SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
26 February 2024

Day 7
Wednesday, 6 March 2024
Susan Goldsmith
Matthew Templeton

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10:06

THE CHAIR: Good morning, Ms Goldsmith. Good to see you again.

THE WITNESS: And to you, (inaudible).

THE CHAIR: Now, you are familiar with the arrangements here. You are about to be asked questions by Mr MacGregor, but first you will take the oath?

THE WITNESS: Yes.

THE CHAIR: Sitting where you are, could I ask you to raise your right hand and repeat these words after me?

Ms Susan Goldsmith
Sworn

THE CHAIR: Thank you very much indeed, and remember my----

THE WITNESS: I do.

THE CHAIR: -- I am hard of hearing----

THE WITNESS: I do.

THE CHAIR: -- and therefore would appreciate any assistance that you can provide.

THE WITNESS: Of course.

THE CHAIR: Mr MacGregor?

MR MACGREGOR: Thank you, Lord Brodie.

Questioned by Mr MacGregor

Q You are Susan Anne Goldsmith. Is that correct?

A That's right.

Q And you have provided a witness statement to the Inquiry which can be found at pages 425 to 443 of bundle 3 of the witness statements. That is the third witness statement that you have provided to the Inquiry and, as with the previous statements, the content of that statement will form part of your evidence to the Inquiry, but you are also going to be asked some questions by me today. As with previous times whenever you have given evidence, a copy of your statement should be available.

A Yes.

Q If you want to look at it at any point, please just do let me know. Any documents I want to take you to should come up on the screen in front of you. If for any reason you cannot see them, please just do let me know.

A Okay.

Q In terms of your background and qualifications, those were covered in your previous statements and in your earlier oral evidence, but in broad summary, you are a former director of finance at NHS Lothian. Is that correct?

A Yes.

Q And you retired in 2022?

A I did.

Q And during your time working for NHS Lothian, you were heavily involved in the-- what I will call "the project" and by that I mean the new hospital, the Royal Hospital for Children and Young People and the Department for Clinical Neurosciences.

A I was, yes.

Q Thank you. I want to really just ask you questions about the period after financial close up until the point when the hospital opened, and the first issue that I want to ask you about is really the dispute that arose between NHS Lothian on one side, and the Project Company, IHSL, on the other, regarding the pressure regime in the four bedrooms, do you remember that?

A I do.

Q And if I could just ask you to have your statement in front of you, please, and if we could look to page 434. So we are in bundle 3 of the witness statements, and page 434. I may have the wrong bundle of witness statements. It may either be bundle 1 or 2, but it is----

A I do have the paper copy in front of me if that's helpful?

Q Thank you. It is just to bring it up for the core participants, but thank you, Ms Goldsmith.

A Yes, yes.

Q So at paragraph 29, you addressed the Settlement Agreement and Supplemental Agreement 1. I will not read out the whole of the paragraph but, effectively, you summarise in there that the dispute came to focus on 14 out of 20 multi-bedded rooms, and if I could just ask you to look at the final sentence, you say that "the focus was very much on pressure rather than air changes." Do you see that?

A I do.

Q This is obviously some time ago. There is a number of contemporaneous documents that I would just like you to look at, really just to see if the focus of the discussions was really solely on pressure or whether there were also associated references to air changes, but I will take you to each of the documents in turn. Perhaps just to refresh your memory, if we could go right back to the start really of where the dispute began, and look to bundle 13, volume 9 and page 92. Bundle 13, volume 9, and if we could go to page 92, please.

THE CHAIR: Thank you.

MR MACGREGOR: And this is a letter from Jim Crombie to Wallace

Weir of IHS Lothian Limited on 13 March 2018. If we look to paragraph at approximately halfway down the page beginning, "We note that notwithstanding." Do you see that?

A Yes.

Q So it says:

"We note that notwithstanding the Independent Tester's email dated 23 January 2018 you have still not confirmed that you intend to revise the ventilation system to the four bedded rooms to meet the Board's Construction Requirements. Indeed, we are dismayed to note that Project Co have not set out their position in relation to the ventilation system to the four bedded rooms at all."

Do you see that?

A I do.

Q So reference effectively to NHS Lothian saying, "Let us look at the Board construction requirements because we do not think you are complying with our brief." Is that fair?

A That's right.

Q Thank you, and then if we look to the next paragraph it says:

"In our letter to Project Co dated 3 November (enclosing a report from David Rollason & Associates) and our letter to the Independent Tester dated 29 November 2017 the Board set out the detailed reasons why the ventilation to the 20 four bedded rooms requires to be balanced or negative. That position is reinforced by the Opinion we have received from Senior Counsel which has been provided to you on a without prejudice basis."

Do you see that?

A I do.

Q So again, just so I am understanding things correctly, the Board, NHSL's position is the Board's construction requirements, properly construed, require balanced or negative pressure for these four-bedded rooms?

A That's right.

Q Thank you, and at this point, again, if you could just assist the Inquiry, it seems that NHS Lothian have obtained senior counsel's opinion on the legal analysis, but they have also obtained an expert engineering report. Is that correct?

A That's correct.

Q Thank you, and then if we look over the page onto page 93, I will not read all of that out, but there is really a summary of the Board's position and why what has set out in

the previous page is required, and one of the reasons for that is if we look to paragraph 2, it says that really NHS Lothian's position, that would comply with good industry practice. Do you see that?

A I do.

Q And again, you were obviously involved in the financial and commercial side, but is that your understanding of what you were being told by the individuals on the technical side?

A Yes, absolutely.

Q And again, we will come on and look at this in slightly more detail, but the Inquiry has heard before that not only was there an in-house Estates team at NHS Lothian that were assisting in the project, but there was a company called Mott MacDonald that were appointed as lead technical advisors. Was that your understanding?

A That's right.

Q So again, could you just explain, in your own words, at this stage that there is clearly a very significant dispute between the parties about what these rooms require, what good industry practice requires, expert opinions have been provided, there is the threat of litigation which is presumably a massive step for any public body. Could you just explain what advice, if any, are NHS Lothian getting from Mott MacDonald at this point in time?

A My recollection is that Mott MacDonald supported our position, and that is that for the four-bedded rooms the ventilation should be balanced or negative. So I'd-- my recollection also was that they, you know, as our technical advisors, that they, with the project team, had identified that there was potentially an issue with ventilation. So although we've just referred to documentation in 2018, I first became aware that there was an issue, potentially an issue, with ventilation towards the end of 2016. It became more of a sort of meaningful issue during 2017, but Mott MacDonald, as our technical advisors and who were part of the Project team, were key to picking up that there was issues with the ventilation.

Q So again, if we just take that in stages, Mott MacDonald involved NHS Lothian's position on the basis of advice it is receiving from an outside expert and Mott MacDonald balanced or negative pressure for these rooms. That complies with good industry practice. If we fast forward, we know that IOM came in at a much later stage----

A Yes.

Q -- in the process and say, "This hospital does not comply with good industry practice, it does not comply with published guidance."

A Yes.

Q Were there some searching questions asked by NHS Lothian of Mott MacDonald at that point?

A There was clearly a concern that it hadn't been identified by Mott MacDonald. I mean, when you talk about as well, you know, about the people that were involved, obviously there was a clinical view as well. So it wasn't, you know, just engineers and the Project team, it was a clinical requirement that the pressures regime should be balanced or negative in those rooms, and clearly the standards, the guidance, SHTM 03-01 at the time didn't include any reference to the four-bedded rooms. In fact, if you go back in the project, you know, to the start, I recall that gaining a derogation from single rooms was a key consideration and a clinical requirement going back to, I don't know, 2008/2009 because it was a clinical requirement that we had a mechanism or a facility that would allow the cohorting of children. It was largely about children and not having children in single rooms and control of infection.

So, I-- yes, certainly when the IOM report-- I mean, we were-- you know, everyone was devastated, you know? I can't underplay how awful it was that-- you know, that time, and so there were-- there's questions not just of Mott MacDonald, but all of us. You know, how had no one identified that critical care should be at 10 air changes and positive pressure? So yes, there was a question of Mott MacDonald, but it's fair to say that, you know, it wasn't just Mott MacDonald that----

Q Yes.

A -- had been party to the requirement for balanced or negative and believing that that was the right pressure regime for those rooms (inaudible) multi-bedded rooms.

Q We will come on and we will talk about other----

A Yes.

Q -- entities, individuals involved in the project, but if we could just perhaps stick with that issue at the moment: Mott MacDonald providing advice, good industry practice----

A Yes.

Q -- balanced or negative, IOM come in and say, "That is not right, it has to be positive."

A Yes.

Q Were there some searching questions asked by NHS Lothian of Mott MacDonald in relation to their role in the project, having signed off that good industry practice means balanced or negative for these rooms?

A If you mean, “Did we call them in or haul them in and ask them what they’d been up to?”, no, we didn’t, because-- why didn’t we? I mean, we obviously took legal advice on our position in terms of Motts as technical advisors, and I think we have, you know, I’ve obviously been away from Lothian for two years, but I think we’ve got assisted, you know, action I’d-- I think, you know, with Motts, depending on how this Inquiry goes. So we certainly took legal advice, but we didn’t haul them in as our technical advisors. We were so focused, to be honest, on resolving the problem and the issue that really, you know, at that point when the IOM report was issued and we were in meetings, it was really about rectifying and occupation-- you know, ultimate occupation of the building. And to be honest, you know, Motts had been part of the team, you know? So yes, in retrospect, maybe we should have actually brought in senior partners, you know, and quizzed them, but we didn’t at that time.

Q Thank you. If we could return to bundle 13, volume 9, and then look on to page 94. Approximately halfway down the page, you will see a paragraph beginning, “In the event that we do not hear.”

A Yes.

Q So bundle 13, volume 9, and we are on page 94, paragraph in the middle beginning, “In the event,” and the letter continues:

> “In the event that we do not hear from you with confirmation of your position by Monday 19 March 2018 we shall assume that you share Multiplex’s view and confirm that we shall raise Court proceedings against Project Co seeking an interim order requiring the performance of your obligations under the Project Agreement pursuant to section 47(2) of the Court of Session Act 1988. Specifically, we shall seek an order ordaining you to design the ventilation to the 20 relevant four bedded rooms such that it achieves a balanced/negative pressure regime relative to the adjacent corridor. A copy of the draft Summons will be provided to you in due course.”

Do you see that?

A Yes.

Q So, threat of litigation and specifically saying, "Our brief requires balanced or negative pressure, and we are going to go to court to compel you to design in compliance with that if you do not agree to do it." Is that right?

A That's right.

Q Thank you. If I could ask you to look on please, still within bundle 13, volume 9, to page 96 – and this time it is a letter of 21 March 2018 to Wallace Weir of IHS Lothian Limited – and if we look over the page on to page 97, please, the first full paragraph states:

> "A significant part of Multiplex's reasoning appears to be that we have not properly explained why infection control would require each of the multi bed rooms to have balanced / negative pressure. We disagree. We refer you to, amongst other things, MM-GC-002408 dated 11 January 2017 and the subsequent discussions at the meeting on 23 January 2017. These discussions and correspondence dovetail with the relevant extracts from the BCRs, SHTM 03-01 and SHFN 30 (see paragraph 5.4 in particular regarding cohorting patients with the same infection)."

Do you see that?

A Yes.

Q Again, communication from NHS Lothian to Multiplex of the clinical need, "This is why we need to cohort patients, and this is what we need you to do." I will not read out the next paragraph, but again there is a reference to the draft summons and supporting affidavits. Then the penultimate paragraph:

> "We cannot allow this issue to remain unresolved. The hospital is already over 8 months late. A further delay pending the outcome of the dispute pursuant to the dispute resolution procedures in schedule part 20 of the Project Agreement is unacceptable. We have therefore obtained the necessary approvals pursuant to our governance procedures to sanction the action outlined in our letter dated 13 March."

Do you see that?

A I do.

Q For those of us that do not work with within a Health Board, what would be the approval procedures if you were looking to raise

a sort of major litigation like this?

A In this case, our legal advisor came to our Finance and Resources Committee to have a discussion about the court action. All members of the Board had a right to attend Finance and Resources Committee and Board members were advised, I think following a board meeting, that we were going into a private Finance and Resources Committee that everyone was welcome to attend to hear the proposition from our legal advisor about court action. And Finance and Resources, having heard the proposition and with quite a significant amount of discussion, agreed that we would pursue court action. I can't recall how we then advised the Board, but the wider Board were certainly aware of the discussion taking place on that same day in the Finance and Resources Committee, and I would imagine we then advised them in some way following the discussion, but certainly Finance and Resources agreed to court action.

Q And would there have to be approval from the Scottish Government for a litigation like that, or is that simply a decision taken by the Health Board independently?

A That was simply a

decision taken by the Health Board, but throughout all of this-- And I think I've said in my previous attendances here that at all times we were keeping colleagues within Scottish Government briefed about how the project was going and the issues that we were facing on ventilation. So, again, I can't recall specifically, but we didn't need formal approval for court action, but we certainly would have discussed it with them and advised them that that's what we were planning.

Q Thank you. Then if we look on, still within bundle 13, volume 9, this time to page 100, you will see that there is an email dated 22 March 2018 from Matt Templeton to a range of individuals, including yourself, really setting out that there are discussions ongoing between the parties at this point in time to see if there is a way to avoid the litigation. So, the second paragraph, "Please find attached a letter from IHSL together with an enclosed proposal for Multiplex. The Multiplex Proposal/Letter contains the following four attachments." There is a mediation tracker report, four bed ventilation options, RHSC liability scenarios and the PCo Change Register. Do you see that?

A I do.

Q So Mr Templeton

effectively sending through IHSL's position in terms of how this might be resolved, and if we look on to page 101, we see the letter that is sent on 22 March 2018.

A Yes.

Q Again, I will not read out the first page but really summarising in the first couple of paragraphs why it would be in all parties' interests to try to reach a resolution. And then if we look on to page 102, paragraph in the middle of the page beginning, "One of the key items that needs to be addressed …." Do you see that?

A Yes.

Q He says:

"One of the key items that needs to be addressed is the technical requirements of the four bedded ventilation to the satisfaction of the Board. The attached paper outlines three ventilation options, each with a capital cost and timeline to completion. We ask the Board considers these options. The attached timeline is based on Option 1. It is recognised that were a different solution to be agreed (either in relation to Option 2 and 3) then the overall program and costs will change to reflect the work required for each of those options."

Do you see that?

A I do.

Q And then if we look on to page 103, the first full paragraph there, if we could pick matters up approximately five lines up from the bottom of that paragraph. Do you see a sentence beginning, "Without agreement"?

A Yes.

Q Where it says:

"Without agreement, Multiplex could not be contractually compelled to carry out changes post completion, meaning other contractors would need to be engaged. If other NHSL Sub-contractors are brought [in] to do certain works, warranties could be invalidated and responsibility for defects to affected areas of the building may become an unnecessary area of dispute between the Board and IHSL."

Do you see that?

A I do.

Q So again, as I understand it, a narration from IHSL of some of the difficulties if you have a Project Company, their subcontractor and then you try and bring into that deal structure yet another

subcontractor. I want to ask you some questions about this at the end, but I would just be interested in your views in terms of-- At this point in time, you are in a revenue-funded project, so it is not as simple as a design and build between Health Board and contractor. There is the Project Company in the middle who ultimately owns the building, various side agreements that are taking place between the company that will manage the building and the company that has actually designed and built it-- Could you just try and explain in your own words the sort of difficulties and complexities that that deal structure created in terms of trying to resolve what seems, on one view, like quite a simple dispute between, is it, balanced and negative or positive pressure?

A I think one of the biggest challenges for the Board was our contractual party was IHSL, but in reality and practice, Multiplex were the partner that really held all the cards. They were building the hospital, and although we engaged directly with Multiplex, our contract was not with Multiplex. We didn't really have any levers at all, or any leverage with Multiplex, and at this time they were obviously, you know, facing some difficulties on the project and were very

tough commercially-- adopted a very tough commercial position, and IHSL had a different responsibility and a different funding structure, which gave them different challenges as well.

So it was really-- At times we tried very hard to negotiate directly with IHSL as our contractual partner but found that that was almost impossible. We had to have Multiplex in the room. We didn't have a contract, and the funding structure also brought complexities because IHSL had a funding structure with two funders who also had requirements and needed to be satisfied that there was no changes in the risk profile at all for IHSL as the SPV, and so throughout this, the funders were engaged with resolving the issues that we were facing at different stages. The funders wanted to meet us, the Board, to try and seek resolution and get this project resolved; but again, they were IHSL's funders rather than our funders, so it was complex, and really it did feel at this time that IHSL were facilitating a dispute between us and Multiplex, although, to be honest, through most of it it felt as if IHSL were supporting Multiplex's position.

But when we got to starting to work through the Settlement Agreement and IHSL did try and play a

facilitation role, although our contract was with them, so it was complex, and obviously at our end we had Scottish Futures Trust who were really the guardians of the NPD contract and had an authority from government about what we could and couldn't do with this contract. Then we had Scottish Government who were funding the revenue who also were a stakeholder, so there were a lot of parties with an interest in this project and it made resolving the ventilation and other issues and understanding the consequences for a 25-year – ultimately it ended up being a 23-year – Project Agreement and what that would mean in terms of IHSL continuing to provide, through another contractor, the facilities management of the hospital for that long period of time. So there were multiple stakeholders, all with different interests and a different assessment of risk and a different risk appetite, so it was really complex.

Q Again, just so I am understanding things: in terms of if there is a simple dispute between the Board and the Project Company, actually to try to resolve that, the Board ended up dealing with a range of third parties that it did not have any contractual relationship with.

A Yes.

Q So you mentioned the funders of the Project Company, Multiplex, who are effectively the contractor or subcontractor of the Project Co. The Board has no contractual relationship with them but is effectively having to try to manage the dispute with that party that it does not have any contractual relationship with.

A Absolutely. To be honest, at the end of the day, the party that probably felt most on the same page as NHS Lothian was actually the funder. M&G and the European Investment Bank did insert themselves into the negotiation and tried to support resolution. Clearly SFT and Scottish Government had a role as well, and we'll no doubt come onto that as we touch more on the Settlement Agreement, but SFT also had a facilitation role. But the funders actually did play an important role in trying to mediate and get resolution to this. But yes, it was very complex with a lot of engagement with the different stakeholders.

Q And again, just at this stage, it would be interesting to review this just a very general level, but certainly the Inquiry has heard evidence that, in terms of the NPD

model, you were meant to have a Project Company that had a public interest director that sat on it, the idea being that that facilitated a collaborative relationship, a partnership approach, between the Board and the Project Company. What are your views in terms of whether that actually worked at a practical level?

A It didn't really work, and that wasn't particularly because of the individual, but what we learned – and I think it has subsequently been changed – is that the individual who was the public interest director had a personal fiduciary responsibility, and so we were obviously not aware at the earlier stage of the disputes but to IHSL clearly became financially a challenge, significantly (sic) financial challenge; and so the public interest director's prime personal responsibility was ensuring that actually IHSL stayed whole, and I think that that was a conflict with their role as public interest director because it inevitably meant that their interest was protecting IHSL's position. That's not to say that, you know, that the public interest director didn't try and resolve the issues because he was then, you know, sitting around the table, but he was definitely conflicted at that stage.

Q Again, just perhaps if we could explore that issue of conflicts, you know, Scottish Futures Trust who effectively have responsibility for overall for NPD contracts. Is that right?

A Yes, they do, yes.

Q They were providing advice and assistance to the Health Board. Is that right?

A That's right.

Q And one of their employees is sitting as the public interest director within the Project Company.

A That's right.

Q So, individuals from that organisation are, on the one hand, effectively advising the Board on the deal structure----

A Yes.

Q -- but they have also got an individual, as you say, who is sitting as a director with all the fiduciary duties that come with that to the Project Company.

A That's right.

Q Again, if we are just looking to the future perhaps, I think you said you did not think that worked well. How could that be improved if there is going to be revenue funded projects that happen again? What are your reflections on how you could

avoid this scenario of potential conflicts or difficulties whereby actually, the Health Board really just deals with the person that is building it, but does not have any contractual relationship with them?

A Yes. I mean, I do think that, just a personal view, that NPD is not an appropriate vehicle for complex acute hospitals. I think it's-- you know, just the very nature of healthcare means that, you know, the mechanisms or the way in which healthcare changes rapidly and is continuing to change rapidly, which means that the facility from which it's delivered needs to be capable of being changed and there needs to be a degree of flexibility, and the NPD project structure makes that quite difficult, you know, as a-- for boards to deliver change. So, I'm almost certain that the public interest director no longer is a full member of the SPV and sits there now as an observer so, if there are NPD projects, I think it's, helpful to have an observer hearing the discussions that are taking place around the SPV Board. Although, of course, no doubt behind the scenes, the more commercial discussions take place without necessarily the public interest director. But I – as I say, it's a personal view – don't think the NPD is

an appropriate model for the delivery of very big, complex, acute hospitals.

