Scottish Hospitals Inquiry
Witness Statement of
Helen Byrne

This statement was produced by the process of a question and answer recorded interview with the witness. The questions and answers are produced within the statement.

Personal Details and Professional Background

1. Name, qualifications, chronological professional history, specialism etc – please provide an up-to-date CV to assist with answering this question. Please include professional background and role within NHS GGC, including dates occupied, responsibilities and persons worked with/ reporting lines.

A. Helen Byrne.

Qualifications:

M.Sc. (with Distinction (1st)) in Strategy and Resource Management – University of Northumbria at Newcastle – 1996

M.A in Applied Social Studies – Warwick University – 1989

B.Soc.Sc. (Hons) in Sociology and Social Administration – University College Dublin, Ireland – 1984

Certificate of Qualification in Social Work (CQSW) – Warwick University – 1989

Chronological professional history in summary:

September 2012 – December 2021: Barts Health NHS Trust, London. Held positions as Director of Strategy at the Royal London Hospital and Director of Operations at Whipps Cross Hospital.

February 2011 – August 2012: Chelsea and Westminster NHS Foundation Trust, London. Held positions as Divisional Director of Operations and Head of Performance Improvement.

March 2010 – February 2011: Croydon Primary Care Trust: Held positions as Deputy Chief Executive and also supported the Quality Improvement Plan across South West London.
January 2006 – March 2010: NHS Greater Glasgow and Clyde. Held the position of Director of Acute Services Strategy, Implementation and Planning.

August 2004 – January 2006: Easington Primary Care Trust: Held the position of Deputy Chief Executive.

March 2002 – August 2004: County Durham and Darlington Strategic Health Authority. Held the position of Executive Director of Planning.

January 1999 - March 2002: County Durham and Darlington Health Authority. Held the position of Deputy Director of Planning.

January 1998 – January 1999: City Hospitals Sunderland. Held the position of Business Manager.

November 1993 – January 1998: Gateshead and South Tyneside Health Authority. Held the position of Commissioning Manager.

1984 – 1993: social work positions held across England and Ireland.

Role within NHSGGC:
I joined NHSGGC as Director of Acute Services Strategy, Implementation and Planning (DASSIP) in January 2006, which I held for 4 years up to February 2010 (I took some leave before starting my new NHS role in NHS London in March 2010).

In summary, my role was to provide leadership on the implementation of aspects of the acute services strategies for Greater Glasgow and for Clyde (Clyde became part of Greater Glasgow and Clyde in April 2006, 4 months after I joined Greater Glasgow). For more detail on role in my NHSGGC, I attach an organisational chart. **(Appendix B)**

One component of my role as DASSIP was to provide leadership on the delivery of Phase 2 of the Acute Services Strategy. The Acute Services Strategy to modernise acute adult health services in Glasgow was agreed by the then Health Minister in 2002 and comprised 4 phases.
Phase 1 (the new builds on the Stobhill and Victoria sites; the centralisation of cancer services at the new Beatson West of Scotland Cancer Centre; and the development of the West of Scotland Heart and Lung services at the Golden Jubilee National Hospital) was well underway when I joined in early 2006.

Phase 2 would see a new hospital on the Southern General site, co-located alongside a new Children's hospital on the Southern General site as recommended in the Calder Report published in March 2006 and agreed, following a consultation process on the new children's hospital, the outcome of which endorsed the proposal to adopt the Southern General as the site for the new children's hospital and was ratified by the NHSGGC Board in June 2006.
During my 4 years in NHSGGC, in delivering Phase 2 of the Acute Services Review (ASR), I was responsible for driving progress on key milestones and ensuring NHSGGC Board / Scottish Government approval at appropriate points in the process.

During that time: Gateway Reviews 1 and 2 were successfully achieved; the Outline Business Case (OBC) for the new Southern General Hospitals and Laboratory Project received Board and Scottish Government approval in 2008; Board agreement was given to the preferred Procurement Model in October 2008, and in November 2009, Board approval was given for the preferred contract bidder to deliver the following stages:
Stage 1 – The design and construction of the new Laboratories (subject to Scottish Government Health Directorates Capital Investment Group approval of the Full Business Case);
Stage 2 – Detailed design of the New Adult and Children's Hospitals;
Stage 3 – Construction of the New Adult and Children's Hospitals; and Stage 3A - Demolition of the Surgical Block and associated buildings and completion of the soft landscaping. The contract was signed between the NHSGGC Board and the preferred contract bidder**,** Brookfield Construction (UK) Ltd, in December 2009.

My reporting line was to the Chief Executive and, in relation to the new hospitals project, the New South Glasgow Hospitals Project Director reported to me, who was appointed in May 2006 (my other Direct reports are set out in the attached organisation chart). The Project Director led a team of colleagues from the Board and a number of advisers and he and those teams were responsible for the detailed work associated with the new hospitals project.

I left Greater Glasgow and Clyde to return to the NHS in England in February 2010.

Site Selection

2. Describe your involvement in the site selection process in respect of QEUH/RHC.

A. When I joined NHSGGC in 2006, the decision had already been made that the new adult hospital would be built on the Southern General site. On reviewing the papers provided by the Inquiry Team, I note in bundle 17, document 27 that work had been underway across Glasgow for a number of years, on the current and future shape of acute health care services for the population. The plan for the south of the city was to create a new single set of facilities for in-patient services on one site to serve the south side and a new state-of–the-art Ambulatory Care Centre at the Victoria Infirmary. Regarding the new single set of facilities for inpatient services on one site, a consultation was carried out in 2000 on two options:

1. A new 'greenfield' site hospital and 2. Redeveloping the Southern General, the outcome of which was that the Southern General was the preferred site for the hospital. While the greenfield option had the potential to offer good benefits in terms of achieving clinical adjacencies, it was an extremely high cost option and considered unaffordable. The new build option on the Southern General site became the preferred option allowing reuse of the existing estate. This had been endorsed in 2002 by the then Minister of Health as part of the acute services strategy for Greater Glasgow. In 2004, the then Health Secretary announced funding for a new Children's Hospital to be built on a site that would allow the 'triple co-location of services' (adults, children and maternity.

The decision had already been made to close the Queen Mother's Maternity Hospital on the Yorkhill site and its activity to be transferred to the SGH and Royal Infirmary). A Ministerial Advisory Group, chaired by Professor Andrew Calder, was established, and in the report of that Group, published in March 2006, the selection of the Southern General site was affirmed as the location for the new children's hospital. This recommendation was accepted by the Minister for Health and Social Care in 2006 following a consultation in Glasgow.

