SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
25 April 2023

Day 2
Wednesday, 26 April 2023
Janice MacKenzie

CONTENTS

10:00

THE CHAIR: Good morning, ladies and gentlemen. Both good morning to those in the hearing room and those who are following us online. We are about to resume our hearing in relation to the Roya Hospital for Children and Young Persons. Again, asking the questions will be Deputy Counsel to the Inquiry, John MacGregor, who is assisted by one of the solicitors in the Inquiry, Kiera Dargie. I am assisted by Ingrid Nolan, who is another of the assistant solicitors in the Inquiry. Now, Mr MacGregor, we have a witness?

MR MACGREGOR: We do. The next witness would be Janice MacKenzie.

THE CHAIR: Thank you.

MR MACGREGOR: Good morning, Ms MacKenzie.

THE WITNESS: Morning.

THE CHAIR: Now, as you understand, if you have been with us before----

THE WITNESS: I have.

THE CHAIR: As you understand, you are about to be asked questions by Mr MacGregor on the right – but first, you are willing, I think, to take the oath?

THE WITNESS: Yes.

Ms JANICE MACKENZIE
Sworn

THE CHAIR: Thank you very much, Ms MacKenzie. Now, if only for me, because my hearing is-- probably heard me say it before----

THE WITNESS: Yes.

THE CHAIR: -- my hearing is not what it was, and I am anxious to hear your answers. So, if I can ask you maybe to speak-- you should get assistance from the microphone, but maybe just a little louder than you would normally and possibly if it is a little slower?

THE WITNESS: Okay.

THE CHAIR: It is not easy, but as I say, my hearing is not what it was. Now, Mr MacGregor.

MR MACGREGOR: Thank you.

Questioned by Mr MacGregor KC

Q You are Janice MacKenzie. Is that right?

A It is.

Q You have provided a witness statement to the Inquiry for this set of hearings which you should have a copy available to you if you require it.

A Yes.

Q For anyone following in the electronic bundles, it is in bundle 13, beginning at page 187. The content of that statement is going to form part of your evidence to the Inquiry. You are also going to be asked questions today. If at any point you want to refer to your statement, please do just let me know. In relation to your career, you tell us within your statement at paragraph 2 that you are retired but you were previously the project clinical director with the Lothian Health Board. Is that correct?

A That is correct, yes.

Q In relation to your career and background, you had already set that out in a previous witness statement that you provided to the Inquiry and also in the oral evidence that you gave in the hearings in May 2022.

A Yes.

Q Yes. So, in terms of today I would simply take all of that background as read and move on to ask you some questions about the procurement exercise and the period to conclusion of the contract in the project involving that the Royal Hospital for Children and Young People. Am I right in thinking that you become involved in the project really at the point that there is the switch that is taking place from the original capital project to the project that is then going to be revenue funded?

A Yes, directly involved in the project. I started on the project in April 2011.

Q Before that perhaps some limited input in your clinical capacity, but really – in terms of being fully engaged in the project – it is at this point in 2011 that you are coming on board.

A That's correct.

Q Thank you. You explain at paragraph 9 of your statement-- it might just be worth turning that up. So, within bundle 13, it is at page 189, and it would be paragraph 9. See, the paragraph beginning "When the switch to NPD…"?

A Yes.

Q You tell us:

> "When the switch to NPD was announced, the design for the RHSC stand-alone hospital was at a relatively advanced stage. Following the switch to an NPD funded model, there was continued engagement with the clinicians (i.e. the user groups) to try and utilise and continue the design work undertaken to date. This is around the point at which I became directly involved."

Do you see that?

A Yes.

Q Could you just explain your understanding of how much design work has taken place and what clinical input has there been into that design?

A So, by that time the departmental adjacencies had been agreed and adjacencies within departments, so the 1 in 5-- what we refer to as the 1 in 500 drawings which are the departmental adjacencies by floor, and then the 1 in 200s which are the room adjacencies. We were about to start on 1 in 50 detailed design of rooms, and the clinicians had attended design meetings with the architects to plan out what was required from their perspective.

Q At this point, in terms of the input from clinicians, mainly input in relation to the architects in terms of the design, rooms' adjacencies, those types of issues----

A Yes.

Q Is that correct?

A Yes.

Q Were you aware at this point that there had been a draft Environmental Matrix prepared by engineers?

A I don't know if exactly at that point I was. I certainly-- at some

point, on joining the project fairly early on, I was aware that there was a draft Environmental Matrix.

Q At this point, you tell us that, understandably, NHS Lothian did not want to waste work that had been done. Is that in terms of the work both done in terms of the design, so sums paid to outside contractors that worked on the project?

A Yes, but I think from my perspective it was the work that the clinicians had given. I mean, as you'll appreciate, clinicians are very busy people, and they had given up a lot of their time, and that the design, from their perspective, wasn't going to change in relation-- just because the funding model was changing.

Q So, whenever you are talking about not wanting to waste the work that has been done, perhaps two issues as I understand you. Firstly, there is the work that has been done by the outside professionals – the architects, the engineers – but also there is the internal work, the time taken up by clinicians who would otherwise be doing their day job of dealing with treating people that need to come into hospital.

A Yeah. Yes.

Q That is entirely understandable that a body that has

done that work would not want to waste that work. Was there an assessment at this point of whether that work on the capital phase was going to be appropriate for a revenue funded project?

A I think, from a clinical design point of view, it would make no difference between a capital funded or a revenue funded project because the care that was required to be delivered to children and their families wasn't going to change, so therefore the facilities that were required weren't going to change.

Q So, from clinical perspective – the second aspect of the work – you really did not see that there was going to be any differences at all.

A No.

Q What about in relation to the work that had been done by the professionals, so the architects, the engineers? Was there any consideration given by the project team to whether that work simply be taken and built upon in the revenue funded model?

A I don't know that there was any formal assessment, but certainly, yes, there was discussions about the relevance of work that had been undertaken.

