SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
17 June 2024

Day 2
Tuesday, 18 June 2024

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10:00

THE CHAIR: Good morning, and again, good morning not only to those in the hearing room in the Inquiry offices in Edinburgh but also to our wider audience following us on the YouTube feed. Now, I am about to ask Mr McKenzie to resume. Mr Barne, I think your agents have been contacted by the Inquiry in relation to your speaking note, which we would very much value having, together with Dr Inverarity's comments, but I understand that that is in hand. Thank you. Mr McKenzie.

Submissions by Mr McKenzie, Continued

MR MCKENZIE: Good morning, my Lord, thank you. My Lord, just on the written aspect of matters, I will be providing your Lordship with my speaking notes as well.

THE CHAIR: Right.

MR MCKENZIE: That will follow on after today, and that means that I can take the matters I wish to take today fairly quickly. In particular, I will not labour any references. Those will be contained in the written material, and I hope that that will meet with your Lordship's approval.

So, it is two points of detail, my Lord, coming out of the closing written statement of the Health Board. The first one is from paragraph 17 of that statement, where assertions are made about the performance of Multiplex on the project from the Health Board's perspective. It suggested that Multiplex, from their perspective, performed extremely poorly, and they referenced the extent of delay in completion, which is, I think, different from the delays to the opening that were caused by the critical care ventilation, and they also referenced the fact that the technical schedule to Settlement Agreement 1 comprised 80 items and that it is said that that gives some justification or indication of just how unsatisfactory IHSL's and Multiplex's performance had been.

So, the point I wish to make is simply there is no evidential basis for any conclusions to be reached about responsibility for project delays generally, and that is as opposed to the delay to opening caused by the critical care ventilation issue, or in relation to any other aspects of Multiplex's performance on the project. That was not the focus of the Inquiry, and the Inquiry is therefore simply invited to note that these broad assertions that are by the Health Board are disputed by Multiplex. That is the first point, my Lord.

The second one is under reference

to paragraph 20.1 of the Health Board's closing submission, and there is a suggestion that the Health Board had no choice but to move away from the original project requirements, including the requirement for a full set of Room Datasheets at financial close. It is said on behalf of the Health Board that that is unfair and overlooks the fact that the Health Board, in reality, did not have a choice, and I just wanted to remind your Lordship that the evidence was to the effect that the Board had already taken a decision at tender stage not to produce full Room Datasheets with the Environmental Matrix being used as the alternative briefing tool, and that decision was taken on the basis of cost, and that comes from the oral evidence of David Stillie. As I say, my Lord, the exact reference will be given up in writing.

The evidence also showed that IHSL produced Room Datasheets for all room types, including critical care for financial close, and these showed that four air changes per hour were the parameters being used and this was not commented upon by either Mott MacDonald or the Health Board.

THE CHAIR: I may be misremembering this detail. We are talking about before financial close?

MR MCKENZIE: Yes.

THE CHAIR: Now, my memory – and just tell me if I am wrong about this – is that some Room Datasheets were produced but not a comprehensive set?

MR MCKENZIE: Yes, that is right.

THE CHAIR: So, I am right about that?

MR MCKENZIE: Correct.

THE CHAIR: Right, but the point you want to make is that among the Room Datasheets that were produced were Room Datasheets in respect of all spaces in Critical Care?

MR MCKENZIE: I think we would have to double check whether it was all rooms in----

THE CHAIR: All right.

MR MCKENZIE: -- Critical Care, but certainly, there were for some of the rooms in Critical Care.

THE CHAIR: And, I mean, given what you have already said, am I to assume from what you say that that would include the single bedrooms and the isolation bedrooms?

MR MCKENZIE: Single bedrooms and multi-bedrooms, my Lord. I think we would have to double-check if there were any isolation rooms included in that.

THE CHAIR: All right, and IHSL had produced that information and provided it?

MR MCKENZIE: Yes----

THE CHAIR: Right, okay.

MR MCKENZIE: -- it was provided

prior to financial close, and there was no adverse reaction from Mott MacDonald or the Health Board. Thank you, my Lord. That is all I wished to say. So unless I can be of any further assistance, those (inaudible)----

THE CHAIR: No. Thank you very much, Mr McKenzie. Thank you. Mr Ross. (Inaudible).

Submissions by Mr Ross

THE CHAIR: Again, my apologies, Mr Ross, for not reading my list accurately yesterday.

MR ROSS: Not at all, my Lord, though I did not realise it was going to be such a long time before I would be back in this position.

THE CHAIR: Right. Can I ask you to keep close to the microphone? As I have said on a number of occasions, my hearing is not that good.

MR ROSS: Certainly, my Lord. For the most part, NSS rests on its written closing statement and on the paper entitled, "NHSScotland Assure's Position On Approach To Research Including Ventilation." That was submitted last week to the Inquiry and is the first document in bundle 13. I noticed in going back over the closing statement that there is a typographical error that I should perhaps draw your Lordship's attention to. I do not think it is necessary to turn up the page, but I can give your Lordship the reference. In the first sentence of paragraph 12, at page 361 of the closing submissions bundle, the reference in the opening sentence should be to paragraphs 434 – not 334 – 434 and 435 of the closing statement by counsel to the Inquiry.

THE CHAIR: 424?

MR ROSS: Yes. Subject to that correction, NSS adheres to and rests upon its closing statement, and there are only a few other matters on which I offer very brief observations, and these are the certain matters raised in your Lordship's note, which was sent to core participants last week.

THE CHAIR: Yes.

MR ROSS: With regard to paragraphs 1-5, NSS has no comment to make, and it is not invited to comment on paragraphs 6 or 7. So I can begin by looking at paragraph 8, which invites core participants to comment on whether they consider, in relation to the matters canvassed in evidence, there to be any weaknesses or drafting deficiencies in the interim 2022 version of SHTM 03-01, which would merit further revision. As is mentioned in NSS's research paper at paragraph 20, this guidance is under continual review and will likely continue to

evolve over time. NSS will consider carefully any views expressed by other core participants at this hearing and, of course, any observations or recommendations which your Lordship may make in due course, and in that regard, NSS looks forward to receiving the detailed comments from Dr Inverarity, to which Mr Barne referred yesterday in the course of his submissions on behalf of NHS Lothian. NSS, on receipt of that paper with comments, will give it careful thought. We have not seen it yet, but it will be considered carefully.

With regard to paragraph 9, which relates to potential recommendations for an interim report, NSS has made some comments on those recommendations in its written closing statement and does not wish to add anything to these.

As to paragraph 10 of your Lordship's note, that relates to NHS Scotland Assure. NSS agrees with the proposition from Counsel to the Inquiry that the arrangements put in place by NHS Assure represent a robust challenge to help improve Boards' governance and compliance with guidance. Having said that, Assure is at a relatively early stage of its journey. As it has emphasised in other material submitted to the Inquiry, it is committed to working collaboratively and it welcomes feedback from Health Boards and others. It will therefore consider carefully observations by other core participants, including those made yesterday by Mr Barne on behalf of NHS Lothian, as well as naturally reviewing carefully in due course your Lordship's report or reports.

Finally, my Lord, paragraph 12 requests a separate written report from NSS by 28 June, and I can confirm that that will be provided. Unless there are any other matters on which I can assist your Lordship, these are the submissions for NSS.

THE CHAIR: Perhaps two matters. Can I take you to Question 2, which NSS declined to answer. The reason I am directing to you, Mr Ross, is that I see you as representing the, as it were, the custodians of the guidance documentation, and therefore perhaps having insights that others might not have. I am asking the question as a matter of generality. There is a suggestion in that question that if in the course of a healthcare construction project there is a change in design – now, I am leaving aside the question as to whether there was or was not in this case – from your perspective, would that reset the HAI-SCRIBE process in respect of the relevant works to Stage 2? Now, Mr Barne addressed that point yesterday and I am going to get his view in detail, but does NSS have a view on that?

MR ROSS: I think, my Lord, that it is quite difficult for NSS to answer that question in the abstract. I think it would be, it is-- I am not sure whether this is an exact parallel, but it may be something in the nature of a mixed question of fact and law, rather than one to which a simple yes/no answer can be given. What I can do, my Lord, is that I can, during the break today or at lunchtime, see whether I can have a discussion with NSS to see whether they are in a position to say more.

THE CHAIR: Well, I would value that and similarly, in Question 3, to an extent this may be academic having regard to my understanding of the answers, again, of Mr Barne in relation to this project. It is in relation to validation as required in terms of Chapter 8 of SHTM 03-01. Now, the proposition that is put forward for comment is – and as I understand Mr Barne, he accepted the proposition – that in a situation such as under this contract, notwithstanding that HAI-SCRIBE has been gone through, notwithstanding that there is provision for – using it as a term of art – "independent tester," nevertheless, who has indicated this satisfaction. Nevertheless, Chapter 8 of SHTM 03-01 requires the healthcare authority to carry out a validation of, for example, ventilation systems, although the text of Chapter 8, I think, tends to

concentrate on theatres. Does NSS have a position on that?

MR ROSS: If my Lord will just bear with me for a moment. (After a pause) My Lord, I think the position here is that the requirement to instruct independent validation is not something which is expressed in terms of the guidance, but I think NSS's view would be that it would be in keeping with the ethos and spirit of the guidance that an independent validation of the ventilation systems would be required.

THE CHAIR: I think I am particularly thinking of the note which either begins chapter-- I think it is the note which begins Chapter 8. But you would say that it was at least in-- consistent with the spirit of the guidance?

MR ROSS: That is as I understand it. I think that-- Yes, the terms of the note I think are that validation of these systems should therefore be carried out by a suitably qualified independent authorised person appointed by the NHS Board.

THE CHAIR: That is what I had in mind.

MR ROSS: So I think the answer to that is yes.

THE CHAIR: Right. Thank you, Mr Ross. These were the only two points I wished to raise.

MR ROSS: Thank you, my Lord,

and if I have further comments from NSS in relation to the issue your Lordship has raised about paragraph 2, I will perhaps provide a short note.

THE CHAIR: Thank you.

MR ROSS: Thank you.

THE CHAIR: Now, the next core participant I would invite to address the Inquiry is the Scottish ministers who are represented by Ms Crawford.

Submissions by Ms Crawford

MS CRAWFORD: Thank you, my Lord, and good morning. My Lord, first of all, the Scottish ministers are grateful to my Lord, the Chair of this Inquiry, for the opportunity to make oral submissions on their behalf. As will become apparent shortly, the oral submissions which I make on behalf of the ministers are at a relatively high level, the reasons being which I will develop shortly under reference to the Statutory Framework for the Provision of Healthcare in Scotland. My Lord may also have noted from the closing statement for the ministers, which I formally adopt for this morning's session, was also at a high level; again for similar reasons, having regard to the statutory framework.

That being so, my Lord, I will address – and again, very lightly – points 1, 8, 9, and 10 in the paper provided by my Lord because the other questions address matters of detail which the ministers under the Statutory Framework for the Delivery of Healthcare are not involved with in the sense of an operational involvement. If the Inquiry comes to the view that there are concerns about the existing framework under which healthcare in Scotland is delivered, for example that the ministers should have greater involvement in operational matters and delivery, that may exceed the terms of reference but in any event, and perhaps more pertinently, I would submit would require far more detailed consideration than this Inquiry has had the benefit of. Then, there would require to be extensive consultation across all sectors, public and private, throughout Scotland; consultation with public bodies, industry, businesses, patients, charitable sector, and indeed perhaps other jurisdictions, because if this Inquiry was to come to the view that the existing framework did not operate satisfactorily, it would be clear that some form of structural change would be required which as I have submitted, would require extensive consideration, consultation, and thereafter parliamentary debate.

THE CHAIR: I understand that, Ms Crawford, but did I gather from what you

have just said that it might be open in a world of possibilities for this Inquiry, with its terms of reference, to-- finding may be too strong, but let us use the word finding anyway, that the framework did not operate satisfactorily. Leaving aside, what might follow from that?

MS CRAWFORD: I think my Lord could make that suggestion or comment to that effect, but that of itself is probably as far as my Lord could properly go because my Lord has not been provided with, as I understand matters, any material to suggest how, if it did not operate properly, it could have been done better. If not anything else, my Lord has perhaps learned from this Inquiry that delivery of health care is a very complex process indeed and, just pausing there for my Lord, thinking a bit more about my Lord's question to me, it may not be entirely satisfactory if my Lord were to make such a comment without indicating a proper basis for that, or indeed which particular aspects of the existing framework did not operate satisfactorily. So, a general observation, thinking matters through further may not be entirely helpful to the ministers once they have seen my Lord's report.

My Lord, a general submission before I proceed to address my Lord on that statutory framework. The ministers, of course, wish to acknowledge the

undoubted distress, anxiety and upset that will have been experienced by patients, families and staff caused by the delay in opening, not to say their experience of the less serious, but still important, inconvenience, so nothing which I submit on behalf of the ministers should be regarded in any way as seeking to move away from recognition of that very real distress and anxiety. As will have been clear from the former Cabinet Secretary's evidence, however, the decision to delay opening was taken by her, for which, of course, the ministers are collectively responsible and accountable. The decision was taken by Ms Freeman to ensure the paramountcy of patient safety and that their care and safety would not be compromised. It is submitted that, having regard to that paramount consideration weighed against the undoubted distress, anxiety and upset, the balance firmly weighed in favour of a delay to opening.

My Lord, I mentioned a moment or two ago the statutory framework and my Lord may have been provided with a copy of part 1 of the National Health Service Scotland Act of 1978.

THE CHAIR: I am pretty certain I have been.

MS CRAWFORD: I can take this relatively quickly, my Lord, because I do not intend this to be a legal debate. It is

simply to direct, my Lord, to certain relevant provisions and, by way of general introduction, my purpose in doing so is not in any way, of course, to deflect the responsibility of the Scottish ministers for the health service in Scotland, but simply to explain how that health service-- the provision of that health service is secured, and my Lord may recollect Ms Freeman, in her evidence, being clear that she was wholly accountable to both the Scottish Parliament and to the people of Scotland in that regard, albeit the actual delivery of health care services is provided by individual health boards across Scotland.

The National Health Service Scotland Act, which has been subject to numerous amendments over the years, initially enacted in 1978. Part 1 is headed up, "Organisation," and in section 1, the ministers have a duty, headed up as a:

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

THE CHAIR: As you say, the Act has been much amended and a lot of the amendments are quite recent. There is a bit of archaeology in the sense that the Secretary of State continues to be mentioned but am I right in thinking that, where I see "The Secretary of State," I should read "Scottish ministers"?