3. Describe the risk assessments, if any, that were carried out? What was the outcome? What consideration, if any, was there in respect of proximity to Sheildhall Sewage Treatment Works? What consideration, if any, was there in respect of the Shieldhall Recycling Centre? What concerns, if any, did you have regarding site selection? What action, if any, did you take in respect of such concerns and what was the outcome?

A. I am unaware if any risk assessments were undertaken following the decision in 2002 that the new hospital be built on the Southern General site, as I did not commence in NHSGGC until 2006. I cannot recall if any risk assessments were undertaken, subsequently. I did not raise any concerns about the site selection, given the clinical benefits of the proposed 'triple co-location of services' and that the site selection had been signed off by the Scottish Government, following a consultation undertaken in Glasgow long before I started work in Glasgow.

a) Are you aware of considerations being made in respect of the proximity of the Shieldhall Recycling Centre when the site was being selected?

A. I was not working in Scotland when the site was being selected and therefore, am not aware of the considerations being made in respect of the proximity of the Shieldhall Recycling Centre.

b) Do you know whether any consideration was given to the location of the sewage works?

A. Because I was not working in Scotland when the site was being selected, I am unaware whether any consideration was given to the location of the sewage works.

Procurement

4. Describe the funding PFI changes, your involvement, why the changes were made, who signed off on the changes and what the escalation process was in respect of the Board authorising these changes.

A. I do not recall the detail about the PFI changes. I do recall, at high level, that there was considerable focus on affordability and deliverability of the New Hospitals and Laboratory project. On reviewing the July 2007 NHSGGC Board Minutes, (**Bundle 37, Document No.27, Page 351**) I note that the then Board Director of Finance 'updated members on the discussions which had been held with the NHS Scotland Director General Health & Chief Executive and Director of Finance on the affordability issues and possible financial models in relation to the new South-side Hospital and Children's Hospital'. 'It was recognised that a flexible partnership approach to funding would be required. The outcome of the National Resource Allocation Committee's review and the Public Expenditure Survey would have an impact on the affordability and financial models for a project of this size'.

In September 2008, I have reviewed a paper which was submitted by me in my capacity as DASSIP to the Performance Review Group (a standing Committee of the Board) entitled Procurement Strategy to develop the Southern General Hospital Site – New Adult and Children's Hospitals and new Laboratory facility, (**Bundle 17, Document No.35, Page 1811)** which set out the detailed work that had been undertaken in developing the procurement model. The paper stated that 'The Project Team, supported by advisers (legal and financial) and other Board Officers, have carried out a robust process to develop, what is proposed as, the most appropriate delivery vehicle for the construction of a New Adult Hospital, New Children's Hospital and Laboratory

Facility on the Southern General Hospital Campus. The New South Glasgow Hospital Executive Board recommend that, subject to a final review by newly appointed Technical Advisers and PUK, the most appropriate method to procure and deliver the New Southern General Development is to implement the method set out in the Market Sounding Report. In other words, during stage one of the procurement process rapidly select down to one preferred bidder. This will be carried out using the Competitive Dialogue procedure. In stage two the preferred bidder is contracted to design the facilities and provide the Board with a Guaranteed Maximum Price' It was proposed that the method set out in the Market Sounding Report be discussed and tested with the new Technical Advisers and PUK in the following weeks, following which it would return to the Board with the final procurement methodology for approval. The recommendation for the Procurement Model (supported by the Board's Legal, Financial, Technical and Procurement Advisers) was formally submitted to, and approved by, the NHSGGC Board in October 2008.

a) Was the way the building was to be maintained and the resource level for the estates team considered at the time of the change of funding mechanism from PPP to conventional procurement.

A. In reviewing various papers to PRG and Board from 2007 to 2009 (as set out in my answer 4 A above) (**Bundle 37, Document No.35, Page 473**) affordability was a key component in consideration of the procurement model. Specifically relating to the paper to PRG in November 2009 (**Bundle 17, Document No.65, Page 2660**), section 5 sets out a section on affordability including capital and revenue affordability, On page 2669, reference is made to the Board's continued work on the development of further cost savings schemes within the context of its annual financial planning process aiming to generate a further £12m of cost savings over a 4 year period. 'This will be ring fenced, along with savings from the Acute specific cost savings schemes as these are released to secure the funding sources required to meet the operating costs of the new hospitals'. Although the estates team is not

specifically mentioned, estates finance colleagues will have been also involved in the financial discussions.

5. Were the risks and the resource implications of changing the procurement model from PFI to traditional (design and build) adequately assessed, in particular:

(i) the impact on commissioning.

(ii) the impact on independent validation; and

(iii) ensuring sufficient resources to manage and maintain the hospital post-handover?

A. I recall, at high level, that a significant amount of work was undertaken in relation to the procurement model. As stated above, papers in my role as DASSIP were submitted to the Performance Review Group in September 2008 and the NHSGGC Board in October 2008 (**Bundle 37, Document No.35, Page 473**) where the decision was approved to proceed with the proposed Procurement Model. The robustness of the model was tested at numerous points including in the Gateway 2 review which was undertaken in January 2009 (see answer to question 6 below). I do not recall specific risk assessments in relation to the impact on commissioning, the impact on independent validation, nor on ensuring sufficient resources to manage and maintain the hospital post-handover. However, reviewing the paper submitted to PRG in November 2009 (**Bundle 17, Document No.65, Page 2660**), I note that section 5 focuses on capital and revenue affordability and the plans to ensure overall affordability.

a) Was an explanation given as to why this could not be any kind of PFI project? What was the rational given for this decision at any meetings you attended? Why did it require to be publicly funded?

A. If an explanation was given as to: why this could not be any kind of PFI project; the rationale given for this decision; and why it required to be publicly funded, I do not recall the detail. These discussions would have been led by the Board's Director of Finance together with key finance colleagues across the acute sector and estates teams, and as noted in my answer to question 4 A (in

reviewing the paper submitted to Board in July 2007) (**Bundle 34, Document 6, Page 52**) 'the then Board Director of Finance 'updated members on the discussions which had been held with the NHS Scotland Director General Health & Chief Executive and Director of Finance on the affordability issues and possible financial models in relation to the new South-side Hospital and Children's Hospital'. 'It was recognised that a flexible partnership approach to funding would be required. The outcome of the National Resource Allocation Committee's review and the Public Expenditure Survey would have an impact on the affordability and financial models for a project of this size'.

