SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
20 January 2026

Day 3
Thursday, 22 January 2026

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10.02

Opening remarks

THE CHAIR: Good morning, and can I repeat the welcome which I extended on Tuesday to the core participants and others attending today in person? You're very welcome, and I trust you're as comfortable as our fairly restricted accommodation permits. Now, I think Ms Watts. Good morning, Ms Watts. Now, you are representing Drs Inkster, Peters and Redding.

MS WATTS: Yes, my Lord, thank you.

THE CHAIR: Thank you.

Closing submissions by Ms Watts

MS WATTS: Good morning, my Lord. These submissions are presented on behalf of Dr Teresa Inkster, who is now an infection control doctor and a consultant microbiologist at Antimicrobial Resistance and Healthcare Associated Infection Scotland; Dr Christine Peters, who is still a consultant microbiologist at the Queen Elizabeth University Hospital in Glasgow; and Dr Penelope Redding, who is a retired consultant microbiologist.

These three doctors have become collectively referred to as "the whistleblowers," although as my Lord is, I think, aware, Dr Inkster did not actually formally participate in any whistleblowing process. I will refer to them as "the whistleblowers."

THE CHAIR: I can entirely understand that. Something which occurred to me is-- And one sees the use of "whistleblowers" in a number of situations and in other closing statements. In some ways, it's remarkable that three distinct professional persons are somehow regarded as a group or a partnership, and that something that is said to be true about Dr Redding is somehow assumed also to be true about Dr Inkster. Now, if you have any observations on that, I would be interested.

MS WATTS: Thank you, my Lord. I mean, they do certainly have, now in particular, very different perspectives because although they at one time held similar jobs in the same organisation, or in Dr Redding's case of course are retired, they now have very different working lives. But I've taken care to discuss with them the content of the submissions that I'm going to make today, and I'm content that, insofar as I'm commenting today, I'm commenting on behalf of all three

of them and I'm representing views that all three of them share, although my Lord's quite right to highlight their at times very different perspectives on the events that occurred.

I will refer to them as "whistleblowers" simply for the sake of brevity, my Lord, recognising the distinction that my Lord has drawn. The Inquiry already has the benefits of detailed written submissions that have been prepared on their behalf, and I'll formally adopt those now.

The further submissions that I'll make today will focus on three distinct areas. These will be firstly the nature and the extent of the apology that's now offered by NHS Greater Glasgow and Clyde to my clients; secondly, the submission made by GGC to the effect that all of its staff acted in good faith at all times; and thirdly, the extent to which the necessary lessons have truly been learned and the necessary changes instigated.

Insofar as the apology is concerned, my Lord, I will explain why, although they are relieved to have received an apology, given the events of the last ten years, the whistleblowers do still have real concerns about the nature and the extent of the apology that's actually being offered to them. In relation to

the question of good faith, my Lord, I will explain why the whistleblowers do not accept the submission made and repeated several times by NHSGGC to the effect that at all times throughout the events with which this Inquiry has been concerned, all GGC staff have acted with good faith towards them. There are, in my submission, a number of examples of what certainly appears to be behaviour that was not well-intentioned, particularly on the part of senior members of NHSGGC's management and directed at the whistleblowers.

In the third part of my submission, my Lord, I will outline why, despite the sessions that GGC makes in its closing submission, and which were repeated by Mr Gray KC during his own submissions this week, the whistleblowers do still have significant concerns about the extent to which the necessary changes have actually been instigated, in particular amongst the senior managers of the Infection Prevention and Control team at the Queen Elizabeth University Hospital.

I wish to make it clear, my Lord, that all three of the whistleblowers would much rather have been in a position to instruct me to make a different submission today. They all wish that they could have simply asked

me to relay that they are now reassured that things have changed and that they are no longer concerned but, regrettably, my Lord, those are not my instructions.

I'll now move, my Lord, to the first of my three substantive chapters, which will be the apology now offered by NHS Greater Glasgow and Clyde to the whistleblowers. I would observe at the outset, my Lord, that GGC's position now appears to be essentially the polar opposite of the position that was presented to this Inquiry, a position which significantly expanded the duration, the scope and the cost of this Inquiry, as well the burden on patients, families and whistleblowers.

GGC now accept that their management of the issues investigated by the Inquiry fell well below what should be expected. They accept that their culture did not encourage reporting of concerns and did not encourage transparency. They accept that there was indeed an exceedance in the rate of environmentally relevant bloodstream infections. They accept that it is more likely than not that a material proportion of those infections had a connection to the state of the hospital's water system, and they accept that there were failures with the design, the build and the commissioning of the hospital, and further failures by NHS Greater Glasgow and Clyde at the handover stage.

Insofar as my client's personal positions are concerned, GGC now states in its written submissions that its previous criticisms of them were neither helpful nor fair, and it withdraws them and unreservedly apologises for having made them. This sentiment is expressed in GGC's closing submissions for the first time at the very end of this Inquiry and at the end of a decade of treatment of the whistleblowers that has at times been wholly unacceptable.

A meaningful and a genuinely felt apology is really important to the whistleblowers. This is not for reasons of personal or professional vanity. As my Lord has already alluded to this morning, although Dr Inkster and Dr Peters and Dr Redding are referred to collectively as the whistleblowers, what they really are of course is three highly-experienced and highly-trained doctors, who have always been held in the highest esteem by their patients and by the vast majority of their clinical colleagues, and who are experts in the field of microbiology and infection control. Their job was and is to keep patients safe, and that has always

been their number one concern and their priority at all times.

The whistleblowers, as this Inquiry has heard, were at times simply unable to do their jobs in the ways that they otherwise would've done because their well-founded and their genuinely held concerns were not investigated properly, openly or respectfully, and that meant that patients were not always kept safe. An apology for this lack of an open and respectful response to the raising of concerns and for the approach that was taken to the whistleblowers in general terms is important because all the whistleblowers have ever wanted to achieve was genuine reassurance that what had happened to them would not happen to any other clinicians who raised concerns in the future and that patient safety would therefore be better safeguarded. If those staff members and, in particular, senior management staff still working in NHSGGC who were responsible for the wholly unacceptable way in which GGC as an organisation responded to the whistleblowers when they raised their concerns, if those staff members were genuinely sorry and recognised the mistakes that they had made, then that would provide the whistleblowers with considerable reassurance, my Lord, for the future.

I note that Mr Gray wishes to avoid being drawn into any criticism of individuals who work for NHS Greater Glasgow and Clyde, certainly in relation to this chapter of the matters that the Inquiry has been investigating, but the practical reality is that there are currently – working within the Infection Prevention and Control team at the QEUH – individuals, including the director of infection prevention and control, who must bear some personal responsibility for the unacceptable treatment that my clients received over the course of a decade. These are individuals who consistently maintained that there was no exceedance or spike in infections and that my clients were not only wrong to suggest that there was, but that in expressing what are accepted to be well-founded and properly expressed concerns about unusual infections, my clients were said by these individuals to be acting in bad faith, to be attention seeking, sensationalising or ignoring basic identified principles of infection control. A genuine apology from those who are actually responsible for what went wrong here would go some way to demonstrating real remorse and a real desire to learn from the serious mistakes of the past and would provide

the whistleblowers with the reassurance that patient safety will be safeguarded from now on.

But the apology which is now offered on behalf of NHSGGC is expressly not such an apology. Instead, as ever, GGC prefer to present things at a very high level and to apologise for what is described as a “culture” but not for any specific failures by any individuals. This Inquiry heard from a large number of witnesses, my Lord, who were past and present senior employees of GGC. Every single one of those witnesses could have said at any point during their evidence that they acknowledged that the whistleblowers were raising valid concerns in good faith, that the response that they received from GGC was unacceptable, and that the whistleblowers deserved an apology for how they were treated. Any of those witnesses, my Lord, could’ve given that evidence to allow this Inquiry to be satisfied that the organisation had fundamentally changed and that the culture which ultimately led to the requirement to convene this Inquiry no longer existed. However, my Lord, not a single witness gave that evidence.

THE CHAIR: Well, certainly, it was after a number of questions, but I have Dr Scott Davidson, who is the current medical director, giving evidence on 9 October, and it's column 49 in the transcript. As I say, there were a number of questions which took him to what I have noted as there should be an acknowledgement to these colleagues, and what I understood him to be saying should be acknowledged is that the whistleblowing should not have been necessary. I think that's my only recollection.

MS WATT: I was going to deal with Dr Davidson's evidence, my Lord. I'll do that----

THE CHAIR: Right, I’m sorry----

MS WATT: No, I'm happy to simply do that now. So, as my Lord has identified, Dr Davidson is indeed the current medical director, and he was asked specifically whether the whistleblowers should receive an apology. That was in the context of him acknowledging that accident and emergency consultants who had also participated in a whistle-blow had received an apology, and Dr Davidson was asked whether the whistleblowers in this Inquiry should also receive an apology.

I've looked at the same section of the transcript that my Lord is referring to, and my Lord might recall that when

he's asked whether or not the whistleblowers should receive an apology, Dr Davidson answers that question with, “So, I think we’re sitting in a public inquiry.” From then on, his failure to directly answer the question of whether the whistleblowers should receive an apology or not was raised during the adjournment at the end of his first passage of evidence. I asked for it to be clarified as part of the Rule 9 process, and he was asked to clarify what he meant because it wasn't possible to discern a clear answer from the evidence that he'd already given.

My Lord will have seen, having looked back at the transcript, that over the next two full pages of transcript, Dr Davidson continues to avoid providing a direct answer to the question that he was asked. Counsel to the Inquiry eventually had to specifically point out to him that he was not able to detect an answer to the question that had been asked and specifically asked him to consider dealing with the matter in terms of a yes or no answer, and only at that point-- and this is, as my Lord has said at column 49, only at that point, what he said was, “So, I’m obviously one member of the Board, and I feel that, yes, there should be an acknowledgement to those colleagues-- whistleblowers.” So, even then, he was still avoiding actually using the word “apology.” It’s worth noting, my Lord, that Dr Davidson also avoided providing a direct answer to key questions about the whistleblowers in his witness statement.

If my Lord looks at his August 2025 whistle statement, and in particular to page 23 of that document, Dr Davidson is specifically asked whether the concerns raised by the whistleblowers were valid concerns, and he simply does not answer that question at all. So the whistleblowers read his statement carefully and they listened to his evidence, and they did not detect an apology but, much more importantly, my Lord, they do not feel reassured by Dr Davidson’s evidence that the necessary fundamental cultural change is actually underway.

THE CHAIR: Sorry, just give me that again, Ms Watts. They do not discern----

MS WATTS: So, they listened to his evidence and they read his statement----

THE CHAIR: Yes.

MS WATTS: -- and they were unable to identify an apology. But more importantly-- because this is much more important to my clients than the question of whether or not

they personally receive an apology, more importantly, they did not find his evidence reassuring from the perspective of identifying real fundamental cultural change.

Dr Davidson is important, my Lord. I mean, a great number of witnesses could be criticised in similar ways, but Dr Davidson is important because he is the current medical director. So not only does he still work in NHSGGC, but he holds that very senior role. There are other individuals in similarly senior and important roles in relation to which similar issues could be raised, and I'll deal with just two of them. Sandra Devine, who's the current director of Infection Prevention and Control, and the chief executive, Professor Gardner. So, the current director of Infection Prevention and Control first, my Lord, provided a lengthy witness statement.

THE CHAIR: Should I be looking at your written closing statement at this point or can I simply just----

MS WATTS: I think, at this point, you can probably simply just----

THE CHAIR: -- listen?

MS WATTS: -- listen, my Lord, yes, thank you. The current director provided a lengthy statement, and also my Lord will of course recall gave evidence to the Inquiry, and I don't propose to take my Lord to the statement but in the context of this submission that is being made about fundamental cultural change. I think it's important to remember the evidence that was actually given to this Inquiry by the people who are responsible now for setting the tone and dictating the culture within the Infection Prevention and Control team at the QEUH. So, there are a couple of passages from Ms Devine's statement that I would particularly draw my Lord's attention to. At paragraph 155, my Lord will----

THE CHAIR: Now, I simply can't recollect. Ms Devine provided one witness statement.

MS WATTS: That's my recollection, my Lord.

THE CHAIR: All right.

MS WATTS: Or certainly she provided one recollection-- she provided one recollection -- I'm sorry, my Lord. She provided one witness statement----

THE CHAIR: Yes.

MS WATTS: -- in advance of giving her evidence, but I'm now questioning myself and wondering if there was a supplementary statement after that, but it's the original statement that I'm referring to, my Lord.

THE CHAIR: Right.

MS WATTS: So, at paragraph 155 of that original statement, Ms Devine -- who is still the director of Infection Prevention and Control and for whom Dr Peters still requires to work -- stated at paragraph 155 that Dr Peters was unable to work in partnership with colleagues. At paragraph 164, my Lord will see that she describes the level of scrutiny that she was receiving from the whistleblowers and in particular from Dr Peters as "intolerable." At paragraph 172, she makes an allegation against Dr Peters that in investigating concerns, Dr Peters is said to have improperly accessed material about infections. So the message is not whether Dr Peters was right to be concerned, but rather that she shouldn't have been looking. At paragraph 178, Ms Devine refers to issues as having been identified first in October 2017, and that is an issue with which the whistleblowers take real issue, my Lord.

THE CHAIR: Do you want to give me a heads-up on what the issues were?

MS WATTS: Well, I think that the matters----

THE CHAIR: Well, I'll just listen.

MS WATTS: I think the matters are probably quite fully canvassed in our written submissions----

THE CHAIR: Right, okay.

MS WATTS: -- but I think it's a high-level point I'm seeking to make, my Lord, which is if it is being maintained that these issues did not come to light before October 2017, that is simply not right, and the Inquiry has available to it an extensive body of material, including contemporaneous emails, that make it clear that these issues were first identified and raised time and time again, starting more than two years before October 2017, as the author of this statement is, or ought to be, well aware.

Finally, my Lord, just on this point of what features in the statement, at paragraph 502, there's reference to what's said to be a "deliberate attempt by Dr Peters to undermine [the work of] the IPCT," and that is an allegation that my Lord will see repeated multiple times throughout that statement. So, again, my Lord, if we are looking at the evidence that was actually provided to the Inquiry, as opposed to simply the assertions that are now being made, my clients do not find the evidence to be reassuring on the question of whether there is a fundamental cultural shift in how people raising concerns will be approached.

That was also the case, my Lord, in relation to the evidence that was given by the current chief executive. She was also specifically asked, my Lord, whether the whistleblowers that I represent should receive an apology, and my Lord has already referred to the passage of the transcript that I was going to refer to, so I won't take my Lord back to it in any detail or take up time reading from the transcript, but suffice to say I agree with my Lord's interpretation of what's contained in the transcript, and in particular agree that it does not actually contain an apology.

THE CHAIR: Does it include the word "apology"?

MS WATTS: No, my Lord, I've not been able to find anything that resembles an apology directed at my clients. I think, again, this is a passage that my Lord himself referred to at one point, Professor Gardner, that she said that she was sorry that my clients "did not feel listened to," which is very different from saying that GGC did not listen to them and that GGC are sorry about that. Even the passage that GGC identify in their written submission as amounting to an apology – and this is paragraph 3.5 of GGC's closing written submission where they excerpt a section from Professor Gardner's evidence and characterise it as amounting to an apology – is, in my submission, self-evidently not actually an apology to the whistleblowers.

THE CHAIR: It's put forward as an encapsulation.

MS WATTS: Again, my Lord, I cannot emphasise enough that the whistleblowers do not want an apology simply for the sake of it or for reasons of professional vanity. What they want is to be genuinely reassured that things have and will change. As I've already said, they are not currently reassured of that.

I'm afraid, my Lord, that events since the evidence concluded has added to their concerns in that regard. My Lord will recall that earlier this week, counsel to the Inquiry referred to a letter which all three of the whistleblowers were sent by Professor Gardner, and those three letters have been submitted to the Inquiry and are available. They all received essentially the same letter, and I agree with the observation----

THE CHAIR: When you say "essentially," is the wording not identical?

MS WATTS: Indeed, my Lord, it is, save for the address, obviously. But I agree with the observation that

counsel to the Inquiry offered, that it is surprising that it was thought appropriate to simply cut and paste the same letter and send it to three very different individuals: one, somebody who's completely retired; one, somebody who no longer works for the organisation and indeed works in a very senior role in a national body; and, finally, someone who is a current full-time employee of the organisation.