MS CRAWFORD: Yes indeed, and that comes from the Scotland Act itself.

THE CHAIR: Yes.

MS CRAWFORD: My Lord, reading further into the Act, we will see that some provisions mention the Scottish ministers and some mention the Secretary of State----

THE CHAIR: Yes.

MS CRAWFORD: -- and my Lord perhaps immediately alighted upon section 1(a) with the duty of the ministers to promote the improvement of the physical mental health of the people of Scotland. Then, if my Lord turns to section 2, my Lord will see reference to health boards who are to be:

"…constituted [reading short] ... for the purpose of exercising functions relating to the health service... and for making arrangements for the provision of services."

Reading further into the document

or the extract from the 1978 Act, if I could invite my Lord to turn to section 2A, which in my print is at page 5, and my Lord will see subsection 1, "It is the duty of every Health Board [reading short] and of HIS and the Agency"-- just pausing there, my Lord. "HIS" is, of course, Health Improvement Scotland and "the Agency" is the Common Services Agency which now operates under the label of NHS National Services Scotland.

THE CHAIR: I mean, the NSS is a sort of trading name?

MS CRAWFORD: Putting it crudely, yes, and probably not legally accurately, but yes.

THE CHAIR: I apologise if that offends anyone, but I do not think that----

MS CRAWFORD: Indeed.

THE CHAIR: I think that is its status.

MS CRAWFORD: Anyhow, it is the duty of those bodies to promote the improvement of the physical mental health of the people of Scotland, and they are given a number of powers in subsection 2. Then, reading on to section 2C, the functions of every health board are listed. Subsection 1:

> "Every Health Board–"
>
> "(a) must, to the extent that they consider necessary to meet all reasonable requirements, provide or secure the provision of primary medical services as respects their area…"
>
> "[and] (b) may, to such extent, provide or secure the provision of primary medical services as respects the area of another Health Board…"
>
> "[and then] the services... may be performed outside their area."

Health boards are given a wide power in subsection 2 to make arrangements, to provide primary medical services.

THE CHAIR: Primary medical services, does that include hospital services?

MS CRAWFORD: As I understand it, yes.

THE CHAIR: Right.

MS CRAWFORD: Then, if I might invite my Lord to read on to internal page 14, section 10, which contains provisions relative to the common services agency, and the agency at 1A has the functions conferred on it by this Act and my Lord need not trouble himself with section 62 of the 2014 Act.

Schedule 5 relates to the composition of the agency and subsection 3:

"The minister may by order delegate to the Agency such of their functions as

they consider appropriate."

Then, if I could invite my Lord to read on to section-- and it is apparent this Act has been copiously amended to section 10ZA, although that is at page 16, only a couple of pages further on. (After a pause) Sorry, my Lord, it was the next-- was not that section, forgive me. If I could invite my Lord, next to look at section 10A which addresses Healthcare Improvement Scotland, and its functions are set out at section 10C, amongst other things.

At subsection 1(a):

> "Functions in relation to supporting, ensuring and monitoring the quality of health care; "

> "(b) ... supporting, ensuring and monitoring the discharge of the duty under section 2B by each body to whom that section applies [in other words, health boards.]"

And so on. The evaluation and provision of advice to the health service, a long list of functions which I do not think it serves the purpose of this morning to read out at length.

Then, if I might next invite my Lord-- and this is where I got my numbering wrong, invite my Lord to look at section 10Z1A-- IA (sic) sorry, which is to be found on page 41 of the print, subsection 1, "For the purposes of its functions as they relate to the provision of independent health"-- sorry, my Lord, I will not invite my Lord to look at section Z1A; I see it is addressing independent health care services which is slightly different.

THE CHAIR: Right, okay. So----

MS CRAWFORD: My Lord should probably just put the red pen through my reference to section 10Z1A.

THE CHAIR: Right. Yes, I mean, what I am looking at at the moment is, as you say, a much-- a much----

MS CRAWFORD: Indeed.

THE CHAIR: 10Z14? I mean----

MS CRAWFORD: 14, I think it might be, yes.

THE CHAIR: I do not know if I have come across a section that has run out of letters----

MS CRAWFORD: Indeed.

THE CHAIR: -- and had to start numbering but, in any event, that is not a provision----

MS CRAWFORD: No, no. I do not think----

THE CHAIR: -- you are----

MS CRAWFORD: -- it is a particular----

THE CHAIR: -- drawing my attention to?

MS CRAWFORD: No, not for the purposes of making the broad submissions about the framework. If I

could – again, looking to letters and numbers – invite my Lord to next turn up a section of provisions relative to, first of all, quality, section 12H on page 51, subsection 1:

> "It shall be the duty of each Health Board, [reading short] and of the Agency to put and keep in place arrangements for the purpose of monitoring and improving the quality of healthcare."

So a general duty there on the part of the Health Board and indeed the Agency relative to quality and monitoring and improving the quality of healthcare.

They then, over the next page, commencing at section 121A (sic), proceed to list a number of duties relative to staffing.

THE CHAIR: I mean, I-- this is not a criticism-- you say 121A – is it 12IA?

MS CRAWFORD: (ia) – sorry it's my eyesight, my Lord, IA. And the primary responsibility, taking these various provisions short, is that the primary responsibility is on the part of the individual Health Board, albeit that the ministers have duty in section 12IG at page 57. Subsection 1:

> "The ministers must take all reasonable steps to ensure that there is a sufficient number of nurses, midwives, medical practitioners (and other such types of employees)... as may be prescribed, available to every Health Board."

So there's a general duty there, but the primary duty to ensure that healthcare facilities are appropriately staffed rests with the relevant Health Board. And my Lord reading on in the bundle in the extract we will see that there are a number of specific provisions relative to staffing.

And finally in this excursive, or perhaps penultimately in this excursus, if I could invite my Lord to turn to page 68 of the copy and section 12J. Subsection 1 provides:

> "In exercising their functions in relation to the planning and provision of services which it is their function to provide or secure the provision of, under or by virtue of this Act, Health Boards shall cooperate with one another and with special Health Boards and the Agency with a view to securing and advancing the health of the people of Scotland."

So a general duty for Health Boards to cooperate amongst each other, between themselves. And we see a similar duty, finally, in section 13 over the page:

> "In exercising their respective functions, Health Board's, HIS (as respects its health service functions only), NHS Trusts, local authorities, integration joint boards and education authorities shall cooperate with one another in order to secure and advance the health of the people of Scotland."

Now, with apologies, my Lord, for taking my Lord through fairly torturous statutory provisions. But the submission I make and the purpose of doing so was to seek to explain to my Lord that ministers have this high level overall responsibility to secure the provision. But the day-to-day management delivery operation of that is carried out by the relevant Health Boards in conjunction with the help and assistance they derive from the Agency and from HIS, and indeed from other knowledge acquired through its cooperation with other Health Boards and other authorities.

THE CHAIR: Don't apologise, Ms Crawford. I have had occasion to try and follow the current structure of the 78 Act and I am grateful for any assistance.

MS CRAWFORD: Well, my Lord has my sympathies if he's already had to crawl through the Act.

My Lord, how this operates in practice was explained by Miss Freeman in her statement, and I shan't invite my Lord to turn up the relevant paragraphs, but those paragraphs can be found at paragraphs 9, 13, 14, 17, 19, 20, 22, 23 and 26.

I just make the following observations under reference first of all to paragraph 17, or draw to my Lord's attention paragraph 17, which explains that the Director General as that person is described for health and social care is also the chief executive of the National Health Service in Scotland.

Paragraph 19 sets out that there are regular meetings between the Director General and the chief executives of Health Boards in Scotland, and paragraphs 20 and 22 explain that there are regular meetings between the Cabinet Secretary and Health Board chairs.

THE CHAIR: Regular meetings between the Director General and the chief executives of the Health Board?

MS CRAWFORD: The chairs. The chairs.

THE CHAIR: The chairs.

MS CRAWFORD: Further information about how this works in practice is also provided in Malcolm Wright's statement, the former Director General, of course. In paragraph 15, he tells us about the body known as the Health and Social Care Management Board and he again sets out in paragraph

20, I think it is, the meetings which take place with himself, with Health Boards and with the Board.

In paragraph 16, he explains that Health Boards are accountable for delivery of healthcare.

And at paragraph 20, he explains the process in relation to healthcare projects, in particular infrastructure projects. Twenty-five-- is that what I said? Twenty-five.

Between paragraphs 79 and 85, Mr Wright explains that NHSL were escalated as it's described to Level 3, and at paragraphs 101 to 103, he describes escalation to Level 4. This escalation framework is part of the ministers ensuring that Health Boards do in fact deliver healthcare. And that is under reference to the escalation framework, which is monitored by annual reviews.

THE CHAIR: Sorry, monitored by?

MS CRAWFORD: Annual reviews.

THE CHAIR: Thank you.

MS CRAWFORD: My Lord will find the escalation framework in volume 13, bundle 3.

THE CHAIR: Is that the right way round?

MS CRAWFORD: Is it bundle 13, volume 3? I think it's volume 13, bundle 3.

THE CHAIR: It is bundle 3, right? You are right and I am wrong. That is fine.

MS CRAWFORD: Just like the 1978 Act, the numbering can be confusing.

THE CHAIR: So, Drew, it is-- right, okay. I am told, and I rely on this, it is bundle 13, volume 3.

MS CRAWFORD: Okay. Whatever.

THE CHAIR: I think we know where to look. Page number?

MS CRAWFORD: Annex 1 is at page 685 and that Annex 1 is to an annex to a paper presented to the management board-- the Health and Social Care Management Board of 10 July 2019, which can be found starting at page 683. Annex 2 to that meeting paper contains the annual review of NHSL for 2017–2018. Pages 687-688 set out the actual framework itself. As my Lord may recollect, there are five levels.

Level 3 is a level to which the Health and Social Care Management Board have responsibility for. A decision to escalate to Level 4, as Mr Wright explained in his evidence, is one taken by the Director General, and Level 5, being the top level, is a decision taken by the Cabinet Secretary, not least because Level 5 involves direct ministerial intervention in the delivery and provision of healthcare by a particular Health Board. And it is only in that event if

matters have got to a stage and it's set out in the criteria for reaching Level 5 that the ministers directly intervene.

THE CHAIR: Just in the context of discussion on its structure, my guess is that the framework is an administrative tool. It is not mandated by any statutory provision?

MS CRAWFORD: Except buried in the 1978 Act, you will find a requirement for ministers to produce guidance and directions and the like. I don't have that provision immediately to hand.

THE CHAIR: Okay. Anyway, so that would be the Scottish Government's action, as you have just described, would be based on whatever the provision is, which imposes an obligation on Scottish ministers?

MS CRAWFORD: I think it is an obligation, but I will double check. I don't have the revision relatively to hand of, if my Lord will allow me, perhaps provide it by way of a short note, once I've double-checked the provision.

THE CHAIR: I mean, I appreciate this is fine detail, Ms Crawford, which is probably not at the end of the day terribly important, but in the context of (inaudible) of getting the structure right, I would value that.

MS CRAWFORD: I will do so, my Lord, but rather than me flicking through the Act this morning, I would rather spend a bit of time to identify the correct provision.

THE CHAIR: I can understand.

MS CRAWFORD: Thank you, my Lord.

Now, my Lord, obviously I have taken my Lord to at least some of the provisions of the 78 Act and the escalation framework, again, to illustrate how the delivery and operation of healthcare in Scotland works, both as a matter of law and in practice, and the broad submission is that that is an appropriate and an effective way to secure provision of healthcare as opposed to an overlay centralised system run and managed directly and operationally by the ministers. Picking up a submission I made earlier, if the Inquiry were to come to the view that there was something not quite right about that and that there should be more direct operational control of some sort and in some way, that, harking back to my original submission, would raise a number of complex issues of, I venture to suggest, a highly sensitive political nature which are properly to be addressed by the Scottish Parliament following a detailed consultation exercise.

Now, my Lord, with that overview, I would, on behalf of the ministers, make a number of points without forming a view one way or the other, more by way of

observation and comment. It does appear to the Scottish ministers that the design brief lacked clarity. In that regard, it is not for the ministers to resolve, either then or now, any ambiguities that may or may not have existed, whether at the time of the procurement itself or as the project developed through all its stages, or indeed, to suggest a concluded view submission before this Inquiry. The obvious point being, of course, that the ministers were not one of the contracting parties, and having regard to the framework under which healthcare is delivered, it was not for the ministers to negotiate contractual terms, nor was it for the ministers to determine what were the requirements – construction requirements as they are described – of NHSL or indeed, any other health board?

THE CHAIR: I am right in thinking that the Project Agreement is in-- I mean, it may be a development, but is based on a text produced by Scottish Futures Trust?

MS CRAWFORD: Correct, and I was going to make some observations about the NPD contract, as it is described.

THE CHAIR: All right.

MS CRAWFORD: "In that regard, the ministers would align themselves with the comments of the Scottish Futures Trust in its closing statement to the Inquiry. In broad terms, to the effect that questions of risk transfer and the like are irrelevant"----

THE CHAIR: Sorry, are irrelevant?

MS CRAWFORD: "Are irrelevant because if the requirements in the design brief were clear, with perhaps a consequent effect on the risk, there would be no need for changes as the project progressed and any changes which went out with the design brief (that design brief being clear), any changes going out with that clear design brief could and should be properly accommodated within the change mechanism."

My Lord, again, and by way of observation or comment:

"The evidence before the Inquiry does appear to be to this effect that NHSL wished to contract for a hospital that complied with the relevant guidance, and if that is so, again, by way of observation, it may well be that the error in the Environmental Matrix is irrelevant because NHSL wished and, indeed, thought they had contracted to secure compliance with guidance."

THE CHAIR: Sorry, can I just take that again? The evidence was to the effect that NHSL wished to construct a

hospital that completed the relevant guidance. Now, did we then go on to say that the error in the Environmental Matrix is irrelevant?

MS CRAWFORD: "Because NHSL thought they had contracted for a hospital that complied with guidance." The Environmental Matrix, to make the obvious point, of course, is not guidance.

THE CHAIR: Right. I may need to be taken over that ground just again. I get the point that NHSL thought it was contracting within guidance and it is also their position that the Environmental Matrix was not of a contractual effect to the contrary.

MS CRAWFORD: Indeed.

THE CHAIR: Now, I just want to be sure that I am following your point. You emphasised the word "guidance"?

MS CRAWFORD: By that I mean SHTM 03-01.

THE CHAIR: Yes.

