiency and sustainability. What was proposed in relation to the ACH – namely, a rate of 2.5 ACH – was made crystal clear to NHSGGC via the ZBP ventilation strategy and the M&E Clarification Log. The log is a record of what was discussed and eventually agreed by NHSGGC. Without doubt, NHSGGC knew that the proposed rate was to be 2.5 ACH and that this did not meet guidance. Nonetheless NHSGGC agreed to that rate. They signed the construction contract on that basis. It was for NHSGGC to assess whether what they had agreed to actually satisfied their requirements from a clinical perspective.

76. As to Mr McKechnie's position, what is said at paras 1524 and 1765 of the CTI Submission is wrong and misleading. By his email of 15 December 2009, Mr McKechnie made it clear to C&B (the party with whom he was in contact) that what was being proposed in terms of the ZBP ventilation proposal did **not** comply with the relevant draft SHTM guidance. This was a vital qualification to his statement that the proposal was a potential way forward given NHSGGC's insistence on reducing the maximum allowable temperature to 26°C.

77. In the result, there is no valid criticism which can be sustained against any of WW or ZBP (or indeed MPX) in relation to the 2.5 ACH rate delivered in the general wards.

(ii) The use of CBUs in the general wards

78. Very importantly, there was nothing in any guidance applicable at the time indicating that the use of CBUs was inappropriate within any of the wards within the hospital. Rather, the opposite was the case. The draft 2009 SHTM 03-01 document recognised

the use of CBUs as legitimate, cautioning only against the creation of draughts by their positioning. At para 2.38 of the draft SHTM-03-01 document, it was explicitly stated that:

> "The use of chilled beams for the provision of heating, cooling and ventilation is increasingly common in healthcare premises. The use of Active Chilled Beams providing temperature filtered air to a heating/cooling device within the room can provide effective local control of environmental conditions"[18].

79. The Employer's Requirements stated that "the use of active chilled beams should be considered within all ward areas": see section 2.4 thereof (Main Hospital Building), at para 2.4.3, emphasis added[19]. This is plainly consistent with the guidance contained in the draft 2009 SHTM 03-01 document.

80. Given what was said at para 2.38 of the draft 2009 SHTM 03-01 guidance, there can be no legitimate criticism of the Employer's Requirements including the aforesaid stipulation relative to CBUs. Nor is there any merit in a suggestion that a building services engineer should not have adopted CBUs as part of the design. The draft 2009 SHTM 03-01 guidance makes it clear that the use of such devices in a healthcare setting was acceptable. There is no proper basis in evidence to the effect that doing so was outwith the reasonable parameters (and engineering judgment) within which an ordinarily competent building services engineer would have been operating in this context at the relevant time, especially given what was said in the draft SHTM 03-01 and the direction contained in the Employer's Requirements.

81. To be clear, the contractual requirements stipulated that the use of CBUs within all ward areas required to be considered. Given this, to the extent that the designer, ZBP, considered and adopted CBUs in their design they can hardly be criticised for doing so – especially when the draft 2009 SHTM 03-01 document recognised that CBUs could legitimately be used.

82. In any event, the proposal to use CBUs and the rationale underlying that proposal were explained by ZBP in their ventilation strategy document. NHSGGC were therefore left in no doubt as to what was being proposed. The proposed use of CBUs was specifically mentioned in the M&E Clarification Log (in the "Brookfield Comment" column) where

[18] Bundle 16, Document 5, p 371.
[19] Bundle 16, Document 14, p 1594.

it was made clear that the contractor's proposal was "to incorporate chilled beams as a low energy solution".

83. NHSGGC agreed to the use of CBUs. This is evidenced by the entries in the M&E Clarification Log. This, in turn, was what was incorporated into the construction contract.

84. NHSGGC therefore got what they wanted.

85. The fact that the use of CBUs may be discouraged in the 2022 version[20] of SHTM 03-01 is irrelevant. There is no suggestion, based on any proper evidence, that this reflected ordinary practice at the time of design more than a decade before. Nor was there anything in any guidance applicable at the material time which indicated that CBUs should not be used as part of the ventilation system. Rather, the draft 2009 SHTM 03-01 guidance very clearly recognised that CBUs could legitimately be used in a healthcare setting.

86. For completeness, it is noted that at para 1304 of the CTI Submission there is a suggestion that "CBUs cannot operate at 6ACH or more so the existence of CBUs in a general ward will result in non-compliant ACH." This does not make any sense as a criticism. As explained above, it was agreed with NHSGGC that the air change rate for the general wards would be 2.5 ACH. On this agreed basis, the general wards would accordingly not operate at a level of 6ACH. The existence of CBUs in that context is therefore neither here nor there.

87. Hence there is no proper basis for any criticism to be made of ZBP or WW (or MPX) in relation to the use of CBUs in the general wards.

(iii) The lack of validation of the ventilation system of the general wards

88. The validation of the ventilation system within the general wards was not part of WW's role.

89. ZBP had ceased trading in 2013. That was well before validation became relevant.

90. It follows that there is no valid basis for any criticism of WW (or ZBP) in this respect.

[20] Hearing Commencing 9 May 2022, Bundle 1 – Scottish Health Technical Memoranda, Document 10, pp 839-840.

(V) RHC Ward 2A – ventilation

Introduction

91. Nine different issues have been raised in relation to the ventilation of Ward 2A of the RHC.

92. First, it is suggested that HEPA filtration should have been installed (CTI Submission, para 1311).

93. Second, there was no air lock entrance provided to Ward 2A (CTI Submission, para 1312).

94. Third, it has been suggested that a rate of 10 ACH should have been provided for this ward (CTI Submission, para 1313).

95. Fourth, a complaint is again made that CBUs were used as part of the ventilation system (CTI Submission, paras 1314 to 1316).

96. Fifth, it has been noted that, as at handover, a room air pressure of +10Pa and a low positive pressure were required, and that the rooms should have been sealed and not had suspended ceilings (CTI Submission, paras 1317 to 1319).

97. Sixth, an issue has been raised about the absence of a pressure monitoring system (CTI Submission, para 1320).

98. Seventh, there was no back-up AHU provided (CTI Submission, paras 1321 to 1323).

99. Eighth, it is said that the isolation rooms in Ward 2A should have had HEPA filtration, but did not (CTI Submission, paras 1324 to 1327).

100. Ninth, once again a question has been raised regarding the absence of validation in relation to the ventilation system in Ward 2A (CTI Submission, para 1328).

WW's lack of involvement

101. As is accepted by CTI at paras 1567 and 1568 of the CTI Submission, WW did not participate in the design of the ventilation systems.

Critical overarching points relative to Ward 2A

102. It should be noted that, at para 1588 of the CTI Submission, it is accepted that the COS applicable here said "little about technical requirements" being necessary in relation to

this ward. That is a massive understatement. At para 1590 of the CTI Submission, it is acknowledged by CTI that "almost the only technical detail included in the COS was a double door, air lock, type, provision". No other technical requirement relating to this ward is identified by CTI as featuring in the COS. Consequently, there is no support for the supposed deficiencies which CTI now allege actually being specified requirements in relation to Ward 2A, in terms of the COS. That is of particular importance when one bears in mind that CTI appear to have accepted the evidence of C&B's Mr Hall (see CTI Submission, para 1545) that the Employer's Requirements and the COSs are "two halves making a whole" – the whole being the specification of what NHSGGC actually wanted in relation to a given ward. Accordingly, to the extent that Ward 2A was designed and built as a general ward, there can be no valid criticism of that in circumstances where there were essentially no technical ventilation requirements specified in the COS indicating that it should be treated otherwise.

103. That conclusion is reinforced by the fact that the only mention of ventilation in the COS applicable here came under the heading of "General in-patient Ward"[21]. Under that heading, as noted by CTI, the sole specific stipulation was for a double-door barrier system.

104. Thus, if and to the extent that the ventilation system of the ward does not meet the clinical requirements of a haematology and oncology and/or teenage cancer ward, this is not something for which the designers or constructors of the ward can be criticised. The sort of features which are now said to be necessary were never contractually specified or required by NHSGGC at the material time in relation to this ward. It would have been for NHSGGC to stipulate specific ventilation requirements if this ward was not to be treated as a general ward. They did not do so. Rather, the COS explicitly referred to the ward as being a general ward.

105. The problem is that the implications of these points do not seem to be followed through by CTI when it comes to assessing whether there are any deficiencies in the ward.

106. Whilst from the perspective of TÜV these points address the issues which have been raised relative to the ventilation of Ward 2A (where WW were not involved in the design anyway), they add the undernoted observations in relation to each specific issue.

[21] Bundle 43, Volume 6, Document 12, p 67, emphasis added.

(i) HEPA filtration in Ward 2A

107. The RHC COS was supposed to be a document of a clinical, technical nature. Neither WW nor ZBP played any role in the compilation of the RHC COS. It was not for parties like WW or ZBP to second guess what was provided for in this type of document. They did not have the clinical expertise to do so.

108. There was no express requirement in the RHC COS for HEPA filtration. This is determinative.

109. As noted above, Ward 2A was identified in the COS as a general ward and was designed and built as one.

110. Furthermore, HEPA filtration was not required by any guidance, such as the draft SHTM 03-01, unless the need for it was identified through clinical assessment. This is recognised in the CTI Submission at para 1374. No such need was ever specified by NHSGGC relative to Ward 2A. There was nothing in the COS to that effect.

111. Taking these points together, there is no proper basis for any criticism of ZBP (or indeed WW, given their lack of involvement in the design) in relation to the absence of HEPA filtration in Ward 2A.

(ii) No air lock entrance for Ward 2A

112. It is recognised by CTI that the air lock entrance was absent from developed drawings produced by the architects, Nightingales: see CTI Submission, para 1590. Given that the architects did not produce a design detailing an air lock entrance in Ward 2A, it is submitted that no valid criticism can be levelled at ZBP for not providing for it in their design.

(iii) The rate of ACH in Ward 2A

113. As previously explained, Ward 2A was designed and built as a general ward.

114. All the points made by TÜV in relation to the rate of ACH which NHSGGC ended up with in the general wards (see section (IV) of this submission) apply equally here *mutatis mutandis*.

115. By parity of reasoning with those earlier submissions, there is no valid basis for any criticism of ZBP (or indeed WW who were not involved in the design) in this context.

(iv) The use of CBUs in Ward 2A

116. As noted above, this ward was designed and built as a general ward.

117. Consequently, all the points made by TÜV in relation to the use of CBUs in the general wards (see section (IV) of this submission) apply equally here *mutatis mutandis*.

118. In line with those earlier submissions, there is no valid basis for any criticism of ZBP (or indeed WW – who were not involved in the design) in this connection.

(v) The air pressure in Ward 2A

119. In terms of the final version of the M&E Clarification Log, the confirmed proposal agreed to by NHSGGC was that there would be "slightly negative pressure to corridor" and that negative pressure was "to be created in the design solution" for the general wards.

120. Accordingly, to the extent that a level of +10Pa air pressure was not achieved in relation to Ward 2A (which was designed and built as a general ward), there is no proper basis for any criticism of the designer or constructor (and thus of ZBP or MPX). The proposal relative to air pressure was clearly explained to NHSGGC and they accepted it, as per the M&E Clarification Log.

121. It was for NHSGGC to assess, from a clinical perspective, whether this agreed feature of the ward would be appropriate for the different use to which Ward 2A was eventually put.

122. A related issue is said to be that the bedrooms and en suites in Ward 2A were not sealed and had suspended ceilings.

123. The short answer to this is that there was no requirement in the RHC COS[22] for sealed bedrooms or en suites. As previously noted, the RHC COS was supposed to be a clinical, technical document, but essentially the only technical requirement which was included in it was a double door, air lock, provision. No other technical requirement relating to this ward is identified by CTI as featuring in the COS. If NHSGGC had wanted sealed bedrooms and en suites in Ward 2A from a clinical perspective, then they should have specified that. They didn't. In addition, it is important to note that the architect, Nightingales, did not specify that there was any requirement for sealing of

[22] Bundle 43, Volume 6, Document 12, pp 62-73.

rooms or suspended ceilings (as appears to be recognised at para 1318 of the CTI Submission). Moreover, the evidence of Ms White of Nightingales was that NHSGGC had signed off on the specification for Ward 2A (see CTI Submission, para 697).

124. Neither WW nor ZBP played any role in the compilation of the RHC COS. There is no basis for suggesting that a building services engineer should have queried the RHC COS or what the architect had specified (or not specified, as the case may be). That is especially the case when there was no indication that this ward was to be used as a specialist ward. As regards ventilation, the COS itself referred to this ward as a general ward.

125. It has also been suggested that the air pressure demands of a ward used as Ward 2A is used mean that the lack of sealed bedrooms and en suites and the use of suspended ceilings constitute deficiencies. Again, however, it must be noted that the ward was designed and constructed as a general ward. In terms of the confirmed proposal relative to general wards, as per the M&E Clarification Log, NHSGGC agreed that there would be slightly negative pressure from the rooms to the corridor (refer to the submissions made in section (IV) above). Thus, NHSGGC accepted a proposal in terms of which there would not be the type of significant positive pressure now said to be necessary for Ward 2A.

126. The end result is that there is no proper basis for any criticism of ZBP (or indeed WW, given their lack of involvement) in this connection.

(vi) The absence of a pressure monitoring system in Ward 2A

127. There was no requirement in the RHC COS for a pressure monitoring system to be installed for this ward. This is recognised at para 1320 of the CTI Submission.

128. If NHSGGC had wanted a pressure monitoring system in this context from a clinical perspective, they should have specified that. But they did not do so.

129. The absence of any requirement for a pressure monitoring system is also consistent with there being no requirements in respect of particular levels of air pressure or sealed rooms (see item (v) above).

130. As a result, there is no valid basis for any criticism of ZBP (or indeed WW, having played no part in the design) in this connection.

(vii) No back-up AHU for Ward 2A

131. The straightforward answer to a complaint that there was no back-up AHU provided for Ward 2A is that there is no requirement (or need) for a back-up AHU in relation to general wards – which is how Ward 2A was, and should be, regarded. Indeed, no complaint has been made in relation to the absence of a back-up AHU in respect of the general wards.

132. The lack of any requirement for such a back-up AHU is further highlighted by the fact that no such requirement was stipulated in the draft SHTM 03-01 guidance available as at 2009. This is accepted at paras 1321 and 1323 of the CTI Submission.

133. To the extent that the CTI Submission proceeds on the basis of the views of Mr Lambert, those views were informed by what was contained in the 2022 version of SHTM 03-01 (as is accepted in the CTI Submission at para 1321). At the risk of stating the obvious, that guidance was not available or applicable at the time of design and construction of Ward 2A many years before.

134. It follows that there is no valid basis for any criticism of ZBP (or indeed WW, given their lack of involvement) in this context.

(viii) PPVL isolation rooms in Ward 2A

135. So far as it is understood, the issue raised here is that the PPVL rooms were not suitable for providing protective isolation to patients in Ward 2A: see para 1324 of the CTI Submission.

136. There was, however, nothing in the COS applicable here which indicated that this ward should be treated as anything other than a general ward when it came to ventilation (the COS refers to the ward being a "General in-patient Ward"[23]).

137. Nor was there anything in the Employer's Requirements specifying particular ventilation requirements in this context. Mr McKechnie confirmed that WW had played no role in assisting with the compilation of the Employer's Requirements in this

[23] Bundle 43, Volume 6, Document 12, p 67.

connection[24]. Nor was ZBP involved in their compilation, as Mr Pardy confirmed (see his witness statement[25], para 14).

138. As is also accepted in the CTI Submission at para 1614, ZBP's Mr Pardy knew nothing of the discussion by a group from IPC – which, very importantly, took place after the conclusion of the Employer's Requirements – in terms of which that group purported to agree what different types of isolation rooms would be desirable for different parts of the adult hospital. That group included the project manager, Ms Griffin.

139. In circumstances where the conclusions of the IPC group's discussions relative to isolation rooms were never communicated to Mr Pardy, he cannot legitimately be criticised for proceeding as he did. As CTI note at para 1614 of the CTI Submission, there was plainly an important "disconnect" between the contractual process (which Mr Pardy was rightly following) and separate and subsequent clinical discussions (to which he was not party and which he was never told about) around the location of and specification for isolation rooms. The point is further underscored by the email from Dr Hood to Ms Griffin sent on 5 June 2009[26], referred to at the CTI Submission at para 1614. That email was copied to Professor Williams for his role in the RHC. The significance of Dr Hood's email is his reference to things which "should be in the spec". The fact is, however, that they never were included in the contractual specification. Further, and in any event, as is recognised at para 1615 of the CTI Submission, the most obvious conclusion to be drawn from the evidence is that the design was signed off and that process should be "taken as indicating assent to what was being provided". That is correct.

140. In the context of Ward 2A, there is no evidence indicating that the clinicians ever communicated to ZBP any requirements or specification regarding any isolation rooms in Ward 2A. Furthermore, the ward was signed off and, as noted above, that indicates assent on the part of NHSGGC in relation to what had been provided (see, again, para 1615 of the CTI Submission).

141. As a result, there is no valid basis for any criticism of ZBP (or indeed WW who were not involved) in this connection.

[24] Transcript, Stewart McKechnie, 27 May 2025, pp 55-56, columns 106-107.
[25] Glasgow IV, Part 1 Hearing – witness statement, Steve Pardy, p 4.
[26] Produced at Bundle 42, Volume 2, Document 21, p 323.

(ix) The absence of validation of the ventilation system in Ward 2A

142. The validation of the ventilation system within Ward 2A of the RHC was not part of WW's role. ZBP had ceased trading well before validation became relevant.

143. There is accordingly no valid basis for any criticism of WW (or ZBP) in this respect.

Concluding points on Ward 2A

144. It is important to note that NHSGGC's Mr Calderwood accepted that, when it came to Ward 2A, NHSGGC 'got what it asked for'. The problem, he said, was that what had been asked for was subsequently thought not to be good enough from NHSGGC's perspective[27]. That is an issue for NHSGGC, not ZBP (nor one for WW).

145. The point is reinforced by the email from Dr Armstrong to the Chief Executive sent on 17 September 2015[28] which is referred to at the CTI Submission, para 1594. As noted there, Dr Armstrong records, in a context which includes consideration of Ward 2A, confirmation from the Director of Facilities that rooms at the RHC had been constructed and commissioned "in accordance with the specifications and plans signed off by the Board to Brookfield Multiplex". That is a key admission. Put another way, NHSGGC recognised that they had got what they had asked for.

(VI) <u>RHC Ward 2B – ventilation</u>

Introduction

146. There are four issues which have been raised relative to the ventilation of Ward 2B.

147. First, there is the suggestion that the rate of ACH in the ward should have been 6 ACH (CTI Submission, para 1362).

148. Second, the use of CBUs has been criticised (CTI Submission, paras 1363 and 1364).

149. Third, an issue has been raised regarding "the air change…going in the wrong direction towards the immunocompromised patients instead of away from them" (CTI Submission, para 1365).

[27] Transcript, Robert Calderwood, 1 October 2025, p 44, column 84.
[28] Bundle 27, Volume 8, Document 28, pp 114-116.

150. Fourth, a question has been raised concerning the absence of validation in relation to the ventilation system in Ward 2B (CTI Submission, para 1366).

WW's lack of involvement

151. As previously noted, it is accepted by CTI at paras 1567 and 1568 of the CTI Submission that WW did not participate in the design of the ventilation systems.

Critical overarching points relative to Ward 2B

152. Ward 2B is the Schiehallion Day Care Unit. As the name suggests, patients only receive treatment on a day care basis. It is understood that no patients stay overnight (see CTI Submission, para 1360).

153. In the absence of any NHSGGC stipulation to the contrary (and there was none), Ward 2B should therefore be regarded as a general ward and assessed on that basis. Consequently, there is no proper basis for applying the clinical requirements of a higher 'level' of ward. Indeed, as is recognised at para 1360 of the CTI Submission, "because patients [in the present context] are out in the general community then they are not given specialist precautions, even though they are still immunocompromised and at an elevated risk of infection"[29]. The point is further reinforced by the fact that CTI do not, for example, suggest that the lack of HEPA filtration is a potentially deficient feature: see CTI Submission, para 1360. Given these points, there is no warrant for applying any standards other than those applicable to a general ward.

154. Thus, if and to the extent that the ventilation system of Ward 2B does not meet the clinical requirements for a higher 'level' of ward, that is not something for which the designers or constructors of the ward can be criticised. The sort of features which are now said to be required were never contractually specified or required by NHSGGC at the material time in relation to this ward. Nor are they objectively justified given the type of ward and the nature of the patients being treated (refer to the CTI Submission, para 1360).

155. Whilst from the perspective of TÜV this point addresses the issues which have been raised relative to the ventilation of Ward 2B, they add the following brief points in relation to each specific issue raised in this connection.

[29] Transcript, Andrew Poplett, 7 November 2024, p 25, column 45, emphasis added.

(i) The rate of ACH in Ward 2B

156. As explained above, Ward 2B should be regarded as a general ward and assessed on that basis. It follows that all the points made by TÜV in relation to the rate of ACH which NHSGGC ended up with in the general wards (see section (IV) of this submission) apply equally here *mutatis mutandis*.

157. In line with those earlier submissions, there is no valid basis for any criticism of ZBP (or indeed WW given their lack of involvement) in this context.

(ii) The use of CBUs in Ward 2B

158. Para 1363 of the CTI Submission acknowledges the highly significant point that the guidance available at the material time did not prohibit the use of CBUs. Indeed, as previously noted, the draft 2009 SHTM 03-01 guidance (at para 2.38) expressly recognised that CBUs could legitimately be used. The Employer's Requirements required that consideration be given to the use of CBUs "within all ward areas": see section 2.4 thereof (Main Hospital Building), at para 2.4.3, emphasis added.

159. Further and in any event, on the footing that Ward 2B is properly regarded as a general ward, all the points made by TÜV in relation to the use of CBUs in the general wards (see section (IV) of this submission) apply here *mutatis mutandis*.

160. As per those earlier submissions, there is no valid basis for any criticism of ZBP (or indeed WW, having not been involved in design here) in this connection.

(iii) Room air pressure in Ward 2B

161. Consistent with an approach to this ward as being a general ward, the design intention would have been that there should have been a slightly negative pressure created. This is what was specifically referred to in the M&E Clarification Log – which recorded what was being proposed by ZBP and MPX and to which NHSGGC eventually agreed (as reflected in the construction contract).

162. At para 1365 of the CTI Submission, it is stated that "the ward areas appeared to have been commissioned to operate at a slightly negative pressure". If so, this would constitute compliance with what had been proposed by MPX and agreed to by NHSGGC. Thus, NHSGGC received what they had asked for in this respect.

163. To the extent that Mr Lambert considered that this amounted to the air change going in the 'wrong' direction, that is not a valid criticism. There was never any intention or indication to provide positive pressurisation in this context. NHSGGC never asked for this in relation to Ward 2A.

164. Hence there are no legitimate grounds for complaint relative to ZBP (or WW either given their lack of involvement).

(iv) The absence of validation of the ventilation system in Ward 2B

165. The same position set out above on this issue is adopted here. The validation of the ventilation system within Ward 2B of the RHC was not part of WW's role. ZBP had ceased trading well before validation became relevant.

166. There is accordingly no valid basis for any criticism of WW (or ZBP) in this respect.

(VII) <u>RHC PICU</u>

Introduction

167. In the CTI Submission, six issues are raised in connection with the PICU.

168. First, it is said that the ventilation system should have delivered 10 ACH, but did not (CTI Submission, para 1376).

169. Second, an issue is again raised regarding the use of CBUs (CTI Submission, para 1377).

170. Third, it is suggested that the air pressure required to be +10Pa, but that this level was not met (CTI Submission, para 1378).

171. Fourth, there is said to be a deficiency because no back-up AHU was provided (CTI Submission, para 1379).

172. Fifth, as regards the PPVL isolation rooms in the PICU, it is suggested that they did not have 10 ACH, +10Pa pressure or HEPA filtration (CTI Submission, para 1380).

173. Sixth, a question has been raised regarding the absence of validation in relation to the ventilation system in Ward 2B (CTI Submission, para 1381).

WW's lack of involvement

174. As before, it is accepted by CTI that WW did not participate in the design of the ventilation systems. Refer to at paras 1567 and 1568 of the CTI Submission.

The applicable COS here

175. There was a COS entitled "The New South Glasgow Hospital Critical Care Department"[30]. At para 1.3 thereof, it expressly excluded care for children of 16 years and under. It should nonetheless be noted that the document contained no stipulations in relation to ventilation when it came to the adult critical care department.

176. There was a specific paediatric COS entitled "New Children's Hospital Paediatric Intensive Care Unit"[31]. Very importantly, it contained no stipulations whatsoever in relation to ventilation in that particular context.

177. The said paediatric COS did refer to a document "HBN57"[32]. But that document contained no ventilation requirements either.

(i) The ACH rate in the PICU

178. No ACH rate was specified in the relevant paediatric COS.

179. Accordingly, there is no valid basis for any criticism of ZBP (or indeed WW, having not been involved in design here) in this connection.

(ii) The use of CBUs in the PICU

180. There was no prohibition on the use of CBUs in this context. As previously noted, para 1363 of the CTI Submission acknowledges the highly significant point that the guidance available at the material time did not prohibit the use of CBUs. The draft 2009 SHTM 03-01 guidance expressly recognised that CBUs could legitimately be used. Moreover, the Employer's Requirements required that consideration be given to the use of CBUs within all ward areas.

181. The paediatric COS did not prohibit the use of CBUs in the PICU.

[30] Bundle 23, Document 29, pp 313-327.
[31] Bundle 43, Volume 4, Document 78, pp 1182-1185.
[32] Bundle 43, Volume 4, Document 78, p 1185.

182. Hence there is no proper basis for any criticism of ZBP (or indeed WW, having not been involved in design here) in this connection.

(iii) The air pressure in the PICU

183. The applicable COS said nothing about there being any particular air pressure requirements here. Thus, there was no specification by NHSGGC of any requirement regarding air pressure in this context.

184. Consequently, there are no legitimate grounds for complaint relative to ZBP (or WW either, given their lack of involvement in the design).

(iv) The absence of a back-up AHU in the PICU

185. The applicable paediatric COS did not specify any requirement for a back-up AHU.

186. The lack of any requirement for such a back-up AHU is further highlighted by the fact that no such requirement was stipulated in the draft SHTM 03-01 guidance available as at 2009. This is accepted at paras 1321 and 1323 of the CTI Submission.

187. To the extent that the CTI Submission proceeds on the basis of the 2022 version of SHTM 03-01, the response to that, rather obviously, is this guidance was not available or applicable at the time of design and construction of the PICU. Indeed, that point is accepted in the CTI Submission at para 1321.

188. There are no proper grounds for criticism of ZBP (or WW who had no involvement in the design).

(v) The PPVL rooms in the PICU

189. In the context of the PICU, there is no evidence indicating that the clinicians ever communicated to ZBP any requirements or specification regarding any isolation rooms in the context of the PICU. Furthermore, the unit was signed off and, as noted above, that indicates assent on the part of NHSGGC in relation to what had been provided (cf para 1615 of the CTI Submission).

190. On this basis, there are no proper grounds for criticism of ZBP (or WW who had no involvement in the design).

(vi) The absence of validation relative to the PICU ventilation system

191. The validation of the ventilation system within the PICU of the RHC was not part of WW's role. ZBP had ceased trading well before validation became relevant.

192. There is accordingly no valid basis for any criticism of WW (or ZBP) in this respect.

(VIII) QEUH Ward 6A – ventilation

193. This ward was originally designated as an adult rheumatology ward. This is accepted at para 1388 of the CTI Submission.

194. As a result, Ward 6A had no specialist ventilation requirements.

195. It follows that Ward 6A should be regarded as a general ward. This is accepted at para 1388 of the CTI Submission.

196. On that basis, TÜV adopt the same position in the present context as they did in section (IV) (dealing with the general wards). By parity of reasoning, there is no valid basis for any criticism of ZBP (or WW) in relation to Ward 6A.

197. As is noted at para 1389 of the CTI Submission, in September 2018 neutropenic patients were moved by NHSGGC into Ward 6A.

198. This post-handover decision by NHSGGC to move these patients was obviously not something which WW had anything to do with (or indeed ZBP which had long since ceased trading).

199. In the light of the foregoing, if and to the extent that any ventilation issues arose from a post-handover decision to move a particular category of patients into Ward 6A, that is not something for which either WW or ZBP could possibly be criticised.

(IX) QEUH Ward 4B – ventilation

Introduction

200. In the CTI Submission, eight issues have been raised in relation to the ventilation of Ward 4B.

201. First, whilst HEPA filtration was installed in patient bedrooms, it has been suggested that the absence of such filtration in corridor and ancillary spaces in Ward 4B is a deficiency (CTI Submission, para 1394).

202. Second, it may be the case – it is not clear – that a complaint is being raised concerning the absence of an airlock (CTI Submission, para 1395).

203. Third, it is said that there should have been a rate of 10 ACH achieved, but only 6 ACH were delivered by the system at handover (CTI Submission, paras 1396 and 1402).

204. Fourth, there has been a suggestion that a room air pressure of +10Pa should have been provided, and also that the Pentamidine treatment room should have had negative air pressure (CTI Submission, paras 1398 and 1399).

205. Fifth, the ward had suspended ceilings at handover, and an issue has been raised that this does not constitute a sealed space (CTI Submission, para 1400).

206. Sixth, there was no back-up AHU installed at the time of handover, and it has been suggested that the absence thereof constitutes a deficiency (CTI Submission, para 1401).

