SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
26 February 2024

Day 9
Friday, 8 March 2024
Tracey Gillies
Timothy Davison

C O N T E N T S

10:05

THE CHAIR: Good morning. I think we are ready to begin with----

MR MACGREGOR: Tracey Gillies, my Lord.

THE CHAIR: Tracey Gillies. Good morning, Ms Gillies.

MS GILLIES: Good morning.

THE CHAIR: As you appreciate, you are about to be asked questions by Mr MacGregor, who is sitting opposite you, but first, I understand your agreement to take the oath.

MS GILLIES: Yes.

Ms Tracey Gillies

Sworn

THE CHAIR: Thank you very much. I do not know how long your evidence will be. If we are not finished by that-- by half past 11, we will probably take a coffee break about that time. Can I ask you to bear in mind that this is quite a large space, and it is important that everyone hears what you have to say. So, if you perhaps speak a little louder, a bit slower than you normally would. I have hearing aids, so I am very conscious of this. Mr MacGregor.

MR MACGREGOR: Thank you, my Lord. You are Tracey Gillies. Is that correct?

A I am.

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

A I have.

Q And for the benefit of court participants, that is available at pages 519 to 527 of bundle 1 of the witness statements. The content of the witness statement will form part of your evidence to the Inquiry, but you are also going to be asked some questions by me today. You should have a copy of your statement available to you. If you want to refer to it at any point, please just do let me know. If I want to take you to any documents, they should come up on the big screen in front of you. If for any reason you cannot see them, please just do let me know. In terms of your background and qualifications, those are set out within your statement, and you tell the Inquiry that you are the Executive Medical Director for NHS Lothian. Is that correct?

A That's correct.

Q And you have held that role since 2017?

A Yes, that's correct.

Q And could you just explain to the Inquiry, in general terms, what is your role as Executive Medical Director? What does that involve on a

day-to-day basis?

A It's quite a varied role. It involves providing professional leadership to a number of different clinical disciplines within the NHS workforce in NHS Lothian. It involves being the main source of clinical advice to the Board for board-based decisions, and it also involves a number of corporate management functions and responsibilities, and one example of that would be, I am the Caldicott Guardian for NHS Lothian.

Q So, you have day-to-day activities, advise the Board, but also sit on the Board of NHS Lothian. Is that correct?

A Correct, and governance committees that form part of that.

Q Thank you. Now, you will be aware that the Inquiry is looking into the project for the Royal Hospital for Children and the Department for Clinical Neurosciences at Little France.

A Yes.

Q I want to begin by asking you some questions about the old hospitals, so the old hospital at Sciennes for children and the old Department for Clinical Neurosciences. Now, you tell us within your statement – I will not bring it up, it is paragraph 28, page 525 – that the hospital at Sciennes, you

considered in your capacity as Clinical Director that it was providing safe patient care. Is that correct?

A Yes.

Q Can you just explain though, for anyone that's not been to that hospital, albeit it was providing safe patient care, was it an optimal environment for treating children?

A Categorically not. It was an elderly building, and the facilities had expanded over time, so there were many adjacent departments that were situated in housing-- houses close to that. So, the actual physical layout of both the hospital itself and the adjacent support departments were less than ideal for the care of children and, particularly with children, the care of families who will want to be with their unwell child, really almost all the time.

Q If we could just, perhaps, think about that for a moment in terms of the fabric of the building and the facilities that were available, really for families that would have ill children staying at the hospital. For anyone that has not visited the hospital and seen the accommodation, what was the accommodation like for families whose children were having extended periods in the hospital at Sciennes?

A So, some of that

accommodation was off-site and close to the hospital, but not actually physically in the same building, and some of it was up in the attics of the old building, and I have personal experience of staying in one of those attic rooms myself with-- you know, when I had an unwell child.

Q And can you just explain, for the attic rooms, as someone who had stayed there, what was it like? Was it a pleasant environment?

A I mean, no. It's not set up to be a, you know, space for families with unwell children, sometimes with other children, sometimes a long way from their home base. Sometimes, some unwell children are there for a long period of time, so it's particularly difficult in terms of that-- providing that more holistic support for a family when a child is unwell.

Q What were the disabled access facilities like at Sciennes?

A So, very difficult, particularly-- you know, obviously where buildings have expanded into every nook and cranny, that is particularly difficult to maintain.

Q And what is different about the new hospital that has now opened at Little France? If you could compare and contrast for us. You have obviously worked at and, as a parent, been to the hospital at Sciennes. How does the hospital at Little France differ in terms of the accommodation facilities for families?

A So, in common with all more modern purpose-built-- buildings are designed for the delivery of 21st century healthcare. The facilities are outstanding, but the facilities are designed for care that we deliver now, so they are-- So, for example, just the rooms for children to stay in are bigger. Each room has a pull-down bed for a parent or carer to stay in. The facilities are much broader. As you say, the access is appropriate, and there is a hotel within the facility that is designed for parents who have that longer stay.

Q Okay. Thank you, and if we can think about the hospital at Sciennes, the Inquiry has heard evidence that within the Critical Care department, there was not actually any mechanical ventilation. There was not any facility to provide a specified regular number of air changes per hour. Is that correct?

A Correct.

Q So, despite the fact that that facility did not exist, the hospital was still a safe environment to treat children within?

A Well, I suppose that that is because safety is a function not only of the built environment, but the practice of the individuals who are providing and supporting care within the building.

Q A number of individuals that have given evidence to the Inquiry have described safety as, effectively, a sliding scale; that you can never guarantee 100 per cent absolute safety, so it is not a binary choice between saying something is safe or unsafe. It is, effectively, how safe you can make the space.

A Yes.

Q Would that be your understanding?

A Absolutely. So, we need to think carefully about how beds are spaced out in an area where there's no mechanical ventilation. We need to think about how we protect staff if there are issues related to infections, as well as how we make sure that we optimally care for the patient in that environment.

Q So, if we just take a simple example, perhaps, of air changes per hour. We will come on, perhaps, and talk about some published guidance, but the published guidance suggests that in Critical Care spaces, it should be ten air changes

per hour. You could have a hospital that had no air changes per hour from a mechanical system, but you could put other facilities in place that that was still a safe environment to treat children. Is that correct?

A Yes, and this is the type of-- sort of dilemma that I would expect to receive advice from colleagues who have more expertise than this, about how we would mitigate any risks related to particular circumstances.

Q So, you might well have to defer to colleagues, Infection Prevention and Control professionals, for example, but just so I am understanding, from a clinical perspective, you could have a sliding scale whereby no mechanical air changes is safe, something like four or five would be safer, and ten would be even safer than that on that sliding scale of safety.

A Yes, and I wouldn't be expert. I wouldn't be able to tell you how much safer one got down that scale. I don't know if that is linear or a scale where that is not quite linear.

Q Thank you. So, that is the hospital at Sciennes. If we could think about the old Department for Clinical Neurosciences, were there any problems with the old Department for Clinical Neurosciences?

A There categorically were and, related to the old Department of Neurosciences, we had actual evidence of patient harm related to the built environment, which was not the case with Sciennes.

Q And if you could just perhaps expand on that, whenever you say Sciennes, crumbling building, not fit for purpose, but safe, what were some of the specific patient safety risks associated with the old Department for Clinical Neurosciences?

A So, that particular patient safety risk that I'm referring to relates to infection where, in the early part of 2019, we had patients who had acquired Pseudomonas as an infection, a brain infection, so Pseudomonas ventriculitis related to external devices that those neurosurgical patients had, and we had clear evidence in the case of one of those patients that that had been acquired from a water source in the building. So, clearly, we managed that as an Incident Management Team. Professor McMahon led that, and we took a number of steps to make that area safe for patients, but that was-- That resulted in some ongoing limitation to the provision of service out of that building.

We had further instances not proven as linked to a water source, but we were very concerned related to a separate area in the hospital in, I think, June 2019. So, those related to Critical Care and the rectification work that needed to be done for Critical Care had a particular relevance for neurosurgery because those patients all go from theatre – not all, but many of them – go through from theatre to Critical Care, and then a step back down to the neurosurgery wards. So, moving neurosurgery from that site was a priority to both take the neurosurgery service into the new facility and back up to full activity, but also to reduce the throughput in Critical Care to allow rectification works to be done to the water supply in the Critical Care ward.

Q Okay. Thank you, and if I could ask you to just look to your statement, please. So, it is in bundle 1 of the bundle of witness statements, and if we could look onto page 525, please, and to paragraph 29. You see paragraph 29 at the bottom, just beginning, "The change of ward area…" Do you see that?

A Yes.

Q And you tell us that:

"The change of ward area between neurosurgery patients

and neurology at the DCN at the Western General Hospital continued along with the cessation of inpatient video telemetry work given the existing concerns regarding the water quality for augmented care patients. Neurosurgery major cases remained reduced to five cases per day."

Do you see that?

A Yes.

Q Can you perhaps, just for those of us that do not work in the environment that you work in-- It says there that the neurosurgery major cases were being reduced to five cases per day. How much of a reduction is that from what would be standard or normal practice?

A So, there would be a level of variation to that. It's probably only a variation of maybe one case per day, but that obviously-- these are important and major cases, so any loss of capacity is significant in that sense and recovery is not predictable.

Q We will come on and talk about the pause, the fact that the new hospital did not open on the day as planned. In relation to Sciennes, not an ideal scenario, but no real major catastrophic risks associated with continuing care and treatment within that building, but the position is slightly different; the need is more pressing in relation to the Department for Clinical Neuroscience for all the reasons you have outlined, problems with the water and reductions in capacity.

A Yes. That's exactly right.

Q The next issue I just want to ask you about in very general terms is about the clinical need to cohort patients. So, the Inquiry has heard quite a lot of evidence about the clinical need to cohort patients, has looked at risk assessments that were completed by the clinicians working on the project in 2017 and refreshed in 2018. From your perspective, from a clinical perspective, cohorting infectious patients, is it acceptable from a clinical perspective to do that with balanced or negative pressure?

A My understanding is that it is acceptable to do that. I would have to say that it's not my area of clinical expertise and I would always look to Infection Prevention and Control colleagues to inform me about that, but my understanding is based on their advice which is that the ventilation regime – and the pressure regime as part of that – is only one part of the physical elements that create that environment for the safe delivery of care and there are other

things, such as the physical distance between patients and barriers such as doors that are closed, that add to that reduction in the risk from cohorting patients.

Q Thank you. Again, just perhaps to ask you a few follow-up questions on that, completely accepting you say, "This isn't my area of expertise," but really looking to the fact that whenever there is the pause in the hospital not opening, you would be involved in the decision-making team, including on the Board of NHS Lothian. The two issues, really, that crop up for the Critical Care spaces are the pressure regime, so it is designed as balanced or negative as opposed to positive, and it is four air changes per hour as opposed to ten air changes per hour. Could you just explain to the Inquiry, in terms of the discussions that are taking place, if clinicians are saying for some environments balanced or negative pressure is fine, was the problem the pressure and the air changes? Or was it really just the air changes?

A In terms of the pause, the move? I think that the problem was, in the main, the number of air changes rather than the pressure regime. In listening to the discussions, I think there are probably more views

about the pressure regime and there is a clinical view, as I understand it, that positive pressure is protective for Critical Care patients, and that may relate to their own vulnerability rather than the vulnerability of others from the infection that they have. It's the number of air changes that I think are more important in that regime. So, the number of air changes, I think, was the absolute reason for the pause, rather than the pressure regime.

Q Again, I am not asking for an expert view from Infection Prevention and Control or microbiology, but as a decision maker, someone sitting on the Board of NHS Lothian, imagine a hypothetical scenario where IOM come back with their test results and they say it is balanced and negative pressure, which does not comply with the guidance in SHTM 03-01, but it is ten air changes per hour. So, it's balanced or negative pressure but with ten air changes per hour. Do you think the hospital would or would not have opened if those had been the test results?

A That's a very-- That's quite a difficult question to answer because what happened during that week after the pause was there was a lot of discussion about how could

rectification be done. So, my understanding is that if ten air changes had been delivered but the pressure regime was wrong, that would not require nearly such major works to actually change the pressure cascade. There may have been-- and this is-- I'm deep, now, out of my own area of comfort, because this is where we would need engineering colleagues as well because we would need to consider where the extracts were, but if ten air changes were delivered but at the wrong pressure regime, my sense is that would be much more straightforward to correct.

Q Thank you.

A But I would definitely want expert advice about that.

Q No, that's fine.

THE CHAIR: Sorry, more straightforward to----?

A Correct. To correct.

Q To correct? Thank you.

MR MACGREGOR: That's completely understandable. Perhaps for any of these areas that are outwith your areas of expertise, if you can just flag that to me and we will proceed on the basis that we are talking about the decision-making role that you would have as opposed to providing expert clinical advice. In terms of the period of time that we are thinking about,

2018/2019, could you just explain how much pressure was NHS Lothian under to deliver the new hospital, to get it open?

A So, under – I would say– a reasonably significant amount of pressure. I wouldn't say that I was particularly close to that because it didn't really impact onto my own direct day-to-day work, other than that understanding that patients are being cared for across both sites in suboptimal environments. It became more heightened as far as Neurosurgery and Neurology were concerned, really, in that early part of 2019.

Q Thank you. You will be aware that after all of the events that take place, Grant Thornton come in and they do a report, and their finding was that the problems with the project were what they described as "collective failure." Do you recall that?

A Yes. I do.

Q And that was a finding, as I understand it, that was accepted by NHS Lothian?

A Yes.

Q Okay. Could you explain in your own words, as someone who was involved in that process, what do you think went wrong? Why did the hospital not open on time and on

budget?

A So, I know that there's been a lot of evidence given and heard related to the Environmental Matrix. That's not something that I was close to. You're referencing specifically the Grant Thornton report which I think does articulate a number of important lessons for us as an organisation that do refer back to that, those reasons why there was a collective failure, and I think what's important is that we have tried to take some of those lessons and embed those into more current practice. I think we did not always help clinical colleagues who were taking part in discussions around a new building.

I'm being quite careful to avoid the word "design" because I don't want to get myself tangled up in the nuances of an NPD project and who's responsible or otherwise for the design, but we ask clinical colleagues to participate in those roles, and one of the points in the Grant Thornton report is that we need to be clearer about those roles and responsibilities because, really, we're asking people to imagine forward into a future which is unknown about how clinical practice will work and what facilities need to be able to deliver, and we're asking them to imagine for colleagues of the future how they will provide clinical care, and that isn't particularly easy. So, we need to help them work with their colleagues to look forward rather than to look back and anchor the things that they want to take into the new building from experiences they've had in the old building that have been sub-optimal.

Q Thank you. I would like to now just take you through a timeline, really from 1 July through to the midpoint in July, just to try to understand what is going on, what discussions are taking place, what decisions are being made, and I will take you to relevant documents because I appreciate this is some time ago. So, if we could perhaps just start with bundle 13, volume 3, at page 692. Bundle 13, volume 3, page 692, and you see this is a paper headed up "Water and ventilation issues in RHCYP and DCN." Do you see that?

A Yes. I do.

Q And at the bottom there is the initials "TG/AMcM". Do you see that?

A Yes. I do.

Q So, is this a paper that you had input into?

A This is a paper written by me.

Q Thank you. You see that

the first paragraph says:

> "The testing and quality assurance work prior to the move into RHCYP/DCN is not yet sufficiently complete and demonstrating adequate assurance to support the finalised move date."

Do you see that?

A I do.

Q So, if at this point in time we are at 1 July 2019, what is happening? What is going on at this point in time?

A So, the time is about 8:30 in the morning when this paper was sent. This paper was a summary that was put together from-- I received information, checked it out with colleagues and sent it on behalf of Professor McMahon and myself to Tim Davison, the Chief Executive, by way of providing a briefing. At the end of the previous week, we had been asked to go down to the new hospital to get involved in some of the discussions about the measurements that were coming back, principally from testing the ventilation in the new hospital. So, on 28 July, which was the Friday, we had gone down in the morning and we had, in particular, been focused on trying to make sure that the theatre ventilation regime was fit for purpose.

THE CHAIR: Sorry. If I heard you correctly, you said 28 July. Perhaps 28 June?

A June. Sorry, yes. Sorry about that. So, 28 June.

Q Okay.

A So, at that time, on that Friday, the testing regime-- the testing of the ventilation that was being undertaken by IOM was coming back showing that there were a number of quite important snags to be corrected for the theatre ventilation, and so we started focusing on making sure that for the move, which was then just under two weeks away, we had sufficient theatres to be able to deliver the expected activity. There were also comments that were made from Infection Prevention and Control colleagues that they hadn't seen the results back from all the water testing, and so we wanted to just produce a short document to make sure that Tim was sighted on where we were up to, but also what we were planning to do to try to address that by way of those important few days ahead of the planned move.

MR MACGREGOR: Thank you. Then, if we could look on to bundle 13, volume 4, at page 16.

A Yes.

Q Bundle 13, volume 4,

page 16. This is an email from you to the chief executive. It is not dated but I think it is generally accepted this is 1 July that this is sent on as well.

A It is. It's about seven o 'clock in the evening. It's something like that. It might be a little bit later.

Q So, we see the minute almost at the start of the day and then we see an email that is sent towards the end of the day. Is that right?

A That's exactly right and so that time difference is quite important because that's where this fundamental difference in understanding emerges.

Q So, I will come on and take you through the minute, but just explain in your own words what happens during the course of the day, 1 July.

A Yes. So, during the course of the day of 1 July, the focus earlier on in the day was again in trying to take-- to make sure that we were able to have four theatres able for use and that everything else was in place as expected, and the way we had been doing this was-- It's a pre-Teams event and it's a good lesson in how much harder it is to try to coordinate a conversation with multiple different people when you're doing it through a teleconference and a-- essentially a phone-- a speakerphone, and so you can't see people, so you don't know when they want to speak. So, I actually went down to the hospital.

Professor McMahon was not at work that day. I went down to the hospital to do the meeting in person in the afternoon because it's very difficult to, essentially, try and understand who wants to speak when, and I was mainly dealing with people who I had really no previous knowledge of in terms of contractors and testers. I obviously knew the project team, but they knew these people much better than I did. So, I went down, and before I went into the planned meeting – which was to really go over the work that had been done during that day and the results that were back about the theatre validation of the ventilation system – Brian Currie, the project director, took me to one side and explained that issues had been-- essentially emerged related to the Critical Care ventilation which was not delivering the required number of air changes, but he categorically didn't want to rehearse that with a number of different contractors and others in the meeting at 4.00 or 4.30. So, essentially, what happened was I completed that meeting doing the

planned work about, “Were we getting the snagging work done around the theatre ventilation?” and then left in order to set out what I understood related to what was a really pivotal moment of knowing that the Critical Care ventilation system did not deliver the required number of air changes to put it in line with guidance.

Q So, you have that discussion with Mr Currie. After that discussion, how concerned are you about the hospital, given how close it is to opening?

A Very.

Q Okay, and if we look to the email of bundle 13, volume 4, at page 16, if we could pick matters up just at the second bullet point, you will see it begins, “It delivers 4 air changes…” Do you see that?

A Yes.

Q So you say:

> “It delivers 4 air changes at balanced or slight negative pressure in the multiple occupancy 4 bedded room and single rooms in critical care. The 19 isolation rooms outside critical care are not affected.
>
> The required standard as per SHTM 03-01 Appendix 1 (version 2 February 2014) for critical care areas is 10 air changes and less than 10 air changes per hour may facilitate airborne spread of viruses more than if 10 was achieved. further advice on the likely impact of air change reduction is required.”

Do you see that?

A Yes. I do.

Q So, at this stage you have identified the non-compliance, but you were flagging up, really, the implications for that are unknown at this stage.

A That’s right. So, that’s a really important difference. I wrote this email in draft and shared it with the colleagues from a technical advice background before sending it. So, that particular phrase was actually added in by Dr Inverarity because what I’m wanting to do is to give Tim as clear an understanding as I can, and to do that, I need to try and make sure that the information I provide is accurate and reliable. So, although the starting draft is mine – and this isn’t the draft, this is the final version – I share it with colleagues. So, I think I shared it with Iain Graham, with Brian Currie, with Donald Inverarity to check that I have understood the consequences of what I’m saying correctly. So, I’m trying to give Tim as clear a summary as I can.

Q Okay, so although this is

an email from you this is really a collective view? We can go to the emails if required, but there is, effectively, markups that are provided by Dr Inverarity----

A Yes.

Q -- and comments that are provided by other individuals----

A Yes.

Q -- including Iain Graham?

A Yes.

Q Thank you. Then, if we look to the next bullet point, the email continues:

> "The only known way to improve air changes with the current plant is to accept positive pressure ventilation (i.e. increasing further the opportunity for spread primarily of pathogens with airborne transmission e .g. respiratory viruses between individuals, staff, visitors and patients in 4 bedded rooms) A request has been asked of MPX to verify the maximum capability of the existing plant while maintaining current pressure regimes."

Do you see that?

A Yes.

Q And then it continues. If we look to the final three bullet points, you see the third last bullet point, you state: "This leads us to the question whether the space is fit for purpose." Do you see that?

A Yes.

Q So, at this point in time, you simply do not know. You know that it is not compliant with guidance, but you cannot answer the question, "Is the space fit for purpose?"

A Yes, that's-- and this is-- this becomes really important that, as a team, we're able to tease out because we're balancing the continued delivery of care in facilities that are suboptimal for a number of different reasons as against, "How important is this non-compliance?"

Q Thank you, and you continued:

> "If occupied now there is risk to the patients, visitors and staff of airborne virus transmission (?how much) and difficulties in correcting (would probably require a decant) Team to contact external experts for advice."

Do you see that?

A Yes.

Q I am particularly interested in the section in brackets which says, "How much?" So, at this point in time, you are saying, "There is a risk, but how much of a risk is it?"

A Yes.

Q Did you ever get to the bottom of that question of how much risk?

A No.

Q Why not?

A So, I need to just flag that after sending this, I was actually on annual leave for the rest of that week, so I didn't necessarily participate in any ad hoc discussions that weren't part of formal meetings. I was replying to emails and I did dial in to as many meetings that were held that week as I could, but my-- and this is so, this is a personal view rather than a sort of-- an organisational position: we didn't get to the bottom of understanding how much risk because the decision was made that we were not moving, and I wasn't actually particularly close on the day about that decision because I wasn't physically in Edinburgh.

Q Dr Inverarity, he gave evidence to the Inquiry and his position was he was never asked to bottom out this question of how much risk----

A Yes.

Q -- and the explanation that he gave was the timeline moved very quickly from 1 July to the Scottish Government saying a few days later, "The hospital will not open and it will not open until the ventilation system in Critical Care complies with the guidance set out in SHTM 03-01."

A Yes.

Q Is that your understanding of what happened?

A Yes.

Q So, essentially, 1 July, you are saying there is a risk, but how much risk is there? Might be a catastrophic level of risk, might be no risk whatsoever, but that question is never answered in any meaningful way.

A It wasn't answered. It was actively-- I think it was discussed along with the other important part of this-- is in wanting a building that we would continue to occupy for a number of decades, we want that building to be as fit for purpose for future challenges which are unknown-- So, the other important question that was being teased out during that week would be, "Could correction to the delivery of ten air changes be made while the building was occupied?"