Q Are you able to kind of give us any more detail in terms of those discussions? Are those internal discussions or is NHS Lothian engaging with other bodies and entities to discuss those issues?

A I don't recall exactly what the discussions were.

Q You do not recall the discussions or do not recall who was involved?

A I don't recall specifics of discussions and who was involved.

Q Thank you. The reason I raise the issue is that there are certain other witnesses that have given evidence to the Inquiry and provided witness statements that have suggested that issues like the Environmental Matrix may have been very helpful on a capital project but were perhaps less helpful on a revenue funded project. Do you remember any discussions around about those issues?

A No, I wasn't really involved in discussions about the Environmental Matrix.

Q Did you understand why it had been produced at all or was that really an issue for other people?

A I think on the whole it was an issue for other people. I understood it was there, and I understood that it had information in it

from a technical perspective, but it wasn't something that I was looking at.

Q But in terms of whether that would be a helpful document, something that could give rise to confusion, is that all outwith your sort of expertise?

A Yeah. Yes, I wouldn't have the expertise to make a comment on that.

Q Thank you. The next issue that I would like to ask you about is just to try and understand that the clinical input that is being provided to the engineers as they go about undertaking their task. So, if I could ask you to look at your witness statement at paragraph 12, I think to pick these matters up. So, that would have been page 189 of bundle 13. You tell us:

> "The clinicians' input at the meetings would include explaining the requirements of their department, particularly what accommodation they required. They would provide information around specific rooms and what they were used for. For example, clinicians would explain what activities would be happening in a specific room and the equipment required so that the architects and other advisors could plan accordingly. The architects could also explain their proposals to the clinicians to seek to ensure that spaces were designed appropriately. Various design changes were discussed during these meetings and subsequently captured in the next revised set of drawings, which were then issued for further review."

Do you see that?

A Yes.

Q So, you tell us within your statement that you do not recall there being any specific discussions taking place with Hulley & Kirkwood, who were the mechanical and electrical engineers. Is that correct?

A That is correct, yes.

Q Can you just shed some light on why were there not discussions between the clinicians and Hulley & Kirkwood?

A As far as I was aware, as such the clinicians wouldn't have been in a position to know the kind of mechanical engineering type of information that would be required; they would be reliant upon experts in that field to provide that. So, they would respond to specific questions if M&E engineers had questions about activities happening in a room, but

they wouldn't have the knowledge to comment on whether or not those were correct or not.

Q Because I think one thing I would raise with you for comment is we have obviously heard from the engineering side, from Hulley & Kirkwood, and they almost put the counterpoint to that, which is to say, "Well, I'm an engineer. I'm not a clinician. So, I can do the technical, mechanical, and electrical engineering, but I can't provide the kind of clinical input into how a space would be used in a room." Do you see it as potentially problematic that there was not a direct discussion between clinicians and the engineers on the project?

A I think the information that was required around activities happening in particular rooms was provided. It was there. It was there initially in what we call "design briefs" that then developed into clinical output specifications. So, the information was there for engineers to look at, and if they had any queries, then they would come back to us. Certainly, as I became more involved in the project, there were queries-- came back from engineers about, you know, some of the more technical aspects of the project that they wanted clarity on in relation to the clinical activities that

would be happening in a room.

Q So, how did that flow of information take place? If you have got the clinicians on one hand, and you have got the engineers, Hulley & Kirkwood, and they are not speaking directly to each other, how does information flow between the two parties?

A So, in relation to Hulley & Kirkwood then, as I say, I wasn't directly involved really with them at that time, but my understanding would have been that that would have been directed through the project team through one of the capital project managers or one of the other project managers, and then if they didn't know the answer, they would then discuss it with the clinicians and then would feedback to the engineers.

Q Is that a direct line of communication between Hulley & Kirkwood and people in the NHS or are other entities such as Davis Langdon, Mott MacDonald-- are they involved in the planning and communication?

A Yes, they would be involved in the communication, yes.

Q You have obviously said in your evidence that you do not think there would have been any point in clinicians looking at something like an

Environmental Matrix. Just as a matter of clarity, do you know whether the Environmental Matrix in draft form or final form was ever provided to clinicians at all?

A As far as I can recall, it was never provided.

Q Again, you have explained why you do not think that would have been a good idea. One other issue that I would just like to ask you about is the Inquiry has heard evidence in relation to the development of technical guidance for ventilation systems in a hospital. So, if you go back prior to 2011, there was really no guidance in terms of air change rates or the like, but from 2011 onwards there was there was developing guidance; you have perhaps heard about Scottish Health Technical Memorandum 03-01 for Scotland, and Health Technical Memorandum 03-01 in England. Whenever that type of guidance was coming in, it is technical guidance in relation to engineering requirements, but is that something that would have been on the radar of clinicians and people working in Infection Prevention and Control?

A I don't think it necessarily would have been something that clinicians would have been aware of or

would have thought it was appropriate for them to look at. I think, yes, Infection Prevention and Control would certainly have an awareness of any new guidance that was coming out.

Q The next issue that I would wish to ask you about is the clinical output specifications which you addressed in your statement. Could you explain to the Inquiry, what were the clinical output specifications?

A So, there was a clinical output specification for every department in the hospital, and in that it explained what the function of that department was, the types of patients that would be there, the activity levels. It then went on to explain the main activities that would be happening in each of the rooms within the department, any specific requirements from a clinical perspective that were kind of different from being kind of standard requirements. It also made reference to technical documents that the designers should be aware of and be following.

Q In very simple terms, would this effectively become the client brief that would go out to tenderers?

A Yes.

Q If I can ask you to look within your statement at page 191 of bundle 13, at paragraph 19. Just at

the very bottom of page 191, do you see the final sentence beginning "The COS became…"?

A Yes.

Q You tell the Inquiry:

"The COS became one of the key documents in ITPD Volume 3 and provided the preferred bidders with the detailed requirements and functions of each of the clinical departments."

Do you see that?

A Yes.

Q Also included in the ITPD within the Board's construction requirements, as they came to be called, was the Environmental Matrix. Were you aware of that?