207. Seventh, a question has been raised regarding the absence of validation in relation to the ventilation system in Ward 4B (CTI Submission, para 1403).

208. Eighth, an issue has been raised regarding the absence of a pressure monitoring system (CTI Submission, paras 1404 and 1405).

WW's lack of involvement

209. It is accepted by CTI that WW did not participate in the design of the ventilation systems: see paras 1567 and 1568 of the CTI Submission. More specifically, WW did not participate in the process between July and October 2013 which is narrated below. There is simply no evidence of that at all.

210. It should also be noted that, by the time of the events of July 2013 and subsequently (as narrated below), ZBP had ceased trading.

Prefatory points

211. On one reading, CTI's submissions in this connection appear to proceed on the basis that as Ward 4B was originally intended to be a form of specialist ward, the absence of corresponding specialist features in the eventual Ward 4B constitute deficiencies (refer to CTI Submission, paras 1584 to 1587 and 1606). That does not make any sense. Once the decision was taken in July 2013 to change the function of the ward, what had

previously been applicable was not relevant. Rather, the requirements of NHSGGC in relation to the 'new' Ward 4B fell to be established by means of the collaborative process which took place between July and October 2013 (as further explained below). It was what was specified in that process – and especially what was not specified – which is important.

(i) The absence of HEPA filtration in non-bedroom spaces in Ward 4B

212. Ward 4B was not originally intended to accommodate BMT patients.

213. No COS in respect of the adult BMT unit was ever produced by NHSGGC during the course of the design and construction of the building.

214. Notwithstanding this, NHSGGC ended up using Ward 4B as the adult BMT unit.

215. By means of a Project Manager's instruction issued to MPX on 2 July 2013 (being PMI 228)[33], NHSGGC instructed MPX: (a) to stop works on level 4 of the building; (b) to provide an assessment of the works already carried out in this area; and (c) to work with the NHSGGC team "to develop the design detail utilizing the RDD process in order to come to a design within the ?700k (inc OH&P) currently identified by [MPX]."

216. Pausing at this point, it is important to note what is recorded here. First, the works which had been carried out to date were to be assessed. Second, the NHSGGC team would collaborate in the development of the detailed design for the 'new' Ward 4B.

217. The process envisaged in PMI 228 proceeded, MPX produced proposals in relation to the ventilation of Ward 4B and these were agreed by NHSGGC in October 2013.

218. NHSGGC's agreement is documented in the Compensation Event Notification no. 10675 (dated 2 October 2013)[34], in terms of which it was recorded that NHSGGC (i) accepted the ventilation proposals made pursuant to PMI 228 and (ii) confirmed that the relevant design and adaptations "should be taken forward and incorporated into the finished building by the contract completion date for Stage 3."

219. The confirmed ventilation system for Ward 4B included the installation of HEPA filtration in ceiling diffusers in patient bedrooms, but all other spaces in Ward 4B – including the corridors and ancillary spaces – had no HEPA filtration. This was what

[33] Bundle 16, Document 27, p 1697.
[34] Bundle 16, Document 30, p 1700.

NHSGGC agreed to. In short, there was no requirement for HEPA filtration in those other areas. It was a matter for NHSGGC to assess whether what was proposed, following their change to the use of Ward 4B, was satisfactory from a clinical perspective. In the end, NHSGGC got what they said they wanted (and agreed to).

220. There is no evidence of any involvement on the part of WW in the process undertaken between July and October 2013.

221. In the light of the foregoing, there is no legitimate basis whatsoever for any criticism of WW (who were not involved) or ZBP (who by this time had ceased trading).

(ii) The absence of an airlock in Ward 4B

222. The short answer to any complaint in this regard is that no airlock was ever specified by NHSGGC in relation to Ward 4B.

223. As noted above, it was a matter for NHSGGC to assess whether what was proposed – following their change to the use of Ward 4B – was satisfactory from a clinical perspective. If NHSGGC wanted an airlock to be provided for Ward 4B, it was incumbent on them to ask for one. They never did. Instead, they agreed to MPX's aforesaid proposals which did not include an airlock. That would be the end of the matter from the perspective of MPX.

224. There are no grounds for levelling any complaint against any of WW or ZBP in this connection. WW were not involved in the aforesaid process of collaborative design relative to the 'new' Ward 4B. As to ZBP, they had ceased trading by this time.

(iii) The rate of ACH in Ward 4B

225. As noted above, no COS for the BMT unit was ever produced by NHSGGC during the course of the design and construction of the building.

226. Consequently, there was no specific stipulation by NHSGGC as to the rate of ACH to be achieved relative to the BMT unit once the decision was taken by NHSGGC in July 2013 to use Ward 4B for the purpose of delivering BMT treatment. As previously noted, WW were not involved at all in the process undertaken between July and October 2013.

227. To the extent that the Adult Haematology and Oncology COS[35] was referred to in relation to Ward 4B, it is important to note that this document made no reference to ACH rates.

228. In any event, in terms of what was eventually delivered in relation to the ventilation of Ward 4B, NHSGGC confirmed (in terms of Compensation Event Notification no. 10675) that they accepted the ventilation proposals made pursuant to PMI 228 and that the design should be taken forward and incorporated into the finished building. In circumstances where NHSGGC were, as at July 2013, changing the nature of the ward, if they had wanted a particular rate of ACH for Ward 4B then they should have specified it. In the collaborative design process which was conducted between July and October 2013 pursuant to PMI 228, it was for NHSGGC to assess the nature of the ward from a clinical perspective (given that they had changed what they wanted to use the ward for), and then specify any requirements which they had in this connection. NHSGGC never specified that any particular rate of ACH had to be achieved in relation to Ward 4B's use as a BMT unit. As before, it is very important to remember that WW played no part in the collaborative design process undertaken in relation to Ward 4B which took place between July and October 2013.

229. Given all this, and the absence of any COS relative to Ward 4B during the design and construction period, there is no legitimate basis for any criticism of WW (or ZBP or MPX) in connection with the rate of ACH achieved in Ward 4B. This position is adopted relative to the issues raised regarding ACH rates at both para 1396 and para 1402 of the CTI Submission.

(iv) The air pressure in Ward 4B

230. Many of the same points made in the preceding sections of these submissions apply equally here.

231. As before, a critical initial point is that NHSGGC never produced a COS for the adult BMT unit during the design and construction period.

[35] Bundle 27, Volume 3, Document 5, pp 157-160.

232. To the extent that the Adult Haematology and Oncology COS was being referred to in relation to Ward 4B, that document simply referred to the ward having "positive pressure to the rest of the hospital". Nothing more.

233. At no point during the collaborative process conducted between July and October 2013 (in which WW played no part) did NHSGGC specify that a particular air pressure level had to be achieved in Ward 4B. Furthermore, NHSGGC signed off on what was being proposed in relation to the ventilation of Ward 4B – which included the delivery of positive pressure, nothing more. Refer to NHSGGC's confirmation in terms of Compensation Event Notification no. 10675.

234. At handover, the room pressure delivered was a positive pressure of 3 to 4 Pa (as confirmed in CTI's PPP12, at para 6.9.3).

235. Given that: (a) NHSGGC decided to change the use of Ward 4B in July 2013; (b) NHSGGC never issued any specific requirement relating to air pressure in Ward 4B despite having the opportunity to do so during the process carried out between July and October 2013; (c) NHSGGC agreed to what was being proposed regarding the ventilation of Ward 4B; (d) the only potentially relevant indication from NHSGGC relative to air pressure – as contained in the Adult Haematology and Oncology COS – was that the ward should have "positive pressure to the rest of the hospital"; and (e) a positive pressure level of 3 to 4Pa was delivered, it is submitted that there is no proper basis for any criticism of WW (who were not involved in the process between July and October 2013). The same applies to ZBP (who had ceased trading by this point).

236. At para 1399 of the CTI Submission, it appears to be suggested that there was a requirement that the Pentamidine treatment room should have had negative air pressure. No basis is offered for this supposed requirement in the CTI Submission. Furthermore, as previously set out, NHSGGC agreed – following the collaborative process conducted between July and October 2013 – to what was being proposed in connection with the ventilation of Ward 4B subsequent to their decision to change the ward's function. WW were not involved in the process undertaken between July and October 2013. Further, and in any event, there is no evidence of it ever being communicated to WW that there was any requirement that the Pentamidine treatment room should have negative air pressure. On the basis of the foregoing, there are no grounds for levelling any complaint

against any of WW in connection with the pressurisation of the said treatment room. The same applies to ZBP.

(v) Suspended ceilings/absence of sealing in relation to Ward 4B

237. Again, it is important to remember that Ward 4B was not originally intended to accommodate BMT patients.

238. Moreover, NHSGGC never produced a COS for the adult BMT unit. Consequently, there was no stipulation from NHSGGC requiring that the bedrooms and en suites in Ward 4B had to be sealed on account of some clinical concern or issue.

239. As explained above, in July 2013 NHSGGC stopped the works which were ongoing at level 4 and initiated a collaborative design process in relation to the use of Ward 4B. That ended with NHSGGC agreeing to the final proposals relative to the ventilation of the ward, as evidenced by Compensation Event Notification no. 10675. There is no suggestion in the evidence that NHSGGC ever specified during that process that Ward 4B required to be sealed in the manner now apparently suggested in the CTI Submission. Further, and in any event, WW were not involved in the aforesaid process relative to Ward 4B.

240. In summary, NHSGGC never asked for a sealed ward here. They agreed to what was eventually delivered. WW were not involved in the re-design of Ward 4B, all as aforesaid. Hence there is no proper basis for any criticism of WW in this connection (or of ZBP).

(vi) The absence of a back-up AHU in Ward 4B

241. The same points just made relative to the absence of a sealed ward apply equally here in respect of any issue about the absence of a back-up AHU in Ward 4B.

242. There was nothing in the Employer's Requirements requiring that a back-up AHU was necessary in relation to Ward 4B – which was, of course, never originally intended to be a ward for BMT patients.

243. Following the decision in July 2013 to change the use of Ward 4B, NHSGGC never asked that a back-up AHU be provided. Further, NHSGGC agreed to what was eventually delivered in Ward 4B.

244. Indeed, it is accepted in the CTI Submission at para 1401 that, "There was no requirement for a backup AHU at handover in 2015…" That is correct, and this is determinative of the matter from the perspective of WW (and ZBP).

245. WW was not involved in the aforesaid collaborative design process relative to Ward 4B. There is no evidence of their having been involved.

246. It follows that there is no proper basis for any criticism of WW (or ZBP) in this regard.

(vii) The absence of validation in respect of the ventilation system in Ward 4B

247. TÜV adopts the same position as before in relation to any issue concerning the lack of validation. The validation of the ventilation system within Ward 4B of the RHC was not part of WW's role. ZBP had ceased trading well before validation became relevant.

248. There is accordingly no valid basis for any criticism of WW (or ZBP) in this connection.

(viii) The absence of a pressure monitoring system in Ward 4B

249. Essentially the same position is adopted here as per the previous items.

250. There was never a COS for the BMT unit.

251. To the extent that the Adult Haematology and Oncology COS was being referred to in relation to Ward 4B, that document did not require a pressure monitoring system for the ward's bedrooms.

252. Nor, following NHSGGC's decision in July 2013 to change the use of Ward 4B, did NHSGGC ever ask that a pressure monitoring system be provided in Ward 4B. Furthermore, NHSGGC agreed to what was eventually delivered in Ward 4B. In any event, there is no evidence of WW ever having been involved in the aforesaid process relative to Ward 4B.

253. In the end, therefore, there is no legitimate basis for any criticism of WW (or ZBP) in this regard.

Concluding points

254. Four concluding points should be noted.

255. First, NHSGGC's Mr Calderwood was correct in his evidence[36] that: (a) the change order (effected by the PMI issued in July 2013) and the process which followed thereafter should be regarded as "spelling out specific works, with a proposed price – a 'buying order'"; and (b) had there been further works, that would have needed another order and another (presumably extra) price. Refer to his evidence as recorded at para 1597 of the CTI Submission.

256. Second, the consideration by CTI at paras 1598 to 1600 as to what *might* have been specified in relation to the "very particular protective environment" (CTI Submission, para 1600) which some thought necessary is essentially neither here nor there given that (i) the change order which was actually issued did not specify any of the features the absences of which are now said to constitute deficiencies and (ii) no further change order was ever issued. With regard to the question raised at para 1602 as to whether the now contended for requirements were ever passed on to MPX, there is no evidence which would suggest that they were. CTI certainly do not identify any such evidence.

257. Third, Mr Calderwood accepted that, when it came to Ward 4B, NHSGGC 'got what it asked for'[37]. The problem, he said, was that what had been asked for was subsequently thought not to be good enough from NHSGGC's perspective[38]. Put another way, the problem, according to what Mr Calderwood is reported to have said, was that Ward 4B "had not been properly specified"[39] by NHSGGC: see CTI Submission, para 1603. That, however, is an issue for NHSGGC, not WW (or ZBP).

258. Fourth, as set out above, given that WW were not involved in the aforesaid process relating to Ward 4B there is no proper basis for any criticism of them (or ZBP who had of course ceased trading by this stage).

(X) QEUH Ward 4C – ventilation

Introduction

259. In the CTI Submission, nine issues are raised in relation to Ward 4C.

[36] His evidence on this point is found at Transcript, Robert Calderwood, 1 October 2025, p 8, column 12.
[37] Transcript, Robert Calderwood, 1 October 2025, p 44, column 84.
[38] Transcript, Robert Calderwood, 1 October 2025, p 44, column 84.
[39] Transcript, Professor John Brown, 3 October 2025, p 27, column 49.

260. First, it has been suggested that HEPA filtration should have been installed in the ward, but was not (CTI Submission, para 1418).

261. Second, it may be the case – it is not clear – that a complaint is being raised concerning the absence of an airlock (CTI Submission, para 1420).

262. Third, there is a contention that a rate of 10 ACH should have been delivered in this ward (CTI Submission, para 1421).

263. Fourth, the use of CBUs in Ward 4C has been questioned (CTI Submission, paras 1422 and 1423).

264. Fifth, it is said that there was a requirement for positive pressure, but that at handover in 2015 only neutral pressure had been provided (CTI Submission, para 1424).

265. Sixth, an issue has been raised that the rooms did not constitute a sealed space (CTI Submission, para 1425).

266. Seventh, the absence of a backup AHU has been raised (CTI Submission, para 1426).

267. Eighth, there is a suggestion that a pressure monitoring system should have been installed in Ward 4C, and that a pressure of +10 Pa was not achieved in the ward (CTI Submission, para 1427).

268. Ninth, a question has been raised regarding the absence of validation in relation to the ventilation system in Ward 4C (CTI Submission, para 1428).

WW's lack of involvement

269. As before, it is accepted by CTI that WW did not participate in the design of the ventilation systems. Refer to at paras 1567 and 1568 of the CTI Submission.

Important prefatory points

270. As is noted at paras 1502 and 1607 of the CTI Submission, Ward 4C was originally to be a general ward.

271. None of the mooted deficiencies mentioned by CTI relative to Ward 4C could validly be suggested as deficiencies in relation to a general ward, as such a ward would never

have had to meet the various supposed requirements set out in the nine issues[40] noted above.

272. With regard to potential criticism of the designer of the ward, that answers the complaints.

273. When the decision was taken by NHSGGC to change the status of Ward 4C, it was incumbent on them to specify whether they wished a particular type of protective environment to be created in the 'new' Ward 4C, featuring the sorts of requirements now mentioned by CTI. But NHSGGC never did so.

274. Nor did NHSGGC instruct that this general ward had to be re-designed so as to meet a higher ventilation specification. This is recognised by CTI at para 1608 of the CTI Submission where it is said that:

> "All that is known is that work was <u>not</u> instructed to turn a general ward into a ward meeting the original COS for Ward 4B"[41].

That is correct, and it is decisive in terms of assessing the conduct of the designer.

(i) The absence of HEPA filtration in Ward 4C

275. As stated above, Ward 4C was originally a general ward. There was no requirement for HEPA filtration in that context.

276. HEPA filtration was not required by any guidance, such as the draft SHTM 03-01, unless a need was identified through clinical assessment. This is recognised in the CTI Submission at para 1374. No such need was ever specified by NHSGGC relative to Ward 4C. Moreover, as CTI have acknowledged, there was no instruction ever issued to turn this general ward into one which met the original COS for the original Ward 4B (CTI Submission, para 1608).

(ii) The absence of an airlock in Ward 4C

277. Ward 4C was originally a general ward. No airlock was required in connection with such a ward.

[40] Or at least the first eight of them.
[41] Emphasis added.

278. To the extent that the Adult Haematology and Oncology COS has any relevance here, it did not require an airlock entrance to be supplied in relation to Ward 4C.

279. It would not be for ZBP (or WW – who in any event were not involved) to second guess what was required, from a clinical perspective, in a COS even if an instruction had been issued – which it was not – instructing that that specification was to apply to the re-designated Ward 4C.

280. As CTI have acknowledged, there was no instruction ever issued to turn this general ward into one which met the original COS for the original Ward 4B (CTI Submission, para 1608).

281. There is accordingly no valid basis for any criticism of ZBP (or WW) in this respect.

(iii) The rate of ACH in Ward 4C

282. As already stated on a number of occasions, the ward was originally a general ward. The applicable ACH rate was therefore as per the agreed position with NHSGGC relative to general wards (as to which the submissions made in section (IV) hereof are applicable and are adopted *mutatis mutandis* in this context).

283. In any event, if the Adult Haematology and Oncology COS had been applicable to Ward 4C (and it was not instructed to be) it did not make any reference to a particular air change rate being required.

284. There was no instruction ever issued by NHSGGC to turn this general ward into one which met the original COS for the original Ward 4B (CTI Submission, para 1608).

285. Hence there is no proper basis for any criticism of WW (or ZBP) in this respect.

(iv) The use of CBUs in Ward 4C

286. The Employer's Requirements stated that "the use of active chilled beams should be considered within <u>all</u> ward areas": see section 2.4 thereof (Main Hospital Building), at para 2.4.3, emphasis added. This particularly applied to general wards – which is what Ward 4C originally was.

287. In addition, and very importantly, there was nothing in any guidance applicable at the time indicating that the use of CBUs was inappropriate within any of the wards within the hospital. Indeed, the draft 2009 SHTM 03-01 guidance (at para 2.38) made it clear

that the use of such devices in a healthcare setting was acceptable. Consequently, there can be no legitimate criticism of the Employer's Requirements including the aforesaid stipulation relative to CBUs. Nor is there any merit in a suggestion that a building services engineers would not have adopted CBUs as part of the design (especially relative to a general ward). There is no proper basis in evidence to the effect that doing so was outwith the reasonable parameters (and engineering judgment) within which an ordinarily competent building services engineer should have been operating in this context at the relevant time.

288. Thus, the contractual requirements stipulated that the use of CBUs within all ward areas must be considered. Given this, to the extent that the designer considered and adopted CBUs in its design it can hardly be criticised for doing so – especially when: (a) there was nothing in any guidance applicable at the relevant time indicating that CBUs should not be used; (b) rather, the draft 2009 SHTM 03-01 guidance contemplated the use of CBUs; and (c) there was no instruction re-designating this general ward, such that different ventilation standards were to be applied to it.

289. As before, it is important to remember that no instruction was ever issued by NHSGGC to turn this general ward into one which met the original COS for the original Ward 4B: see the CTI Submission, para 1608.

290. Hence there is no proper basis for any criticism to be made of ZBP (or WW) in relation to the use of CBUs in Ward 4C.

(v) The air pressure in Ward 4C

291. As a general ward, Ward 4C did not require any positive pressurisation.

292. As CTI have acknowledged, there was no instruction ever issued to turn this general ward into one which met the original COS for the original Ward 4B (CTI Submission, para 1608).

293. In any event, the Adult Haematology and Oncology COS simply referred to a ward having "positive pressure to the rest of the hospital", nothing more.

294. A positive pressure relative to the rest of the hospital was delivered. Thus, the requirement in the Adult Haematology and Oncology COS was met.

295. There is accordingly no valid basis for any criticism of ZBP (or WW – who were not involved) in this respect.

(vi) Sealing of the rooms in Ward 4C

296. The points that Ward 4C was originally a general ward and there was never an instruction issued re-designating this general ward such that higher protective environment standards were to be applied to it are again of obvious relevance here.

297. A sealed environment was not required in relation to a general ward. There is no suggestion of that in the evidence at all.

298. When the ward was re-designated, there was no indication of any requirement on the part of the NHSGGC that sealed rooms had to be provided.

299. Furthermore, as noted below in the context of the issue regarding the absence of a pressure monitoring system (see item (viii) below), no requirement has been identified by CTI in relation to the provision of a pressure monitoring system. The absence of any requirement for a pressure monitoring system is consistent with there being no requirement for a sealed environment.

300. There is accordingly no valid basis for any criticism of ZBP (or WW) in this respect.

(vii) The absence of a backup AHU in Ward 4C

301. This point can be dealt with very briefly. As is recognised in the CTI Submission at para 1426, there was no requirement for a backup AHU at handover. That is determinative of the matter from the perspective of ZBP (or WW – who in any event were not involved). NHSGGC received what it had asked for, and that did not include a backup AHU in Ward 4C.

302. Consequently, there is no valid basis for any criticism of ZBP (or WW) in this respect.

(viii) The absence of a pressure monitoring system in Ward 4C

303. CTI do not suggest that there was any requirement that a pressure monitoring system had to be provided for Ward 4C. No basis for such a requirement is identified in the CTI Submission.

304. It should also be noted that there was nothing in the Adult Haematology and Oncology COS indicating that NHSGGC required that a pressure monitoring system be installed

in Ward 4C. As with previous items, it was not for ZBP (or WW even if they had been involved) to second guess what was required, from a clinical perspective, in such COS (if and to the extent it was applicable; it being again noted it was never instructed as being applicable)).

305. As to the suggestion at para 1427 of the CTI Submission that Ward 4C should have had a +10Pa pressure, there is simply no basis for this. In particular, there was nothing in the Adult Haematology and Oncology COS stipulating such a requirement.

306. No instruction was ever issued to turn this general ward into one which met the original COS for the original Ward 4B: see the CTI Submission, para 1608.

307. Thus, there is no proper basis for any criticism of ZBP (or WW) in this connection.

(ix) The absence of validation in respect of the ventilation system in Ward 4C

308. The validation of the ventilation system within Ward 4C of the RHC was not part of WW's role. Further, ZBP had ceased trading well before validation became relevant.

309. Accordingly, neither WW nor ZBP can be the subject of legitimate criticism in this respect.

(XI) <u>PPVL isolation rooms – ventilation</u>

Introduction

310. In the CTI Submission, the issues which are raised in connection with the PPVL isolation rooms appear to be two-fold.

311. First, it is noted that none of the PPVL isolation rooms at either the RHC or the QEUH had HEPA filtration (CTI Submission, paras 1443 and 1445).

312. Second, it is suggested that, given certain concerns about the unsuitability of PPVL rooms for "severely immunocompromised or highly infectious patients", having all the isolation rooms in the hospital as PPVL rooms constituted a deficiency (CTI Submission, para 1448).

WW's lack of involvement

313. As before, it is accepted by CTI that WW did not participate in the design of the ventilation systems. Refer to at paras 1567 and 1568 of the CTI Submission.

(i) The absence of HEPA filtration relative to the PPVL rooms

314. In the ZBP Engineering Services Specification, August 2012[42], it was said:

> "Isolations 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 overcoming the additional resistance imposed by the HEPA filter by a simple speed change on the motor inverter" (emphasis added)

315. 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[43]. In short, ZBP advanced a proposal which did not include the provision of HEPA filtration, and this was accepted by NHSGGC.

316. There is accordingly no valid basis for any criticism of ZBP (or WW – who were not involved) in this respect.

(ii) All the isolation rooms being PPVL rooms

317. In the heading above para 1614 of the CTI Submission, CTI ask why all the isolation rooms were PPVL rooms. CTI answer that question at para 1614 as follows:

> "Having had the benefit of evidence from the ventilation designers, ZBP, there is a simple answer. They were all PPVL rooms because ERs specified that they should be constructed in accordance with guidance notes – HBN 04 Supplement 1 and SHPN4 – both of which refer to designs of PPVL rooms. Mr Pardy knew nothing of the conclusions of a meeting on 18 May 2009 (shortly after the ERs had been finalised in April) when a group from IPC discussed, and agreed, a position on what different types of isolation rooms would be desirable for different areas in the adult hospital. That the communication deficit is so notable is even more surprising when one sees that Ms Griffin, one of the Project Managers, was present…The apparent disconnect between contractual process – where the contractors work to ERs compiled by the client – and the existence of separate (later) discussions around 'specification', can also be illustrated by an email of 5 June 2009 from Dr Hood to Ms Griffin (copied to Professor Williams

[42] Bundle 23, Document 11, p 77.
[43] Transcript, Steve Pardy, 27 May 2025, pp 47-48, columns 89-91.

for his role in the Children's Hospital). In that email, he refers to the HEPA filters which 'should be in the spec'" (emphasis added).

318. As CTI recognise, the critical points here are: (a) the IPC group's discussions relative to isolation rooms post-dated the conclusion of the Employer's Requirements; and (b) these discussions were never communicated to Mr Pardy. Given this, he cannot legitimately be criticised for proceeding as he did. As CTI note, there was plainly a "communication deficit" which led to a crucial "disconnect" between the contractual process (which Mr Pardy was rightly following) and the separate and subsequent clinical discussions (to which he was not party and which he was never told about) around the location of and specification for isolation rooms.

319. In conclusion, no proper basis for any criticism of ZBP (or WW – who were not involved) exists in relation to this matter.

(XII) The water system

320. In the section of the CTI Submission relating to the water system, three issues are addressed by CTI – namely, when the water system was filled, what processes were in place to 'look after' the system and the issue of open pipe ends: see CTI Submission, para 1623 et seq.

321. Overall, TÜV's position in relation to the water system is that the issues with contaminated water arose from the physical use of the system, as well as being the result of the pipes not having been properly stored during the build phase, rather than being attributable to any design issue which might 'engage' ZBP or WW.

322. The evidence from the relevant experts in connection with the water system strongly suggests that it was the commissioning, maintenance and lack of early testing which caused the problems in the water system.

323. None of these matters was the responsibility of ZBP or WW. Neither was involved in the physical installation of the system or with its commissioning or maintenance.

324. No criticism is levelled by CTI in their submission against either ZBP or WW when it comes to perceived deficiencies in the water system. That was the correct approach by CTI. There was, and is, no proper foundation for any criticism to be made against either party relative to the water system.

(XIII) The issue of infections

325. At para 399 of the CTI Submission, it is stated that "there clearly was a link between patient infections and features of the water system in the hospital" (see also CTI Submission, paras 402 to 404). That is a submission on which, no doubt, CTI and NHSGGC's counsel will engage intensively. For present purposes, however, what should be noted is that CTI are plainly suggesting that a causal link between defective features of the hospital's water system and certain infections has been established, at least to their satisfaction (though of course it will ultimately be a matter for the Chair).

326. In contrast, when it comes to the ventilation system, all that said by CTI is that patients with immunocompromised systems "are put at risk" from potential *Aspergillus* and *cryptococcus* infections "by being housed in environments that do not have HEPA filtration or pressure differentials and that lower air change rates mean lower dilution of anything harmful which may have entered the room": see CTI Submission, para 405.

327. The specificity of this observation is extremely important. The suggestion is that immunocompromised patients "are put at risk" by certain features of the hospital's ventilation system. Even if one assumes that this is correct[44] (and it is anticipated that NHSGGC will have much to say on this topic), what is **not** said by CTI is that if such a risk existed or exists it has ever manifested itself such that a patient has actually become infected thereby.

328. In other words, CTI do **not** suggest that any causal link has been established between any specific ventilation deficiency (or indeed any deficiencies generally) and actual infections suffered by patients. Indeed, this point appears to be accepted by CTI in that, at para 407 of the CTI Submission, they appear to adopt the evidence of Mr Bennett that it is "probably impossible" to establish whether any particular infection was actually caused by any specific feature of the building now alleged to be deficient[45]. If the Chair were to adopt the position of CTI in this regard, it is submitted that he should make the foregoing points clear in any findings which he makes.

[44] A point on which TÜV does not take a stance.

[45] For completeness, it should be noted that CTI also acknowledge that there has been no statistically significant increase in the rates of *Aspergillus* infections amongst paediatric haemato-oncology patients at the RHC, as compared to the Yorkhill hospital. Refer to para 1684 of CTI Submission.

(XIV) Overall conclusions and final observations

329. TÜV make ten final points.

330. First, there is no proper basis for any criticism of the role or conduct of WW (or ZBP for that matter).

331. Second, NHSGGC got what they asked for in relation to the design and construction of the QEUH and the RHC. This has been acknowledged by representatives of NHSGGC, such as Mr Calderwood.

332. Third, to the extent that it is now considered in hindsight that what was delivered was deficient, that arose from a failure on the part of NHSGGC properly to specify their requirements. Again, this has been acknowledged by representatives of NHSGGC, such as Mr Calderwood.

333. Fourth, it is submitted that it is the relevant health board which is best placed to identify which particular output parameters and requirements the key building systems are required to deliver for the specific clinical uses which the board intends for the facility and for its specific constituent elements, rooms and areas. The health board's brief must very clearly identify its requirements, so that the building and its component systems can satisfactorily meet them. That did not happen here.

334. Fifth, it should be remembered that NHSGGC stood down its technical advisory team (of which WW had been a part) in January 2010.