Q If we could, perhaps, just imagine a hypothetical scenario whereby the Scottish Government-- it is not escalated to the Scottish Government, they do not come in, and it is the board of NHS Lothian that has got to make the ultimate decision. Do

we stick with the ventilation system as designed and built, or do we spend a very significant amount of public money bringing it up to comply with the guidance? Okay? So, that would be the decision that would have to be made. Would you want to understand whether what had been built was a significant risk to patient safety and care before making that decision?

A Yes, you would, but you would need to understand that answer would not be absolute. You would get a range of answers from different people and if it's a decision that needs to be made in a short period of time, you will naturally be limited to the range of people that you can ask. So, in asking lots of people, you would be trying to reach a point of consensus, or see areas where there was an overlap or people were quite close in what they said. If you're trying to make a decision in a short period of time, you won't be able to ask many people. So, you don't know if you're asking people who are at one end of a range of opinions, or if you're getting that full range, and it's important that that would be a decision that would be made for, you know, what you could write down as justifiable reasons at that time, but you wouldn't know where future criticism might come from that

decision. So, if we had accepted a building with four air changes an hour in Critical Care, we would need to understand, "In what circumstances would that be a particular risk? What mitigations would we need to take to keep both patients and their families and staff safe in that setting?" and we would need to make sure we built that into organisational systems and process so it didn't just rely on somebody remembering, and we don't know what would come in the future.

Q No----

A But that's quite important in the context of COVID, probably.

Q Yes. We will perhaps come on and discuss that in a bit. Again, just so that I am understanding things, and if we think back to the discussion that we had slightly earlier this morning about Sciennes; no air changes per hour, but it could be made safe. SHTM 03-01 guidance, ten air changes – that is recognised best practice.

A Yes.

Q You would have to try and calibrate where four air changes fell, but that was simply, in your understanding, never done.

A So, I think it was being done, along with the being-- along with the "How would we correct it? If we

occupied the building, could we still stay in the building and correct it if we chose to do that?" and that might not have been immediate, but it might have been at some time in the future, and I think those discussions were ongoing, but I wasn't close to those. I could only see what I could see through email or what I picked up in the conference call meetings.

Q Yes. We will come on and, perhaps, just look at a couple of emails-- that you were interested in this issue of how much risk-- That was something that you wanted to understand.

A Absolutely.

Q Yes because, if I could ask you to look within bundle 13, volume 8, please, at page 2223. So, bundle 13, volume 8, page 2223, and it is the email just in the middle of the page, sent by yourself to Dr Donald Inverarity quite late in the evening, 10.23 p.m. Let us just pick matters up in the third last line there beginning, "It would be helpful…" Do you see that?

A Yes.

Q Whereby you say:

"It would be helpful to have some sense of what the 10 air changes an hour is based on- How much is science, how much is received wisdom and how much because that's what the SHTM says. So would be 8 ok??"

Do you see that?

A Mm-hm.

Q Again, I appreciate that you say that you are not directly involved, you are looking at emails, and there is a point comes where this is all academic, but did you ever get to the bottom of that series of questions, how much science, how much received wisdom, and how much just because that is what SHTM says?

A No.

Q If I could ask you to look on, please, to bundle 7 volume 1, at page 33. So, bundle 7, volume 1, at page 33, which is an email from Jacquie Campbell to Iain Graham and others, and you will see that you are cc'd into that correspondence. So, the timeline has now moved on to 2 July, and you will see that a range of issues are covered in this email including, at point 3, Critical Care. Do you see that?

A Mm-hm.

Q And there are some options that are put forward. So, option 1 is:

"Use existing air handling units and ducting but reduce volume serviced by not opening

one 4-bedded bay and one single room. This would allow us to open with the same number of critical care beds we currently have in RHSC- 19 beds Early calculations are that this could potentially increase 4- bedded rooms to 5.2 air exchanges and single rooms to 7.1."

Do you see that?

A Yes.

Q And it continues:

"Detailed calculations of this option and potential air exchange rates will be brought to 430 meeting. Indicative timescale is 3 days of work – mobilise Wed, Work Thurs, Fri and Sat. Testing of newly delivered air exchanges Monday."

Do you see that?

A Yes.

Q So, at this point in time, there is a discussion that, within a relatively short period of time, there could be increases from the four air changes per hour to 5.2 in some spaces and 7.1 in other spaces. So, again, we are not immediately going to get up to the magic number of 10 but we are going to increase from the four. Can you explain your understanding of where discussions got to in terms of whether 5.2 air changes for some spaces and 7.1 for other spaces, would they have been safe for patients to occupy the hospital?

A So, I think it's back to your earlier point that safety is a continuum-- that safety is a function both of the built environment, but also of practice and other modifications that are made to both of those. I think this just illustrates that we were trying to explore, were there possible solutions to continuing with the move that would deliver an adequate regime of air changes, understanding that we might need to defend that view of adequate in the future? I think that's just us trying to explore; is there an option to make this good enough rather than compliant?

Q A range of options are clearly on the table at this point in time. Those options get escalated to the Scottish Government. Do you recollect the Scottish Government coming back and asking yourself, your colleague, Dr Inverarity, for an assessment of whether 5.2 air changes in certain areas and 7.1 in other areas-- whether that would be a safe environment to provide patient care?

A No, but that's what I'm saying. I was distant from some of

those discussions----

Q Thank you.

A -- but I was not involved.

Q If I could ask you to look over the page onto page 34, please. Do you see the penultimate paragraph states:

> "Donald Inverarity advised that all air exchange rates are currently better than what we have today, therefore will be in an improved position, but would wish external advice from HFS/HPS. He felt there were best people to advise of risk running with less than 10"?

Do you see that?

A Yes.

Q Again, is that back to that complex calibration about what is safety? You can have something that is, in a binary sense, safe, but not as safe as best practice. Is that the type of discussion that's taking place in these email exchanges?

A I think so.

Q Thank you. So, that was 2 July. If we can now look on and have a discussion about what happens on 3 July. If I could ask you to look, please, to bundle 7, volume 1 at page 51. This is a minute, or a note, of a meeting held on Wednesday 3 July 2019. Do you see that?

A Mm-hm.

Q A range of individuals listed as being present, including yourself by telephone. Can you just explain in your own words what's happening on 3 July? Why is this meeting convened and what is being discussed?

A So, we had regular meetings, at least one every day during that week, and I think this is a meeting to summarise and go through the options ahead of what is obviously a meeting with Scottish Government colleagues that is to follow in an hour's time.

Q Thank you, and then if we look-- I will not take you through it, but point one is there is an agreement of various options. Do you see that?

A Yes.

Q Then at point two, it is headed up "**Clinical Team and Clinical Modelling**." Do you see that?

A Yes.

Q And it states:

> "Fiona Mitchell advised that the clinical team had taken a measured view around the current situation concluding that anything was workable with the caveat that the Critical Care standard needed to be secure. The lack of robust information

had been raised as an issue as most of the detail had been relayed on a verbal basis."

Do you see that?

A Yes.

Q So again, at this point in time, the issues identified a couple of days ago on 1st, but by the time we are at 3rd there is still not a clear, robust set of information for decisions to be made on. Is that correct?

A Yes, and I think that principally relates to how difficult it would be to get to ten air changes. So, could that work be done with Critical Care in situ? Could they be moved into another setting? And if they were moved into another setting, would there still be residual impact on others occupying the building?

Q Thank you. Then the discussions continue. If we look to the bottom of page 53, please, do you see that there is a paragraph beginning "Tim Davison"? So, there are comments attributed to Mr Davison and, if we look over the page just at the top of page 54, approximately five words in from the right hand side, you see that Mr Davison is recorded as having said, "He did not feel comfortable about pressing ahead with the proposed move on the basis of the evidence currently available." Do you see that?

A I do. I think this might be a meeting that I left part-way through----

Q Okay.

A -- and I think it might be on the previous page where it notes that I left. I didn't manage to catch that as it all flicked through. I just didn't see that, so I'm not quite sure-- No, I think am still there. Sorry, I can see myself in the fourth paragraph down. There's one meeting where I leave part way through. I wasn't sure if it was this one.

Q Whether it is this meeting or another meeting, did there come a point where, on the NHS Lothian side, there is a discussion about whether or not NHS Lothian would be comfortable with the new hospital opening?

A I think there is and that is because there are a range of views about the difficulties or otherwise of a partial move, so moving some services and not others, and it becomes increasingly clear during the discussion that the comments that are being made about the level of disruption that would occur to bring the unit up to full compliance is just really not understood. Therefore, that's what leads, I think, to a feeling of increasing difficulty about partial occupation

because even for services not in Critical Care in the paediatric part, there may be disruption related to the size of duct work, noise, dust, etc., that would be unacceptable, and we just can't pin that down enough to know how big an issue that is.

Q Thank you. Then if we look on within the minute to page 56, the third last paragraph, you will see that the minute records, "The preferred option was therefore to rephrase the timing of the move in to the building and allow a phased occupation over the next few weeks and months."

A Yes.

Q Do you see that?

A Yes.

Q And again, is that your recollection that certainly in the NHS Lothian side, because of the unknowns, because of the risk, the view internally was the move really cannot go ahead until there is more robust information to be able to make a decision?

A Yes, and we're tempering that with that important, clinically-pressing need to try to move Neurosurgery and Neurology, so Neurosciences more than the Children's Services.

Q Thank you. The Inquiry has heard evidence that really what

happens next, the next major step is 4 July, the Cabinet Secretary simply makes the decision the hospital is not going to open, and it is not going to open until there is full compliance with the published guidance, SHTM 03-01. Did the discussion still continue internally within NHS Lothian, though, about safety? Albeit the discussion moves on from "Is the as-built solution safe?" to "Will compliance with SHTM 03-01 be safe?"

A I mean, there are ongoing discussions. I don't think I would frame them as specifically about safety, per se, rather than-- most of the following small number of weeks are taken up with "How do we"-- well, small number of days really, "How do we unwind the move that isn't happening?" That was the more-- the next immediate focus. Then it's a discussion about, "Well, what needs to be done in order to try to bring us to compliance in Critical Care?" I don't think there was a huge amount of discussion about whether ten is right or not, if that's what you're referring to.

Q Thank you, and if I could ask you, please, to look at an email on 5 July. If we could look to bundle 7, volume 1, page 125. Do you see that the second email there is an email from yourself----

A Yes.

Q -- to Donald Inverarity on 5 July 2019, which states:

"You are aware of the material concern we raised to you on Tuesday 2nd July regarding the shortfall in the standard of air changes provided in paediatric critical care areas and that this was the reason why we did not believe we could provide safe patient care in this environment, even with an interim solution."

Can you see that?

A Yes.

Q If I could just try and understand what you are trying to communicate, had there been an analysis and a decision that, definitively, the space was not safe? Or, when you are talking about safety, are you still talking in the concept of, "We do not know it is safe and because we do not know it is safe we cannot open"?

A So, this email is me testing out a draft response to provide to Malcolm Wright on Tim's behalf. That's what this email is. I'm testing it out with Donald and Lindsay specifically, really, as well as George, to make sure that I am providing factually accurate information about things about which I am not a technical expert, and I think what is happening in that word about "provide safe patient care in this environment," I think it's a sort of a relatively shorthand language. What we really mean is "optimally safe" related to the built environment factors.

Q Thank you.

A It's not that-- because it's back to your point earlier on, we can still provide safe care that is-- we believe is safe in a suboptimal environment, but in the new building, we want to be providing it within the optimal built environment that will allow us to deliver care for many years to come.

Q Thank you. Then if we could perhaps look on to a slightly later point in time to 11 July. If I can ask you to look to bundle 7, volume 1 at page 316. Bundle 7, volume 1, page 316, which is an email from Janice MacKenzie to Brian Currie and others. You are copied into that email on 11 July 2019.

A Thank you.

Q Part of the backdrop to this email, just by way of introduction, is clinicians and IPC professionals had a range of discussions that took place, which I do not believe that you were involved in, and this email is really the culmination of the discussions that

take place amongst others, and just for your observations on the second paragraph:

> "Following much discussion and looking at a range of different scenarios related to the patient groups they will be caring for and the requirement for the ability to cohort patients with the same infection the consensus is that the requirements of SHTM 03-01 in relation to ventilation within a Critical Care Unit will provide a safe ventilation design in conjunction with the design of paediatric intensive care unit and good staff practice to achieve best outcomes for patients."

Do you see that?

A Mm-hm.

Q So, at this point in time, we have moved slightly on in the timeline. You are now being told, along with other individuals, that clinicians, IPC professionals, they have looked at the new solution and they are satisfied it's going to be safe.

A Yes, and I think this relates more to the change in the pressure regime.

Q Thank you. I just want to ask you a few questions about a slightly different matter, and it is really the knowledge that you had and any of your colleagues had of emerging issues at the Queen Elizabeth University Hospital around about this period of time. So, if we perhaps think from late 2018 until summer of 2019, what understanding, if any, did you have of emerging issues with the water and ventilation systems at the Queen Elizabeth University Hospital?

A I obviously had a professional knowledge that was through discussion in various meetings that I would attend, as well as, obviously, having sight of coverage in the press of issues that were emerging related to the Queen Elizabeth. There was a water report published by HPS, I think, at the end of 2018, which outlined some of the issues that were there and I would have had informal discussions, more by way of just providing colleagues support than anything else across that time.

Q In that period of time, so late 2018 through to the summer of 2019, did you attend any meetings with colleagues working at the Queen Elizabeth University Hospital?

A So, I would have attended meetings where some colleagues who worked there might have been present, but up until that stage, I don't think I attended any meetings specifically about the Queen

Elizabeth. This would've been like-- I would have found myself in the same meetings about other subjects. The one meeting we did have was not until 2020.

Q Not till 2020. Okay. The reason that I raise that is the Inquiry has heard evidence that there were certainly emerging potential issues relating to the water system and ventilation system at the Queen Elizabeth University Hospital, late 2018 into 2019. As an outsider looking in, it seems slightly strange that there are emerging issues at the Queen Elizabeth University Hospital, but there is not a structured platform or a set of structured meetings so that any learnings from the Queen Elizabeth University Hospital could be fed into the Royal Hospital for Children and Young People. I would be interested in your observations on that issue.

A So, there may have been meetings that related to the Infection Prevention and Control community, and so by that time – so from March/April 2018 –
that responsibility was sitting with Professor McMahon, not with me. So, I may have been less sighted on them. I had a sense that this was still something that was being worked through in that setting, so it may be

that it hadn't quite reached the stage of exactly what had been learned being set out for other people to understand. The reason why we had one specific meeting in January 2020 was to explore some of their learning related to the water system because there had been various discussions since July 2019 that we wanted to follow up on with them.

Q Okay. Thank you. Perhaps, just to try and frame some of these issues, if I could ask you to look to bundle 13, volume 8, at page 2226. So, bundle 13, Volume 8, at page 2226----

A Yes.

Q -- and it is the email towards the bottom. It is the email from Dr Donald Inverarity to Alex McMahon, Tracey Gillies, and others on 5 July 2019, and you see that Dr Inverarity says:

> "Dear All,
>
> Please see the reply I received this morning from my equivalent, Dr Teresa Inkster…"

Do you see that?

A Yes. I do.

Q And then, really what follows is – from the "Hi Donald" is the pasting-in end of the email from Dr Inkster.

A Yes.

Q And if I could pick matters up just three lines up from the bottom of the page, on page 2226. Do you see that?

A Yes.

Q Where Dr Inkster stated:

"As part of the investigation we asked for an external review of the ventilation system. What we found was air changes of < than 3 (due to chilled beams), rooms at slightly negative pressure to corridor, thermal wheel technology and duct work configuration issues."

And then, if we look over the page onto page 2227:

"All of this combined was felt to be a factor in these outbreaks as mixing of dirty and clean air was occurring. HPS were asked to investigate and the conclusion of their report was that our outbreaks were not due to practice or IC issues but to the environment. Difficult to prove that retrospectively, but it makes sense."

Do you see that?

A Mm-hmm.

Q Having seen that email, do you recall receiving that email or having those types of discussions with Dr Inverarity?

A So, I actually don't recall this email. Normally, I have a reasonable recall, but I actually don't recall this email. I think it does relate to the fact that it came in at the time when we were unwinding the move, and that's where the focus of attention was. I would say that we-- and I know that Donald did quite a careful check about our ventilation system, and we didn't have the same chill beam part as the Queen Elizabeth did. I do know that in-- and I can't remember the details about the thermal wheel technology; there's something to do with the thermal wheels that one needs to be particularly mindful of, and we did explore that across the summer to make sure that things were compliant, but the immediate piece of learning that we took from the discussions that were probably happening between other colleagues between Glasgow and Edinburgh was that piece, that we were now not going to occupy a building that had a filled water system.

So, we did quite carefully take the learning to make sure that Bouygues were instructed to make sure that all outlets were run and there was adequate turnover of the water system because we understood, principally through the authorising engineer, who

had also I think been part of the Glasgow work, that that had been one of the issues.

Q Okay. Thank you. If we could just think about what is stated in Dr Inkster's email, and again, Dr Inverarity said exactly the same thing that you did, that he looked into this issue and there were real differences between the ventilation systems in Glasgow and in Edinburgh, but that was really just through direct discussions with his colleagues. But within the issues being raised in this email, Dr Inkster does say that the air changes being achieved are less than three and the pressure cascade is negative to the corridor.

Given those similarities to what was being experienced at the Royal Hospital for Children and Young People – so it is three air changes in Glasgow, it is four at the Royal Hospital for Children and Young People – the pressure regimes are the same. Do you think there should have been some form of meetings or structured process whereby there could be a formal dialogue between colleagues at the QEUH and individuals working on the RHCYP project?

A Do you mean working on the project ahead of completion?

Q I think really, just-- at this point in time, I accept what you say, your focus is on patients, families in the short term, but at some point, should there have been a structured process, or a structured set of meetings, to discuss what is happening in Glasgow and see if there are any learning points for Edinburgh?

A I think when there was a clear summary position from Glasgow, yes, but I think the important part is actually on the previous page. I think it's about patient placement. It's about that context of the type of patients that are in that built environment, and so I really go back to a few emails ago. There was a line where I've said to Donald-- poor language, but I think I said, "Which patients would be suitable for four?" and what I meant was, would we need a differential placement of patients because it's the interaction of the built environment with the type of care that's being delivered, with the vulnerabilities of the patient that I think we need to pay attention to. So, there are some specifics about the Glasgow unit, that this is a Paediatric Haematology Oncology ward with non-bone marrow transplant patients, but we weren't close enough to be able to separate out the part related to their Bone Marrow Transplant unit.

So, we need to be careful that we're not -- that we have enough understanding of our context and how that would be different to make sure we can learn appropriately is probably the summary of that.

Q The reason I raise that is there does seem to be contact that is taking place, particularly between Dr Inverarity and his colleague, Dr Inkster, but those are, effectively, relatively informal communications that are taking place between colleagues. The wider issue that I would really like your views on is not specific to this project, but there does not seem to be formalised structures within the NHS; if one board is having a particular issue, for there to be a formalised capturing of that knowledge, and a centralised forum for learning and discussions. Do you think that is a gap in governance, oversight or procedures? Or actually, does the system of colleagues just talking informally negate the need for those formal networks?

A So, I can understand why it is perceived as a gap. I think in this and other situations, the issue might be one of timing, and whether the learning is-- it will never be complete, but whether it's far enough through that cycle of everybody having

reached, really, an understanding of what needs to change, and how can that be articulated in a way that makes it generalisable, that takes it out of specific context. Because of the nature of the health care and then, particularly, the timing of some of this with COVID then coming along, I think that might be why there's been less opportunity, or opportunities have not been crystallised. I accept that that formalisation in a way that is-- leaves a trail that others can refer to is not always something that we're very good at doing, and it does often happen in those more informal settings and, partly, that's because it allows people to speak more freely.

Q If there was going to be a formalised procedure, what would be helpful – because again, the last thing anyone would want to do is create just another process that adds to the work of clinicians – but if there was going to be a more formalised procedure for capturing knowledge and sharing knowledge between NHS boards, what would be helpful?

A I think it is that bit that says, "Okay, what"-- if I was to personalise it to, say, for Lothian and what would we want to share with others, we would need to do that in a way that was clear enough about what

we've changed within our systems and processes, and why we've done that.

Q Thank you. Just perhaps to cover this off, you mentioned that there was a meeting with colleagues from the Queen Elizabeth University Hospital, I think in January 2020. Is that correct?

A Yes.

Q Can you explain, we will go through it, but why does that meeting take place?

A So, that meeting took place because there were some differences of opinion between professional experts about some of the aspects of the water system and what should be tested, and how that should be tested, that we found ourselves, from our own Infection Prevention and Control experts, with a difference of opinion from others within national bodies, and so we wanted to test. So, what we were being told was that this was based on the learning from Glasgow, but it was coming to us secondhand, and it becomes really important to know why you're doing something because undertaking actions that give you results back, if you don't know what to do with those results, you have to ask yourself why you did that action in the first place. So, we wanted to understand firsthand from Glasgow colleagues about what they were doing and why.

Q Who was present at the meeting?

A So, from memory – and I can explain to you why it's from memory – I think present at that meeting were the Medical Director for Greater Glasgow and Clyde, and I don't think their deputy for the Acute Medical Director was there, but they may have been, and then their senior nurse from the Infection Prevention and Control team, and the lead Infection Control doctor for the Queen Elizabeth.

Q Was Dr Inkster present?

A No.

Q Why not?

A I don't know why not, but it was Professor Leonard who was present, who was introduced to us as a Lead Infection Control doctor for the Queen Elizabeth, and it was the actions related to the water system in the Queen Elizabeth that we were trying to explore.

Q Okay, and----

THE CHAIR: Sorry. I just missed the reference to the doctor who was there.

A Professor Alistair Leonard.

THE CHAIR: Thank you.

MR MACGREGOR: And what did they tell you about the water system at the Queen Elizabeth University Hospital?

A So, they-- I have a fairly loose recollection of it, but I think we did explore some of the issues related to the type of testing that was being asked for and why and our understanding, summarised at the end, I think, would be that that did relate to particular types of incidents that they had seen. Then, we also rehearsed with them some of the actions they were taking about dealing with biofilm and the particular configuration of sink traps that they had. The reason why recollection is loose is because it's immediately juxtaposed in my diary, when I've looked back at it, with a Wuhan meeting and I think, truthfully, that we ended up with a very significant focus across the latter part of January 2020 related to what went on to become the COVID pandemic.

We did take the learning, or the observations, that we got from Glasgow and they were crystallised into the water paper that we provided back to the Oversight Board, which was the agreed way that we were trying to reconcile the professional differences in what should be done

where there isn't actually guidance, but these professional differences between colleagues from national bodies, principally I think in HPS and HFS, and then our own Infection Prevention and Control team. So, I don't have a very clear trail about what we took out of that meeting, but what we took out of it, we put into that paper, and the paper really stands as a record of our learning from that meeting.

Q So, this was an example of a formal meeting taking place between individuals from the Queen Elizabeth, individuals from the Royal Hospital for Children & Young People, to try to learn from experiences at the Queen Elizabeth University Hospital on the other project in Edinburgh. Is that correct?