THE CHAIR: All the letters, I think, are-- The letters of 13 January?

MS WATTS: That's correct, my Lord, yes.

THE CHAIR: Yes.

MS WATTS: With my Lord's leave, I'll just read aloud a couple of passages from the letter. It begins by stating that:

> "Within my evidence at the SHI, I outlined my objective to improve opportunities in NHS Greater Glasgow and Clyde for the balanced views of our staff to be heard and to learn from previous experiences. I recognise that we need to build capacity to support healing and repair relationships as we progress into the organisation's next chapter."

It then goes on to say, my Lord:

> "Aligned with this commitment, you may also be aware that NHSGGC and NSS have commissioned external management support to work across the infection control teams of both NHSGCC and ARHAI to assist with the building of relationships to support enhanced collaboration going forward. It is hoped this engagement will re-establish trust across our respective teams."

So, my Lord's already identified that these three letters were written on 13 January, which is of course after GGC lodged written submissions in which they indicated that their organisational position was one of a full and unreserved apology to the whistleblowers. So, against that background, the letter from Professor Gardner is as striking for what it doesn't say as it is for what it does say. It does not say, my Lord, that GGC is sorry for what happened to the whistleblowers either before or during this Inquiry. Instead, my Lord, essentially, it just consists of phrases that amount to management speak and from which I would respectfully suggest that it's difficult to discern any real meaning.

THE CHAIR: Sorry, "difficult to"--

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MS WATTS: Discern any real meaning, my Lord. Now, it's of course accepted, my Lord, that giving evidence to this Inquiry over many hours is a difficult task, and one might not always express oneself as clearly as one might have wished with the benefit of hindsight. However, if Professor Gardner felt that perhaps she had not been as clear or gone quite as far as she would have wished in her evidence, in making it clear that she wished to offer a full and an unreserved apology to my clients, then these letters provided an obvious opportunity to correct that oversight; but it is an opportunity that Professor Gardiner obviously chose not to pursue.

Instead, we see phrases like "opportunity to balance views" and "rebuild trust on both sides," which suggests two well-intentioned parties with conflicting positions, and also suggests a return to a previous approach taken by GGC, which was to focus on personality and relationship issues at the expense of actually engaging substantively with the clinical concerns that were being raised.

So, these letters, my Lord, do not, in my submission, reflect what is said at paragraph 4.5 of the GGC submission – what is said to be an unreserved apology for the treatments that my clients received – and the whistleblowers do not believe that these letters which they've now received are demonstrative of any real change.

That's all that I want to say, my Lord, about the question of the apologies that are now offered by NHSGGC, so with my Lord's leave I'll move on to the second part of my submission, which is to address GGC's position on good faith. Now, it's entirely a matter of course for my Lord to accept or to reject the submission that's now made on behalf of GGC to the effect that all of its staff have acted in good faith at all times throughout all of the events that this Inquiry has considered.

GGC do not offer a particular definition of what is meant by "good faith," so I am proceeding on the basis that what is intended to be conveyed is a sentiment that the actions of all staff were well-intentioned at all times and I'm afraid, my Lord, that the whistleblowers simply do not accept that there has never been any bad faith directed towards them.

There are, in my submission, a number of examples of behaviour directed towards the whistleblowers

which are simply not consistent with being done in good faith or being well-intentioned, and I'm going to mention two today, my Lord: firstly, Position Paper 1 and, secondly, the SBAR of November 2024.

There are, of course, many other examples. I would suggest that the circumstances in which Dr Inkster was removed as the chair of the water IMT is such an example, but I've already made detailed submissions about those, so I won't rehearse those here. But I do think, given the submission that's now made about good faith, it's worth taking a little bit of time to look at Position Paper 1 and at the November 2024 SBAR.

So I'll start, my Lord, with Position Paper 1. This document has already been considered at length, but there are a couple of matters which, in my submission, do bear repeating. My Lord will recall that at paragraph 63 of Position Paper 1-- I can give my Lord the bundle reference if that would assist, although it's already available. Paragraph 63 of Position Paper 1, Dr Inkster is specifically accused of having misled a patient's parents.

At paragraph 69 of Position Paper 1, the whistleblowers are said to have made false allegations against their colleagues; to have made false allegations about the accuracy of public statements by the Board; to have deliberately failed to follow proper processes in airing their concerns; to have made excessive and unnecessary demands of the IPCT, Estates and Facilities and IMTs; to be guilty of basic failures relating to risk management and observing recognised scientific principles; to have provided inaccurate information to patients, families, the media and politicians; and to have breached their patients' confidentiality.

And it is, in my submission, difficult to imagine a worse response to whistleblowers than to produce a list of allegations like this and then to have to withdraw them because no witness will substantiate them.

THE CHAIR: Can I just take that again? "Difficult to imagine a worse"----

MS WATTS: Response to whistleblowers than to make a list of allegations like that, and then to have to withdraw them because no witness is prepared to substantiate them. Dr Peters, my Lord, has had to go to work every day, through this Inquiry and in the lead up to it, and deal with the people who said these things about her. Her other professional colleagues and her friends and her family were all

aware that these allegations were being made against her by her employer, and that she was being accused of dishonesty and incompetence. The same is, of course, true of Dr Inkster and Dr Redding, although they've subsequently left GGC's employment.

So, given the nature of what was said in Position Paper 1, I would suggest that GGC's position now, which is that what was said wasn't helpful or fair, is something of an understatement given the nature of the allegations that were made against whistleblowers who were raising well-founded concerns in good faith.

At paragraph 4.6 of GGC's closing submission, it stated that this position paper was produced on a counsel-to-counsel basis in order to assist previous counsel to the Inquiry in understanding the position of GGC on a wide variety of issues. Now, clearly, I can't make any comment on the basis upon which the document was submitted – and indeed no detail or explanation of that is offered by GGC – but from the whistleblowers' perspective, GGC's position on this just makes it worse, because this was intended to be a list that my clients would not see. So these incredibly serious allegations would be made against them, they wouldn't know about them, and they would never have the chance to defend themselves.

GGC specifically states, my Lord, in paragraph 4.6 of their closing submission that Position Paper 1 was submitted in good faith, and that is not accepted by my clients. Now, for the avoidance of doubt, I'm not suggesting that Mr Gray or Ms Toner have acted anything other than properly in recording the position as stated to them by their client in this document, but the fact that counsel were provided with this position in the first place, when no witness was actually able to support any of it, does not appear to the whistleblowers to be consistent with good faith or with well-intentioned actions.

THE CHAIR: Well, as I recollect what Mr Gray-- And let's just underline how you start this. You're making no adverse criticism----

MS WATTS: Absolutely not.

THE CHAIR: -- of Mr Gray----

MS WATTS: No.

THE CHAIR: -- and there's no reason to do so. However, he explained to me that the-- what appears in Position Paper 1 was on the basis of material that was put before him by GGC. Now, he may

have used the words “witness statements,” but I-- First of all, that may have been sort of general, because Inquiry witness statements had not been taken at that stage but, as I understand it, material sufficient to satisfy him that he could make these statements had been put to him.

MS WATTS: I’m not for a second suggesting that that’s anything other than a properly made submission, my Lord.

THE CHAIR: But he accepted, as you’ve just said, that they were not supported, in his view, by the evidence led in the Inquiry.

MS WATTS: Indeed, my Lord. In fact, my Lord might recall the evidence of Professor Steele, who still holds a very senior role within NHSGGC, whose witness statement was very critical of the whistleblowers, and I asked at the end of his evidence, via the Rule 9 process, for him to be specifically asked whether the criticisms that were listed in Position Paper 1 were directed at Dr Peters or Dr Inkster or Dr Redding, and he said they were not. I’ve already made a submission about whether my Lord should accept that evidence or not in my written submissions but, I mean, the point is an obvious one, my Lord: there’s nobody else they possibly could have been referring to. But he wasn’t even willing to accept that the document related to the whistleblowers, even though it self-evidently does.

So that, my Lord – unless my Lord has any particular issues about Position Paper 1 – is all that I would propose to say about it, and I’ll move on now to deal with the November 2024 SBAR.

THE CHAIR: Yes.

MS WATTS: This is in bundle 52, my Lord, volume 5 and it’s page 148.

THE CHAIR: Can I just take that from you again? Bundle----

MS WATTS: Bundle 52, volume 5, page 148. This, in my submission, is a really important document. It provides the most contemporaneous evidence, as opposed to assertion, that the Inquiry has of the current attitudes of the senior leadership of the Infection Prevention and Control team at the QEUH. No author is identified, no individual author is identified, but as the Inquiry knows, NHSGGC employs a director of Infection Prevention and Control and a lead infection control doctor, and the holders of those roles now held those roles at the point when this document was produced, so it seems reasonable in my submission to

assume that one or both of them must bear some responsibility for the content of this document.

THE CHAIR: Right. Can I just get that from you again? The document, as I recollect, is, as it were, attributed to the Infection Prevention and Control team. Is that----

MS WATTS: That's correct, my Lord.

THE CHAIR: Can I just take from you again what you said following "no individual author"?

MS WATTS: Of course, my Lord. So, no individual author is identified but, as my Lord knows, NHSGGC employs an individual in the role of director of Infection Prevention and Control – that's Sandra Devine – and also employs a lead infection control doctor, Dr Bagrade, and the holders of those roles also-- my understanding is that they also had those positions in November 2024. So, in my submission, it seems reasonable to assume, in the absence of an identified author, that one or both of those individuals must bear responsibility for the content of this document.

Indeed, my Lord, if one considers the terms of the Vale of Leven Inquiry report, and, in particular, I would direct my Lord to Recommendation 46, that inquiry recommended that the infection control manager must have direct responsibility for the Infection Prevention and Control service and for its staff. So if that recommendation has been implemented in GGC then, again, that would tend to suggest that the director of Infection Prevention and Control, which I understand is the role formerly known as "infection control manager," the person holding that role is ultimately responsible for the Infection Prevention and Control service and for its staff, and therefore must have some responsibility for this document.

My Lord heard, earlier in the week, my learned friend, Mr Gray, offering an excuse of the unprecedented events and the unprecedented pressures that existed to justify behaviour during some of the earlier events that this Inquiry has looked at, but even if my Lord is satisfied by those excuses in relation to earlier events, and I say that he should not be, such an excuse cannot reasonably be said to mitigate the preparation of this document in November 2024.

My Lord will see that this document was prepared on 20 November 2024, which is about six weeks after the director of Infection

Prevention and Control gave evidence to this Inquiry. The lead ICD, Dr Bagrade, has not given evidence to this Inquiry, although my client's firm view is that she should have done, and we requested on a number of occasions that she did. My Lord will recall that Professor Gardner sent this SBAR on to the director general for Health and Social Care at the Scottish Government on 25 August 2025.

This document, my Lord, goes to the heart of the central premise, or certainly what I understand to be the central premise, of the GGC closing submission, which seems to be that: insofar as they did things wrong, they are sorry; that insofar as they did things wrong, they have learned and are continuing to learn the necessary lessons; and also that everyone has done their best to act in good faith throughout. In my submission, analysis of this SBAR document and the approach that was taken to it by Professor Gardner cast significant doubt on all three of those propositions.

My Lord will see under the heading, "Assessment," in the document, the following passage appears:

> "It's said by the authors that there have been multiple statements recently made by the whistleblowers, ARHAI colleagues and experts appointed to the public inquiry criticising NHSGGC's compliance with the National Infection Prevention and Control Manual, and requirements for reporting infection episodes to ARHAI. All these opinions have been based on incomplete information, biased by people's personal beliefs and interests, trying to sensationalise the fact that if there is a case of Cryptococcus, it most likely will be found in a patient hospitalised in or linked to QEUH. These statements have been made without providing any evidence or facing any consequences for giving misleading information."

Now, that is not, in my submission, suggestive of an author or authors who are-- sorry, who have learned the necessary lessons, or who always act in good faith. Instead, what we see in the SBAR is simply another set of incredibly serious and utterly baseless allegations of bias and giving deliberately sensationalised and misleading information to this Inquiry being made against both the whistleblowers and their professional

colleagues at ARHAI. This document was simply sent on by the current chief executive, even though it obviously contains allegations which she should not simply have transmitted without initiating a detailed inquiry as to how on earth a document of this nature had come to be prepared.

Again, returning to the Vale of Leven Inquiry, my Lord, that inquiry recommended – this is Recommendation 47 – that there should be a direct reporting line between the infection control manager and the chief executive, and the chief executive should, in my submission, clearly have been using that line of communication here before simply rubberstamping and sending this SBAR on. The whistleblowers, my Lord, believe that if GGC had truly learned the necessary lessons to ensure that the issues that arose in relation to my clients are not repeated, then as soon as this document came to light, it would have been unreservedly withdrawn, rather than transmitted to the government, and it would have been apologised for. And those who are responsible for preparing it would have been subjected to an appropriate disciplinary process.

THE CHAIR: I think I missed what, immediately, you said after "if." What was the premise to what followed?

MS WATTS: So, my clients are concerned that if GGC had truly learned the lessons and implemented the changes to ensure that what happened to my clients couldn't be repeated, then this document would've been withdrawn and apologised for, and those who are responsible for preparing it would've been the subject of a full and appropriate disciplinary process.

THE CHAIR: Withdrawn by whom?

MS WATTS: I suppose by the chief executive, my Lord. Obviously, we don't know where this document went. I certainly don't know where it went, other than that it was sent to ARHAI and it was sent to Caroline Gardner, who's the director general for Health and Social Care.

THE CHAIR: Right.

MS WATTS: I don't know where else it might have been transmitted.

THE CHAIR: It's dated 20 November 2024. Now, that is about three months prior to Professor Gardner----

MS WATTS: It is.

THE CHAIR: -- being in post, and my recollection is that Ms Grant,

who would've been the chief executive at that date, she demitted office, I think her evidence is, in January 2025, so there was not a gap. I can look again at Professor Gardner's evidence, but I don't know if this is sort of is intended as some sort of handover document.

MS WATTS: I don't know, my Lord, I'm afraid, but what I do know is that on 25 August 2025, so after Professor Gardner had been in post for some time and must have had a degree of familiarity with the issues with which this Inquiry has been concerned, she elected simply to send this on to the director general for Health and Social Care. I don't know when this first crossed her desk, this document.

My submission is that the proper response would have been one of horror that people had seen fit to reduce allegations like that to writing and an appropriate inquiry of how it came to be prepared, rather than simply to send it on to the government, which is what, in fact, Professor Gardner did. Now, unless my Lord has any questions, that concludes what I want to say about the question of good faith and well-intentioned behaviour but, suffice it to say, the whistleblowers simply do not accept that the behaviour which NHSGGC have inflicted upon them has at all times been well intentioned and the product of good faith.

Now, the third, my Lord, of my three substantive chapters is to offer the whistleblowers' views on the current working culture and what that means for patient safety. As has already been said this week, infection prevention and control is indeed a multifactorial process, and the culture and the attitude of the senior leadership of the Infection Prevention and Control team is a critical aspect of this multifactorial process. If that culture and attitude is flawed, then the infection control team will not operate effectively, and the lack of an effectively operating Infection Prevention and Control team will render the hospital unsafe.

Dr Peters still works in the hospital as a full-time employee of NHSGGC. No one has apologised to her for the baseless allegations made against her, and no one has told her, other than through the conduit of the submissions now lodged in this Inquiry, that any of those very serious allegations are withdrawn. My instructions from Dr Peters are that she has not seen evidence of the necessary changes having taken place. Her consistent and repeated

experience up until the present date is that the culture has not changed, learning has not been implemented, and there remains a default assumption that the environment cannot be the cause of infections.

Dr Peters tells me that she feels that she is treated with a combination of mistrust and of hostility from senior managers when she's at work. She tells me that information is withheld from her by the senior leadership of the Infection Prevention and Control team at the QEUH, who she believes continue to view her as a troublemaker who asks difficult questions and who is best avoided. She wishes, my Lord, that this were not true, but her genuinely held belief is that it is, and she doubts whether any real change can be achieved with the current IPC leadership in place, and that is a view that my other two clients entirely agree with. Dr Inkster is in a position to offer an informed view on this because she deals regularly with the current QEUH IPC leadership in her new role at ARHAI, and she tells me that she also sees no evidence of any learning, insight or contrition. So to the extent that GGC are attempting to reassure the Inquiry that all is now and will continue to be well, that position is simply not accepted by the

whistleblowers.

