SCOTTISH HOSPITALS INQUIRY

Hearing Commencing
16 September 2025

Robert Calderwood
Wednesday, 01 October 2025

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10.03

THE CHAIR: Good morning. Now, resuming with Mr Calderwood.

MR CONNAL: Yes, my Lord.

Mr Robert Calderwood
Continued

THE CHAIR: Good morning, Mr Calderwood. Now, Mr Connal.

Questioned by Mr Connal (Cont'd)

Q Thank you, my Lord, and good morning from me also.

A Good morning.

Q I'm going to turn now to the Bone Marrow Transplant unit move from the Beatson into the new hospital. In part-- and this may be my fault because, although you deal with this in various places in your statement, I'm perhaps struggling to get them in some kind of order. So what I'm going to do is, first of all, suggest to you that – and I don't need the detail at the moment, I'm just wanting to see if you accept what I'm saying – there were a number of stages.

Obviously, the first stage is, "Should we move the Bone Marrow Transplant unit into the new hospital at all?" I'm not concerned with that stage; we've had evidence about that, we've seen papers on it, we don't need to ask about it. So, the first question is, well, what was done, as it were, to prepare the new hospital for the arrival of the unit which hadn't been originally envisaged?

The next stage happens around the time of the official opening; in other words, issues arise, and I won't go into the details at the moment. So, Stage 2 is: issues arise and the decision has to be made as to whether the unit stays in the new hospital or goes back to where it came from in the Beatson, at least for the moment. So, that's two stages.

Then there's perhaps what I might describe as the intermediate stage while attempts are made to see if things can be done of one kind or another to improve the position. Then, finally, there is the decision which happens, I think, after you left, which is ultimately whether it goes back in. Now, do you agree that these are the right stages to look at?

A Yes.

Q Thank you. Now, if we can start, then, by looking at your witness statement again at page 44 and running on to 45-- Now, on page 45 you say, "The environment in Gartnavel"-- So, that's the old Beatson, correct?

A Yes, that's-- that is the Beatson West of Scotland Centre which

was opened in 2008.

Q "The environment in Gartnavel was, what would be the right phrase? More appropriate for the patient. It had a stronger specification; 4B didn't. So, at that point, money was made available, because you referred to it later regarding the base change noticed. Money was made available to the Project team and the operational directors to bring across the environment in Gartnavel into 4B."

Now, am I right in understanding from that that the first stage was to say, in effect, "We need to see what environment these patients require"? One way of doing that is to look at what they've got in their existing location----

A Yeah.

Q -- and then try to bring that across, as it were, into the new hospital, correct?

A Correct.

Q And that's essentially what you're saying there?

A It is, yes.

Q Now, if I can just, then, diverge a moment from the witness statement, we've subsequently heard evidence, which would be after you prepared this statement, from Mr Gavin Jenkins, that he and the Haemato-oncology consultant and the ward manager all went to see the Project team on several occasions in order to explain to them what was required to accommodate their cohort of patients and what they had in the Beatson. Now, first of all, assuming that to be correct, is that what you would have expected to happen?

A Yes. Once-- Once the Board accepted that the Adult Bone Marrow Transplant unit, which is a small component of the Beatson West of Scotland service, should be co-located with acute adult facilities and, in particular, Critical Care, the Board then instructed, at the time, the regional director, Jonathan Best, to proceed with regard to affecting the inclusion of these patients in-- in the new hospital.

My expectation would have been very similar to that point you've just made, that they would meet with the Project team, they would get an understanding of what 4B was being constructed to, which we touched on last night with the employer's requirement statement that we saw, and-- and, from there, they would give advice to the Project team of what further enhancements would need to be made, and, to that extent, funds were released by the Board to the Project team to make these enhancements.

THE CHAIR: Now, just so that I'm

keeping up, Mr Calderwood, when you say, “The employer requirements that we discussed yesterday”----

A Yeah.

THE CHAIR: -- what you have in mind is the clinical outcome----

A It’s the clinical output specification that we-- we saw last evening, my Lord.

THE CHAIR: Yes, which related to not the Bone Marrow Transplant----

A No, not the Bone Marrow Transplant unit----

THE CHAIR: -- Marrow Transplant patients----

A The Haemato-oncology service.

THE CHAIR: But the then-located in the Southern General Haemato-oncology service?

A Yes.

MR CONNAL: Right. Sorry, Mr Connal.

No, the reason I’m asking about this, Mr Calderwood, is there is a gap that is not addressed in your statement, not because you’ve forgotten about it, but because it probably hasn’t arisen at the time. That is this, and I want to ask you about it. Assuming that what you expected to happen, happened – this is what Mr Jenkins tells us, and he tells us who went and who they met and so on and so forth – and assuming that he then tells them what is required, then the question is, why was what he and his colleagues conveyed to the Project team apparently not built? Do you know?

A I have no idea. In fact, I’ve not heard it expressed that the-- in that terms that there was in fact, in the spring of 2015, a suite of rooms handed over which didn’t meet the enhanced specification that we had agreed with-- with Multiplex.

Q The reason I ask is this, that the step that you envisaged, i.e. a communication from, let’s just say, the Beatson, to the Project team saying, “This is what we need, here are the details, write it down, whatever you need to do”-- You thought that’s what was happening. Now, when questions arose, when difficulties arose, however you want to put it, at the time that patients migrated into that unit, did you try to find out whether what you expected to happen had happened?

A No, not-- not until later. The-- The building and, in particular, this clinical service transferred as part of the migration across the site because the Project team and the commissioning officials said it was fit for purpose and patients moved. It first was brought to my attention that it wasn’t fit for purpose when the new hospital-based Infection Control team deemed that it wasn’t

suitable for these highly compromised patients, and, at that stage, I set about the process of trying to identify what was the deficiencies that the Infection Control team were raising. At no time, to my knowledge, did the clinicians-- the cancer clinicians ever come to me and say, “The rooms that we are in are not to the standard we asked for.” I’ve never heard that statement before.

THE CHAIR: Right. Can I really just secure that point? My understanding, and I’ll be corrected if I’m wrong, of Mr Jenkins’ evidence was that the clinicians, and indeed he as a manager of the unit, identified that what was provided at the Queen Elizabeth was not what they had made clear to the Project team, that was what they had at the Beatson and what they had told the Project team they required at the Queen Elizabeth.

Now, that’s my understanding of the evidence. I do see from your statement that your focus is on the Infection Prevention and Control clinicians, but my understanding of Mr Jenkins’ evidence is that it was the clinicians and managers from the Beatson who pretty well immediately realised that what was being provided was not what they’d asked for. Now, Mr Connal, do you share my understanding of the evidence we’ve heard?

MR CONNAL: I have no issue with that at all, my Lord. I think the reason I’m asking you this now at the start of this passage of evidence is that-- I suppose what I was trying to get at-- If it had been anticipated that there would be an information exchange, you know, you tell the Project team what to do, and this was done, we are told, as you had anticipated, I’m just trying to find out why, during all the various to-ings and fro-ings, no one seems to have raised it with you and you don’t seem to have asked about it?

A Well, I-- If we could take it in stages, in 2013, the then regional services director Jonathan Best signed the Change Control order. That was the order that we, we being the Board, through the Project team raised with Multiplex to say, “Please do these additional works at an agreed cost of X,” and that’s one of the documents you-- you have shared with me through the preparation for for-- this Inquiry. That sign, in old speak, that buying order to buy additional.

So, I go back to some of the points we touched on last evening. At the time of handover in February 2015, the Project team should have carried out a series of tests to confirm that the individual rooms, and, in particular, the specific high-risk areas, were to specification. Then, during the three-month-plus

commissioning period, the clinical teams should be assuring themselves that the environment was to their specification.

Q Sorry.

A If the clinical teams were of the view on day one that these rooms were not to the specification that they asked for, then, with all due respect, I would have to say they should never have moved. There was no-- There was no requirement on the Board to move them. Unlike the Western Infirmary where we were moving the hospital out, therefore everything had to go or stay, the Beatson was not in that critical path. So, if the doctors said in day one, "It is not right," they should have stayed at Gartnavel, and Mr Jenkins, with all due respect, he's a colleague of mine, was in charge of that move. So, if he was saying they were not right, he should never have moved.

Q Well, I understand that. Can I come to one point you just mentioned? Can we just look at bundle 16, page 1699, to try and understand the role of this document? Now, this is Change order----

A Yes.

Q -- signed by Mr Best. Now, I think, and I'll be corrected, no doubt, both Mr Best and certainly Mr Jenkins who was shown this thought that this was a kind of initiating document, if I can put it that way; that this document didn't specify everything that was did because that communication hadn't happened yet, this was simply a starting point. That's what prompted Mr Jenkins and his team to go over and have something like five or six meetings with the Project team to go over the details. Now, you described it as a buying order. So, from your perspective, did you understand this to set out everything that was required?

A Well, personally, until this was shared with me in the preparation for the-- my witness statement, I had never seen this document before, nor-- nor would I have expected to see it. When I read it, in the opening paragraph, under "Description of change", I thought it was fairly comprehensive in the context of what they were asking for.

To-- To say that this was the start of a narrative, then I can't argue with that, but, if you read it in detail, it includes a definitive cost of £840,000 as a quote valid until 10 July 2013. That reads to me as works, i.e. conversations had taken place between the Project team, the regional directorate, and Multiplex to arrive at, "(a) These are the changes we want and this is the cost," and the Board made the cost available.

Now, if Mr Jenkins is saying, "Yes, but that was only day one. We wanted that 850,000 plus more," then there should be another document at a later

date adding more, and-- and I'm not saying there isn't, I'm just saying I've never seen it, and if Mr Jenkins has it then that's absolutely fine. So my starting point would be the document we saw last evening, plus this put together should have been the schedule against which this area was tested before acceptance from Multiplex, and this is the standard that the commissioning team should have achieved before saying that it was safe for the patients to transfer.

Q Right. Well, we asked Mr Jenkins about this and we have his evidence on it, and we asked Mr Best about it as well. Mr Jenkins didn't draft this, nor did he and his consultant team from the Beatson-- management team from the Beatson drafted.

A I----

Q So it's what he says.

A No, no, I----

Q We can only go on what he says.

A That's----

Q He says they go over and they don't get any, let me use that colloquial phrase, "pushback." They go to the Project team and they say, "These are the things we need," and the Project team apparently make note, certainly don't reject anything that's proposed, don't say to him, "Well, you can't have any of that because it's not within the change order," or any such thing; they simply spend considerable time going through all the requirements and then he hears no more.

A No, I'm not disputing that. I think the point I'm trying to make is the paper that the Board received setting out the clinical arguments as to why the service should move, the fact that betterment would need to be achieved, and would the Board make the money available? That was the process I was involved with the Board and approved. Mr Best was the regional services director. Mr Best and the chief operating officer signed this change control which represents a starting-- I'm not arguing that this is a total, I'm just saying that starting point.

Mr Jenkins became the regional director after Mr Best. If he's saying that in 2014, in preparation for the move, he and his clinical colleagues wanted more, then there's nothing wrong with that but there should be a process. He should be able to point to a document where the Project team recorded their needs, showed negotiation with Multiplex and showed a similar buying-- and, my phrase, "buying order," for that additional works. So leaving that to one side, and I can't comment on that because I wasn't party to it and I haven't seen any documentation to the effect that there was such a-- but I come to the point in

May 2015, when the clinical teams were responsible for commissioning. At no time, either in a run-up to the patients transferring or in the immediate aftermath of the patients transferring, did anybody come to me to say, "This building, this area is not to the specification we asked," because my answer to them then was exactly-- would have been exactly same as my answer was to them in the beginning of 2016 which is, "Get out and get back to the Beatson. It is not-- there's nothing we can do while you are in situ."

Q It's interesting that you put it that way. We asked Mr Jenkins whether, perhaps with the benefit of hindsight, the series of meetings that he says and were checking was the others who were said to have been there, should have been documented in some way that we don't have. And he said, "With hindsight, yes." However, what he'd also told us was that when questions started to arise over the facilities in the new hospital, which initially I think were prompted by some air-to-air quality tests----

A Yes.

Q -- and, therefore, people started to think, "Have we got what we wanted?" He did two things. First of all, he went back to his two colleagues who were with him during these meetings and said, "Were we imagining this? Can I just check, we did go through all of this, didn't we?" And he says he got a positive answer, and then he remembered that they were asked to sign drawings at one stage during the meeting to cover the various things they discussed. So he said, "That's fine, we'll go and get them," and was then told, if I remember rightly, that they had been destroyed due to lack of storage space since they were prepared in 2013. So he wasn't then able to, as it were, to produce the material.

But if we just bear in mind, please, when we go through what's in your witness statement, that the one part that we have heard about that you hadn't is what Mr Jenkins told us about all these meetings with the Project team during which nobody said yay or nay, everybody just seemed to be content and matters, he assumed, would proceed. Now, whether that was naive of Mr Jenkins is not for this hearing today, but that's what we've been told.

A No, I-- I can't fathom how that would work out. If during-- if we're in the same time frame, if he's saying during 2014----

Q 2013, because it was as he got this change order and then he went-- that's when he started the process.

A So he's that after July 2013, after this work had been instructed, he and his colleagues entered into discussions for more work?

Q Well, he didn't think it was more work. So just-- let's not-- What he thought was that this was the initiation of a process and he wanted to know, "What do we do next?" and I'd understood----

A Yes, no, I----

Q -- he would go and meet with the Project team.

A No, I can understand-- I'm not in a position to dispute what he's saying. The point I'm trying to make is that this piece of work was the end-- this document represents the end of a piece of dialogue that took place earlier in 2013 to agree a series of structural and other changes for a cost over and above the original project to which the Board approved, and this is the change control procedure documentation. At this point in July 2013, Mr Seabourne was still the project director, albeit Mr Loudon was there along with him. So from my point of view and the paperwork chain, there was the original specification that Multiplex had agreed to create 4B to-- for a different patient population. This was added to it in the expectation of putting a more complex patient population into the space and, therefore, I would have expected if in the second half of 2013 Mr Jenkins and the clinical staff enhanced this requirement and saying, "We need more," the outcome of those discussions would have been an equivalent document

being issued to Multiplex. If there isn't a document issued to Multiplex, then there is no instruction for anything to be done. You having a conversation with me will not result in Multiplex doing anything if we do not instruct them.

THE CHAIR: Does this document go to Multiplex?

A It is, yes.

THE CHAIR: Can we look at the next two pages? (After a pause) Now, I may have got the details wrong. What do you understand that document to be? This is page 1700.

A The document I have in front of me is a compensation event.

THE CHAIR: Right.

A It's dated October 2013.

THE CHAIR: Yes. Now, I've understood that as relating to the space which is being provided for the bone marrow transplant service and, I mean, just looking at what it said, the Board is confirming proposals presumably set out by Multiplex.

A Yes. My reading of the document would be that this follows on from the point that's been made about conversations continuing after 'July 13. This would suggest that the the Board accepted or requested further alterations and Multiplex agreed to do these additional works for the price, and this is my reading-- I'm assuming, reading this,

given that Sypro contract manager isn't us, is this is Multiplex's request for confirmation that we are going to pay this amount for this additional work. So that would infer that we asked for, and subsequently paid for, further enhancements to this area in preparation for these patients.

THE CHAIR: Can I put to you – and this is just what I'm inferring from the material that is before me and I'm looking for a correction – the document at 1698 is, as I would see it-- if we can go back to 1698----

MR CONNAL: That's it.

THE CHAIR: -- an authorisation by officers with the necessary authority to do so of payment of a sum in respect of certain works to the space that the bone marrow transplant service is going into. Now, listening to Mr Jenkins, he did not tell us anything about additional works. The expression that I've noted him as using, as he would say that he had five or six meetings with the Project team to "define the specification." Now, my note may be inaccurate, but that's I have noted it. That would include, for example, pressure differences between spaces and rooms, about which there's no reference in the document at 1698.

Now, the way I've understood things, and I may be entirely wrong, is there was an approach-- the authority was given by the Board to, on the basis of a paper presented by Dr Armstrong, I think-- I may got this out of order, but authority was given by officers with the authority to do so, to spend this money on locating the bone marrow transplant service. But the purpose of this document was not to completely define exactly what works were required. That was something which, if I followed Mr Jenkins, he and his colleagues attempted to do in their five or six meetings with the Project team. I have assumed that, whether or not fully informed by these meetings, the team requested Multiplex to come forward with a proposal, and the document that we see at page 1700 is the Board's confirmation of that proposal, but the proposal is not in respect of incremental or additional work, but is in respect of the work which authority was given for in the document at page 1698. Now, that is how I have understood things thus far, and I'm looking for help to see the respect to which that is wrong.

MR CONNAL: I think perhaps what-- I don't think it differs from the understanding held in the Inquiry team, my Lord. I think what Mr Calderwood is pointing out, if I'm understanding correctly, is that if-- let's just assume the meetings took place and lots of information was passed on. I'll give you a good example, 10 to 12 air changes

required.