MS CRAWFORD: And the point I make that if-- and I realise that my Lord is not obviously resolving a dispute between NHSL and the contractors, but if the contract was to secure a hospital which complied with SHTM 03-01, the fact that there was an error in the Environmental Matrix, which is a different aspect, a different factor, may well be irrelevant. I should add, my Lord, that the ministers do not enter into any discussion or debate about what "the contract properly construed" means.

Picking up that last observation, a further observation is to this effect, again, underpinned by the statutory framework and the practical operation of that. Respecting, of course, the way in which health boards deliver healthcare, it is not for Scottish ministers to, I might put it this way, mark NHSL's design brief. It is not for the ministers to check if that design brief has been drafted properly, if I might put it that way, so that it does in fact secure compliance with guidance.

My Lord, another comment, if I may, relative to the question of staffing, and my Lord may recall that I took my Lord to section 12I in the various provisions and also picked up section 12IG, which is the minister's strategic duty, if I might describe it that way, relative to ensuring staff are available so that health boards can provide properly staffed facilities. In that regard, in the minister's closing statement, paragraph 17-19 provide my Lord with information relative to the topic of ICT staffing and what has been done in that regard. My Lord may recall there was some evidence at the Inquiry session and matters moved on since my Lord heard evidence relative to that, and the closing statement for the ministers at paragraphs 17-19 provides my Lord with some detail relative to ICT staffing.

THE CHAIR: I should have the detail at my fingertips, but my recollection is that we have been provided with some written material.

MS CRAWFORD: As well, I think that is right. I think there is some-- I cannot remember offhand myself either, my Lord. It was obviously a topic my Lord heard some evidence about----

THE CHAIR: Yes.

MS CRAWFORD: and it is clear it is a matter of concern and, as I say, the updated position, as the ministers understand it, is set out in their closing statement. My Lord, I can now turn to the points, questions or issues request made by my Lord in the paper. As I indicated at the outset, I propose only to address issues 1, 8, 9 and 10 for the reasons discussed.

So far as Question 1 is concerned, the ministers' position is that this is really a matter for NHSL, whether or not a technical audit was both-- would be disproportionate, unnecessary, or the contrary, and I make that observation again because of the underpinning statutory framework. But I do make a couple of observations.

First of all – and I think this has already been referred to yesterday – if there is to be some form of technical audit, how does that fit in with the contractual matrix, and questions of

design responsibility and risk? And at best, as we know from the chronology, any technical audit would only have disclosed the non-compliance issue about five months earlier than it was discovered. But as my Lord knows, by that time the ventilation had been built and would still have required remedying, or to be remedied, I should put it that way.

Question 8 relates to the interim revision of SHTM 03-01. The position on the part of the Scottish ministers is that this is a matter which is a function of NSS Assure. They are the experts on such matters, noting in that regard that one of the aims of Assure is to be recognised as experts in the field of quality healthcare-built environment, and the ministers look to and rely upon that expertise.

Regarding Question 9, my Lord has the closing statement on behalf of the ministers and I have nothing else to add to that closing statement.

Finally, on Question 10, the ministers agree with Counsel to the Inquiry's assessment to the effect that the arrangements put in place by Assure represent a robust challenge to help improve governance and compliance with guidance. But picking up the submission made by Mr Ross on behalf of Assure this morning, Assure is at a relatively early stage of its journey. The ministers

would expect Assure to continue to develop its expertise as time passes, drawing on experience and knowledge gained from research, past projects, past experiences, other jurisdictions, experts across all relevant disciplines in relation to the healthcare-built environment. And indeed, my Lord may have got a flavour of that in the evidence provided by Assure, to the effect it will continue to develop and evolve so that it can be that source of excellence and expertise to secure the promotion of a quality healthcare service in Scotland, relative to the built hospital environment. One other aim, I note, of Assure is to facilitate wider collaboration as well and on that point, question of collaboration and sharing of knowledge, I should again draw my Lord's attention to a submission made at paragraph 16 of the ministers' closing statement, which refers to a body known as the Strategic Facilities Group, which existed then and still does, and that is a further group used to share knowledge.

My Lord, unless there are any other matters my Lord would wish me to consider and address, noting my homework, if I might describe it that way, those are the submissions on the behalf of the ministers.

THE CHAIR: Thank you very much, Ms Crawford. We are now, I think, coming close to half past eleven, when we usually take a break. I would propose to call next on Ms Donald on behalf of TUV SUD. Now, looking at the time estimate, I think it might just make sense if we break now, and I look forward to hearing from Ms Donald at about twenty to twelve.

(Short break)

THE CHAIR: Now, Ms Donald? (After a pause) Good morning.

Submissions by Ms Donald

MS DONALD: Good morning, my Lord. I appear this morning, my Lord, on behalf of TUV SUD, and I am----

THE CHAIR: I encourage you to use the microphone and remember that I am hard of hearing.

MS DONALD: I will bellow.

THE CHAIR: Yes.

MS DONALD: Good morning, my Lord. I am appearing this morning on behalf of TUV SUD, and I am grateful for the opportunity to provide these oral submissions, which are supplementary to the closing statement already lodged. I intend to address specific points arising from the closing statement, which I formally adopt; address the specific

points raised by my Lord in his recent note of request where it is appropriate for my clients to comment; and respond to some of the criticisms raised by other parties in their closing submissions and set them into the context of a public inquiry compared to a litigation in civil courts.

My Lord, my submission is in writing, but it is not quite in the state in which I would like your Lordship to see it.

THE CHAIR: Well, it is----

MS DONALD: I will tidy it.

THE CHAIR: There was no requirement to provide a written speaking note, Ms Donald. It is just a question of speed. If I can take it down, that is good, but if I cannot take it down and it is detailed, it is not very effective.

MS DONALD: That is understood.

THE CHAIR: Yes.

MS DONALD: My Lord, at the outset, it is my submission that it is inappropriate to consider Mr McKechnie as an outlier in his views of SHTM 03-01, the 2014 version, at least insofar as the evidence the Inquiry has before it. He is described as an "outlier" in his Lordship's note of request at para. 6 as we set out in our written submission.

THE CHAIR: I think I picked up an expression used by Counsel to the Inquiry.

MS DONALD: That is exactly where it came from, my Lord, from Counsel to the Inquiry.

As we set out in our closing statements, it is clear in hindsight that the 2014 guidance is open to different interpretations. It is our position that the Inquiry has heard evidence only from one other independent witness on that interpretation, Mr Maddocks. As was set out in writing, Mr Maddocks has not referenced any other hospital in Scotland on which he has worked and where he knows that his interpretation of the Scottish guidance, SHTM 03-01, has been used. The Inquiry has not heard from any other witnesses to the effect that other hospitals in the same timeframe or earlier have been designed and built in accordance with Mr Maddocks' interpretation of the Scottish guidance.

For example, the new Dumfries and Galloway Royal Infirmary was opened in 2017. We had the Forth Valley Royal Hospital in 2011, although that, I accept, was earlier than the 2014 version of SHTM 03-01. We do not have any evidence to disclose the standards to which those hospitals were built. In my submission, that may be relevant for your Lordship to consider.

THE CHAIR: Hold on. How is it relevant to the question as to whether this hospital was built according to----

MS DONALD: Mr McKechnie's understanding and evidence was the fact that he didn't understand other hospitals to have been built to a greater standard than was designed in this case. If his understanding or if his interpretation of SHTM was taken by other parties in other hospitals, it would be of interest and relevance to the Inquiry to know that.

THE CHAIR: Do you accept that anyone who we have heard about, who we have heard from or heard about, no-one other than Mr McKechnie argued for Mr McKechnie's construction?

MS DONALD: Yes, I'll come back to that, my Lord.

THE CHAIR: All right.

MS DONALD: My Lord noted in his note of request at paragraph 5 that he understood Mr McKechnie was supported by his employer in his interpretation. I can confirm that to be the case.

Mr McKechnie was not indulging in a frolic of his own when considering the ventilation design issues for a major new health project in Scotland. He led the Wallace Whittle team of designers, an experienced team which had delivered other projects of a similar nature as set out in his statement at paragraph 6 and in his oral evidence at transcript pages 126-127. Had others within the team disagreed with Mr McKechnie, then a discussion would likely have taken place. I put it no higher than that, my Lord: a discussion may have taken place.

The outlying view is a team one held by the experienced and well-regarded design team. Internally, at Wallace Whittle, there were checks and balances to ensure that the design was compliant with guidance. My Lord, those documents don't form part of the evidence, but they can be provided if the Inquiry would like to see them, just to set out the checks and balances which are done internally.

The usual checks carried out by M&E firms such as Wallace Whittle will be well known to other core participants in the same vein. There are a variety of internal reviews and approvals, with review workshops where appropriate. In addition, whilst ventilation was very much a matter for Wallace Whittle to design, and that is accepted, drawings issued by the design team, not just by Mr McKechnie, were reviewed and commented upon by the Multiplex in-house technical team, as well as IHSL's facility management contractor prior to submission to NHS Lothian and Mott MacDonald.

In light of that, my Lord, it is my submission that it's not a fair characterisation to state that Mr McKechnie could possibly be a single point of failure. I do note the IHSL

submission to that effect as well.

My Lord, it is my submission that in the absence of a body of opinion, setting aside the fact that other witnesses now say that their interpretation of SHTM differed from Mr McKechnie's at the time, in the absence of a body of opinion with the requisite demonstrable experience of designing systems under the Scottish guidance in Scotland, to the effect that Mr McKechnie, whether alone or as part of his team, erred in his interpretation, it is my submission it would be wrong of the Inquiry to take the line of least resistance and follow Mr Maddocks, the English expert who was able to reference no experience of building Scottish hospitals under the Scottish guidance with which we are concerned.

THE CHAIR: Can I ask you a question which I asked yesterday? Lawyers consider that lawyers can understand documents. Am I not entitled to come to my own view as to what the document means?

MS DONALD: I agree that my Lord is entitled to come to his own view as to what the document means.

THE CHAIR: Sorry, you would?----

MS DONALD: I do agree.

THE CHAIR: You would accept?

MS DONALD: You are.

My Lord, Mr McKenzie in his submissions yesterday noted the

suggestion that Mr McKechnie's interpretation was wrong has only appeared during the Inquiry or as a result of the Inquiry. He commented that in the period between 2014 and 2018 there was no evidence to declare that his interpretation of the guidance was wrong.

As your Lordship has picked up, it is clear that Mr McKechnie has always held the view that his interpretation was correct, given the change made to Guidance Note 15. The corollary to that, I see, is that we have no idea what interpretations were in fact put on the guidance by others at the time.

Mr McKechnie or his team were the only people to pick up on an inconsistency, to correct something in writing such that your Lordship has it for posterity. We do not know what other parties' interpretation of the guidance was in 2014, other than what they are saying in evidence now, in hindsight. We cannot know that other parties would have interpreted the guidance any differently at the time. It is not recorded.

Looking specifically at Mr Maddocks as being the appropriate expert in terms of the Scottish guidance, his report-- Sorry, my Lord. His report, that is 12 December 2023 report, was relatively neutral in writing.

He did not express a view on Mr McKechnie's interpretation of the

guidance in that report and it was not until he was specifically taken to the detail by Counsel to the Inquiry that he expressed that view; he was asked, in my submission, fairly leading questions to draw him to agree that Mr McKechnie's views made him an outlier. That is Mr Maddocks' transcript at page 45. His Lordship has referenced the other evidence on the interpretation of SHTM 03-01 in his note of request, that is paragraph 5, and we note that both Multiplex and IHSL have confirmed in written submissions that the guidance - and it is only guidance - was open to interpretation.

Finally, my Lord, in this short chapter of submission, it is important to emphasise and to remember that there was no incentive on Wallace Whittle to misinterpret the guidance. Had they considered the brief they were provided with to have been produced in error, then they may have raised it. It was not a difficulty for them to have raised any errors. It would cost them nothing and involve no extra work. Wallace Whittle were clear that the four air changes was a briefed performance, which, from their own review, and they concluded, met the criteria for sufficient fresh air to allow the expressed rate of 10 litres per second per person. The adoption of four air changes, as was set out in the

Environmental Matrix, does not change the design task facing Wallace Whittle. It simply alters the scale of the solution they have to provide.

Just finally on that point, my Lord, I do note that a number of parties have-- Counsel to the Inquiry and others have commented that there was no bad faith intended on the part of Mr McKechnie and unsuggested by any party delivering submissions to your Lordship.

I am turning now to the note of request. In relation to Question 1, whilst Wallace Whittle had involvement in respect of the technical resolutions and technical discussions prior to Settlement Agreement 1, they were not invited to participate in any discussions relating to the Settlement Agreement itself. They do, however, agree that it would have been appropriate for either NHSL or the Scottish Government to have instructed a technical audit. However, the comment they make is that it would have been appropriate for that technical audit to have been undertaken prior to the Settlement Agreement discussions. By that I mean at the point where the technical resolutions were actually in the process of being agreed, to ensure that NHS Lothian was adequately supported when entering into agreement on the technical matters.

THE CHAIR: So just so-- it is my

fault-- so your position would have been that what would have been necessary-- it would have been prudent for NHSL to do what?

MS DONALD: To consider a technical audit at the point.

THE CHAIR: A technical audit, and this would have been before March of 2018?

MS DONALD: Around then, when the technical discussions were taking place, before they were signed off.

(After a pause) Turning to Point 2, my Lord. Although the HAI-SCRIBE process is one for the Health Board, Wallace Whittle are of the view that they believe that the HAI-SCRIBE process should be followed in all healthcare projects. They do not consider that the process was properly adhered to, in this case, by NHS Lothian, and they take the view that there was an obligation on NHSL to go back to Stage 2 of the HAI-SCRIBE procedure following the changes in the design of the ventilation system. In this, we are aligned, I note, with Multiplex, Mr McKenzie's submissions yesterday.

THE CHAIR: Is that answer in the generality or in relation to the facts in this particular case? Bearing in mind that NHSL, I think, if I have understood it, take the position that-- well, NHSL's position was that the settlement agreement did not involve a change. Have I got that right?

MS DONALD: The changes had already been agreed by the technical resolution the year before. So I think my client's position is that the HAI-SCRIBE should have taken place before, in advance of the Settlement Agreement.

THE CHAIR: Right. So, it certainly as a matter of generality, during a healthcare project, if there is a material change in design which impacts or may impact on Infection Protection and Control, you would say, as a matter of generality, the healthcare authority should go back to Stage 2.

MS DONALD: Yes.

THE CHAIR: Right.