6. Describe the Gateway Review process and your involvement in it, if any,

A. In terms of the Gateway Review Process, I have reviewed the paper submitted to Board in February 2008, in my role as DASSIP, entitled New Southside Hospital, New Children's Hospital and New Laboratory Build – Approval of the Outline Business Case, (**Bundle 37, Document 32, Page 413**) and note that it set out 'The New South Glasgow Hospitals project is subject to Office of Government and Commerce (OGC) Gateway Review. Projects which are commission critical or deemed to be high risk projects are required to go through the six stages the OGC Gateway Review Process. The review is an independent assessment of the robustness of the business case, that it meets business needs, is affordable, achievable with appropriate options explored and likely to achieve value for money. In doing this the review outcome highlights whether aspects of the project are red, amber or green (traffic light system).

I was involved at high level in Gateways 1 and 2. The Project Director and team, with support from advisers completed the detailed work. I have reviewed the paper that went to Board in February 2008 and note that it sets out the outcome of Gateway 1. 'The Southern General development has completed the Gateway Review Stage 1 which was carried out from 8th to 10th of January 2008. The review was carried out by a review team consisting of 2 Office of Government and Commerce Consultants and two senior

technical NHS Scotland managers. During the three days of the review interviews were undertaken with 18 members of staff including clinicians, senior managers, project team, staff side representatives and finance colleagues'. Many positives were identified including that the business case was robust, likely to be affordable, achievable, with the appropriate options explored, and likely to achieve value for money. The Project team was well established; there was good communication with Clinicians, Staff side, the Scottish Government and Community Health Care Partnerships (CHCPs) and a strong focus on community engagement. The Gateway Review resulted in five ambers (areas requiring more detail and information before the next Gateway Review) and one green light. It was regarded as positive that there were no reds (areas which would have required immediate action).

I have reviewed the February 2009 Board paper, entitled New Southside Hospital, New Children's Hospital and New Laboratory Build – Approval of the Outline Business Case (**Bundle 37, Document 32, Page 413**) and note that I updated the Board on Gateway review 2, again, the detailed work for which had been completed by the Project Team, supported by the Board's advisers. The review investigated the assumptions in the Outline Business Case (OBC) and proposed the approach for delivery of the project including details of the sourcing options, proposed procurement route, supporting information and project methodology and also checked that plans for implementation were in place. The review was carried out on 27th to 29th January 2009.

The Review Team found that the project has made significant progress since the first Gateway Review in January 2008. The key managers across the project all had a very detailed understanding of all areas of the project which reflected both the quality and level of communication and the Board's approach to accountable officer responsibilities, which had led to the involvement of key players in a large number of project boards and groups. It concluded that the project had taken a very robust approach to the

identification of a suitable procurement route, seeking input from advisers and the marketplace.

The prudent financial planning in the OBC means that the project was as well-positioned as possible to manage the uncertainties of the current economic climate. The public support of the Scottish Government in approving the OBC was expected to bring increased confidence to the market. The overall rating of the review was amber based on the single amber rating namely that the project should develop a more detailed benefits management plan. All other areas were classed as green.
I had no further involvement in the Gateway Review process as I left NHSGGC in February 2010.

a) The Inquiry understands that Gateway Review 2 was carried out between 27 and 29 January 2009 and issued to you as Senior Responsible Owner on 29 January 2009. What did it mean for you to be Senior Responsible Owner, when were you appointed to that role and what were your duties and responsibilities?

A. As Senior Responsible Officer (SRO) in the role as DASSIP, I was the person responsible for ensuring progress on delivery of Phase 2 of the Acute Services Strategy (as I set out in my answer to question 1). I was responsible for ensuring the project met its objectives and that key deadlines and timescales were met and for keeping PRG and Board updated and that key decisions were made as appropriate by PRG and Board. In my role as DASSIP, I was responsible not only for the NSGH project but also interrelating programmes including (but not exclusively): health inequalities; community transport and patient engagement; acute services planning; and ensuring, where appropriate, the interface with the NSGH project. Specifically in relation to Gateway 2, I was responsible for ensuring the Board understood the outcome of the Gateway review (this paper was presented to Board in February 2009, see answer of question 6 A above) and for assuring PRG and Board that the amber rating (see my response to question to 6A above) would

be addressed and necessary action taken to ensure it became green. This detailed work was led by the Project Director and Team.

Employer's Requirements

7. Describe your involvement, if any, in the preparation of the Employer's Requirements (ERs).

A. I had no direct involvement in the preparation of the Employer's Requirements. This work was led by the Project Director, who reported to me, and the NHSGGC Project Team, with support from the advisers working with the Project team.

a) What was reported to you by the Project Director regarding the Employer`s Requirements? What actions' (if any) did you take?

A. I do not recall the detail reported to me by the Project Director. My role was to ensure the ASR Programme Board, the Performance Review Group and the Board of NHSGGC were kept updated on progress including on the development of the Employers Requirements (ERs) and that decisions as appropriate were made. From memory, the Project Director, as the subject matter expert and lead for developing the ERs had an input into all papers and indeed was involved in many meetings where he had a lead role in presenting the papers. During the period 2007 – 2009, a significant number of papers, as referenced throughout my response, were submitted to the Performance Review Group and Board setting out the work underway.

b) Who was responsible for providing the requirements for the Clinical Output Specifications and who approved the COS for inclusion in the ERs?

A. This work was led by the Project Director and his team including the Board's advisers involved in the project, who worked with clinicians across the various clinical specialties that would be based in the new hospital. I cannot recall who approved the COS for inclusion in the ERs.

c) Who was responsible for confirming what the relevant NHS Guidance was for the project

A. I cannot recall who was responsible for confirming what the relevant NHS guidance was for the project.

d) It appears that the employer's requirements in the tender documentation for the ventilation system included a requirement to comply with SHMT 03-01. Were you aware of this and what impact did you understand such a requirement to have on the ventilation standards in terms of air change rates, pressure differentials and the presence of HEPA filtration in (a) general wards, (b) the proposed new Schiehallion Unit and (c) the planned isolation rooms?

A. I do not recall that I was aware the employer's requirements in the tender documentation for the ventilation system included a requirement to comply with SHTM 03-01. In terms of understanding the impact such a requirement to have on the ventilation standards in terms of air change rates, this was and is an area entirely out with my level of expertise and knowledge. I would not have understood the pressure differentials and the presence of HEPA filtration in (a) general wards, (b) the proposed new Schiehallion Unit and (c) the planned isolation rooms and would have needed the advice of relevant experts and advisers, had I been in Glasgow when such decisions were being made.

e) How did sustainability and energy targets impact on the design

A. I am aware that section 6.9 of the OBC focuses on sustainability and energy conservation and sets out at high level sustainability and energy targets and the impact on the design. However, I do not recall the impact on the design and I do not recall having any involvement in this work.

f) Describe your involvement and understanding, if any, in the removal of the maximum temperature variant? **(Bundle 17, Document No.26, Page 1063)** Why was the decision taken and by whom? What risk assessments, if any, were taken prior to making this decision? What was the impact, if any, in removing the maximum temperature variant?

