Scottish Hospitals Inquiry
Decision and Note of Reasons by the Chair in relation to motion to admit in evidence the Report produced to the Inquiry Team by NHS GGC on 24 July 2024 (the GGC Report)

Introduction

1. On 10 July 2024 the Solicitor to the Inquiry received from the Central Legal Office (CLO) acting for NHS Greater Glasgow and Clyde (NHS GGC), a draft report titled "Expert Report for the Scottish Hospitals Inquiry on the evidence of risk of infection from the water and ventilation systems at the Queen Elizabeth University Hospital and Royal Hospital for Children, Glasgow". The draft was dated 26 June 2024. The report's authors are stated to be Professor Peter Hawkey, Professor Emeritus of Clinical & Public Bacteriology and Consultant Clinical Microbiologist, Grampian Health Board; Dr Samir Agrawal, Consultant Haematologist, St Bartholomew's Hospital and Senior Lecturer Queen Mary University of London; and Dr Lydia Drumwright, Research Assistant Professor, University of Washington.

2. A final version of the report was received by the Inquiry on 24 July 2024 (the GGC Report). The Inquiry has also been sent copies of the letters of instruction issued by CLO, the legal representatives of NHS GGC to Professor Hawkey, Dr Agrawal and Dr Drumright.

3. On behalf of NHS GGC, CLO requested that the GGC Report be included in the upcoming hearing's bundles and Professor Hawkey, Dr Agrawal and Dr Drumright be called to give evidence at the hearing scheduled to begin on 19 August until 15 November 2024 (the Glasgow III hearing).

4. I convened a procedural hearing on 30 July 2024 to hear submissions from Counsel to the Inquiry and the legal representatives of the Core Participants who wished to make a submission in relation to this request. Not all Core Participants

chose to make submissions. I heard submissions from: Fred Mackintosh KC, Counsel to the Inquiry; Clare Connelly, Advocate, on behalf of the Cuddihy and Mackay families; Helen Watts KC on behalf of Drs Inkster, Peters and Redding; Una Doherty KC on behalf of National Services Scotland; Steve Love KC on behalf of parents and representatives of children; and Peter Gray KC on behalf of NHS GGC

5. At the hearing Peter Gray KC, on behalf of NHS GGC, confirmed that his formal motion was to invite the Inquiry to determine whether the GGC Report should be considered as part of the evidence to be led at the Glasgow III hearing, and that its authors be called to give evidence.

6. Having heard submissions, I adjourned the procedural hearing to consider them. This is my decision and a note of my reasons for that decision.

The scope of the hearing fixed to begin on 19 August 2024 (Glasgow III)

7. The Inquiry has heard evidence in relation to issues relating to the Queen Elizabeth University Hospital and Royal Hospital for Children (QEUH/RHC) at two previous hearing sessions (Glasgow I and Glasgow II). The hearing set to begin on 19 August 2024 has accordingly been designated as Glasgow III. Arrangements have been made to allow it to run until 15 November 2024.

8. The scope of Glasgow III was set out on 13 December 2023 in Direction 5. This set the objective of providing sufficient evidence to enable four key questions to be answered.

   These four questions are:

   1. From the point at which there were patients within the QEUH/RHC was the water system (including drainage) in an unsafe condition, in the sense that it presented an additional risk of avoidable infection to patients?

2. From the point at which there were patients within the QEUH/RHC was the ventilation in an unsafe condition, in the sense that it presented an additional risk of avoidable infection to patients?

3. Are the water and ventilation systems no longer in an unsafe condition in the sense that they now present no additional avoidable risk of infection?

4. Is there a link, and if so in what way and to what extent, between patient infections and identified unsafe features of the water and ventilation systems?

9. In early 2024 the Scottish Ministers asked that the Glasgow III hearing include sufficient additional witnesses to follow on from the evidence already heard in Glasgow I and II and to determine (in terms of Term of Reference 8) whether communication with patients and their families supported and respected their rights to be informed and to participate in respect of matters bearing on treatment.

10. The witnesses who are planned to be called at Glasgow III will include persons directly involved in the events that are the subject of the Inquiry.

11. The witnesses will also include experts who have not had such direct involvement. The first group of witnesses is made up of the six independent experts instructed by the Inquiry: Dr Mumford, Ms Dempster, Dr Walker, Mr Mookerjee, Mr Bennett and Mr Poplett (the Inquiry Experts). Mr Mookerjee has carried out an epidemiological study based on the experience of the Schiehallion Unit and water testing results obtained from NHS GGC, on which he has reported. Reports from the independent experts have been provided to CPs. Mr Mookerjee is preparing a supplementary report in the light of comments received on his study.