For that reason, my Lord, the whistleblowers were concerned to note Mr Connal's submission earlier this week to the effect that he agreed with recommendations sought by my clients about oversight of the ventilation and the water systems at the hospital, but he did not agree that the same oversight of the Infection Prevention and Control team was required. For the avoidance of doubt, my Lord, my clients regard that as the most important area in which further oversight is required, not the least.

THE CHAIR: On what you've described as "oversight of the Infection Prevention and Control team," or "service"?

MS WATTS: It's the senior leadership of the Infection Prevention and Control team at the Queen Elizabeth University Hospital. I think that's an important point to make, my Lord, because my clients are not making and would not wish to be associated with the suggestion that they've made allegations about the many colleagues who they greatly value and respect not in the senior leadership of the IPC team, or working in infection and prevention and control in GGC, not in the Queen Elizabeth University Hospital.

THE CHAIR: Now, in your written closing statement, do you address that topic? I mean, I read your closing statement, but I can't recollect at this moment everything that's in it.

MS WATTS: We address specifically the recommendation that there needs to be oversight of the senior leadership of the QEUH IPC team----

THE CHAIR: Right, okay. My concern was I couldn't immediately see what that might amount to, but I can find that in the closing----

MS WATTS: There's a suggested recommendation, my Lord, yes.

THE CHAIR: Right.

MS WATTS: My Lord will be pleased to hear I just have a few more points to make. I'm nearly finished. Essentially, the whistleblowers have asked me to relay that, having listened carefully to the submissions of Mr Gray KC, it appears to them that the Inquiry is being asked to accept assertions of fundamental and ongoing change but with no actual evidence to support those assertions. GGC have previously made assertions to the Inquiry, including in Position Paper 1, for instance, and it has turned out that in fact there was no evidence to support those assertions, so the Inquiry should be extremely reluctant to simply accept bare assertion at face value in these circumstances.

I note that my Lord has asked GGC to produce a document setting out the nature and the extent of the change that's taking place, and what more is planned, and I would ask that those who I represent get the opportunity to consider and to respond to that when it is produced.

THE CHAIR: Well, they certainly will have access to it as a document in the Inquiry. What follows on, I think, has to be for further consideration. I mean, as you will appreciate, exchange of views has to come to an end at some point.

MS WATTS: I entirely appreciate, my Lord, that that's of course the case, but I had rather thought that was happening this week, and in fact it would appear that GGC are being given a further opportunity to represent a position, so I would respectfully suggest that it's important that my clients are given an opportunity to respond to that, but I'm quite content to cross that bridge when we when we come to it, my Lord.

THE CHAIR: Yes.

MS WATTS: Now, an unrelated matter, I know that very serious

allegations that have previously been made about counsel to the Inquiry have been repeated by GGC----

THE CHAIR: Yes.

MS WATTS: -- in their submissions this week, and it rather appears to me that one of the many difficulties associated with being counsel to an inquiry is that it's impossible to keep everyone happy, but I am bound to say that those who I represent have never felt that they were on the receiving end of the sort of preferential treatment or bias that is alleged by GGC. I also feel it, in fairness, requires me to point out that I'm quite sure that Mr Mackintosh in particular will have less than fond memories of me remonstrating with him forcefully and at length on the many occasions when I felt that actually it was GGC, and not those who I act for, who were being advantaged by the approach taken by the Inquiry.

I also feel, again in fairness to Mr Mackintosh, that it's important to point out that those who I act for listen very carefully to the evidence, and a large number of Rule 9 questions were prepared and sent to him and Mr Connal for their consideration. Whilst they were good enough to ask quite a lot of them, there were also a large number that they declined to ask, so I simply make all of those observations, my Lord, just to perhaps provide a bit of context to the suggestion that my myself and my clients have been on the receiving end of the benefit of a biased team of counsel to the Inquiry because that certainly hasn't been my experience or perception of things.

THE CHAIR: Right. So, the position I'm in is that Mr Gray's clients feel that they were harshly treated or their witnesses were harshly treated, and your clients feel that they were harshly treated.

MS WATTS: For the avoidance of doubt, my clients have no complaint to advance in relation to counsel to the Inquiry, and that's not what I'm seeking to do. I'm merely pointing out that it's very difficult as counsel to the Inquiry to keep everyone happy, and there were certainly times when neither me nor those who I represent were happy. So the suggestion that things have been dealt with in a biased and one-sided manner is not accepted.

THE CHAIR: Mm-hmm.

MS WATTS: Finally, my Lord, my clients would wish to conclude by having me say that they believe that the most amazing things are done in the QEUH every day by incredibly dedicated and skilled staff, and all that

they have ever wanted to do was contribute to the positive change that all of those staff, and more importantly their patients, deserve. They are very concerned, my Lord, that if this Inquiry were simply to accept a statement made by GGC, and contrary to the evidence that has actually been led before this Inquiry, that the organisation has and is continuing to change fundamentally and that all is and will be well, then my clients fear that their efforts to improve patient safety at the QEUH, which have come at enormous personal and professional expense, will have been in vain. Unless there's anything else which my Lord would wish me to address, those are my submissions.

THE CHAIR: No, I have a very full written statement----

MS WATTS: Thank you.

THE CHAIR: -- which I will obviously spend some time on, as with all the other written statements. Thank you, Ms Watts.

MS WATTS: Thank you.

THE CHAIR: Now, Ms Connelly, I think you're the next person I would wish to call on. Would it be convenient if we took our coffee break now and invited you to address the Inquiry following the coffee break?

MS CONNELLY: Yes, my Lord, thank you.

THE CHAIR: Right. It occurs to me that, because we have more people who I hope we'll be able to provide coffee to, it might be wise to be a little bit generous on the coffee break. If I was to ask you to be back for quarter to twelve, would that give you sufficient time this morning?

MS CONNELLY: It may result in me running over by 5 or 10 minutes beyond one o'clock, my Lord, but I will try and----

THE CHAIR: Well, we can accommodate that by maybe abbreviating the-- Maybe you might want to liaise with Mr Love as to how you can best use the time, but I think I will suggest that we rise now and try and be back for quarter to twelve in the hope that everyone who wants coffee can have coffee.

(Short break)

THE CHAIR: Now, good morning, Ms Connelly. You represent the Cuddihy and Mackay families?

MS CONNELLY: I do, my Lord.

THE CHAIR: All right.

Closing submissions by Ms Connelly

MS CONNELLY: My Lord, on behalf of those families, I thank you for the opportunity to make the following oral submissions. I formally adopt the written closing submissions laid before the Inquiry. My Lord, I wish to record the thanks of those whom I represent for the opportunity to participate in this Inquiry. We acknowledge the dedication and hard work of the whole Inquiry team in conducting the Inquiry. We trust that all of our submissions to date and recommendations will be considered by your Lordship in reaching his final determination of the terms of reference.

My Lord, my submissions this morning will be in three chapters. Chapter 1 identifies the aspirations or rights contained within the United Nations Convention on the rights of the child, which I'll refer to as UNCRC, and also Getting It Right For Every Child, GIRFEC, which I respectfully submit are relevant to Terms of Reference 8. My Lord, the second chapter will comprise a brief response to the closing submissions of NHSGGC, and my third chapter reflects on the experiences of the Cuddihy and Mackay families, incorporating the words of Molly and John Cuddihy and Eilidh and Lisa Mackay.

My Lord, turning to chapter 1,

UNCRC and GIRFEC. Prior to identifying the aspirations or rights contained within the UNCRC and GIRFEC that are relevant to Terms of Reference 8, I wish to briefly set out why UNCRC and GIRFEC are relevant to this public inquiry. GIRFEC is the Scottish Government's commitment to provide all children, young people and their families with the right support, at the right time, so that every child and young person in Scotland can reach their full potential. GIRFEC takes a rights-based approach, with its principles upholding UNCRC. Both documents have a shared perspective, where all children and young people are recognised as individuals and rights holders, and where their human rights are embodied in all aspects of society.

My Lord, GIRFEC is not a slogan. It is the national framework that is meant to run as a golden thread through every decision affecting children in Scotland, including those taken by health boards. It sets out a clear expectation that all agencies will work together to get it right for every child by safeguarding their wellbeing across the SHANARRI indicators.

THE CHAIR: Now, you may have to bring me up to speed on that.

MS CONNELLY: My Lord,

SHANARRI is the acronym that represents that children are to be safe, healthy, achieving, nurtured, active, respected, responsible and included.

THE CHAIR: I suppose I should be able to work this out, but the letters which make up the----

MS CONNELLY: S-H-A-N-A-R-R-I.

THE CHAIR: S-H----

MS CONNELLY: A for apple, N--A for apple. R-R-I.

THE CHAIR: Right, and that is found in GIRFEC?

MS CONNELLY: Yes, my Lord.

THE CHAIR: Right. Okay. Thank you.

MS CONNELLY: My Lord, for a tertiary children's hospital, this translates into a duty to provide care and environments that are not only technically competent, but are demonstrably safe, coordinated, rights based and centered on the child and family. My Lord, the role of UNCRC principles and GIRFEC were confirmed by the children's commissioner, Bruce Adamson. My Lord, prior to the commencement of this Inquiry, Professor Cuddihy had contacted Mr Adamson, and following the announcement of the Inquiry he wrote to the cabinet secretary, and a copy of that letter was previously supplied to the Inquiry.

THE CHAIR: And I take it we've included it in a bundle?

MS CONNELLY: My Lord, that's something that I'm not sure that I can find. I have tried to, but I'm not sure that I can find it. If your Lordship would rather that I didn't mention the contents of the letter----

THE CHAIR: No, that's not the point. It's just to make sure that it's available for me to read and, therefore, you may wish to check with the Inquiry team if we don't have it in the bundle, you may need to supply it again, but it's just a question of making sure I'm able to read it.

MS CONNELLY: Of course, my Lord, and I had anticipated that you may wish an additional copy and that will be made available to the Inquiry. Within that letter, my Lord, to the cabinet secretary, the children's commissioner seeks assurance that any public inquiry will take a human rights-based approach, in line with the Scottish Government's commitment to incorporate the UNCRC into Scots law and to embed human rights within the work of government. He states that, in taking such an approach, it is important to recall that human rights are interdependent, indivisible and interrelated, and he provides the

example, my Lord, using Article 24 of UNCRC which is the right to the highest attainable standards of health, to state that that depends-- and fulfilment of that article depends on other rights being similarly respected. In particular, Article 13 provides the right to receive and impart information, whilst Article 12 requires children to be able to participate in decisions made about and for them.

THE CHAIR: In that context, should I also have regard to the Children's Act of 1995?

MS CONNELLY: Well, my Lord, the GIRFEC principles are incorporated in the Children and Young People Act of 2014 and----

THE CHAIR: Right, sorry. I'm rather behind the curve, in that case.

MS CONNELLY: -- my understanding, my Lord, is that the UNCRC was directly incorporated into Scots law in a 2024 Act and, again, my Lord, these are things that I can provide to the Inquiry team with details for your Lordship's assistance.

THE CHAIR: Right. Just for my note, the 2014 Act, the title----

MS CONNELLY: Children and Young People Scotland Act.

THE CHAIR: And then you're going to give me the detail of the statute incorporating the UN Convention?

MS CONNELLY: Yes, my Lord, but I've failed on that front, as I don't have the name of that particular statute to hand. However, I will identify it----

THE CHAIR: Yes, yes.

MS CONNELLY: -- over-- some notes that are on my desk, my Lord. My Lord, we submit that your consideration of Terms of Reference 8 directly engages the rights and aspirations of both UNCRC and GIRFEC. Hospitalisation of children in Scotland is managed through the GIRFEC framework, and GIRFEC applies to hospitalised children by requiring that, firstly, the child's and family's needs and voice are all central to decisions thereby promoting participation. Secondly, that wellbeing indicators help assess the child's overall health, not just their physical condition and, thirdly, there is alignment with UNCRC principles ensuring that rights are upheld.

My Lord, the three GIRFEC goals in a hospital setting are as follows: first, reducing anxiety by addressing the psychological impacts associated with hospitalisation through supportive care; secondly, ensure continuity in terms of maintaining education and family connections where possible;

and, thirdly, shared decision-making involving children and families in choices about their care.

My Lord, as I've said, GIRFEC aims to align with UNCRC to ensure that those principles are upheld. There is an obligation in the United Kingdom for professionals working with children and young people, including doctors and executives in charge of healthcare, to comply with its principles and provisions.

My Lord, the key principles, in my submission, of the UNCRC relevant to Terms of Reference 8 are: firstly, Article 3, that the best interests of the child must be a primary consideration in decisions affecting children; the right to be heard in Article 12, which provides children with the right to express their views freely on all matters affecting them, with their opinions given due weight in accordance with their age and maturity; third, Article 24 relates to health and health services. It states that every child has the right to the best possible health. Governments must provide good quality healthcare, clean water, a clean environment and nutritious food. Article 31 provides that children have a right to leisure, play and culture, and Article 28 provides for a child's right to education.

THE CHAIR: My fault. The article on education----

MS CONNELLY: 28, my Lord.

THE CHAIR: 28. Thank you.

MS CONNELLY: My Lord, in my respectful submission, NHSGGC's failures should be understood not only as shortcomings in healthcare and governance, but as a systemic breach of Scotland's own commitments under GIRFEC, the UNCRC and the duty to use child rights and wellbeing impact assessments when making major decisions affecting children.

THE CHAIR: Now, the impact assessment, does that have a particular policy or statutory basis?

MS CONNELLY: My Lord, yes. It's attached to GIRFEC. It's part of the larger picture about a wellbeing framework for children. My Lord, the national practice model attached to GIRFEC describes how concerns about a child's wellbeing should be identified, shared, assessed and acted upon across services with a coordinated plan and a clear point of contact for the family. It expects services to respond early and proportionately, to communicate openly with families and to ensure that no child falls through the gaps between agencies.

My Lord, I submit that the

evidence before this Inquiry shows that children in the Royal Hospital for Children and Queen Elizabeth University Hospital were not always kept safe from avoidable harm; their health needs were not always anticipated and addressed in a timely way; and known risks in their care environment were allowed to persist.

Families were left feeling excluded, disbelieved or marginalised when they tried to raise concerns. Information was fragmented. Planning was often reactive rather than proactive, and the system behaved as if each incident were an isolated misfortune rather than a signal of wider risk. My Lord, that is not evidence of getting it right for every child; it is a sustained departure from the GIRFEC principles that were supposed to guide GGC's culture and practice.

GGC's failures also sit squarely in conflict with the UNCRC. The UNCRC recognises children's right to life, survival and development to the highest attainable standard of health; to protection from harm; to information; to be heard in decisions that affect them and to have their best interests treated as a primary consideration.

My Lord, in the context of a children's hospital, those rights mean more than access to a bed and a

treatment protocol. Those rights require an environment where preventable risks are actively identified and reduced; where each child's welfare is placed before institutional reputation; and where children and their parents are fully informed partners in care.

My Lord, I submit that the evidence before this Inquiry is of avoidable harm occurring in a specialist setting; of delays in recognising and acting on risks; of families not being told the whole story; and of organisational responses that prioritise defence and damage limitation over openness and learning.

My Lord, what I've said leads to quite an obvious question of, "Well, what should have happened?" And in my submission, in Scotland, child rights and wellbeing impact assessments are designed to ensure that when public bodies make significant changes to policy or service delivery that affect children, they systemically consider how those decisions will impact on UNCRC rights. Sorry, my Lord.

THE CHAIR: Just for this point, can I take that just a little slowly? I mean, your pace is entirely acceptable, but I want to get every word here.

MS CONNELLY: Thank you, my Lord. Shall I start from the beginning, my Lord?

THE CHAIR: You ask the rhetorical question, "What should have happened?"

MS CONNELLY: Yes, my Lord.

THE CHAIR: And you then answered that by starting, "Children's rights," yes?

MS CONNELLY: And wellbeing impact assessments---

THE CHAIR: Yes.

MS CONNELLY: -- are designed to ensure that when public bodies make significant changes to policy or service delivery that affect children, they systematically consider how those decisions will impact on UNCRC rights and on GIRFEC wellbeing.

My Lord, the purpose of such an impact assessment is preventative; namely, to identify before the event where a proposal might make children less safe, less healthy, less included or less able to learn, and to respond with mitigation or reconsideration.