MS DONALD: Turning to Point 3, my Lord, my clients note this point is more for the Health Board and the project company. However, we do recognise your Lordship's point that the independent tester potentially has competing demands and duties as a good one and agree with Mr McKenzie that the essence in instructing any independent tester is ensuring that the instruction given to that tester is one which is clearly understood and covers what is important to the client. I have in mind here that the original tester, Arcadia (sic), tested to the contract specification; when IOM came in, they tested to the guidance.

My Lord, in passing, had the Environmental Matrix not been the brief for building the hospital, but rather that NHSL expected the hospital would be built to the guidance, whichever guidance they were referring to, then I wonder why Arcadia was not instructed to test to the guidance but rather to the contract specification. It rather points, in my submission, to the Environmental Matrix being the client brief.

THE CHAIR: Well, presumably, Arcadis was proceeding on the basis that they were testing having regard to the contract, their position being that as far as the ventilation specification was concerned, that you found the ventilation specification in the Environmental Matrix. I mean, presumably, Arcadis was doing its work in relation to the ventilation system incrementally from a period before October 2018 until October 2018, and I think I have assumed that they were working to their understanding of the contract and their understanding of the contract is the contractor's understanding of the contract, not the Health Board's understanding the contract. Have I got that right?

MS DONALD: Yes, I think that is my point, Lord, that everyone from the project side understood the contract to involve the Environmental Matrix, and it is only later when IOM are instructed to test

to the guidance that the problems appear.

My Lord, turning to Point 4, the Wallace Whittle understanding at the material time was that neutropenic patients were only one group of patients being accommodated within the Lochranza ward. They had to check that at the time with HLM Architects, and my Lord, I did ask to see an email; I could not find it within the documents. I understand it has been submitted to the Inquiry, and I have discussed it with your Lordship's team. If we need to find it, we can find it. Mrs Robertson of HML (sic) explained in email correspondence that while neutropenic patients had been briefed as part of the patient group, they did not make up the entire group, and I think in that submission, I am at one with Mott MacDonald because that appears to reflect their written response to this question, which your Lordship had circulated yesterday.

THE CHAIR: Sorry, I am being a bit slow on this. I mean, as you identify, the question is whether the Lochranza ward was constructed to guidance. Now, if neutropenic patient ward is to be equated with haemato-oncology, which I think is the way that Department C1 is described, the answer to that would appear to be it was not. Now, I think you are introducing a further factor, which is that, are you saying that Wallace Whittle made some

enquiry as to the patient mix in relation to Department C1?

MS DONALD: Whether the whole department was to be regarded as neutropenic – that is the nursing station, the corridors, etc. – and they understood from email correspondence that the specification referred to did not apply to the whole of the ward, and thus, we do not agree that the specification of neutropenic patient ward applied to the whole of Department C14.

THE CHAIR: But it would apply to the bedrooms?

MS DONALD: The bedrooms containing neutropenic patients? If all patients were neutropenic.

THE CHAIR: Well, on the basis of the evidence I have heard in the Inquiry, a particular patient may be neutropenic at a particular stage in his or her treatment. I think I have rather understood it that a haemato-oncology patient in the course of treatment is at least potentially neutropenic. I think I am right in saying that there are three single bedrooms, four single isolation bedrooms, a multi-bed day care and six other single bedrooms in Department C1. Now, as far as these bedrooms are concerned, are we agreed that as constructed, these bedrooms in Department C1 were not compliant with guidance?

MS DONALD: We would disagree

that they did not comply with the guidance. Our understanding, from the material and the questions asked at the time, in 2018, was that the Environmental Matrix did not highlight that all single bedrooms within the department were to have the capability of treating neutropenic patients. That is set out in writing in an email, which I will provide to the Inquiry and ensure is available.

THE CHAIR: Well, there are maybe two issues here. Whether the rooms complied with guidance, and it would appear to me, at least if haemato-oncology is to be equated with neutropenic patients, it did not. There is another question which is whether Wallace Whittle was led to believe that the circumstances were such that the department or certain bedrooms in the department did not require special ventilation?

MS DONALD: The latter question, the answer is yes. That is what was (inaudible).

THE CHAIR: And that depends on an email which we have yet to see.

MS DONALD: I understand from my clients it has been submitted. I could not find it in the documents, but I do not profess to be an expert.

THE CHAIR: All right, do you have a date for the email?

MS DONALD: The latest date in

the email chain that I have is 19 March 2018. Email chain started on 8 March 2018. I can provide a copy if that would be of assistance.

THE CHAIR: Well, I will welcome the information in order to understand it. I do not anticipate making any-- Well, we will just have to see how things go, but if there is any real issue that arises out of this-- Because I appreciate this is arising out of a question that I asked, if there is anything arising out of it, I will give notice to see these, but----

MS DONALD: My Lord.

THE CHAIR: -- I would be happy to see the email. Yes. Now, where are we?

MS DONALD: My Lord, moving on to Point 5, I have already made my submission on Mr McKechnie and the position on oversight and scrutiny provided by the Wallace Whittle team and other parties to the project on the development of the design of the ventilation system and Environmental Matrix. My clients do wish to emphasise that the oversight provided by the other relevant core participants involved in the project throughout the design process cannot lead to the conclusion that any inconsistency between the specification for critical care and the terms of SHTM would have been identified earlier were it not for Mr McKechnie's interpretation of the guidance.

Furthermore, Wallace Whittle do not agree with the contentions of Mott MacDonald in respect that the lack of a finalised document clearly identifying-- I realise I am going a bit faster than I have been, my Lord. Wallace Whittle do not agree with the contentions of Mott MacDonald in respect that the lack of a finalised document clearly identifying technical requirements for ventilation at financial close had no causal effect. A lack of any such document is contrary to accepted industry practice and poses a risk to any project. My recollection is that Mr Maddocks agreed with that. My understanding is that the current latest guidance issued by HFS records this as a prerequisite.

THE CHAIR: I am not quite following this and the fault is entirely mine. I would be interested in your response to the contention which I think is put forward both by NHS Lothian and Mott MacDonald, that given Mr McKechnie's interpretation of the guidance, any lack of clarity had no impact because whether one looks at the Environmental Matrix or one looks at the SHTM 03-01, through Mr McKechnie's eyes, one comes to the same conclusion. So I, as I say, would welcome-- and maybe just if I can throw in something else at this stage. Do you accept that Mr McKechnie's evidence was that he or his

team had carried out a line-by-line review of the Environmental Matrix?

MS DONALD: My recollection is that Mr McKechnie offered a line-by-line review of the environment----

THE CHAIR: No, I appreciate there may be two stages in this. I mean, is it right or is it wrong that Mr McKechnie said that Wallace Whittle did carry out a line-by-line examination?

MS DONALD: I cannot recollect that detail, my Lord.

THE CHAIR: Right. Well, let us leave that out of the equation, but do you have a comment in relation to the argument that the difference between the Environmental Matrix and SHTM 03-01 becomes academic if you look at these two documents through Mr McKenzie's eyes-- Mr McKechnie's eyes?

MS DONALD: Yes, it becomes academic. If looking at it through Mr McKechnie's eyes, and if Mr McKechnie is in error.

My Lord, in relation to the requirement for the finalised document, clearly setting out technical requirements for ventilation at financial close, Mr Maddocks gave evidence to the Inquiry where he noted in response, I think-- Well, it must have been in response to Counsel to the Inquiry, that the Board's technical requirements for the ventilation system ought to have been in their final

form by the time the Project Agreement and contract were signed. That is Mr Maddocks' transcript, my Lord, at page 16. I think that point was picked up by Mr McKenzie in his submissions yesterday.

My Lord, on Point 6, I addressed this issue earlier in my opening remarks.

In relation to Point 7, this is not a matter for Wallace Whittle to comment on, in our submission.

Turning to Point 8, and the issue of the interim 2022 SHTM 03-01. My Lord, my clients invite me to point out at this stage that the fact that the updated-- the changed version of SHTM 03-01 was not in place at the relevant time is fundamental to the issue of design compliance. Though the guidance has now been updated, it would be contrary to logic to hold the design specifications as implemented when the 2014 guidance was in place to the same standards as provided by the newer, 2022 standards guidance. To lend support to this, my Lord, Wallace Whittle have also provided comment to me to the effect that their understanding is that the guidance contained within the new table in SHTM 03-01 2022 has not been used within any other Scottish hospital at the time, it not having been governing guidance at the relevant time.

My Lord, in terms of the question posed about whether there are any

weaknesses or drafting deficiencies in the interim 2022 version, my client is of the view that whilst the document is highly useful as a guide for dialogue between parties, they consider that the document is still by nature open to interpretation and, as such, does not lend itself particularly well to promoting certainty on design requirements between the parties to a project.

THE CHAIR: Just if I can get that, it is useful but still open to interpretation, therefore?

MS DONALD: Therefore, it does not lend itself particularly well to promoting certainty on design requirements between parties to a project.

My Lord, I will turn back to the guidance under Point 10. We are discussing NHS Assure. In terms of Point 9, I can confirm that the understanding is that Wallace Whittle agrees with the potential recommendations proposed by Counsel.

Turning to Point 10 and NHS Assure, my clients agree that the arrangements put in place by NHS Assure represent a robust challenge to help improve Boards' governance and compliance with guidance. I recognise the comments made this morning by Mr Ross and Ms Crawford in relation to NHS Assure being a relatively young body and

one which is continuing to develop. One matter of importance, my Lord, in relation to NHS Assure is that-- I cannot remember which witness gave evidence, but I do recall there being some evidence at the Inquiry that staffing was difficult for NHS Assure. Provided NHS Assure have sufficiently qualified staff to deliver on their duties, it is a robust arrangement.

My Lord, I said I was going to return to the question of guidance. As part of NHS Assure, my clients would propose or suggest that a review of all the current guidance be considered such that, where appropriate, elements of the guidance may be produced as mandatory requirements, and any review would ensure that conflicting guidance be sifted out from circulation between parties to a project. Removing such conflicts would improve on compliance with the guidance, whether that guidance remained as guidance or became mandatory.

Having suggested, my Lord, that perhaps some of the guidance could become mandatory if a full review were carried out, I should say that I do recognise that where it does remain guidance, it needs to remain fluid to allow for changes in medical practices. This recognises, my clients views-- other views, that the clinical needs and patient safety should be first and foremost in

defining the patient environment.

THE CHAIR: Sorry, I just missed that last sentence.

MS DONALD: My clients are of the view, along with others, that patient safety and clinical needs should be first and foremost in defining the patient environment.

My Lord, as a final point on NHS Assure, my submission is, as instructed by my clients, that the current derogation process allows for some robust review of any changes. However, Wallace Whittle believe that NHS Assure, or a body such as NHS Assure, should be the body to take overall responsibility for approval or rejection of any requested derogation, and this is instead of it being by the Health Board or their technical advisors. Having NHS Assure as an overarching body to comment on such matters would be of great assistance.

THE CHAIR: Right, so Wallace Whittle would suggest that in any project, in the event of any proposal to derogate from a then-current guidance should be subject to the approval of NHS Assure?

MS DONALD: Yes.

THE CHAIR: Is that what you have just said?

MS DONALD: Yes.

THE CHAIR: Right.

MS DONALD: Turning now, my Lord, or turning away from the note of

request and turning just briefly to submissions by other parties. My Lord will appreciate where I am coming from when I ask him to consider the nature and purpose of a public inquiry like this one. It is an inquiry set up under statute, intended to be inquisitorial, not adversarial, for your Lordship to hear and test the evidence to allow him to reach conclusions on what did happen and how it might be prevented from happening again. Core participants and recognised legal representatives are here only by the good grace of the Inquiry after having applications approved. The Inquiry is not, in my submission, a forum in which to air matters which are more properly left to the civil courts. Recognised legal representatives are here to assist the Inquiry, provide balanced and reasonable submissions, and not to advance arguments which are not for the Inquiry.

My Lord, I do not suggest that arguments have been advanced that are not for the Inquiry, but the way in which Mr McKechnie was characterised in some of the written submissions, in my submission, went too far. He has been characterised variously as an "outlier," a "single point of failure," and "a golden thread." My clients do not consider these descriptions as fair or reasonable, not least because Mr McKechnie was part of a wider team.

THE CHAIR: I mean, as you have said before, you are presenting Mr McKechnie's interpretation, really, as a Wallace Whittle interpretation?

MS DONALD: Yes. He was part of the design team; I certainly do not demur from that, but it was a design team, and some of the characterisation in writing has, in my submission, been unhelpful. I will leave it at that for your Lordship to make comment as he feels fit.

My Lord, my clients have asked that I highlight two fundamental questions to which we can find no satisfactory explanation or answer from other submissions or indeed from the evidence. In the original Environmental Matrix, it is not clear where the value of 4 air changes per hour originated. It appears to have been from the original Hulley and Kirkwood design, and it may be, in my submission, that that was their interpretation of the guidance. I could not find any reference to that in the evidence.

THE CHAIR: So, this is a point as to, as it were, what was the mechanics when Hulley and Kirkwood were preparing their first version in 2010? Sorry, is that the point or not?

MS DONALD: Yes. Why did they put 4 air changes in? We do not know. The Inquiry does not know.

The second part, my Lord, the second question I am asked to raise is

why, if the 2014 guidance was so clearly interpreted as suggested by NHSL and Mott MacDonald in particular, why was the 2022 interim guidance provided with such a fundamental and basic addition of the table, which we have reproduced in our written closing statement.

It is my client's position that, if the guidance was clear in 2014 SHTM, then that addition of the table in 2022 was not necessary. In essence, my Lord, it is my submission that Wallace Whittle are being criticised for failing to comply with guidance which simply did not exist at the relevant time and in respect of which we are only seeing retrospective interpretations.

Just to finish on that point, Lord, Mr McKenzie gave a submission yesterday, or made a comment in his submission yesterday, to the effect that, until IOM came along in 2018, nobody had expressed a differing view from Mr McKechnie. IOM expressed a different view, and that different view caused a delay to the opening of the hospital. That delay having been caused, it would be remarkable if anyone after that turned to the guidance and chose to adopt the interpretation provided by Mr McKechnie. All I am saying there, my Lord, is that everything-- we are looking back at this matter retrospectively, and it is very difficult for us to know whether-- if Mr

McKechnie's interpretation had been interrogated by anyone, whether anyone would have come up with a different view at that time. That is my submission, my Lord.

THE CHAIR: Now, can you just give me a moment?

MR MACGREGOR: Lord Brodie, just one matter that you had raised with Ms Donald was the issue about the line-by-line review----

THE CHAIR: Yes.