A I was aware that, yes, it was part of the Board construction requirements, yes.

Q Again, there seems to be a controversy between core participants participating in the Inquiry in relation to the status of that document. In terms of the board's construction requirements and the Environmental Matrix that was included as an appendix, there seems to be two schools of thought: on the one hand, it was a mandatory brief that set out absolute requirements that had to be followed by tenderers; but there is a differing view which is that it was just really provided as a guide, or it could not be relied upon at all by tenderers. What was your understanding of the intention of the document?

A My understanding was that it was a draft. It was at a point in time when we went out to tender and that it would continue to be developed as the design developed as many of the documents that were provided. I mean, they changed the reference design no longer(? 00:50:09). Once the bidders were appointed, they developed that, and it became their design.

Q Were you aware that within ITPD, that room data sheets were not provided, that they had not been produced by NHS Lothian or its advisor?

A I was aware that, yes, they hadn't been provided.

Q Can you recall why that decision was taken not to produce room data sheets?

A No, I don't recall. I don't-- I wasn't involved in any discussions about that.

Q Because, again, you may not be able to help, but one issue that the Inquiry is interested to try to explore is whether, really, the

Environmental Matrix came to be a brief instead of the room data sheets. Are you able to shed any light on that issue?

A The only thing that I'm aware of is that the Environmental Matrix contained some information that would be in room data sheets.

Q In relation to reviewing what you call the clinical output specification that comes to be included in the ITPD – obviously, you have talked about the internal work that takes place on the part of NHS Lothian – what advice, if any, is NHS Lothian getting from external advisors?

A So, the clinical output specifications, the templates that we used was reviewed by Capita, who were healthcare planners at the time, and also Mott MacDonald reviewed them as well.

Q You have mentioned Mott MacDonald. Perhaps if we just explore that a little. Who are Mott MacDonald and what was their role in the project?

A So, Mott MacDonald were our technical advisors and also helping with project management aspects.

Q What about when it came to the assessment of tenders, were Mott MacDonald involved at that stage?

A Yes, they were involved, yes.

Q What were they doing at that stage?

A They were assisting us with evaluating the tenders.

Q Again, if we just look to your witness statement in bundle 13 and look to paragraph 22, you tell us:

> "From my perspective, the review of the COS by Motts included ensuring that the correct design guidance was stated, including in relation to mechanical and electrical ('M&E') engineering. Motts' role would have been to ensure the relevant guidance set out at section 9 of the COS."

Is that----

A Yes.

Q So, that is your understanding of what Mott MacDonald's role would have been in terms of the production and reviewing of the documentation that goes out to tenderers?

A Yes.

Q Thank you. If I can ask you to then look on to page 195, paragraph 34, the final sentence there, you state, "They [this is referring to Mott MacDonald] were our technical

advisers who could and did advise on all technical issues." Could you just explain what you mean by that, advising on all technical issues?

A I suppose anything that was related to mechanical engineering or architectural, they were providing advice to us around whether or not drawings or proposals from their perspective were meeting our brief.

Q Mott MacDonald's role has been described by another witness who provided a witness statement to the Inquiry as being akin to that of a shadow design team. Would you agree with that assessment of the role of Mott MacDonald effectively being a shadow design team?

A I'm not sure that I would. I don't think they were there to design the new hospital. They were there to provide us with advice but, you know, it's not something I would recognise their role as.

Q Thank you. Now, in relation to Mott MacDonald's role in the review of tenders, the Inquiry has got witness statements that have been provided on behalf of Mott MacDonald whereby their view is that what they were doing at that stage is they were not conducting a forensic audit of tenders that had been submitted, they were not conducting a line-by-line review of environmental matrices provided by prospective tenderers. Was that your understanding of the relatively limited role that Mott MacDonald would have?

A I don't know that I would necessarily be aware of the kind of the level of scrutiny that they were providing. I think, as far as I was concerned and certainly my interactions with them were that they were providing a lot of scrutiny and review, but I was predominantly, obviously, involved in the more architectural aspects of the design, and certainly my main contact in Motts attended all the design meetings and was very helpful at those meetings.

Q Did they provide any assurances before a preferred bidder was appointed, perhaps to the Finance and Performance Review Committee?

A I didn't attend those meetings so I'm not sure.

Q Well, I appreciate it is a long time ago----

A Yeah.

Q -- so perhaps if we turn the minutes up that might be more productive. If I could ask you to look within bundle 10 please, volume 1, and to go to page 5. This is minutes of a finance and resources committee of

NHS Lothian of 5 March 2015.

A Yes.

Q Do you see that?

A Yes.

Q In attendance, in the final line of the attendees, you were an attendee----

A I was.

Q I appreciate this is----

A Yes.

Q -- nearly 10 years ago now, so it is perhaps more helpful to go through the minutes rather than to ask you a few general questions. We see, at paragraph 61, the bold heading:

> "**Royal Hospital for Sick Children and the Department of Clinical Neurosciences, Little France, Project Procurement and Recommendation of Preferred Bidder."**

61.1:

> "The Committee received a previously circulated report confirming completion of the evaluation of Final Tenders for the Royal Hospital for Sick Children and Department of Clinical Neurosciences at Little France."

Do you see that?

A Yes.

Q So, at this point you are getting to the point that documents have been issued to bidders, bids have come in, assessments have taken place, and there is now a consideration by this committee of what has come in. Look at 61.4, this is a point I will come back to, but just so we do not have to jump backwards and forwards in documents:

> "The Committee noted that the Scottish Futures Trust required that 60% of the evaluation of Final Tenders had to relate to commercial/cost and that 40% of the evaluation of Final Tenders had to relate to quality."

Do you see that?

A I do.

Q Just, in relation to that 60/40 split, was that something that NHS Lothian was completely comfortable with?

A My recollection is that, no, we weren't comfortable with it. Obviously, this was the first project that I had been involved in, but I recall that, in being told that in previous capital funded projects, it was the other way around; so, 60 per cent was for quality and 40 per cent with finance, and that that was what NHS Lothian would have preferred.