A Yes because we needed to understand, were they applicable to our context? That's what we were trying to get to.

Q Do you recall, was a formal minute kept of that----

A No, and that's what I'm saying. So, there wasn't a formal minute kept and that's-- I'm trying to offer you the excuse of Wuhan, and I accept that there should have been just a brief note of the minute. I mean, there were only, probably, six or seven

people in the meeting. It was done by a video conference, but the place where we landed, what we had taken out of it was into that paper.

Q Thank you. Now, in terms of the project, Royal Hospital for Children & Young People, perhaps the next part in the chronology is the escalation to level four-- sorry, the escalation to level three, then the escalation to level four and the creation of the Oversight Board.

A Yeah.

Q Can you just explain in your own words, what was the Oversight Board? What was its purpose?

A So, the Oversight Board was really bringing together colleagues from Scottish Government, colleagues from national bodies and NHS Lothian to find a way forward to be able to offer advice and recommendations to Scottish Government about the next steps in moving towards getting the hospital completed and opened.

Q Thank you. Were you a member of the Oversight Board?

A Yeah.

Q If I could ask you to look to the "Terms of Reference" for the Oversight Board, so it is bundle 7, volume 2, at page 352. You see this is the "Terms of Reference" from July of

2019, and if I could ask you to look on, please, to page 354, and it is the bottom box on page 354. It is the "Scope of work" which sets out that the Oversight Board is going to advise on the phased occupation and a range of other matters. You see the final bullet point says that the Oversight Board is going to have within its scope of work "Identification of areas that could be done differently in future". Do you see that?

A Yeah.

Q Now, the Inquiry has heard evidence from other members of the Oversight Board that the Oversight Board did not actually formally document any areas that could be done differently in the future. Is that your recollection?

A Yes.

Q And could you just explain why not?

A I think there were a number of different chairs of the Oversight Board over time and, obviously, by the time the Oversight Board closed with the final occupation of the children's part of the hospital, it was probably not quite two years, but nearly, since establishment of that, and it may be that that was less of an area of focus at that time of closure. I think internally, within NHS Lothian, we

would really be clear that the actions that we took on the back of the Grant Thornton report were our particular attempts to capture and make sure we embedded different systems and processes for the future.

Q Okay. Thank you. Now, I will not take you through all of the Oversight Board minutes. The Inquiry has looked at those before, but again, I will go through some stages and if you have any observations or corrections, please do just let me know. The Oversight Board consider the proposed change to the Critical Care rooms, which is going to be positive pressure and ten air changes per hour and, as a group, the Oversight Board agrees that that would be an appropriate specification for the hospital. Is that correct?

A Mm-hmm.

Q If I can ask you to look to an Oversight Board minute from 29 August 2019, please. It is in bundle 3, at page 142, which you will see is an Oversight Board minute from 29 August 2019, and it is really just to ask for your observations on the science, back to this question of the science around about air changes. So, the section of the minute I want to take you to is page 144 in section 1.6, and I will just take you through it and then ask for your recollection of what was being discussed, recognising that it is some time ago. So, point 1 says that:

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

Do you see that?

A Mm-hmm.

Q Could you just explain to the Inquiry, what were the Oversight Board grappling with at this point in time?

A I think it was back to that bit about looking for the evidence of the science that the numbers were based on. My recollection is this is more based on the difference of opinion about four air changes of mechanical ventilation plus two natural versus six of mechanical.

Q Thank you, and I think we see that later and I will not take you through all of it, but point 4, for example, it says:

> "Air changes is not a specific hurdle to get over but is the level generally found to be suitable in the majority of developed countries."

Do you see that?

A Yes.

Q And is that the type of discussion that is taking place on the Oversight Board at this point in time?

A I think so because this is about trying to make sure that the professional views of those who are looking at the building from the point of compliance are balanced off to those who will be using the building.

Q Thank you, and then if we look to point 6, it says:

> "Air changes are covered by guidance not standards. Guidance states air changes can be a combination of mechanical and naturally ventilated but there has to be an element of control about it."

NHSL did not make a decision to move to four air changes per hour. Six air changes by multi-modes was accepted at the point of the Settlement Agreement. Again, I think that accords with your recollection that it is the six to the four as opposed to it is ten, the magic number, that is being discussed.

A Yes.

Q I welcome your observations as someone who, obviously, was involved in the project. Right at the start, you are told it does not comply with guidance. At this point in time, in the Oversight Board, there are still discussions around about the guidance, around about the science. Do you think for critical building systems – whether we are talking about water, whether we are talking about ventilation – that having a document that is simply called "Guidance" that is open to interpretation is the ideal model? Or should there actually be a hard-edged legal standard for new-build buildings that a Health Board simply has to comply with so there is no dubiety as to what the standard of the guidance is?

A I think the level of detail in some of the guidance at the moment is less than helpful in these situations where there is a need to balance compliance with the guidance and what are the consequences of not complying with the guidance with the cost of the building, other impact – that might be noise, or discomfort from a particular ventilation regime. I'm not sure that an absolute binding statutory piece is potentially helpful because my experience is this is where we do get into this tension between the built environment and what are the consequences of some things of the built environment, and then how is clinical care delivered? What is the work like for clinical staff in looking

after patients? I think the place for experts to come in is to advise Health Boards, who do do these things relatively infrequently, about the risks and consequences of any derogations that are made in not meeting standards and, secondly, to draw out or develop guidance where it is ambiguous.

Q Thank you. If I could ask you to look on, still within bundle 3, to page 531, please, and that is a minute of the Oversight Board on 5 December 2019. Do you see that?

A Mm-hmm.

Q And if we could look over the page onto page 532 and to the first bullet point beginning "The NHSL Board…" Now, I will take you through this, but I would really be interested in your observations both as a member of the Oversight Board and as a member of the Board of NHSL. There is a discussion recorded here which says:

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

Do you see that?

A Yeah.

Q Can you just explain what is being discussed and recorded here in the Oversight Board?

A Please can you just remind me of the date?

Q So, the date is 5 December 2019.

A So, I think this relates to the difficulty we had in actually getting to a point where all the actions coming out of the two reports from NSS were complete, but please could I just see the previous page again, just to look at the bottom?

Q Certainly. We will just go back.

A Yeah. So, I think this relates to the fact that we ended up having to go back, essentially out to the market, and I wasn't close to this. I wasn't part of the commercial subgroup, but I think this relates to the fact that, actually, we couldn't do this through the existing supply chain, contractors and subcontractors, multiplex, TÜV SÜD, etc. I think it was the fact that we had to get Imtech to come in and do this, but that's a little bit of a loose recollection. I think that's what it is, because I think this might relate to the procurement not only of the additional-- to the procurement of the changes to deliver the ventilation, but also the additional air handling units. I don't-- that's-- that would be-- It's a little bit of a guess.

Q Thank you. The Oversight Board continues its work; Mary Morgan comes in as Senior Programme Director, assists with matters. The final minute that I would ask you to look at is bundle 3, page 1095, and this is a minute of the Oversight Board from 25 February 2021. If we could pick matters up on page 1097, the second last bullet point and approximately three lines up from the bottom of that paragraph, you will see a sentence beginning "The new Hospital was now one of the safest…"

Do you see that?

A Mm-hmm.

Q This is what Mary Morgan is telling the Oversight Board. So, Mary Morgan says:

> "The new Hospital was now one of the safest and best buildings in the whole of Scotland."

Do you see that?

A Mm-hmm.

Q So, is that what you were being told whenever you were sitting on the Oversight Board?

A Yeah.

Q And, again, I will not take you through all the minutes, but the Oversight Board narrates that technical advisors have been involved, HFS have been involved, HPS have been involved, all in terms of reviewing the design solution. Does the Oversight Board get to a point where it is satisfied that the system, as designed and implemented, is an environment that is going to provide safe and effective patient care?

A Yes. So, there are-- I think the Oversight Board had overseen both the rectifications required to bring Critical Care up to a level of compliance with the air changes, but a number of what would be regarded as enhancements to the

building to absolutely optimise that built environment. So, the safety from the built environment, I would agree, was absolutely as good as it could be.

Q Thank you. The final set of questions I want to ask you about are really about what happened next after the project, so NHS Assure and any reflections you have in terms of how these projects could be done better in the future. So, you will be aware that the Centre for Excellence, NHS Scotland Assure has been established. In your view, is-- does that cure all of the problems that had existed on the RHCYP project and on similar projects? Has it addressed all of the issues in these types of projects?

A No.

Q Why not?

A So, I think it's very early days for NHS Assure. I think that my observations of what I've seen, which have been from a distance although I've heard some presentations of their intentions-- is that there is a-- still a significant focus on compliance with guidance and the problem is if you're complying with guidance that is open to interpretation, you could still find yourself left with a situation where, with all good faith, one interpretation had been placed on that and, actually,

there was subsequently a view that the interpretation should have been otherwise. So, I would prefer to see NHS Assure supporting boards to tease out what are the consequences of some of the ambiguities in the guidance, what are the risks for patients or staff that follow from that, and how could they be mitigated, in your particular circumstances, so that the building solution that was put in place took account of those?----

Q Thank you----

A -- and I don't think we've really reached that stage yet.

Q One would assume, with a Centre of Excellence, that if a Health Board is doing one of these major Health Board projects and there is an issue about interpretation of guidance that they would either be able to phone or send an email and get a very quick expert definitive view on what the guidance means. Is that how NHS Scotland Assure works in your experience?

A I don't have any direct experience of NHS Assure like that, but that is what we would expect to have got from the forerunners of HPS and HFS, and that has happened, really, as far as I have ever had any line of sight into any of these projects-- is that there is involvement from those

experts. I think it's the next step on, for me, that I may maybe not articulating very clearly. If a particular interpretation is placed on guidance, it is helpful for the organisation that's going to continue to use that building to know what that evidence is based on and what are the risks that might follow so that we keep our eyes on what we need to do to minimise that risk. So, without that level of detail – and I don't think that's-- we haven't got there yet – it's quite hard to actually move on from just a compliance assessment.

Q Okay. So, the Scottish Government established the new Centre for Excellence, NHS Scotland Assure. It has got its procedures, including the key stage assurance reviews. What package of resourcing and support and finance did the Scottish Government provide to Health Boards such as NHS Lothian to help them comply with the new procedures that have been put in place?

A So, obviously, there is support from Scottish Government, or support has been received from Scottish Government in the past, by way of financial support for project teams in the development of cases relating to new build. Is that what you mean?

Q It was really just to try to understand-- There is a new system that is set up; it has got new procedures----

A Yeah.

Q How does the Health Board deal with that? Can it deal with it with its existing staffing and resources, or does it need more staffing resources and support from the government?

A Well, we-- To fully comply with what is proposed, we will need more people with skills and expertise. The difficulty is growing and developing those people with skills and expertise. So, sometimes it's not always a financial resource constraint that is the issue, it's a people resource constraint, and I think there is a people resource constraint, potentially, in this setting----

Q Okay. Thank you.

A -- and we might be using colleagues with quite a scarce expertise in a way which does not allow them to add most value.

Q If the current model is not optimal, how could it be improved?

A So, I think that's a bit about being clearer. So, Infection Prevention and Control colleagues are a scarce resource; that's really who I'm thinking of. So, in that NHS Assure

KSAR review process, we really need to be clear about where those Infection Prevention and Control colleagues add value and avoid them, essentially, sitting in a lot of meetings talking about things about which they have no expertise to add.

Q Thank you. If I could ask you to look to an email, please, bundle 13 volume 7, at page 319. It is at bundle 13, volume 7, at page 319. 319. Do you see this is an email that you sent a number of colleagues within the NHS on the 16 March 2022?

A Yeah.

Q Do you see that? And you set out your understanding----

A Yes.

Q -- as you say. "So my understanding from LG on this…" and then----

A Yes.

Q -- if we look to point 4: "The usual advice and support on offer to boards appears to have moved to a more 'mark your homework approach…" What did you mean by that?

A Just to give you a small amount of context at this time, because we have an interim position around the executive nurse director, the Infection Prevention and Control portfolios come back to me and so, I had been briefed by Lindsay on this. So, Lindsay is the LG that I'm referring to, and that is really about the key star (sic) review process where there seems to be a distancing of colleagues within the NHS Assure setting from the offering advice to boards about how they should deal with any ambiguities or any difficulties they find themselves in construction projects, but it's much more, "We are less able to offer you advice. We are much more just wanting to assess whether you're compliant or not."

Q Thank you. Then, if we could look within that email, just to the final paragraph, you say:

> "Given that we have already have to reduce HAI scribe attendance as there are simply not enough nurses in IPC to provide the essential service to clinical areas in the here and now, and not enough IPC nurses in Scotland with the requisite qualifications to do this more technical work, someone will need to feedback to SG capital colleagues that their programme will be undeliverable."

Do you see that?

A Yes.

Q And is that your view?

A Well, it's possibly put in

slightly stronger language because it's an email to a colleague to help them understand what my concerns are. It's not an email that's intended for wide public consumption, so I accept that the point about their programme will be "undeliverable" is relatively strong language. I'm trying to convey an opinion in that we do find Infection Prevention and Control nursing staff, in particular, hard to recruit and retain, and there are a series of qualifications that those staff need to have, but they also need to have experience in doing the core work around Infection Prevention and Control to build up to the level of expertise that we really require at a more senior level, which is to help us through Incident Management Teams, situations of ambiguity. So, it is quite important that they're a group we need to really protect and nurture.

Q Do you still hold to the view that, if there are not changes made to NHS Scotland Assure, that what it is wanting boards to do at the minute will simply be undeliverable?

A I think my view is that it doesn't take us really much further forward than from what we've had. So, I think that there is a place where they need to have less emphasis on compliance and more emphasis on

support and interpretation.

Q Okay. Thank you. If i could ask you to have your statement in front of you, please. So, that is at bundle 1 of the statements, and if we could look to page 524 and to paragraph 24, and it is just about three lines up from the bottom, there is a sentence beginning, "I have raised questions…"

A Yes.

Q Do you see that?

A Yes.

Q And you say:

"I have raised questions to ask that increased clarity is brought to the distribution of accountability between individual boards and NHS Scotland Assure."

A Yeah.

Q Do you see that? Can you just explain what you're talking about here, about this division of accountability between NHS Scotland Assure as opposed to a Health Board?

A So, I think this is probably a relatively personal point for me, having been through all the events around the difficulties in moving into the new hospital and understanding how significant an event that is. I'm still not really clear – if there are future issues with compliance about another

building project – where NHS Assure sit in that space about accountability for such a future collective failure, if one happened, as opposed to the board who is obviously the contracting body with whoever is building the building, or whichever vehicle is leading the financial support to build the building.

I don't really feel that's been properly teased out and understood because I don't understand the purpose of augmenting the structures from HPS and HFS into an organisation to hold the expertise about the built environment if we don't either make it more straightforward for boards to access significant expertise around difficult areas of ambiguity, or if there isn't some clearer articulation of where that responsibility and accountability lies. It just feels that that has not been properly thought through yet.

Q If that is not clear, in your view, your personal view, what would the optimum model be for distribution of that accountability?

A So, I'm not necessarily asking for the risk to transfer to NHS Assure. I think it is about-- My own view, from within the board, is we need to be able to get clearer advice about those areas where, as you've pointed

out, the guidance is actually not binding, and what happens if we derogate from that guidance? We have put in our own process about derogation, but I think clearer input from those experts in the built environment would be helpful.

Q Thank you. The final question for me at the moment, really, is an open question that-- You have set out very clearly in your statement, observations, reflections, how you think things went wrong, how you think these types of projects could be done better in the future. We have covered, again, some suggestions you have as to how these projects could be done better. Is there anything that we have not covered, either in your statement or in discussions today, that you think could be done to try to improve these complex new build hospital projects in the future?

A So, I have touched on the roles and responsibilities for clinical colleagues. So, I think that is quite a challenge for them. We have just very briefly mentioned the derogation process, and I am really clear that I think that is an important change, but internally, within NHS Lothian, where we have a derogation within a building project from guidance, we are much more rigorous around

understanding, “What advice have we received? Why are we still choosing to derogate? What risks are there? How are we mitigating those risks, and what residual risk does that leave us with?” and that that requires an executive level sign-off because we need to put that into systems and process, and not rely on memory.

The third thing that we have changed – and I also think this is important to prevent tensions between teams who are well-intentioned, but not always focused on the same thing – is to be clearer about the actual process of handover of a new building. The project team are focused on getting that building commissioned, complete and handed over, and the Infection Prevention and Control teams are rightly focused on making sure they are able to provide assurance, and that is more than just the completion of the HAI-SCRIBE Stage 4. They need to not just be told that standards have been met, they need to see the evidence that that is based on, and that’s because that may become important in the future. So, we’ve taken steps to bridge that tension and we have tested that out with a handover of other settings.

Q Thank you. Just one final point from me. You obviously

raised the issue of derogations----

A Yeah.

Q -- which you see as being important. There is now the concept of the Ventilation Safety Group that has been created that would have to make any key decisions in the ventilation system. The Inquiry has heard evidence from other witnesses who have said, “Yes, there is the Ventilation Safety Group. Yes, there is some guidance around about derogations, but there is not a standard form that you could simply pick off the shelf from the NHS that would tell a board exactly what they have to do, exactly what they have to document in terms of the derogation.” Do you think that standard form or standard procedure would be helpful?

A Yes. I could see that that would be helpful.

MR MACGREGOR: Thank you. Well, thank you very much for answering my questions this morning. I do not have any further questions. Lord Brodie may have further questions, or equally there may be applications from core participants, but thank you.

THE CHAIR: I do not have any further questions at this point, Ms Gillies. What I need to do is find out if there are any questions in the room

which legal representatives would wish either to direct through Mr MacGregor or otherwise. So, what I propose is this: we are a little after twenty-to-twelve. We would usually take a coffee break, so what I am proposing is that we combine a coffee break with a break to allow legal representatives to check in with Mr MacGregor as to whether there are any further questions. First, you would get coffee as well, and perhaps we could plan to sit again about five-past twelve to find out what the question position is – but I hope after you have had a cup of coffee.

THE WITNESS: Thank you.

THE CHAIR: Right, thanks.

(Short break)

THE CHAIR: Thank you. Mr MacGregor.

MR MACGREGOR: There is just two questions that have been raised with me which I am content to raise, my Lord.

THE CHAIR: I understand that there is perhaps two questions to be asked and Mr MacGregor will ask them. Mr MacGregor.

Q There is just two matters. You have-- recall that, earlier this morning, we were discussing the situation that could arise whereby the guidance says a particular standard for the RHCYP project. The guidance says, “positive pressure,” “10 air changes per hour,” and you have a facility that’s built to a different standard, and we discussed the process that might have to take place to try to do a risk assessment of: how much risk is there if you depart from the standard? Appreciating that you are not an Infection Prevention and Control expert, but to try to answer the question you had posed of how much risk, what would the process be, what disciplines would be involved in trying to answer that question?

A So, I think it would be principally Infection Prevention and Control; it would be clinical staff from the disciplines that might be using that space because that would be important for understanding what procedures they might undertake in that space; and it may or may not involve health and safety, or occupational health, if we were particularly thinking about staff or patients. If there was a particular patient group who might have additional vulnerabilities, then we might draw in additional expertise from there.

Q Okay, and just in terms

of an estimate, and I appreciate it would be an estimate, how long a process do you think that would be to get an answer?

A I mean, once you've got the right people in the room, you would expect to do it in a number of hours, but the assembly of the right people would be the difficult part.

Q So, you would have to have the right people there, but if you had the right people, they should have that type of information really at their fingertips?

A Yes. They're each bringing their perspective about clinical care and risk, and then somebody has to assimilate that and put that together. It would be fair to say that that would be a series of opinions put together. There's no solid evidence base behind that.

Q Okay. Thank you very much. I do not have any further questions, but thank you again for answering my questions today.

THE CHAIR: Thank you on behalf of the Inquiry, Ms Gillies. You are now free to go, but can I just emphasise that we appreciate the amount of time involved, not only in attendance, but in preparation. So, thank you for that. You are now free to go.

MR MACGREGOR: The next witness, my Lord, would be Timothy Davison.

THE CHAIR: Timothy Davison. Good afternoon, Mr Davison. As you appreciate, you are about to be asked questions by Mr MacGregor, who is sitting opposite you, but I understand you are prepared to take the oath.

THE WITNESS: I am, yes.

Mr Timothy Paul Davison

Sworn

THE CHAIR: Thank you very much, Mr Davison. We will be sitting until one o'clock and then take a break for lunch.

A Thank you.

THE CHAIR: Mr MacGregor.

MR MACGREGOR: Thank you, my Lord.

Questioned by Mr MacGregor

Q You are Timothy Paul Davison.

A I am.

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

A Yes. I have.

Q Just for the benefit of core participants, that can be found at pages 189 to 241 of bundle 2 of the

witness statements.

A Yes.

Q Mr Davison, that witness statement will form part of your evidence to the Inquiry, but you are also going to be asked some questions by me today. If you want to refer to your witness statement at any point, please just do let me know – a copy should be available to you. Equally, if I want to take you to any documents, those should come up on the big screen in front of you. If for any reason you cannot see the document, please just do let me know.

A Yes. Could I just bring your attention to a typographical error that has been brought to my attention this morning in relation to paragraph 74 of my witness statement where I make reference to Tuesday 2 July? I think that is more accurately to be restated as Wednesday 3 July.

Q Well, I think we will just bring that up. So, within bundle 2 of the witness statements, and if we could look to page 211, please. So, we see at paragraph 74, three or four lines up from the bottom, there is a reference to a "course of day on Tuesday 2 July 2019." Should that be 3 July 2019?

A Yes. It should.

Q Thank you. Is there any

other corrections or amendments you would wish to make to your statement?

A No.

Q Thank you. Now, in relation to your background and qualifications and career history, you set that out from paragraph 2 onwards of your statement, but in essence, you are now retired. Is that correct?

A Yes.

Q But you spent your entire career working within the NHS?

A Yes. I did.

Q And your final post within the NHS was as Chief Executive of NHS Lothian?

A Yes.

Q But you had had similar posts at other Health Boards before you came to NHS Lothian. Is that correct?

A Yes. I was Chief Executive of NHS Lanarkshire for seven years prior to Lothian, and then in the days of NHS trusts, I'd been Chief Executive of three NHS Trusts in Glasgow in the 1990s.

Q Okay. Thank you, and the position that you held latterly at NHS Lothian, you held that position from May 2012 until you retired in August of 2020. Is that right?

A Yes. I retired at the beginning of August, but I had some

leave to take and so my last working day was actually 24 June 2020.

Q Thank you. Now, you explain within your statement that the role you had was really a strategic leadership role. Is that correct?

A Yes.

Q Could you just explain in your own words, what were the day-to-day activities that you were carrying out in your role?

A Well, actually, I should probably amend my response to your earlier question; was it just a strategic role? It was a strategic role, and it was very much about strategic leadership, but it was increasingly-- had become increasingly, over the course of the previous few years, very much focused on operational delivery, particularly around things like Scottish Government access targets. Now, in an organisation the size of Lothian, you know, £1.7 billion of turnover or whatever, 28,000 staff, there was a huge amount of activity, and so the extent to which I could drill down into enormous kind of detail for individual issues was somewhat limited, and hence the reference to the strategic approach.