MR MACGREGOR: -- which is obviously something you're interested in, something that it may be relevant for TUV to comment on. Your Lordship may wish to consider the transcript of the evidence from 29 February 2024. It is page 79 of the transcript and page 42 of the PDF. There is a quotation from an email and then the question is posed to Mr McKechnie. It says here that, "TUV SUD had carried out a line-by-line review. Had that been done?" and Mr McKechnie's response is, "Yes." I think that was perhaps the chapter of evidence that your Lordship was considering.

THE CHAIR: That, I think, is what I had in mind. Can you just give me the transcript-- I have got the PDF----

MR MACGREGOR: Yes, my Lord. So, it is----

THE CHAIR: -- pages 42.

MR MACGREGOR: Yes, my Lord.

So, it is the transcript of 29 February 2024. It is PDF page 42, and it is page 79 of the transcript itself.

THE CHAIR: Let us have a look at the transcript. I do not know if you want to respond on that.

MS DONALD: Thank you----

THE CHAIR: If you just-- Yes, there is really maybe no need for comment, Ms Donald, but the point I wanted to draw your attention to was at paragraph 24 of your written closing statement, and it is in relation to the reviewable design data process, and what you say there is that-- the closing statement that Mr McKechnie was unfamiliar with the concept of operational functionality. It goes on to note that Mr McKechnie interpreted NHSL approval under the RDD process as confirming that the proposals were accepted, and then you go on to say:

> "Given the RDD process was operating as a conventional RDD process with comments being fed back on various elements, it is our submission reasonable for Wallace Whittle, TUV SUD, suit to rely on that."

So, I think it is pretty clear there, but Mr McKechnie and Wallace Whittle were working on the basis that, if NHSL approved something – an item, a

proposal – then that was acceptance, full stop, as opposed to acceptance that it was a way of doing it which was consistent with operational functionality. I think I am really just saying that-- I mean, have I understood what you are saying correctly?

MS DONALD: I think the word "approved" might have been better than accepted.

THE CHAIR: Well, approved if you like. I think that was the only point. Thank you, Ms Donald. Thank you. (After a pause) Mr Thornley, on behalf of the parents and representatives of the children. Mr Thornley.

Submissions by Mr Thornley

MR THORNLEY: Thank you, my Lord, for the opportunity to provide an oral submission to the Inquiry on behalf of the patients and families. We have previously submitted two written closing statements after the recent hearings earlier this year and the hearings in 2023, which we adopt. We wish today to make a number of-- a small number, I should say, of further comments and observations, and also respond to the questions raised by your Lordship.

Now, Counsel to the Inquiry have identified a number of key themes which emerged at the hearing which they set out in section 2 of their closing statement, which is at page 8, my Lord. We propose to make a number of further comments about some, but not all, of these key themes.

Turning firstly to the question of the guidance, my Lord, and that is in SHTM 03-01, our view is that the guidance for the ventilation system was clear and we agree with the submission by counsel to the Inquiry in paragraph 35, where they state:

> "The problems with the project did not arise due to a lack of clarity in the published guidance for Critical Care areas."

THE CHAIR: Right, and the interpretation of "critical care area" is what?

MR THORNLEY: Is as defined in counsel to the Inquiry's, closing statement, my Lord. We do not demur from that. Now, in terms of compliance with the guidance, we are very critical of the failure by the Health Board to follow the clear guidance set out in the HAI-SCRIBE Procedure Stage 4, my Lord, and that's at paragraphs 5, 6 and 7 of our recent closing statement.

THE CHAIR: Sorry you are critical of----

MR THORNLEY: The failure by the Health Board, my Lord, to follow the clear

guidance set out in the HAI-SCRIBE Procedure Stage 4, and that is referred to in detail at paragraphs 5, 6 and 7 of our recent closing statement.

THE CHAIR: Well, and in what particular?

MR THORNLEY: My Lord, we say the failure by the Health Board to follow Stage 4 of the HAI-SCRIBE led the Board to accepting practical completion and hand over the hospital when it was actually incomplete, which again is in accordance with the closing statement by Counsel to the Inquiry.

THE CHAIR: Well, maybe I should listen to you first, Mr Thornley, but I am not quite following the point here. The NHSL did go through Stage 4 of HAI-SCRIBE. Are you criticising-- I mean is the point that they-- Well, what is the point, that it was not done at the right stage or what?

MR THORNLEY: Yes, my Lord, that it was done too late, effectively.

THE CHAIR: When should it-- Are we talking about completion of Stage 4?

MR THORNLEY: Stage 4. Yes, my Lord.

THE CHAIR: When should Stage 4 have been completed on your submission?

MR THORNLEY: It should have been completed before the Board accepted practical completion of the

hospital, my Lord, which was at the time of January 2019.

THE CHAIR: Well, first point. Practical completion is an expression in terms of the Project Agreement subject to certification by the independent tester. The HAI-SCRIBE procedure is a requirement of HFN 30. Now, I suppose Point 1 is, do you say they were not necessarily connected?

MR THORNLEY: My Lord, I do not propose to go into that level of detail. I think what I am trying to say is that we are simply adopting what is in the closing statement of counsel to the Inquiry. I do not have the specific paragraph, but I could provide that later, my Lord. (After a pause) It is actually paragraph 40 of counsel to the Inquiry's closing statement, my Lord, where the Health Board-- the reasons given by the Health Board for failing to follow the guidance in HAI-SCRIBE Stage 4 as set out, my Lord.

THE CHAIR: All right, so you are simply adopting 40.

MR THORNLEY: Yes, my lord. Now, if we take into account the purpose of the guidance, which is in the name, Healthcare Associated Infection System for Controlling Risk in the Built Environment.

THE CHAIR: I mean, you talk about guidance, am I not right in saying that the-- we are talking about Stage 4 at the

moment is mandatory?

MR THORNLEY: Sorry, my Lord?

THE CHAIR: Is a requirement to go through the question set at Stage 4 not a mandatory provision?

MR THORNLEY: Yes, my Lord, that's correct.

THE CHAIR: Well, why are you describing it as guidance?

MR THORNLEY: Well, to avoid any confusion, I am simply adopting what is said in paragraph 40 there and making a comment which will follow about the approach of the hospital Health Board.

To repeat, my Lord, what is said in Counsel to the Inquiry's closing statement of paragraph 40:

> "By accepting that practical completion and hand over the hospital in its incomplete state, NHSL triggered its obligation to pay IHSL, the contractors, alleviating the risk of the latter's insolvency."

I am simply adopting that, my Lord. I am not going into any more detail. That is a matter for other-- for your Lordship to determine.

My Lord, we further agree with Counsel to the Inquiry that when considering the risks associated with failing to comply with HAI-SCRIBE, the risk is that a hospital will be accepted as complete from a contractor when it does

not provide a safe environment for patients.

Now, turning to the role of advisors, my Lord, we have already commented in our written submissions on what we consider to be the confused state of the relationship between the Health Board and their technical advisors, Mott MacDonald.

Despite all the evidence that has been led by both parties, we question whether we are any clearer as to what Mott MacDonald's role was as technical advisors. Mr Barne yesterday for the Health Board said that Mott MacDonald were providing technical input and providing assurance to the Board, yet Mr McBrearty said their role was providing technical advice that did not include checking that the design followed the guidance.

My Lord, in terms of the patients and families, we question what is to be made of that, and it is a matter for your Lordship to determine whether the technical advisors were providing reassurance to the Board, which did not involve checking compliance with the guidance in SHTM 03-01. I do not wish to go into any further detail other than make that as a general observation, my Lord.

Now, in my submission, there is no acceptance of responsibility by the Health

Board or Mott MacDonald for this confused situation about what technical advice was, and without such acceptance of responsibility by both parties, we consider that there is surely a risk that this may arise in a future project.

My Lord, turning to the role of the Infection Prevention Control, we adopt what is said by Counsel to the Inquiry at paragraph 53, where they say:

"Had the guidance in SHFN 30 been followed and had IPC been engaged in the decision-making process around SA1, the problems of the ventilation system could potentially have been spotted at an earlier stage."

We previously referred to the failure to involve the Infection Prevention Control team until a late stage in our closing statements, my Lord.

Turning now to the governance and oversight of the Health Board, again we adopt what is said by Counsel to the Inquiry in paragraph 57 in relation to approval of SA1 by the Finance and Resources Committee and the Board. Both of these parties said they took comfort from assurances purportedly provided by Mott MacDonald, but neither of those bodies saw any written confirmation confirming this. In our submission, it seems hard to believe, quite frankly, that they both effectively took this reassurance on trust without

documentary confirmation. And that is simply reiterating what is said in paragraph 57, my Lord.

THE CHAIR: When you say it is hard to believe, are you challenging that evidence or are you doing something else?

MR THORNLEY: No, I am simply passing comment, my Lord. The account of the evidence as set out in Counsel to the Inquiry's closing statement is acceptable.

Now, looking next at the Scottish Government, and adequacy of the governance. At paragraph 61, Counsel to the Inquiry has asked your Lordship to consider whether more should have been done by the Scottish Government. As pointed out there, they could have asked Health Facilities Scotland to conduct a review in advance of providing funding. The question is whether that would have detected the problem and that is a matter for your Lordship, but it seems not unreasonable in our opinion-- our submission, that they would have done.

THE CHAIR: Well, what stage are we talking about? What stage in the chronology are we talking about?

MR THORNLEY: We are talking at the point that funding was provided around SA1.

THE CHAIR: Is that February 2019?

MR THORNLEY: Yes, my Lord.

THE CHAIR: So, presumably before NHS Lothian has signed the agreement or after it has signed the agreement?

MR THORNLEY: Before it had signed the agreement.

THE CHAIR: And so what do you say the Scottish Government should have done?

MR THORNLEY: We say that they could have asked Health Facilities Scotland to conduct a review in advance of finding the funding. We do not go any further than that, my Lord, simply to say that.

THE CHAIR: Right, so you are not actually suggesting what might have been done, or are you?

MR THORNLEY: No, we are suggesting what could have been done, my Lord.

THE CHAIR: So, what would Scottish Government have asked Health Facilities Scotland to do?

MR THORNLEY: To carry out a rev-- well, my Lord, I do not really think that's our position as the parents and families. The question is a broader one as to whether there should have been intervention by Health Facilities Scotland and all we are suggesting is that could have been done, my Lord, not that it should have been done.

The next point I wish to highlight, my Lord, is that the Health Board had a very highly specialised infection control doctor in the shape of Dr Inverarity, who in our view could and should have been asked to assist more often, as it is clear from the evidence that he was not involved until the very late stages. Again, that is no doubt another matter for your Lordship to consider.

Now, in terms of the reference to Glasgow, in terms of Reference 12, which was to examine whether NHS Lothian had an opportunity to learn lessons from the experience of issues relating to ventilation, water and drainage systems at the QEUH, and to what extent they took advantage of that opportunity. My Lord, there's been some evidence about that which is addressed by Counsel to the Inquiry at paragraphs 303-310. And the evidence of Dr Inverarity was that he was aware of some of the problems affecting Glasgow since it opened from his colleagues at the Queen Elizabeth Hospital. And he also raised an issue in an email dated 4 January 2019, flagging up the requirements for formal validation reports, which was before the SA1 agreement was signed.

Now, the Scottish Government, we say, appear to have been aware of potential ventilation problems in Glasgow by the latest January 2019, and the

director of health and social care wrote to every single Scottish Health Board on 25 January 2019 seeking confirmation that all of their Critical Care ventilation systems were being inspected and maintained.

Now, my Lord, we suggest it is not unreasonable that the government ought to have been on alert for potential problems with the ventilation system at the new hospital in Edinburgh, given that it was the same construction company, but we do not-- we cannot go any further than that on the basis of the evidence which your Lordship has heard.

THE CHAIR: I have got that submission, "It is not unreasonable to be on alert."

MR THORNLEY: Yes, my Lord.

Now, the position of the Scottish Government in the evidence that we heard was that the blame was placed firmly on the Health Board, despite the fact that it was their money paying for the whole project. In our view, that represents an abdication of responsibility by the Scottish Government, or at the very least, a major failure of oversight.

THE CHAIR: How do you respond to Ms Crawford's observations about the balance of responsibility between Health Boards in general and Scottish Government as set out in the 1970 Act-- 1978 Act?

MR THORNLEY: I do not disagree with that balance of responsibility set out by Ms Crawford.

THE CHAIR: Right, well, where do you identify the failure in governance by the Scottish Government?

MR THORNLEY: The question is whether, and it is for your Lordship to determine, whether the government were or ought to have been aware of a potential problem with the ventilation system in Edinburgh. Now, it is more "ought to have been aware" on the basis of a very serious problem that was developing at the Queen Elizabeth Hospital in Glasgow. The evidence from Glasgow is that there was intervention at a very high level by the Health Minister towards the end of 2018.

THE CHAIR: End of 2018 or end of 2019?

MR THORNLEY: End of 2018, my Lord. And----

THE CHAIR: What intervention do you have in mind?

MR THORNLEY: So I am talking about awareness, my Lord.

THE CHAIR: I thought you used the word "intervention". I may have misheard you.

MR THORNLEY: I said "awareness," my Lord.

THE CHAIR: Right, so what do you point to as-- well, what in particular did

you have in mind?

MR THORNLEY: We have heard evidence, I mean I can provide the details afterwards, my Lord, but there was a meeting that was attended by the Health Minister with patients and families. There is the letter sent in January by the Director of Health and Social Care about ventilation systems-- Critical Care ventilation systems, requiring them to be inspected and maintained. Now, it is at a general level. It is not at a specific-- it is what they ought to have on notice or alert for, my Lord.

THE CHAIR: All right, so what flows from that?

MR THORNLEY: What do you mean by that?

THE CHAIR: Well, you have said that the Scottish Government should have been on the alert. You have mentioned-- I think you make a correct reference to a meeting between the Cabinet Secretary and I think patients in Glasgow at the end of 2018. Now, what do you ask me to take from that, or what do you take from that?

MR THORNLEY: That the government were aware of significant problems with the water and ventilation systems at the Glasgow hospital, and the evidence for that is the letter from the Director of Health and Social Care in the January.

THE CHAIR: And do you say something more should have been done?

MR THORNLEY: I think that there must have been an awareness of a potential problem, and the issues with the hospital in Edinburgh over the funding and the delayed construction ought to have known to the Scottish Government. It would be very surprising, my Lord, if they were not.

Now, in terms of the further matters raised by your Lordship, the only matter that we wish to comment on is Number 10 about NHS Assure, and whether NHS Assure presents a robust challenge to help improve Boards' governance and compliance with guidance. It appears to us that the new arrangements put in place are very thorough, although we note, as one other legal representative noted, that several witnesses expressed concern about the shortage of infection prevention control staff. All we say is it is a matter for your Lordship to determine whether NHS Assure would have been likely to identify the mistake that occurred. We do have some concerns about that, but it appears to be a robust process which has been put in place. Those are the submissions, my Lord, for the patients and family.