Q In your view, what would be the optimum model?

A I still believe that they should be capital-funded. I mean, you know, there is a capital-- in the past there's been a capital budget. I've been on boards where we've delivered projects that are funded by capital and I think at the end of the day, if we want good hospital facilities then we need to fund them with the capital resource that's available through the tax system and the funding system, so that would be my personal preference.

Q Again, just looking at some of the difficulties that arose here that we have just discussed a moment ago, do you think those types of difficulties would have arisen on a capital build project, or would it have been much easier to try to resolve the disputes?

A Yes. I think it would have been easier to resolve the dispute because the Project team identified-- were aware from 2016 because there had had been the failure of the piles, there'd been a supply-- one of the suppliers had went bankrupt. There was evidence-- you know, the Project team could see that there were challenges on the site and

did, through 2016, become increasingly anxious about the quality of the workmanship. I mean, the Project team, were on site and were frequently going around the building and observing. We didn't have a formal clerk of works because it was not a capital-funded project but-- when I say the team, not just NHS Lothian's team but Mott Macdonald were observing and identifying issues.

So, if that'd been a capital-funded project then we would have been able to have discussions with the contractor and identify those issues and make adjustments to the-- or hold them to account more clearly than-- or more easily than we were able to. So, during 2016, the latter part 2016 and into '27 (sic) there was a huge amount of frustration with the NPD model because we weren't able to actually rectify, or influence the rectification of, issues that we saw that were emerging on-site.

Q So, the Board, effectively, on the sidelines can see issues that they think are problems, would like to change them----

A Yes.

Q -- but because of the very nature of the structure, just simply have to sit on the sidelines and have very limited influence.

A I mean, they didn't sit on the sidelines, and I guess that's why we ended-- well, it's not a guess, I know that's why we ended up with a Settlement Agreement that had 81 items listed in it, because through the whole period of that latter stage of 2016 and 2017, the team with Mott Macdonald were capturing the issues through a register – I can't remember what it was called – but the system were recording all of the issues that they were uncomfortable with. And so, when we came to the Settlement Agreement, one of the you know the key issues was that Multiplex knew that the Project team-- you know, on the ground, the Project team were discussing issues with the project manager from Multiplex and so there was a knowledge between NHS Lothian and Multiplex that it wasn't just ventilation; there were other issues.

So one of Multiplex's key requirements when we eventually sat around the table for the Settlement Agreement was that everything went on the table – everything – because they said, "we want the list, we want the list." So, it wasn't that we weren't doing anything, it's just that we-- it took the Settlement Agreement, which obviously came with a further capital injection, to actually resolve issues that

would have been dealt with probably more easily as a capital-funded project. That's not to say that we wouldn't-- as a capital-funded project, you wouldn't have had to put more capital money into it but obviously every capital project is different but it was-- it just took a long time and I'm sure then was part-- you know, that added to the delay because we couldn't resolve many of those issues until the Settlement Agreement.

Q Thank you. If we could look back to bundle 13, volume 9 and move on to page 110. This is email correspondence that you probably will not have seen before because it is from Andy Clapp of Dalmore Capital, and it is really an email to people on the IHSL side. You will see it says:

> "Dear all, Please find below a brief overview of the meeting between IHSL and NHSL."

Do you see that?

A I'm sorry, where did you say that?

Q So, we are bundle 13, volume 9.

A Yes.

Q And it is the email:

> "Dear all, Please find below a brief overview of the meeting between IHSL and NHSL."

A Ah yes, yes, I see it at the top, yes.

Q So, it is referring to a meeting. Then the next full paragraph:

> "Following the submission of the Multiplex Proposal dated 22 March 2018, representatives from IHSL met yesterday with NHSL at their offices. Jim Crombie, Susan Goldsmith, and Ian Graham attended from NHSL, and Tony, Andy, and Matt from IHSL. The premise of the meeting was to ensure that NHSL had properly understood the proposal; and whether there were any clarification points we could answer."

Do you see that?

A Yes.

Q Again, I will not summarise all the bullet points, but it effectively says that the court action has been taken off the table, and there is a summary of what, certainly from the IHSL side, was discussed. Now, if we could look over the page onto page 111, you will see the first bullet point beginning, "NHSL advised." If we could just pick matters up four lines up from the bottom of that paragraph, do you see wording:

> "NHSL agreed to progress on the basis of ventilation?"

A Yes.

Q So certainly from the IHSL side, they are recording their understanding of what is discussed at this meeting that you are at, and they say:

> "NHSL agreed to progress on the basis of ventilation Option 2 in the MPX Paper (balanced/-VE, 4 ac/hr to 14 rooms)."

Do you see that?

A I do.

Q Again, it is a long time ago, I appreciate that you probably went to a lot of meetings but having seen that, certainly the recollection of the IHSL side, do you remember for the four bedded rooms discussing the solution being both balanced and negative pressure, and four air changes per hour?

A I do recall the discussion about four air changes per hour, but really in relation to single rooms, I'm not saying I wasn't aware of the discussion about the number of air changes in the four bedded rooms, but I don't specifically recall that, but I do recall the air changes in relation to the single rooms.

Q And in fairness to you, you are obviously at this meeting, there is a range of people there. Presumably, you are more interested in the commercial aspects of the

resolution, and there are other people there that would be perhaps more focused on the technical aspects.

A No, absolutely. I relied on the team with the technical advisors to come to an agreement on those technical resolutions.

Q Again, I will just ask you to look at a couple more emails that talk about the technical solution. Again, if your recollection is, "These things might have been discussed but I don't remember them, it's a long time ago," please do just say at that point.

A I will do, thank you.

Q So, if we could look to bundle 13, volume 9, and it is the email at the bottom, the email from Brian Currie of 29 March 2018. So, that is bundle 13, volume 9, page 113. So, Mr Currie contacting Dan Pike and he says:

> "Catch up at 2pm this afternoon but in advance we have prepared our thoughts on a collaborative framework going forward (see attached). This has been approved by Principals within the Board."

Do you see that?

A Yes

Q Then if we look on to page 115, there is the collaborative framework. I will not read out point 1

but just below the point 1, above point 2, you see there is wording, "These works will incorporate?"

A Yes.

Q

"These works will incorporate agreed balanced/negative ventilation specification works to the multi-bedded rooms (scope being 14 rooms at 4 ac/hr)."

Do you see that?

A I do.

Q So again, do you recall any discussions with Mr Currie or what is referred to in that email as "Principals within the Board" wanting to move forward with IHSL to resolve the pressure issue on the basis of balanced or negative pressure, four air changes per hour?

A Again, I do recall that that was part of the agreement in terms of moving forward, and I certainly recall the 14 rooms being balanced or negative, but as I said earlier, I'm sure I obviously knew, but I just don't recall the discussion for the multi-bedded rooms on the four air changes.

Q Thank you. Then if we could just look on to bundle 13, volume 9, at page 116. This is an email from Darren Pike on 29 March 2018 to a range of individuals including Andy Clapp, James Crombie, and you see yourself, Susan Goldsmith, listed there.

A Yes.

Q Do you see that?

A I do.

Q What Mr Pike states in this email is:

"Jim, Susan, and Ian. Action from me from the call earlier to circulate and confirm the following. Our understanding is that 14 number 4 bed wards are to have 4 air changes per hour at a negative or balanced pressure and this will satisfy NHSL requirements for these spaces with regard ventilation."

Do you see that?

A I do.

Q I will not take you through all the emails in the chain, but if we just go forward in bundle 13, volume 9, to page 189. So, we are now at the 28 June 2018 letter from NHS Lothian to Wallace Weir of IHS Lothian Limited. Do you see that?

A I do.

Q And then just under the bold heading, "Without Prejudice," the second full paragraph states:

"As previously advised, the schedule sets out what the

"Agreed Resolution" for each Dispute item is as well as describing the technical solution for each Dispute item. Further obligations incumbent upon Project Co and the Board to achieve the technical solution are also stated."

Do you see that?

A I do.

Q And then if we just look down to page 218, please. Do you see there is a draft of item 7. Do you see that?

A I do.

Q And if we just look to the right-hand box. So, that is the description of agreed resolution. Bundle 13, volume 9. The front page of the letter is page 189, and then the schedule is at page 280 (sic). Right-hand box, "Description of Agreed Resolution," second full paragraph:

"The resolution submitted [and then there's some track changes] by Project Co through the Review Procedure is for 14 No 14 bed rooms be balanced or negative to the corridor at 4ac/hr."

Do you see that?

A I do.

Q So, again, I will not take you to the actual technical schedule to

the Settlement Agreement but there is some minor tweaks, but that draft effectively becomes the technical schedule. But should the Inquiry understand from the email chain that we have looked at that really there was quite a detailed process that led up to what was ultimately captured within Settlement Agreement 1?

A There was a very detailed process which, yeah, took some time.

Q Whenever you were negotiating Settlement Agreement 1, was one of the concerns on the Board's part the potential for there to be a change in the entire risk profile of the deal, because the Inquiry's heard that with the NPD model, if it works perfectly, all of the design risk should be shifted from the public sector on to the private sector to the Project Company. So, whenever you were looking to agree the Settlement Agreement, did you have any concerns that agreeing that the settlement might impact on that deal structure?

A We did. I mean, we did have a concern, but we mitigated that concern by ensuring that we had legal advisors who, you know, were sitting alongside us, and there were attempts by IHSL to change the risk profile in

their favor through the process. I mean, that really was part of my role. A significant part of my role with Iain Graham and the team was to ensure that there was no shifting of risk to the Board because, although this was a change-- the Settlement Agreement was trying to capture what essentially we were paying for and what we'd agreed. We had to ensure that the risk didn't change over the 23-year period. So, at all times, we had a legal advisor who was giving us advice on what was being proposed for the Settlement Agreement to ensure that there was not that shift in risk to the Board.

Q Thank you, and if I could just ask you to look to bundle 13, volume 9, at page 184. Bundle 13, volume 9, page 184. This is an email from yourself to Andy Clapp, Tony Rose, Matt Templeton. We see that the first point that you raise there is the NHSL business case, the fact that there'd have to be a business case that was put forward to justify any settlement. Then if we look to point 2, which is headed, "Full and Final Settlement," and pick matters up with the final sentence in the first paragraph. You say:

> "I believe that the current approach set out in the Settlement Agreement is somewhat artificial and (no doubt unintentionally) cuts across the existing risk profile in the Project Agreement."

Do you see that?

A Yes.

Q So, again, is that just the concern you had that, yes, you wanted to agree changes, but you didn't want to fundamentally alter the deal structure that had been signed off in all the business cases and ultimately entered into by the Board?

A Yeah. Absolutely.

Q And then if we look over the page, there is some, I think, suggestions to the wording put forward. Page 185, within the first full paragraph there, if we look approximately five lines up from the bottom of the page, you sort of summarise, I think, your position. There is a sentence beginning, "This avoids any change to the risk."

Do you see that?

A I do.

Q You say:

> "This avoids any change to the risk profile under the Project Agreement and therefore protects both parties, and would remove the need for the drafting around Disputed Items, Dispute and Released Claims, which would

not be acceptable to the Board in the current form in any case. To be clear, it is not proposed that this process would alter the settlement sum, which is the subject of the separate issues I have outlined in item 1 above and item 3 below."

Do you see that?

A I do.

Q Thank you. I want to take you to an email in a moment, an email exchange between Graeme Greer of Mott MacDonald and Brian Currie, and it is really about this issue about what is the brief, what is the design, were does design risk sit, but I would just be interested in your views before we go there. In terms of Settlement Agreement 1, was that a document which, from the NHS Lothian side, was seeking to change the brief, or was it seeking to alter the design solution? What was your understanding?

A That's a good question because it's difficult. I wouldn't have articulated it in that way. I would have said that there were a whole range of technical issues, which I would-- I mean, not having a technical background, some of them related to design. So, for example, the one I remember most, because I remember the discussion about it, was drainage. So, that the hospital had not been designed in a way that matched our Board construction requirements. So, it had been designed in a different way, and the Board were not happy because we saw that there were potential operational risks but the hospital-- you couldn't-- once the hospital was built, you couldn't change the drainage solution.

So, the Board was put in a position where we had to find a way with ISHL and Multiplex to mitigate the risk through other mechanisms. So SA1 captured what we had agreed would be acceptable to the Board. So, that cut across design and the brief, and there were other issues where we believed that IHSL had not-- or Multiplex had not constructed the hospital to the brief, which were design issues. So, for example, I think there was an issue about the cable calculations and the loading of the cables but it was too late, really, to change the infrastructure of the hospital. So, we were agreeing what would be a solution to our perceived risk that the hospital had been designed in a particular way that we felt there was a risk against our brief, and so, at all times, we were trying to get that captured in the Settlement

Agreement what we thought the issue was and what the solution was. So, it cut across both the design and the brief but all through the lens of, you know, how this hospital was going to function and what the risk would be for the Board.

Q With the benefit of hindsight – and I appreciate you are now looking back; I am not asking what your thought process was at the time – do you think there is a confusion in relation to Settlement Agreement 1 whether the technical schedule is the NHS Lothian brief or whether it is the design solution?

A Sorry, say that again.

Q Do you think that there is an ambiguity in Settlement Agreement 1 in relation to the technical schedule as to whether the technical requirements set out there as to whether they are NHS Lothian's brief or they are the design solution?

A I'm not sure-- Yes, there is an ambiguity, and it would have been almost-- although, you know, you could take a purist view of-- the design responsibility is with the Project Co, and operational brief and responsibility and Board construction requirements are the Board responsibility, and we tried to keep that purist line all the way through this but the reality is if the

Board spotted something that was questionable about the design, which it did in terms of-- I take the cable (inaudible)-- or if the Board spotted something that was questionable about the design, then it would have been irresponsible of the Board not-- just to ignore that because it happened to be the SPV's responsibility or IHSL's responsibility. So, the ambiguity arose because I think it's quite a purist view that you keep the two completely separate.

Again, I'm not technical but from a non -technical perspective, we inevitably we cut across-- in picking up issues that were of concern to the Board, then we cut across the design but ultimately the Settlement Agreement is very clear that design responsibility through the live period still rests with IHSL. So, if anything emerges in the future that relates to design, then it's the responsibility of IHSL.

Q Because perhaps if we just take things stage by stage in terms of how matters developed with the threat of litigation but as I understand it from the documentation we have looked at, NHS Lothian's position was the Board construction requirements were the brief. Is that right?

A That's right.

Q And the Board construction requirements properly construed required balanced or negative pressure for these rooms. Is that correct?

A Yes.

Q So, whenever we see that the technical schedule with all the agreements, is that not really just NHS Lothian clarifying their brief to the Project Company, "This is what we want"?

A It makes it very clear what the Board has agreed. So, yes-- very simply, yes, it does. It documents what the Board has agreed meets its brief, and essentially what we are buying or paying for, it makes it crystal clear where there wasn't clarity before, perhaps.

Q Thank you, and if I could just ask you to have a look at an email exchange between Graham Greer of Mott MacDonald and Brian Currie. It is in bundle 13, volume 5 at page 1 ,272. Bundle 13, volume 5, page 1,272. If we could pick matters up just in the third paragraph, please. Well, Mr Greer states:

> "I think the intentions from IHSL were constructive (we all just wanted to close the technical issues), and I think we are agreed that 'all items are to be defined with precision', however the comment about the BCRs is concerning. As you've described in your email, in effect we had thought the process would conclude in the Board removing any further objections to the design solution proposed and recorded via one of the mechanisms already established in the Contract.
>
> The risk allocation set out in Clause 12 of the PA is clear, and I am concerned that if the Board agreed to write the above BCR statements, it could significantly alter the PA risk allocation in IHSL's favour. Furthermore, I don't think the Board is in a position to fully confirm compliance with the BCRs, the burden of responsibility should always remain with Project Co. As we are not the designers, Mott MacDonald would not be in a position to provide that design assurance to NHSL."

Do you see that?

A I do.

Q Do you recall any discussions with Mr Currie or other members of the Project team about that issue, about is this a design assurance issue, and if it is, Mott

McDonald are not going to be providing any design assurance?

A I don't recall that. I'm sure-- I probably was party to it, but it's not something that I can remember.

Q Because, again, it is just, I think, for the Inquiry, trying to clarify exactly what Mott McDonald's role is at this point in time. So, the Inquiry's heard evidence from Mr Greer. He was very clear that Mott McDonald assisted NHS Lothian, provided *ad hoc* advice, helped with the drafting of the technical schedule to the Settlement Agreement, but his position is that that was being done on the understanding that Mott MacDonald were not really providing any form of real design assurance, and I think it was just to try to understand your understanding of what MacDonald were doing at this point in time, because certainly Mr Greer's analysis-- and it is not to get to the bottom of what the correct legal technicalities are, it is more to try and understand what people thought what was happening, certainly Mr Greer's position was that yes, Mott MacDonald are helping out, they are doing their best, but they were not really advising or taking any responsibility for the solution that ultimately ends up being into the Settlement Agreement. What was your understanding of what Mott

MacDonald are doing in terms of the Settlement Agreement?

A My understanding was that Mott MacDonald were providing assurance to the Board or advising the Board that the IHSL were delivering a hospital that would meet the Board's construction requirements. I think inevitably there were some-- as I said earlier, there were some draw-in to design issues because-- but that was, you know, again, if you take the cable calculations, that was because it wasn't-- we considered or the technical advisors and the team considered that the solution that was in place would not meet the Board's construction requirements, and so there was a question mark about whether it (inaudible) or not.

I mean, again, as somebody who's not technical, I find it, you know, sometimes quite-- find it quite difficult to have that purest view because I-- because it-- the two are so interlinked, the Board construction requirements are reliant on the design, you know, the correct design. So inevitably, there were some discussions that cut across design, but Mott's responsibility simply was to ensure that the Board's construction requirements were delivered by IHSL and give us advice where they didn't believe that they

were being met.

Q So that, obviously, is your understanding.

A Yes.

Q That might be different-- other people may have different recollections.

A Yes.

Q Again, we will come on and talk about the Grant Thornton report later on, but one of the issues that the Grant Thornton report raises is it is not often clear when decisions were being made, how they were being documented----

A Yes.

Q -- what specific advice had been provided. If we were looking to another project and there is a similar dispute that crops up and there is these types of issues, is the design risk changing, is it a brief change, is it a change to the design solution, how do you think this type of issue could be done better so that there was crisp, clear capturing of who is doing what and who is advised on what particular issues? How could that be done better?

A I think that, you know, when I look at the decisions that were made from a commercial financial perspective, those are all very formalised in terms of a proposition, a paper goes to Finance and Resources, legal advice documented. I think, certainly by the time I left Lothian, there was work well underway on ensuring that there was much-- we had set out how technical advice is received and being clear about, you know, where we have technical advisors as part of the team working alongside NHS Lothian and where we're relying on their professional indemnity. I guess that's the key distinction.

So I can't remember the detail of what was being proposed, but we were certainly clear that we needed to make that distinction. So if you appoint technical advisors for this purpose, they're just providing advice as part of the team. If you're requiring them to give us formal, professional advice that's supported by their professional indemnity, we need to make that clear. So I think it was just that distinction was perhaps lacking and needs to be more formal. It wasn't like-- it wasn't-- it requires to be more formalised than it was.

Q So greater clarity in terms of rules----

A Yes.

Q -- and greater clarity in terms of what is specifically being done, and in particular if advice is

being given that is being relied upon on----

A Yes.

Q -- that is clearly and crisply captured so that there is no dubiety as to who is advising and what they are advising on?

A That's right.

Q Thank you. In the run-up to the conclusion of Settlement Agreement 1, so by that I really mean the period throughout 2018, whenever the discussions are taking place, the Project team, the core Project team, are obviously working very hard on trying to resolve all of these issues. The Inquiry has heard evidence from Dr Inverarity and Lindsay Guthrie, who were infection prevention and control professionals working within NHS Lothian. They say that they really did not have any involvement in those discussions, and they simply learn about the conclusion of Settlement Agreement 1----

A Yes.

Q -- by a sort of "all staff" email. Why were infection prevention and control not involved in the process of discussing the solution and documenting the solution?

A They were-- I mean, Donald himself personally wasn't, but certainly the Infection Control team were part of the wider Project team, and certainly the discussion on the multi-bedded rooms included infection control. I mean, before we agreed the proposition on the 14 rooms being shifted to balanced or negative, Janice MacKenzie engaged with Clinical team, including Infection Control. So the project was structured in a way that infection control were part of the wider team and would be, you know, part of the discussion at any point where there was-- there's issues of prevention infection control to be considered, but SA1 was essentially a commercial agreement and I guess I wouldn't have expected Donald to be involved in a commercial settlement, but his team were involved earlier in the project and certainly involved in part of any clinical discussions on solutions.