The responsibility for ensuring that NHS Lothian met operational targets was also a very significant part

of my role and so, liaising with my direct reports, whether that be the Chief Officer for Acute Hospitals or my Deputy Chief Executive managing the more operational components of acute hospital services, or the directors of Health and Social Care who were responsible for things like delayed discharge targets, etc. There was a great deal of interaction that I was involved in, personally, in terms of overseeing that level of performance as well.

Q Thank you. Did part of your role involve liaison with the Scottish Government?

A Yes.

Q I want to start by asking you some questions about the Royal Hospital for Children and Young People, and the Department for Clinical Neurosciences that-- I am just going to refer to that as “the project”. Can you just explain, in the period up until July 2019 – we will talk about what happens after July 2019 – but up to July 2019, what is your involvement in the project?

A Well, principally, from a governance perspective as a member of the full board and as a member of the Finance and Resources Committee, but also from a managerial context. If I can distinguish between

board governance and then management from a management perspective, I was the direct line manager of the lead directors involved in the project. So, Susan Goldsmith, who had been the SRO for the project for three years, I think, from 2012 to 2015, and then Jim Crombie, who was my deputy latterly, who became the SRO between 2015 right up until I retired in 2020. I was their line manager.

I was responsible for overseeing their performance, for agreeing their personal objectives, and so we had a great deal of managerial dialogue alongside the governance dialogue that would be taking place through committees. So, I was not involved in the detail of the project. I wasn't involved in detailed discussion with any of the external parties involved in the project, but I was fairly closely in touch with what was going on at a relatively high level of detail.

Q Thank you. Again, just in general terms, we will talk about the specifics slightly later, but from July 2019, is there a shift change in your involvement in the project?

A Yes. There is an enormous shift change and I think, as I set out in my statement, that we had a crisis situation when it was brought to

my attention that we had a compliance problem with ventilation standards in the Critical Care Unit. I would have been drawn into the detail in any event, but I was particularly drawn into the detail because just by circumstances, a number of my senior staff were not available that week, and I think I referenced that in my witness statement, but yes. I became very, very hands-on from the morning of Tuesday, 2 July.

Q Thank you, and you have retired before the new hospital at Little France opens. Is that correct?

A Yes. We had moved in. We had begun to move in, on a phased basis, some of the DCN administrative staff, I think, by recollection. It was just before my retirement and then, within a few weeks of my retirement, there was a further phased move of further staff, but the move of patient services had not taken place until a few weeks later.

Q So, albeit final checks have not been done and the hospital has not physically opened, but by the time you retired, were you satisfied that there were procedures in place to ensure that the new hospital, when it opened, would provide a safe environment for the delivery of effective, patient-centred care?

A Yes. I think the involvement, in particular of the assurance processes around HPS and HFS, who had been involved subsequently, I think, gave everyone a great deal of assurance. It probably-- ultimately, before it opened, I think, it had been described by colleagues as probably the most inspected and tested hospital probably in the world, and so I think, yes. I was confident not only that it was going to be a good and safe environment, but also that the moves that we had been talking about for so long would actually happen as planned. Obviously, COVID became a very significant influencer in timetabling, eventually, but at that point, yes.

Q Again, the Inquiry has heard evidence that at an Oversight Board meeting, Mary Morgan, the Senior Programme Director, she describes the new hospital, at the time it is going to open, as potentially being one of the safest buildings in Scotland. That was her view because of the various assurance processes that the building had had to go through and, as you say, involvement from technical advisors, HFS, HPS. Albeit you are not there for the day that the hospital finally opens, you were satisfied before you left that all of those processes and

procedures were in place?

A Yes.

Q Thank you. Now, the hospital did not open as planned in 2019, and we will come on to look at the detail of that. Grant Thornton got brought in by NHS Lothian, and they describe the reason for the hospital not opening. They describe that as a collective failure. Are you familiar with that phrase?

A I am. Yes.

Q You tell us within your statement that you agree with that characterisation. Is that correct?

A Yes.

Q And if I could ask you to look to your statement, please. If we could look to page 225 at paragraph 122, and if we could pick matters up three lines down, you will see a sentence beginning, “I was hugely shocked.” Do you see that?

A Yes.

Q You tell the Inquiry: “I was hugely shocked and embarrassed by the whole thing.” Do you see that?

A Yes.

Q We will come on and talk about some of the specifics, but taking that phrase, “collective failure” and the shock that you experienced, just in broad terms, explained in your own words, what went wrong with the

project?

A The totality of the project? Oh, goodness. Well, I think from the outset, it was a hugely complex process to begin with. We-- in Edinburgh, we not only had the capital city of Scotland, we had the PFI Capital of the NHS in that a great deal of our infrastructure was actually privately financed as opposed to treasury capital funded. So, the Royal Infirmary of Edinburgh itself was a PFI. Midlothian Community Hospital was privately financed.

The other two big projects in Lothian that were happening at the time that I was Chief Executive, the Royal Edinburgh Hospital Phase 1 redevelopment and the East Lothian Community Hospital were privately financed, and so we had a very complex landscape of PFIs, and what we were trying to do with-- or what we did do with the new hospital was plug a new PFI into an existing PFI, and the complexity of doing that, dealing with the project company of the existing Royal Infirmary and all of their lenders and all of their approaches to risk, for example, was a hugely complex task.

Many of the delays in the beginning of the project were actually about creating the physical footprint for the new Hospital for Sick Children and

DCN, which involved significant enabling works at the Royal Infirmary, tens of millions of pounds worth of enabling works, and all of those had to be resourced, but also agreed with the project company and their lenders.

There was a significant issue in relation to the project having been initiated as a children's hospital only and also as a capital-funded project, which meant that we were going to be in charge of the design and have a direct relationship with a building contractor in terms of a traditional approach to a capital-funded building.

That shifted not only from a capital-funded building to a PFI, or to an NPD project, but also brought together DCN and Sick Children into the same building. So, that was an added complexity, and that transitioning of planning for a children's only hospital to children and DCN, and moving to a new procurement model having already initiated one, was a problem and I think Grant Thornton, you know, pick up that issue about whether that was appropriately risk-assessed at the time.

I think in retrospect, some of the work that we'd done initially for the capital-funded Sick Children's hospital may have complicated the relationship

that we had, ultimately, with IHSL and Multiplex, etc., because we'd done so much work on designing the hospital and working out clinical adjacencies and there'd been so much clinical input to that that the project team were really keen not to lose that intelligence and wanted to share that with bidders for the NPD process in a way that we thought would be a) helpful and b) useful to us, but actually may have caused confusion down the line.

Q Thank you. So, in terms of your initial observations: extremely complicated project. Is that fair?

A Very much so. Yes.

Q A project that starts as a children's only hospital and then, at a later point in time, you have the complexity of adding the Department for Clinical Neurosciences----

A Yes.

Q -- and then you have the switch from an initial capital-funded project to a revenue-funded model. Those are, in your view-- really that is the germ of the problems that we see later on.

A Yes, and I think when you talk-- when we come to talk about things like the environmental matrix, for example, then I think, I mean, had we not been planning to build a hospital in a more traditional way, we

may not-- well, we wouldn't have had an environmental matrix relating to that project, and so it would have been starting with a cleaner sheet.

Q We will come on and discuss each of these issues, and possibly some more issues in terms of potential problems with the project, but before we do, I want to begin by asking you for your observations on what you think the impact of the delayed opening of the hospital was on patients and families. Okay? So, if we perhaps take things stage by stage. The Inquiry has heard a lot of evidence about the old hospital at Sciennes, the children's hospital, and the evidence available to the Inquiry indicates that it was a safe environment, but it was a sub-optimal space for providing modern health care to children. Is that your understanding?

A Yes. Absolutely.

Q So, what were some of the problems and challenges about providing safe health care at Sciennes?

A Well, it was a very cramped site. One of the issues that underpins a lot of the challenges facing Lothian is that Lothian has the fastest-growing population of all of the Health Boards in Scotland, and that impact was on Paediatric Services as

well as on Adult Services. So, we had a, I think, Victorian hospital, which was very cramped, which had really inadequate space.

It had very little expansion scope because it was in a congested area of Edinburgh, and it didn't allow us to have some of the technological standards of safety like, for example, mechanical ventilation that were required in terms of new builds, and so in Lothian's estate, we had a mix of very old buildings.

We had some more modern buildings from the `70s and `80s and `90s, and then we had some very relatively new buildings, like the new Royal Infirmary, and across that range of buildings, the newer the building, the more likely the infrastructure systems around safety – whether that be ventilation, or water, or whatever – the more likely it would be that they were able to comply with modern standards, whereas the older the building, the more difficult it was and we saw that at the Western General, at St John's Hospital, at the Royal Infirmary So, for example, not having mechanical ventilation at all at Sciennes was significantly suboptimal compared to modern standards.

Q What was disabled access like at the hospital?

A Poor. I'm trying to remember. I mean, there were ramps and there were disabled access, but I think lift access-- poor from memory.

Q What was the accommodation like?

A I really can't recall now. I don't think I ever visited the family accommodation.

Q So, that was the Children's Hospital at Sciennes. What about the Department of Clinical Neurosciences? Was it providing an environment for optimal, safe and effective patient care?

A I think it was as safe as we could make it. It was a more modern building than Sciennes, but I think it was a building probably from the 1950s or 60s and no, it was well past its sell-by date, and we had inadequate space and there were particular issues around water safety. In the run-up in, in particular, the early part of 2019, we had some very significant operational management concerns about how to contain SHTM 03 in the facility which had actually led to us having to reduce some patient activity because we were having to do things like close down some of the bathrooms or toilet areas, for example, and so we did have some reduced activity at DCN. So, there was an

impact.

Q So, the water system at the old DCN presented a risk for infection to patients? Is that correct?

A Yes.

Q And because of that there was reduced clinical activity that was taking place there?

A Yes. We had to reconfigure how we used the building and so, from memory, we had to swap spaces between wards and functions in order to accommodate the fact that we were closing off some hospital-- some shower and toilet areas because of our inability to manage the water safety issues in there adequately, and so we closed those down. Because we closed that down, we-- it impacted on how many bed spaces we could have and how many patients we could accommodate and, as a consequence of that, it knocked onto how many, for example, neurosurgical operations we could carry out in a day.

I think, from memory, the reduction in capacity because of the Pseudomonas thing was relatively small at a population level. I think we had a maximum of something like five surgical operations a day, a limit of five which had previously been perhaps six or seven, and so that lack of activity at a population level was relatively low,

but at an individual patient level it was obviously significant.

Q And whenever we are talking about “significant,” the Inquiry has heard evidence that whenever we are talking about those risks, it is risks including brain infections for patients at the DCN. Is that correct?

A I don’t think I really can recall the detail of the specific infection rates, but my recollection was that the clinical team and my directors, who were involved in the detail of trying to manage that in Infection Prevention and Control-- there was a level of infection risk that we had to manage and contain.

Q So, would it be fair to say that for both hospitals, but particularly for the old DCN, there was a pressing need to move to modern facilities?

A That is absolutely correct. I think the pressing nature of the need to move was probably greater for DCN because there was a particular risk that we were having to manage in a very direct way. I think the feeling about Sciennes was that, actually, it presented a safe and known environment, and while all of the things I’ve said were true – it was too small and it didn’t meet current standards – the feeling there was that actually the hospital was a safe environment. So,

DCN was really more pressing in terms of the need to move as quickly as we could.

Q We will come on to talk around some of the decision-making around the decision not to open the hospital, but that decision was taken by the Cabinet Secretary on 4 July 2019. Is that correct?

A Yes.

Q And when was the new hospital due to open?

A We had a phased move from-- starting, I think, with some administrative functions and equipment over that weekend. So I think the 6th and 7th we were going to begin and then we had, from memory, I think about a ten-day commissioning period, something like that, which involved moving department by department and function by function over the course of those-- that following week.

Q So, at the point the decision was made by the Cabinet Secretary not to open the hospital, really, we were days away from patients occupying the space if the plan had gone correctly. Is that----

A We were. Yes.

Q What impact do you think that had on patients and families, days away from thinking they were going to the new hospital, being told the new hospital is not going to open?

A Well, I think shock, probably, for those patients. For example, in-patients who are currently in the hospital who were physically going to be transported by ambulance to the new site, being told-- I think that that was an impact.

For emergency patients, we'd been running a big publicity campaign, reminding people that emergency paediatric cases should go to the new hospital from a certain date, 12 July or whatever the date was that we were aiming for, and so we had to reverse all of that, of course. So, that was-- gave us a communication error and a potential risk about children and families turning up at the wrong site. We had a significant number of outpatients whose appointments had been booked for patients and families to attend the new hospital in the later weeks of July and into August and we had to reappoint all of those patients. I think every patient was seen, but they all had to be communicated with and advised to go to their outpatient appointment or their diagnostic appointment in the old hospital rather than the new hospital.

I think in terms of impact-- So, I think patients were shocked. Patients

were inconvenienced. I think, from recollection, the direct impact on the clinical care and treatment of patients was limited to one or two patients whose scheduling of appointments or treatment interventions may have been altered by a week or two because of the potential date of the move and, as I say, the fact that we were running with limited surgical capacity in DCN, the delay meant that that reduced capacity or activity would continue for a longer period.

So, I don't think catastrophic impact in terms of clinical care outcomes for any patients. I think direct consequences for patient care were very limited and very small in nature, but some impact was definitely apparent for those patients who had to change appointments, for example.

Q So, if we just think about the in-patients, children that thought they were going to a brand-new facility, families that thought they were going to a brand-new facility, they were told a matter of days out from the move, "You're staying at the hospital at Sciennes"?

A Yes.

Q Is that correct? And for some patients that are at the DCN, they are being told, "You're staying at the hospital that there is a known risk

arising from the water system." Is that correct?

A Yes.

Q And in terms of outpatients, the picture you paint sounds like quite a chaotic situation, situation whereby patients have been told that they have to go to the new hospital and suddenly, at very short notice, they are being told the new hospital is not opening – "You're not going there."

A Yes.

Q What impact do you think that had on patients and families?

A Well, I think it would have been confusing. I'm not sure I would describe it as chaotic. I think there was an urgency around it, but it meant communicating with, I think, from memory, a couple of thousand patients, whose appointments were over the course of the coming weeks, to say, "We had appointed you to turn up to the new hospital. We now would like you to go to the old…" whether it was the Western General or Sick Children's.

We did put in place that weekend-- after the week we found out about the delay, 2, 3, 4 July, we put in place communications with patients, but also we had staff available in the new hospital and transport available in

the new hospital to receive anyone who had turned up at the new hospital, hadn't perhaps been advised or received a letter about going to the old hospital. So, we were prepared to be able to assist people with taking them to the right place, but actually, the number of patients who did that were very, very, very small. I mean, literally a handful of patients, from memory. In the end, I think patients were-- we managed to get to the vast majority of patients and their outpatient appointments were fulfilled, albeit in a different venue.

Q So, your reflection on that period as former Chief Executive of NHS Lothian is that it was difficult, some challenges, but I have got you noted as saying "not catastrophic"?

A Indeed.

Q If I could ask you to look to bundle 7, please, volume 1 and page 303. This is a communication sent to the Cabinet Secretary for Health and Sport. It is probably not a document you have seen before, but it is really just to try and get a handle on the volume of patients that we are talking about, and if we could pick matters up just under the bold heading "**NHS Lothian Patient Contact**". Do you see that?

A Yes.

Q The document states:

"As you're aware NHS Lothian have been contacting patients by telephone for those who have appointments in July and issuing letters to patients who have scheduled appointments from August. We met NHS Lothian today and requested regular information on the patient contact position and these reports will now be provided from Thursday 11th July. The total number of outpatient appointments for the month of July across affected areas are…"

And then you see Paediatrics is "1586", the DCN is "669" and the total number we are talking about for this one month is "2255". Do you see that?

A Yeah.

Q And presumably that is a snapshot for July, but there is going to be a similar knock-on impact for further months. Is that correct?

A Yes. I think, from memory, we generally gave patients six or eight weeks' notice of outpatient appointments where possible, so that was the kind of horizon. I think, from memory, July and August would be probably the heaviest months in terms of patients who had been given an appointment letter and then, as the

months then progressed beyond August, the numbers who had been given appointments would have reduced.

Q And then we see at paragraph 3 it says:

> "NHS Lothian have made contact with over 800 paediatric patients and 109 [sic] of the DCN patients."

Do you see that?

A I do.

Q Is that the scale that we are talking about? About nearly a thousand individuals that had been impacted by the decision not to open the hospital?

A Yes, and there would have been more patients, obviously, because if there had been 2,255 who'd been appointed, then all of those patients would require to be reappointed.

Q There came a point where you visited the Children's Hospital, is that correct, in the period after the decisions made not to open the site at Little France?

A Yeah. So, I visited the hospital several times and had, in particular, a close dialogue with the Medical Staff Association. Yes.

Q And what were they telling you about the impact on

patients and families of the decision not to move?

A Well, I think they were hugely disappointed, hugely irritated. The project had been delayed so significantly in any event. It was already two years late from what we'd hoped to be able to achieve, so I think there was a lot of frustration. There was a lot of interest in understanding, well, why this had happened, but probably more importantly, well, how long is it going to take to fix this problem and when are we going to move?

Curiously, though, there was an acceptance that Sciennes was a safe and known environment and that actually, had the move gone ahead without the Critical Care ventilation standards having been compliant, then that was a risk that would have been unacceptable, and so, I think, an acceptance that if we're trying to deal with the reality of the situation we faced, the right decision had been made, that we needed to defer the move until we could fix the ventilation problem, but I think a lot of frustration and disappointment.

Q And what about the impact on staff members who thought they were moving to the new hospital, but were going to have to deliver care?

A Yes. I think some probably were relieved because one of the issues that I'd been personally involved with in the weeks running up to the July 2019 period had been concerns about car parking and the fact that there were more staff at Sciennes who wanted car parking permits at the Royal Infirmary than were available, and so I think there might have been a little bit of a view that that hurdle was going to be deferred.

But I think a lot of other staff-- yeah, I mean, they'd made holiday arrangements. Sometimes staff had actually accepted appointments in either DCN or Sciennes on the basis that they were going to take up their new role in the Royal Infirmary-- yes, in the Little France site and, in particular, DCN was at the other end of town in the north of Edinburgh and the Royal Infirmary is in the extreme south of Edinburgh, and so I think there were issues like that that did have an impact on staff. Yes.

Q And the Inquiry has heard evidence that staff were understandably disappointed by the failure to move, but displayed a remarkably stoic attitude and continued to provide extremely high levels of care to patients.

Q Is that your understanding of what happened in the days that followed?

A That is absolutely my case. I mean, I remember, for example, talking to a ward sister at DCN where I was walking around and, I mean, there were still boxes of things, you know, packing boxes in the corridors because of the arrangements that had been made, and one of the ward charge nurses at DCN just simply said, "Well, you've just got to get on and make the best of it." So, there was a remarkably stoic attitude from staff, but I think nothing could, though, diminish the shock and embarrassment – the phrase I used earlier – and disappointment that all of us felt that-- I mean, we could see this hospital. It was a fantastic facility. Just a week or two before the events we're talking about now, I had hosted an open day in the new hospital for families, and for children, and for local schools, and for the media where we were opening up the hospital to say, "This is the environment we're about to open in a couple of weeks," and we were really excited about it. The place looked absolutely amazing, and yeah, to be told at the last-- literally at the last hour that we had a problem that meant, you know, we were going to

have to defer the move was a huge shock and disappointment.

Q The Inquiry has received a lot of evidence from patients and families of their experiences, and I just want to share some of those with you for your observations on those. So, the first individual that I would like to draw to your attention is a Ms Lesley King who provided a statement to the Inquiry. She was the mother of a child that was diagnosed with neuroblastoma, and her child was in the process of having doctors deciding a treatment plan when the decision was not made to open the hospital. This is her observations at paragraph 51 of her statement. She says:

> "We were just flattened by this delay and very, very scared. We'd planned this whole treatment plan around being told these new facilities were going to help manage the risks surrounding the treatment. The medical staff now had to try and manage this treatment in the old hospital with just a few days' notice."

She then goes on at paragraph 85 of her statement to say:

> "Initially when the move did not happen we were very, very upset. At the time, we were very scared that not moving to the new hospital would mean an increase in risk…"

So, when we are talking about the hostel not opening, is this the type of human impact that we are talking about on patients and families? Were you aware of this?

A I don't recall being aware of that particular patient or family but, yes, I was aware. I had dealt personally, or had been involved in dealing with personally, a complaint from another family member of a patient whose treatment the family member was unhappy about and who made very similar points, that they were very disappointed about the move and were hoping that the move had gone ahead and felt that there was an increased risk. If you think that DCN did have a clinical risk associated with Pseudomonas and lack of capacity, or reduced activity compared to moving into a new hospital which would not have had reduced capacity and would not have had that Pseudomonas risk, then I can absolutely understand why families and patients and staff would have concerns about that, but on the other hand, we had a reality to deal with.

We had a DCN building that we did believe could provide safe patient

care; not as safe as we would have liked to have been able to provide in the new building, for the reasons I've described, but we had a reality and we had to deal with it. My heart goes out to families who were feeling distressed by the consequences of the decision. I still think the decision was the right decision because-- to defer, particularly in relation to Critical Care-- I know you're talking about DCN here, but particularly in relation to Critical Care. Although none of us wanted to be in a situation where Critical Care didn't comply with standards, the reality is that it did and you have to deal with that situation, and I think the decision not to press ahead with the move was the right decision, albeit that it then had consequences that we required to manage.

Q We will come on and talk about whether it was the right or wrong decision, but just focusing on-- the minute-- your position, Chief Executive of NHS Lothian, when you are taking the decision that the hospital was not going to open, are you aware at that period of time that patients and families were scared and upset by the implications of that decision?

A As I say, I don't recall that particular case, although there was a similar case for another patient,

I believe, which had similar sorts of anxieties. So, yes, I was aware in that particular individual complaint where a family member had written directly to me about their concerns, but more generally I was aware that, yes, there would be an impact on patients – less of an impact than had we occupied the hospital and found great deficiencies, but nevertheless, yes, I was aware.

Q Ms King continues in her statement, at paragraph 74, to address the physical condition of the old building. So, she makes very clear that she saw the level of care that was being provided as absolutely magnificent, but she has got this to say about the physical condition of the building and what clinicians were dealing with. She says:

> "They were trying to look after the infection control, but you'd see plaster coming off walls in places, and the maintenance guys would be around immediately that day, trying to patch things up. It was just a constant job of them trying to patch up things, to try and keep on top of the condition of the building, so that they could do the infection control. I mean, the cleaning staff were tremendous, but there's only so much you can

do with the building as it was."

Is that your understanding of the physical fabric of the building? "Yes, it is safe, but it is a crumbling infrastructure that patients are having to deal with."

A Yes. Absolutely, and how we managed that involved having maintenance staff very immediately available to try to manage that risk as best we could.