A Mm-hmm.

Q Now, that's what he says was one of the topics. As he understood it, he wasn't to contact Multiplex.

A No.

Q He was to speak to the Project team?

A Correct.

Q So he was not in control of or participant to any communications with Multiplex but he assumed, having had all these meetings, that there would then be further communications between the Project team and Multiplex and something would then happen. And if I can take an example, maybe you can tell me if you think this is realistic, if he comes and he says, "I want gold plated taps," and the Project team dutifully writes that down and says to Multiplex, "You'll be providing the gold plated taps," and they say, "No way."

A Yes.

Q Then he would have been told. Somebody would have come back him and said, "We put your request for gold plated taps to Multiplex. They don't see why they should do this." It's a bad example, but you see the point I'm making?

A No, I follow the point-- I follow the point you're making, yes.

Q So that what we don't have here, and you don't have and Mr Jenkins didn't have, was anything after the meetings, other than he remembers signing drawings which he then were told had been destroyed. So take it from me, if you would please, for the purpose of these questions, that we do not have any detailed communications from the Project team pursuant to those meetings, any responses going through the details from Multiplex or any other documents beyond the ones you've seen.

A Well, the point-- I'm not disputing that the process would have been iterative, that as each set of conversations resulted in a requirement to change, right, the Project team would then communicate with Multiplex about (A), the ability to do that, and (B), the cost and time scale to achieve it. These two documents seem to suggest that we had at least two sets of instructions to Multiplex to make changes in relation to the HEPA filtration in this document, page 1700, and structurally in relation to the previous document signed by Mr Best. There could well have been a third document part of this iterative process. The point I'm making is that the Board and its legal position with regard to Multiplex can only be assessed at the handover in the context of these written instructions. So in other words, 4B was to be built to a certain standard, original

contract in 2010. 4B and associated areas were to be modified and there are two documents here that suggest we had entered into arrangements with Multiplex to achieve betterment. Put those three documents together, you get the picture of the environmental area that was to be handed over to us in February 2015.

The Project team's responsibility in February 2015 was to confirm that this, which was a very specialist area, was to the combination of those specifications. The commissioning team, which is Mr Jenkins and his clinical colleagues, then had to satisfy themselves between March 2015 and June 2015 when the service moved, that the area was fit for purpose. I became aware of the concerns expressed by the Infection Control team in the summer of 2015 that it wasn't, in their opinion, fit for purpose. I suppose the point I'm trying to make is, if Mr Jenkins is saying that in the period between June and the summer of 2015, almost from the get go, the area was not acceptable-- the point I am trying to make is that service should not have moved. There was no need for it to move. It wasn't a building we were knocking down; the Adult Bone Marrow Transplant unit was still there. But my understanding of when I became involved was that the Clinical team were in and happy, the Infection Control team were not. That resulted, as I have said in my statement, in a series of works and-- and seeking data and seeking information across the UK to try and come to a view as to whether the Infection Control team's concerns were correct and, if they were, how would we address it, in other words, make the unit acceptable. We concluded at the beginning of 2016 that the unit was not compliant with the latest guidance for immunosuppressed patients and that we couldn't make it compliant.

Now, they are two-- in my opinion, two different stages. If we conclude now, with the benefit of hindsight, that 4B to its enhanced status was never built correctly, that is a dispute that the Board should have had with Multiplex in February 2015, or shortly thereafter as we became aware of it. To the extent that even if the unit had been built to the enhanced specification correctly, it was still not compliant by the time of 2016, we still had to move the patients back out. To me, the operational considerations are Project team's acceptance at handover and the Commissioning team's acceptance of acceptability and moving in.

Q I'll need to go back to your witness statement to make sure we're covering everything that you cover, but let me just ask you one pretty broad question, because I think it will help us to

understand the conundrum that you and I are now exchanging comments and evidence on. That is this. One of the reasons why in due course it was said that you could not get the specification you needed for a Bone Marrow Transplant unit was that you could not get 10 to 12 air changes in that location. Do you remember that?

A I believe so, yes.

Q Yes. Now, the challenge we are facing here when we're trying to reconstruct things a very long time later, is that we do not know why that issue did not emerge in 2013. So in other words, if you couldn't do it, then if Mr Jenkins is right and he comes in and he says, "I want 10 to 12 air changes," and somebody dutifully writes it down, says, "Thanks very much," writes it on the drawings, go talk to Multiplex, and Multiplex look at it and go, "Oh, wait, you can't get 10 to 12 changes here, given the state of the construction"-- For whatever reason, it doesn't matter. I'm not looking to get into the contractual debates here.

A No, no.

Q Then one might have thought that the response to Mr Jenkins' series of meetings would pretty quickly have been, via the Project team, an answer saying, "No can do".

A I would have expected the same, yeah.

Q "Here is why"----

A Yeah.

Q -- and that would have no doubt been fed back and debated and things might have been different. I don't know whether you can help us as to whether in all your exchanges that you had on this, right through this period until-- it was still going when you retired----

A Correct.

Q -- you had any understanding of why this didn't emerge a lot earlier?

A Well, I can't say that-- Well, first of all, from my involvement, I started from the status quo, which is what was at 4B at that time in the context of environment and M&E, and once David Hall had found the English guidance on what is an absolutely ideal environment for these patients and we compared 4B as was to the specification as required, Multiplex responded that they couldn't achieve that. Now, I'm kind of hesitating here, because part of this-- That's a factual statement of what I knew.

Reading the documentation that has been shared with me, 4B as originally specified, was to have more air changes per hour than the whole-- than the generic hospital. Therefore, moving from whatever that number was – which wasn't 3; it was a higher number – to the 10 to 12, at the point I became involved, was

said it couldn't be done. I would share your view that if the Clinical team had conveyed to the Project team and the Project team had conveyed that religiously to Multiplex, that issue would have been back in my desk in the autumn/winter of 2013/14, because the cancer clinicians would not have given up in their expectation of moving.

Q I'm going to come to this English guidance, because at the moment we here are a little puzzled as to exactly what it was that we were looking at. I will come to ask you about that. Let me just explain why I'm puzzled and then we'll pick it up later in your witness statement. The guidance document we've spoken about earlier in your evidence was SHTM 03-01.

A Mm.

Q Now, there was an English equivalent, HTM 03-01.

A Yeah.

Q These are documents which, if you may just take it from me, are, if not identical, very, very similar----

A Yes.

Q -- as is apparently not unusual. There are tweaks made, but essentially the UK guidance remains similar. We couldn't see what it was that you had found or David Hall had found that was said to be so different. You can't remember what the document was called, can you?

A No, I can't, but I think-- I think I read something in one of the documents that you sent me last week, which was a note of the meetings and the process, which I believe contained reference to the English document that David Hall had produced.

Q Okay. It might be easier now if we just go back to your witness statement. We'll see what now matters and perhaps what doesn't matter. Please just bear in mind when going through it, if you would, the discussion we've just had about the Jenkins evidence that you didn't know about, which on one view impacts at least the process that's happened. In your witness statement at 154, you say:

> "... these changes were made, instructed by us, paid for by us, carried out by Brookfield."

Now, just pausing there, what changes-- Let's leave in there for the moment because of the conversation that we've had, because all you knew about was the change order.

A Yes.

Q Then you say there was an impasse between the IPC and clinicians. Now, that's your recollection of what happened.

A Correct.

Q Yes. Then what you go on to say in the next several paragraphs-- you're talking about air sampling results and what you tried to find out about air sampling results elsewhere and how difficult it was to get information and so on. I'm not going to ask you about that because in the bigger picture, perhaps, it becomes less critical. But you come, by the time you get to page 47, in paragraph 161 to the stage-- in effect you're saying, you've got a problem, you've had a look at it, but for the moment at least a decision is made, "Back to the Beatson". Is that correct?

A Correct.

Q I see you end that paragraph by saying that's why-- Was this your decision? To go back to the Beatson?

A Sorry?

Q Was this your decision?

A It would be, yes.

Q You say here:

> "... I went back to Gartnavel, and the view of the doctors was they were moving from one environment to another that they didn't think was better."

Just pausing there, am I right in understanding that you thought that what was being provided for the Beatson Bone Marrow Transplant unit would have been equivalent to or better than what they had at the Beatson?

A Not put like that. The Adult Bone Marrow Transplant unit at the Beatson had been certified as appropriate during its construction in 2006, and it was, as far as the Infection Control team at the Beatson was concerned, an acceptable clinical environment. The cancer clinicians would argue – and this is me commenting with hindsight – that by 2016, the Beatson was ageing and potentially not the optimal environment. The critical area in this debate was the argument that the cancer clinicians needed access to Acute Medicine and Critical Care alongside Oncology. We couldn't provide that at Gartnavel, therefore that resulted in the paper to move.

When I moved them back, the Board had to spend over £1 million a year to create an interim High-dependency unit in Gartnavel because they couldn't-- you couldn't acknowledge that there was a safety issue clinically and move them back without addressing it, but we couldn't resolve the Infection Control issue. So I was endeavouring, as I set out in the statement, to try and tabulate the pros and cons of how poor or otherwise was the environment from an Infection Control perspective versus the rest of services in Scotland and the United Kingdom and specifically within

Glasgow at the Beatson.

When David Hall produced this guidance that said, the optimal specification for these Category 3 extremely compromised patients was X, I took the view that you had to look at that as being the new emerging guidance and therefore the Queen Elizabeth, if it was going to be the new centre for adult bone marrow transplants, had to meet-- well, ideally meet those standards. I was advised that I couldn't achieve that at the Queen Elizabeth at that time. Without being able to reach a compromise where the Infection Control Doctors were saying, "If you do X ,we are prepared to accept Y". I then had to negotiate with the cancer doctors to go back, and what-- what support did I have to put into the Beatson to make them feel safer at the Beatson? Well, we established a process which took place during 2016/2017 to come up with a long-term solution to the co-location of Adult Bone Marrow Transplant with Acute Services.

THE CHAIR: Appreciate this is going back a step, really: were you ever shown a document which contained what David Hall described as the English guidance?

A I cannot recall if he tabled a document or an actual schedule of specification at the meeting. There was a- There was a bit of paper, but I don't think it was an actual HTM document.

THE CHAIR: As Mr Connal has indicated, we're a bit puzzled by this, because we simply do not know of the existence of an English document about this time other than in relation to ventilation other than HTM 03-01 and possibly the JACIE requirements, which are international requirements. We simply don't know of any other source of guidance, and I just wonder if it's-- This is an unfair question, really, but I just wonder if it's possible that when David Hall was talking about English guidance, he was talking about HTM 03-01 in its 2007 edition.

A I don't believe so. I-- I wish I could recall the document I was reading on Monday where there was a kind of brief note of-- of our discussion and reference to David Hall's producing this schedule. I can't remember which one of the documents it was, but it was submitted and taken by me to be what was emerging as the optimal specification for this area. My recollection is that in Scotland there wasn't at that time a published technical memorandum specifically to Stage 3 compromised immunosuppressant patients, and that this was guidance that was emerging in England, that this is what you should achieve. My view at the time was that if this is what was emerging, and given that

we were doing something that was going to be our "unit" the 20, 30 years, we needed to be on the front foot and looking to achieve that. That debate was what I founded my decision on to-- to move the service back.

THE CHAIR: Thank you. Sorry, Mr Connal.

MR CONNAL: (After a pause, to the witness) Okay, I'm going to take you to some of the other stuff you've said about this. We'll see if it helps. If not, we'll move past it. Can we go to the next page of your witness statement, page 48, and just pick up briefly paragraph 164? Now, you have commented about the aging Beatson, and I won't bother asking you about that, but I see in 164 you say:

> "The ventilation specification was allegedly the same standard as the Beatson if not marginally better, that is what I was told."

Do you remember who told you that?

A Well, that would be a combination of the Project team and the Clinical team. By that, I mean the Managerial Clinical team of the Clinical team.

Q I can understand why the Clinical team might say, "Well, we understood the specification to be what we had, but probably a bit better." That makes sense. Do you think you might have been told the same thing by the Project team? And if so, by who?

A Well, the only-- the only people on the Project team that I interacted with on a regular basis was the project director and, in essence, the deputy project director, Peter Moir. They would be the people I speak to, but I come back to the point we discussed earlier: 4B was to be of a certain standard and I was told was it was of that standard.

Q By whom?

A By the Project team as part of the commissioning process.

Q Well of course it was never commissioned as in its original form. Is that right? Are you talking about once the Bone Marrow Transplant changes had been made?

A I'm saying that, in February 2015 when the building was recommended to the Health Board to take over, and during the period thereafter when all the services were tested, the environment in Ward 4-- the wider environment in Ward 4B should have been tested and signed off as meeting the standards that we had paid for.

Now, we have discussed whether we had 1, 2, 3 or numerous variations on that, but, cumulatively put together, they would be the specification they went

against. So, when I am talking to these people in late 2015, I am starting from the point that, "You have told me the building is of this standard. Why is it failing Infection Control?" and, "Is it better than the Beatson?" and people are saying to me, "Yes, it is."

Q Right, and the people who are saying that to you are the Project team?

A Yes. By this stage, not the Project team, they're the Operational team in the context of the director of the Esates.

Q Okay, yes.

A Yeah-- No, no, but it-- it is the Project director, just he's not----

Q Yes, okay.

THE CHAIR: Just for my note, when you use the term "Operational team" in conversation with you in the latter part of 2015, who do you mean?

A Well, the-- the project director, David Louden, became the Board's director of Facilities and Estates, so, on a day-to-day basis, he had oversight of the-- the maintenance. But the point I'm, kind of, labouring is that, if we said the building met our requirements in February 2015, it should have been tested and certified. During the 100-day commissioning period, the clinicians should-- not en masse, but should have been in and around the environment and-- and testing it as-- as with the Infection

Control team. Therefore, from June 2015 onwards, we have accepted that we got what we paid for from Multiplex, we've moved on, but we've got operational problems occurring which couldn't be resolved on the ground, and hence they get escalated.

The point that Mr Jenkins is making, and I can't-- I can't comment because I just have no recollection of it, that-- that, from day one, the clinicians were concerned that the environment wasn't what they had asked for, is news to me.

THE CHAIR: At risk of maybe just restating the obvious, when you talk about things happening in February 2015, I'm taking that as a reference to the certification of completion by Capita?

A Correct.

THE CHAIR: And, when you're talking about commissioning over a 100-day period, that is the clinical teams that are going to be responsible for the various services in the various areas of the hospital satisfying themselves that they've got facilities that are ready to receive patients in June?

A Yes.

THE CHAIR: They're not going through, perhaps, a very formal procedure, they're just making sure that they have got what they think they need for the service that they will be providing?

A Yes. The-- The

commissioning teams-- groups, clinical groups, rely, at that stage, on the confirmation from the Project team that the services comply. So, if-- and I don't know the detail for this, but, if Mr Jenkins-- or Gary had set out that they need 10 to 12 air changes, there should have been, in the certification log, a note that the ventilation plant had been running for a period of time and had achieved with-- you know, within that parameter, i.e. no less than 10 air changes an hour. That----

Now, if you do a test and it doesn't achieve 10 air changes an hour, you-- you would-- assuming that's the contract that you've paid for, you would then go back to Multiplex and-- and work with them to-- to rectify why that wasn't occurring. As I referred to last night, the-- in-- in my time, this would all be just working our way through a rather large lever-arch file of certification and-- So I-- you know, I can't comment why the-- if indeed that happened, that it-- that it didn't perform to the specification, and I would have thought Gary and his team might have asked for and sought that as part of their commissioning to ensure themselves that it was clinically safe.

MR CONNAL: Is it possible, as I think you suggested a moment or two ago, that, so far as services are concerned, because they have a lot of stuff to look at----

A Yeah.

Q -- as far as services are concerned, they may have relied on assurances or an assumption of assurance from the Project team that what they were moving into was what they had asked for?

A Oh, absolutely, in a sense of M&E.

Q Yes. I think that's the point I was keen to get. Now, I'm now not going to ask you about everything you say in your witness statement about this, in part because we've gone a little off-piste because of the change, and in part because some of it may not now make a great deal of sense, but can I just come to-- Let me preface my question by saying that we are aware, in the Inquiry, that, in between the point when 4B moved back to the Beatson and Mr Jenkins' options paper, which, for your purposes, is the end of the trail because you're not a decision taker on that, attempts were made to see if things could be done to make things acceptable, and none of these ultimately produced an answer that was universally acclaimed as correct.

So, let's leave out the detail of that because, in a sense, the unsuccessful attempt to sort it may not matter. Can I just come back to the point that his

Lordship was asking you about earlier? And that is this English guidance, because I want to put to you one or two documents that are mentioned in your witness statement to see if this helps at all. The English HTM-- Sorry, go to page 77, that's my fault, I shouldn't have taken you there. Now, you say, in paragraph 259:

> "Eventually, we found guidance that was issued by the English Health Service, which set out the standards that should be achieved for these highly compromised patients and, at that point, Multiplex and the project team came back and said, 'You cannot achieve that in 4B.'"