Q They would have

preferred the 60/40 split but the other way around?

A Way around, yes.

Q We can come on to-- but I think in your witness statement you described that as being imposed on NHS Lothian. Is that a fair assessment of your view?

A That's certainly my recollection of, yes, what was happening. I mean, I wasn't involved in discussions with SFT about that, but certainly that that was what we were told.

Q Because, again, just to be fair, the Inquiry might hear evidence from witnesses from the Scottish Futures Trust who say 60/40 split in terms of price and quality was standard, but it could have been departed from if there were exceptions to that. So, yes, it was standard, but it was not actually imposed by Scottish Futures Trust. Do you have any assistance you can provide the Inquiry on that issue?

A No I don't. As I say, I wasn't involved in the discussions, so---

Q Thank you. If we could return to the minutes – we are still within bundle 10, volume 1, page 5 – and if we could move on to page 6, look at 61.10. The minutes record:

"Mr Cantlay, representing Mott MacDonald, advised the Committee that as technical advisors for the reprovision of the Royal Hospital for Sick Children and Department of Clinical Neurosciences at Little France NDP project he believed from a technical perspective that the technical evaluation had been carried out in a manner consistent with the evaluation methodology. From their involvement in this process, the considered scores awarded for the technical evaluation criteria seemed to be correct and it appeared appropriate for the Board to conclude the evaluation process and appoint the bidder identified as having the most economically advantageous tender as the preferred bidder."

Do you see that?

A I do, yes.

Q Having refreshed your memory in the minutes, do you remember that statement being made by Mr Cantlay?

A I don't specifically remember it, no.

Q Do you remember the weight, if any, that was accorded by the Board to the statements made by Mr Cantlay?

A No, I don't.

Q Moving onto page 7, paragraph 61.16: "Mr Currie confirmed that all three bids had been of an acceptable quality…" Do you see that?

A Yes.

Q And then perhaps just reading short to the last three lines, final full sentence: "Everything possible had been done to mitigate the risk of poor quality facilities and/or poor services being provided to NHS Lothian." Do you see that?

A I do, yes.

Q Do you have any recollection of that type of discussion taking place around about this time?

A I do now recall attending the meeting. I'd say I wouldn't normally attend those meetings. From my recollection, the reason for my attendance at that meeting was in case any of the Finance and Resource Committee had questions about anything clinical in relation to the tenders but I don't recall the detail of the meeting.

Q Just the final couple of sections to look at, paragraph 61.20,

that is on page 7. Do you see the paragraph at the bottom beginning, "Mr Cantlay confirmed…"?

A Yes.

Q

"Mr Cantlay confirmed that the scores were all appropriate and he was happy with the evaluation and satisfied that the preferred bidder was in full accordance with the requirements."

Do you see that?

A Yes.

Q Then over the page, page 8, paragraph 61.23, we see the resolutions that are made by the committee:

"The Committee agreed to note the outcome of the scored evaluation and the assurance statements provided by Legal, Technical and Financial Advisers along with the completion of the Key Stage Review (Appointment of Preferred Bidder) by the Scottish Futures Trust.

The Committee agreed unanimously, with no dissent from any members present, to approve the recommended of the Project Team, as endorsed by the Project Steering Board, to appoint Integrated Health

Solutions Lothian as the preferred bidder for the development of the Royal Hospital for Sick Children and the Department of Clinical Neurosciences on the site at Little France and to authorise the Project Director to issue the formal Preferred Bidder Letter and the two associated unsuccessful bidder letters in order to formally commence the contract 'standstill period' required under the relevant procurement regulations."

Do you see that?

A Yes.

Q It seems from the terms of this minute that effectively the committee is being told that there has been an assessment of tenders, everything is in accordance with the evaluation, and that there is a recommendation that a preferred bidder should be appointed. There does not seem to be any concerns that are being raised by any parties. Is that your understanding of the position at that time?

A At that time, yes.

Q Were you involved at all in the assessment of the tenders that were submitted for the project?

A I was involved, yes. I

was part of the Core Evaluation Team.

Q You tell us within your statement that you were not involved in the mechanical and electrical engineering assessment, but can you just explain to us what were you doing? How were tenders being assessed? How were they being scrutinised, scored as having a pass or fail and then, if they got through that, being awarded specific scores for the aspects you were involved in?

A So, for the aspects that I was involved in, we reviewed the tenders. So myself, Fiona Halcrow, who was one of the project managers, James Steers, who was the clinical lead for Department of Clinical Neurosciences, Infection Prevention and Control also reviewed specific elements as well, so we would review them and then we individually scored then came together and developed a consensus score.

Q If we perhaps just take it in stages. As I understand it, there is two levels to the assessment. There are certain criteria that are pass/fail. Is that correct?

A Yes.

Q Then if you get through all of that as a tenderer, there is then almost a second exercise whereby specific scores are awarded for

various criteria?

A Yes. I mean, some of the criteria were just scored. They weren't a pass/fail, and most of the aspects that I was involved in were scored. They weren't a pass/fail criteria.

Q Did you have any involvement in any pass/fail criteria?

A I might have done in the strategic and management, but I don't recall.

Q Because, again, you might not be able to assist the Inquiry, but one issue that the Inquiry is interested in is intensity of review in relation to the pass/fail issues. So, there is a number of issues within the criteria whereby a tenderer would be asked to do certain things, and a tenderer might say, "I am going to do that," and then provide a solution. Can you shed any light on the intensity of review that would be undertaken for solutions put forward by tenderers?

A No, because I wasn't involved in those. No.

Q Now, you tell us in your statement you are not involved in the mechanical and electrical engineering side of assessment, but presumably there is a point whereby everyone involved in the assessment comes together to share knowledge, have a

discussion, draw matters together?

A Yes, we did, yes.