THE CHAIR: Sorry, did you say that it does appear to be a robust----

MR THORNLEY: Yes, my Lord.

THE CHAIR: But you have got concerns about it?

MR THORNLEY: I think some concerns were expressed by witnesses in terms of the staffing, and it is a new project, it has got much more resource--much higher resources behind it than Health Facilities Scotland did, which it has effectively replaced.

THE CHAIR: All right, and that is what you proposed to say?

MR THORNLEY: Yes.

THE CHAIR: Thank you. Well, we will take a break for lunch. Mr MacGregor, is two o'clock convenient to you?

MR MACGREGOR: Yes, my Lord.

THE CHAIR: Right. We will sit again at maybe just after two o'clock.

(Adjourned for a short time)

14:02

THE CHAIR: Mr MacGregor?

Submissions by Mr MacGregor

MR MACGREGOR: Lord Brodie, two closing submissions have been submitted in writing on behalf of counsel to the Inquiry. Those dated 2 June 2023 and 7 May 2024. In addition to those written closing statements, your Lordship also has the provisional position papers and the responses that set out much of the detailed background information in relation to the terms of references. Core participants have had an opportunity to comment on the written submissions produced by Mr McClelland and myself, and I adopt no partisan position today in terms of any specific findings that your Lordship should make, that your Lordship should clearly accept or reject any submissions I make as your Lordship deems appropriate. It is clearly not for the Inquiry to determine civil rights and obligations, and your Lordship should not determine the correct meaning of any contractual provision. But, equally, your Lordship should not be unduly timid or feel inhibited in the discharge of the functions of The Chair, by the likelihood of liability potentially being inferred from any factual determinations that are made.

In terms of my submissions today, I propose to address your Lordship on three issues: firstly, to provide a broad overview; secondly, to address the terms of reference; and then, thirdly, to address the issue of recommendations. In terms of Chapters 2 and 3, those will effectively be a boiled down summary of what is contained within the written submission itself.

In relation to Chapter 1 and

providing an overview, there were significant problems with the project for the Royal Hospital for Children and Young People and the Department Clinical Neurosciences. The ventilation system for Critical Care at the hospital, as originally installed and commissioned, was not adequate and had the potential to adversely impact on patient safety and care. That issue was only identified a matter of days before the hospital was due to open, and the Inquiry has been established to work out what went wrong and to advise on how that can be avoided in the future. At the very front and centre of the Inquiry is the impact the hospital not opening on time has had on patients and families. In my submission there is no question that the Cabinet Secretary was correct not to open the hospital given the potential for risk to patients. But, the Inquiry has heard significant evidence of the human impact on patients and families that arose from that decision. Your Lordship will recall the evidence of patients and families setting out that they were shocked and scared by the decision not to open the hospital. That was in no small part due to the very limited information they were provided with as to why the hospital did not open as planned.

Now, in relation to the Royal Hospital for Children and Young People, care could continue to be provided in a

safe environment at the Old Sick Kids Hospital. That was a Victorian hospital whereby the physical environment was suboptimal, but there is no question and no evidence before the Inquiry of any adverse clinical outcomes for patients arising from being treated in that hospital. However, the issues were much more acute in relation to the Department of Clinical Neurosciences. It had problems, known problems, with the water system, including pseudomonas. Patients had contracted brain infections linked to the water system and there was a reduced capacity for operations to take place. There were, therefore, significant risks associated with patients continuing to be treated in that hospital. However, in my submission, the headline point for your Lordship to take away from the evidence that has been led in the Inquiry is a positive one. The evidence indicates that there were problems with the hospital, but those problems have been completely resolved. In my submission, your Lordship can have confidence in making a finding that the new hospital provides a suitable environment for the delivery of safe, effective patient centred care.

In terms of the overview, in my submission, your Lordship will wish to ascertain what the very genesis of the problem with this project was and, in my submission, that was an error in a

technical spreadsheet called the Environmental Matrix. Now, the author of that document, Mr O'Donnell of Hulley and Kirkwood, he accepts that that document contained an error. Now, that's important because there does seem to be, in the oral submissions made to your Lordship, a general acceptance amongst core participants that there was ambiguity in relation to the status of that document, the Environmental Matrix, both at the procurement stage and at the point the contract was concluded. In my submission, that issue of ambiguity, in both the procurement documents and the contract, is simply a matter of common sense for your Lordship as chair. There are robust arguments put forward by a number of core participants, putting forward radically different interpretations of both the procurement documents and the provisions included in the ultimate contract. Put short, the debate is: was the document a fixed client brief, or was it a document upon which no reliance whatsoever could be placed by a tenderer? The division between those two extreme positions results in radically different submissions being made by core participants in relation to the causative potency of any error in the Environmental Matrix.

Now, in relation to that issue, the causative potency of the error in the

Environmental Matrix, your Lordship has heard eloquent submissions on behalf of core participants in relation to that point. It is perhaps helpful to contrast the submissions made on behalf of Mott McDonald with those made on behalf of Multiplex. Mott McDonald's counsel, Mr McBrearty, his submissions that there was no causative issue arising from the Environmental Matrix, the drafting of the procurement documents or the drafting of the contract itself. Mott MacDonald's position is that really the key issue, the key causative issue, was Mr McKechnie and TUV SUD/Wallace Whittle's interpretation of guidance. That is characterised as being a single point of failure. That proposition can be contrasted with the submissions made on behalf of Multiplex by Mr McKenzie, who characterised that proposition as being unsound. Multiplex's position being that a health board needs to clearly state its brief and cannot simply abdicate responsibility for the brief to the designer.

Now, in my submission as Counsel to the Inquiry, your Lordship may not be faced with a simple binary choice between those two extreme positions. Your Lordship may consider that there is actually a much wider landscape of problems and a range of missed opportunities along the procurement journey through the contract and through

commissioning and validation. One way of considering that broader landscape is perhaps to take the submission made by Mr McBrearty, whereby Mr McBrearty drew a distinction between situations whereby problems could have been spotted and drew a distinction to situations where, in his submission, the problem should have been spotted. Looking through that lens of what should have been done at various stages in the project may be a helpful tool to your Lordship.

NHS Lothian has been clear in its position that it wanted a hospital that fully complied with published guidance. Now, if the very genesis of the problem is in a technical document, an environmental matrix, your Lordship may wish to ask two questions. Your Lordship may wish to firstly reflect on whether NHS Lothian should have had an Environmental Matrix that complied with published guidance.

THE CHAIR: Sorry, just give me that again. Whether the----

MR MACGREGOR: Whether NHS Lothian should have had an Environmental Matrix that complied with published guidance. Secondly, your Lordship may wish to reflect on whether NHS Lothian, assisted by its advisors, should have clearly set out the brief for the ventilation system. I raise those issues for your Lordship's consideration

in the context of causative potency. If the spreadsheet does not contain any errors, there is no scope for changes to be made. If there is a clear and unequivocal brief, there is no scope for changes to be made. Another way of approaching that issue is to consider what would have happened if Mr McKechnie had conducted the line-by-line assessment he stated in his evidence he would have carried out. Presumably, if the Environmental Matrix had contained the correct air change and pressure parameters, at the very least, Mr McKechnie would have told NHS Lothian that he disagreed with the values set out in that document and NHS Lothian would then have had the choice as to whether to maintain the original values or to change those values to reflect Mr McKechnie's interpretation of the guidance.

Pausing there, my Lord, there is a related issue that will have to be grappled with, and that is the question, what was the brief? Even at this stage of the Inquiry, ambiguity remains in relation to that issue, with two broad schools of thought. IHSL and Multiplex have a straightforward position: the brief was the Environmental Matrix. NHS Lothian and and Mott MacDonald disagree with that proposition. Now, it is not a matter of dispute that a full suite of Room

Datasheets, produced using the Activity DataBase, were not provided to prospective tenderers. So Room Datasheets were not the brief. Your Lordship will then have to consider----

THE CHAIR: Sorry, the full suite of Room Datasheets were not provided----

MR MACGREGOR: As the brief to tenderers.

THE CHAIR: As the brief, yes.

MR MACGREGOR: Now, that being the case, your Lordship will have to consider the requirements of CEL 19 (2010), that an appropriate briefing document would be Room Datasheets produced using the Activity DataBase or something of equivalent value.

Now, on the Mott MacDonald and NHSL analysis, the Environmental Matrix cannot be the document of equivalent value because it is not being used as the brief. So that leads to a position on behalf of NHS Lothian and Mott McDonald, that the brief is a requirement to comply with guidance. Guidance which, at that point in time, at least, was open to interpretation, which in my submission, brings one back to the fundamental submission made in the submissions made by Mr McClelland and myself, that the lack of clarity in relation to the brief at tender stage and the brief at the point of conclusion of the contract is at the very heart of the problems. My

Lord, that is not----

THE CHAIR: I was going to ask whether you are opening the question as to whether reference to an SHTM ever could be insufficient?

MR MACGREGOR: Well, indeed, my Lord. I think that is a question. There has been a lot of evidence led in relation to what is SHTM 03-01? It is guidance. It is not a legislative requirement, and it is not something that it is absolutely mandatory to comply with. So in itself, sometimes the guidance is open to interpretation, but also it is not binding. You can depart from guidance if there is a good clinical reason for doing so.

THE CHAIR: On the other hand, if the brief is (inaudible) SHTM 03-01, as I think a number of people have said, through that mechanism, SHTM 03-01 becomes a contractual obligation, but I was just wondering if you were at least raising the question as to whether such a contractual obligation could ever be certain enough to provide a clear brief?

MR MACGREGOR: Well, my Lord, I think that is at the very heart of the problem. What does "comply with guidance" mean if that guidance is open to differing interpretations? And that was something that there was a range of evidence provided on in terms of the difficulties of simply saying, "Just comply with the guidance" if that means different

things to different professionals.

So, my Lord, that deals with the issue of the clarity of "the brief." There are clearly a range of other potential missed opportunities that your Lordship will have to consider, both at the period through the procurement exercise and beyond. Perhaps, just to take one example, that was touched upon in the submissions made, and that is the characterisation of the review of tenders as being a low intensity review.

My Lord, that is statement of fact. It is not a criticism necessarily of what took place, because the Inquiry has heard a lot of evidence about how detailed the Environmental Matrix was, the time and cost of a more intense review, but your Lordship will have to consider just exactly what assessment was made at the tender assessment stage, and perhaps, just to take one example: the Inquiry heard evidence that there were a small sample of Room Datasheets provided by tenderers with their tenders. The evidence provided to the Inquiry indicates that those Room Datasheets were not reviewed by either NHS Lothian or Mott MacDonald at the tender assessment stage, and your Lordship may ask, "Why did that simple exercise not take place? Given that Mr Macrae of Mott MacDonald, his evidence was that that could potentially have spotted the problem right at the start."

So the submission I make for your Lordship's consideration is whether the low intensity review, whereby bidders effectively self-certified compliance with published guidance, was a significant missed opportunity. But that is one example among many for your Lordship to consider. So, if that deals with the brief and some of the associated issues, your Lordship will, in my submission, also have to grapple with the evidence provided by Mr McKechnie as to his position and the submissions made by a range of core participants that Mr McKechnie was the single point of failure and the causative potency of the problems with this project.

In relation to Mr McKechnie's position, in my submission, for the purposes of your Lordship's interim report and final report, it is perhaps more accurate to call it the TUV SUD Wallace Whittle position. It is Mr McKechnie's view. In my submission, he gave his evidence in very clear and straightforward manner. There is no suggestion in any submission I have made, either in writing or today, that there is any element of bad faith in the position that he has adopted and there is certainly no personal criticism made of Mr MrKechnie or the TUV SUD / Wallace Whittle interpretation of the published guidance. But your

Lordship will have to reflect on how that position sits with what, in my submission, is the body and weight of evidence provided to the Inquiry in relation to the interpretation of the guidance.

THE CHAIR: I think what you have said is absolutely clear, Mr MacGregor, but just to sort of run over it again. There is no criticism of Mr McKechnie's sincerity, honesty, accuracy in his evidence in relation to this interpretation point, but to say that he is wrong is not the same as criticising?

MR MACGREGOR: Indeed, my Lord. I think it comes back to the point that I made at the outset, that if your Lordship considers on a plain textual reading of the document backed up by another body of evidence that your Lordship disagrees with Mr McKechnie's position, your Lordship should not shy away from recording that in any report. The converse would be true. If your Lordship accepts Mr McKechnie's position and rejects position put forward by Mr Maddocks and other individuals, your Lordship should not shy away from saying that either.

So on one side of the debate, there is the TUV SUD/Wallace Whittle position. In my submission, on the other side, you have Mr Maddocks, but this is not a scenario whereby you simply have one expert putting forward one view and another expert putting forward a contrary view. Mr Maddocks disagrees with the position put forward by TUV SUD / Wallace Whittle, IOM Limited disagree with that position, Mr McLaughlin from Health Facilities Scotland, he disagrees with that position, and Mr O'Donnell of Hulley & Kirkwood also disagrees with that position.

And perhaps, just while I am touching on Mr O'Donnell and Hulley & Kirkwood, the submission was made earlier today that the Inquiry just simply does not know where the air change rates in the original Environmental Matrix came from and that might have been a conscious choice made by the draftsman. In my submission, we do know the answer to that question, and it was covered off by Mr O'Donnell, both in his witness statement and also in the oral evidence that he gave. If I perhaps just read out paragraph 29 of Mr O'Donnell's witness statement. His evidence was in the following terms:

> "I have been asked why the EM for RHCYP/DCN stipulated that the mechanical ventilation system for Critical Care multi-bedrooms would deliver four air changes per hour despite SHTM 03-01 guidance which sets 10 air changes per hour. This was not a derogation from the

SHTM 03-01 guidance, but a discrepancy, an error."

So, we know Hulley & Kirkwood's position is that it was simply an error.

THE CHAIR: The-- just a failure of noting on my part, the witnesses who gave contrary interpretations to Mr McKechnie were Mr Maddocks, Mr McLaughlin, Mr O'Donnell-- I think I missed another one?

MR MACGREGOR: I simply recorded the fact that IOM Limited when they came in and did their testing, disagreed.

THE CHAIR: Right, okay.

MR MACGREGOR: And your Lordship may also wish to note that the Scottish Government, ultimately the Cabinet Secretary, disagreed with that position.