And then you explain some of the issues that you were facing. In 260, you referred, I think, to the English HTM. Now, according to my reference, this is Edinburgh bundle 2 at page 698. It should be on the document list. Before we worry about looking at anything in it, do you remember this being shown to you as the basis for the points you were making?

A No. No, I don't remember.

Q I'm not going to go through it because-- if you just take it from me, for the moment, that it's pretty common ground, that there are no huge differences between this and the Scottish guidance. The reason I mention it at all is that, if you have immuno-compromised patients, possibly neutropenic ward depending on whether that's the right definition, a basic provision is 10 air changes an hour. You don't know whether that was what was originally intended for this location in 4B or not, 10 air changes?

A No, I-- No, I don't know the detail. I mean, the point that we discussed yesterday, and I think we-- we came to an agreement or understanding, was that the patient profile that was going into 4B back in 2010 was the Ward 7B service from the Southern General.

Q Yes, thank you.

A And the clinical output specification, which was prepared by a member of the Project team, we-- we saw last night, and it inferred that Infection Control input had been achieved and----

Q Okay.

A In the summer----

Q Let's take this document off the screen, if we would. Thank you very much.

A In the summer of 2013-- The point I'm making is that you start from the 4B specification and you enhance it. Now, if, from day one in-- in the summer of 2013, a minimum of 10 air changes was specified in all of the relevant

documentation, then there is no issue other than that is the starting point for your instruction to improve 4B. Now, at no time between the summer of 2013 and when I became involved again in the summer of 2015 did anybody say to me that they didn't specify what was correct for the patients and they didn't get it.

THE CHAIR: Sorry, no one said to you that----?

A That-- That, in 2013, they asked for something and didn't get it, and then no one said to me that, at commissioning, we didn't get what we had asked for.

MR CONNAL: This then moves, if we look at page 78 of your witness statement, to a position which you outline in paragraph 263, that what you were being told-- This is the "rock and the hard place" scenario.

A Yeah.

Q You were being told, after all this digging around and to happen for whatever reason, that, to get the kind of air changes you need, you were asking for, whether it's 10 or 10 to 12 or whatever, you'd need to put another floor in the hospital?

A That's a generalisation, but yes, the volume of plant that would be needed couldn't be accommodated within the space available.

Q Yes. Meantime, you had clinicians who would really quite like to be back in the Queen Elizabeth for all the reasons that were originally set out, and that was your "rock and a hard place"?

A Well, yes, because, from the Health Board's perspective, Infection-- and I've said this in the statement, Infection Control were saying the-- the environment, as per their testing regime, gave a rise to a risk that patients could be affected-- and infected. Consultants at the Beatson were saying that highly-- particularly ill patients in the Beatson who were receiving chemotherapy could have a major medical relapse during the night and, in the absence of immediate on-site support of Critical Care, could die.

Now, both of these comments were absolutes. Now, they weren't happening in-- in the day-to-day operation, but they were there. So, from the Board's point of view, there was no right and wrong answer; there had to be mitigation, whichever-- whichever way we went.

Q Can I just ask you to look, since we've got that page up, at the document referred to in paragraph 265. So that's bundle 3, page 36.

A Mm-hmm.

Q Now, this is something where HPS, Health Protection Scotland, are helping out, because, as it's narrated there, the support had been requested because of this focus on the provision of

a safe environment. It's dated December 2015. Now, had you seen this before?

A Not at the time, no, though it-- it fairly accurately reflects the situation.

Q So, if we just look at this document, we see, basically, "Narrative" in the "Background" section, and, if we go on to the next page, reference to guidance near the top of the page:

> "There is no single piece of suitable guidance applicable in this situation."

Interestingly, HPS say:

> "The UK guidance comes from various sources including Scottish Health Technical Memoranda, Health Technical Memoranda [and so on] ..."

Some other reference, and then it goes on to consider the various issues. This is not a document you remember seeing during all the debates that took place?

A No.

Q Can we go on to the next page, just to make sure we've at least opened them up? Because there's a lot of discussion there about positive pressures and HEPA filtration, and you see, in the middle of the page:

> "The recommended bedroom air changes detailed within SHTM 03-01 is 10 per hour ..."

And so on, corridors to be HEPA filtered. I don't think we need go through all of that, but it's not something you remember looking at?

A No, I'm wondering the date of this document.

Q Well, perhaps-- It should show on it. Can we go----

THE CHAIR: December 2015.

MR CONNAL: December 2015, I think. Can we go to the next page, just to-- Yes, and then there are recommendations at the end.

A Yeah.

Q But take it from us it's December 2015, so it's while there are still ongoing discussions about what is to be done, to put it no higher.

A Yes.

Q Perhaps you can help us in one respect. On page 79 of your witness statement, when you got whatever it was you say you got from England and you say you were "light years away from it". Now, that's just a figure of speech, but can you remember what it was that you thought was light years away from whatever?

A Well, I mean, it-- it's just alluding to, in part, in that document we've just looked at from HPS about segregation corridors and air changes, just fundamentally the design of the unit needed in-- in order to comply with that

guidance, would need to radically be different than it was.

Q Thank you. Well, in light of the conversations we've had today, let's just jump ahead to what, for you, became the end of this process, because you were asked to look at an options appraisal issued by Mr Jenkins following a group exercise. He's explained who the group was, how they did the scoring, what assistance they obtained and so on. Now, this came in, I think, just around the time that you were heading towards retirement. Is that right?

A Well, I-- It-- The document that you sent me was dated March 2017. Appendix 5 in the document, around about page 22/23 is actually dated April 2017.

Q Okay. Let's just get this up, if we may. Bundle 27, volume 7, page 158.

A The----

Q Do you remember seeing it?

A No, I-- I've never seen it and-- Well, sorry, I've now seen it twice in preparation for this, but I'd never seen it. It-- Two comments I would make. One is that, as I say, if you go a little later on into the paper, and I think it's-- I didn't take a note at the time of the page number, but around about page 22/23, there is one of the appendixes is dated April 2017. I am-- I would need to see the Board minute of the Acute Services committee to see what discussion took place. I am of the opinion this paper did not go to the Board until after April 2017. This was a-- the paper that-- that Gary was preparing. I have-- I have read the document. I personally would have a significant number of questions about it before I would have taken it to the Board. I don't think it properly sets out all of the issues that the Board should have been aware of.

Secondly, again, reading the paper, the Board never received a paper that's got a request for capital, but no numbers and no description of what the capital's for. So had I received that paper and discussed it with Gary, I would have sent him away to do significantly more work on it before I would have been comfortable to take it to the Board. That said, the options in it I'm aware of because I attended many an evening meeting with the cancer clinicians about their desire to move forward quickly and discussing the only estate that the Board had access to and to which we could consider creating the proper unit.

Q It's a slightly unusual conclusion, I think, in this paper in that, in effect, what it does, does it not, is suggest that you move back into the new hospital for the moment, as a sort of temporary solution.

A I can only comment with the benefit of hindsight and how I would have approached this particular thing. I do not think you could put a paper to the Board members that talks about "temporary" without there being a definitive plan that the Board has accepted. You know, my expectation would have been that if you concluded, clinically, that the risks of patients suffering an adverse effect at Gartnavel was materially greater than the risk that may catch an infection in the environment at Queen Elizabeth, I understand you could come to that view and you could articulate that to the Board clinically, led by the clinicians. You would have to provide the Board with significantly more background information than this paper has. You couldn't, in my opinion – and this is a personal opinion – you couldn't say it's an ad hoc arrangement but not actually outline to the Board what the final destination and conclusion is, and you can't ask for an undefined capital sum. The board has to allocate, you know, money, and therefore it has to know the number, and you can't not have a scheme. You know, "Please give me some money and I'll go and do something with it."

Now, as I say, had I-- had that paper been presented to me, I would have sent them away to do more work on it. I'm not saying I wouldn't have taken it to the Board, because the debate was raging between the cancer clinicians and the Board was always going to have to confront this challenge. This paper starts to allude to the fact that the Adult Bone Marrow Transplant environment at Gartnavel was deteriorating.

Q In paragraph 338 of your witness statement, you say this:

> "I was surprised by the decision [because that's what the paper had in it] to return the BMT to the QEUH as published guidance that I had seen in 2015 was so black and white that..."

In effect, you would have had the Board putting BMT patients into-- I think I'm paraphrasing what you say, you would have been putting BMT patients into a unit that did not comply with the current recommendations for a unit of that kind.

A Yes.

Q And you found that a surprising conclusion?

A I did, yes, but that's a personal comment.

Q Yes. But as you say, the constant has been that the clinicians want to co-locate with everything else that's in the new hospital.

A I'm accepting, and have accepted since I became involved in this

debate in the autumn of ‘15, that the Board was confronted with a real issue that the environment, the clinical support environment that Gartnavel was deemed a risk, the physical environment in the Queen Elizabeth was deemed a risk, and a process would have to be entered into to try and-- I’m trying to think of a phrase, but that would, in effect, calculate those two risks and be able to compare and contrast them. Because at my time, there was no movement on the Infection Control team’s views, and in an ideal world you would have got the Infection Control teams, the cancer document-- doctors ultimately presenting singularly to the boards. That’s why I’m saying I would like to have seen the Board minute of the debate, because that would have been the clinching factor that if the Infection Control team and the cancer doctors jointly advised the Board, then the Board could have moved back to the Queen Elizabeth.

Q I think unless my Lord has further questions about Bone Marrow Transplant, I might leave that topic, my Lord. I haven’t gone through everything you’ve said in your witness statement. We have it, obviously, in writing in any event. Can I ask you about another topic? Because it keeps coming up repeatedly, whatever attempts are made to push it back into the backwoods again, and that’s what’s been described as the “Horne taps saga.” Now, the reason I wanted to ask you what you knew about it is that the issue first arose in 2014, so during the build of the hospital.

A Yes.

Q It arose because there had been an incident in Northern Ireland involving neonatal deaths----

A Yes.

Q -- and recommendations, alerts flowed from that. Now, first of all, were you aware of that?

A No.

Q You weren’t aware of the incident in Northern Ireland?

A Not that I can recall.

Q I think the-- sorry?

A I was going to say that in the documentation you sent me, the kind of comprehensive note of the meetings that took place between the Project team, Health Facilities Scotland, Health Protection Scotland, following on from the circulation of the learning from the Northern Ireland incident, and the conclusion of that meeting said that all parties were content with the arrangements that were proposed to the Queen Elizabeth University Hospital. But that Mr Powrie, who was in attendance at the meeting, needed to make sure in building the maintenance schedules up that there was need for a regular six-

monthly action on behalf of the Estates team and that was in the document.

So, from my point of view, reading that, it appeared to me that we received the recommendations coming out of the Northern Ireland Review, a properly constituted meeting with all of external parties took place, and they agreed to stick with the, in my words, "the status quo." As I said in my statement, had that meeting concluded that the status quo was not the way forward, then because of the costs involved, the project director would have had done a report to the Board asking for the release of a significant amount of additional funds. So my comment really is, organisationally, we were aware of the Northern Ireland learning; proper action was taken within the Project team, external advice was sought, a conclusion was reached and enacted. I should add, just adding the point that from the conversation we had last night about the Estates team knowing and not knowing about how to run the building, Mr Powrie, as you'll see, was fully involved in the project in 2014.

Q Well, the first point I wanted to ask was this, and I think you do deal with this in your witness statement. There were various participants in these discussions, who no doubt have brought to these discussions their own thoughts and interests and so on and so forth, and we can only see what's in the notes. If one of the concerns that may have been at least in the back of the minds of the Project team was that, "If we have to rip all these things out and basically start again with different taps that don't have flow straighteners, thus eliminating the problem rather than working around it, that'll cost money."

A Yes.

Q Possibly quite a lot of money.

A Certainly seven figures, yes.

Q Right. Seven figures. Can you help us at all? Because it's been suggested, or posited at least by some parties that, "Well, money was obviously the driver behind the scenes here, they didn't want to spend the money, so they decided to take the cheap route of hoping to deal with it by maintenance." What would have happened if they'd said, "No, we can't have money interfere here, let's go and ask the chief executive for £1 million"? Was there money available?

Well, there is-- Correct, there actually was. I mean, this project, as I alluded to in answer to some of the questions yesterday, was well-funded by the Scottish Government. In our Business Case, as I think I said last night, we asked for and received authority to get up to £842 million. Our contract with Multiplex, both for the initial works and then the subsequent addition of the multi-

storey car park and other bits and pieces came in below 600 million at the end. At the time of that meeting in 2014, the project would be sitting in surplus of something like £60 million. That was available to the Board because the government had confirmed that any underspend could be used to accelerate Phases 2 of the Queen Elizabeth site redevelopment, which is the teaching and learning centre and the other multi-story car parks.

Therefore, I would contend that if the project director had written to me saying that he wished in excess of £1 million to be released to make these changes, and he evidenced the Northern Ireland-- and he evidenced the meeting with the external experts and the conclusion, I may well have been grumpy about spending money, but the money was there. So I cannot understand how anyone representing the Board at these meetings would be saying that money is an issue.

Thank you. My Lord, for my Lord's notes, that discussion effectively appeared in paragraphs 413 and 414 of this witness' witness statement around the money side of matters.

A Thank you, Mr Connal.

Q I see from the time we're possibly at the break.

THE CHAIR: Very well. We'll take our coffee break. If I could ask you to be back for five to twelve.

A Five to twelve.

THE CHAIR: Thank you.

(Short break)

THE CHAIR: Mr Connal.

MR CONNAL: Thank you, my Lord. Mr Calderwood, just before I leave the Horne taps saga, which we touched on briefly before the break, I have been asked to ask you this: how did you, as the Chief Executive, respond to the warnings that were being issued by senior leaders such as Sir Harry Burns about the Northern Ireland incident and the issue of flow straighteners in taps?

A The Health Board would have received the guidance and any particular Scottish Government directives, and then that would be issued to the operational directors with a requirement that they review whether or not the Horne taps were in existence in any of the hospitals and the action needed, and that would have resulted in reports coming back should they have been identified as an issue.

Q I think, at the risk of repeating the question, I'm really directing it at what you did, if anything.

A Nothing. That kind of

communication doesn't come through my office.

Q I see. So you weren't aware of it until later?

A Well, it's two different questions. The issue about the Queen Elizabeth University Hospital and the action taken we've discussed, and I wasn't aware of it at the time because the conclusion was as recorded. The Northern Ireland incident would have been, I have no doubt, raised at the Chief Executives' monthly meeting with the Scottish Government and the director general, and we would all have been commended to make sure that organisationally the learning was taken on board.

Q So the communication might not come over your desk, but it would probably be raised in one of your Scottish Government meetings. Is that what you're saying?

A In the context of a briefing, yes, yes, it may have been raised.

Q Assuming that happened, what did you then do about it?

A As I said, the organisation would circulate on my behalf the information to all the directors, asking them to check the estate to see whether we had in the operational parts of our organisation any of these taps, and to come back with that audit and the action that we needed to take. Therefore, in the context of this, David Loudon as project director would have got that communication in respect of the Queen Elizabeth.

Q Can I just go back temporarily to a couple of things about Ward 4B which have cropped up in the interval? What you had in 4B was a group of high-risk patients, just to use that term generally, patients with particular needs for protection. This is the Bone Marrow Transplant group. Given what had been discovered, the problems, challenges, however you want to describe it, had been discovered in 4B, did you ever consider, as Chief Executive, i.e. the man ultimately on whose desk the buck stopped, that you should immediately review what had been provided for other vulnerable patients such as paediatric oncology?

A Not directly in relation to that incident, no. There had been a process in place in regard to the Schiehallion, which had been led by the Board's medical director, Dr Armstrong.

Q Well, I can understand that, but here you've got this shiny new hospital. We were hearing from Mr Jenkins that he remembers the decision to move out and go back to the Beatson partly because it was taken the same day as Her Majesty was opening the hospital,

so it sticks in his head. You've got this shiny new hospital. I think the point being put is, in a shiny new hospital, you might not have expected to have had the kind of issue that you had on 4B, and did that not therefore prompt you to say, "Stop, let's go and check other critical areas"? It may be I'm simply repeating the question and you'll give me the same answer, but if you----

A Yeah-- Well, no, the position-- To answer your question, no. As a consequence of being alerted to the issues with regard to 4B for the new patient profile Adult Bone Marrow Transplant and finding that it was deficient to the specification required for that patient group, I didn't then say, "Hang on, I don't trust everybody else in the hospital to have done their job, therefore I will systematically go through every department and check their work". No.