Q Within the context of those types of meetings, how significant would a concern have to be for one side of the assessment team to raise it with another side of the assessment team? So, for example, the issues you are dealing with, how significant would an issue have to be for you to feel you wanted to share it with other people involved in the team?

A So, I suppose the things that I would be looking at would be-- I would view as being significant if the bidder had deviated completely from the reference design, so all of the clinical adjacencies were not as in the reference design. So I would raise that, and that did happen by one bidder.

Q So that is the type of high level issue that you would be raising----

A Yeah.

Q -- internally with other members? Now, one issue that the Inquiry is going to explore is the Environmental Matrices that were submitted by various tenderers. So, that is a specific aspect of mechanical and electrical engineering. One tenderer simply says the draft that was

included with the ITPD will comply with those values. Another tenderer changed the number of values, marked them up in red within that document. Do you remember there being any discussion at a project level in relation to that issue?

A I don't, no.

Q Is that the type of issue that you would have expected to be raised with you by other members of the project team?

A I suppose the honest answer is I don't know, because it would depend how significant, potentially, those changes were. I don't know.

Q Another issue that I want to move on and ask you about is production of room data sheets. Am I correct in thinking that by financial close the party that was appointed as preferred bidder had to provide 100 per cent room data sheets, so a room data sheet for every room in the hospital?

A Yes, that was my understanding.

Q Yes. So perhaps if we just look to that requirement. If I could ask you to have bundle 2 in front of you please at page 965. We are within the Invitation to Participate in Dialogue, and do you see the bold heading, "**2.5.3 Room Data Sheets**"?

A Yes.

Q And just below the various bullet points, there is a paragraph beginning, "During Dialogue…"?

A Yes.

Q It says:

> "During Dialogue Bidders will be required to develop Room Data Sheets, incorporating the Room Information, for those rooms for which 1:50 layout drawings have been prepared. For the avoidance of doubt this shall include all Key Rooms and Generic Rooms in addition to those rooms identified in the table at paragraph 2.5.2 above."

Do you see that?

A Yes.

Q So that is what had to be submitted as part of your tender, and then it continues:

> "The Room Data Sheets will form part of the Bidders' proposals. The Preferred Bidder will be required to complete Room Data Sheets for all remaining rooms prior to Financial Close."

Do you see that?

A Yes.

Q Now, at this stage you

are involved in the assessment process. If as part of their tender a tenderer had submitted a bid that said, "I'm going to provide you with some room data sheets, but I'm telling you now I won't produce all room data sheets by financial close." What would have happened to that tenderer?

A I think there would have been a discussion about that in which we pointed out to the bidder that that was a requirement.

Q Would a bid of the nature that I have put to you, would that not be a variant bid that should be rejected?

A I would have thought so, yes.

Q I just want to be clear on what your position is. If a tenderer admitted a tender that said, "I see there is a requirement in the procurement document for me to produce all room data sheets by financial close, but I am not going to do that." What do you think the Board would have done?

A I mean, I think it's difficult to say. From my perspective, I think we would have said that's not acceptable and therefore you would fail the process.

Q Thank you. The Inquiry has heard evidence that IHSL gets

appointed preferred bidder, but by financial close 100 per cent room data sheets were not provided. Is that your understanding?

A Yes.

Q Why did that happen?

A As far as I can recall, I think it happened because IHSL felt that there wasn't sufficient time for them to complete them all and that the information that was contained within the room data sheets was in other documents and that they had provided ones for the key and generic rooms.

Q Why did NHS Lothian agree to that position?

A I think it was a pragmatic decision because we had got this far and that we needed to get on and build the hospital.

Q In your view, would that amount to a material variation to the requirements that we have seen in the invitation to participate in dialogue?

A I don't know that I'm in a position to answer that one.

Q Okay. Thank you. Now, can I ask you to have your statement in front of you again, please? This time, bundle 13, page 216, paragraph 121. Do you see a paragraph beginning, "I would have reviewed…"?

A Yes.

Q

"I would have reviewed the RDS provided by IHSL at FC along with Fiona Halcrow in relation to operational functionality, i.e. not in relation to the m&e environmental data. I would have relied on Motts as our Technical Advisors to review the RDS in relation to that environmental data and flag any issues with the Project Team. If Motts needed clinical input in relation to any issues with the RDS, they would flag this with myself or Fiona Halcrow."

Do you see that?

A Yes.

Q Can you just explain who is Fiona Halcrow, and what is her involvement in this?

A So, Fiona Halcrow was one of the project managers in the team. She is a nurse by background, and she had been involved in the project prior to me joining the project.

Q We have looked at the ITPD. There had to be certain room data sheets provided as part of a tender bid with the remainder to follow by financial close, and you say that you are undertaking a broad review of the room data sheets. Why are you undertaking a review of the room data sheets?

A We were looking at it from an operational functionality point of view, so to ensure that activities within the room were relevant.

Q But you mention that your expectation was that Mott MacDonald would also be conducting a review of the room data sheets?

A Yes.

Q In terms of that review, was that a review of all of the room data sheets, or was that just a review of some of the room data sheets?

A From my perspective, I thought they were reviewing all of them. Certainly, I could see that they potentially wouldn't-- if there was a single bed room in a ward, they wouldn't necessarily review all of the room data sheets for all 10 single bed rooms because they should be the same but, yes, I would expect that they were reviewing the majority.

Q Again, the Inquiry will hear evidence from witnesses from Mott MacDonald at a later stage, but as I understand their position from various witness statements is they were undertaking what they refer to as a sample review. They were just reviewing samples. Do you remember having any discussions about whether that would be the approach Mott MacDonald would adopt at that time in

the project?

A I certainly don't recall any discussions about that.

Q If I could ask you to look within bundle 5, please, page 885. This is the contract that was actually agreed between NHS Lothian and IHSL. Bundle 5, page 885. Do you see a list of key rooms?

A Yes.

Q If we just take some examples, there is B1609-01, there is "4 beds Low Acuity." Then two lines down, "B1401-01 Single-bed cubicle: Isolation." Couple down, "B1609-02 4 beds High Acuity." These are described as key rooms. Do you remember how the key rooms were identified and what function they had?