12. The second of the expert groups are the CNR witnesses: Professor Michael Stevens, Ms Gaynor Evans and Professor Mark Wilcox, who were commissioned as an Expert Panel to carry out a review of the case notes of Haemato-Oncology paediatric patients who had Gram-negative environmental pathogen bacteraemia

in the RHC and the QEUH from 2015 to 2019. This review was part of the work of the Oversight Board appointed following the escalation of GGC to Level 4 of the NHS Scotland Performance Management Framework on 22 November 2019. The CNR witnesses authored the Case Note Review Overview Report (the CNR Report) which was published on 22 March 2021. The CNR Report is based on a cohort of 118 episodes of blood stream infection in paediatric haemato-oncology patients being treated in the Schiehallion Unit. Paragraph 3.2 of the CNR Report states that the selection criteria for inclusion of patients in the review (and hence the cohort of 118 episodes) was approved by the Oversight Board. The criteria were: all patients cared for in the Paediatric Haematology Oncology service at the RHC who, between May 2015 and December 2019, with either at least one positive blood culture of Gram-negative bacterium associated with the environment, or at least one positive culture of atypical Mycobacterium spp (acid-fast environmental bacteria).

13. The CNR witnesses are currently scheduled to give evidence during the week of 28 October 2024.

The GGC Report

Terms of instructions

14. The letters of instruction sent to Professor Hawkey and Dr Agrawal are dated 21 November 2022. They are in similar terms. They include the following:

> "As you are aware, a public inquiry, known as the Scottish Hospitals Inquiry (The Inquiry) is underway concerning issues which have arisen in relation to ventilation and water safety and other matters at the QEUH & RHC.
>
> There is also an investigation conducted by Police Scotland in respect of issues relating to water and ventilation at the QEUH & RHC campus. Also, a number of civil claims have been raised against NHS GGC where it is alleged that patients have contracted infections as a result of the hospital environment at the QEUH & RHC.

> This instruction is requested in order for the CLO to provide legal advice to NHS GGC in respect of the police investigation, for the Inquiry and NHS GGC's defence to the civil claims.

15. The letter of instructions dated 21 November 2022 also refers to an “ongoing civil legal claim by NHS GGC against the contractor”.

16. The letter of instructions sent to Dr Drumwright was dated 8 February 2024. It includes the paragraphs quoted above. Dr Drumwright is instructed to provide assistance with statistical analysis. She is advised that the relevant documentation and data is held on a Microsoft Teams site, to which she will be given access. She is provided with a copy of the letter of instructions sent to Professor Hawkey and Dr Agrawal.

17. Dr Agrawal has previously provided a report to NHS GGC dated 18 May 2021 in response to the HSE enforcement actions in respect of Ward 4C.

Contents of the GGC Report.

18. The GGC Report is set out over 218 pages and 12 chapters. Of these 109 pages (18 to 126) and 7 chapters (2 to 8) are substantive. Of the ancillary chapters, chapter 1 is the Introduction; chapter 9 lists the 20 tables and 24 figures referred to in the preceding substantive text; chapter 10 lists 101 references to journal articles; chapter 11 is in the form of a declaration; and chapter 12 (pages 148 to 218) contains the authors’ CVs.

19. Chapter 2 is a brief description of what micro-organisms are, under reference to how they are named, what is meant by an outbreak and the potential for Blood Stream Infection (BSI) to have its source in the patient’s gut. A theme developed in the GGC Report is that whereas the source of a BSI may be a pathogen in the environment (an exogenous source), on the other hand it may have a cause which is internal to the patient, what the GGC Report refers to as the colonised patient (an endogenous source). A colonised patient may bring a source of infection into the hospital environment from the community. There may be person

to person cross-colonisation. A further theme is the value of Whole Genome Sequencing (WGS) as a technique for discriminating among strains of a microorganism.

20. Chapter 3 is titled “Clinical significance and epidemiology of the most common groups of presumed environmental bacteria selected for inclusion by the CNR”. The chapter describes what are presented as the characteristics of bacteria considered in the CNR Report listed by order and genus, particularly under reference to their potential as endogenous rather than exogenous sources of infection, thus, as it would appear, questioning the appropriateness of the criteria used to define the cohort which was subject to review.

21. Chapter 4 is a methodological critique of the work of the CNR.

22. Chapter 5 discusses, in general terms, water contamination and widespread contamination in hospital water systems and how that may be demonstrated. It does not address the actual condition of the water system of the QEUH/RHC at any stage. It explains that where there is an increased risk of infection due to water contamination one does not usually see an increase in infection rates across the whole of a hospital population, rather, when there is an occurrence of nosocomial infection invariably one sees local rises in particular physical locations or among particular groups of patients.