But your Lordship may want to think in terms of these differing views, if guidance is genuinely open to different interpretations, it would only be a Health Board that knows how it is going to use a clinical space that would be able to give a clear direction as to what particular parameters it wanted in a specific space.

And leading on from that point, my Lord, if your Lordship accepts the characterisation of Mr McKechnie being the single point of failure, your Lordship will also require to reflect on whether he was given the opportunity to be that

single point of failure by the lack of clarity that the Health Board provided in its brief, and it is really back to that earlier point I made: if there is a very clear brief there is no room for interpretation. If there is an ambiguous brief, you are then ceding control for what could potentially be an erroneous interpretation.

THE CHAIR: Understandably, we are talking about interpretation. In relation to what turned out to be a problem, the interpretation is, I think it really just comes down to a question of, "What is meant by the critical care area?"

MR MACGREGOR: Indeed.

THE CHAIR: And as you have, I think, really rather suggested, one might think that that is not a decision that should be left to the judgment of a layman such as myself or Mr McKechnie, who is a highly experienced engineer, although no doubt he has picked up a lot of knowledge in relation to hospitals, but really is a question for specific advice from the appropriate clinician; in other words, the clinicians who want to use this space for critical care, whatever they mean by that.

MR MACGREGOR: Indeed, my Lord. It is the difference between the brief and the design solution to meet that brief.

THE CHAIR: Just so that I understand that point: the brief being the

output?

MR MACGREGOR: Indeed, the brief being the clinical use of the space and the required-- the requirements for that space as opposed to the design to meet those requirements.

THE CHAIR: Uh-huh. When we are talking about design, the dimension of the vents and whatever?

MR MACGREGOR: Indeed, my Lord, but I think perhaps in layman's terms, it comes to be that a designer cannot tell a client what they want. The client has to tell the designer what they want and they then meet the design.

But your Lordship will, in the context of the TUV SUD/Wallace Whittle position, have to grapple with the notion that a line-by-line review was conducted and on their interpretation the correct parameters were provided, and that is relevant to the analysis of whether it is part of the broader picture or it is really the single point of failure on the project.

Linked to that, your Lordship will have to consider the changes made to Guidance Note 15 and whether there has been a cogent explanation for the changes that were made. I would simply remind your Lordship of Mr Maddocks' evidence that his position was if you were faced with a fixed client brief, that brief could not be changed without client approval. In my submission, that comes

back again to the inherent tension of the issue that your Lordship has to resolve, of whether this type of issue is just one issue amongst many in a very broad spectrum, or whether it is truly the nub of the issue, the single point of failure. So, my Lord, that hopefully deals with the planning, the procurement and the contract in terms of a broad overview.

In terms of an outline summary, the other two key stages of the project your Lordship will have to consider is firstly Settlement Agreement 1 and the period leading up to that, the fact that NHS Lothian had identified certain clinical requirements, were prepared to litigate to try to achieve those requirements, and documented a technical solution within Settlement Agreement 1. But again, even at this stage in the Inquiry, parties take radically different approaches to what the technical schedule to Settlement Agreement 1 actually is. It is back to that previous question: is what we see there the brief or is it the design solution to meet the brief?

And that is relevant to a range of issues within the NPD contract. It is relevant to the risk transfer. And it is also, in my submission, relevant to the advice, if any, that NHS Lothian was receiving from its technical advisors, including Mott MacDonald. It is understandable from the evidence the

Inquiry has heard, if what we see within that document is a design solution that neither NHS Lothian nor any of its advisors would take any responsibility for that. The whole concept of a PPP, PFI, or NPD contract is to put all of that design risk onto the private sector.

Your Lordship may consider it slightly more difficult to apply that analysis if what the technical schedule was setting out was a client brief. I think that is back to the point characterised by Mr McBrearty: the difference between providing technical advice as opposed to technical assurance.

In relation to the minutiae of Settlement Agreement 1, the impact of the HAI-SCRIBE procedure, etc., that is all set out in the written submission and I would not propose to go into that in any more detail at this stage.

The next key stage though is, ultimately, having entered into Settlement Agreement 1 and made the payments under Settlement Agreement 1, it then transpired that NHS Lothian wanted something different and achieved that through Supplemental Agreement 2 and High Value Change Notice 107. But, ultimately, where that High Value Change Notice takes one to is a positive outcome in my submission. It is a hospital that fully complies with published guidance and that has been confirmed by Mr Maddocks in his report that the hospital provides a suitable environment for the provision of safe and effective patient-centered care.

That concludes the first chapter of my submissions. I now propose to turn and deal with the terms of reference. Your Lordship may not feel it necessary to take a verbatim note of everything I am going to say because this really is a broad summary of what is set out within the written closing submissions.

The focus of the evidential stages of the Inquiry, the hearings, has really been on pressure and air changes in Critical Care. But the remit of the Inquiry is wider: it is to consider the planning, design, construction, commissioning, and where appropriate, maintenance of the hospital. All of the detail in relation to all issues other than pressure and air changes in critical care are set out in Provisional Position Paper 7, the accompanying note and the responses from core participants.

In relation to Term of Reference 1, in my submission, your Lordship can find that the specification for the ventilation system for the hospital in the period from financial close until the remedial works were completed did not clearly conform to relevant guidance.

Now, that is not an invitation to make a finding that there was any breach

of the Project Agreement, but simply a finding that there was not full compliance with published guidance, namely SHTM 03-01. The key deficiency was with air changes per hour. The ventilation system in critical care provided fewer than half the recommended air changes per hour for certain rooms.

There were also some pressure regimes that did not conform to published guidance, but those pressure regimes had been risk-assessed and found to be either preferable or at least adequate for the proposed clinical functions. The remedial works undertaken was effectively to replace the ventilation system and that is a system that now conforms to applicable recommendations, guidance, and good practice.

Term of Reference 2 concerns procurement and the contractual structure, but the detail on the contractual structure and the financing arrangements are addressed in Provisional Position Paper 10. In my submission, the contractual structure did not directly contribute to the defects and problems that arose, but your Lordship will have to grapple with whether it had an indirect impact on relevant issues.

THE CHAIR: Sorry, say that again? The contractual structure did not----

MR MACGREGOR: Have a direct contribution to the defects that arose. But your Lordship will have to grapple with whether it had an indirect impact on the problems with the project. The reason I characterise matters that way and, in my submission, if there had been a very clear brief and a very clear contractual specification at financial close, it seems unlikely that these problems with the project would have arisen. That is really back to the submissions that I made earlier today: what was the brief? Is the brief the Environmental Matrix? If it is not the Environmental Matrix, what is it? It is the Board construction requirements that simply say "comply with guidance," guidance that is open to different interpretations.

In the context of the procurement exercise and in the contract itself, your Lordship will also have to consider decisions taken by NHS Lothian at key points: one key decision being the determination that a full set of Room Datasheets would not require to be provided at financial close, as has been stated in the original tender documents.

In relation to the NPD model itself, your Lordship will recall the evidence of some of the difficulties that are created within that contractual structure if you try to make changes after the contract has been concluded. Your Lordship will also recall the problems that arose in relation to the financing of the project, whereby

the special purpose vehicle is set up, it has debt obligations to pay but because of the delays in the project, it is not receiving stage payments under the Project Agreement to finance its debt obligations. That has been characterised in a variety of ways. It is neutrally described as being a "driver for settlement" because there was a potential risk of insolvency of the project company. Other core participants have characterised what happens at Settlement Agreement 1 as a "bailout." But in my submission, it is relevant to consider the necessity of a settlement which triggered the payments under the Project Agreement, and whether that fed into some of the decision making, including not completing the Stage 4 HAI-SCRIBE procedure prior to the handover of the hospital.

THE CHAIR: Let me just ask you about that. Help me on this. NHSL had agreed to a technical solution in about March 2018. Multiplex then implemented that and were probably finished by that in October 2018. We assume, because we have not heard anything to the contrary, that the independent tester was attending and doing what an independent tester does in order to certify incremental completion with a view to practical certificate. Now, I think I understand that until Settlement Agreement 1 was signed, which formalised what was really a previous agreement to accept as within the contract the solutions and the technical schedule, was NHSL really in a position to delay the independent tester's certification of practical completion on the grounds that HAI-SCRIBE Stage 4 had not been completed?

MR MACGREGOR: I think, my Lord, it depends how one views the HAI-SCRIBE and how it relates to the settlement, because this was a commercial settlement that was reached. The evidence of the Scottish Government is that the funding for that is signed off during 2018; albeit the payment is not made until 2019. So, if one views it simply in terms of a commercial relationship, then it makes perfect sense because you make the payment, you trigger the stage payments. But what that does not do is take account of Stage 4 HAI-SCRIBE, which should be done according to the published guidance before the hospital is handed over, and I think that gets into the tension. NHS Lothian's position is, "We were always going to do the Stage 4 HAI-SCRIBE, it is just we did not do it at point because the hospital was not at that stage." Now, the other way of looking at that is, "Well, why not just wait until you get to that point that you can do the Stage 4 HAI-SCRIBE before you accept the handover of the

hospital?" That is related, in my submission, to the funding structure. The need for the special purpose vehicle to have funds to service its debt is the driver to that Settlement Agreement.

THE CHAIR: I just wondered if Multiplex-- I am pretty sure that there will be reference to-- in fact, I am pretty sure there will be reference to SFHN 30 and HAI-SCRIBE procedure in the Project Agreement, but I just wondered if it follows from that that Lothian was in a position to say, well, "We have not carried out HAI-SCRIBE, therefore, either we can a withhold payment notwithstanding certification of practical completion by the independent tester, or we can delay certification by the independent tester." I mean the fault may be mine, but I am not necessarily-- And I think something else I was wondering about, whether handover for the purposes of HAI-SCRIBE is the same as handover for the purposes of the Project Agreement.

MR MACGREGOR: Well, certainly, my Lord, in terms of the individual contractual obligations, it would not be any remit of the Inquiry to make a definitive determination what those obligations are, but if one looks at the HAI-SCRIBE procedures, that should be completed before the hospital is handed over. If your Lordship considers there is any lack of clarity as to when that should

take place, that is something that could possibly form suitable recommendations. But certainly, the way it was characterised by a number of individuals that gave evidence was that the whole notion under an NPD contract of transferring risk to the private sector is one that is theoretical as opposed to actually being real.

Your Lordship will recall the evidence of the commercial necessity to reach a settlement so that the funds could flow to service the debt obligations and, in my submission, that is something that your Lordship will have to reflect upon in terms of whether the contractual structures were relevant to the problems. But for the special purpose vehicle, your Lordship may ask the question, "Why not just wait until the hospital has completed the point that the Stage 4 HAI-SCRIBE can be completed?" But again I say that against the backdrop that the evidence from the NHS Lothian witnesses were clear it was never a question of just skipping and never doing the Stage 4 HAI-SCRIBE. It was a question they simply could not do at that stage in time but by the law of unintended consequences, that reaches a situation where the Health Board's paying for a hospital that cannot be used.

THE CHAIR: Help me with this. Am I right in remembering that part of

Settlement Agreement 1 was an agreement which would not have otherwise been the case that practical completion should be certified, notwithstanding the fact that additional works would be done?

MR MACGREGOR: That was the commercial position that was agreed between the parties.

THE CHAIR: If works are still to be done, NHS Lothian would say, well, we cannot finish the HAI-SCRIBE----

MR MACGREGOR: Indeed, my Lord.

THE CHAIR: -- because it includes things like checking on towel dispensers, and if the work is not completed, the towel dispenser may not be there.

MR MACGREGOR: Indeed, my Lord.

THE CHAIR: Right, okay.

MR MACGREGOR: In relation to the Term of Reference 3, my Lord, that deal was one of the most important the issue of governance. The governance procedures that were put in place were essentially standard for a project of this nature. They fully complied with the Scottish Capital Investment Manual. The real detail in the governance structure is set out in Provisional Position Paper 9. One of the issues, in my submission, that your Lordship will have to grapple with is the governance around Settlement

Agreement 1. The fact that there was no vouching provided to support statements made, that technical advisors fully supported the position, and it does not appear that there was any meaningful input from infection prevention and control – certainly Dr Inverarity – in relation to technical solution. But as I have set out in the written closing submissions, the only way the problems with this project could really have been spotted by the governance bodies is if they had insisted on some form of independent technical review being undertaken.

The term "technical audit" I think is a term that I coined; it is not a technical term of art, and apologies if that set hares running, but it is really back to the wider point about just exactly what would be expected. Would it be a full shadow design team that would have to be in place, with all the costs and expense that goes with that? Because if that was not what was going to be required, what would be required of a governance body? And that again perhaps comes back the TUV SUD/Wallace Whittle position. If they had been asked to provide a report, or a document, or a certificate that says, "Does the technical solution fully comply with published guidance?" we know what the answer to that would be. The answer would be "yes." Mr McKechnie still

maintains that view. TUV SUD / Wallace Whittle still maintain that view. So, in my submission, it is perhaps if one is talking about causative potency, issues of governance are not at the absolute heart of the problems that arose on this project.

The Term of Reference also deals with issues such as organisational culture, whether there were adequate whistle-blowing policies and the like, and in my submission, those are fully addressed in Provisional Position Paper 9. The evidence does not suggest that individuals with concerns were not able to raise those concerns. Perhaps the best example of that is Dr Inverarity raising the fact that he required an independent validation report as opposed to the raw data before he could progress the HAI-SCRIBE procedures.

In relation to Term of Reference 4, in my submission, there is no evidence whatsoever indicating any deliberate concealment or failure to disclose wrongdoing in relation to the evidence that has been laid before the Inquiry.

Term of Reference 5 deals with the issue of national oversight. The Scottish Government clearly had an oversight role but, once the funding was put in place given the structure – the separation of powers effectively between central Government and the Health Boards – national oversight was relatively limited.

That is simply a statement of fact, I do not make any particular either criticism or observation of that light touch approach, but your Lordship will have to reflect on whether that standard division of responsibility really is appropriate for these large hospital and infrastructure projects, and I would simply remind your Lordship of the evidence provided by the former Cabinet Secretary. In her evidence, she indicated that she was not convinced that the light touch approach from central Government was actually appropriate for these types of projects.

THE CHAIR: At the stage of drafting the Terms of Reference, one might have assumed that in compared with a particular health board, even a big health board like Lothian, the balance of expertise would lie with the Scottish Government as opposed to the people on the ground who are being asked to do this for the first time. I wonder if the evidence really did reflect that imbalance. There was NSS, but the manning of its various manifestations was not generous and I just wonder if, as I say, the balance of expertise was in favour of Scottish Government, or so clearly in favour of Scottish Government.