A Yes, so the key rooms were rooms that we identified as having specialist requirements, whereas the generic rooms were common rooms that happened at least four times throughout the building. So it was to differentiate, so they were more specialist type rooms.

Q In terms of room data sheets being produced by IHSL for these key rooms, was your understanding that they would be reviewed by Mott MacDonald?

A Yes.

Q If we could perhaps just look to those room data sheets, still within bundle 5, if we go to page 1010, please. Can you see at the top right-hand corner, this is B1609-01?

A Yes.

Q We see a range of environmental parameters for this room of "4 beds Low Acuity." Just as an example, with "Winter Temperature," "Summer temperature," then "Mechanical Ventilation (Supply ac/hr)" and "Mechanical Ventilation (Extract ac/hr)," and we see in the requirements section "4.0" and "Positive." Is that correct?

A Yes.

Q Then if we look to page 1030, this is the room data sheet for B1609-02, bundle 5, page 1030. In the top right hand corner, "B1609-02." This time it is a "4 beds High Acuity." Again, we see the "Winter Temperature."

THE CHAIR: Mr MacGregor, can I take the opportunity just for my own benefit here – we are looking at an example of a room data sheet?

MR MACGREGOR: Yes.

THE CHAIR: Yes. Now, other than the descriptor, "4 beds High Acuity," am I right in thinking there is no narrative explaining what "4 beds High Acuity" means? In other words, tell me – or Ms MacKenzie may be in a

better position to do that – the room data sheet is where a translation into air, lighting, noise and safety specifications of fairly brief descriptor, "4 beds High Acuity." That is my understanding.

MR MACGREGOR: That is correct. So, these are the corresponding room data sheets for the key rooms that we looked at within bundle 5 at page 885.

THE CHAIR: Yes. So someone coming to it fresh either is assumed to know what "4 beds High Acuity" means or is not concerned with that detail, but is only concerned with the specification?

MR MACGREGOR: Yes, because they have got the descriptor in the top right hand corner that the code that-- the B1609.

THE CHAIR: Thank you. Sorry for the interruption.

MR MACGREGOR: So, we are looking in bundle 5, just to look at the three examples. The B1609, "Key Rooms," "4 beds High Acuity," and we see in the body of the document air temperature, summer temperature and then mechanical ventilation, and mechanical ventilation both as supply and extract, with the values being 4.0 and positive. Then the third example, if we look to page 1004, this time, top

right-hand corner, B1401, is a "Single-bed cubicle." You see the values, winter temperature, summer temperature, and the mechanical ventilation (supply) and mechanical ventilation (extract). In the requirements section we see 4.0. You see that?

A Yes.

Q We can put those documents to one side. I would like to move on and ask you about something else now, please.

A I suppose just it might be helpful to Lord Brodie to pick up on the room data sheet, actually, how we identify them, and the bidders as well would identify them as there's a room number there. So if it says 1B1039, so B1 relates to Critical Care. So the bidder would find out more information from the clinical output specification.

THE CHAIR: Right. So I will just maybe, as it were, take that by dictation. So the first point is that each of these rooms has a specific----

A Room number.

Q Room number.

A Room number, so basically for the Critical Care it's 1, so that means it's in floor 1. B1 is the department, Critical Care, and then the room number then relates so-- I can't remember the room number that was

on that room data sheet, but if it was 039 and then it would say that was "4 bed Low Acuity." So----

Q So if anyone wanted to understand what 4 bed high acuity or low acuity meant, a reference document would be the clinical output specific which would define the term used? In other words, would that define what is meant by "4 bed high acuity"?

A Yes, it would. It would say what was happening in that area.

Q Right**,** and the definition say what is happening in that room.

A Yeah.

Q Thank you. Thank you for that. That was what I was less effectively exploring. Give me a moment. Thank you. Sorry, Mr MacGregor.

MR MACGREGOR: I just wanted to move on to ask you about a different issue. So, in your statement you mentioned a concept of Healthcare Associated Infection – System for Controlling Risk in the Built Environment, which the Inquiry has seen referred to often by its acronym HAI-SCRIBE. Could you explain to the Inquiry, what is HAI-SCRIBE? What is the system designed for?

A So, HAI-SCRIBE is used for any construction. So, either that

being you are within an existing hospital doing building works or you're building a new hospital, and it's a risk management tool. So it's to identify any risks in relation to the building works and how those risks can either be avoided or mitigated, and there's four different stages that you use depending on the type of project. So a project of this scale would go through all four stages of an HAI-SCRIBE at different times in the project.

Q Who would undertake the report?

A So, again, it depends at what stage you're doing, but Infection Prevention and Control would always be there. For a project, again, of this scale, there would be people from the project team, and there would be people from the bidder team.

Q In the period after IHSL was appointed as preferred bidder, do you recall there being any HAI-SCRIBE reports produced?

A Yes, there were.

Q We will come on and look at that, but just at a level of generality, can you explain what is happening in terms of HAI-SCRIBE reporting at that point, the point from preferred bidder to financial close?

A At that point there would be an HAI-SCRIBE Stage 3

undertaken, which is prior to construction starting, and you have to obviously do that before the construction. From memory, I think there was at least two that were undertaken, because there was one undertaken for the actual building of the new hospital but also for the works when there was going to be the join into the existing Royal Infirmary. So a different HAI-SCRIBE had to be undertaken for that, and then prior to building, as such, becoming operational you'd do a final HAI-SCRIBE at Stage 4.

Q What type of risks was the system and the report aimed at trying to identify?

A I mean, it ranges. It's a wide range. There's a series of questions that that are asked, and you respond to them. So, I mean, it varies from things like, "Are there sufficient clinical wash hand basins?", to hand sanitizers, to some of them ask some ventilation questions.

Q In terms of the stage 3 report that we are talking about for this project in the period from preferred bidder being appointed to financial close, do you remember the HAI-SCRIBE reporting identifying any specific problems with the ventilation system?