Q Can I ask you to look at a document, please, if you would? This is bundle 13, page 840. This is still around 4B, and the reason I'm going here is that I don't want to go take the time, because time is short, to go through everything you've said in your witness statement, but there are certainly implications in your witness statement that the identification of issues and the creation of issues was really down to IPC and not the clinicians.

Now, this is a paper prepared by Mr Jenkins which summarises events and talks about what was found about testing and so on and so forth. Now, first of all, we see at the foot of the page:

> "Following clinical debate, it was agreed on balance of risk, it would be safer to transfer the patients back to the Beatson..."

Now, this is being written by Mr Jenkins, not by Dr Peters. So if we have a look at the top of the next page, page 841, Craig Williams comes back, he joins in, says he concurs. He wants the validation of Commissioning units – not surprisingly, along the same lines as you're saying, "Why do you just get out the big folder and look at the check sheets?" in the days of paper? I suppose my point is, do you accept that in fact the decisions to move were agreed not only by a range of people concerned with IPC, but also by clinicians?

A Yeah, I mean, I can't-- I haven't seen this particular briefing note, but I have no reason to dispute that. My personal recollection was that the cancer clinicians were not particularly happy about the conclusion to move back.

Q Yes. Can I ask you about an entirely different topic, please? It's one where I think there is particular reason for going there, which we've heard a lot

about earlier in the Inquiry. So if we just go to your witness statement, please, at page 29, the first question on the top of page 29 is simply because, in the course of exchanges about a problem with inadequate resource to do what needed to be done on site after handover, it was suggested to these people like Ian Powrie that the management thought that Multiplex would maintain the hospital for two years, and that's why-- you know, presumably as an excuse for not having adequate budget. You don't recollect ever thinking that?

A Well, first of all, I cannot accept that any senior Estates manager in the NHS of Scotland could say that he thought a contractor was responsible for maintenance. Defects liability, yes, maintenance-- routine maintenance, no. That's never existed in Scotland.

Q It's not suggested that the Estates thought that, it's suggested that management thought that.

A And who was management in this instance? It certainly wasn't me.

Q Possibly you, I don't know.

A Well no, I've been involved in enough capital expenditure and contracts over many years to know that maintenance has nothing to do with the contractor.

Q The next questions I think really follow from this, that we've had a lot of evidence that once the hospital was handed over, the Estates team were – and I don't think I'm exaggerating by reference to the earlier evidence, to say – overwhelmed. There was so much going on between snagging and supervising contractors coming on, problems with the building, unexpected issues that they did not have enough people or enough time to do what needed to be done. Just take it from me, if you would, for the purpose of my questioning, that that is the evidence that we have had, which has been combined with evidence of people routinely working 12-hour days, sometimes 7 days a week, and basically complaining up the line and saying, "We need something done, we need more resource". Now, the evidence we've had is that that goes to you and your answer, which comes back through the line of command, is "No more money. You can get no more money for this service. You have to make do with what you have". Now, am I right in thinking from your witness statement that you don't accept that you were ever asked for that or gave that answer?

A Correct. I mean, as I've tried to explain in my witness statement, as Chief Executive of an organisation the scale of Greater Glasgow & Clyde, one does not have conversations about money. There is a very defined process

which budget holders go through. I think, as I tried to set out in my statement, the hospital did not have a budget in its opening first year, 2015/2016. The Board underwrote the actual expenditure incurred. Again, I gave specific examples where, because the performance of the hospital didn't meet the then Scottish Executive's standards, many of the operational policies that had been put in place had to be rewritten and the costs associated with them increased. I have evidenced Portering, Domestic, nursing staffing. So, the process in '15/'16 was very fluid. There was no set budgets.

Going into 2016/17, the hospital moved into the same budget-setting process as every other clinical facility in Greater Glasgow & Clyde. The Board receives the allocation from the government. The Board then passes through to the Operational units those budgets that are earmarked for them are those budgets that are approved. So, approximately 45 per cent of the Board's budget goes to the Health and Social Care Partnerships, and the balance goes to the responsibilities of the Board (inaudible 12:14.13). That is then distributed through the Chief Operating Officer, that is then split over the directors of the various hospitals, and the director of Estates and Facilities gets the budget. He – in this case it was a he – splits that between Catering, Portering, Domestic, Estates, etc.

The budget process is quite straightforward. If the Estates department on the Queen Elizabeth site put forward a case explaining what they need, that goes to the director of Estates, he would be expected to look across the totality of his budget and decide whether he can move money from one budget to another. If that is not practical, he would go to the Chief Operating Officer to see if there were funds within the Acute division that could be transferred to Estates within the Acute division, and then, failing that, a paper would go to the Board's director of finance setting out the reasons and the value of the request.

The Board at that stage doesn't hold funds, all the Board's funds have been allocated to the directors, but the Board does have usually what we call development funds for new schemes, and we have what you would call slippage within them. They would be budgeted to, say, start in July, but might not start to September. Therefore, in that year, there would be what we would refer to as slippage, and we could make allocations non-recurrently to a deal with a problem. So, that process was never followed, and therefore I have no-- I have no recollection of or evidence that anyone ever come up. But it would not come up

to me as, you know, just a, "Can I have X for the Estates department at the Queen Elizabeth?"

Q Well, I don't think we know the form in which it came to you.

A It didn't come to me.

Q We've had a number of witnesses saying either that was sent all the way up to the Chief Executive and the answer was, "No more money," or being told that that was what had happened, but you're adamant that you weren't aware of this?

A I am adamant that I was never requested for funds for Estates within the Queen Elizabeth University Hospital.

Q Were you aware of complaints that the Estates team did not have the money or people to do the work that they needed to do----

A No.

Q -- in the new hospital?

A No.

Q At all? You've never heard of this?

A No.

THE CHAIR: Mr Calderwood, in the description you gave, am I right in understanding that you were simply not part of the structure you went through whereby additional funding could be requested by a particular director?

A I personally had no budget, other than the budget headings that had been allocated. So for something to come to me, it would be the Board director of finance would come to me to say that there was an operational issue and he-- we would debate where, if at all, we could divert funding. But that is the word, "divert" funding. There's no extra funding.

THE CHAIR: Right, so maybe I didn't pick up correctly what you'd said. So there was the possibility----

A Correct.

THE CHAIR: -- that you and the director of finance might decide if you could find the funds to allocate funds to a particular demand?

A Correct.

THE CHAIR: Right. Sorry. Right. I hadn't picked up correctly what you'd said. Sorry, Mr Connal.

MR CONNAL: No, no. The reason I'm pursuing this point, I think it needs to be made clear to you that if you take-- Well, let me give you two examples. One is the DMA Canyon report which was received about water safety.

A Yes.

Q Not actioned in the way it should have been.

A As I inferred yesterday, my understanding retrospectively is that 80 per cent of the cost of dealing with the DMA Canyon report would have been picked up and funded by Multiplex.

Q Well, my point was simply – if you just let me finish that particular question – that having interrogated a number of the participants in that process in one way or another, the general thrust of what the more junior people said was, "We were all grossly overworked. Yes, we should have done X or Y, and things just didn't get done because we were all too busy". So you can understand why it's of importance to a number of the participants in the Inquiry to find out what you as the Chief Executive, who was at least nominally responsible for the whole exercise, knew about it. Do you understand that?

A I didn't know about it, and again, I have to stress, not knowing who is saying what, in the period from June 2015 when the building was fully operational and under the responsibility of the Board and therefore, in this particular example, the Estates department, there was no definitive budget set for the 2015/'16 year. I have emphasised on numerous occasions the excess funds that existed within the scheme. Therefore, in the period 2015/'16, up to-- actually, up to March 2016, I would dispute any issue about resources being a-- a restricting factor. From April 2016, the hospital was the same every other part of the Board.

We were under annual-- what was called "Cash-releasing efficiency saving" targets set by the government, they were part-- every year. So, in April 2016 the Board's director of Estates would have received a budget allocation which would be based on the money received by the Board, uplifted by the money given by the Scottish Government. The real cost that he or-- or she might be facing could be significantly a variance to that, but that would have to be achieved by efficiency savings.

Q Right. I'm going to ask you a separate question about that, if I can. Can we just come back-- Before you went on to the Scottish Government's efficiency----

A Well, the point I'm trying to make-- Sorry to interrupt, but the point I'm trying is that debates after April '16 need to be looked at in the context of routine Board business. The period-- And you referenced the DMA Canyon report. In the period, just to take that as a practical example, there was no financial restriction to get that done. None at all. And I would dispute any of my colleagues saying that that's why they stayed awake at night in that period. After that, then they would join the period of all the directors in dealing with the challenging rising costs of the service versus a fairly static cash budget. So, in the period after April '16, then I have no doubt the

Estates department, like every other department, was faced with challenges.

Q Okay. Well, let me just take that point, then, since you've gone back to it. The way it has been presented to us is that the junior people complain, their managers complain, it goes up the chain, the people who know of these complaints try to intervene to see if they can assist, and the answer comes back, "Nothing can be done. We can't get any more resource for you, do what you can." Then, because that's the picture I've already painted for you, going into the next year, they're told, "Well, you know these resources that you were telling us were not adequate to do half the work you needed to do? Well, we've just been told we have to cut the staff numbers." Is that the efficiency savings you're talking about?

A Efficiency savings are-- are implemented by the directors as they see fit. Sometimes it's relatively straightforward; you mechanise a-- a function, and therefore you get the efficiency out of investing in a new plant and equipment. In other services, it can be that you redesign the tasks so that they can be performed differently. But, in-- in real terms, cash-releasing efficiency savings are-- are that.

Now, cash-releasing efficiency savings are not cash taken out of the

system. They are-- They are generated by the difference between the uplift-- So, if-- if you receive a 2 per cent uplift on your allocation, but the wage rises that year are negotiated at 3 per cent, then you have to find the 1 per cent difference between your uplift and your costs, and directors each year submit these proposals to the Board as part of the budget setting exercise.

Now, the point I'm making is, in the budget-setting exercise for April '16, Mr Louden would have been expected to bring forward all of the challenges as he saw them, all of the cash that he expected to receive versus what he thought his costs would be, and he would work through that process with the Board's director of finance, and, where major change was being proposed in order to affect the service being delivered within budget, that is reported to the Board each year round about June or July when the-- when the budget-setting exercise----

So, I-- I need to differentiate between '15/'16, where there was, in my opinion, no budgetary pressure on the Queen Elizabeth as distinct from other parts of the business, and then business as usual, as I would refer to it, from April '16 onwards, and I do not recall, in-- in the papers that went before the Board in April-- well, for-- for the year April '16 to

March ‘17, there was any statement that maintenance staff posts were being cut.

Q The other reason I wanted to ask you this now was that the decisions that were taken on Horne taps were dependent, in terms of effectiveness, on a particular maintenance regime being put in place, which, we’ve heard from other witnesses involved, thermal disinfection, as it were, in a separate location at a particular level, and we’ve heard all the details of that.

Now, by the time what’s subsequently been known as the “water incident” happened in 2018, after your time, that wasn’t in place. Why? Because Estates didn’t have the time and resource to get it done, although they knew it was supposed to be done. That’s at least what this Inquiry has been told. So you can understand why those who are concerned about patient safety see a tap which is causing risks if not maintained properly not being maintained, and say, “Well, why are we in a hospital where there isn’t enough people to do the work?”

Ultimately, I suppose it’s just, perhaps, surprising that there seems to have been this upswell of concern at the time, no proactive maintenance being done, people were just doing firefighting, struggling to get that done. Asset tagging, as you know, hadn’t been done properly anyway, so all of the things they wanted to do were not being done, and you basically said you knew nothing about this at all?

A Not in the period that-- that we are discussing, and certainly not in that detail. I-- I would have to say that all patient safety issues, if I was the director of Estates on-- on the Queen Elizabeth site would be the first charges I would make to any budget I had. Bearing in mind budget holders have the discretion on how they spend their money, they-- these aren’t lump-- You know, so the director of Estates will receive a multi-million-- you know, a multi-hundred million pound budget. He then dispenses that to budget holders. Mr Powrie, who is the sector-- the Estates manager on the Queen Elizabeth site, would get a multi-million pound budget. He would decide how he spent that.

THE CHAIR: Can I just-- I apologise for being slow on this. If we look at the period from handover in June 2015 until the next financial year begins in April of 2016, when you say that Estates had “no budget”, does that mean that the director of Estates could simply spend, essentially, what he considered appropriate or necessary, or is it a little bit more complicated than that?

A It-- It’s a little bit-- My Lord, it’s a little bit more complicated than that

in the sense-- When I say there's "no"-- There was a staffing establishment agreed with the-- agreed by the the Estates directorate in staffing the Queen Elizabeth. So, staff transferring to the hospital from the closing hospitals, the Victoria, Southern General, Western Infirmary, etc., they would apply for and be appointed to posts within a-- an established workforce. So, the workforce, numerically, had been set out in-- in setting the budget-- the indicative budget for 2015/'16.

Because of issues in-- in the first year of any new facility, and in light of changing practice, the Board constantly revisited the resources that were allocated to the Queen Elizabeth campus to respond to-- to the-- So, a new nurse staffing regime came out which reflected that our-- our original assumptions about nurse staffing for single rooms was wrong, and we had to increase the number of whole-time equivalent nurses per 32-bed ward because the-- the layout of the single rooms and the tasks that had to be repeated was not reflected in-- in the staffing numbers.

Likewise, and I think I referred to it in my statement, when we opened, we applied the same domestic services schedule to the Queen Elizabeth we used in every other hospital in Glasgow. Infection Control doctors, i.e. the new Infection Control doctors appointed for the Queen Elizabeth, deemed that single rooms could not be cleaned that way, they had to be cleaned 100 per cent on the discharge of one patient before the next patient can get in. That resulted in the domestic workforce having to be increased so that the domestics were on duty all the time to clean the rooms as patients were constantly being admitted and discharged.

Likewise, portering was deemed to be causing a problem in the A&E department of not being able to move the patients quickly enough, and, as the hospital wasn't performing to the Scottish Government targets, we had to increase the portering budget. So, it was an iterative and dynamic process in '15/'16, but the point I'm trying to make in Estates is that there was access to significant non-recurring money to make sure that all of the issues in '15/'16 were addressed.

In '16 and '17, the-- the financial discipline that the Board was under was applied to every budget holder. The Board did not take individual decisions as to whether the Royal Infirmary should get X for maintenance versus the Queen Elizabeth, or whether the Victoria and Stobhill hospitals should get Y compared to the Queen Elizabeth. That was a professional judgement of the Estates Directorate, and, therefore, to ask for

more, you have to go through the process of saying why you cannot move the money about within your own areas of budgetary responsibility.

THE CHAIR: Thank you.

MR CONNAL: I'm just wondering about this business of there not being a budget initially, because we have had some evidence that has actually identified why the resources were inadequate: because the assumption was made that – I'm paraphrasing – by moving from a number of old hospitals into a nice, shiny new one, you'd be able to do things with less people among other things. Then it turned out that all the new systems weren't working properly and so on and so forth, and, certainly initially, it seems to have been----

A Yeah. I mean-- But the point I'm making is that the establishment, the-- the manpower, was set out by the Estates Directorate and therefore funded by the Board. The-- The supply of expenditure, in other words-- The DMA Canyon report is an example of a one-off cost, right? There were funds available to do that and there were responsibilities in-- particularly between us and Multiplex as to what was a defect and what was routine maintenance.

To-- To the extent that the Estates Directorate at the Queen Elizabeth disagreed with the staffing establishment or the supplies budget, would, as I'm trying to point out, require to be a very documented process whereby he would set out his arguments for more, that would be received up through the management chain to the director of Estates. If he agreed with the request and then couldn't find the resources within his own budget, he would speak to the chief operating officer to see if there were other funds. And the point I'm trying to make is it would never be a corridor conversation with me, because I don't have funds-- the Board doesn't hold a budget. One hundred per cent of what the Board receives on 1 April goes out of the Board to the budget holders on 1 April.

Q Even if it's not budget related, if I understand your evidence correctly, the fact that there was-- or what's been described to us at least, there's a real issue about getting things done because of pressure on resource as a problem, nevermind a budget. That didn't come to you either?

A No.

Q Can I ask you briefly about one or two other topics? We've kind of touched, in passing, on other topics on this question of what should have happened at the point of handover/commissioning, whatever you want to call it.

THE CHAIR: Well, maybe, really, we should pick a word.

MR CONNAL: Well, you had, I think, at one point said, and tell me if I'm misremembering, that, from your experience of doing project work or being involved with projects, you would have expected that, at the point when the building is moving from the builder to the client, there would be, in old terms, a big folder with all the certification of what the systems were, what they achieved, and so on and so forth.

A Yeah.

Q That's what you would have usually expected. Now, leaving aside whether things are digitised or not, because it doesn't matter for the purposes of my question, would you have expected that material to be available at the point of handover of the new Queen Elizabeth Hospital?