My Lord, within the GIRFEC rights-based framework, the failure of GGC to undertake such a wellbeing impact assessment at key decision points is not a mere technical omission, it's evidence that children's rights and wellbeing were not placed at the centre of decision making by GGC, and, my Lord, I'm going to go on and provide you with an example that, in my submission, supports that position.

My Lord, when GGC chose to relocate highly vulnerable Schiehallion patients to Ward 6A without any meaningful assessment of how that environment would affect their rights and wellbeing, it bypassed the safeguard.

THE CHAIR: Right. And, again, it's not so much just the words; I want to sort of understand what you're proposing. So, the decision was made round about 18 September 2018 to undertake significant work on Ward 2A. So the question arises, where the children are to be accommodated, and what happened was that – and tell me if I'm getting the details wrong – the bone marrow transplant patients would be transferred to the adult BMT Ward. The others from the Schiehallion Unit would be located in what had previously been, I think, a rheumatology ward, which was Ward 6A in the adult hospital. So, let's take the date being 18 September, what should have happened and what didn't happen?

MS CONNELLY: Well, my Lord, I'm going to go on to say----

THE CHAIR: I don't want to take

you out of your structure.

MS CONNELLY: No, no, not at all, my Lord. In essence, my Lord, we submit that the evidence of the accommodation of Ward 6A, the evidence of what that provided and didn't provide to the children, and the evidence of the personnel from GGC who were involved in making that decision-- there has been no direct evidence before this Inquiry that these appropriate impact assessments took place. The evidence around the decision to decant was an identification of alternatives to Ward 2A accommodating the patients, and it was decided that 6A was the best of the options available.

However, within that, there is no evidence before the Inquiry that the consideration was made of the impact on the children and to try and either mitigate that impact or reconsider the decision. And, my Lord, at a later stage in the Inquiry's evidence, after some persuasion, counsel to the Inquiry asked the question of, "Was there a business continuity plan?" to which the answer was, "There is one now, but there wasn't one then."

My Lord, the reason why that's relevant is that such a plan, if it had been in place, would have anticipated, say, for example, in the event of fire,

that there would have been a proper wellbeing impact assessment carried out on what you do with a cohort of very ill children if they require to be accommodated elsewhere.

Now, GGC hadn't done that in advance, but, in my submission, the evidence before the Inquiry doesn't evidence it taking place when the reactive decision was made, and in the event that there was an adminicle of evidence to say, "Oh, there was some consideration," the poor quality of Ward 6A to address and to meet the needs and the rights of those children suggest it wasn't done effectively, and that's really what I'm going to go on and say in my submissions in a bit more detail, my Lord.

THE CHAIR: Right. Well, I'll just follow on your submission.

MS CONNELLY: Thank you, my Lord. And if it's not clear, please, my Lord----

THE CHAIR: I mean, just maybe to give you a little bit of a heads-up, you pointed me to the principles, you pointed me to the impact assessment and the reference to the impact assessment in the GIRFEC document. I am interested in what you say that requires in practice, and-- This may not be a good analogy. Public authorities have obligations under the

European Convention on Human Rights, but I don't imagine that every decision-maker necessarily applies her mind to Article 8 before she does an Article 8 relevant thing, but that might not mean that she has failed in any way.

She may have tried correct principles, but she might have done that without applying her mind to Article 8 of the Convention. So something that I will be interested in, listening to you, is to know how far you would submit that a decision-maker has to be conscious of the source of an obligation and apply any detail that the written statement in this case, the GIRFEC framework, has to be sort of in the front of the decision-making process, if I've made myself clear.

MS CONNELLY: Yes, my Lord, and I can answer that now. GIRFEC is absolutely central to the operation of public authorities. Now, I appreciate that your Lordship's inviting me to consider the individual that makes a decision who isn't thinking, "Oh, yes, in terms of GIRFEC principles, that's number two." To some extent, that's really immaterial. As long as the person knows what the Scottish Government has committed to as a welfare and rights-based system, that should be central to any decisions that are being made in respect of children.

So, whether they can be articulated with reference to the article of UNCRC or to GIRFEC is far less important than what I would say is the essential and inexcusable failure to not understand what those rights and welfare obligations are, and that no public authority should be making decisions for children unless they are within that framework; and if they're not within that framework, then they're not compliant either with government policy or with legislation.

And it is different from some of the human rights that might be-- You know, there's the absolute rights in Article 6 to a fair trial, and there's others that have to take account, really, of the bigger picture. That's not the way this policy works. That is not the way, in my respectful submissions, these rights and obligations work, and therefore I think, as I'm going to go on to, if one looks at the experience of children in 6A, in my respectful submission, that is evidence that NHSGGC failed to discharge its duties and obligations. Thank you, my Lord.

The Inquiry has heard that Ward 6A was not compatible with the needs of immunocompromised children. The move to Ward 6A imposed additional burdens on their mental health,

education and family life.

In those circumstances, the absence of a child's rights and wellbeing impact assessment is itself powerful evidence that GGC did not treat children's best interests as a primary consideration in that decision. The lived experience of children and young people on Ward 6A brings this into sharp focus. The Inquiry has heard about the psychological toll of isolation, the loss or degradation of access to education, and the impact on identity and morale for children who were already facing life-threatening illness.

Those are not collateral issues. Under GIRFEC and the UNCRC, a child's right to education, to play, to participate in ordinary life as far as possible, and to receive care that supports their mental, as well as physical health are core rights, not optional extras. When a young person such as Molly Cuddihy described how the environment on 6A affected her to the point that, for the first time, she felt defeated and accepted interventions she had previously resisted, that is not only a moving personal account, it is evidence that the setting and provision of care were actively undermining her wellbeing, autonomy and resilience. Her oral evidence about how the move

to Ward 6A made her feel sick, and led her to give in to a feeding tube in circumstances where the environment itself had become intolerable, underlines that these decisions had direct adverse consequences for children's mental health, sense of control and experience of treatment.

When parents' concerns about 6A were dismissed, when children's distress about isolation and loss of education was minimised, and when no structured assessment was undertaken to weigh those impacts before the move, the rights to participation, information, education and respect for family life were not being honoured. As I've said, my Lord, had a properly conducted child rights and welfare impact assessment taken place, that would have asked, "Will this ward keep these children safe?" and we must recall, my Lord, that was the ward that had the same water system and the same unvalidated ventilation system. It would also have asked, "Will it protect their mental health? Will it allow them to continue learning? Will it respect their agency and dignity? If not, what alternatives or mitigations are required?"

THE CHAIR: Just thinking about this, so you would say the failure to

make an impact assessment might lead to another decision-- Sorry, if an impact assessment had been made, that might have led the management of the hospital to think about whether the move to 6A was, I suppose, justified. But, on the other hand, it might say, "Well, we have only so much accommodation, and 6A looks to be the best solution." However, if, in the absence of an impact assessment, there's at least the possibility of a failure on the part of the decision-maker to apply her mind to whether mitigations are necessary, and then, if necessary, possible----

MS CONNELLY: Yes. Exactly, my Lord.

THE CHAIR: This is what you're putting forward.

MS CONNELLY: Indeed, my Lord.

THE CHAIR: All right. Okay.

MS CONNELLY: We fully accept that we live in a real world----

THE CHAIR: Yes.

MS CONNELLY: -- with limitations and, therefore, you know, one can't go, "There's no evidence that this was done, so"-- But one can't go back and say, "If it had been done and done properly, there weren't alternatives." I would dispute that, but that's-- I'm not here to give evidence, my Lord, but in the event that it was conducted and conducted properly and the decision was, "Well, this is-- we have to work with this," then the next stage is mitigation, and that's absent.

THE CHAIR: Yes.

MS CONNELLY: My Lord, in short, I would say that the decision-- that that decision illustrates – but it's not the only instance, my Lord – where children's rights were treated as peripheral rather than foundational. My Lord, I respectfully submit that the Inquiry and your Lordship is entitled to conclude that GGC did not just fall short of best practice, it fell short of Scotland's National Wellbeing Framework for Children and of its international human rights obligations.

My Lord, that's the end of chapter 1 of my submissions and, with your leave, I'll move on to chapter 2, which considers, in brief terms, a response to Greater Glasgow and Clyde's submissions. My Lord, I begin by adopting the counsel to the Inquiry's submissions in respect of paragraphs 1.3, 3.2, 3.4 and 3.6.

THE CHAIR: That's the Glasgow IV's closing statement?

MS CONNELLY: So, this was the submissions-- the oral submissions by Mr Connal----

THE CHAIR: It was----

MS CONNELLY: -- my Lord, at the beginning of the week.

THE CHAIR: Right.

MS CONNELLY: So, my Lord, I'd first like to comment on the involvement of Greater Glasgow and Clyde's position. In short, my Lord, we submit that this is disingenuous, and whilst the change in position is welcomed, it has caused further distress and frustration for the patients and families. There is a complete lack of a candid recognition that the denial and defensiveness that informed the position adopted in position papers, prior submissions and oral evidence of senior GGC personnel reflected the denial, lack of candour and defensiveness that similarly informed the interaction of senior management with patients and families. My Lord, the statement that the position has evolved is not only contradicted by the earlier positioning papers and submissions made, but perhaps most clearly by the oral evidence of those who were formerly, and some remain part of, senior management.

My Lord, the second issue is the comment in paragraph 3.2 of GGC's submissions that relates to senior management being "committed to patient safety beyond all else." My Lord, we accept that the clinicians and nursing staff at all times did what they considered was best for patients, but we do not accept that all of GGC senior management were committed to patient safety beyond all else, and the following are a couple of examples, amongst what I would say is a substantial body of evidence that's been laid before this Inquiry, that commitment to patient safety was lacking.

My Lord, the first of these is a failure to ensure that the new hospital was validated and safe to be occupied by patients prior to migration, particularly the ventilation system.

THE CHAIR: I suppose, strictly speaking, the client and building contract could arrange for validation, which I think, as we've understood, is the process of a client taking the advice of an independent engineer or architect, determining whether what it specified had been provided. I mean, strictly speaking, validation is not necessarily about safety.

MS CONNELLY: My Lord, I suppose I'm perhaps not using the term correctly----

THE CHAIR: No, no. Yes----

MS CONNELLY: -- as commercial and construction is not my field, my Lord, but, really, I'm really referring to the evidence of an

unvalidated ventilation system and-- Or perhaps the word “validation” is not the correct one.

THE CHAIR: No, it may be----

MS CONNELLY: However, the ventilation system in Ward 2A was subjected to an excess of an £8 million refurbishment, my Lord, and, ultimately, for the patients, they’re relying on senior members of GGC, for the Board of GGC that when they migrate patients into hospital, that that hospital is not exposing them to unnecessary risk, and unnecessary risk that, a few years later, incurs an additional massive spend of public money in excess of £8 million to rectify.

My Lord, a similar example is found in terms of the lost DMA Canyon reports: failure to appoint duty holders, authorised and designated persons who actively discharged their responsibilities; failure to manage risk effectively. My Lord, I would submit, a clear example of that is the Horne taps installation, where it was recognised that there were risks and mitigations recognised, but the mitigations were never carried out.

The persistent failure to investigate source of infection: your Lordship may recall the evidence of Jane Grant, that, in response to infection, she didn’t seek to look for the source but only respond to the incident. Perhaps one of the most startling for patients and families is that when the Bone Marrow Transplant Unit returned to the Beatson, when it became apparent in July 2015 that Ward 4B was not appropriate in terms of the provided ventilation for immunocompromised patients and did not meet the required standards, that did not trigger any assessment by NHSGGC as to whether there may be issues elsewhere, particularly in other areas for immunocompromised patients were being accommodated.

My Lord, I’ve already mentioned that the evidence of Jane Grant contradicts-- or, rather, GGC’s submission at paragraph 6.21 that staff work tirelessly to identify infection source and mitigate against recurrence, in my submission, is directly contradicted by Jane Grant’s evidence, and she’s not alone. But perhaps the most important one for many people in this room today is that, at paragraph 6.19, GGC states that they have rebuilt relationships with patients. 6.19, my Lord.

THE CHAIR: Right.

“NHSGGC has
strengthened transparency,

improved communication, and rebuilt relationships with staff, patients, families and external partners. It continues to do so. This includes more timely information sharing and active listening. Patients, families and staff should have confidence in the services NHSGGC delivers."

MS CONNELLY: My Lord, in my respectful submission, I see there is no evidence that the patients and families who were affected in the 2015 to 2019 period feel that relationships have been rebuilt. The evidence of those whom I represent, and the submissions made on behalf of the other patients and families, does not evidence a rebuilt relationship but one of anger, frustration and extreme distress that has in no way been alleviated but only exacerbated by the oral and written evidence that has emanated from GGC.

THE CHAIR: Again, I'll think I look for dictation here.

MS CONNELLY: Yes, my Lord.

THE CHAIR: Your submission is that no evidence, in respect of the infected families relationships, has been rebuilt.

MS CONNELLY: Yes, my Lord.

THE CHAIR: If you could just continue from that.

MS CONNELLY: My Lord, I go on to say that instead there's no evidence of a rebuilt relationship but of the anger, frustration and extreme distress that has in no way been alleviated but only exacerbated by the oral and written evidence that has emanated from GGC. My Lord, I refer to extracts of statements from those whom I represent, and I submit, my Lord, that this is the strongest evidence to challenge GGC's position.

My Lord, I begin with the words of Molly Cuddihy. Molly provided a statement for the hearing that was due to commence on 16 September 2025. Prior to that hearing commencing, Molly died in the Queen Elizabeth Hospital on 26 August 2025 when she was 23 years old. In her statement, Molly commended her clinical team for the care she was receiving, and she goes on to state:

"The same cannot be said for the management of NHSGGC, and I feel the evidence they have given only highlights that fact. Their utter contempt for the entire process has been clear, and the total disregard they have shown for the patients and their families has been startling. I mentioned the

physical impact, but it feels like there is no thought given to the psychological torment that patients have been and continue to be subjected to with this. In my own case, it's been the most challenging aspect of my care that has only been compounded by my participation in the public inquiry."

My Lord, I should say that I will come back to that statement again, and it does form part of the witness statements before the Inquiry, and Molly goes on to say that she doesn't regret at all her participation in the public inquiry.

My Lord, since Molly's death, the position of GGC has changed. It's not evolved, my Lord. I would say it's fundamentally changed, and that change in position came at the end of 2025 and has caused indescribable distress to John and Maria Cuddihy. Their incalculable grief and distress following the death of their daughter, Molly, has been further exacerbated by the fact that Molly did not hear or read of that change in position prior to her death, and for the Cuddihys that has caused unimaginable pain.

If GGC genuinely wished to rebuild relationships with patients and families, they have much work to do and, to start with, an apology is a rather obvious suggestion. I remind the Inquiry that the GGC communications director, Sandra Bustillo, stated that Professor Cuddihy may have won the battle, but he won't win the war. In both her written and oral evidence, she admitted that the language she had used was inappropriate, but she also said that she'd subsequently apologised to Professor Cuddihy. My Lord, that is not correct; no apology has ever been received by Professor Cuddihy from Ms Bustillo.

My Lord, moving on to the statement at paragraph 13.3 where GGC state that it's not appropriate or correct to say that water and ventilation were unsafe, my Lord, I've already made reference to the DMA Canyon reports, the lack of responsible persons to manage water and risk on a continuous basis. Your Lordship's heard there was no water safety group and ineffective use of the risk register, and in terms of ventilation, my Lord, at paragraph 13.8, GGC say that:

"Given the limited number of infections, the experts cannot identify an increase and so cannot identify a link [to

ventilation]."

THE CHAIR: Give me a moment. I'm just----

MS CONNELLY: Yes, my Lord.

THE CHAIR: -- reflecting again precisely on what it is that GGC say. (After a pause) What do you say that GGC-- Or how do you read that paragraph, 13.3?

MS CONNELLY: Yes, my Lord. My reading of that is that GGC are inviting your Lordship to find or agree that it's not appropriate or correct to say that water and ventilation were unsafe, such that they caused increased risk of avoidable infection. They go on later in the paragraph, my Lord, to say that:

> "Water systems and airflow can never be sterile. Other control measures can be used such that there is no 'avoidable' increase in risk."