335. Sixth, it is highly important, as CTI have noted, that there is no real evidence of the involvement of the IPC team in any of the detail of the design process regarding the hospital as a whole: see CTI Submission, at paras 1478 and 1577.

336. Seventh, CTI have stated that:

> "To describe the availability of competent scrutiny of ventilation design on the NHSGGC side as sorely lacking is not an overstatement. That process, and the participants in it, is in our submission **the major contributor** to the outcomes which many have felt were unsatisfactory" (CTI Submission, para 1578, emphasis added).

It is submitted that this conclusion is well-founded.

337. Eighth, the necessary level of granularity should not be underestimated if a successful project of this type is to be delivered. Clinical output specifications for departments or other areas having a clinical function should set out, in detail and in the clearest terms possible, the relevant patient cohorts and activities which the relevant area is intended to accommodate, together a schedule of accommodation identifying how areas are to be laid out and their adjacency to other areas. In addition, the health board's brief should include documentation identifying the environmental parameters of all spaces within such areas, including precise specification of applicable ventilation parameters, such as air change rates, pressure differentials, levels of filtration and temperature.

338. Ninth, it is submitted that a process whereby there was a greater, clearer and more active degree of collaboration amongst the health board's project team, clinicians, infection control specialists and engineers in relation to the board's clinical requirements would have been desirable, with a view to ensuring that the clinical output specifications and requirements of the health board correlated with appropriate environment parameters.

339. Tenth, it should be recognised, however, what has just been described would increase the burden on those concerned with managing the project, and would be likely to extend the length of time necessary to deliver such a project as well as increasing upfront costs.

GARRY BORLAND, K.C.

Senior counsel for TÜV

19 December 2025

THE SCOTTISH HOSPITALS INQUIRY

Closing Statement for the affected Core Participants: the adult patients and their families and the parents and representatives of the child patients affected by their treatment at QEUH/RHC

Following the Glasgow IV Hearing Diet: 13 May to 10 October 2025

In

SECTION

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1. Introduction

1.1 The Core Participants represented before this Inquiry by Messrs Thompsons, Solicitors are adult patients and their families and the parents of child patients who were, or are still being, treated on adult wards, the children cancer ward and in the neo-natal unit at the Queen Elizabeth University Hospital and Royal Hospital for Children in Glasgow ('QEUH/RHC').

1.2 The stated purpose of the hearings was to enable the Inquiry to obtain evidence with a view to allowing Lord Brodie, the Chair to the Inquiry, to determine: (i) whether issues relating to adequacy of ventilation, water contamination and other matters including communication impacted on patient safety and care and, if so, whether those issues could have been prevented/avoided; (ii) whether any issues relating to adequacy of ventilation, water contamination and other matters including communication impacted on patients and families and, if so, what those impacts were; and (iii) whether the QEUH/RHC provides (current tense) a suitable environment for the delivery of safe, effective, patient-centred care.

1.3 It is submitted on behalf of the Core Participants we represent that that stated purpose has been achieved subject to certain critical ‘gaps’ that we will seek to identify and expand upon in this Closing Statement.

1.4 The evidence taken throughout the course of this Inquiry resonates with and supplements the evidence that has been heard throughout from patients and families affected by the issues under investigation by the Inquiry.

1.5 It is our submission that the Inquiry’s remit has not been assisted by the belligerent, confrontational and dismissive attitude and tone demonstrated by NHS Greater Glasgow and Clyde (‘NHS GGC’) witnesses. The evidence presented throughout this Inquiry has painted a damning picture of a Scottish health board far more concerned with its reputation and cost-cutting than with the fundamental safety and well-being of the vulnerable individuals entrusted to its care. The narrative that the hospital was a world-class facility has been exposed as a cruel facade, behind which lurked a "sick building" with fundamentally deficient water and ventilation systems.

1.6 The Inquiry has heard overwhelming evidence that the environmental failures at QEUH/RHC were not just an ‘unfortunate coincidence’ but were, on balance, a direct cause of life-threatening, sometimes fatal, infections suffered by adult and paediatric patients.

1.7 That this could have happened, or been allowed to happen, is astonishing. The fact that this has happened, or been allowed to happen, has, in the eyes of those Core Participants we represent, been compounded by the manner in which NHS GGC and their apparently scripted witnesses have conducted themselves before and throughout this Inquiry. That is so up to the point that its current Chief Executive, Professor Jann Gardner, gave her evidence emphasising that, since she took up office in February 2025, NHS GGC had become more humble, diligent and committed to improvement. We submit that

Professor Gardner's evidence effectively amounted to wholesale condemnation of and apology for the conduct of those who preceded her taking up office. It has yet to be seen whether her observations and claims about NHS GGC's new found humility, diligence and commitment to improvement amounts to more than just words.

1.8 It is with great sadness that we have to submit that this Inquiry has not yet heard evidence from which it could be held or reasonably inferred that, under the control of NHS GGC, QEUH/RHC currently provides a suitable environment for the delivery of safe, effective, patient-centred care. It is with that in mind and for the reasons that will be expanded upon in due course that we will invite The Chair to conclude that this Inquiry has not yet fulfilled its Terms of Reference and its work should, accordingly, be seen as incomplete at this time.

1.9 QEUH/RHC is not a Superhospital. Its ventilation does not comply with SHTM 03-01. There is currently no compliant ward suitable for adult immunocompromised patients at the QEUH.

1.10 The lives of patients and families have been adversely and irrevocably affected by the many avoidable systemic failings at the QEUH/RHC that this Inquiry has heard evidence about. Those we represent have listened with astonishment to the evidence taken from witness after witness about the appalling failures of NHS GGC's past and present executive board and managers – without meaningful acknowledgement or apology.

1.11 The board members and managers who presided over the environmental failures at QEUH/RHC must be held to account for their failures.

1.12 At this remove, and given the conduct of NHS GGC before and throughout this Inquiry, any apology alone is insufficient. A genuine apology must start with a clear admission of fault. Such an apology avoids excuses and focuses solely on the wrongs committed and their consequences. Taking ownership. The most significant

demonstration of a meaningful apology is the effort to prevent the same mistakes from happening again – actions speak louder than words. While the words "we are sorry" are easy to say, their true meaning is found in the underlying intention and the positive changes that follow. As stated above, time will tell whether Professor Gardner's observations and claims about the 'new NHS GGC' amounts to more than just words.

1.13 We adopt the content of previous Closing Statements lodged on behalf of the Core Participants represented by Messrs Thompsons and invite the Chair to give due regard to their content. At the conclusion of the Hearing Diet commencing on 20 September 2021, then Counsel to the Inquiry posed a question: *On the particular question of infection risk, are Core Participants able to say whether they consider that there is evidence that either establishes or indicates links between infections and the built hospital environment?* The response to that question is contained at Section 4 of the Closing Statement lodged at that time on behalf of the Core Participants represented by Messrs Thompsons. We adopt that response observing that, despite years of protestation, NHS GGC now accepts the findings of the Case Note Review Overview Report dated March 2021. We submit that the evidence that has been heard by this Inquiry demonstrates a clear link between infections developed by patients and the hospital environment.

1.14 Recommendations must be made by this inquiry with a view to ensuring that past mistakes are not repeated. Only by doing so will the appalling failures of NHS GGC be learned from with the result that future, public funded, NHS infrastructure projects deliver safe, effective and patient centred environments operated by a health board who puts patients, and not itself, first.

2. Closing Statement by Counsel to the Inquiry

2.1 In their Closing Statement, Counsel to the Inquiry propose that the evidence before this Inquiry identifies systemic failures by NHS GGC in the procurement, design, commissioning and management of the QEUH/RHC's water and ventilation systems; those failures adversely impacted patient safety and led to avoidable patient risks, with organisational culture, governance, and communication requiring significant improvement to prevent recurrence and restore public confidence; deficiencies in the water and ventilation systems at the Queen Elizabeth University Hospital and Royal Hospital for Children (QEUH/RHC) did adversely impact patient safety and care.

2.2 We agree with Counsel to the Inquiry and, as a generality, adopt what is said by them in that regard.

3. Executive Summary

3.1 In the design and construction of the new hospital NHS GGC appointed someone as the Project Director – Alan Seaborne – who had no prior experience of such a large and technically complex project and had no technical expertise to be able to lead on such a project.

3.2 Alan Seabourne and the Project Team terminated the use of outside experts who were able to advise on ventilation and water in 2009.

3.3 In 2009 Alan Seaborne and the Project Team decided to agree to a reduction in the air change rates ('ACR') for the single rooms in the hospital without any assessment whatsoever of the potential and consequential risks to patient safety.

3.4 The Project Team did not have the necessary technical expertise in or personal experience with ventilation issues to agree to such a reduction, although Alan Seabourne believed he did.

3.5 The Project Team failed to seek the advice of independent experts on this issue before agreeing to the construction contractor's proposals.

3.6 Bizarrely, the Project Team even failed to seek the advice of NHS GGC's own Infection Prevention and Control team and its Microbiologists in connection with this course of conduct.

3.7 The Scottish Government allowed the contract to build the new hospital to be signed in 2009 without carrying out any, let alone adequate, checks that the design of the hospital was safe for patients.

3.8 NHS GGC's Chief Executive and Executive Board failed to put in place any, let alone adequate, measures to check and assure themselves that the Project Team were carrying out the design of the new hospital so that it was safe for patients.

3.9 The Chief Executive and Executive Board also failed to carry out all (or even any) reasonable checks on the construction of the hospital before handover in January 2015.

3.10 The hospital ventilation system was built to a sub-standard level well below the health guidelines (SHTM 03-01).

3.11 The ventilation system was not validated by an independent engineer before handover as it should have done.

Had this validation have been carried it is highly likely that NHS GGC would not have accepted the hospital and it would not have opened in 2015 (see the example of The Royal Hospital for Children and Young People and Department of Clinical Neuroscience, Edinburgh).

3.12 NHS GGC failed to properly take into account the fact that the contractors filled the water system around 18 months before the hospital was opened.

3.13 NHS GGC instructed a report on the water system from a specialist company called DMA Canyon before the hospital opened (a required legionella risk assessment), which highlighted numerous problems with the water system that needed to be addressed to make the

system safe. When the report was received in early 2015 the Estates Team failed to address and action any of the recommendations made in the Report.

3.14 These failures were not identified by the Duty Holder for Water who was the then Chief Executive, Robert Calderwood. Mr Calderwood did nothing as the Duty Holder for Water while in his post and until he retired in 2017.

3.15 A Designated Person for Water should have been appointed at or before the opening of the hospital – NHS GGC failed to do this.

3.16 A Water Safety Group (an essential part of managing a water system) should have been appointed before the hospital was handed over – NHS GGC failed to do this until years after the hospital was occupied by patients.

3.17 Expert evidence heard by the Inquiry is clear – early filling of the water system and lack of proper management of it by NHS GGC resulted in widespread contamination of the QEUH water system.

3.18 The failures by NHS GGC were allowed to persist even after QEUH opened for patient occupation in 2015.

3.19 The Healthcare Associated Infection System for Controlling Risk in the Built Environment (HAI-SCRIBE) provides a framework around which potential infection risks associated with a proposed site development, design and planning, construction or refurbishment and ongoing maintenance of healthcare facilities can be identified, assessed and subsequently managed or mitigated – NHS GGC failed to carry out this key process before the hospital was opened.

3.20 There were numerous warning signs for NHS GGC after the hospital opened and before they started to take significant action. Action was only taken in 2018, three years after the QEUH was occupied by patients, despite high levels of unusual blood stream infections being

identified and significantly increased levels of infections amongst the most vulnerable patients noted.

3.21 The specialist Beatson Bone Marrow Transplant Unit moved from its original location to the QEUH when it opened in May 2015, but it immediately became apparent that the allocated ward (Ward 4B) did not meet the required ventilation standards. Patients were exposed to increased risks to their health and safety and the BMT unit moved back to its original Beatson location in July 2015.

3.22 Even this highly unusual event did not stimulate an assessment by NHS GGC as to whether the ventilation for the whole hospital had been validated properly or even at all.

3.23 It beggars belief that Robert Calderwood, the Chief Executive until 2017, states that he was completely unaware of any issues with the ventilation system or made no effort to take any steps after the BMT Unit issue.

3.24 Jane Grant, the Chief Executive from 2017, only became aware of the deficiencies in the ventilation system as a result of the actions of whistleblowers and a document called an SBAR of 3 October 2017 by Dr Redding and colleagues.

3.25 The independent Case Note Review led by Professor Mike Stevens concluded that at least two patient deaths were, in part, the result of infections linked to the QEUH environment, and a third of infection episodes in child cancer patients were "most likely" linked to the hospital's fabric.

3.26 NHS GGC's attempts to deny this link through alternative expert reports ('the HAD report') was rightly challenged and, ultimately, the HAD Report did nothing to diminish the substantial body of evidence connecting the environmental failures at QEUH to patient infections and harm.

3.27 NHS GGC's failures have led to adults and children undergoing treatment while patients at the QEUH contracting rare, severe infections, with devastating consequences that

included extended hospital stays, delayed treatments, avoidable symptoms and, in some tragic cases, death.

3.28 Families have lost loved ones (including Milly Main, Andrew Slorance and Tony Dynes) and patients and families have suffered preventable harm. This Inquiry has heard evidence about their pain, anger and calls for accountability.

3.29 No one in NHS GGC has been disciplined for the gross errors that have been made.

3.30 Robert Calderwood was invited to apologise for his failings and those of NHS GGC whilst he was Chief Executive – he declined to do so.

3.31 The NHS GGC Executive Board's culture of failing to accept responsibility for actions, inactions and numerous failures of oversight was clear and obvious from the evidence of all the executive board members who we heard from.

3.32 The contrast with the positive message portrayed by the evidence of the 'new' Chief Executive, Professor Gardner, was startling. It is submitted that her evidence drove something of a coach and horses through the apparently co-ordinated position that NHS GGC witnesses had, up to that point, sought to present throughout the course this Inquiry.

4. The Water System

4.1 According to Mr Poplett, an expert called by the Inquiry, water becomes contaminated when it is not managed properly, where the risk assessments are not implemented, where the planned preventative maintenance is not undertaken, where the staff are not trained, where there is a lack of communication between staff and where the risks identified in the system are not addressed.

4.2 This was not disputed. Each of those factors was present at the new hospital. All were avoidable.

4.3 It is submitted that the evidence before this Inquiry is clear. The water system at the QEUH was filled around 18 months before the hospital opened and remained filled for an extended period without regular flushing. Pipe ends were routinely left uncapped during construction, allowing dust, debris, and bacteria to enter the system. This practice increased the risk of contamination and biofilm development. This created ideal conditions for microbial growth and biofilm formation, especially as the system was not managed as an operational system during this time. There was use of copper pipework 'tails' and EPDM flexible hoses, both of which are susceptible to microbial colonisation and biofilm formation. Installation of Horne Optitherm taps with complex internal components provided increased surface area for bacterial growth and acted as potential dead legs. Inclusion of expansion vessels that were made from materials prone to contamination. A bypass pipe allowed unfiltered mains water to enter the system, bypassing filtration and storage tanks, thereby introducing sediment and bacteria. All of this allowed contamination to occur and persist. Biofilm became established. Once established, biofilm is very difficult to remove.

4.4 Water tests before handover of the water system to NHS GGC in December 2014 and January 2015 cannot be relied upon to provide assurance that the water system was not contaminated at handover. NHS GGC completely failed to take steps to assess the safety of the QEUH water system prior to handover. They failed to take steps to put in place any plan to put in place any Water Safety Plan, a Water Safety Group and a Written Scheme after handover.

4.5 The Chief Executive, Robert Calderwood, was ultimately responsible for the water system at the hospital at handover given that he was, he accepted, the Duty Holder for Water. Robert Calderwood completely failed to carry out any of his duties as Duty Holder for Water at the QEUH from the hospital's handover and down to his retirement in 2017. He should be held to account for his serious failures in duty.

4.6 NHS GGC failed to follow any of the available guidance on how to operate and manage a water system safely at a hospital, including the appointment of key 'responsible persons' for water safety. There was, as already identified, no Water Safety Group. This should have been a multidisciplinary group of those involved in the management of the hospital water system. There was no Designated Person for Water appointed as there ought to have been. Again, as there ought to have been, there was no Authorising Engineer appointed to provide an annual audit to the Designated Person for Water. Moreover, there was inadequate record-keeping.

4.7 In early 2015 NHS GGC did, as they required to do, instruct a company (DMA Canyon) to carry out a Legionella risk assessment of the water system. This report advised that there were numerous problems with the water system that required immediate action. DMA Canyon produced a written scheme for management of the system. Not only was this not put in place, but none of the recommendations in the report were actioned by NHS GGC. In fact, it is extraordinary that this report did not come to light until 2018 during the height of the investigations into the numerous unusual blood stream infection. Ultimately the "Water Incident" in early 2018, marked by a spike in bloodstream infections among vulnerable paediatric patients, finally prompted systemic investigation and recognition of widespread contamination.

4.8 These were, in our submission, gross errors by NHS GGC from the estates department all the way up to the Chief Executive (whether Robert Calderwood or Jane Grant). To date, NHS GGC have failed to apologise to all the patients, families and staff for their failures which led to the existence of a contaminated water system. None of their executives or managers have been disciplined let alone removed from office.

4.9 In summary, the water system at the QEUH suffered from design flaws, early filling, inadequate commissioning and a failure to act on critical risk assessments. This led to the proliferation of biofilm and microorganisms, resulting in what was widely described as

"widespread contamination" of the water system, particularly evident during the 2018 Water Incident. There was a clear exceedance of environmentally relevant bloodstream infections (BSIs) among paediatric haemato-oncology patients between 2016 and 2020, with infection rates peaking in 2018 and only returning to expected levels after significant interventions such as installation of point-of-use ('POU') filters and chlorine dioxide dosing.

4.10 It seems that, by 2023–2025, external audits (such as the July 2025 Authorising Engineer Audit) found that 'most issues' had been addressed and the system was being appropriately managed, though some areas for improvement remained.

4.11 All of that said, we observe that the water system at the QEUH is still being dosed with chlorine dioxide and that POU filters remain in use.

4.12 In his evidence, Mr Andrew Poplett said that he considers that the water testing undertaken by NHS Greater Glasgow and Clyde (NHS GGC) is at the minimum required by the Scottish Health Technical Memorandum (SHTM) standards. He states, "*The water sampling undertaken and the range and extent of micro-organisms tested for is in my experience the minimum required by SHTM and given the intended clinical activities and patient groups involved I would have anticipated a greater degree of testing*". Mr Poplett specifically indicates that, due to the high-risk clinical profile of patients at the hospital, he would have expected more extensive testing for a wider spectrum of microorganisms, even under the standards in place in 2015. He believes NHS GGC should be testing for more microorganisms than is currently required by the minimum standards (Transcript of Evidence Andrew Poplett 16th September 2025, Pages 60 to 62).

4.13 It is our submission that there is strong evidence that Stenotrophomonas maltophilia bloodstream infections in the QEUH/RHC were linked to the hospital's water supply particularly, but not exclusively, during the period 2016–2019. Peaks in Stenotrophomonas infections among paediatric haemato-oncology patients coincided with periods when the water

system was found to be contaminated, especially during the 2018 “Water Incident”. Most of the robust epidemiological and microbiological evidence of water-associated Stenotrophomonas infections relates to the paediatric haemato-oncology cohort, particularly in the Schiehallion Unit, rather than adults. That said, there was a “true spike” in environmentally relevant BSIs, including Stenotrophomonas, among adult haematology patients in early 2018. It is accepted that this spike was less pronounced and less sustained than in the paediatric cohort. We agree with and adopt what Counsel to the Inquiry says at Paragraphs 398 to 404 of their Closing Statement (Commencing at Page 132). During the 2018 Water Incident, the water system was found to be widely contaminated with Gram-negative bacteria, including Stenotrophomonas, especially in high-risk areas.

4.14 The lower and shorter exposure of adults to the contaminated water system, and possibly shorter inpatient stays, may explain the lower rates of Stenotrophomonas infections compared to paediatric patients. The IMT and Water Technical Group identified the water system as a likely source of Gram-negative infections, but most focus and evidence pertained to the paediatric population (Bundle 27, Volume 5, Document 19, Page 46). The ‘South Sector’ adult haematology patients (Ward 4C) were exposed to the QEUH water system for a significant period.

4.15 Applying the Bradford Hill criteria to the paediatric data demonstrates a strong, consistent, and plausible association between water contamination and infections. For adults the evidence is, we accept, weaker, but we nevertheless submit that the clear temporal association of the 2018 spike with the “Water Incident” supports an environmental association.

5. Ventilation

5.1 The QEUH ventilation system was built to a sub-standard level significantly below the safe health guidelines set out in Scottish Health Technical Memoranda (SHTM 03-01). None of the 1,300 single rooms in the QEUH/RHC were constructed in accordance with those guidelines.

5.2 SHTM 03-01 provides guidance for the ventilation systems in general wards and specialist rooms. The expectation of Scottish Government was that that the Technical Memoranda would be adhered to in connection with the design and construction of QEUH/RHC.

5.3 SHTM 03-01 "provides best practice guidance on the design and installation of ventilation systems and the close-control (mechanical cooling or air-conditioning) of general and "specialised" healthcare environments". The aim of the guidance states: "*Only by having a knowledge of these requirements can the healthcare organisation's Board and senior managers understand their duty of care to provide safe, efficient, effective and reliable systems which are critical in supporting direct patient care.*" (pages 16 and 8 Scottish Health Technical Memorandum 00: Best practice guidance for healthcare engineering: Bundle 1).

5.4 General wards at QEUH/RHC were built with about 2.5–3 ACH instead of the 6 ACH required by SHTM 03-01. (Appendix 1 SHTM03-01 page 287 Bundle 1)

5.5 The specialist wards, those required for immunocompromised patients (like Ward 2A, the Schiehallion Unit), did not meet the 10 ACH and +10 Pa positive pressure required for neutropenic patients. The ventilation system in Ward 2A was designed and built with an air change rate of 2.5 to 3ACH.

5.6 Specialist ventilation, including HEPA filters, is essential for protecting immunocompromised patients from airborne pathogens such as Aspergillus and Cryptococcus. The lack of compliant ventilation systems meant these patients were at increased risk when accommodated outside of properly protected environments.

5.7 Patient rooms, including isolation rooms, lacked proper positive pressure relative to the corridor, and ceilings and fixtures were not being sealed. This undermined infection control

5.8 In critical care areas, including Ward 4B, there were no backup air handling units installed. Any maintenance or failure of the AHU could compromise ventilation and therefore patient safety.

5.9 In 2009, and shortly before the contract was signed, the Project Director, Alan Seaborne, agreed air change rates for all of the rooms that did not follow or meet the requirements of the safe health guidelines.

5.10 In the design and construction of the new hospital, NHS GGC appointed a Project Director who had no prior experience of a project of such scale and technical complexity. He plainly did not have the technical expertise to lead on the project.

5.11 NHS GGC should accept responsibility for the consequences of appointing someone who was plainly out of his depth.

5.12 In addition, the Scottish Government, given the nature, extent and very significant public cost of the proposed infrastructure project, ought to have exercised oversight over the competence of the Project Director put forward by NHS GGC and at the very least assessed independently whether he had the necessary experience and credentials for the performance of such a project. It is clear on the evidence that he did not.

5.13 It is submitted that consideration should have been given to the appointment of a Project Manager from outwith the NHS. At the end of the day, the Scottish Government provided the public money required for the hospital build and, it is submitted, ought to have exercised scrutiny over the crucial appointment of the Project Director.

5.14 It may have been sufficient to use the advice of external experts in aspects of the design such as the water and the ventilation of the hospital. Unfortunately, Alan Seabourne and the Project Team terminated the use of outside experts who were able to advise on ventilation and

water in 2009. This was, we submit, a gross error. It is clear from the evidence that this action was not picked up by NHS GGC's Executive Board and their Chief Executive. It can only be assumed that the Executive Board failed to exercise adequate oversight of the Project Team. Even if the Executive Board was not informed of this decision it ought to have discovered the error through a reasonable system of oversight.

5.15 In 2009, Alan Seaborne and the Project Team decided to agree to a reduction in the air change rates for the single rooms in the hospital without any assessment of the potential risks to patient safety having been carried out. As stated above, the Project Team did not have the necessary expertise with ventilation issues to agree to such a reduction on any advised basis. Alan Seabourne believed he did. He was wrong. Ventilation and air changes in a room impacts on the safety of patients.

5.16 In the Scottish Hospitals Inquiry Interim Report ('Interim Report') Lord Brodie emphasised that ventilation systems are critical for patient safety in healthcare settings. He noted that ventilation plays a significant role in infection prevention and control, particularly for vulnerable patients, by reducing the risk of healthcare-associated infections through proper air change rates and pressure differentials. Ventilation systems are essential for maintaining air quality, removing contaminants, and controlling infection risks in hospitals. Achieving the recommended air change rates and pressure differentials is vital for creating a safe environment, especially in critical care areas (Interim Report Page 13) and all the more so in a sealed building entirely reliant on mechanical means for ventilation. Departures from recommended ventilation parameters, such as those set out in SHTM 03-01, increase risk to patients unless robust alternative control measures are implemented (Interim Report Pages 12 and 13).

5.17 In the Interim Report, Lord Brodie describes SHTM 03-01 as reflecting a broad consensus on best practice for hospital ventilation. Lord Brodie states that, while SHTM 03-01 is

technically guidance and not law, its recommendations should be treated as prescriptive standards for new hospital builds unless there are strong, risk-assessed reasons to deviate (Interim Report Paragraphs 5.88 and 9.143. Lord Brodie highlighted that failure to comply with SHTM guidance, without a documented and justified risk assessment, constitutes a defect in terms of patient safety and good practice Interim Report Paragraphs 5.99 and 5.100). The guidance is not a substitute for clear project briefs, but it is the benchmark for safe design and operation of ventilation systems in healthcare facilities (Interim Report Paragraphs 9.143 and 9.144).

5.18 We submit that adherence to SHTM guidance is fundamental to ensuring ventilation systems are fit for purpose and that any derogation from such guidance must be risk-assessed, justified, and properly documented. None of that was done by the Project Team. No steps were taken in that regard by the Chief Executive or executive board. In the absence of such process, non-compliance increases the risk to patient safety and is, we submit, unacceptable in the delivery of modern healthcare.

5.19 There is no evidence that the Project Team and Alan Seaborne considered carrying out any risk assessment to consider the potential impact of a reduced air change rate on patient safety. They did not consult with the Infection Prevention and Control team. They did not consider the adverse impact of a reduced rate of air change on patients, in particular, the impact on immunocompromised patients.

5.20 Healthcare building projects require to follow guidance for infection prevention and control known as HAI-SCRIBE (Healthcare Associated System for Controlling Risk in the Built Environment published 2007). Health Facilities Scotland developed this system or "tool", its aim being to allow for assessment and management of the risk of infection in the built healthcare environment. This system provides a framework around which potential infection risks associated with a proposed site, development, design and planning, construction or

refurbishment and ongoing maintenance of healthcare facilities can be identified, assessed and subsequently managed or mitigated.

5.21 Implementation of HAI-SCRIBE should be the responsibility of a multidisciplinary team of specialists with appropriate skills such as an engineer, infection control specialist, risk manager, estates facilities manager and other appropriate specialists (Bundle 27 Volume 6 page 33-34). There are different stages to the process. Only one stage of the process was carried out. On 7 July 2010 Ms Barmanroy (lead Infection Control Nurse) from the Project Team completed the Stage 2 HAI-SCRIBE assessment by speaking to Mr Hugh McDerment, NHS GGC's Senior Project Manager, and was given verbal reassurance by him that things were "*going ok*". Jackie Barmanroy had no technical experience of water and ventilation systems. The decision to appoint her to the Project Team and leave her unsupported was, in our submission, a significant error. She made assumptions without supporting evidence and ticked every box on the form. She expressed regret when giving evidence about making a mistake she would not make again (Transcript of Evidence Jackie Barmanroy, 13th May 2025, at Pages 201 to 205). In addition, she assumed stage 1 had been completed when she had no evidence that it had been. It had not been done. Neither Stage 3 or 4 of HAI-SCRIBE were carried out. We agree with Counsel to the Inquiry (para 1783) that responsibility for carrying out the HAI-SCRIBE process must lie with the Senior Responsible Owners (Bryne and Calderwood) and the Project Manager (Seaborne). Nobody at any time before the hospital opened checked the documentation about HAI-SCRIBE, including the Infection Control Manager, the Lead Infection Control Doctor and the Lead Infection Control Nurse. Yet more oversights and failures by those with responsibility for oversight and assurance at NHS GGC. There was no HAI-SCRIBE carried out at either the commissioning phase or at handover in early 2015.

5.22 It is reasonable to submit that, had NHS GGC carried out the HAI-SCRIBE process for the ventilation system, the defects and deficiencies would have been identified much earlier

than they were. In consequence, patients, particularly those who were immunocompromised, would not have been exposed to an increased risk of infection due to the substandard ventilation system.

5.23 In addition to these failures NHS GGC failed to instruct an independent engineer to validate the ventilation system before the hospital opened. It is reasonable to suggest that had the ventilation system been validated the independent engineer would have discovered the numerous faults with the ventilation system. In particular, it would have been identified that the specification of the system was in contravention to the SHTM 03-01 healthcare guidance on air change rates. It is submitted that had non-compliance been identified it is highly likely that the hospital would not have opened (as was the case with The Royal Hospital for Children and Young People and Department of Clinical Neuroscience, Edinburgh).