23. Chapter 6 is titled “Ventilation”. Again, it is expressed in general terms rather than addressing any of the specifics of the systems installed in the QEUH/RHC. The chapter lists the major sources of infection. It lists parameters for the management of risk. It notes that hospital patients located in specially ventilated areas may require to leave this protected environment in the course of their treatment. It notes the ubiquitous nature of Aspergillus spp spores. It notes sources of guidance and standards. It observes that while the filtering of airborne organisms and air exchange functions of a ventilation system play a role in reducing the airborne burden of fungal spores, they cannot eliminate the risk. It further observes that the risk of infection arising from an inadequate or insufficient ventilation system would not be equal across all patient populations. Within a

large hospital serving many types of patients, the impact would be greatest in patients with the greatest degree of immunocompromise, either because of their underlying medical condition, the treatment they are receiving or both. Therefore, any increase in infection rates due to airborne transmissible diseases would be most visible in these patients and one of the highest-risk populations is the group of patients with haematological, and other, cancers undergoing intensive chemotherapy and/or haematopoietic stem cell transplants (HSCT).

24. Chapter 7 makes up the largest part of the report (pp 57 to 117). It is titled “Water - an analysis of infection rates and data from QEUH & RHC”. It contains:

    a. A comparison of the positive results for Pseudomonas aeruginosa in Dr Chaput’s summary of water testing results and the rates reported in two published studies
    b. An epidemiological review of the incidence of bacteraemia in adult and paediatric settings in NHS GGC for QEUH and other “comparable” NHS GGC hospitals. Paediatric and adult care settings are examined separately. Bed days are used as a denominator. The review of adult cases is presented under reference to:

        i. Incidence of bacteraemia in adult patients in GGC January 2013 to June 2023 with potential environmental relevance.

        ii. Listing (table 5A to D), in respect of adult haemato-oncology patients, cases of bacteraemia with potential environmental relevance, of microorganism species in low abundancy, by year, consultant sector, hospital, month, year and location, together with an allocation of a degree of probability that the case was part of a cluster. The list is followed by a summary of its contents including the observation that the three most common organisms of environmental relevance detected in the bacteraemia were Enterobacter cloaca, Pseudomonas aeruginosa, and Stenotrophomonas maltophilia. The cases of infection associated with each of these organisms are listed, respectively, in tables 6, 7 and 8, by the same categories used in table 5. Table 9 is headed Summary of

adult whole genome sequencing (WGS) data available compare[d] with epidemiological clustering data.

iii. Assessment of potential epidemiological clusters of Blood Stream Infections (BSIs) with the comment that the pattern observed at QEUH in environmentally relevant bacteraemia is indicative of the norm in the GGC area (figure 8).

iv. Comparison of rates and trends of BSIs in adult haemato-oncology cases as between QEUH and other GGC hospitals presented graphically by reference to whether or not environmentally relevant bacteraemia, with and without adjustment for instances where there were low bed/day numbers (figures 9 to 14) with commentary.

v. Presentation of incidence of bacteraemia in relation to adult bone marrow transplant patients only (figures 15 and 16).

c. Incidence of bacteraemia in paediatric patients (principally in Schiehallion Ward) in Yorkhill and then QEUH/RHC for the period beginning in 2005 and ending in 2022. The review of paediatric cases is presented under reference to:

i. Figure 17 which presents what is said to be the incidence rates for January of each year of the period. Figure 18 presents the rates for organisms of potential environmental concern.

ii. Table 11A to F which lists the microorganism species in low abundancy in relation to bacteraemia in paediatric patients, by year, consultant sector, hospital, month, year and location, together with an allocation of a degree of probability that the case was part of a cluster.

iii. Table 12 which presents the instances of Enterobacter cloaca, table 13 Klebsiella pnemoniae, and table 14 Stenotrophomonas maltophilia, by the same categories used in table 11.

iv. Table 15A to C which presents what is described as a summary of paediatric whole genome sequencing (WGS) data compare[d] with epidemiological clustering data. Table 16 is described as a summary of epidemiological clustering assessment for paediatric patient by hospital [QEUH/ RHC or Yorkhill]. Figure 19 is described as Incidence of bacteraemia cases attributable to environmentally relevant microorganism that may cluster epidemiologically among haemato-oncology paediatric patients in GGC.

v. Figures 20 and 21 are said to illustrate rates of BSIs over the month of January in the period 2005 to 2022 at Yorkhill and QEUH in respect of infections attributable to microorganisms with environmental relevance and with no environmental relevance, with the comment that BSIs with environmentally relevant organisms are following the same pattern as BSIs overall and that significant reduction in BSIs, both environmentally relevant and others, continues to occur at QEUH.

vi. A summary of what is considered to be what the data reveals. The final sentence states: “Taken together these data provide little to no evidence for environmental sources of bacteraemia in patients at QEUH and conversely suggest that policies and procedures for patient management over time could be decreasing incidence of bacteraemia attributable to environmentally relevant microorganisms, as well as all BSIs, although this is speculative and the patient population still has significant bacteraemia burden overall.”

d. A section titled “What does the available sequencing data show?”