MR MACGREGOR: Well, indeed, my Lord. I think that is one issue to be reflected upon. It is obviously important to remember that is the past----

THE CHAIR: Yes, or indeed (inaudible)----

MR MACGREGOR: -- and to think about what the present and the future is.

THE CHAIR: -- may be very different now with NHS Assure.

MR MACGREGOR: Well indeed, my Lord. Now, I will come on to deal with that----

THE CHAIR: Yes.

MR MACGREGOR: -- in the context of recommendations, but it is appropriate to record that the narrative has moved on very significantly. We now have the ventilation safety group, we now have NHS Scotland Assure. NHS Scotland Assure is much better resourced than any predecessor body, and yes, there are questions that could be asked in terms of the role of the Scottish ministers. Could they have asked Health Facility Scotland for a view? I think the generally accepted view, certainly from the evidence, was yes, they potentially could have done that but who would they be turning around to? Perhaps one or three engineers, or alternatively, you are going to have the expense of going to an external consultancy to provide that form of assurance, and that's back to whether that would be necessary and proportionate if ultimately the designer would have been providing a certificate or report saying this really complies with published guidance.

My Lord, clearly there is a step change in the national oversight that is provided after 2 July. The Cabinet Secretary gave-- or the former Cabinet Secretary gave clear evidence that she effectively took control of all decision-making and the project from that point onwards. Your Lordship will recall the evidence of the NHS Board performance escalation framework, the governor's procedures put in place at the escalation to level 3 and then ultimately the escalation to level 4, and the national oversight provided by Scottish Futures Trust, albeit that was on commercial and financial aspects of the project as opposed to technical aspects.

The Term of Reference 6 deals with the issue of inspection and testing. I think the only point I would wish to raise is in terms of SHTM 03-01. A validation report should be produced that sets out that the system will only require routine maintenance in order to remain so for its projected lifespan. There did seem to be a degree of confusion on the part of Mr Henderson at NHS Lothian as to just exactly what had to be produced, whether the raw test information was enough or whether it had to be a specific validation report, and that is really the point that Dr Inverarity became involved. He was not

content with the information that was available and he insisted on the independent report that contained that pithy summary being provided. I raise that, my Lord, because it might be relevant to a wider issue in terms of the recommendations in relation to-- for revenue funded projects, just exactly who is responsible for doing the independent validation. Is it the Health Board that is running the facility, albeit it is not the Health Board that actually owns the facility itself?

(Inaudible) Term of Reference 7 relatively quickly, my Lord. Simply to remedy the defects, the Critical Care ventilation system was effectively replaced. Imtech and Hoare Lee were engaged to design and install a ventilation system that provided positive pressure and 10 air changes per hour, and your Lordship can take comfort from Mr Maddocks's report that the system is now designed and operating in full conformity with SHTM 03-01.

Term of Reference 8 concerns the impact on patients and families. I address that really at the outset of my submissions in terms of the impact the hospital not opening on time had on patients and families, and the fact that that would seem to be a significant issue for children that had to be treated in the old Sick Kids, but a particularly acute issue for those that are required to be treated at the old Department of Clinical Neurosciences.

Your Lordship will also have to consider the communication strategy that was put in place in relation to patients and families. The evidence indicates that patients were clearly informed that they would not be treated at the new hospital and where their treatment would be provided but, in my submission, patients and families were not provided with a clear, direct explanation for the reasons for the hospital not opening as planned, either by NHS Lothian or by the Scottish Government.

Now, that could be contrasted with the letters that were sent by the former Cabinet Secretary to staff at NHS Lothian, and your Lordship will recall the evidence of both Mr Davison and Ms Freeman both agreed that the communications to patients and families were sub-optimal, with Ms Freeman acknowledging that, if a similar problem was to arise in the future, a direct communication should be sent to patients and families.

In relation to Term of Reference 9, that does not arise in relation to the Royal Hospital for Children and Young People or the Department of Clinical Neurosciences, and Term of Reference 10 deals with the choice of site. That is

fully addressed in the 2023 closing submissions and, in my submission, there is simply no issue arising from the choice of site. It was entirely appropriate for the hospital to be based at Little France so that there was a major trauma centre for the East of Scotland.

Terms of Reference 11 and 12 effectively deal with knowledge transfer arrangements and opportunities for lessons to be learned. In my submission, there was no systemic knowledge transfer arrangements in place to learn lessons from health care construction projects in the period prior to the creation of NHS Scotland Assure. There were opportunities and the Scottish Government did write to health boards in relation to certain discrete issues that arose on the Queen Elizabeth University hospital project. However, in my submission, the key take-away from the evidence before the Inquiry is that there was not any centralised system for capturing and recording learnings from health care construction projects. Therefore, any board faced with a new-build hospital would not have been able to readily access learnings from previous projects, but that landscape has radically changed with the creation of NHS Scotland Assure.

So, in terms of closing the chapter of my submissions in relation to the

Terms of Reference, in my submission, your Lordship has a solid evidential basis to address all relevant aspects of the Terms of Reference, and that would bring me on to the final chapter of my submissions in relation to potential recommendations.

In the written submissions, Mr McClelland and myself have really split the recommendations for your Lordship's consideration into two categories: recommendations that we consider could be made immediately by your Lordship in an interim report; and then further wider recommendations that, in our submission, would best be made after your Lordship has heard the evidence in relation to the Queen Elizabeth University Hospital and had a period for reflection. It may be, for some of the bolder suggestions, that a symposium or roundtable meeting to discuss potential recommendations with stakeholders would be of some benefit but, in addressing recommendations, it is appropriate to record the significant changes made by creation of NHS Scotland Assure and the changes made in the most up-to-date version of Scottish Health Technical Memorandum 03-01.

In relation to SHTM 03-01, in my submission, the introduction of the ventilation safety group is perhaps the most important improvement in terms of seeking to avoid the issues that arose on

this project in future projects. It is a group that should fully embed the partnership approach to working, whereby all relevant disciplines are involved in key decisions. The revised guidance also improves the clarity around recommended parameters that should reduce misunderstandings on future projects.

In relation to potential recommendations suitable for an interim report, the first would be that a risk assessment should be carried out if a funding route changes. The evidence indicates a well-intentioned desire on the part of NHS Lothian not to waste work that was done in the capital phase of the project, but that was carried forward into the revenue-funded project without an adequate risk assessment as to whether the work that had been done was either adequate or appropriate for the revised funding and procurement model.

In my submission, there should be a risk assessment undertaken with a recording of the rationale for carrying forward work done on one funding model into another.

The next recommendation we suggest is clarity in brief. In my submission, there must be a clear, unambiguous and finalised brief before a contract is signed. The way it was described by Mr Maddocks is that there must be one source of truth; truth, not documents open to interpretation, one source of truth.

In relation to derogations, there is currently no standard form for derogating from guidance. Now, any such derogation is going to be agreed by the Ventilation Safety Group, but the evidence before the Inquiry, from the public sector, including health boards, and industry, indicates that a standard form derogation for use throughout the whole NHS would be beneficial. It would result in consistent and uniform practices.

The next recommendation suggested is headed, "Duplication of procedures." The Inquiry has heard evidence of a range of processes, procedures and reviews. To take three, the NHSScotland Design Assessment Process, the NDAP, the Sustainable Design and Construction procedure, the SDaC, and NHSScotland Assure's Key Stage Assurance Review procedures. Each of these procedures can be time-consuming and demanding to complete. There is a risk that they become unduly bureaucratic and focused on process rather than substance, and your Lordship may consider that one streamlined procedure would be appropriate.

We have suggested a recommendation about recording common errors. Your Lordship will have

to reflect on whether the Lessons Learned process introduced by NHSScotland Assure adequately addresses this issue or whether further work requires to be done.

Now, we have suggested a recommendation in relation to the commissioning and validation of revenue-funded projects and that is really to try to address that point of which entity should be responsible for the commissioning and validation of the project.

We have suggested a recommendation in relation to role specifications and that is both role specifications within the NHS and in relation to the role of advisors. Now, in relation to role specifications, in relation to that point, in the closing submissions for various core participants, updates have been provided in relation to new role specifications that have been introduced for Infection Prevention and Control personnel, and your Lordship will have to consider whether those are adequate and proportionate. But consideration, in my submission, also needs to be given to whether there are sufficient Infection Prevention and Control professionals to adequately resource the current system.

We have also suggested possible improvements that could be made in relation to the appointment of advisors

and the recording of any technical advice that is provided at key stages of a particular project. Linked to that is a suggested recommendation in relation to training for the various disciplines that would be involved in key decisions on engineering systems. Simply put, engineers do not have the acquired knowledge of Infection Prevention and Control personnel and vice versa, but if one is dealing with a true multidisciplinary team, your Lordship may consider that it is helpful for engineers to have some basic training in Infection Prevention and Control principles and, equally, for microbiologists and Infection Prevention and Control personnel to have a basic understanding of engineering principles.

The final recommendation suggested is that a risk assessment is undertaken in relation to the implications of non-compliance with guidance before any final decision is taken on what approach to adopt. Now, the reason that is included, within the context of this project the decision was simply made not to open the hospital because it did not comply with published guidance. Now, I make no criticism of that decision in the specific circumstances of this case, but I highlight within the written submission that mere non-compliance with the recommendations or guidance does not always automatically equate to an unsafe

environment. It may be appropriate in future cases for a risk assessment to be conducted before a decision is made in relation to what should happen in any particular hospital environment.

That concludes, my Lord, the interim recommendations that your Lordship may wish to consider. There are potential wider recommendations that your Lordship may wish to return to at a later stage in the Inquiry. One would be whether there should be a wholesale review of hospital ventilation. The evidence before the Inquiry indicates that there is a lack of clear research-based evidence in relation to the healthcare built environment and, in particular, the link between specific air changes per hour and infection risk, and I would simply remind your Lordship of the evidence given by Professor Humphreys on that point. That is one issue to be considered.

Another issue would be whether there does need to be legislative intervention in this area. Now, when the new Centre for Excellence was under consideration, one of the issues that was identified was that published guidance required more teeth, and your Lordship may wish to consider whether the current regime adequately meets that aspiration. But this really stems from the point that the Scottish Government adopted the approach that because the hospital did

not comply with the guidance, it simply was not safe enough to treat patients. Now, if that is a correct analysis, your Lordship may pose the question, why are we dealing with guidance as opposed to a mandatory legal standard?

If your Lordship was considering such issues, that may require changes to be made to The Building (Scotland) Regulations 2004 and the associated Technical Handbook, and in that regard I would simply draw to your Lordship's attention that the corresponding English regulations, the English building regulations, introduce the concept of an approved document. Effectively, if you comply with the approved document, then you meet the standards set out in the regulations, but there is not any corresponding provision in Scotland.

THE CHAIR: You make the point that Scottish Government proceeded in July 2019, or you could characterise what Scottish Government did in July 2019 as equating failure to comply with a state of unsafety. I suppose another way of characterising it is that non-compliance with a guidance leads to a situation where there is an absence of assurance of safety, but it would seem to me that whichever way you characterise that, your point is the same. In other words, if it is that important, it should have legislative backup.

MR MACGREGOR: Indeed, my Lord, and I do not shy away from the fact that that may be a difficult issue to capture within legislation.

THE CHAIR: Mm-hmm.

MR MACGREGOR: If we think back to what people said about saying within a contract, "Just comply with the guidance," those difficulties are equally going to arise in a legislative context, but if there is an acceptance that certain parameters in guidance need to be met for a space to be safe, it does seem somewhat curious that that is non-mandatory guidance as opposed to a hard-edged legal standard.

My Lord, I will not take you through the rest of the potential recommendations; those would include a review of the role of NHSScotland Assure. The Inquiry has heard a range of views as to whether it should have more of an inspection role, a role in signing off or whether it should simply be at providing the current review that it does at the moment. Those are all issues, perhaps, for another day later in the Inquiry.

Linked to that would be whether there should be any recommendations made in relation to the procurement process for projects of this nature. Again, the target operating model for the new Centre of Excellence, NHS Scotland Assure described current procurement processes as not fit for purpose. Now, that was an issue that was tested with a number of witnesses. No one was actually able to assist the Inquiry in terms of how the procurement process was not fit for purpose, but clearly at this stage your Lordship has only heard evidence in relation to procurement of an NPD model contract. Your Lordship may wish to hear further evidence in relation to the Queen Elizabeth University Hospital before reaching any final view on that issue.

So, my Lord, that really concludes the submissions I would wish to make in relation to the aspects of the Inquiry dealing with the Royal Hospital for Children & Young People and the Department for Clinical Neurosciences. In my submission, your Lordship has a large body of information and a lot to consider, but that body of evidence should permit your Lordship to make clear findings and to make helpful practical recommendations.

The fact that your Lordship finds himself in that position is in no small part due to the hard work of the core participants, and in closing I would thank the core participants and their representatives for the assistance that they have provided and the spirit in which they have approached matters. I would also thank the Inquiry team for their

efforts, and I would specifically mention Mr McClelland and thank him for his hard work and diligence in the Inquiry. In my submission, he has made a truly outstanding contribution to the work of the Inquiry. But, my Lord, that concludes my submissions, unless I can leave any further assistance on any point?

THE CHAIR: Thank you very much, Mr MacGregor. Now, as Mr MacGregor has indicated, this is the conclusion of the public hearings of the Scottish Hospital Inquiry in relation to the Edinburgh Hospital, the Royal Hospital for Children & Young Persons. The Inquiry, again, as Mr MacGregor has reminded us, has terms of reference which are also directed to the circumstances of the Queen Elizabeth University Hospital in Glasgow, and the next session of evidential hearings in relation to the Queen Elizabeth are planned to begin on 19 August of this year. As I say, this is the conclusion of the public hearings in relation to Edinburgh, although as Mr MacGregor has said, I have a lot to consider. But before finishing this afternoon, can I endorse Mr MacGregor's thanks? Thanks to the core participants and their legal representatives, not only for their contributions today and yesterday, and their attendance at, and therefore contribution to, the oral evidential hearings, but in providing documents and responding to papers. I am very grateful for the assistance of core participants, the legal representatives who have appeared, but also the teams, legal teams, and no doubt support teams behind these, the legal representatives at the hearing.

Could I repeat Mr MacGregor's thanks and acknowledgement of the extraordinarily high quality of the work of Mr McClelland and the members of the Inquiry team. And can I just conclude with reinforcing my thanks to you, Mr MacGregor, for the very considerable work that you have done and the excellent quality of that work. But with these words, I can now conclude, as I say, the public hearings in relation to the Edinburgh Hospital with thanks to everyone involved. Thank you.

(<u>Session ends</u>)

15.34