A. I have no recollection of any involvement in, nor understanding of, the removal of the maximum temperature variant. I cannot recall why the decision was made nor by whom it was made. I would not have made that decision as this was an area about which I had no knowledge, nor understanding of impact. I cannot recall if any risk assessments were undertaken. I do not know the impact, if any, of removing the temperature variant.

g) Describe your involvement and understanding, if any, in the decision to use chilled beams. Why was the decision taken and by whom? What risk assessments, if any, were taken prior to making this decision? What was the impact, if any, in using chilled beams?

A. I do not recall any involvement in, nor understanding of the decision to use chilled beams. I do not know why the decision was made nor by whom. I would not make a decision on a subject about which I had no knowledge nor understanding of impact. I cannot recall whether risk assessments were undertaken prior to making the decision. I do not know the impact, if any, in using chilled beams.

h) Who provided the specification for environmental data relating to air change rates, pressure differentials and filter requirements

A. I cannot recall who provided the specification for environmental data relating to air change rates, pressure differentials and filter requirements.

i) Who was responsible for HAI-SCRIBE assessment regarding the proposed site development, design and planning and new construction?

A. I cannot recall who was responsible for the HAI-SCRIBE assessment regarding the site development, design and planning and new construction.

Tender and appointment of Main Contractor

8. Describe your involvement, if any, in respect of the appointment of Currie and Brown as technical advisors. Confirming the selection process, why they were selected, setting out their role and responsibilities.

A. As DASSIP, in reviewing papers to PRG, I note that I submitted a paper entitled Appointment of Technical Advisers for the New South Glasgow Hospitals Project (**Bundle 34, Document 16, Page 120**) to PRG in August 2008 requesting that PRG note that the process to appoint a new Technical Adviser team for the procurement of the New South Glasgow Hospitals Project was now complete and that the successful team was led by Currie & Brown Ltd. Currie and Brown were formally appointed on 2nd September 2008.

In reviewing the August 2008 PRG paper, I note that the process had two stages. The first stage, pre-qualification, invited teams expressing an interest to demonstrate their legal, financial and technical credentials to undertake the work. From the nine teams returning pre-qualification documentation, four were rejected and five were short-listed to proceed to the next stage. The second stage required the five teams to prepare a detailed financial response to the Board's Invitation to Tender document, which was based on the proposed contract strategy arising from the market sounding exercise. Five bids were received on the 6th August. These bids were evaluated against the criteria in the Invitation to Tender document. The Board had stated in their tender document the intention to short-list three teams to proceed to interview, and the interviews took place on Monday 18th August.

Although I do not recall the detail, the PRG paper states that the membership of the interview panel, chaired by the Director of Acute Services Strategy Implementation and Planning, comprised senior Board representatives representing the Project, Clinical, Estates and Facilities and Finance colleagues, and a representative from Architecture + Design Scotland. Each of the three teams was afforded a one hour slot to present their team, their

proposed methodology, and answer questions prepared by the panel. At the conclusion of the interviews, the panel discussed the presentations and undertook an evaluation of their overall performance and financial submission. At the conclusion of this exercise scores were allocated to the three teams.

The team scoring the highest marks and thus providing the most economically advantageous offer was the team led by Currie & Brown. The evaluation panel concluded that the Currie & Brown team should be appointed as preferred bidder pending the ten day mandatory standstill period (required by Public Contracts (Scotland) Regulations), the ten day period being allowed should there be any legal challenge to the process by an unsuccessful candidate. The 10 day period elapsed on 1st September 2008 and Currie and Brown were formally appointed on 2nd September 2008.

9. Describe your involvement, if any, in respect of the selection process whereby Multiplex were selected as the preferred bidder.

A. I had no involvement in the detailed selection process whereby Multiplex were selected as the preferred bidder. In reviewing the November 2009 PRG paper, provided by the Inquiry Team, entitled Approval of the New South Glasgow Hospitals and Laboratory project, (**Bundle 17, Document 65, Page 2660)** I note that in section 2, the quality evaluation process followed to select the preferred bidder is set out. The appendices A-E set out the detail underpinning the evaluation process with Appendix E setting out the Board and Advisors' membership of the 4 groups (design, logistics, labs and commercial) who undertook the detailed evaluation.

The conclusions of the Evaluation Group were presented to the New South Glasgow Hospitals & Laboratories Project Executive Board Seminar on Thursday 22 October 2009, which, although I do not recall the meeting, I believe I chaired. This meeting included the attendance and involvement of the NHSGGC Board's Chair, Vice Chair and Non-Executive Member of the NHS Board. With the comments from the seminar on 22nd October incorporated; on 26 October 2009, the Project Executive Board considered

the proposal. The meeting formally endorsed the outcome and recommended that it be submitted to PRG for approval, on 3rd November 2009.

a) Question for witness; Given your position, can you explain why you were not involved in the detailed selection process whereby Multiplex were selected as the preferred bidder.

A. It was not appropriate in my leadership role as DASSIP to be involved in the detailed selection process. I had not been involved in the detailed work in developing the tender documentation that went to the potential bidders following the pre-qualifying questionnaire process. This was led by the Project Director and his team, supported by the technical, legal and other advisers. Given the level of detailed (including highly technical) information required from the potential bidders and the level of detailed knowledge, experience and skills required to evaluate the submissions, it was not appropriate that colleagues, who were not involved in the development of that detailed work (over many years), be part of the evaluation process. This included me. In my leadership role as DASSIP, I was responsible for ensuring the conclusions of the Evaluation Group were presented to the appropriate Boards and Committees. As stated in 9 b) A below, 'The conclusions of the Evaluation Group were submitted to the New South Glasgow Hospitals & Laboratories Project Executive Board Seminar on Thursday 22 October 2009, which included the attendance and involvement of the Chair, Vice Chair and Non-Executive Member of the NHSGGC Board. With the comments from the seminar on 22nd October incorporated; on 26 October 2009, the Project Executive Board considered the proposal. The meeting formally endorsed the outcome and recommended that it be submitted to PRG for approval'. PRG gave approval to the preferred bidder at the PRG meeting in November 2009.

b) Why were Multiplex awarded the contract following the competitive dialogue process? What distinguished Multiplex from the other bidders to make them the preferred bidder? Include details of the tender process and explain how Multiplex engaged and became distinguished as the preferred bidder.