Q Mr Mark Bissett, his child was also receiving care around about this time. In his witness statement, at paragraph 108, he told the Inquiry this----

THE CHAIR: Sorry, my fault Mr MacGregor, the name of----

MR MACGREGOR: Mr Mark Bissett.

THE CHAIR: Thank you.

MR MACGREGOR: Paragraph 108, he said:

> "… we had to take our own blankets because the rooms were freezing as it's an old building. Even with the heating on it was still a really cold ward… the room was really cold at night. The windows weren't great either."

Is that what the Inquiry should understand, when we are talking about a Victorian building, that is the implications for patients and family members that were being treated within it?

A Well, I have no reason to doubt that family member's experience. I wasn't particularly aware of there being an issue about temperature being inadequate in the hospital, but the general inadequacy of a cramped, old Victorian site which did not meet modern standards in a variety of ways is absolutely an accurate reflection of what I thought about the building. Yes.

Q And with the planned move taking place, presumably gradually as one got nearer, maintenance was being reduced and areas of the hospital were being closed off. Would that be fair?

A I'm not sure about areas being closed off. I think cosmetic maintenance probably would not have been followed in the way that it might have been and so, when the decision was taken to delay the move, one of the things we did, for example, was try to freshen the place up a bit, just with literally a new lick of paint in areas. I mean, signatures on walls had been part of the leaving celebrations in the days before the delay happened, and so there was a bit of redecoration. I can't recall areas of the hospital being closed down because none of the

move had happened. That would have been the case had a phased move happened but-- but, yes, I mean cosmetically the hospital was looking well past its sell-by date. Definitely.

Q Well, again, let me just bring up to your attention some observations that Ms King makes about the physical environment for children in the days after the move does not take place. So, she has this to say at paragraph 54 of her statement:

> "… the playroom had gone. The toys and resources had either been packed up or given away or put in the skip because there were new toys and equipment at the new hospital. So following the cancelled move there was nothing for the children to play with until the staff got permission to buy new equipment or bring things back from the new hospital."

Were you aware of that?

A I wasn't aware of that. I can imagine that, and I think that probably-- to caveat, what I said earlier about areas of the hospital not being closed down. I mean, I can absolutely imagine things like toys and things being put in boxes ready for the move and, therefore, not being available.

That's not quite what I interpreted by your question, areas of the hospital being closed down, but I have no doubt that that was a disappointing situation for that family. Yes.

Q But what impact do you think that had on the children that are physically residing in that hospital?

A Well, it's a lack of amenity, clearly, and so-- Perhaps, if I go back to the point about catastrophe, and you say-- summarise what I said when I said there wasn't catastrophic failure. I mean, what I mean by catastrophic failure would be a patient dying, or a significant material outcome of harm to a patient. That's what I mean by catastrophic. I mean, at an organisational level, at a financial level, this delay was a catastrophe. I mean, let me be clear about that, but I use that word in the context of patient harm or patient mortality. In relation to not having access to toys, for example, I don't put that in the same league as a catastrophic patient failure in relation to harm, but I would say that that it's clearly not an acceptable situation, and the hospital had put so much effort into supporting children and families that, yeah, it was just an unacceptable situation.

Q Do you think the communication with patients and

families was good enough at this time?

A I would probably imagine not. I think we were moving at an enormous pace, and I think it was-- I think it was handled well in the context of being able to contact so many-- as you've just described, 1000 patients within a few days to be able to redirect them to the appropriate place of their appointment, but I'm sure we could have done better as well.

Q Ms King's reflections at paragraph 79 of her statement are as follows:

> "As parents, we did not have any formal communication from the hospital or the Health Board about why the move to the new hospital had been delayed in July 2019. I only heard about the reasons for the delay from what I read in the press… The staff in the hospital were very open and frank with us and told us what they knew, which was not a lot."

A Yes.

Q Is it acceptable for patients and families to be finding out about these details from the press rather than direct communications from the Health Board?

A No, that-- I mean that takes us into the broader communications. I mean I think I would sort of differentiate in my mind between direct, named patient communication about an appointment, for example, saying, "Please don't go to Little France. Please go to Sciennes," or "Please go to DCN." I would differentiate between that sort of communication and more general communication about the problem, why it happened, how it happened, and what we're going to do about it and I think I cover in my witness statement that the Scottish Government, as part of their decision to defer the opening of the hospital on 4 July, also took the decision that they wanted to control all communications.

Now, I mean by that the general communications, media and public communications as opposed to individual patient communications about appointments. That meant that our ability to communicate was significantly diminished, and that was a huge frustration for us. It got to the situation where we had to-- or my communications director had to actually have intended communications from NHS Lothian to the broader patient population, or to the media, approved in advance by Scottish Government before we could issue them. Frustratingly, that approval often didn't come quickly

enough; it didn't come for hours, or sometimes it didn't come for a day or two, by which time the communication was actually out of date and things had moved on or there were other things to say. So, while I wouldn't want to use that entirely as an excuse for poor communication, that significantly hindered our ability to tell people what was happening.

Q Did you write directly to patients and families to explain what was happening at this time?

A No, I didn't.

Q Did you contact the Scottish Government to see if there could be an approved strategy to directly contact patients and families to explain what was happening?

A No, I don't think-- in terms of writing to patients. I think-- I mean, I did raise with Scottish Government colleagues that I thought the government control of the communications was stultifying and was preventing us from being able to keep people up to date. I don't think, though-- Had that been relaxed a little and had we been able to be communicating more freely, I don't think what was in my mind at the time was about writing to individual patients or their families; more about public statements through social media,

through our website, through newspaper and television, etc., through radio. So, I think that's probably more what I was thinking. Of course, many of the future patients of the hospital, "future" meaning in the next hour, the next day, the next week, etc., were not known to us because they would be emergency patients. So, I think our focus at that point was more about population level communication rather than individual patients.

Q Because again, in Ms King's reflection in her witness statement at paragraph 80 are as follows:

> "There was never any communication from the Chief Executive of the hospital, or anyone in management to us acknowledging the delay or the effects it had on the patients and families. Yes, the Chief Executive had been on the ward at the time of the delay but we were focussed on [a child's] treatment and too upset to speak with the Chief Exec at that point. It was a similar situation when the Health Secretary visited the ward."

Would you accept that the communication with patients and families just simply was not good

enough at this time?

A Yes. I mean, I can't deny the experience of that patient and I am sure that that experience must have been replicated and that is unacceptable, and I would have hoped that we would have been able to have done better than that and I can only, all these years later, apologise.

Q So, if there was an event like this that happened in the future – you obviously have the lived experience of how difficult it was, how many moving parts there were – how could the communication strategy with patients and families be improved in the future?

A Well, I think by being allowed to communicate openly and as urgently as the situation described. I mean, we were in a situation where I know, obviously, patients and families were our absolutely top priority, but also communications with staff were a top priority and we were placed in a situation where we weren't able to communicate with our staff, where we were told we shouldn't be communicating anything until the Cabinet Secretary had agreed the lines. So, from-- in the period, in particular, between 3 July, when I wrote to the government setting out my assessment of the situation and the

various options that we were considering about how to deal with the situation, we were-- my natural leadership style was to be open and to tell it as it is and to have very little held back unless there was a particular reason to hold it back. Staff knew that there was a problem because a number of managers were running around deferring briefing meetings with staff that had been arranged in boardrooms and in lecture theatres to be able to tell them what was happening, and so staff didn't know either.

So, I think that, you know, in the future, rather than closing down communication lines, communication lines should be opened up and, actually, people should be encouraged. I would say that sometimes, I think organisations find it difficult to communicate unknowns or uncertainties and a lot of advice about communications is about, you know, be clear and don't add to confusion and be as explicit as you can be whereas, of course, in a very fast moving situation like this where, literally, things were becoming apparent by the hour and by the day, sometimes what has to be communicated is there is uncertainty, and there is ambiguity and we don't

yet have the answer to, “Well, when am I going to be able to move into the new hospital?” and I think we just have to have the courage to be able to say there are things that we know, but there are also things that we don’t know yet, and be able to communicate that.

Q Just to make sure that I have got you noted correctly, my understanding is what you have just told the Inquiry is that your observation is that the Scottish Government stopped you being open with your own staff. Is that correct?

A They stopped us issuing communications without their explicit approval.

Q Was that the same in terms of open communications with patient and family members?

A So, we were communicating-- just reiterate what I said earlier, when it came to things like individual patient care or appointments, we were communicating unfettered, and so there was no restriction in that level of communication, but in terms of what I describe as more population level, so whether that be the public or staff, we were advised that we were to say nothing until the Cabinet Secretary had issued her statement and this is-- I am

talking about the day now on 4 July and, yeah, that was significantly problematic.

Q How difficult and frustrating was that for you in your role as Chief Executive?

A Well, it was extremely frustrating and, I mean, it was also impractical because, you know, we live in a world of social media. People knew that there was a problem and, inevitably, people begin to develop their own theories about what’s going on. So, rumours would be swirling around and, yeah, it was just-- it was very-- it was very frustrating. I think I say in my witness statement-- I mean, I can understand why-- if I go back to this, I don’t know why I’m obsessed with the word “catastrophe,” but this-- nothing I have said in my witness statement or say today should diminish the fact that this was an enormous issue – this was a big deal – and I understand why politicians who are accountable to the public and to Parliament would have a nervousness about communications, but the reality is that we never communicated anything that I would regard as inappropriate, or that was in any way confrontational, or critical of government, or whatever. We weren’t interested in that at all. So, I think that

although I can understand some nervousness on behalf of the government about trying to manage communication lines, I think that strategy was not the right strategy and that we should have been more open and been able to speak to our staff more openly than we were.

Q Was there any explanation provided to you as to why the Scottish Government wanted to so closely control any communications that were issued on the fact the hospital was not to open?

A No. Not an explanation, no.

Q Thank you. Lord Brodie, I am conscious that is just after one o'clock. That may be an appropriate time to break for lunch.

THE CHAIR: Yes. We will take our lunch break now, Mr Davison. If you could be back for two o'clock.

A Sure.

Q Thank you.

(Adjourned for a short break)

THE CHAIR: Good afternoon, Mr Davison. I think we are ready to resume. Thank you everybody.

MR MACGREGOR: Mr Davison, before lunch we were talking about communication strategy and the fact that no communications had to go out without the approval of the Scottish Government. Is that correct?

A Yes.

Q Did the Scottish Government, though, ask you to work on a communication strategy, albeit that it would have to be approved by the Scottish Government?

A Yes. When I and colleagues met with John Connaghan on 3 July, one of the outcomes of that was that we agreed that we would need a joint communication strategy, and my Director of Communications was working closely with Scottish Government Director of Communications. My understanding at the end of 3 July is that we would have put together an agreed communications strategy for the following day. It was clear to me that the Cabinet Secretary was reserving the right to make the decision on what we were communicating, but at that point, my view was that we were pulling together a collaborative communication strategy on behalf of us both.

Q Thank you. And Ms Freeman in her statement gives a range of reasons as to why she took control of the communication strategy,

including, for example, that in her view, she did not think boards necessarily communicated that well. Was any reason given to you as to why Scottish Government retained absolute control over communications?

A No. I was never given a reason. I mean, I had to, you know, use my own imagination to wonder, but I was never told really why.

Q Thank you. I want to move on now and explore with you some of the reasons why the problems with the project happened.

Within your witness statement, you very candidly say, at paragraph 125 on page 226, that you found it astonishing that no one on the project team, the project director or the project board, the technical advisors, IHSL, or Multiplex ever raised these issues. You make similar comments at paragraph 122 of your statement, and paragraph 203, that you really cannot understand how these issues were picked up. Is that----

A Were not picked up.

Q Or not picked up. Is that a fair summary?

A It is.

Q And we touched at the very start of your evidence on, perhaps, some of the reasons why the project may have got into difficulties.

You indicated firstly that it was a complex project, a revenue-funded PFI and almost a revenue-funded project within a revenue-funded project because of the Little France site. Having worked on this project, do you think the revenue-funded model is appropriate for new build hospital buildings because of the complexity those projects have?

A Not in the way that it had been configured as a procurement model. I mean, I think when government treasury capital is limited, there may well be a place for revenue-funding, but the contractual arrangements were so complicated, I think my view would be we would need to have a more simplified way of dealing with a revenue-funded model.

I mean, the idea that-- and, you know, just thinking back about some of the evidence that has been given in the last couple of weeks to this Inquiry, that one of the complexities of a revenue-funded model was that we were not the designers of the hospital. We, the client, were not designing the hospital, nor did we have a contractual relationship with the company that was building the hospital, nor did we have any contractual relationship with the subcontractors that were designing the ventilation for the hospital, and so

everything seemed to be one or two or three steps removed, and that is almost, you know, designed to cause a degree of confusion.

I mean, I do recognise-- obviously, I'm aware you're looking at the Glasgow Hospital, which was a capital-funded project. So, I think it's too simplistic to say all of the problems were to do with the revenue-funded model. I don't think that is true. I think there could be problems in a traditional capital-funded project as well, but I do think that it was a significant factor in the delay and the lack of ability to collaboratively work with the designer and the contractor and subcontractors because of this sort of artificial separation between them and the project company, and its own company for day-to-day running of the project. It was a bit Byzantine, I think.

Q Other witnesses have told the Inquiry of the fact that within the project agreement-- if you simply had the project agreement, there are change protocols that you can make changes which may well be necessary in healthcare projects, but the reality is quite different because there is a web, a nexus that sits beneath that. If you want to change the project agreement, the funders may well want to change the funding arrangements; the subcontractors may want to change their arrangements. Was that a difficulty you saw in terms of, at a very simple level, there is the project agreement, but this web, a nexus exists whereby you are a third party looking in but cannot really influence the process?

A Yes. So, we could-- I mean, we tried to influence the process, and we tried to work-- I think as Susan Goldsmith said in her evidence, you know, we did actually have dialogue with Multiplex directly, almost because we had to, but yes, we didn't have that direct contractual relationship. So, I think it was overly complex and we must simplify that going forward if revenue-funding is to remain a method of bringing capital into the system.

Q Thank you. You mentioned that you had considered an added complexity to the project, starting with the Children's Hospital, and then adding the Department for Clinical Neurosciences, and why was that problematic?

A Well, just because we had done a huge amount of work on the design of the Children's Hospital and then we were adding to it a DCN, which increased its size, increased the number of stakeholders involved. I

mean, eventually, the project involved actually moving three different services from three different sites.

So, we were bringing DCN from the Western, we were bringing sick kids from Sciennes, we were bringing Child and Adolescent Mental Health Inpatient Services from the Royal Edinburgh Hospital. So, it just made it a bigger and more complex project with a greater number of stakeholders.

Q And you mentioned at the outset of your evidence today the difficulties of taking what was initially a capital-funded project and then turning that into a revenue-funded project.

A Yes.

Q And I had you noted as saying one of the problems was you had spent a lot of money and done a lot of work, particularly with the clinicians, and understandably there would be a desire not to lose all of that work or squander the money that had been spent.

A That's correct.

Q That is completely understandable, but within your witness statement, I think you acknowledge that there was not really any meaningful risk assessment done, albeit that is well-intentioned, taking that work and putting into a revenue-funded model, but there was not really

any meaningful risk assessment as to whether that would, in the long run, be beneficial. Is that fair?

A Yes. That's right and I think that, you know, the reason for that was actually that the Board was under a lot of pressure to bring forward the business case for the new procurement vehicle, and because we-- the project was already delayed as a consequence of all of this, and the non-availability of capital, we were keen to get on, but yes.

I think if we'd been able to say, well, you know—so, for example, we had the design and we had the environmental matrix, and there were some numbers in that environmental matrix. Are we going to pause and stop and say, are we issuing this and are we going to amend it before we issue it, or should we not issue it? I think that's-- in hindsight, I think if that had happened then we may have avoided some of the complications of later.

Q So, the failure to do a risk assessment whenever the funding model changes, in your opinion, is that an error in judgment, albeit looking back with hindsight?

A I think with hindsight. Well, I think it would have been helpful. Well, you know, at the time would I

have considered it an error? I'm not sure I would use the word error. I think it-- I can understand why it didn't happen, so therefore I can understand there was some justification for that because of timescales.

I think never has a delayed project been so urgently pursuing urgent timescales. It seems we were forever racing to eventually slow down, but I think it would have been extremely helpful if we'd done it, and if that risk assessment had raised the issue of, for example, the environmental matrix.

Q And in your view, for future projects, if they are switching from one funding model to another, do you think there should be a risk assessment that is done as to whether the work that has been done is going to be beneficial for the new stages of the project?

A Yes. Whether it should be issued at all, or whether it should be issued in an amended form, or-- yes.

Q And again, just touching on the environmental matrix, I accept that you are not an engineer or a designer, but some of your former colleagues from NHS Lothian have given evidence to the Inquiry saying, with the benefit of hindsight, they wish

they had just never used the environmental matrix at all. It was there. Money had been spent on developing it, but they think that, again, is one of the germs of the problem. Would you agree with that?

A I would because we thought, and I think, thinking back to the time, that our Board's construction requirements trumped anything else, but I think there was some confusion among other stakeholders about whether that was the case and they took the environmental matrix to be our brief, rather than a helpful piece of design work that had predated that particular procurement model. Yes.

Q Thank you. Does that, perhaps, bring us onto a discussion about the clarity of the brief for the project as well? If I could ask you to look to your witness statement, please, page 197, paragraph 28, and it is really just three lines up from the bottom. You see there is wording:

"Board construction requirements that were absolutely clear about the need to adhere to SHTM 03-01."

Do you see that?

A Yes.

Q So, again, is that your own personal view, that the Board construction requirements were just absolutely clear on what had to be

provided?

A At the time, yes, and-- well, and still now. I think we were very clear that SHTM 03-01 had to be complied with. I mean, what I've subsequently learned is that there was probably inadequate specificity about, in this case, Critical Care. So, I think some people maybe thought SHTM 03-01 was about Critical Care whereas, of course, it's about ventilation systems in a myriad of different rooms, with a myriad of different air change rates, and pressure regimes, etc., and I think it would have been clearer if we had been able to be really clear about what we mean by the application of SHTM 03-01 in relation, in this case, to Critical Care.

You know, we do think it-- We are assuming that it applies to this ward of 24 beds and all of these rooms, and I think, you know, it's easy with hindsight to have said that, but I think there was no shadow of doubt, and I think the KPMG audit picked this up and Grant Thornton picked this up. We were very explicit about SHTM 03-01 being a core requirement, and not only a core requirement, but being the default position in the situation where there was any contradictory advice within anything else.

Q The Inquiry has heard evidence from a number of witnesses who have said, in their view, one of the problems, if you are trying to have a crystal-clear brief of what you want, is actually saying, "I want you to comply with guidance," because that guidance can be open to interpretation. So, you are saying, "Yes. I want you to comply with the guidance," but that assumes that the guidance can only be read in one way.

A Yes.

Q Do you think that is a problem with this project, of taking something that is guidance that is open to interpretation and slotting that in as a contractual brief?

A Well, yes. I mean, I didn't know at the time, but I mean, I've learned subsequently that it wasn't just about interpreting the guidance. It was about whether the guidance was trumped by the environmental matrix, for example, and so there appears to have been scope for a confusion that I didn't believe should have been there, you know?

I've sort of simplistically, even now looking back at the original version of SHTM 03-01, I mean, it's clear to me, Critical Care has ten air changes per hour. I think the thing that I could never understand was that

even had there been this issue of the fact that the environmental matrix had four air changes per hour, and that the one that we issued-- at least that contradiction should have been raised. I subsequently learned, I didn't know at the time, that when they were tendering for the preferred bidder, one of the bidders who was not successful in getting the project did actually raise with some of our staff that there was a contradiction between the environmental matrix and our BCR for SHTM 03-01.

Now, if one of the bidders was capable of picking up that contradiction and raising it, it goes back to the question you asked me earlier. I don't understand why so many other key stakeholders – internal and external – didn't, similarly, pick up that contradiction and at least raise it for discussion because I think if that had happened, there would have been an opportunity to have nailed the situation there, but it was missed. Then, it was kind of baked into the project for the next few years.

Q And if we just perhaps think about that point about the clarity, we will come on and talk about the potential litigation that was going to be raised in a moment, but if we just think about the point that the dispute arises

when we are thinking about the clarity of the brief. There are two senior counsel that come to diametrically opposing views on what the contract means. Is that correct?

A Yes. I think our counsel and IHSL's counsel did have different views, yes.

Q And again, there are two different expert reports from different engineers that come to different conclusions as well.

A Yes.

Q So, again, when we are just thinking through the clarity of what was put in the documentation, we have lawyers reasonably disagreeing about what it means from a legal perspective, and engineers reasonably disagreeing about what it means from an engineering perspective. Does that really flag up the need for absolute clarity and precision in these contracts as to what the brief is?

A Yes-- Yes, but I think the complexity of some of these acute hospital buildings is such-- and the fact that there could be greater standardisation and there are some things that are the same wherever you go, but there are other situations that are much more bespoke to a particular set of circumstances, and for-- I mean, for example, you could say the

Scottish Government was crystal clear from whatever date it was, 2008 or something, that all new hospital builds should be 100 per cent single rooms, and you say, “Well, as there’s crystal clarity, get on with it.”

Our clinicians didn’t want 100 per cent single rooms, and particularly in Critical Care, but-- well, for the hospital as a whole. They wanted to be able to cohort patients in multi-bedrooms, and so, the Health Board, at the time – I think it actually even predated my appointment – discussed with Scottish Government whether there could be a derogation to that high-level principle of 100 single rooms being forgiven, if you like, in favour of a multi-bedded construction to allow the cohorting of patients. So, I think that’s a good example where you say-- well, you know, you can’t be clearer than, “100 single beds is required,” but then, even then, you have a clinical view that said, “Ah, but our situation is slightly different, and Paediatric Critical Care is different from Adult Critical Care.”

So, I think there has to be-- I think you could have a standpoint that says, “Let’s start with crystal clarity.” I think my suggestion would be that it probably should be anticipated, in a huge and complex acute hospitals building, there may well be requests

for derogations, but I think the process around agreeing derogations and having some sort of oversight of those derogations to ensure that there aren’t unintended consequences, for example, should be much greater.

Q Thank you. I would like to ask you some questions about Settlement Agreement 1, so that is the Agreement that is effectively reached through 2018, but the agreement that is signed in the February of 2019. Do you think that the process leading to Settlement Agreement 1 is part of the problem relating to the hospital not opening on time?

A I think-- I mean, I should say, as I think I mentioned in my witness statement, that I was off having major surgery and recovering from it for half of 2018, and so I missed a lot of the debate from, sort of, April 2018 through till the autumn of 2018, but-- you know, nevertheless, I was there when we signed the Settlement Agreement. I don’t think the process necessarily affected the delay other than that the process resulted in NHS Lothian erroneously including four of the four-bedded rooms within the derogation from six mechanical air changes to four plus mixed mode. So, because of that erroneous situation, it was an error. Again, it was another

example of something not being (inaudible) or picked up.

I think that that reinforced the error that I was suggesting had been baked into the situation way back in, sort of, 2016 or whatever, when the environmental matrix was set at four. I think the reality is, though I now know-- I didn't know then, I now know, that IHSL and Multiplex had already designed and commissioned and installed the ventilation system that was only capable of delivering four mechanical air changes an hour in Critical Care before we got to the point of signing the Settlement Agreement.