A There was a query about the pressure in single bed rooms-- were highlighted as needing further clarity.

Q If we could just look to that HAI-SCRIBE report then, within bundle 10, volume 1, if we could look to page 283. We can see in the top left-hand corner, "Healthcare Associated Infection System for Controlling Risk in the Built Environment (HAI-SCRIBE)." There is the project, "RHSC & DCN Re-Provision Project, Little France." It is dated 19 November 2014. If we then look on to page 285, do you see "Section 2 – consultation"?

A Yes.

Q We see that, in terms of the department, there is reference to the clinical director Janice MacKenzie. Do you remember being consulted on this HAI-SCRIBE report?

A I remember being present, yes, at the-- because you-- the people-- In effect, it's a meeting going through the risk assessment.

Q Just so that I understand, it is called the HAI-SCRIBE system but there is a meeting where matters are discussed and then the report is produced. Is that correct?

A Yeah, so you basically go through the questions, complete it

whilst you're in the meeting, and then the report is formally completed.

Q If we look on to page 286, entry 2.2. Entry 2.2 states: "Is the ventilation system designed fit for purpose, given the potential for infection spread via ventilation systems?" See that?

A Yes.

Q That is ticked as "No." Was that a matter of concern at this point in the project in November 2014, that the ventilation system was described as not being fit for purpose?

A I think they kind of-- Yes, there was concern about it. I think at the time of the meeting, from my recollection, the query was raised and it couldn't be answered at the meeting, so therefore, at the actual meeting, we had to say-- score it as a no; we didn't have the answer to the question. So, yes, it was a concern at the time, but we didn't have the information to know whether or not it was an issue or not at that time.

Q Because the reasoning given at paragraph 2.2 is:

> "Some concern has been raised in relation to a potential issue with ventilation with regard to negative/balance pressure in single bed rooms. Awaiting drawings and further information to fully understand if there is a risk/issue."

Do you see that?

A Yes.

Q Can you just explain your understanding of what was the problem with the negative balance pressure in the single bed rooms?

A So, I don't recall who raised this as an issue. I would expect it would either have been Infection Prevention and Control or Motts' technical advisor who was there, but it was-- I suppose we were wanting clarity that the standard single bed rooms did have negative balance pressure, which as I understand is what it says in SHTM 03-01 is required, so we wanted confirmation that that was the case.

Q Just so I am absolutely clear, are we talking about single bed rooms in a general ward or are we talking about single bed rooms in Critical Care wards or all single bed rooms in the hospital?

A No, from my recollection, we were talking about what we would deem as standard single rooms, so not in Critical Care.

Q It says, "Awaiting drawings and further information to fully understand if there's a risk/issue." At this point, you are in late November

2014. As I understand it, financial close takes place in February of 2015. You are a few months out from financial close. Was this risk issue that had been identified, was that resolved before financial close?

A From my recollection it wasn't resolved. We were-- did get the drawings and were told that, in fact, the rooms were positive pressure, which was obviously not acceptable, and we had gone back to IHSL to tell them that was the case and that they had to comply with SHTM 03-01. Therefore, as far as I can recall, the understanding was that they knew that and that that was going to happen.

Q I just want to explore that a bit more. So, at this point in November 2014, the ventilation system design is not fit for purpose and that issue is not resolved before a contract is signed with IHSL. Why did NHS Lothian consider that it was appropriate to conclude the contract?

A In all honesty, I can't answer that question. I think there was-- At the time of moving to financial close, there were lots of discussions going on about what could be resolved and would therefore go into the RDD process, which this obviously would.

Q Whenever you say that

"the RDD process," what do you mean by that?

A That is the reviewable design data, so that-- after financial close we were reviewing a lot of design proposals, drawings, etc. and signing them off from an operational functionality perspective or giving comments back to IHSL.

Q Just, again, so I am understanding you, this issue with the ventilation system not being fit for purpose, that is resolved by that issue becoming reviewable design data in the end?

A Yeah.

Q Within your statement, and we will come on to look at this, you address what you describe as a number of outstanding issues as at financial close. Perhaps if we just turn that up, it is in bundle 13, page 218, begins at paragraph 131 and goes in to paragraph 132. See paragraph 131, "In my view this does resolve the specific query…":

> "In my view this does resolve the specific query – i.e. we responded to the request for information by IHSL in relation to the pressure issue as we agreed to do at the HAI Scribe meeting on 13 January 2015. I was aware that there were some

design issues that were unresolved at financial close and, accordingly, were subject to the Reviewable Design Data (RDD) process, It was part of my role as Clinical Director to engage the clinicians during the RDD process to review the continuing design."

Then, paragraph 132:

"I have been asked whether I would have been concerned in my role as Clinical Director about the number of issues that were not resolved by February 2015 and the answer is yes, because the expectation was that those were meant to have been resolved by FC."

Could you just expand a little on what were these outstanding issues and what were the concerns that you had?

A I mean, I don't recall the detail of all of the design issues that were still outstanding. Now, obviously, as we've spoken about previously, the room data sheets hadn't-- didn't have all of them. There were still outstanding issues in some of the architectural design, the specifics of which at this point I don't recall, but certainly there were enough of issues being raised as not being resolved to be of concern.

Q Were certain of those issues captured in the Board's comments that got put into the contract?

A As far as I'm aware, yeah.

Q If we could perhaps just go back to the contracts, that is bundle 5. Go to page 869, please, first. You see the bold heading "**Part 4: Non-Approved Project Co's Proposals Design Data comments**." Then, the second full paragraph:

"These Board comments shall be incorporated into each relevant item of Design Data (which shall primarily relate to drawings accompanying the relevant Project Co's Proposals) by Project Co and the drawings shall be submitted by Project Co to the Board through Schedule Part 8…"

See that? So, effectively, as I understand it, this is non-agreed issues that are going to form part of reviewable design data after the contract has been signed. If we could look on then, please, to page 880. See, on page 880, there is the box with "Environmental Matrix." "Project Co shall update the Environmental Matrix to reflect the following Board

comments…" If we look to the fourth bullet point, the wording beginning "Detailed proposal awaited on bedroom ventilation…"

A Yes.