Q The Inquiry has also heard evidence that there is an HAI-SCRIBE process that is embedded within the NHS.

A Yes.

Q Presumably, you do not know the detail of that, but you will have heard the term HAI-SCRIBE?

A Absolutely, yes, I do, yes.

Q And that is a four-stage process, with Stage 4 being a check

that should take place before the new-build hospital is effectively handed over. So if it is a design and build, handed over from the contractor that is building it to the Health Board----

A Yes.

Q -- are you familiar with that (inaudible)?

A I am, yes.

Q The Stage 4 HAI-SCRIBE was not completed before Settlement Agreement 1 is signed and the hospital is accepted by NHS Lothian and handed over. Why did that not take place?

A That didn't happen then because, essentially, the Settlement Agreement was a commercial business settlement, and part of--- so that the site, and this is one of the challenges that we faced, and we go back to the discussion that we've had in previous hearings where the Board was clearly very focused on the programme and, you know, by this time we had seen significant slippage in the programme and there was a concern that we would go into another winter where, you know, moving into the facility would be challenging. So, as part of the Settlement Agreement, recognising that it's always better to move services, acute hospital services, during the summer when it's quiet-- not that services are quieter any time of the year now, but they're marginally quieter in the summer. So the Board was cognisant of making sure that we tried to capture, having lost however many summers, try and ensure that the move happened over the summer.

So as part of the Settlement Agreement, we agreed that we would run commissioning in parallel, which we always knew was going to be really challenging for the Board. So when the Settlement Agreement was signed, essentially the hospital was still a construction site. There was still work ongoing on, the issues that were the drainage, the voids detectors-- I mean, what else? So it was essentially still-- the contractor was still on site, and there was a lot of work done to determine how the Commissioning team would work alongside a contractor on site and there was designated zones that were contractor zones, and designated zones where we were able to get on with our commissioning.

So you wouldn't have been able to undertake the SCRIBE process while there was-- the hospital was still a construction site, and really it was, only once the work was concluded would you be able to test the systems,

and I guess that's where we ended up with a problem because the testing was so late, the ability to do SCRIBE and then the commissioning, the Board commissioning, was so late that by the time we identified a problem, we had to defer or the Cabinet Secretary deferred the opening. So it was because it was a construction site, it was a commercial agreement and the SCRIBE process would not have been possible while it was a construction site.

Q But if we just think about that and think about that term, the "SCRIBE process" for a moment.

A Yes.

Q If Settlement Agreement 1, there might be a dispute about whether it is changing the brief or it is changing the design solution, surely the clock should have been wound back in the SCRIBE process to the Stage 2 sign off because that is-- where there has to be the Stage 2 SCRIBE for the design process. So why was the thought process on the part of NHS Lothian, "We will just defer the Stage 4 SCRIBE." Why were they not looking back if they were either changing the brief or the design to the Stage 2 of the SCRIBE?

A I don't know the answer to that. I don't think I'm best placed to

answer that question, I'm sorry.

Q Again, I am just interested in your views. Obviously everyone who is working on Settlement Agreement 1, as you say, is really focused on the commercial angle, looks like the clinical angle, the IPC has been sorted out with the decision that you need to cohort patients.

A Yes.

Q But do you think again, looking back, that the lack of infection prevention and control input was perhaps problematic because the detailed knowledge on the SCRIBE process simply was not embedded in the individuals that were focused on the commercial side of the deal?

A I mean, there was-- so I suppose I would just reiterate my point. There was infection control input throughout the project. I mean, there was facilities input, there was, you know, a wide sort of multidisciplinary input to the project. With the benefit of hindsight perhaps there wasn't the right level of infection control input, and the profile of infection control, in a short-- relatively short period of time in the health service has increased enormously. We know much more about the relationship between-- you'll have

heard there's multiple factors that influence infection control, but the relationship between the building and its infrastructure and infection control has, you know, I would certainly be aware that it's got a much heightened profile and is much better understood than it's ever been before, and that, you know, that certainly emerged, that heightened awareness and corporate awareness, certainly emerged through the life of this project. So with the benefit of hindsight, I think it was the level-- you know, the level of infection control input, it could have been improved.

Q Because again, the Inquiry has heard evidence that really the infection prevention and control aspects of the built environment, so how IPC really links into the water systems, the ventilation systems, that was effectively an emerging area 2007 right up to 2014 and beyond.

A Yes.

Q Again, as someone who has obviously worked within a Health Board, sat on the Board, has been through a project like this, looking back, is that your reflection as well? That this was something that-- it is easy for us to sit here in 2024 after the COVID pandemic and say, "Why did this not happen?" But this was not

something that really, generally, health boards were thinking about on these types of projects?

A No, and to be honest, there was much more flexibility from a clinical perspective. So I guess that's one of the reasons that, you know, the SHTMs are guidance and not mandated. So it certainly didn't have the profile that it does now, the standards and the guidance and, clearly, there was issues emerging from Queen Elizabeth that then also started to infiltrate into our consciousness as part of the-- as the project was being concluded. So that absolutely would be my recollection.

Q Dr Inverarity gave evidence yesterday and he said one of the reasons he was concerned whenever he found out about Settlement Agreement 1 and that the HAI-SCRIBE Stage 4 had not taken place was that very issue: that he knew from late 2018 into early 2019 that there were emerging issues at the Queen Elizabeth University Hospital, potentially with the water and ventilation system. In terms of the individuals involved in the commercial side, was that something that those individuals were aware of in February 2019 whenever they were signing Settlement Agreement 1?

A I can't recall. I mean, we were certainly becoming aware and trying to use our networks to establish what the issues were. I would struggle to pinpoint when it was-- My sense of it is that it was after the Settlement Agreement, but I think I'm guessing. I'm trying to retrofit, possibly. I just can't remember.

Q And again, please just tell me, in terms of the decision, was it a conscious decision, "We'll sign Settlement Agreement 1, we'll accept the hospital, and we will skip the Stage 4 SCRIBE and do it later," or was there just no consideration of the Stage 4 SCRIBE? What was happening in that Settlement Agreement?

A I don't recall a discussion about the Stage 4 SCRIBE. What I do recall is the fact that there was-- You know, I was certainly aware, as the director, that there was a huge amount of work to do on commissioning and that would include the Stage 4 SCRIBE. So there was the issue of all the equipment that had to be put in place – that was the Board's responsibility – and tested. There was work to do in terms of packing up and getting the teams ready for the move. So there was a huge amount to do, and this HAI-SCRIBE Stage 4 would just be one component of a multi-- I

do remember the lists of items that had to be worked through by the commissioning team and that would have just been one. But clearly there was a very strong imperative to sign the Settlement Agreement because of the financial difficulties you'll have heard of, because of IHSL, and there was a debt repayment that was due, I think, in the March for which IHSL had no funds. So all of us that were involved in the Settlement Agreement from a corporate-- You know, Scottish Government, SFT, myself and my team was about trying to ensure that we met that timescale.

Q We will come on and discuss that in a moment, the financial position of Project Company, but leaving the financial position to one side, this is a hospital now that is already late.

A Yes.

Q How much pressure did the Project team feel under to just get this over the line and deliver the hospital?

A To be honest, I think they felt more pressure when they could see that things were not going particularly well on-site. So, as I said earlier, during 2017 in particular, there was a huge frustration and concern building up. I mean, it was-- And then

relationships became difficult. So I think at that point, the pressure was probably quite-- Well, when you can't control things and you're frustrated, that creates more pressure. I think there was a huge pressure on the team, but with the Settlement Agreement there was such relief that there was a pathway to the hospital opening. I think that generated a bit of excitement, to be honest, that at long last-- And also the hospital was looking fantastic. There was a pride in how the hospital was looking and so a real enthusiasm that at long last we were actually getting there, but I was also aware that they felt the responsibility to undertake the commissioning well, having spent all this time overseeing getting the project through the different stages, that nobody wanted to not deliver a good commissioning programme. So I don't think it was bad pressure. It was good pressure.

Q And again, Dr Inverarity, he gave evidence the inquiry and he said, really, the main concern he had about the Stage 4 HAI-SCRIBE not being completed was that NHS Lothian accepted the hospital without having checked that it was fit to be occupied by patients. Looking back, is that a decision that perhaps should not have been taken, or do you think it was still commercially justifiable?

A Well, we did actually have the independent tester, so there was a formal process for the-- Which was-- The formal process the SA1 linked to was the Project Agreement, and so there was an independent tester who was a technical individual, and one of the reflections was that he was another person who didn't actually make any reference to critical care, so it's just factual. So, there was a technical process linked to Project Agreement that he did whatever he did to ensure that the Board was receiving the hospital that it had contracted for. So there was a formal process with an independent tester, but that again was linked to the contractual position as opposed to, "Is this hospital commissioned and ready to receive patients?" which was the commissioning of the hospital.

Q But at a time where, as I understand it, NHS Lothian's understanding was that the specification for the hospital was fully compliant with all published guidance, including SHTM 03-01.

A Yes, yes. I mean, at that point, anyone within the team would have anticipated that critical care would have been ten air changes and

positive pressure. Although yes-- Well, we'll no doubt come on to that, but----

Q Again it is just so I am understanding things correctly and it is really to see what assurance, if any, NHS Lothian took from the independent tester's certificate. But am I right in thinking that, certainly on the NHS Lothian side, the assumption was if the independent tester is issuing the certificate, regardless of whether that is under the contract or it is against published guidance, that would not matter because the NHS Lothian understanding was they were exactly the same thing?

A Absolutely, yes, and we would have expected the independent tester to identify any issue where that wasn't the case.

Q Thank you. I would just like to ask you a few questions about the commercial context of the deal, and perhaps the easiest thing is just to look back to your statement, please. If we look on to page 435 and to paragraph 32, and within paragraph 32, approximately six lines up from the bottom of the page, there is a sentence beginning, "In short, SA1 provided…" Do you see that?

A Yes.

Q And you tell us:

"In short, SA1 provided financial support for IHSL, who were facing financial distress, without which they may not have been able to complete the hospital."

Can you just explain in your own words, what are the financial difficulties as you understood them and how significant are they?

A So, the way in which the SPV is set up is that they only start receiving payments from-- So IHSL, we'd only start receiving payments from NHS Lothian once the hospital has been completed and accepted by Lothian, at which point we start paying the unitary charge, the annual revenue charge, for the hospital. IHSL was set up with a loan structure financing that assumed that they would be in a position to start repaying or servicing their debt to both M&G and to the European Investment Bank following completion in July 2017. We're clearly now in 2019 and IHSL have not had a source of income as anticipated for 18 months.

If I recall correctly, the way in which the financing was set up, there was sufficient provision within the budget that IHSL had to ensure it had for covering its costs in advance of the flow of the unitary charge so that

they're funded, so that they have resource that allows them to fulfil their roles and responsibility up to handover of the building. So they did have resource, but they didn't have sufficient resource for an ongoing-- To cover that period.

But within their financing, they had sufficient resource. There was a reserve that allowed them to make payment to serve as the first element, first payment on the debt, and so I think we had to agree that that could be released. But by the time we got to the Settlement Agreement, there was no cash within IHSL to make the second payment which was due to M&G and European Investment Bank, and if I recall, that was due in March 2019.

Q And what were your concerns if Settlement Agreement 1 had not been signed?

A Well, IHSL would have gone into default of the Project Agreement and the project would have been further delayed because the funders would have had to have stepped in. We had a right of termination but the funders had first right to step in, so although we could have terminated, it didn't mean we could then step in and take over the hospital. Effectively, we had an

agreement with the funders so they had a right to try and sort the issue, take over the running of the project and get another SPV or, if Multiplex were not there anymore, get another contractor, but another SPV in the first instance.

We didn't know how long that would take, and we would also then effectively have had to reimburse for the hospital because clearly we would have been taking ownership of the hospital at some point and we-- I'm not sure how this calculation was made, but we had financial advice that indicated we would have to pay IHSL £150 million to take the hospital as it was constructed at that point, and clearly NHS Lothian didn't have £150 million. It would have had to be agreed by Scottish Government, and at that point, as I understood it, Scottish Government didn't have £150 million that they could make available to us to reimburse IHSL and the funders. So there was a significant pressure to agree the Settlement Agreement and to get the flow of funds so that IHSL remained liquid.

Q So again, just so I am understanding things: standing back, looking back retrospectively, it is perhaps very easy to say, "Why didn't you do the Stage 4 HAI-SCRIBE?

Why didn't you just let matters play out as they should?" But should the Inquiry understand from a commercial perspective, you did not really feel that you had the luxury of time? Really from two perspectives. On the one hand, there is an absolute demand and need for a brand-new hospital in Edinburgh and there is the potential for a cliff edge moment with a payment of up to £150 million landing on either NHS Lothian's desk or the Scottish Government's desk for this project.

A Absolutely, and importantly, no certainty on programme, which we've discussed in previous inquiries; no certainty in when the hospital would become available for patients and Lothian and staff. So, I mean, we did spend a lot of time considering all our options and taking technical, financial advice and legal advice on whether it was a viable option for the Board to allow the IHSL to go into default of its debt obligations and how we could take on the building. So there was a lot of discussion about that, but we concluded it just was not in the Board's interests.

Q Thank you, and I think if we could look on to bundle 13, volume 7, page 1049, we will see a minute of the Finance and Resources Committee from 19 September 2018.

So, bundle 13, volume 7, page 1,049. So, you see, "Finance and Resources Committee," and minutes of a meeting on 19 September 2018. Then if we look over the page onto page 1,050, paragraph 15.2, we see there is an update on the RHCYP/DCN Project. Do you see that?

A Yes.

Q And it states:

"Mrs Goldsmith tabled a position paper on a proposed Settlement Agreement. The paper provided detail and an update on the current situation with the RHCYP/DCN project. There was discussion on the IHSL financial difficulties…"

Do you see that?

A Yes.

Q Now, that's one line in a minute which simply records the IHSL financial difficulties, but should the Inquiry understand – albeit it's dated in very matter-of-fact terms – what that's recording is all of the difficulties you've outlined in terms of potential insolvency, risk to the project, potential bill of £150 million. Those are the types of issues that are being discussed and recorded in this minute?

A Absolutely.

Q Thank you, and it

continues:

> "…the need for a finalised supplemental agreement to move forward, the factors delaying the signing of this and the position of senior funders; residual technical issues with the key issues being around drainage systems; amendments to the business case; the leadership and competency around IHSL and the next steps to make progress."

Then 15.2.1:

> "The Committee noted the current position with the project and gave its absolute support to the project team in terms of the current strategy and approach."

Do you see that?

A I do.

Q And, again, although we are slightly back in the chronology here, we're in September 2018, is that strategy to effectively agree a Settlement Agreement so that this project can move forward and the hospital can open?

A Yes, that was very much the objective of the Board.

Q And again, perhaps just to close off this chapter again, it is to look back at that issue of the deal structure, the whole NPD model – theoretical transfer of risk from the public sector to the private sector – but if you are staring down a scenario whereby the Project Company is potentially going to go bust with a half-built hospital is it ever going to be realistic for a health board like NHS Lothian to simply walk away?

A No. I mean, the Board has a responsibility to deliver safe services to the citizens and patients across NHS Lothian, and that's its prime responsibility. So, I think the risk ultimately sits with the public sector.

Q Thank you. Lord Brodie, I am conscious that it is just after half past eleven. That would certainly be an appropriate point from my perspective to take a break if that was convenient.

THE CHAIR: Yes. As you will perhaps recollect, we usually take a coffee break. So, if we try and be back for ten to twelve.

A Okay. Thank you.

(Short break)

THE CHAIR: Mr MacGregor.

MR MACGREGOR: Thank you. If I could ask you to have in front of you, please, bundle 4, page 9, which is a letter from Wallace Weir of IHSL to Brian Currie on 31 January 2019. So,

bundle 4, page 9. So, at this point in time, we are a few weeks before Settlement Agreement 1 is formally signed. Albeit, as the Inquiry understands, actually the agreement in relation to the multi-bedrooms was reached in 2018 and the works have actually been completed at IHSL, Multiplexes risk, albeit the contract is not formally signed until the February. So, when we are looking at this letter, 31 January 2019, all of the works for the ventilation system have actually physically been completed. Is that correct?

A Yes, that's correct.

Q And if we just look over the page on to page 10, please, do you see that the letter states in bold:

> "All critical ventilation systems inspected and maintained in line with Scottish Health Technical Memoranda 03-01: Ventilation [and] healthcare premises.
>
> Construction: - All ventilation systems have been designed, installed and commissioned in line with SHTM 03-01 as required, systems are maintained in such a manner which allows handover at actual completion to meet SHTM 03-01 standards.
>
> Operations: - All critical systems will be inspected and maintained in line with "Scottish Health Technical Memorandum 03-01: Ventilation for health care premises."

Do you see that?

A I do.

Q Albeit this letter is addressed to Mr Currie, is this a letter that you had seen in in the early part of 2019?

A It is.

Q And can you just to explain in your own words, how much reassurance, if any, did NHS Lothian take from the terms and contents of this letter?

A I mean, if I recall, the letter was on the back of an issue, I think, at Queen Elizabeth with pigeon droppings, I think. Assurance, we certainly took assurance, but I don't think it was-- we wouldn't have expected anything else, so I think we noted it and accepted it but that's probably as far as it went, to be honest.

Q Thank you and, again, I would just be interested in your views-- obviously, you have been finance director of NHS Lothian, sat on the Board of NHS Lothian. One of the issues the Inquiry is interested in is

both decision making and governance. On one view, what happens in this project is a spreadsheet error or a technical misstatement at some point in the project, and perhaps individuals looking in could say, “Well, why was that not spotted; why was there not governance checks that took place; why are there not checks and balances to spot this?” Could you just chat us through the processes?

As someone who has sat on boards providing governance, if you were provided with a letter like this that says there is still technical compliance with published guidance, would you be expecting to do anything more in terms of doing checks before entering into an agreement like Settlement Agreement 1?

A No, we wouldn't because we rely on-- in this instance, we had a contract which brought with it obligations, and we had a process agreed with the independent tester giving us assurance that our contractual requirements had been met. So, quite simply, you know, that's what the Board had in place and the Board would expect that that system would provide assurance to the Board.

Q So, the Board puts in place the system and then it effectively relies on the system to make sure that

the decision-making is done in an adequate proportionate manner?

A Yes, I mean, I guess management put the system in place and then the Board has a system of assurance that relies on the management systems being tested. But, yes, there are systems of control in place for numerous things, and this was just one of them.

Q Thank you, and just in relation to the-- I think you mentioned the systems that the Board had in place, including advisers. If we could just look to the Board minute of Lothian NHS Board, which is within bundle 13, volume 7, page 1,159. So, bundle 13, volume 7, page 1,159. So, this is a minute of a private meeting of Lothian NHS Board held on Wednesday, 6 February 2019.

THE CHAIR: Thank you.

MR MACGREGOR: And if we look over the page onto page 1,160, do you see that item 37 is, “Final Draft Supplementary Agreement RHSC/DCN”? Do you see that?

A I do.

Q So, is that effectively what I have been referring to throughout as Settlement Agreement 1?

A That's right.

Q And if you look to 37.2,

three lines down, you will see a sentence beginning, “The board was asked to receive.” Do you see that?

A Yes.

Q It says:

“The Board was asked to receive assurance that all negotiations on the terms of this Settlement Agreement had been supported by the Board's legal and technical advisors in addition the board approved the Settlement Agreement with IHSL and considered a short extension to the long stop date to allow all commercial and technical matters to be concluded.”

Do you see that?

A I do.

Q That is the formal sign-off by the Board but taking reliance from the legal and technical advice that had been put in place?

A That's right, and being regularly briefed, you know, in advance of the formal process.

Q Thank you, and just in relation to the governance structures that were put in place for the project, were they reviewed by Audit Scotland and Scott Moncrieff at a later date?

A The structure-- The governance around the Settlement Agreement was reviewed and found by

both Scott Moncrieff and Audit Scotland, and they identified that there'd been good governance around the signing of the Settlement Agreement.

Q To your understanding, in terms of the Settlement Agreement being signed off if there were problems with that document, it was not a systemic problem in terms of the governance structure, certainly according to Audit Scotland and Scott Moncrieff?

A That's right.

Q You will be aware that at a later stage the Settlement Agreement 1 is signed-- at a later stage, infection prevention and control are not able to formally sign off the Stage 4 HAI-SCRIBE----

A Yes.