A Yes.

Q Did you ever try to find out about that?

A No. I-- I received assurances from the project director that everything was in order to proceed and then, as I'll explain, that process was then repeated by the individual directors advising me of their decision that building was acceptable for clinical services.

Q So, the persons who would have the access to the kind of information that we've just been discussing, would you expect that to be what was on day one or day one hundred-- the Project team, day 101, the Estates director?

A Yes.

Q And who did you get assurances from, just so we're absolutely clear about it?

A The-- The report to the Board to accept handover of the building was prepared by the project director, David Louden, which resulted in-- in us moving to accept the building in February 2015. The work between February and May and June of 2015 to move clinical services in was coordinated by the chief operating officer through the commissioning schedule. I've already alluded to the-- the budget that was set aside, some 15/16 million pounds, to double staff and double run the new hospital alongside the existing hospitals for the period March to-- to June 2015.

Q Are you familiar with the technical difference, in ventilation system terms, between two terms: one is commissioning; the other is validation?

A Yes.

Q So, what I want to ask about is validation. Now, our understanding – and, again, I'm paraphrasing complicated documents – is essentially that the commissioning means that the contractor tests all this kit, makes sure the buttons

are working and the air is coming through and so on and so forth, in the way that he thinks is correct. Then, validation is instituted by the client – in this case, the Board----

A Yeah.

Q -- usually by getting somebody, an external specialist, to do a test and basically see whether they're getting in the ventilation systems what they thought they should have been getting.

A Yes.

Q Now, have you any knowledge of validation being done at the Queen Elizabeth hospital?

A No, I have no detailed knowledge of that. I had the assurance of the project director and the validation was, in the main, through a process he set up with Capita.

Q Now, if you were told, as I think is now common ground with the Board, that validation was not done, would that surprise you?

A Well, it would have been a serious error and deviation from the protocols that we have expected, and it would have been something that I would have expected the project director to report to the Board on why.

Q I'm just wondering, I mean, I can understand if you were in contact with Mr Loudon, and he says to you, "All good to go, everything's fine, everything's done, safe to move in," whatever phrase he uses.

A Yes.

Q If that's said to you, given the possible importance of some of these systems for patient safety, are you not looking for something a bit more than a verbal reassurance?

A I think I've tried to explain that, as the chief executive of the organisation, I was not personally hands-on on every aspect of the Board's business and I was not hands on in relation to the building and subsequent commissioning of the Queen Elizabeth Hospital. Therefore, I relied on the reports that went to the Board and I relied on the reports that were given to me between my direct reports and me. Therefore, if you're asking me, "Did I second guess and double check everybody else's homework?" No, I didn't and never would have expected to.

Q Did anybody check what Mr Loudon was apparently saying, so far as you were aware?

A I have no idea whether the chief operating officer or any other director as part of the commissioning saw information from David Loudon, but David Loudon in the role that he was in was one of the top 10 directors in the Board, both in financial terms and in status. So no,

he was subject to performance management system, as anybody else, but he wasn't----

Q Does that mean if Mr Loudon says it's happened, no one would think to say, "Well, that's very interesting, David, but can you show me the validation certificate for Ward 2A," for instance?

A Well, I think we-- well, first of all, the answer is I expect a lot of people might have asked them questions and I certainly, if I was a director taking over responsibility for my clinical environment, I would have expected to get some detailed information. If I was the director, we've already seen in the context some of the discussions with Infection Control doctors, they asked the project team to provide documented evidence. So yes, I suspect, or I would have expected, there to be a fairly regular dialogue between the operational team and the Project team in the run-up, you know, over the 3½ months or so in the run-up.

Q The only reason I asked that particular question was, and I'm afraid that the fault is mine, but at least one witness, when asked, "Well, given what you'd found on site, you're being told that everything had been done, would you not have said to Mr Loudon, 'Well, I know what you say, David, but would you mind giving me the certificates?'" And the answer was, "Oh, I wouldn't deign to challenge what someone at that level told me." Now, is that an acceptable attitude if that's what happened?

A Well, I can't comment on what happened because I have no knowledge of what happened. I'm saying that if I had been in that operational role, I might have been more demanding of getting access to the information I thought was pertinent.

THE CHAIR: When you talk about the operational role, is this the chief operating officer or--?

A It would be a combination of the chief operating officer and the individual directors of the services. So in relation to the Children's Hospital, I would have expected Mr Hill to have been seeking relevant information for him to do-- discharge his duties. We've already spoke this morning about Mr Jenkins and the role that he would have been performing in relation to the Adult Bone Marrow Transplant and other regional services, Ms Harkness in relation to the general elements of the Queen Elizabeth Hospital.

THE CHAIR: Just my failure in noting. Just a moment or so ago, you say during the period, this is the 100 day----

A Commissioning.

THE CHAIR: -- as I would understand it, you would have expected dialogue between the Project team, and I

just failed to note--?

A And the operational teams.

THE CHAIR: Right.

A The incoming clinical teams.

THE CHAIR: Right.

A But I was inferring that it would be at the kind of managerial level.

THE CHAIR: Right. People like Gary Jenkins?

A Yes.

THE CHAIR: Right. Sorry, Mr Connal.

MR CONNAL: Okay. Can I ask you another-- I'll move from validation for the moment. I think you probably understand, Mr Calderwood, that other participants in the room are also raising questions, not all of which I've got round to yet and I have to come back to some of these topics with no doubt. Can I ask you something else? Applying a little bit of hindsight for the moment, we know that Ward 2A, the Schiehallion Unit, was ultimately subject to a major piece of work long after you had gone. Now, the information we have suggests that questions about the protective environment in the Schiehallion unit were being raised right from 2015 onwards on various topics. Are you aware of that?

A When I was asked the question the first time in my interview, I'd said I had no recollection of that. I subsequently was shown an email from Dr Armstrong to a number of staff which was copied to me referring to the work that she was taking forward with the operational team about concerns about the environment in 2A. I've gone back over in my mind trying to remember all of those issues, and the answer is yes. I was briefed by Jennifer that there were some concerns raised again by Infection Control, and as a consequence of which the Paediatric Bone Marrow Transplant service was suspended for a number of months while Jennifer and the team sought to resolve the issues that had been raised and, subsequently, the Board was advised that the Paediatric Bone Marrow Transplant program had recommenced following resolution of the issues, but I wasn't involved in the detail of those issues.

Q Just for his Lordship's notes, your initial response to that which was:

> "I didn't know anything was going wrong with Schiehallion, I only found out it was wrong since I got involved in this process. I was not aware of this in 2015."

Appears in paragraph 79 of your witness statement, and that's the point that you've just referred to. I suppose that the kind of broader question is, "Here's your shiny new hospital." You've got the 4B issue we've dealt with from--

way from 2015, so pretty early on. You're then discovering another issue about protective environment.

A Yes.

Q Now, whether you're hands-on with the detail----

A Yes.

Q -- which we accept you're not, does that not suggest some form of failure of management oversight, if I can put it as generally as that, that you ended up in this situation on your watch?

A Well, I think you have to kind of look at it in two points. The way that the issues were being presented to me in 2015 was that we had received the physical environment with the M&E services that we had specified, but that it was unacceptable to the Infection Control team.

Q Well, just pause there, that you'd got the physical environment that was expected for the BMT and associated cohort in 2A, you were being told that?

A Yes. Well, sorry, I was never told we didn't.

Q Well, but you were told you-- I thought you said you were being told that you did have it?

A Yes-- no-- yes, the point I'm trying to make is that all the starting points where I became involved in started from, "We've got what we asked for, but it's not good enough," and the issue is, "Why is it not good enough, and what are we going to do about getting it good enough?" You've inferred with the benefit of hindsight, clearly with the benefit of hindsight some 10 years later, it would appear that in certain areas we did not get what we had asked for, but in no discussions with me did they start from, "We haven't got what we asked for," because the involvement then would have been entirely different and would have involved using the legal processes through the contractual agreement to go back to square one. Now, to the extent that the Board's processes for validation have proved, with hindsight, perhaps not to have been as robust as they should have been and not as robust as they were made out to be, I can only comment on that with hindsight.

Q Well, I want to avoid, if I can, getting into a discussion with you which focuses on the contractual provisions with the contractor because that's not something that's within this Inquiry.

A No, but sorry-- it's very important that if in June 2015 when the decision was taken to move the Children's Hospital from Yorkhill, and this is exactly the same point I made about the Adult Bone Marrow Transplant, if the clinical environment was not that that we had specified and "paid for" and therefore

was not safe for the patients, the service should not have moved. There was no requirement to shut Yorkhill one weekend and only one weekend. We could have delayed the move for a period of time. The same point I'm trying to make is that if that had been the issue that had been flagged, the resolution process is entirely different. (After a pause) You can't-- if the environment is not right, you cannot resolve that issue in situ. You have to deal with it differently. I was confronted with an issue where we were told, "Starting point was fine, but the new team think it's not good enough."

THE CHAIR: Who articulated that to you in that way?

A I couldn't name or point to an individual, it was just a general gist of the conversations that were presented to me before I became involved.

THE CHAIR: So would I be right in thinking that on the basis of the information you had, no one was suggesting that Multiplex had not provided what had been specified?

A No. That never came up in the conversations.

THE CHAIR: And did it, or did the conversation include a question as to whether what had been specified was what should have been specified?

A That was more of the tone of the conversations I was involved in,

which was, had we made mistake by not getting a state-of-the-art accommodation? And if so, why hadn't we done that? Or was it a case of the Infection Control team applying different standards in 2015 to that that we had applied during the design process in 2010/11 and, therefore, what was the basis for that? And trying to come to an understanding of these issues. The point I'm really trying make is that there was two-- from where I was sitting, there's two entirely different ways of resolving or seeking to resolve the issue, depending on your starting point. My understanding of both issues, 4B and 2A, was the starting point when they were being discussed in 2015 was, "What we've got was what we asked for, but it's not good enough."

THE CHAIR: Would I be wrong to detect in your statement a sort of flavour that the Infection and Prevention Control doctors in 2015 were looking for more than had been properly specified? In other words, there was a sort element of changing the goalposts?

A My----

THE CHAIR: My question is would I be wrong to read your statement as including that sort of flavour?

A No, I think that's a fair reflection, my Lord. My attempt was to understand why the environment was not

acceptable and that started from the premise that we had properly specified what we needed and had been given what we specified and, at that time, there was an element that thought the new Infection Control doctors who had not been part of the earlier process were, perhaps, applying different standards and the question was, How do we address those concerns, (A) practically or (B) were they just to be noted? (After a pause) So in relation to 4B, as I've said and we've discussed already this morning, they went back to the Beatson and in relation to Schiehallion, Dr Anshong reported to the Board that the service had started again because the issues had been resolved.

MR CONNAL: Obviously, all of these issues depend on precisely what perspective you're applying to them, but I'm just keen to start by looking at what you thought was to be provided in the Schiehallion Unit. Now, if you go to 64 of your witness statement. I think you say after a description of process, you say it was, "Front and centre," as part of the design of the hospital. "The Schiehallion was front and centre," right at the bottom of the page, "It should have been," if we go onto page 65:

> "I was advised that it had been designed involving all of the appropriate clinical people and was to a significantly higher standard than Yorkhill."

So am I right in thinking that whatever the debate about IPC or not, what you thought should have been sitting in the new hospital was something better than they'd had at Yorkhill?

A Oh, absolutely. I mean, Schiehallion was Scotland's only, and is Scotland's only Paediatric Bone Marrow Transplant Unit, and that was the service in Yorkhill in 2009 when we sought to procure a new children's hospital, and that's why I say it was front and centre. It was to be the Scottish National Centre, and it needed to comply with all appropriate regulations and, to the best of our ability, to be as future-proofed as possible.

Q Who told you it had been designed involving all the appropriate clinical people?

A The project director and the chief operating officer as part of the on-the-go process.

Q We've had evidence from Dr Gibson that neither she, nor anybody she knows saw clinical output specification, which surprised us. Does it surprise you?

A Well, you're telling me that. I didn't know that she'd said that. That does surprise me. I had been referred to, or a comment had been made about a

number-- or the number of meetings that was held which copies were kept and the participants recorded, which included doctors.

THE CHAIR: Sorry, could you just repeat that last sentence, "Including the"--?

A Sorry, that meetings-- regular meetings had been held during the design phase and that the minutes of these meetings had been kept, and the participants included a number of the medical clinicians from Yorkhill, had been at these meetings in signing off the design.

MR CONNAL: Well, just so we don't get at cross-purposes, it is probably my fault. What I was asking, remember we were talking about clinical output specifications as part of the Employer's Requirements such as we saw for original 4B? We asked about the clinical output specification for 2A, Schiehallion, showed it to Dr Gibson and she said, "Hadn't seen it and I don't know anybody who did. I think it's been written by a manager." So, would that surprise you?

A It would surprise me that clinical staff hadn't seen it. The initial work on the Children's Hospital, as I referred to in my statement, was led by Dr Morgan Jamieson, who was a cardiothoracic surgeon.

Q I think if we go to the next stage, which is the design process, I think we know that clinicians among others participated in lots of meetings about layout and other issues, although, in relation to the Schiehallion, were you aware that Dr Gibson declined to sign off the plans for the Schiehallion because she was very unhappy with what was being provided?

A I've never heard that, no.

Q Basically she was told by the Project team, in what I might suggest are fairly dusty terms, "Tough". That was the impression she got. You've not heard that before?

A No. One of the documents you sent me included a reference to Dr Gibson clearly stating that the facilities at the Royal Hospital for Children were significantly superior to that that she was leaving behind at Yorkhill. I understand that she may have more recently reversed that statement.

THE CHAIR: I think I'd like to be reminded of that----

MR CONNAL: I'm not sure what that----

THE CHAIR: -- statement attributed to Professor Gibson.

MR CONNAL: Professor Gibson. When we were looking for the plans to see who'd signed them off, we couldn't find a sign off for 2A, and Professor Gibson said she didn't sign it off or, if she

did, which she didn't remember, she was pressed to do it. I'm not aware of a statement saying that she'd got a better result. I think she has stated in the context of the refurbished----

A No, this is-- In the documents you sent me last Wednesday to read in preparation for my attendance yesterday and today, which I read on Monday when I came back from holiday, there was clearly in those documents a minute of a meeting back during the design process and the commission process in which Dr Gibson made that statement. I'm not making any comment in any way; it's the document you sent me. But the point-- I don't know the detail of the process, who would sign off, but basically sending the drawings back to Multiplex, signed off by saying they're acceptable to the client, that could well have been a managerial process or through the Project team. I don't know to what extent you would expect a practising clinician to sign off an operational-- you know, a practical drawing, and----

Q (After a pause) Well, perhaps this would be an appropriate point to pause, my Lord. We can always check what that document was, because it's not one, I confess, I'm familiar with. Can I just put the last point, perhaps, in case we can move from the Schiehallion point? (To the witness) Your assumption was you were getting the best you could get because of the role that the Schiehallion unit played in Scottish medical care.

A Correct.

Q And that's what you would have expected to get?

A Correct.

Q So, leave aside what was contractually demanded or anything else, that's what you were looking for and that's what you would expect your team to be looking for?

A Absolutely.

Q But you weren't aware – other than in exchanges with Jennifer Armstrong – that there was any issue with it?

A No. As I explained, the issue that was explained to me by Jennifer Armstrong in the context of suspending the Paediatric Bone Marrow Transplant service was that there had been issues raised by the Infection Control team with regard to the environment and the risk that that would pose to these patients, and work was being taken forward to resolve those issues. They were subsequently resolved and the report back was that the Paediatric Bone Marrow Transplant service had restarted.

Q That was the last question I wanted to ask before lunch, my Lord.

THE CHAIR: Well, we'll take a lunch break and could I ask you to be

back for five past two, Mr Calderwood?

A Certainly.

(Adjourned for a short time)

THE CHAIR: Good afternoon, Mr Calderwood.

A Good afternoon, my Lord.

THE CHAIR: Now, Mr Connal.

MR CONNAL: Thank you, my Lord. Thank you, Mr Calderwood. I've got to a point in proceedings when I'm conscious of the timing that we have available with you, and I need to move to questions that various parties have suggested. The net result of that may be that we jump around topics even more than we've done already, so-- I make no apologies for that, that's just the way the system will operate.

Can I ask you, first of all, one question on staffing, just before I turn to some other matters? What you were saying, I think, was that, if somebody had had a problem with the staffing levels, there would need to have been a process and it would have needed to have gone through various hands and up to various levels.

Now, I'm reminded by another of the participants in the room that we had evidence that Mr Powrie produced a paper in which he said – and the figures may not be exactly right, but take it from me that they're roughly correct – that, whereas he had 63-- I suspect that was FTE people, he needed somewhere around 111. A paper to that effect went into system and, according to him, went right through the process, through David Louden, and came back to him with a message, "It's been all the way up, including to Mr Calderwood, and he says you just have to stick with the budget." Does that help your recollection at all?