So, I'm sort of troubled by that because I think if we'd picked up the issue of the erroneous inclusion of the four four-bedded bays in Critical Care within the derogation, we would have known sooner and we wouldn't have been cancelling the move within days of the opening. So, there would have been a benefit to that, but we would just have been where we were in July 2019 a year earlier. Sorry, July-- Yes, July 2019 a year earlier. Yeah.

Q Because-- It is just quite difficult to understand. You have the process for the potential litigation leading up to Settlement Agreement 1, where NHS Lothian demand the project company provides balanced or

negative pressure and four air changes per hour for certain rooms, including some rooms in Critical Care, and then you have a scenario after the hospital does not open whereby NHS Lothian requires positive pressure and ten air changes per hour. Can you explain, how does that happen?

A Yes. I find I struggle to see how that happens. I think-- I mean, my-- and at the time I had really no awareness of that, the-- I mean, I understand, from what I've read subsequently, that the clinicians were clear in their view-- our clinicians were clear in their view that they wanted balanced or negative because they wanted the four bedroom-- four-bedded bedrooms to be treated as single bedrooms, and they wanted to be able to cohort people and prevent pathogens from leaving rooms when doors were open, etc. I think there was a clear clinical rationale for that, that our clinicians still held to, actually, at a time that we were then moving to 10 positive Pascals, but the design-- our project team did not appear to either have been aware or have been informed that that was in direct contradiction to the SHTM that we were demanding was complied with. So----

Q Is that a failure in

decision making, is it a failure in governance, or is it a bit of both?

A I think it's a failure of-- A bit of both. I mean, I struggle with the concept of "a failure of governance." I have heard that term bandied around quite a lot, and I think we did have appropriate governance arrangements, and I did think they operated as they required to, but even with the best design governance arrangements, people have to ask the right question, and if they don't ask the right question, then things can go astray, and I-- Yeah, I-- I think my feeling about that, the pressure regime-- you know, I am as flabbergasted by that as I am about the fact that the four air changes per hour wasn't—weren't picked up in the environmental matrix. I think there were enough people, and the Grant Thornton report, I think, does set that out, whether it was our own project team, or whether it was our own external advisors, or whether it was IHSL and their supply chain. I still find it amazing that there was that lack of clarity.

Q Because what ended up being in the technical schedule to Settlement Agreement 1, that was not a mistake.

A No.

Q It is perfectly clear, if one

works through the chronology, that-- albeit you may not have been at work at the time, but if we think about the threatened litigation, NHS Lothian, as an entity, has taken legal advice and has had court documents drafted up that are demanding balanced or negative pressure in rooms with the code B1, which is a Critical Care space. That does not seem to be spotted by anyone one that is working on it. Is that correct?

A Yes.

Q This is at a time whereby, when the litigation is potentially going to go forward, NHS Lothian has obtained supportive affidavits from Janice Mackenzie on the one hand, Clinical Director, but also from Graeme Greer of Mott MacDonald, who were the lead technical advisors. Is that correct?

A Yeah. As far as I'm aware, yes, that is-- that is right.

Q Mr Greer and Mott MacDonald, they are not flagging this issue in the context of the litigation and saying, "You need to stop because the guidance, SHTM 03-01, it requires positive pressure, not balanced or negative pressure." Is that right?

A Yes. I think-- Again, I mean, we're perhaps even in danger in this dialogue about confusing and

conflating the non-critical care beds with the Critical Care beds, and I think there was a view that the SHTM 03-01 – it might be worth putting it up on the screen – did have balanced or negative pressure in relation to single bedrooms, for example, and SHTM 03-01 was silent on the issue of four-bedded rooms, and so there was a-- At the heart of the dispute was that IHSL and their supply chain were of the view that the four-bedded rooms should be treated as general wards, and we were of the view that the four-bedded rooms should be treated as single rooms. That's my recollection of the dispute, and actually, in relation to the four-bedded rooms that were not in Critical Care, I think that was entirely-- you know, appropriate.

I think that the key issue was that, in the technical schedule that accompanied SA1, all of the four-bedded rooms were detailed, but as I say, erroneously, one line included four of the bedrooms in Critical Care, and that's the bit that I think was particularly difficult, but as I say, even by then, the reality is the ventilation system had already been installed at the level of four air changes an hour, so even if that error had not been made, we still would have been in a situation where Critical Care was

incapable of delivering ten air changes an hour at that point. So, the Settlement Agreement didn't cause that to happen. It just confirmed an earlier error that had already been installed.

Q If we just think through the settlement discussions taking place through 2018 and then the Agreement that is signed in 2019, those room codes for Critical Care, B1, they are hiding in plain sight. It is perfectly obvious that those relate to Critical Care. IHSL and its contractor, Multiplex, they are not raising at all that these rooms are in Critical Care and required ten air changes per hour. Are they?

A No, and I think-- you know, again, everything-- well, not everything. A lot of what I'm saying is in relation to the benefit of hindsight. I didn't know that at the time, but I didn't know that they had already designed and installed a system that was only capable of delivering four, so you might say it was quite understandable that they would be quite keen to ensure that that was something that would be enshrined in any Settlement Agreement. They were very keen for us to agree the derogation from six to four, but we did not believe that that's what we were agreeing to.

Q Do you think part of the problem here, though, is IHSL and multiplex not flagging up the issue? The reason I say that is the Inquiry has heard evidence that the whole thrust behind the NPD revenue-funded model was that the project company was meant to be working in a collaborative manner with the public sector body; just take, for example, the public interest director that sat there. It was not simply meant to be a commercial entity that did not have any interest in the public sector.

A Yeah.

Q So, do you think there is a failing on the project company and its contractor side in not flagging up this potential non-compliance?

A Yes. I do, and I say that in my witness statement and I think Grant Thornton said that as well, that-- you know, there were lots of opportunities for all stakeholders to have raised this.

Q You might not be able to answer this question through 2018, whenever you were not at work, but it is relevant for when the Agreement is signed in 2019. The Inquiry has heard evidence from a number of Infection Prevention and Control professionals that work within NHS Lothian – both the lead Infection Prevention and Control nurse and the lead Infection Prevention and Control doctor – and they say that they had no involvement in, or knowledge of, the potential litigation, the settlement discussions through 2018, the drafting of the technical schedule, or the signing-off of Settlement Agreement 1. Is that your understanding?

A It is now. Yes.

Q Again, I would be interested in your views, is that perhaps a significant failing, that Infection Prevention and Control are not involved in those discussions?

A Well, I-- Infection Prevention and Control were embedded in the project team, just not those two individuals that you mentioned, and so, in governance terms, I think Infection Prevention and Control were baked into the advisory structure of the project, not just in nursing, but also in terms of a microbiologist. So, I mean, I've also-- I recognise I'm sort of conflating this-- my thinking at the time, but also thinking about what's been said in subsequent-- you know, in these hearings.

I think-- Let's (inaudible), yes, the most senior of our IPCT staff, so Donald and Lindsay for example, should have been involved, and yet

we've also heard witnesses say there's inadequate capacity for IPCT to be involved and, in fact, they're beginning to get involved in projects that they don't believe they're really central to. So, I think, had we had our most senior people focus specifically on the Settlement Agreement, then that could have been helpful if they had flagged the problem because they would have identified it earlier than it subsequently became apparent to, but whether there's the capacity for that to be happening in these projects because of workforce pressures, I think, is an uncertainty.

Q Do you know what Infection Prevention and Control input, if any, took place through the 2018 negotiations and at the point that the Settlement Agreement 1 was signed?

A I don't know. I know that they were part of the project team and they were available, but I think there is a distinction in my mind, and I'm not sure whether it's been brought out as fully for other people. I think there's a-- I've lost my train of thought. Sorry, there's a-- Sorry, I've lost my train of thought.

Q I was just simply asking you about IPC involvement, and I think you fairly said you did not know. The reason I raise that is Janette Rayer-

Richards, who was one of the Infection Prevention and Control nurses, she retires in late 2018. Sarah Jane Sutherland is very new to the post, and comes in, and she's being shadowed-- or she is shadowing Lindsay Guthrie and Donald Inverarity. Those three individuals who would be in Infection Prevention and Control, late 2018 up to 2019, whenever the Settlement Agreement is signed, they say that they have no knowledge of the discussions that are going on and had no involvement whatsoever in the drafting of the technical schedule----

A Right.

Q -- or in the signing off of Settlement Agreement 1, and really, what I am asking for your observations on is whether that was a failure on the project.

A I'm not sure I would use the word failure. Again, I would say it may have been helpful, if that intervention that you're describing didn't happen, had happened and been able to pick up the problem. If someone had said, "Oh, you know we're reviewing what you've included in this derogation, and it includes Critical Care. That's a problem." If their intervention had flagged that, then that would have been helpful. I don't know. I'm hypothesising about

whether their intervention would have flagged that. I hope it might have done. It didn't because it didn't happen, but I think also-- I think what needs to be clear is when we signed that hospital over, it was a contractual handover. It was not a handover assuming that patients were about to occupy the building, and so Infection Prevention and Control, when it came to, for example, HAI-SCRIBE level four etc., could not have happened at that time, as you know, because the hospital was still a construction site, but did subsequently happen, albeit very late in the day because of the double running of finishing the project and commissioning the hospital. So, I'm sorry for being so long-winded. It may have been helpful if they had picked up the error. I'm not sure I would categorise their lack of involvement at that particular point as an error contemporaneously.

Q You have touched upon the HAI-SCRIBE procedure and the fact that the Stage 4 HAI-SCRIBE – that is not completed before the agreement is signed, which involves the building being handed over to NHS Lothian and NHS Lothian start paying for the building. Is that correct?

A Yes because it couldn't have been completed.

Q Can you help the Inquiry, though? If we are talking about Settlement Agreement 1, that is either a change to the brief, or a change to the design for the ventilation system for the hospital. Is that correct?

A Is it the change to the brief? To the extent that we agreed six mechanical ventilation changes to four, then that was a change to the brief. To the extent that it resolved the issue about the pressure regime in four-bedded bays, for example, it resolved the dispute.

Q So, if there are changes that are being made to an aspect of the brief, why were the project team not going back to the Stage 2 HAI-SCRIBE, which is the review of the design?

A Yes.

Q Why was that not done?

A I don't know. I don't know whether that was at all considered or not, and I think, in retrospect, I mean, that would have been helpful.

Q And is that the type of input that, yes, other members of the project team SHFN 30 tells us should know about HAI-SCRIBE, but is that the type of specific advice that you could have got from Lindsay Guthrie, Donald Inverarity, or another IPC

professional if they are involved at the point that Settlement Agreement 1 is being signed?

A Well, it could have if they had picked it up, but it didn't require an IPC specialist to have picked that up. A technical advisor could have picked that up.

A project director could have picked it up. A clinical director could have picked that up. I mean, I think there was enough understanding that Critical Care required ten air changes, and so, if someone-- You say hiding in plain sight-- I don't think it required an IPC background to have picked that up. I think anyone with a knowledge of the hospital and the contract could have identified that problem.

Q But does that not make the entering into Settlement Agreement 1 all the more astonishing because the whole thrust of SHFN 30 and the HAI-SCRIBE process is that all members of the project team should know about it? The state should know about it. Contractors should know about it. Everyone involved in the project should know about it. It is hiding in plain sight, and no one gives it any consideration. How does that happen?

A Yes. I can't answer that.

Q If I could ask you to look

to your witness statement, please, to page 199 and to paragraph 34.

A Yeah.

Q And if we could look three lines up from the bottom, you see a sentence beginning, "We had agreed to…" Do you see that?

A Yes, yes.

Q And you say:

"We had agreed to commission the hospital at the same time as the outstanding works were being completed, which I think was probably a mistake in retrospect…"

Do you see that?

A Yes.

Q That is quite equivocal. Even at this stage, years on, you are saying you think that that was probably a mistake. Is there still doubt in your mind as to whether that was a mistake?

A Sorry, say----

Q Is there still doubt in your mind as to whether that was a mistake?

A No. I don't think there's doubt in my mind. I think there was good reason for why we agreed to it and, at the time, we were keen to get the hospital opened and we were keen to get the hospital opened before the winter. We had agreed that we were

going to start paying for the hospital, so we wanted to be able to use it, and all of the issues you asked me about earlier about DCN and inadequacy and-- So, there was a huge urgency at every level to try and get this hospital open, and we had a lot of experience of working in building sites.

You know, at the same time as this was happening, we were doing a major refurbishment of the emergency department at St John's Hospital when we were completely reconfiguring it while maintaining it as an open Emergency Department. So, I think, at the time, there was good reason for wanting to do it, but I think there was just so much work, and that caused there to be the problem being identified when IOM eventually did their testing, that we ended up only a week out from the opening of the hospital when it became a problem. That was a major problem and it caused major disruption, as we discussed earlier this morning. Had we done it conventionally, had we allowed the work to have-- even if we were paying for the hospital, if we'd allowed the work to happen and then had taken the subsequent three months, which would be more normal, to do the commissioning, then we would have identified the problem

because we would have done the high-level scribe-- the HAI-SCRIBE level four, but we would have known about it months in advance of the opening of the hospital, not days in advance. I think, looking back, that would have been better than what actually happened.

Q Thank you. I would like to look please to bundle 13, volume 7, page 1160.

A Yeah.

Q So, this is a minute of a board meeting held on 5 December 2018. Do you see that?

A Yes.

Q And there is reference at paragraph 37 to "Final Draft Supplementary Agreement RHSC/DCN". Do you see that?

A Yeah.

Q And if we could look to paragraph 37.2, four lines down, there is a sentence beginning, "The Board was asked to receive assurance..." Do you see that?

A Yes.

Q It says:

"The Board was asked to receive assurance that all negotiations on the terms of this settlement agreement had been supported by the Board's legal and technical advisers. In

addition the Board approved the settlement agreement with IHSL and considered a short extension to the longstop date to allow all commercial and technical matters to be concluded."

Do you see that?

A Yes.

Q And there are, perhaps, two aspects I want to ask you about. The first is the assurance provided by the technical advisers. How much weight was being given to the assurances given by the technical advisers?

A I don't know. I don't think there was a huge amount of weight. I think there was less-- Although I think the board was aware of the discussion around pressure regimes, for example, I think there was probably more emphasis on the financial issues than the technical issues. I think there was less debate about the technical issues. I think it was probably assumed that our technical advisers had advised us appropriately.

Q Okay, come onto that in a moment, but you will be aware that the Cabinet Secretary indicated that, in her view, the problems were a failure in governance.

A Yes.

Q We are looking here at a board minute whereby the board is saying, "We are relying on the advice that we have got from our legal and technical advisers." In your own words, can you explain do you think it is really a failure in governance, or is it other issues that resulted in the problems with the project?

A Well, I probably should have looked up the definition of a failure in governance. As I said earlier, my understanding of what we put in place in governance terms – about the role of the board, the role of the committees, the role of advisers, SROs, etc. – I think the arrangements put in place were appropriate. I'd never experienced a project that had, you know, two executive directors playing a really significant lead role in a project, for example, rather than normally just the SRO. I believe the governance system did what it was supposed to do, but unless the people involved in the-- You know, governance system doesn't work without human beings making it work, and the human beings in the governance system have to be able to ask the critical question that would reveal the problem, and unless someone actually says, "Can we just have a look at these derogations?" and "Can we be absolutely clear that they

comply with guidance?" – and the answer to that would have been "Yes, they comply with guidance SHTM-03-01," – and explicitly to these-- all of the-- You know, unless the governance system allows some person or people to be able to drill down to the kernel of the problem, then the governance system will fail.

So, is that a failure of governance? I'm not sure. You have to think, if you look at a board agenda, or even a committee agenda, there are huge amounts of paperwork dealing with several major issues often, you know, within a meeting, and the extent to which, particularly in a big organisation, non-executive members, particularly, of governance structures can identify the killer question is, to some extent, limited. So, there has to be a reliance that that other bits of the governance system, like advisors for example, are doing the job that we're expecting them to do.

Q And again just while we are, perhaps, talking about the governance around Settlement Agreement 1, are you aware that Audit Scotland and Scott Moncrieff-- they reviewed the Settlement Agreement entered into with IHSL and considered the system of governance?

A Yes. I do recall that the-- that was in relation to our external audit, and then Audit Scotland's report. Yes, I do remember that. I couldn't immediately remember exactly what it concluded, but yes, I was aware of that. Yes.

Q Well, if I was to suggest you that they reviewed it and they did not consider that there were any systemic problems with governance, would that be your recollection?

A Yes.

Q I want to ask you some questions about the commercial context. It is very easy, years after the event, to look back and pick through very small individual issues. Can you just explain to the Inquiry your understanding of the commercial context in late 2018, early February 2019, the backdrop to the signing of Settlement Agreement 1?

A Commercial context? Well, I guess this was the-- IHSL were in financial distress. We had signed a contract that had financial close at 2015. £150 million of debt had been borrowed. It was due to be paid back. The mortgage payments, if you like, were due to have started in 2017. Here we were in 2018 and 2019. We hadn't accepted the building. We were in dispute. There was no prospect of that dispute being resolved easily.

Had we gone to litigation, there would have been significant delay. We didn't even know how much delay. We didn't know whether the outcome would be acceptable, or whatever, and with every passing month, the financial situation of IHSL became worse. I mean, I think-- I'll not reiterate all of Susan Goldsmith's advice, but I think it was very clear to us that we were in a major problem in that the hospital could either be potentially delayed without measure, or the whole thing could collapse, actually, and if IHSL did collapse, the problem then was that, although we were able to-- we could have stepped in, the principal debt lenders actually had a right to step in and see whether they could resolve the situation. So, I think we were kind of-- you know, I'll just put it colloquially-- as between a rock and a hard place. The hospital was-- the contract was going nowhere; the delay had no end; we were in dispute about a significant issue; there was lots of work that we still wanted to go on; it wasn't just ventilation, there were heater batteries and drainage issues; and it had to be unlocked. It had to be unlocked, there was a-- we needed a mechanism to unlock.

Q Again, if we just take a step back from this and think about the suitability for the NPD model for these types of hospital projects, the Inquiry's heard a lot of evidence about, theoretically, the whole idea is that you transfer all of the risk to the private sector. Is that the reality, though, if you have a scenario like happened on this project whereby you have the special purpose vehicle starved of money, potentially about to go insolvent, with a bill for £150 million landing either on NHS Lothian's desk or the Scottish Government's desk? Like, is that the type of context the Inquiry should understand you mean when you talk about these structures potentially not being fit for purpose.?

A Yes, or they just-- yeah. They make it more complicated, more convoluted. Yeah.

Q Again, just to pick up on the governance arrangements, if I can ask you to look to bundle 13, volume 7, please, at page 1049, which is a minute of the Finance and Resources Committee from 19 September 2018. Do you see that?

A Yes.

Q And if I could ask you to look on, please, over the page, onto page 1050, paragraph 15.2, which states:

> "Mrs Goldsmith tabled a position paper on a proposed

settlement agreement. The paper provided detail and an update on the current financial situation of the RHCYP/DCN project. There was discussion on the IHSL financial difficulties; the need for a finalised supplemental agreement to move forward, the factors delaying the signing of this and the position of senior funders; residual technical issues with the key issue being around drainage systems; amendments to the business case; the leadership and competency around IHSL and the next steps to make progress."

And actually, the next paragraph:

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

Do you see that?

A Yes.

Q Is that really capturing those real time, real-life commercial pressures as to why it is very easy to say, "You should not have just skipped the stage for HAI-SCRIBE," but this is the real-life commercial context as to why that happened?

A Yes.

Q Thank you. I want to ask you some questions about the role of MacDonald, and if I could ask you to have your witness statement, please, page 198, at paragraph 28, and you see approximately three lines down from the top of the page, there is a sentence beginning, "That said, NHS Lothian…" Do you see that?

A Yes.

Q So you tell us, "That said, NHS Lothian had already taken and relied on technical advice from Mott MacDonald Ltd (MML) in relation to the SA1 technical schedule." Do you see that?

A Yeah.

Q So, again, was your understanding that the technical schedule, that has been reviewed by Mott MacDonald, the lead technical advisors for the project?

A Yes.

Q Can you just try and explain in your own words what the role of Mott MacDonald was? The reason I say that is having heard from certain witnesses from Mott MacDonald, it is sometimes quite hard to pin down just exactly what Mott MacDonald were and were not doing at various points in the project. So, again, I am not asking you for a legal analysis as to what the legal obligations of Mott MacDonald were,

but in your position as Chief Executive, what is your understanding of what Mott MacDonald were doing on this project at the point of Settlement Agreement 1?

A Yes. So at the time, I had not been involved in the detail of their appointment or the specification of the contract with them, but my understanding was that they were commissioned to work as an integral part of our project team. They were physically located with our project team in Little France working on a day-to day basis, advising the project team on a whole range of issues that were coming across their desk. Then pause there, stop to then think about more recent things. Were they a shadow design company? In my view, at that time, no, they weren't the shadow design company, but I think in terms of the criticality of, "Did anyone pick up the environmental matrix problem?" or "Did anyone pick up the derogation erroneous inclusion of the four bed Critical Care beds?" I would have expected Mott MacDonald to have picked those issues up. Both of those issues.

Q Because again, one issue I would like to raise with you now is a point that is made in the Grant Thornton report, and if you contrast the

legal advice that NHS Lothian are getting as opposed to the technical advice from Mott MacDonald, if you look through the paperwork, whenever there is legal advice being given, it is very often crisply captured in a briefing note, or an advice note. It sets out what the advice has been sought on and the advice that is being provided.

A Yes.

Q It is very difficult from the documents the Inquiry have seen on the technical side to try to find anything similar.

A Yes.

Q Do you think that is – again, this is not a criticism of people at the time but a reflection on how things could be done better – it might be better in the future if technical advice was crisply captured in a similar way to the way that the legal advice was captured?

A Yes. I mean that sounds like a plausible supposition, doesn't it? I just think that no matter-- it goes back to a point I mentioned earlier about, you know, guidance, for example, being crystal clear. These are hugely complex situations, complex legally, financially, operationally, clinically, etc., and I'm just-- I'm slightly thoughtful about whether we will ever be able to be just crystal clear in a way

that will capture the complexity of individual projects,

Q In particular, if we are thinking about the technical schedule to Settlement Agreement 1, whether the review or the advice was provided by Mott MacDonald or by a third party, do you think that NHS Lothian at that point in time should have had a detailed technical review of what went into the technical schedule?

A Yes. I think you have to presume that would have been helpful. As I say – sorry, just to reiterate though, just for a second – that would have picked up the problem then rather than later, but it wouldn't have stopped the problem, the problem of the ventilation system already having been installed by this point.

Q But would it not have stopped the problem in 2018?

A Yes.

Q Because the negotiations are taking place through 2018. Late 2018, it is built out at the risk of IHSL and Multiplex and then it is documented in the February----

A Yes.

Q -- but if at the point the agreement, the heads of terms, the principles are being agreed, there had been a detailed technical review, that would have captured the problem.

Would it not?

A Well, you would hope so, but-- and, well, why did we not capture the problem without that? I would, you know, continue to ask the question, well, you would assume so, but can you guarantee that that would have captured the problem?