Q -- and it is then, at that point, that IOM Limited come in and they do their testing and identify, on their view, a non-compliance with published guidance SHTM 03-01, but the next part there-- so IOM come in and then the next big chapter would be High Value Change Notice 107 and the Settlement Agreement 2.

A Yes.

Q So at this point in time, when IOM are doing the testing, it is balanced or negative pressure, four air

changes per hour for certain critical care rooms and there is there a later agreement whereby it is determined that it is going to be positive pressure, 10 air changes per hour.

A Yes.

Q The Inquiry heard evidence from Dr Inverarity. His position was that effectively Scottish Government simply said, “This hospital must comply with published guidance,” and it is then for the Board, and by that we will come on and look at the Oversight Board, the ESG----

A Yes.

Q -- but effectively, Scottish Government said, “It has got to comply.”

A Yes.

Q And NHS Lothian then implement that decision. Is that your understanding of how we get from the IOM testing to Settlement Agreement 2?

A Yes, although the Board-- so yes, it is. So simply, yes, but the Board did also consider how it could get critical care and could implement, you know, ensure that critical care complied at a later stage. So there was a consideration about the works being done at a later stage to ensure that critical care complied with the guidance.

Q And can you remember, who is it that communicates down the chain from Scottish Government to NHS Lothian that, simply, the hospital has got to comply with the published guidance?

A I wasn’t party to that discussion at all, but it would be the Director General.

Q So your understanding is that-- you are operating within the Project team, director of finance, but those types of decision were being taken really one level above that?

A Yes.

Q But your understanding, from what you have been told by colleagues, is Scottish Government simply said, “It has got to comply with the guidance”?

A Yes.

Q Ten air changes per hour and positive pressure. Thank you. In terms of decision-making structures, the Inquiry has heard evidence that there is an Incident Management Group established which is then renamed as the Executive Steering Group.

A Yes.

Q Could you just explain what that body was and what your involvement was with them?

A Yes. So, as a

Management team, an Executive Management team, as you would expect, we have or had had management meetings, routine management meetings, but when there is a critical issue then we set up a separate, more regular forum for meeting. So the Executive Steering Group was established to bring the key directors together every week to oversee the-- all the work involved in actually agreeing what needed to be rectified, to have an opportunity to discuss within Lothian whether how we were dealing with things, to consider the practical implications, to get advice from our advisors and to be able to have the opportunity to consider everything before we engaged with Scottish Government colleagues and NSS.

Q Thank you, and you tell us within your statement that that was really discussions about technical, commercial and operational issues. Is that right?

A Yes.

Q There was also an Oversight Board that was established.

A Yes.

Q Can you just explain, in your own in words, what was the Oversight Board and how did it come into being?

A The Oversight Board was established to allow Scottish Government key directors within the health directorate to engage formally with directors from NHS Lothian and directors from NSS, and to ensure that all the discussion and consideration of the issues around rectification and indeed some enhancements and the programme for delivery were considered within a formal meeting that was, you know, had an agenda, minutes were taken, decisions recorded, and occasionally there's always that engagement with Scottish Government colleagues and other boards, but this allowed directors – key directors – to come together in a formal way to ensure that everything was recorded appropriately.

Q Thank you, and just in relation to that revised governance structure effectively in the period leading up to Settlement Agreement 2, if I could ask you to look, please, to bundle 13, volume 3 and to page 696. So bundle 13, volume 3, page 696.

THE CHAIR: Thank you.

MR MACGREGOR: So, you see there is a graphic there, really setting out the project governance structure?

A Yes.

Q If we look on the right-hand side, the NHSL side, right at the

very top you have still got the board of NHSL, but we have got the Executive Steering Group sitting below that, is that right?

A That's right.

Q And that is the group that you talked about which was effectively so that there could be this coordinated discussion in relation to various issues relating to the project, is that right?

A Yes, that's right.

Q And then we see, really sitting in the middle, we have got the Project team. Now, there is mention of Mary Morgan sitting there. Obviously, we have talked about the Project team which originally would have included Brian Currie, yourself, Ian Graham for example. What was the revised Project team and how did Mary Morgan come to be involved?

A So I would not be part of the Project team because I was the lead director, but-- so the Project team was led by Brian Currie. In effect, Scottish Government appointed Mary Morgan as-- was it strategic-- programme director I think her title was, and she essentially came in and led the Project team and reported directly to the Oversight Board. She also worked alongside me and the Executive team and supported us in-- because the Board still had its own

governance, the Board was-- remained the statutory authority with the contract and the second supplementary agreement had to be signed off by the Board. So Mary, her responsibility was to the Oversight Board, but she also supported us in the Board.

Q Thank you, and then on the left-hand side, we see that we have got the Oversight Board and then below that, a commercial subgroup with your name next to it, S Goldsmith.

A Yes.

Q Can you just explain why was the commercial subgroup of the Oversight Board formed and what was your role within it?

A The subgroup was formed because there were some significant challenges in securing a supply chain for the rectification of critical care and other works that were to be undertaken. There was a lot of detail around that-- those commercial arrangements and, to be honest, there wasn't really enough time in the Oversight Board to get into the detailed discussion that was required around the commercial arrangements. So the subgroup was set up, chaired by myself, to consider all the matters that were emerging with IHSL and (inaudible) and then Multiplex. I mean, in essence, what it did is it formalised

what would have happened in practice. So I've talked before about working with SFT, working with Scottish Government colleagues and working with other parties, so this was really-- it was at a more senior level because it included, for example, the chief exec of NSS, it included the then-director of finance in Scottish Government Health, but it formalised the arrangements for engagement around the commercial arrangements with IHSL.

Q Thank you, and if we are just looking at those top graphics, so on the left-hand side we have got the Oversight Board and on the right-hand side we have got the Board of NHSL. How is their engagement towards Scottish Government? Is that coming from the Oversight Board, the Board of NHSL or another entity? How are matters escalated to the Scottish Government?

A Through the Oversight Board.

Q Through the Oversight Board. Thank you. If I could ask you to look to the Oversight Board terms of reference, bundle 7, volume 2 at page 352. Bundle 7, volume 2, page 352. So you see this is the Oversight Board, the terms of reference, and this iteration is July 2019.

THE CHAIR: Thank you.

MR MACGREGOR: And if I could just ask you to look on to page 354, please. We see that the background set out which states:

> "Following the decision to halt the planned move to the new Hospital facilities on 9 July an Oversight Board is being established to provide advice to ministers on the readiness of the facility to open and on the migration of services to the new facility."

Do you see that?

A I do.

Q So in broad terms, is that the issues that were being discussed within the Oversight board?

A Yes.

Q And then if we look down the page, towards the bottom of the page, there is box three which is the scope of work, which says, "The Oversight Board will provide advice in relation to," and then there is a range of matters. The first is "advice on phased occupation." Do you see that?

A I do.

Q There is obviously issues identified with the Royal Hospital for Children and Young People at this point in July. Were there similar issues in relation to the Department of

Clinical Neurosciences? Why could it not simply have opened immediately?

A No, there were no issues in relation to DCN, and there was a discussion about whether there was a phased move into DCN because there were issues with the facility at the Western General Hospital. So my understanding, and again I was less involved in this, that there was-- options were put forward to have a passed-- a move with DCN going into the facility. I think there was perhaps some issues with rotas of staff, whether those rotas were going to be joint, that might have created problems but certainly that was considered.

Q But was that ultimately a decision for the Scottish Government when the DCN did or did not open?

A It was, yes. It was.

Q Thank you. We see the second bullet point, to provide:

> "Advice on the proposed solution for ventilation and critical care areas and on any other areas that require rectification works."

Do you see that?

A I do.

Q But is that against a backdrop that, certainly by this point, by July when the Oversight Board is being formed, certainly a newer evidence Scottish Government have already said, "It has got to comply with the guidance, positive pressure and 10 air changes per hour." (Inaudible).

A That's right.

Q Thank you, and then we see:

> "Advice on the facility operational readiness to migrate; Gain information and give advice to NHS Lothian about commercial arrangements with IHSL for completion of works; [and then the next bullet point] The approach to NPD contract management."

What was being discussed within the Oversight Board on the approach to NPD contract management?

A I'm not sure that that we-- I'm not sure that would be a right description. We needed to use the NPD contract to secure the changes. So Peter Reekie was the-- I think the then-chief exec of SFT was on the commercial subgroup. So we did talk about the challenges we were facing with delivering the changes that were required with IHSL. So actually, perhaps that is a right description, but the actual detailed discussion around the Board changes was undertaken in the commercial subgroup.

Q Thank you, and then the

final bullet point there in terms of the scope of work, it says that the Oversight Board, what one of its areas for advice is "Identification of areas that could be done differently in future." Do you see that?

A I do.

Q What did the Oversight Board determine, if anything, in terms of areas that could be done differently in the future?

A I don't recall that we discussed what could be done differently in future at all.

Q Okay. Can you recall why not? Because there is this Board that is set up. It has got all of these various tasks to iron out perceived problems. It is asked to identify if it could be done differently, but certainly the Inquiry is not in possession of any crisp report or minute that says, "These are the things the Oversight Board should do differently." Do you know why that was not closed off by the Oversight Board?

A I would just be speculating, but I think that at some point during this year, and I can't recall exactly when, the policy decision was made on the establishment of NHS Assure, and I would surmise that any changes that were going to be made to the capital project procurement and

delivery would be considered through the establishment of NHS Assure, and so really that was taken away to a different area of work. So that would be my-- I mean, as I say, I'm speculating, but I think that's possibly the reason why----

Q In terms of, if we just focus on the material in front of us-- Oversight Board established, one of the things it is to do is identify areas that could be done differently, but ultimately the Scottish Government did not insist on the Oversight Board providing any learnings in terms of its ideas on what could be done differently in the future.

A I don't know, but I-- You know, certainly Mary Morgan sat around the Oversight Board and she, as chief exec, would have responsibility for the establishment of NHS Assure, so I'm assuming that learning from supporting us on the project would be factored in to the establishment of NHS Assure, but it wasn't something that we considered. It was probably a good early example of NSS coming in and working with a board on standards and how those should be delivered, so I'm assuming that there was learning from that, but it wasn't formalised in any way.

Q Thank you. Then if we

look on to page 355, we will see that the membership of the Board-- I will not go through everyone that is listed there, but we see a range of individuals from Scottish Government, a range of individuals from NHS Lothian and individuals from other organisations including Scottish Futures Trust. Do you see that?

A I do.

Q If I could ask you to look to bundle 3, please, page 8. You see there is an agenda for the Oversight Board. Do you see that?

A I do.

Q And if we look at item 3 there, so this is one example agenda. I will not take you through all of them, but you will see that item 3 there is "Ventilation Solution – air changes per hour and pressures for all clinical areas against SHTM standard; works required to bring acceptable standard." Do you see that?

A I do.

Q And did that effectively become a standing item in the agenda for each of the Oversight Board meetings?

A As I recall, it did until we had an agreed solution, and then it was about the delivery of that solution. It certainly took some time to agree the solution.

Q And then if we look, still within bundle 3, on to page 43, you see that there is an Oversight Board minute of the meeting on 8 August 2019. Do you see that?

A Yes.

Q A range of people attend, including yourself; and if we then look over the page on to page 44, see the bold heading, "2. Ventilation Solutions"?

A Yes.

Q

> "2.1: Mr Graham presented the previously circulated paper regarding ventilation in the critical care area. Members agreed in principle that if a technical solution was designed that would allow 10 air changes per hour in the required rooms in the critical care area, which complied with the relevant SHTM standard, and was properly implemented, then the critical care area would be fit for use."

Do you see that?

A I do.

Q So is that effectively the agreed solution to the problem that the Oversight Board then works on implementing?

A Yes, I think so. Yes, sorry, I'm just reading the second

paragraph. Yes, those were the plans that would deliver the solution.

Q And then if we look on to page 46, please, you see bold heading 6 is “Commercial Position and Contract Management,” which all seems to be blanked out on your copy.

A It’s blanked out, yes.

Q I will not take you through everything, but could you just summarise your understanding of what was being discussed on the Oversight Board in terms of the commercial position and the contract management? How was the problem going to be resolved?

A In the Oversight Board, probably at this stage, we were still-- Sorry, I can’t recall when this meeting was.

Q This meeting is in August of 2019.

A August 2019. So, we would be updating the Oversight Board on the progress we were making with IHSL and other stakeholders to identify-- Or, sorry, we’d be updating them on the progress we were making with securing a supply chain, and I can’t recall whether in August IHSL had secured a supply chain, but there were significant challenges in IHSL securing a supply chain. So there was a piece of work to develop the plan and the design for the ventilation, but in parallel we were working through how this work would be delivered and what that would mean for the Project Agreement, so I am guessing that it was just an update.

Q Thank you. If we could look on to bundle 3, page 142, please. So bundle 3, page 142. This is a minute of the Oversight Board on 29 August 2019. Do you see that?

A I do.

Q Again, a range of individuals attending, including yourself. If I could ask you to look onto page 144. Again, you are obviously sitting on the Oversight Board because of your financial and commercial input, but there is also going to be discussion on ventilation issues as well while you are there. The minute records 1.6(1):

> “Literature review now complete - demonstrated limited and sub optimal evidence around air changes and clinical outcomes. Most evidence had been expert opinion, modelling and outbreak reports.”

Do you see that?

A I do.

Q Do you remember any of those types of discussions taking place whenever you sat on the Oversight Board?

A I do remember there was a lot of discussion about not just the ventilation but other enhancements, but I would struggle-- In terms of that specific point, I'm not exactly sure why a literature review was undertaken, but I do recall there was a lot of discussion about best practice.

Q Would that effectively be for other people within the Oversight Board to deal with rather than yourself?

A Absolutely.

Q And then if I could just ask you to look on to page 145, please, into section 7, "Migration Planning." At the bottom it says:

> "Clinical risk assessment of the potential move to Children's Outpatient services in the new hospital in advance of inpatient and associated services - Ms Gillies stated that there was too much risk to manage working across a split site and moving some services ahead of other services. It was noted that DCN could move in one block and all children's services also in one block."

Do you see that?

A I do.

Q So again, could you just please tell the Inquiry, what was your understanding of the discussions about how the migration was going to take place? There is the solution that is being worked on presumably that has to be done for the children's hospital, but how were decisions being made in terms of when the hospitals would open?

A As I recall, the decision on the move rested with the cabinet secretary and so it wasn't a decision for the Board, and this would just relate to a consideration of the revised plan because the previous plan obviously had all services going in in a particular phased way over 10 days-- I can't remember exactly, but a week or two weeks. So the plan for the move into the building had to be revised because of the works that were being undertaken taken, so I think this would just be a consideration of what the options were for moving services in and how that-- I'm not sure that it would have been much different from the previous plan, but I assume that's all it was.

Q But ultimately at this point, this is now a decision that has been taken by the Scottish Government, which would then be implemented by NHS Lothian.

A That's right, yes.

Q Thank you. If I could ask

you to look on, still within in the same bundle, bundle 3, to page 531, please. So bundle 3, page 531, which is a minute of the Oversight Board from 5 December 2019. You see at the bottom there, there is item 4, "Commercial Arrangements paper to NHS Lothian Private Board 4 December 2019". Do you see that?

A I do.

Q If we look over the page onto page 532, please, and if we pick that up at the first bullet point, it states:

> "The NHSL Board had taken their governance responsibility seriously and whilst not happy about the current situation realised that this was the only option available to progress the opening of the hospital. The board reluctantly agreed to the proposal.
>
> "The NHSL Board had requested oversight board approval of the decision which they were agreeing to as it was appreciated that the NHSL board would be signing the public sector up to unknown financial risks, and currently no programme certainty associated with progressing with the proposal. They wished this concern to be made clear to the Scottish Government and Cabinet Secretary, given how the actions of any of the NHSL board may be viewed in the future."

Do you see that?

A I do.

Q And then at section 5, we see reference to the "High Value Change 107 - Ventilation Works to Paediatric Critical Care and Haematology / Oncology", and there are references to the Oversight Board approving that high value change. Can you just explain your understanding of what were the commercial arrangements that are being discussed here in section 4?

A I'm just trying to remember. So one of the issues was that because we couldn't secure, or IHSL could not secure, the works to be done through the normal mechanism. You know, if this had been a board change then we as the FM provider would have delivered the change, and because they would not agree to that and clearly Multiplex had also ruled themselves out of doing the change because of the commercial arrangements that they wanted to be put in place, IHSL had to secure the works through a different contractual mechanism. And if I recall correctly, there was still an unknown about the

financial cost of this at this point. So we had to agree the solution and the works without absolute certainty on the cost and the programme at this point because of the urgency of getting on the works.

Q If we just think back to the original business case that was presented for the new hospital, presumably that had to say in great detail what the financial position was going to be for the lifetime of the project. Is that correct?

A That's right.

Q You then go through a procurement exercise to supposedly get to a point where you have a fixed contract whereby all the risks, liabilities and costs are known. Is that correct?

A That's right.

Q But you get to a point towards the end of the project whereby we see the Oversight Board and the board of NHSL discussing that, actually, we have now got to a point where there is going to be what is described as "an unknown financial risk to the public sector."

A Yes.

Q Again, just reflecting on the whole NPD structure, which is meant to take a situation where all of the risk simply goes on to the private sector, I would be interested in your

observations as to how the NPD model is operating from a health board perspective.

A Well, in this case, clearly it didn't work as it is supposed to work and, as director of finance, I had some concern that we were prioritising investment in this area, recognising we had to-- we had to do the works but we-- given how financially constrained the capital budget is across the NHS in Scotland then this-- because of the nature of the works, and the timescale, and the pressure, the works were prioritized and delivery of the works were prioritised compared to the budget. So, I think I spoke before about the quality cost criteria and the cost criteria being given a greater weighting than the quality at an earlier stage in the project. This obviously flipped at this point where quality was the key driver, including, yes including the enhancement works and the financial arrangements. So, the financial budget was less of an issue.

Q Again, in terms of what would ultimately become Settlement Agreement 2, that is formally entered into by NHS Lothian.

A Yes.

Q But we see the Oversight Board minute communicating that really, NHS Lothian wanted it to be

clear to the Scottish Government and the Cabinet Secretary just exactly what those obligations and liabilities were going to be.

A Yes.

Q Thank you. If I can ask you to look on still within bundle 3 to page 928, please. This is a minute of the Oversight Board on 23 April 2020. Do you see that?

A I do.

Q So bundle 3, page 928. Bundle 3, page 928.

THE CHAIR: Thank you.

MR MACGREGOR: Oversight Board minute of 23 April 2020, and if we could look on to page 930, please. You see Section 5 is "Progress with Ventilation Remedials and Fire Enhancements." 5.2 is, "HVC107 Design sign off," which states:

> "The Oversight Board accepted the assurance from Mott MacDonald (Technical Advisors), Health Facilities Scotland (for NSS), and the Authorising Engineer that the specification for air handling units meets NHS Lothian's requirements for critical care and haematology-oncology. The Oversight Board agreed to approve sign off of the specification to allow IHSL and Imtech to procure the Air Handling Units. The minor derogation in the spare capacity of the units (25% down to 18-19%) was noted."

Do you see that?

A I do.

Q Is this effectively, at this point in time, the Oversight Board approving the changes that are going to be made, albeit it is the Project Company that will implement them, but this is the new, whether it is the new brief or the design solution, this is being signed off by the Oversight Board?

A It is, yes.

Q And that is on the basis of assurances provided by a range of entities, including Mott MacDonald, Health Facilities Scotland, and an authorising engineer?

A Yes, that's right.

Q If I could ask you to look on still within bundle 3, this time to page 1082, please. This is a minute of the Oversight Board from the 14th of January 2021. So, bundle 3, page 1082. You see at Section 2.2, there is

reference to publication of SA 2:

"Noted SA 2 had now been published with redactions and was available on the NHSL website along with the project agreement."

Do you see that?

A I do.

Q So, is that effectively by this point in time, High Value Change Notice 107 and the Settlement Agreement 2, which formally records the change including for critical care units to positive pressure, 10 air changes per hour, that has been signed and it is publicly available for anyone to review that wishes to see it?

A That's right.

Q Thank you. Then if we look on, still within this minute, to page 1084. Within "Any Other Competent Business" at paragraph 6.1. See the bold heading, "Technical Assurance." Page 1084, 6.1:

"Noted that the Oversight Board on 19 November 2020 had discussed the HFS role in the completion of commission and testing process. Confirmed that HFS had been involved throughout the process and once the IOM Report was available later this month, HFS would only get involved if there was anything substantive identified as an issue."

Do you see that?

A I do.

Q Again, should the Inquiry understand that HFS has really been involved right throughout this process in terms of signing off the solution, the implementation, and then the formal testing by IOM Ltd?

A Yes.