5.24 Mr Andrew Poplett considers that; (i) there could be increased frequency and scope of air testing, especially in high-risk and critical care areas; (ii) there would be benefit from a clearer document control process; (iii) there could be clearer detail provided about what remedial actions are taken following unsatisfactory test result (which must surely be a given in terms of NHS GGC's Duty of Candour); (iv) formal risk assessments should be produced for all air conditioning and chilled beams to ensure all potential risks are systematically identified and managed; and (v) use of advanced monitoring technologies should be embraced (Transcript of Evidence Andrew Poplett, 16th September 2025 at pages 8, 40-42, 44, 95 and 96).

5.25 We propose to turn now to look at specific wards:

Ward 2A

This Ward was earmarked for children, most of whom were immunocompromised or neutropenic. In accordance with SHTM 0301 guidance, the ventilation air change rate in the Ward should have been 10 air changes an hour ('ACH'). When tested some years after the

Ward had opened, it was found that the rate was around 3ACH. Moreover, there was no double door entry system in place. This was included in the clinical output specification for the ward and was similar to what there was in the old Schiehallion Unit at Yorkhill. There were no HEPA filters as there ought to have been. Chilled beam units (CBU's) had been installed in voids above the patient's beds resulting in the foreseeable risk of condensation dripping onto the patient and the potential for contaminated recirculated air immediately above the patient (since there were no air filters within the CBUs). The CBUs are also a source of contamination due to maintenance activity, the collection of dust on them and the creation of mould. CBU's should not be used in rooms for immunocompromised patients. There was a lack of room air pressure differential such that positive pressure was required in the bedrooms to push the air from clean to less clean spaces to control any potential contaminant risk. (Poplett report Para 5.23: Bundle 21, Volume 1, Page 484). There was no air pressure monitoring system on the ward as there should have been. It was a recommendation of the Innovated Design Solutions Report for Ward 2A (See Bundle 6, Document 34, Page 695). No satisfactory explanation for this terrible state of affairs has been provided by NHS GGC witnesses. We submit that, as a result of the many design and construction failures by NHS GGC, the most vulnerable child patients being treated on Ward 2A were put at significantly increased risk of infection and illness.

These gross failures caused the decant of the entire Ward in September 2018 in order to carry out remedial works to improve the ventilation system and bring it up to the standard that it should have been built to in the first place. The impact on the patients and families was enormous and has been the subject of extensive evidence in the Glasgow 1 hearings and subsequently.

In February 2022, before Ward 2A reopened a ventilation validation report (Bundle 52 Volume 10 document 45 page 225) was obtained from an outside company called Sutton Service International. This essential step was something that was not carried out before the hospital opened to patients in 2015 and remains an astonishing oversight by NHS GGC. An engineer from SSI assessed each of the bedrooms in Ward 2A and found that they had air change rates at or above 10ACH and were within the specified positive pressure of +8 Pa to +12 Pa. There was no assessment of the corridor/ general areas to see if they were at the recommended level of 6ACH. Given the fact that the child patients move around the ward and move into and through the corridor on Ward 2A it is very important for patient safety that the corridors and general areas on the ward meet the SHTM 03-01 guidance figures. NHS GGC should be required to assess the ventilation and air changes in the corridors and general areas and if the air change rates do not meet the SHTM guideline figures they should be required to carry out the necessary changes to bring the ventilation system up to the required level in order to reduce the risk of infection for the patients.

Ward 4A

At the handover Ward 4A had 2 Positive Pressure Ventilation Lobby (PPVL) isolation rooms. Neither of those rooms had HEPA filters installed. Since then one of the isolation rooms has had the HEPA filters installed (Room 20), but not the other PPVL room (Room 19). Room 19 is, accordingly, not safe for immunocompromised patients. No risk assessment appears to have been carried out. The ventilation system in Ward 4A was not fully comply with SHTM 03-01 or with the recommendations in HBN 04 Supplement 1 and SHPN 04 Supplement 1, which state that PPVL rooms are not suitable for severely immunocompromised or highly infectious patients.

As stated above, the ventilation system in Ward 4A was not fully compliant with SHTM guidance and standards at the time of handover, particularly regarding HEPA filtration and suitability for high-risk patients. Some of the patients from Ward 2A in 2018 were decanted to Ward 4A, thereby exposing them to an increased risk of infection. Some deficiencies persist, with at least one room still lacking HEPA filtration, and the original design choices did not meet the recommended requirements for protecting immunocompromised or infectious patients (Counsel to the Inquiry CS at page 443 and 546). The Inquiry has heard no evidence about the validation or commissioning of the ventilation system on Ward 4A or about any maintenance that may have been carried out to that system since 2015.

If the PPVL rooms on Ward 4A are considered suitable for use in connection with highly vulnerable patients it is noted that they are not contained in NHS GGC's patient placement policy , including the current version which appears to have been updated on 22nd October 2025 (https://live.nhsggc.scot/downloads/patient-placement-sop-v2/).

Ward 4B – the BMT Unit

There were very similar problems with the ventilation system in Ward 4B. Low air change rates, lack of HEPA filtration, pressure differentials as at the Beatson, lack of a double entry door as at the Beatson and the absence of a pressure monitoring system. It is accepted that SHTM 03-01 does not specify double door entry systems and pressure monitoring systems.

The deficiencies in the ventilation system in Ward 4B were identified after the patients moved in. Gary Jenkins, who was the General Manager for Specialist Oncology Services based at the Beatson West of Scotland Cancer Centre gave evidence that, shortly after moving into Ward 4B, he became very concerned about the results of air sampling which had been found to far

exceed the acceptable particle count (Witness Statement of Gary Jenkins, Witness Statements Bundle 8, Volume 4, Bundle Page 166). He was advised by Professor Williams that the Ward was built to specification and so should provide a safe environment for the patients. Gary Jenkins asked for the specification drawings and was told that they had been destroyed. It was discovered that the BMT unit was not built to the specification that had been set out by Gary Jenkins, which was to the same safe level of ventilation specification as the Beatson and that set out in SHTM03-01. There were urgent discussions with Infection Control Doctors about the potential risks to the patients. The risks were considered to be too great to patients so that the safest option was for all of the patients to move back to the Beatson. This decision was made after a meeting with Infections Control doctors and Ian Powrie of Estates.

The question of whether the ventilation system had been validated was raised. Gary Jenkins reported the reasons for the move back to the Beatson to Jonathan Best. He also had a meeting with Robert Calderwood, Craig Williams and David Louden (Transcript of Evidence Gary Jenkins, 17th September 2025 at pages 172 and 173) so they were all aware of the problems with the ventilation system in Ward 4B. It is unclear what was discussed at those meetings, but the whole episode certainly raised a large "red flag" about the deficiency of the built ventilation system in the new hospital literally weeks after it opened. This turned out to be yet another missed opportunity for GGC.

Some limited remedial works have been carried out to the ventilation system on the Ward, but the air change rate remains significantly below the guidance figures for the BMT patients. It is now 6ACH, not at the rate of 10ACH as required by SHTM 03-01.

The QEUH was not originally designed with sufficient protective isolation capacity for the BMT/haemato-oncology service, making retrofitting challenging and resulting in suboptimal

environments for high-risk patients (See Minutes of Cryptococcus IMT Expert Advisory Sub-Group: Bundle 9, Pages 73 and 267).

The corridors and lobbies on Ward 4B are not HEPA filtered. The impact on patients was to effectively imprison them. There is no evidence that the imposition of closed door policy as a control measure is being implemented/adhered to despite its importance on Ward 4B where rooms do not have a PPVL (self-closers on doors was ruled out in Augst 2019: Bundle 9, Page 103). Absence of a PPVL and/or suitable control measures allows for the ingress of microorganisms from the Ward itself and from other level 4 Wards.

Dr John Hood reported that small numbers of fungi were found from sampling carried out in the HEPA filtered rooms on Ward 4B BMT Unit and identified that the reason for this could be that the BMT unit does not have HEPA filtered air in the corridor but only in the rooms (Bundle 9, Page 13).

Dr Hood and Ian Powrie looked at the pressure differences across the door leading to the entrance of Ward 4B opposite the entrance to Ward 4C. (See Minutes of Cryptococcus IMT Expert Advisory Sub-Group of 9th May 2019: Bundle 9, Page 46). Off the same corridor (between Wards 4B and 4C) is noted to be a Medical Staff office which had an external door leading to the Level 4 roof. This was looked at again on 10th May 2019 and 4 Pascals of positive pressure was noted to be coming out of Ward 4B corridor and 10 Pascals coming out of the entrance to Ward 4C. If the door to Ward 4C was then opened - Ward 4B (previously putting out 4 Pascals) then became negative - to minus 1.5 Pascals. In other words, dirty air from the corridor was being pulled into Ward 4B. A number of the doors are to be improved with the seals replaced including Ward 4B door to corridor (see Minutes of Cryptococcus IMT

Expert Advisory Sub-Group dated 22nd May 2019: Bundle 9 at page 51). Peter Hoffman suggested reducing the extract in the corridor in Ward 4B. The door to Ward 4B is locked and not to be used unless there is an emergency (i.e. it is a fire exit). As part of future modifications Ian Powrie said there should be a lobby proposal to protect both wards and perhaps to change the use of the Medical Staff Room for use by only Estates staff to access the roof. The air brought in from the roof will be external unfiltered dirty air. Dr Hood felt that this area of Ward 4B, Ward 4C and the Medical Staff Office (with a door out onto the roof) was a real issue that needed careful robust planning/mitigation of control of the air quality/protective isolation in critical BMT Unit and other patient areas (See Minutes of Cryptococcus IMT Expert Advisory Sub-Group: Bundle 9, Page 52).

If patient rooms on Ward 4B are not maintained under positive pressure there was and remains a real risk of unfiltered air entering. The building's design led to complex air movement patterns, with multiple entry points, doors, and corridors affecting pressure cascades and air quality. The lack of robust control over these airflows increased the risk of contaminated air entering protected environments The positive pressure regime, crucial for protective isolation, was often compromised by door openings, corridor configurations, and lack of airlocks. This intermittently allowed unfiltered or "dirty" air to enter clinical areas, particularly at ward entrances and intersections (e.g. between Wards 4B and 4C, or 6A and 6B). (See for example Minutes of Cryptococcus IMT Expert Advisory Sub-Group: Bundle 9, Pages 72, 74, 204, 256, 262 and 277)

The Minutes of the Cryptococcus IMT Expert Advisory Sub-Group Meeting on 2 September 2019 (Bundle 9, Page 141) records among other things: '*On looking at the plan of the Ward areas on level 4 (QEUH) there is a 'Facilities' corridor which is runs between the entrances to*

Wards 4B and 4C…with essentially Wards 4B and 4A 'above' this corridor…and Wards 4C and 4D below the plan. Interestingly one half of this corridor is served by PR123/07 (D) and the other half of corridor is served by PR124/07(C). This further emphasises the very complex nature of the ventilation systems of this hospital. We have previously noted that there are issues with intermittent reversals of airflow on the intersection of this corridor with 4B and 4C (with F7 filtered air moving into the bottom of the BMTU corridor (by Bed nos in the 70's)". On the evidence before this Inquiry, it would appear that the risks associated with what was identified as an issue by the Sub-Group have not been assessed.

This Inquiry has not heard evidence about what rectifications, if any, were made following the findings of the Cryptococcus IMT Expert Advisory Sub-Group.

It is noted that, in connection with the issue of Aspergillus infections, the NHS GGC HAD Report states as follows:

"*32. From 2013 to 2023, there is no indication of increased cases of infections with [aspergillus] in the Adult BMT service, including after the permanent move to QEUH from the Beatson unit in June 2018.*

33. From 2013 to 2023, there is no indication of increased cases of infections with [aspergillus] in the Adult Haematology South service, including after the permanent move to QEUH May 2015." (Bundle 44, Volume 1, Page 10).

It is submitted that these conclusions are incorrect. Scrutiny of patient records apparently demonstrates that there were five cases of Aspergillus infections in patients being treated on Ward 4B in October 2020. It seems that Dr Peters is aware of the clinical journey of the patients in question given her own clinical practice at QEUH. [redacted]

[redacted]

A link in time, place and person is not picked up in Figures 23 and 24 of the HAD Report (Bundle 44, Volume 1, Page 125 and 128 respectively). Such a link is not made in the HAD Report as the patients were on different wards at the time of their diagnosis. The HAD analysis may be criticised for failing to identify, consider and evaluate such a link.

A study that fails to take account of patient movement cannot consider and define the periods of environmental fungal exposure in order to differentiate between exposed and non-exposed patients. Considering links in time, place and person in relation to Healthcare Associated Infections provides the core framework of descriptive epidemiology, which is crucial for identifying patterns, guiding investigations allocating resources and developing targeted prevention and control measures. This approach helps transform raw data into actionable insights for public health officials. It is standard good practice when investigating even a single case of a potentially health care acquired invasive fungal infection.

Any approach to infection protection and control that relies solely on statistical significance being achieved with rare infections is inherently flawed and likely to miss opportunities to learn and put in place evidence based preventative measures. We understand that Dr Peters is extremely concerned that this is still the approach being taken by NHS GCC.

In the course of 2019, the Cryptococcus IMT Expert Advisory Sub-Group grew Aspergillus from nine air samples taken from rooms in Ward 4B. In comparison, corridor samples in Ward 4B had higher overall fungal figures that the rooms but specific Aspergillus data for corridors was not separately detailed (Minutes of Cryptococcus IMT Expert Advisory Sub-Group: Bundle 9 at pages 282 and 283).

In the course of his evidence, Dr Agrawal was asked to comment on the issue of informed consent where the Ward ventilation system was not validated in relation to Aspergillus and said: *"If they need a bone marrow transplant, so are we not just engendering increased anxiety, in fact, a severe degree of increased anxiety, 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, but we don't know that. So that would be my one big caveat: If I don't know the system is not making things worse then I would have - I wouldn't proceed with high risk procedures in that environment. So I come back twice: I would need to know something to convince me that there wasn't – there weren't Aspergillus spores being pushed into the space. I would need some reassurance…."* (Transcript of Evidence Dr Agrawal, 22nd August 2025 at Page 245).

Asked by Counsel to the Inquiry if he was correct to get the impression from his evidence that what he was saying that if he discovered that there were spore counts in an unvalidated system, his reaction would have been to not consent the patient but to send them somewhere else, he answered*: "Yes, then I would be concerned we were actually causing harm."* (Transcript of Evidence Dr Agrawal, 22nd August 2025 at Page 246).

In any event, it is noted that the Ward 4B Ventilation system is not on NHS GGC's Corporate Risk Register despite its ongoing non-compliance with SHTM 03-01 and unassessed but acknowledged risks. That is very difficult to reconcile given the risk to patient safety, particularly given the vulnerability to infection of a high proportion of the patients likely to be admitted to Ward 4B.

At QEUH there are only 24 Positive Pressure Isolated Rooms for adult patients. They all lie within Ward 4B.

This Inquiry should recommend that NHS GGC be required to take immediate and urgent steps to see to it that the ventilation system in Ward 4B is complaint with SHTM 03-10.

Ward 4C

Ward 4C at the QEUH was originally designed as a general ward, specifically intended to house renal and renal oncology patients. However, after changes in service planning by NHS GGC, it became the location for adult haemato-oncology patients, including those with acute myeloid and lymphoblastic leukaemia, who typically endure long periods of neutropenia following intensive chemotherapy. Despite this change in patient cohort, the ward's ventilation and environmental features remained those of a general ward and did not meet, and were not adapted to meet, the specifications required for a 'neutropenic ward' or a specialist haemato-oncology unit such as inclusion of HEPA filtration, positive pressure and higher air change rates. This mismatch between intended use and actual patient group has been identified by the evidence heard by this inquiry as a significant issue impacting patient safety and care.

Why, then, was ward 4C categorised it as a General Ward on the NHS GGC risk assessment (Bundle 20, Document 62, Page 1428)? This categorisation appears to have been made despite the fact that the risk assessment states that the ward caters for patients with leukaemia and lymphoma, many of whom have long periods of neutropenia following chemotherapy, and those receiving stem cell treatment. Furthermore, the clinical lead for Ward 4C, Dr Hart, who was part of the risk assessment team, wrote in an email to Teresa Inkster in 2019, that patients are "constantly" neutropenic on Ward 4C, there is prolonged use of steroids for all patients and many patients are on t-cell suppressant drugs. (See Bundle 27,Volume 7, Document 20, Page

375) It is our understanding from what we have been told by our Core Participant clients that both these medication treatments greatly lower immune function.

When the Cundall report published its findings in May 2022 (Bundle 20, Page 1434), the ACH rates on Ward 4C were between 2.7 and 3.2 ACH in 4C. This is the accepted ACH for a non-medical public building such as a school or library but not for a hospital. It is well below the recommended 6 ACH for general wards and 10 for immunocompromised wards.

We submit that, in all the circumstances, Ward 4C cannot properly be described as a general ward in terms of the risks and requirements for its patient population. The lack of appropriate upgrades to its environment for the new patient cohort is a key deficiency and presents an ongoing risk to its patient cohort.

All the groups of patients on Ward 4C are highly immunosuppressed and are all therefore at significant risk of fungal infections on Ward 4C.

The risk assessment for Ward 4C puts the overall risk as moderate. Risk is assessed as moderate because the likelihood of injury is rated as 3 (*possible - may occur occasionally, has occurred before on occasions*), and the severity is graded as 2 (*minor illness or injury, first aid required*) (Bundle 20, Document 62, Page 1430).

Counsel to the Inquiry acknowledges the “severe consequences” of contacting infections such as Aspergillus and Cryptococcus, and points to “a number of known or suspected deaths with a connection to Aspergillus and Cryptococcus infection” concluding that “rooms in the general wards in hospital are unsafe for them” (Paragraph 1794).

In light of the foregoing, we submit that the risk assessment for Ward 4C is fundamentally flawed.

At Paragraph 1841 of their Closing Statement, Counsel to the Inquiry say: "Ward 4C, notwithstanding improvements, does not have an environment designed for the patient cohort envisaged (in the original COS3045). NHS GGC now considers that the ventilation system in this ward poses a medium risk of infection by airborne pathogens, but that risk reduction may well be partly reliant on the use of anti-microbial prophylaxis which cannot be tolerated by all patients. The "routine use" of prophylaxis medication as a way of mitigating risk poses its own risks and is acknowledged not to be suitable for all patients. This is not, of course restricted to Ward 4C and is true for any and all immunocompromised patients.

This Inquiry should recommend that NHS GGC re-categorise Ward 4C as a neutropenic ward and increase its standards to comply with SHTM 03-01/re-visit its risk assessment.

The adult patients in Ward C were exposed to the contaminated water system for extended periods. There was a "true spike" in environmentally relevant bloodstream infections (BSI's) among adult haematology patients in Ward 4C at the start of 2018, which coincided with the peak period of infections and water contamination ("The Water Incident"). There were neutropenic patients in Ward 4C at the time and they were, accordingly, exposed to an increased risk of infection arising from the ventilation deficiencies and the contaminated water system. This was an avoidable risk. There has been no evidence of any risk assessment being carried around this time to assess the risk to the safety of patients being treated in Ward 4C and take any necessary mitigating measures.

<u>QEUH Hospital General Wards</u>

The SHTM 03-01 health guidance states that all general ward single rooms in a hospital built after they came into force should have an air change rate of 6ACH. It has been identified that the rooms in all general wards have an air change rate of only around 2.5ACH. No remedial

steps have been taken to remedy this. NHS GGC have so far failed to carry out a risk assessment of the impact on patient safety of the reduced air change rate. No explanation has been provided for this at the Inquiry.

The ventilation system's key problems existed from initial design (2009) and persisted through construction and hospital opening in 2015. Ward 4B had work carried out after 2015 to improve the level of ventilation. Nevertheless, the ventilation on Ward 4B still fails to meet SHTM03-01 guidance primarily due to insufficient air change rates, incomplete HEPA filtration, inadequate pressure differentials, lack of backup AHU, and initial absence of validation and pressure monitoring. Some deficiencies have been partially addressed. It was not until 2018 when the deficiencies in Ward 2A's ventilation system were rectified. This was in response to serious infection outbreaks, particularly of unusual infections and external scrutiny including from the media and MSP's. They remained largely unaddressed until 2018, when systematic remediation began in response to infection outbreaks and external, including media, scrutiny. Remediation for some critical areas was only achieved between 2019 and 2022, with some improvements ongoing as of 2025. Despite remediation, issues, especially in general wards, have not been resolved and, it is said, are now managed through 'risk assessment' and 'policy' rather than engineering fixes.

In summary, therefore, major ventilation problems persisted for 3–5 years after the QEUH opened to patients before substantive remediation was carried out with some residual issues remaining even after a decade. Wards 4B and 4C continue to have a ventilation system that is almost half what the recommended figure for air changes. This also applies to the general wards. Today, some ten years after the hospital was built, only a very small proportion of the patient rooms comply with the SHTM 03-01 guidelines despite some improvements having been made.

6. The link to infections suffered by patients

6.1 The Inquiry has heard clear and compelling evidence that the NHS GGC failures with water and ventilation systems were not merely technical or procedural. They resulted in real harm to adult and paediatric patients, frequently those who had least resistance to infection given the treatment that they require to undergo at QEUH.

6.2 Evidence points to there having been a statistically significant increase in environmentally relevant bloodstream infections among paediatric haemato-oncology patients between 2016 and 2020. That increase correlates directly with the periods of unmanaged water systems and patently deficient ventilation. There was a "true spike" in environmentally relevant BSIs, including Stenotrophomonas, among adult haematology patients in early 2018. The 'South Sector' adult haematology patients (Ward 4C) were exposed to the QEUH water system for a significant period.

6.3 It is clear that, in general terms, if you fail to take care with the design, construction, validation, commissioning, maintenance and testing (including air and water sampling/testing) of water and ventilation systems there is likely to be an increased risk of infection to patients, particularly those who are immunocompromised/neutropenic.

6.4 It is submitted that the evidence supports the following propositions:

(i) The failures with the water system as identified above created conditions for pathogens to thrive and reach patients, leading to infections that were both severe and, for some, fatal. On the balance of probabilities, there was a link between the deficient water supply and an increased risk of infection to both adult and paediatric patients and that risk is, on the evidence, demonstrated to have caused infections.

(ii) Deficiencies in ventilation systems, especially in wards required for the most immunocompromised, plainly increased the risk of airborne infections to patients. On

the balance of probabilities, it can be said that patients, particularly immunocompromised individuals such as paediatric and adult haemato-oncology patients, were exposed to an increased risk of fungal infections, including Aspergillus and Cryptococcus, as a result of deficiencies in the ventilation system at the Queen Elizabeth University Hospital (QEUH). Any encounter that an immunocompromised patient has with Aspergillus or Cryptococcus poses a potential risk to life. Absent HEPA filtered corridors or lobbied rooms as was and remains the position with Ward 4B, the simple opening of a room door has the potential to allow Aspergillus or Cryptococcus spores (and many other potential contaminants including Coronavirus disease particles) into the patient space. With an air change rate below that recommended by SHTM 03-01, the risk to the patient is greater as the contaminant is present for longer.

(iii) The ventilation systems in QEUH/RHC, including general wards and specialist units such as Wards 2A/2B, 4B, and 4C, did not conform to the recommended standards set out in SHTM 03-01. Notably, there was a lack of HEPA filtration, insufficient air change rates, and inadequate positive pressure in areas where immunocompromised patients were cared for. Multiple expert witnesses, including Dr Mumford, Mr Bennett and Mr Hoffman, agreed that the absence of HEPA filtration and low air change rates in these wards posed a material risk of airborne fungal infection to highly vulnerable patients.

(iv) While the precise proportion of infections attributable to the ventilation system cannot be established on the evidence led before this inquiry, the consensus is that any exposure to airborne fungal spores in immunocompromised patient groups is clinically significant and is avoidable in a hospital setting. Retrospective epidemiological studies, including those by Dr Agrawal and Dr Drumright, did not demonstrate a statistically

significant increase in Aspergillus infections among paediatric haemato-oncology patients after the move to QEUH/RHC compared to the predecessor hospital. However, the small number of cases in a ‘brand new, state of the art’ hospital and the severe consequences of such infections mean that even isolated incidents are of high concern.

(v) While it is impossible to state with certainty on the evidence heard by the inquiry that specific individual fungal infections were directly caused by the ventilation system, the failure to provide compliant ventilation created an unnecessary, avoidable and material risk.

(vi) It is our submission that the evidence heard by the Inquiry supports the proposition that it is more likely than not that some patients did suffer fungal infections as a result of being accommodated in environments with deficient, sub-optimal ventilation at QEUH.

(vii) These were not isolated incidents, but part of a pattern of avoidable harm caused by systemic neglect, poor governance and a failure to prioritise patient safety.

(ix) The Case Note Review concluded that at least two patient deaths were, in part, the result of infections linked to the QEUH environment, and a third of infection episodes in child cancer patients were "*most likely*" linked to the hospital's fabric

(x) Interventions such as the extensive water system remediation and ventilation upgrades resulted in measurable reductions in infection rates. That, we submit, is further evidence supporting the causal link between the environment and the incidence of infection.

(xi) We have evidence from multiple independent, and NHS GGC commissioned reports, as well as expert testimony, confirming a significant association between environmental infections and the condition of the water and ventilation systems. It should be noted that Dr Lydia Drumright’s evidence ‘evolved’ as the Inquiry

progressed. She analysed the BSI rates particularly in paediatric haemato-oncology and focused on whether patterns of infection could be explained by contaminated water, constructing statistical models (including linear and generalised additive models) to identify trends in infection rates over time. She identified a significant increase in environmentally relevant BSIs between September 2016 and January 2018 followed by a rapid decrease after interventions. These findings support a temporal association. It was her evidence that the data was consistent with the environment contributing to a substantial proportion of cases, perhaps 1/3 of the environmentally relevant BSIs. She considered other possible causes for the infection spikes, such as line care, nursing practice, sample contamination and antibiotic use, but found these could not fully explain the observed patterns. The rise and fall of infection rates matched the timing of environmental interventions, strengthening the plausibility of an environmental link. The link was 'biologically plausible' i.e. a poorly managed hospital water system might develop biofilms and harbour microorganisms capable of causing patient infections, especially in immunocompromised patients - the totality of evidence, statistical, temporal, and biological, indicated a clear link between the hospital environment (especially water) and patient infections (Transcript of Evidence Dr Lydia Drumright, 21 August 2025 at Pages 14 to 58: Bundle 44, Volume 1, Document 1, Section 7.2.2 and Figure 6, Pages 73 to 75: Bundle 44, Volume 1, Document 1, Pages 117 and 118 – Fig. 21): Bundle 44, Volume 5, Document 2, Pages 50 and 51, Fig. 2.F.3 for environmentally relevant BSIs and at Pages 52 and 53; and Bundle 44, Volume 7, Document 4, Pages 57 to 60).

(xii) What we have heard evidence about may, however, simply be the tip of the iceberg. We observe that absence of evidence does not mean absence of connection. There was a demonstrable and negligent lack of air and water testing performed by

NHS GGC. There are, in addition, real questions to be asked about NHS GGC's honesty and candour in the recording of infections and the reporting of them.

7. Impact on Patients and Families

7.1 The physical, psychological and emotional toll on patients and their families has been immense. Infections interrupted life-saving treatments, caused pain and distress, and, in the most tragic cases, led to the loss of children and loved ones. Families were too often left uninformed, unsupported, and, at times, misled about the true nature and causes of these harms.

7.2 The manner in which NHS GGC has conducted itself in relation to this Inquiry has had a significant impact on the patients and families we represent.

Karen Stirrat states:

"I don't trust anything NHSGGC say. The last few months I have had to step back, I couldn't read anymore lies and denial. It is clear the witnesses were coached. If someone is telling them how to word things, then it isn't from the heart. We wanted the PI to get the truth, but will it happen? Their true colours are partly coming out, not all the truth has been revealed so will they get away with it? The long term effects on what has happened have been significant. I am thankful that my son is still with us, but not all are. I will never believe the hospital, I believe the clinical staff but never those at the top. Most have got away with it because they are retired, no consequences. What about the people left behind? The thing that angers me the most, we should never ever have been put in that position. We were having to try and maintain a normal family setting, trying to support our son going through horrific treatment and at the same time try and work out what was happening with the environment. We have been reading documents, campaigning MPs, attending meetings before the inquiry even existed. We should never have

been put in that position. That time should have been with [redacted]. [redacted] will have long term effects from the prophylaxis that was solely to protect him from the hospital. No apology will make up for that. They are still giving patients prophylaxis now for the environment, there are still filters on the taps, things are still unclear. This inquiry will finish soon but for us it remains an ongoing fight. We still have to fight the environment at the hospital for our children. The heroes of the story are the whistleblowers, Dr Inkster, Dr Peters and Dr Redding. I can't imagine what they have gone through professionally and personally, they really were trying to protect us."

Annemarie Kirkpatrick says:

"*As a family, we confront the ongoing denial and misrepresentation of evidence by NHS GGC. We are reminded that the truth is not merely a defence of reputation, but a vital step towards our healing. The continued lies deepen our pain, highlighting the urgent need for accountability and transparency in the face of these tragic failures*."