25. Chapter 8 presents what are described as the results of a study about the numbers of Aspergillus spp infections (Invasive Aspergillosis) in the haemato-

oncology population of the QEUH/RCH and in predecessor units in Glasgow from 2013 for adult patients and from 2005 for paediatric patients with interpretations. Figure 23 shows the total number of adult patients. It poses the question: "Is there an increased rate of airborne infections in QEUH consistent with a failure of the ventilation system?" which it answers: "For both the paediatric and adult services, the observed number of cases and variations over time do not show evidence of the built environment increasing infection rates."

Submissions by counsel

Counsel to the Inquiry

26. Counsel to the Inquiry, Mr Mackintosh KC, had circulated in advance of the procedural hearing a Written Submission to assist me and the legal representatives. He highlighted his principal points in an oral submission which fell under four heads: (1) the nature of a public inquiry; (2) the approach of the Scottish Hospitals Inquiry to date; (3) the impact on the scheduled hearing if the GGC Report is received into evidence; and (4) the potential courses of action that might be taken in response to Mr Gray's motion.

27. (1) Mr Mackintosh reminded me that in terms of section 17(1) of the Inquiries Act 2005 the procedure of the Inquiry is such as the Chair may direct. However, that discretion is fettered by section 17(3) which provides that the Chair is obliged to act with fairness and that he must "have regard also to the need to avoid unnecessary cost (whether to public funds or to witnesses or others)". The obligation to act with procedural fairness required the Chair to provide for informed representation, but that did not mean an adversarial process; rather, the process should be inquisitorial. It is for the Chair to investigate the subject of the inquiry, to hear the evidence that he considers relevant and where that evidence requires skills or expertise that he does not have to obtain the opinion evidence of such experts as he considers necessary. While the procedure was for the Chair, among the objectives of that procedure should be the avoidance of delay.

28. (2) Mr Mackintosh drew attention to aspects of what has been the Inquiry's approach. The CNR Report was published on 22 March 2021. The cohort

definition was approved by the Oversight Board with input from NHS GGC and Health Protection Scotland. NHS GGC made public statements when the CNR Report was published which did not include criticisms of the CNR's methodology.

29. The Inquiry has now held five evidential hearings. It has heard from the patients and their family members in a context where most had received a report from the CNR setting out the CNR's conclusion as to whether there was a link between a child's infection and the hospital environment. It has heard evidence from treating clinicians as to their experience of what they regarded as unusual numbers and types of infection. It has heard evidence on the principles and practices of hospital ventilation, its role in infection prevention and control and the merits of compliance with Scottish Health Technical Memorandum 03-01.

30. In April 2023 the Inquiry received a Positioning Paper from NHS GGC framed as a response to the four key questions posed by the Inquiry. The Inquiry has had regard to the contents of that Positioning Paper in planning and carrying out its work. In particular it has been put to the Inquiry Experts, together with other reports and draft statements of persons with differing views. The Inquiry's terms of reference require it to look at key building systems which may have been defective and, if they were, the impact that that may have had. Provisional Position Papers have accordingly been prepared by the Inquiry and issued in relation to the potentially deficient nature of the water and ventilation systems. Reports have been instructed from the Inquiry Experts and these reports have been issued and made subject to the protocol in Procedure Direction 5 for questioning the Inquiry Experts. However, in addition to hearing from the Inquiry Experts, the Inquiry will hear from a wide range of skilled or expert persons, from a variety of disciplines, who were involved in the events which are the subject of the Inquiry's terms of reference.

31. Mr Mackintosh accepted that the Inquiry Team had been aware of the possibility of Dr Agrawal and Professor Hawkey producing reports for more than a year, but the Team had not been made aware of the scale of the exercise represented by the GGC Report. At no time had any mention been made by those representing GGC of Dr Drumwright or the major epidemiological study, the apparent results of

which are recorded in chapter 7. Counsel submitted that the approach of GGC in relation to the GGC Report is a breach, at best, of the frequent solemn declarations of cooperation and collaboration made by NHS GGC and those representing them to the Inquiry.