A. The detailed process to appoint Multiplex is set out in the November 2009 PRG paper, which I reviewed and note the following. In summary, the notification of the Project was placed in the European Journal in February 2009. Five potential bidders participated in the pre-qualifying questionnaire process, from which 3 were shortlisted to the next stage of the project, Multiplex being one of the 3. The tender documentation, which had been developed by the Project Team and Technical advisers who had worked with users, legal and financial advisers and others between September 2008 and April 2009, informed bidders of the Board's requirements. This documentation constituted 3 volumes: 1. Project Scope and Commercial document; 2. Employer's requirements; and 3. Bid return and evaluation.

The documentation was issued electronically to the bidders on 01 May 2009 stipulating that bids were to be returned by noon on Friday 11 September 2009, following the competitive dialogue process. Competitive Dialogue commenced on 11th May 2009. This involved a series of 16 scheduled meetings with each of the three bidders to discuss and clarify the Board's requirements in four main areas of the project: i) Design; ii) Site Logistics; iii) Laboratories; iv) Commercial. Four corresponding Groups were formed to represent the key areas with members from a range of stakeholders and advisers including Board Representatives, Medical, Nursing, FM and infection control representatives and Technical, Legal & Financial Advisers (appendix E sets out the Board and Advisors' membership of the 4 groups. The bidders were represented from their own internal teams and their associated partners. As part of the dialogue process the bidders formulated the agenda items based on their need to clarify any aspects regarding the tender documentation/project.

The agenda items were discussed and subsequently action/query lists were drawn up and responded to within agreed timescales. A Request for Information (RfI) process was also operated whereby bidders sent questions for clarification to the Board. The Competitive Dialogue concluded on 14 August 2009 following a bidder presentation and final feedback and direction from the Board. Three bids were received on 11 September 2009 and following formal receipt and recording, were initially checked for completeness.

To ensure that the Evaluation Team complied fully with due process, training workshops for the evaluators were held in advance of the tender return date. An Evaluation Centre was established at Gartnavel Royal Hospital, providing a secure base from which to manage and undertake the process. All members of the Design and Logistics groups co-located to this Centre for the full 5 week duration, thus ensuring interaction between individuals and Groups was possible at all times. A detailed evaluation programme was produced for the Team in advance, setting out the key actions and dates for the Groups. Areas covered by the evaluation, as set out, were: i) Design; ii) Logistic; iii) Commercial. The outputs of the Design and Logistics sub-groups were reviewed, for consistency of approach, scoring and reasoning, by Senior Managers in the first instance and then by the Commercial Group. The tender prices submitted were first assessed for errors, inconsistencies, exclusions and caveats, then equalised to adjust for bid allowances and missing items. The outturn adjusted bid prices reflecting the estimated target were then calculated.

The Most Economically Advantageous Tender (MEAT) scores , calculated as a ratio of quality and price were then generated using the full quality score and the adjusted bid prices, with a higher score representing better Value for Money. As stated above, the conclusions of the Evaluation Group were presented to the New South Glasgow Hospitals & Laboratories Project Executive Board Seminar on Thursday 22 October 2009, which included the attendance and involvement of the Chair, Vice Chair and Non-Executive

Member of the NHSGGC Board. With the comments from the seminar on 22nd October incorporated, on 26 October 2009 the Project Executive Board considered the proposal. The meeting formally endorsed the outcome and recommended that it be submitted to PRG for approval. PRG gave approval to the preferred bidder at the PRG meeting in November 2009.

c) Describe the scoring for value for money within the tender process, including your role, if any. How did Multiplex score relative to other bidders?

A. I had no involvement in the scoring for value for money. In reviewing the papers provided by the Inquiry, I note the November 2009 PRG paper, section 3, sets out the following: Financial Evaluation. The requirement to select the successful bidder on the basis of the Most Economically Advantageous Tender (MEAT), required the Board to consider the financial aspects of the bidders proposals. MEAT has been defined in this process, and discussed with bidders, as the offer that provides the greatest ratio of quality points for each pound of price. The pricing structure which bidders were required to follow was set out in the NEC 3 suite of documentation was an industry standard form of contract familiar to all bidders. The key elements of the financial evaluation were • The target and maximum price offered by bidders, and in particular the affordability • The bidders proposals for sharing both cost under and over spends (Pain/Gain) • The risks identified by bidders that may impact upon the final price paid. The evaluation methodology also required the consideration of risks retained by NHSGGC.

In summary the financial analysis found that • All the bids received were within the affordability limits set by NHSGGC • That only one bidder offered the opportunity of less than 50/50 sharing of costs overruns reflecting their confidence in their pricing • That the bids submitted by bidders 1 and 3 offered a high degree of certainty around pricing when risks were statistically assessed. Bidder 2 however, as the result of its consideration of a fewer, larger risks, offered a less certain price outcome. Based upon the statistical

analysis there is realistically no prospect of price outturns occurring that would change the order of preference for bidders proposals.

In terms of the MEAT Scores, they were as follows: Bidder 1: 417.2 Bidder 2: 369.6 Bidder 3: 377. Following consideration at the Project Executive Group in October 2009, as set out above, PRG was asked to approve the appointment of preferred Bidder 1 (Brookfield Construction (UK) Ltd (also referred to as Multiplex))

d) How did compliance with ER`s and guidance such as SHTM`s factor into the evaluation?

A. I was not involved in the evaluation and, therefore, am unable to comment on how compliance with ER's and guidance such as SHTM's was factored into the evaluation.

e) When did you first became aware that Brookfield could not achieve six air changes per hour in the wards of the hospital?

A. I have no recollection of being aware that Brookfield could not achieve the air changes in the wards in the hospital. This may have been a timing issue as I left in February 2010 and was not further involved in discussions about what could be achieved.

Ventilation Derogation

10. Explain your understanding of the ventilation design strategy contained in the Contractor's Tender Return Submission (11 September 2009) (**Bundle 18, Volume 1, Document 8, Page 205**). Was the ventilation system to be a mixed mode ventilation system (dependent on a non-sealed building) or a mechanical ventilation system (dependent on a sealed building)?

A. I have no understanding of the ventilation design strategy contained in the Contractor's Tender Return Submission. I have no recollection of this document.