Q If I could ask you to look on, still within bundle 3, to page 1095, please. We have a minute of the Oversight Board held on 25 February 2021. Do you see that?

A I do.

Q If we could look on to page 1097 and look to the final two bullet points on the page. You see the second last bullet point states:

"Ms Morgan outlined that the last year had been spent correcting the pressure cascade in the new Hospital. In that period, the Critical Care and Lochranza Ward Ventilation Systems had been rebuilt, CAMHS had

been stripped out and reopened and all other items in the HFS report had been addressed. The new Hospital was now one of the safest and best buildings in the whole of Scotland."

Do you see that?

A I do.

Q So again Mary Morgan, who I think you said was brought in as the senior program director, she is providing-- she is not a member of the Oversight Board but attends the Oversight Board and is providing an update, and she is saying in her view, now that all of the changes have been carried out, testing done, that this new hospital was, "One of the safest and best buildings in the whole of Scotland." Do you see that?

A I do.

Q Again, is that characteristic of the discussions that you are having on the Oversight Board at this time, that you have now got to a point in time where all the works have been done?

A Yes.

Q The minute continues:

"To delay the final service moves further when no issues

relating to the ventilation piece had been identified would be very risk averse."

Do you see that?

A I do.

Q So again, should the Inquiry understand, certainly from Mary Morgan's point of view, at this point in time, she doesn't have any concerns about the hospital opening?

A That's right, yes.

Q Then the minute continues:

"Miss Gillies stated it was not clear why the previously discussed and agreed course of action, now appeared not to being followed. Mr Morrison confirmed that there was a desire not to end up in the same place as July 2019 and recognised that this could be seen as overly risk-averse but testing and exploring options was part of having as much assurance as possible that the previous position would not be repeated. There was support for the direction of travel to

continue the plan for w/c 22 March 2021 but to wait until the Independent Tester report is received before any public announcements.

"[And then over the page on to page 1098, continues] Miss Gillies made the point that in July 2019 the Independent Tester did not pick up the issues that stopped the moves last time. The 2021 IOM Report has been done in conjunction with others and so no surprises were expected as the data around the ventilation systems had had been shared. This was an important difference from July 2019 and rectification work now had been done on the back of working with NSS."

Do you see that?

A I do

Q Was there effectively a disagreement between attendees as to when precisely that the hospital should be opening?

A I'm not sure that-- I'm just

trying to recall what that discussion was about and, again, I think it was more about the public announcement. I think the date was agreed, but it was more about the public engagement and particularly with staff. I think that we were probably wanting to engage with staff, and we were being required to wait a bit longer.

Q Thank you. If I could just ask you to look towards the final minute that I want to take you to of the Oversight Board. That is in bundle 3, page 1,496. So, bundle 3, page 1,496, which is a minute of the Oversight Board of 8 April 2021.

THE CHAIR: Thank you.

MR MACGREGOR: If we look to point 2, which is "NSS Action Log Closeout," do you see that?

A Yes.

Q And 2.1 states:

"The circulated action log spreadsheet from Ronnie Henderson, Commissioning Manager – Hard FM, NHS Lothian, showing all actions now closed following discussions and correspondence with Ian Storrar was accepted.

Do you see that?

A I do.

Q So by this point in time, effectively, the Oversight Board has been set up with a specific task of taking all issues with the hospital and resolving them. By this point, 8 April 2021, had all of that work now been completed?

A Yes.

Q Then we see point 3 in the minute is the closing of the Oversight Board, 3.1:

> "The Oversight Board referred to the originally agreed Terms of Reference for the group and accepted that it was now clear that the point of completion had been reached."

Do you see that?

A I do.

Q So by this point in time, successful completion of everything that had been on the Oversight Board agenda. In relation to what became Settlement Agreement 2, I think you mentioned in both your statement and in your evidence that that IHSL remains in place, but it was not Multiplex that ultimately ended up taking the works that were set out under Settlement Agreement 2. Is that correct?

A That's right.

Q Within the period of time from the original IOM testing, so just before the hospital was originally due to open, were there discussions that took place with Multiplex in terms of whether it would be able to provide solutions or rectification works to achieve what NHS Lothian wanted now, namely positive pressure or ten air changes per hour?

A There were discussions. I can't recall whether those were with-- between IHSL and Multiplex only, or whether we were in the room. We were certainly in the room with Multiplex at different points after the IOM report, but I just can't recall whether we were in the room, or it was a two-way discussion.

Q Thank you. Perhaps it might be helpful just to refresh your memory to look at some of the contemporaneous documents----

A Yes.

Q -- in relation to these matters. So, if we could look to bundle 7, volume 1, please, and to page 101. Bundle 7, volume 1, page 101. An email from Brian Currie to Matthew Templeton, copying in a range of people including yourself, and then it is really the email, approximately halfway down the page, beginning-- it is Mr Templeton beginning, "Brian, I

understand arrangements." Do you see that?

A Yes.

Q So it says:

"Brian, I understand arrangements are in place for the design workshop tomorrow with both IHSL and Multiplex attending, which is good.

Can we please allocate some time following the design meeting to discuss and agree the basis upon which we're progressing? In the circumstances we agree it's important we commence the design process immediately and without delay, however, it is equally important that we understand what is being requested of IHSL and their sub-contractors."

Do you see that?

A Yes.

Q So, at the point IOM have done their testing and identified potential problems, in the immediate aftermath, do we see that there is some form of engagement here from IHSL and Multiplex?

A There was, yes.

Q Again, we will come on and look at the details, but can you remember exactly what was being discussed at this point in time?

A Well, at this point in time, I mean, Multiplex were, as the contractor and the designers, they had all the information on the specification for ventilation, so they at that point, they had to be in the room in terms of the discussion on what could be done to rectify the ventilation. So, those were technical workshops. I suppose just previously, when I talked about Multiplex, whether we were in the room with them, I was more thinking about the commercial discussions, but in the technical workshops, yes, Multiplex were there.

Q Thank you. Because if we look on to bundle 7, volume 1, to page 311, you see that there is a minute of a meeting on 11 July 2019, range of individuals attending, including yourself. Then if we look over the page onto page 312, you see at 2.3 there is a heading, "Critical Care Design." Do you see that?

A Yes.

Q And, again, it stated:

"Brian Currie curry advised that he had met on Tuesday with multiplex managers and done a

tour of the area where the following options had emerged: -

- Increase capacity of air handling unit to deliver 10 air changes per hour
- Find a room to install an additional unit
- [and thirdly] Identify external space to put in a larger air handling unit."

Do you see that?

A I do.

Q So, discussions with Multiplex being involved in relation to whether there could be changes made to the system. Do you recall the discussions, if any, taking place with ISHL and Multiplex at this time, though in relation to the commercial side? So, it looks like on the technical side there is engagement from both ISHL and Multiplex in terms of trying to help with the technical solution. Do you remember discussions around about the commercial side as to how, if there is going to be rectification works, how they would be done and who would pay for them?

A To be honest, I mean, I do remember the discussions about how the work was going to be delivered, but I would struggle to recall at what point-- I'm sorry, we started

that discussion because the first priority was identifying a technical solution. So, there was a huge focus on how would this be resolved, and that was the first priority but there certainly were discussions about the commercial arrangements. I just would struggle to know exactly when those started.

Q It is a long time ago and it is not a memory test. So, perhaps, if I could just ask you to look to bundle 7, volume 2, and to page 176. So, bundle 7, volume 2, page 176, and it is the email from Matthew Templeton to yourself on 31 July 2019. Do you see that?

A Yes.

THE CHAIR: Thank you.

MR MACGREGOR: And if we could perhaps just look to the second full paragraph beginning, "IHSL and their supply-chain." Do you see that?

A Yes.

Q Which says:

"IHSL and their supply-chain require a clear and clean instruction from NHSL to proceed with the required amendments to the Critical Care ventilation, backed up by an obligation on NHSL to pay for the design, installation and any additional FM/lifestyle costs. Furthermore,

the IHSL parties do not wish to proceed with any amendments to the critical care ventilation where NHSL are reserving their rights in respect of any alleged breach of the PA/SA with respect to critical care ventilation as signed off by the Independent Tester."

Do you see that?

A Yes.

Q So, just in terms of the commercial side, what is being communicated to you here from the IHSL, Multiplex side?

A So, IHSL were prepared-- were working very closely with us to get a solution to the critical care the rectification works to critical care but as I understand it, roundabout at some point during this time period, Multiplex made it clear that they would-- some of their-- I can't remember the terminology but they would-- if there was any future problems with the ventilation, then there would be no comeback against them. So, they were already starting to identify their commercial position at this point, and I think it's probably around about this point that it became clearer that getting Multiplex through the works was going to be difficult because of their commercial requirements.

Q Again just thinking back to the discussion that we had earlier today about the whole model here, is this what you mean by some of the difficulties, that your relationship is with IHSL, but you have their subcontractor that's actually done the physical works. You need to engage with them, but you do not have any direct contractual relationship with them?

A That's right, yes.

Q And, again, some of the difficulties perhaps on the Multiplex side-- that they are saying, "We are nervous about altering this contract because there is a whole web of other contracts that that could have implications for."

A Yes.

Q Thank you, and if we could just look on bundle 7, volume 3, to page 308. So, bundle 7, volume 3, page 308.

THE CHAIR: Thank you.

MR MACGREGOR: Bundle 7, volume 3, page 308, and it is to the email from Margaret Kinnes to yourself, Brian Currie and various others. So, we are now on 22 August 2019. You see that email states, "Revised draft LOI…"-- Is that letter of intent?

A Letter of intent, yes.

Q

"… and a draft Contractor

collateral warranty now issued to IHSL and MPX legal advisors, to reflect discussion yesterday. Please see attached."

Do you see that?

A I do.

Q So, certainly by this point, it would seem that there has been some engagement, at least so that there could be a letter of intent and collateral warranties being drafted. Is that on the basis that you are still anticipating that IHSL and Multiplex would potentially do the works?

A Yes, it must be.

Q But there came a point where those negotiations broke down. I think you had mentioned that there were contractual difficulties perhaps, or other commercial positions, that simply meant that there wasn't a resolution that could be agreed.

A That's right.

Q And, again, just for completeness and perhaps for the Chair's benefit, if we could look to bundle 7, volume 3, to page 326. Bundle 7, volume 3, page 326. This is an email on 30 August 2019 from Matthew Templeton to Stephen Gordon and other people, and it is discussing a-- what is headed up, "Call with Susan Goldsmith." Do you see that?

A I do.

Q There is no formal minutes of that call. So it is just to see whether what is recorded in the IHSL, Multiplex side accords with your own views. So, you will see that there is the points 1, 2, 3. If we could perhaps just pick matters up just above that. So, in relation to the telephone call, Mr Templeton says:

"Susan provided the following rationale for the NHSL decision which has been ratified by the Oversight Board and Christine McLaughlin was due to be briefing the cabinet secretary:

1. NHSL consider there to be poor engagement from the designers TUV SUD. There is clearly a clash between TUV SUD and NHSL's project team and indeed Brian Currie has been requesting for weeks that MPX consider an alternative designer."

Do you see that?

A I do.

Q Again, is that your understanding, thinking back of all the types of discussion you were having with Mr Templeton?

A I do recall that Multiplex were very very commercial and made this difficult, and I know there was

issues with the designer. It was-- I do recall it was a very difficult time because there was clearly a pressing need to get on with this.

Q And then if we look to point three, it says:

"NHSL has a lack of confidence MPX will resolve the IOM ventilation issues."

Do you see that?

A Yes.

Q Do you remember having a discussion like that with Mr Templeton?

A I do, yes.

Q So, should the Inquiry understand that really by the summer of 2019, NHSL is at a point that it has really lost confidence in Multiplex's ability to rectify matters?

A Yes. I mean, at the start of this when we had the IOM report, Multiplex did engage quite positively about resolving issues but by the time we had reached the end of the summer, then the relationship was becoming quite fraught again.

Q Thank you, and then if we just look towards the end of that email, just a penultimate paragraph, Mr Templeton says:

"I briefed Ben Keenan on the above and MPX are considering, although he stated it was highly unlikely MPX will participate in critical care given no waiver is being provided."

Do you see that?

A I do.

Q And again, is that back to the discussion we had a moment ago whereby you indicated that Multiplex took a particular commercial position and if there was not going to simply be a waiver of rights by NHS Lothian, they were unlikely to engage further?

A Absolutely, and clearly for the Board, again, it goes back to the point that this is a contract over many years. To be able to give a waiver in an area such as critical care was just-- it was not going to be-- you could not take that kind of risk.

Q We have obviously looked at the Oversight Board minute that recorded the discussion in relation to the fact that that creates quite a difficult situation on a revenue-funded project, but you still have the Project Company in place but their contractor is not going to take place in any of the rectification works, and that can have significant financial consequences. If we look on to bundle 13, please, volume 9, to page 335. Bundle 13, volume 9, page 335 is a letter from IHS Lothian Limited to you, dated 26 November 2019.

THE CHAIR: Thank you.

MR MACGREGOR: If I could ask you to just look over the page, please, on to page 336, and to the bullet point at the top which states:

> "With the endorsement of IHSL's proposal to self-deliver and appoint a third party (Imtech), NHSL accepts that the nature of the relationship with Imtech is via a standard construction industry form of contract. We previously agreed that given the nature and scale of the works, limited market interest and challenging programme aspirations, it would not be possible to impose 'PPP/NPD risks' on a third -party contractor. Consequently, we require NHSL to accept that Imtech's liabilities would be limited to standard NEC provisions and cannot, for instance, extend to the flow-down of Deductions from the Project Agreement."

Do you see that?

A I do.

Q And, again, can you just explain, perhaps in your own words, what has happened by this point? What is been communicated to you in this letter?

A So, through an NPD,

you've clearly got a very clear establishment of where roles and responsibilities are. Multiplex, as the contractor, would have a series of warranties that would be held by, I suppose, IHSL and Multiplex. In this case, effectively, we would be employing the new contractor-- or IHSL would be employing the new contractor with the contract not tied in to the Project Agreement. Sorry, it's a while since I've talked about this.

So, they're not part of that NPD supply chain. They sit to the side with a different type of contract, and so their obligations would not be over the longer period of the NPD. It would be for a set period of time. So, it was just-- it was a different-- it hadn't been done before, bringing in a separate contractor, and so this was quite unusual and there was a significant amount of discussion about this but certainly, from the Board's perspective, there was a confidence in the contractor. So we were happy to go with this, provided it didn't dilute IHSL's responsibilities and the risk profile in the Project Agreement.

Q It does not alter the risk profile technically in the Project Agreement but perhaps alters the overall risk profile of the project. Would that be correct?

A Yes, it does.

Q Thank you. Lord Brodie, there is only one further sort of chapter of evidence I really want to cover off with Ms Goldsmith, and it is really to look at the Grant Thornton report and any reflections that she has. I would not be confident of finishing that in the next 10 minutes. So that is just before one o'clock. It might be an appropriate point to break.

THE CHAIR: Perhaps take our break there. Could you be back for two o'clock?

A Two o'clock, yes.

Q Thank you. All right. I will take our lunch break.

(Adjourned for a short time)

THE CHAIR: Good afternoon, Ms Goldsmith.

THE WITNESS: Good afternoon, Lord Brodie.

THE CHAIR: Mr MacGregor?

MR MACGREGOR: Thank you, Lord Brodie. Ms Goldsmith, before lunch, we were looking at some Oversight Board minutes. There is just one more minute I would like you to look at, please. It is in bundle 3 at page 87, which is an Oversight Board minute from 22 August 2019, and if I could just ask you to look on, please, to page 89 and paragraph 4.2.12----

THE CHAIR: Thank you very much.

MR MACGREGOR: -- which says:

> "Consideration was given to potential criticism for agreeing to the waiver but this was felt to be a reasonable step to allow the timeline to progress. Mrs Goldsmith stated that she was confident and comfortable that the decision to agree to the Multiplex waiver would be in the best interest of the public purse and patient safety. There was a good ongoing relationship with the funders and IHSL had briefed the funders about the works."

Do you see that?

A I do.

Q So, I think before lunch we were discussing the fact that there was the possibility of a waiver being granted. It was not ultimately granted and Multiplex did not take forward the works, but at one point, did you think a waiver was the right course of action?

A I clearly did, judging by the minute. Although I must admit, I don't recall that. I think the context would have been the need to get the hospital opened, and I also mentioned earlier in the day that we had

established a very good relationship with both M&G in particular and the European Investment Bank, and I did, throughout all of the complexities of the dispute and then the subsequent Settlement Agreement, feel that we had a positive relationship that they were very committed to not only the hospital being built and open, but they both wanted to have a long-term relationship over the subsequent number of years as the hospital, you know, when it was a live environment. That was different from-- Lothian had a PFI, the Royal Infirmary, and there were something like 11 funders and it was just impossible to have a relationship. But certainly with the funders of IHSL, I felt that they had the public's interest, patients' interests at their heart. I mean, clearly they had financial, you know, at the end of the day if the money doesn't work-- but they were very supportive and that's clearly why I felt it was a good idea, but my guess is that it was before we spoke to lawyers or legal advisors.

Q I was just going to ask that: can you recall why your views changed on the waivers?

A It would have been legal advice.

Q Legal advice.

A Our legal advisors were

very crystal clear about ensuring that there was no transfer of risk on the back of the need to get on with the works.

Q Thank you. Before lunch, you also mentioned in your evidence your recollection that the Scottish Government effectively said to NHS Lothian that the hospital had to comply with published guidance. Did you agree with the Scottish Government view that the new-build hospital should be complying with best practice guidance?

A Yes, I did. The Board had thought it was getting a hospital that would comply with current guidance and best practice.

Q Thank you, and then just finally in relation to these miscellaneous issues, in relation to Settlement Agreement 1, we have talked a lot about the multi-bed rooms which were included within Settlement Agreement 1. Can you recall why single bed rooms were included within Settlement Agreement 1?

A I think, and I don't recollect clear-- crystal-- with crystal clarity, I think it was because there was a request to derogate from six air changes to four-- six mechanical air changes to four mechanical and two natural.

Q Thank you. The next set of questions I want to ask you about, they are not really specific about the nuts and bolts of the project. It is really more about reflections and what happens after the project. So if I could ask you, please, to have the Grant Thornton report in front of you. That is bundle 10, page 4, please, and can you just explain to the Inquiry what was the Grant Thornton report, why was it instructed and what was its purpose?

A It was instructed so that the Board itself could learn the lessons from the capital project on Sick Children's and the Department of Clinical Neurosciences. There had been an audit commissioned by KPMG not long after we had identified the issue in critical care and that audit was produced for Scottish Government. So it was-- they were the commissioner of the report and the client, so to speak, and the Board considered that it was important that they had their own independent internal audit to look at what lessons might be learned, but also to try and identify how this had happened but, equally, what lessons we could learn as a Board around our systems of control on major capital projects.

Q Thank you, and if we look on to page 9 and look to paragraph 33, please. Paragraph 33 states:

> "Our review identified a collective failure from the parties involved. It is not possible to identify one single event which resulted in the errors as there were several contributing events."

Do you see that?

A I do.

Q Was that your own personal view that this was just collective failure through the project?

A Yes, I suppose I-- until we had this audit, you know, I wasn't absolutely certain why the critical care element had been missed. There was one version of the Environmental Matrix which had been changed to isolation rooms rather than critical care, and I wondered whether that had been deliberate and just missed, but clearly there was other opportunities through the project to pick up the issue with critical care and so until we had this audit report, I wasn't entirely certain what had gone wrong. So the report was really helpful in that regard that we had, you know, everyone had missed it.

Q So, from your perspective, there is not one single individual or entity that has one

catastrophic failure; it is a collective responsibility and collective failure over the whole project?

A Yes. So, I think it was an error that was-- became sort of embedded in the project, and there were obviously a number of opportunities where we could have picked it up or individuals could have, you know-- I mentioned earlier that I was surprised that the independent tester didn't pick it up. Clearly our advisors didn't pick it up either. So yes, there were opportunities, but it was a failure by us all.

Q Thank you, and if we could look on, still within the Grant Thornton report, to page 39, please, you will see that there is a set of recommendations made.

A Yes.

Q And there is also a management response at the bottom. During your time working within NHS Lothian, were you involved in considering the recommendations made and the management response to the Grant Thornton report?

A Yes, I mean, there was-- with all internal audit reports, there is dialogue between the internal auditors and the clients, so to speak, on ensuring that the recommendations are appropriate and implementable,

and so I had been involved in the discussions. This was a really complex audit that took Grant Thornton months and months to complete because they had to go back such a long way in time and looking at multiple documents. So I was heavily involved through, you know, in liaising with the lead auditor for Grant Thornton and discussing the recommendations.