Q "Detailed proposal awaited on bedroom ventilation to achieve balanced/negative pressure relative to corridor," see that?

A Yes.

Q So, is that effectively the issue that was highlighted in the HAI-SCRIBE report, and it is unresolved at the point the contract is signed----

A Yes.

Q -- and put into this reviewable design data process to be resolved after financial close?

A Yes.

Q If I could ask you to have in front of you, please, within bundle 12, volume 2, page 1852. Bundle 12, volume 2, page 1852. This is a set of minutes for a project management group meeting held on 1 October 2014. This is not a meeting that you were present at, but it is simply one entry that I am looking for your views on. If we look over the page onto page 1853, see number 2.2 in the top left-hand corner? The action point here is:

"Sch Part 6, Section 3 – BCR's sub-sections D&E to be reissued by Board. Where agreed these will incorporate correction of drafting errors note on BMCE derogations list."

Then it is really the next sentence. It says, "Review of RDS by Janice MacKenzie to be included. (NB only anticipated change to sub-sections A-C in relation to bus stop appendix)." Do you know what is being referred to there by the "Review of RDS by Janice MacKenzie"?

A I think, looking at the date of the meeting, I think that relates to the-- IHSL had provided us with a list of room data sheets that they were going to provide for financial close, and myself and others in the team were asked to review that to see if we felt there should be any additional rooms that required room data sheets for financial close. So, that's the only thing I was kind of involved in.

Q What happened? Was there a list provided and did you review that list?

A So, there was a list provided which, from memory, was all of the key and generic rooms, there was no other additional rooms, and we put forward a small number of other additional rooms that we thought it would be helpful to have room data sheets for.

Q I think the final issue that

I wish to raise with you at this stage is, as the Inquiry understands it, NHS Lothian accepts that there were some errors in the Environmental Matrix, spreadsheet errors, that resulted in the hospital not opening on time and remedial works having to be carried out thereafter. Obviously, you were involved particularly in the procurement stage. Do you have any reflections to offer in terms of whether there were any issues that arose during the procurement stage that perhaps contributed to those issues and perhaps issues that could, with the benefit of hindsight, be done better?

A I think that's quite a difficult question to answer. I'm not sure that I'm best placed for that. I think hindsight is a wonderful thing, and I suppose it is about how something like this wouldn't happen again. As I say, I'm not sure that I am best placed to give a response to that, really.

Q Thank you. I do not have any other questions at the moment. Lord Brodie may have questions, or equally there might be applications from core participants.

THE CHAIR: I do not have any questions at this time. However, as Mr MacGregor indicated, I would wish to give an opportunity to legal

representatives to consider their position, the possibility of answering questions. Had we been likely to take up all of the morning, I would have taken a coffee break anyway. So, what I would propose is that we, as it were, have an earlier coffee break with the time available to us. We might sit again at quarter to twelve. I would ask you-- certainly hope you have the option of coffee before then.

THE WITNESS: Yeah.

THE CHAIR: I would ask you to be in the witness room at that time.

THE WITNESS: Yeah.

THE CHAIR: At quarter to twelve we will resume, and I would expect any parties who wish to have further questions asked to be in a position to tell me what the position is then. But for the moment, will rise and aim to sit again at quarter to twelve.

(Short break)

THE CHAIR: I understand from Mr MacGregor that there is one point of clarification that he has been asked to pursue with Ms MacKenzie, but otherwise there is no wish to ask additional questions. So, on that basis, I would as Ms MacKenzie to join us. (After a pause) Hello again.

THE WITNESS: Hi.

THE CHAIR: I think there is just one matter which Mr MacGregor will explore with you, and I will ask him to do that. Mr MacGregor.

MR MACGREGOR: Thank you. Ms MacKenzie, there is one very small point of detail that I would pick up with you. If we could turn up bundle 5 and go back to page 1030 that we had looked at before. This is the room data sheet for B1609-02. Do you see that in the top right-hand corner?

A Yes.

Q And there was a discussion with Lord Brodie about various activities and how that would be shown. If we look back to page 1029, this is still the Activity Database sheet for B1609-02. Do you see that?

A Yes.

Q And then we see various issues listed, so activities and personnel. So we see the activities, that in this room there would be clinical hand washing, patient records reviewed and recorded, etc. Then we see the personnel that would be in the room, so "4 x patients," "5 x staff," "6 x visitors." Do you see that? So is that setting out some of the types of information in terms of how the room would be used in the room data sheet itself?

A Yes, it is, but what I would say is it's probably-- Those are very generic statements. It's not necessarily picking up the specialist elements that would be happening.

Q So, again, just so I am understanding your evidence, a shorthand summary in the room data sheet and, for all the reasons you have explained, there were other documents to go to to try and find out more detail if you required that.

A Yeah.

Q Thank you, Ms MacKenzie. I do not have any further questions.

THE CHAIR: I do not understand that anyone else has either so, Ms MacKenzie, thank you again for your evidence. I am very appreciative of the fact that giving evidence to the Inquiry is not simply a question of turning up for a morning or part of a morning. It has involved you doing work and I am, first of all, conscious of that and, secondly, would wish to thank you for that. You are now free to go.

(The witness withdrew)

THE CHAIR: As I understand the position, we do not have a witness immediately to follow on. We will have a witness, Mr Stevenson, at two

o’clock this afternoon. I take the opportunity, lest I forget later, that we have had to do some rescheduling of witness for tomorrow in respect that Mr Cantlay had other obligations to fulfil. I think at one stage it was suggested we would only sit in the afternoon, but Mr Stillie has accommodated us, effectively, and he will be available at ten o’clock. So, lest I forget, we are sitting tomorrow at 10. But, for the moment, we will adjourn until two o’clock.

(Short break)

12:20