Suzanne Brown says:

"*I think it was shocking hearing all the evidence, I feel very let down by the health board and the Scottish Government. They knew this was going on but ignored us, we were saying things at the time and it was getting overlooked. It was like gambling with our children's lives. It was all secrets, witnessing what was going on and then being told we were wrong. Worrying about our son and if he would get sick from the environment on top of everything else he was going through. More compassion was needed, it still needed. The Health Board should be ashamed and I hope they start to take accountability for this. They have never owned up, this tells me they are still hiding things.*"

Sharon Barclay tells us:

"I refuse to take [redacted] *to the hospital, I have moved away from Glasgow because I am so terrified that we will have to return to the QEUH/RHC. I have PTSD now and* [redacted] *is terrified of going back there. She cries every time we come close. During our time there when we were saying there was something really wrong, we were ignored, and left to feel like we were troublemakers. The inquiry has revealed that we were put through hell, and that we were correct. What is going to happen to NHSGGC? What are the consequences? We still have to live with this trauma, what will happen to them? The hospital is disgusting, it needs to be pulled down but I know it won't be because of the cost even though the ventilation system still isn't ok. The QEUH has destroyed me how many more families will it destroy because of the environment?"*

Denise Gallagher tells us:

"We have lost all trust in NHS Greater Glasgow & Clyde and the Scottish Government. Serious negligence was followed by a systemic failure of candour, accountability, and oversight.

Our family was not only harmed but met with denial, defensiveness, and institutional contempt, causing profound distress to our personal and professional lives. This response exposed a culture of arrogance and entitlement, where self-protection took precedence over patient safety and truth.

This experience has destroyed our confidence in the ethical integrity of the NHS. The duty to "do no harm" was abandoned and replaced by incompetence and reputation management.

Without independent scrutiny and enforceable accountability, this system will continue to cause harm and forfeit public trust."

Mark Bisset has identified his ongoing concerns and their consequences:

"*Whenever possible we make sure that* [redacted] *is treated in Edinburgh as we are fearful of returning to the QEUH at this point.*

I have been thinking about the impact of everything on all of my family since [redacted] *was admitted to the Glasgow hospital. We were considering moving to the Isle of Bute at one point but realised that would mean hospital appointments for all family would most likely be at the QEUH so we soon changed our minds. If God forbid any of us needs any transplant we will ask..no demand..to go to Newcastle instead of Glasgow. We all have suffered with either rage anger despair depression anxiety at some point and here we are all these years later living this NIGHTMARE DAY IN DAY OUT with not one person accepting responsibility and attempting to apologise. I no longer want to hear an apology in public because its now past the point of ever feeling sincere".*

Louise Cunningham states:

"I'm angry at them all, what we have read, NHSGGC are the ones that hurt the families. :Now they hurt us further by not admitting anything. [redacted] *has passed away from cancer but the environmental infections shortened her life. Everything that is going on with the investigations and uncertainty have become a nightmare for me, I feel as though I can't let my daughter rest. The hospital hasn't confirmed its safe in my view there is still more to be done. My daughter did not deserve the struggles she had, the infections on top of that are too much to bear and NHSGGC have a direct responsibility for that."*

Louise Slorance has stated:

"*In respect of evidence heard, it goes without saying that the disregard shown toward adult patient deaths by both NHS GGC and Scottish Government is devastating. The overriding message I have received is the lives of adults don't matter. Scottish Government have failed*

over and over again, since 2018 to investigate the substandard environment that adult patients are treated in at the QEUH, instead choosing to focus almost entirely on the RHC. The HAD data is the only time I have seen data published on adult infections, in particular aspergillus adult infections, despite the Chief Nursing Officer instructing Healthcare Improvement Scotland to review aspergillus at the QEUH in 2021. This data was eye opening and disturbing. While NHS GGC, and the First Minister in the Scottish Parliament, suggested that my husband's aspergillus was the only case, the data has revealed a cluster of Aspergillus linked in time, 2020, and place, 4B. It has taken nearly 5 years for this truth to see the light of day in spite of a Crown Office investigation for the same length of time. There are only two realistic reasons why this could be the case – the first is complete incompetence by the Crown and Police Scotland. The second, concealment by NHS GGC.

Andrew's death took a part of our family and when we started to ask questions the NHS GGC board sought, not to answer our questions with honesty and transparency, but to break us further. Every delay, every denial, every attack, every report, every communication took another piece of us – it took the normal safe, trusting and carefree childhood my kids deserve, it took the happy memories and it suspended our grief. The impact of the NHS GGC response has left lifelong scars on every single one of Andrew's family and will haunt us forever."

Sharon McAllistair observes:

"*The failures at the hospital had a devastating and lasting impact on my daughter and our family. On more than one occasion, my daughter's life was placed in danger because concerns raised by me as her parent were dismissed. My daughter developed a serious infection in her leg, acquired while in hospital. The injury to her leg was severe, the photographs are harrowing, and the permanent scar she now lives with is heartbreaking. This injury should never have happened. In addition to these life threatening events, there were drug errors, one*

that put my daughter into a drug induced coma, constant stress, and ongoing concerns about dirty water and ventilation systems within the hospital. As families, we are repeatedly told that it is not cancer that will kill our children, but infection.

Yet we were caring for some of the most vulnerable children in a building that was not fit for purpose.

What has been particularly distressing is the dishonesty. I was directly told to my face that the water was safe. Hours after my daughter was discharged, I received a phone call telling me she had to start prophylactic medication due to water contamination risks. I struggle to understand how a professional can reassure a parent in person, then later make a call that completely contradicts that reassurance. That moment destroyed any remaining trust I had.

The emotional toll on our family has been immense. We lived in constant fear, knowing that our child's survival depended not only on cancer treatment, but on whether basic hospital systems were safe and whether our voices would be listened to. On two separate occasions, we were told that the likely outcome would have been death had intervention not happened when it did.".

Sandie and Beth Armstrong were shocked and upset to learn from Dr Teresa Inkster's evidence (Transcript of Evidence Dr Teresa Inkster, 2nd October 2024 at Pages 52 and 53) that she had been instructed to remove any mention of the plant rooms from the Significant Critical Incident ('SCI") drafts about their mother's death. They surmised that this must have been why the scope of the IMT had changed, and no longer included an investigation of the source of the infection. In her oral evidence, Teresa Inkster also talks about her difficulty in obtaining photos and information about the state of the plant rooms which, to the Armstrongs, was suggestive of a cover up. Photos later came to light in the course of this Inquiry's investigations providing evidence of pigeon infestation in all the plant rooms.

The Armstrongs speak about NHS GGC's handling of the SCI report at length in there written statement and the course of oral evidence. They have asked us to repeat here some of the points we made in our written statement and their oral evidence concerning the SCI with a view to ensuring that it is not overlooked:

> *"The SCI states that it was commissioned on 11 March 2019 and finalised on 6 April 2020. It was not sent to us until 28 April 2020, 3 weeks after it was finalised, and 1 year and 3 months after our mother's death. The guidelines state an SCI should be completed within 3 months of the incident.*
>
> *Presence of infection: There is no mention that mum was antigen positive for cryptococcus when she died, although we were told that her blood cultures were negative. We were repeatedly told by Jonathan Best and senior clinicians that our mother showed negative blood cultures for cryptococcus from mid December 2018. It has later come to light that she was antigen positive for cryptococcus and that she was being treated for a fungal eye infection throughout December 2018 and her medical records appear to show that they suspected this was connected to an active cryptococcus infection. None of this is mentioned in the SCI report.*
>
> *We believe that the hospital failed in its duty of candour to us when producing the SCI report, for a number of reasons: We were not notified about the SCI until it was already underway. We were not included in any conversations about the SCI process and the investigations. Details of the procedures they carried out were not disclosed in the SCI. The scope of the SCI had been changed without our prior knowledge or discussion, and investigating the source of the infection became out with the scope. The possibility of an active infection was not disclosed. The way we were told about the scope change we believe was also evasive and misleading, as we note in our statement to the Inquiry.*

We also repeatedly asked for written results of air sampling tests in Ward 4C and our mother's room in January and February of 2019 and never received these results."

David Campbell has told us:

"*Parents are expert witnesses for their children. We are the biggest and best form of risk mitigations GGC has and they chose to not only shun us from much needed information which would have allowed us to safely protect our children, they knowingly put them in harm's way. GGC continue to misconstrue the truth until this day, the impact of this has created fear and anger.*

"My son's natural flora was taken by prophylaxis he should never had been on.. If there was no issues with the water or be ventilation then he would not be on that prophylaxis for 7 months. Something unique to him was taken." Parents are home schooling their children while in hospital for long periods, Its difficult to continue to raise them with good morals, scruples and standards when we are surrounded by those in NHSGGC and Scottish Government who lack all of the above.

Kenneth Murdoch says:

"I have an overwhelming hatred to the hospital/NHSGGC no hope about it getting better either with the evidence I have heard. The Scottish Government are worse, they gave them all that money and just left them to get on with it there was zero oversight. This will be our 4th Christmas at a grave site, our 5th year of the family gathering at a cemetery for [redacted]*, a wee girl who died at the age of just 5,which could and should have been prevented. No matter the outcome we will never be the same,* [redacted] *did not deserve this, she deserved better, she deserved the right to be in a safe hospital and live. We feel let down by all and rage towards the management of the hospital. There is no resolution. Even after her death they were not*

transparent, deny and use evidence against us, never once were honest right up until now. Sorry is just a word but even that was denied to us. It means nothing now."

Theresa and Matthew Smith have said:

"*The death of our daughter at the overlooked NICU of Glasgow Queen Elizabeth University Hospital has left a wound that will never heal. Her loss was sudden, gruesome and utterly incomprehensible, tearing the heart out of our family and shattering the sense of safety we once had. Every day since has been marked by grief that is not only deep but relentless , a grief made heavier by unanswered questions and the knowledge that her final moments should never have unfolded as they did. Our family has been left trying to survive in the aftermath of something no parent should ever have to endure. The emotional impact has been devastating. We are not just grieving the loss of a beloved daughter; we are living with trauma, anger, and profound disbelief. Birthdays, holidays, and ordinary family moments are now reminders of absence rather than joy. The future we imagined for her and for us was taken away, leaving a silence that permeates every part of our lives.*

What has compounded this pain is the response of the GGC Health Board. Rather than openness, compassion, and transparency, we have been met with obstruction, silence, and defensiveness. Every attempt to uncover the truth about what happened has felt like a battle against an institution more concerned with protecting itself than acknowledging our daughter's life or our family's suffering. This lack of accountability has prolonged our grief, leaving us trapped in a cycle of unanswered questions and unresolved pain.

Our family did not seek conflict, we sought honesty, dignity, and the truth. We wanted to understand how such a tragedy could occur, not only for our own healing but to ensure no other family endures the same loss. Instead, the stonewalling has deepened our sense of injustice and abandonment. The impact of our daughter's death is not confined to the day we

lost her, it continues every day we are denied clarity, compassion, and the basic human decency of being heard."

Carolanne Baxter asks the Chair to note:

"[redacted] *came into this world fighting. He was loved and in his short time on earth he had a big impact on my family. He lived his entire life in neonatal and never saw the sky or the world outside. He contracted environmental infections and it has been to my distress that this Inquiry has not yet properly justified setting it aside. Neonatal was refurbished at the point the hospital was built, and I remain with questions and nightmares about what could happen to other babies that have to travel through their corridors.*"

[redacted] says:

"I'm still really struggling with what happened. To deal with a child being diagnosed with cancer there is nothing that can explain the world you are thrown into. And then on top of that you are lied to, dismissed and made to feel that what you are seeing isn't happening. All the things that we weren't told about has left me horrified. We were at the hospital so much, we lived there and became institutionalised to the system. Children died because of NHS GGC's failures. As well as children who were infected, some who died from environmental infections, there were also children that had their treatment delayed because of infections which in turn ultimately cost them their lives as well. I have had time off work because of the distress of all of this. Our rights were taken away, our basic right to be given the truth has gone. It has filtered into every aspect of our lives. There are no words at how disgusted we are with NHSGGC. What happens if [redacted] *and I need medical help in the future? It's frightened us to the point we trust nothing. We have to worry with the fear of a relapse, where do I take my child if that happens, I can't take him back there."*

Lesley Ann Coyles on behalf of [redacted] and [redacted] states:

"The way they were treated, [redacted] never got upset but every time he had to discuss the hospital after [redacted] died, he would. [redacted] towards the end of her life just kept saying "I'm going to be with [redacted]", "I'm going to be with [redacted]". NHS GGC have shown no compassion, no empathy, and still try and sweep it under the carpet. It is cruel. Their entire family unit has been destroyed, by unbelievable failures as a result of NHSGGC. Where is the justice, there is no justice here. We believed the NHS and now we feel sick." It should be noted that the family have requested that the restriction order in place be lifted.

Kimberley Darroch states:

"The pain of losing my daughter is not just the pain of death, it is the pain of trust being broken. I brought her to a hospital believing it was a place of healing, only to leave without her. Knowing that the environment meant to save lives was unfit for habitation haunts me. It feels like she was failed when she was most vulnerable. My grief is tangled with anger, helplessness, and a lifelong question of why my child had to pay the price for negligence."

Maureen Dynes says:

"I make this statement to explain the profound and lasting impact that the death of my husband, Tony, has had on my life and the lives of our family, as a result of failures in the care he received at QEUH.

My husband was more than a patient; he was a loving partner, a family man, and an integral part of our home. His death was unexpected as we were making plans to leave the hospital. We

placed our trust in the hospital and its staff to provide him with safe, competent, and timely medical care. That trust was broken.

Since his death, my life has been irrevocably changed. I live with constant grief, shock, and unanswered questions about how this was allowed to happen? Was I to blame by not seeing something or not asking more questions? The circumstances surrounding the discovery of his death and the lack of transparency from the hospital have compounded my distress and made it difficult to find any sense of closure.

Emotionally, I experience ongoing anxiety, sadness, and anger. I struggle with sleep, concentration, and daily functioning. Simple tasks can feel overwhelming, and milestones and memories are now accompanied by a deep sense of loss. The absence of my husband is felt every day and has also had a significant impact on our family. Clare and Paul have lost a father and role model, their weddings were affected by not having a father to walk Clare down the aisle and Paul didn't have the support a father would give. I have been left to manage not only my own grief but also theirs. The emotional strain on our family relationships has been immense.

Financially I lost my business partner and the children we cared for have lost a grandfather figure. These challenges have added further stress at a time when I am already vulnerable.

What makes this loss even harder to bear is the knowledge that my husband's death may have been preventable had appropriate care been provided. Knowing that failures within the hospital system contributed to his death has left me feeling powerless, betrayed, and deeply distressed. It is like a form of PTSD triggered by every mention of the hospital.

I submit this statement not only to describe the devastating impact of my husband's death, but also in the hope that accountability will be taken, lessons will be learned, and no other family will have to endure the pain and suffering that we have experienced."

Alfie Rawson says:

As parents of a child that has gone through treatment at the sick kids hospital in Glasgow. We have lost faith in not only in the hospital but also Scottish Government. There is no solid trust in the staff due to ongoing pressures the NHS is under.

On a personal note our child has been left with ongoing health issues and will continue to have these issues for the rest of her life. My partner suffers from anxiety and PTSD which takes its toll on a daily basis, I myself suffer from anxiety and panic attacks with frequent attacks due to the stress of the ongoing enquiry and day to day hospital exposure has in the press and on tv, there has been no lessons learned from the day the inquiry started. What we continue to see on our daughter health check at the hospital is a hospital being rebuilt in the main auditorium and in rooms, continued use of tap filters, dirty wards, cracked flooring, still there are people smoking outside the main entrance. We hope as the Inquiry draws to a close we can find the answer we are looking for that this hospital and its senior management isn't fit for purpose.

Charmaine La Cock has expressed:

As a parent of a child who had cancer treatment at the Queen Elizabeth Hospital in Glasgow, we already stare death in the face when you get your child's diagnosis. Then being told that your child has a gram-negative infection that is potentially caused by the environment that is meant to protect her, that it is life-threatening is another death-sentence. The fear is unreal.

The long-term impact is we are now seven years on from diagnosis and I still wake up in the middle of the night in panic. I still have flashbacks from being told we don't know how this will go. Still wake up convinced my child is dead. We were told so clearly at diagnosis that it will probably be

infection that would kill our kids and not the cancer, it became a way of living. We are all germophobe's.

Do we trust that the hospital is safe now? Absolutely not. We've been into the hospital in November 2025 for a check up and the amount of building works in the atrium is shocking. Water buckets in the main area in the Childrens' Hospital catching rainwater dripping through the roof is still going on. Showers are still flooding.

We can upgrade the cancer ward as much as we want the environment is unhealthy and that is not going to change.

Do we trust the government and NHSGGC for keeping our children safe? No!

How do you tell the nation that the "Super Hospital" that has been built at cost of closing all small hospitals around the area it's not fit for purpose?

It's been 5 years since my daughter ended treatment and if you ask her what is the one thing she remembered about the hospital her answer is always "don't touch the water."

From meetings with the Core Participants we represent the following themes, comments and views in terms of impact have been identified:

- There is a very strong level of anger that the HAD report was produced so desperately late in the day and, also, that NHS GGC instructed the report at all to seek to undermine the independent Inquiry experts.
- There is concern that the HAD experts were not given all the relevant information by NHS GGC and, furthermore that the report revealed data that the Inquiry experts had

not received. This has contributed to the feeling that there has been an NHS GGC attempted coverup.

- Some have expressed that they believe there is a higher rate of infections in the hospital than has been reported, because of the skewing of figures as has been demonstrated in the ARHAI evidence. This has caused both fear and anger about what risks remain in the hospital today. It has stood in the way of trust.
- A deep dive needs to be done into the laboratory data to find out the extent of the adult infection rates on every ward.
- There is a view that informed consent on the risks to the patients must become a prerequisite prior to treatment at the hospital because of the problems that have occurred with the environment. If that does not happen, the question has been raised as to how can it be said that all the patients are fully aware of the risks in the environment?
- There is distress to families (Mark Bissett) in relation to ward Ward 4B and a skewing of figures of infection rates. His daughter [redacted] was in Ward 4B and contracted Aspergillus but this is not included in the data for the HAD report and was set aside by the CNR when he feels it shouldn't have been. She contracted Aspergillus in August 2019. [redacted] had to travel through the main campus where the remediation works were being carried out and at no point was she required to wear a mask or any sort of PPE. She travelled daily from Ward 4B to a standard taxi, not an NHS vehicle, outside to get her radiotherapy at the Beatson which happened twice a day. Mr Bissett recalls witnessing other children and adults becoming unwell with Aspergillus as well when [redacted] was admitted. The belief on first-hand experience is that there were more cases then have been reported by NHS GGC.
- Sharon Ferguson wants to highlight that her son [redacted] caught Aspergillus in ward Ward 4B in 2017. NHS GGC say there are and were appropriate mitigations in place to

protect patients travelling through the building. That is disputed and not in accordance with the experiences of the parents.

- No discussions took place with the patients and families about patient pathways. Parents consider that they should be key in that conversation and 'involved'. There is strong consensus throughout the group that there remains an "invisible" figure of infections for many patients which hides the truth.
- Many clients believe that NHS GGC have demonstrated that they have set aside a patient centred approach.
- There is a strong desire for NHS GGC to take responsibility for their role in exposing the patients to dangerous environmental infections. At present the evidence, from the group's perspective, is that NHS GGC has demonstrated a desire to dismiss and downplay what they have done.
- There is a concern that the Inquiry and the hospital are downplaying the events in Ward 4B and its ongoing failure to meet expected ventilation standards.
- Management of NHS GGC shouldn't be allowed to claim their pensions, after making repeated serious errors that have put lives at risk.
- Bottled water has been used throughout the hospital creating the reasonable impression that the hospital throughout is at risk from the water.
- The Inquiry setting a deadline so close to Christmas for the submission, does not feel like it has made the investigation patient centred. This is a significant time of year for many.
- Many documents so frequently being released close to the Hearings has concerned many as they feel this has been done without the Inquiry considering the impact on and consequences for investigation and preparation by the group's legal team.

- Mitigations can only be temporary – never permanent. What will happen if and when they start to fail?
- The Case Note Review started to provide families with answers they sorely needed. They are grateful to Michael Stephens and his team for the work they put in and are angry that NHS GGC were not accepting of their findings until Professor Gardner gave her evidence.
- There is a strong anger towards NHS GGC executive and management. In particular, Jane Grant, Robert Calderwood and Jamie Redfern. Jane Grant's evidence often featured the quote "moving forwards", however this becomes impossible if the realities of what has occurred has not been accepted by the witnesses. It should always be remembered that some families will never be able to move forwards as their family member has now passed away.
- Robert Calderwood seems unable to acknowledge the basic premise of his job in his evidence and should be stripped of his pension and held to account.

8. Communication by NHS GGC with patients and families

8.1 In the evidence of patients and families, NHS GGC was repeatedly criticised for poor communication with them throughout the events at the QEUH/RHC. The evidence demonstrates that this failure had significant and lasting consequences for those affected. It should be noted that all that follows bears upon the experiences of both adult and paediatric patients and their families.

8.2 Key Patient and Family Perspectives:

(i) Lack of Timely and Transparent Information

Patients and families often first learned of major events, such as ward closures, decants, or infection outbreaks, from the media rather than directly from NHS GGC. This abject failure to communicate proactively left many feeling excluded, uninformed and concerned. Information provided was frequently described as incomplete, unclear, or evasive, with some families perceiving NHS GGC's conduct as a deliberate attempt to downplay or even cover up problems.

(ii) Loss of Trust and Heightened Anxiety

The absence of open and honest communication fostered a profound sense of suspicion and mistrust towards NHS GGC management, even among those who continued to praise the clinicians and nursing staff for their application, hard work and empathy. Many families reported feeling "fobbed off with excuses," which increased their anxiety, anger, and frustration during already stressful treatment periods.

(iii) Failure to Respect Patient Rights

Communications were found to be not patient-centred; the Board did not respect families' rights to be informed or to participate in decisions bearing on their care. Some parents and family members of adult patients believe they were not told about risks or changes that directly affected their loved one's treatment, leading to a sense of disempowerment and exclusion.

(iv) Emotional and Psychological Harm

The lack of clear, timely information contributed to significant emotional distress, with some families experiencing anger, anxiety, and even symptoms consistent with post-traumatic stress. The uncertainty and suspicion caused by poor communication compounded the trauma of dealing with serious illness and hospital-acquired infections.

(v) Impact on Clinicians and nursing staff

NHS GGC's approach to communication also had significant impact on clinicians and nursing staff. Clinicians and nursing staff have given evidence that they often felt inadequately informed about emerging risks, operational changes or decisions being made at a senior management level. There was a recurrent sense that information was either withheld, delayed or filtered through hierarchical layers, making it difficult for frontline staff to understand the full context or rationale for key decisions. Important updates, such as ward decants, infection outbreaks, or changes to protocols, sometimes reached staff through the media or informal channels before official communication was provided. This undermined confidence in the Board's communication processes and left staff feeling excluded from critical discussions. The defensive and opaque communication style adopted by NHS GGC management fostered a culture of suspicion and frustration among clinical teams. Many clinicians and nurses perceived that communications were crafted to protect the organisation's reputation rather than to support staff or prioritise patient safety.

Staff reported feeling unsupported and, in some cases, blamed when problems emerged, rather than engaged as partners in resolving issues. This led to a sense of professional isolation and eroded morale, especially during periods of intense scrutiny and public concern. (Transcript of Evidence Fiona McQueen, 2nd October 2025, Pages 60-61, Columns 115-117). The lack of open dialogue and the perception that concerns were not being listened to discouraged staff from raising issues or "speaking up" about safety. Whistleblowers and those who challenged management narratives faced marginalisation or were labelled as "troublemakers," which further stifled open communication and learning. (Statements of Theresa Inkster: Glasgow III Witness Statements, Volume 7, Pages 298 – 299)

We submit that the general thrust of the evidence before this Inquiry shows that NHS GGC's communication failures contributed to increased stress and emotional exhaustion among clinical staff, who were already managing complex care in a challenging environment. Many

felt caught between their duty to patients and the constraints of an unresponsive organisational culture. The sense of not being trusted or respected by management, and the experience of being left out of key decisions appears to us to have led to long-term damage in relationships between staff and the NHS GGC Executive Board and senior management.

(v) Practical Impacts on Care and Wellbeing

Misinformation or lack of information led to confusion about the safety of wards, water and ventilation, which affected families' willingness to use facilities and their confidence in the care environment. The sense of being left in the dark made it more difficult for families to make informed decisions about their child's or family member's care and led to unnecessary worry or avoidance of hospital services and feelings of guilt that they could and should have done more to protect their loved ones.

(vi) Damaged Relationships with the Health Board

Ultimately, the cumulative effect of NHS GGC's desperately poor performance with communication was a breakdown of trust between families/patients and NHS GGC Executive Board and management. That breakdown persisted even after improvements were made to the hospital environment. This mistrust made it harder for NHS GGC to restore confidence, rebuild relationships, and engage families in ongoing service improvements.

(vii) Acknowledgement and Regret

NHS GGC itself ultimately conceded that there were failures in communication, admitting that some families first learned of critical developments from the media and expressing "deep regret" for these failures.

In their Closing Statement, Counsel to the Inquiry stated that NHS GGC's communications "*were not satisfactory*" and that the Board did not respect patients' and families' rights to be

informed, falling short of patient-centred care (Paragraph 1847). We agree, though use of the words "*were not satisfactory*" risks seriously underplaying what we submit was abject failure (or, worse, a positive decision made not) to communicate proactively with patients and families in accordance with NHS GGC's Duty of Candour.

Those we represent welcome the comments made by Counsel to the Inquiry at Paragraph 1806 of their Closing Statement. By not disclosing their refusal to accept the findings of the CNR to patients, families, the public or Scottish Government years after the Report was issued to the patients and families, there is the possibility of deliberate concealment on the part of senior officials of NHS GGC. Such concealment amounts to wrongdoing and offends against the corporate Duty of Candour and the Nolan Principles of Public Life. The oral evidence and witness statements from the Core Participants we represent support the proposition that there are many more examples of senior NHS GGC Executive Board members and management failing in their duty of candour.

8.3 In summary, we submit that NHS GGC's admittedly poor communication caused avoidable distress, undermined trust and left families feeling excluded and unsupported at times of crisis. The consequences were not only emotional and psychological, but also practical, affecting the ability of families to participate in care and make informed choices. These failures in communication represent a fundamental breach of patient-centred values. They have had a lasting impact on the relationship between patients, families and the health board.

9. Accountability and the Need for Change

9.1 NHS GGC's repeated refusal to acknowledge the scale and consequences of its failures, its unwillingness to be open with patients, families, and even its own staff, has compounded the

suffering and undermined trust in NHS GGC. It is not enough to express regret. What is required is a full and public acknowledgment that these failures in water and ventilation systems were foreseeable, avoidable, and directly connected to the infections suffered by patients.

9.2 We urge the Inquiry to ensure that the lessons of this tragedy are not lost. The failures of NHS GGC must be recognised as systemic and organisational, not simply the result of individual oversights. Patients and families deserve not only answers but genuine accountability and a commitment that future patients will not be exposed to the same avoidable risks. Patient safety, transparency and candour should be the foundation of our healthcare system.

10. Scottish Government Oversight

10.1 The journey that patients and families have endured at the QEUH is one marked by pain, uncertainty, and a profound sense of betrayal. At the heart of this suffering lies not only the technical failures of a hospital meant to provide sanctuary and healing, but also a fundamental abdication of responsibility by the Scottish Government, a government entrusted to safeguard Scottish public health and ensure the highest standards in our national health infrastructure.

10.2 It is now clear that, despite providing the strategic direction and funding for one of the largest healthcare projects in Scotland, the Scottish Government chose to operate ‘at arm’s length’, relying on a system based largely on trust rather than robust oversight or intervention. The absence of meaningful scrutiny over the procurement, design, and construction phases meant that critical decisions—such as departures from national guidance on ventilation and water safety—went unchallenged and unreported at the highest levels. The Government’s own witnesses have acknowledged that, while local health boards have some autonomy, the Scottish

Government retains strategic accountability and should have taken a more direct role in such a major capital project.

10.3 Indeed the Scottish Government had required BREEAM excellence and the contract provided for a £250,000 bonus in the event that contractors achieved it. This 'cash incentive' may to some extent be causative of the approach taken by NHS GGC and should not be ignored. For example, in his evidence Mr Seaborne stated that the carbon filters were removed, in part, for energy efficiency reasons (Transcript of Evidence Alan Seaborne, 29th May 2025, Page 144).

10.4 When early warning signs emerged (be it through technical reports, whistleblowers, or the distress of families) the Scottish Government's response was delayed, insufficient and reactive when it ought to have been proactive.

10.5 Mechanisms to assure themselves that commissioning and validation had been carried out at QEUH were lacking; the system, by their own admission, was based on trust alone. Even as the scale of the crisis became apparent, interventions were limited, confused or focused too narrowly with oversight boards established too late and given too little remit to address the root problems.

10.6 This abdication of responsibility had real, human consequences. Families were left in the dark, learning of risks and ward closures from the media rather than from those responsible for their care.

10.7 Patients, many of them children, suffered avoidable infections, prolonged hospital stays, symptoms and the trauma of knowing that the very environment meant to protect them had failed. The distress was compounded by communication failures and a culture of defensiveness, eroding trust in both the hospital and the government meant to guarantee its safety.

10.8 We submit that the Scottish Government's failure to provide direct, effective oversight at an early stage and to intervene decisively when problems arose represents not just a policy failure but a moral one. It is not enough to cite complex governance or to delegate accountability downwards. When the health and lives of the most vulnerable are at stake, the duty of care must be active, visible, and unrelenting.

10.9 The Scottish Government should acknowledge its role in these failures, not merely as a distant funder, but as the ultimate steward of Scotland's healthcare system. Patients and families deserve not only answers, but a commitment from their government that such abdication of responsibility will never be repeated. The lessons of the QEUH must be a catalyst for reform, transparency and a new era of genuine accountability at every level of government.