Q And did NHS Lothian accept the recommendations made by Grant Thornton and seek to implement them?

A Yes, they did.

Q And was that process still ongoing in the period up to your retirement?

A It was, because actually, although when you see them black and white it seems quite simple, the recommendations were that the work that had to be done to respond to the recommendation and to improve our systems of control was complex, a big piece of work. The time scale was completely ambitious, and actually we didn't manage to deliver it to 2020 because we required to have engagement with staff, with clinicians and as you'll recall, this was during the pandemic----

Q Yes.

A -- so we weren't able to engage with some of the key stakeholders to develop our management response, and the other element that influenced how we developed our response and the changes to our system control was the establishment of NHS Assure.

However, we had set up a working group with key individuals from my team and other teams who worked through each of the recommendations. For example, in our scheme of delegation, we had already set the roles of, as it says here, the SRO, the project director. So we'd already done during my time-- And as capital projects developed, we would update our systems, update the scheme of delegation.

That was something that happened regularly, so when I left we had already done some work on the framework of assurance, so the broader document that set out the whole process of capital and how the Board would get assurance at different stages and what they required to get assurance on. So that work had-- We'd really got to the first stage of that, and then as I was leaving that was about to be tested with some either live or projects that we'd completed, to test what would they

have done differently if this framework had been in place, and there was also dialogue with NHS Assure.

Q So if we look at the first recommendation – and I am just reading from three lines down in the main box – the problem identified by Grant Thornton was:

> "Responsibility for decision-making on the RHCYP project was not always clear and there was potentially less of a distinction between management and assurance."

That is the problem. And then we see the management response in the bottom box, which says that there are already quite reasonable procedures in terms of demarcating (senior responsible officer, project director) but the innovation is the third paragraph: "a framework for decision making to be developed for capital projects."

Could you just explain in your own words-- We do not need to look at the detail of that, but in broad terms, if you already had the scheme of delegation, the role of senior responsible officer, what was the framework trying to do?

A So there are many stages in a capital project and we've obviously covered some of them through the course of the hearing, so

there's a-- I've probably got the terminology wrong because things will have changed, but there used to be an initial agreement phase. So, you had almost a request to consider a project. That now has a strategic context sitting in front it and that strategic context has to cover certain areas, so for example within that you would want to be able to give the Board assurance. So, there'd be a decision about the project and there'd be a decision about the options that had to be considered to deliver the Board's strategic direction or strategy.

So at that stage, you want to be clear about how you've made a decision on the option that you're going to pursue and you need to be clear about what decision you've made, how the decision sits with the Board's strategy, so you want to evidence that for the Board. So the Board-- You'd probably just need some clarity on that.

Now, I think that clarity was already there at that stage. I think as you get further into the project, areas like derogations, for example-- Now, that's a management decision, but the Board would want to be clear about the process of derogations, and you would want to take something to the Committee to evidence what

derogations had been agreed, potentially – some of them were minor and you wouldn't want to flag them – and you would want to evidence how you'd reached that decision and what kind of advice had been received. So that's an example.

Q Thank you, and I think that possibly also deals, if we look over the page onto page 40-- Again, I will just paraphrase the box at the top, but it said one of the recommendations was that it was not always clear, based on the project documentation, what decisions were being made when and by who and how these were shared with the SRO through the Project Board or Project Steering Group; and again, the management response seems to be:

> "A process for agreeing and documenting technical changes/derogations is currently being developed by all capital projects."

Again, is that part of the same framework that you've just talked about?

A It is, yes.

Q Thank you. Then if we look over the page on to page 41, just above the bullet points, the problem identified is a framework for clinical engagement not really being in place.

And again, do we see the management response, really, that this is where the centre for expertise is going to come in in NHS Lothian's view?

A Well, the Boards themselves will have to have a framework for clinical engagement, and I'm now speaking not being there, but NHS Assure employ some clinicians, but it's the boards that employ the clinicians largely; so the boards will also have to have some framework or some explicit set of rules or standards for using or for asking clinicians to participate in capital projects with clarity about why they're there, what their role is, what their responsibility, what their accountability is for, and clearly clinical time is quite precious. So at what point do you need clinicians and at what point are you relying on-- For example, if there's more standardisation of guidance, then you don't need clinicians to give advice on pressure regime, for example, because it's mandated, so boards will still require some kind of framework for clinical engagement.

Q Thank you. Then if we look over the page onto page 42, one of the issues identified is that the legal advisers tended to give advice that

was very formal in nature, captured either through reports or formal email correspondence, and that was not necessarily something that was done for other disciplines; and we see the management response there that it is fully accepted that there requires to be more clarity of the role of advisers and their responsibilities at each stage of a capital project. Can you just explain, in your own words, what did NHS Lothian do to try to put in place that process and procedure?

A There is a sort of industry standard, as I recall, on use of advisers. When I left, we did actually take a paper that set out the roles of advisers and when you were seeking advice, the situations in which you would be seeking advice, and the difference between that and formal professional advice. I can't recall what it was called, but we did work with our partners in industry to pull together a framework that described the role of technical advisers.

Q Thank you. And then over the page onto page 43, we see the recommendation at the top:

> "In the case of the RHCYP project although the project board (and then the project steering board) had an agreed term of reference, this was not clear

about who should attend, for what purpose and how this particular board was to support decision making."

Then the management response is effectively that there was an acknowledgement that there needed to be a gap analysis of membership skills and experience for the Strategic Project and Programme Boards. Is that correct?

A Yes.

Q And what, at a practical level, did NHS Lothian do to try to address that issue?

A I think that-- To be honest, I can't completely recall. One of the challenges, though, is the NHS is a big complex organisation with multiple stakeholders, so one of the issues that we were considering is – and we've tried different models – do you have a very small project board with limited attendance and a much wider stakeholder group? So that model had been tried previously, but then because of the need to have specific roles and responsibilities and some accountability for decision making, project boards were then expanded again. So it's quite a different-- difficult model to get right, but the Board were certainly revisiting that and I don't know what conclusion

they reached because I think that would probably be after I left.

Q Thank you, and then just finally on to page 44. The recommendation is essentially that the roles and responsibilities were not necessarily always clearly understood on the project. Was the management response, again, back to the framework that we've talked about previously or was it a different management response from NHS Lothian?

A Sorry, what was the----

Q Sorry, I was paraphrasing, but if we look at, on page 44, the second full paragraph, just the one above the bullet point, it says:

"Based on our review of documentation the respective roles and responsibilities were not always clearly understood, by all parties in the project."

That was the problem identified.

A I suppose this recommendation is different because the previous one relates to the NHS Lothian employees and those that are going to be identified as being responsible or having a role in a project and some responsibility. This recommendation was in relation to other public sector bodies, so being

clear about the role of SFT and the role of the Board and the role of government in a project, and it might differ from project to project. So if it's an NPD or a variation of NPD, then the roles and responsibilities are slightly different from a capital. Maybe not a great deal, but they're certainly nuanced.

Q Thank you and then if I could ask you to look on to bundle 13, volume 11, please, at page 93. I think you mentioned in your evidence that there was the Grant Thornton report, effectively the high-level response we see captured in the report itself; and then you thought perhaps towards the period when you were coming towards retirement, there was almost a trial run of some of these procedures on a new planned project.

A Yes.

Q So what we should see at bundle 13, volume 11 is a paper for the Finance and Resources Committee from 20 April 2022. Do you see that?

A I do.

Q And then if we look to paragraph 3.1, it says that:

> "An overall assurance framework has been developed previously, providing a comprehensive approach to assurance and Capital Projects together with key suggestions as to how assurance can be sought. From this a draft checklist has been developed detailing milestones throughout the whole of the project life cycle and the suggested evidence to provide quality assurance."

Do you see that?

A I do.

Q So is that is that the framework that you just talked about that had been developed and was being developed?

A Yes, it is.

Q And then if we look over the page onto page 94-- Again, I will not take you through each of them, but you will see for each of the recommendations that we have just looked at, the recommendation from the Grant Thornton report is set out, and then there are further details of the response and the policies and procedures that have been put in place by NHS Lothian. Is that correct?

A That's correct.

Q And that had been developed and was still being developed in the period up to your retirement. Is that correct?

A That's right, because I suppose Financial Resources is the

committee that oversaw the capital projects, but all of this had to go to the Board's Audit Committee, because at the end of the day, the internal audit was commissioned by the Audit Committee, and the Audit Committee would need to be satisfied that what we were proposing met their criteria for assurance.

Q Thank you. The final issue that I just wish to ask you a few questions about today is really on some more of your reflections in relation to the project and specifically how these potential projects could be done better in the future. So, we have already covered quite a lot in your statement and also in your evidence today. You said that you really think that the NPD model is very challenging and perhaps not the right model for these types of projects. Is that correct?

A Yes, I do.

Q What are your views on the procurement model that is used for these types of projects? Do you think the procurement model as opposed to the contract structure is fit for purpose?

A I suppose the first thing to say is that there have been a number of capital projects developed well, and there's a lot of good hospitals

that have been delivered, and the Sick Kids itself is-- I don't mean this in an offensive way, but the hospital has been delivered and it's a fabulous facility, albeit there were significant challenges in arriving at its delivery. But in my experience, one of the best projects that, in terms of experience of delivering it, was when the contract was with-- And I can't recall the type of contract it was, but where there is more of a partnership between the procuring body and the contractor and their supply chain, something that allows a bit more flexibility.

I think that is when it's worked best, is that the contract reflects a partnership rather than a black and white, "This is what's to be delivered and no variations." So I think if-- and there are obviously contract structures and that's what I'm struggling to remember the name of it because we have used it in the past, where you do actually have that kind of flexibility and there's more of a shared risk between the public sector and the private sector.

Q Thank you. If I could just ask you to look at one page from the Target Operating Model for the new Centre of Excellence, NHS Scotland Assure, and if we could just look to bundle 9, and to page 59. So, bundle

9, page 59. You see that at the very bottom there, there is the box for procurement. Do you see that?

A Yes.

Q So, what was identified within the Target Operating Model for the new Centre for Excellence was that the:

> "Current procurement processes are not fit for purpose."

Do you see that?

A I do.

Q Would you agree with that from the evidence that you have given today?

A It's quite a broad statement and so there are-- I'd go back to the point I made just earlier, that we have used other forms of contract that have successfully delivered capital projects without the difficulties that we faced on the Sick Kids. So, I think that's quite a broad statement, so I'm not sure about that.

Q Perhaps if you just help me with one further question. Given that it seems to have been identified here in the Target Operating Model for the new Centre for Excellence, in the period up to your retirement, were you aware of any significant changes that were made to the procurement models for these types of projects?

A No.

Q I think within your statement you touch upon the issue of guidance.

A Yes.

Q And again, a lot of what the Inquiry is talking about in dealing with is guidance; it is not a hard-edged legal standard that must absolutely in all circumstances be complied with.

A Yes.

Q The Inquiry has heard evidence that the guidance in SHTM 03-01, certainly the 2014 version, there were a variety of interpretations. IOM obviously had one particular interpretation; TUV SUD another interpretation.

A Yes.

Q Just as someone who has worked on that type of project, how difficult and frustrating is it to have guidance that is open to so many different interpretations?

A Yes. Well, it's very frustrating and clearly it's not-- you know, it's not a positive thing to have it as open and variable as that. It does reflect, I think, a different era when actually, there was more flexibilities around the clinic-- we discussed earlier, you know, that relationship between the built environment and infection control. I mean, that's just

one element, but I think the guidance reflects an era where there was more ability, or greater ability, for clinicians to influence how buildings were.

Q And as someone who has worked on these types of projects, particularly from the commercial side----

A Yes.

Q -- would it be much simpler if there was simply for new buildings – I am not talking about refurbishing the old estate, but for new buildings – if there was simply a base-level, set, minimum standard, legal standard that had to be met for things like ventilation systems, water systems, all the critical building systems, so that a health board knew that is the bare minimum that has to be met? Would that be an improvement?

A Yes. I mean, I think that-- I think all of us who've been involved in this would say that guidance, some of the guidance, should be mandated and there can't be that much variation between acute hospitals across Scotland and the UK. We're all delivering the same kind of healthcare and so that definitely-- because it does create ambiguity, and is it guidance or is it not guidance, and so I think there certainly should be a set of criteria or standards that are mandated, and

others where you've perhaps got a bit more flexibility to reflect local circumstances.

Q Thank you very much. I think the final question – we have obviously covered a lot of ground both in the statement and in your evidence today and previously at the Inquiry hearings – it was just really to ask you an open question at the end. You have obviously had a lot of time to reflect on this project.

A Yes.

Q Is there anything else that we have not covered today that you think, in terms of improvements for the future, in terms of how these projects could be done better in the future?

A I think that the Health Service needs to invest in-- well, it needs to invest in a lot but there's no money. But I think as we understand the built environment better, we do need access to broader skills, technical skills, than we've had, you know, over recent past. I hadn't really appreciated how complex-- you know, Sick Kids I have obviously had to get much closer to some of the technical requirements. So, there is a risk, though, that with NHS Assure, you have NHS Assure with advisers, and the Boards with advisers. And so, I

think there, I would support the fact that we need more technical access to more technical resource but what we can't have is different bodies employing technical advisers who then have got the risk of saying different things. So, I think any investment in technical support, additional technical support, needs to be aligned with clarity on roles and responsibilities and not duplication.

The other thing that I have learned, particularly through the Sick Kids, is the importance of good project management. The NHS tends not to train people in project management, or if it does, it's quite *ad hoc*. We brought somebody in from the private sector to be the project director, and I must admit I personally learned a huge amount around the skills that a project director, or project manager, has and their focus on the project, almost to the expense of everything else, and actually that's a real skill because the NHS is so operational and it's quite difficult not to be distracted by what's going on operationally, but a good project director and project management skills can make a huge difference to the success, or otherwise, of a project.

I guess the other thing is just the thing that we probably didn't do

enough of is the learning from projects. There is a post-project evaluation that's supposed to take place with every project, but you need to resource that because it can't just be done-- it can't be done without people doing it and talking to the users. So, I think we all agreed within Lothian that that's something we needed to be better at, is to learn the lessons from projects that we delivered.

Q Thank you. Ms Goldsmith, thank you for answering my questions. I don't have any further questions at the moment.

A Okay.

Q Lord Brodie may have questions or there may be applications from core participants.

A Okay, thank you.

Questioned by THE CHAIR

Q Mrs Goldsmith, on one or two points, or at one or two points in your evidence, I think looking to your previous experience, you talked about the concept of greater flexibility. Could you just maybe tease that out a little bit for me?

A It's more about the dialogue, I guess, that is enabled in delivering a project. The NPD was-- we came up with our Board

construction requirements, the contractor designed, or IHSL with the supply chain designed, and then it was all fixed into a contract. I really meant that buildings are so complex and the delivery of them are so complex and the circumstances for each hospital will be different, so in terms of the site that they're being built on, it was more just, if we had a contract that allowed more dialogue through the process of building, I think that would be helpful.

Q All right, thank you. Mr MacGregor has indicated he has no more questions. What I need to do is find out from the other people in the room whether they have more questions, so if you could maybe give us another 10 minutes or so and retire to the witness room, and in that 10 minutes we will find out if there are any questions from any other sources.

(Short break)

THE CHAIR: I understand we have just one more question. Mr MacGregor.

MR MACGREGOR: Just one question, and it is really relating to Settlement Agreement 2 and High Value Change Notice 107. Can you remember why single bedrooms in critical care were included within those

documents?

A This is Settlement Agreement----

Q 2 and High Value Change Notice 107.

A Because they didn't meet-- I think it was because they didn't meet the standard. They didn't meet the 10 air changes.

Q Thank you.

A That would be why they would be in the Settlement Agreement.

Q Thank you. I do not have any further questions.

A Okay.

THE CHAIR: Thank you, Mr MacGregor.

A Thank you.

Q Now, you're now free to go, Ms Goldsmith, for I think the third----

THE WITNESS: Third time.

Q -- time. Thank you very much for this attendance. Thank you again for your previous attendances. But can I thank you especially for the enormous amount of work that-- preparing statements for the Inquiry will have involved you looking at documents, researching questions. I found your contribution to the Inquiry very helpful, and I am very grateful for it and perhaps you will not be offended if I say I trust we will not be seeing

each other again in this particular forum. That certainly is the plan, but you are free to go with my thanks. Thank you.

THE WITNESS: Thank you very much, Lord Brodie. Thank you.

(The witness withdrew)

THE CHAIR: Mr MacGregor.

MR MACGREGOR: The next witness is Matthew Templeton, my Lord.

THE CHAIR: Matthew Templeton. Good afternoon, Mr Templeton. I appreciate you have been here probably for a couple of hours now. We try and predict when witnesses will be taken, but it is not always possible to be exact, but I appreciate you have probably been here for some time. Now, you are about to be asked questions by Mr MacGregor, who is sitting opposite but first of all, I understand you are prepared to take the oath.

THE WITNESS: Yes.

Mr Mathew Templeton

Sworn

THE CHAIR: Thank you, Mr Templeton. Mr MacGregor.

Questioned by Mr MacGregor

Q You are Matthew Templeton. Is that right?

A Yes.

Q And you have provided a witness statement to the Inquiry?

A Yes.

Q For the benefit of core participants, that is available at pages 208 to 260 of bundle 3----

THE CHAIR: Thanks very much.

MR MACGREGOR: -- of the witness statements.

THE CHAIR: Thank you.

MR MACGREGOR: Mr Templeton, the content of your statement will form part of your evidence to the Inquiry. You are also going to be asked some questions by me today. If you want to refer to your statement at any point, please do just let me know. If there is any documents that I want you to look at, they should come up on the screen in front of you. So, if for any reason you cannot see them, please just do let me know.

A Okay.

Q If I could just begin with your background and qualifications. Those are set out from paragraph 2 onwards of your statement, but you are a qualified engineer. Is that

correct?

A I graduated as a civil engineer, yes.

Q But you do not work as an engineer. You now work for a company called Delmore Capital?

A Correct.

Q And that is a fund management company that holds infrastructure assets to, effectively, provide returns to investors?

A Yes.

Q And Dalmore Capital invested in the Royal Hospital for Children and Young People, and the Department for Clinical Neurosciences?

A Yes.

Q And you have been a director of HIS Lothian since 15 January 2019. Is that correct?

A Yes.

Q And you still remain in that position?

A Yes.

Q But you tell us within your statement that was not your first involvement in the project. That is what I mean by, "The Royal Hospital for Children and Young People, and the Department for Clinical Neurosciences." You say you had an earlier involvement from 2018 to 2019. Can you just explain to the Inquiry

what involvement did you have 2018 to 2019 before you become a director acting for Dalmore Capital?

A Certainly. So, I've worked for a long time in infrastructure investments, and I had my consultancy business during that period, at which point, I had done some consultancy work through the NSA provider, HCP at the time, and I think the demands of the project at that point-- they were looking for additional resources to support both-- to support the Project Company. I recently had some experience of taking another children's hospital through financial close, through construction, and into operations for patients. So, it was deemed I had some recent experience that I could assist the IHSL Board in some of the ongoing issues on the project.

Q Thank you, and just to try to understand the deal structure of the project, you have got the special purpose vehicle or Project Company. That is IHS Lothian. Is that correct?

A Correct.

Q And then I think you said the NSA as well. Who or what is the NSA in this type of project?

A Yes, certainly. So, generally, the Project Company employs another company to run the

project on a day-to-day basis, that company being HCP and they report into the IHSL Board.

Q And the Inquiry has also heard evidence on the project (inaudible) had a role. What was their role in the project?

A So (inaudible) would be the FM company who would provide the hard facilities management to the project once it had achieved practical completion.

Q And what would they do at a practical level?

A So, they look after the building fabric and a lot of engineering systems such as, as we probably talked today, like the ventilation system, the water system. So they maintain the building.

Q So, in terms of the deal structure, you have got the Project Agreement, which would be between NHS Lothian and IHSL, but IHSL is really just a special purpose vehicle. It engaged Multiplex as the contractor to physically build the hospital. Is that right?

A Yes. So, I think IHS Lothian is the contracting entity opposite NHS Lothian, but IHSL enters into a number of other related contractual relationships with senior lenders, junior debt provider, Multiplex, building and design contractor, and the FM contractor. So, we bring of those under an umbrella arrangement, if you like.

Q So, if we just think of that deal structure whereby you have got the Project Agreement at the top but effectively another web of contracts and arrangements that sit below that, as you say, between the lenders, contractors, those types of entities-- Once you have entered into the Project Agreement and set the deal up, what are the difficulties and complications if you want to change aspects of the deal further down the line?