A None at all.

Q Okay.

THE CHAIR: I take it "FTE" is full-time equivalent?

MR CONNAL: Full-time equivalent, I apologise, my Lord. I think the witness understood my reference to----

THE CHAIR: Yes. Yes, he did.

A (Inaudible 14:11:23).

MR CONNAL: Can I then ask you something that cropped up just before lunch where you referred to a minute in which Dr Gibson had been involved and thought that it might show that Dr Gibson had said one thing then and had changed her tune now? Now, I think you've now had a chance to look at it.

A I-- I don't think I said that she'd changed her tune. I said the statement on the television the other week that she gave to Inquiry was the opposite to the statement that was

contained in that minute. That's what I said.

Q In fact, do we see from the minute that she didn't make any such different statement?

A Well, I-- I----

THE CHAIR: Can we look at the minute?

MR CONNAL: Yes, please. It's bundle 27, volume 8, page 97. Now, this is what we understand you were referring to. Am I correct?

A Correct.

Q As you can see, there are a number of people in attendance: Mr Louden sends his apologies; Professor Gibson is present. There's discussion about the progress being made: two rooms currently under scrutiny; other rooms which they hope over time will reach the level of specification required. Then we come to the bottom of the page and we see "BH/DL", which is Billy Hunter, who I think was in an Estates role at the time, and David Louden, DL. We see from the top of the page they were to write up:

> "... a summary document which compared old RHSC and current RHC unit in terms of specification and performance. The purpose of this was to provide formal audit trail that the new arrangements for transplanting children in current RHC were as good if not better than the previous arrangements in old RHC/Yorkhill."

That reads, at least on the face of it, as if somebody is to go away and try and produce a trail to show what you thought should have been the position, i.e. that it was better than----

A No, that wasn't my interpretation of the outcome of the discussion. The-- The-- My interpretation of reading that, just on Monday, was that the group had agreed that was the position. It goes on to say:

> "This document also needed to formally confirm that the specification in RHC ... [and that] The document needed to confirm [various issues] ..."

But it does say, in the sentence before all of that:

> "The purpose of this was to provide formal audit trail that the new arrangements for transplanting children in current RHC were as good if not better than the previous arrangements ..."

Now, that was the point I was referring to in-- Having read that on Monday, that was my interpretation. That-- That's a minute of the outcome of the meeting.

THE CHAIR: Well, I wonder if we can-- Mr Connal, maybe you're going to do this, but I think I'd like to understand what this minute is indicating. There's no year against the date, but our understanding is that this was a meeting that was held on 7 September 2015.

A Correct.

THE CHAIR: Right. Now, it was brought together to identify the progress made in resolving the Bone Marrow Transplant room Estates' issue in RHC and determine the position for the Paediatric Haematology-oncology service in being able to start new cases. Now, my reading of this minute is that it indicates that two rooms either achieved or nearly achieved the required specification for a Bone Marrow Transplant room, and that's two rooms out of eight.

A Yes.

THE CHAIR: Right, and that means six rooms which had been designated for Bone Marrow Transplant patients did not meet that specification, but it was planned that work should be done incrementally to bring them up to that standard. Am I right so far?

A That was my reading, my Lord, yeah.

THE CHAIR: Now, the Schiehallion unit has-- I think it's 24 rooms. I may be wrong about the precise figure, but it has more than 8 rooms. Now, how I read this minute is that it indicates that there was no specialised ventilation provision made in respect of any part of the Schiehallion unit as at September 2015 other than in respect of the two isolation rooms that either achieve or nearly achieve the standard. Now, am I understanding this correctly?

My Lord, I don't-- I don't have the detail of-- of the whole area. The-- My understanding, and the reason I made reference to this in the context of the point about the starting point, which was, "Did we have the specification correct and did we have the building to do it in?" that was purely-- that minute, when I read it on Monday, seemed to me to capture the spirit of the debate I had with Dr Armstrong, which was, "Why are we not doing paediatric bone marrow transplantation?" because the Board was under pressure from the government to why a national service was not being performed.

The outcome of this, when I read it, was that it was agreed that-- subject to certain actions being taken, that the paediatric bone marrow transplant service would commence and that these individual patients would be-- would be treated. I was really just trying to reference a point in relation to Mr Connal's comments about where I

understood the situation to be in 2015.

If we turn to page 98 and go to Point 3 on the right-hand column-- Now, the way I'm reading this, and I've already said this, is that it would appear that, in order to discharge the national function in relation to bone marrow transplants, which you've just referred to----

A Mm-hmm.

THE CHAIR: At that point, the RHC had two rooms to do that, but the plan was that further work should be undertaken to fully seal the remaining four BMT room suites:

> "On completion of this work plan service would have an incremental uplift of 2 - 4 - 8 fully performing BMT suites over an agreed project time."

Now, what I'm taking from this, and, if I'm wrong, tell me, in September 2015, in order to discharge the obligation to provide a national service, the Children's Hospital had two BMT rooms up to specification, they had another six rooms that were allocated for that purpose but were not at that point up to specification. Now, have I got that right?

A I-- I-- You have, my Lord, in relation to the six rooms. I personally can't comment on what number of rooms were-- were allocated to the national paediatric bone marrow transplantation service-- But, yes, the minute sets out a plan that we can't restart the programme because we have two. We would be, in the context of the people present, taking work to move quickly to four, and we'd have a medium-term plan to get to eight within this area. That was my reading of it. My-- that was the only point in----

THE CHAIR: Right.

A -- having read it on Monday.

THE CHAIR: Right.

A And----

THE CHAIR: I mean, I've already put this to you, but my reading of the minute confirms that, as far as the rest of the unit, that's the whole of the the unit other than the two bone marrow transplant rooms that we've discussed, did not have specialised ventilation.

A I have no personal knowledge of what the output-- you know, clinical specification was for the rest of the area.

THE CHAIR: Right. Thank you. Sorry, Mr Connal, I'm just anxious to-- because this seems to be a snapshot of the-- what was the situation September 2015?

MR CONNAL: As far as Professor Gibson is concerned and as far as at least the minutes reveal, she is present at the meeting but doesn't actually contribute directly to the discussion, is that right?

A Well, I'm not sure you can read

into that from the way the thing's written up. I may have been wrong in my inference that Dr Gibson said it, but Dr Gibson was at the meeting. That was the note of the meeting. I therefore assumed that she concurred with the actions and the statements.

Q Let's move on. I'm now moving to some completely different questions so we can take the document off the screen. Thank you. This is a question that's been asked to one or two other witnesses. At the time when you were chief executive, did you have in place for this hospital a business continuity plan covering possible ward closure?

A There would have been operational policies in place to cover disruption to certain services. There are certain services, for example, the paediatric-- the national paediatric bone marrow transplant where you cannot have alternative plans in place. The only alternative arrangements is to contact the English national centres and look to do that. But for all other areas, yes, there were contingency arrangements. The design of the hospital being single rooms is that, unlike the older hospitals with Nightingale wards, you were unlikely, through an infection outbreak, to lose significant areas of the hospital. Whereas in an older setting, like Glasgow

Royal Infirmary, you could lose significant numbers of beds.

Q When you say these would have been in place, do you recollect them being in place, or are you just assuming that that was something that would have been in the system?

A These are the day-to-day operational requirements of the directorate teams. They are not issues that you would collate into a document that went to the board.

Q I suspect the question may being asked because at one point, Ward 2A was actually decanted into another ward elsewhere in the hospital with the BMT people being moved one place and the rest of the patients being moved together, but that was done on an ad hoc basis after a lot of analysis. So that may be what's promoting the question as to whether----

A I know nothing about-- the operational decision that was taken later after my retirement to undertake a significant redesign of the Schiehallion Unit and the operational arrangements that were made during that period, that would have been discussed and approved by the Board at the time.

Q Now, one of the issues that's beginning to emerge in part from your evidence, Mr Calderwood, is just how the management structures operated, what

the chief executive did or didn't do----

A Yes.

Q -- should or shouldn't have done, should or shouldn't have known and so on, and I think you can understand that already from a number of the questions that have come. Given what we've heard about some of the issues that arose during your tenure there, I've been asked to put this question to you. Can you tell us what principles and practices shaped your approach to corporate governance and risk management and how you ensured accountability and transparency in board decision making during times of crisis? Did you have any particular approach there?

A No, I couldn't address that generic question in that way. My approach to issues would have been based or was based on my experience and understanding or, in some instances, lack of understanding of the issues being discussed.

Q I suppose the question then, the follow-up question to that is if there is a problem, a crisis, an issue, and we've heard, for instance, the 4B shift back to the Beatson described as "unprecedented," you know, people that say they've never seen anything like that happen before and the like.

A So I----

Q Where a unit comes into a new hospital, takes a relatively quick look and says, "Not staying here, we're going." Did you have any issues of transparency in your mind when you were involved in that process?

A No, I mean, 4B was a set of circumstances that had to be resolved in the interest of patient wellbeing, and I think we set about it in a very inclusive and transparent way and the conclusion was reached and the decision enacted.

Q I have asked you already about where responsibility ultimately rests in a structure such as the one you operated in. Who is ultimately accountable for ensuring effective risk management?

A I'm sorry, could you amplify on that question? Effective risk management?

Q Well, one of the issues that's cropped up on various topics is whether risk assessment was done, whether any risk management process took place before X or Y was then proceeded with. The question I suspect is directed at who's ultimately responsible for making sure that you have systems in place which, as it were, ensure that effective risk management actually happens, as opposed to sitting in a book somewhere?

A Well, it's the Board's responsibility to ensure that there are

systems in place and the executive responsibility for actioning the Board's decisions is chief executive. Below that, each of the individual board directors and subsequently chief operating officer and directors have their roles and responsibilities.

Q Now, I'm told there's something called the "Corporate Risk Register." Is that something you're familiar with?

A Yes.

Q And in the context of risks, the phrase is often used, "Who owns a particular risk?"

A Yes.

Q So who's the owner of the Corporate Risk Register-- on the Risk Register?

A The Risk Register was compiled and submitted to the Board, I think, quarterly, and probably looked at through the Audit Committee more regularly. It would be-- well, I can't actually remember the actual group of staff that were responsible for pulling it together, but it involved obviously all of the directors having an input on their areas of responsibility. The Corporate Risk Register for Glasgow incorporated many risks including, and most prominently, financial and other risks. As I say, it was reported to the Board on, at least I think, quarterly basis.

Q So is it a Board response-- you've explained who puts it together?

A Yes.

Q Once it's been put together, who owns the risk? Is that the Board?

A Well, the Board owns the risk. It then allocates actions to a post holder, depending on the risk.

Q And are water systems in the Corporate Risk Register, can you tell us?

A I couldn't comment on what was in the risk register at that time.

Q I suppose the question comes to be this, I think, if I'm picking this up correctly, that if you create a risk register and you put risks on there, whether you're division A or division B or division C, it didn't matter; is there somebody ultimately accountable for saying, "Right, there's the risk, I need assurance that-- I or we need assurance that that risk is being effectively managed?"

A Yes, but the Corporate Risk Register to the Board is an amalgam of a whole range of Risk Registers that work throughout the system. The ones that go to the Board are obviously ones that require a corporate approach or input and, depending on their probability and the consequential outcome of a risk occurring, they are scored and noted in the red register to the Board. The Board would expect an action plan to be forthcoming to take the red register item

off of red and to at least amber, if not ideally green. Many of these issues could involve issues that were both internal and external to the organisation.

Q So, you say the Board would expect this to be done. Would that mean that, as the Board's instrument, you and the executive would be responsible for making that happen?

A For ensuring that the appropriate people were tasked to take it forward, yes.

Q Yes. Because we're coming back to this issue of delegation.

A Yes.

Q It's all very well to say, "Well, here's a risk, that lands on the desk of Mr Smith. I'll pass it down to him," but presumably somebody then needs to make sure that it's done?

A Yes, the Board secretary would chase up reports so that a report goes back to the Board to confirm that the register has moved from red to either amber or green. Some elements of the Risk Register might never leave red. So, for example, the financial challenges is an issue between the Board and the Scottish Government and other health authorities for funds, we may always view the fact that the funds are challenging. But in the context of a physical issue, then the expectation would be that, over an agreed period of time, action would be taken and clearly, if on the return of the updated risk to the Board, it hadn't occurred, then I would be-- I would be then chased by the committee and the chairman to personally make sure that these actions move forward.

Q Can I just ask you something else about delegation, because we asked a lot of questions which you dealt with in your statement about schemes of delegation. Some of them were written down, some of them were not, some of them were perhaps capable of being worked out from standing orders, others not so clear. Clearly, the concern of a number of participants-- well, concern in some ways of all of the participants, but particularly of a number of participants in this Inquiry is focused on patient safety issues, of matters that can affect patient safety. Just giving us the benefit of your experience as the chief executive, how does the scheme of delegation ensure a balance between, on the one hand, operational autonomy, the people to whom the thing has been delegated, and on the other hand, oversight to make sure that safety is maintained? How do you get that balance?

A Well, it can be with difficulty in some instances, but it's basically cascaded. So at the lowest level with the clinical directorate, so there's a clinical medical director, there's a clinical nursing

director, and there was the hospital operational director, they they are charged with the responsibility to make sure that the discharge of services from a patient safety perspective are followed through. Now, if they identify a patient safety issue that they cannot resolve then they would escalate that up to the next level which, in this instance, would be the chief operating officer, the deputy medical director and the chief nurse. They would then seek to help resolve this because the point I was making earlier, it's about looking at the totality and seeing how you address and influence the required outcome.

Clearly, if the issue still at that point was unresolved and all parties concerned remained of the view that there was a patient safety risk, that would be escalated to the board executive directors. Then depending on what the issue is, it would go through, certainly if it was a nurse staffing issue, it would go to the Board's director of nursing, and if it was a medical or Infection Control issue, it would go to the Board's medical director and, ultimately, they and I would get involved trying to resolve it, but at that point there would be visibility to the Board that we were addressing an issue within the system or system-wide.

Q I understand that answer and, to an extent, it makes perfect sense, "I can't solve it, I need to push it up, next person, they can't solve it, up it goes." Perfectly logical. The only issue with it, and I want to put to you, is that it is dependent on the person at the lower level pushing it up. It's not dependent on the person above saying, "I need to check with you what you're doing."

A Correct.

Q So, you know, was there any process for those, as it were, in that hierarchy to ensure that what should be happening at the level below was being done? Because otherwise, if, you know, the director X has a bit of a problem but didn't tell chief operating officer, it sticks and nobody knows about it.

A Well, that's possible in the system and the way it works, but as I think it was outlined in a number of the schematics that have been seen by the Inquiry, there are professional lines of accountability outwith the managerial lines of accountability. So if a director was not to accept or address an issue that was raised on-- in this instance, call it patient safety, then both the medical and the nursing heads can come outwith the managerial line and escalate the issue to a higher level. So it can't be buried because the director didn't seek to-- see it with the same concern as others.

Q So there's no downward supervision, you're dependant either on it

coming up from the lower person in the hierarchy or, as it were, coming out sideways and going a different route?

A No-- well, that's the way the system works in the context of the issue. The director of nursing will carry out her own or his own views into the quality of the nursing care provided in all of our establishments. The medical director will interact with all of the medical staff in a downward way about the quality of care and patient safety. So there are individuals looking at the system in a downward way, as well as the primary route being up through the directorate chain. I, as a chief executive, would have general conversations on performance management with the chief operating officer and could make enquiries if I was concerned about anything.

Q Thank you. One of the topics I didn't ask you to go to in your witness statement for reasons of time was the introduction of the Infectious Diseases Unit into the new hospital.

A Yes.

Q Which was not originally planned.

A No.

Q And summarising, this was not a decision that you had been told about at the stage when you would have expected to have been told about it, if I can put it that way?

A Correct.

Q And you described some heated communications. Now, was there any process for dealing with something like that, where a decision is taken without your knowledge? Was there any sort of management process that that should have gone through?

A In that particular instance, there should have been a paper to the Board highlighting the reasons as to why the Infectious Diseases unit at Gartnavel General should also transfer to the Queen Elizabeth, because it was not in the original clinical strategy underpinning the Queen Elizabeth Hospital. So that-- the Chief Operating Officer should have brought a paper to me, and then personally he would have then taken it to the Board so that there would be transparency around the issue and an understanding of the reasons why we wanted to make that change.

Q So, in this case, the system didn't work in that way, in the way you would have expected it to work.

A No, it didn't. No.

Q I suppose I'm trying to think, there was a process that should have happened, it didn't happen, but nevertheless, the decision was taken to move the Infectious Diseases unit in, apparently without going through that process. Was there any other sort of trip

wire that might have been triggered that should have picked this up?