10.10 The evidence presented to this Inquiry has made clear that the Scottish Government's approach to the planning, procurement, and oversight of the QEUH was at best "arm's-length" and, at worst, an abdication of its fundamental responsibilities.

10.11 While the Scottish Government set the strategic direction and provided the funding for this flagship project, it failed to ensure that robust oversight, governance and technical scrutiny were in place throughout the life cycle of the hospital's design, construction and commissioning. This lack of direct engagement and accountability created a vacuum in which critical deficiencies in the hospital's water and ventilation systems were allowed to develop and persist, placing patients, particularly the most vulnerable, at avoidable risk.

10.12 Former Cabinet Secretary Jeane Freeman herself acknowledged to the Inquiry that the Scottish Government should have taken a more active role in large-scale, costly hospital projects, and criticised the "arm's-length" approach that prevailed. The systems of assurance relied upon by government were based on trust rather than verification, and there were no effective mechanisms to guarantee that essential processes, such as commissioning and

validation of key building systems, were completed to the required standard before patients were admitted (as had been the case with The Royal Hospital for Children and Young People and Department of Clinical Neuroscience).

10.13 When problems did emerge, the Scottish Government's interventions were belated and limited in scope, often restricted to supporting local management rather than exercising the full oversight and direction that we suggest the public has a right to expect.

10.14 For patients and families affected by the failings at QEUH, the consequences of this abdication of responsibility have been profound. Many endured unnecessary physical, emotional and psychological harm, compounded by a lack of transparency and clear communication. The Scottish Government's failure to exercise its duty of care in the delivery of this major public asset has eroded trust, undermined confidence and faith in the healthcare system and left families feeling abandoned by those ultimately responsible for safeguarding their wellbeing.

10.15 It is essential that lessons are learned from this experience. The Scottish Government must accept that with strategic leadership and funding comes the non-delegable duty to ensure that new hospitals are safe, effective and truly fit for purpose. Anything less is a failure to uphold the most basic obligations to the patients and families in Scotland who depend on the NHS.

10.16 The QEUH was built with public money, entrusted by the people of Scotland to deliver a safe, modern environment for healthcare. It is the Health and Social Care Directorate's duty and responsibility to ensure that taxpayer's money is being spent wisely and that Scottish healthcare is safe and effective.

10.17 Patients and families had every right to expect that those responsible for commissioning, funding and overseeing such a major project would uphold the highest standards of

accountability, diligence, and transparency. Instead, the evidence shows a fundamental abdication of responsibility by the Scottish Government at key stages of the QEUH's planning, procurement, and construction.

10.18 Failure of Oversight and Accountability

- The Scottish Government approved and funded the project, yet failed to ensure robust oversight or intervention at critical milestones. Despite being the principal funder, there was no direct Scottish Government involvement in scrutinising the construction contract between the issue of the tender and contract signature, even though taxpayer money was at stake.
- The Government relied on assumptions that internal mechanisms within NHS GGC would provide assurance that guidance and standards were properly considered and applied. In reality, these internal processes were inadequate and failed to detect or prevent major departures from essential safety standards.
- There was no requirement for clear reporting or escalation to the Scottish Government when significant derogations from guidance, such as the ventilation standards, were made. This lack of transparency meant that fundamental risks to patient safety went unchallenged and unaddressed at the highest level.

10.19 Inadequate Response to Emerging Failures

- When serious deficiencies in the water and ventilation systems became apparent, the Scottish Government's response was slow and reactive. It was not until the situation had escalated to a crisis, with significant harm to patients and families, that meaningful intervention occurred.

- Even then, the scope of government intervention was limited, failing to provide the robust oversight and assurance that the public could reasonably expect after such a catastrophic failure in a publicly funded project.

- The Government's "arm's-length" approach, as described by its own former Cabinet Secretary for Health, left local health boards with a degree of autonomy but without the necessary checks, balances, or support to manage a project of this scale and complexity.

- It is our submission that the Scottish Government should have reacted to the emergency situation at QEUH/RHC and invoked the Powers available to it in Stage 5.

10.20 Consequences for Patients and Families

- The result of this abdication of responsibility was a hospital environment that failed to provide safe, effective, person-centred care for some of the most vulnerable patients in Scotland.

- Families endured avoidable harm, distress, and loss, compounded by inadequate communication and a lack of candour from those in positions of authority.

- The public's trust in the health system and in government stewardship of public funds has been severely undermined.

10.21 The Need for Change

Patients and families have borne the consequences of systemic failures and a lack of government accountability. Public money demands public responsibility. The Scottish Government must acknowledge its failures in the QEUH project and ensure that robust, transparent, and enforceable systems are in place for all future NHS infrastructure projects—so that no family ever again suffers as a result of such abdication of duty. We call for a clear

public apology, a commitment to meaningful reform, and the assurance that the lessons of QEUH will be fully learned and acted upon. The people of Scotland deserve nothing less.

11. General Submissions and Observations on Counsel to the Inquiry's proposed recommendations

11.1 One way of restoring public confidence in the QEUH/RHC would be for NHS GGC to undertake to meet water and ventilation standards required by the relevant SHTM guidance. Evidence supports the proposition that NHS GGC have demonstrated that guidance will be ignored unless it is compulsory and, in terms of recommendations, it may be that the Chair would consider recommending that, for future healthcare facility builds, the following of SHTM guidance be mandatory.

11.2 Individuals, past and present, within NHS GGC's executive board and management team for QEUH/RHC must be held accountable for their actions. Those that we represent have reported that they find it astonishing that, in all the circumstances, nobody within NHS GGC appears to have been subjected to disciplinary action to date.

11.3 Accountability is crucial because it drives learning, ensures that issues are addressed and not ignored and builds or stands a chance of rebuilding confidence in the hospital and NHS GGC. Who is or ought to be held accountable would depend on the position held by the individual within the NHS GGC structure, their duties, their responsibilities, their knowledge of the risk posed by the environment and their ability to take steps towards effective remediation. In that regard we note that NHS GGC instructed a report from AECOM in May 2019 into the ventilation system, but that report has never been made public. The Chair ought, in our submission, to request a copy of this report as that may assist him with his consideration of the accountability of individuals in NHS GGC.

11.4 There should be a public apology, in the presence of patients and families, for NHS GGC's failure to acknowledge and take timeous steps to address the link between the environment and infection, and the distress caused by the attitude towards them. That in person apology should come from Professor Gardner and her board.

11.5 There should be an acknowledgement by this Inquiry that the failings of NHS GGC and the Scottish Government have impacted upon adult patients and their families as well as paediatric patients and their families. It is wrong of Counsel to the Inquiry to consider impact statements as almost exclusively centring on children and parents (Paragraph 9.14 – TOR 8). Adult patients and their families have given evidence and submitted statements to this Inquiry discussing the significant and serious impact on them. Where appropriate, this Inquiry ought to take care to refer to patients and families rather than just parents and children.

11.6 It is our submission that the routine use of prophylaxis medication at QEUH/RHC as a means of mitigating risk is fraught with danger and should not be condoned. The Inquiry has heard evidence that the use of such medication poses its own risks and side effects and is not suitable for all patients. In their Closing Statement Counsel to the Inquiry propose that a recommendation be made about the prescription of antimicrobial prophylaxis for all high risk immunocompromised patients, such as those in haematology and bone marrow transplant units, when the environment does not fully meet the ventilation standards set out in national guidance (Paragraph 1758). We submit that any recommendation should note that prophylaxis is not universally tolerated by all patients, and alternative or additional risk reduction measures (such as environmental controls or patient placement policies) must be available for those who cannot receive prophylaxis. In addition, there ought to be regular review of both the environmental risk and the appropriateness of continued prophylactic medication, especially as environmental improvements are implemented. Any decision to prescribe prophylaxis medication must be informed by a thorough and documented risk assessment of the ward environment, taking into

account patient vulnerability and the presence or absence of engineering controls. Such an approach ensures that the risk of infection is reduced to the lowest practicable level for the most vulnerable patients, while recognising the limitations and potential and serious side effects of prophylactic therapies, such as deafness and organ damage.

11.7 **At Paragraph 58** of their Closing Statement, Counsel to the Inquiry observes, regarding Cryptococcus, that "*had the two patients who died been accommodated in HEPA filtered positive pressure rooms, it would have been possible to exclude a connection to the hospital environment*". The presence of HEPA filtration of itself could not, we submit, have excluded a hospital connection without all the protective environment specifications, including those relating to ventilation, being in place. The Inquiry should recommend that: (i) NHS GGC introduce these measures at QEUH in a timely fashion so that the situation does not arise again; and (ii) Ward 4C should, in all the circumstances, be categorised as a neutropenic Ward and its ventilation provision upgraded in accordance with SHTM 03-01.

11.8 **At Paragraph 408** of their Closing Statement, Counsel to the Inquiry makes observations regarding risk for immunocompromised patients contracting Cryptococcus and Aspergillus: "*Acknowledgement of this risk and the conversion of significant numbers of PPVL rooms to Positive Pressure Isolation Rooms (PPIR) should now enable policies and protocols to be delivered to ensure that this group of patients is not exposed to these risks.*" It is also proposed that the risk of contracting Aspergillus and Cryptococcus is only a risk for a "small group of patients". Firstly, we challenge this solution for immunocompromised patients. At Paragraph 1447 of their Closing Statement, Counsel to the Inquiry notes that there are 24 PPIR rooms at QEUH for adult patients (all on Ward 4B). We submit that there is no evidence before this Inquiry that identifies the number of immunocompromised patients accommodated from time to time at QEUH and whether, therefore, the provision of 24 PPIR rooms will in fact, as proposed, suffice to ensure that this group of patients is not exposed to the identified risks. In

any event, it should be noted that PPIR rooms do not have the ventilation specification required for a safe patient environment for bone marrow transplant patients. The main deficiency is the air change rate, which is 6 ACH instead of the required 10 ACH. This could increase the risk of airborne infections for highly vulnerable patients, even though other protective measures (HEPA filtration, positive pressure, sealing, and monitoring) are in place. The absence of a backup AHU is also a material concern. These issues mean the rooms are not fully compliant with national standards and best practice for protective isolation of BMT patients. It will be recalled from the evidence before this Inquiry that the return of the Beatson BMT Unit to Ward 4B was seen as a temporary measure or solution. The 2017 Bone Marrow Transplantation: Options Appraisal (Bundle 27, Volume 7, Document 6, Page 158) explicitly described the Beatson's return to Ward 4B as 'not a long-term solution' and noted that the risks to patient safety from airborne pathogens had been reduced to an 'acceptable level' only as a temporary measure. On the evidence there does not appear to have been any reconsideration, scrutiny or risk evaluation of this temporary measure.

It is important to note that routine care of immunocompromised patients should allow for interaction with visitors if a patient-centred approach is to be taken. Secondly, we do not see the evidential basis for Counsel to the Inquiry proposing that the risk of contracting Aspergillus and Cryptococcus is only a risk for a "small group of patients".

11.9 **At Paragraph 1721** of their Closing Statement, Counsel to the Inquiry also discusses "*the question of the four additional cryptococcus cases in 2024*". The available evidence suggests that there have (potentially) been 7 cases from 2020 till 2024 and 6 cases from 2016 till 2019 associated with the QEUH. Mumford and Dempster referred to a possible 6 cases associated with QEUH: one in 2016 and five in 2018 (Mumford and Dempster, Qualitative Infection Link Expert Report, Bundle 21, Volume 1, Document 4 at Ch 10.5, pages 73 – 74). In November 2024 it transpired that there had been an additional 7 cases from 2020 until 2024 with potential

links to the QEUH (See Bundle 52, Volume 4, p 77 – email from Natalia Hedo, GGC to Laura Imrie, ARHAI)**.** In her email to Laura Imrie, Ms Hedo states that only one of these further cases was reported to ARHAI. We are now unclear about the total number of cases potentially associated with the NHS GGC since 2016, but it may in fact add up to 13. Not all of these cases may be associated with QEUH, but the fact that we are still in the dark about this is frustrating for those that we represent. It is plainly not the case that only 4 cases remain to be investigated. It may be that their occurrence is not as rare as NHS GGC would like us to believe or that there are as few cases for investigation as Counsel to the Inquiry alludes to in their Closing Statement.

11.10 Counsel to the Inquiry refers in the same paragraph (Paragraph 1721) to a letter dated 20 August 2025 from the Director General of Health and Social Care, Caroline Lamb, to the current NHS GGC CEO, Jann Gardner (see Bundle 52, Volume 5, Page 144-145). The email gives an overview of the difficulty ARHAI had in obtaining information from NHS GGC after the initial request in November 2024 until they finally received some data in July 2025. ARHAI had contacted every NHS board in Scotland requesting cryptococcus data with a view to securing a national picture. We agree with Counsel to the inquiry that this shows grave deficiencies in the NHS GGC/QEUH/RHC reporting system, but their Closing Statement omits to mention that Ms Lamb writes in the letter: "*The data provided demonstrated that NHS GGC are an outlier for this organism in relation to the number of cases in QEUH*". Or that she writes that "*ARHAI's assessment has identified an area of the QEUH ...with Cryptococcus cases potentially linked in time and place.*" She recommends further investigation in order to determine whether they are a cluster, "*...to explore the possibility of an environmental source in the estate.*" These are very important points that need to be brought to the public's attention. Concerns about a possible cluster of cases which has gone unreported should be acknowledged by this Inquiry in its findings.

11.11 It is our submission that the admitted failure of NHS GGC to follow reporting standards has resulted in the creation of a skewed picture of infection rates at QEUH. There is, we submit, no sound evidential basis upon which infection rates at QEUH may be identified and discussed. Accordingly, any statements about risks being low, or even moderate, are rendered meaningless. **Absence of evidence is not evidence of absence.**

11.12 At Paragraph 1842 of their Closing Statement, Counsel to the Inquiry states: "*The failure to build general ward rooms in accordance with SHTM 03-01 has not been rectified and may be impossible to rectify in the existing building structure*." We would question whether use of the word "impossible" is appropriate when the Cundall report issued in May 2022 (Bundle 20 Page 1434 at page 1466) gives clear recommendations about how Wards 4C, 5C, 6C and 7C might be brought up to SHTM 03-01 standard.

11.13 At Chapter 10 of their report, Counsel to the Inquiry propose recommendations. The Core Participants we represent have made the following observations and comments about those recommendations which we seek to bring to The Chair's attention:

"10.2: Proposed Recommendations addressed to the Scottish Government"

Many of the proposed recommendations made to the Scottish Government are welcomed, however, they lack discussion of robust accountability for government bodies, NHS senior leaders and external contractors if they should fail to implement, record, assess and complete these recommendations

Paragraphs 1880, 1881, 1882: the wording of these paragraphs does not compel contractors to follow SHTM as compulsory and does not discuss, as they ought, the consequences for non-compliance.

Paragraphs 1893 and 1894: *HAI Reporting and Investigation*: the wording does not discuss consequences for senior leaders of Health Boards if HAI reporting does not comply with

recommendations. Moreover, what is not discussed is the accountability of the Scottish Government/ARHAI if they fail to take steps to enforce reporting. HAI reporting should be made compulsory and clear so there is absolutely no ambiguity about the requirement for mandatory reporting by Health Boards.

Paragraph 1895 Communications: the paragraph does not discuss the consequences for Scottish Government and/or senior leaders of Health Boards if a clear, open and transparent communication strategy is not adhered to. The Corporate Duty of Candour must be adhered to, both for Health Boards and the Scottish Government, and disciplinary measures should be implemented if there is a demonstrated failure to do so.

"10.2.7: Healthcare Governance"

Paragraph 1896: we submit that managers and members of the executive board, the Chair or any Chief Executive of a health board should be retrospectively brought to account if found guilty of wrongdoing or jeopardising healthcare, with whatever measures can be employed (for example, the removal, reduction or adjustment of pensions related to NHS employment).

Paragraph 1897: those we represent fully endorse and support the need for a Regulator for the NHS in Scotland charged with overseeing and enforcing performance of IPC practice and HAI reporting. Had such a Regulator been in place, many of the demonstrated, serious failures on the part of the NHS GGC Executive Board and management might have been avoided or, at the very least, identified and acted upon sooner.

"10.3 Proposed Recommendations addressed to NHS GGC"

Paragraph 1898: what is proposed does not go far enough. It neither compels NHS GGC to acknowledge the risk to patients nor, to rectify the problem so that it meets current SHTM 03-01 guidelines. This Inquiry has clearly demonstrated that NHS GGC will not act unless it is compelled to do so. Those we represent ask for stronger wording with a demand of

consequences for non-compliance. The timeline for implementation recommendations is not clear and, it is submitted, needs to be more specific.

Paragraph 1899: SHTM 03-01 recommends a minimum of the provision of 60 litres per second in general wards and corridors and 100 for immunocompromised patients. NHS GGC should be required to reach this standard at the QEUH/RHC as a minimum. It should be made clear to the Scottish Ministers, Scottish Government and the people of Scotland that there is currently no ward at the QEUH that meets the SHTM 03-01 guidance requirements for adult immunocompromised patients at QEUH. Moreover, there is only the provision of relatively few isolation rooms for adult immunocompromised patients**.** We agree that pending risk assessments of all the patient rooms that receive air supply at or about 40 litres per second NHS GGC should implement a recommendation limit of no more than 4 persons per room. This is not patient centred care. It is important for families to be able to visit and for patients, staff and visitors to be in a safe environment, so there needs to be a specific and rapid timescale in which to carry out these risk assessments and the necessary changes to be made.

"10.4Proposed Recommendations addressed to the Health, Social Care and Sport Committee of the Scottish Parliament"

*Paragraph 1906***:** we endorse the view that the Health, Social Care and Sport Committee should carry out a review of the implementation of the recommendations of this Inquiry. We would add that the Scottish Government ultimately holds responsibility for ensuring that all recommendations are being addressed. The Scottish Government must use its powers to support, facilitate and enforce implementation and must be held accountable if it fails to do so.

12. Closing Summary

12.1 Public Inquiries are held in the public interest. It is in the public interest that any recommendations made (so the future is better and past mistakes are not repeated) are 'fully

and properly considered' and, if they are to be rejected (whether by NHS GGC, the Scottish Government or any other body) then that should be for good reason and the public should be told, clearly, what the reasons for rejection are.

12.2 Parliament's intention in passing the Inquiries Act 2005 was to give the chair of a statutory inquiry the power to scrutinise the actions of Government in accordance with its terms of reference, and to do so in a flexible and more expansive way than is available to a court considering a judicial review challenge. Indeed, it could be argued that the primary purpose of the Act and of many inquiries, is to scrutinise the decisions and actions of the Executive.

12.3 Section 14(1)(a) of the Act provides: "*For the purposes of this Act an inquiry comes to an end – on the date, after the delivery of the report of the inquiry, on which the chairman notifies the Minister that the inquiry has fulfilled its terms of reference*". An inquiry does not end with the delivery of the report, but with the Chair's notification to the Minister.

12.4 If assurances or undertakings to act are given it is important that they are kept and, that there is no dragging of feet.

12.5 It is, looking at the impact on the patients/families and their lack of faith in NHS GGC, the Scottish Government and the current safety status of the QEUH/RHC, important that The Chair takes steps to see that there is no failure to act on recommendations with reasonable alacrity.

12.6 We submit that, within a year of issue of the Chair's Report, NHS GGC and the Scottish Government should be required to consider the recommendations made and either (a) commit to implementing them or, alternatively, (b) give sufficient reason in sufficient detail for others to understand why it is not considered appropriate to implement any one or more of them.

12.7 This proposed approach is in keeping with approach taken by the Chair of the UK Infected Blood Inquiry, Sir Brian Langstaff, and as more full set out and explained by him at Pages 280 to 285 of Volume 1 his Report following his hearing of the evidence in that Inquiry.

We commend that approach to Lord Brodie as Chair of this Inquiry and adopt the reasoning for Sir Brian' Langstaff for taking it.

12.8 This Inquiry should not be seen as complete for those reasons and for the following further reasons:

- There is no evidence that airlock doors have been fitted to the rooms on Ward 4B or, if they were, when and what maintenance has been performed.
- The QEUH/RHC ventilation generally, but specifically for adult immunocompromised patients, is still not compliant with SHTM 03-01. For the sake of public confidence, the whole hospital needs to be air tested, and a clear picture of ACH rates across the whole campus made public, alongside the corresponding guidance.
- Water testing is below where it should be.
- NHS GGC reporting to and the tension with its relationship with ARHAI is not as it should be (see Professor Jann Gardner's evidence).
- Communication and Whistleblowing – Professor Gardner said she acknowledged past errors and described ongoing efforts to improve (Transcript of evidence, Professor Gardner, 9th October 2025 Page 99 Column 193) – the result of those efforts should be made known and publicly available .
- There is a lacuna in the current healthcare system in that there is no effective regulator for NHS executive board members or managers

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SCOTTISH HOSPITALS INQUIRY

NHS GREATER GLASGOW AND CLYDE

CLOSING SUBMISSIONS

1. INTRODUCTION

1.1. These written closing submissions are provided on behalf of NHS Greater Glasgow and Clyde ("NHSGGC") in response to Inquiry Direction 12. They have been prepared following the conclusion of the oral evidence in respect of the Queen Elizabeth University Hospital ("QEUH") and the Royal Hospital for Children ("RHC").

1.2. The Inquiry has heard evidence from 186 witnesses over a total of some 29 weeks of evidence, all in respect of the QEUH/RHC. That includes evidence from those responsible for the design, build and commissioning of the "new hospital" but also from those acutely impacted by the subject matter of the Inquiry: patients, their families, and the clinicians and staff who care for them. The evidence paints a picture of a highly complex, evolving and unprecedented situation. At all times, all staff and clinicians, without exception, were doing what they honestly believed was in the best interests of patients.

1.3. NHSGGC has reviewed Counsel to the Inquiry's written submissions dated 21 November 2025. Save insofar as provided in these submissions, NHSGGC agrees with CTI's assessment of the evidence.

1.4. Direction 12 invites core participants to detail where they depart from previous submissions or positioning papers. NHSGGC submitted in its earlier submissions and positioning papers that it was premature to reach any conclusions without hearing all of the evidence. The Inquiry has now heard all evidence and is in a position to reach conclusions and make recommendations. These closing submissions contain NHSGGC's complete submissions in respect of the evidence heard by the Inquiry. These submissions supersede all positioning papers and all previous submissions on the evidence.

2. PURPOSE OF THE INQUIRY

2.1. The Inquiry was established on 17 September 2019 to examine issues at the QEUH/RHC and RHCYP. The investigation into the QEUH/RHC followed concerns about patient safety arising from a number of incidents of infection. The Inquiry has focussed on two particular aspects of the QEUH/RHC built environment, being the water and ventilations systems. The purpose of the Inquiry is to determine the safety of these systems, with particular reference to how the systems were designed, built, commissioned, operated, maintained and tested.

2.2. However, the Inquiry's broad-ranging remit goes beyond these physical systems and includes communications with patients, culture within NHSGGC and the management of NHS capital projects. This wide-ranging scrutiny is welcomed and, indeed, appropriate. Infection prevention and control is multifactorial. It goes well beyond the physical systems within a building. It includes culture, communication and attitude. Clearly responsibility for that lies, in the first instance, with NHSGGC.

3. POSITION OF NHSGGC FOLLOWING CONCLUSION OF THE EVIDENCE

3.1. At the outset, NHSGGC wishes to state that, in a number of respects, its management of the issues investigated by the Inquiry fell well below what patients, families, clinicians and staff should expect. There can be no doubt that the QEUH/RHC provides highly complex specialist care. Clinicians within it treat patients with extremely complex and serious conditions. The Inquiry has focussed on haemato-oncological patients, because those patients are severely neutropenic and particularly susceptible to infection. The QEUH/RHC are national centres for the treatment of haemato-oncological conditions. Highly specialist clinicians who treat these highly vulnerable patients are skilled and dedicated experts. The building they work in should be world leading. A diagnosis is life changing for the patient and their families. The treatment is gruelling. A patient diagnosed with such a condition, and the families supporting them must have confidence in the buildings and the systems within them. They should be able to devote all of their attention to their treatment, not concerns about the environment in which that treatment takes place.

3.2. Patients and their families are at the centre of everything that NHSGGC does. The same is true of staff. The situation faced by NHSGGC was unprecedented. From 2015, following the handover of the QEUH/RHC building, all of NHSGGC's staff and

clinicians, at all times, did what they considered was best for patients, acting in good faith. They are all committed to patient safety beyond all else. Nothing in the evidence heard by the Inquiry calls that commitment into question. The suggestion that they would put self-interest, or worse organisational interest, before patient safety is entirely without foundation.

3.3. NHSGGC's clinicians and the staff supporting them must be confident that they are working in the best possible environment. Their unwavering commitment to patients must be supported by the Board. The culture within the organisation should encourage reporting of concerns. It should encourage full transparency. It should put clinicians at the heart of investigating any concerns and ensure they are heard. Colleagues must be supported.

3.4. It is clear following the work of the Inquiry that these fundamental requirements have not been met. These shortcomings require to be seen, however, in the context of a unique and complex building project on an unprecedented scale. NHSGGC acknowledges that there were failures on its part. This was an extremely complex project requiring expert capability, experience and knowledge within NHSGGC, NHS Scotland and external experts. Prior to handover there were failures with the design, build and commissioning of the QEUH/RHC. The hospital that NHSGGC received at handover was not to the standard expected and placed significant pressure on NHSGGC's clinical and operational teams. NHSGGC accepts that there were failings at handover and commissioning for which it must accept some responsibility. NHSGGC has worked continuously to improve the hospital infrastructure to the extent that it now presents a safe environment for the delivery of care for all patients. There were also further failures from 2015 onwards, which are addressed later in these submissions.

3.5. The fact that NHSGGC fell below the standard expected in its management of these issues is a matter of utmost regret. Prof Gardner encapsulated this in her evidence where she stated that:

We need to do better for the people who come to work every day to do amazing things for our patients, because our patients deserve our staff to be in the best place and we have amazing experts in our system and we need to look after them, we need to look after our patients and we need to look after the families [Glasgow IV, Part 3, Day 15: Column 160].

3.6. The Inquiry can be assured that NHSGCC, as an organisation, has developed and improved from the organisation it was. Significant changes have been made to continually improve the culture within the organisation and to further enhance robust procedures for monitoring and reporting infection concerns. In addition, an entirely new procedure is in place in NHS Scotland in respect of the commissioning of new infrastructure with the establishment of NHS Assure. Its new systems are designed to deal proactively and reactively with any emerging issues. Whilst significant lessons have been learned to date, NHSGGC regards its improvement and learning as a journey, one upon which it continues to learn. The Inquiry has been a key part of that learning and improvement process. As Prof Gardner explained, NHSGGC has already implemented significant and wide-ranging measures to deal with issues arising from the Inquiry, rather than simply wait to respond to recommendations made by the Chair in due course.

3.7. QEUH/RHC is a critically important hospital in Scotland and in the United Kingdom. It is essential that patients, families and the public have full confidence in it. There is considerable public interest in the report and recommendations of this Inquiry. Public perception of the QEUH/RHC has undoubtedly been negatively influenced by the incidents that have been investigated by the Inquiry. It is critical that the public can see, through the work of the Inquiry, that people have been held to account. Where criticism is due, it is right that it be made robustly.

3.8. It is important, however, that the Inquiry also recognises the position of the QEUH/RHC now, in particular that the environments within both hospitals are wholly safe and suitable for patient treatment and care. It is imperative that the public have full confidence that the hospital is a safe environment for patients. The water testing and dosing regime and the air monitoring are bespoke, and more rigorous than any other hospital in the UK. It is submitted that there can be no doubt that the QEUH/RHC is safe and patients can be confident of the environment in which they will be treated because of the proactive and reactive work that goes on every day.

3.9. It is correct that the position of NHSGGC can be seen to have evolved over the life of the Inquiry in certain respects. However, from the outset of the Inquiry, the position of NHSGGC has been that: (i) the QEUH/ RHC buildings are now safe and appropriate environments in which to deliver high quality patient care through active maintenance, monitoring and risk mitigation, taking significant remedial action

where required; and (ii) at no stage did NHSGGC deliberately conceal, or attempt to conceal, information from patients and families. It is acknowledged that there is significant learning in terms of communication with patients and their families, staff and external partners. NHSGGC is committed to learn and evolve its approach in this regard. The position of the board on those critical matters has not altered.

3.10. NHSGGC's position going into the Inquiry was that it would listen carefully to the evidence and take forward any and all learning from the Inquiry process. Its position throughout has been that "*the overarching purpose of the Inquiry will be to ensure that (a) where there have been failings on its part that they are put in their fair and appropriate context; (b) where criticisms made are considered to be without foundation, in whole or in part, that all relevant evidence in support of its position is presented to the Inquiry; and (c) in relation to all Terms of Reference that all relevant evidence is presented to the Inquiry to provide reassurance to the Inquiry and to the public that, where mistakes have been made, lessons have been learnt, and appropriate actions taken to ensure the safety of all patients in the future."* [NHSGGC Positioning Paper 14 December 2022].

3.11. Following the conclusion of the evidence, NHSGGC has been able to reflect on a more informed basis on the evidence which has been heard and its impact upon the Inquiry's terms of reference and, significantly, its impact on patients, families and staff. Further, it is implicit from the evidence of Prof Jann Gardner that, under new leadership, NHSGGC acknowledges its shortcomings of the past and has already made significant progress towards addressing those. It is clear that work remains to be done: this is wholly recognised and the recommendations of the Inquiry will inform that ongoing process.