My Lord, the submission I wish to make in respect of that is that, in my respectful submission, I accept that being completely void of risk is rarely or ever possible, but organisations like GGC have an obligation to have people and processes in place that identify risk, for that risk to then be recorded and owned, and for that risk to be mitigated, monitored and

managed. My Lord, I would say in respect of water, there are examples, for example, the lost DMA Canyon reports, the failure to appoint responsible persons, ineffective use of the risk register, amongst many examples, including of course the expert scientific evidence of the possible link of water contamination to infection, that undermines that statement. If your Lordship's content for me to----

THE CHAIR: Yes, yes, mm-hmm.

MS CONNELLY: -- proceed, my Lord, in respect of ventilation, I would direct your Lordship to paragraph 13.8 of the GGC's submissions. I want to focus, my Lord, on the statement that, given the limited number of infections, the experts cannot identify an increase and so cannot identify a link to ventilation.

THE CHAIR: Yes.

MS CONNELLY: My Lord, in my submission, we accept that the limited number of infection prohibits experts opining that there is a statistically significant link between ventilation and patient infections. However, we invite your Lordship to look beyond statistical significance of the numbers of infections and rather look at the wider body of evidence to ascertain if the

ventilation system in Ward 2A, which has undergone the extensive remedial works I've referred to, resulted in there being an increased risk of infection to the patients who were in that ward.

My Lord, I refer back to evidence that has been before the Inquiry of Aspergillus being found in Ward 2A in very high numbers in 2015, to Eilidh Mackay's contraction of Aspergillus on the 7 July 2016 and Pseudomonas on 9 July 2016. We say, in our submission, my Lord, that Eilidh Mackay's experience is an example of a patient being placed at increased risk of infection. We submit that proper consideration of whether the ventilation system adversely impacted on patient safety and care, which is raised within Terms of Reference 1 and the remit about the -- to consider the adequacy of ventilation, water contamination and other matters adversely impacting patient safety and care.

In considering that, my Lord, we suggest and submit respectfully that it requires cognisance of the following. This is a small selection of examples, my Lord: Dr Agrawal's opinion that it would be unsafe, due to the unknown nature of any risk, to open a new ward that had a ventilation system that had not been validated. When pressed on this, he explained that he would be unhappy about an unvalidated space because he would not know if the HEPA filtration was working or if the ventilation system was pushing pathogens in.

Ms Dempster's oral evidence, my Lord, that there was clearly a risk, a risk that was unnecessary for those patients. My Lord, in respect particularly of ventilation, we remind the Inquiry that the innovative design solutions in their report on Ward 2 ventilation state in the executive summary that the existing ventilation strategy would appear only likely to promote the risks associated with uncontrolled ingress of infectious aerosols into patient areas, and that's paragraph 1 in the executive summary, my Lord.

THE CHAIR: In relation to that---

MS CONNELLY: Yes, my Lord.

THE CHAIR: -- we had evidence from the author of that report. I don't recall it being suggested to him that anything in that report was inaccurate. Am I right about that?

MS CONNELLY: That's my recollection, my Lord.

THE CHAIR: Right. Am I right in thinking that as part of the history, Professor Cuddihy made reference to that report?

MS CONNELLY: Yes, he did, my Lord.

THE CHAIR: And am I right in thinking that there's a reference in one of the GGC position papers to that?

MS CONNELLY: I believe so, my Lord. I'm less certain of that, but I believe that that is the case.

THE CHAIR: Yes. No, what I had in mind was paragraph 51 of positioning paper-- the first positioning paper of 14 December 2022. Right.

MS CONNELLY: My Lord, if you're content for me to move on----

THE CHAIR: Yes.

MS CONNELLY: -- this is my last issue in respect of the GGC submissions, my Lord, and that relates to communication failures. My Lord, I provide two examples of this. The first one, your Lordship may recall, is in relation to a meeting that took place on 8 August 2019, involving Professor Cuddihy, Dr Inkster and Jamie Redfern, and the evidence was around the failure to inform Professor Cuddihy of a subsequent Mycobacterium chelonae infection that occurred in the hospital, and despite having asked to be kept informed, the evidence, in my respectful submission, suggests that there was a decision made not to inform Professor Cuddihy, and your Lordship may recall that that evidence was Dr Inkster saying to Jamie Redfern, "Tell Professor Cuddihy the truth, Jamie."

The second example, my Lord, is the means by which the hospital communicated with patients and parents who had experienced infections. I'm going to refer, my Lord, to the words of Lisa Mackay, Eilidh Mackay's mother, and they're found in the witness statement that Mrs Mackay provided for the Glasgow IV hearing, and is found in the second bundle of witness statements for the September 2025 hearing.

THE CHAIR: Yes.

MS CONNELLY: And Mrs Mackay states:

> "At no time during our 2016/2017 hospital stay of 338 days was Eilidh, or us, her parents, advised that her infections were connected to the hospital environment, ventilation system or water supply. It was not until October 2019 when we received a letter from NHS Greater Glasgow & Clyde advising that they were investigating infections at the hospital, which then led me to find online, a newspaper article dated May 2019. This article

> spoke of a child [whom I identified as my daughter, Eilidh] on the cancer ward at the RHC being infected with Aspergillus in 2016 and how it was suspected to have come from mould in a ceiling void, which developed following a leak. We became aware that the hospital environment was the source and cause of the infections she had contracted, contributing to the ongoing health difficulties she continues to suffer from..."

My Lord, that completes chapter 2 of my submissions. I'm conscious of the time, my Lord. It's a bit later than I expected.

THE CHAIR: Well, you've had to deal with questions from me.

MS CONNELLY: My Lord, I estimate 20 more minutes would be required. It may be slightly less, because much of what I'm going to refer to is contained within statements that are already before the Inquiry, and therefore the speed should increase, my Lord. However, I'm in your Lordship's hands and I'm happy to split the submissions over lunch.

THE CHAIR: What we might do is break for lunch now, try and sit sharp at two, and no doubt you will keep in touch with Mr Love and see-- I mean, there's no reason why we shouldn't sit beyond four, but I'll leave---

MS CONNELLY: Thank you. I'm pleased to confirm Mr Love has already confirmed he will indulge my overrunning, should it occur.

THE CHAIR: Right. Very well. Well, we'll try and sit again at two.

(<u>Adjourned for a short time</u>)

THE CHAIR: Ms Connelly.

MS CONNELLY: My Lord, I just---

THE CHAIR: I should confirm-- Sorry to interrupt you. Can I just confirm that I have seen and read the children's commissioner's letter of October 2019?

MS CONNELLY: You have. Thank you, my Lord. Thank you, my Lord. Before lunchtime, I said I would be moving on to chapter 3. My Lord, in my respectful submission, the most important evidence to address Terms of Reference 8 is found in the voices of the patients and the families. My Lord, I referred earlier to Mrs Mackay's comments on communication and, in the same statement that she provided in September 2016, she referred to the emotional, physical and the other impacts that her daughter and the

family had suffered. In that statement, she says:

> "It is very difficult to detail the impact on Eilidh. Her life has forever been altered. She has to work harder for everything she wants and will forever face barriers. She has had to learn to accept the far greater changes in her life, becoming a wheelchair user, being diagnosed with epilepsy, to name but a few. Her physical changes are evident but the severe psychological effects caused by these debilitating infections run far deeper than her visible scars. More so than would have been the consequence of her cancer diagnosis. Eilidh chooses not to revisit her dark days as it is a chapter of her life that she finds too traumatic. She prefers to concentrate on her recovery, moving forward with her life and her plans for the future.
>
> Our family life has been impacted and changed forever. The shockwaves permeating from this have reeked(sic) devastation on us all and will reverberate for many, many years to come. We have been left in a state of stress, mistrust, disbelief, fear, worry and with an enormous sense of guilt. Guilty for taking her to the RHC, in the first place, for treatment of her ALL diagnosis. A place that has become the vessel for the countless flaws, failings, consequences and misplaced actions. A place where she should have been made better, a place where she was meant to be safe, a place that has let her, us and countless others down.
>
> I have accepted the baton on her behalf, and aim through the Scottish Hospital Inquiry to seek justice, accountability and clarity. Listening to the evidence of the Inquiry, the missed opportunities, the complete disregard, the countless flaws and failings, the monumental deficiencies, the negative culture, the mistrust and misgivings, the negativity and toxicity, feels like physical blows raining down on me. Our family will never recover from this and in our lifetime, we will never experience anything as traumatic again. But what we must all never lose sight of, is the reason why we are all here doing

what we are doing. The issue that is far bigger than all of us. The victims at the core of it all, the children. Our daughter Eilidh! In this fight, there are no winners, only victims seeking the truth!"

My Lord, Professor Cuddihy has provided the following additional statement in January 2026, and this statement, unlike the one that was included within the bundles in September 2025, reflects on the impact of Molly's death within the context of the Inquiry. Professor Cuddihy says:

"Molly first appeared before this inquiry in 2021, then aged 19, when she bravely provided written and oral testimony about her fight against metastatic Ewing sarcoma at the Royal Hospital for Children. In that evidence, she described repeated infections from unsafe wards, ventilation failures, water risks and a lack of coordinated child-centred care under GIRFEC. Molly said plainly, 'I got infections repeatedly. The wards weren't safe. They kept moving me around, but nothing changed.' Those words exposed not just clinical shortcomings but systemic ones: absent escalation, minimised risks and families left feeling gaslit rather than supported.

Since that time, tragedy has struck. Molly died at the age of 23 on 26 August 2025 at the Queen Elizabeth University Hospital, and her death is now the subject of an active criminal investigation. This Inquiry, therefore, sits at a pivotal moment. Will it issue recommendations that, in line with its remit to learn lessons from the planning, design, construction, commissioning and maintenance of these hospitals, make similar failures in the future and consequent criminal investigations unthinkable? Or will Scotland be left with more reports gathering dust on shelves?

Molly's legacy calls for the former: enforceable governance that honours her voice and protects every child by ensuring that future NHS infrastructure provides a safe, effective, person-centred environment for care. Molly's evidence revealed breaches of the blueprint for good

governance at every level. The blueprint demands good and active governance in which boards and senior management rigorously pursue risk minimisation, escalate life-critical threats such as hospital water systems and ventilation, and ensure decisions prioritise patient safety over operational pressures in the design, commissioning and operation of major hospital facilities.

Yet in the period Molly described, wards were closed reactively, not proactively. Infections recurred despite clear warnings and there was no visible senior oversight of the environmental and infrastructure risks now at the heart of this Inquiry. Corporate risk registers omitted these problems until inquiries forced the disclosure.

Molly's case shows diffused responsibility, translated into no responsibility. The statutory duty of candour, which should help ensure that patients and families are given clear information and meaningful involvement in decisions about their care, did not operate as intended. Families in similar situations to our own were not met with openness and apology but with dismissal, blamed for complexity while the evidential picture mounted. In paediatric oncology and palliative care, where children endure prolonged vulnerability, that culture is indefensible and directly relevant to the Inquiry's focus on communication with patients and families."

My Lord, I can provide a copy of that statement to your Lordship.

THE CHAIR: I would appreciate it, yes.

MS CONNELLY: My Lord, Lisa Mackay, Eilidh Mackay's mother, gave a further statement in December 2025, and that is included in our written submissions. She said in that:

"Finally we have reached the conclusion of the oral evidence heard by the Scottish Hospitals Inquiry in relation to the QEUH/RHC. This is a milestone in this Inquiry which was originally announced way back in September 2019.

We now stand at a crossroads reflecting on the evidence heard and admissions learnt. The fundamental question

'What happened?' remains the same and the hope is that with the Inquiry and the passing of time, this question will finally be answered.

Getting it right for every child (GIRFEC) is Scotland's long standing, national commitment to provide all children, young people and their families with the right support at the right time. It is both an approach and framework used by services across Scotland to improve and uphold the wellbeing of children and their families. A commitment adopted and implemented by Eilidh every day of her working life within an educational setting for the children in her care. Can the same be said for her, and the countless other children and young people who were patients? Did [GGC] get it right for every child?

The QEUH/RHC Glasgow, [was described as] a state of the art acute hospital integrating adult and children's services that we never once questioned. This flagship Hospital is now permanently tainted with serious operational issues. Hearing and learning so much about ventilation and water systems, prompts the memories to resurface. Rooms too hot to bear, and requiring a fan to be on 24 hours a day, the build up of dried blood in mine and Eilidh's noses due to the dry air and in 2018 being told not to touch Eilidh with the water, are memories that are definitely abnormal.

'Moving forward' and 'lessons learned' are phrases widely considered overused clichés, that have lost their impact due to frequent use. Their overuse highlights a lack of genuine change, as organisations often repeat the same mistakes despite 'learning' lessons. We can only hope and pray that this will not be the case here."

My Lord, Eilidh Mackay also provided a statement that was part of our written submissions in December 2025, where she said:

"I will need to carry this for the rest of my life and where I want to get to in the future has been made harder for me due to this whole situation and what I have been forced to live with.

I am paying the price to basically live but I have so much to live for. I have had to battle through emotional and physical traumas to get here and I am lucky I have survived as I wasn't expected to. In this hospital I should have been safe but the building was killing me. My life is important and should never have been jeopardised the way it [was]. I was just a teenager whose life was turned upside down with a cancer diagnosis. It should never have got to the extent it did with the infections I contracted and how ill they made me. Myself and my family should never have had to go through this nightmare. For us and for me this torment will never go away, our lives have been changed forever and we have to live with this horror for the rest of our lives. In hospital, we are asked What Matters To Me? A question which relates to patient centred care and what is important to each child. Now when I think of this same question, my answer would be that the truth matters to me and I think it is the least that I, and my family deserve."

My Lord, the last patient voice I wish to include in this chapter is that of Molly Cuddihy. As I said earlier, Molly prepared a statement to be considered as part of the hearing that was commencing on 16 September 2025. Sadly, Molly didn't survive for that hearing to take place. Your Lordship has a copy of this in the witness statements. Molly said:

"In October of 2021, I sat before the Inquiry and gave evidence of my experience throughout my treatment. At that point I was in recovery from my first relapse of my original cancer diagnosis, as well as the two separate incidences of Mycobacterium chelonae infection. I was 18 years old and truly believed that I had at that point suffered enough for a lifetime.

However, I did not get that lucky and over the past four years my health has only further deteriorated, in no small part due to the intensive antibiotic treatment. I realise that my sarcoma was always a life-threatening condition, but there is a large difference between that and the life-limiting conditions that I now have to contend with.

It's not just a difference of treatments and learning new medications and the like, but the sheer difference psychologically is immense. There is now no end in sight. There is no day to look forward to a cure, and I'm very likely to have a much more limited lifespan than the majority of my peers. I understand life isn't fair, that I had already been diagnosed with a rare, aggressive cancer that is more than likely to be terminal the majority of the time. But surely, at 22 years old, I should not be so resigned to such a future?

I'm under the regular care of renal, gastrointestinal, oncology, endocrinology, fertility and vascular specialists, with input often having to be given by pain teams and a whole host of others for my treatment. Many of my team are world-renowned in their own right, and every single one of them is incredible and are an exemplary show of our NHS. I'm so very grateful to them all, and in no way have I found the medical side of my healthcare treatment to be lacking.

The same cannot be said for the management of NHSGGC and I feel the evidence that they have given only highlights that fact. Their utter contempt for the entire process has been clear and the total disregard they have shown for the patients and their families has been startling. I mention the physical impact, but it feels like there is no thought given to the psychological torment that patients have been and continue to be subjected to with this. In my own case, it's been the most challenging aspect of my care that has only compounded by my participation in [and referring then to the public inquiry].

Now, do not misunderstand me. I have never once, nor will I ever, regret participating in the public inquiry, but it continues to have an effect on my daily life and mental health such that I've had to seek consistent help over this period. I've had to watch members of the management sit and not only contradict the immense amount of evidence to the contrary, but their very own written statements. They haven't even had the decency to check

beforehand to match facts.

It has never been any one individual's fault, and nothing has ever been done with ill intent. Of that, I'm sure. However, when faults began to show, when they were asked for information, when they were simply asked, 'Why?' their actions from that point on were done with the knowledge of what was wrong, but, of course, in some opinions, we were cancer patients anyway, weren't we? It's all right for us to get sick. It was going to happen anyway. Why not just write us off when we get the initial diagnosis, if that is your thinking? If that is your attitude, for that, I'll never be able to forgive.