32. (3) As to the impact on the scheduled hearing if the GGC Report is received into evidence, Mr Mackintosh began by identifying some of its features. The conclusion of the GGC Report appears to be that there has been no excess of infections in the QEUH/ RHC compared to other hospitals in Glasgow. This was, as Counsel put it, a big conclusion. It contradicts other views of which the Inquiry has become aware: what was stated in the NHS GGC Core Brief of 22 March 2021 in response to the publication of the CNR Report; evidence of clinicians heard at Glasgow II; the more general concerns over infections summarised in the Inquiry's Provisional Position Paper 5; and the experience of patients and families, including those whose children were part of the CNR review, who gave evidence at Glasgow I. The GGC Report does not address any of this. Neither does it address the condition of the key building systems at the hospital, notwithstanding Dr Agrawal's previous report on ward 4C for the purposes of the proceedings arising from the action of the Health and Safety Executive. The authors of the GGC Report were instructed to advise GGC in relation to the police investigation and the defence of civil claims. Were Mr Mackintosh to have to present the GGC Report as the work of independent experts as that expression is to be understood under reference to Kennedy v Cordia (Services) LLP 2016 SC (UKSC) 59, then a significant amount of work would be necessary to satisfy himself as to the precise status of its authors. It would, for example, be necessary for him to find out just what information has been given to them by GGC about the state of the systems, steps taken to manage those systems and steps taken to remedy them.

33. In addition to the work required fully to ascertain on what basis the authors of the GGC Report were instructed on behalf of NHS GGC, a great deal of other work would have to be done by the Inquiry Team within the short period of three weeks, but also by others. From the Inquiry's perspective, the CNR witnesses would have to be given the opportunity to consider and respond, particularly to

chapters 3 and 4. The topic of the principles and practice of hospital ventilation canvassed at previous hearings would have to be re-opened. The data used in the study described in chapter 7 would have to be acquired by the Inquiry whereas it might have been made available by NHS GGC in February 2024 when Dr Drumwright was instructed. The Inquiry Experts would require to consider and comment on the epidemiological approach taken in chapters 7 and 8. The Inquiry Experts have advised that if they had access to the data used by the authors of the GGC Report, this would involve 70 hours of work but they would wish to obtain comparative data from hospitals across the UK of similar size and vintage using Freedom of Information Requests. The experience of the Inquiry is that this is a very time-consuming business. At earliest, this work might be capable of completion by the end of October 2024. It will involve cost. Witnesses scheduled for Glasgow III may wish to have the opportunity to consider the report. Counsel for the Inquiry and other members of the Inquiry Team will be faced with having to absorb and understand matters which they have not had a previous opportunity to consider prior to having the benefit of a full response from the Inquiry Experts.

34. (4) The available options are: (i) refuse to receive the GGC Report; (ii) receive the GGC Report and delay the hearing; (iii) receive the GGC Report and proceed as planned; (iv) receive the GGC Report and restructure the hearing by leading the authors and if necessary, recalling other witnesses. None were very palatable. Mr Mackintosh had considered but rejected as not possible, the option of dealing with only some but not all of the topics in the GGC Report; it was all or nothing.

The Cuddihy and Mackay families

35. Ms Connelly, on behalf of the Cuddihy and Mackay families had previously provided a written submission to the Inquiry. She adopted that statement and also what was contained in the written and oral statements by Counsel to the Inquiry.

36. As explained in her written submission, it was Ms Connelly's submission that were the GGC Report to be admitted in evidence this would be to change the nature of the Inquiry's procedure from inquisitorial to adversarial. If one core

participant is allowed to “lodge” and have considered their own expert report, it would necessitate the authors appearing as witnesses and for all other core participants to be allowed to cross-examine them in evidence. All core participants would have to be afforded the opportunity to present their own reports and lead their own witnesses. In some cases, core participants such as those whom Ms Connelly represented, would require seeking funding for this. This exercise would be different and could be distinguished from funding to allow a consultation with an expert to enhance the understanding of the expert reports commissioned by the Inquiry. The consequence would be that both the cost and the duration of the Inquiry would increase. There have already been delays in the conduct of the Inquiry. NHS GGC instructed or at least intended to instruct their expert report months ago. For it now to be produced and leave sought for the GGC Report to be received and considered when the next hearing is merely weeks away was unacceptable

37. In developing her submission, Ms Connelly relied on the date on which the GGC Report had first been produced and the impact its receipt would have on the Inquiry, viewed from the perspectives of procedural fairness. All core participants had obligations to the Inquiry which included a duty of candour which comprehended a duty to put forward relevant information and not to do so on a selective basis. The GGC Report did not address infection caused by Gram positive bacteria and in particular by Mycobacterium Chelonae. There was the question as to why the GGC Report was being produced at this late stage, with the underlying data not being produced, notwithstanding that it was instructed on 21 November 2022. It was at best naïve and at worst dishonest to argue that, as was proposed, this piece of work could be used in both adversarial and inquisitorial proceedings. The only available conclusion was that the purpose of seeking to have the report received was to undermine the evidence that the Inquiry had already heard.