A At a Board level, no, because the-- When the clinical staff and the managerial staff agree they want to do something operationally, and the Chief Operating Officer takes a decision to support it, there are no red flags raised anywhere in the system that would cause me to know it until I start walking about and see an empty building where it should be occupied.

Q Thank you. Again, on occasion we'll find we're going back over ground that you may think you've covered, but bear with me. The Schiehallion unit-- We've just discussed some of the events after handover. Did you get any assurance during any of your routine, more or less informal meetings about the design and build of the Schiehallion unit?

A No, the-- the Schiehallion unit opened in June 2015. It was a centrepiece of the late Queen's visit to open the hospital was to the Schiehallion unit, along with the First Minister and others. So, at that point, all appeared to be progressing satisfactorily. The issue was raised by Infection Control as part of their routine programme, that they were concerned that the environment was not correct. You have seen the minute of the meeting that Jennifer Armstrong chaired

to address: a, the Infection Control Doctors' concerns; and b, agree a plan forward so that the service could safely continue. So, at no point up to-- and we're now into October 2015, was anybody saying that we didn't get what we specified. The concern was to make sure that we had specified what we needed.

Q Now, I may be misremembering, but was there not an issue under which HEPA filters had not been fitted?

A That was during the commissioning period.

Q 2A?

A Correct.

Q Which you learned about and were clearly not happy about. Is that fair?

A That would be fair, yes.

Q Did that not raise flags as to what processes had been in place? Not so much for the HEPA filters, but to check that the rooms that the HEPA filters were not in were correct? I just wonder----

A At the time, the absence of the HEPA filters was identified during the commissioning period. Multiplex then set about rectifying the error. That rectification programme was achieved within the time scale agreed, and the rooms were signed off as being acceptable. The truthful answer is that

the unit should never have been signed off without the HEPA filter units, because that was the whole purpose of the commissioning and validation process. It takes us back to the conversation at the end of yesterday evening, when we were talking about Capita. Capita signed off on behalf of the Board that the room as fitted was operationally compliant.

Now, to you and I going into the room, all we would see is the grille, and therefore, there were six grilles in the room. Before the grille was put up, it was Capita's responsibility to assure us that above the grille was the HEPA filters, which patently were not there, and therefore when the Operational team switched on the filters to check that they were working, clearly there was nothing to switch on, hence it was discovered. So the process we had in place failed. Well, it failed in the context of, the room should never have been signed off. It was caught during the commissioning period-- The distinction you were making this morning between validation and commissioning. So it was caught in the commissioning period, but it should never have been validated.

Q We've put the same question to other witnesses, and that is basically this. We now know, with the benefit of hindsight, that validation of critical areas didn't happen at all, validation as distinct from commissioning in the way that we discussed earlier. Here you have a part of your key area, flagship area, whatever you want, the jewel in the crown, national centre----

A Yeah?

Q -- and you've just discovered that it couldn't have been validated because it couldn't have been validated without the HEPA filters in it. The question we've asked a number of other witnesses and we'll just ask you, is, did it not then occur to you to say, "Hold on, I mean, whether this had been done properly, could it easily have been identified by somebody asking to see the certificates or whatever it was? It clearly wasn't. Should we not be stamping our little foot and making sure we've got everything in line for all of the areas?"

A That's a reasonable assertion. My conversations with the project director-- I can't quote them verbatim, but my recollection would be that I did ask him if there were any other areas that we had any concerns about that we wanted to recheck.

THE CHAIR: May I just take that from you again, Mr Calderwood? "My recollection is"?

A That as part of discussing this particular incident, the absence of the HEPA filters, whether we were-- or in this case me asking him whether he was

clear that all the other areas were fine, were compliant, but it was part of a general conversation. I am not-- I didn't ask for a complete audit of all that had gone before, or hadn't gone before, with the benefit of hindsight.

THE CHAIR: When you were using the expression "were fine or compliant", I rather assume that what you would have in mind were "conformed to contract"?

A Yes, my Lord. Yeah.

THE CHAIR: Thank you.

MR CONNAL: Now, it's been suggested-- I may have touched on this point yesterday, but the question I've been asked to put to you is this. Which group or committee was responsible for ensuring statutory inspections such as Legionella checks were followed up with appropriate action? In other words, never mind the individuals down at the Estates level, which committee was in----

A It was the Water Safety Group.

Q The Water Safety Group?

A Yes.

Q The Board's Water Safety Group?

A Well, their Water Safety Group which was-- didn't contain Board members, but----

Q No, I'm sorry, my fault. What I meant by that was, the Board-wide Water Safety Group?

A They should be getting a report from the director of Estates that the statutory compliance had been performed.

Q Were you aware as time went on, 2015 drifted on into 2016, no doubt, that Infection Prevention and Control teams were raising concerns about the state of the hospital environment?

A In what sense? I was aware of and was involved in a number of firefighting incidents with regard to-- I was aware with regard to Dr Armstrong's work in relation to the Schiehallion. I personally got involved in 4B and I laterally got involved in an issue with regard to Infectious Diseases and the use of isolation rooms within critical care. More generally, or on a-- I don't know if you're inferring on a daily, weekly, or monthly basis Infection Control continues to raise issues. That would be-- No, I wasn't aware of that, and that go through the Infection Control management structure, reporting to the Board Infection Control committee and Dr Armstrong.

Q With the benefit of hindsight, and bearing in mind we're approaching the end of the oral sessions of the Inquiry, so we're starting to think about what could we suggest, what could we offer other-- Has anyone got any easy answers here? And we've asked therefore questions of a number of witnesses about anything they could

suggest. Do you think that the structures and leadership approaches that were in place at the time which related to the new hospital were adequate to safeguard patient safety during this project? And if not, what could you suggest to make things better?

A I believe in relation to this project that at each of the stages the Board brought to bear both internal and external experts capable of leading that stage of the process, be it procurement, planning, and then ultimately construction. To the extent that individuals or organisations didn't perform their roles adequately, it is difficult to see how you set a system above that that is second-guessing the experts below. There has been discussion within the Health Service over many years about the fact that we as staff rarely in our career do more than one major construction project, and therefore there's no learnt-- there's no in-house learning carried forward. So, Mr Seabourne would have taken this project forward over a six- or seven-year period and, in the context of his career, would never have expected to be a project director on such a project again.

So there has been discussion over many years in the Health Service about whether you could have a cadre of people who would in essence flip from one organisation to another, bringing that expertise and practical knowledge, but it's-- that's a role and a career that over the years has proved to be difficult in those discussions, because there's been-- there's no rolling programme of investment in in the public sector-- well, specifically in health. So to have a cadre of these people, there could be a two- or three-year period where they're "not working", because there's no schemes to roll on to.

THE CHAIR: Can I just pursue, with Mr Connal's permission, that point? Essentially, my question is, does that argue for the position of project director to be sourced from outside the Health Service with an appropriately qualified professional, or would that raise challenges, or sort of additional problems? I mean, we've heard that Mr Seabourne had an engineering background, but essentially I understand his skills to be as a Health Service administrator. Incidentally, I think we heard from Mr Gallacher that he was essentially-- If I'm remembering correctly, although his skills are financial, he had some experience in having been a project director in relation to something I think outside GGC. So, would your observation about Health Service officers being asked to be project directors on perhaps quite large projects argue for

that role to be outsourced to a professional, or would that bring other problems or difficulties or challenges?

A In historical discussions, the view was that it would have been preferable for the project directors to have Health Service experience and be knowledgeable about the clinical issues issues and clinical adjacencies, and interacting on a regular basis with medical and nursing staff. The experience we gained through the PFI projects-- The point you were making about Mr Gallacher. Mr Gallacher was one of the project directors in Lanarkshire in one of the Lanarkshire PFI hospitals. These were, particularly in a PFI sense, financially-- The kind of project director role had more to do with understanding the financial aspects of it, but with a team below them to do the clinical input. So, in my discussions over the years, that's been the debate about how you would get someone competent and skilled with Health Service experience and be able to remunerate them at the level consistent with these roles and give them a programme of work which they could see stretching for an acceptable period of a career.

Going back to earlier in my career, we had-- we had what was called the Common Services Building Agency, which was an attempt to do just that: a group of professionals who-- who did Scottish Health Service building projects. That was disbanded for various reasons in the 90s, but there has been discussion since about how one might create a more relevant organisation going forward. That's been the challenge, is to how to-- to get people to voluntarily go into that as a kind of career, because once you-- As I say, most people do it once and then move back into a senior operational role. I mean, had Mr Seabourne been younger, for example, he would have completed this project and he would have taken on one of the director's roles within the Board going forward.

THE CHAIR: Right. What I take from that answer is that consideration has been given in the past to who best should carry out project director roles.

A Yes, discussions have taken place just generally on how to harness the experience we gain within the Health Service in taking forward a major building project, and how to make sure that that learning can be carried over to another. But, because we have, historically, all been employed by our local board, most health boards will only take forward one major project in the, kind of, reasonable aspect of a-- kind of, 20-year career.

THE CHAIR: The other thing I've taken from your answer is that, were a health board to outsource the project

director role, it would lose the particular health service experience which someone like Mr Seabourne had.

A Correct.

THE CHAIR: Right. Thank you.

MR CONNAL: That's a very interesting discussion. Thank you for that, Mr Calderwood. At a slightly more micro level, can I just put this to you for any thoughts that you have? You and sundry other witnesses have spoken during the course of this Inquiry of getting assurances from the project director – "The project director told me," "The project director assured me," "I asked and the project director told me" – assurances which in some cases turned out to be somewhat short on substance on the basis of what we have.

Now, I wonder whether a smaller step that might be taken would be to introduce some form of much more demanding scrutiny of assurances/communications from the Project team. I mean, for instance, we even had evidence from some witnesses early in the Inquiry of asking questions of the Project team and being unable to get an answer at all, that they just weren't responding. So, I'm just wondering whether some form of more demanding audit requirements of what the project director says might have helped. Any views?

A Well-- To have an organisation that sets up an organisation to audit the organisation with the appropriate skills at both levels seems, you know, bureaucratically burdensome. To have a suite of documentation that requires the project director to submit that documentation with the evidence to the client, and, in this case, the Board, on a more regular basis may well be one of the elements of-- of learning.

But there-- In any scheme of delegation and the appointment of a senior executive, there is an element of trust assumed from day one. If performance is poor and that is noted by others and reported, then you would take steps-- as I said in my statement, the Board would expect me to take steps to either help that individual to improve or to move that individual on so that we have the right people with the right skills in the roles. It has not been, in my experience, the case where either I or my previous bosses over me would automatically say, "I don't believe what you're saying, give me external," you know, "validation of what you're saying." That's not been my experience.

Q The reason I ask that is some participants have expressed surprised that, when the hospital was handed over, it seemed to be handed over on the basis of an oral assurance from Mr Louden that

everything was fine, everything was safe to go, everything was ready to roll, whatever phrase you cared to mention.

Now, if you were employing an external private contractor to do a job for you and he appears on-site and says, “Okay, Gov, all okay here,” you’d be more likely to say, “Well, thanks for that. I take it your report with all the supporting structural certificates,” or whatever it is you needed, “will be with me this afternoon or tomorrow,” or whatever it is. That doesn’t seem to have happened here, because, otherwise, for instance, it would have revealed what only turned out much later, that no validation had been done, if somebody had said, “Good, but, David, you have to jump through some hoops here, you know that. Give us the stuff.” So that’s why I’m asking the question.

A Well, no, I appreciate the question, but I-- There is-- There is what we did at the time, and there is the conversation I’m having with you this afternoon, 10 years later. Truthfully, at the time when we agreed to accept the building in February 2015, there were certain-- certain steps that had to be taken. We had to have a certificate of occupation from the council. We had to have various other documentation in place.

So, when I speak to the project director to say, “David, have we got the necessary paperwork?” and I am told that we have-- That might have been naive on my part to not say, “No, I don’t believe you just go to cupboard and bring them all out,” but my expectation when I ask the question is that he has got the documentation because I don’t believe, or didn’t believe, that there was any reason to tell me an answer that wasn’t truthful.

Because, as I keep saying, from the Board’s perspective, people-- people were not being put under pressure to-- to do something, that-- The project, from the Board’s perspective, looked to be going really well. There was a very good partnership working between the-- you know, between the Project team, the chief operating officer and his clinical groups, and Multiplex. That all appeared to the Board to be a very positive set of experiences.

The commissioning period thereafter-- again, in my experience, when I had done these projects – smaller projects, obviously – in earlier parts of my career, there is a documentation checklist that you would expect these people to go through, and that brings a bit of check and balance into it because they are not starting from, “You’ve told me it’s okay so I won’t test it.” Their job is to put all the equipment in place, everything-- switch on the plant, and-- and it needs to work.

You allude to-- to the external versus internal. This particular project, you know, had both. We had external people carrying out critical tasks on behalf of the Board.

Q I'm not suggesting you would say to Mr Louden, "I don't believe you, go and get the paperwork," but you might say to him, "Can you send me the paperwork, David? Because, if I don't ask for it, somebody else out there is bound to say, 'Have you seen X or Y?'" There would be ways of doing this without making it hugely bureaucratic, would there not, while nevertheless imposing a discipline to avoid reliance on oral assurances?

A Yeah, but I can only comment on what-- what I did at the time and-- and the confidence I placed in-- in that process or that way of working. The documentation for this particular hospital, it would run to many thousands of pages, most of which would be entirely unintelligible to me. So, I'm not actually-- I mean, if I was a smart project director and I had a chief executive that was being too nosy, I would send them a-- lots of paperwork that he or she probably couldn't determine whether it said the right or the wrong answer. But that-- that's the way the scheme was set up, to have, we expected, the right people with the right skills in the right roles.

Q Can I ask you this, and it's really a follow up to a point that his Lordship put to you about what he took to be something that sort of emerged from your witness statement, or was perhaps stated directly. The question I've been asked to put to you: do you accept the closure of the Schiehallion Ward was due to patient safety risks associated with the wards, or do you believe that positioning and decisions made by what you call the "new IPC" doctors move the goalposts, thus precipitating the closure?

A At the time, the-- the unit was deemed not to be appropriate for the patients, which I think, from memory, was sort of late June 2015 through to the resolution of that issue and the service commencing in October '15-- I think was, as I have said it already-- my understanding started from, did we-- did we ask for the right specification and did we get it? So, the answer to that starting point was, "Yes. Why is the Infection Control team now saying that's not enough?" and the minute that we discussed after lunch encapsulates the outcome of the work that-- that took place over that three months to answer those questions and create an environment in which the service could restart.

Q Can I ask you something completely different? Given that we're talking about what management should

and shouldn't know, and looking to some of your answers earlier in your evidence when you've talked about, "Well, I didn't know the technical details. I wasn't involved in detail," am I right in understanding that, in April 2014, you and a number of others, including Mr Louden and Mr Archibald, went to Australia to visit a hospital there to try to get useful information about handover issues in hospital projects?

A That's correct. In April 2014, we went to Port Royal Hospital (sic) in-- in Perth for three days to-- to discuss with the team there their commissioning processes in preparation for our own commissioning programme, and, as that particular complex had been built by Multiplex, to talk to them about the-- the handover issues and whether there was any learning there.

It transpired when-- when we arrived that, due to a major failure with their external IT supplier, the hospital wasn't operational. They-- It had been due to open at the Christmas of 2013, but the statutory authorities in Australia had outsourced their IT provision and there were ongoing operational issues about getting that up and running.

So, what we-- what we got was quite good information in relation to the commissioning programme, not least some little learning points that we would never have twigged with regard to transferring clinical teams in and transferring new ways of working into a-- that were built into the design of the hospital into working in real life, in the sense of, although they were not operational, they had gone through all of the teething problems with the clinical teams.

Q When you-- I think I'm right, I'm just checking. You, David Louden, Grant Archibald, and, I think, David Stewart----

A Yes.

Q I can only really ask you, from your position, having gone out there and picked up these learning points, what did you do with them when you got back? Did you have some kind of seminar or briefing or-- Who did you pass them on to?

A Well, the individuals took that-- took back the general learning. So, for example, one of the, kind of, points that-- that I ended up getting involved in, just in-- on the site, was meetings with the various medical groups to talk about the new ways of working in relation to-- they were all losing their offices. Up until 2015 when we opened the Queen Elizabeth, every NHS consultant had their own office, not to say some of them had their own car parking spaces.

So I ended up meeting most of the

medical staff societies to talk about the fact that we were going to hotdesking and shared open space, and that the site was having no dedicated car parking, but car parking permits based on use, and, at that point, quite a lot of consultants would not have qualified for one of these permits because they didn't actually leave the hospital, their working day was in a single location. So, I decided I would front up those meetings, which were usually in the evening and boisterous.

Q Can I just ask you one question about water which I've been asked to put as a follow up to the exchange we had way back at the start of your evidence? I mean, you said you didn't know you were the duty holder and so on and so forth. Did you come to a point where you did check that systems were in place for dealing with various water responsibilities?