This past year, I was so incredibly fortunate to receive a kidney donated to me from my older brother, Darragh. I cannot quite articulate how much I love and am grateful to him for that, for giving me a little of my life back, but it should never have had to be done. That risk should never have had to be taken. I should not have been terrified that not only was I risking myself staying in Ward 4C – whilst their care has been nothing short of exemplary, I knew fine well, given the evidence on Ward 4B, that the ventilation alone was not safe – I was also risking my big brother, my favourite person, when he was already giving up so much for me.

It's not just hospital stays, though, it's having showers, it's staying on edge to make sure all my medications are always right, it's trying to simply sleep. It all terrifies me, and it's totally illogical and, in my opinion, frankly, ridiculous, because it's not exactly like I can avoid them, can I? Like I said before, the hospitals are a huge part of my life.

The impact of it all has been so profound that it's even the little things that have changed. The big life decisions that have had to be made, or have been completely taken away from me is remarkable. My priorities have entirely changed, and the things I have been totally desensitised to genuinely frighten me. I am 22 years old, and I have totally lost count of the amount of times I've almost died, even accepted it as

imminent at a few points. Like I said before, how is any of that fair?

I do, however, want to note that I am incredibly grateful to the professionalism, respect, and genuine kindness that the Inquiry team have shown throughout this process. I also want to note how delighted I am that we've progressed to the point of having a safe environment for the children of the Oncology and Haemato-oncology Department at the RHC.

After working with the Glasgow Children's Hospital charity, I've been lucky enough to make a fair few visits to the Schiehallion, and cannot emphasise the sheer delight and relief I feel whenever I see the children back where they belong, as safe and as happy as they can be whilst they go through their already tumultuous journey."

My Lord, in conclusion, on behalf of the Cuddihy and Mackay families, there are three additional precise and actionable recommendations that we present for your consideration. These are expressly rooted in the Blueprint for Good Governance in Health, the duty of candour, and this Inquiry's evidence and terms of reference. My Lord, to provide context, the reason for these and why they're being presented to your Lordship now is not unrelated to the submission of others, particularly other patients and families, that it's important that this Inquiry and the report that it will produce does not become part of a library collection, but there is monitoring and assessment of both your Lordship's recommendations, but also-- and potentially could be done at a near point, there's also an assessment or an audit of the extent to which the Blueprint for Good Governance in Health is evident across Scotland's health boards and hospitals.

In light of that, my Lord, three things are recommended, the first of which we've called "blueprint audits." These would be mandatory independent audits of all boards on hospital infrastructure risks to certify senior oversight, and those-- that should be accompanied by parliamentary reporting, with ministerial enforcement. My Lord, the second recommendation is "family pathways," and by this we intend independent duty of candour pathways for deaths or serious harm that arises from infrastructure failings, and that

these should include neutral reviews and national monitoring of communication practices. The third and final one, my Lord----

THE CHAIR: Sorry, just give me the end of that one, "Family pathways, independent duty of candour pathways for death and serious harm resulting from infrastructure failings." Now, what did you-- How does it conclude?

MS CONNELLY: Ensuring neutral reviews and national monitoring of communication practices.

THE CHAIR: Do you want me to ask a question about that, or do you want to----

MS CONNELLY: I'm content for you to ask a question now, my Lord. Thank you.

THE CHAIR: Could you just tease out the concept of family pathways and identify at what point they should begin to be implemented?

MS CONNELLY: Yes, my Lord. My understanding of how this might operate is that we have, obviously, the duty of candour, but in the context where children and families are impacted by death or serious harm arising from infrastructure failings, this is a suggestion that there is a clearly defined family pathway that would be relied upon/implemented in those

circumstances, and that that pathway, the duty of candour pathway, would be independent. So it wouldn't be something that would be reliant upon the management, for example, of the hospital where the incident happened to deliver. It's about neutral-- a neutral review and national monitoring of communication. In essence, my Lord, what it's seeking to achieve is that both the duty of candour is being honoured within the healthcare setting, and that there is effective communication practices in place. It ties back, my Lord, to the aspect of the terms of reference of the Inquiry in terms of communication with patients and families.

THE CHAIR: Would it be triggered by any adverse outcome, or an adverse outcome that had been identified, and it would have to be by the hospital authority, as environmentally linked?

MS CONNELLY: My Lord, I haven't thought of that in that level of detail. However, I don't think it could operate in that way if it was to be-- It couldn't be only triggered by the hospital identifying an environmental issue. This is about really improving communication with -- and by "communication" I don't mean just talking. I mean listening as well, by

hospital management bodies to patients and families, and that's why it would be important for there to be a neutral element that's-- neither of these parties that would require to input. If there was a negation that there was an infrastructure problem, there would have to be an-- If there's a conflict over whether there is that infrastructure failing and that that's led to the harm or the death, in circumstance where that would be-- If that's accepted by all parties, such an investigation wouldn't be required.

THE CHAIR: Right.

MS CONNELLY: Thank you, my Lord. The final and third, my Lord, is the implementation of national paediatric safety standards and hubs for paediatric oncology and palliative care.

THE CHAIR: Yes.

MS CONNELLY: My Lord, on behalf of those that I represent----

THE CHAIR: Again, with apologies for interrupting, so that third recommendation would be to add to the existing standards, which admittedly are stated in a fairly high level, particular standards in relation to paediatric oncology cases.

MS CONNELLY: Yes, my Lord.

THE CHAIR: Right. Sorry, I interrupted.

MS CONNELLY: Not at all, my Lord, thank you. My Lord, on behalf of those that I represent, we hope that all of our submissions to date and recommendations will be of some assistance to your Lordship in reaching your determination of the terms of reference. Implementation of our recommendations will not only honour Molly's memory and Eilidh's ongoing journey, but hopefully will guard against recurrence of such harm and should catalyse genuine reform and restore public trust in NHSGGC services.

My Lord, if I can be of any further assistance to you----

THE CHAIR: No, you have been of considerable assistance. Thank you very much.

MS CONNELLY: Thank you, my Lord. I'm obliged.

THE CHAIR: Mr Love. Now, Mr Love, you represent a substantial group.

MR LOVE: I do, indeed, my Lord, yes.

THE CHAIR: Both patients and family members?

Closing submissions by Mr Love

MR LOVE: Yes, that's correct. Along with my learned friend, Mr

Thornley, somewhat distant, we represent and appear on behalf of the patients and families affected by their treatment at the Queen Elizabeth University Hospital and the Royal Hospital for Children in Glasgow. Thank you, my Lord, for this opportunity to present this oral closing submission on their behalf. Your Lordship has already observed that the public gallery is slightly fuller today than it has been, and I'm very grateful to, and would like to thank the Inquiry team for the steps they've taken and the measures that they've put in place to accommodate some of those on whose behalf I appear today.

THE CHAIR: Well, I acknowledge there's a limited amount of space that we've been able to offer.

MR LOVE: The coffee has been appreciated, my Lord. Before I carry on, has your Lordship had the opportunity of reviewing the collage or montage of photographs that appeared in the Scottish media today?

THE CHAIR: It's, for example, on the STV news website, I think.

MR LOVE: Yes. It's the same collage, I think, as was submitted along with the closing statement for those I represented last December. But your Lordship has seen that?

THE CHAIR: I have seen it, and I've taken time to look at it.

MR LOVE: Okay. Thank you. I've listened – and I should say this at the outset – very carefully to everything that Ms Connelly has said, and I would associate myself with everything that she has said, including the observations that she makes towards the end of her submission about recommendations. What she says resonates to a remarkable extent with the experiences of those that I'm appearing on behalf of today, and there is nothing in what she said or in what she's presented that I take any issue with. (After a pause) Thank you, my Lord.

THE CHAIR: There are only certain things I can control, Mr Love. I hope you're not going to be distracted.

MR LOVE: I will not be. Thank you, my Lord. It has in the past been stated that this Inquiry is, to a significant extent, about patients and families. I had a discussion with Mr Mackintosh fairly recently where he asked me the question, "Why should that be so?" And I would suggest, if I might, the following explanation. The Inquiry, as its website states, came about as a result of public concern over issues arising in relation to the built environment at the QEUH and RHC and its potential impact, including

infections, on patients and others. This concern had been reflected in widespread media coverage in relation to issues raised by patients and their families. Debates and questions to the cabinet secretary in the Scottish Parliament, and a number of other investigations. The Inquiry's scope, and its terms of reference, was developed with input from patients and families, and specifically aims to address the impact on patient safety and wellbeing: ensuring their rights in particular, to be involved with patient safety and wellbeing, ensuring their rights to be informed and to participate in their care were respected.

From the start, this Inquiry prioritised hearing evidence from affected patients and families about the physical, emotional and practical effects of these issues on their lives, their lived experiences. Patients and families shared stories of children and adults dying as a result of infections and receiving potentially inappropriate prophylactic treatments because of the prevailing hospital conditions. Their evidence demonstrated, or illustrated, how technical failures might lead to devastating personal tragedy. One key theme in this Inquiry has been how GGC's failure to provide timely, accurate and full information to patients and families went to erode trust and made them feel unheard, and for the patients and families we represent, this Inquiry is crucial: first, for their understanding of who was responsible for decisions that led to harm; and, secondly, in ensuring that such failures in design, building, maintenance, treatment, communication and candour never happen again. This is crucial, in my submission, to the protection of future patients and families.

It is not unreasonable in these circumstances, my Lord, to suggest that a very significant aspect of this Inquiry is to deal with the experiences of patients and their families to date, and to look to the protection of future patients and families not just under the GGC umbrella but nationally and that, in those circumstances, I submit it is fair to suggest that a significant aspect of this Inquiry relates to patients and families.

My Lord, this Inquiry has heard about the provision of safe, effective, patient or person-centred healthcare, and I'd like to explore what is meant by that. Ms Connelly has already provided your Lordship with some submissions in a paediatric connection. I would point your Lordship to the fact that hospital

patients in Scotland have a comprehensive set of rights, primarily enshrined in the Patient Rights Scotland Act 2011 and summarised in the Charter of Patient Rights-- I'll take this slowly, the Charter of Patient Rights and Responsibilities. Essentially, what the charter seeks to do is to provide a careful analysis of what the Act requires. But having considered both what-- Sorry, my Lord, yes?

THE CHAIR: Can I look for your assistance on a matter of detail?

MR LOVE: Yes.

THE CHAIR: The reference to the charter, the basis for that is in the Patient Safety Commissioner for Scotland Act 2023, or have I got that wrong?

MR LOVE: It is.

THE CHAIR: Right.

MR LOVE: But I think the current-- No, it can't be because the current iteration is dated June 2022.

THE CHAIR: Therefore, I must be wrong.

MR LOVE: So, yes, my understanding of the charter is that, effectively, it provides a summary of what patients are entitled to expect, given the provisions of the 2011 Act. I could check the genesis of that and provide some further information to your Lordship through the Inquiry team.

THE CHAIR: As I say, I might have got that wrong.

MR LOVE: What I'm proposing to do, and what I say now, is what I have to say about what safe, effective, patient or person-centred healthcare is, based on my reading of the statute and the charter.

In my submission, my Lord, patient-centred healthcare should require the patient to be at the heart of their own care. If I might expand upon that, that means treating them, along with their family, as an equal partner, and by that I mean making decisions with them, not just for them, and providing clear, understandable information about conditions, and by that I mean their conditions and also the conditions in which they're being treated. That should encompass the risks and the options, looking towards obtaining meaningful and appropriate informed consent.

Your Lordship has heard evidence about that in this Inquiry. My submission to your Lordship is that that requires their values, their needs and their preferences for a personalised, coordinated and empowering experience to be respected and, that being so, it moves

beyond just clinical outcomes to consider the patient's emotional and social wellbeing involving them and their families and carers in the planning and management of their care. Echoing what Ms Connelly said, showing them respect, affording them dignity, telling them the truth, affording them the right to provide feedback, comments, concerns or complaints with support being made available to them in that regard, participation in their care journey.

Why does that matter? From what I've been told – if I might take this slightly more quickly, my Lord – what I've been told by patients and family members, it would allow them to become more engaged and active in managing their health, perhaps even leading to improved results. It would see a move away from what some of those I represent have called "outdated," a one-size-fits-all approach, turning to a set of circumstances that seek to fit individual needs. That would go some way to addressing the feelings of powerlessness described by some, increase satisfaction, and improve the experience of what is frequently the toughest of times in that patient or family's life. That matters. It would matter to all of us and our families if we required hospital treatment.

It's been interesting to review the evidence heard in Glasgow: one, for the purpose of presenting this submission today; and to see that there were so many plaudits and positives from patients and families about the excellence of the healthcare professionals engaged with their treatment and clinical care. Again, that resonates with what your Lordship has heard from Ms Connelly.

The evidence that your Lordship heard about lack of honesty, issues with candour and communication was directed at the GGC board of managers. As was stated in the closing statements submitted at the end of Glasgow I, it was felt that management did not keep patients and families informed about risks, about ongoing remedial works or the causes of infections.

Now, many felt they were kept in the dark and that frontline staff were left to field questions about adequate support or information from management. Not a single witness identified a good example of communication by GGC managers on these issues, and that contrasted starkly with the generally exemplary communication from doctors and nurses about direct clinical care.

Patient-centred healthcare puts the patient first.

That's all I propose to say about safe, effective patient or person-centred healthcare. I think that, based upon the charter and the statute, is my analysis of what might be sought to be provided. There's also been discussion about what a safe healthcare facility might look like, and I would agree with those who have suggested that there are many aspects to safety.

Your Lordship's heard a positive and proactive culture where safety concerns are listened to, where incidents are investigated and where lessons are learned to embed good practice; competent and sufficient staff; safe systems and processes, including risk assessment and management; and, tied with that, infection control and medicine management, including their safe prescribing, storage and administration.

Ultimately, in my submission, a safe hospital is one where the fundamental principle of "first, do no harm" is upheld through a robust, systemic approach to avoiding preventable harm----

THE CHAIR: Sorry, can I take that again? You refer to the principle of "do no harm," the familiar----

MR LOVE: Yes, and suggested to your Lordship that that is a hospital where the fundamental principle of "first, do no harm" is upheld through a robust systemic approach to avoiding preventable harm.

THE CHAIR: Right. I think I failed to get the word "avoiding."

MR LOVE: Yes, there has to be-- Perhaps I omitted to say it, but the system is important within that model. In any event, following that rather lengthy introduction, I would formally adopt the content of each of the closing statements already submitted on behalf of the patients and families, and with your Lordship's leave, I propose to make additional oral closing submissions under six chapters. That might sound ominous, but given what Ms Connelly has said, I will seek to do what I can to foreshorten what I had intended to say.

THE CHAIR: You mustn't feel under any time pressure, Mr Love.

MR LOVE: But there are-- I would not want to take up your Lordship's time with duplication, with matters that I acknowledge and accede to in terms of what Ms Connolly has said, facts that I take no issue with.

So, the six chapters that I present

to your Lordship are firstly comments on GGC closing statements for Glasgow IV and the impact that that has had on those I represent. Secondly, what I intend to do is to read some extracts from the personal impact comments that have been received from patients and families in response to the GGC closing statement, which I understand your Lordship has a copy of. I think they've also been circulated around other representatives of core participants.

THE CHAIR: I do.

MR LOVE: Thirdly, I propose to make some very brief observations about ventilation before, fourthly, going on to Scottish Government oversight. Fifth, I will look at the issue of accountability, including personal blame and responsibility and the importance of that. And, finally, I will make some comment about the proposal made in our closing statement to the effect that your Lordship might wish to consider it appropriate to keep this Inquiry open.

So, the first chapter is impact of the GGC closing statement. At the outset, the patients and families have asked me to communicate to your Lordship that the conduct of GGC throughout these proceedings has left them with a profound sense of anger and feelings of betrayal. Their pain, they say, is not simply rooted in the suffering they have endured; it has been deepened and magnified by the shifting positions and evolving narratives adopted by GGC as this Inquiry has unfolded.

If I might say, it is my experience that these changes of approach have left patients and families questioning the integrity of those entrusted with their care, and that is to date. They feel that early denials and minimisations have given way, only after fairly exhaustive evidence and public scrutiny, to what have appeared to them to be somewhat brief, grudging and incomplete admissions of failures and individual responsibility, as presented in both the written closing statement and in what Mr Gray KC said in his oral submissions earlier this week.

Now, this pattern of response, if I might call it that, has eroded trust. Instead of openness and candour, the patients and families consider they have been met with defensiveness, delayed acknowledgements and an apparent reluctance to accept the scale of the failures at QEUH/RHC.