38. Ms Connelly invited me to refuse the application by NHS GGC to have the GGC Report received and considered by the Inquiry. In the event that I was to allow its admission, those she represented would require to receive funding to instruct expert reports in all areas where the Inquiry have obtained reports to date in

order to be able to cross-examine the authors of the GGC Report but also the authors of all reports as may be instructed by Core Participants. This would involve an adversarial approach being adopted, at great public expense and would result in substantial delay, which is neither in the interests of patients and their families nor the general public who are funding this Inquiry.

Drs Inkster, Peters and Redding

39. Ms Watts on behalf of Drs Inkster, Peters and Redding, explained her clients' position as being that the provision of an expansive new report, first circulated after close of business on 25 July 2024 and now being discussed at an emergency procedural hearing exactly three weeks before Glasgow III is due to start is fundamentally at odds with the manner in which any legal proceedings ought to be conducted, but in particular is unacceptable in the context of a public inquiry in which a candid and collaborative approach is critical, and therefore that the Inquiry should not allow the report to be included in the hearing bundles, or allow its authors to be called as witnesses.

40. It was surprising to note that what appears to be in contemplation by NHS GGC is an attack on the CNR review, many years after it was completed, and in a manner that is at least arguably at odds with NHS GGC's previous publicly stated positions.

41. Ms Watts agreed with and associated herself with what is said in Counsel to the Inquiry's Written Submission. She highlighted the likelihood of delay if the GGC Report were admitted but also the uncertainty associated with that. She pointed to cost. If the authors of the GGC Report were allowed to be led then her clients would, in the interests of basic procedural fairness, have to apply to the Inquiry for their own funding to instruct expert witnesses to enable them to properly respond to and challenge the report which has been prepared. Then there was the additional work which would be involved in a context where legal representatives were already receiving a steady stream of extensive and complex documents. An additional burden would be imposed on witnesses. This was

particularly true for those whom Ms Watts represented, two of whom were in employment.

42. In conclusion it was Ms Watts' submission that the approach which GGC seeks to take can fairly be characterised as lacking in both candour and courtesy to the Inquiry and to all those who participate in it and for whom its outcome is so desperately important. In her submission the Inquiry should refuse to receive the report or to allow its authors to be called as witnesses.

National Services Scotland

43. On behalf of National Services Scotland (NSS), Ms Doherty explained that the position of NSS was neutral. It neither supported nor opposed the proposal made on behalf of NHS GGC. The GGC Report might be of assistance to the Inquiry but if it were to be admitted the question arises as to how it can be dealt with. Five members of ARHAI Scotland had carried out an initial review of the report and concluded that five weeks was the minimum required to carry out the process described in the protocol in Direction 5. Of the options which had been put forward by Counsel to the Inquiry in the event of the GGC Report being admitted, none were either fair or practical. It would be necessary to postpone beginning Glasgow III by at least five weeks. When asked how that might impact on the availability of legal representatives Ms Doherty agreed that it was likely that this would present difficulty.

Parents and representatives of children treated at QEUH/ RHC

44. Steve Love KC appeared on behalf of the parents and representatives of children who had been treated at QEUH/RHC. He provided a written submission to which he referred and developed. He adopted the written submission of Counsel to the Inquiry and associated himself with what Ms Connelly had said. He agreed that what was proposed would be to change the fundamental nature of the Inquiry. He was not aware of such a proposal having been adopted by any other UK public inquiry.

45. Mr Love began by emphasising that the Inquiry was about patients. It was in this context that he submitted that I should refuse the application to receive the GGC Report at this very late stage. Core participants had only been advised of its existence on 24 July and provided with a copy on 25 July. Those Mr Love represented asked why this was happening three weeks before commencement of forthcoming hearing? Why did it not materialise years ago when patients were being affected by problems and infection issues? Where was it when clinicians were giving evidence at the previous hearing? Why was the CNR not challenged long ago? NHS GGC has done nothing but deny everything. Those whom Mr Love represented have asked who has paid for this report and, specifically, whether it was paid for by the Inquiry.

46. Mr Love opposed receipt of the GGC Report on four grounds. Firstly, it came too late. Secondly, the Inquiry was not the appropriate forum in which to challenge for the first time the findings of the CNR review. Thirdly, to admit the GGC Report would undermine the essential character of the Inquiry in a way that is unsupported by anything in the Inquiries Act 2005 or the Inquiries (Scotland) Rules 2007. Finally, to admit the report would require as a matter of procedural fairness the opportunity for those whom he represented to instruct their own experts and to seek funding from the Inquiry for that, with inevitable consequences for delay and cost.

