SCOTTISH HOSPITALS INQUIRY

ADDENDUM STATEMENT
TO CLOSING SUBMISSIONS ON BEHALF OF JOHN AND MOLLY CUDDIHY AND LISA MACKAY

HEARING DIET 12-23 JUNE 2023

Counsel representing the Cuddihy and Mackay families are grateful to the Chair of the Inquiry in allowing a late submission in response to the Core Participant draft submissions.

The submissions by all Core Participants have been carefully read. It is of note that most, but not all Core Participants responded to the request by Counsel to the Inquiry to answer specific questions posed. Said questions were general in nature and also specific in respect of Chapters 4 and 6. It is noted that GGC has evaded answering the direct questions posed by Counsel to the Inquiry, stating that their position in respect of same is set out in their response to PPP5. It is submitted that this amounts to evasion on the part of GGC who have refused to answer questions based on evidence led at the June hearing. If GGC disagree, as they appear to, with evidenced led to date and the opinions expressed, specific and clear rebuttals with reference to specific documents and evidence that has been submitted to the SHI is the only credible way to do so. As noted in our original submission, GGC response both to position statements and Counsel's submissions have the tenor of denial rather than evidence based rebuttal. The evasiveness and denial by GGC is contradicted by the responses offered by NSS who have accepted a link between the hospital environment and infections contracted by patients.

DOCUMENTATION

Appendix 1, produced by GGC, references 13,328 documents having been submitted to the SHI since March 2021. GGC submissions express their view that an incomplete evidential picture has been presented to the SHI. They also suggest that an incomplete evidential picture has been considered by Counsel to the Inquiry. It is clear that, at this stage, only a fraction of the documents produced by GGC have been shared in the bundles disclosed to Core Participants. Of note, is the number of documents (7380) that are said to ~~be~~ have been submitted in March 2021 and relate to "documentation on: water, ventilation, governance, project management and effects of issue on patients and their families". The position of GGC is in stark contrast to the suggestion by departing Counsel, that GGC have not produced all relevant documentation to the SHI. This does not assist Core Participants to maintain confidence in the Inquiry. If it is indeed the case that this documentation will be shared with Core Participants, it would be helpful to have that confirmed. If it is to be shared in advance of relevant hearings, it would again helpful and assist in restoring Core Participant confidence if a timetable would set out what the nature and estimated timing of all future hearings will be. It is respectfully requested that all documentation produced by GGC should be shared with Core Participants as a matter of urgency to allow Core Participants to assist the Inquiry by identifying any documentation that is missing, for example, those documents that evidence that GGC undertook and fulfilled their maintenance of taps as was agreed, where and when such maintenance was carried out, who carried it out and what maintenance works were done.

APPENDIX 4 : NHS GGC Draft Positioning Paper on Infection dated April 2023

Paragraphs 23 - 30 of Appendix 4 discuss that the remit of the Inquiry is to explore the extent to which ventilation and water issues impacted adversely on patient safety and that these issues are the principal focus in considering whether the built environment was "unsafe". The submission goes on to suggest two approaches that could be adopted to answer that question, namely first, a technical approach that focuses on relevant technical guidance or standards (albeit this is caveated by stating that non-compliance does not necessarily equate with being unsafe) and second, whether testing provides evidence of any widespread issues.

In respect of the technical approach, reference is made to limited evidence. The submission by GGC states at para 28:

“28. Therefore where there is a deviation from the guidance as set out in SHTM 03:01, it is far from evident that any such deviation would render the hospital “unsafe”. There is no evidence to support why SHTM proposed minimum ventilation requirements are as they are, and there is nothing to suggest that particular rates of air changes themselves have any direct impact upon rates of infection.”

This position conveniently fails to address the evidence of Susan Grant to the Inquiry. Reference is made, in particular, to paragraphs 18-30, 56, 58 and 77 of Ms Grant’s statement to the Inquiry.

In Para 29 onwards, Ms Grant states:

29. …I would add, and this is not specific to SHTM 03-01, this is generic and applicable to all Guidance, is probably best summed up in the last section of Paragraph D, quoted below:

“ Departures from the recommendations and the guidance may be justified in some circumstances, but this would have to be a matter of professional judgement based on the prevailing circumstances and be acceptable to whoever are ultimate responsibility for the hospital.”

30. I believe the above statement is true, but would elaborate on the use of the term “may be justified”. I have had examples of some circumstances in which “may” would not always be applicable, i.e. “would” or “should” is more applicable. I reiterate earlier statements that NHS Guidance describes the aim, and then provides a series of generic recommendations to meet an aim. e.g. the underlying legal obligation or duty of care. Therefore, the legal duty always remains the aim, and similar to a Code of Practice, e.g. Highway Code, whenever NHS Guidance does not describe the exact or correct recommendation for a particular given circumstance, then it “would” or “should” be user duty to adapt guidance, and thus evidence, to ensure they meet its underlying aims or their legal duty of care. Given our ever developing clinical practice

and technology, it is not practicable for NHS Guidance to describe every circumstance or scenario.

56. Ultimately, the decision on detailed applicability of NHS Guidance within their specific circumstance is up to the Boards. As it is role of the client, to set their own brief and to make very clear statements on the quality standards required to be delivered, and ultimately fulfil their legal and public sector duty of care. The NDAP gives Boards support and guidance to assist in doing that, i.e. provide an applicability list of the current guidance at a particular point in a brief, or review a design at key decision-making point. For example, CEL(2007)18 mandates SHFN 30 use, but key decisions of Guidance clause applicability are taken by key stakeholders, reflecting between X, Y, and Z options, for any given infection control scenario through design development.

77. I would emphasise to the Inquiry, that patient safety and care is not guaranteed by a number on a table, any more so than any single element e.g. architectural image, contained in any one of our 170 NHS Guidance documents. NHS Briefing, Design and Delivery is a whole process, with a series of documents that requires multi-disciplinary clinical and HBE experts to support. This process starts with questions, e.g. what do we need to do clinically in that room?, what are the risks?, what quality standards are applicable?, how will outcomes be measured/ met?, and what are the key components from a variety of guidance and ADB inputs, that will allow us to meet the NHS's overarching legal duty of care? Success is not, a blind application of individual sections of NHS Guidance, as out of context, an individual element could breach a legal duty of care."

It is disappointing that GGC make no reference to evidence which supports that their departure from guidance met the legal duty of care owed by them to patients. Instead, this is one of many examples where GGC focus on presenting smoke and mirrors, in this case by undermining the credibility of guidance, rather than provide either an explanation or justification for departing from that guidance. This is very clearly seen in the statement in para 28 of GGC Draft Positioning Paper on Infection April 2023, which states:

“There is no evidence to support why SHTM proposed minimum ventilation requirements are as they are, and there is nothing to suggest that particular rates of air changes themselves have any direct impact upon rates of infection.”

Given the evidence of Ms Grant, the legal duty of care owed to patients, the duty of candour, not to mention the obligations owed to this Public Inquiry, it is hoped that GGC will move from their established position of evading direct questions and using smoke and mirrors to distract from rather than explain the many decisions that were taken including departure from applicable guidance on ventilation, maintenance of the taps that were installed, failing to act to address safety concerns highlighted by external bodies such as DMA Canyon and provide detailed evidence that negates the presumption expressed by clinicians and NHSNSS that the built hospital environment was not as safe~~ty~~ as patients were entitled to expect.

Clare Connelly, Advocate

30 August 2023