11. Was the design and/or specification of the ventilation system as recorded in the Building Contract, in particular in the M&E Clarification Log **(Bundle 16, Document No. 23, Page 1664-5**) compliant with NHS Guidance?

A. I am unable to answer this question as it is out with my area of expertise.
If not, please explain:

(i) Why this design was proposed;

(ii) Why this design was accepted; and

(iii) What role, if any, BREEAM played in the acceptance of this design.

A. I have no recollection as to (i) why this design was proposed; (ii) why this design was accepted; and (iii) what role, if any, BREEAM played in the acceptance of this design.

a) If you are of the view that it was compliant, please explain why, with particular reference to SHTM 03-01 2009 (Ventilation Design) (**Bundle 16, Document No. 5, Page 342**)

A. I do not have sufficient knowledge nor expertise on this subject to have a view about compliance.

12. The Inquiry is aware of the agreed ventilation derogation recorded in the M&E Clarification Log. (**Bundle 16, Document No. 23, Page 1664-5)**

a) What was the scope of the agreed ventilation derogation recorded in the M&E Clarification Log?

A. I have no recollection of the scope of the derogation.

b) When did you first become aware of it and how?

A. I have no recollection of being made aware of the derogation although I note in question 12.g it is stated that 'Currie and Brown [in their response to PPP13] said that the GGC Project Team had advised me (Helen Byrne) of the Agreed Ventilation Derogation, alongside Alex McIntyre (Director of Facilities) & Peter Gallagher (Director of Finance).

c) The Inquiry understands that Alan Seabourne briefed you on the Ventilation Derogation and its importance. Please confirm your position.

A. Although it is stated that Alan Seabourne briefed me on the Ventilation Derogation and its importance, I have seen no record that Alan Seabourne briefed me about the Ventilation Derogation and its importance nor on any subsequent discussions. I have no recollection that Alan Seabourne briefed me. Therefore I am unable to confirm my position. If there is any documentation, it may assist me with answering the question more fully.

d) Was the agreed ventilation derogation restricted to general wards only?

A. I have no recollection of which areas in which the derogation would be applied.

e) If so, how is this interpretation evidenced within the documentation (such as the M&E Clarification Log) and where is the specification located for areas that required specialist ventilation and isolation rooms?

A. I do not recollect how this interpretation was evidenced within the documentation nor where the specification is located for areas that required specialist isolation and ventilation rooms.

f) Who else from the GGC project Team and Board were aware of the Ventilation derogation?

A. I do not recall who from the GGC Project Team and Board were aware of the ventilation derogation.

g) What action, if any, did you take to escalate your knowledge of the derogation to the Board? If you did not take any action, why not?

A. I have no recollection of taking any action to escalate knowledge of the derogation to the Board.

h) How was the agreed ventilation derogation signed off by the Board? The Inquiry understands from the response from Currie and Brown to PPP13 that the GGC Project Team had advised you of the Agreed Ventilation Derogation, alongside Alex McIntyre (Director of Facilities) & Peter Gallagher (Director of Finance). Please confirm your position. Please also confirm how this was discussed with the Board having regard to the paper you drafted alongside Alan Seabourne; Drafted Acute Services Review paper in 2010 which stated the Acute Services Strategy Board will “Approve change control in that any change which impacts upon the project must be authorised by this Board before it can be implemented”.

A. I have no recollection of being advised of the derogation.

I have reviewed the paper Acute Services Review Proposed Governance Arrangements (**Bundle 30, Document No.6, Pages 36–50**) and note that this paper contained the revised Terms of Reference for the proposed new bi-monthly Acute Services Strategy Board which included the proposal to

"Approve change control in that any change which impacts upon the project must be authorised by this Board before it can be implemented". This paper was submitted to the ASR Programme Board for approval on 19th February 2010. I have also reviewed the minutes of that meeting **(ASR Programme Board Meeting, held on 19th February 2010 - in Bundle 30, Document 11, Pages 69 -71)** and note that this was my last meeting (page 71) before I left NHSGGC to return to the NHS in London. Therefore, I had no further part in discussions relating to the new hospitals.

13. When did you first become aware of the ZBP Ventilation Strategy Paper dated on or around 15 December 2009? (**Bundle 16, Document No.21, Page 1657**)

A. I have no recollection of becoming aware of the ZBP ventilation strategy paper.

a) As director of Acute Service Strategy, who should have informed you of the existence of the ZBP Ventilation Strategy Paper?

A. If that had been the correct action to take, then I believe, it should have been the Project Director. I note in email chains submitted to the Inquiry **(Bundle 17, Document No.72, Page 2861 – R Ballingall, M Baird and S McKechnie - NHS Ward Ventilation Strategy Air changes, 15-16 December 2009 and Document No.73, Page 2869 – Email from M Baird to S McKechnie NSGH air changes 16 December 2009**) that issues relating to ventilation were being discussed by the Technical Advisers, so it is possible timing was an issue. As DASSIP, I was not involved in detailed discussions / decisions (certainly in relation to issues about which I had little or no knowledge) and I left the Board in mid-February 2010.

b) What action, if any, did you take when you became aware of this document and why? If you did not take any action please explain why not.

A. I do not recall seeing the ZBP ventilation strategy paper and do not recall any actions taken.

c) What concerns if any did you have on reading this document?

A. I do not recall reading the ZBP ventilation strategy paper.

14. What risk assessments (if any), whether in compliance with the standards in HAI Scribe or otherwise, did GGC carry out or have carried out in respect of the change in the ventilation strategy that appears to follow the ZBP Ventilation Strategy Paper dated 15 December 2009? (**Bundle 16, Document No.21, Page 1657**)

A. I cannot recollect what risk assessments (if any) were undertaken in respect of the change in the ventilation strategy that appears to follow the ZBP ventilation strategy paper dated 15 December 2009.

15. Was the Ventilation Derogation recorded in the Full Business Case? Who was responsible for doing this? If not, why not? If you were aware that it had not been recorded in the Full Business Case please explain what action, if any, you took.

A. I left NHSGGC in February 2010 and was not involved in the Full Business Case development.

a) Did you attend a meeting at NHS GGC Project Team Hillington office on or around 16 December 2009 which was attended by Mr Baird of Currie & Brown and Stewart McKechnie of Wallace Whittle? If so, please describe what was discussed, what the outcome of the meeting was and what action was taken in response to the meeting.

A. I do not believe I was at this meeting. I note in an email chain submitted to the Inquiry (**Bundle 17, Document No.72, Page 2861 – R Ballingall, M Baird and S McKechnie - NHS Ward Ventilation Strategy Air Changes, 15-16 December 2009**), that this references a meeting on 16th December.