NHS GGC

47. Mr Gray's submissions followed the written outline which he provided, the purpose of which was stated as being (a) to invite the Inquiry to determine that the GGC Report should be considered as part of the evidence to be led at the Glasgow III hearing to commence on 19 August 2024; and (b) to respond to the criticisms made in the written submission by Counsel to the Inquiry regarding the circumstances in which the report has been submitted.

48. Mr Gray refuted Counsel to the Inquiry's criticism that the approach of NHS GGC in relation to the submission of the NHS GGC was in breach of the standard of candour and cooperation that it sought to persuade the Inquiry it intended to

meet. In Mr Gray's submission NHS GGC and those acting on its behalf had adopted a wholly collaborative approach, best seen when, on a wholly voluntary basis, it had submitted two Positioning Papers dated 14 December 2022 and 5 April 2023, comprehensive in their terms, setting out NHS GGC's position and identifying witnesses from whom the Inquiry might wish to take statements. The Positioning Paper of 14 December 2022 disclosed the instruction of Dr Agrawal and Professor Hawkey, just three weeks after that had formally been done. According to Mr Gray, thereafter, those acting for NHS GGC had kept the Inquiry abreast of progress towards completion of their report, the issues being explored by Dr Agrawal and Professor Hawkey having been described, in broad terms, in the Positioning Papers. As far the instruction of Dr Drumwright was concerned, the fact that a statistical analysis was being undertaken was at no time deliberately concealed from the Inquiry, indeed it had been specifically referred to as the principal cause of delay in completion of the report at a meeting on 10 June 2024. As far as the critique of the CNR was concerned, contrary to what was suggested by Counsel to the Inquiry, NHS GGC had not been involved in setting up the CNR, nor was it in a position to influence the framework of the review. As far as the suggestion that the report might have been released in tranches that would not have been reasonably practicable given that there were so many overlapping issues. It would not have been normal to release the report before it was finalised and Counsel to the Inquiry had stated a preference to receive any report once completed. As far as the criticism that the GGC Report had only been produced "at the last minute" was concerned, it was, of course, unfortunate that it had only now become available but it had been produced as soon as was reasonably practicable. The authors have busy professional lives and the issues which were required to be considered are of complexity. Furthermore, a considerable volume of material had to be obtained from NHS GGC which required to be provided by employees of an organisation which, too, is extremely busy. These challenges will no doubt have also been experienced by the experts instructed by the Inquiry.

49. Mr Gray's outline included an argument that the effect of section 18 of the Inquiries Act 2005 which relates to public access to inquiry proceedings and information was, subject only to the terms of section 19, to impose a duty on the

Inquiry to publish all “documents given, produced or provided” to it and that the GGC Report was such a document. On questioning, Mr Gray did not seek to pursue the argument and abandoned it.

50. In what he described as his concluding remarks, Mr Gray accepted that the Inquiry process was not an adversarial process, but that was not to say that a core participant was precluded from producing material in support of its position. There were reasons to admit the GGC Report. The Inquiry Experts’ reports had been critical of NHS GGC. These criticisms have been challenged by NHS GGC. The GGC Report is relevant. The GGC Report may allay public concern as to the safety of the QEUH/RHC, whereas if the GGC Report was not properly placed in evidence, there was a material risk that public confidence in QEUH/RHC will be damaged irreparably and needlessly.

51. Mr Gray was unable to comment on what Mr Love had said about what was proposed by NHS GGC never having been adopted in any other UK public inquiry.

52. I asked Mr Gray if he had anything to say in response to what had been said by Counsel to the Inquiry and the legal representatives of core participants in relation to the fairness of the consequences of what he proposed in his motion but he expressly indicated that he had nothing to add.

Decision and reasons

53. For inter-related reasons of principle and practicality, I have decided to refuse Mr Gray’s motion and therefore the Inquiry will not consider the GGC Report as part of the evidence to be led at Glasgow III and will not call the authors of the GGC Report as witnesses.

54. I have already described the GGC Report and the circumstances in which it has come into existence. It should not be inferred from that description or anything I have to add that I have come to any view whatsoever as to the soundness or otherwise of its contents and apparent conclusions; I am not in a position to do so

and I have not done so. Nor should it be inferred that I am in any way questioning the integrity, professionalism or good faith of its authors or those who instructed them. Mr Gray specifically stated that there was no question as to the impartiality of the experts instructed by NHS GGC and no question of them having been invited to adopt any position. For present purposes I accept that. The fact remains that the authors of the GGC Report were instructed by NHS GGC's legal advisers (CLO) in order for CLO to provide legal advice to NHS GGC in respect of the Inquiry, and also in respect of a police investigation and the defence to civil claims. The GGC Report was therefore a piece of work commissioned on behalf of NHS GGC for NHS GGC's purposes, entirely legitimate as these purposes may be, but with all the natural consequences of that. NHS GGC and its advisers had control over choice of author, scope of the work, the extent of information provided, and the use made of the eventual product. In short, the GGC Report is an NHS GGC document. In his submission Mr Gray characterised the terms of GGC Report as being to "restore some degree of balance" in the face of the criticisms made by the Inquiry's Expert Reports. That is to confirm its purpose is thus to advance an argument or arguments in favour of the position taken by NHS GGC in its Positioning Paper, and more generally. The GGC Report is an advocacy document prepared for a single core participant.