That said, they do ask that I publicly acknowledge and welcome the apologies that have now been offered

by GGC while making the observation that these are insufficient, and come far too late for many families. Late apologies made only after public exposure and Inquiry evidence cannot erase the distress, suffering and, in some cases, irreparable losses that have been experienced by some over the many years since the hospital opened.

It's observed that changes have occurred on so many fronts, from denial to acceptance, coming more than ten years after the hospital opened its door to patients. Rightly or wrongly, it appears to those I represent to be driven not by genuine remorse but rather by the weight of evidence and public pressure, and this only deepens their sense of anger and feelings of injustice; and, taking all on board that Mr Gray said in his closing submissions, time will ultimately tell if the promises and undertakings that Professor Gardner gave in her evidence about a humble, patient-centred, proactive health board are more than just words.

There are observations that I would make that, really, Ms Connelly has already made and I think were touched upon by other representatives. This Inquiry has been ongoing for over four years, at

significant expense to the Scottish public purse, and only now, in its final throes, have GGC conceded many significant and impactful failings on their part. Had they done so sooner, much of what has transpired might have been avoided.

As your Lordship knows, the patients and families that I represent have been using this hospital since 2015, and they've been astonished and in fact angered to hear GGC now state openly that their flagship hospital was not ready to open when they took control of it from the contractors in 2015. GGC now say in their December closing statement that it is clear that the hospital was not in a state to be handed over when it was.

THE CHAIR: That is, indeed, what they say. I'm not sure if I recollect the evidential-- I mean, they're in the best position to judge. I have to say, speaking frankly, as I would hope I would always do, I can't quite remember a strong evidential basis for that. There was the evidence from Mr Powrie about the challenges he met, and we do have the evidence about contractors still being on site.

MR LOVE: It seems to be a reasonable inference to draw from the other concessions that have been made about the ventilation and water

systems and culture-- and all of these factors taken together, looking at the responsibility of senior board members, in particular in terms of their oversight of the project, it's not unreasonable to say, with the benefit of hindsight, this hospital, at the time it opened, was not fit for purpose.

Of course, we're not looking at small or discrete sections of the hospital. Rather, we're talking about the water and ventilation systems, fundamental hospital systems, the ventilation system, fundamental in a hospital where it was required to be mechanically ventilated for the reasons that your Lordship has heard about in the evidence. Those systems, which your Lordship has heard evidence about, presented an increased risk to the health of patients being treated there.

The patients and families have asked questions, "Why did it take until December 2025 for GGC to publicly admit an increased rate of environmentally relevant bloodstream infections amongst paediatric haemato-oncology patients in the RHC during the period of 2016 to 2020? Why have they only now admitted that a material proportion of those environmental infections were connected with the hospital's water system? Why have they only now admitted that the water system presented a risk to patients, including adults, and that there was a causal connection between some infections suffered by patients in the hospital environment, particularly the water system?"

In that regard, I've been asked to point out that the closing statement for GGC does not restrict the acknowledgement to risk to paediatric patients, and the risk is discussed in the context of all patients exposed to the hospital environment. In that regard, I would refer you to GGC's closing statement at paragraphs 4.3, 4.4 and 5.3. The fact that it has taken a four-year public inquiry for GGC to make those admissions is difficult to excuse.

Other observations that have been made by those that I appear for today are that there has been no explanation from GGC as to why they have denied all responsibility for the mistakes, admitted mistakes, in the procurement, design and validation of the hospital before it was opened.

THE CHAIR: It would appear that they no longer deny, I think the expression is, "failures relating to design and construction," or am I wrong about that?

MR LOVE: I haven't been able----

THE CHAIR: I understand that Mr Gray accepts counsel to the Inquiry's analysis, and I have assumed that there's an acceptance of the use of that language one sees, "failure."

MR LOVE: Where does that failure lie?

THE CHAIR: Am I wrong in this?

MR LOVE: Where does that failure lie though? I think that's the issue.

THE CHAIR: There is a lack of precision----

MR LOVE: Yes.

THE CHAIR: -- but there seems to be an acceptance of failures which had consequences.

MR LOVE: They do accept that there were failures on their part with the design, build, commission and validation and operation of the hospital, but what they have not done, in my submission, is specified exactly what those failures were and who was responsible for them.

THE CHAIR: That is true.

MR LOVE: Who is to blame?

THE CHAIR: That is true.

MR LOVE: Their closing statement and their submission is, from what I can see, silent on that front. They do accept that multiple parts of the procurement process was fundamentally flawed. They admit there was a lack of appropriate in-house expertise in the project team. They admit that there was insufficiently rigorous scrutiny of the decisions and actions of contractors. The individual who was put in charge of the project to design and build the new hospital had no experience at all of a construction project on anything like the scale he was faced with.

This fundamental, in my submission, lack of experience and knowledge at the head of the project team, and of the team itself, ought to have been obvious to the Executive Board of GGC at the point the project board was being set up. Indeed, it should have become all the more apparent to them, if they had exercised oversight as the project progressed, that there were issues, and given the lack of crucial expertise or any meaningful attempt to secure advice from someone who had that expertise, it is perhaps not surprising that there were multiple faults and failings with the hospital when it opened.

Sticking with that point, the project team made multiple mistakes during the design phase that have, so far, cost many millions of pounds, and despite these clear and obvious

mistakes, we have never heard any acknowledgement or admission or apology from any member of the project team throughout the evidential hearing in this Inquiry. Nor, for that matter, my Lord, has there been any acknowledgement or admission or apology from anyone who was a member of the Executive Board of GGC both prior to the opening of the hospital and thereafter, down to the point of Professor Gardner's appointment in February 2025.

THE CHAIR: When you use the words "Executive Board," could you just help me with what you're referring to?

MR LOVE: Well, the chief executive and his board.

THE CHAIR: Well, it's not the chief executive's board. It's----

MR LOVE: Sorry, the chair.

THE CHAIR: I suppose it's the chairman's board insofar----

MR LOVE: The chairman's board.

THE CHAIR: -- as it's any individual's. Are you referring to the Health Board, or are you referring to the executive directors of the Board?

MR LOVE: It's the Health Board, the executive members of that Board, and the managers.

THE CHAIR: Right, so I think

I've got that.

MR LOVE: Yes. Thank you, my Lord. GGC now says that it accepts that governance up to the point the building opened had weaknesses. That is, with respect, a gross understatement. The project team agreed with the contractors to have a ventilation system for the hospital, which not only did not meet the requirements of the prevailing Scottish Health Guidelines, SHTM 03-01, but the system provided less than half the required levels in terms of air changes.

They did this without, it appears, any assessment at all of the additional risks likely to be posed to patients in consequence. There is no evidence to that effect. It's my submission that the public might be entitled to expect that such a crucial or critical decision would have been subjected to intense scrutiny and oversight by NHSGGC before it was agreed. It is clear, in my submission, on the evidence that that did not happen.

The explanation given for the fact that they did not know about this until the hospital opened was based on individual failures to advise, and we've yet to have an explanation as to why there was no proper scrutiny or oversight by GGC or its managers of the key decisions made by key

individuals. In fact, what GGC explain in their closing statement is that it was due to extreme pressure caused by the evolving situation. That's at paragraph 6.15 of their statement. That, I submit, is simply not correct but, ultimately, that's a matter for your Lordship.

The head of Estates admitted in his evidence that he failed to action the 2015 DMA Canyon report and admitted in his evidence that he dropped the ball. In my submission, GGC ought to accept its failures and to apologise, rather than trying to blame it on an evolving situation. Many more people dropped the ball.

THE CHAIR: One might observe, in relation to that evidence, that that indicated a frankness and an acceptance of personal responsibility on the part of that one witness.

MR LOVE: I looked at his evidence yesterday, and he answered questions from Mr Connal very carefully and agreed and accepted that, with hindsight, he dropped the ball. I looked to see if there was an apology for that, but I didn't think he needed to in those circumstances. He was very clear that he did not do as he accepts he ought to have done.

THE CHAIR: Yes.

MR LOVE: So, GGC accepted

the hospital from the contractors at a point when it had a water system that needed significant actions to ensure that the water did not pose a risk to patients – I don't intend to go beyond what Ms Connelly has already submitted to your Lordship in that regard – and it comprised a ventilation system that was way below the recommended level in Scottish Health Technical Memoranda for general wards, all the more so for the specialist wards catering for immunocompromised paediatric and adult patients.

While Ward 2A is following substantial upgrades suitable for paediatric immunocompromised patients at the RHC, there is currently no SHTM 03-01 compliant ward suitable for adult immunocompromised patients at the Queen Elizabeth Hospital. I would also make the observation that while Ward 2A has been validated, I'm not aware of any evidence before this Inquiry about validation of either general wards or specialist wards such as Ward 4B, the BMT Unit. That was something that Mr Gray KC raised in the course of his closing submissions, that it was his understanding that there had been validation.

THE CHAIR: Well, he'd be

surprised if there had not been, and I think in the context – I hope I'm not misrepresenting him – he wasn't taking issue with the evidence that, as at 2015, nothing had been validated, but he would be very surprised if, where there has been remedial work, such as in 2A, that it has been validated, and he may very well be right about that.

MR LOVE: What I'm submitting to your Lordship is that we have no evidence in this Inquiry that, beyond 2A, the ventilation system has been validated anywhere else in the hospital.

THE CHAIR: Certainly, there's no suggestion that-- I'll take that back. I'll take that back, I think you're right about that, yes.

MR LOVE: I hear Mr Gray saying that he would imagine that it has been done, but that's not the same as saying that it has been.

THE CHAIR: Indeed.

MR LOVE: I simply point to the absence of evidence in that regard.

THE CHAIR: I hope this is not an unfair point. I mentioned paragraph 51 of Positioning Paper 1 of GGC, it's just in the context of ventilation and Ward 2A. What one sees – and in fairness, I didn't raise this with Mr Gray – it's in the context of discussing the innovated design solution report of October 2018----

MR LOVE: '18.

THE CHAIR: -- which I raised with Ms Connelly in December of 2022, which is the date of the first positioning paper, in discussing that-- So the context is October 2018. The GGC refer to "evolving knowledge" that the ventilation arrangements on the ward were not compliant with the standards set out in SHTM 03-01. Do you have any comment on the concept of "evolving knowledge" in October 2018 that 2A did not comply?

MR LOVE: It seems astounding that that could not have been identified at the point in time when the hospital opened. Given the specialist nature of that ward and the moving of the old Schiehallion Unit to its new premises, with the patient cohort likely to use that ward and to have their treatment facilitated and their safety safeguarded in that ward, that it should have been known at the outset. The day the hospital opened its doors to that paediatric cohort, in my submission, GGC ought to have known whether or not the ventilation system on that ward was or was not suitable for the treatment and accommodation of those patients and, if they didn't know, they should have known.

It ties in with the evidence about

the move of the Beatson from its original home to 4B, and what was found out when they moved, that to have-- it was one thing to look at the general wards within the hospital, to make provisions in that regard, but to look at the specialist units which are being used to treat and accommodate immunocompromised and neutropenic patients, where it's known that the ventilation system and its requirements have to be high end to protect them against the environment and the risk of infection, not to know or to suggest that the knowledge about what the ventilation system provides is something that evolved over a period of years is astonishing.

That concludes all that I have to say about the first chapter of my submissions. I now move on to the reactions of some core participants to the GGC closing statement and, as Ms Connelly I think said in the course of her submission, perhaps the evidence of the patients and families is the strongest evidence that's available to challenge what GGC says about the extent of which relationships have been rebuilt. Now, for the avoidance of doubt, the statements that have been produced to your Lordship and to the other core participants merit the label of "new." They're not extracts from statements previously tendered or evidence that's been submitted to the Inquiry or alternatively contained within any of the closing statements previously tendered on behalf of the group that I represent. So these are new statements.

So, firstly, if I might read what Denise Gallagher has said:

> "They are backtracking and only skimming over the issues after denying it all for years in a bid to protect their reputation. The risks all remain and the submission is disrespectful to what the families have been put through."

Kenneth Murdoch says:

> "We feel betrayed, lied to and appalled by what has been allowed to happen. All the years of denial and then, December 2025, we get a total U-turn with the GGC submission. In our eyes, it's disgraceful. Our daughter was a ball of light, energy and had a right to thrive and live. NHSGGC have entirely extinguished that light to protect their own reputation. Patients must always be kept at the centre of any key decisions, including by this Inquiry."

Beth Armstrong says:

"We have been unable to grieve properly for our mum and remember her remarkable life. Instead, we have been subjected to seven years of evasiveness, denial and disrespect by the QEUH management and board, the very people who were supposed to protect us and put our safety first. Our grief has been extended, delayed and turned into anger as we have listened to representatives of the NHSGGC Board and QEUH management, including CEOs and CFOs, give evidence to this Inquiry, refusing to admit their mistakes or take any accountability. We have listened to them, blaming others and refusing to apologise for the terrible consequences of their actions. We have read the GGC closing statement, where they have had to admit in part to a link between the water and some infections. This has done nothing to restore our faith in the leadership of the QEUH or NHSGGC. As one of the families that was not included in this partial admission, it is yet another insult on top of many others."

Her sister Sandy:

"After all these years, this submission is just backtracking in an attempt to protect their reputation. In my evidence to the Inquiry, I spoke about the SCII(sic) report..."

It should be, that's the Scottish Centre for Infections and Infectious Diseases report that was commissioned by NHSGGC:

"...everything that was ignored and dismissed, and what happened to my mum? This is too little, too late. It adds insult to injury. For example, the HAD report. This does not give us hope with the current CEO or management structure. They are vague and being non-specific, taking no responsibility. It leads to further distrust and shows nothing has changed with their approach, merely suing Multiplex is not taking responsibility for their failings."

David Campbell:

"Nothing has changed. I've told GGC that the problems I've been identifying, even today, have been causing me mental health issues and concern for me

and other families. I still feel I am ignored. The submissions are only words in a bid to minimise the reality. I am shocked that the submission is so short given what they were facing and have admitted."

Maureen Dynes says:

"I am concerned and worried that there is a desire to highlight now. Sorry how the mitigation measures are working, particularly after 2019. I would like to remind Lord Brodie that in 2012, two years after mitigation measures were put in place, my husband, Tony Dynes, passed away. I was advised he contracted Aspergillus, but there were no indications that it had come from the environment. One other infection he caught was Stenotrophomonas. I've never been advised by NHSGGC of the Stenotrophomonas infection that Tony contracted. I only found that out by looking myself at his medical records."

Sharon Barclay notes:

"I'll cry when I go near the hospital, and this submission only confirms to me that GGC have mistreated everyone for years."

Karen Stirrat:

"We have been put through so much, and for NHSGGC to deny they concealed anything is laughable. All the way through we were told we were in a safe environment. Years of being told we were imagining it, that everything was safe and that our children were being treated with respect and that NHSGGC would never put our children in danger. Days spent sifting through papers, liaising with MPs, attending interviews, attending court, being in the media all the while fighting a horrendous cancer battle with our poorly child. Still, they denied everything. There is no elation, there is no celebration that we have been proven correct, just a sheer anger and sadness that it should never have happened in the first place."

Kimberly Darroch says:

"What they have said in their submission is eye opening. Children with cancer must be protected from the environment and NHSGGC had no right to gamble with their lives. I feel angry, not fleeting or irrational,

but justified anger; anger at a system that denied there was a problem for six years, anger at the lies, the minimising and the refusal to take responsibility until the final hour while my child paid the ultimate price."

Charmaine Lacock and Alfie Rawson:

"The evidence and what NHSGGC now say confirms that we were right all along. The amount of money that has been wasted by the public purse has been huge. This could have been solved years ago with communication, honesty and a hospital that was fit for purpose. Getting to the end of the Inquiry, we are hoping for answers, for change. We are hoping that someone will be held accountable. We are mad that it took this long for the answers to come. We are angry at the money and time this has cost. We are angry that our lives have been put on hold for years to have a total U-turn in the last stretch. There's no winners here. We don't feel relieved or happy with any of what is going on. We are broken beyond belief."

And then finally, Louise Slorance says:

"The GGC closing submission is a work of fiction. Stating something in a document doesn't make it true. The idea that the whole QEUH, and in particular Ward 4B is safe today is, quite frankly, ridiculous. The response leaves me with the feeling that I have failed in my aim to prevent what happened to my family happening to other families."

That concludes the second chapter of my submission.