A I think, obviously, at the point of financial close, if we consider that Multiplex, the building contractor, will have fixed the price and program for their construction works. I think it's always acknowledged that on these PPP, NPD structures where the concession length is 25 years, that change will occur, particularly in a healthcare environment where the treatment changes or new technology changes. So, there is generally a change mechanism built in, which is integral to the Project Agreement to facilitate change. Although, in PFI, it can be quite clunky.

Q Because if you are going

to make some of the changes, that has implications for the debt obligations, as one example?

A It would only-- It depends. If the changes come during the operational term, then they are generally funded by the authority. In this case, it would be NHS Lothian. So, it doesn't necessarily impact the funding but as the lenders have security over the asset, then they would have to be consulted and generally require their consent.

Q And how would changes work? If you want to make a change to the Project Agreement, how does that then filter down, for example, to the relationship between IHSL and Multiplex?

A So, if it was a change during construction, then we would just pass that board change down, and during construction, Multiplex are required to develop that change. So, they would agree a price in discussion with both IHSL and NHS Lothian on the scope and price for that change, and indeed there was several changes through the construction period of the project, as there is on numerous PFIs.

Q Okay. We will come on and talk about the specifics in a moment, but you talked through the fact that these are long-term

obligations, there needs to be some flexibility in the contract structure to allow for changes. What was the particular complexity around about the project whenever one side was saying we want balanced or negative pressure for certain rooms, the other side were saying we don't agree with that, we think it has to be positive pressure. Why did it prove so difficult to try and resolve what seems a relatively simple issue?

A I suppose I would differentiate that that wasn't so much a change; it was a dispute because the parties had different opinions on the interpretation of the Board's construction requirements. So, I think at the time of the project, (a) there would be the capital cost of amending the design to meet the client's requirements but at that point, because we were past the date of the plan-- date of practical completion, then there was also the financing cost to consider as well.

Q So, does that really come back to clarity in terms of the specification? If you are absolutely clear if you are the Health Board, what you want, the obligation is then on the Project Company effectively to deliver that but there is a problem if you are not clear, and you then fall into dispute

as to exactly what the contractual requirements are. Is that, in simple terms, the difficulty that arose?

A Yes, I think that would be a fair characterisation.

Q Okay. Thank you. Just while we are talking about the deal structure, within IHSL, was there the concept of a public interest director?

A Yes. So, that is a characteristic of the NPD model, that there is a public interest director. So, in IHSL, you have the A shareholders who are the investors. So, I represent Delmore Capital as an A shareholder and there is a B shareholder who is a public interest director who is nominated by the Scottish Futures Trust but appointed to the ISL Board by NHS Lothian.

Q And the Inquiry has heard evidence-- was the whole concept behind a Public interest director to try to make sure that there was a more collaborative approach to these types of projects so that there was someone who had, effectively, a public sector interest that sat within the company itself?

A I think my understanding is that the public interest director is independent from both the NHSL and the A shareholders. The public interest director, I understand the

intent was to bring more transparency to a Project Company's operations, provide a degree of independence and maybe provide a broader view to some of the Project Company's deliberations. Within the NPD, because there are specific requirements to maximise the financial surpluses, a role or a task of the public interest director was to monitor the financial performance of the Project Company and ensure that those surpluses were generated and distributed out to a public sector body, in this case being NHS Lothian.

Q Thank you, and did the concept work well in the project?

A Yes, I think it did. I sit as a director on this and have on another NPD, and I think the public interest director role works well. We've got a good relationship with the PID director and they generally always, as we all did, endeavour to try and resolve the disputes and in this case achieve hospital opening.

Q And in terms of the project itself, the individual who took on the role of the Public interest director was an employee of Scottish Futures Trust, is that correct?

A Yes.

Q And Scottish Futures Trust, the Inquiry has also heard, was

effectively responsible for the whole NPD model and was providing guidance and support in terms of the project. Do you think there was any difficulties or conflicts in terms of SFT having the role generally to support NPD projects and a specific individual sitting as the public interest director?

A I didn't experience any such conflicts, but it's possibly worth an inquiry understanding that there has since been a change where a number of the Public interest directors were changed from SFT employees to independent parties-- sorry, not SFT employees.

Q And the Inquiry has heard that the NPD model is not taking place anymore for different reasons to do with financing. In terms of revenue-funded projects, is the model still that you would have a public interest director who is an actual director of the special purpose vehicle, or would that individual simply perhaps sit in in an advisery capacity? How are the deals structured at the moment?

A So for the existing deals, the public interest director is a director of the company with the full fiduciary duties that other directors would have of that company.

Q Okay, and in terms of future projects, do you know whether there is any innovations as to whether the individual stays as a public interest director or not, or are you simply not privy to that information?

A I don't know, sorry.

Q Thank you. I would just like to ask you some questions about the dispute that arose. So this is really, we are talking about the pressure regime in various rooms within the hospital. On one side, NHS Lothian thought it had to be balanced or negative pressure, on the other side, IHSL and Multiplex thought it really did not matter. There was nothing specified, and it was really to be positive pressure. Is that correct?

A Yes.

Q And the dispute got to a point that there was the threat of litigation made by NHS Lothian. Is that correct?

A Yes.

Q Can you just explain, in your own words from the IHSL side, the letter comes in saying, "Here is the court documentation, here is the affidavit from Janice MacKenzie, the affidavit from Graeme Greer," what is happening round about this time?

A So, I think there had been some sort of mediation meetings prior to them, maybe in four weeks prior to that, and we were making good

progress with a number of the other disputed items but I think that we weren't really making any headway on resolution of the four-bed ventilation. So, certainly we received the summons or draft summons from NHS Lothian. I think what was important at that point, it certainly escalated matters and maybe changed things slightly for IHSL was that, prior to that, both Multiplex and NHS Lothian had both consulted with mechanical and engineering designers to give opinions on their two respective positions. They both sought an opinion from senior legal counsel, so it was very much we had engineering and counsel opinion from both sides, which both supported each party's position.

I think what was salient within the court summons was the affidavit from the Health Board's clinical director, project clinical director, was really that we understood better the way in which NHS Lothian wanted to cohort-- treat patients and cohort patients, particularly in a paediatric environment, and it was also linked to, I think, resourcing around nursing. So I think it became apparent to us that this was-- NHSL were absolutely clear that they required negative balance, and it's very difficult from either a design and build contractor or IHSL to

counter a clinical opinion like that because we have no expertise in that area, and if that was a requirement of the Health Board then certainly, as I'm sure the Inquiry have seen the letters received, it was very clear that that's what NHS Lothian wanted. So we, at that point, we proposed without prejudice discussions to move forward on how we could deliver NHSL's requirements, but within the construct of a Settlement Agreement.

Q Thank you. If we just pause there for a moment. You obviously did a degree in engineering and you work as a businessman. Did you find it surprising that when you are talking about guidance, what that means that there could be such diametrically opposing interpretations of that guidance? On the one side of the debate you had DSSR offering one particular view, but on the other you had Rollason's offering a completely different view in relation to the same guidance. Did that surprise you?

A I think (inaudible) I'm a civil engineer, and we were mainly involved in pouring concrete and things, so I don't think I've ever really dealt with any systems which would be as complex as ventilation which is dealing with controlled infections. So I didn't really have an appreciation or an

understanding to be able to comment.

Q If we come back and think about the Board construction requirements, that was what really placed obligations on IHSL as the Project Company. Did you find it surprising that in relation to Board construction requirements that said things like "Comply with SHTM 03-01," that there could be such varying interpretations of what compliance with SHTM 03-01 meant?

A I think my understanding is that in the Board's construction requirements, and when you receive brief for a healthcare PFI that it will list out what the requirements are for the different clinical spaces, but then there are generally the riders at the bottom which say, "You will comply with SHTM, British Standards, Good Industry Practice." So they are more-- almost like catch-alls but you take it as the actual requirement. The design brief, if you like, is what you work from with obviously with cognisance to meeting those various other standards.

Q And whenever the court documents come in, including the affidavit from the clinical director explaining that the clinical need to cohort patients and why NHS Lothian thought really these spaces needed to have balanced or negative pressure,

on the IHSL side, did you interpret that really as a change to the brief under the contract?

A From our review at that time, yes, we did consider it to be a change.

Q And in terms of the discussions that are taking place at this point in time, obviously we will come on to talk about the Settlement Agreement, but leading up to the Settlement Agreement, are the discussions solely focused on pressure or are there discussions about pressure and other issues such as air changes per hour?

A No, I think it's fair to say it was. The pressure regime was the absolute main focus of the discussion.

Q The main focus of the discussion. So we could look through various emails where air changes per hour are also mentioned, perhaps relevant, but your understanding was really that the focal point was the pressure regimes?

A Yes. I took it that the parties were both agreed that four air changes was the correct air change rate. It was just the air was moving in the wrong direction, as in it was meant to be-- the NHSL sought it to be negative to balanced to the corridor, where at that time, the pressure

regime was positive to the corridor.

Q Okay. So from the IHSL perspective, the original brief as you understood it was four air changes per hour. So if we see references to four air changes per hour and various proposals that go backwards and forwards, that is just a continuum of what was always wanted and it is just simply being tagged on with the change to the pressure regime?

A Yes, certainly from whenever I came involved in the project, the two were always stated together.

Q And in terms of the discussions that take place, you mentioned that the principles meeting that takes place at the Sheraton, I think in the February, resolve some issues but the discussions continue. March, there is the threatened litigation, then there is the engagement and without prejudice settlement discussions that continue on. Can you just try to explain who are you dealing with on the NHS Lothian side? Who are you having the discussions with?

A Initially, it was Jim Crombie and Susan Goldsmith, and then during-- I think Jim had to take a period of absence and then it was Susan Goldsmith I would primarily deal with, but I would also engage with Ian

Graham and Brian Currie, but in the majority of the principles discussions it would be with Susan Goldsmith and Ian Graham.

Q Okay. So they are the principles that you are dealing with. Did they have any advisers that were also involved that were providing assistance?

A Yes, there was obviously their technical adviser, Mott MacDonald, but I think in most of the principle meetings, their legal adviser, MacRoberts, would be their principle adviser.

Q Thank you. So if I could just ask you to have your statement in front of you, please. So it is in bundle 3 of the witness statements, and if we could look to page 215. Up to this point, you are discussing the negotiations that lead up to Settlement Agreement 1. Just at the tail end of paragraph 33, four lines up from the bottom, you will see that you state:

> "When NHSL and IHSL entered into SA1 pursuant to the Project Agreement, IHSL and Multiplex entered into an equivalent Settlement Agreement pursuant to the Construction Contract which had been negotiated in tandem with SA1."

And then paragraph 34:

"Other parties were also involved in the discussions around SA1. NHSL's technical advisers, Mott MacDonald Limited, were heavily involved in the discussions."

Do you see that?

A Yes.

Q Could you just perhaps expand on that? What do you mean by Mott MacDonald were heavily involved in the discussions?

A Yes, I think what I'm referring to there is that-- really the development of the technical schedule. So those two workstreams: there was a development of a technical workstream which I wasn't involved with, and then there was the commercial, legal and financial which I was involved with, which primarily involved those principal discussions with Susan, Iain and MacRoberts.

Q Okay. So the discussions take place during 2018. The Inquiry has heard evidence that there comes a point where there is broad agreement, heads of terms that are agreed, albeit there is a number of other issues that need to be resolved before the overall dispute is resolved. Is that correct?

A I'm not sure I entirely follow.

Q So it is perhaps easier if I take things as (inaudible). The Settlement Agreement is signed in the February of 2019. Is that correct?

A Yes.

Q But the Inquiry has heard evidence that actually a lot of the works, certainly in relation to the ventilation system, had been completed before the document is formally signed. So I was really just trying to ascertain what happens. February 2018, you have the principles meeting, some agreement but no resolution. March, threatened litigation, and then you get to a point where there is a start of without prejudice discussions, but the agreement is not signed until 2019. What is happening in that period from March 2018 up to the agreement being signed in the February of 2019?

A Thank you. So in March, Multiplex and IHSL put forward a settlement proposal, and key to that settlement proposal was that Multiplex would accept the undertaking of what we were calling "without prejudice works" at their cost, and they progressed with that. The parties agreed with a settlement that we would all contribute towards providing the 14 four-bed rooms with the four air changes and the negative to balanced

pressure. I think that came around roughly at the end of March 2018, and I recall there was a decision that obviously because the four air changes and the negative balance is the design requirement, if you like, Multiplex then had to engage their Design team because it was obviously built at that time to provide positive pressure. So Multiplex engaged their Design team and went ahead and converted those 14 rooms from positive to negative to balanced, and I think that work was completed around late September/October.

There was other events which happened while we were negotiating both the technical schedule and what we'd classify as the front end of the Settlement Agreement where other issues arose on the project, primarily around drainage, heater batteries and void detection. So we had this when we started in the Settlement Agreement and were getting very close to finalising it, and certainly the parties were hoping to enter into the Settlement Agreement around September 2018 to enable certainly an occupation of patients prior to 31 October 2018 before winter pressures commenced. So we were certainly targeting that, but then other issues arose with respect to those three items

I mentioned which NHSL sought assurance on.

Q So the original dispute about the pressure regime, that is effectively resolved at some point by, say, summer 2018?

A Yes.

Q The works are actually physically done but there are other disputes that arise between the parties so that the formal agreement does not get signed until the February of 2019?

A Yes.

Q Okay. And whenever the agreement is signed, the Inquiry has heard evidence that, effectively, the certificate of practical completion is done at the same time, so that in simple terms the building is handed over and becomes the responsibility of NHS Lothian. Is that correct?

A I think we achieve practical completion, which is the trigger that NHSL can occupy the building, and it would be the commencement of services for the Project Company and their supplier, Bouygues.

Q Thank you. At the time that you were negotiating and signing Settlement Agreement 1, were there any discussions taking place in relation to the need to complete a process called the HAI-SCRIBE Stage 4 before

practical completion took place?

A I don't know. I wasn't aware of that.

Q You were not aware of it? It is not something that is cropping up in in discussions, not something that the principals from NHS Lothian are raising with you?

A No, I don't really know what an HAI-SCRIBE is.

Q You do not know what HAI-SCRIBE is. Is there anyone who would be on the IHSL side of the dispute that would have any knowledge or familiarity with what was required by the process I have called HAI-SCRIBE?

A Not the Stage 4 you talk about. When we do certain works in hospitals, I think it's a requirement to complete one if we were doing any amendments or changes, if we're doing construction works in an operational hospital, but I wasn't aware of there being a process as part of SA1.

Q It is just that it might be helpful just to look at a couple of documents because you might be saying, "What? Why are you raising this issue of HAI-SCRIBE with me?" but if we could look to the bundle 1, please, and to page 779. So these are the Board's construction requirements.

Do you see that?

A Okay.

Q If we could look on to page 800, please. You see that it sets out the NHS requirements in addition to the standards listed in paragraph 2.4 of this, subsection C?

> "Unless the Board has expressed elsewhere in the Board's Construction Requirements a specific and different requirement, the Facilities shall comply with but not be limited to the provisions of the NHS Requirements as the same may be amended from time to time."

Do you see that?

A Yes.

Q If we look down to letter F. Do you see that? It says HFN and SHFN. Do you see that?

A Yes.

Q SHFN is defined later within the document as Scottish Health Facilities Notes, so there has to be compliance with those unless there is a specific agreement otherwise, and if I could just ask you to look at one of the SHFNs, so that is bundle 13, volume 3, and if we could look to page 464, please. So this is probably not a document that you are familiar with or have seen before, but it is called

SHFN 30 and it's Part B of the HAI-SCRIBE. It is a document that the Inquiry has looked at before. Now, I will take you to the relevant sections of it, and it was really just to look on, please, to page 469 and to the notes section. So, effectively, to summarise what this document is, it is guidance that is issued, it is mandatory for NHS bodies to comply with it, and it sets out various procedures to try to avoid healthcare-acquired infections. One of those procedures is the HAI-SCRIBE procedure, which is four stages. Stage 4 being "needs to be complied with before the building is handed over." Okay?

A Okay.

Q And it was just to draw your attention to the notes section. You see that the note section in the box says:

> "This document can provide an insight to the key factors within the built environment which can impact on prevention and control of infection. It is an intended point of reference for healthcare estates and facility managers, designers, project managers, contractors [now, I place just some emphasis on that and I will come back to it in a minute], engineers, surveyors, health planners, and Infection Prevention and Control Teams working on healthcare estates, new build and refurbishment projects."

Do you see that?

A Yes.

Q So again, one of the concepts that comes out of the HAI-SCRIBE process is it is not really just directed at infection prevention and control professionals. Other individuals, estates personnel, contractors, etc., need to be aware of it. From what you have told me in evidence, this presumably was not something that was being discussed at all, really, in the run-up to the Settlement Agreement. Is that correct?

A No, not that I can recall.

Q So whether it should or should not have been on IHSL as a special purpose vehicle as opposed to a contractor's radar, as a matter of fact, this was not a document that was on your radar or you are considering at the point that Settlement Agreement 1 is being negotiated.

A No, it wasn't.

Q And it is not something that anyone, any of the principals on the NHSL side, are raising during the context of discussions?

A No.

Q We can put that document to one side now. The next thing I would like to ask you about is, in the period coming up towards Settlement Agreement 1, what was the financial position of IHSL that the special purpose vehicle-- Because at this point the project is already late. Presumably the funding arrangements are already in place, but until Settlement Agreement 1 is signed and the Certificate of Practical Completion gets handed over, there is no money that is actually flowing into the special purpose vehicle. So can you just explain what is happening on the financial side of the deal at this stage in time from the IHSL perspective?

A Yes, certainly. So obviously plan completion was in July 17, so there was an expectation in our model that we would start receiving unitary charge from that point, which we obviously didn't because the hospital hadn't been certified as complete. For a period, because our building contractor Multiplex had missed that completion date, they are required to pay what we call liquidated damages, which is essentially in lieu of the income we would have received from the unitary charge, which gives us sufficient cashflow to service our

senior debt obligations.

For a period, Multiplex did pay those LDs up to the point that they felt they were required to do so, or they felt it was appropriate they do so because the delay was attributable to them. When we started entering into the amendments around the four-bed ventilation, part of the settlement deal and the share of costs amongst the parties was to cover the financing associated with the elongated time to make those changes.

So I think I said earlier that the parties had agreed that we would target a Settlement Agreement in September to enable that patient "go live" date on 31 October or prior to. I think it became evident to IHSL in early September that that wasn't going to be achieved and that did create financial challenges for the Project Company, because the way it's structured is we make two senior debt payments a year, one at the end of March, which we had done in 2018, and then one again in September 2018.

So I wasn't a director of IHSL at that time, but I was certainly aware, because I was working with the board, that they had taken some professional advice and they were certainly monitoring closely the financial

accounting of the company, but also they were liaising closely with their creditors, that being the two senior lenders, so M&G and EIB. I think it's fair to say both lenders were supportive of a Settlement Agreement to resolve the disputes and achieve completion and were assured by the progress that we were making at that point. So part of the funding arrangements is that they allowed us to utilise the debt service reserve account to make that September payment.

Q And in terms of that point in time, just imagine a world where the Settlement Agreement does not get signed in the February of 2019. What financial risks, if any, would IHSL be facing at that time?

A There would be the potential risk of insolvency should we not be able to make that debt payment.

Q Was that risk because of the support you mentioned that you had from the lenders and the fact that there seemed to be goodwill on all sides? Was that a theoretical risk, late 2018, early 2019, or was that a real risk?

A It was certainly a potential risk. We did receive further payments from Multiplex in late 2018

with respect to liquidated damages but, yes, it was a potential risk. But obviously there were options available to the shareholders of IHSL, such as having further discussions with their contractor with respect to the debt on the liquidated damages or speaking to our senior lenders over any restructuring or, indeed, shareholders could have made a----

Q So should the Inquiry understand that this was effectively a known risk on both sides which perhaps applied significant focusing of minds to try to make sure that there was an agreed resolution before the payments that you have mentioned required to be made?

A Yes, I think that would be fair.

Q I would like us to look at a document, please. If we could look to bundle 13, volume 9. Would you just bear with a moment, please? Sorry, if we could go to bundle 4, please, page 9. It is bundle 4, page 9, which should be a letter from Wallace Weir to Brian Currie dated 31 January 2019. Do you see that?

A Yes.

Q And if we just look over the page onto page 10, you see that it says in bold:

"All critical ventilation

systems inspected and maintained in line with 'Scottish Health Technical Memorandum 03-01: Ventilation for healthcare premises.'

"Construction: - All ventilation systems have been designed, installed and commissioned in line with SHTM 03/01 as required, systems are maintained in such a manner which allows handover at actual completion to meet SHTM 03/01 standards.