4. QUESTIONS POSED TO NHSGGC BY COUNSEL TO THE INQUIRY

4.1. In the closing submission of CTI at paras 138-139, questions are posed to NHSGGC for its response. The basis for NHSGGC's responses to these questions is set out more fully in these submissions. The position can, however, be summarised as:

4.2. NHSGGC accepts that there was an exceedance in the rate of environmentally relevant blood stream infections (BSI) amongst paediatric haemato-oncology patients in the RHC in the period 2016-2020, with a decrease when remedial measures, including those pertaining to the water system, began to be put in place in 2018.

4.3. Whilst it has been broadly acknowledged that there is no definite link between infections and the water system, NHSGGC accepts, having regard to the evidence led, that it is more likely than not that a material proportion of the additional environmentally relevant BSI in the paediatric haemato-oncology population between 2016 and 2018 had a connection to the state of the hospital water system. As previously stated, the rate of infection steadily decreased following the commencement of remedial measures, including those pertaining to the water system, in 2018. On that basis, NHSGGC accepts that, on the balance of probabilities, there is a causal connection between some infections suffered by patients and the hospital environment, in particular the water system, beyond the 2019 case of *Mycobacterium Chelonae* in Ward 6A and the 2016 *Cupriavidus* case. NHSGGC departs from its earlier submissions in this regard, having heard all expert evidence.

4.4. NHSGGC has accepted and has acted upon both the conclusions and the recommendations of the CNR Overview Report. NHSGGC's position on the CNR is set out in more detail below at paras 13.11- 13.12.

4.5. NHSGGC accepts that its previous criticisms of Dr Inkster and the "whistleblowers" were neither helpful nor fair. NHSGGC withdraws these comments and fully and unreservedly apologises for having made them. NHSGGC recognises the importance of creating the right conditions and culture to ensure that all staff are listened to equally. Where there are differing opinions, staff should be supported to resolve any issues. It is clear from the evidence that events post-handover at QEUH/ RHC gave rise to significant concerns amongst professionals about the built environment and incidences of infection. These concerns in what was, on any view, a challenging and pressured situation, led to differences of professional opinion as to how to address the problems encountered. It is accepted that Dr Inkster and the "whistleblowers," as with all other NHSGGC fellow professional colleagues, did what they genuinely believed was in the best interests of patients at all times in working through the varied and significant issues which presented. NHSGGC's position on its treatment of the "whistleblowers" is set out in more detail below at paras 7.1- 7.5.

4.6. The NHSGGC Positioning Papers of December 2022 and April 2023 were prepared on a counsel to counsel basis, in order to assist previous Counsel to the Inquiry in understanding the position of NHSGGC on a wide spectrum of complex issues associated with the terms of reference. Principal amongst the purposes of these papers was to share with Counsel to the Inquiry, at their request, details of witnesses from

whom the Inquiry might benefit from hearing evidence in order to properly fulfil its terms of reference. These were presented in good faith and in co-operation with a request made of the board to assist the Inquiry, pending the hearing of evidence in full. Each positioning paper was clear that it was premature to reach any conclusions without hearing all of the evidence. Plainly, these papers were not to be regarded as submissions on evidence. NHSGGC's final closing submission following conclusion of the evidence of the Inquiry should be regarded as its position on the evidence and the Inquiry's terms of reference.

5. TERMS OF REFERENCE

5.1. The Inquiry's terms of reference are broad and wide-ranging. The central theme, however, is the safety of the QEUH/RHC. In that regard, it appears that TORs 1, 7 and 8 are key.

5.2. TOR (1) requires the Inquiry to examine the issues in relation to adequacy of ventilation, water contamination and other matters adversely impacting on patient safety and care which arose in the construction and delivery of the QEUH. TOR (7) requires the Inquiry to examine what actions have been taken to remedy defects and the extent to which they have been adequate and effective. The Inquiry has framed those terms of reference by asking whether the ventilation or water adversely impacted on patient safety and care and whether the QEUH is, or was, "unsafe". What is "unsafe" is defined by the Inquiry as "*present[ing] an additional risk of avoidable infection to patients*". Impact on patients and communication with those patients (TOR 8) is also of critical importance. These are all addressed below.

5.3. In respect of TOR 1, NHSGGC agrees that many aspects of the design, build and commissioning of QEUH/RHC were flawed. These flaws included issues in relation to water, ventilation, design and build quality. As evidenced by the ongoing legal action against Multiplex and others, NHSGGC did not receive the building it asked or paid for. Extensive remedial action has been taken to mitigate risk and enable the provision of a high-quality environment for patient care. NHSGGC notes that, whilst ventilation did not conform to guidance, the potential impact on patient care remains the subject of debate. More detail is provided in paragraph 11.3.

5.4. In respect of TOR 7, NHSGGC confirms that extensive remedial actions have been implemented. These included chlorine dioxide dosing to the whole water system, and

the installation of point of use filters on outlets in key patient areas. Systematic monitoring of water quality, beyond national requirements, has been put in place to ensure that high standards are achieved and maintained. Improvements to the ventilation systems have been made where practicable. It is welcome that CTI now acknowledges Ward 2A to be 'safe' and other specialist areas to be acceptable at present. The Inquiry's expert panel have given evidence that governance of both water and ventilation systems is now optimal and water system safety is at a high level. As noted for TOR 1 the general air change rate in single patient rooms is acknowledged as not compliant with SHTM 03-01, however the impact of this on patient safety is a subject of debate. As infection control is multifactorial, any perceived risk can be managed in other ways.

5.5. In respect of TOR 8, NHSGGC reaffirms its absolute commitment to the quality of care, outcomes and experience for patients and families. Patient safety is NHSGGC's greatest priority. It is acknowledged that patients and families experienced distress, anguish and suffering as a result of the events considered by the Inquiry. NHSGGC offers the greatest sympathy for their related distress and suffering, with sincere condolences to all who have lost loved ones.

5.6. NHSGGC does not accept CTI's analysis of the evidence in respect of TOR 4. TOR 4 requires the Inquiry to consider whether any individual or body deliberately concealed or failed to disclose evidence of wrongdoing or failures in performance or inadequacies of systems whether during the life of the projects or following handover. This includes consideration of the impact of such matters on patient care and patient outcomes and whether disclosure of such evidence was encouraged, including through implementation of whistleblowing policies, within the organisations involved.

5.7. Counsel to the Inquiry submits that the Chair should conclude that there was deliberate concealment on the part of NHSGGC, or its staff, in respect of infections. It is submitted that the Inquiry has heard no evidence to support any conclusion that there has been a "cover-up". Indeed, the evidence all points towards all staff doing what they genuinely believed was in the best interests of patients, acting in good faith at all times.

5.8. Failures in communication on the part of NHSGGC have long been recognised and, indeed, regretted. To be clear, however, it is not accepted that any failure in communication amounted to a deliberate attempt to withhold information from

patients, families or colleagues. It is submitted that such suggestion is not borne out by the evidence.

5.9. Further, it is not accepted that NHSGGC was in any way disingenuous or dishonest as to its position on the CNR. This issue is addressed more fully below at paras 13.11-13.12.

5.10. It is the position of NHSGGC that the question posed in TOR 4, therefore, falls to be answered in the negative.

5.11. In relation to TOR 2, NHSGGC accepts that multiple aspects of the process were flawed. There was a lack of appropriate inhouse expertise and of sufficiently rigorous scrutiny of the decisions and actions of contractors. However, a number of aspects of this stage of the project were not solely a matter for NHSGGC's oversight. During this period Capita were the appointed named supervisors within the NEC3 contract and were responsible for checking and providing assurance to NHSGGC that the building was delivered in line with the agreed contract.

5.12. In relation to TOR 3, NHSGGC accepts that governance up to the point of the building opening, had weaknesses, especially in regard to role definitions, both within NHSGGC (including the role of local clinical and estates teams) and in terms of expectations of contractors. NHSGGC accepts that the organisational culture at this time was insufficiently responsive to concerns raised by NHSGGC's staff prior to opening. Concerns about aspects of the building when raised after its opening were acted upon. On occasion communication and engagement with staff members was flawed and issues were not approached holistically or with adequate management of differing clinical opinions. There was inadequate resourcing for building maintenance at the time of opening, which was due, at least in part, to the unexpected number of problems within the new building. There were inadequacies in some aspects of routine maintenance, internal communication, definition and understanding of responsibilities and record keeping. These have now been resolved.

5.13. In response to TOR 5, NHSGGC welcomes the creation of NHS Assure as a support for future building projects throughout the NHS Scotland estate. No equivalent was in existence at the time of planning or construction of QEUH/RHC.

5.14. In response to TOR 6, NHSGGC acknowledges that it was its responsibility (directly or indirectly via dedicated commissioning of external contractors) to ensure the

adequate design, build and commissioning of the QEUH/RHC. There were failures, notably the failure to fully validate the specialist ventilation systems and to have a clear understanding at handover of the nature of the building delivered. Prior to 2018 there were inadequacies in relation to maintaining the building. There was a lack of systematic training and appointments for authorised persons and related required roles. NHSGGC accepts that it was its responsibility to maintain the building through both proactive and reactive work and to have sufficient monitoring established to ensure that associated actions and mitigations to reduce risks were put in place. These measures have been implemented including, for example, systematic and rigorous microbiological testing which exceeds national requirements.

5.15. In relation to TOR 9, NHSGGC has, at all times, monitored and reported infections. NHSGGC notes, however, that due to the increased concerns in relation to the built environment, there was a heightened level of clinical concern and consequently, increased demands placed on the IPCT team. This, at times, led to professional tensions. NHSGGC acknowledges that relationships between NHSGGC's infection prevention and control team and ARHAI became challenging over an extended period of time. The Incident Management Framework (IMPF) has now been reviewed, updated and agreed by ARHAI. During 2025, there has been ongoing engagement and intervention at Chief Executive level between NHSGGC and NHS NSS and a commission agreed to support teams to further build relationships that draw on the expertise of both organisations. NHSGGC supports the implementation of a national electronic surveillance system for Health Care Acquired infections, with all data on infections flowing to ARHAI. This will facilitate oversight and scrutiny of hospital acquired infections nationally, allow benchmarking, and increase shared learning. This is addressed more fully at para 10.1- 10.3.

5.16. In response to TOR 10, NHSGGC notes that Mr Bennett concluded in his review that that the proximity of QEUH/ RHC to the Shieldhall Sewage Works and Recycling Centre did not create a significant risk of infection to patients through airborne transmission, based on available evidence and prevailing environmental conditions. NHSGGC is supportive of Mr Bennett's view.

6. CONTEXT

6.1. NHSGGC does not ask that the Inquiry reject the evidence of any witness. Specific comment is made in respect of the expert evidence below. However, it ought to be recognised that everyone who gave evidence is an expert in their particular field. NHSGGC submits that it is important to note that this was an extremely complex situation taking place over a long period of time.

6.2. The events from 2015, following handover, resulted in tensions and professional differences of opinion. That, it is submitted, is inevitable when dealing with a situation which was, and remains, unprecedented. Professionals will have different views. That ought to be respected. Tensions did arise and it is clear that those tensions were not managed appropriately.

6.3. The criticisms and findings that the Chair is invited to make must be put in full and proper context. In doing so, NHSGGC seeks to identify why the tensions arose. Following handover, the situation faced by NHSGGC clinicians and staff was unprecedented and highly complex. There was an obvious need to investigate and manage infections, which was made considerably more difficult in the new built environment of the QEUH/RHC.

6.4. The Oversight Board in its Interim Report described it as a,

> *"non-textbook situation", and that, "there was little precedent for the challenges arising from a large, newly-built hospital complex such as the QEUH – not least in understanding the scale and nature of the infection issues and the diversity of organisms that appeared";*[1] *Paragraph 43 at page 23 of the Oversight Board Interim Report dated December 2020.*

6.5. The Joint Independent Review described it as being one of a scale and complexity that, *"…few Infection Prevention and Control teams internationally [would ever have encountered it]".*[2]

6.6. The QEUH/RHC was, and remains, one of the largest hospitals in the United Kingdom. The scale of the QEUH/RHC project is one of the most significant and complex construction projects in Scotland. The construction of a new hospital on that scale, bringing together three pre-existing hospitals in one location, is unprecedented in Scotland and the UK. The point was made by Mr Hall of Currie & Brown in his

[1] Paragraph 43 at page 23 of the Oversight Board Interim Report dated December 2020.
[2] Page 133 of Queen Elizabeth University Hospital Review Report dated June 2020.

evidence in Glasgow IV. When asked by CTI whether he had been involved in any similar projects, he replied "*look around Scotland and you would find it hard to find a more complex building*" [Oral evidence of D Hall, 22 May 2025, transcript page 37]. Its systems were entirely new. It amalgamated three existing hospitals and, in so doing, required to bring together three existing staff groups, with their own cultures and practices.

6.7. The events can be separated into three key periods of time:

Phase 1 - Pre 2015 before hand over of the QEUH / RHC to NHSGGC

6.8. It is submitted that the evidence heard shows that there were failures in the design, build and commissioning, resulting in NHSGGC not receiving the building it asked or paid for.

6.9. A design and build form of contract is a design process requiring the appropriate responsive resources at the required time to iteratively develop the design. The failure to have adequate resources available at key stages meant not everything that was requested could be provided. However, it should not be the case that clinicians, and patients, moving from older hospitals should have lower quality facilities to the ones they left which negatively impact on patient care. It should not be the case that patients who migrated from an aged hospital should have to return there because the facilities at the new hospital did not meet the required standard. There should not have been a need to decant an entire unit in order to retrofit what were newly built wards. A new state of the art hospital should live up to that standard.

6.10. Multiple legal actions are ongoing against Multiplex and others, in relation to contractual defects. The losses associated with these multiple actions are in excess of £90 million.

Phase 2- 2015 to 2025

6.11. It is submitted that the evidence shows that this was a period of significant additional activity to address the many challenges faced as a result of the failures in the design, build and commissioning of the QEUH/RHC. This led to enormous pressures for clinicians, prevention and control of infection teams, estates and facilities staff,

operational managers and the NHSGGC Board. This created tension. NHSGGC accepts there were failings in management, leadership and governance.

6.12. The evidence of those present at handover, in particular Mr Powrie, was that there were numerous issues at handover with more being identified as patients moved in and systems came into use. When the QEUH/RHC opened, there were over 200 contractors on site. It is clear that NHSGGC did not get what it asked for. Legal action is ongoing against Multiplex arising from some of these issues.

6.13. Evidence has been heard from the members of the facilities and estates team who describe the extreme pressure they were under to manage a situation which was not of their making. The scale of the building meant that the systems were immensely complicated, with nothing comparable in the NHS Scotland estate.

6.14. It is accepted that there were insufficient estates and facilities resources to manage the handover process. Mr Powrie asked for additional finance and staff, and that was refused. The culture at that time was such that that decision could not be challenged. Issues ought to have been identified before handover and patient migration. Pressure was applied to open the hospital on time and on budget, and it is now clear that the hospital opened too early. It was not ready. An obvious example of this is the provision of filter casings on Ward 2A without HEPA filters in them, an issue which was immediately resolved but should not have been encountered in the first place. Management, and the project board, failed to anticipate the challenges. They did not resource or manage the project properly. They ought to have done.

6.15. As a consequence of these admitted failings, which are addressed more fully at paras 12.1 to 12.6 below, the staff who were there were tested to the extreme. That is exemplified by the evidence of what occurred in relation to the 2015 and 2017 DMA Canyon Reports. The report identified steps which ought to have been taken to maintain the proper functioning of the water system and, at that time, the report was not actioned. Mr Powrie explained, candidly, what occurred following receipt of the report: the report was passed in good faith by Mr Powrie to others in the estates department to action; there followed a degree of confusion as to responsibility for actioning the report, against a background of all of the operational issues with which the estates department was faced following the opening of the hospital; the report was not appropriately escalated for a period; and no action was taken in respect of the report's recommendations until it re-emerged in June 2018. It was then immediately

actioned. The extreme pressure caused by the evolving situation was the reason for the failure to action it earlier. Systems should have been in place to manage this. Those systems are now in place.

6.16. During this period NHSGGC also accepts that there were failings in its communication approach including: (i) tone, timeliness and content of communication with patients, families, staff, Scottish Government and; (ii) in how it engaged with the media. NHSGGC acknowledges these failings. NHSGGC is committed to learn and to improve its approach.

6.17. NHSGGC also accepts that, in relation to staff raising concerns and whistleblowing, it did not adequately listen, nor did it act in a timely manner to respond to those raising concerns or those disputing the concerns being raised. NHSGGC apologises unreservedly for this.

Phase 3 - 2025 onwards

6.18. The focus has been to continue to learn from events and from the remedial actions taken since the opening of the hospital. NHSGGC is committed to ensuring it effectively engages with, and listens to, patients, staff and the public.

6.19. NHSGGC has strengthened transparency, improved communication, and rebuilt relationships with staff, patients, families and external partners. It continues to do so. This includes more timely information sharing and active listening. Patients, families and staff should have confidence in the services NHSGGC delivers.

6.20. The failures in the design, build and commissioning of the QEUH/RHC have created a significant and continued additional burden on clinical, estates and management colleagues. Comprehensive steps have been taken to address physical defects in the building and the failings identified in maintenance. Multiple legal actions are ongoing against Multiplex and others, in relation to contractual defects.

6.21. The primary purpose of identifying this context is not to provide an excuse. It is to emphasise that staff and clinicians, without exception, did their best to manage a situation that was not of their making. Clinicians and staff worked tirelessly to manage the endless challenges faced. That included the considerable and constant work done to identify sources of infection and mitigate against recurrence. The

situation was fast moving and required decisive action. That was all driven entirely by concern for patient safety, a concern shared by all NHSGGC employees.

7. WHISTLEBLOWERS

7.1. Against that background, it is entirely understandable that there were very considerable tensions at IMTs. Detailed evidence was heard from the whistleblowers and from those who interacted with them. Prof Leanord, Prof Steele, Mr Walsh, Prof Williams, Dr de Caestecker, Dr Crighton and Dr Stewart are all criticised in CTI's submissions following Glasgow III on the basis of the way they interacted with Drs Inkster, Peters and/or Redding. It is submitted that personal or professional criticism should not be made of any of these individuals for how they reacted to the extreme pressure they were under. That includes the whistleblowers. They are all experts in their fields dealing with serious and unprecedented situations. They all did what they genuinely believed was in the best interests of patients.

7.2. It is recognised, however, that NHSGGC's treatment of the whistleblowers fell far below the standard expected. They were not adequately supported. They were not treated as they ought to have been. The process had a significant impact upon their wellbeing. Prof Gardner apologised in her evidence that they did not feel listened to and entirely accepted that they were not treated in a way that allowed them to feel empowered to assist with reaching a solution [Evidence of Prof Gardner Day 15, page 159-160]. That apology is renewed here.

7.3. It is accepted that the failure to effectively manage the whistleblowing process caused damage to professional relationships. Significant harm was caused to staff, all of whom were doing their best to promote patient safety in a highly challenging environment. Significant support was required in order to move forward. This was an issue for NHSGGC to manage and it failed to do so. NHSGGC deeply regrets the damage caused to staff morale as a result.

7.4. Whilst not seeking to excuse NHSGGC's management of whistleblowing processes in the past, it is important, nevertheless, to provide an appropriate context for those failings. At the time of the water incident, procedures for whistleblowing were in their relative infancy within NHSGGC. The first NHS Scotland National Whistleblowing standards were only introduced on 1 April 2021. These were not in

place at the time of the water incident at QEUH/RHC. Processes for whistleblowing are now nationalised and intended to provide clarity and consistency.

7.5. Steps have been taken by NHSGGC to ensure that its whistleblowing process will be conducted effectively in the future, in line with the now available national standards. All staff ought to feel supported and empowered to raise concerns and ought to be able to contribute, if they wish, towards a solution. Staff and clinicians must feel supported to raise issues without requiring to engage formal whistleblowing procedures. If the formal procedure is necessary, however, steps have been put in place to ensure that the procedure is appropriately managed. This includes putting the individual at the centre of resolving the concern, bringing in external facilitators and providing necessary psychological safety and support. NHSGGC is committed to fostering a safe, supportive and transparent working environment where colleagues feel empowered to speak up. This is all closely linked to the corporate commitment to culture moving forward, which places greater emphasis on listening to staff, building positive and respectful relationships, and ensuring robust escalation processes are in place.

8. REPORT FROM SIR ROBERT FRANCIS

8.1. It is implicit in the evidence from Prof Gardner that the points raised by Sir Robert Francis in his report, both at level of principle and also in relation to those points with direct application to NHSGGC, are accepted.

9. NO DELIBERATE CONCEALMENT OF INFORMATION

9.1. Nothing in what is said amounts to any acceptance of a "cover-up". At no point did any witness put their own interests, or organisational interest, ahead of patient safety. At all times, patient safety has been paramount. Any suggestion of absence of good faith has been rejected by the many sources from whom the Inquiry has heard, including those external to NHSGGC. The evidence reflected that all NHSGGC staff have endeavoured to act in the best interests of patients and families at all times.

9.2. Failures on the part of NHSGGC in respect of communications have long been accepted. It is entirely accepted that these failures gave rise to a deep sense of mistrust on the part of patients and families which is a matter of significant regret to the board. That does not amount to a "cover up". The clinicians and staff who gave evidence are all experts in their fields. They are dedicated healthcare professionals. Without exception, patient safety and care was their paramount concern. There were

professional differences of opinion. That ought to be expected. They were dealing with a highly complex and unprecedented situation. They did their best to react to the situation they were faced with. Any suggestion that they put their own interests or the interests of NHSGGC ahead of transparency about patient safety is completely without foundation and ought to be rejected.

9.3. NHSGGC in its submissions following Glasgow III submitted that there should be a presumption against healthcare professionals putting their own interests, or organisational interests, ahead of patient safety. CTI criticises NHSGGC for making that submission and suggests that it is without any legal foundation. NHSGGC's submission merely reflects the inherent unlikelihood that those who have dedicated their professional lives to patient care would engage in a "cover up". This element of the Inquiry's investigation has caused significant upset to those members of staff who are subject to unjustified criticism. CTI fails to recognise the impact that such a submission has on these individuals. Instead, they are criticised, with the benefit of hindsight, for their reactions when they were trying to manage a complex and unprecedented situation.

9.4. Whilst shortcomings in communications are accepted, it is submitted that these failures were not brought about as a result of any deliberate attempt to conceal or attempt to conceal information from patients and families. NHSGGC's position as regards communications is set out more fully below at paras 14.1- 14.6.

10. RELATIONSHIP WITH ARHAI

10.1. The Inquiry heard significant evidence in Glasgow IV part 3 as to the reporting of infections from NHSGGC to national bodies such as ARHAI. The implementation of the Incident Management Process Framework (IMPF) in 2021 and its subsequent iterations was the subject of detailed questioning. The relationships between NHSGGC IPCT and ARHAI became challenging over an extended period of time. This ought not to have occurred. NHSGGC has engaged in work to rebuild relationships with ARHAI.

10.2. The recent engagement and intervention at Chief Executive level between NHSGGC and NHS NSS seeks to ensure a joint path for building relationships across both organisations moving forward. The IMPF has now been updated and agreed with ARHAI with regular dialogue now in place.

10.3. There is a commitment to a joint development session, supported by external organisational development expertise, and facilitation to: (i) promote understanding of roles and responsibilities within NHSGGC IPCT and ARHAI and the respective challenges faced by the organisations in delivering their respective services; (ii) reflect on formal reporting processes whilst also exploring opportunities to build relationships with mutual understanding and respect; (iii) explore traits of high performing teams to set direction moving forward; and (iv) to reflect and re-establish collective values, trust and behaviours.

11. THE HOSPITAL IS SAFE

11.1. NHSGGC submits that there is no evidence heard that demonstrates that any aspect of the QEUH/RHC is presently unsafe.

11.2. It was of great concern that CTI suggested in closing submissions to Glasgow III that the ventilation system is presently "unsafe". This conclusion serves, wrongly, to undermine the confidence that the patients and families place in the hospital and its staff. It is a conclusion that was reached without hearing the totality of the evidence. Now that expert evidence has been heard, it is submitted that any concern is without foundation.

11.3. In respect of ventilation, significant weight is attached to compliance with SHTM 03-01. It is accepted that the QEUH/RHC does not comply. However, non-compliance does not equate to unsafety. The authors of the HAD Report comment on the ventilation system and whether its safety is impacted by non-compliance with SHTM 03-01. The conclusion is that compliance with SHTM 03-01 does not impact on patient safety where infection risk is managed in other ways. That is in line with other evidence heard during Glasgow III from NHSGGC's witnesses and is in line with the Chair's conclusion in the interim report that management of infection risk is multifactorial. Evidence has now been heard in respect of the robust air testing in place, the reporting mechanisms, cleaning regimes and the management of infection. Taken together, it is submitted that the ventilation system is safe, a matter confirmed by the Inquiry's expert panel in their audits. The public can have complete confidence in that.

11.4. In respect of the water system, it is noted that there is no suggestion that the system is now unsafe. The QEUH/RHC has in place a robust and thorough testing regime. Mr Poplett in his evidence accepts that the water system is now very well managed and there has been significant improvement. His conclusion clearly reflects the work undertaken to rectify issues. The water testing and dosing regimes are bespoke and more rigorous than any other hospital in the United Kingdom. The present regime for testing exceeds requirements and recommendations set out in national guidance (where such guidance exists) in terms of testing frequency, locations tested (general as well as high risk), types of tests performed and thresholds to trigger action. Much of the routine testing carried out at these sites is bespoke to QEUH/RHC as there continues to be no formal national requirements and recommendations applicable to these tests.

11.5. Robust monitoring and testing is in place. It is the intention of NHSGGC to enhance formal reporting to the Board as part of the Integrated Performance and Quality Report. Data are benchmarked so that any increase in infections is picked up and actioned at the earliest opportunity. Each health board reports these data in a different way. NHSGGC suggests that it may be appropriate for the Inquiry to make a recommendation to standardise this reporting so that comparisons can be made across different health boards.

12. CHANGING GOVERNANCE

12.1. The Inquiry has heard detailed evidence on the design, construction and handover of the QEUH/RHC. The context is outlined above. However, it is clear that the hospital was not in a state to be handed over when it was. 200 contractors remained on site and the estates and facilities team were ill equipped to manage the process. Mrs Grant in her oral evidence referenced the absence of a proper management structure when she joined the board. She took steps to improve that management structure, but it is an ongoing process.

12.2. A pattern emerged from the evidence of a lack of scrutiny and challenge in respect of project governance on the part of NHSGGC. Many witnesses considered that responsibility for particular issues sat elsewhere, leading to no one taking responsibility for those issues. No individual acted in bad faith. It was simply a failure to allocate and adequately specify roles and ensure that reporting lines were in place. These issues would not occur in the present day NHSGGC.

12.3. This issue was particularly acute when it came to receiving advice on the design of the hospital. There was little expertise within the board to cope with a project of this magnitude. The board was accepting of what it was told during the design and construction phase. It was reliant on the technical team and did not properly interrogate what it was told. The project team operated on assumptions that others would take responsibility. This also manifested in an absence of full commissioning and validation. At handover, authorised persons were not in place. When they were identified, they required significant training. The board was poorly advised but lacked the expertise to challenge that advice. The board is now in an entirely different place.

12.4. It is also notable that, since 2015, there have been significant changes to the wider landscape. In 2015, there was no NHS Assure. Nothing like it existed before. The infection control manual had been fundamentally revised shortly before handover. It is now far better understood. The processes to deal with whistleblowing and duty of candour within the NHS were in their infancy. These relatively new mechanisms were tested beyond breaking point by the new hospital.

12.5. In respect of broader governance Prof Gardner spoke to the new governance structure in her evidence. She explained that NHSGGC from 2015 is "hugely different" to NHSGGC now. In 2015, there were instances of decisions not being reported to the board. The Inquiry heard evidence of the new governance structure within NHSGGC. Arrangements are in place to ensure robust, accountable and transparent governance throughout the healthcare system in NHSGCC. The Board and its Standing Committees have clearly defined and documented roles and responsibilities. In line with the NHS Scotland Blueprint for Good Governance, NHSGGC has an integrated approach to governance across clinical areas, performance management, staff. This ensures that NHSGGC is involving and engaging people in its services and developments.

12.6. Prof Gardner made clear that people were now, more than ever, at the centre of the structure. There is a new standing committee of the Board (the "Staff Governance and People Committee") which is looking at the cultural issues and challenging culture within the organisation. Mechanisms are in place to ensure that those with concerns are fully supported. An external facilitator is available should that be necessary to manage tension. Ultimately, those with concerns will be given the opportunity to be part of the resolution. It is essential that leadership encourage clinicians and staff to treat each other with dignity and respect. Professional difference of opinion is to be expected and is encouraged. However, it is recognised that it can be challenging. The

steps in place should ensure that these difficult discussions are managed appropriately and there is not a repeat of the events between 2015 and 2019.

13. EXPERT EVIDENCE

13.1. The Inquiry has heard detailed evidence from a number of experts on the incidences of "unusual infection". NHSGGC submitted in its positioning papers and its previous submissions that it was premature to reach any conclusions as to causation. Prior to hearing the expert evidence in Glasgow IV, NHSGGC submitted that, aside from two incidents of paediatric infection, there was no definitive link between the built environment and infection risk. It is clear, now that expert evidence has been heard, that there was an increased number of BSI that are, on the balance of probabilities, associated with the water systems. The increase of BSI has now fallen. Again, this supports the conclusion that the hospital is now safe.