55. The GGC Report is also a very substantial document. I accept what was said by Counsel to the Inquiry and the representatives of core participants about what would be required properly to understand and evaluate it. NSS have assessed that task as requiring five weeks for a team that is already assembled. Nothing in what was said about this by the legal representatives of the other core participants was challenged on behalf of NHS GGC.

56. At risk of repetition, I imply no criticism of what NHS GGC and its advisers have done, subject only to the qualification that the GGC Report must be seen for what it is and treated accordingly. I proceed on the basis that the GGC Report would be admissible as an expert report in adversarial court proceedings with a view to it being referred to and the authors led as witnesses by legal representatives acting for NHS GGC. However, the Inquiry is not a court. Its proceedings are not

adversarial. It is not proposed that its authors be led by NHS GGC's legal representatives; that responsibility is to be left with Counsel to the Inquiry.

57. In adversarial proceedings, whether civil or criminal, it is for the parties to determine what evidence goes before the factfinder (the judge or the jury), subject only to that evidence being relevant to the matters of fact in issue. Moreover, it is for the parties to protect and advance their respective positions. While the judge has a duty to attempt to ensure that the procedure adopted is efficient and fair, that duty is informed by an expectation that parties have a responsibility to look after their own interests but only a very limited responsibility to look after other parties' interests. Thus, adversarial proceedings are of the nature of a contest in which all the parties are entitled to put such relevant evidence before the court as they wish. The court is bound to hear that competing evidence and make its decision solely on the basis of that evidence.

58. As Ms Connelly succinctly explained in her written and oral submissions, the procedure of inquiries under the 2005 Act, and in particular this Inquiry, is not intended to be adversarial; it is inquisitorial. Ms Connelly cited what had been said by Lord Saville in making his opening statement to the Bloody Sunday Inquiry as illustrating the difference between an inquisitorial approach to be taken in an inquiry and an adversarial approach such as taken in litigation:

> "An Inquiry like the present Inquiry is quite different. Here the Tribunal takes the initiative in trying to ascertain the truth. Unlike an adversarial contest, it is for the Tribunal to seek all the relevant material. Its task is not to decide the matter in favour of one party or side or another. Indeed, from the point of view of the Tribunal, there are no parties or sides. There will, of course, be those who have material evidence to give or who have a legitimate interest in challenging such evidence, but the Tribunal will not treat them as sides or parties in an adversarial contest, but rather as a means of seeking out the truth. (Volume X, A2.1 Opening Statement of the Tribunal (3rd April 1998) p.45)."

59. It was Ms Connelly's submission that to admit the GGC Report as part of the evidence to be considered by the Inquiry would be to make a fundamental change in the procedure adopted from an inquisitorial method to an adversarial method, with the consequence that fairness would require that what had been allowed to NHS GGC should be allowed to other core participants and all that would follow from that. I understood Ms Watts and Mr Love to associate themselves with Ms Connelly's submission. I heard nothing to contrary effect.

60. I accept Ms Connelly's reference to what was said by Lord Saville as entirely apposite and I accept her submission that to allow the GGC Report to become part of the evidence to the Inquiry would be to abandon the inquisitorial procedure controlled by the chair, which the Inquiry has adopted until now, and turn it into something like an adversarial litigation. I would see that as entirely inconsistent with my duties in terms of section 17 of the 2005 Act.

61. While what I require to decide can be resolved at the level of principle, the inevitable consequences of admitting the GGC Report narrated by Counsel to the Inquiry and the legal representatives of core participants and not disputed by counsel for NHS GGC and which I accept would arise, underline why it should not be admitted. Put short, it would mean not being able to conduct a Glasgow III hearing beginning on 19 August 2024 which met the requirements of procedural fairness. That is something which should be avoided.

62. Counsel to the Inquiry and legal representatives of core participants made criticisms of the conduct of NHS GGC in this matter which Mr Gray was eager to refute. It is not necessary for my decision to express any view on what was said and I do not do so. I simply welcome Mr Gray's reaffirmation of NHS GGC's wish to adopt a wholly collaborative approach in its engagement with the Inquiry.

Lord Brodie
Chair, Scottish Hospitals Inquiry
01 August 2024