A Yes, I-- I was aware of the Water Safety committee. I was aware of the-- the scheme of delegation setting out the responsibilities on the director of Estates, the director-- the chief operating officer, and the hospital directors in the structure that we introduced in April 2015.

Q Did you do anything to check it was functioning?

A No.

Q Now, if I can come to some other questions I've been asked to put to you, and we are jumping back again, back to the ventilation derogation. Let's use that phrase for simplicity. Now, your position is that you were not aware of it and therefore the Board wasn't aware of it. Can you remember when you first found out about it?

A No, I think in a-- in my statement I never-- I said I-- I became aware of it during general discussions after 2011, but I couldn't recall exactly in-- in what context and in discussions with whom. I think the key that we were discussing was that, at the time of signing the contract on 18 December, I was not-- my attention was not drawn to any "movement" from a mandatory to a non-mandatory standard.

Q Now, we know from evidence about what happened later on, particularly post 2015, that a number of parties thought they needed to try and investigate why this had happened; what had happened, why was it done, and so on. Did you take any such steps when you first heard about the derogation?

A No, because the information I had and to this day still have is that, in the generic clinical areas where we-- "the Project team, on behalf of the Board" accepted a ventilation strategy based on three air changes, not six, supported by chilled beams, was acceptable.

Q Well, I mean, you say the

Board had accepted that. I mean, what you actually mean by that is the Project team.

A Well, (inaudible 15:18:49) the Project team acting as the Board's agent.

Q So, I'm just wondering whether it occurred to you, given that you were the CEO in charge of governance, that you ought to at least try to find out how this had happened, why you didn't know about it, perhaps why Helen Byrne did or didn't know about it, and so on?

A Well, I-- We're-- We're going way back into the mists of time, and-- and trying to stick to my oath about what I knew and what I didn't-- The position up to and signing the contract in December 2009, Helen Byrne, as project director, supported with Mr Seabourne, in some context or other, in developing the emerging ventilation strategy, accepted a design solution that was-- as far as I'm aware now, was accepted by the Board's technical advisors as being acceptable, and that that decision was able to be made by the Board to go with that strategy, and all of the sensitive clinical areas had their own specification for ventilation, etc.

MR CONNAL: Well, I----

A So at no time to me-- when I became aware of it later, at no time was it ever presented to me in the sense of, "We had to do something and we have chosen not to." That would have raised significant red flags which would have required a detailed report to be prepared and submitted to the Board.

Q The reason I ask is very simple. One of the questions that has arisen here, and I think it's a mystery as much to us as it is to the NHS GGC team, is why no one could find any paperwork on this at all through any of the systems that were in place to manage this construction job. No one could find anything, and that's why when people came in in 2015 they had to go, "What? What has happened here?" And dig back and ask. Now, if it had occurred to you to say, "Well, when I was signing the contract, I didn't know anything about this, did anyone-- did somebody give me that? Helen, do you know about it? Did it go to the Project Committee or anything?" It might have raised it a lot earlier. I suppose this is the question we're trying to get to.

A Well, as I say, when I became aware, the exact date-- as I say, I can't comment, would be, as I say, after 2011 during the construction. I was advised that the decision to accept that strategy was reasonable and was within the Board's ability to agree to it, that it was not breaking any mandatory guidance.

Q Well, I understand that, but you keep saying, "the Board." What you

were told was the project director had agreed this. You were not told, as I understand it, anyone further up the chain (inaudible)----

A No, no, no, no, absolutely. No, absolutely. I use the word, "Board" meaning that within our-- it was within our powers, i.e., as a statutory body----

Q Right.

A -- to accept a ventilation strategy not of six but of three, right? Because the six was guidance, not mandatory, and we have discussed and agreed that the use of "mandatory," it refers to the contract specification specification where we had put the air changes into the mandatory column and then agreed-- the project director agreed to take it out of that column and put it into the advisory column. Now, so when I became aware that it was three, I was then told that simple thing. So----

Q It's interesting if you'd read the contract, which I know you didn't for very good practical reasons, you would have found that the Employer's Requirements still contained SHTM 03-01 in the list of mandatory compliance documents, albeit that in this case a derogation from it had been agreed, and that's why we've been using the question of derogation. But I suppose that the question is simply, did it occur to you to go and ask somebody else how this had happened? Without you knowing about it?

A No, because the way it was explained to me at the time was that it came out of the kind of narrative, iterative process of design evolving and hardening up in the context of going from, as I referred to before, the high-level outline 1-200 drawings down to the detailed 1-50 drawings throughout the building. So it was explained, it didn't register any bells with me that it was an issue to double check or to do anymore about it because it was explained as being technically competent and appropriate. The key areas were that the ventilation strategy for the specialist areas was correct and in working.

Can I come back to some other topics that I've been asked to put to you? Whatever your recollection is, this Inquiry has heard evidence that the Estates team at the hospital was under significant resource pressure, and the result of that was that critical infrastructure was not maintained, maintenance was not done. I mean, the Horne tap maintenance wasn't done, notwithstanding it being said to be critical. The DMA Canyon report was not actioned when it should have been, just to take two examples. Now, do you accept any responsibility for that having occurred?

No. The original staffing profile for the hospital was designed by and set out

by the professional Estates management. To take the figure that you quoted, which I've never heard before, to get that staffing requirement wrong by 90 per cent is unbelievable that you could have a professional group of Estates managers that could look at something and get it wrong by 90 per cent within months. We have talked about-- we have to differentiate between your two examples, the Horne taps absolutely should have been done. It was there, the man responsible was at the meeting, the man responsible agreed to do it and the man responsible then, you're telling me, didn't do it. The DMA Canyon report is a mystery to me because it was a no-brainer. It would have paid for. It had no resource implications at all to Mr Powrie and his team. It would just have been handed over and Multiplex would have done most of it and they would have billed us for the bits and pieces that were not part of the defects. So the DMA Canyon is just an astounding issue to me.

To get into the nitty-gritty of why the Estates Department, having agreed structure, then very shortly after opening decided it was so wrong, I don't know how you get there, that's-- I've never come across managers starting with an opening number getting it so wrong. The other interesting part is that over 70 per cent of all of the equipment in the hospital was brand new and, therefore, covered under maintenance contracts by external suppliers. There was a range of external maintenance contracts for specific specialist equipment and plant, and the major boiler plant, the major heavy plant was covered by a two years' warranty with the contractor. So in the opening year, I am surprised to hear that people were under excessive stress and workload. I would have expected that stress and workload to build up in subsequent years as more and more responsibilities transferred to the day-to-day Estates team. I would not have expected it on day one.

Q Another suggestion I've been asked to put to you is that the way the governance culture operated while you were chief executive created a situation that had an unfocused approach to risk management and didn't create robust systems for escalating concerns. Now, do you agree with that proposition?

A No.

Q The result, it is suggested, of all of this is that environments were created in which, as we've heard, it was standards, whether it's water or ventilation, were consistently not as they should have been and, accordingly, patients were put at risk. Do you agree with that?

A No, but can we be clear, are

we talking about that the staff at the Royal Infirmary or Gartnavel or Stobhill or Victoria are all saying that they didn't do their maintenance or they didn't have risk in place, or are we talking only about the Queen Elizabeth University hospital?

Q We're only talking about the Queen Elizabeth.

A Well, I'm chief executive of the whole organisation and if I can put systems in place in 90 other per cent of the organisation, why would I not have that same situation in the Queen Elizabeth? The Board's responsibility are for board-wide issues and policies. The water policy, all policies are board-wide. They need to be monitored that they're being delivered everywhere. We're over 40 premises, major hospitals which, put together, are as big as the Queen Elizabeth campus. It is surprising to me that everything is inferred as being broken at the Queen Elizabeth but working, apparently, everywhere else.

Q Well, of course, we don't know what was or was not working anywhere else. We only know what's happened at the Queen Elizabeth.

A Well, I'm questioning whether it happened at the Queen Elizabeth.

Q (After a pause) I think a number of the participants in the room have directed questions which really focus on whether you, as chief executive, had enough effective oversight of this major once-in-a-lifetime project that was taking place to build what was probably the biggest hospital in Europe as a building project at the time?

A The campus, not the hospital building.

Q Well.

A Some of the marketing my PR people use was "campus," because you had to add in the 800 beds that were already on the site, to which we added another 1400.

Q Yes. Well, do you accept that you showed a lack of effective oversight on this project with the----

A No, I don't accept that. Other people will form their own views, but I don't accept that, no.

Q My Lord, I think this might be an appropriate point, if I may, to take a short pause that we usually do at this stage, given the hour, so that I can see what the position is.

THE CHAIR: Mr Calderwood, Mr Connal would wish to canvass with the legal representatives in the room whether there are any more questions. So can I invite you to retire to the witness room and this should maybe take 10 minutes.

A Thank you.

(Short break)

THE CHAIR: Some questions, I gather?

MR CONNAL: Yes, my Lord.

THE CHAIR: (After a pause) I understand some further questions, Mr Calderwood. Mr Connal?

MR CONNAL: Thank you, my Lord. (To the witness) I'm afraid some of these range from the narrow to the very broad. I'll just try and put them to you as concisely as I can. First one is perhaps my fault. When I was planning to go through your witness statement with you, I had originally intended to ask you this and avoided it due to lack of time, but I've been asked to go back to it. In paragraph 449 of your witness statement, which is on page 125, you referred to the fact that your successor, Jane Grant, had made a statement that she'd inherited a difficult set of circumstances, and you didn't think you knew what she meant by that. Well, first question, did she come and ask you about it?

A No, I mean, I should clarify that in relation to 449, I was-- the question I was asked was, "Jane Grant made a public statement, what is your comment?" No, I-- Jane and I haven't spoken outwith meeting at two funerals of former colleagues since I retired.

Q In responding to that in the witness statement, you identified two issues that occurred to you. One was the 4B issue that we've already discussed – and I won't go back to that – and the other one was what one might describe as a general financial challenge for the Board. I don't think, unless you particularly want to go there, I'll get you to read through that answer orally. Are you content with that?

A Correct.

Q Thank you. At one point in your witness statement – I'm afraid I haven't had time to find it – you described the Schiehallion unit as an "entirely different debate". Do you remember saying that, and if so, what did you mean by that?

A Well, yeah, I remember saying it, and it was in answer to a question about the subsequent issues of the Board taking a decision to do a major refurbishment of the area, and I'm saying that clearly in the media, what has come out since my retirement was that there were issues, apparently, with regard to the suitability of the unit that resulted in the Board deciding to spend, I think according to the media, something between £6 and £9 million in doing additional works.

Q You may simply say you didn't do this, but I've been asked to put to you this, that when you had this new hospital project coming on stream, how did you

seek assurance that the hospital environment, ventilation, water, etc., was safe for patients?

A I personally, as I've explained, didn't do anything in the sense of-- The brief that the team were given in 2009 and subsequently developed through 2010 was to create, you know, the best clinical facilities that would then be available in Scotland and to provide these service-- well, the infrastructure that would provide the best clinical environment for both the patients and the Clinical teams.

Q At the time you were Chief Executive, can you tell me whether the Board recognised patient safety was dependent on good governance?

A Well, patient safety was a significant feature of the Board's oversight and good governance was considered to be part of the overall organisation of the Board, not unique to patient safety.

Q One of the comments that's been fed back to me is that, in a number of instances of issues that we've discussed over the past two days, you said, "Oh, I didn't know about that, no one raised this with me." Does that say anything to you about what the culture was at the time in the management of that hospital, that things didn't appear to percolate up to you?

A I've clearly failed over the last two days to try and explain the breadth and width of the role of the organisational Chief Executive. I mean, to say that I would be aware of and be involved in and be consulted on everything before people did it would be an unworkable organisation. It would be like asking the Chief Constable of Police Scotland did they know what was happening in the canteen at the Govan Police Station. The organisation can't work-- The scale of the organisation can't work like that. I-- I personally was charged by the Board to take forward an annual work plan that was set out by the Board, and the hospital, the procurement, construction and commissioning, was one element of, in most years, a 25-point performance plan for the Chief Executive. So I believed that the systems that we put in place were correct, they were properly resourced, and that the people were, in my opinion at the time, competent to take the project forward.

Q Can I ask you this: with the benefit of hindsight, what do you think went wrong on this project and why did it go wrong?

A I-- I cannot honestly answer that question, because quite clearly issues are appearing and-- and now, ten years on-- for which I don't have access to-- to what is fact and what is

speculation-- So I believe it would be wrong of me to try and distil my thoughts into a statement.

Q Can I just ask you a much smaller question which I've been asked to put? Craig Williams, that's a name familiar to you, I take it, from your time there.

A It is, yes.

Q Can you remember what his role was, as you recall it, in relation to the procurement and subsequent issues in the hospital?

A My recollection of Dr Williams was that his-- I don't think he was involved in the project through the procurement and appointment of Multiplex. I think at that time, from memory, he was a Consultant Microbiologist Infection Control Doctor at Yorkhill. My understanding was that subsequently in his role as the Lead Infection Control Doctor for Greater Glasgow & Clyde Health Board, he inputted into the latter stages of the project in, I believe, around about 2014 onwards, and obviously as Lead Infection Control Doctor, he was working with Dr Armstrong in relation to addressing the issues that were being brought up by the then-appointed Infection Control team at the Queen Elizabeth.

Q I think I just have two questions left. One of them does engage a question that you've already touched upon, so apologies if I need to go back to it. You explained that you had a work project which covered lots of things. I think the point is being suggested that the production of a hospital of this scale and this importance to the Board was at least a very significant part of what the Board had to do in those years in question. Would effective leadership therefore not mean that critical issues did require your personal attention and sign off?

A Well, that didn't happen in that-- that extent. The Chief Operating Officer can-- who had significant responsibilities took the lead on the clinical issues concerning the Queen Elizabeth campus development. My role was to do with the strategy and the finance and and the issues emerging external to the organisation in relation to the Queen Elizabeth.

Q The final question is this. I think you told us a minute or two ago that you thought you had the correct systems in place and, as far as you understood, the correct people in place to deliver this project. Now, given what we now know about this project, does that mean there's nothing that you feel you need to take this opportunity to apologise for?

A Well, given, with all due respect, that I don't know what you know with regard to your statement about what

we now know because I don't know what is now known.

Q Well, let me go back to that, then. We know that-- Well, we've heard that there were enormous problems on handover with the Estates team not having time to do their work. We know water systems weren't maintained in the way they should have been. We know that there were problems with 4B which led to the drastic result of patients moving over and then moving away again.

We know that there were issues with 2A which, albeit slightly after your time, led to that ward having to be decanted and ultimately redone. We know, I think, and you probably know as well, that, broadly speaking, the Board's position is that they did not get the hospital they had hoped to get. Now, you were in place as chief executive from a date prior to contract signature to a date after handover.

A Yeah.

Q I'm just giving you this opportunity to consider whether, in light of your evidence to date, there's anything you feel you need to apologise for?

A Well, clearly, on behalf-- had I been still chief executive, I would be apologising. Should any of the actions that we took or any of the decisions that were taken gave rise to sub-optimal outcomes for patients, that-- that is devastating for me to hear or to acknowledge. But I would reiterate that-- that, when operational issues became apparent to me and/or were reported to me-- My statement sets out fully, and over the last two days we've discussed quite fully, we immediately took action to identify the problem and to create a-- a remedy.

Now, you use the words "drastically transferring a patient population back". I regard that as a required outcome, because of a perceived risk. We sought to remove that element of risk. That was exactly the same situation we saw when-- when we prudently suspended the paediatric haemato-oncology bone marrow transplant service. So, at no time during my period did we not act on patient safety issues by seeking to either remove the patients from the risk or remove the risk from the environment that the patients were in. I-- And I think that's demonstrated by-- by my actions.

My disappointment that certain of the systems appear to have failed and that, at the time within project management arrangements in the NHS in Scotland, there was no failsafe mechanism to catch them, you know, I'm bitterly disappointed with that. I could go on to say that I would therefore be bitterly disappointed in some of the people I appointed and bitterly disappointed in

some of the external consultants that we employed to help us, but that-- that's a personal view of someone long retired.

Q I have nothing further to ask, my Lord.

THE CHAIR: Mr Calderwood, that brings your evidence to an end and you're free to go, but, before you go, can I thank you for your attendance today and yesterday and for the preparation that went into that evidence in responding to our questions for the preparation of the statement? You're now free to go.

A Thank you very much.

(<u>The witness withdrew</u>)

THE CHAIR: Now, my understanding is perhaps Mr Mackintosh will take the next witness----

MR CONNAL: He will indeed, my Lord.

THE CHAIR: -- who is Ms McQueen.

MR CONNAL: My Lord, that's correct.

THE CHAIR: Well, we will see each other tomorrow, all being well, and if I can wish you a good afternoon.

(<u>Session ends</u>)

(16.04)