13.2. The Inquiry's experts initially focussed on particular aspects of the built environment, namely water and ventilation. Mr Bennett, Mr Poplett and Dr Walker all gave evidence that was of assistance to the Inquiry. Whilst their evidence was restricted to particular systems, the evidence was largely agreed with by the HAD authors.

13.3. It is undeniable that features of the water and ventilation system did not conform to guidance. The experts, including the HAD authors, were aligned that these features could impact on infection risk. The water and ventilation systems are critical to managing infection. The ventilation at the QEUH/RHC does not conform to SHTM 03-01. Whilst that is guidance, and still in draft at the time of the employers' requirements being set, it was specified that the design should comply with it. It did not. Again, the Board did not challenge why there was a derogation. It accepted what it was told. However, safety is not binary. It is not appropriate or correct to say that these elements are unsafe such that they cause increased risk of avoidable infection. Systems should not just be looked at in isolation. Water systems and airflow can never be sterile. Other control measures can be used such that there is no "avoidable" increase in risk.

13.4. The multifactorial nature of infection control has been recognised by the Chair in the interim report in connection with RHCYP/DCN. In that report it is noted that:

> *The evidence before the Inquiry indicated that safety is not a binary issue. Rather, there is a sliding scale of risk from safe to unsafe, which can be influenced by many factors. SHTM 03-01 sets out recommended parameters for the outputs of ventilation systems which reflects a general consensus about what is required in order to create an acceptable level of patient safety. These are consistent with parameters set in other countries. A departure from such recommendations, taken in isolation, has the potential to increase risk. However, other control measures can be introduced to make a space that does not have ventilation compliant with SHTM 03-01 sufficiently safe for the patients being treated there. For example, the Sick Kids had no mechanical ventilation but nevertheless provided a safe environment in which to treat patients. The available evidence indicates that achieving 4 air changes per hour when 10 are recommended, creates an unacceptable level of risk to the safety of patients unless other sufficient control measures are introduced.*
>
> *[Executive Summary, pages 12-13]*

13.5. It is also noted that:

> *The evidence heard by the Inquiry was consistent with what appears in that report. The scientific basis for the current recommendations as to particular ventilation parameters is very limited and to a significant extent depends on work published in the early 1970s when hospital environments and other aspects of medical care were very different from what would be expected today. It is however generally accepted that a ventilation system that maintains changes of air within spaces in a hospital and pressure differentials between certain adjacent spaces has an important contribution to make, together with other available measures, to reducing the risk of healthcare associated infections. This is particularly so in the case of patients who are especially vulnerable to infection by reason, for example, of their compromised immune systems. Accordingly, for the present, there is a strong consensus that the recommendations in current guidance are appropriate and that material deviations from these recommendations will be likely to increase the risk of infection, albeit that the increase is unquantifiable and will be dependent on what other control measures are in place.*
>
> [*Paragraph 14.16*]

13.6. CTI's submissions are, correctly, addressed to the terms of reference. CTI has framed the question for the Chair as "*Is there a link, and if so, in what way and to what extent, between patient infections and potentially deficient features of the water and ventilation systems? [Para 192, Key Question 4].* The Inquiry is to comment on a general link between infections and the built environment, and any consequent impact on patient safety. It is not the role of the Inquiry to comment on any link between a particular patient infection and the built environment.

13.7. To determine whether there was an increase in infections, taking into account the other mitigations, it is necessary to carry out a comparative exercise. The HAD authors undertook that exercise, as did Mr Mookerjee. NHSGGC has submitted at length elsewhere its criticisms of Mr Mookerjee's methodology. However, concessions were made in his oral evidence and revised calculations. NHSGGC maintains that Mr Mookerjee made a number of significant errors. He has since attempted to rectify those. The Chair does not have to engage in how those errors came to be made, or to conclude whether to prefer the HAD authors over Mr Mookerjee. The HAD authors are now more aligned with Mr Mookerjee in so far as they all identify an increased rate of infections, some of which, it is agreed, are on the balance of probabilities linked to the water systems, albeit nowhere near the increased rate that Mr Mookerjee initially suggested. This allows the Inquiry to conclude that, on the balance of probabilities, there is a link between water and infections during 2016 to 2018.

13.8. Ventilation is different. Given the limited number of infections, the experts cannot identify an increase and so cannot identify a link. However, all experts are aligned that lower rates of ACH, no HEPA filtration and issues in connection with pressure in isolation rooms could present an additional risk of avoidable infections. Dr Agrawal accepted that conformity with SHTM 03-01 can reduce airborne transmission in line with the Inquiry panel. The issue then becomes one of effective risk management including the built environment, infection control measures and also disease treatment guidelines.

Instruction of HAD Report

13.9. It is submitted that the Inquiry has benefitted from the evidence of the HAD authors. The purpose of the HAD report is to assist the Inquiry and provide detail on the wider management of infection risk. As noted above, it is appropriate that the Inquiry robustly interrogate the issues and make necessary recommendations. The opinion of

the HAD authors led Mr Mookerjee to revisit his calculations and provides additional perspective from world leading experts on the wider management of infections. Whilst a rise in infection rate was identified, it is nowhere near as pronounced as Mr Mookerjee initially claimed. He revised his analysis in light of the HAD Report. All experts made concessions.

13.10. NHSGGC is in a unique position in this Inquiry in that it is the subject of stringent criticism. Prior to the HAD report, it is submitted that that criticism was being made on a flawed basis. Criticisms and consequent recommendations should not be made on the basis of flawed or incomplete expert evidence. The opinion of the HAD authors provides additional perspective from world leading experts on the wider management of infections. The position following the oral evidence is that the experts are more aligned in their opinions. There was an increase in infections, which on the balance of probabilities were linked to QEUH/RHC. There is no longer an increased rate of infections and the hospital is now safe due to the monitoring of the systems.

Case Note Review ("CNR")

13.11. The HAD authors also comment on the Case Note Review ("CNR"). Prof Gardner stated in her evidence that NHSGGC accepts and has acted upon the conclusions and the recommendations of the CNR. It is not a case of NHSGGC changing its position on the CNR. The CNR requires to be put in context. It was never supposed to be an expert review to support the conclusions and recommendations of a public inquiry. Its purpose was far more restricted. Throughout the earlier stages of the Inquiry, it became clear that much of CTI's approach to the evidence was informed by the CNR. The CNR did not consider other infection mitigations, and it did not look at rates in other hospitals. It looks at probability in particular cases. It is undoubtedly of assistance. However, the work of the Inquiry's expert panel, including the HAD authors, provides overall views on causation. They do different things and they are complementary.

13.12. If the instruction of the HAD authors to comment on the CNR has caused patients or families any upset then that is a matter of extreme regret. That was not the intention. The intention was to provide a full and detailed review of wider causation.

14. COMMUNICATIONS

14.1. NHSGGC accepts, in respect of Term of Reference 8, that there were shortcomings in communications with patients; this was accepted in NHSGGC's positioning paper following Glasgow I.

14.2. The failure in communication was not deliberate and at no time was any communication, or lack of communication, ever with a view to concealing or attempting to conceal information from patients and families. However, it is accepted that NHSGGC's failures in communication did not assist in reassuring patients and families as to patient safety within the QEUH/ RHC; rather, failures in proper and effective communication had, at times, the opposite effect. It is important to note that some shortcomings in communications require to be seen within the context of the Board's escalation to level 4 of the NHS Scotland performance management framework.

14.3. Whilst the situation with which NHSGGC was faced was unprecedented and unusual, it is accepted that NHSGGC did not take appropriate steps to deliver its communications to patients and families on that situation effectively. It did not seek help on how to address its communications and it ought to have done so. It is accepted that its communication style was, at times, defensive and that this approach was unhelpful to patients and families. Faced with an uncertain, complex and evolving situation, NHSGGC sought to avoid causing patients and families unnecessary anxiety by focusing its communications only on those matters upon which it had certainty. The trust of patients and families was lost as a result of that approach which NHSGGC recognises will be hard to fully rebuild.

14.4. The parallel failures of failing to properly address the concerns of the whistleblowers and failing to deliver effective communications combined to create additional and avoidable distress and anxiety to patients and families. It is matter of great regret to NHSGGC that there were failures in its communications, despite its efforts in a challenging and unprecedented situation, and it is wholly understood that this increased anxiety to patients and families.

14.5. It is important to emphasise that at no stage did NHSGGC (the organisation or staff members) deliberately conceal, or attempt to conceal, information from patients and families. No evidence has been heard that contradicts that NHSGGC (the organisation or staff members) was, at all times, acting in good faith, with no collusion or "cover-up," in circumstances which were both challenging and unprecedented.

14.6. There is no doubt that communications could have been handled much better. Communications should always have patients at the centre. It is also important that, where there is such an unprecedented and serious situation, those at the top of the organisation be front and centre of the communications. Those in executive director positions should have been meeting patients and families and been more accessible and available. The basic interaction was missing. Such an omission would not happen now.

15. LOOKING FORWARD

15.1. Throughout these submissions, NHSGGC has sought to emphasise that it is a very different organisation to the one that was responsible for the design, construction, commissioning and validation of the new hospital. It is very different to the organisation that was faced with the "water incident" and other incidences of infection through to 2019. NHSGGC was faced with an unprecedented challenge. Failings are acknowledged but that must be seen in context of the scale and complexity of the project and the numerous issues encountered with the built environment at handover. Steps have been taken to improve governance, to put people at the centre of the organisation and to make significant improvements to communication. That process is by no means complete.

15.2. The governance paper spoken to by Prof Gardner provides the Inquiry with details of the new structure and how people are at its centre. This is a new structure but the systems and processes in place should give assurance that: (i) appropriate oversight exists; (ii) issues are being addressed both proactively and reactively; and (iii) the management of issues is being addressed in a timely and proper manner. 2025 marks the beginning of a new chapter for NHSGGC, with new leadership. The organisation is moving forward with humility and no room for complacency. NHSGGC is dedicated to providing the best care possible for its patients and to fully supporting its staff to enable it to provide this care.

15.3. Steps continue to be taken to improve relationships both internally and externally. That includes the relationship with external bodies such as ARHAI. It is clear that the relationship with ARHAI had broken down with some reasonably requested information not been given in a timely manner. Steps have now been taken to improve

reporting to ARHAI. Regular meetings are taking place at senior level and all requested information is being provided.

16. **RECOMMENDATIONS**

16.1. NHSGGC notes the recommendations proposed to the Chair by Counsel to the Inquiry. In relation to those recommendations directed specifically to NHSGGC, NHSGGC offers its full assurance that it will take forward any and all recommendations which may be addressed to it in due course by the Chair, to the fullest extent possible.

16.2. In addition, NHSGGC offers its own proposed recommendations for the consideration of the Chair, namely:

Integrated Performance and Quality Report: NHSGGC has initiated an Integrated Performance and Quality Report (IPQR) which brings together key performance, corporate, quality and clinical governance, and finance measures. The IPQR highlights the quality and safety of care, patient experience, and organisational effectiveness. Helping to ensure performance is not achieved at the expense of quality. Ultimately the IPQR supports more informed decision-making and better assurance, offering a clearer line of sight from the Board to frontline services. Integral to this is monitoring the built hospital environment and maintenance, ensuring escalation of issues pertaining to the built environment and infection risk.

16.3. *Standardised reporting of incidents of infection across NHS Boards:* Boards should be reporting the same information in the same way with the same supporting detail. The level of detail and information should be informed in consultation with the NHS Boards and ARHAI. This will ensure that sufficient detail is provided and will allow comparison between hospitals.

16.4. *The strengthening of national surveillance:* All NHS Boards report incidents of infection electronically and through the same system. NHSGGC supports the implementation of a national electronic surveillance system for Health Care Acquired

Infections, with all data on infections flowing to ARHAI. This will facilitate oversight and scrutiny of such infections nationally and will allow benchmarking as well as increased shared learning.

16.5. *Facilitated discussion/mediation prior to and during whistleblowing:* NHSGGC supports bringing in the expertise of an external facilitator as a standard means of managing tension where clinicians or staff report concerns. This should take place prior to any whistleblowing to avoid concerns being escalated to the point of a formal whistleblowing procedure. It must also be available throughout the formal whistleblowing process.

16.6. *Professional mediation:* Evidence was heard by the Inquiry in relation to the need for a culture which supports openness and transparency and which welcomes the raising of concerns to support patient safety. Many of the issues experienced during the Glasgow water incident were underpinned by differing professional opinions. It is recommended that a mechanism be put in place for professional mediation to be invoked, swiftly and effectively, to ensure all parties in professional disagreements are supported.

16.7. *Psychological support for those raising concerns:* In addition to facilitated discussion, those reporting concerns should have access to external psychological support.

17. CONCLUSION

17.1. The QEUH/RHC is safe. Patients and their families should be assured that they will experience high quality, specialist and expert care from committed expert clinicians. Patients and families can have confidence in the safety of the built environment which is the subject of rigorous testing and monitoring.

17.2. The identified shortcomings in respect of culture, communications and the reporting of infection are acknowledged in full and are in the process of being resolved. Prof Gardner was clear in her evidence that the period under review has "*not been good in the history of NHSGGC, and we want to build back strongly, and we have strong ambitious plans" [Day 13, Page 196].* Staff and clinicians should feel assured that, if there is an issue that they identify, they will be listened to. Patients and families should feel assured that NHSGGC is fully supportive of its clinicians and staff. External agencies should be assured that incidents will be reported with full

cooperation and transparency. The issues encountered, and as explored fully by the Inquiry, will not happen again.

17.3. It is a matter of profound regret that those who NHSGGC care for have experienced distress, anguish and suffering as a result of these events. NHSGGC offers an unreserved apology for the distress and trauma experienced by patients and families during this time. NHSGGC has listened to the evidence of all those impacted. Shortcomings have been identified. Lessons have been learned. That journey is continuing and the recommendations suggested by CTI are welcomed. They align with NHSGGC's current trajectory. Any and all recommendations made by the Chair will be acted upon to the fullest extent possible. It is hoped that the additional recommendations suggested above will assist the Chair.

17.4. NHSGGC accepts that the expert evidence shows, on the balance of probabilities, that there was an increase in infections and that increase was linked to the water system. Comprehensive steps have already been taken to address physical defects in the building and the failings identified in maintenance. The hospital is safe. Ensuring that safety is an ongoing process. The testing and monitoring regime at QEUH/RHC is more comprehensive than at any other UK hospital. The public should therefore take comfort that the hospital is safe and will continue to be safe.

Peter Gray KC,
Emma Toner KC
And
Andrew McWhirter, Advocate

22 December 2025

WHISTLEBLOWING QUARTER 1 REPORT 2025/26

NHS Greater Glasgow and Clyde

Kim Donald (Corporate Services Manager – Governance)
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Quarter 1
Executive Summary
In the reporting period 1 April 2025- 30 June 2025, the following were received:

- There was 1 Stage 2 case taken forward in the quarter.
- There was 1 case not that did not meet the whistleblowing criteria
- There were no Stage 1s received in the quarter.
- **Stage 2 performance was 50%** against the target of 20 working days to respond.

1. Introduction

The National Whistleblowing Standards (the Standards) set out how all NHS service providers in Scotland must handle concerns that have been raised with them about risks to patient safety and effective service delivery. A staged process has been developed by the INWO.

• Stage 1: Early resolution – for simple and straightforward concerns that involve little or no investigation and can be handled by providing an explanation or taking limited action – 5 working days.

• Stage 2: Investigation – for concerns which tend to be serious or complex and need a detailed examination before the organisation can provide a response – 20 working days.

There are 10 Key Performance Indicator Requirements:

1. Statement outlining learning, changes or improvements to services or procedures as a result of consideration of whistleblowing concerns
2. Statement to report the experiences of all those involved in the whistleblowing procedure
3. Statement to report on levels of staff perceptions, awareness and training
4. Total number of concerns received
5. Concerns closed at stage 1 and stage 2 of the whistleblowing procedure as a percentage of all concerns closed
6. Concerns upheld, partially upheld, and not upheld at each stage of the whistleblowing procedure as a percentage of all concerns closed in full at each stage
7. Average time in working days for a full response to concerns at each stage of the whistleblowing procedure
8. Number and percentage of concerns at each stage which were closed in full within the set timescales of 5 and 20 working day
9. Number of concerns at stage 1 where an extension was authorised as a percentage of all concerns at stage 1
10. Number of concerns at stage 2 where an extension was authorised as a percentage of all concerns at stage 2

The report indicates which KPI is being met throughout each of the reporting sections.

More information on how NHSGGC handles whistleblowing can be found on the website: https://www.nhsggc.org.uk/working-with-us/hr-connect/policies-and-staff-governance/policies/whistleblowing-policy/

Learning (KPI 1)

Learning from whistleblowing is crucial for several reasons. It helps NHSGGC identify and address issues, ensuring that risks to patient safety and effective service delivery are mitigated. After a case is closed, monitoring continues until all recommendations are completed. This ongoing oversight ensures that actions are taken seriously and that improvements are sustained over time. The responsibility of actions sits with the Director and Chief Nurse of the service; however, an action tracker is monitored and overseen by the Director of Corporate Services and Governance.

By learning from whistleblowing, the Board can continuously improve and ensure the safety and well-being of patients and staff and maintain a culture of openness and accountability.

The following table outlines a high-level summary of the concerns received to maintain confidentiality, and the recommendations made following investigation. Some are noted as ongoing in recognition that the actions would require to be filtered through to business-as-usual practices.

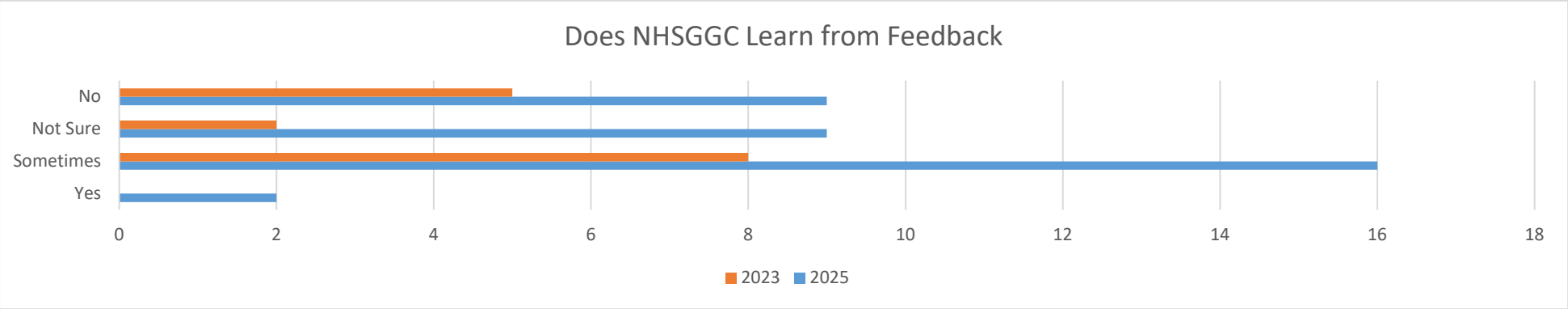
Table 1: Recommendations and learning from closed cases:

Issues Raised	Outcome	Action / Recommendations	Status
Anon concerns re unwitnessed falls and management nepotism	Not upheld	• SMT to be more visible to staff on ward • Review of Nurse in Charge policy	BAU Ongoing
Lack of rotation through service impacting staff competency and affecting patient safety	Partially upheld	• OD session to be arranged to rebuild relationships within the team • Stress at work survey to be used in conjunction and action plan to be created collaboratively with the team	OD session date confirmed Ongoing

Feedback Survey (KPI 2)

An anonymous survey is circulated to everyone involved in a whistleblow, whether they are the whistleblower or assisting with the investigation, to establish their thoughts on the process, access to support as well as offering them the opportunity to feedback to the Board on what we should be doing to assist colleagues through the whistleblowing procedure, which we recognise can be daunting. Unfortunately, despite amendments to the survey, the format and platform, we have had minimal response. This is something that is being discussed nationally at the Whistleblowing Practitioners Forum and is not unique to NHSGGC.

In June 2025 an anonymous survey was circulated to colleagues via the Core Brief as part of a 'gap analysis' exercise in comparison with the same survey circulated in 2023 which found the following. Overall, there was a more positive view of the process, but work remains underway regarding wider engagement and feedback.



Speak Up! (KPI 3)

Work continues with HR and Comms colleagues regarding the ongoing publicising of Speak Up! and the methods available to colleagues to raise their concerns. The outcome of the gap analysis survey has been shared with the Whistleblowing Champion and factored into the 2025/26 action plan.

Confidential Contacts meet quarterly and feedback any key trends or themes and are encouraged to undertake localised projects within their area to ensure ongoing engagement with colleagues throughout the year. The Whistleblowing Champion is overseeing

a programme of work in this regard (APPENDIX 1), including information sessions for colleagues and working with key stakeholders to widen understanding and knowledge of the processes and protection in place.

We have increased our Confidential Contacts pool and have increased overall engagement by working across sites to take part in key events, including the Equality, Diversity and Inclusion event hosted on 13th August 2025.

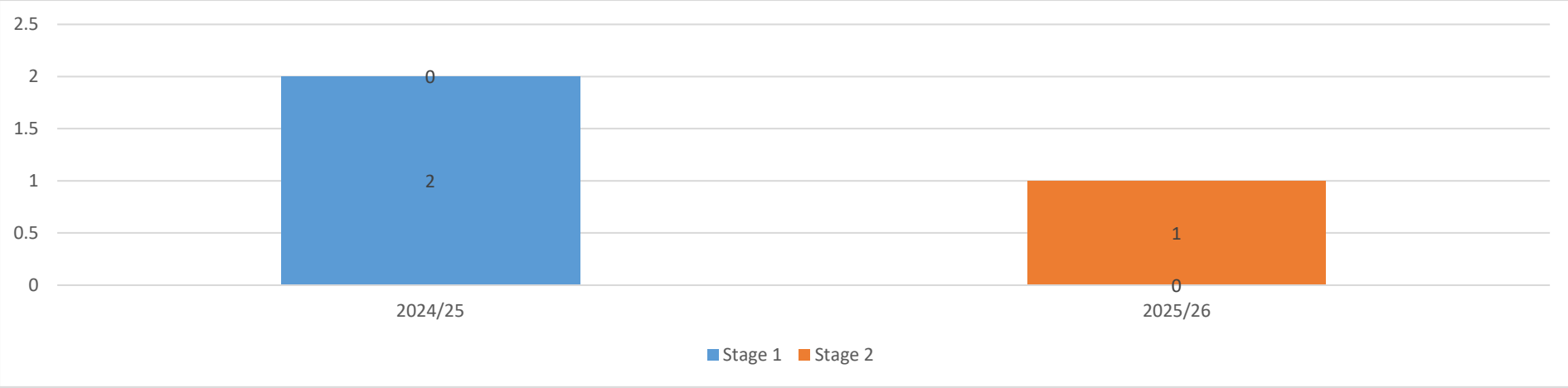
Cases Received (KPI 4)

Table 2: Cases Received and Accepted as Whistleblowing

	Acute	Corporate	HSCP/Prisons	TOTAL
Stage 1	0	0	0	0
Stage 2	1	0	0	1
TOTAL	1	0	0	1

The above table gives the figures for cases that were received, and which met the criteria for whistleblowing, and were therefore taken forward via the Whistleblowing Policy. The graph below details the comparison number of cases received from Quarter 1 2024/25 and 2025/26:

Graph 1: Whistleblowing Cases Received



The number of cases received within Quarter 1 remains low. Work is underway with the Whistleblowing Champion regarding wider engagement and training sessions across the sectors with the aim of increasing overall confidence in the process.

Cases Closed (KPI 5)

The information in this section relates to the performance for whistleblowing cases that were closed in the reporting period. More detailed information regarding the nature and learning from the cases is contained in Section 2.

Table 3: Closed Cases by Outcome **(KPI 6)**

	Acute	Corporate	HSCP / Prisons	Total
Upheld	-	-	-	0
Partially Upheld	1	-	-	1
Not Upheld	-	-	1	1
TOTAL	1	-	1	2

Table 4: Average Time to Respond (in working days) **(KPI 7)**

	Acute (working days)	Corporate (working days)	HSCP / Prisons (working days)	Total Average (working days)
Stage 1	-	-	-	-
Stage 2	8	-	26	12

Table 5: Closed Cases by Stage **(KPI 8)**

	Acute	Corporate	HSCP / Prisons	Total
Stage 1	-	-	-	-
Stage 2	1	-	1	2
TOTAL	1	-	-	2

The 20-working day target was met for both cases within the quarter. The focus remains on a thorough and high-quality investigation. The individuals involved remain fully informed of progress and offered support **(KPI 9 and 10)**.

Stage 3 – INWO Investigations

	Acute	Corporate	HSCP/Prisons	TOTAL
Stage 3	1	-	-	1

Within the quarter we received 1 decision notice from the INWO. All outcome reports are published and can be found here:- Our findings | INWO (spso.org.uk)

Conclusion

There remains an ongoing focus within the Board regarding increasing engagement and confidence in the speaking up processes and support available. This is being taken forward by the Corporate Services Manager - Governance and the Whistleblowing Champion through a 2025/26 action plan. This includes ongoing engagement with services, wider colleagues through the Core Brief as well as management teams.

Kim Donald
Corporate Services Manager - Governance

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Date: *13th January 2026*
Our Ref: *JG/LLBM*

Enquiries to: *Professor Jann Gardner*
Direct Line: [redacted]
E-mail: [redacted]

Dear Teresa

I am writing to you today to invite you to meet and provide the opportunity for a face-to-face discussion. While I have been keen to meet you since coming into post, I also wanted to be fully respectful of the SHI timeline ensuring that there was adequate time for the evidence to conclude.

Within my evidence at the SHI, I outlined my objective to improve opportunities in NHS Greater Glasgow & Clyde for the balanced views of our staff to be heard and to learn from previous experiences. I recognise that we need to build capacity to support healing and repair relationships as we progress into the organisations next chapter.

Aligned with this commitment, you may also be aware that NHSGGC and NSS have commissioned external management support to work across the Infection Control Teams of both NHSGGC and ARHAI to assist with the building of relationships to support enhanced collaboration going forward. It is hoped that this engagement will re-establish trust across our respective teams.

With this work now underway, I felt that it was timely for us to arrange to meet. I would suggest that there may be value in us being joined by my executive colleagues Dr Scott Davidson (Executive Medical Director) and William Edwards (Deputy Chief Executive). You are also very welcome to be accompanied by a colleague or friend.

Can I propose the following potential times to meet although am happy to flex to another mutually acceptable time:

Friday 30th January	2pm-3pm
Wednesday 4th February	11:30am -12:30pm
Wednesday 18th February	12:30pm – 1:30pm
Friday 27th February	2pm-3pm
Wednesday 18th March	12:45pm – 13:45pm

I would appreciate if you could acknowledge receipt of this letter and if you would like to meet, please let me know what date(s) suit best and if you would like to bring a colleague or friend. I am available on, [redacted] and I look forward to hearing from you.

Yours sincerely

[redacted]

Professor Jann Gardner
Chief Executive
NHS Greater Glasgow and Clyde

Greater Glasgow and Clyde NHS Board

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Date: *13th January 2026*
Our Ref: *JG/LLBM*

Enquiries to: *Professor Jann Gardner*
Direct Line: [redacted]
E-mail: [redacted]

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Yours sincerely

[redacted]

Professor Jann Gardner
Chief Executive
NHS Greater Glasgow and Clyde

Greater Glasgow and Clyde NHS Board

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Date: *13th January 2026*
Our Ref: *JG/LLBM*

Enquiries to: *Professor Jann Gardner*
Direct Line: [redacted]
E-mail: [redacted]

Dear Penelope

I am writing to you today to invite you to meet and provide the opportunity for a face-to-face discussion. While I have been keen to meet you since coming into post, I also wanted to be fully respectful of the SHI timeline ensuring that there was adequate time for the evidence to conclude.

Within my evidence at the SHI, I outlined my objective to improve opportunities in NHS Greater Glasgow & Clyde for the balanced views of our staff to be heard and to learn from previous experiences. I recognise that we need to build capacity to support healing and repair relationships as we progress into the organisations next chapter.

Aligned with this commitment, you may also be aware that NHSGGC and NSS have commissioned external management support to work across the Infection Control Teams of both NHSGGC and ARHAI to assist with the building of relationships to support enhanced collaboration going forward. It is hoped that this engagement will re-establish trust across our respective teams.

With this work now underway, I felt that it was timely for us to arrange to meet. I would suggest that there may be value in us being joined by my executive colleagues Dr Scott Davidson (Executive Medical Director) and William Edwards (Deputy Chief Executive). You are also very welcome to be accompanied by a colleague or friend.

Can I propose the following potential times to meet although am happy to flex to another mutually acceptable time:

Friday 30th January	2pm-3pm
Wednesday 4th February	11:30am -12:30pm
Wednesday 18th February	12:30pm – 1:30pm
Friday 27th February	2pm-3pm
Wednesday 18th March	12:45pm – 13:45pm

I would appreciate if you could acknowledge receipt of this letter and if you would like to meet, please let me know what date(s) suit best and if you would like to bring a colleague or friend. I am available on, [redacted] and I look forward to hearing from you.

Yours sincerely

[redacted]

Professor Jann Gardner
Chief Executive
NHS Greater Glasgow and Clyde

Bundle of documents for Oral hearings commencing from 20 January 2026 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow

Core Participants' Closing Statements following the Glasgow 4 Hearings from 13 May to 10 October 2025

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