I was not included in the email chain. Given the highly technical issues to be discussed in that meeting as set out in the email chain, in my view, it would not have been appropriate for me, as DASSIP, to have been invited to that meeting, nor do I believe I was invited nor that I attended.

Design and Construction and Role in the QEUH/RHC Project

16. When did you first become involved in the design of QEUH/RHC. Please describe your role and responsibilities.

A. I have described in my answers to the questions above, my role and responsibilities in relation to the New Hospitals. I had a leadership role, ensuring progress in relation to the project and that key objectives, requirements and milestones were met. I was not involved in the detailed work associated with the Project nor in the design of the QEUH/ RHC. Board colleagues with relevant skills, knowledge and experience, with support from Advisers, in relevant areas, led on aspects of the detailed work. The detailed design (stage 2 of the contract) occurred after I had left NHS Greater Glasgow and Clyde.

17. The Inquiry understands that you were **Director of Acute Services Strategy Planning and Implementation**. Describe in detail this role, including dates of appointment and when you left this role and why.

A. Please see the response to Question 1 as to my role. I commenced in role in January 2006 and left in February 2010, taking a period of leave before I commenced in my new role as Deputy Chief Executive in Croydon Primary Care Trust, in London. I believed this new post was an excellent next step in my career. I wanted to return to the NHS in England in which I had spent almost all my career

18. Explain how the Clinical Output Specification (COS) for the design of the Wards was confirmed and signed off. In doing so describe the purpose of the clinical output specification, and your involvement.

A. In relation to the work that was completed on the COS for the design of the wards, before I left NHSGGC, I do not recall how these were confirmed and signed off nor that I had any involvement. In terms of the purpose of the COS, my view is that this would have to been to set out construction and design requirements for clinical areas.

19. Explain the purpose of the guidance relied upon by the design team and why this was important.

A. In my view, the guidance relied upon by the design team will have been to assist in decision making regarding the design and construction of the hospitals and laboratory building, setting out obligations and ensuring safety.

20. The Inquiry understands that designs and Room Data Sheets (RDS) were approved through the Reviewable Design Data (RDD) process. Describe your role, if any, in the RDD process and User Groups.

A. I do not recall any involvement in this process.

a) How were members selected to be part of a user group?

A. I do not recall how members were selected to be part of a user group.

b) Confirm who attended the user groups meetings from IPC, Estates, Clinical and the GGC Project Team for the following areas: Ward 4B – QEUH; Ward 4C – QEUH; Level 5 – QEUH; Critical Care – QEUH; Ward 2A & 2B – RHC; PICU RHC – RHC; All Isolation rooms

A. This level of detail was developed after I left NHS GGC in February 2010 and I was not involved.

c) What steps, if any, were taken to ensure that an appropriately qualified source of IPC advice was an integral part of the Project Team?

A. Before I left NHSGGC in February 2010, I do not recall if IPC colleagues were an integral part of the Project team although I note in the November 2009 Paper to PRG that IPC colleagues were involved in the preferred bidder selection process.

d) How often were user group meetings scheduled to review design proposals and agree the design with the user groups

A. I left NHSGGC in February 2010 and do not have this information.

e) How often were user groups scheduled before you left in February 2010. What was the outcome/ recommendations following these group meetings?

A. I have seen no record of how often the user groups were scheduled before I left in February 2010 nor have I seen any record of the outcomes / recommendations following these group meetings. The detailed design work occurred after I left the Board in February 2010, as part of the next step, Stage 2, in the new hospitals project.

f) How were designs and the RDS approved to proceed to construction.

A. I left NHSGGC in February 2010 and was not involved.

g) Describe your involvement in the design and RDD process for the Scheihallion unit, PPVL and BMT rooms and PICU in the RHC

A. I left NHSGGC in February 2010 and was not involved.

h) Describe your involvement in the design and RDD process for the spaces to house immunocompromised patients, Ward 4C, BMT Unit, Infectious Diseases and the Critical Care Unit in the QUEH.

A. I left NHSGGC in February 2010 and was not involved.

i) Describe your involvement in the design and RDD process for Isolation rooms.

A. I left NHSGGC in February 2010 and was not involved

21. Please describe how the technical requirements (air change rates, pressure differentials and filter requirements) for the rooms were managed and approved, including your role and involvement.

A. I left NHSGGC in February 2010 and was not involved.

22. What guidance was considered in the design of wards to accommodate immunosuppressed patients, what processes were in place to ensure guidance compliance? Were there any changes to the design during the design and build, if so, please describe any such changes, describe the impact, if any, on guidance compliance, and described the sign off process for any such changes, your involvement and how any changes were communicated to the Board. Was external advance ever sought in respect of design changes?

A. I left NHSGGC in February 2010 and was not involved.

23. Who was responsible for confirming filtration and HEPA requirements and who approved this from the GGC Project Team?

A. I left NHSGGC in February 2010 and do not know who was responsible

24. In respect of any detonations/ departures from guidance which senior IPC individual was responsible for signing this off?

A. I left NHSGGC in February 2010 and do not know who was responsible from IPC in signing off any detonations / departures from guidance.

25. Describe your involvement and understanding, if any, of the decision to remove carbon filers? What was the rationale behind this decision, who was involved and what advice, if any, was sought in reaching this decision?

A. I left NHSGGC in February 2010 and did not have any involvement in or understanding of the decision to remove carbon filters

Bone Marrow Transplant Unit (BMT) and Ward 4C

26. The Inquiry is aware the BMT service was to transfer from the Beatson to the QEUH as noted in the meeting minutes from the Quality and Performance Committee dated 2 July 2013 (**Bundle 43, Volume 6, Document No. 45, Page 931**). This was confirmed in a change order request, issued by Jonathan Best in July 2013 (**Bundle 16, Document No.29, Page 1699**). What was your understanding and involvement, if any, in respect of the following:

a) Risk assessments/ HAI Scribes carried out prior to the change order request?

A. I left NHSGGC in February 2010 and do not know who was responsible

b) Confirmation of technical and environmental requirements (in particular air change rates, pressure regimes and HEPA and air permeability requirements) to accommodate the BMT Unit at QEUH/RHC?

A. I left NHSGGC in February 2010 and did not have any involvement.

c) Attendance and involvement in any design review meetings were held to confirm with the user groups to confirm the requirements for the BMT Unit.

A. I left NHSGGC in February 2010 and did not have any involvement.

d) Discussion with Multiplex regarding the proposed change order and the impact on Air Change Rates and Pressure Differentials?