Q Just, I think, reflecting for a moment on the role of Mott MacDonald, could I ask you to have in front of you, please, bundle 13, volume 5, page 1272. Bundle 13 Volume 5, page 1272. It is the paragraph in the middle of the page beginning, "The risk allocation set out in Clause 12..." Do you see that?

A Yes.

Q This is an email from Graeme Greer of Mott MacDonald to Brian Currie and Mr Greer states:

> "The risk allocation set out in Clause 12 of the PA is clear, and I am concerned that if the Board agreed to write the above BCR statements, it could significantly alter the PA risk allocation in IHSL's favour. Furthermore, I don't think the Board is in a position to fully confirm compliance with the BCRs, the burden of responsibility should always remain with Project Co. As we

are not the designers, Mott MacDonald would not be in a position to provide that design assurance to NHSL."

Do you see that?

A Yes.

Q It is just to try to understand your understanding of what was happening with Settlement Agreement 1 because this is saying, "We cannot provide you with design assurance," but was the technical schedule to the Settlement Agreement 1 not confirming and making crystal clear what NHS Lothian's brief was and it was then for Project Co to design in accordance with that brief?

A Yes. I think so. I don't think I had ever understood, as I said earlier, Mott McDonald being a shadow design team. I mean, these concepts of a shadow design team have been used and discussed in the past. We literally do have a shadow design team to sort of forensically and microscopically second guess everything that your contractor is doing. We were never in that situation. So, I'm not sure I really fully grasp the point that's being made here. At the time, as I recall it, I wasn't expecting Mott MacDonald to be taking on the design risk; Project Co was supposed to be taking on the design risk. What we were signing up to though, erroneously included rooms that should never have been there, and I don't believe now that it would be unreasonable to have expected technical advisors closely embedded in the project not to have been able to flag that, so.

Q If we just think about Mott MacDonald's involvement, Mr Greer is providing a supportive affidavit for the litigation, no problems are being flagged at that point and there is no problems being flagged when Mott MacDonald are assisting with drafting the technical schedule, albeit Mr Greer's making clear that Mott MacDonald aren't acting as a shadow design team.

A Yeah.

Q Thank you. In terms of roles on the project, you raised the concept of the independent tester within your witness statement. Do you think there were problems on the part of the independent tester for the project?

A Yes.

Q Can you just explain, what do you think those problems were?

A I think it came down to a lack of understanding on our part that the independent tester was testing

against the Environmental Matrix rather than against the Board's construction requirements or-- so testing against what he had understood to be agreed between the parties – in this case the derogations – rather than against the SHTM 03-01 standard, and so I think that confusion was not helpful, but also, I think the independent tester could have raised that contradiction.

I think, again, I just would have expected the independent tester to say, "Well, I've looked at this and the air changes are only at four an hour. I see over here that you've agreed to that, but I'm flagging to you that that is in contradiction to your Board's construction requirements." Again, you know-- but I don't know why. I understand, I think, now the rationale is "because I was testing it against the contract, not against the standards," but I think it would have been helpful if we'd been clear about that and it would have been helpful if the independent tester had been potentially doing both because if he'd been doing both, he would have said, "Well, there's, you know, a dichotomy here; there's a contradiction." At least it would have allowed us to have had a discussion at that point about the contradiction, even if we had been in

error. It would have been flagged earlier.

Q Thank you. I am going to move on in a minute and just really ask you about the period from July onwards, but perhaps before we leave your statement, if can ask you to look to page 202, please, and to paragraph 42. You see that there is a heading, "6 [air changes per hour] to 4 [air changes per hour]" and at paragraph 42, you say:

> "Even before we had signed off SA1 from around May 2018 onwards IHSL were desperate for us to agree a derogation from six air changes to four air changes."

Do you see that?

A Yes.

Q Could you just perhaps expand on that and explain just exactly what you mean by that statement?

A Well, that they had-- I can't remember the date, but significantly earlier than that, and I don't know what-- I can't remember the dates. IHSL had asked us to agree derogations from six to four and we had rejected those, and yet it appeared that the only way, when it came to SA1, we could resolve the dispute about the pressure regimes was if we also agreed to the derogation, and although it's called six

to four, I believe at the time it was six mechanical to four mechanical and two mixed mode. So, although it's been characterised as six to four, I think there was at least a belief that it was six to a different type of six but, nevertheless, I think that was my understanding.

Q Thank you. I now want to move on just to ask you about some questions about what happens within that critical period from 1 to 4 July 2019. When the issues are identified by IOM Limited, they say in their opinion, there was non-compliance of the Critical Care rooms with SHTM 03-01. Mr McKechnie of TÜV SÜD, he still maintains that what he had designed fully complied with SHTM 03-01. Is that correct?

A I didn't know that at the time. My understanding from the witness statements and evidence I've seen recently that that was the case, but I didn't know that at the time.

Q So, that is not something you knew at the time. So, is that-- should we understand that is not something, then, that you would have been raising with colleagues at Scottish Government?

A No.

Q And I think you say in your witness statement, and you have

said in your evidence as well today, that in this period there is lots of work going on, and does that include work on some interim solutions?

A So, are we talking about the period sort of, 2 July?

Q Around about that time. Yes.

A Yes. So, I mean, when it became clear to us that IOM were confirming that we weren't achieving ten air changes per hour in Critical Care, as I say in my witness statement, I convened an emergency meeting and we were looking at, well, what's the scale of this issue? Is it fixable? Are there any-- What options are available to us? We were all brainstorming, you know, urgently. I mean, I was clear. It was the Tuesday morning when I became fully aware of the problem, even though Tracey had emailed me the previous evening, and that had caused me to call an emergency meeting on the first thing on the Tuesday morning.

The Tuesday morning, when I had as many people as I could gather around me to talk about the IOM reports, yes, it was a question of, do we understand them? Are they accurate? Are they comprehensive? Are the issues remediable? Are there-- you know, etc., and so we were

generating lots of options, both about how we-- whether the existing system could be tweaked in a way that would increase, for example, air change rates. I know there were-- IHSL did come forward. Multiplex did come forward with some suggestions that, if we closed a four-bed bay or whatever, we could ramp up to five an hour or seven an hour or whatever, and we were looking at the options that I set out in my notes to Scottish Government the following da, where I was saying, well, it seemed to us the options were the four options that I described.

So, yes, there was a huge amount of activity going on that day, where-- and lots of interactions going on, both internally with clinicians, with the advisors, with HFS and HPS, with Scottish Government. We were really-- I mean, I was really clear we needed to make a decision within a day or two. This was not something we could avoid, and unless we could be confident about making a decision that we could fix this and continue with the move, then we would have to defer the move, and I think Tracey had come to that conclusion anyway on the Monday evening. You know, she was saying, if this is right, if this IOM thing can't be fixed, we shouldn't move.

Q And again, obviously the Scottish Government come in and say that that is what is going to happen, but it is a very similar thought process on the NHS Lothian side as well of if it is an unknown risk, we simply cannot open the hospital.

A Yes. I mean, we found the risk, albeit late in the day, and I escalated the risk to Scottish Government, and I escalated the risk because I thought there was a very high chance that we would not be able to move in as planned.

Q And again if we just-- we will come and look at this in a bit more detail but fundamentally, the issue is identified by NHS Lothian. Is that correct?

A Yes.

Q NHS Lothian is working on solutions, including an interim solution. Is that correct?

A Yes.

Q Giving consideration to whether the hospital should or shouldn't open. Is that right?

A Yes.

Q And in relation to any remedial works that are going to be done, it is ultimately going to be NHS Lothian that has the legal liabilities for instructing and paying for those works. Is that right?

A Yes.

Q But the Scottish Government would not simply let NHS Lothian get on with implementing that solution. The Scottish Government wanted to take control. Is that right?

A I don't think we had a solution. I think we had a proposed way of handling the problem, so I don't think it would be fair to say we had a solution and that it was all fixed because it was certainly not all fixed. You'll see from my evidence that what I was setting out to Scottish Government, that all of the options we considered had risk and uncertainty, and I mean, we'd only had something like 32 hours, including sleeping time, from discussing the problem at the emergency meeting on the morning 2 July to my correspondence with Scottish Government just before five o 'clock on the Tuesday.

So, we had had about 32 hours, but I think what we were able to set out was our view of what the options were and how we thought we should progress, and I think, as I said earlier in response to the communications plan, I mean, John Connaghan was very helpful in working with us, and he was part of the discussion on 3 July. I think my understanding was that that we would collaboratively agree a way forward.

I mean, this was a big deal, as I was saying. I wouldn't expect the Scottish Government just to wash their hands of it and say, you know, "Carry on, Lothian." I would have expected government to be hugely concerned and involved, but I would have expected it to have been done collaboratively, and that we would have led on it.

Q Thank you. If I could ask you to look, please, to bundle 7, Volume 1, then to page 38, so bundle 7, Volume 1, page 38. Is this the briefing note that you have talked about?

A No.

Q No, that is not the----

A That, I think, is Alan Morrison's briefing note to government-- from government to government. I'm talking about my email of Wednesday 3 July at 4.46 p.m. or whatever it was.

Q Well, we will come on to look at that in a moment then. So, the document that we have got up on screen, you think that is Alan Morrison's briefing note?

A I think it is.

Q Well, before we go on further in the chronology then, could you just summarise that 2 July, you

say you have got the emergency meeting, various meetings going on that day-- what discussions are you having with the Scottish Government at this time?

A Well, I had-- I mean, it was it was pretty apparent to me from Tracey's email that we had a major problem. Then, it was very apparent within about an hour of the emergency meeting that we definitely had a major problem, and so I put a call in to Scottish Government in the morning to say I need an urgent conversation with the Director General because we have a major problem that we've just found out about in relation to the plans to move the hospital, and that that move is now seriously in doubt.

The Director General, understandably, was busy doing other things and we agreed a lunchtime phone call. I, as it happens, was briefing my Chairman later that morning anyway, and I thought it would be helpful if he sat in on the conversation, just to be another set of ears in a crisis situation. As it happens, John Connaghan was, I think, performing a similar function with the Director General. So, there was a four-way conversation going on and I briefed them fully on what we'd found and what our assessment was at that

time, and what we were intending to do over the next few hours, and we had a very detailed and lengthy discussion that was entirely appropriate.

They were asking questions; they were coming up with suggestions. My memory is they raised issues like, well, could you move in a phased way, could you decant, and you know, so we were having actually a very good discussion, and it was agreed that we would then get on with our endeavour. We would meet with people, we would engage with all the stakeholders that I was describing earlier and that we would speak to later, and we did speak later. Again, it was becoming clearer that the solution for Critical Care was going to be not something that could be fixed easily and quickly.

The following morning, Iain Graham, our Director of Capital had a meeting with HPS and HFS and Scottish Government in Glasgow. One of my colleagues, Jacquie Campbell, and I phoned into that meeting first thing on the Wednesday morning, 3 July. We set out-- similarly as I had done to Scottish Government, I set out the case with colleagues, and HFS and HPS were very good. They asked questions about how confident we were that our potential plans around

remediation could work; how confident we were that we had a contingency plan in the event that the remedial works couldn't work; if, for example, there'd been a view that, well, we could move in and decant, or we can move in and fix it by closing four beds at a time and fixing the air handling systems etc., and they were really posing, I think, very helpful questions, which I was posing of myself which was-- well, okay. So, that's fine if it works, but if it doesn't work, what do you do then? I think it became very clear their advice was very strong, I think.

It was about there's too much risk here. Yes. Our advice is you should defer it. It was not their decision to make. I regarded it as my decision to make, albeit in concert with Scottish Government, and I wouldn't have escalated to Scottish Government if I didn't believe that that it was a decision that we would have to make jointly or collaboratively, even though I was the accountable officer and it was, you know, my contract, or my organisation's contract.

But then, you know, the following day, I think there are minutes of two sort of seminal meetings, one at one o'clock and one at two o'clock, where our thinking, you know, sort of

solidified with----

Q Perhaps it is helpful if we just look on to the minute of the two o'clock meeting. If you could have bundle 7, volume 1 at page 57 in front of you, please, and I think you say that your thinking had crystallised by this point. If we look to the bold heading, "**1. Position to Date**" we see recorded:

> "Tim Davison advised that after significant soul searching the main punch line was that the system did not feel confident in moving the RHCYP in its totality in the forthcoming weekend and felt that it would be sensible to re-phase the process."

Do you see that?

A Yes.

Q So, again, can you just explain in your own words, what was being discussed at this meeting?

A Yes, well, I think actually-- the following sentence though, I think is also important because recognising what we were saying earlier about wanting to move before the winter and Sciennes being really, you know, a conflicted site because of its age and size and etc., and DCN having all the problems we talked about, with Pseudomonas, etc. I think what I was keen to reflect was that although we

thought we really couldn't move in Critical Care – and, therefore, all of the clinical interdependencies that rely on Critical Care, like Inpatient Services, the Emergency department, anything other than sort of minor day surgery, etc., all those clinically interdependent services couldn't move – it was possible that we could, however, continue with our plans to move DCN, and what I've described here is ambulatory Paediatric Services that are listed there, and these are potentially very high-volume services that would have taken a lot of pressure off the Sciennes site etc., but I think what's also critical is the last sentence of that paragraph where I say these things, "…being able to move over the course of the next few weeks and months."

I think it was already clear in my mind this was not something that was going to happen in the next few days, and this is where I think there's a sort of distinction between my option three, which was to rephrase the move, and option four which was defer the move altogether, and then rephrase it, you know, kind of merge into almost one, actually, but yes. What's going on here, I think is-- yes. We were setting out what we thought we should do, and the punch line was we can't move

in Critical Care.

Q Cannot move in Critical Care, but you were reasonably positive, albeit there is a pause when the possibility of moving the DCN in a relatively short time window--

A Yes. At that point, absolutely. That was our hope. I mean, it would be useful to find this email that followed this meeting.

Q I think we are just coming onto it, so----

A Okay. Well, maybe I'll pause then and----

Q No, that is fine, and perhaps just for completeness, if I could ask you to look on to page 60, please. The second paragraph after the bullet points, you will see there is a paragraph, "John Connaghan…" Do you see that?

A Yes.

Q It says:

"John Conaghan commented that he felt that the technical aspects of the derogation and advice from technical advisers should have flagged the problem earlier in the process."

Do you see that?

A Yes.

Q So, again, do you recall Mr Connaghan saying that at the

meeting?

A I can't specifically remember that, but if it's in the minute, I'm pretty sure he would have said it. Yes.

Q Thank you. If I can ask you to look to bundle 10, please, page 124. This is an email of 3 July 2019 at 16.36.

A Yes. This is it.

Q Do you see that?

A Yes.

Q And is that the email that I think you have referred to a couple of times? You said you thought that it would be helpful for the Inquiry to consider.

A Yes. This email followed those two meetings and was based around what I said earlier, which was my view was whatever decision we made, we had to make a decision, and we had to make the decision by the following day, and although this was incredibly late in the day, this was, you know, 4.36 on the Wednesday, my view was, "We can't wait any longer than Thursday because of all the things we talked about." We had patients booked, we had moves booked, we had staff having taken time off, or come in, or whatever. This whole juggernaut of commissioning the hospital was about to start and we

couldn't delay any further, and so I set out these four options, but perhaps on the second page, I just wanted to identify--

Yeah, so on the second page, you'll see that-- what I was saying is-- although I'm saying-- The option that was supported was to rephase the timing of the move to allow a phased occupation over the next few weeks and months, reflecting the fact that later in that email, I say, in the third bullet point, that we would have to clinically risk assess and plan the rephased moves that I described. My clinical advisors who were part of the discussions on those two days, and in particular the Associate Medical Director, Eddie Doyle, and the Paediatric Services Director, Fiona Mitchell, they were very clear that, although ambulatory care services, like outpatients and-- you know, that kind of thing, could move – it was a plausible suggestion to make that they could move – there'd be no time to engage with clinical teams about, "Well, just what are the practicalities of that? What are the hidden consequences? What are the unintended consequences?" etc., and so we would have to do a clinical risk assessment, and so--

Although, I think-- personally, and

many of my colleagues were of the view that we were really wanting to move quickly, I think there was, you know, already at least an understanding that it couldn't be that weekend.

Q Yes.

A It would have to be, hopefully, as quickly as possible thereafter, but it would be weeks and months, not days.

Q Because if we look back to page 124, please, you will see, in the second paragraph, you make the point that patient safety is, really, absolutely key. You say:

> "It's worth reiterating that our guiding principle in dealing with this problem and all previous problems and delays associated with this building project has been to prioritise patient safety and only to commission services in the new building when we believe that it was really fit for purpose."

Do you see that?

A Indeed.

Q So, patient safety is absolutely key. You then set out a suite of options from 1 to 4. I will not go through each of those options, but you end up setting out the pros and the cons. Over the page, onto page

125 after point 4, "Rephase the timing of the move." In the next paragraph, you say, "This option was supported as the best option." So, for all the reasons you have given you considered, albeit it is not an ideal scenario, that was the best option in a difficult situation?

A Yes.

Q Then, if we look to the very bottom of this email, four lines up from the bottom, you will see there is wording, "It is proposed that the key outcomes would be shared…" Do you see that? So, the final paragraph, four lines up from the bottom, there is wording, "It is proposed…"----

A Yes.

Q

> "It is proposed that the key outcomes would be shared within NHS Lothian and with our NHS bodies in Scotland as appropriate to help with cumulative understanding of the issues arising and to help with both preventative and reactive measures to mitigate the likelihood and impact in future projects."

Do you see that?

A Yes.

Q So, again, albeit you are in the midst of the issue, you are

already thinking, “Well, we need to learn from this for the future.” Is that right?

A Yes.

Q I think-- We have not looked at the earlier meeting on 3 July, but it is perhaps helpful just to look at that as well. If I could ask you to look to bundle 13, volume 4, please. So, bundle 13, volume 4, page 1326. You see that, at the bottom, there is an email from Edward McLaughlan that says, “Colleagues, modified version of our discussion notes as agreed below.” Do you see that?

A Yes.

Q It is the email at the bottom that says, “Modified version”----

A Yes.

Q -- “of our discussion notes as agreed below.” Then, if we look down, if we go on to page 1328 first, do you see that there is a range of meeting participants listed, including yourself, Tim Davison, by phone?

A Yes.

Q It is really just to look back up the page to page 1327, towards the bottom of the page. You see-- So, 1327, you see – we can keep scrolling down – there is the heading, “Unknowns.”

A Yeah.

Q One of the “Unknowns” is, “The safety implications of running the facility with 4 air changes rather than 10.” Do you see that?

A Yes.

Q So, at this point, by 3 July, should the Inquiry understand that all the participants on this meeting understand that there is non-compliance with the guidance, but whether four is safe, that is an unknown at this point. It has not been bottomed-out whether it is or it is not safe?

A I have to think about that. I mean, I know there’s been a lot of discussion in previous hearings about this. I mean, you know, Sciennes had no air changes and it was safe. I think we all-- I think our expectation was never anything other than that we needed to achieve ten, and you’ll see in the correspondence we’ve just been looking at, you know, when I was presenting the options available to us to the Scottish Government, there was no option that said, “Let’s move in with four.” All of the options were about, “How do we get to ten?” and so-- I mean, I hadn’t actually thought about this until you’d raised it with me. I’m not sure I remember there being much discussion about, you know, “Is it safe with four?” because all of us, I think, had assumed, “It has to be ten,” you

know? "This is a brand new building, it's cost £150 million, it has to meet the most modern standards," and-- Yes, so that's my recollection.

Q Again, just at the bottom, you see the "Consensus view," which is that:

> "Given the information available, the consensus was that, with unknown risks associated with moving patients and then modifying the ventilation of the building, combined with the 'believed safe' environment of the current facility, the safety of patients might be better served by [and then, over the page] delaying the move and modifying the ventilation of the new building, before moving patients."

Do you see that?

A I do, and I think that's a really good example of what I would call a collaborative discussion of a really serious crisis issue that involved NHS Lothian, Scottish Government, HFS, HPS, and I think it's a good example of how, actually, you know, the agencies can work together in a productive and helpful way.

Q So, what happens now? This is-- We are at the 3rd, and we are going to come on and look at the letter that you get on 4 July, but can you just-- At this point, it all seems very collaborative, everyone is discussing matters, nothing is agreed. What happens next?

A I might have to rely on my statement for the detail, but I think-- As we said earlier, my comms director was working closely with the Scottish Government to pull together a communications plan for the following morning. John Connaghan had had made it explicitly clear, in the meeting at two o'clock that day, that there would be no decision until the Cabinet Secretary had come to a conclusion about what the best thing should be. So, it was very clear that NHS Lothian was not able to make its decision alone, and I accepted that fully. As I say, I wouldn't have engaged the Scottish Government if I didn't think they had a huge role to play in, "What do we do? We're in this crisis."

So, it was known to me that, you know, we would have to wait for the Cabinet Secretary. We anticipated the Cabinet Secretary would-- we'd have a meeting in the morning, the view would be known, and we would take things from there, and the timelines would-- you know, would follow later in the day that the Cabinet Secretary made a decision (inaudible) the late-- known that, later in the day, other things could

have happened.

There was a flurry of telephone calls and emails that evening. I spoke, from memory, with Malcolm Wright and with John Connaghan and with, I think, one or two of my own colleagues in the evening, and that-- That evening, John Connaghan particularly was saying, “The Cabinet Secretary will make the decision hopefully tomorrow and wants to lead on all of the communications, and wants there to be nothing said to the”-- what I was describing as “the public,” “the media,” “the staff” or whatever, “until she had advised us of her decision.”

So, we-- That’s fine. We all came into work the next day, and we were literally sitting, you know, in the sort of area outside the executive team’s offices waiting for the phone call to say, you know, “The Cabinet Secretary has considered this, and can we now consider where we go to from here?” and we waited, and we waited, and we waited, and then at half past four in the afternoon, I think I got a copy of-- I can’t remember whether it was an email or a telephone call to say that the Cabinet Secretary had issued a media statement saying that she was pausing the whole move, and that was the first I’d heard of that.

Q Okay. So, it was

announced publicly before NHS Lothian is told of what is going to happen?

A Yeah. I mean, I think within minutes, but you know, I think-- Yes, I think the announcement was made and then we were told.

Q How difficult a situation was that for you to deal with?

A It was difficult. I think, as I said earlier, you know, we-- because we’d been expecting the decision to be made in the morning, we had set up briefing meetings for staff in the later part of the morning, or in the early part of the afternoon or whatever, and we were having to cancel these meetings. We were literally, you know-- I say “we,” my colleagues were standing in Sciennes and DCN saying, “The meeting’s cancelled. There’s a problem. We don’t know what’s happening,” and so-- yeah, it was very-- it was very difficult.

Q Okay, and then if I could ask you to look to bundle 7, volume 1, page 79, please. Bundle 7, volume 1, page 79. Do you recognise this document?

A I do.

Q So, we will come on and look at the detail, but what is it?

A It’s a letter from the Director General formally confirming

the Cabinet Secretary's decision and what government wanted me now to do.

Q So, if we think of the minutes and the correspondence that we have looked at that have quite a conciliatory tone, a collaborative approach, it is quite a different tone that we see in in this letter. Is it not?