"Operations: - All critical ventilation systems will be inspected and maintained in line with 'Scottish Health Technical Memorandum 03/01: Ventilation for healthcare premises'."

Do you see that?

A Yes.

Q Were you involved in the drafting of this letter?

A No.

Q Were you aware that it was sent in late January 2019, or was this simply a different part of the Project Company to your involvement?

A It wasn't a different part of the Project Company. I just wasn't involved in the response, although I have since, because I think there was some follow-up correspondence. So

after the fact, I learned of the letter.

Q And do you know anything in terms of the context of why it was sent, or why it was drafted in these terms?

A Yes, yes. I understood it to be related to events at the Queen Elizabeth University Hospital in Glasgow, where there had been an incident with respect to vermin in plant rooms, which had potentially contaminated the air supply going into patient areas.

Q And a letter going out saying, certainly from the IHSL perspective, their understanding was that everything within the hospital was fully compliant with the published guidance set out in the letter.

A Yes, I think-- obviously, I think the letter, the original letter from NHS Scotland was obviously aimed at operational hospitals because it was very much in the term of making sure the plant rooms were maintained in a cleanly condition and not allowing vermin, but obviously I think it was issued to the project because we were obviously very close to becoming-- to handover. So, they were simply checking that we were-- and I suppose reflecting on it, because the hospital had been complete for a number of months, we were in a position where

Multiplex were actually doing maintenance on the equipment. So, it was right that Multiplex should confirm that they were-- although they weren't a maintenance contractor, they were maintaining the ventilation equipment to the right guidelines prior to handover to (inaudible).

Q Thank you. So, we have this letter that goes out late January, Settlement Agreement 1 is signed in the February of 2019. Is that correct?

A Yes.

Q And then you will be aware, in terms of the chronology, that the IOM Limited come in and do various testing, and their analysis is that the ventilation system in particular, there are aspects of it that do not comply with the published guidance SHTM 03-01. Is that correct?

A Yes.

Q Was that analysis by IOM Limited, that it is non-compliant, was that accepted by IHSL?

A It was accepted by IHSL that it didn't meet the SHTM guidelines that they had pointed out, but we did consider it met our contract.

Q Okay. It is just that the 31 January letter, it does seem to be written in quite stark terms that there is full compliance. It does not talk about any specific derogations, does it?

A Well, sorry, I read that it's, "Installed and commissioned in line with SHTM 03-01 as required," because obviously this letter was from Brian Currie at NHS Lothian and obviously the previous year, we had agreed that there would be derogations with respect to the four-bed ventilation, with respect to the single bedrooms, and the neutropenic. So, Brian was aware-- or sorry, NHSL were aware that there was derogations from SHTM 03-01, even although we-- and we had agreed those and built those, but we hadn't actually signed the contract enforcement.

Q So, the "as required" really meant to, "Look back and think of what we've agreed in principle, albeit not documented yet within Settlement Agreement 1," which follows a few weeks later.

A Yes, it's certainly documented, but not signed and enforceable.

Q Okay, thank you. So, in the period that comes after IOM do the testing, there is then a period whereby there are negotiations to make changes that actually NHS Lothian, having said "we want balanced or negative pressure," then said, "actually, what we want is positive pressure." Can you explain from the

IHSL side what engagement is there to try to give NHSL what it now says it wants, in terms of its interpretation of compliance with the guidance?

A I think when the IOM Reports were issued, there was an element of disbelief that even after all of the disputes, and the engagement, and scrutiny prior to SA1 that, unfortunately, it was wrong. And I think because all respective teams have been through so much on what was quite a complex and challenging project, that we were all very much wanting just to work out what we needed to do to enable the hospital occupation to go ahead as planned in around mid-July 2019.

Q And was there engagement from IHSL and Multiplex to try to put forwards potential interim solutions to meet the ventilation system that was installed slightly better than it was as installed, albeit not still fully compliant with NHSL's interpretation of the guidance?

A Yes, it was actually quite-- let me just think. So, it must have been around late June that the IOM Report was issued, and I think we met on around 1 and 2 July. I think it was two days of meetings, all-party meetings. At that point, there was very good collaboration between all parties,

that I think NHS Lothian had advised us that at the existing Sick Kids hospital, there was a lesser number of rooms than what was being provided in the new hospital, so for transferring patients, they didn't need all of the rooms. That gave the opportunity to eventually close a four-bed bay, a four-bed room, and close a single bed room and effectively steal the air from there and divert it into the other single bed rooms and four-bed wards which I think would move the single bed ventilation from around four air changes up to seven, and I think the four beds were only marginal, so from four to five air changes, I think. So, that was done early that week on an instruction received from NHS Lothian to proceed with those works.

Q Thank you. So, should the Inquiry understand that, certainly from your perspective on the IHSL and Multiplex side, there was a willingness to try to make changes to improve the ventilation system, at least closer to what NHSL's preference would be?

A Yes, and sorry, I should have probably said that was very much the discussions, that was very much an interim solution because there was an acknowledgement at that point that the 10 air changes and 10 Pa of pressure would need to be achieved,

but it was just can we improve the current conditions by, in layman's terms, effectively turning up the fan speed of the air handling units to deliver more air whilst the permanent solution was implemented.

Q Okay, so just so I am understanding things, NHSL tell you that there has to be a permanent solution, 10 air changes per hour and 10 Pa of positive pressure. Is that correct?

A Yes.

Q That just simply has to be done, but if there is an interim solution that can be done, as you say, by cranking the system up so it is slightly better in the interim, there was also an instruction to do that?

A Yes, yes. It was, "Do the interim first whilst we develop the permanent solution."

Q By the time we get to say, late summer, late August, had the goodwill and negotiations involving Multiplex, had that broken down by that point in time?

A Yes. S, I think, so we certainly engaged through the rest of July and probably into August where we did have-- there was a number of technical meetings going on which I didn't attend and there was some commercial meetings as well, where I

suppose IHSL and Multiplex would set out our requirements and the Board set out their requirements, because we were seeking clarity on how would these works be implemented, the permanent solution. Because obviously although we had discussed that interim solution at the very beginning of July, there was then the announcement from the Secretary of State for Health that the migration to the new hospital going to be postponed. So, the interim solution was then never implemented, and it was just a focus on, "How do we amend the current ventilation system to meet the new requirement?" And we engaged, and then there was technical and commercial meetings to make that happen.

Q In terms of the commercial meetings, is that discussing who is going to pay for these matters?

A Yes, so it was who, yes, who was going to pay and also initially, the Health Board has said that they would instruct a Board change, they would pay for the works, but they wanted to reserve the rights. I think at that point, Multiplex are only required to deliver board changes whilst during the construction work. So, once you achieve practical completion on 22

February, there's no obligation on your building contractor to do any board change in the operational period, that would fall to your FM provider. Clearly, Multiplex had much more knowledge of the systems, and were the obvious person to go to because there was obviously a phenomenal time pressure. So, Multiplex said that they would, but they were looking for a waiver of release from NHSL, just essentially confirming that NHSL agreed that the works, as built, were in accordance with SA1 and were compliant prior to taking those works out and putting new ventilation systems in.

Q Again, the Inquiry has heard evidence that at one point in time, NHS Lothian were perhaps amenable to granting that type of waiver but their position then later changed to a point that they really were not comfortable granting that waiver. Was that that your understanding?

A Yes, certainly the waiver was offered, and we did have some legal meetings at MacRoberts and a letter of intent was issued with the waiver enclosed, but at a later date, which I can't recall when, that waiver was withdrawn.

Q So, we get to a point in

time whereby NHS Lothian is issuing letter of intent associated documentation that is on the hypothesis that there was going to be a waiver. The waiver then is not forthcoming, and is that the point, effectively, that Multiplex disengaged because from their perspective, it simply was not possible for them to move forward with that type of deal structure?

A Yes.

Q If I could just ask you to have in front of you, please, bundle 7, volume 3, page 326, which is an email from you dated 30 August 2019. Do you see that?

A Yes.

Q And it's summarising a call that had taken place with Susan Goldsmith. Do you see that?

A Yes.

Q You begin by saying:

> "I spoke with Susan last night, who provided an update of how they wish to proceed following the Oversight Board."

Do you see that?

A Yes.

Q Then if we just look to the text just above the numbers one, two, three, you say:

> "Susan provided the

following rationale for the NHSL decision, which has been ratified by the Oversight Board and Christine McLaughlin was due to be briefing the Cabinet Secretary:

1. NHSL consider there to be poor engagement from the designers TUV SUD. There is clearly a clash between TUV SUD and NHSL's project team and indeed Brian Currie has been requesting for weeks that MPX consider an alternative designer.
3. NHSL has a lack of confidence MPX will resolve the IOM ventilation issues."

Do you see that?

A Yes.

Q So, is that what you were being told by Ms Goldsmith that, effectively, NHS Lothian had lost confidence in Multiplex's ability to resolve what they saw as issues with the ventilation system?

A Yes. I think just for clarity-- So yes, so primarily yes. I think just the reference to IOM ventilation issues: although IOM highlighted the issues in critical care, there was a number of other issues

highlighted by IOM which Multiplex were continuing to work on, so I think what Susan was saying was there's a lack of confidence that Multiplex would complete those issues on the IOM tracker.

Q Thank you.

A But those were completed.

Q Then if we look to the second last paragraph beginning, "I briefed Ben Keenan." Do you see that?

A Yes.

Q You said:

"I briefed Ben Keenan on the above and MPX are considering, although he stated it was highly unlikely MPX will participate in critical care given no waiver is being provided."

Do you see that?

A Yes.

Q Again, is that effectively what happened? The negotiations really broke down at this point because of this issue around about the waiver?

A Correct.

Q In terms of IHSL, did it move forward and engage Imtech, and Imtech in turn engaged wholly to effectively address the issues with the

ventilation system to make it have positive pressure and ten air changes per hour?

A Correct.

Q Just in terms of engaging Imtech, we have talked through the Project Agreement that is in place. There is still the subcontract with Multiplex, there are obligations that (inaudible) will have as the Hard FM provider. How complicated a process was it in terms of trying to identify another entity that is going to come in and do design and build work on a ventilation system that had already been built and installed?

A I think possibly if we take ourselves back to that time, the project had been in the press quite a lot, so there was a certain degree of notoriety around the project at that point. So, we were aware there was a limited degree of market interest, if I put it like that, on coming on to the project and working, although Imtech were amenable and I had worked with the managing director of Imtech on another healthcare project and they were interested in coming and doing the work.

Q Again, the Inquiry has heard evidence that really, in terms of the deal structure for an NPD contract, you have the Health Board, you have

the Project Company, the idea is that all the design risks should be pushed onto the private sector rather than the public sector. Presumably then there would be a series of warranties between the Project Company and their contractor. Can you just talk through why there is not much market appetite for a third party to try to slot into that arrangement late in the day?

A Well, I think we were concerned bringing in a third party because that would invalidate some warranties, and it would always be difficult if you did have to bring back your build contractor for a defect because the claim could then be that, “Well, it was fine when I left it.” So, I think we were concerned invalidating warranties. I think as well as-- it’s what I described as tier one, designing bill contractors coming to do large acute PFI style projects because of the potential liabilities, where-- Imtech, I wouldn’t describe as a tier one contractor but a tier two or tier three M&E contractor. So, they just don’t have the wherewithal or financial covenants to take on the type of liabilities which can arise on an NPD project because of some of the payment mechanism and flow down of the deductions.

Q Thank you, and if I could

just ask you to look to bundle 13, volume 9 page 335, which is a letter from IHSL to Susan Goldsmith dated 26 November 2019. Do you see that?

A Yes.

Q And if we could just perhaps look over the page on to page 336 at the first bullet point at the top, whereby the letter states, "With the endorsement of IHSL's proposal to self-deliver, and appoint a third party"----

A Sorry, I think I'm on a-- Apologies, I think I've-- My one starts off at (inaudible)----

Q Sorry. So, we should be in bundle 13, volume 9, at page 336. If we look back over the page, just so you can have the context-- back over the page on 335, you see the IHSL letter dated 26 November 2019 to Susan Goldsmith, and then it is over the page onto page 336.

A Yes.

Q Which says:

> "With the endorsement of IHSL's proposal to self-deliver and appoint a third party (Imtech), NHSL accepts that the nature of the relationship with Imtech is via a standard construction industry form of contract. We previously agreed that given the nature and scale of the works, limited market interest and challenging program aspirations, it would not be possible to impose PPP/NPD risks on a third-party contractor. Consequently, we require NHSL to accept that Imtech's liabilities would be limited to standard NEC provisions and cannot, for instance, extend to the flow down of Deductions from the Project Agreement."

Do you see that?

A Yes.

Q And is that effectively just summarising what you have already told us in evidence about the difficulties and the position of a third party coming in, what they would and would not accept commercially?

A Correct.

Q So, those works are ultimately done. Imtech (inaudible), commissioning works done, and the hospital eventually opens. The last thing that I would wish to ask you is really some of your reflections, obviously, being a member of IHSL. This is a project that ended up being years late, millions of pounds over budget. From your perspective, what went wrong and how could any issues be rectified for future projects?

A So, I think in terms of the

delay, I think it could be-- and the reason for it-- I think it's characterised in a few elements. First of all, when I joined the project in early 2018, it was already six or seven months behind programme, and that programme delay was primarily due to construction delays, the responsibility of Multiplex. So, I think the Inquiry's already heard, you know, there was a failed pile. Two subcontractors went into administration and there was a flood-- the flood was later. So, some of those were just-- the construction works took longer than Multiplex had anticipated when they originally programmed the works.

I think, then, when I got involved, it became clear that the hospital couldn't be completed because of disputes with regards to the client brief. I think certainly reflections-- or what's reflected-- I think it's very important that the client brief is really clear on what their requirements are, and then I think-- laterally, I think we've also explored that around the guidance-- can sometimes be ambiguous or interpreted in different ways but certainly I think greater clarity around the guidance would be helpful, or the guidance could be more clear and less ambiguous, or open to interpretation.

Q Because, again, the Inquiry has heard evidence from other witnesses who have said it is very difficult to take something that is guidance that is open to interpretation and to effectively shove that in as a contractual standard. You are not talking about a hard-edge legal requirement that a ventilation system must achieve six or seven or eight air changes per hour. There is no dubiety. From your side, as one of the contracting parties, is that a difficulty or frustration with these types of projects that do refer to guidance which is open to interpretation?

A Yes, although, in fairness, I've never had to pick up that guidance and design anything. So I'm not really-- I don't really understand why it's ambiguous or open to interpretation. I just know that there seems to be quite a few instances where it is.

Q And in terms of the deal structure itself – this was an NPD model, but it's not radically different to other PFI, PPP projects – do you think there is something inherently problematic about using that structure for healthcare projects, or are the issues that cropped up specific to this project because of what you have described as being a lack of a clear

brief? Is it a real system problem or is it project specific issues, from your perspective?

A I think the term has a number of healthcare PFIs, and I think there's probably over 700 PFIs in the UK, and the vast majority are successful and do deliver the outcomes that the client wants. I think it is fair to say that of all the sectors where PFI has delivered new facilities, healthcare definitely seems to encounter more challenges than any other sector. I think, certainly speaking to NHS clients, that they do have concerns over the inflexibility, sometimes with the PFI model, but healthcare probably changes more frequently than, say, education or roads.

Q So, just in terms of the model itself, if there is a problem with it, it might work quite well for certain generic buildings but whenever you have something that is fluid, science technologies moving on, it is quite hard on day one to hardwire in what you are going to need over a 25 year your project in a hospital building even if you have standard change protocols?

A Yes.

Q Thank you. The final question I would just ask you is a general open question. You have

obviously covered a lot within your statement. We have covered a lot today. Do you have any other reflections or observations drawing on your experience not just in this project but on other projects of how these new-build hospital projects could be done better in the future?

A I certainly think, irrespective of the model, there certainly seems-- there appears to be the opportunity for greater collaboration between the designers and the builders, the NHSS, the state professionals and those clinicians that maybe create more of a collaborative environment, and maybe if there's-- and maybe where it does get into difficulties-- we were fortunate with this project. Sometimes third parties would come in and assist in mediating and unblocking those differences, but I think certainly an environment which promotes greater collaboration between all of those disciplines, which all seem absolutely required to deliver the facilities at the end would certainly be a positive step.

Q Thank you. Mr Templeton, thank you for answering my questions today. I do not have any further questions for you at this stage. Lord Brodie may have questions or there may be applications from core

participants.

A Thank you.

THE CHAIR: Mr Templeton, I do not have any further questions at this point, but I want to give those in the room the opportunity to raise any points they may have with Mr MacGregor. So, if I can ask you to return to the witness room for maybe 10 minutes, and we will then be in a position to advise you whether there are more questions or whether or not more questions.

A Okay. Thank you.

MR MACGREGOR: Lord Brodie, just the final issue before your Lordship rises, obviously just-- Professor McMahon was listed for this afternoon. I would not be confident about finishing him in 15 to 20 minutes. I will make arrangements through the Inquiry team to see when he can be rearranged for but, subject to any observations your Lordship has, I would not be minded to start Professor McMahon this afternoon.

THE CHAIR: All right. While you are dealing with the matter of questions, we should ask the Inquiry team, effectively, to enquire after Professor McMahon's availability.

MR MACGREGOR: Yes, my Lord.

THE CHAIR: Yes. I mean,

certainly unless his evidence was pretty brief, I would not be inclined to sit on if it means really going beyond half past four.

MR MACGREGOR: Obliged, my Lord.

THE CHAIR: Right. Okay. Thank you.

(Short break)

THE CHAIR: Mr MacGregor?

MR MACGREGOR: Thank you, Lord Brodie. Mr Templeton, there is just one issue that has been raised with me by a counsel for a core participant, which I am happy to deal with. If I can ask you to look to bundle 2, please, and to page 70. So bundle 2, page 70, there is two emails on that page, if we could start with the email towards the bottom. So, bundle 2, page 70. The email at the bottom is from Matthew Templeton to Darren Pike on 3 July 2019 at 18.48. Do you see that?

A Yes.

Q And it says:

"Darren, with regards to the Critical Care single bedrooms and air change rates, to what extent is that affected by Item 13 in the Dispute Works Schedule of the Settlement Agreement? This

debated whether single rooms (ref to Table A1 of Appendix 1) should be 6 ac/hr V's 4 ac/hr; however it was decided upon 4 with an increased extract through the en-suite. With this Item 13 'Single Bedroom Ventilation Air Changes" was discussed and agreed, was the intention it also covered critical care single beds or are these covered under a different part of the SHTM and hence not covered under the SA?"

Do you see that? Can you just explain what are you raising here with Mr Pike?

A So my understanding is I think earlier in early June/July, on the 1st and 2nd, after the IOM report had been issued the week prior, there was a number of joint meetings and design workshops to try and find the interim solution. I think that after those meetings with NHSL, it had been raised that NHSL considered that the single bedrooms may not be covered under the Settlement Agreement. That was what they were considering, and I just emailed Darren to say, "Look, this is what's been suggested. What's your view?"

Q Okay, and then if we look up the page to page 70, you see Mr Pike sends a reply----

A Yes.

Q -- on 4 July and it says:

"Matt, reading that through, it would apply to all single bed rooms. I'm checking the SHTMs for specifics around HDU/Critical Care. Be interested if you stroke/pinsents read it in the same way."

Do you see that?

A Yes.

Q And he says that he is checking the SHTMs for specifics, interested in any differing views. Was there a definitive position that you reached with Mr Pike in terms of what all of this meant?

A No.

Q Thank you. I do not have any further questions. Thank you.

THE CHAIR: Thank you very much, Mr Templeton. You are now free to go but before you do go, can I say thank you for your attendance and the preparation that is inevitably involved in what is quite a substantial statement. So thank you very much indeed, but you are now free to go.

THE WITNESS: Thank you.

(The witness withdrew)

THE CHAIR: Now, before we

rise, I have been giving some consideration to witness scheduling, and the result of that is subject to anything that Mr MacGregor has to say, that I propose that we sit at half past nine tomorrow morning with a view to beginning with the evidence of Professor McMahon, who was scheduled for today, and I have taken the view that beginning him would not be very useful now. Does that sort of fit in with your-- well, probably it does not fit in with your plans, but is that acceptable?

MR MACGREGOR: As has been made clear from the outset in terms of the timetabling, Mr McLelland and myself have done the best in terms of estimating how long witnesses will take. That is very much an art rather than a science. I think that may have implications as to whether we can get through all of the witnesses tomorrow but that is something that I will reflect on overnight, and if we think that there are other witnesses that would need to be moved about, I will do my best to give as much notice to both witnesses and core participants as is possible, my Lord.

THE CHAIR: Thank you. So if I could ask legal representatives to be available at half past nine tomorrow morning. Thank you.

(Session ends)

16:14