A. I left NHSGGC in February 2010 and did not have any involvement.

e) Involvement with Infection Prevention and Control in respect of the proposed change order?

A. I left NHSGGC in February 2010 and did not have any involvement.

f) What ceiling types were specified and approved for use in Ward 4B? Who from the GGC Project Team approved this? Describe your involvement, if any? What was the impact, if any, of the choice of ceiling tiles? What concerns, if any did you have regarding the choice of ceiling tiles?

A. I left NHSGGC in February 2010 and did not have any involvement.

g) What concerns, if any, did you have regarding the final design specification of Ward 4B, and what action, if any, did you take in respect of these concerns?

A. I left NHSGGC in February 2010 and did not have any involvement.

27. The Inquiry is aware that the change order not only confirmed that the Bone Marrow Transplant (BMT) service would transfer to Ward 4B in the QEUH but also that the haematology patients that were originally planned to accommodate Ward 4B would move to Ward 4C.

a) Describe how this change was communicated to the project team and Multiplex and how this change was captured in the design and specification documentation.

A. I left NHSGGC in February 2010 and did not have any involvement.

Ward 2A

28. The Inquiry understands that Ward 2A/2B is the paediatric-oncology Unit and includes the Teenage Cancer Trust and the paediatric Bone Marrow Transplant (BMT) Unit - the department is known as the Schiehallion Unit.

a) What is your understanding of the intended use and purpose of the Ward 2A/ 2B?

A. I left NHSGGC in February 2010 and did not have any involvement

b) What guidance was considered in the design of these wards?

A. I left NHSGGC in February 2010 and do not know what guidance was considered

c) What processes were in place to ensure guidance compliance?

A. I left NHSGGC in February 2010 and do not know what processes were in place.

d) Were there any changes to the design during the design and build? If so, please describe any such changes, describe the impact, if any, on guidance compliance, and described the sign off process for any such changes, your involvement and how any changes were communicated to the Board. Was external advance ever sought in respect of design changes?

A. I left NHSGGC in February 2010 and did not have any involvement

e) Describe the IPC involvement in the design of Wards 2A and 2B, who was involved and who signed off the final design and when.

A. I left NHSGGC in February 2010 and do not know who was involved.

f) What concerns, if any, did you have regarding the final design specification of Wards 2A and 2B, and what action, if any, did you take in respect of these concerns?

A. I left NHSGGC in February 2010 and did not have any involvement.

Isolation Rooms

29. Describe how was the number and location of isolation rooms agreed? Who approved the final number and locations in the QEUH and RHC?

A. I left NHSGGC in February 2010 and did not have any involvement

30. Who was responsible for producing the drawings and the specification for isolation Rooms; who approved these from the GGC Project Team?

A. I left NHSGGC in February 2010 and do not know who was responsible

31. What concerns, if any, did you have regarding isolation rooms and compliance with SHTM/HTM? What action, if any, did you take in respect of any such concerns?

A. I left NHSGGC in February 2010 and did not have any involvement

32. The Inquiry has reviewed the RDS in excel format and note there is an entry under 'Design Notes' relating to Ward 2A isolation rooms; the entry states:

WARNING NOTICE: This room is based on a theoretical design model; which has not been validated (see paragraph 1.8 of HBN 4 Supplement 1). Specialist advice should be sought on its design. The lamp repeat call from the bedroom is situated over the door outside the room.

a) Was this note entered on the RDS? If so, why and by whom?

A. I left NHSGGC in February 2010 and did not have any involvement

b) What specialist advice was sought relating to the design of these rooms?

A. I left NHSGGC in February 2010 and do not know what specialist advice was taken

c) What was the final agreed design for isolation rooms and who approved this?

A. I left NHSGGC in February 2010 and do not know what the agreed final design was nor or who was involved

33. What ceiling types were specified and approved for use in isolation rooms? Who from the GGC Project Team approved this? Describe your involvement, if any? What was the impact, if any, of the choice of ceiling tiles? What concerns, if any did you have regarding the choice of ceiling tiles?

A. I left NHSGGC in February 2010 and had no involvement

Taps

34. Describe your involvement, if any, in respect of the decision to use Horne taps.

A. I left NHSGGC in February 2010 and did not have any involvement.

a) What concerns, if any, did you have regarding the use of Horne taps?

A. I left NHSGGC in February 2010 and did not have any involvement.

b) What risk assessments were carried out in respect of the use of Horne taps?

A. I left NHSGGC in February 2010 and did not have any involvement.

c) Who was involved in, and who signed off the use of Horne taps

A. I left NHSGGC in February 2010 and did not have any involvement.

Declaration

I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

The witness was provided or made reference to the following Scottish Hospital Inquiry documents for reference when they completed their questionnaire statement.

Appendix A

A47851278 - Scottish Hospitals Inquiry - Hearing Commencing 19 August 2024 - Bundle 16 - Ventilation PPP (External Version)

A49342285 - Scottish Hospitals Inquiry - Hearing Commencing 19 August 2024 - Bundle 17 - Procurement History and Building Contract PPP (External Version)

A48235836 - Scottish Hospitals Inquiry - Hearing Commencing 19 August 2024 - Bundle 18 - Documents referred to in the expert report of Dr J.T. Walker - Volume 1 (of 2) - External Version

A51598597 - Scottish Hospitals Inquiry - Hearing Commencing 28 April 2025 - Bundle 30 - Acute Services Review Papers (External Version)

A51785179 - Scottish Hospitals Inquiry - Hearing Commencing 13 May 2025 - Bundle 34 - Performance Review Group and Quality and Performance Committee Minutes and Relevant Papers (External Version)

A51799939 - Scottish Hospitals Inquiry - Hearing Commencing 13 May 2025 - Bundle 37 - Board Minutes and Relevant Papers (External Version)

A52371801 - Scottish Hospitals Inquiry - Hearing Commencing 13 May 2025 - Bundle 42 - Volume 1 - Previously omitted meeting minutes - AICC/BICC minutes and papers (External Version)

A52862169 - Scottish Hospitals Inquiry - Hearing Commencing 13 May 2025 - Bundle 43 - Volume 6 - Procurement, Contract, Design and Construction Miscellaneous (External Version)

The witness provided the following documents to the Scottish Hospital Inquiry for reference when they completed their questionnaire statement.

Appendix B

A51854228 - Helen Byrne - 2007 Organisation Chart as referred to in questionnaire response - Glasgow 4 Hearings - 20 February 2025.