The third chapter is to deal with ventilation. As I said, there's a significant overlap with what Ms Connelly said. So I have taken the time to omit from my submission certain aspects that I intended to comment upon but, ultimately, GGC provided a hospital where the air change rates were and remain significantly below the recommended levels identified in SHTM 03-01 for most of the Queen Elizabeth University Hospital and Royal Hospital for Children. This deficiency has, on the evidence before this Inquiry, the potential to increase the risk of harm to patients.

Despite that fact and the length of time GGC have been aware of this issue, they appear to have failed still to carry out a risk assessment of the ventilation system for the rooms and corridors in the vast majority of the hospital. I've made play in closing statements of the absence of evidence not being evidence of absence, but what we have not heard in this Inquiry, in my submission, is about the extent to which the ventilation system and its consequences for patients, individual patients, has been risk assessed. As I've already said, we are not aware on the evidence to this Inquiry about the extent beyond Ward 2A, to which the ventilation system has been validated. It's accepted that the system doesn't conform to guidance. It's accepted that such non-compliance has the potential to increase infection. It is said that safety is not a binary issue, and that other control measures can mitigate risk, and that's plainly correct.

The expert evidence before this Inquiry, as Ms Connelly stated, did not identify an increase in infections attributed to the ventilation system. It appears that, in those circumstances, GGC does not accept a direct causal link between the ventilation system and actual harm to patients, though they recognise that increased infection risk. Absence of evidence is not evidence of absence, and GGC accepts in its closing statement that there were failures in monitoring and in maintaining the air systems, including shortcomings in sampling and testing, particularly in the period following handover. They make those concessions at paragraphs 5.14, 6.15, 11.4 and 12.3 in the closing statement.

In that regard, I think it would suffice for me, unless your Lordship wishes me to comment further, to simply adopt what is said in that regard at section 5 and paragraph 6.4 of the closing statement submitted on behalf of the patients and families in December last year.

If I could move on now to chapter 4, which is the issue of Scottish Government oversight. To make matters easier and to short-circuit things a little, I would adopt what Mr Connal said on Tuesday in this regard, and also the recommendations proposed by counsel to the Inquiry at section 10.2 of their closing statement, and that's commencing at page 584. It's my submission that the evidence demonstrates that there was no meaningful scrutiny or oversight by the Scottish Government over the procurement, design and construction phase of the hospital. The lack of any

proper oversight of a construction project of this scale, when the government are paying for the project from public funds, might (inaudible 15:47:41) Scottish Government's responsibility in managing funds.

What Term of Reference 5 requires this Inquiry to do is to examine whether, based on the governance arrangements in place, national oversight and support of such large scale infrastructure projects was adequate and effective, and whether there was effective communication between the organisations involved. The key phrase, in my submission, is "national oversight and support" and whether that was adequate and effective, and that ultimately, as all things are, a matter for your Lordship, but it seems reasonable to submit on the evidence we have heard that there was an absence of effective and adequate national oversight, because if there had been, the catalogue of mistakes and errors that have been conceded may have been identified sooner.

In their closing statement, the Scottish Government appears to me, in any event, to ignore the question of whether there was effective national oversight for this project. Ms Crawford KC made submissions about that yesterday, but it nevertheless seems to patients and families that many of the mistakes and problems that afflicted the project before the hospital opened might have been avoided or at least minimised, if not identified, had there been some level of meaningful oversight by the Scottish Government.

I don't offer, I'm afraid, to your Lordship any particular scheme by which that might occur, and to that extent it is a high-level observation; but to largely rely on a health board to get on with the procurement, design, build and ultimate acceptance of one of the largest healthcare projects in Scotland merits more scrutiny than appears to have been provided.

THE CHAIR: I understand what you say. You're making a high-level submission that further supervision would have required some method of intervention subsequent to approval of the full business case. Am I right?

MR LOVE: Yes.

THE CHAIR: Yes. And you say there should have been something.

MR LOVE: Something, yes. And looking at what is said by the Scottish Government in its closing statement, there's reliance placed on a document called the Blueprint for Good Governance in NHS Scotland, which sets out the ten principles, apparently,

for good governance, that NHS boards are required to follow. The Scottish Government submits that these principles provide a solid foundation for the adequate and effective oversight and support of large scale infrastructure projects.

They may well, but I submit there's no evidence from which this Inquiry might conclude that these principles alone would have been likely to prevent the failures in procurement, design and build stages of the QEUH/RHC project; and, specifically, it fails to address the fact that the Scottish Government left the project – a project funded by a spend of £840 million of public money – largely in the hands of a health board that lacked the technical experience to implement and manage it.

By adopting that approach, the Scottish Government perhaps lost the opportunity for some level of professional oversight, which might ultimately have prevented the mistakes, mismanagement and failures. The reason that I mention the technical expertise element is that that doesn't figure at all in the Blueprint for Good Governance.

THE CHAIR: But a well-governed organisation with no particular expertise, albeit one that may have responsibility for all sorts of things, can always hire that, either in direct employees or in contracted consultants.

MR LOVE: Absolutely, my Lord, and I suppose I could expand upon what I've said to say that the fact that the Health Board itself did not have the personnel with the requisite expertise would not have prevented them from seeking that expertise elsewhere, but it may be that oversight at a national level by the government might have seen that that level of experience was available, if not internally, then certainly contracted in.

THE CHAIR: Would you accept that-- I mean, you accept the point you're not putting forward a scheme, but if there was to be some scheme of national supervision, it's beginning to sound at quite a detailed level, I mean, for example, checking whether or not Currie & Brown are still employed.

MR LOVE: Yes, I accept that, my Lord. I'm not offering up any option, as it is complex, but I make that submission, in any event, on that proposal. That's all I have to say under that heading. Moving on to personal blame and responsibility, we'd open by saying that we agree with GGC in their recent closing statement when they say at paragraph

3.7 that it is critical that people have been held to account and where criticism is due, it is right that it be made robustly. To date, no individual who was responsible for the serious failures and accepted mistakes, both before and after the hospital opened, appears on the evidence that we've heard to have been held to be accountable.

It is my submission that, where appropriate – and that's entirely a matter for your Lordship's discretion – this Inquiry ought to be holding those individuals who were responsible, those who contributed to failures and mistakes, those who were to blame, to account. And I say-- Sorry, my Lord.

THE CHAIR: You use the word "account." I mean, there's a limited amount that a report of an Inquiry can do.

MR LOVE: I fully accept that.

THE CHAIR: I mean, a report can name names and describe behaviours, but that's really all it can do.

MR LOVE: Yes, there's no teeth to do anything beyond that. I suppose it's my loose use of language, for which your Lordship has my apologies. I mean blame. Who is to blame?

I say that because during a public inquiry, it's more likely than not that criticisms are going to be made of individuals and organisations. That's more likely than not with a public inquiry. As a result, what your Lordship as chair can do is to make findings or conclusions based on those criticisms, the criticisms made of individuals. Alternatively, your Lordship as chair might use the findings and conclusions to raise criticisms about individuals.

And obviously, it is accepted that section 2 of the Inquiries Act makes it plain that an inquiry has no role to determine any person's civil or criminal liability, but an inquiry panel is not to be inhibited in the discharge of its functions – this is subsection (2) of section 2 – by any likelihood of liability being inferred from facts that it determines or recommendations that it makes. And as your Lordship will be aware, warning letters ensure that before being named and criticised in a report, individuals and organisations have to be given a fair opportunity to respond to any proposed criticisms.

THE CHAIR: I mean, I asked Mr Gray about-- I think the expression I used was "attribution of responsibility," and I don't think he departed from what was set out at 3.7, but when we turn to the paragraph which might be seen to be pointing in a different

direction – I'm just wondering if I can find my note – because there is a paragraph where he, or rather GGC-- Yes, it's paragraph 7.1:

> "It is submitted that personal or professional criticism should not be made of any of these individuals for how they reacted to the extreme pressure they were under."

So I was trying to explore with Mr Gray how he distinguished these two categories. Now, I may have failed to entirely take on board everything he said, but it appeared to me that he was distinguishing between persons who, I picked up from him, were responsible for the procurement and construction phase, and then those who may have not done terribly well in the situation of crisis which he described, or the-- I can't now remember the phrase but the----

MR LOVE: It was "the extreme pressure that they were under by virtue of the prevailing circumstances" very broadly, I think.

THE CHAIR: Yes. And if I picked up the distinction he was making-- Well, it's one thing to blame people at a sort of planning stage, but if you're dealing with a very untoward situation, it is inappropriate to-- What we're talking about here is "name names." Now, do you have any comment or can you assist? Would you make a distinction, or what would your submission be?

MR LOVE: My submission is that the purpose of a public inquiry is to look at what happened, to explore the facts and to identify what happened with a view to asking the question, "Why did it happen?" and I think inherently or intrinsically involved with that is the question, "Who is to blame?" And, having followed through those two steps, to move on to look at what can be done to prevent this happening again. There are many books and articles and documents produced by the Scottish Parliament's Information Centre, references to Jason Beer KC in relation to the issue of why have public inquiries and why is it important to name names and to name the people who are to be blamed, and in-- I would draw your Lordship's attention-- I've provided, I think, three PDF documents, I think, through the Inquiry team.

There's the briefing by the Scottish Parliament Information Centre dated 13 May 2025, which looks at, among other things, the cost effectiveness of Scottish public inquiries. But at page 2 of that

document, it provides a statement attributed to Jason Beer KC that answers the question, “Why are public inquiries held?” and that’s the basis upon which I make the submission to your Lordship about why public inquiries are held, to find out what happened and who’s at fault. The briefing by SPICe, as it’s headed, refers to the Institute for Government’s 2017 reports, which I think your Lordship should also have, headed “How public inquiries can lead to change.”

THE CHAIR: Yes. I mean, I think we’re on the same page but, for those listening to us, you’re drawing my attention to a document headed “Finance and Public Administration Committee,” and that’s the committee of the Scottish Parliament, dated 13 May 2025 that I take it was an information paper issued prior to the Public Administration Committee’s inquiry to sort of provide people with background information.

MR LOVE: A backdrop, yes.

THE CHAIR: And you’re referring me to what was said by Jason Beer KC, who’s a nationally recognised-- well, he’s the author of the leading textbook and, in turn, you’re referring me to the Institute for Government’s “How public inquiries can lead to change.”

MR LOVE: Yes, I am, my Lord, and they may provide a bit of insight into why public inquiries should name people, and the extent to which inquiries uncover the truth, in my submission, is critical to whether they succeed in restoring public confidence in the institutions involved, and to providing the victims and their families with some sense of having been heard. So, affected parties and the public alike are keen to understand who is at fault, and inquiries can and, in my submission, often do highlight where failings have occurred. Although, as I’ve said, they can’t establish criminal or civil liability, and my submission to your Lordship is that public confidence in bodies such as health boards and the government is often damaged by crises. In my submission, transparent identification of those involved or responsible can help to restore trust by demonstrating that the Inquiry is thorough and hasn’t shielded those who are demonstrated by the evidence to have been at fault.

THE CHAIR: Something that occurs to me, and I’m just asking for comment, is that naming an individual can perhaps be unfair, in the sense that if you name one individual and you don’t name half a dozen others, it

may not be an entirely fair attribution of responsibility. However, if you don't mention people, place, time, it's very difficult actually to communicate the idea that you're putting across. I mean, I listened to what's been said about deficiencies in culture. Culture's not a terribly easy thing to hold on to, and if I were to use the word "culture," I might have to go into some detail in trying to explain what I'm talking about. Whereas, if I described a particular event, it might have a more concrete quality to it. Do you have any comment?

MR LOVE: Yes. I would absolutely accept that, but, for example, the prevailing position with the water system at the hospital-- at the time the Queen Elizabeth opened its doors to patients in 2015, against the backdrop of the water system having been filled for over a year prior to population of the hospital, there was no Water Safety Group. The person responsible for water within the organisation didn't even know he was responsible, and to be able to look at that framework and who was responsible and where ultimately blame lies is, in my submission, of key importance to getting to the root of the issue and determining the issues that the Inquiry requires to look at.

The individual's failure, in the role that they were performing at the time, is instructive, in my submission, to ensuring that the same situation doesn't arise again in the future. In addition to that, it demonstrates to those who have an interest in the Inquiry and those that I represent, the patients and the families, have an interest in the transparent identification of those who were involved in and responsible for the decisions that ended up making mistakes that resulted in patients being put at increased risk of infection, but it's very difficult to see any justification for not naming people in those circumstances, subject to the observations that your Lordship made about fairness. Unless I can assist any further with that heading----

THE CHAIR: No.

MR LOVE: -- I would propose to move on to my final and, I suspect, least appealing paragraph about keeping the Inquiry open. I would simply adopt what's said at section 12 of our closing statement, lodged in December last year, and I don't intend to take your Lordship to it. I would also refer your Lordship to section 14(1), paragraph A of the Inquiries Act 2005, and it provides that, for the purposes of this Act, an inquiry comes

to an end on the date after the delivery of the report to the inquiry, on which the chairman notifies the minister that the inquiry has fulfilled its terms of reference. An inquiry, accordingly, does not end with the delivery of the report but rather with the chair's notification to the minister. So what's the issue that I'm seeking to raise here?

THE CHAIR: Well, just thinking about the mechanical point, if the minister receives what, on the face of it, is a final report with a caveat or an absence of information from the chair, I suspect a question would then go to the chair as to, "Where exactly are we?"

MR LOVE: And "Where are we?" is the issue, and this submission is presented following discussions that I've had with colleagues who've been involved in other public inquiries, where a level of frustration has been experienced after the chair's report has been issued, where there have been criticisms made and where recommendations have been made that where those who've been criticised and those who would have to act, in light of the recommendations, have simply stated that they disagree with the findings, with the criticisms and the recommendations, and so what I'd say to your Lordship is that that comes back to what the purpose of a public inquiry is, and I won't go back to that.

On Tuesday, what Mr Connal said in his submission-- I went back on a couple of occasions and noted it in detail:

> "Given everything that has happened since, NHS Assure [NSS Assure, it should be] onwards, we hope that it should be possible to convince even the most doubtful reader that there are mechanisms in place and being operated to ensure that any recommendations that may be made will be carried through."

I'm not entirely clear what is meant by that. I suspect that much will depend, obviously, on the nature and extent of any criticism and recommendations that your Lordship may make, who they're directed at, and whether it's within NSS Assure's gift to assist in those circumstances but, again, that's a matter for your Lordship's discretion. The concern would be that if your Lordship does make criticisms and makes recommendations, what is the scope for calling the party who's the subject of the criticism, and recommendation

back to explain why it is that they do not accept or disagree with either, and I'm not suggesting that all core participants should be reconvened to come back to deal with matters, but if your Lordship is to make criticisms and recommendations, it has to have teeth.

THE CHAIR: Well, I will consider that. I am aware of discussion, in various forms, about what is seen as the difficulty when an inquiry makes recommendations and then it may be the case that nothing much happens or----

MR LOVE: Or the criticisms and recommendations are simply rejected.

THE CHAIR: Or rejected. Well, we've heard the word "humility." An inquiry process, and the power which is given to the chair of an inquiry, is circumscribed by the act, and in broad terms-- I appreciate this is in very broad terms. An inquiry in the person of-- the Act uses the word "panel," but one might substitute the word "chair," is to find facts, listen to as many competing views as are relevant, try to resolve disputes, and then present what's essentially a finding of fact.

Now, it's for politicians or the relevant minister to decide what to do with that, and these may very well come to be political questions, which certainly are clearly beyond the competence of the chair of an inquiry. I mean, to put it in familiar terms, I'm not sure that an inquiry chair's function, as defined by the Inquiries Act 2005, is that of a policeman. It's more than a----

MR LOVE: No, I can absolutely accept that, my Lord.

THE CHAIR: It's more of an observer.

MR LOVE: Yes, I do accept that.

THE CHAIR: Yes. Anything else?

MR LOVE: No. Nothing at all other than to, in closing, extend my personal thanks, and those of the core participants that I represent, to counsel to the Inquiry and their team for their work in this Inquiry, to express sincere appreciation for their diligence, fairness and commitment to uncovering the truth, acknowledging the complexity of the issues that this Inquiry has raised and their role in guiding the process, ensuring a voice for those I represent and driving future improvements, and also to thank your Lordship for the care that has been demonstrated throughout the whole conduct of this Inquiry.

(<u>Session ends</u>)

16:18