A Yes. It's very different tone, yeah.

Q How did you feel when you received this letter?

A I felt hurt by it. Yeah. What it-- That was not the tone of language I was using with my own team, despite the fact that I was frustrated that we were in a major a problem, so I-- Yeah, I wasn't impressed with the tone.

Q Again, just if we think back to the background to this letter, NHS Lothian has identified the problem, escalated it to Scottish Government, and has been working on potential solutions with Scottish Government. Is that correct?

A Yes.

Q The NHS Lothian internal view was that there should be a pause on the move until NHS Lothian was satisfied that it was safe for the hospital to be open. Is that correct?

A Yes.

Q If we look at what this letter from Mr Wright is saying-- so if we pick matters up on page 79, three lines down, do you see, just in from the right-hand side, there is wording, "The cabinet secretary has taken the decision..." Do you see that?

A Yes.

Q It says:

> "The Cabinet Secretary has taken the decision to halt the planned move of the Edinburgh Children's Hospital and the Department of Clinical Neurosciences for the time being. As I have already advised you this is taken in the best interest of patient safety and to ensure that we provide sufficient time for resolution of the ventilation issues."

Do you see that?

A Yeah.

Q Is that not exactly the same rationale that you were putting forward in your email which was, "We need a pause and patient safety needs to be absolutely key"?

A Yes.

Q If we then then look to the bullet points, you are to, "Put in place and maintain a Communications Plan." Do you see that?

A Yes.

Q Is that something that you were already working on collaboratively with the Scottish Government?

A Yes.

Q Bullet point two, "I also require an assurance that there are **no other material specification deficiencies** in the new building." Do you see that?

A Yes.

Q Then, if we look to the next paragraph, it says:

> "Please note in respect of the external scrutiny of the adherence to technical standards and the Governance process surrounding these, we wish to ensure that any planned re-sequencing of moves will only occur once we have received clearance that all facilities meet the required technical standards, including those applying to infection control and lessons learned from the commissioning of the new Queen Elizabeth building."

Do you see that?

A Yeah.

Q Do you get told in this letter what the required technical standards were? Because, again, if we think back to your statement-- in your witness statement where you talk about the clarity around complying with SHTM 03-01, did that really help, to be told you have just got to comply with the technical standards, or does that come back once again to what is required of technical standards that are open to interpretation?

A Yes, I think so. I mean, I think we were particularly focused on SHTM 03-01, and we were particularly focused on Critical Care within that. So, I think my feeling was that there could have been a greater clarity around that and I think that-- I mean, it's difficult to say because the events were moving so quickly, but we had already engaged with HFS and HPS, as I was describing; you showed me the minute of the meeting. I think we-- in the days that followed, we would have been engaging with HFS and HPS anyway in a more formal way to say, "Right, you know, we've got this major problem. We need your help in in working out how we risk assess the re-phasing." I think I didn't explicitly cover all of that in my email to Malcolm, and he is covering that in this letter, but I think there was-- By the fact that we'd met with HFS and HPS and we'd been involved-- we'd involved them in our consultation, I think, showed that we were you know

planning to engage with them in how we move the thing forward in any event.

Q Then, if we look on to page 80, the second full paragraph beginning, “While I require your personal assurance…” Do you see that?

A Yes.

Q So, it says:

> “While I require your personal assurance on this I also need you to be clear that any planned re-sequencing of the moves must also now be pre-approved by Scottish Government…”

A Yeah.

Q And then, if we look to the next bullet point, three lines down, it states:

> “Your revised plan should include support for transport, a telephone helpline and direct communication to each of the patients who are impacted by this change. This is an immediate requirement and I require that you will have such plans available for our scrutiny and approval by tomorrow morning (Friday 5 July).”

Do you see that?

A Yes.

Q And had you already been working on that in a collaborative manner with the Scottish Government?

A Not as explicitly-- I think-- Yeah, I mean, that we would have to engage with patients, etc., yes, but I think that was probably a little more explicit than that, but I mean we knew we had to do it. We didn’t need to be told that we were going to have to do that.

Q If I could ask you to look back to your witness statement, please, page 227, paragraph 128, approximately five lines down, you are referring to interactions with the former Cabinet Secretary. You see, approximately five lines down, there is wording, “… she expressed her view that it was the Board’s…” Do you see that?

A Yeah.

Q **“…** she expressed her view that it was the Board’s failure and in particular a failure of governance.” Do you see that?

A Yeah.

Q Do you think that was a fair comment?

A No.

Q Why not?

A Well, as I go on to say, I thought it was premature to have come to that conclusion and-- I mean, it was

the Board's failure. I mean, let's just be clear, this-- You know, as I said earlier, this was a major problem. It was a huge shock to us and it was a significant event, and it was our project, and we were in charge of it, and we had this problem. So, I think-- I don't think you could pretend other than that this was a failure. The project had not delivered what we wanted it to deliver, and it was going to be hugely disruptive and financially costly to remedy. So, I would agree. I would expect her to be, you know, concerned about it as we were, but I'm not sure that-- Well, just I didn't think it was a failure of governance. I thought we had the appropriate governance arrangements in place and, as I said earlier, KPMG, you know, I think came to the same view. So, I think my understanding was, yeah, it goes along with the tone of the previous letter. It was just very much-- I think, the conclusion had been made that the Board-- it was all the Board's fault, and I think that that was a simplistic and premature conclusion to have reached, in my opinion.

Q The next thing I want to ask you about is the escalation of NHS Lothian to level three and then to level four. For those of us not familiar with that scale of escalation, can you just

explain in your own words what an escalation to level three would be, and then a subsequent escalation to level four?

A Yes. I mean they reflect increasing degrees of concern about the ability of the Board to deliver on significant issues. So, in level three, it would involve close scrutiny, possibly some external support, possibly some-- yeah, involvement of Scottish Government directors. Level four was to another level altogether, and that really would be where the Scottish Government were taking more of a direct control of an issue. Still, as Chief Executive, even under level four, I would remain as the accountable officer, etc., but it was a more serious level, and then level five is really where there's a view that the Health Board cannot deliver what it requires to deliver and, you know, the government would step in and, in effect, run the Board. So, you know, organisationally it was quite a scary thing to be on the escalation ladder because, although you can go down, you can also continue to go up. We were escalated to level three for a range of access performance issues, and then subsequently to level four for the project.

Q I will not take you to the

escalation letter – just for the benefit of the Chair's notes, that can be found at bundle 7, volume 1, at page 339 – but you disagreed with the decision to escalate NHS Lothian to level three. You describe it in your witness statement on page 232, at paragraph 143, as being "punitive and undermining". Can you just explain why did you think it was unnecessary for the escalation to level three?

A Because, I mean, there were a number of Boards that had already been escalated. There were a number of Boards that were suffering similar performance challenges to the ones we were performing, which were largely around waiting times, although not totally. Our performance had actually been improving over the previous 12 months and so, in a number of key areas, our performance was actually improving. Now, there may well have been other areas where our project was stalling or going backwards, but across the piece, generally, we were in an improving situation. So, I was thinking that the timing was surprising because, if we were going to be escalated, I would have thought we would have been escalated earlier. Also, when we were escalated, there were other Health Boards – and I mean, I mentioned

Glasgow's example – which were as challenged, in my view, in a range of areas that were not being escalated. It was so close to the event of the delay to the hospital, and the attitude of government towards us-- yeah, they did feel like it was a very-- seriously unhappy with us, and emotions were running high. We were all hugely embarrassed and shocked by the situation we were in. It just felt like if you were going to escalate us, why now? You know, it's like a week later and it's just ladling on more pressure onto something that wasn't a new thing. You know, our performance issues had been around for a long time and, as I say, had been improving.

Q And again, you tell us within your witness statement about the escalation to level four. You say in paragraph 149 that that was in some ways difficult, but it was really just regularising the position because the Cabinet Secretary had really taken personal control of the project by this point. So, that was almost just regularising what was already happening on the ground. Is that fair?

A Yes.

Q And the escalation to level four, that involves the appointment of Mary Morgan as the Senior Programme Director. Is that

correct?

A Yes.

Q And you say within your statement that, albeit you did not think it was necessarily the right decision to bring Mary Morgan in, you welcomed her appointment, and you thought she did a good job in terms of assisting with remedying the issues with the hospital.

A Yes. I'm not even sure whether I said I wasn't-- I didn't agree with it. If I did say that, I'm not sure that quite-- but I think-- I thought Mary was very helpful and we worked with her very well, and I think she brought fresh eyes and expertise, and, yeah, we were pleased to have her on board. Yeah.

Q Thank you. The next stage is obviously the Oversight Board comes in; it does its work with the Senior Programme Director. There is High Value Change Notice 107 and Settlement Agreement 2. If I could just ask you to look, please, to bundle 3, page 531, which is a minute of the Oversight Board from 5 December 2019. Do you see that?

A Yes.

Q And it is-- just to look over the page, onto page 532, please, and the first main bullet point begins "The NHSL board…" Do you see that?

A Yes.

Q Thank you. It states:

"The NHSL Board had taken their governance responsibility seriously and whilst not happy about the current situation realised that this was the only option available to progress the opening of the hospital. The board reluctantly agreed the proposal."

A Yes.

Q **"**The NHSL Board had requested Oversight Board approval of the decision which they were agreeing to as it was appreciated that the NHSL Board would be signing the public sector up to unknown financial risks, and currently no programme certainty associated with progressing with the proposal."

A Yeah.

Q **"**They wished this concern to be made clear to the Scottish Government and Cabinet Secretary, given how the actions of the NHSL board may be viewed in the future."

Do you see that?

A Yeah.

Q Can you just explain what is happening at this point in time?

A Well, I think the kernel of the issue is that although the Oversight Board was making the decisions-- or, sorry, the Oversight Board was supporting the Cabinet Secretary to make the decisions, the contractual and legal responsibility for the contract and the financial consequences of the contract and, in this case, the Settlement Agreement too was the Health Boards. There was a degree of uncertainty about what the ultimate cost of SA2 would be, and the Health Board was in a difficult situation in being legally responsible for a contract, signing up to something that didn't have an absolutely given financial cost that they would have responsibility for, but perhaps not the financial means to support, and recognising that, in any event, the decisions actually about the project were being taken now by Scottish Government.

So, I think the non-executive directors around the board table, in particular, were anxious about that situation. I was probably slightly less anxious in that, you know, I knew that there was a clear audit trail, the decisions were being taken by the government, and if the board defaulted financially, the government would have to pick up the tab in any event, but in

governance terms, it was definitely, you know, challenging and difficult, and so therefore, I think it was right that the Board was saying, "Well, look, we're going to make this decision, but we want you to approve it so that there's a clear line of decision-making accountability between the board and the government. They did agree to do that, and that's good.

Q Thank you, and then, in terms of the project, those agreements are entered into, the works are ongoing, and you retire, as we have established, just slightly before the hospital opens. Is that right?

A Yes.

Q I just want to ask you now about some separate issues, and it's some correspondence that happened in January of 2019. So, if I could ask you to have in front of you, please, bundle 4, page 8, which is a letter from the Scottish Government dated 25 January 2019.

A Yeah.

Q And you see that it is a letter headed up "Queen Elizabeth University Hospital," and it is a letter raising issues that happened at the Queen Elizabeth University Hospital. If you see the bullet points in the middle of the page, it is seeking confirmation that:

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

Do you see that?

A Yeah.

Q So, would that be one example of some learnings from the Queen Elizabeth University Hospital that the Scottish Government are applying more widely to other Health Boards, including NHS Lothian?

A Yes.

Q And if we look over the page, onto page 9, we will see that this is a letter dated 31 January 2019 to Brian Currie. Do you see that?

A Yes.

Q And if we look onto page 10, you see the bold heading:

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

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

And so it continues. Now, that is a letter that seems to be written in response to the request that comes in from the Scottish Government. Can you remember what reliance, if any, did the project team, the Finance and Resources Committee and the Board of NHSL place on the assurance there about the compliance of the systems in the context of the project?

A I'm not sure I could say for the Board as a whole, but I personally took it as being reassuring that it confirmed what we believed we were buying. We were buying a hospital that would comply with that because they were a clear part of our BCRs. So, I mean, I took assurance from it but it's also-- it was what I would have expected them to say because that's what we thought we were getting.

Q If I can ask you just to look on within this bundle, if we look on to bundle 4, page 244, you see that is a later letter dated 12 February 2019. Do you see that?

A Yes.

Q Addressed to Wallace Weir. This is about the re-provision of

RHSC and DCN at Little France. It said:

"We would be grateful if you could provide your written assurance:

1. That engineering systems have been designed and are being installed and commissioned to meet current guidance and statutory requirements."

Do you see that?

A Yes.

Q Again, you are not involved in the granular level of detail in the project, but do you understand why that letter was written to Wallace Weir of IHSL?

A I think it was part of the-- I think it was still part of the process of the earlier letter that you showed me, that the Scottish Government were asking for levels of assurance from Boards in light of what was emerging from Glasgow, and my understanding was that some of that-- if not that previous letter, other things as well; there was an HPS inspection of Glasgow that detailed 14 recommendations for Glasgow that were then circulated to all Boards to confirm whether or not they could reassure themselves and government that they were on the case on all of those issues, but I think that was what it was. In specific relation to the project, we couldn't give that confirmation at that time because the building was being built and designed by HSL. So, I think that's what we were asking for, just "You-- we need you as the"-- "You've got the design risk, you're building the project, you need to confirm that these things-- for us, you need to confirm that these things are in place."

Q Thank you, and if I could ask you to look on, still within bundle 4, to page 246, please, which is a letter of 12 March 2019 from IHSL to Mr Currie. Do you see that?

A Yes.

Q Yes, there is various confirmations provided, but if we look at point 1, it says, "The engineering systems are designed and have / are being installed and commissioned to meet the relevant Project Agreement Standards." Do you see that?

A Yes.

Q Again, it is easy looking back with hindsight, but it is a slightly different formulation of words that are used----

A Yes.

Q -- as opposed to compliance with SHTM 03-01 as required. At this point in time, did that

have any alarm bells ringing for anyone on the project?

A Well, again, I can't really speak for others, but for me, it didn't, because at that time, we thought that the project agreement and the standards were one and the same.

Q Thank you. Within your statement, you address the issue of whether the department for Clinical Neurosciences could have moved and opened perhaps, or not, on a phased basis earlier than it did. You are not necessarily critical of decisions that were made, but is your own personal view that the department for Clinical Neurosciences could have moved at an earlier date than it did?

A Yes.

Q Can you just explain why you hold that view?

A I think for all the work that HPS and HFS did, which was important and good, I still remain of the view that the Critical Care issue was the showstopper and the Critical Care issue was the thing that caused the delay, and that had there been more of a focus on saying, "What is it we need to assure ourselves on?" – not that the entire hospital is safe, but the DCN components are going to be safe – I believe that could have been done more quickly. I think-- I mean, COVID

came and that kind of changed everything again, but I think-- yeah, I think DCN could have moved more quickly than it did.

Q Thank you. You will be pleased to know I have just got a couple more questions to go. One would be to ask you for your views about NHS Scotland Assure. Obviously, you retire from NHS Lothian, but you have got a lot of experience having worked your whole career within the health service. NHS Scotland Assure has been set up. It is a centre for excellence in the built environment, but it is very clear that it is not a regulator; it is not an inspector; the duties still sit with the Health Board. Do you think that is the right model for a centre for excellence?

A I don't-- I don't know. I'm not sure even whether a regulator is needed. I think, well-- to my mind, if you go back to one of the first questions you asked me – "Why did this problem occur?" – I think it has to start with the specification for the hospital, whatever it does, and I think something that has fresh eyes independently saying, "Pause. Before you go to market, before you procure, are we-- is-- can there be a view of the specification of this building?" So, I think, if that could happen that would

be great. Then, the point around derogations, would we say, “Actually, in hugely complex buildings, derogations are highly likely to be at least requested if not agreed,” and, I think, if there was a similar process of saying, “Okay, pause. These are the derogations, this is why. What are the consequences? Are we all clear that we still want to do them, or we want to stop them or modify them?” or whatever.

I think those things-- I think the sort of key stage reviews that would then follow that would be more straightforward if there was a confidence that the spec had been right and that any changes to the spec through derogations were sensible, but I think, if you like, to just overlay Scotland – whatever it’s called – Assure, or whatever, on the projects that are already in progress, I think, is probably quite problematic. I think it probably, to my mind, would be better sequenced in the way I’ve set out.

Q So, again, just so I am understanding things correctly, you think more standardisation would be helpful, greater clarity in projects in terms of exactly what you are doing, and a very clear procedure for derogating from standards if that is what is happening.

A Yes. Particularly in these very complex projects. I mean, it should be said, even in my career, I was responsible for dozens and dozens and dozens of projects over 37 years that we actually achieved without that level of scrutiny, but I think these-- the big hospital projects, I think, in particular, yes, that would be good.

Q Thank you. Now, the final question from me, at least for the moment, is really-- it is an open question. You worked on the project. You are retired now. I am sure you have had a lot of time to reflect and think about matters. You cover a lot of ground in your statement, we have covered a lot of ground today, but in terms of reflections, is there anything we have not covered to date that you think would be helpful in terms of trying to make improvements to these types of projects for the future?

A Well, for brevity, I think I would just reiterate what I just said-- confirm what I just said. I think there is a place-- I mean, at the moment all of the capital projects, as I understand it, have been paused because of a lack of capital and if you think, “Well, that’s likely to be a feature of the next few years possibly,” not that it would be paused but the capital would be

scarce, then I think revenue-funded models have to be considered rather than finding big lumps of cash. Paying a mortgage type option would have to be there, but I think-- So, rather than the revenue funding or private finance being demonised, I think it could have a role, but it should have a-- it should be much more simplified. I mean, if Health Boards could just borrow the money themselves, for example, rather than having to create a sort of project company or a special purpose vehicle to borrow money on their behalf, you know, this kind of thing, I think that there could be some more simplistic ways that would leverage in private finance without it just being so complex.

Q Thank you. Mr Davison, that is all the questions I have at the moment, but thank you for answering all my questions today. Lord Brodie, I do not have any questions at the moment.

THE CHAIR: Thank you, Mr MacGregor. What I would like to do, Mr Davison, is just check with the room that there is no more questions that anyone wishes to direct to you or, if there are questions, we can make arrangements for that. So, could I ask you to return to the witness room, maybe, for 10 minutes?

A Sure.

(Short break)

THE CHAIR: Mr MacGregor.

MR MACGREGOR: There are six short points that have been raised with me which I am content to deal with.

THE CHAIR: Mr Davison, a few more questions which will come from Mr MacGregor.

A Thank you.

MR MACGREGOR: Mr Davison, one of the issues we discussed today is the clarity of the Board construction requirements, and you had said your own personal view was that they were very clear in terms of what they would require. Do you recall, in terms of the Board construction requirements, that they do say that you have to comply with certain requirements unless something else is specifically stated? Do you remember wording like that that appears within the Board construction requirements?

A I think the only recollection I have I covered a little earlier, which was something to the effect of where there's a contradiction in any of the paperwork, you should default to the more onerous

requirement. That's my recollection.

Q But fundamentally, and this is meant as no disrespect, you are not a lawyer and you are not offering an expert opinion in terms of what the correct definitive interpretation of the contract is, including the Board construction requirements.

A No.

Q Thank you. The second issue is just to clarify. It is in relation to when the works were done under what became Settlement Agreement 1, and I think you fairly say, well, at the point Settlement Agreement 1 is signed, the works have already been done. Is that right?

A The ventilation works. Yes.

Q Yes, but again, should the Inquiry understand that the discussions are taking place-- the dispute arises 2016, discussions in 2017, broad agreement on the principles, March, April, May of 2018, then it is throughout the rest of 2018 that IHSL and Multiplex effectively do the works that had already been agreed. So, the works are done in late 2018, albeit formally recorded in the agreement in 2019. Is that right?

A Yes. I think so.

Q Thank you. The third matter would be the issue of the

independent tester. In terms of Settlement Agreement 1, was the independent tester to test against the project agreement as amended by Settlement Agreement 1?

A I can't-- I don't think I knew what the independent tester was actually being asked to do. I-- I think I would refer to my earlier answer, which is I think I would probably have expected, or hoped, that he would test against the requirements of SHTM, etc., as well as the contract, and I had hoped he would-- in retrospect, I had hoped that he would have been able to have flagged the contradiction.

Q But that is your hope or expectation as to what should have happened, as opposed to you having gone through the contract with a fine-tooth comb?

A Yes.

Q Thank you. The next issue I would like to ask you about-- you will remember that we had looked at the letter that Malcolm Wright sent to you, saying the decision that had been taken by the Cabinet Secretary. If I could just ask you to look to bundle 7, volume 1 please, at page 98. So, bundle 7, volume 1 at page 98. Bundle 7, volume 1, at page 98. Do you see that is an email on 4 July 2019 at 4.10 in the afternoon?

A Yes.

Q That is the email that is attaching the letter that we have already looked at. Do you see that?

A Yes.

Q Are you aware of when the Scottish Government actually made its press release? Are you aware of the exact timing of when that was done?

A No.

Q Okay. The only reason I raise that issue is the Inquiry might hear evidence that the press release is around about this time, possibly just shortly thereafter at 4.17. So, there could be evidence before the Inquiry that, technically, you get this email before the press release is made, but from what you have said, you would not be able to comment on that?

A No. My recollection is that we didn't know of what the public statement was going to be until it had been made, and I think I said in my evidence earlier it was within minutes, or it was almost simultaneous, but that-- my recollection is that we didn't know about it in advance.

Q Thank you. In relation to Mott MacDonald, you said that, in your view, they were not acting as a shadow design team. Did you know precisely what their responsibilities

were, or was that an issue for the project team?

A It was an issue for the project team and Board and SRO etc. Yes, I didn't-- I wasn't involved in the detail of their appointment.

Q Thank you. You will be pleased to know that this is hopefully the final question for me in what I am sure has been a long day. If we could think back to late 2018 into early 2019 when Settlement Agreement 1 is signed, and you have given evidence about your understanding of the financial distress that IHSL were potentially in, where did that knowledge come from? Who was telling you that?

A I think mainly Susan Goldsmith.

Q Okay. So, in terms of knowledge about the financial circumstances of IHSL, potential for insolvency, those types of risks, your knowledge effectively comes from what Susan Goldsmith, the Finance Director, would be telling you?

A Yes.

Q Thank you. I do not have any further questions, Mr Davison, but thank you very much again for answering my questions today.

A Thank you.

LORD BRODIE: Can I add my

thanks, Mr Davison? Thank you for your attendance, but also thank you for the work that will have gone into the preparation of the statement, particularly now you are retired. Reminding yourself of work details no doubt has required that extra bit of work, so thank you very much for your assistance to the Inquiry. You are now free to go.

THE WITNESS: Thank you, Lord Brodie.

LORD BRODIE: I think the plan is to sit again on Tuesday.

MR MACGREGOR: Tuesday, my Lord, yes, when it will be the former Cabinet Secretary, Ms Freeman.

LORD BRODIE: If I can wish everybody a good weekend, and we will see each other, all being well, on Tuesday.

(Session ends)

16.30